Jan Marie Fritz

Editor

International Clinical Sociology

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CLINICAL SOCIOLOGY: Research and Practice

Series Editor: **John G. Bruhn**, *New Mexico State University, Las Cruces, New Mexico*

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Springer

Jan Marie Fritz
College of Design, Architecture, Art & Planning (DAAP)
School of Planning
University of Cincinnati
Cincinnati, OH 45221-0016
USA
jan.fritz@uc.edu

Printed on acid-free paper.

9 8 7 6 5 4 3 2 1

springer.com

Foreword

Sociology always has had various paradigms, and this has meant tensions and, frequently, intellectual and, sometimes, political conflicts. One constant conflict always has opposed the perspective of the actor, and the perspective of the system, even if important sociologists, those who gained the more sustainable intellectual influence, have generally tried to articulate or combine these two points of view. Sometimes the same social thinkers or scientists have known, in their intellectual life, moments when the first one dominated their work, and moments when it was the second one. In the 1960s, for instance, the French Marxist philosopher Louis Althusser proposed that Karl Marx be seen as two different people: the young one was subjectivist and interested much more in the perspective of action, while the old one was science oriented and developed the analysis of capitalism as a system of domination.

We are, at the present time, in an era when the notions of actor, subjectivity, and subject have much more room in the social sciences than thirty or forty years ago, and this intellectual and general conjuncture plays in favor of clinical sociology, which is frequently on the side of the actor or the subject. This was not the case when structuralism was stronger, and, in some extreme cases at least, was not embarrassed in declaring the "death of the subject" and would only deal with instances, structures, apparatus, mechanisms, and contradictions.

Clinical sociology is now an important field or specialization in sociology. One of its strengths is its interest in individuals as human beings, their everyday lives, their histories and trajectories, their knowledge, and their hopes and fears as well as their capacity to build an understanding of their situation and to change it. Another strength is that clinical sociology entails intervention by researchers, who do not remain in their ivory tower. Under the influence of psychologists or social psychologists, starting with Kurt Lewin, and with a deep interest in psychoanalysis, most of the clinical sociologists develop practical interventions where they contribute to improving the capacity of persons or groups to develop a critical understanding of their own situations and problems, and then to change their situations and possibly reduce or solve their problems.

Let us say it differently: Clinical sociology proposes a close relationship between theory or analysis and action. This means that sociologists are not neutral characters; rather, they are part of the situation that they are studying, and part of the process of change that their intervention will induce. Such a perspective should lead to very important debates that are not often heard or sufficiently developed. For instance, for clinical sociology, the proof—the demonstration or the tests of an analysis—is not, or not only, in the scientific rigor or the procedure, or in the judgment of peers connected with some academic journals. It is in the very process of transformation that the analysis contributes to creation or activation. This means that research can be scientific and directly connected with social needs and demands and also that it can be developed by academics, with a real involvement of the people who are studied and their active and conscious participation in the analysis. This is why clinical sociologists, such as the contributors to this very interesting book, are so successful not only among social scientists, but among social workers, teachers, psychologists, consultants, and others involved in concrete social activities dealing with real individuals.

As the president of the International Sociological Association, my duty is to encourage all schools of sociological thought in their own development and in their capacity to debate. But as a researcher, I always have felt closer to clinical sociology than to many other ways of doing sociology. Like clinical sociologists, I consider the relationship between researchers and their "object" is a central issue, and that the test of any sociological research is related to its capacity to modify the level of understanding of people.

I welcome this new book on the history and state of the art of clinical sociology. Its international and comparative perspective make it a particularly useful volume.

Michel Wieviorka
Professor and Directeur d'études à Ecole des hautes
études en sciences sociales (EHESS) and
Directeur du Centre d'Analyse et d'Intervention
Sociologique, CADIS (Paris)

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Introduction

Jan Marie Fritz

International Clinical Sociology presents the art and science of clinical sociologists around the world. This is not the first volume to look at the global development of the specialization. It is, however, the first to present basic clinical sociology diagrams and models as well as detailed histories of clinical sociology in a number of locales and a wide range of interventions discussed in light of a region or country's economic, social, political, or disciplinary history.

Defining Clinical Sociology

Clinical sociology is a creative, humanistic, and multidisciplinary specialization that seeks to improve life situations for individuals and collectivities. Clinical sociologists work with client systems to assess situations and avoid, reduce, or eliminate problems through a combination of analysis and intervention. *Clinical analysis* is the critical assessment of beliefs, policies, or practices, with an interest in improving the situation. *Intervention* is based on continuing analysis; it is the creation of new systems as well as the change of existing systems and can include a focus on prevention or promotion (e.g., preventing environmental racism or promoting community sustainability).

Clinical sociologists have different areas of expertise, such as health promotion, organizational development, social conflict, or cultural competence, and they work in many capacities. They are, for instance, university professors (full-time or part-time) who are consultants or advisers, community organizers, sociotherapists, mediators, focus group facilitators, social policy implementers, action researchers, managers, and organizational analysts. The clinical sociologists who have an organizational focus may be interested in helping organizations in the public sector (government and nonprofit organizations) or for-profit enterprises that are publicly or privately owned.

Clinical sociologists usually have training in more than one discipline and a great deal of experience in working with intervention teams whose members have a variety of backgrounds. Because of this, clinical sociologists use a range of theoretical approaches (e.g., grounded, standpoint, multicultural-liberationist,

psychoanalytic, systems, land ethic, conflict, social constructionism, symbolic interaction, critical, and/or social exchange) and frequently integrate them in their work. If clinical sociologists conduct research or collaborate with researchers, they also have exposure to or use a range of research methods.

Clinical Sociology in Its Global Context

Clinical sociology is as old as the field of sociology, and its roots are found in many parts of the world. For instance, the clinical sociology specialization often is traced back to the fourteenth-century work of the Arab scholar and statesperson Abd-al-Rahman ibn Khaldun (1332–1406). Ibn Khaldun provided numerous clinical observations based on his varied work experiences such as secretary of state to the rule of Morocco and chief judge of Egypt.

Auguste Comte (1798–1857), Emile Durkheim (1858–1917), and Karl Marx (1818–1883) are among those who frequently are mentioned as precursors to the field. Comte, the French scholar who coined the term *sociology*, believed that the scientific study of societies would provide the basis for social action. Emile Durkheim's work on the relation between levels of influence (e.g., social in relation to individual factors) led Alvin Gouldner (1965) to write that "more than any other classical sociologist (Durkheim) used a clinical model." Karl Marx, as Alfred McClung Lee noted in 1979, brought to his written work "the grasp of human affairs only possible through extensive involvement in praxis…, social action, …agitation, and… social organization."

Clinical sociology has developed in a number of countries including the United States, France, Canada, and Italy. If one focuses on the use of the words *clinical sociology*, the specialization has its longest history in the United States and has resulted in many English-language publications directly linked to the specialization. The American clinical sociologists emphasize intervention, designed a certification process, and have a commission that can accredit clinical as well as applied sociology programs. French is the language of many of the current international clinical sociology conferences, and many publications clearly linked to clinical sociology have appeared in Quebec, Canada, and France. The French clinical sociologists emphasize clinical analysis and frequently focus on the relationship between psychology and sociology. They have a solid international network and have done an excellent job of attracting psychologists and professionals in other fields to their network. During the last fifteen years, Italians have hosted clinical sociology conferences and workshops, published clinical sociology books and articles, offered a graduate program in clinical sociology, and established associations of clinical sociologists.

Clinical sociology also is found in other parts of the world. Of particular interest would be developments in Greece, Brazil, Mexico, Japan, Malaysia, and South Africa. In South Africa, for example, one university's sociology department put a sociological clinic in place and another sociology department developed a graduate

specialization in counseling. Mexico, Brazil, France, Canada, Italy and Greece are among those countries that have hosted international clinical sociology conferences.

The international development of clinical sociology is supported primarily by two organizations. The clinical sociology division of the International Sociological Association (ISA) was organized in 1982 at the ISA world congress in Mexico City. The other major influence is the clinical sociology section of the Association Internationale des Sociologues de la Langue Francaise (International Association of French Language Sociologists).

It is clear that a global clinical sociology has emerged. While there is a common core, there are differences. In some countries there is more of an interest in analysis and providing advice rather than in undertaking intervention. There are practitioners working at all levels of intervention (e.g., individual through global), but some areas of intervention (e.g., health or organizations) may be more of a focus in one country rather than in another. In some countries, individuals and their approaches are clearly labeled as clinical sociology, while in other countries the label is not used very frequently. Finally, it should be mentioned that while scholar-practitioners in the United States, Quebec and France have had important roles in the development of clinical sociology, there are now a number of other national influences that will help shape the future of this global specialization.

The Organization of This Volume

Chapters 1 and 2 are both introductory chapters with Chapter 2 outlining some of the basic concepts, diagrams and models in the field. Chapter 2 also includes details about rights-based intervention and the influences on actions of individuals and collectivities.

The introductory chapters are followed by the two main parts of the volume. *Part I, Selected Regional Histories*, discusses the history of clinical sociology in four areas. The chapters in this part of the book are presented in order of the continuing use of the term clinical sociology. In Chapter 3, I discuss the history of clinical sociology in the United States, where the term clinical sociology was first used in the late 1920s and early 1930s by a physician, and the sociologists Louis Wirth and Ernest Burgess. In Chapter 4, Jacques Rheaume discusses the history of clinical sociology in Quebec. The term clinical sociology first appeared in Quebec in the 1950s in the work of sociologist Fernand Dumont and those affiliated with Laval University. In Chapter 5, Vincent de Gaulejac discusses the history of clinical sociology in France, where the term clinical sociology was first used in 1963 by Jacques Van Bockstaele, Maria Van Bockstaele, and two of their colleagues. Chapter 5 traces the continuous development of clinical sociology beginning with the 1980s and connects this development to the work of Emile Durkeim, Marcel Mauss, and Georges Gurvitch. In Chapter 6, Yuji Noguchi discusses the history of clinical sociology in Japan. The term clinical sociology was introduced in a continuing way in 1993, although earlier references to clinical sociology were made in 1954 and 1985.

The second part of the book, *Clinical Sociology Applications*, provides examples of interventions and analyses by clinical sociologists from eight countries. Chapter 7 is placed first because it covers important concepts—multilevel system intervention, cultural competency, empowerment, theoretical analysis, and redefinition of the situation—that are basic not only for clinical sociologists who work as mediators, but also for the specialization in general.

The next three chapters deal with issues of individual health and illness. In Chapter 8, Sarah Brabant examines three problems with the psychological model of bereavement and the shift to a sociological perspective. She follows this discussion with illustrations from her clinical practice in Louisiana working with bereaved individuals and as a consultant to Healing House. In Chapter 9, Anastasia-Valentine Rigas and Andriani Papadaki discuss drug problems in Greece and note that "sociology seems vital in clinical work with individuals whose psychological problems are linked to social factors." In Chapter 10, Robert Sévigny explores "the patient's personal experience of schizophrenia in the context of a changing Chinese society" and discusses some important aspects of clinical sociology including his idea of an "implicit sociology."

Chapters 11 to 14 cover a variety of interventions. In Chapter 11, Giuseppe Gargano contributes to the definition of clinical sociology and then discusses the "Casa di Giona" (House of Giona), a therapeutic house for adults that is a project of the Italian Association of Clinical Sociology. Chapter 12 is written by Jacques Van Bockstaele, Maria Van Bockstaele, Jacques Malbos, Martine Godard-Plasman, and Nathalie Van Bockstaele-Theilhaber. The Van Bockstaeles have developed, over the last thirty years, a technical instrument—socioanalysis—that they use in their work with organizations in France. In Chapter 13, Janet Mancini Billson covers many aspects of focus groups and details her work with international clients such as the World Bank Group, the United Nations, and the European Commission. In Chapter 14, A. Halim Wan and P. Melati Wan discuss the training of grassroots leaders in multiethnic Malaysian communities. The authors identify different kinds of intervention (promotion, prevention, conflict resolution, rehabilitation), provide a great deal of information about ethnic relations in Malaysia, and outline what they have identified as the 20 tasks that must be undertaken by anyone mediating a community's intergroup disputes.

Chapters 15 to 17 focus on national and global issues. In Chapter 15, Elvia Taracena discusses, from a clinical sociological point of view, the survival culture of street children. She and her colleagues have been concerned with the topic of street children for fifteen years and discuss here the "proliferation of belts of misery." In Chapter 16, Selene Herculano and Tania Pacheco provide an excellent socioenvironmental introduction to Brazil, outline the struggle against environmental racism in the country, and emphasize "the need to work towards a just and democratic planet." In Chapter 17, Walda Katz-Fishman and Jerome Scott discuss the development and activities of Project South, a leadership institute that is based in the southern United States and dedicated to the elimination of poverty and genocide.

A list of the 22 contributors is provided at the end of the volume. Each author's current affiliations, accomplishments and contact information is provided.

References

Gouldner, A. (1965). Explorations in applied social science. Social Problems 3, 169–181. Reprinted in A. Gouldner & S. M. Miller (eds.), Applied Sociology (pp. 5–22). New York: Free Press.
Lee, A. M. (1979). The Services of Clinical Sociology. American Behavioral Scientist. 22/4, 487–511.

Selected Readings in International Clinical Sociology

The following list of basic readings in the area of clinical sociology was developed with two objectives in mind: (1) include publications that are basic in the different countries, and (2) include publications that mention clinical sociology in the title. Readings that are less well known, do not mention clinical sociology in the title, or cover specialized areas of application are not included in this short list.

Alinsky, S. (1934). A sociological technique in clinical criminology. Proceedings of the Sixty-Fourth Annual Congress of the American Prison Association, (pp. 167–178). New York: American Prison Association.
Bruhn, J. G., and Rebach, H. M. (1996). Clinical Sociology: An Agenda for Action. New York: Springer.
Clark, E. J., Fritz, J. M., and Rieker, P. P. (1990). Clinical Sociological Perspectives on Illness and Loss: The Linkage of Theory and Practice. Philadelphia: Charles Press.
Clinical Sociology Review and Sociological Practice. CD-ROM. Available from Dragonfly Press, Grand Ledge, Michigan.
Enriquez, E. (1992). Remarques terminales vers une sociologie clinique d'inspiration psychana-lytique [Final Remarks Toward a Clinical Sociology with Psychoanalytic Inspiration]. L'organisation en analyse. Fevrier. Paris: P.U.F.
Enriquez, E. (1997). L'approche clinique: genèse et développement en France et en Europe de l'Ouest [The clinical approach: genesis and development in Western Europe]. International Sociology, 12, 151–164.
Enriquez, E., Houle, G., Rhéaume, J., and Sévigny, R. (1993). L'analyse clinique dans les sciences humaines [Clinical Analysis in Human Sciences]. Montreal: Éditions Saint-Martin.
Fritz, J. M. (1985). The Clinical Sociology Handbook. New York: Garland.
Fritz, J. M. (1991). The emergence of American clinical sociology. In: H. Rebach and J. Bruhn (eds.), Handbook of Clinical Sociology (pp. 17–32). New York: Plenum.
Fritz, J. M. (2005). The scholar-practitioners: the development of clinical sociology in the U.S. In: A. J. Blasi (ed.), Diverse Histories of American Sociology (pp. 40–56). Leiden and Boston: Brill.
Fritz, J. M. (ed.). (2006). The Clinical Sociology Resource Book (6th ed.). Washington, DC: American Sociological Association Teaching Resources Center and the Clinical Sociology Division (RC46) of the International Sociological Association.
Gaulejac, V. de, and Roy S. (eds.). (1993). Sociologie clinique [Clinical Sociology]. Paris: Desclée de Brouwer.
Giorgino, E. (1998). Per un ridefinizione del lavoro professionale in sociologia [For a Redefinition of Professional Work in Sociology]. Sociologia e Professione, 29, 8–23.

Glassner, B., and Freedman, J.A. (1979). Clinical Sociology. New York: Longman.

Lee, A. M. (1944). Sociology, clinical. In: H. P. Fairchild (ed.), Dictionary of Sociology (p. 303). New York: Philosophical Library.

Lehnerer, M. (2003). Careers in Clinical Sociology. Washington, DC: American Sociological Association.

Luison, L. (ed.). (1998). Introduzione alla Sociologia Clinica: Teorie, Metodi e Tecniche di Intervento [Introduction to Clinical Sociology—Theory, Methods and Intervention Techniques]. Milano: FrancoAngeli.

Noguchi, Y., and Ohmura, E. (eds.). (2001). Rinshou-Shakaigaku no Jissen [The Practice and Experience of Clinical Sociology]. Tokyo: Yuhikaku Publishing. (In Japanese.)

Ohmura, E. (ed.). (2000). Rinshou-Shakaigaku wo Manabu Hito no Tameni [For the People Studying Clinical Sociology]. Kyoto: Sekaishisousha. (In Japanese.)

Ohmura, E., and Noguchi, Y. (eds.). (2000). Rinshou-Shakaigaku no Susume [Introduction to Clinical Sociology]. Tokyo: Yuhikaku Publishing. (In Japanese.)

Rebach, H. M., and Bruhn, J. G. (1991). Handbook of Clinical Sociology. New York: Plenum.

Rheaume, J. (1997). The project of clinical sociology in Quebec. International Sociology, 12, 165–174.

Sévigny, R. (1996). The clinical approach in the social sciences. International Sociology, 12, 135–150.

Sévigny, R., Rheaume, J., Houle, G., and Enriquez, E. (1993). L'Analyse Clinique dans les Sciences Humaines [Clinical Analysis in the Human Sciences]. Montreal: Editions Saint-Martin.

Sévigny, R., Weng Y., Yang, Z., Loignon, C. and Wang, J. (in press). Jingshenbingxue kangfu: youguan lingchuang shehuixue de tansuo [Psychiatric rehabilitation: a clinical sociology approach]. In: W. Yongzen, R. P. Liberman, and X. Yingqing (eds.), Jingshenfenliezhen Kangfu Caozuo Shouce [A Handbook of Rehabilitation for Patients With Schizophrenia]. Beijing: People's Medical Publishing House.

Straus, R. A. (1999). Using Sociology: An Introduction from the Applied and Clinical Perspectives (3rd ed.). New York: Rowman and Littlefield.

Tosi, M., and Battisti, F. (eds.). (1995). Sociologia Clinica e Sistemi Socio-Sanitari: Dalle Premesse Epistemologiche allo Studio di Casi e Interventi [Clinical Sociology and Public Health Systems]. Milano: FrancoAngeli.

Van Bockstaele, J., and Van Bockstaele, M. (2004). La Socianalyse: Imaginer-Coopter [Socioanalysis: Imagining and Co-opting]. Paris: Edition Economica/Anthropos.

Van Bockstaele, J., Van Bockstaele, M., Barrot, C., and Magny, C. (1963). Travaux de Sociologie Clinique [Clinical Sociology Work]. L'Année Sociologique. Paris: Presses Universitaires de France.

Wan, A. H. (2004). The Crowning of Sociology: The Genesis of Clinical Sociology. Unpublished manuscript.

Wirth, L. (1931). Clinical sociology. American Journal of Sociology, 37, 49–66.

2
The Basics: From Concepts to Models

Jan Marie Fritz

Clinical sociology is a humanistic and creative specialization that seeks to improve the quality of people's lives. Clinical sociologists bring contributions from two or more disciplines (frequently sociology and psychology) to their work and incorporate knowledge and experiences from the areas of practice (e.g., health, criminal processing system, community development, organizational analysis, human rights) in assisting with or undertaking an intervention process.

This chapter presents some of the basics of the analysis and intervention that is clinical sociology—the concepts, ideas about intervention, theory, diagrams, and models. Concepts (important terms), diagrams (simple visual representations), and models (explanations or visualizations of how practitioners should function) help us define our field and can serve as a baseline for discussions regarding intervention.

The concepts, diagrams, and models discussed here were influenced by those found in the literature and some were developed, in part, based on the work of the contributors to this volume. These basics provide a useful starting point for readers interested in intervention by/for/with the dreamers, plodders, survivors, and activists who live among us.

Rights-Based Intervention and Other Basic Concepts

The authors contributing to this volume have mentioned or discussed many concepts that are basic to sociology and clinical sociology. The concepts used particularly by clinical sociologists include humanism, cultural competence, client system, social identity, explicit sociology, disenfranchised grief, multilevel intervention, sustainability, well-being, social justice, redefinition of the situation, and empowerment. Especially important to clinical sociology, but not defined in sufficient detail elsewhere in this volume, are the concepts of rights-based intervention, creativity, and socioeconomic development.

Rights-based intervention refers to the creation of new systems as well as the change of existing systems (including a focus on prevention or promotion) while taking into account everyone's human rights. A rights-based approach means that

an intervention will "promote and maintain a minimum standard of well-being to which all people… would ideally possess a right" (Johnson and Forsyth, 2002). Interventions should "protect and promote," or at least not undermine, "the interests of [those who are] poor and vulnerable" (Johnson and Forsyth, 2002). As Alfred McClung Lee noted in 1979, a clinical sociologist could not work for just any client, as the specialization has to serve humane goals.

Creativity, a process that is essential to innovation, attempts to generate new concepts, ideas, objects, or associations. Vraneski (2006) stated that the "ability to take existing objects, concepts or ideas and combine them in different ways for new purposes is shared by all human beings." Even if all people have the capacity to be creative, fostering creativity is particularly important in an intervention process. You have to examine situations to see which foster or hinder creativity or imaginative thinking.

As Neil Smelser (1962) reminded us when he discussed conditions necessary for episodes of collective behavior, the first condition is *structural conduciveness*. Smelser noted that the organization of the community—including a good communication network and open administration—set the stage for forms of collective activity. Creativity, according to Debra Gerardi (2001), requires openness, listening, risk-taking, trust, and collaboration. Therefore situations or structures that allow or encourage these characteristics should promote creative analysis and intervention.

Socioeconomic development is a planned and comprehensive economic, social, cultural and political process in a defined geographic area. It is a rights-based and ecologically-oriented process that aims to continually improve the well-being of the entire population and all of its individuals (Fritz, 2004). Economic development is the process of raising the level of prosperity through increased production, distribution, and consumption of goods and services. Social development, on the other hand, refers to the complexity of human dynamics (the interplay of social structures, processes, and relationships) and focuses on (1) the concerns of the people as objects of development and (2) people-centered, participatory approaches to development. Individuals would be actively involved in open, meaningful participation in development and in the fair distribution of benefits. This comprehensive definition of socioeconomic development[1] has three components: social development, economic development, and environmental protection.

There has been a growing recognition that economic development is a source of dynamic changes and generates wealth, but it does not, by itself, create prosperity

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[1] According to James Midgley (1994), it is not a new idea to link social interventions and economic activities. In the late 1800s, for example, the volunteer workers of the Charity Organization Society in England helped impoverished individuals find employment and start small businesses. In 1954, the British authorities adopted the term *social development* to link social welfare and community development to the economic development efforts in their colonies. The development processes, however, were not smooth or effective for a number of reasons. For instance, postcolonial development efforts often were centralized, top-down approaches, and development strategies in the Global South frequently focused only on economic growth for the benefit of national elites and transnational corporations.

for all. Intervention is required for socioeconomic change. Three points about inter-vention are specific to socioeconomic development intervention:

1. Harmony between social and economic interventions: Social interventions should contribute in a positive way to the economy, and economic interventions should improve the quality of people's lives. A review of this situation is particu-larly important when one or more parts of a client system assume that economic changes will inevitably lead to social progress.
2. Protection of vulnerable populations: These populations could include refugees, immigrants, victims of war, racial/religious/ethnic minorities, children, the elderly, and women. Women, for instance, have been gaining formal rights, but this progress has not been matched by improvement in their quality of life. Hidden barriers and ceilings to women's participation are still in place, and the shift to more responsibilities for families and communities has been an increasing burden for women.
3. Appropriate level of intervention: Many countries have had, at some point, national social planning agencies, but the planning approach has been weakened or abandoned over the years. This occurred because of factors such as indebted-ness, lack of resources, or political pressure from politically conservative groups, which thought that planning should not be done at a national level, as well as from advocates of community-based planning, who thought that national agencies often had an inappropriate, top-down style of planning. Effective development requires a participatory approach to planning; because intervention levels are intercon-nected, most if not all of the levels are involved to some extent.

Intervention and Interventionists

The role of the clinical sociologist can involve one or more levels of focus from the individual to the global. Even though the clinical sociologist specializes in one or two levels of intervention (e.g., marriage counseling, community consulting), the practitioner will move among a number of levels (e.g., individual, organization, community) in order to analyze or intervene.

The intervention levels (from individual through global) are represented in Figure 2.1 by circles to indicate that no level is assumed to be more important than another. The lines among the levels help show that clinical sociologists focus on one level (which could be shaded for emphasis) but also have an additional focus or at least a back-ground in one or more other levels and integrate that knowledge in their work. The global level refers to work done on a worldwide basis as well as to a time when other worlds may converse with us (and we with them).

The basic intervention process with a client system (the individual or group that uses the assistance of a clinical sociologist or intervention team), as outlined by Ronald Lippett and his colleagues (1958), is divided into seven stages: (1) The client system discovers the need for help, sometimes with assistance from the change
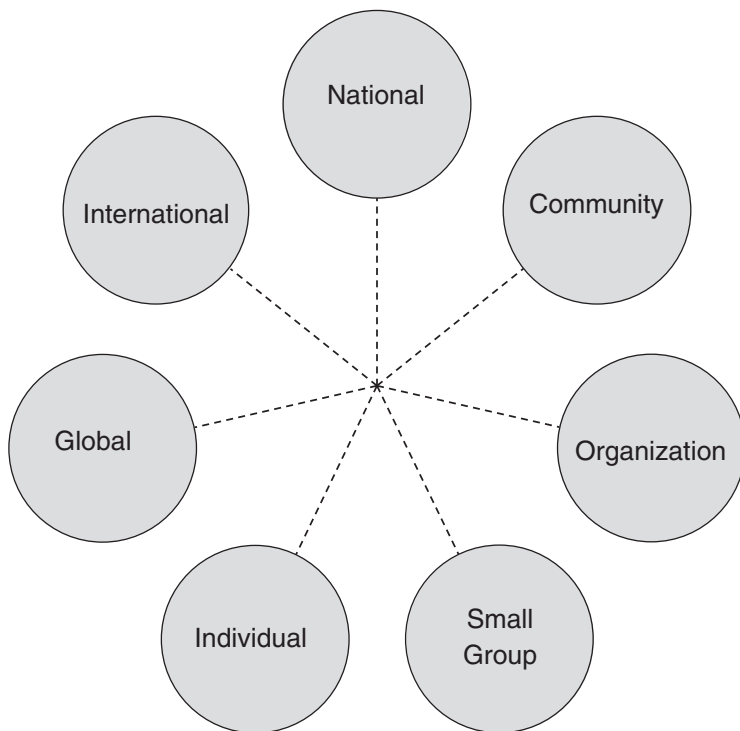
Figure 2.1 The levels of intervention

agent. (2) The helping relationship is established and defined. (3) The change problem is identified and clarified. (4) Alternative possibilities for change are examined and the goals of the change are established. (5) Change efforts are attempted. (6) Change is generalized and stabilized. (7) The helping relationship ends or a different type of continuing relationship is defined.

Two general points can be made about these stages. First, it is possible not only to progress through the stages but also to cycle back through them as necessary. Figure 2.2 shows that progress toward a goal should not be depicted by a straight line.[2] One might expect that if the project generally stays on track, more of the cycling back will be at the beginning of the process. If there are unusual problems (e.g., change of leadership, change of direction of the organization, plateau in terms of effort), the trajectory and cycling back might be represented in a different way. The second point is that the length of time required for each stage will depend on a number of factors, including the kind of change under consideration.

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[2] This same idea is captured in a slightly different way by David Sternberg (1981) in his discussion of doctoral students' progress on their dissertations and W. Warner Burke's (2002) discussion of the "nonlinear nature of organization change."
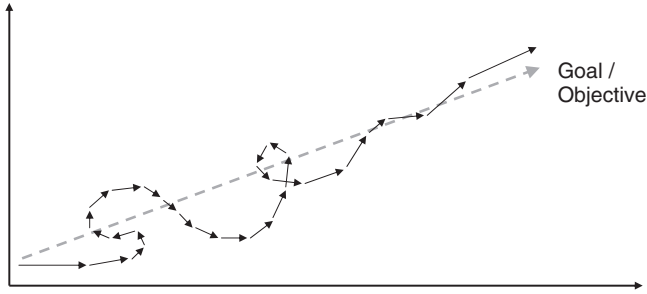
Figure 2.2 Progress toward the goal or objective
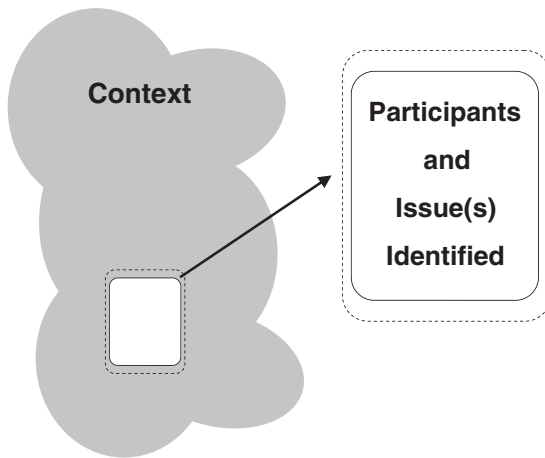
Figure 2.3 Identification of the issue or problem

Lippett's stage three, in which the helping relationship is established and defined, is interesting for two reasons. First, it is at this point that the issue or change problem (and eventually the participants) are fully identified. Figure 2.3 shows that the issue or problem is identified and separated from its context.[3]

The issue (the focus) may be changed somewhat after more information is collected, but it is essential for the intervention process to initially establish the issue or issues by this point. Second, initial assessments of the situation may be conducted during the third stage.[4]

Clinical sociologists differ in their consultation models (e.g., control or influence, extent of citizen participation). The ends of the line in Figure 2.4

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[3] This figure is based, in part, on Eva Soeka's (2004) presentation on the development of a dispute.

[4] Research efforts (which could include initial assessments) are discussed later in this chapter.

| Collaborative | Facilitative | Directive |
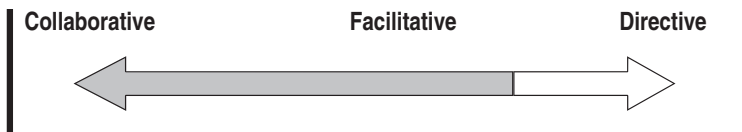
Figure 2.4 Influence of the intervenor

indicate that a consultant's approach might be directive (telling clients what to do) or collaborative (part of a client group and, like other members of the group, offering one's skills to help the group make a decision). The shading on the main line indicates that most clinical sociologists operate in a facilitative or collaborative way.

The characteristics of the client system are particularly important during a period of change. The largest share of work in any change initiative generally must be undertaken by the client system. Therefore, the extent and quality of the change will depend, in large part, on the energy, capability (including available resources), and motivation of the client system.

It is useful to outline the principles, attitudes, and tools needed by clinical sociologists in conducting interventions. While these may differ somewhat depending on the level of intervention (e.g., individual, community, nation), they include: having an ethical framework, practicing inclusiveness, working with the people's interests and opportunities, encouraging recognition of other viewpoints, demonstrating interdependence as a factor in the change process, encouraging capacity building, having relevant knowledge and knowing how to access more of it, and having a long-term perspective. Change agents need to be open-minded, courageous, and able to work well with others.

James Laue and Gerald Cormick discussed the approach of intervenors in their 1978 article, "The Ethics of Intervention in Community Disputes." Based on their discussion and diagram, Figure 2.5 visualizes the relationship between an intervenor's basic assumptions, values, ethical principles, decision-making and actions. For Laue and Cormick, the basic values were freedom, justice, and empowerment. It certainly is worth discussing if the assumptions, values, and principles will be the same for different intervenors and in different circumstances, particularly when the outside influences (e.g., funders, participants, intervenor's employer) may have different assumptions, values, and principles.

The context in which change takes place is very important. The change agent and the client system need to identify and review the internal and external forces that foster or resist change at the onset as well as throughout the process. This is a particularly creative part of the change agent's work, whether the interventionist is collaborative, facilitative, or directive, and is basic in the selection of intervention tools and techniques for effective, sustainable change.
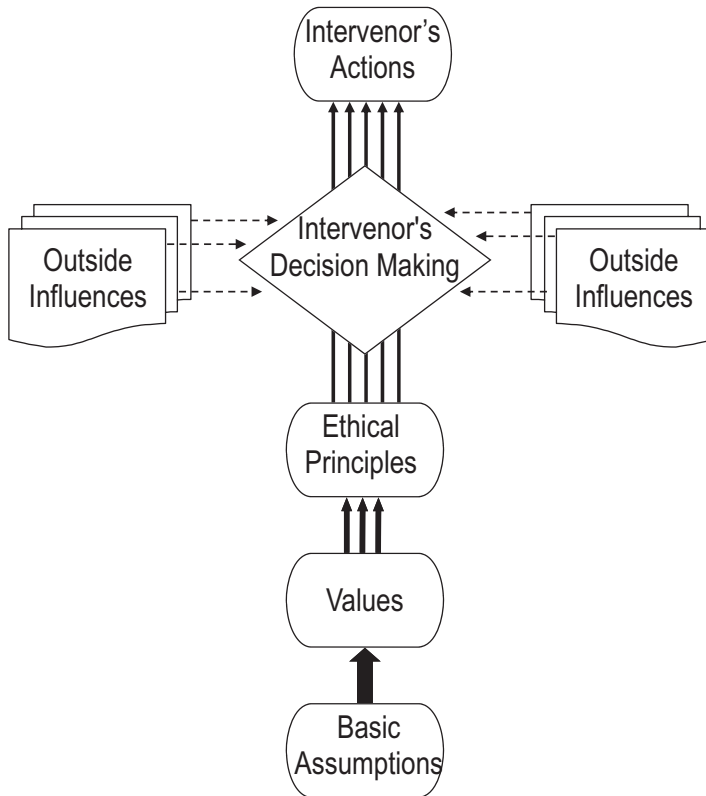
Figure 2.5 The intervenor's decision-making process. (Adapted from Laue and Cormick, 1978)

Research and Intervention

Clinical sociologists who conduct research may do so before beginning an intervention project, to assess the existing state of affairs; during an intervention, to follow the process or possibly change directions; or after the completion of the intervention, to evaluate the outcome. Figure 2.6 illustrates the role of research if undertaken by an interventionist or intervention team. For some clinical sociologists, the research activity is an important part of their own clinical work and they look for opportunities to conduct research.[5] Other clinical sociologists may be interested only in research in a very limited way and only as it is useful (e.g., for assessment) for a specific project. They may prefer to concentrate on the interventions and leave any research to other team members.

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[5] Epistemology, theory, and research methods are linked. The kind of research methods used and the ways in which they are used generally reflect the epistemology and theories held by the clinical sociologist or those responsible for the intervention.
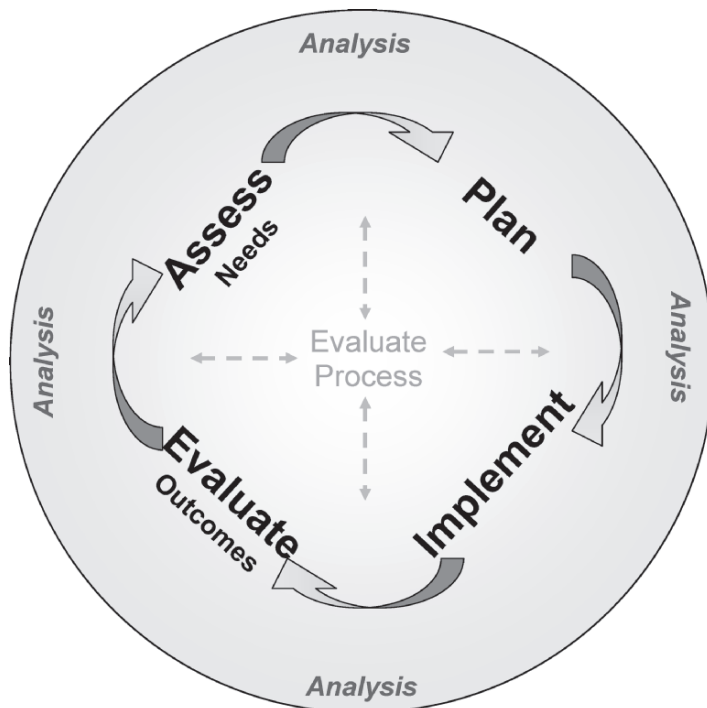
Figure 2.6   The role of research in the intervention process

Theory, Diagrams, and Models

Theory is generally defined as a hypothetical explanation for one or more observations or a possible answer to a question (Derksen and Gartrell, 2000). The concept of *scientific theory* has been referred to as a "hypothetical explanation that states the possible relationships among scientific concepts" (Derksen and Gartrell, 2000) or as "a set of interrelated constructs (concepts with high levels of abstraction), definitions, and propositions that present a systematic view of phenomena by specifying relations among variables, with the purpose of explaining and predicting the phenomena" (Kerlinger, 1973). Theory, then, is defined in different ways. It can be used to examine issues of all sizes, but also can be seen as a worldview—one's lens on the world.

Theory gives a scientist or a practitioner a focus, defining what is interesting and relevant. In doing so, it excludes elements that are not seen as central. Theory allows us to understand and advance our understanding, but the cost of moving forward may be that certain considerations are diminished or left out completely.

It might be useful here to mention a few points about theory in relation to clinical sociology. First, in any discipline or area of practice, there might be only one or primarily one theoretical approach (or paradigm) and it may be implicitly or explic-

itly held. Clinical sociology can be characterized as a specialization that has many theories and paradigms that compete for our attention. Second, models or frameworks (which concretely explain how something works) are often used in a discipline or area of practice. These models or frameworks may be explicitly connected to certain theoretical approaches, but also may be presented as if they almost were without theoretical connections. As will be seen in this book, many clinical sociologists are very interested in identifying and discussing the theoretical underpinnings of their work. Third, theories have different levels (e.g., micro, meso, and macro) of explanation. In disciplines that cover one or more levels, there is a need to integrate the theoretical approaches that might be used at the different levels. Clinical sociologists, because of their varied applications and interdisciplinary backgrounds, frequently are concerned with theoretical integration. Fourth, clinical sociologists have found it particularly important to critically examine the use of social theories by practitioners to assess effects on the practice as well as participants.

Clinical sociologists, in good part because of their multidisciplinary education and varied work experiences, use a wide range of theories. Some theories frequently used by clinical sociologists are as follows: grounded, standpoint, social constructionism, symbolic interaction, multicultural-liberationist, systems, conflict, critical, and social exchange. Theories, implicitly or explicitly, are a basis for the models that explain how practitioners should function. As Lang and Taylor (2000) have noted, "models represent appropriate, aspirational, or best practices; they include guidelines for implementing them."

Clinical sociologists use theories to formulate models that will be helpful in identifying and understanding problems and strategies to reduce or solve the problems. Clinical sociologists also have shown that practice can influence existing theories and help develop new ones.

Influences on the Actions of Client Systems

The contributors to this book provide a great deal of information that allows us to begin to understand and raise questions about the similarities and differences in clinical sociology in various areas of the world. One interesting point to consider is to how these authors (as well as interveners with different disciplinary backgrounds) view the actions of client systems (such as those of individuals, organizations, communities, and nations) in relation to the influences affecting those actions or behavior.

Figure 2.7 provides one possible way of viewing these influences. This diagram (defined as a visual representation of all or part of a model) shows the client system's behavior/actions (in the center) influenced by social, psychological, biological, and environmental factors such as air, land, water, and the built environment. Some social scientists do not include environment or biology as major influences and others might want to highlight one or more of these areas as more important. Even though the behavior/action part of the diagram is not very big, the central part could be
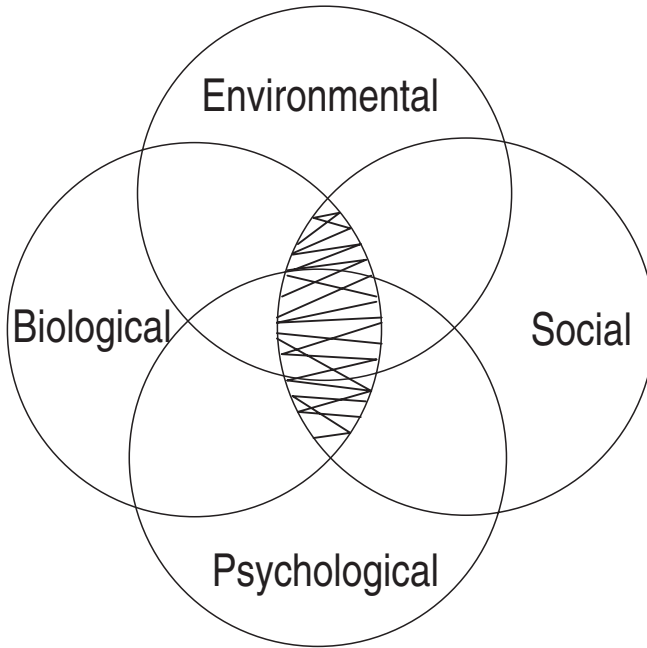
Figure 2.7 Influences affecting the actions of the client system
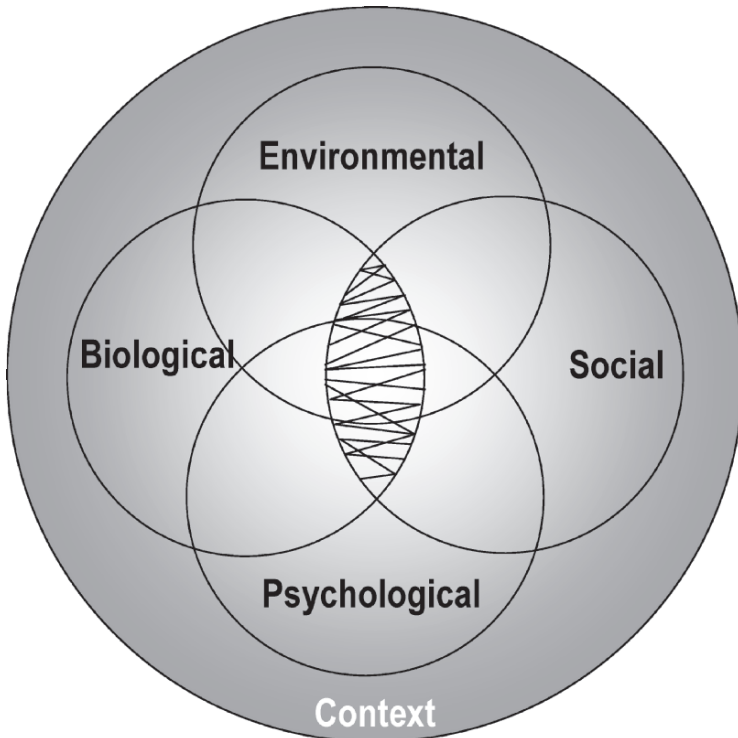
Figure 2.8 Influences (including the historical/political/economic context) affecting the actions of the client system

highlighted, shaded or increased in size to indicate that the client system is influenced but not controlled by these factors.

Figure 2.8 shows the same set of influences depicted in Figure 2.7 with one new element added. In this figure, the context surrounds the more immediate influences on the client agency. The context is meant to include historical, economic, and political considerations. In many situations, the context is a necessary factor and may provide an important explanation of the more immediate influences.

Figure 2.9 shows the same set of influences on actions as in Figures 2.7 and 2.8, but in this case the context is very important (as indicated by its size and dark color) and perhaps even overwhelming. In an era of globalization, some social scientists think (sometimes before but also after completing a project) that the client system (even a nation state) may not be able to act effectively within the national and global context in which it operates. Examples of this problem are found in Chapter 15, about street children in Mexico, and Chapter 16, on environmental justice in Brazil.
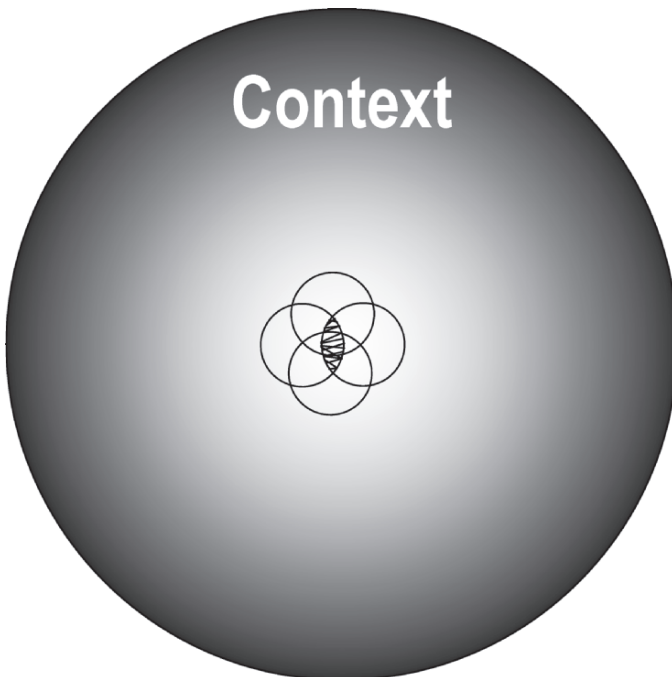
Figure 2.9 The historical/political/economic context strongly affecting the actions of the client system

Conclusion

This chapter only begins our discussion of the basics in international clinical sociology. There is agreement on most of the basics in the different countries, but one does find some differences in the concepts and theories that are generally adopted as well as the areas of practice and approaches to intervention.

The use of diagrams and models helps the reader as well as a client system to visualize what is being discussed. The problem with models and diagrams is that if they are too complicated, they are difficult to understand and remember; if they are too simple, important points may be diminished or omitted. We need to remind ourselves that diagrams and models only serve as starting points for our discussions.

References

Burke, W. W. (2002). Organization Change: Theory and Practice. Thousand Oaks, CA: Sage Publications.

Derksen, L., and Gartrell, J. (2000). Scientific explanation. Encyclopedia of Sociology, 2nd edition, E., F. Borgatta and R., H. Montgomery (eds.). New York: MacMillan 4, 2463–2473.

Fritz, J. M. (2004). Socioeconomic developmental social work. In: UNESCO Encyclopedia of Life Support Systems, UNESCO-EOLSS project on sustainable world Development. Oxford, UK. http://www.eolss.net.

Gerardi, D. (2001). Developing creativity and intuition for resolving conflicts: the magic of improvisation. http://www.mediate.com.

Johnson, C., and Forsyth, T. (2002). In the eyes of the state: Negotiating a "rights-based approach" to forest conservation in Thailand. World Development. 20/9, 1591–1605.

Kerlinger, F., N. (1973). Foundations of Behavioral Research. NewYork: Holt, Rinehart and Winston.

Lang, M. D., and Taylor, A. (2000). The Making of a Mediator: Developing Artistry in Practice. San Francisco: Jossey-Bass.

Laue, J., and Cormick, G. (1978). The ethics of intervention in community disputes. In: G. Bermant, H. Kelman, and D. Warwick (eds.) The Ethics of Social Intervention (pp. 205–232). Washington, DC: Halsted Press.

Lee, A. M. (1979). The Services of Clinical Sociology. American Behavioral Scientist. 22/4, 487–511.

Lippett, R., Watson, J., and Westley, B. (1958). The Dynamics of Planned Change. New York: Harcourt, Brace and World.

Midgley, J. (1994). Defining social development: historical trends and conceptual formulations. Social Development Issues, 16(3), 3–19.

Smelser, N. (1962). Theory of Collective Behavior. New York: Free Press.

Soeka, E. M. (2004, June). Presentation as part of a mediator training for the Ohio Office for Exceptional Children. Columbus, Ohio.

Sternberg, D. (1981). How to Complete and Survive a Doctoral Dissertation. New York: St. Martin's Press.

Vraneski, A. (2006). Al di là dell'arte e della scienza: Cultura e creativita nella mediazione. [Beyond art or science: creativity and culture in interactive mediation] In: L. Luison (ed.), La Mediazione come Strumento di Intervento Sociale (pp. 58–80). Milano, Italy: FrancoAngeli.

I
SELECTED REGIONAL HISTORIES

3
The History of Clinical Sociology in the United States

Jan Marie Fritz

Sociology in the United States emerged as a discipline at a time when the nation was struggling with issues of democracy, capitalism, and social justice. Sociology began to develop during the Progressive Era, a period that dates from about the mid-1890s through 1916. It was an age marked by reform and, at the same time, the emergence of corporate capitalism (Sklar, 1988). There was rural and urban poverty, a growing need for economic security,[1] women were still without the vote,[2] and there were lynchings.[3] At the turn of the twentieth century, frustration led to public protests and the development of public interest groups and reform organizations (Clemens, 1997; Sanders, 1999). In this climate, it is not surprising that many of the early sociologists were scholar-practitioners interested in reducing or solving the pressing social problems that confronted their communities.

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[1] People's economic security was affected by movement to the cities and by an economic depression. Between 1880 and 1920, a huge number of rural residents moved to the cities. The U.S. population went from 72 percent rural to 51 percent urban and this "dramatically increased workers' dependence on monetary earnings" and also "deprived individuals and families of (the) effective support networks" in their rural communities, particularly when a worker became incapacitated or died (Moss, 1996).

The depression of 1893 lasted five years and is seen as the second worst depression in U.S. history. It had an enormous effect on the United States, influencing the development of an interventionist state and increasing labor strikes and agrarian movements. There was "heightened class tension" and a rise in anti-immigrant, anti-Black, anti-Semitic, and anti-Catholic feelings (Steeples and Whitten, 1998).

[2] According to the U.S. National Archives (2007), "Passed by Congress June 4, 1919, and ratified on August 18, 1920, the 19th amendment guarantees all American women the right to vote. Achieving this milestone required a lengthy and difficult struggle; victory took decades of agitation and protest. Beginning in the mid-19th century, several generations of woman suffrage supporters lectured, wrote, marched, lobbied, and practiced civil disobedience to achieve what many Americans considered a radical change of the Constitution. Few early supporters lived to see final victory in 1920."

[3] According to Martin (1987), there have been at least 4,736 lynchings between 1882 and 1962, and about 70 percent of the victims were black. The 1890s "saw the heaviest toll—154.1 lynchings annually."

In 1896, Albion Small, chair of the Department of Sociology at the University of Chicago and founding editor of *The American Journal of Sociology*, published an article, "Scholarship and Social Agitation." Small thought that the primary reason for the existence of sociology was its "practical application to the improvement of social life" (Timasheff and Theodorson 1976, 2). In Small's (1896, 564) words:

> Let us go about our business with the understanding that within the scope of scholarship there is first science, and second something better than science. That something better is first prevision by means of science, and second intelligent direction of endeavor to realize visions. I would have American scholars, especially in the social sciences, declare their independence of do-nothing traditions. I would have them repeal the law of custom which bars marriage of thought with action. I would have them become more profoundly and sympathetically scholarly by enriching the wisdom which comes from knowing with the larger wisdom which comes from doing.

Clinical sociology in the United States developed with the goal and practice of merging thought with action. This chapter traces the development of the field beginning with profiles of two prominent sociologists, a white woman and an African-American man. The following sections discuss the earliest use of the term *clinical sociology* (in the late 1920s), the first courses, and clinical placements. Finally, there is a brief discussion of contemporary contributions and some concluding remarks.

Practitioner Profiles

This discussion of the development of clinical sociology begins by noting the contributions of two scholar-practitioners: Jane Addams (1860–1935) and William Edward Burghardt Du Bois (1868–1963).

Jane Addams

Jane Addams is remembered as a clinical sociologist, social worker, peace activist, and urban reformer (Fritz, 1991b, 2004, 2005). In 1889, Addams and her good friend Ellen Gates Starr established a settlement house in the decaying Hull Mansion in Chicago. Hull-House, as it was called, had many aims, not the least of which was to give privileged, educated young people contact with the real life of the majority of the population. The core Hull-House residents, an important group in the development of urban sociology, were well-educated women bound together by their commitment to progressive causes such as labor unions, the National Consumers League and the suffrage movement. During the next 45 years, Addams traveled widely, but Hull-House remained her home.

Hull-House, a national symbol of the settlement house movement, was a center for activities for the ethnically diverse, impoverished immigrants in the Nineteenth

Ward of Chicago. Within five years, some forty clubs were based in the settlement house, and over two thousand people came into the facility each week. Hull-House, among its many activities, operated a day nursery, hosted meetings of four women's unions, established a labor museum, ran a coffee house, and held economic conferences bringing together business owners and workers. The Working People's Social Science Club held weekly meetings, and a college extension program offered evening courses for those living in the neighborhood. A few University of Chicago courses were available there, and the Chicago Public Library had a branch reading room on the premises.

Hull-House was known as a base for promoting political, economic and social reform as well as social investigation.[4] In 1895, *Hull-House Maps and Papers* (Residents of Hull-House, 1970) was published by the residents. Addams wrote the preface as well as a chapter on the effects of the settlement house on the labor movement. *Hull-House Maps and Papers* was a groundbreaking document dealing with tenement conditions, sweatshops, and child labor. The book was the first systematic attempt to describe immigrant communities in an American city.

Nearly every major reform proposal in Chicago from 1895 to 1930 had Addams's name attached in some way. Her involvement in major issues-such as factory inspection, child labor laws, improvements in welfare procedures, recognition of labor unions, compulsory school attendance, and labor disputes-catapulted her to national prominence. Intellectuals, including Beatrice Webb and Sidney Webb, came from around the world to Chicago to meet Addams and her colleagues.

Addams wanted to "rid the world of war" and so she "created or seized" opportunities to advance the cause of peace (Haberman, 1972). In 1906 she gave a series of lectures at the University of Wisconsin that she later published in *Newer Ideals of Peace* (Addams, 1907). She spoke about peace at a 1913 ceremony at The Hague's Peace Palace and, during the next two years spoke against America's entry into the World War I. Because of her pacifist views, she was attacked in the press, expelled from the Daughters of the American Revolution, "socially and politically ostracized" (Deegan, 1991), and, as John Haynes Holmes (1960) noted, "with grace, integrity and unfaltering resolution she faced angry audiences and slanderous attacks."

In 1915, Addams chaired the Women's Peace Party, a U.S. organization, and, that same year, became president of the International Congress of Women. In 1922, Addams published *Peace and Bread in Time of War*, which she described as "a brief history of the efforts for peace made by a small group of women in the United States during the European War, and of their connection with the women of other

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[4] According to Rosenberg (1982, 32–34): "Most of the Chicago social scientists participated in some way in the work of Hull House, leading seminars, giving lectures or just having dinner with the exciting group of people who always gathered there.… Hull House became a laboratory for sociologists, psychologists, and economists, who helped to transform it from a home for moral uplifting of impoverished immigrants to a center for systematic social investigation and an agency of political and economic reform."

countries, as together they became organized into the Women's International League for Peace and Freedom." John Dewey (1945) described this book as a "record, searching and vivid, of human aspects of the First World War."

Addams served as president of the Women's International League for Peace and Freedom until 1929 and honorary president for the remainder of her life. In 1931, she became the first American woman to win a Nobel Peace Prize.

Addams died on May 20, 1935. According to Mrs. Joseph T. Bowen, in a letter written in 1935 and published in a book honoring Hull-House (Bryan and Davis, 1990),

> People poured into Hull-House by the thousands before the funeral to say how she had been the inspiration of their lives and how they felt bereft that she was no longer with them.… [Four and a half hours before the funeral at Hull-House] the Court Yard was crowded with people, one or two thousand standing there all day in order to be present at the services [that afternoon].… It was a most touching and democratic gathering. Strong men and women with children in their arms all stood weeping for the friend they had lost.

W.E.B. Du Bois

William Edward Burghardt Du Bois was one of the American pioneers of sociological practice (Fritz, 1990a). Du Bois made major contributions as a clinical and applied sociologist to the development of this country through his many scientific and popular publications and through his organizational efforts. He was a founder and general secretary of the Niagara Movement, an early advocate of women's rights (H. Aptheker, personal communication, 1988), a founder of the National Association for the Advancement of Colored People (NAACP), and, from 1910 to 1934, the internationally known founding editor of the NAACP's *The Crisis*.

Du Bois's autobiographical essay, "The Negro Wants First-Class Citizenship," was written when he was in his mid-seventies. It provided some information about Du Bois's direct connections to sociology, such as his academic work at Harvard,[5] his studies with Schmoller and Weber, his offer to teach sociology at Wilberforce,[6] his development of the Atlanta Conferences (including the 1943 meeting for the seventeen Negro land grant colleges in the South) and his research in Philadelphia. Du Bois's pioneering work, *The Philadelphia Negro: A Social Study*, was published in 1899.[7]

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[5] Sociology was not a separate discipline when Du Bois was at Harvard (Du Bois, 1944) from 1888 until 1891, but Du Bois took many social science courses and, in reviewing his background, has written that his "course of study would have been called sociology" (Du Bois, 1940).

[6] Du Bois taught at Wilberforce University in Ohio from 1894 to 1896.

[7] E. Digby Baltzell, in his introduction to the 1967 edition of *The Philadelphia Negro*, noted that "a classic is sometimes defined as a book that is often referred to but seldom read. *The Philadelphia Negro*, written by a young scholar who subsequently become one of the three most famous Negro leaders in American history, surely meets this requirement."

Particularly interesting are the ties that Du Bois made between science and social change. Du Bois (1944) recalled that, when he was in his forties, he "followed the path of sociology as an inseparable part of social reform, and social uplift as a method of scientific investigation." He said he was changing his attitude about the social sciences. He thought there "could be no … rift between theory and practice, between pure and applied science." Du Bois (1944) discussed the times when urgent action was imperative:

> I faced situations that called—shrieked—for action, even before any detailed, scientific study could possibly be prepared.… I saw before me a problem that could not and would not await the last word of science, but demanded immediate action to prevent social death. I was continually the surgeon probing blindly, yet with what knowledge and skill I could muster, for unknown ill, bound to be fatal if I hesitated, but possibly effective, if I persisted.

A review of Du Bois's earlier work shows he had a long-standing interest in sociology, science, and social change. In a speech to the sociology club at Atlanta University in 1987, for instance, Du Bois stressed the mission for such an organization:

> The aim… ought to be to furnish accurate information to such agencies as are engaged in the work of social reform, to endeavor to increase the cooperation between these agencies and to seek to establish new agencies for reform in neglected and unknown fields of effort.

Du Bois's concerns also is evident in his "A Program for Social Betterment." Du Bois gave a presentation, with this title, around 1908 to the first sociological society of Atlanta, Georgia. Du Bois again indicated the important link between science and social reform and gave examples of thirty-two specific initiatives that might be undertaken by the group. The listing included many practical suggestions such as a "mission" that would "provide ice for [the] poor and encourage flower-raising"; "maternity refuges" for "women in confinement"; an "anti-credit crusade," which would "encourage cash buying," and a "dress reform," which would advocate "warm, simple clothing and [the] prevention of extravagance."

Du Bois engaged in numerous important activities that are not very well known. In 1900, for example, he unsuccessfully challenged the Southern Railway systems for denying him, on racial grounds, a sleeping berth and petitioned the Georgia state legislature regarding cuts in funds for black public schools. In 1917, he was in the front ranks of an NAACP-organized march in New York City to protest lynching. That same year, he collected testimony from survivors of an East St. Louis massacre of blacks. In 1918, Du Bois helped organize the Negro Cooperative Guild to study and coordinate black-run cooperatives, and in 1919 he organized and was elected executive secretary of the first Pan-African Congress. In the 1920s, "along with Alain Locke [Du Bois] was a founder of the so-called Harlem Renaissance" (H. Aptheker, personal communication, 1990) and in 1950, Du Bois was the Progressive Party candidate for the U.S. Senate from the state of New York. Over the years, Du Bois also was a newspaper columnist, a novelist, a poet, the founding editor of *Phylon*, and a cofounder and the editor of *The Brownies' Book*, a magazine for black children.

Du Bois repeatedly tried to bring about a more just society.[8] In the course of doing this, he put new initiatives in place and did not hesitate to criticize individuals or programs when he felt the criticism was warranted. At times, he was at odds with Booker T. Washington, the NAACP, Marcus Garvey, the American Communist party, and the trustees of Atlanta University. In 1918, the Department of Justice warned him that he risked prosecution for his criticism of racism in the U.S. armed services.

In 1951, when Du Bois was 83, he was indicted by the U.S. Government, accused of being "an unregistered, foreign agent," and in 1952 the federal government arbitrarily refused to issue him a passport. The last two matters were resolved, eventually, but not without restriction, pain, and, finally, a change of citizenship.

At the age of 93, in 1961, Du Bois left the United States to work in Ghana, a country where he received "worshipful, esteemed status" (Horne, 1986), and was given citizenship and a passport. He went there to undertake a major project, the *Encyclopedia Africana*, but he also left the United States because he was completely frustrated. Several weeks before his departure, he wrote a letter to a woman who was having difficulty securing decent housing: "I just can't take anymore of this country's treatment.... We leave for Ghana October 5th and I set no date for return.... Chin up, and fight on, but realize that American Negroes can't win" (Horne, 1986). In 1963, Du Bois died in Ghana, a country where he was honored both in life and in death (Du Bois, 1971).

Clinical Sociology in Print

While many of the trail-blazing sociologists, including Jane Addams and W.E.B. Du Bois, were very involved in practice, the earliest known written proposal using the words *clinical sociology* was put forward by Milton C. Winternitz, a physician who was dean of the Yale School of Medicine from 1920 through 1935 (Fritz, 1989). At least as early as 1929, Winternitz began developing a plan to establish a department of clinical sociology within Yale's medical school. Winternitz wanted each medical student to have a chance to analyze cases based on a medical specialty as well as a specialty in clinical sociology.

Winternitz vigorously sought support from the Rosenwald Fund, but was unable to obtain funds for a department of clinical sociology. Winternitz did note, however, the success of a course in the medical school's section on public health that was based on the clinical sociology plan. In 1929, Winternitz wrote about his effort to build a department in a report to the university president, and the report was published in the Yale University *Bulletin*. Also published in 1930 was the speech

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[8] According to Aptheker (personal communication, 1988), Du Bois "thought people were like himself" in that he "never thought of making money [and] was singularly dedicated to service and truth."

Winternitz gave at the dedication of the University of Chicago's new social science building in which he mentioned clinical sociology.

Abraham Flexner, a prominent critic of medical education and director of the Institute for Advanced Study (1930–1939) at Princeton University, mentioned clinical sociology in 1930 in his *Universities: American, English, German*. Flexner did not approve of the Institute of Human Relations that Winternitz was establishing at Yale but did note that "only one apparent novelty is proposed: a professor of clinical sociology."

Winternitz continued to write about the value of clinical sociology until 1936. One of his most forceful statements in support of the field appeared in his 1930–1931 annual report, which stated, in part, "Not only in medicine and in law, but probably in many other fields of activity, the broad preparation of the clinical sociologist is essential."

The first published discussion of clinical sociology by a sociologist was Louis Wirth's 1931 article, "Clinical Sociology," in *The American Journal of Sociology*. Wirth wrote at length about the possibility of sociologists working in child development clinics, though he did not specifically mention his own clinical work in New Orleans. Wirth wrote, "It may not be an exaggeration of the facts to speak of the genesis of a new division of sociology in the form of clinical sociology."

In 1931, Wirth also wrote a career development pamphlet in which he stated:

> The various activities that have grown up around child-guidance clinics, penal and correctional institutions, the courts, police systems, and similar facilities designed to deal with problems of misconduct have increasingly turned to sociologists to become members of their professional staffs.

Wirth "urged (sociology students) to become specialists in one of the major divisions of sociology, such as social psychology, urban sociology… or clinical sociology."

In 1931, Saul Alinsky was a University of Chicago student who was enrolled in a clinical sociology course. Three years later, Alinsky's (1934) article, "A Sociological Technique in Clinical Criminology," appeared in the *Proceedings of the Sixty-Fourth Annual Congress of the American Prison Association*. Alinsky, best known now for his work in community organizing, was, in 1934, a staff sociologist and member of the classification board of the Illinois State Penitentiary.

Edward McDonagh's "An Approach to Clinical Sociology" was published in 1944. McDonagh proposed establishing social research clinics that would use groups to study and solve problems. The first formal definition of clinical sociology also appeared in 1944 in H.P. Fairchild's *Dictionary of Sociology*. Alfred McClung Lee,[9] the author of that definition, later used the word *clinical* in the title

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[9] Alfred McClung Lee (1906–1992) was one of the founders of the Society for the Study of Social Problems, the Association for Humanist Sociology, and the Clinical Sociology Association and also was, from 1976 to 1977, president of the American Sociological Association.

of two articles, his 1945 "Analysis of Propaganda: A Clinical Summary," and the 1955 article "The Clinical Study of Society."

In 1946, George Edmund Haynes's "Clinical Methods in Interracial and Intercultural Relations" was published in the *Journal of Educational Sociology*. Haynes was a cofounder of the National Urban League (in 1910) and the first African American to hold a U.S. government subcabinet post. His 1946 article, written while he was executive secretary of the Department of Race Relations at the Federal Council of the Churches of Christ in America, discussed the department's urban clinics. The clinics were designed to deal with interracial tensions and conflicts by developing limited, concrete programs of action.

The First University Courses

The first clinical sociology course was taught by Ernest W. Burgess at the University of Chicago (Fritz, 1990b, 1991a). In 1928 and 1929, the course was a "special" course and did not appear in the catalog. It was offered as a regular course from 1931 through 1933 and, though it was listed in the catalog for the next several years, was not taught after 1933.

The University of Chicago's catalogs did not include a description of the clinical sociology course, but it always was listed under the social pathology section. All these courses dealt with topics such as criminality, punishment, criminal law, organized crime, and personal disorganization. According to the notes of one of the students enrolled in the 1933 course (Fritz, 1991a), Burgess said clinical sociology "denotes an interest in pathological cases," and that students used forms to analyze personalities and conduct a case study. Required reading for the course included *The Soul of a Child* (Bjorkman, 1922), *The Natural History of a Delinquent Career* (Shaw, 1931), *Reluctantly Told*, by Jane Hillyer (the 1926 story of the author's mental breakdown), and *You Can't Win*, by J. Black (a 1926 account of the author's life as a professional thief).

Many students in these first clinical sociology courses were placed in Chicago's child guidance clinics. Clarence E. Glick, for instance, was the staff sociologist at the Lower North Side Child Guidance Clinic, and Leonard Cottrell was the clinical sociologist at the South Side Child Guidance Clinic.

Clinical courses also were offered in the 1930s at Tulane University and New York University. The Tulane University (1929) course was designed to give students the opportunity to learn about behavior problems and social therapy. The New York University course, taught by Harvey Warren Zorbaugh, provided undergraduate and graduate preparation for visiting teachers, educational counselors, clinicians, social workers, and school guidance administrators.

Zorbaugh was a faculty member in the School of Education and, along with Agnes Conklin, offered a seminar in clinical practice in 1930. The course was intended to qualify students as counselors or advisers dealing with behavioral difficulties in schools. From 1931 through 1933 the clinical practice course, titled

"Seminar in Clinical Sociology," was open to graduate students who were engaged in writing theses or conducting research projects in educational guidance and social work.

Zorbaugh, author of *The Gold Coast and the Slum: A Sociological Study of Chicago's Near North Side* (1929), had been involved with clinics at least since 1924, when he and Clifford Shaw organized two sociological clinics in Chicago. Zorbaugh was associate director of the Lower North Child Guidance Clinic in 1925 and also a founder, in 1928, of New York University's Clinic for the Social Adjustment of the Gifted. Zorbaugh was director of this clinic for intellectually gifted and talented preadolescent children at its inception, and was actively involved in its work for more than fifteen years. The clinic gave graduate students the opportunity to have supervised experiences in teaching, clinical diagnosis, and treatment of children with behavioral problems.

During the 1953–54 academic year, Alvin Gouldner[10] taught a foundations of clinical sociology course at Antioch College in Ohio. The college bulletin provided the following description of the course:

> A sociological counterpart to clinical psychology with the group as the unit of diagnosis and therapy. Emphasis on developing skills useful in the diagnosis and therapy of group tensions. Principles of functional analysis, group dynamics, and organizational and small group analysis examined and applied to case histories. Representative research in the area assessed.

Contemporary Contributions

While publications mentioning clinical sociology appeared at least every few years after the 1930s, the number of publications increased substantially after the founding of the Clinical Sociology Association in 1978. The association, which later became the Sociological Practice Association, made publications a high priority, particularly in its early years, and helped make available the world's most extensive collection of teaching, research, and intervention literature under the label of clinical sociology.

The *Clinical Sociology Review* and the theme journal, *Sociological Practice*, were published by the association beginning in the early 1980s. These annual journals were eventually replaced by a quarterly publication, *Sociological Practice: A Journal of Clinical and Applied Sociology*. The Sociological Practice Association merged with the Society for Applied Sociology in 2005. The new association, the Association for Applied and Clinical Sociology (AACS), now publishes *Applied Social Science*.

In the thirty years since the founding of the Clinical Sociology Association, numerous books and articles about clinical sociology have been published. For

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[10] Alvin Gouldner (1920–1980) was the Max Weber Professor of Sociology at Washington University (1959–1967) and a president of the Society for the Study of Social Problems.

instance, John Glass, the first president of the Clinical Sociology Association, had published a book on humanist sociology in 1972 (Glass and Staude) and a theme in Glass's later articles about clinical sociology was the connection between humanism and clinical sociology. In 1979, Roger Straus edited a special issue on clinical sociology for the *American Behavioral Scientist* and, that same year, Barry Glassner and Jonathan Freedman published *Clinical Sociology*.

The Clinical Sociology Handbook, by Jan Marie Fritz, was published in 1985 and included information about many of the publications of the members of the Clinical Sociology Association. In 1984 and again in 1986, Elizabeth Clark, a former president of the Sociological Practice Association who later became executive director of the National Association of Social Workers, and Jan Marie Fritz, the second president of the Clinical Sociology Association, edited the first two volumes about clinical sociology courses for the American Sociological Association Teaching Resources Center. (The sixth edition of this volume, edited by Fritz, was published in 2006.) Three editions of *Using Sociology*, a textbook for introductory sociology courses or for courses in clinical sociology, were edited by Roger Straus (e.g., 2002) and contained chapters by association members such as Phil Robinette, David Kallen¸ Harry Cohen, and Arthur Shostak.

Among the earliest publications that mentioned clinical sociology was the 1931 careers pamphlet written by Louis Wirth that indicated that clinical sociology was one of the major divisions of sociology. Over seventy years later, Melodye Lehnerer published the booklet *Careers in Clinical Sociology* (2003) for the American Sociological Association. It includes a definition of the field of clinical sociology, discusses career preparation, and gives examples of career possibilities such as advocate, sociotherapist, trainer, organizational consultant, and program evaluator.

When reading the wide range of publications about clinical sociology, it is interesting to think about what brought these people together under the label of clinical sociology. The core group that developed the specialization in the 1970s and 1980s was tied together by an interest in wanting to address society's social problems and their connections to humanism. For instance, Alfred (Al) McClung Lee, a past president of the American Sociological Association, and Elizabeth (Betty) Briant Lee, a past president of the Association for Humanist Sociology, were among the founders of the Clinical Sociology Association.[11] The book written by Galliher and Galliher (1995) about Al and Betty's life contributions contains six chapters and two of them include clinical sociology in the chapter titles.

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[11] Al and Betty Lee were remarkable people in many ways. I remember Al coming to an 8 a.m. roundtable session on clinical sociology (with a large room full of tables) and Al how he could help. Al noticed that there were two young sociologists at one table who were ready to give presentations, but there was no sitting at their table to hear them. They were overwhelmed that a founder/president of important sociology organizations would select their presentations and he was genuinely happy to join them.

For both Al and Betty, a clinical sociologist could not work for just any client; they thought the specialization had to serve humane goals (Lee, 1979).

There also is the series of clinical sociology books published by Springer. Volumes include John Bruhn and Howard Rebach's (1996) *Clinical Sociology: An Agenda for Action*, Melvyn Fein's (1999) *The Limits of Idealism*, Rebach and Bruhn's (2001) *Handbook of Clinical Sociology*, Linda Weber and Allison Carter's (2002) *The Social Construction of Trust*, and Rosalyn Benjamin Darling's (2000) *The Partnership Model in Human Services*.

There were other contributions in addition to publications. The Sociological Practice Association's certification process for clinical sociologists was available at the Ph.D. and M.A. levels. The Ph.D.-level process was adopted in l983 and certification was first awarded in 1984. The association began to offer M.A.-level certification in 1986. In 1995, the Sociological Practice Association, along with the Society for Applied Sociology, put in place the Commission on Applied and Clinical Sociology (2007). The commission set standards for the accreditation of clinical and applied sociology programs at the undergraduate and graduate levels.

Clinical sociologists from the United States also have been active in at least two international groups. The clinical sociology division of the International Sociological Association (ISA) was organized in 1982 at the ISA World Congress in Mexico City. A number of clinical sociologists also are members another ISA section—the sociotechnics—sociological practice division.

Conclusion

The term *clinical sociology* has had its longest use in the United States. The strongest pushes for the specialization were from a core group in sociology at the University of Chicago (in the 1930s) and from a core group scattered around the nation but linked through the Clinical Sociology Association and then the Sociological Practice Association (mid-1970s to mid-1990s).

Clinical sociologists in the United States now use a wide range of theories, intervention techniques, and research methods (in addition to the standard case analysis). These clinical sociologists are interested in many different topics, as evident in the work (mediation, focus groups, movement building, and bereavement) described by U.S. authors for this volume. Because of the different areas of application, the clinical sociologists belong to many kinds of professional associations. As their interests have broadened, their work might not be explicitly labeled as clinical sociology and it has become harder to know and profit from each other's work. Clinical sociologists in the United States still have the only significant contributions in terms of teaching materials, certification processes, and accreditation, but developments in other countries may soon change this situation.

References

Addams, J. (1907). The Newer Ideals of Peace. New York: Macmillan.

Alinsky, S. (1934, September). A sociological technique in clinical criminology. Proceedings of the Sixty-Fourth Annual Congress of the American Prison Association (pp. 167–178).

Bjorkman, E. A. (1922). The Soul of a Child. New York: Knopf.

Bruhn, J. G., and Rebach, H. M. (1996). Clinical Sociology: An Agenda for Action. New York: Plenum.

Bryan, M. L. McCree and Davis, A. F. (eds.). (1990). One Hundred Years at Hull-House. Bloomington: Indiana University Press.

Clemens, E. S. (1997). The People's Lobby: Organizational Innovation and the Rise of Interest Group Politics in the United States, 1890–1925. Chicago: University of Chicago Press.

Commission on Applied and Clinical Sociology. (2007). http://www.sociologycommission.org/.

Darling, R. (2000). The Partnership Model in Human Services. New York: Springer.

Deegan, M. (1991). Jane Addams. In: M. Deegan (ed.), Women in Sociology: A Bio-Bibliographic Sourcebook (pp. 37–44). New York: Greenwood Press.

Dewey, J. (1945). Democratic versus coercive international organization: the realism of Jane Addams. In: J. Addams, Peace and Bread in Time of War (pp. ix–xx). (An edition of the 1922 book issued by the United States Section of the Women's International League for Peace and Freedom.) New York: King's Crown Press.

Du Bois, S. G. (1971). His Day is Marching On. Philadelphia: Lippincott.

Du Bois, W. E. B. (1940). Dusk of Dawn: An Essay Toward an Autobiography of a Race Concept. New York: Harcourt, Brace.

Du Bois, W. E. B. (1944). My evolving program for Negro freedom. In: R. W. Logan (ed.), What the Negro Wants (pp. 31–70). Chapel Hill, NC: University of North Carolina Press.

Fein, M. L. (1999). The Limits of Idealism: When Good Intentions Go Bad. New York: Kluwer Academic/Plenum.

Fritz, J. M. (1989). Dean Winternitz, clinical sociology and the Julius Rosenwald Fund. Clinical Sociology Review, 7, 17–27.

Fritz, J. M. (1990a). In pursuit of justice: W. E. B. Du Bois. Clinical Sociology Review, 8, 15–26.

Fritz, J. M. (1990b). The uses of sociology in clinical settings. In: E. J. Clark, J. M. Fritz, and P. P. Rieker (eds.), Clinical Sociological Perspective on Illness and Loss: The Linkage of Theory and Practice (pp. 10–22). Philadelphia: Charles Press.

Fritz, J. M. (1991a). The history of American clinical sociology: the first courses. Clinical Sociology Review, 9, 5–26.

Fritz, J. M. (1991b). The emergence of American clinical sociology. In: H. Rebach and J. Bruhn (eds.), Handbook of Clinical Sociology (pp. 17–32). New York: Plenum.

Fritz, J. M. (2004). Jane Addams. In: R. Caves (ed.), Encyclopedia of the City (p. 5). London and New York: Routledge.

Fritz, J. M. (2005). The scholar-practitioners: the development of clinical sociology in the United States. In: A. J. Blasi (ed.), Diverse Histories of American Sociology (pp. 40–56). Leiden/Boston: Brill.

Galliher, J. F. and Galliher, J. M. (1995). Marginality and Dissent in Twentieth-Century American Sociology: The Case of Elizabeth Briant Lee and Alfred McClung Lee. Albany, NY: State University of New York Press.

Glass, J. F. and Staude, J. R. (ed.). (1972). Humanistic Society; Today's Challenge to Sociology. Pacific Palisades, CA: Goodyear.

Haberman, F. W. (ed.). (1972). Nobel Lectures, Peace 1926–1950. Amsterdam: Elsevier.

Hillyer, J. (1926). Reluctantly Told. New York: Macmillan.

Holmes, J. H. (1960). Introduction to section on international peace. In J. Adams, Jane Adams: A Centennial Reader (pp. 250–251). New York: Macmillan.

Horne, G. (1986). Black and Red: W. E. B. Du Bois, Writings. Boston: Twayne.

Lee, A. M. (1979). The services of clinical sociology. American Behavioral Scientist, 22(4), 487–511.

Lehnerer, M. (2003). Careers in Clinical Sociology. Washington, D.C.: American Sociological Association.

Martin, R. E. (1987). Lynching. The Encyclopedia Americana, 17, 884–885.

Moss, D. A. (1996). Socializing Security: Progressive-era Economists and the Origins of American Social Policy. Cambridge, MA: Harvard University Press.

Rebach, H. M. and Bruhn, J. G. (eds.). (2001). Handbook of Clinical Sociology (2nd ed.). New York: Kluwer Academic/Plenum.

Residents of Hull-House. (1970). Hull-House Maps and Papers. New York: Arno Press.

Rosenberg, R. (1982). Beyond Separate Spheres: The Intellectual Roots of Modern Feminism. New Haven, CT: Yale University Press.

Sanders, E. (1999). Roots of Reform: Farmers, Workers, and the American State, 1877–1917. Chicago: University of Chicago Press.

Shaw, C. (1931). The Natural History of a Delinquent Career. Chicago: University of Chicago Press.

Sklar, M. (1988). The Corporate Reconstruction of American Capitalism, 1890–1916: The Market, the Law and Politics. New York: Cambridge University Press.

Small, A. W. (1896). Scholarship and Social Agitation. American Journal of Sociology, 1(5), 564–582.

Steeples, D. and Whitten, D. O. (1998). Democracy in Desperation: The Depression of 1893. Westport, CT: Greenwood Press.

Straus, R. A. (ed.). (1979). Special issue on clinical sociology. American Behavioral Scientist, 22, 475–608.

Straus, R. A. (ed.). (2002). Using Sociology: An Introduction from the Applied and Clinical Perspective (3rd ed.). New York: General Hall.

Timasheff, N. S. and Theodorson, G. A. (1976). Sociological Theory, Its Nature and Growth. New York: Random House.

Tulane University. (1929, June 1). Bulletin of the Tulane University of Louisiana 30/6. New Orleans, LA: Tulane University.

U.S. National Archives. (2007). 19th Amendment to the U.S. Constitution: Women's Right to Vote. http://www.archives.gov/historical-docs/document.html?doc=13andtitle_raw=19th%20Amendment%20to%20the%20U.S.%20Constitution:%20Women

Weber, L. R., and Carter, A. (2002). The Social Construction of Trust. New York: Kluwer Academic/Plenum.

Zorbaugh, H. W. (1929). The Gold Coast and the Slum: A Sociological Study of Chicago's Near North Side. Chicago: University of Chicago Press.

Selected Readings

Addams, J. (1922). Peace and Bread in Time of War. New York: Macmillan.

Association of Applied and Clinical Sociology (AACS). (2007). http://www.aacsnet.org/wp/.

Black, J. (1926). You Can't Win. New York: Burt.

Bowen, L. (1990). Note to friends written on May 27, 1935. In: M. L. Bryan and A. F. Davis (eds.), 100 Years at Hull-House (pp. 203–205). Bloomington and Indianapolis, IN: Indiana University Press.

Bruhn, J. G., and Rebach, H. M. (2007). Sociological Practice: Intervention and Social Change. Second edition. New York: Springer.

Burawoy, M. 2004. The critical turn to public sociology. In: R. Levine (ed.), Enriching the Sociological Imagination: How Radical Sociology Changed the Discipline (pp. 309–326). Leiden and Boston: Brill.

Clark, E., and Fritz, J. M. (eds.) Clinical Sociology Courses: Syllabi, Exercises and Annotated Bibliography. Washington, DC: American Sociological Association Teaching Resources Center.

Clark, E. J., Fritz, J. M., and Rieker, P. P. (eds.). (1990). Clinical Sociological Perspectives on Illness and Loss: The Linkage of Theory and Practice. Philadelphia: Charles Press.

Du Bois, W. E. B. (1897). A program for a sociological society. Speech to the first sociological club, Atlanta University, Atlanta, Georgia. Microfilm edition of the W. E. B. Du Bois Papers. Reel 80, Frame 1. Amherst: University of Massachusetts Library.

Enriquez, E. (1992). Remarques Terminales Vers Une Sociologie Clinique D'inspiration Psychanalytique. L'organisation en Analyse [Final Remarks Toward a Clinical Sociology Inspired by Psychoanalysis]. Fevrier, Paris: P.U.F.

Enriquez, E. (1997). The clinical approach: genesis and development in Western Europe. International Sociology, 12(2), 151–64.

Enriquez, E., Houle, G., Rheaume, J., and Sévigny, R. (eds.) (1993). L'analyse Clinique Dans les Sciences Humaines [Clinical Analysis in the Human Sciences]. Montreal: Editions Saint-Martin.

Flexner, A. (1930). Universities: American, English, German. New York: Oxford University Press.

Fritz, J. M. (1985). The Clinical Sociology Handbook. New York: Garland.

Fritz, J.M. and E. Clark (eds.) (1986). The Clinical Sociology Resource Book (2nd ed.). Washington, DC: American Sociological Association Teaching Resources Center.

Fritz, J. M. (2004a). Socioeconomic developmental social work. In: UNESCO Encyclopedia of Life Support Systems, a Project on Sustainable World Development. Oxford, United Kingdom: UNESCO-EOLSS.

Fritz, J. M. (2004b). Dierriere la magie: models, approaches et theories de mediation [Behind the magic: mediation models, approaches and theories]. Esprit Critique, 6(3). http://www.eolss.net.

Fritz, J. M. (2006). L'approccio al conflitto [Approaching conflict]. In: L. Luison (ed.), La Mediazone Come Strumento di Intervento Sociale (pp. 24–36). Milano, Italy: FrancoAngeli.

Fritz, J. M. (ed.). (2001). The Clinical Sociology Resource Book (5th ed.). Washington, DC: American Sociological Association Teaching Resources Center and the Sociological Practice Association.

Fritz, J. M., Bistak, P. and Auffrey, C. (2000). The bumpy road to a tobacco-free community: lessons from Well City. Sociological Practice, 2(2), 113–126.

Gaulejac, V. de and Roy, V., (eds.). (1993). Sociologies Cliniques [Clinical Sociology]. Paris: Hommes et Perspectives.

Glassner, B. and Freedman, J.A. (1979). Clinical Sociology. New York: Longman.

Gouldner, A. (1965). Explorations in Applied Social Science. Social Problems, 3(3), 169–181. Reprinted in A. Gouldner and S. M. Miller (eds.), Applied Sociology (pp. 5–22). New York: Free Press.

Harding, S. (ed.). (2004). The Feminist Standpoint Theory Reader. New York: Routledge.

Haynes, G. E. (1946). Clinical methods in interracial and intercultural relations. Journal of Educational Sociology 19(5), 316–25.

Haynes, J. M. (1994). The Fundamentals of Family Mediation. Albany, NY: State University of New York Press.

Lang, M. D., and Taylor, A. (2000). The Making of a Mediator: Developing Artistry in Practice. San Francisco, CA: Jossey-Bass.

Lascoux, J. L. (2001). Pratique de la Mediation: Une Methode Alternative a la Resolution des Conflicts [The Practice of Mediation: An Alternative Method for the Resolution of Conflicts]. Issy-les-Moulineaux, France: ESF Editeur.

Lee, A. M. (1944). Sociology, Clinical. In: H. P. Fairchild (ed.), Dictionary of Sociology (pp. 303). New York: Philosophical Library.

Lee, A. M. (1945). The analysis of propaganda: a clinical summary. American Journal of Sociology, 51(2), 126–135.

Lee, A. M. (1955). The clinical study of society. American Sociological Review, 20(6), 548–653.

Leopold, A. (1949). A Sand County Almanac and Sketches Here and There. New York: Oxford University Press.

Lippitt, R., Watson, J., and Westley, B. (1958). The Dynamics of Planned Change: A Comparative Study of Principles and Techniques. New York: Harcourt, Brace and World.

Luison, L. (ed.). (1998). Introduczione Alla Sociologia Clinica: Teorie, Metodi e Tecniche di Intervento [Introduction to Clinical Sociology: Theory, Methods and Intervention Techniques]. Milano: FrancoAngeli.

McDonagh, E. C. (1944). An Approach to clinical sociology. Sociology and Social Research, 27(5), 376–383.

Midgley, J. (1994). Defining social development: historical trends and conceptual formulations. Social Development Issues, 16(3), 3–19.

Minardi, E. and Cifiello, S. (2005). Ricercazione: Teoria e Metodo del Lavoro Sociologico [Research: Theory and Method of Sociological Work]. Milano: FrancoAngeli.

Rebach, H. M., and Bruhn, J. G. (eds.). (1991). Handbook of Clinical Sociology. New York: Plenum.

Rheaume, J. (1997). The project of clinical sociology in Québec. International Sociology, 12(2), 165–174.

Tulanian. (1928). Child Guidance Clinic Planned by Sociologists. The Tulanian, 1(7), 8.

Tosi, M. and Battisti, F. (eds.). (1995). Sociologia Clinica e Sistemi Socio-Sanitari: Dalle Premesse Epistemologiche Allo Studio di Casi e Interventi [Clinical Sociology and Public Health]. Milano: FrancoAngeli.

Van Bockstaele, J., and Van Bockstaele, M. (2004). La Socianalyse: Imaginer-coopter [Socioanalysis: Imagining and Co-opting]. Paris: Edition Economica/Anthropos.

Van Bockstaele, J., Van Bockstaele, M., Barrot, C., and Magny, C. (1963). Travaux de Sociologie Clinique: Quelques Conditions d'une Intervention de Type Analytique en Sociologie [Some Conditions on Intervention of an Analytic Type in Sociology.]. L'Année Sociologique (pp. 238–262). Paris: Presses Universitaires de France.

Van Bockstaele, J., Van Bockstaele, M., Barrot, C., Malbos, J., and Schein, P. (1968). Nouvelles observations sur la définition de la socianalyse [New observations on the definition of socioanalysis]. L'Année Sociologique (vol. 19, pp. 279–295). Paris: Presses Universitaires de France.

Wan, H. (2004). Unpublished manuscript on the development of the field of clinical sociology.

Winternitz, M. C. (1930). Practical study of social relations: Plan for Graduate Department of Clinical Sociology at Yale (Records of Dean, YRG-27–A-5–9, Box 174, Folder 3608). New Haven, CN: Yale University Archives, School of Medicine.

Wirth, L. (1931a). Clinical sociology. American Journal of Sociology, 37, 49–66.

Wirth, L. (1931b). Sociology: Vocations for those interested in it. Vocational Guidance Series (No. 1) [Pamphlet]. Chicago: University of Chicago. Louis Wirth Collection, University of Chicago, Department of Special Collections. Box LVI, Folder 6.

Zorbaugh, H. W. (1939). Sociology in the clinic. Journal of Educational Sociology, 12(6), 344–351.

4
Clinical Sociology in Québec: When Europe Meets America

Jacques Rhéaume

Clinical sociology is a way of doing sociology, so formally it is a methodological approach within sociology. However, methodology cannot be separated from theory, and clinical sociology involves, in some respects, a construction of a particular field of sociology. Methodology is not only a set of techniques used to gather data for analysis by sociologists in their role as an expert; methodology, in a broader sense, is about what kind of social issues are of interest, who is producing the proper knowledge to address those issues, and how can we develop not only theory but practical knowledge about those issues. This chapter illustrates this approach by examining the development of clinical sociology in Québec.

It is interesting to note that we speak of such a development in Québec and not in Canada. Sociology in Québec, as is the case for most social and human sciences, has been much more influenced by ideas and contributions from the United States or Europe than from the other Canadian provinces. The particular political status of Québec stems from a long history of resistance in an attempt to remain Francophone and culturally different from the rest of Canada. This is also reflected in the way sociology developed. Perhaps a more careful and extensive search would point to similar U.S. influences among Toronto or Vancouver sociologists. Nevertheless, cross-references between Québec and Canadian sociologists in publications, manuals, and, even more importantly, in actual research and practice projects are rare or nonexistent. Such is also the case for clinical sociology.

This discussion of the historical development of clinical sociology is divided into four parts. The first two parts are more chronological and bear on the precursor and founding disciplinary influences. Clinical sociology appears in the 1950s as a sociographic approach. Its development in the 1970s and 1980s was influenced by the field of psychosociology. The third part accounts for the actual development of clinical sociology as an emerging institutional field in diverse professional or academic associations and conferences, starting in the late 1980s. The final part relates to specific clinical sociological practices and refers to the more important publications and theoretical developments of the period. The basic issue concerning the existing gap between the formal and institutional development of clinical sociology on one hand, and the actual clinical sociology in practice on the other hand will be addressed. I conclude by identifying some basic characteristics of a clinical approach to sociology.

Clinical Sociology: Foundations

The term *clinical sociology* appeared explicitly in Québec sociology in the 1950s and associated in particular with the works of the sociologist Fernand Dumont and with the majority of the work in sociology at Laval University in the city of Québec. The social and political context in Québec during the 1950s was marked by the policies of the conservative government in power and supported by a strong institution, the Catholic Church. The emerging social sciences faced criticism. At the helm of this opposition were people affiliated with the Church.

At the same time, in the period following World War II, a progressive movement appeared supported by dynamic economic growth and a significant increase of international and intercultural relations. Social research was able to build on these progressive trends as well as the numerous conflicts that ensued between clashes among traditional conservatives and those espousing a more progressive and modern outlook. The arrival of the Révolution Tranquille (Quiet Revolution), with the election of the more progressive Liberal Party in 1960, heralded a new progressive era for Québec. Until the 1960s, clinical sociology, given its marginal place in the wider developments occurring within the social sciences, was mostly oriented to a better understanding of the shift between traditional practices and values to modern, open, and pluralistic values within the context of active industrial society.

In this context, clinical sociology took on an ethnographic aspect. Its principal objective was to examine regional or subregional cultures in their totality in order to better understand the processes of social transformation. One such significant social change concerned the passage from a preindustrial society in Québec to an industrial one, and the potential for development strategies. This general question was at that time a real concern for Québec society, which was principally characterized by a rural economy. One good example of clinical sociology during this time is the study directed by Fernand Dumont (Dumont and Martin, 1963) on the region of Saint-Jérôme, a semirural center north of Montreal, Québec. Among the methods used by Dumont to explore the specificity of this local culture were personal accounts, meticulously detailed descriptions of cultural and political institutions (school, church, and local government), statistical analysis, documentary analysis, survey by questionnaire, and participant observation. Dumont labeled this type of approach *clinical sociology*. To quote Marcel Mauss (1950), it aimed to understand the total social phenomena under study.

It is certainly not a coincidence that Laval University's journal of sociology, founded in the early 1960s, was given the title *Recherches Sociographiques* (Sociographical Researches). In that sociographical context, one of the methods adopted by researchers trained at Laval (Nicole Gagnon, Gilles Houle) was the analysis of *life stories*, a method designed to examine the transformations of social structures on the basis of the histories of individuals selected according to specific research criteria (such as age or experience). The *Institut Québécois de la Recherche sur la Culture* (IQRC) (Québec Research Institute on Culture), created in the 1970s and directed by Fernand Dumont, identified the global study of Québecois culture as its mandate.

This research orientation also was represented at the University of Montreal, in the work of sociologist Robert Sévigny, who had studied at Laval University and had shown an early interest in the ethnographic perspective. While contributing to the development of a psychosociological practice in the early 1970s (which is discussed later in this chapter), he also collaborated with Marcel Rioux and other sociologists in an innovative ethnographic study on alienation in the everyday lives of Montrealers. In a later publication, *Le Québec en Héritage*, Sévigny (1979) analyzed the content of five in-depth interviews undertaken with couples from different social origins. It was a project that served as a point of departure for what would later become a research program of *implicit sociology*, that is, the sociological knowledge present in the everyday life of social practitioners (Rhéaume and Sévigny, 1988). The general idea was that practitioners in any professional field possessed a real social knowledge to be discovered in order to better understand social practices. In this sense it was the people's sociology at work.

This type of research can be linked to the very influential tradition of cultural anthropology and to contributions of the well-known Chicago School at the beginning of the century. This was a period characterized by a very inventive and original sociology adopting an interdisciplinary perspective; a sociology in which the commitment of researchers to the social problems of the day, such as immigration, family breakdown, alcoholism, poverty, and street gangs, is emphasized. The well-known work of Thomas and Znaniecki (1918–1920), reflecting on their fieldwork in urban contexts, was published in this period. The objective of these authors was the study of social life in transformation. Their sociology also was distinctive in its choice of an interpretative approach. W.I. Thomas was convinced that we can understand nothing of human action if we ignore the goals that actors pursue and the particular perception that they have of their situations and possibilities. Here again, epistemological questions were translated methodologically by using a strategy of multiple data collection techniques: the study of city maps and open-ended interviews, and the analysis of documents of all types (such as periodicals, personal journals, and life stories). As for theoretical and empirical relations, the sociologists of the Chicago School viewed theory construction as a long and patient process characterized by a constant movement between observation and theorizing and the consideration of each observed case rather than just the principal tendencies. They placed more emphasis on the concepts themselves than on the validation of hypotheses, and on the relations between the concepts (Bertaux, 1976, 14–15).

The Chicago School has also been an important source of influence for contemporary clinical sociology. It has been at the crossroads of different influences, including phenomenology (Schutz, Berger, and Luckman) and symbolic interactionism (Mead, Goffman). The almost simultaneous publication of three key texts illustrates these orientations: *Symbolic Interactionism* by Herbert Blumer (1969), *Studies in Ethnomethodology* by Harold Garfinkel (1967), and *The Discovery of Grounded Theory* by B.G. Glaser and A. Strauss (1967). The social construction of reality in symbolic interaction between social actors, the active and sustained reference to implicit rules and meanings of human interaction (ethnomethodology), and the progressive construction of theory from representations in everyday language

(grounded theory) are some of the basic approaches that have been incorporated into clinical sociology.

We can recognize also influences from European authors and theories. Marcel Mauss (1950) is one such author who espouses a vision of an anthropological sociology in studying total social phenomena. That is to say, he includes the individual and the collective, the cultural and the economic, the local and the general through varying sources of data. Max Weber's (1964) comprehensive sociology is also a decisive influence; likewise is the American Talcott Parsons (1957) and his theory of social action. Another theoretical field that has had a great influence on many sociologists in Québec during that period is that of culture and personality (Dufrenne, 1953; Kardiner, 1969) The latter, with its focus on the relationship between the individual and society, will become a central focus of psychosociology, as well as another source of influence for clinical sociology.

Three important points central to the study of clinical sociology can be drawn from these primary sources of inspiration: a direct and intimate field knowledge of a given social group considered in the complexity of its everyday life, the involvement and critical distance of the observer in the situation being studied, and the corresponding theoretical preference of a sociology where the subjectivity of social actors should always be included in a global and integrated understanding of social practice. Thus, in clinical sociology we need to understand the different social actors' viewpoints in order to build an appropriate knowledge of a given situation. These three points are interrelated; it is difficult to have access to the internal, the more subjective knowledge of social actors, without a minimum involvement in the interaction with them and without a shared conceptual frame of reference.

At the same time, the preoccupation of the researcher as a sociologist is to maintain a critical distance and to develop a solid theoretical perspective. In those first early studies, the theoretical reference is mostly structural functionalist. It was not so difficult from a clinical sociographic point of view to maintain a much-detached attitude toward actual social intervention. Understanding was the key word, empirical data gathering and systematic analysis were the methods, including, as a main source of data, the subjective input from social actors. This tendency toward an objective stance will change with the second major influence of psychosociology and community development in clinical sociology.

A Major Development: Human Relations and Psychosociology

Psychosociology is another major school of thought that must be examined in order to situate the current network of researchers in clinical sociology. This school of thought emerged in Québec in the early 1960s.

In the 1960s, Québec was marked by significant social changes. This period of drastic transformation is referred to as the Quiet Revolution. After many years of a Conservative Party regime, the Liberal Party came into power with the aim of

constructing a modern state. The main priorities of the new government included the establishment of a new educational system, the development of a complete health and social services public program, and the secularization of society. In this new context, the human and social sciences, which were once at the margins of society, suddenly became essential resources for planning change. Management sciences and related academic fields became highly valued in order to prepare leaders for industry and public services. Democratic participation, planned change, and social innovations were the buzz words used in the public arena. Certain sociologists, social workers, and other social scientists became involved in this social transformation, and their contributions prepared new perspectives for a clinical approach to sociology.

Robert Sévigny, of the sociology department at the University of Montreal, is one of the pioneers of this approach. Toward the end of the 1950s, he attended specialized training sessions in group dynamics and organizational consultation at the National Training Laboratory in Bethel, Maine. These sessions were part of the work of Kurt Lewin and his collaborators in the 1940s and 1950s in the United States. In Québec, the vast Alcan manufacturing intervention project in the 1960s, in which many psychosociologist-consultants were involved, marked the beginnings of a psychosociological practice.[1] The training group method (small groups), more authentic interpersonal communication, conflict resolution, and participative problem solving were some of the strategies and tactics developed for this type of practice, which aimed at improving social organizations. It is to be noted that those practices were referred to as human relations approaches or applied behavioral and social sciences. The terms *psychosociology* and *psychosociologist* came later from France.

This practice was influenced by the action research approach initiated by Kurt Lewin in social psychology in which the constitution of scientific knowledge was considered inseparable from social practice. More precisely, the scientific project becomes one of problem solving through action, based on an epistemological model of radical pragmatism. The solutions put into practice—from the resolution of problems specific to enterprises to the functioning of small groups or community development—are the functional equivalent of the validation of hypotheses set out in the early stages of a project. Moreover, these social experimentations become privileged spaces for advancing the understanding, and science, of social change. Action, in this sense, precedes knowledge.

While maintaining its focus on the specificity and singularity of the social and historical situations under study and on the participation of social actors and researchers, psychosociological practice constitutes a laboratory for social experimentation. This participation is particularly evident in small groups. Group dynamics was, for instance, the principal method of intervention used in the Alcan study

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[1] Robert Sévigny was trained in Québec by the social psychologist Bernard Mailhot, a disciple of Lewin. Other psychologists—Fernand Roussel, Roger Tessier, Michelle Roussin, Yvan Tellier, Yves Saint-Arnaud, André Carrière—also played important roles in the development of psychosociology.

mentioned above. Based on democratic participation, such an approach was attractive in Québec in the 1960s because of the societal transformations taking place.[2] It was also a period in which researchers and practitioners grouped together in private training, research, and consultation centers, such as the Centre d'Études des Communications (Center for the Study of Communications), Institut de Formation par le Groupe (Training Group Institute), and Centre Interdisciplinaire de Montréal (Interdisciplinary Montreal Center). The principal domains of intervention were industrial organizations and the educational system, the latter being the object of major reforms by the state in the 1960s. The principal psychosociological practices were organizational consultation and the training group method.

Psychosociology was not only a product of American influences. Collaboration with Europeans also was initiated in this period and continues with, for instance, French psychosociologists such as M. Pagès, E. Enriquez, and V. de Gaulejac. It also was influenced by institutional analysis (the study of basic institutions, of power and values in formal organizations) as developed, for example, by R. Loureau and G. Lapassade; social analysis or group psychoanalysis (social interaction examined from the point of view of psychoanalysis); and the sociotechnical approach (optimal integration of technique and human relations in formal organizations).[3] The theoretical and practical integration of European and American ideas could be considered a characteristic trait of psychosociology in Québec.

Psychosociological practices involve the use of the same basic methods, such as group dynamics, action research, consultation, and participatory research. However, the theoretical references are quite different. For instance, the terms used to describe the field vary accordingly. The term *psychosociology* is specifically derived from France. In the United States and in Québec, the most common terms used in resolving social problems include the study of human relations and applied behavioral sciences. Psychosociology refers, more importantly, to a disciplinary issue, and of a relationship to be established between psychology and sociology. It is also distinguished in this respect from social psychology, which is either a specific subfield of psychology or of sociology. What is common throughout this whole discussion is the idea that psychosociology or the study of human relations or applied behavioral sciences is multidisciplinary and related to the resolution of social problems.

However, the debate goes further than differences in the terms that are used. In England and France, when people speak of psychosociology, importance is given to psychoanalysis, rather than to behavioral or cognitive psychology, while they are more receptive to humanistic psychology. In the field of sociology, Marxist and post-Marxian views are dominant, a departure from the functionalist and positivist schools of thought. Social power issues, social inequalities, and social class movements constitute the more or less main referents of such a view. Pierre Bourdieu,

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[2] This period of Québec history, known as the Quiet Revolution, was also characterized by a major reform of state institutions, under the direction of new political leadership, following the election of the Liberal Party and its program of participative and democratic changes.

[3] Social analysis and sociotechnical approaches were first developed in England.

Alain Touraine, and Michel Foucault are good examples of European referents. This is why, in France, psychosociological intervention is frequently seen as the development of a reflexive and critical consciousness of participants in groups or organizations rather than simply a pragmatic problem-solving technique. *Critical understanding of situations* is the key term.

Québec sociology often mixed influences from the U.S. and from France or England. A sort of critical pragmatic view progressively emerged, one that tried to take into account both perspectives. Still, the functionalist, pragmatic, and humanistic views would come first in Québec, while psychoanalysis and the Marxist views and their various proponents become secondary in psychosociological practices.

The term *clinical sociology* was not used during this period to describe these developments and practices. Nevertheless, these practices later defined the project of clinical sociology while adding new dimensions. The principal new aspect relates to the close relationship between theory and action; the notion of action-research strongly indicates a shift from a more objective stance. Understanding and theorizing are not enough; instead, research must relate at least to some intentional social change. This leads to a revision of the relationship between the researcher and the participants in a project: involvement and interpersonal interaction. This does not mean that the researcher must become an activist or a simple participant. He or she continues as a social scientist to uphold a critical understanding of the situation. Finally, there is another consequence for clinical sociology: the necessity to combine different disciplinary contributions in order to gain a better understanding of social problems. Can we still speak of clinical sociology? Or do we speak of a clinical psychosociology? As long as we define ourselves as sociologists, the focus will remain on clinical sociology. Still, to be clinical necessitates complementary contributions from related disciplines such as psychology, anthropology, and communication studies. Certain other specific influences need to be briefly mentioned in the development of clinical sociology in Québec—namely, those of social intervention and the counterculture movement.

Community Development and Social Action

Social intervention is another practice that emerged in Québec during the same period (1960s and 1970s). More specifically, it was used in urban–rural community and regional development projects in which facilitators and researchers experimented with different modes of collective social participation. Social intervention shares many characteristics with psychosociological practice. It emphasizes, for instance, the relationship between research and action, between participation and teamwork, and the important relationship between researcher and population. Michel Blondin (1968) and Louis Favreau (1989) are the pioneers and principal representatives of this type of practice. Generally speaking, it is also a more politicized practice whose inspiration comes largely from critical sociology, Marxism, or other influences. Important references for social intervention during

this period include literacy projects undertaken by Paolo Freire (1973) in Brazil and Chile, and Saul Alinsky's (1976) work on urban social movements in Chicago. Practitioners from this social intervention trend tend to criticize Lewin's (1948) psychosociology, which is considered to be, in the political spectrum, a right-wing ideological practice.

   An important interrelationship developed between numerous psychosociologists and social practitioners of social intervention, of which many were social workers. The development of health and social services based on state regulations and institutions (in neighborhoods, subregions, agencies, hospitals, and the like) appealed to professionals coming from both fields of practice. The critical sociological perspective was more present in social work training and practice, but the pragmatic and humanistic views of psychosociology were gradually adopted in many social intervention approaches. Social intervention's main contribution in clinical sociology was the development of a *critical perspective* that stressed power relationships and social inequalities within society. Working with poor, marginal, or vulnerable groups raises the question of empowerment. But is such a normative perspective acceptable for sociologists as scientists? It seems that in any case a clinical approach with people has to deal in some respect with the issue of ethical involvement.

A Radical Change of Culture

Other practices relating to the counterculture of the 1970s should also be mentioned in order to complete this portrait of various influences. The counterculture movement of the 1970s was strongly influenced by so-called humanistic psychology (Bugental, 1967). In North America, the nondirective or person-centered approach of training and personal growth groups was well known to the psychosociologists of the day. Within this approach two opposed yet complementary camps can be identified: the Rogerians (followers of Carl Rogers) and the Lewinians (followers of Kurt Lewin). The first were identified by the priority given to working with and helping individuals, the second by its more collective and pragmatic approach to problem resolution particularly in industrial contexts. With increasing interest in new therapies and personal growth experimentation associated with the counterculture, ideas became even more radical. Primacy clearly was given to the individual and to an alternative vision of social organization, which called into question the domination of a centralized, rationalized bureaucracy in every sphere of society (such as work, education, and family). Advocates of the countercultural approaches distanced themselves, however, from the critical perspective of Marxist analysis, which they considered to be too rationalistic and collectivistic.

   Thus, a certain number of new culture techniques based on body awareness or the exploration of the "imaginaire" (imagination) were added to the arsenal of psychosociological techniques of intervention, although not without very lively debates that only accentuated the polarization between Rogerians and Lewinians.

Many proponents of these approaches became psychotherapists or management counselors. A small number continued practicing while maintaining a necessary tension between these two poles of reference. The majority of the partisans of clinical sociology came from this latter group, the ones who combine collective and rational action and individual and affective change.

Counterculture is also important because it reflects a social transition in Québec and North America. The 1970s marked a turning point for culture and social movements about minority rights, women's equality struggle, and union development due to continuing postwar economic growth, increasing global richness, and a stronger appeal for citizens' participation. Counterculture goes even further, looking for a radical change to bring about individual well-being and a greater leisure life. But by the end of the decade, a much more complicated situation emerged with the energy crisis and an increased focus on a market economy, which reintroduces new types of restrictions on expected social developments. It is in this new context that Québec clinical sociology develops during the 1980s.

Clinical Sociology as an Academic and Professional Reference

The notion of clinical sociology was explicit in the early texts of sociographic sociology. At that time, however, clinical sociology represented a point of view, which we would now consider to be limited. Therefore, it became marginalized even within the sociographic approach. The second important influence on clinical sociology, that of the psychosociological approaches, remained mostly implicit. This is particularly evident in such varied practices as planned change, organizational development, human relations, social intervention, group dynamics, and personal growth groups. Furthermore, for these practitioners, the term *clinical* referred particularly to the clinical practice in psychology (psychotherapy) or medical practice. Sociological analysis was more or less important in these practices, depending on the approach—less important in personal growth groups and more important in social intervention. The relative marginality of clinical sociology, in the sense of not having a clear and formal labeling had to be addressed. Some sociologists use an indirect strategy, that is to say, getting international recognition in order to be recognized at home.

An important turning point for clinical sociology came about in 1982 when Robert Sévigny and Gilles Houle (Houle, 1987), both from the University of Montreal, participated in the creation of the ad hoc Research Committee in Clinical Sociology within the International Sociological Association (ISA) Conference in Mexico in collaboration with American colleagues. Their initiative drew from the double tradition that we have just outlined, but went further in redefining the field of clinical analysis according to the evolution of its practices and ideas. This redefinition was worked through formal steps of development in further ISA conferences: as a Working Group in 1986 at New Delhi and in Madrid in 1990. In 1992, the status of a regular research committee was obtained and maintained until now, meeting

regularly in the successive International Global Conferences: Bielefeld (in 1994), Montreal (in 1998), Brisbane (in 2002), and Durban (in 2006).

Another similar development is produced in the "cousin," l'Association Internationale des Sociologues de Langue Française (AISLF, the International Association of French Language Sociologists). In 1988, a research ad hoc group in clinical sociology was created (Geneva, Switzerland), meeting again in 1992 (Lyons, France) and then transformed as a regular research committee in 1996 (Evora, Portugal), meeting after that on a regular basis (Québec, Canada, in 2000, and Tours in 2004).

Many clinical sociologists from Québec also were present at the creation (2003) of a research committee in clinical sociology in the new and revised national Sociological French Association (AFS, l'Association Française de Sociologie), at a conference held in Paris. It's a long way since the creation of the American Clinical Sociology Association and Sociological Practice Association in the late 1970s. It should be noted that clinical sociology associations have been created in many countries, particularly in the late 1990s or more recently in Uruguay, Mexico, Italy, and Moscow.

These developments helped established a network of researchers who serve as a source of reference and common vision of a clinical approach to sociology. What happened in Québec during that period? What were the kinds of practices and results? What was the historical and political context?

Clinical Sociology Redefined in the 1980s and 1990s

The Quiet Revolution of the 1960s transformed Québec into a stronger province. Bureaucratic tendencies also increased with the creation of a much larger public service sector, both in structure and volume. During the same period, the independence or nationalist political movement formed a party, the Parti Québécois, which won the election in 1976 and remained in power for many years. The reinforcement of the public service sector was an important dimension of Parti Québécois policy; this contributed to even more bureaucracy. At the same time, in the early 1980s and further on in the 1990s, the world energy crisis (petroleum prices) and the emerging globalization phenomena resulted in fierce competition among companies for survival. Management sciences were replacing social sciences as basic references for social practices in the workplace and also in public services. The focus was on efficiency and rational and technical problem solving with the help of the new computerization technology that had penetrated every sphere of social life.

Psychosociology, clinical sociology, and the like were challenged by this dominant technocratic and information-based culture. Nevertheless, these social approaches were still very much needed to address the social issues raised by these new social, political, and economic forces. Human factors became even more crucial in the development and management of industrial or public organizations. On the opposite side

of the labor force, an increasing number of people joined the excluded and marginal, the unemployed—a fragmented population. Clinical sociology could now develop.

Two particular events put forward the idea of clinical sociology in Québec. The first one occurred in the January 1990 colloquium in Québec City, Clinical Analysis in the Human Sciences. The objective of this colloquium was to describe the principal characteristics of a clinical approach in the social sciences, its defining issues, and its challenges for the future. The intention was to determine the specificity of this approach from the point of view of theory and empirical research. A second colloquium was held in September 1993, Clinical Approach in the Human Sciences: Possibilities and Limits. In both cases, the participants and the content of the presentations demonstrated the originality and force of the clinical sociology project. The colloquia were organized by representatives of the two principal institutions involved in the current network of clinical sociology: the University of Montreal and the University of Québec in Montreal (UQAM). In addition to a core group of sociologists, there were 200 or so participants from widely varied disciplines and sectors of intervention (management, psychiatry, psychology, education, criminology, social work, communication, and anthropology). This multidisciplinarity and the inclusion of different sectors of intervention are characteristic of the clinical approach in Québec. The same can be said of the principal themes addressed—work and organizations, mental health and therapy, social problems, and methodological questions—which well represented the targeted fields of activity. Finally, the presence of several European and American researchers was an indication of the international collaboration that existed in the network of researchers in clinical sociology.

The colloquia were good illustrations of what constitutes clinical sociology in Québec: an open network rather than a formal organization; a project rather than an established practice; a new vision of the social sciences rather than just another method or new sector of research; and, of course, a dedicated group of individuals and institutions.[4]

Additionally, there are numerous links with researchers who identify little, or not at all, with clinical sociology per se, but whose ideas and practices converge with this approach. Some examples include those working in the field of mental health intervention (the *Revue de Santé Mentale in Québec* [Québec Journal of Mental Health] and researchers at the Douglas Hospital); the field of organizational intervention (researchers from the *Hautes Études Commerciales*, or the Higher Studies School of Business) studying the individual-organization relation and organizational cultures; researchers at UQAM in management and human resources;

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[4] A number of names can be mentioned: Robert Sévigny and Gilles Houle (sociologists at the University of Montreal); Jacques Rhéaume, a sociologist, and Simone Landry, a psychologist (Department of Communication, University of Québec in Montreal); Danielle Desmarais, an anthropologist (Department of Social Work), and Shirley Roy, a sociologist (Department of Sociology), from the same university; Monique Morval, a psychologist and the director of the doctoral program in Applied Social Sciences, University of Montreal; Adrienne Chambon, a sociologist, University of Toronto; and others.

and, in the field of social work, the *Revue Internationale d'Action Communautaire* (International Journal of Community Intervention), University of Montreal, and the journal *Nouvelles Pratiques Sociales* (New Social Practices) at UQAM. Links also exist among researchers with interests in qualitative research,[5] action research, life stories, or science action. This latter approach is represented in the work of psychologist Yves Saint-Arnaud, professor at the University of Sherbrooke (Québec, Canada). The University of Sherbrooke offers an academic program (master's level) in the psychology of human relations, which adopts a psychosociological perspective. The University of Québec in Montreal also offers a program at the bachelor's level in communication and human relations, in which psychosociology is very much present.

But what would be the common characteristics shared by all these people that allow us to speak of a clinical sociology approach to social practice? We will give two actual examples of sociological practice that illustrate the clinical perspective: research and intervention in life narratives or life stories, on the one hand, and research and intervention in mental health issues in the workplace on the other.

Clinical Sociology Today: From Life Story to the Workplace

Life narratives as a social practice in research, training, and intervention have developed a great deal since the first experiences of the sociographic school in the 1960s and the seminal work edited by Danielle Desmarais and Paul Grell (1986). The life narrative research and training approach is based on the basic postulate that social actors are built through time and history, and that gaining better access to their own lived history helps to improve future choices and leads to empowerment, either on an individual or collective basis. The forms of intervention are varied: personal written life stories commented on in small research and training groups; personal narratives using more verbal and nonverbal expressions; life stories produced in more classic research interviews; and collective life narratives produced by a group of people in formal organizations. A recent book, *Récits de Vie et Sociologie Clinique* (Life Narratives and Clinical Sociology), edited by Lucie Mercier and Jacques Rhéaume (2007), presents the theoretical and methodological dimensions of this approach as well as providing numerous examples.

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[5] Some of the orientations of qualitative research in Québec are shared with a clinical perspective.

Consciousness Raising Through Life Stories

One such dimension is the family novel and social trajectories, a method of life narratives developed first in France by Vincent de Gaulejac (1999), a clinical sociologist, and then in Québec by Jacques Rhéaume (2000) and others. Typically, this research and training experience is offered or requested by professionals in social intervention: social workers, psychologists, nurses, consultants, and teachers. The method is based on intensive small groups meetings of three to four days, on a particular theme. It uses verbal and nonverbal techniques (such as drawings, socio-dramas, genealogical trees, and photos). For example, a research topic can focus on life stories exploring the participants' views of money and wealth. This not only permits an exploration of the psychosocial life experience of the many dimensions of wealth and poverty, but also touches upon the social and economic transformations that condition these experiences. The most developed aspect centers on the importance of family intergeneration transmission of different capitals—economic, cultural, professional, and social—that constitute one's social status. The people participating in such an experience appreciate the increased understanding they gain about their own lives, but more significantly prepare them to better understand the people they meet daily as professionals. This is part of their training so they can improve their work and practice in institutions such as schools, hospitals, community groups, and enterprises. In a way, this approach can be seen as a preventive social intervention, helping people to prepare themselves to better meet complex people problems. There is also, unavoidably, a personal interest in exploring and resolving one's own life issues. Professional and personal motives are involved in this kind of experience.

Healthy Work

Another sector of research and intervention is the psychodynamic of work, a method developed in France by the physician and psychoanalyst Christophe Dejours (1993) and colleagues, and adapted and developed in Québec by Marie-Claire Carpentier Roy and Jean-Pierre Brun, both sociologists. A group of ten researchers from five universities and different social or health sciences (sociology, psychology, social medicine, ergonomy, and ergotherapy) have established in 1998 the Québec Institute of Psychodynamic of Work. Since 1992, more than fifteen research projects have been completed using this social clinical approach in industrial plants, hospitals, social and health local services, unions, penitentiaries, and governmental agencies. Some of these experiences are reported in two publications edited by Carpentier-Roy and Vezina (2000) and the institute (Institut de Psychodynamique de Travail, 2006). This approach closely follows a typical sociological clinical format that we can describe in four phases.

First, a social demand or request leads to a study in a given organization. The request can originate from human resources people, or, more often than not, from union representatives or the medical services. Usually there is a problem situation in the workplace marked by health issues, even suicide casualties. A real need exists to examine the troubled work situation. At the beginning, there is a complex process of establishing a contract between researchers and management and employees' representatives. One guiding principle that should be kept in mind is that the concerned employees should remain the principle actors and that they should get involved in the research after having been informed on every aspect of the procedure. Information meetings, discussions, and free voluntary participation precede the more formal contract to be signed between parties.

Second, a preinvestigation step consists of document analysis, visits, and direct observation of the workplace sites, as well as preliminary interviews with representatives. The aim of this phase is for the researchers to get familiarized enough about the situation, the culture, and the specific terms to be able to conduct properly future collective interviews and to establish a relationship of trust with the participants. It is also during this phase that the group of researchers (usually three or more working together) becomes familiar with the case and exchange ideas with respect to their proper expertise. For example, the occupational therapist will particularly appreciate being able to directly observe work activities, while the sociologist becomes most interested in the conflict history between union and management.

Third, collective interviews are conducted with groups of eight to twelve employees who share a similar type of work. At least four meetings are conducted. Two meetings address participants' self-expression of their relationship with work, the suffering or pleasure they experience, and the defensive strategies—individual or collective—they employ to resist an increase in suffering. This gives a very specific picture of the work situation as it is subjectively experienced by the workers, accompanied by concrete and detailed description of incidents. A third meeting addresses the analysis produced by the researchers, which is then confronted with the participants' own analysis. This debate forms the basis of the written research report, which is presented and discussed in a fourth meeting with each group of workers.

The final phase of this research process is the validation and diffusion of the written report. Comments are included from every group of employees that took part in the research. This process can minimally include two groups or it can extend to fifteen groups or more depending on the size of the organization. The groups of participants are the ones who decide, with the researchers, what will be put in the report, to whom it will go, and for what purpose. The researchers present the reports to different publics, inside or outside the organization, and comment on them and answer ensuing questions. Their intervention stops here; the researchers leave the responsibility to the different leaders and collectives in the situation to take action based on the study's findings. The researchers, however, do not completely disappear; they remain available to provide support and to further explain the study.

This is a typical process representative of a clinical model of sociology. It is clinical, because we can see the multilevel interaction among researchers and social actors, theory and action, and social problem resolution as an ultimate aim. The particular psychodynamic approach just described is partially sociological in that the sociology of work and organization are at the center of the analysis: how work can cause good mental health or mental illness. However, this research object cannot be completely understood without the contribution of other scientific knowledge, namely the works of psychology, occupational health, and medicine.

The Clinical Sociology Approach

The confrontation of ideas and practices developed in Québec through the sociographic approach in sociology, psychosociology, social intervention (social animation), counterculture, and action research introduces several themes that define a clinical approach in sociology.

A Social Contract

First, these social practices enable us to clarify even further the relations of involvement between researchers and other social actors. This involvement is revealed through the development of increasingly sophisticated analyses of how the researcher/practitioner treats social demands of groups asking for intervention, and through a better understanding of the contractual relations between the researcher/practitioner and client, and the power inherent in this relation.

Second, these practices involve a closer link between the researcher and the field since this relation is defined as an action situation. It is no longer sufficient to arrive at an understanding of the situation from the point of view of social actors, with all the distance implied by a sociographic perspective. Instead, the objective is to help them understand the situation in order to be able to act on it. This reference to action is necessary and calls into question purely speculative and detached perspectives of social research.

Interdisciplinary Complexity

Third, the debates surrounding the different forms of social clinical practices introduce the necessity for researchers and practitioners to redefine research and intervention in light of the theory of complexity and dialectical interaction between action and analysis; between different so-called levels of reality, from the individual to the group, to the organization, to global social categories (ensembles); between different modes of expression, whether rational, emotive, concrete, symbolic, or

imaginary; and between a critical sociological perspective, which gives all its weight to structural constraints and determinations, and an interpretive sociology of the construction of meaning by social actors in interaction. The special issue of the journal *Sociologie et Sociétés* (1977) (Sociology and Societies), published under the title *Psychologie, Sociologie, Intervention* (Psychology, Sociology, Intervention) provides an excellent discussion of these themes.

An Ethical Issue: Democracy

Fourth, clinical sociology cannot separate scientific knowledge production from values or ethical issues. Given that clinical intervention and research are closely linked to action and based on a shared project between the researchers and the participant, goals and values need to be made explicit. Most generally, clinical sociology projects aim at developing a greater reflexive consciousness, social justice, and democracy. For example, responding to workers' demands for a better understanding of a difficult work situation can facilitate improvement of people's work quality of life, which in turn means personal and collective empowerment. This is also true of community development projects and even professional training, as illustrated earlier with the life-stories approach.

Conclusion

We cited some examples of clinical sociology today in Québec—life stories and mental health in the workplace. But there are many other domains where similar practices develop without explicitly referring to clinical sociology. The development of clinical sociology in Québec follows a network pattern without an explicit formal organization of clinical sociology as was done in other countries. But clinical sociology principles and approaches are very much present. A final example can be given to illustrate this reality and also serve as a conclusion. It refers to one of the founders of clinical sociology in Québec.

In 1992, Robert Sévigny founded the Center of Research and Training in a local community services center (health and social services) in a large neighborhood in Montreal, characterized by a dominant immigrant population. He developed an intensive, multidisciplinary research program on social and health services for the immigrants and refugees. Nowadays, this center involves, on a regular basis, forty or so researchers from fields such as sociology to medicine, social work, nursing, and anthropology. The basic principles or orientations of the research center are essentially clinical:

- Research is a response to needs expressed by professionals and the population.

- The process of creating research must follow a basic rule: people, researchers, managers, professionals, and the general population must be involved in the process.
- The production of knowledge refers to a pluralistic epistemological basis, mixing different disciplines and confronting the scientific knowledge with professional knowledge and common sense, each representing a necessary contribution in the understanding of social action and social problem.

Clinical sociology, however, is rarely explicit at the center and very few researchers, even among sociologists, will identify themselves with this label. Yet, why is it so, when practices are so close to a clinical model? Two reasons could be invoked. First, the word clinical is generally associated with medicine and the biomedical model; therefore, many sociologists resist such a label. Second, mainstream sociology, and this is not only true for Québec, does not easily accept the involvement of researchers in social intervention, especially when it is done in response to specific social demands. Actually, the important thing is that clinical sociology exists in practice and is at least recognized by an active minority of sociologists, which allows research and training to be pursued in this way. Clinical sociology has only survived in Québec on the basis of social practice, specifically contributing to the development of sociology.

References

Alinsky, S. (1976). Le Manuel de l'Animateur Social [Rules for Radicals]. Paris: Seuil.

Bertaux, D. (1976). Histoires de vie-ou Récits de pratique? Méthodologie de l'approche biographique en sociologie [Life Stories or Practice Stories? The Biographical Approach Methodology in Sociology]. Mimeographed report to CORDES.

Blondin, M. (1968). Vie urbaine et animation sociale [Urban life and social animation]. Recherches sociographiques, 9(1–2), 111–119.

Blumer, H. (1969). Symbolic Interactionism. Perspective and Method. Englewood Cliffs, NJ: Prentice-Hall.

Bugental, J. F. T. (1967). (Ed.). Challenges of Humanistic Psychology. New York: McGraw-Hill Book Company.

Carpentier-Roy, M. C. and Vézina, M. (Ed.). (2000). Le travail et ses malentendus [Word and its Misunderstandings]. Québec: Presses de l'Université Laval & Octarès.

Dejours, C. (1993). Travail, Usure Mentale [Work and Mental Wearing]. Paris: Bayard Editions.

Desmarais, D. and Grell, P. (1986). Théorie, Méthode et Trajectoires Types [Theory, Method and Typical Trajectories]. Montreal: Editions Saint-Martin.

Dufrenne, M. (1953). La Personnalité de Base [The Basic Personality]. Paris: Presses Universitaires de France.

Dumont, F. and Martin, Y. (1963). L'Analyse des Structures Sociales Régionales [Analysis of Regional Social Structures]. Quebéc: Presses de l'Université Laval.

Favreau, L. (1989). Mouvements Populaire et Intervention Communautaire (de 1960 a nos Jours): Continuités et Ruptures [People's Movements and Community Intervention (from 1960 to Nowadays): Continuities and Ruptures]. Montréal: Editions du Fleuve, CFP.

Freire, P. (1973). La Pédagogie des Opprimés [Pedagogy of the Oppressed]. Paris: Maspero.

Garfinkel H. (1967). Studies in Ethnomethodology. Englewood Cliffs, NJ: Prentice Hall.

Gaulejac, V. de (1999). La Névrose de Classe [Class Neurosis] (3rd ed.). Paris: Hommes et Groupes Editeurs.

Glaser, B., and Strauss, A. L. (1967). The Discovery of Grounded Theory: Strategies for Qualitative Research. New York: Aldine de Gruyter.

Houle, G. (1987). Le sens commun comme forme de connaissance: de l'analyse clinique en sociologie. [Common sense as a knowledge form: about clinical analysis in sociology]. Sociologie et Sociétés, 19(2), 77–87.

Institut de Psychodynamique du Travail. (2006). Espace de Réflexion, Espace d'Action en Santé Mentale au Travail [Space for Reflexive Thinking, Space for Action in Work Mental Health]. Québec: Presses de l'Université Laval.

Kardiner, A. (1969). L'Individu dans sa Société. Essai d'Anthropologie Psychanalytique [Individual in his Society. A Psychoanalytic Anthropological Essay]. Paris: NRF, Editions Gallimard.

Lewin, K. (1948). Resolving Social Conflicts. New York: Harpers.

Mauss, M. (1950). Isociologie et Anthropologie [Sociology and Anthropology]. Paris: Presses Universitaires de France.

Mercier, L. and Rhéaume, J. (Ed.). (2007). Récits de Vie et Sociologie Clinique [Life Stories and Clinical Sociology]. Québec: Presses de l'Université Laval.

Parsons, T. (1957). Toward a General Theory of Action. Cambridge, MA: Harvard University Press.

Rhéaume, J. (2000). Le récit de vie en groupe: réflexions épistémologique et méthodologique [Life story in groups: epistemological and methological thinking]. Revue Internationale de Psychosociologie, 6(14), 107–121.

Rhéaume, J., and Sévigny, R. (1988). La Sociologie Implicite des Intervenants en Santé Mentale. Vol. I, Les Pratiques Alternatives: Des Groupes d'Entraide aux Groupes Spirituels; vol. II, Les Intervenants Professionnels: de la Croissance Personnelle à la Guérison. [Implicit Sociology of Mental Health Practitioners. Vol. I, Alternative Practices: From Self Help Groups to Spiritual Groups; vol. II, Professional Practitioners: From Personal Growth to Healing]. Montreal: Éditions Saint-Martin.

Sévigny, R. (1979). Le Québec en Héritage: La Vie de Trois Familles Montréalaises [Québec's Heritage: Three Montrealese Families' Life]. Laval, Québec: Editions Saint-Martin.

Thomas, W. I., and Znaniecki, F. (1918–1920). The Polish Peasant in Europe and America (5 volumes). Boston: Gadger.

Weber, M. (1964). The Theory of Social and Economic Organization. New York: Free Press of Glencoe.

Selected Readings

Carpentier-Roy, M.C. and Vézina, M. (eds.). (2000). Le Travail et ses Malentendus [Word and Its Misunderstandings]. Québec: Presses de l'Université Laval and Octarès.

Sévigny, R., Rhéaume, J., Houle, G., and Enriquez, E. (1993). L'Analyse Clinique dans les Sciences Humaines [Clinical Analysis in the Human Sciences]. Montreal: Éditions Saint-Martin.

Sévigny, R. (1991). Communauté et santé mentale à Singapour: une autre vision du 'communautaire' [Community and mental health: Another view of the 'community']. Revue Canadienne de Santé Mentale Communautaire, 10(1), 29–48.

5

On the Origins of Clinical Sociology in France: Some Milestones

Vincent de Gaulejac

Clinical sociology emerged in France in a continuous way in the 1980s and was affiliated with psychosociology and the work of the Laboratoire de Changement Social (Social Change Research Center) (LCS) at the Université Paris Diderot. In Geneva, in 1988, a workshop was launched within the Association Internationale des Sociologues de Langue Française (International Association of French Language Sociologists, AISLF) on the initiative of Robert Sévigny, Gilles Houle, Eugène Enriquez, and me. A working group that included these members also became a permanent research committee within the International Sociological Association (ISA) in 1992.

The first clinical sociology conference organized in France was held at the Université Paris Diderot in the same year. Co-sponsored by the AISLF and ISA research committees, the conference brought together more than 150 researchers from over fifteen countries. An account of these events and the papers they produced were published the following year (Gaulejac and Roy, 1993).

In the 1980s, clinical sociology, which is essentially based on the research led by the LCS, gradually imposed itself as a new perspective in the field of the social sciences. Two events marked the recognition of this new research trend: first, the foundation of the Institut International de Sociologie Clinique (International Institute of Clinical Sociology) in 1999 in Paris; and second, the creation of a French committee of clinical sociology within the Association Française de Sociologie (French Association of Sociology) in 2004.

This recognition of clinical sociology is the result of debates and discussions that have run through sociology since its birth. It was as though clinical sociology was a reemergence of questions lying at the very foundations of sociology. This chapter explores these origins, starting with the sociology of the French School, particularly that of Emile Durkheim, Marcel Mauss, and Georges Gurvitch, to trace the debates surrounding psychology and psychoanalysis, and to identify the influence of the Frankfurt School, Freudian Marxism, and American social psychology in the 1950s. Finally, I will discuss psychosociological sources to the extent that they influenced the founders of French clinical sociology.

In an article introducing the genesis of the clinical approach in sociology, Eugène Enriquez (1993) wrote, "Clinical sociology, a recent branch of sociology still in progress, has a long history, [which has] long been forgotten, obscured or repressed." He evokes the famous quarrel between Emile Durkheim and Gabriel Tarde, the former

considered a real sociologist while the latter was cast off to collective psychology because he was preoccupied with psychological forces. Here, I will not mention the causes of this quarrel, which must be placed in context to be fully understood. I will focus instead on the difficulties that many sociologists have in taking psychic dimensions (such as thoughts, desires, affects, emotions, ideals, and beliefs) of social relations into account. It appears as though such dimensions are the concern solely of psychologists or psychoanalysts, because they simply could not be considered social facts.

The celebrated rule of sociological method—"treat social facts as objects" (Durkheim, 1937)—drives a good number of sociologists to produce a rigid representation of society, without soul and without passion. It is as if the preoccupation with objectivity should be rewarded with the elimination of all that expresses the emotional and affective parts of the human being. However, many, if not the majority, of writers, who were no less talented often opposed this tendency. To begin with, there is Durkheim, the founder of French sociology.

We have here a paradox. Most sociologists make reference to Durkheim to justify their rejection of psychic dimensions, even though he himself wrote that "the study of psychic-sociologic phenomena is not a simple annex of sociology; it is the substance itself" (Durkheim, 1885). We can suppose, therefore, that the deep suspicion held by many sociologists toward psychology is at odds with the work envisioned by the founder of French sociology. Understanding how the founders of sociology addressed these issues is not a trivial matter, considering how the privileged objective of clinical sociology is, to restate a proposition of the Collège de Sociologie (Caillois, 1938/1979), to study the mutual relationship of the *being* of an individual and the *being* of society.

Durkheim and Sociopsychic Processes

The Rules of Sociological Method (Durkheim, 1937) clearly affirms the primacy of social account and the exclusion of all psychological interpretation:

> The determining cause of a social fact should be sought among the social facts preceding it, not among the states of the individual consciousness.

Durkheim affirms sociological explanation over all other forms of explanation including metaphysical, organic and psychological. As Durkheim states:

> The function of a social fact can not be but social. . . . It is because sociologists have been often been unaware of these rules and considered these social phenomena from an overly psychological point of view that their theories appear to numerous minds as too vague, too baseless, too distant from the special nature of things which it assumes to explain.

The defense of one fundamentally sociological position drove Durkheim to formulate a basic rule of method: "In all instances where the social phenomena are directly explained by a psychic phenomena, we can be certain that the explanation is false." On the grounds of this formulation, several generations of sociologists have adopted a hostile and combative attitude toward psychology, and also psychoanalysis, distancing themselves from the study of sociopsychic facts.

In the same work, however, Durkheim is much more specific and dialectic on the relationship between the social and the psychic than most of his disciples. Although his arguments on this issue are certainly not as clear as his affirmation of the primacy of sociological causal explications, a less elaborate quote reveals his predicament:

> This is certainly not to say that the study of psychic facts are not indispensable to sociology. If collective life is not derived from individual life, the one and the other are [nonetheless] bound; if the latter can not explain the former, it can, at least, facilitate an explanation.

In this remark, we sense his concern over protecting sociology and assuring its independence from psychology as he defends the basic principle—explain the social with the social. It is only appropriate to go to the furthest rims of sociological thought before crossing the boundaries in search of explanatory factors in other disciplines.

The point of departure that Durkheim proposes for interaction between sociology and psychology is detailed in the hierarchy he established between the two disciplines. The object of psychological study is reduced to no more than that which sociological explanations do not consider:

> We can see it clearly in the development of Durkheimian collective psychology, which would focus on the tensions and not on the cooperation between the two sciences. The part that Durkheim has left to pure individual psychology would, little by little, be eroded by his disciples. [Bastide, 1962]

Here, René Bastide (1962) underlines a decisive point—the transformation of the theoretical debate from the aspect of knowledge to that of disciplinary corporatism.

How many times, during conferences, university classes, or thesis defense examinations, have we heard colleagues assert that "it's not sociology" in a peremptory manner? As soon as researchers venture to the frontiers of the discipline, and particularly on the relationship between social and psychic processes, they are brought to order and forced to choose their camp.

We could understand this position if it was stated at a time when sociology was not recognized as a discipline, in an epoch when it needed to build and assert itself. Yet today, sociology still clashes with an inevitable element; social facts are also psychic facts. Durkheim (1937) explicitly recognized this:

> It is irrefutable that social facts are produced by an elaboration *sui generis* of psychic facts. … A psychological culture, rather than a biological culture, constitutes, therefore, a necessary foundation course for a sociologist; but it will not be useful to him unless he frees himself from it after having received it and unless he transcends it in completing it with a specifically sociological culture.

Sociologists, therefore, must acquire psychological training and then abandon psychology in order to ground themselves "at the very heart of social facts." Durkheim (1937) also adds in a footnote that "psychic phenomena can not have social consequences except when they are so intimately united with social phenomena that the action of one and the other is necessarily bound. This is the case for certain socio-psychic facts." To illustrate this point, Durkheim

draws on the "social energy" which lies at the junction of the drive and power bound to professional status:

> Thus a public official is a social force, but he is at the same time an individual. It ensues that he can be useful as a social force which he bears, in a sense determined by his individual nature and, through this, he can have an influence on the constitution of society.

While the behavior of actors is mostly conditioned by their social status, function, and position, they are also individuals who can use their "social energies to fulfill personal ideas." Here, Durkheim (1937) evokes not only the interest of the actors, their strategies for keeping their positions of power, but also their desires, aspirations, feelings, and the manner in which their drives underlie their conscious intentions. This is another opening from sociology toward psychoanalysis.

From Durkheim to Freud

There is another point in the Preface to Durkheim's (1937) *The Rules of Sociological Method*, which calls for our attention: "Simultaneously, as institutions impose themselves on us, we comply with them; they oblige us and we like them." The relationship between individual and institutions or organizations is social relations. They are imposed on us and they are also affective relations; for instance, we love and we hate them. We must read Freud and his 1921 essay, "Group Psychology and the Analysis of the Ego," to better understand the love relationship that is established in a group, especially in an organization such as the church or the army. Each person projects one's own ideal on the object of love and interjects the qualities of that object. This double movement, at the core of passion, of fusion with the beloved person, is found in the relationship of soldiers with their army or the clergy with their church.

The social relation, today the object of multiple interrogations, is fundamentally a libidinal link, and yet it cannot be reduced to the dimension of drive or impulse. It is both totally social and totally psychological.

There is then continuity between Durkheim and Freud. In Durkheim, from 1895, we find the attention he paid to the notion of sociopsychic facts. He develops the links that exist between individual psyche and collective psyche in his last work, *The Elementary Forms of Religious Life* (1912), in which he insists on the essential role of faith and passion in collective life. In particular, Durkheim (1912) evokes "the state of effervescence of collective life which changes the conditions of psychic activity: mental energies are over-excited, passions more alive, sensation stronger."

The topics and themes that concern clinical sociologists, therefore, were present from the founding of sociology. It is befitting to underline this point to those who think that clinical sociology is nothing more than a new costume for psychosociology, a Trojan horse of social psychology that will attempt to secretly penetrate the field of sociology or, even worse, that it will take the side of Gabriel Tarde against

Emile Durkheim. This debate can seem rather farfetched at this point, but we have here the same processes at work in family histories. The sociological "family" is still inhabited by a primary antipsychologism often attributed to Durkheim, although this "great-grandfather" advocated a deeper relationship between sociology and psychology, a theme that has been developed by his nephew.

Mauss and Psychological Sociology

Since Durkheim, many sociologists have defended the need to have an interest in the psyche. To begin with, there is Marcel Mauss (1924), according to whom "social phenomena are principally social, but are, in the same instance, psychological and sociological simultaneously."

In a conference of the French Society of Psychology, March Mauss (1924), Durkheim's nephew, gradually developed his conception of the relationships between the two disciplines. He considered sociology as a living science:

> There is no society but among the living. Sociological phenomena are of life. Therefore, sociology is but a part of biology, just like psychology for you, and we deal only with men of skin and bones, living or having lived.

Consequently, sociology and human psychology "belong to this part of biology that is anthropology, that is to say, all of the sciences which consider man as a living being, conscious and social."

Mauss (1924) thought that as sociology and psychology have complementary perspectives on human facts, it is only fitting, therefore, to construct a psychological sociology that has "the relationship between psychic and material facts within society" as an object of analysis. Sociology has as an object "material facts," which require analysis from three perspectives—morphological, statistical, and historical—but it also has as an object of analysis the relationship between material and psychic facts, which constitute "an essential part of sociology or even collective psychology."

The object of this psychological sociology concerns the collective representations that gather the "thoughts, concepts, categories, and motives of action and of traditional practices, collective sentiments and rooted expressions of emotions and of sentiments" (Mauss, 1924). In conclusion, the study of people cannot be divided: "Today, we are dealing with man's body, his entire mentality, given at the same time and suddenly. Fundamentally, body, soul, society are blended together."

The analysis of this complex combination, which Mauss (1924) refers to as the "totality of phenomena," demands from sociology, as well as psychology, a multi-disciplinary opening in order to take into account all the aspects of the individual, "his body, his instincts, his emotions, his will, his perceptions and his intellect." The notion of the total social fact becomes, therefore, the point of connection between a concrete psychology and sociology, equally concrete, which come together to describe individuals as "complete and complex beings, in their organisms and their psyches" (Mauss, 1924).

Mauss brings us some of the strongest ideas at the base of clinical sociology: the importance of the *vécu* (the lived experience) as an inevitable specificity of the human; the need for an anthropological approach, which evokes the definition of the clinical as "the study of the man in situation" (Lagache, 1949); the attention representations, sentiments, and emotions; the apprehension of the human beings in three components—biological, psychological, and social; the project to construct a sociopsychology, which considers social phenomena in their material and psychic dimensions; and the need for sociology to take into account the meaning people give to their lives and to the history of which they are the protagonists.

The College of Sociology and the Analysis of "The Vital Elements of Society"

In the 1930s, similar concerns were shared by the founders of the Collège de Sociologie (the College of Sociology). In particular, Georges Bataille and Roger Caillois, joined by Michel Leyris, led a project to define "the vital elements of society" or what is more "the points of coincidence between the fundamental obsessing tendencies of individual psychology and the guiding structures which govern the social organization and command their revolution" (Hollier, 1979).

Sociology should identify the turbulences of social life in connection with the intimate experience of the individual's tragedies, cursed relationships, excess in eroticism, wars, celebrations, games, and all the human activities that have "communal value in the active sense of the word, which is to say that they are creators of *unity*" (Bataille, 1937). Three concerns are highlighted as priorities: power, consecration, and myth. It is fitting, therefore, to develop "critical work having as its object the mutual relationships of the *being* of man and the *being* of society: that which man expects of society and that which society demands of man" (Caillois, 1938). In the end, it is a matter of bringing into question the academic separation between knowledge and action. Between Marx, who wanted to transform the world, and Rimbaud, who wished to change life, there is space for a third voice, that of an engaged science, which tackles "the burning subjects" of its time. Researchers form part of their object of study. Researchers are engaged whether they want to be or not. There is no possible neutrality when we study the deepest aspects of social life.

At the first meeting of the Collège de Sociologie, Bataille (1937) stressed with force how the sociologist engages one's own life in the analysis:

> Depending on how men consider the whole that they form either as heaps of dust or bundles of grains, [that is either] as waves composed of molecules which are united by nothing but [their common] movement or, on the contrary, as the organizations, possessing all rights over the members who compose them, they take arms in one camp or in the opposing camp and the game to the death begins among them.

These words took on particular resonance within the context in which they were written. Europe was in economic and social crisis. The popular front governed in France, the civil war caused rage in Spain and opened fire on the pro-Franco dictatorship, while Hitler took over all powers in Germany. Faced with the rise of

Nazism and the threat of war, the sociologist was obliged to choose a camp. The scientist was forced to take up issues that were overwhelming but could not be ignored. In this context, the sociologist had no choice but to take risks. The existential engagement of the researcher was inevitable because analysis became an integral part of one's life. Hollier quotes Bachelard, who was not part of the Collège of Sociology, but we can be certain that his remark, published by Caillois in 1936, was known and appreciated by the members of the college: "We must give back to human reason its function of turbulence and of aggressiveness…. We must go where reason loves to take risks." It is a matter of questioning the taboos of knowledge, of blending reason into the most obscure sphere of *the being of the individual* and in the shadows of *the being of society*.

The endeavors of the Collège de Sociologie would not last (Hollier, 1979). The meetings stopped in July 1939. The war put an end to its creativity, and its influence on French sociology became almost nonexistent. In fact, its members are more often cited in the field of literature than in the human or social sciences. Their influence has been marginal even though the topics they raised have remained essential: the importance attached to the existential dimension of social relations; the opposition to all the forms of thinking that, in the name of science, evacuates "the irrational"—the cursed, sexuality, eroticism, drives, the affective—all that constitutes the viral element of society; attention to the obscure forces of social life, to "the cursed parts" of economic and social phenomena; and the involvement of sociology in knowledge and in action as two indissoluble facets of the same motion.

World War II put a stop to this intellectual effervescence. The German occupation, liberation, and then the reconstruction consumed all energies, and France was left livid from this ordeal. We must wait until the 1950s to witness a renaissance of the intellectual debate, marked by the influence of Jean-Paul Sartre and of Marxism on the intellectual milieu.

Following the liberation by the allied forces and the Marshall Plan, the "made in America" culture became a model in the domain of music, the arts, and culture. In the human sciences, this influence arose primarily in a diffuse manner and ran between two poles, the one quantitative and positivist, of which the figurehead was Paul Lazersfeld, and the other qualitative and humanist, dominated by the figures Kurt Lewin and Carl Rogers who later accompany the emergence of the French School of Psychosociology. In academia, French universities also were dominated by the Sorbonne where students read Daniel Lagache in clinical psychology and psychoanalysis, Jean Stoetzel in social psychology, and Raymond Aron and Georges Gurvitch in sociology.

Gurvitch and Total Psychic Phenomena

The postwar rebuilding of sociology after the war also was marked by the decline of Durkheimian influence followed by the rise of Marxist sociology, American sociology, and structuralism. Raymond Aron and Georges Gurvitch

were profoundly affected by World War II. Aron witnessed the rise of Nazism and of anti-Semitism in Germany while he prepared his thesis. In 1940, he rejoined General Charles de Gaulle in London where his interest in political and geopolitical issues grew stronger (Aron, 1983). Aron and Gurvitch fought the ideologies, all the forms of totalism, professing a practical liberalism inspired by Alexis de Tocqueville and Max Weber.

Gurvitch was a companion of Lenin, and he participated in the Russian Revolution of 1917 before taking refuge in France in the mid-1920s. The anti-Semitic rule of the Vichy regime obliged him to take exile in the United States, from where he returned after liberation. If Marx remained for him an incontrovertible thinker, particularly in terms of dialectical analysis, he rejected the idea of a principle of causal determinism of the economic type for a pluralist approach compatible with freedom (Gurvitch, 1955a). Gurvitch denounced simple oppositions between the individual and society, structure and conflict, the individual and collective, or psychology and sociology. He defended the "reciprocity of perspectives" between the different "*paliers*," levels, of social reality.

To study social fact, Gurvitch thought the sociologist must analyze its different platforms without any of them being, *a priori*, determinant. These elements interact in a dialectical complementary sense, which he defines as "opposites completing each other within a whole by a double motion which composes to grow and intensify itself, at times in the same direction, at others in opposite directions" (Gurvitch, 1955b). At these different levels, we can obtain the demography, social models, organizations, collective attitudes, collective values and ideas, mental states, and psychic acts.

Individuals make up society; society in return constrains them. It is only fitting to rethink the relationship between sociology and psychology:

> It is in the most intimate depths of our "I" that we find again the collective consciousness; we observe that it is under the most intense conditions that the collective consciousness ceases to exert pressure on the individual consciousness. The collective consciousness is therefore in each of us and each of us is in the collective conscience. [Gurvitch, 1957]

The relationship between individuals is placed within a "We" who renders the distinction between individual and collective consciousness rather uncertain.

From this perspective, Gurvitch proposes the completion of Mauss's proposition on total social phenomena through the study of "total psychic phenomena." He defines the psyche as follows:

> A play of growing and decreasing tension towards spontaneous reaction, which can also be individual, interpersonal or collective, preferably the three simultaneously. We have in the psyche… [diverse] tendencies towards the collective (us, groups, classes, global societies), the interpersonal (inter-individual or inter-group) and individual entangled. Under these conditions, the concept of total psychic phenomena… comprehends, at once, all the degrees of the psyche, all its colorations, all its unconscious, conscious, subconscious manifestations, all its directions towards the collective, the interpersonal and towards the individual, and finally the entirety of conflictual situations upon which the psyche transplants itself. [Gurvitch, 1956]

Thus, the psychic manifestations are at work in all the aspects of social life. They are integral parts of social being.

The disciplinary frontier between sociology and psychology is blurred. The psychic aspect and the social aspect obey rules of their own, but their interwoven complexity renders them inseparable. They support each other, come together, mutually influence one another, and connect themselves in permanent and indissoluble relations. It remains for sociology, as well as for psychology, to analyze these reciprocal influences insofar as we can never isolate individuals from their social context, just as we cannot separate the analysis of social phenomena from the psychic manifestations that constitute them.

Wilhelm Reich: Between Marxism and Psychoanalysis

In the reestablishment of French sociology after World War II, references to Marx, Weber, and Freud became central. The defeat of Germany revived different lines of thought formerly repressed by the Nazi regime. More than anything, the horror of the war and the Holocaust compelled intellectuals to attempt to understand what was considered the defeat of reason. How and why was civilization driven to barbarism? Was it conceivable that modernity, in all its radiant ideas of progress and rationality, could fall into savage, destructive, and irrational regression? One author, Wilhelm Reich, totally marginalized except for during the events of 1968, attempted to answer these questions by returning to historical material, the dialectics of Marx and the psychoanalytic analysis of Freud.

From 1929, Reich set the basis for an articulation between Marxism and psychoanalysis, attentive to the risk of confusion between socioeconomic and intrapsychic aspects. If sociological questions are not overrun by the psychological method, the psychoanalytical approach permits us to understand certain social phenomena such as the setting up of ideologies, the problem of class-consciousness or even the internalization of ideals. The veritable object of psychoanalysis is "the psychic life of man which became social being" (Reich, 1929).

According to Reich (1929), we must not see economic causes and unconscious motivations as opposites, but consider psychic processes as the "mediating forces between the social being and the mode of human reaction." Reich applied this theoretical model to understand the adherence of the masses to Nazism, to a dictatorial, repressive, and foolish power.

Reich (1930) wrote that "what must be explained… is not why starving people rob or why the workers strike, but why all starving do not thieve and why the majority of the exploited do not go on strike." Two hypotheses were brought forth to explain this double motion of adhesion and submission. On the one hand, there existed a strong correlation between the economic structure of one society and the psychological structure of its members and, on the other hand, the sexual repression that produced citizens adapted to an order based on private property. The sexual suppression reinforced the political reaction by means of substitute satisfaction such as sublimation. Herbert Marcuse developed this idea of repressive sublimation. Sexual morals inhibited the class-consciousness, and, therefore, the revolt against

the forces of oppression. The result was the acceptance of a socially unjust, inegalitarian order, and submission to authority that was simultaneously feared, idealized, and infallible.

Reich struggled against what he believed to be sexual repression, economic exploitation, and political repression—the major causes of alienation of the masses and their incapacity to revolt—by undertaking research on "character armor," the unleashing of sexual energy through the use of bioenergetic techniques. Reich became the inspiration for movements such as vegetotherapy, action analysis (AA), communitarianism (advocating sexual freedom), those who wanted the abolition of private property, and others who espoused the collective upbringing of children. Despite its deeply innovative nature, Reich's work was discredited.

Reich's theory, though, had a considerable impact on Freudian–Marxist thought and certain members of the Frankfurt School. This influence was particularly noticeable among the young participants of the movement of 1968 and in that decade. It petered out, however, with the collapse of Marxism as a theory of reference among intellectuals following the collapse of the communist regimes in Eastern Europe, on the one hand, and the eruption of psychoanalysis. Today, if the influence of Reich is forgotten or even repressed, it remains eventful for the "sixty-eighters." We retain, in particular, the connection between social contradictions and sexual conflicts; the analysis of relationships among emotional, corporal, and social inhibitions; the critique of the "small family" as an enterprise of a neurotic generation; the articulation between socioeconomic structures, forms of intrafamilial power, and intrapsychic processes; and, finally, the need to support theoretical reflection as a mode of practice at once clinical and political.

Freudian Marxism and the Frankfurt School

In many instances, we find these same questions in the debates of the Frankfurt School. The Institut för Sozialforschung (Institute of Social Research) in Frankfurt was founded in 1923 by Felix Weil, and the first director was Carl Grünberg. Beginning in 1930, the director was Max Horkheimer. Among the well-known collaborators were Theodor W. Adorno, Herbert Marcuse, and Erich Fromm.

The school developed "critical theory," which was based on Marxism and, in an interdisciplinary way, took into account Hegelian philosophy, psychoanalysis, and sociology. Critical theory rejects the Hegelian idea of identity as a conceptual unity that overcomes its contradictions. For critical theory, there can be no final resolution of inherent contradictions. The illusion of a universal truth, therefore, must be renounced.

Against rationalism, positivism, and the abstraction of scientific activity disconnected from social life, the development of a critical sociology was required. The first renowned topic of research proposed by Horkheimer at the Institute of Social Research was the project of clarifying "the question of the rapport between

economic life and society," including the psychic development of individuals. It involved researching the social mentality of qualified workers and employees under the Weimar Republic to find the answers to one theoretical question:

> What kind of relationship can be established in a definite social group… between the role of the group in the economic process, the transformation of psychic structure of its individual members, and the ideas and institutions which affects the psychic structure?

The methodology proposed for this study had to combine statistics, the examination of sociopsychological texts, and in-depth questionnaires completed by workers and employees. This first investigation would not be published. The Nazi dictator forced the members of the institute to take refuge in Paris, and later in the United States.

The second investigation on authority involved articulating a theoretical question with an empirical study. The mandate sets out "the aptitude, conscious or unconscious, to integrate or submit the faculty… of living to dependence on imposed orders and foreign volition" (Horkheimer, 1936). The investigation had three sections—a theoretical part combining philosophical (Horkheimer), psychosociological (Fromm), and political (Marcuse) approaches—to which the addition of an economic approach was sought but not realized; an empirical part with questionnaires supervised by Fromm; and a third part consisting of monographs developed from a qualitative analysis of interviews with fifty-nine families.

The multifocused articulation between theoretical questions and field investigations, the introduction of case analysis, and the combination of sociological and psychological insights also can be found in a third study of anti-Semitism that was undertaken by the Institute of Social Research after it moved to the United States. In a period dominated by positivist quantitative approaches, the study combined quantitative data with in-depth interviews. The final document combined a psychological and sociological study of veteran combatants and included a contribution from Bruno Bettelheim, a psychoanalytical interpretation of anti-Semitism, with Adorno's section on the authoritarian personality. The introduction, by Max Horkheimer (Adorno and Horkheimer, 1947) stated:

> Our objective is not just to describe the prejudice, but to explain it so that we may contribute to making it disappear. … This disappearance implies a re-education scientifically organized on the basis of established scientific knowledge. Also, education in the strictest sense is by nature personal and psychological.

These points illustrate the struggle against the negative aspects of human behavior and the destructive forces of society. On the status of psychoanalysis, as in the link between research and intervention, the debate is opened. Psychoanalysis supplies the elements of comprehension to decipher the social consciousness in its unconscious dimensions. A link between fantasy and historical consciousness develops, opening a path to Freudian Marxism and to sociopsychoanalysis. However, the psychoanalytical theory remains a theory of reference among others and not the basis of a universal theory of the individual and of society. It becomes an element inserted in a theory of the social, "one of the components in a box of critical tools" (Assoun, 1987).

Critical sociology resorts to psychoanalysis in order to explore the unconscious dimensions of social processes, for example, the aspects of the processes that constitute an authoritarian personality. The idea here is to constitute a social analytical psychology. As Paul-Laurent Assoun (1987) notes: "Marxist analysis found in psychoanalysis an instrument to decipher the famous link between superstructure and infrastructure, which supposes a significant articulation from the libidinal structure to the social structure."

For the Frankfurt School, research should not only resolve theoretical problems but also respond equally to social and political concerns. Scientific knowledge should produce diagnosis revealing concrete interventions and projects of emancipation. Here, we find the beginnings of a clinical approach on the social in a context where it concerns understanding "why humanity sunk into a new form of barbarism," or even "the auto-destruction of Reason" (Adorno and Horkheimer, 1947). This historical crisis of logos, linked to the rational ideal of the domination of nature and to the will to master the self and the world, was driven to a critique of instrumental reason and an analysis of the genealogy of evil. Thus, Marcuse introduced himself as the "progressive doctor of culture" and reintroduced the idea of "therapy" as conceivable at the level of society (Barus-Michel, 2004).

This review of some of the "ancestry" on which French clinical sociology is constructed shows continuity in how the psychic in social phenomena was addressed. We find another similar debate within psychology about the presence of the social in psychic phenomena. Clinical sociology does nothing more than return to these sources of sociology to study the narrow and indissoluble relationships between the individual and society. The links between social phenomena and psychic processes are central; they are at the heart of the psychosociological history.

Social Psychology, Psychosociology, Socioanalysis, and Sociopsychoanalysis

The need to reconnect psychology and sociology, to integrate psychoanalytical reading in the analysis of social phenomena has continued, since the 1950s, from theoretically heterogeneous reference points. The history of this nebulous situation is not clear as it spilt out of the university, which is often perceived to be the exclusive site in the production of knowledge.

In the years after World War II, French psychosociology develops under the influence of French psychologists who surrendered to the United States under the execution of the Marshall Plan. Anne Ancelin-Schützenberger began to study group dynamics at the Research Center for Group Dynamics at the University of Michigan, which was founded by the students of Kurt Lewin. She participated in the first training group in Bethel, Maine, in 1951. She met Léon Festinger, Ronald Lippitt, and particularly J.L. Moreno, whose works she came to know in France. Throughout these discoveries, there was a new conception of social psychology emerging. As Ancelin-Schützenberger (2005) noted, "Kurt Lewin thought that

psychology should be linked to life and to that which occurs in normal and active life, and the only thing that matters is social change."

Action research, group dynamics, and psychodrama would legitimize the investigative methods constructed on paradigms closer to clinical measures than the psychotechnical methods used by the partisans of so-called scientific psychology. A cleavage had already emerged between experimental methods and clinical measures, between, on the one hand, a psychology founded on observation and experimentation and, on the other hand, a clinical psychology built in the wake of and in rivalry with psychoanalysis (Ohayon, 1999).

Other French psychologists went to the United States to discover these new methods. According to (Ohayon, 1999), "They bring back, hastily stuffed in their suitcases, human engineering, group dynamics, Morenian psychodrama and the non-directive orientation of Carl Rogers."

In 1950, Max Pagès met Carl Rogers at the University of Chicago. Rogers obtained a grant that enabled Pagès to take part in his postdoctoral seminar. "I have fallen in love with the ideas of Rogers," Pagès (1996) wrote, explaining the three reasons for his attraction: (1) a way to integrate two contrary positions (a very rigorous scientific demand to conceptualize, verify, and measure made compatible with an engagement in the subjectivity, which is more than a dimension but the very motor of therapy); (2) decompartmentalization of diverse professional practices—psychotherapy, counseling, psycho-pedagogy, social work, education, and mental health—which are all variants of the aid relationship but in France, correspond to differentiated and compartmentalized crafts and functions; and (3) the empathy, congruence, openness, availability to the self, taking into account of emotions, capacity to recognize one's own sentiments, and a permanent search for authenticity. (There were so many elements that defined a clinical posture.)

Hired upon his return by CEGOS, a large consulting organization, Pagès developed forms of intervention in firms that utilized nondirective methods and group talks. In this context, he recruited collaborators such as Eugène Enriquez, André Lévy, and Jean-Claude Rouchy, who became significant actors in the history of psychosociology. In 1955, he returned to Bethel in the United States for an Organization for Economic Cooperation and Development (OECD) mission (organized by the National Training Laboratory) that introduced Europeans to training groups and methods of bringing change, inspired by the works of Lewin.

In 1958, with Guy Palmade, Pagès founded the Association de Recherche et d'Intervention Psychosociologiques (ARIP, Association of Psychosociological Research and Intervention) within which reflection and practice of action research and of intervention developed from training and encounter groups. The group is the nodal element between the individual and collective, between personal change and social change.

In an intellectual context dominated by Marxism and psychoanalysis, psychosociology was the object of virulent attack. Some accused it of being a pawn. Its arrival in France as luggage accompanying the Marshall Plan was obvious proof to some of its collusion with American imperialism and of its adaptive capitalistic aims. Others placed it at the service of the psychology of the "I" (ego psychology),

negating unconscious intrapsychic conflicts. For example, Jacques Lacan stigmatized "the ideal of impulsive harmony" and "the ideal of group conformity" and said the believers of "human engineering" ("engineers of the soul") were devoted to these ideals (Lacan, 1956).

These debates influenced, in a lasting manner, the history of French psychosociology. This particularly was true for the years around 1968. The question is, Which parts of human behavior, and to what extent, can be attributed to social determinants, intrapsychic conflicts, and corporal factors? These debates are no doubt intellectual, but also are existential insofar as the theoretical options have affective, political, and professional consequences. "I can bear witness," wrote André Lévy (1997), who had fully experienced the events,

> to the shock provoked by psychoanalysis among psychosociologists who, until then, were nicely tied up to the cozy herd led by Lewin and Rogers.… The discovery of the unconscious did not occur without provoking a veritable crisis of personal, professional and institutional identity, leading at times even to a breach of old friendships. The contributions of psychoanalysis have been acquired none other than at the price of painful, and at times brutal, questioning of representations and securely anchored modes of thinking.

The conflicts were also as virulent concerning the question of social change. Must we wait for a structural change, a rupture from capitalism, a revolutionary action of overturning the bourgeois order? Or should we await a transformation of human relations, a renovation of personal or therapeutic development? Are the debates of French society—between Marxism and psychoanalysis, sociology and psychology, structuralism and phenomenology, revolutionary and adaptive positions, social and personal change—cut across psychosociology?

In this context, some authors, nonetheless, open a channel to overcome this opposition. Let me note, in particular, the movement surrounding *Socialisme et Barbarie*, founded by Cornélius Castoriadis and Claude Lefort (Castoriadis, 1975), who denounced Stalinism and militants for founding the social and political sciences on new paradigms. Castoriadis and Edgar Morin (2001), who was engaged in a critical questioning of Marxism, became "woven together" to understand the processes that connect the individual and society, the imaginary and reality, objectivity and subjectivity, the rational and irrational, reason and sentiment, the psychic and the social, and of course psychology and sociology. If they did not claim a link between psychosociology and clinical sociology, even though Morin (2001) used the term *clinical sociology* and Castoriadis practiced psychoanalysis, they provide a legitimacy in the eyes of many psychosociologists who are more involved in practice than in theoretical and epistemological issues. Adopting a position at once critical and clinical, they have become irrefutable references in pyschosociology and clinical sociology.

Psychosociology enjoyed a "golden age" in the 1960s and 1970s. However, it was not known as a scientific discipline among academics despite university placement of numerous psychosociologists by universities. Sociology rejects it on the pretext that psychosociology commits itself to adaptive interventions to serve management and that it promotes psychologism. Psychology, rallied around its internal conflicts among the cognitivists, experimentalists, and psychoanalysts,

marginalized social clinical psychology (which found refuge elsewhere), while social psychology, with the notable exception of Serge Moscovici (Faucheux and Moscovici, 1971), locked itself inside experimental and scientist constructs. Here, the paradox is that the majority of students are able to find work in the clinical domain, although the training received gives them little more than marginal positions.

This is the reason, above all, that psychosociology grew outside the universities in numerous practices and under heterogeneous denominations. Institutional pedagogy (F. and J. Oury, F. Tosquelles, F. Guattari), for instance, brought together psychiatry, pedagogy, education, nursing, and psychoanalysis to develop educative and therapeutic practices that question the relationship among the problems of pupils, the sick, and the functioning of institutions charged with taking care of them (Barus-Michel et al., 2002). Institutional analysis, under the initiative of R. Loureau and G. Lapassade, proposed to uncover the "blind spots" of research on institutional power, so as to struggle against repressive and alienating aspects. Jacques and Maria van Bockstaele et al. (1963) developed "socioanalysis," a device designed to organize and analyze the social transfer of groups, or of individuals, invested in a project. Also, G. Mendel (Mendel and Prades, 2002) founded a "sociopsychoanalytical" method of analyzing the mutual influence between social and individual psychic facts, including the unconscious, and a method of intervention to help groups reflect on the forces that influence their personalities. Didier Anzieu and René Kaës, at the Centre d'Études Françaises pour la Formation et la Recherche Active en Psychologie (CEFFRAP, French Center of Studies for Education and Action Research in Psychology), developed interventions in group psychoanalysis grounded on a group psychodramatic technique (Kaes and Didier, 1976). They proposed the notion of group psychic tools, which give accounts of transversal psychic phenomena in groups and also in institutions.

In 1969, Pagès founded and directed the Laboratoire de Changement Social (LCS, Social Change Research Center) at Paris 7 University. I succeeded Pagès as director in 1980, and we have developed a significant research program that focuses on the question of power in organizations—the relationship between transformations in managerial practice and its effects on employees in terms of stress, professional exhaustion, social harassment, and symptoms of depression. We conduct research in both state and private companies, and strive to develop forms of socioclinical intervention on the links between ongoing conflicts and organizational and economic contradictions that include the silent partners and workers. Furthermore, we set up groups for personal development and research using the biographical approach that allows participants to analyze their family history and their social trajectory. Reflection on the links between the psychic and social aspects drove us, along with Pagès, to conceive of complex therapeutic devices. We practice dialectical and pluridisciplinary analysis, which adopts multiple theoretical referents and varied methodological tools.

The various orientations in universities are reflected by practitioners who intervene in different professional fields such as mental health, government, private firms, social work, education, maternal and child protection, delinquency

prevention, and community-based organizations and associations. Even if the practitioners do not draw on both psychosociology and clinical sociology, they are all invigorated by the convergences of clinical measures analyzing interferences between psychic and social processes, the need for a pluridisciplinary approach combining psychoanalysis, social psychology, sociology and anthropology, and, finally, continuous reciprocity between research and intervention.

Conclusion

Clinical sociology in France stems from the different schools discussed here. In its more recent history, there is still much to be done. As an actor in this adventure, I leave the historical recording of my own contribution to others. I cannot but be a witness from my own path (Gaulejac, 1997). When I completed *La Névrose de Classe* (Class Neurosis) in 1986 with the theme "for a clinical sociology"(Gaulejac, 1987), I was not aware that others, such as Robert Sévigny in Canada and Jan Marie Fritz in the United States, were advocating the creation of a working group on this very topic in the International Sociological Association.

When I transferred to Paris 7 in 1989, I rejoined Eugène Enriquez and I greeted Jacqueline Barus Michel after the closing of the Laboratoire de Psychologie Sociale Clinique (Laboratory of Social Clinical Psychology). The Laboratoire de Changement Social (LCS, Social Change Research Center) became a major pole of clinical sociology in France. We built an international network that grew rapidly in liaison with our colleagues in Quebec and the United States. Moreover, we have a network representing Southern Europe (in Greece with Klimis Navridis and in Italy with Michelina Tosi and Massimo Corsale), but also in Russia (with Igor Massalkov) and in Latin America (with Elvia Taracena in Mexico; Norma Takeuti, Teresa Carreteiro, and Jose Newton in Brazil; Ana Maria Araujo in Uruguay; and Francisca Marquez and Dariela Sharim in Chili). Since the first Clinical Sociology Conference in France in 1992, meetings have been organized on three continents providing occasions for numerous publications in French, Portuguese, and Spanish.

This final part of our history remains to be written. Before being written, however, it first will be built and enlivened.

References

Adorno, T. and Horkheimer, M. (1947). La dialectique de la Raison [The Dialectic of Enlightenment]. Paris: Gallimard.

Ancelin-Schützenberger, A. (2005). Eléments d'histoire de vie et choix théoriques [Elements of life history and theoretical choice]. In: Parcours de Femmes, Collection Changement Social (pp. 159–235). Paris: L'Harmattan.

Aron, R. (1983). Mémoires. Paris: Julliard.

Assoun, P. L. (1987). l'École de Francfort [The Frankfurt School]. Paris: PUF.

Barus-Michel, J. (2004). Souffrance, Sens et Croyance [Suffering, Meaning, and Faith]. Ramonville-Sainte-Agne: Erès.

Barus-Michel, J., Enriquez, E. and Lévy, A. (2002). Vocabulaire de Psychosociologie [Glossary of Psychosociology]. Ramonville-Sainte-Agne: Erès.

Bastide, R. (1962). Sociologie et Psychologie [Sociology and Psychology]. In: G. Gurvitch (ed.), Traité de Sociologie Génerale. Paris: PUF.

Bataille, G. (1937). L'apprenti sorcier [The sorcerer's apprentice]. In D. Hollier (ed.), Le Collège de Sociologie (pp. 36–59). Paris: Gallimard, 1979.

Caillois, R. (1938). Pour un collège de sociologie [For a college of sociology]. In D. Hollier (ed.), Le Collège de Sociologie, (pp. 29–35). Paris: Gallimard, 1979.

Castoriadis, C. (1975). L'Institution Imaginaire de la Société [The Imaginary Institution of Sociology]. Paris: Seuil.

Durkheim, E. (1885). Texte 1—Éléments d'une Théorie Sociale [Text 1—Elements of a Social Theory]. Paris: Editions de Minuit.

Durkheim, E. (1912). The Elementary Forms of Religious Life. Trans. By Carol Cosman. Oxford, New York: Oxford University Press, 2001.

Durkheim, E. (1937). Les Règles de la Méthode Sociologique [The Rules of Sociological Method]. Paris: PUF Quadrige, 1981. Enriquez, E. (1993). L'approche clinique: genèse et développement en France et en Europe de l'Ouest [The clinical approach: genesis and development in France and Western Europe]. In: V. de Gaulejac and S. Roy (eds.), Sociologie Clinique (pp. 19–35). Paris: Desclée de Brouwer.

Faucheux, C., and Moscovici, S. (1971). Psychologie Sociale Theorique et Experimentale. Recueil de Texts Choisis et Presentes [Theoretical and Experimental Social Psychology] La Haye: Mouton.

Gaulejac, V. de. (1987). La Névrose de Classe [Class Neurosis]. Paris: Hommes et Groupes.

Gaulejac, V. de. (1997). S'Aautoriser à Penser, Cahiers du Laboratoire de Changement Social (No. 2) [Dare to Think, Papers of the Social Change Research Center]. Paris: L'Harmattan.

Gaulejac, V. de, and Roy, S. (eds.). (1993). Sociologie Clinique [Clinical Sociology]. Paris: Desclée de Brouwer.

Gurvitch, G. (1955a). Déterminismes Sociaux et Liberté Humaine [Social Determinism and Human Liberty]. Paris: PUF.

Gurvitch, G. (1955b). Dialectique et Sociologie [Dialectic and Sociology]. Paris: PUF.

Hollier, D. (1979). Le Collège de Sociologie [The College of Sociology]. Paris: Gallimard.

Horkheimer, M. (1936). Autorité et famille [Authority and family]. In: M. Horkheimer, L. Ferry, and A. Renaut (eds.), Théorie Critique: Essais. Paris: Payot, 1978.

Kaes, R., and Didier, A. (1976). Chronique d'un Groupe: le Groupe du Paradis Perdu: Observation et Commentaries [History of Group: The Group from Paradise Lost: Observation and Commentaries]. Paris: Dunod.

Lacan, J. (1956). Écrits [Written Works]. Paris: Seuil.

Lagache, D. (1949). L'Unité de la Psychologie [The Unity of Psychology]. Paris: PUF.

Levy, A. (1997). Sciences Cliniques, Organizations Socials [Clinical Sciences, Social Organizations]. Paris: PUF.

Mauss, M. (1924). Sociologie et Anthropologie [Sociology and Anthropology]. Paris: PUF, 1968.

Mendel, G., and Prades, J. (2002). Les Méthodes d'Intervention Psychosociologiques [Methods of Psychosociology Intervention]. Paris: La Découverte.

Morin, E. (2001). Une Sociologie du Présent [A Sociology of the Present]. Histoires de Vie et Choix Théoriques, Cahiers du Laboratoire de Changement Social, No. 6 (pp. 39–81) Paris: L'Harmattan.

Ohayon, A. (1999). L'Impossible Rencontre, Psychologie et Psychanalyse en France 1919–1969 [The Impossible Encounter; Psychology and Psychoanalysis in France 1919–1969]. Paris: La Découverte.

Pagès, M. (1996). Le Travail d'Exister [Work to Exist]. Paris: Desclée de Brouwer.

Reich, W. (1929). Matérialisme Dialectique, Matérialisme Historique et Psychanalyse [Dialectical Materialism, Historical Materialism and Psychoanalysis]. Paris: La Pensée Molle, 1970.

Reich, W. (1933). Psychologie de Masse du Fascisme [The Mass Psychology of Facism]. Paris: La Pensée Molle, 1970.

Van Bockstaele, J., Van Bockstaele, M., Barrot, C. and Magny, C. (1963). Quelques Conditions d'une Intervention de Type Analytique et Sociologie [Some Conditions of an Analytical and Sociological Kind of Intervention]. In: L'Année Sociologique (pp. 238–262). Paris: PUF.

Selected Readings

Enriquez, E., Houle, G., Rhéaume, J., and Sévigny, R. (1993). L'Analyse Clinique dans les Sciences Humaines [Clinical Analysis in the Human Sciences]. Montraal: Ed. Saint Martin.

Freud, S. (1921). Psychologie Collective et Analyse du Moi [Group Psychology and Analysis of the Ego], S. Jankélévitch (Trans.). Paris: Payot, 1975.

Gaulejac, V. de (1997). Clinical sociology. International Sociology 12(2), 175–190.

Gurvitch, G. (1956). Les Phénomènes Sociaux Totaux et la Science de l'Homme [Total Social Phenomena and the Human Sciences], Esprit, March, 390–421. http://www.esprit.presse.fr/.

Gurvitch, G. (1957). La Vocation Actuelle de la Sociologie [The Contemporary Vocation of Sociology]. Paris: PUF.

Marcuse, H. (1955). Eros et Civilisation [Eros and Civilisation]. J. G. Nény and B. Frankel (Trans.). Paris: Ed. de Minuit, 1963.

Pagès, M. (1993). Psychothérapie et Complexité [Psychotherapy and Complexity]. Paris: Desclée de Brouwer.

6
Clinical Sociology in Japan

Yuji Noguchi

Clinical sociology has a rather short history in Japan, where it began, in a continuing way, in 1993. Although we do not yet have a consensus on the definition and theoretical framework, we share the practical concerns for problem solving of clinical sociologists in other countries.

This chapter is divided into four parts. First, a brief history of clinical sociology in Japan is presented. Second, my theoretical position as a clinical sociologist is explained through a self-narrative. Third, two examples of my practice in clinical fields are introduced. Finally, the contribution of a narrative social constructionist approach to the development of clinical sociology is discussed.

History of Clinical Sociology in Japan

Because Japan is an island chain in eastern Asia, it was relatively isolated beginning in the 1600s, but in the mid-1850s, following the treaty of Kanagawa and the Meiji Restoration, it began to rapidly modernize and industrialize (Matsumoto, 2000; United States Central Intelligence Agency, 2007). The population of 127,463,611 is 99% Japanese in terms of ethnicity, and in terms of religion, 84% of the population both observe Shinto and are Buddhist. The rate of literacy is 99%. The nation has a constitutional monarchy with a parliamentary government. Japan is a major economic power in the world, but also has "huge government debt (175% of gross domestic product)" and an aging population (United States Central Intelligence Agency, 2007).

According to Ayukawa (2000), while Japanese sociology was "established by introducing the works of H. Spencer and A. Comte…, [it was] mainly imported" from Germany before World War II. After the war, "there was wholesale importation of sociological theory from the United States without any regard to… the Japanese situation." In the 1950s and 1960s, sociologists began to use social surveys and statistical analysis, and a lot of research was conducted using these methods, particularly in the fields of rural sociology, urban sociology, and sociology of the family.

By the 1970s, structural-functional theory was mainstream and, in the 1980s, microsociological approaches such as symbolic interactionism and ethnomethodology were popular among younger sociologists. In the 1990s, postmodern philosophical theory and social constructionism had great influence. At the same time, some clinical problems in the mental health field (e.g., child abuse, domestic violence, and codependence) gradually attracted attention because Japan experienced an extraordinary number of crimes, accidents, and disasters. Some sociologists became interested then in doing research on these phenomena. The clinical perspective in Japanese sociology was born in this sociocultural context and, as Ayukawa (2000) noted, by the late 1990s, young sociologists were interested in a number of areas including medical sociology and clinical sociology.

The history of clinical sociology in Japan is quite short. Clinical sociology was introduced in a continuing way in 1993, although it was mentioned before that time. For instance, Masayasu Kato (1954) wrote *An Introduction to Clinical Sociology,* which was inspired by psychoanalytic studies by Freud and neo-Freudians and social psychological developments in the United States (e.g., group dynamics, sociograms). Some thirty years later, Kouji Kashikuma (1985) wrote *Clinical Sociology of Juvenile Delinquency,* a collection of articles, some of which were published previously in journals written for officers of reformatories or the court. The term *clinical* here may refer in general to approaches to dealing with delinquency, but no definition of clinical sociology is provided. Neither volume refers to the development of clinical sociology in the United States or any other country.

At the annual meeting of the Japanese Society of Health and Medical Sociology in 1993, I introduced clinical sociology to Japan. I discussed the contents of the *Handbook of Clinical Sociology*, a book written by the American authors Howard Rebach and John Bruhn (1991), referring particularly to the history of the field in the United States, the theories mentioned in the volume, and the potential applicability of this work to Japanese society. Until then, few Japanese sociologists had used the term *clinical sociology,* and, if they did, they only used it as a kind of rhetoric that meant sitting "beside patients" or "beside clients." They had not illustrated the original framework of the concept and did not refer to the development of clinical sociology in the United States or other countries.

The paper that resulted from the 1993 presentation was titled "Clinical Sociology: Its Methods and Implications" (Noguchi, 1994) and it appeared in the *Annual Review of Japanese Health and Medical Sociology* the following year. This journal was not very well known at that time because its primary audience was medical or health sociologists. It was not until a few years later that many Japanese sociologists became aware of the concept of clinical sociology.

A special session, with the title "Clinical Sociology," was held for the first time at the annual meeting of the Japan Sociological Society in 1998. The session was planned jointly by Eishō Ohmura, a professor at Kanseigakuin University and one of the foremost sociologists of religion in Japan, and me. Ohmura and I agreed on the necessity of clinical sociology in Japan for two reasons. First, many kinds of social problems are generated in the context of the Japanese social system, and require practical solutions from the sociological perspective. Second, a large

number of sociologists analyze many different kinds of social problems in the Japanese academic context, but few had taken part in actual problem-solving processes. We thought both of these contexts required us to acknowledge the importance of sociological practice and particularly of clinical sociology.

We held another session on clinical sociology at the annual meeting of the Japan Sociological Society in 1999. As the former session had focused on the theoretical dimension of clinical sociology, this one presented the actual experiences of sociologists working in Japan. Research was presented based on work in a wide range of settings: a general hospital, school classroom, halfway house for mentally disabled, nursing home for the elderly, and psychiatric hospital.

Given the kinds of presentations mentioned here, readers may have the impression that clinical sociology in Japan looks like clinical social work in the United States. There is a good reason for this thinking. As clinical sociology has not been known in Japan, a sociology graduate who was oriented toward sociological practice had to take a formal role in clinical settings as a social worker, nurse, or some kind of therapist. The difference between clinical sociology and clinical social work is important. For instance, all the contributors to the 1999 session had specialized in sociology (not social work) in graduate school and, therefore, their different kinds of practice were all inspired by the sociological perspective. Until this session, their practice work had never been called clinical sociology. The introduction of the new terminology has since then allowed them to refer to their own practices as clinical sociology.

The first textbook about clinical sociology to appear after 1993 was *Rinshou-Shakaigaku no Susume* (Invitation to Clinical Sociology) written by Eisho Ohmura and Yuji Noguchi and published in 2000. This volume, based on the 1998 session on clinical sociology, focused on the theoretical framework of the field, and it discussed a variety of subjects—psychotherapy, identity work, the problem family, school classrooms, child-rearing policies, regional policies, death, and religion. The material tended to argue the necessity of a clinical sociology rather than focus on the details of different kinds of practice. A second textbook, *Rinshou-Shakaigaku wo Manabu Hito no Tameni (For the People Studying Clinical Sociology)* by Ohmura was published that same year. This volume also focused on theoretical analyses rather than actual practices.

The third textbook, Rinshou-Shakaigaku no Jissen (*The Practice and Experience of Clinical Sociology*) was edited by Noguchi and Ohmura and published in 2001. This volume was based on the second session in 1999, and all of the contributors were asked to introduce their own practices through a self-narrative style. We expected that this style would inevitably require the contributors to focus on their own practice rather than on analysis. But it was a difficult challenge for us as editors. Because sociologists are trained as scientists who analyze a matter from an objective point of view, they are not trained to write papers in such a subjective way. Some contributors told me it seemed more like writing an essay rather than an article. Nonetheless, we supposed that if we adopted an objective format, no one would understand the uniqueness of clinical sociology. Thus, this style was indispensable for informing many other sociologists of the necessity for clinical sociology.

Stimulated perhaps by the publications in the field, presentations including the term *clinical sociology* at academic conferences have been increasing, and the number of people who introduce themselves as "clinical sociologists" also has been growing in Japan. Some interesting sociological practices have been reported with the term *clinical sociology*. Nakamura (2001), for instance, reported that he had managed a therapeutic group activity that was called a "men's support room." This group was for adult male batterers and it developed a unique educational program aimed at reorienting them and rethinking masculinity. Nakamura (2003) discussed the characteristics of his program as follows:

> Because men, in general, are located at the center of society, when they come to realize the constraints and antisocial behaviors as well as the power and privileges in their own gendered lives, their increased critical awareness and practices related to the construction of masculinity will, together with the efforts of women, engender the possibility for greater social change.

This program is based on the sociological perspective and understanding of the problems. Nakamura et al. (2004) have become interested in the narrative social constructionist approach and they apply it to manage group work.

Another example of sociological practice is an application of the reflecting process to a help line (telephone counseling service) for victims of child abuse (Yahara, 2004). The reflecting process is a unique clinical method developed in the family therapy field (Andersen, 1991). The uniqueness is derived from the role conversion between observers and observed persons. In a regular family therapy session, a client family may be observed by therapists through a one-way mirror. However, Andersen and his colleagues added a reversal to this structure. In the first session, therapists take a normal role as observer, but in the second session, the role is reversed. The conversation then is observed and commented on by the client family. Following this, the roles continue to be reversed again and again. This structure has been called the "reflecting team" or "reflecting process."

Yahara (2004) identified a sociological meaning of this process in relation to the concept of observation in Luhmann's (1990) social system theory. Yahara introduced this idea into the help-line staff meeting and found that it was effective for the staff's understanding (from a different point of view) of the clients' problems, to promote mutual understanding among staff members, and to help reduce the staff members' stress or pain.

Clinical sociological work certainly is increasing in Japan. Some sociologists have begun to reconsider the relationship between social pathology and clinical sociology (Hatanaka, 2000; Hatanaka et al., 2004), and another discusses the problems of a psychologized society from the viewpoint of Lacanian psychoanalytic theory (Kashimura, 2003). Moreover, the Japanese *Journal of Addiction and Family* published a special issue on the present and future of clinical sociology in Japan (e.g., Nakamura et al., 2004; Noguchi, 2004). However, in spite of these publications, we think the number of clinical sociologists is still too small to establish an academic association devoted to this field. We need to accumulate more actual results to prove the effectiveness of clinical sociology and increase the number of sociologists involved in sociological practice.

Theoretical Framework: Narrative Social Constructionist Approach

As already established, clinical sociology applies sociological theories to practical problem solving. Which theory should be adopted? It depends on the case or the practitioner's orientation. My approach is characterized by social constructionism and the narrative approach.

In Japan, the paradigm shift in social problem studies occurred in the early 1990s. During this time, *Constructing Social Problems*, written by Malcolm Spector and John Kitsuse and originally published in 1977, was translated into Japanese. It invited exciting debate in the academic arena in Japan in the same way it had in the United States (Holstein and Miller, 1993). By the late 1990s, the study of social problems had mainly adopted the social constructionist method.

I also was involved in the debate and expressed my views in some anthologies on social constructionism (Nakagawa, et al., 2001; Ueno, 2001). But my position was ambivalent. In actuality, I agreed with the argument that social problems were socially constructed through people's everyday language activities. But I could not agree that such a study or analysis often nominally treated social problems and consequently neglected the victims' reality or pain.

At the same time, I was interested in the new movement occurring in the family therapy field. This movement is now called "narrative therapy" or a "narrative social constructionist approach." It was difficult to understand because it was based on postmodern social and linguistic theories. After finding a certain book, however, I grasped the outline of the movement and its vision for sociological practice. The book was *Therapy as Social Construction* (McNamee and Gergen, 1992). It was very exciting for me, and so my colleague Naoki Nomura and I eventually translated the book into Japanese and published it in 1997.

One of the editors of *Therapy as Social Construction* is Kenneth Gergen, a famous social psychologist who has published many books including *Realities and Relationships* (1994) and *An Invitation to Social Construction* (1999). From my view, Gergen should be called a sociologist, rather than a social psychologist, as his theories are very sociological. For example, the title *Therapy as Social Construction* is extremely suggestive for clinical sociologists. If the therapy at the micro level can be considered as social construction, sociological practice at the macro level must be social construction too. This perspective largely helped me to dissolve my ambivalence caused by the debate within the study of social problems. Sociological practice is also social construction. Sociologists can analyze social problems, but they also can contribute to solving problems through social constructionism, because both the problem and solution are socially constructed. I had found my theoretical position.

The theoretical premises of the narrative social constructionist approach can be formulated as follows (Noguchi, 2002, 2005):

1. Realities are socially constructed.
2. Realities are discursively constructed.
3. Discourses are organized by narratives.

The first premise has been quite familiar to us since Peter Berger and Thomas Luckmann's (1966) *The Social Construction of Reality*. The second and the third have not been fully elaborated in the sociological field. They are mainly originating from the linguistic turn in postmodern thought in recent years. These premises lead us to some epistemological changes and to the following questions: What discursive resources have constructed the realities of problems? How can we eliminate the present realities and reconstruct new realities through our discursive practices? These questions suggest a new direction for clinical sociology.

Case Presentations

The narrative social constructionist approach alters the stance and perspective of clinical sociologists, proposes new relationships among sociologists, clinicians, and clients, and contributes to constructing new clinical realities. The two cases below are examples of such new realities.

Case 1: Beteru no Ie (Group Home of Psychiatric Ex-patients)

In a small town beside the Pacific Ocean in Northern Japan, there is a group home for ex-patients of a psychiatric hospital. It is called *Beteru no Ie* (Bethel), which means the "House of God" in the Old Testament of the Bible. The facility houses about 150 mentally disabled people with psychiatric disorders such as schizophrenia, bipolar disorder, mental retardation, and alcohol dependence. The residents have gained a great deal of attention because of some of the home's unique activities. They are now widely known to many academics and mental health professionals in Japan and they have been awarded prizes by professional organizations such as the Japanese Society of Psychiatry and Neurology and the Mainichi Newspapers (Urakawa Beteru no Ie, 2002).

One such unique activity is *Genkaku Mousou Taikai,* which means the contest of delusions and hallucinations. The contest is held once a year and the champion is honored with the Best Delusion or Hallucination of the Year Award, with supportive laughter and humor. This is quite a fantastic and extraordinary idea for the tradition of the mental health professions. It has been supposed that a delusion or hallucination should not be public because it is not real and that it would not be formally accepted by the profession. But the contest radically challenged this commonsense attitude, and the patients obtained new realities that encouraged them in their lives.

When I first heard about the contest, I was very surprised, not only because it was a fantastic idea, but also because I was familiar with a very similar idea in the field of family therapy that had been proposed by Michael White and David Epston (1990), famous narrative therapists in Australia. They formalized the method of

externalization of problems. In the mental health field, problems are generally internalized in the clients as deficits. But this internalization often makes the problem difficult or severe and leaves the client debilitated. When the problems are externalized, the client becomes encouraged in the new reality that it is the problem that is bad, not the client. In this way, clients have changed their self-image from persons having inner deficits to persons who are bravely fighting an external opponent. Put differently, the problems are constructed by our everyday discursive practice. Therefore, if the discourse is changed, the problems can be changed too. Needless to say, this idea is derived from social constructionism.

As I was surprised by the similarities between *Genkaku Mousou Taikai* and narrative therapy, I told the staff of *Beteru no Ie* that I thought they had an excellent idea and I connected it to the externalization of problems, an idea that was drawing attention from around the world as an admired new method in the field of family therapy. They also were surprised with this coincidence and, since then, they began using the term *externalization* to explain their own activities.

In this case, I may not be called a direct practitioner, but I have been called an indirect practitioner or co-practitioner. As a consultant or co-practitioner, I provided the staff members with a concept to understand the sociological meaning of their unique practice and encouraged their activities. On the other hand, I also have taken every chance to lecture many other clinical professionals about this topic; I have tried to publicize the significance of externalization of problems as a therapeutic tool proposed by clinical sociology. I see this as one of my sociological practices.

Case 2: Reminiscence Board (for Elderly with Dementia in a Geriatric Hospital)

Remembering past events or episodes has positive therapeutic effects for the elderly who have dementia. This method is called a *reminiscence approach* and has been adopted in many geriatric hospitals and nursing homes by psychologists and therapists. This case is one of those approaches, but it is unique in that it uses a display board, not just conversation with patients. A reminiscence board is the presentation of the important events or episodes in a patient's life. A therapist asks a patient about memories of his/her younger days, negotiates whether it can be put on the display board or not, and then illustrates the patient's life history on the board. The board is then placed at the patient's bedside, open to everyone in the ward.

This approach is closely connected with the narrative approach in that both of them consider life as narrative. One day, a student who planned to use the reminiscence approach with elderly patients who have dementia consulted me on the relationship between reminiscence and narrative. She also had been interested in the narrative approach and supposed that a reminiscence board might be a powerful tool for this approach. I agreed with her in two senses. First, the negotiation process between the therapist and patient is simply a social construction process. The self-narrative of the patient becomes more real through the social discursive

process. In other words, words create worlds. Second, if the life history of the patient can be shared by many of the staff or patients in a ward, the patient may experience some changes. If so, this can be an example of the social construction of a new reality.

Interestingly, the outcome that emerged was on an entirely unexpected level. Clear change was found in the staff rather than the patients. One of them said that the patient was, in fact, not a patient before coming here, that she had lived a long life and had ended up here. Another said that the patient had suffered from many troubles in her younger days, and that he hoped she was happy here. What does it mean that the staff changed? The reminiscence board made them aware that the patient possessed not only the symptoms of dementia that annoyed them, but also a unique and respectable past. The board constructed a new reality and changed the relationship between staff and clients (Ohshima, 2003).

Clinical Sociologists as Co-Constructors of Clinical Reality

As both of the cases presented here are indirect practice, you might wonder if this should be called clinical sociology. I think there are many ways to practice clinical sociology. In the first case, I located the sociological meaning of the practices and encouraged their activities by giving them the concept behind the practices. In the second case, I suggested a sociological outcome of the practice and encouraged the practitioner to try the new method. In both cases, I was not just an observer or adviser because I engaged in constructing new clinical realities jointly with the practitioners. This role should be called a co-constructor of the clinical reality. Sociologists can take on these kinds of roles in clinical settings through their discursive practices.

These examples of my sociological practice were inspired by social constructionism. As mentioned before, social constructionism tells us that social problems exist in the universe of discourse. If so, sociological discourse can help us to see social problems and give them reality. Of course, some discussions might have a major influence, while others would be minor. Every sociological discourse, including definition, analysis, interpretation, and discussion, contributes to some extent to the construction of social problems. Social constructionism is now one of the influential frameworks in Japanese sociology and clinical sociology has led this discussion by introducing a narrative social constructionist approach.

This theoretical position changes the role of clinical sociologists in confronting social problems. They cannot stand and solve the problems at the objective point of view like a physician, but they can participate in the linguistic system constructed around the word *problems* and enlarge the universe of discourse on the problems (Anderson and Goolishian, 1988). They can "open conversational spaces and thus increase the potential for the narrative development of new agency and personal freedom" (Anderson and Goolishian, 1992). They can participate in the linguistic system not as advisers for problem solving, but as co-constructors of the reality.

Social constructionism proposes a new approach to social problems, and clinical sociology can be considered as one of the discursive practices around social problems. From this point of view, whether a practice is good or not should be evaluated not by the correctness of assessment and intervention but by the power to enlarge the discourse of problems and change the socially constructed reality. It would be interesting to use this point of view to reexamine many sociological practices already completed and identify their discursive power in changing realities. Social constructionism is constructing a new reality of clinical sociology in Japan.

References

Andersen, T. (1991). The Reflecting Team: Dialogues and Dialogues About the Dialogues. New York: W.W. Norton.

Anderson, H., and Goolishian, H. (1988). Human systems as linguistic systems: evolving ideas about the implications for theory and practice. Family Process, 27, 371–393.

Anderson, H., and Goolishian, H. (1992). The client is the expert. In: S. McNamee and K. J. Gergen (eds.), Therapy As Social Construction. London: Sage.

Ayukawa, J. (2000). The sociology of social problems in Japan. American Sociologist 31(3), 15–26.

Berger, P. L., and Luckmann, T. (1966). The Social Construction of Reality. A Treatise in the Sociology of Knowledge. New York: Doubleday.

Gergen, K. J. (1994). Realities and Relationships. Boston: Harvard University Press.

Gergen, K. J. (1999). An Invitation to Social Construction. London: Sage.

Hatanaka, M. (ed.). (2000). Rinshou-shakaigaku no Tenkai [The Development of Clinical Sociology]. Tokyo: Shibundou.

Hatanaka, M., Hirose, T., and Shimizu, S. (2004). Shakai-byourigaku to Rinshou-shakaigaku. [Social Pathology and Clinical Sociology]. Tokyo: Gakubunsha.

Holstein, J. A., and Miller, G. (Eds.). (1993). Reconsidering Social Constructionism: Debates in Social Problems Theory. New York: Aldine de Gruyter.

Kashimura, A. (2003). Shinrigakuka suru Shakai no Rinshou-shakaigaku [Clinical Sociology of the Psychologized Society]. Yokohama: Seori-Shobo.

Kashikuma, K. (1985). Hikou no rinshou-skakaigaku [Clinical Sociology of Juvenile Delinquency]. Tokyo: Kakiuchi-Shuppan.

Kato, M. (1954). Rinshou-shakaigaku Josetsu [An Introduction to Clinical Sociology]. Tokyo: Chudai-Shuppansha.

Luhmann, N. (1990). Die Wissenschaft der Gesellschaft [Science of Society]. Frankfurt am Main: Suhrkamp Verlag.

Matsumoto, Y. (2000). Japanese urban sociology: development and current times. The American Sociologist, Fall, 58–71.

McNamee, S., and Gergen, K. J. (eds.). (1992). Therapy as Social Construction. London: Sage.

Nakagawa, N., Kitazawa, T., and Doi, T. (Eds.). (2001). Shakaikochikushugi no Supekutoramu [The Spectrum of Social Constructionism]. Kyoto: Namanishiya-Shuppan.

Nakamura, T. (2001). Domestikku Baiorensu: Kazoku no Byouri [Domestic Violence: Pathology of the Family]. Tokyo: Sakuhinsha.

Nakamura, T. (2003). Regenderig Batterers. In: J. E. Robertson and N. Suzuki (eds.), Men and Masculinities in Contemporary Japan: Dislocating the Salaryman Doxa. London: Routledge Curzon.

Nakamura, T., Ishikawa, Y., and Noguchi, Y. (2004). Zadankai: Rinshou-shakaigaku no kanousei [Discussion: Present and future of clinical sociology in Japan]. Adikushon to Kazoku [Journal of Addiction and Family], 20, 397–411.

Noguchi, Y. (1994). Rinshou-shakaigaku no houhou to kanousei [Clinical sociology: its methods and implications]. Hoken iryou shakaigaku ronshu [Annual Review of Japanese Health and Medical Sociology], 5, 46–51.

Noguchi, Y. (2002). Monogatari Toshiteno Kea [Caring as Narrative]. Tokyo: Igaku-Shoin.

Noguchi, Y. (2004). Rinshou-shakaigaku no kanousei: tokushu ni atatte [Foreword: present and future of clinical sociology in Japan]. Adikushon to Kazoku [Journal of Addiction and Family], 20, 355.

Noguchi, Y. (2005). Naratibu no Rinshou-Shakaigaku [Narrative Based Clinical Sociology]. Tokyo: Keiso-Shobo.

Noguchi, Y., and Ohmura, E. (eds.). (2001). Rinshou-Shakaigaku no Jissen [The Practice and Experience of Clinical Sociology]. Tokyo: Yuhikaku.

Ohmura, E. (ed.). (2000). Rinshou-Shakaigaku wo Manabu Hito no Tameni [For the People Studying Clinical Sociology]. Kyoto: Sekaishisousha.

Ohmura, E., and Noguchi, Y. (Eds.). (2000). Rinshou-Shakaigaku no Susume [Introduction to Clinical Sociology]. Tokyo: Yuhikaku.

Ohshima, M. (2003). Chihousei-koureisha heno narativu apurouchi [A narrative approach to elderly people with dementia: working with elderly people with reminiscence board]. Kango Kenkyu [Japanese Journal of Nursing Research], 36(5), 73–82.

Rebach, H. M., and Bruhn, J. G. (eds.). (1991). Handbook of Clinical Sociology. New York: Plenum.

Spector, M., and Kitsuse, J. I. (1977). Shakai-Mondai no Kouchiku [Constructing Social Problems]. N. Murakami, N. Nakagawa, J. Ayukawa, and S. Mori. (Trans.). Tokyo: Maruju-Sha, 1990.

Ueno, C. (ed.). (2001). Kouchikushugi Towa Nanika [What Is Constructionism?]. Tokyo: Keso-Shobo.

United States Central Intelligence Agency (CIA). (2007). The World Factbook.https://cia.gove/cia//publiscations/factbook/print/ja.html.

Urakawa Beteru no Ie. (2002). Beteru no Ie no Hi-Enjoron [Not-Helping in Beteru no Ie]. Tokyo: Igaku-Shoin.

White, M., and Epston, D. (1990). Narrative Means to Therapeutic Ends. New York: Norton.

Yahara, T. (2004). Chairudorain ni Okeru Rihurekutingu-Purosesu no Ouyou [Application of the Reflecting Process to Child Line]. Adikushon to Kazoku [Journal of Addiction and Family], 20, 388–396.

II
CLINICAL SOCIOLOGY APPLICATIONS

7
Clinical Sociological Contributions to the Field of Mediation[1]

Jan Marie Fritz

Many disciplines and organizations have contributed to the field of mediation. One of these influences, the discipline of sociology, has assisted with the theoretical analysis of conflicts and dispute intervention mechanisms such as mediation. Not only has clinical sociology, a subfield of sociology, contributed to the theoretical analysis of conflicts and conflict intervention techniques, but clinical sociologists also are involved in conducting mediations and putting appropriate dispute resolution (ADR) systems in place. This chapter defines mediation and then identifies and discusses some of the clinical sociological contributions to the field of mediation.

Mediation

Mediation is a creative, humanistic, and flexibly-structured process in which an impartial individual or individuals (third party) help disputants identify their individual and mutual interests and perhaps reduce or resolve their differences. This nonadversarial process is sometimes referred to as facilitated negotiation. The mediator establishes an open, trusting environment in which parties are encouraged to discuss the facts of the matter as well as their personal feelings about the issue or issues that brought them to the table.

It is useful to distinguish between the terms *conflict* and *dispute*. Conflicts are larger (perhaps very large) and their boundaries cannot easily be established. In a conflict, it sometimes is not easy to identify all the stakeholders (parties) or all the relevant issues. A dispute can be part of a larger conflict (e.g., a disagreement between a manager and an employee in a company located in a war zone), but it also may be a disagreement that is much less likely to be part of anything larger (e.g., a disagreement between male acquaintances at a bus stop about who should get on the bus first). A dispute is a disagreement between identified stakeholders who can define their issues.

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[1] This chapter is based on "Contributi della Sociologia Clinica alla Mediazione" (Fritz, 2006b).

Mediation is used to discuss, and possibly settle, a wide variety of disputes between individuals, organizations, communities, and governments as well as combinations of these disputants (e.g., community residents might have a dispute with a company that they believe is polluting their neighborhood as well as with the government agencies they believe should protect their interests). Mediation can be an excellent method for resolving some kinds of disputes, in part because it can be faster and less expensive than the alternatives. Most importantly, the parties can create their own resolution to a dispute rather than have a decision imposed on them.[2]

Mediation is carried out by different kinds of individuals and groups, and this is particularly true at the community, national, or international level. In Chapter 14 of this volume, for instance, Wan and Wan discuss the role community leaders can play as mediators who facilitate the communication and problem-solving processes among various groups in the community. Also, Byrne (2006) has outlined the following mediator roles in international disputes: *insider-partial mediator* (comes "from within the conflict and is accepted by the parties"), *quasi-mediator* (party to the conflict who seeks to facilitate de-escalation of the conflict, undertakes quasi-official work in preparation for diplomatic methods), *principal or primary mediator* (perceives their interests will be affected by the outcome, has "benefits to deny; ... can threaten harm"), and *external ethnoguarantor mediators* (external and "regionally powerful third-party mediators... with regional interests who perceive they have a direct... connection as well as a shared national identity with the internal disputants").

There are times when mediation is not seen as an appropriate method for resolving a dispute (e.g., parties prefer another dispute intervention mechanism. a settlement needs to be decided by a court, parties are too upset to talk, or one or more parties refuse to participate). Lois Presser and Emily Gaarder (2000) have made the argument that mediation is not appropriate in regard to victims of domestic violence or battering. Presser and Gaarder think that the mediation model resembles the "hands-off tactics of police responding to domestic assaults" and "serves the interests of the batterer, not the victim."

A *New York Times* story on divorce (Fritsch, 2001) quoted Jane Rutherford, a law school professor, as saying that some divorce lawyers and women's groups dislike mediation for divorce cases because women who can come up with money to litigate will come out better in financial terms. Rutherford thinks there is "a tremendous problem with emotional and physical power in mediation" and "women back down because they are afraid, and mediators won't necessarily take control." A nongovernmental organization (NGO) in England that counsels parents about their children's rights in terms of special education does not think mediation is a good option because parents do not know enough about their rights. And Toronto lawyer Markus Koehnen has noted that mediation and mediators are only there for

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[2]Clinical sociologist Phillip Robinette and Robert Harris (1989) have developed a very useful, structured approach to conflict resolution that can be used by a pair of individuals (e.g., a married couple, roommates, or coworkers) with or without the assistance of a mediator. This method allows the disputants to consider a number of possible solutions.

compromise (Daw, 2001). Koehnen was quoted as saying that "mediation is not necessarily about justice… it is about negotiation."

Some mediators, particularly those who specialize in areas such as economic development, transportation, education, community governance, or environmental disputes, also have facilitation skills. Facilitation is "any meeting of a group of people in which a facilitator structures and manages group process to help the group meet its goal" or "a meeting between two people: a facilitator and an individual who accepts process help and guidance" (Rees, 1998). For instance, I was contacted by the head of a chapter of an NGO that was located 1000 miles away to help with the design of a facilitated conflict intervention process. The caller discussed the suicide of an important community figure and how it had laid bare strong divisions within the community. We talked about options that could be put in place for a community discussion process, a timeline for this work, and how to locate local facilitators who could help with this process.

Sometimes the word *facilitation* may sound as if it is a more acceptable process than mediation. For example, I was asked to help design a process for discussing a contentious community issue. The dispute was about whether some concrete stairs—located in a public space (a woods) behind expensive houses—should be left open (providing access to all community members) or be closed (possibly providing safety for nearby homeowners). This dispute had been going on for two years. In this particular case, those who wanted to keep the stairs open said they wanted to take part in a mediation, but the homeowners who wanted the stairs closed said they would not agree to a mediation (because they thought this was a binding decision and they expected the city leaders would decide in their favor). The local homeowners might have considered taking part in a facilitated meeting. The word *facilitation* sometimes takes less explaining and can be more acceptable as an option in certain kinds of disputes.

An Example of a Mediated Case

It might be useful at this point to provide an example of an actual case that I mediated for one of the largest employers in the United States. The case was difficult because there were strong feelings on each side—an employee had frequently experienced differences of opinion with several supervisors, the main issue had been unresolved for a long period of time, and everyone was sure that no agreement of any kind was possible.

The complainant, a black woman, was expected to work overtime but, without permission, had walked away from the assignment. She had told her new and inexperienced supervisor, a white man, on the morning of the day in question that she needed to waive any possible overtime assignment that evening. Some problems were that she had not asked in writing, explained why she needed to waive the overtime that particular evening, or submitted her written request in advance of the day she needed to waive overtime. While none of these actions was required by her employer, all of them would have increased her possibility of not having a problem.

In the afternoon, when the supervisor told the complainant that she would have to work overtime that evening, she questioned him about this. He declined to answer (because he felt there was nothing to discuss) and walked away. A separate case about this overtime issue was going to the third level of grievance (a separate procedure involving her union and management) when she filed an equal opportunity case alleging that the supervisor excused a white man from overtime duty that same evening. This mediation for the equal opportunity office was expected to be about the alleged discrimination, the issue of not staying at work to complete the overtime assignment, and any other issues that the parties wished to raise.

The complainant brought a union representative to help her with the case and the new supervisor brought the regular supervisor as his representative. The manager to whom the supervisors report was also there as a management representative. In all, there were five participants.

All the participants were sure that this three-month-old case would not settle. The complainant wanted the letter of warning that had been placed in her file to be removed instead of remaining there for the usual two-year period. The supervisors and manager were adamant that the letter should remain in her file for two years. When an employee is given an order, it is to be followed. The supervisors and manager felt the employee was lucky that she had not been given a stronger reprimand. The management team also thought that it would look bad back on the floor if they did not treat this failure to obey an order in the way it would usually be handled.

After three-and-a-half hours of discussion, the parties agreed to settle this case. They agreed that (1) the letter of warning would remain in the employee's file for nine months instead of two years (if there were no other violations), (2) the employee would ask the union to withdraw the grievance because the matter was now resolved, and (3) the employee and the new supervisor would continue to improve their communication about workplace matters.

This seemed like a textbook case of how a mediation could reach an agreement. The parties and their representatives came to the mediation convinced that this issue would not be resolved and they had firmly held positions. Then they really listened to each other during the course of the conversation. The employee learned that the supervisor had not treated her differently (the other employee had been released from overtime because of equipment failure and so there was no discrimination), and the new supervisor learned that the employee had not lied to him. The employee, supervisor, and representatives did "role reversals" and talked about the various ways the situation might have been handled by the two people. The parties discussed what the outcomes might have been if things had been done differently.

Near the end of the mediation, the employee stated she had never before walked away from an assignment or done anything like this in her eleven years with the organization, had not helped her case when she decided not to submit a written request or explain her problem, and said she would never again walk away from an assignment. The new supervisor apologized for misunderstanding some things and for not communicating. He said he could have done things differently, and he now realized he could have been the employee's advocate in talking with those who made the overtime assignments.

Five Contributions to the Field of Mediation

The contributions made by different groups to the mediation process usually fit with their values and general approaches. For instance, the Friends Conflict Resolution Programs, an organization connected with the Philadelphia Yearly Meeting of the Society of Friends (Quakers), developed a system of community mediation, beginning in 1976, that airs emotions; values reconciliation; emphasizes improving future relations and problem-solving ability (as more important than reaching a detailed agreement); and uses co-mediators (Beer with Stief, 1997). All of this was to be expected as the Religious Society of Friends (Quakers) believes in equality (because there is "that of God in every one"), simplicity, harmony (peace and pacifism), and community (fellowship) (Louis, 1994).

The United States Postal Service, which delivers the mail, uses a transformational approach[3] to mediation because the postal service wants its employees, whatever the outcome of a mediation, to have better working relationships. A mediator working on a commercial dispute or one working in a court system may use a form of mediation that puts a premium on a shorter mediation process (for efficiency) and puts a high value on reaching agreements.

Clinical sociology also has made contributions to the field of mediation that reflect the subfield's orientation—to improve programs and people's lives. Five of these contributions—multilevel system intervention, cultural competency, empowerment, integrated theoretical analysis, and redefinition of the situation—are discussed here.

Multilevel System Intervention

Mediators, in general, not only are trained in a mediation process but also usually pair this with knowledge of procedures in at least one particular area of practice. For instance, a mediator who works in a court setting must understand the general mediation process and has to have knowledge of the special forms, terminology, case types, and procedures used in that particular court.

Clinical sociologists, as part of their general education, are expected to be knowledgeable about social systems as well as intervention at two or more system levels (e.g., individual and organization). This theoretical and practical knowledge, when paired with training in mediation and knowledge of a mediation setting (e.g., court, family law practice), makes the clinical sociologist a particularly valuable mediator. For example, a clinical sociologist/mediator who is knowledgeable both about employee/management relationship issues and about various organizational structures and styles might be helpful if an employee and the employee's company

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[3] Transformative mediation stresses the empowerment and recognition of parties so that parties can discuss current and future issues in a more productive way (Bush and Folger, 1994).

sort through how things might be handled differently in the future. The mediator might facilitate a settlement of immediate issues and also deal with prevention.

In two cases I mediated for the U.S. Equal Employment Opportunity Commission female employees had filed sexual harassment charges against their employers for situations that had developed during work hours. In both cases, employers tried to understand what happened and, when convinced that the complainants had credible cases, the employers also wanted to discuss how they might adjust the work situation so that this kind of problem might be less likely in the future. In some mediations, this discussion might never take place because it might not be raised by either side, but this "prevention door" might be opened by the mediator.

Clinical sociologists are trained to work at two or more system levels (e.g., individual and organizational; local community and national) and can move between or among the levels when working as mediators to help participants in a mediation "make sense of the complex social contexts that shape conflicts" (Winslade and Monk, 2000). This means a clinical sociologist can bring a number of important resources to the table. This same effect can be achieved when a mediator who is not a clinical sociologist has been trained in two distinct disciplinary settings or when a dispute is co-mediated by mediators with different backgrounds (e.g., counseling and law; interest-based and narrative mediation).

Cultural Competency

Sociology, according to Sztompka (1999), made a paradigmatic shift in the last half of the twentieth century. The move has been from an emphasis on "social collectivities (societies)… (to an emphasis on) socially embedded individuals." This current emphasis on social action is "rich" in that it not only includes rationality and calculating exchanges but also emotions, value orientations, social bonds, and cultural components.

American clinical sociology, with its more than 75-year history, has grown up with the theoretical and research interests in culture (that Sztompka traces) and also a practical interest in culture. Like a number of other practice areas (e.g., nursing, counseling, management), there has been increasing attention to culture and particularly to cultural competency.

Cultural competency is an ongoing process as well as a goal toward which systems, agencies, or individuals "must continually aspire" (Rorie et al., 1996). Cultural competency refers to a set of attitudes, behaviors, policies, and procedures that enable a system, agency, or individual to function effectively with culturally diverse individuals and communities with diverse heritages/approaches (e.g., nationality, religion, socioeconomic class) (Chung, 1992; Rorie et al., 1996; Lecca et al., 1998; Siegel et al., 2000). The components of cultural competency are *cultural assessment* (a periodic appraisal of one's own individual or agency cultural background and how it may affect practice); *cultural sensitivity* (appreciation of

other cultures and subcultures); *cultural knowledge* (education about the variety of cultures and subcultures); *cultural skills* (methods that are appropriate to use with particular cultures and subcultures); *cultural encounters* (having direct interaction with people from other cultures and subcultures); and *initiative* (taking action in some way to deal with a discovered problem/oppression). Some discussions of cultural competency do not include the assessment or initiative components, but I think it is important for both to be included. Clinical sociologists are expected to be striving for cultural competency,[4] and those who are mediators would introduce cultural competency in any mediation training that they may contribute to or put in place. I consider this to be such an important concept for mediators that I introduce it at the beginning of mediation training and courses (Fritz, 2001) along with other basic values such as empowerment. While there certainly are cases that should not go to mediation, those that are mediated deserve a mediation where the "playing field" has been made more even in terms of power and where the mediator is dealing with issues of power and justice. This, then, brings us to the topic of empowerment.

Empowerment

Empowerment is of interest to researchers in many fields. One of the best statements on empowerment is still the one put forward in 1978 by James Laue and Gerald Cormick.[5] They connect the mediator's values with her/his principles and actions, and they believe that justice, freedom, and proportional empowerment are the basic values for the ethical principles they proposed. (See Figure 2.5 in Chapter 2.) Laue and Cormick (1978) believe that proportional empowerment refers to the intervenor's (mediator's) contributions to structural changes:

> It refers to a condition in which all groups have developed their latent power to the point where they can advocate their own needs and rights, where they are capable of protecting their boundaries from wanton violation by others, where they are capable of negotiating their way with other empowered groups on the sure footing of respect rather than charity.

Laue and Cormick (1978) noted that it was the intervenor's responsibility "to promote the ability of the weaker parties to make their own best decisions" by

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[4] Sociologist Margaret Herrman and her colleagues (2001) have identified "cultural and diversity competency" as one of thirteen skill areas and "cultural issues" as one of eighteen knowledge areas that are important for mediators who intervene in "interpersonal disputes (e.g., community, employment, family or smaller commercial disputes)."

[5] Laue, a clinical sociologist, was asked by President Carter in 1979 to chair a commission to create a national academy to teach peacemaking techniques. The commission's work led to the establishment of the U.S. Institute of Peace, an independent, nonpartisan federal institution that promotes research, education and training on international peace and on conflict resolution. Gerald Cormick has a Ph.D. in business administration and more than 40 years experience mediating and facilitating complex disputes in the United States, Canada and other countries.

"helping them obtain the necessary information and skills to implement power."
As the authors saw it:

> The intervenor should assess the relative level of information, negotiating skills, and
> analytical ability of the parties and, if there is a considerable differential, help even the odds
> through training or other forms of advocacy.

The mediator role envisioned here is an active one. The intervenor is expected
to be very familiar with the dynamics of power and the possibly oppressive
situation at hand (e.g., sexism or racism), and the intervenor's actions should
contribute to the empowerment of the less powerful. Laue and Cormick (1978)
caution that the intervenor should "not claim to be (or worse, actually feel)
neutral." If the intervenor makes neutrality claims, Laue and Cormick think "the
intervenor's actions (even if well motivated) will result in damaging the position
of the weaker party and strengthening the hold of the party in power." Although
Laue and Cormick were discussing the role of the intervenor (mediator) in com-
munity disputes, their points are just as appropriate for those mediating other
kinds of conflicts.

Mediators must go over in their mind the opportunities taken or lost with regard
to fostering empowerment. A clear example of the empowerment process can be an
environmental dispute in which all the parties agree that some experts need to
educate all the parties, or it might be agreed by all that community members might
need certain kinds of training (e.g., negotiation skills training, workshops that
provide assistance on understanding technical reports or language).

Sometimes empowerment decisions are not so apparent. Once I was mediating
a case in a small-claims court between a landlord and his tenant. The landlord
had brought the case to the court and mediation in part to hassle the tenant. He
knew that the tenant was an hourly worker and she was losing money every hour
the case was in court. I thought I was making a lot of progress with this case by
helping her so that she could articulate her problems with the landlord and work-
ing with the landlord so that he could really hear and understand what she was
saying. Every time she and I had a private meeting, however, the landlord would
return to our meeting room in a terrible mood and we always seemed to be start-
ing over. Finally, I told both parties to stay in the meeting room and I went out to
the waiting room to see if I could figure out what was going on. I found two
teenage boys in the corner who seemed to be in a rather good mood. It turned
out that one was the son of the tenant and the other was his friend. Each time the
landlord had come into the waiting room, the boys had talked loudly about him
in negative ways. I "banished" the teenagers to the court's lunchroom and told
them the mother would come down there to look for them as soon as we finished.
After that, the discussion between the parties was very productive. They settled
their main issues and were even were able to discuss the boys' behavior. (The
roads to empowerment are frequently foggy and unfamiliar, but the benefits justify
the journey.)

Integrated Theoretical Analysis

Theory, whether implicit or explicit, is important. It affects how mediators, their employers, and agencies, establishing or funding, view disputes and the kind of mediation process they put in place. Theories also are important to parties. Parties involved in a dispute probably would find it useful to understand that there are a variety of mediation styles and formats even if they do not discuss the theories that underlie the different approaches.

The following approaches to mediation have been identified (Fritz, 2004, 2006a): facilitative/participant-centered, solution-oriented, transformative, narrative, and humanistic/integrated process (HIP). The latter approach is participant-centered but very flexible. Depending on the circumstances of the mediation, the mediator may integrate aspects of any of the other approaches.

Each of these approaches has ties to one or more theories. The facilitative/participant centered approach is connected to humanism; the solution-oriented approach is connected to utilitarianism; Della Noce et al. (2002) stated that their transformative approach is related to a social/communicative view of human conflict in the discipline of communicative science; and the narrative approach is connected to humanism and particularly to postmodern thought. The HIP approach described here is connected to a kind of humanism that is neither anthropocentric (human centered) or biocentric (moral consideration given to all living things). This form of humanism includes respectful consideration of the natural environment and fits very well with Aldo Leopold's (1949) land ethic theory. Mediators following the HIP tradition may have a strong connection to standpoint or multicultural/liberationist theory.

Traditional sociological education emphasizes classic and contemporary theory. Clinical sociologists, because of their traditional education in sociology as well as their additional interests in interdisciplinary studies and theoretically based practice, are knowledgeable about a range of theories, approaches, and models. Clinical sociologists interested in conflict analysis are knowledgeable about a number of biological, individual, social, and land-based theories that are used to explain conflict. They also are interested in the theories that are basic to mediation (as well as other conflict intervention approaches) in different settings, and they usually find it is useful to integrate these theories in their work.

Redefinition of the Situation

The "definition of the situation" (Thomas, 1928, 1931) is a basic idea in sociology, and it means that whatever a person or group believes to be true becomes real in its consequences. To analyze any social situation, then, "requires an understanding of how it looks to those persons who are the constituent parts of the situation or structure, because the persons will act according to how it looks to them" (Glassner and Freedman, 1979).

Mediators are interested in starting with the stories of the participants in part to get to underlying interests. One of the techniques of mediation is for the mediator to restate what the participants have said and another technique (used "cautiously as parties can easily feel patronized or coerced") is to ask the parties to restate what the other party or parties have said (Beer with Stief, 1997). Each party needs to broaden its definition of the situation in order to work on solutions. The problem needs to be "reframed." This can be done as the parties "shift from presenting their conflict as stories and positions" to viewing the situation in a new, more comprehensive way that focuses on "mediatable issues" (Beer with Stief, 1997).

Clinical sociologists, whatever their specialization, realize the importance of reframing or redefining the situation when trying to reduce or resolve social problems. Given their humanistic values and interest in empowerment, clinical sociologists who are mediators are not working just to have individuals adapt to their situation (Straus, 1984). That is only one option and may not be best or even acceptable for one or more of the parties in a mediation. A clinical sociologist as a mediator, then, can be particularly helpful to individuals and groups in improving their communication, identifying a variety of ways to define or redefine the situation, and then assessing their options.

Conclusion

The magic in the mediation process can happen when all the parties at the table want to find a way to resolve a matter and really listen to each other. The mediator can foster the mediation process, in general, by being patient, empathetic, impartial, gentle, imaginative, flexible, and comfortable with arguments as well as by being willing to "respectful[ly] confront" (Weinstein, 2001). The mediator also should have a low need for personal recognition in the resolution process (Beer with Stief, 1997). While the characteristics mentioned here are particularly valuable in mediation, different kinds of disputes do need different kinds of mediators in terms of disciplinary background, experience, and personal characteristics.

Would the workplace case outlined in this chapter have settled if the mediator had training other than in clinical sociology? To begin to answer that question, let's return to the five contributions that were detailed in this chapter. While this case did involve working at several levels (individual and organizational) and did involve cultural competency (e.g., different ages and racial backgrounds of the parties), issues of empowerment were not central here. The last contribution, the redefinition of the situation, was particularly important in this case. The role reversal technique allowed the participants to begin to see the situation from the standpoint of the other and, I believe, really moved the parties toward settling the issues.

This case required a mediator who had a good deal of experience, knowledge of organizations and, because of the high energy level and conviction of all the participants, the ability to help participants with the process. Even though the contributions of the

clinical sociologist were useful in this case, the case certainly could have been resolved by an experienced workplace mediator with training in an area other than clinical sociology.

It should be highlighted here that the point of this chapter is not that clinical sociologists are the only ones to bring to the table multilevel intervention, cultural competency, empowerment, integrated theoretical analysis, and redefinition of the situation. This discussion is intended to show that (1) clinical sociologists generally can be expected to establish or strengthen these four areas in new and existing mediation processes, and (2) it can be useful to identify the strengths that different disciplines and experiences bring to the interdisciplinary field of mediation.

References

Beer, J., with Stief, E. (1997). The Mediator's Handbook. Gabriola Island, British Columbia, Canada: New Society Publishers.

Bush, R., and Folger, J. (1994). The Promise of Mediation: Responding to Conflict through Empowerment and Recognition. San Francisco: Jossey-Bass.

Byrne, S. J. (2006). The roles of external ethnoguarantors and primary mediators in Cyprus and Northern Ireland. Conflict Resolution Quarterly, 24(2), 149–172.

Chung, D. (1992). Asian cultural communities. In: S. Furuto, R. Biswas, D. Chung, K. Murase, and F. Ross-Sheriff (eds.), Social Work Practice with Asian Americans (pp. 274–275). Newbury, CA: Sage.

Daw, J. (2001, July 12). Mediation's half loaf better than none. Toronto Star, E02.

Della Noce, D. J., Baruch Bush, R. A., and Folger, J. P. (2002). Clarifying the theoretical underpinnings of mediation: Implications for practice and policy. Pepperdine Dispute Resolution Law Journal, 3, 39–66.

Fritsch, J. (2001, July 29). New York law may fan the fire in divorces like Giuliani's. New York Times. http://query.nytimes.com/gst/fullpage.html?res=9F05E2DB103DF93AA15754C0A967 9C8B63. Accessed September 1, 2007.

Fritz, J. M. (2001). Mediation skills. In: J. M. Fritz (ed.), The Clinical Sociology Resource Book (pp. 49–53). Washington, DC: American Sociological Association Teaching Resources Center.

Fritz, J. M. (2006a). L'approccio al conflitto: il ruolo della teoria nella mediazione [Approaches to conflict: Social theory and mediation]. In: L. Luison (ed.), La Mediazione come Stumento di Intervento Sociale (pp. 24–36). Milano, Italy: FrancoAngeli.

Fritz, J. M. (2006b). Contributi della sociologia clinica alla mediazione [Contributions of clinical sociology to mediation]. In: L. Luison (ed.), La Mediazione come Stumento di Intervento Sociale (pp. 81–93). Milano, Italy: FrancoAngeli.

Glassner, B., and Freedman, J. (1979). Clinical Sociology. New York: Longman.

Herrman, M., Hollett, N., Gale, J., and Foster, M. (2001). Defining mediator knowledge and skills. Negotiation Journal, 17(2), 138–152.

Laue, J., and Cormick, G. (1978). The ethics of intervention in community disputes. In: G. Bermant, H. C. Kelman, and D. P. Warwick (eds.), The Ethics of Social Intervention (pp. 205–232). Washington, DC: Halsted Press.

Lecca, P. J., Quervalu, I., Nunes J. V., and Gonzales, H. F. (1998). Cultural Competency in Health, Social, and Human Services: Directions for the Twenty-First Century. New York: Garland.

Leopold, A. (1949). A Sand County Almanac, and Sketches Here and There. New York: Oxford University Press.

Louis, M. R. (1994). In the manner of Friends: learnings from Quaker practice for organizational renewal. Journal of Organizational Change, 7(1), 42–60.

Presser, L., and Gaarder, E. (2000). Can restorative justice reduce battering? Some preliminary considerations. Social Justice, 27(1), 175–195.

Rees, F. (1998). The Facilitator Excellence Handbook. San Francisco: Jossey-Bass.

Robinette, P. D., and Harris, R. A. (1989). A conflict resolution model amenable to sociological practice. Clinical Sociology Review, 7, 127–140.

Rorie, J. L., Paine, L. L., and Barger, M. K. (1996). Primary care for women: cultural competence in primary care services. Journal of Nurse-Midwifery. 41(2), 92–100.

Siegel, C., Davis-Chambers, E., Haugland, G., Bank, R., Aponte, C., and McCombs, H. (2000). Performance measures of cultural competency in mental health organizations. Administration and Policy in Mental Health, 28(2), 91–106.

Straus, R. A. (1984). Changing the definition of the situation: Toward a theory of sociological intervention. Clinical Sociology Review, 2, 51–63.

Sztompka, P. (1999). Trust: A Sociological Theory. Cambridge: Cambridge University Press.

Thomas, W. I. (1928). The Child in America. New York: Knopf.

Thomas, W. I. (1931). The Unadjusted Girl. Boston: Little, Brown.

Weinstein, R. J. (2001). Mediation in the Workplace: A Guide for Training, Practice, and Administration. Westport, CT: Quorum.

Winslade, J., and Monk, G. (2000). Narrative Mediation: A New Approach to Conflict Resolution. San Francisco: Jossey-Bass.

Selected Readings

Capece, M., and Schantz, D. (2000). An approach to community facilitation using mediation techniques: skills for the sociological practitioner. Sociological Practice, 2(1), 23–32.

Fritz, J. M. (2004). Dierriere la magie: Models, approaches et theories de mediation [Behind the magic: Mediation models, approaches and theories]. Esprit Critique, 6(3). http://www.eolss.net.

Gale, J., Mowery, R., Herrman, M., and Hollett, N. (2002). Three factors of effective mediation. Conflict Resolution Quarterly, 19(4), 389–420.

Luison, L., and Liaci, S. (eds.). (2000). Mediazione Sociale e Sociologia: Riferimenti Teorici ed Esperienze [Social Mediation and Sociology: Theoretical References and Experiences]. Milano, Italy: FrancoAngeli.

Miller, J. S. (1985). Sociologists as mediators: clinical sociology in action. Clinical Sociology Review, 3, 158–164.

Miller, J. S. (1991). Clinical sociology and mediation. In: H. M. Rebach and J. G. Bruhn (eds.), Handbook of Clinical Sociology (pp. 247–257). New York: Plenum.

8
Clinical Sociology and Bereavement

Sarah Callaway Brabant

In the United States, the origin of thanatology (death, dying, and bereavement) as a discipline can be traced to two time periods and two different foci of interest. Academic and clinical interest in the death and dying components of thanatology emerged in the 1950s as a result of the death awareness movement[1] and, from the beginning, has been interdisciplinary. One of the earliest publications in the field, *The Meaning of Death* by Herman Feifel (1959), was a collection of essays that "encompassed theoretical approaches, cultural studies, and clinical insights" from different disciplines (DeSpelder and Strickland, 2002).

Although in the United States the psychiatrist Elisabeth Kubler-Ross (1969) is probably the best known among the pioneers in the death awareness movement, sociologists were major contributors. Talcott Parson's "Death in American Society" (1963), for instance, focused on the impact of technology on the dying process; Barney Glaser and Anselm Strauss (1964) introduced the concept of "awareness contexts" to explain differences and changes in communication with dying patients; and Vanderlyn Pine and Derek L. Phillips (1970) applied sociological insight to functionaries of death, for example, the funeral industry. Robert Fulton not only contributed one of the pioneering books, *Death and Identity* (1965), but also designed and taught the first formal course in death and dying at an American university.[2]

Academic and clinical interest in bereavement (loss) and grief (response to loss) in the United States preceded the death awareness movement by several decades and can be traced specifically to a paper by Sigmund Freud, "Mourning and

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[1] Doka (2003) suggests that the emergence of the death awareness movement in the United States in the 1950s can be traced to four factors: (1) demographic changes, that is, the increase in an elderly population; (2) the beginning of the nuclear age and an increase in death anxiety; (3) a return to an attitude of death as natural rather than a failure of the medical system; and (4) it "filled a void in a secular society where many segments of the population previously found no significance in the culture's understandings of death." Evidence that this movement has been institutionalized includes "the establishment of large self-help networks, hospices, professional associations…as well as the development of certification and educational programs."

[2] Sociologists mentioned in this chapter are included for discussion purposes only and do not represent an exhaustive list.

Melancholia" (1925). In contrast to the interdisciplinary approach with respect to death and dying, this paper cast bereavement firmly within a psychological framework. For decades, the sociological perspective was all but ignored.

This chapter examines three critical problems with the psychological model of bereavement and the gradual shifts to a sociological perspective: the bereaved person as social self rather than ego, culture as a milieu rather than a factor, and grief and grief work as deviant/anomic rather than abnormal/pathological. Examples from my clinical practice illustrate the efficacy of the sociological perspective.

My Work as a Clinical Sociologist

Although my primary role as a sociologist in an academic setting has been teaching, I also have been involved as both researcher and clinical practitioner throughout my career at the University of Louisiana at Lafayette beginning in 1973.[3] In the mid-1970s, I served as the co-coordinator of an internship program in cooperation with

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[3] Southwest Louisiana is home to a population diversified by national origin, culture, and race due to historical circumstances, which include colonization by the French and Spanish, the Acadian exile, the Louisiana Purchase, and statehood. It resulted in the settlement of French and English speakers, Catholics and Protestants, small agriculturalists and large plantation owners, independent colonists and slaves, as well as in the emergence of the unique Cajun and Creole cultures. These circumstances continue to shape life in southwest Louisiana today, especially in the eight-parish area known as Acadiana. (In other states a parish would be a county.) In Acadiana, 32 percent of the population claim Acadian ancestry and another 18 percent claim French or Canadian origin; claims of some French-based heritage are even higher in some parishes (60 percent in the parishes of Acadia and Vermilion).

French is a language reportedly spoken by 25 percent of the area residents who are at least 5 years old. There are variations by parish, race, and age group: French is spoken more (by about 4 out of 10 people) in Evangeline, St. Martin, and Vermilion and it is also more likely to be used by whites (approximately 27 percent) than blacks (12 percent). Whereas 72 percent of people older than 50 speak French, 8 percent of those under 30 do. Finally, 17.6 percent of older Cajuns are linguistically isolated, that is, they do not reside with another person speaking a shared language. White French-speakers of Acadian ancestry are generally known as Cajuns, while blacks claiming some French heritage in Acadiana are referred to as Creoles.

Although it is difficult to measure, it appears that Roman Catholicism is a major religion among both ethnic groups; according to the Diocese of Lafayette, about 65 percent of the local population is Catholic. Although most Cajuns live in urban areas, about a third live in rural areas. Regarding occupations, they are more likely than their non-Cajun neighbors to be employed in agriculture, forestry, or fishing (about 4 percent) and blue-collar jobs (about 30 percent). Research has shown that, statewide, reported use of French is correlated with lower household income for both whites and blacks. Finally, Cajuns report lower educational levels; if we consider the 30 to 50 age group, less than 10 percent are college graduates (half the level of non-Cajuns) and 27 percent have not graduated from high school (compared to 17 percent of non-Cajuns). I am indebted to Professor Jacques Henry, Department of Sociology, University of Louisiana at Lafayette, for this summary.

the city of Lafayette, Louisiana. This program focused on identifying and assisting low-income persons by providing them information on and access to community resources. It was clear that poverty was highly correlated with being the single female head of household. As a result, in the mid-1970s, I and my co-coordinator from the city invited three other women from the community to join us and together we designed and implemented the Mayor's Commission on the Needs of Women. I served as the first president and on the steering committees to develop a rape crisis center, a battered women's shelter, and a shelter for homeless women. All of these programs continue to this day.

In my work with these programs, I became aware that loss is a common element across rape, abuse, and homelessness. Following my mother's death in 1980, I decided to explore death/loss in a seminar. I intended for this to be for one semester only. The repeated requests of students for another semester and the continuing popularity of the course resulted in my teaching each semester as well as the addition of a second course taught by a former student. Although retired, I continue to teach a course on death and dying each semester as an adjunct.

In 1984, I was asked to become a consultant for the local chapter of Compassionate Friends, an international support program for bereaved parents. As I listened to these parents share their loss and pain and to the invited speakers, most often psychologists and social workers, I became increasingly aware of the inadequacy of the prevailing psychological model. I also became aware of the needs of bereaved siblings. In 1988, I co-initiated the first support group for bereaved siblings in south Louisiana. In 1996, I joined with four other women working in the area of bereavement to establish the Grief Center of Southwest Louisiana, Inc. now named Healing House.[4] For eight years I served as a group coordinator and as the volunteer trainer, and continue to this day, as a consultant. In 1989, I initiated the first support group for persons living with AIDS through Acadiana Cares. I continue to conduct workshops for this agency and recently I worked with several children impacted by both AIDS and Hurricane Katrina.

Thus, for the past twenty-five years, I have been actively involved in the area of bereavement as an educator, a researcher, and as a clinical sociologist. As a practitioner, I have worked with bereaved persons one-to-one, in groups, through workshops, and through program development and implementation. Central to my work as educator, researcher, and practitioner has been my effort to bring a sociological perspective to both the study of bereavement and to the design of tools and programs to alleviate the impact of bereavement on the individual's physical, intellectual, emotional, and social well-being. A cursory look at the historical development of the psychological model of bereavement is germane to this chapter.

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[4] Healing House, patterned after the Dougy Center in Portland, Oregon, is a nonprofit organization with trained volunteer facilitators. Currently over eighty children and teens who have experienced the loss of a caregiver or sibling attend bimonthly support groups. All services are free. Groups for the adults accompanying the children and teens are also provided.

An Historical Overview of Bereavement in the United States

The "Normality" of Grief and the Bereaved as Ego

In his article, "Mourning and Melancholia," Freud (1925) stated that grief is "normal," although "painful." The return to "the normal attitude toward life" requires "work" which compels the bereaved, that is, the ego, "to give up the [lost] object." When this work is completed, "the ego becomes free and uninhibited again." This suggests both a linear projectory in which pain over time gradually decreases and eventually ceases altogether, as well as a need for "work" on the part of the bereaved to bring this about.

The notion that grief is a natural human response to a bereavement or loss and that some effort on the part of the bereaved person is required is generally accepted in the bereavement literature. The delineation between normal grief and abnormal or pathological grief, however, is probably one of the least resolved issues (Brabant, 1977). Several questions emerge. How intense is too intense? How long is too long?

In some instances, the intensity of the emotion may render it inappropriate. *Distorted grief*, for example, refers to a grief characterized by "extreme anger and extreme guilt" (Rando, 1993). The timing of the emotion also may render it inappropriate. This includes both *chronic grief*, in which "the [emotional] reaction is one that is excessive in duration and never comes to a satisfactory conclusion" (Worden, 1991), and *delayed grief*, in which "the person may have had an emotional reaction at the time of the loss, but it is not sufficient to the loss."

Although the focus on time and intensity continued to be of interest to early researchers (Brabant, 1989–90), mitigating circumstances were gradually added to justify abnormal grief. *Anticipatory grief* may precede the death when the dying process is prolonged (Lindemann, 1944); delayed, continued, or pronounced pain may be related to the relationship of the bereaved to the deceased (Franz, 1981) or sudden death as opposed to anticipated death (Raphael, 1983). The concept of *anniversary reaction* (Hilgard et al., 1960) suggests that dates associated with the deceased (for example, birthdays and death anniversaries) explain the reappearance of pain.

Through the years a number of psychological, social, and cultural factors were added to the list of factors assumed to impact the grieving process. These include not only circumstances surrounding the loss and suddenness of loss, but also the meaning of the loss to the survivor, prior losses, coping skills, and available resources and support (Rando, 1993). The term *complicated grief* was an attempt to eliminate the need for pejorative words such as *pathological* and *abnormal* for any grief that does not follow the prescribed projectory described originally by Freud. The continued use of terms such as *distorted, chronic*, and *delayed grief*, however, demonstrates that intensity and time continue to be major factors in delineating uncomplicated from complicated grief.

"Mourning:" Conceptual Confusion

In addition to the confusion with respect to normal versus abnormal grief, there is a conceptual problem with respect to the multiple meanings applied to the concept *mourning* (Brabant, 2002). For Freud (1925), mourning is "the reaction to the loss of a loved one, or to the loss of some abstraction which has taken the place of one." Lindemann (1944) added the "disintegration of [the] social system" to the consequences of bereavement and acknowledged the function of rituals to "maintain the patient's [mourner's] interaction with others."

Maris (1974) refers to grief as "the psychological process of adjustment to loss" and mourning as "the more or less conventional institutionalized expressions of grief." For Maris, grief includes specific emotional states that continue for a period of time. Culturally prescribed rituals or customs are the means through which these emotional states can be expressed.

Parkes and Weiss (1983) define grief as "the overall reaction to loss" and mourning as the "observable expression of grief." The expression of grief "signifies to others the distress of the grieving individual," thus establishing "a social situation in which normal laws of competitive behavior are suspended." Additionally, these researchers note that the death of one member of a social unit affects not only the other members of that unit but also the unit itself.

Despite these early efforts to incorporate social and cultural factors into the grief process, Rando (1993) argues that the emphasis on extending the limits of normal grief tends to obscure the problematic or complicated mourning process experienced by many bereaved persons. Although she includes "sociocultural and technological trends" as one of the risk factors that predispose an individual to complicated mourning, these factors remain peripheral ones. Her definition of "mourning" is of particular interest to this chapter for it is clearly a return to the Freudian definition. She writes:

> Traditionally, mourning has been defined as the cultural and/or public display of grief through one's behaviors. This definition focuses on mourning as a vehicle for social communication. However, as defined in this book, the term follows the psychoanalytic tradition of focusing on intra-psychic work, expanding on it by including adaptive behaviors necessitated by the loss of the loved one.

Thus, in the psychological model of grief, the bereaved person is ego. Social and cultural factors are contributing factors at best, and grief (and grief work) may be pathological or abnormal.

As mentioned earlier, sociologists in the United States who were interested in thanatology concentrated on organizational structure, roles, or social processes and left the emotional aspect of bereavement to the psychologists and psychiatrists. It is unclear whether this was due to public policy (the control of licensing almost precludes sociologists from certain types of clinical practice[5]) or the training common to the discipline itself (a focus on theory, research, and education).

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[5] The use of the term *counseling* in Louisiana, for instance, is limited by law to those who are licensed in the state to practice, primarily psychologists and social workers.

A Sociological Perspective

Sociologists Kathy Charmaz (1980) and John Stephenson (1985) represent important exceptions. Charmaz argued that the cultural impact on grief was limited to the expectation that certain persons should feel grief and that this grief should be expressed and worked through. She writes:

> Culture does not simply give rise to the patterned ways of handling grief, but instead implies that the subjective interpretation of cultural meaning in conjunction with the backlog of personal experiences of the bereaved give rise to the very feelings that are defined as "grief."

Stephenson noted that popular psychological thinking tends to put the entire responsibility for grieving on the individual and warns that this approach implies a naive and even dangerous approach to the impact of the social milieu. Both Stephenson and Charmaz assert that the norms govern what one feels as well as the way in which one is allowed to express this feeling.

In 1989, I argued that thinking of the bereaved as a social self rather than ego is critical to understanding a grief often referred to as abnormal, that is, recurrent grief, and that what may appear to be the recurrence of old pain is, in fact, a new pain brought about by a new loss to the social self.[6] Using George Herbert Mead (1934) as my guide, I wrote:

> The notion of a self that acts spontaneously and protectively of itself [explains the] acute grief triggered by a special day or occasion on which the bereaved person would almost certainly have interacted with the deceased if, in fact, the deceased had not died. The self may approach this situation having resolved to some extent the original loss, but the new situation presents a loss not previously experienced. Examples include the day one's deceased child would have graduated, one's wedding day when one's parent(s) is/are deceased. On these new occasions, new roles would have been performed, i.e. mother of the graduate, parents who celebrate a child's wedding. The loss of these roles causes new grief.

Sociologists are not the only ones who have challenged the traditional model. More recently, a growing number of psychologically oriented thanatologists, such as Neimeyer (1998), Silverman (1998), and Wolfelt (1998), challenged the traditional perspective as well.

The Bereaved as a Social Self, Not Ego

Two concepts, the *social self* and *the looking-glass self*, are particularly relevant. The social self "is simply any idea, or system of ideas, drawn from the communicative life, that the mind cherishes as its own." The looking-glass self is the process through which this social self emerges. "The social reference takes the form of a somewhat definite imagination of how one's self appears in a particular mind (of

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[6] Interestingly, the editor of *Omega* at that time refused to allow me to title my paper "A Sociological Approach" and insisted on "A Social Psychological Approach."

another) and the kind of self-feeling one has is determined by the attitude toward this attributed to the other mind" (Cooley, 1961).

The social self implies an individual who is different from a physical/psychological entity in two important ways. First, the social self is one that is constantly changing as a result of interactions with others. Second, the social self is one that both defines situations and interacts with others within a cultural milieu. It is only when meanings are shared that true communication can take place (Mead, 1934).

Two further sociological concepts are pertinent to a sociological perspective of bereavement. One is the Thomas (1968) theorem, which proposes that "if [people] define situations as real, they are real in their consequences." The other is Robert K. Merton's (1968) progression of Thomas's work, the *self-fulfilling prophecy*. A false definition of the situation evokes a new behavior that makes the originally false definition come true. The following clinical tool (a metaphor) is grounded in the above concepts.

Clinical Sociology: The Bereaved as Social Self

My book, *Mending the Torn Fabric: For Those Who Grieve and Those Who Want to Help Them* (1996), is a clinical tool based on a sociological, primarily symbolic interaction, perspective. In this book, bereavement is a loss; grief is the response to that loss. In the mending-the-torn-fabric metaphor, loss is a tear in a piece of fabric; grief is the response to that tear. Mending is the grief work required to repair the fabric for future use. It is generally accepted by thanatologists that the magnitude of the loss for the bereaved person is directly correlated with the investment that person had in his or her relationship with the deceased (Kalish, 1985). From a sociological perspective, however, this loss is more than a psychic/emotional loss to ego, but includes all of the social roles shared by the bereaved and the deceased. Thus, bereaved people have lost not only who the deceased was to them, but also who they were to the deceased. The bereaved person grieves the loss of roles as well as the loss of roles anticipated in the future. All of these losses need to be recognized. This is why the sheer magnitude of loss when a significant other dies can be overpowering. The metaphor of multiple tears in a fabric facilitates the grieving process by allowing an individual to identify the different losses, yet focus on one loss at a time for mending. In essence, the metaphor separates the overall goal of mending a torn fabric into smaller and more manageable tasks. In addition, it allows the bereaved person to normalize pain that seems to shift or change over time.

Having one's grief affirmed by someone is recognized as an important component in grief work. People are better able to do grief work when they believe that others think the loss warrants the pain, and that the grief work itself is both justified and appropriate. What happens when affirmation from others, particularly significant others, is not forthcoming? What happens when others, either with or without cultural backing, define the bereaved person as neurotic or even exploitative? The

bereaved person's pain becomes the source of another tear or tears (e.g., loss of self-esteem, loss of group membership, loss of identity).

Loss, then, is defined at the personal and individual level; loss is also defined by others with whom the bereaved interacts as well as within a particular cultural milieu. These definitions of loss may not, and often do not, correspond. In the absence of cultural or social support, the pain itself becomes the only affirmation that grief work is warranted. Through the metaphor, the bereaved person is urged to follow the pain to the tear rather than allow the tear to justify the pain.

The metaphor permits an individual to define both the existence of a tear as well as the magnitude of the tear without outside interference or interpretation. It also provides the possibility of a mended fabric, at least to some degree, and the hope of future worth and usefulness. Further, the metaphor encourages individuals to define themselves as the only person who can mend their fabric.

To even consider the magnitude of the loss of a loved one may evoke such terror that denial is necessary for survival. This is particularly true in the "denial of death" culture in the United States, in which the word *death* itself is unspeakable (e.g., the loved one "passed away"), and talking about the deceased is defined often as morbid. The metaphor provides a safe place to adjust to an idea or a thought that is too terrible to contemplate in its pure form. The metaphor of a torn fabric allows the bereaved person to withdraw from the existential horror without denying the reality of the loss.

Grief is an experience that can take a number of forms. Bereaved people may deny that there is a tear, or, if there is one, that the tear is a large one. They may get angry, feel sad, or feel relieved at the same time or at different times. They may get angry at the cause of the tear, at the tear itself, or at their clumsy mending. People even get angry at having to mend. The metaphor allows bereaved people the opportunity to identify where they are at a given time (or at least where they have been), to define that place as appropriate without evaluation or judgment, and to move freely back and forth between places. It also encourages the bereaved to consider how each of these places affects or impacts their mending rather than bestowing on these feelings the power to define the worth or merit of the mender. For example, a bereaved person may say, "I am angry so much of the time; there must be something wrong with me." Within the metaphor, the bereaved are angry because of the tear in their fabric. The question then becomes, "How can being in a place of anger benefit my mending process?"

Anger, sadness, fear, relief, and jealousy are natural emotions in that we do not learn to feel them. True, we may learn how to express them or learn whether or not we may express them. The feelings themselves are attributes of being a human being. In contrast, guilt and shame are feelings that we learn to feel in interaction with others. We cannot feel guilt or shame until we first have learned to think of our behavior or ourselves in some way. Rando (1993) writes: "Very briefly, in guilt the individual perceives her behavior as bad, whereas in shame the individual perceives herself as bad." Either is problematic in grief work at best and "can take on major destructive dimensions" when grief is complicated. Guilt and shame, then, are places to avoid or exit.

To do this, however, the paths toward guilt and shame need to be identified. Four paths, each with its own point of origin, are identified in the metaphor: (1) cultural background, (2) personal experience, (3) the expectations of those with whom one interacts, and (4) the relationship one had with the deceased. Once these are delineated, individuals can then explore each of these paths to determine how or why they are in a place of guilt or shame.

Rando (1993) refers to "both prior and concurrent losses and stresses" as well as the individual's mental health as "mourner liabilities." I like her use of the term *liability*. In *Mending the Torn Fabric*, these liabilities are the earlier tears in a person's fabric, tears that often must be recognized and mended prior to mending the more recent tear. The concept of earlier tears allows individuals to assess their fabric in a way that does not evoke shame or guilt. It also provides the clinician an opportunity to explore with the bereaved person the possibility of rips that need specialized help (e.g., a therapist skilled in childhood sexual trauma) without minimizing the recent loss.

As mentioned earlier, the reappearance of pain years after a loss may be a response to a new loss that has evoked new pain rather than the return of the pain associated with the original loss (death) (Brabant, 1989–90). Focus on intensity and duration of pain is not limited to researchers and clinicians. Bereaved persons often define a sudden reappearance or increase in intensity of pain following a period of relative calm as a failure in the recovery process. Defining this pain as a response to a new loss relieves the bereaved from the burden of self-blame for regressing, and allows them to redefine themselves as people who have worked through past grief and can now work through new grief. Instead of a failure, they are accomplished menders.

To mend a torn fabric, the owner needs needles and threads. Sometimes these are already available in the person's sewing basket. Sometimes new needles and threads are needed. New stitching techniques may have to be learned. These can be found in a variety of places, but people will have to look for them and select the ones that suit their particular fabric and particular tears. It may be necessary to try quite a few before finding the right ones.

Working through the pain of grief is abstract. How does one work through pain? What is involved? What is required? For the newly bereaved, stripped of energy or deprived of their former source of support, just bearing the pain is difficult enough. The thought of having to work through the pain may require more effort than they think possible at the moment. Again, the metaphor provides a picture that makes sense. It also divides the overall task into smaller more manageable tasks. This is important, because succeeding at even one small task empowers them to work at others.

This, of course, is consistent with Merton's concept of the self-fulfilling prophecy. If the bereaved think that they cannot mend, then they probably cannot. Indeed, the bereaved may create a situation that not only precludes mending but also results in further tears or tearing. According to Worden (1991), although most people do not take a negative course, some people work against themselves by promoting their own helplessness, by not devoting the skills they need to cope, or by withdrawing from the world and not facing up to environmental requirements.

Mending even one small tear can help the bereaved redefine the process as one that is possible rather than impossible.

In the early days and weeks following a loss, I often use a piece of fabric with multiple tears in it to help the person "see" what is happening. Later I may use this visual aid to help the person identify additional tears associated with the loss of the loved one, earlier tears that may complicate mending, and tears that may be subsequent to the original loss (future tears). I have also used this visual aid to help family or friends comprehend what the bereaved person is going through, particularly when the grief is very complicated.

Because sewing is universally recognized, the metaphor provides a commonality for persons with different life experiences, both cultural and personal. Thus, it can be used when the practitioner and client have different lifestyles or class differences. It is also useful in groups of participants who have little in common with one another. In each of these situations, the metaphor becomes a meeting place for those involved.

Since the metaphor can be presented verbally or visually through a torn piece of fabric, it is also useful for different age and educational levels, for example, persons in the same family or in the same community. It also can be used with the mentally challenged individual or when communication is minimal because of language or dialectical differences.

I have found the metaphor useful for crisis intervention, one-time workshops, or groups of longer duration. I also have found it useful in training persons who will come in contact with the bereaved, such as hospice volunteers or pastoral care personnel.

A Conceptual Breakthrough: Doka's "Grieving Rules"

The response of thanatologists to the sociologist Kenneth Doka's (1989) introduction of the concept of *disenfranchised grief* was immediate and widespread (Brabant, 2002). This enthusiasm, which has continued for more than a decade (Corr, 1998–99), indicates the value of this new conceptual tool for both academics and clinicians engaged in grief related work. As useful as this new concept has proven to be, however, the premise upon which it rests may be even more important. Doka (1989) writes:

> The concept of disenfranchised grief recognizes that societies have sets of norms—in effect, "grieving rules"—that attempt to specify who, when, where, how, how long, and for whom people should grieve.

The importance of rituals as socially approved means of expressing emotion associated with grief has long been recognized in the bereavement literature, and the impact of social and cultural factors on both grief and grief work is generally conceded. The notion of grieving rules, however, shifts the emphasis from social/cultural factors as vehicles through which grief can be expressed or as possible factors in complicating both grief and grief work, to social/cultural factors as

integral components of the grieving process itself. This shift in paradigm has both theoretical and clinical implications.

I suggest that it is within a climate of discontent with traditional models that Doka's conceptualization of "disenfranchised" grief has been so enthusiastically received. Doka's concept does not rest on the notion of an ego that exists as an entity apart from other entities, one that may be impacted by a number of factors including social and cultural ones, but remains in effect a discrete unit. In contrast, Doka's concept comes out of a tradition that perceives people as who they are because of their interactions with others, both the actual interactions as well as the cultural expectations regarding these interactions. This approach is rooted in a sociological explanation of human behavior, and it is within this perspective that the importance of both cultural and social factors can be fully considered.

For the sociologist, culture is not just one of many factors. It is the very milieu within which social interaction takes place and it is through the interactions that transpire within this milieu that people make choices. It is the unique individual who chooses, but these choices are made within a social and cultural setting. Doka's example of the gay man whose partner dies of AIDS provides an example. This man can choose to publicly express his grief, but at what economic, social, psychic, emotional, and possibly physical cost? Given these costs, does he, in fact, have a choice? I suggest that he does not. Indeed, he may have so inculcated the cultural homophobia that he has come to believe that he has no right to even feel the pain, much less express it. He may even come to loathe himself for feeling pain. In other words, as a result of grieving rules, he may be compelled to hide his feelings; he may not even allow himself to feel his own feelings.

What, then, are grieving rules? Doka (1989) defines them as "sets of norms… that… specify who, when, where, how, how long, and for whom people should grieve." As such, they are guidelines for human behavior that emerge out of human interaction. They define our expectations for our own behavior as well as our expectations for the response of others to that behavior and become part of the cultural context within which further interaction takes place. They govern what we think we should do, think, or feel and what we have a right to expect others will do, think, or feel. Although norms have been associated primarily with behavior, sociologists have long recognized that they extend to emotions as well.

The relatively recent emergence of the sociology of emotions provides new insight into the interplay between individual emotion and emotion with respect to social systems and culture. There is a consensus that at least some emotions as well as some emotional arousal is learned and thus governed by the norms. Human emotions are also "objectified in culture and reproduced in culture-meaning institutions" (Denzin, 1990).

The concept of *expression rules* is generally attributed to the sociologist Erving Goffman (1956, 1969). These are rules that have to do with the displaying or masking of feelings. The concept of *feeling rules* can be traced to the work of another sociologist Alice Hochschild (1979, 1983, 1990). In contrast to expression rules, feeling rules tell us how we should try to feel. These rules include not only the appropriate emotion that should be felt in a given context, but the appropriate

intensity and the duration as well (Hochschild, 1979). Similar to expression rules, feeling rules are not simple yes-no norms. Instead, they provide "zoning regulations that demarcate how much a given feeling, held in a given way, is crazy, unusual but understandable, normal, inappropriate, or almost inappropriate for a given social context" (Hochschild, 1990). For Hochschild (1990), "emotion work" is "the emotion management we do in private life." Feeling rules are what "guide emotion work by establishing the sense of entitlement or obligation that governs emotional exchange" (Hochschild, 1983). In contrast, "emotional labor" is "the emotion management we do for a wage." Thus, feeling rules may be a matter negotiated with another person in private or they may be required as a means of employment, for example, bureaucracy's handbook. She suggests further:

> There are probably cross-cultural variations in the formation of different types of tension in the leeway that exists between what we *do* feel and what we *expect* to feel, between what we *expect* to feel and what we *want* to feel, between what we *think we should* feel and what we *expect* to feel.

We can now enlarge Doka's definition of grieving rules to include norms that tell us whether we should or even have the right to grieve, how much we should grieve; how we should grieve with respect to our behavior; our thoughts and our emotions; where and with whom we may grieve; what we should do to resolve the loss; what recovery entails; and if and how long this should take. If particular grieving rules are mores, they constitute the moral way to define and respond and leave little if any leeway to individuals if they are to continue both socially and psychically in the group. If the norms are folkways, the bereaved have greater latitude. Since grieving rules emerge out of human interaction, they may vary widely from group to group within a society as well as from society to society. It is also important to note that norms are not simply external guidelines, but become part of the self-identity as a result of socialization. The individual cannot ignore these guidelines for they are now a part of who he/she has become.

Clinical Sociology: Grief, Grief Work, and the Cultural Milieu

Doka's introduction of "grieving rules" to the literature has clinical as well as theoretical implications. In the psychodynamic approach, the individual is primarily focused on the loss of another. The task, then, is to cope with and adapt to this loss in such a way that the loss is incorporated into one's cognitive life. Only then can the bereaved begin to focus on the here and now rather than what was or might have been. There may be stumbling blocks that complicate this process, but it is the individual who can and must take responsibility for removing these barriers. When this is accomplished, the grieving process will continue in an orderly fashion. To fail to do so indicates a problem that may require professional help.

The addition of a sociological perspective offers the possibility that at least some obstacles are outside of the individual's control. If people's emotional or cognitive responses are in conflict with group norms, they can refuse to comply with the group

norms; they cannot choose to do away with them. An example of an obstacle outside the individual's control, which I often encounter in my work with bereaved parents, is the set of norms that governs the feelings that are appropriate for holiday celebrations (Brabant et al., 1995). One is supposed to be happy on such occasions. To fail to be happy, or to cause others to be unhappy or even uncomfortable, is not acceptable. Thus, bereaved parents might be told by members of their family that their sad face will ruin the holiday meal. Note that others in this case are part of a social system and not an individual person. The tacit, and sometimes expressed, request is to refrain from any emotional expression, speech, or behavior that brings attention to either death in general or to the deceased child specifically. In Goffman's (1971) terminology, the deceased child becomes an uninvited guest. The bereaved parents cannot simply ignore the request/command. They can, of course, refuse to attend the dinner. This, however, may result in strained or even severed ties with a social system that is important for both self-identity and social support. They can attend the dinner and not comply with the request. To do so, however, is to violate the grieving rules of that group (e.g., one does not express grief at occasions dedicated to celebration of community), and thus, invite criticism or even ostracism from the group. They can attend the dinner and comply with the request, but the consequence of this action results in the parents' abandoning the deceased child. After all, other parents are bringing their children and the bereaved parents are asked to ignore their child. None of these options is without cost.

The psychodynamic approach alone cannot help these parents, for this is not an ego-oriented problem; it is a social/cultural one. When feeling rules are considered, however, the bereaved parents can then choose which of the consequences associated with compliance or noncompliance is least damaging and explore ways in which damage control can be initiated. It is the bereaved, not the clinician, who must define the problem and identify what is appropriate for them. The clinician's social and cultural experience is irrelevant. This is important both from the standpoint of the relationship of the bereaved with the living as well as their relationship with the deceased. Thus, a new therapeutic approach is needed.

Many clinicians in the United States employ the Gestalt empty chair technique with bereaved persons. It is typical to ask the bereaved what they wish they had said or want now to say to the deceased. It is important to also include the grieving rules. I do this by asking what they think others think they should have said, or should want to say, or what the deceased should have said. The sociologist Charles Corr (2002) expanded the notion of disenfranchisement to include the "dynamic or functional components of the bereavement experience." Of particular relevance to this chapter is his argument that physical, cognitive, social, and spiritual functioning are as important as emotional functioning and the need to pay attention to the "language of symptoms," which serve to "pathologize grief."

All of these dimensions of grief can be discussed within the same framework. What do you think you should have felt? What do you think others think you should have felt? Beliefs can be included as well. Is grief something that should be experienced, or is it something that should be mastered? What do the bereaved think? What do they think others think? In this manner, the clinician is able to

identify at least some of the grieving rules that govern the bereaved and to discuss the impact of these rules/norms.

The Challenge Continues

In what one reviewer described as breaking new ground, DeAnn Kalich and I (2005–6) argue that just as grief rules eliminate dependence on the convoluted concept mourning, the sociological concepts of *deviance* and *anomie* remove the need to focus on a psychological perspective that emphasizes individual deficiencies in dealing with loss, that is, abnormal or pathological grief. As such, deviance and anomie are a natural progression of Doka's work. When death occurs, individuals are thrust into situations in which adherence to old norms may be impossible, thus resulting in deviance, or the norms may be undefined, thus resulting in anomie. Sometimes the act of deviance may result in anomie. Sometimes anomie and the resulting struggle to find new ways of adapting may lead to deviance. Both paths lead to additional stress.

For example, a major task for bereaved parents is deciding how they will respond to questions concerning how many children they have. There are no cultural guidelines for this, and parents often do not agree on whether or not to include the deceased child (Brabant et al., 1994). Not agreeing with each other in a social situation, however, may be defined as strange, or may open the door to further, and often unwanted, inquiry. This is an excellent example of the additional stressors that may impact bereaved persons as they attempt to adjust to the changes brought about by the death of a loved one.

Clinical Sociology: Grief and Grief Work as Deviant/Anomic

A bereaved father came to me for advice. His demeanor was one of dejection, his shoulders slumped, his face a picture of sadness. His young son had died four years earlier. Shortly after his child's death, he started going daily to the cemetery. At first he only wept. At some time during the first year, he began to read a poem. Now he went taking his morning coffee with him and chatted with his child about what was happening. This father was a good employee, a good husband, and a good father to his living child. Going to the cemetery each morning before going to work was a special time for him to be with his son. An aunt, however, lived in a house on a street he traveled to the cemetery and she watched each day as he passed on his way there. She reported his activity to his family and urged all to persuade him that this was "abnormal." He should be over his grief by now.

He came to me to ask if he should stop. I sat for a moment and then asked him if there were a way to the cemetery without passing his aunt's house. He responded that another way would take an additional five minutes. I commented that it seemed

to me that it would be worth the extra time. He sat there a few minutes before he realized what I was suggesting. His shoulders straightened and he smiled, tentatively at first and then broadly. He agreed. After a short discussion, he and I agreed that his aunt's definition of him as a deviant was not as important as carrying out what for him was a consoling ritual.

Sometimes there are no apparent rules for grief and grief work, either personal or from someone else. When my ex-husband died, I realized that despite receiving rules for behavior for every conceivable social situation from my southern-bred mother and grandmothers, no one had told me what to wear to such a funeral. Should I even go? It seemed to me that our three children required my presence if only to support them. If I went, however, where should I sit? Was I included in the open invitation to attend a gathering following the funeral? For me, the ongoing anomie was far more stressful than the death itself.

The difficulty in following cultural guidelines or the lack of any cultural guidance for the bereaved is very apparent among families of murder victims. In the part of Louisiana in which I live, Roman Catholicism is a strong influence. For years, the mandate at the annual mass for survivors of violence was to forgive. But forgiveness is not easy if a family member was murdered, and trying to pretend forgiveness creates enormous stress.

The lack of cultural guidelines presents another kind of stress. A bereaved father whose son was tortured for hours before being shot and left to die shared the following with me. When his son's murderer was executed, he felt that he owed it to his son to witness the execution. Following the execution, however, he was unable to rest until he had written two responses to the execution. One was as the father of the murdered son; the other was as a citizen of the society that committed the execution. His explanation, "I could not be both of these people at the same time. I had to become two different people."

This man had found a way to hold very conflicting thoughts at the same time. In this instance, the response may be defined by others as positive. According to F. Scott Fitzgerald (1945), "The test of a first-rate intelligence is the ability to hold two opposed ideas in the mind at the same time, and still retain the ability to function." Defined by the psychological model, however, this man disassociated, a neurotic response at best, psychotic at worst. For him, however, forced to respond in a state of anomie, it was a creative way of surviving a situation for which there were no guidelines.

For those who survive the horrific death of a loved one, both grief and grief work are cognitively problematic. Some thoughts, such as the desire to hurt the murderer, may be deviant both to the person and those with whom he or she interacts. These thoughts need to be normalized. New ways of ordering one's world need to be constructed (see Neimeyer, 2001). This reconstruction needs to be affirmed.

Redefining the situation and creating new ways to respond is an alternative view of grief and grief work offered to the children and teens at Healing House, which provides a confidential, nonjudgmental space in which children and teens can grieve and undertake the work that is necessary to walk through that grief. The children at the center are told that it is okay to hate, to rage, to laugh, and to cry after death. It is okay

to run and giggle and jump and hit after death. It is okay to sit and cry or be silent. It is okay to talk or scream or tear up or throw things. It is okay to participate in group discussion and it is okay to pass one's turn. The only rules are (1) you cannot hurt another person, and (2) you cannot hurt yourself. The norms the children bring with them to the center are redefined. Trained facilitators will listen and not run away in discomfort; they will not judge the grief as excessive or the grief work as inappropriate.

Sometimes when a grandfather, a baby sister, and a dog have all died, it is the dog that is missed most. This is redefined as understandable and natural when the child was not close to the grandfather, and never knew the baby sister, but held the dying dog, the best friend, in his or her arms. The group facilitators are met with gratitude. Sometimes this is verbalized by the children or their caregivers. Often it is reflected in an energetic attendance and a reluctance to depart at the end of the evening.

When we are interacting with people whose lives have been shattered by death, it is essential to normalize their response and to applaud their creative attempts to develop new ways of coping. The concepts of deviance and anomie allow us to focus on the redefinition of self rather than the response itself. Grieving rules within the individual's particular social context and cultural milieu can be considered, adapted, or exchanged for new guidelines. The choice may have undesirable consequences, but these consequences can now be anticipated and dealt with.

Conclusion

The shift from a psychological to a sociological perspective eliminates problems that have long perplexed bereavement theorists and clinicians across disciplines. The lack of traditional supports—such as the loss of family and friends in a mobile society, rapid technological changes that render traditional norms meaningless, and the increasing threat of mass destruction—make grief a major concern in today's world. No longer can we rely on the traditional norms or the local community to provide the support and guidelines bereaved individuals require in order to move through the pain.

Pearlin (1989, 241) notes that "sociologists have an intellectual stake in the study of stress." He writes:

> [Such a study] presents an excellent opportunity to observe how deeply well-being is affected by the structural arrangements of people's lives and the repeated experiences that stem from these arrangements.… To a large extent these arrangements determine the stressors to which people are exposed, the mediators they are able to mobilize, and the manner in which they experience stress.

Sociologists, at least in the United States, have allowed psychologists to control the field of mental health. This chapter has illustrated how the clinical sociologist has the conceptual base and the expertise to both design and implement clinical tools to alleviate the distress that accompanies bereavement and perhaps embark on seeking the means to relieve other stress issues as well.

References

Brabant, S. (1977). Guilt and shame: problematic emotions in grief counseling. In D. D. Franks (ed.), Social Perspectives on Emotion, vol. 4 (pp. 103–124). Greenwich, CT: JAI Press.

Brabant, S. (1989–90). Old pain or new pain: a social psychological approach to recurrent grief. Omega, 20(4), 273–279.

Brabant, S. (1996). Mending the Torn Fabric: For Those Who Grieve and Those Who Want to Help Them. Amityville, NY: Baywood.

Brabant, S. (2002). A closer look at Doka's grieving rules. In K. J. Doka (ed.), Disenfranchised Grief: New Directions, Challenges, and Strategies for Practice (pp. 23–38). Champaign, IL: Research Press.

Brabant, S., Forsyth, C., and McFarlain, G. (1994). Defining the family following the death of a child. Death Studies, 18(2), 197–206.

Brabant, S, Forsyth, C., and McFarlain, G. (1995). Special moments, special times: problematic occasions following the death of a child. Clinical Sociology Review, 13, 57–69.

Charmaz, K. (1980). The Social Reality of Death. Reading, MA: Addison-Wesley.

Cooley, C. H. (1961). The social self. In: T. Parsons, et al. (eds.), Theories of Society (pp. 822–828). New York: Free Press.

Corr, C. A. (1998–99). Enhancing the concept of disenfranchised grief. Omega, 38(1), 1–19.

Corr, C. A. (2002). Revisiting the concept of disenfranchised grief. In: K. J. Doka (ed.), Disenfranchised Grief: New Directions, Challenges, and Strategies for Practice (pp. 39–60). Champaign, IL: Research Press.

Denzin, N. K. (1990). On understanding emotion: he interpretative-cultural agenda. In: T. D. Kemper (ed.), Research Agendas in the Sociology of Emotions (pp. 185–116). Albany, NY: State University of New York Press.

DeSpelder, L. A., and Strickland, A. L. (2002). The Last Dance: Encountering Death and Dying. New York: McGraw-Hill Higher Education.

Doka, K. J. (1989). Disenfranchised Grief: Recognizing Hidden Sorrow. Lexington, MA: Lexington Books.

Doka, K. J. (2003). The death awareness movement: description, history, and analysis. In C. D. Bryant (ed.), Death and Dying: The Presence of Death (pp. 50–56). Thousands Oaks, CA: Sage.

Feifel, H. (1959). The Meaning of Death. New York: McGraw-Hill.

Fitzgerald, F. S. (1945). The crack-up. In: E. Wilson (ed.), The Crack-Up (pp. 69–84). New York: New Directions.

Franz, T. T. (1981). Helping grieving and dying people. Journal of Popular Culture 14, 745–752.

Freud, S. (1925). Mourning and melancholia. In: Collected Papers, vol. IV (pp. 152–170). London: Hogarth.

Fulton, R. (1965). Death and Identity. Bowie, MD: Charles Press.

Glaser, B. G., and Strauss, A. L. (1964). Awareness contexts and social interaction. American Sociological Review, 29, 669–679.

Goffman, E. (1956). Embarrassment and social organizations. American Journal of Sociology, 62(2), 264–271.

Goffman, E. (1969). Strategic Interaction. Philadelphia: University of Pennsylvania Press.

Goffman, E. (1971). Relations in Public. New York: Harper Colophon.

Hilgard, J. R., Newman, M. F., and Fisk, F. (1960). Strength of adult ego following childhood bereavement. Journal of Orthopsychiatry, 30, 788–798.

Hochschild, A. R. (1979). Emotion work, feeling rules, and social structure. American Journal of Sociology, 85(3), 551–575.

Hochschild, A. R. (1983). The Managed Heart: Commercialization of Human Feeling. Berkley, CA: University of California Press.

Hochschild, A. R. (1990). Ideology and emotion management: A perspective and path for future research. In: T. D. Kemper (ed.), Research Agendas in the Sociology of Emotions (pp. 117–142). Albany, NY: State University of New York Press.

Kalich, D., and Brabant, S. (2005–6). A continued look at Doka's grieving rules: Deviance and anomie as clinical tools. Omega, 53(3), 227–241.

Kalish, R. (1985). Death, Grief, and Caring Relationships. Monterey, CA: Brooks/Cole.

Kubler-Ross, E. (1969). On Death and Dying. New York: Macmillan.

Lindemann, E. (1944). Symptomatology and management of acute grief. American Journal of Psychiatry, 101, 141–148.

Maris, P. (1974). Loss and Change. New York: Pantheon.

Mead, G. H. (1934). Mind, Self, and Society. Chicago: University of Chicago Press.

Merton, R. K. (1968). Social Theory and Social Structure. New York: Free Press.

Neimeyer, R. A. (1998). Lessons of Loss: A Guide to Coping. New York: McGraw-Hill.

Neimeyer, R. A. (Ed.) (2001). Meaning Reconstruction and the Experience of Loss. Washington, D.C.: American Psychological Association.

Pearlin, L. I. (1989). The sociological study of stress. Journal of Health and Social Behavior, 30, 241–256.

Parkes, C. M., and Weiss, R. S. (1983). Recovery from Bereavement. New York: Basic Books.

Parsons, T. (1963). Death in American society: a working paper. American Behavioral Scientist, 6, 61–65.

Pine, V. R., and Phillips, D. L. (1970). The cost of dying: a sociological analysis of funeral expenditures. Social Problems, 17, 405–417.

Raphael, B. (1983). The Anatomy of Bereavement. New York: Basic Books.

Rando, T. A. (1993). Treatment of Complicated Mourning. Champaign, IL: Research Press.

Silverman, P. (1998). Promoting competence or treating illness. Keynote address presented at the 1998 annual meeting of the Association for Death Education and Counseling, Washington, DC.

Stephenson, J. S. (1985). Death, Grief, and Mourning. New York: Free Press.

Thomas, W. I. (1968). The Self-fulfilling prophecy. In: Robert K. Merton Social Theory and Social Structure (p. 475). New York: Free Press.

Wolfelt, A. (1998). Companioning versus treating: beyond the medical model of bereavement. Keynote address presented at the 1998 annual meeting of the Association for Death, Washington, DC.

Worden, J. W. (1991). Grief Counseling and Grief Therapy: A Handbook for the Mental Health Practitioner (2nd ed.). New York: Springer.

Selected Reading

Durkheim, E. (1915). The Elementary Forms of Religious Life. New York: Free Press.

9
Psychosocial Interventions and the Rehabilitation of Drug Users in Greece

Anastasia-Valentine Rigas and Andriani Papadaki

Any human problem is a problem of the society to which we belong. The problem cannot be isolated from its natural environment, which is the group, the region, or the country. If we consider any given human problem as a problem of only the specific individual or family, we cannot study it from the broader perspective that offers many chances of understanding the problem in the best possible way and intervening effectively. Recognizing that each problem is a consequence of group structures and interactions of human groups and societies, we need to bear in mind that we should not only watch the forest of trees, but also the single tree. This holistic research method is founded on the idea that a system's properties cannot necessarily be accurately understood independently of each other.

In this way, sociology seems vital in clinical work with individuals whose psychological problems are inevitably linked to social factors. Clinical sociology is the integration of the sociological approach and the clinical method (Gaulejac, 1997). As Rhéaume (1997) has noted, "from the 1980s onwards, clinical sociology appears to be an integrating framework for diversity of theoretical views (e.g., cultural anthropology, social ethnography, psychosociology, and theories of social intervention) related to the study of social practices." Clinical sociology requires the application of various critically applied practices and attempts to treat group members within communities (Glassner and Freedman, 1979).

Clinical Social Science in Greece

According to Kokosalakis (1998), the "collapse" of the Greek dictatorship in 1974 was a "historical landmark for the development of democracy and the growth of sociology as an academic discipline in Greece," and it is only after 1974 that an organized and critical sociology developed. While sociology had been taught in the interwar period by two eminent Greek sociologists, the first sociology departments in universities emerged after the socialist government came to power in 1981. Sociology, then, also was taught in "the lyceum in secondary education and in various post-compulsory educational establishments." For more than a decade, Marxist sociology "dominated… without any other major theoretical orientation emerging."

In 1991, social clinical psychology in Greece was developed in the psychology department of the University of Crete and the chair of social-clinical psychology has been Anastasia-Valentine Rigas. Social clinical psychology is one of the main research interests of the Greek Association of Clinical Social Research. The association, which is now known as the Greek Association of Clinical Social Psychology, was founded in 1998 in Athens by Professor Klimis Navridis and twenty-five other social science researchers (Rigas, 1997a,b). Twenty years before, Navridis, then at the University of Ioannina, had established a small group of students and social scientists who were conducting research on clinical social psychology and qualitative methodology. In 1998, and every few years after that, the Greek Association of Clinical Social Research, in collaboration with clinical sociology division of the International Sociological Association (ISA), has organized symposia on the Island of Spetses concerning clinical sociology and clinical social psychology.

Clinical sociology is not widely known or developed in Greece. Its study objectives, however, are quite similar to those of social clinical psychology. Both clinical sociology and clinical social psychology deal with qualitative research methods, systematic analysis of social problems, and ways of intervening in society especially with minority groups, individuals with psychosomatic problems, substance-dependent individuals, people with special needs, and senior citizens.

The State of Drug Problems in Greece

It is useful to start this discussion with some basic information about Greece. It is situated at the southern end of the Balkan Peninsula next to the Ionian, Mediterranean, and Aegean Seas, and has been a member of the European Union since 1981. During World War II, Greece was invaded by Italy and then occupied by Germany (1941–44). A civil war followed (1945–49) between the supporters of the king and the communists. The king's supporters were defeated in that war and a dictatorship was put in place (1967–74).

Greece had a total population of 11,244,118 in 2005 (Ethniki Statistiki Ipiresia Ellados, 2006). This population is 98% Greek and 98% Greek Orthodox. A change in the immigration policy during the 1990s resulted in an influx of economic immigrants and, in 2007, this number was about 500,000. According to the U.S. Central Intelligence Agency's *World Factbook* (2007), "immigrants make up nearly one-fifth of the work force, mainly in menial jobs."

In ancient Greece, drugs were used in religious ceremonies, and drugs, such as cannabis, were widely used by doctors. Drug use, up to the nineteenth century, was controlled by the society as socially acceptable (Liappas, 1992; Matsa, 2001). The World Health Organization (1964) has defined a *drug* as "any substance that, when taken into the living organism, may modify one or more of its functions."

Illegal drug abuse is one of the leading problems in the world. Patterns of drug use have changed. Once controlled, hidden or restricted to sectors of larger cities, drug use has now spread throughout most countries and to every section of society

(Willis, 1969; Matsa, 2001). Drug abuse is growing at a rapid pace and, most frighteningly, it has become unbridled among schoolchildren (Matsa, 2001; Malliori, 2006; Venizelos, 2006). Young people are increasingly using a wide range of drugs at a younger age, and the age of initiation into drug use appears to have lowered in recent years (Parker et al., 1995; Ereunitiko Panepistimiako Institouto Psychikis Igiinis, 2004, 2005, 2006; Eurobarometer, 2005; Kentro Therapias Eksartimenon Atomon, 2006; Gazgalidis, 2007).

In 2004, one third of young people (15 to 24 years of age) in the European Union reported that they had tried cannabis (33%), while in the Greek community the percentage was low (7%). In fact, Greece recorded the lowest percentage of respondents who declared having tried one substance or another (Eurobarometer, 2004). However, during 1993 and 2003 there was a great increase in the percentage of children of ages 13 to 18 years (from 6.1% to 14.9%) who already had an experience with illicit drugs (Ereunitiko Panepistimiako Institouto Psychikis Igiinis, 2004, 2005). This is not surprising, as some kinds of youth entertainment depend on the abuse of illicit substances such as "ectasy" (Rigas and Triadafyllidou, 2001; Malliori, 2006).

During the period 1984 to 1998, rates of illicit drug use increased in Greece, while from 1998 to 2004 there has been a general decrease. The latest data on drug use suggest that 8.6% of the Greek population aged 12 to 64 years have used an illicit, psychoactive drug one or more times in their lives. Although drug use has decreased during the last six years, drug-related deaths have increased during the last two years. The percentage of increase from 2004 to 2005 was 10.4% (Ereunitiko Panepistimiako Institouto Psychikis Igiinis, 2005, 2006; Antoniou, 2006). Greece is now fifth among the countries in Europe in the percentage of individuals under the age of 25 years who have died because of drug abuse (Thliveri Hellenic protia sta narkotika, 2006).

The majority of drug users are males, ages 13 to 34, and residents of Athens. (Drug use is higher in larger cities.) The highest rate of drug use is in Athens (12.4%) and Thessaloniki (7.9%), followed by other large cities, and then semiurban and agricultural districts (Ereunitiko Panepistimiako Institouto Psychikis Igiinis, 2004, 2005, 2006).

The Drug Market in the European Union and Greece

Illicit drug use is a crisis that we can no longer ignore. It results in drug-related deaths, addiction, crime, and disorder. Illegal and dangerous drugs are more widely and cheaply available than ever before (Ereunitiko Panepistimiako Institouto Psychikis Igiinis, 2004, 2005, 2006; Malliori, 2006). In the European Union, it was easier to get drugs in 2004 than in 2002, and the majority of young people tend to agree that it is easy to obtain them, especially in places where there is evening entertainment (e.g. parties, pubs/clubs) (Eurobarometer, 2004). Moreover, the largest problem in the southwestern Balkan countries and southwestern Europe is the

illegal drug market. Since Greece is located on the southern Balkan route, its location makes it susceptible to drug traffic (Ereunitiko Panepistimiako Institouto Psychikis Igiinis, 2004, 2005, 2006; Antoniou, 2006).

European and Greek Anti-Drug Plans

The objectives of the European strategy against drugs involves (1) limiting drug use in general (especially among the young), and decreasing the availability of illicit drugs; (2) decreasing drug-related deaths and the health consequences for the user, including drug-related deaths; (3) increasing the effectiveness of therapeutic interventions; and (4) reducing crime. The latest research findings suggest that some of these objectives have been met. A significant accomplishment is that all the European Union member states are moving toward the preparation of action plans against drug abuse (Ereunitiko Panepistimiako Institouto Psychikis Igiinis, 2005).

The Greek national strategy on drugs, as specified in the national action plan (Ereunitiko Panepistimiako Institouto Psychikis Igiinis, 2004, 2005), assigns equal importance to demand and supply reduction as well as to cooperation among the agencies involved. In the years 2003 and 2004, there was a significant increase in the expenses of private and public treatment units, compared to previous years. The most important development was the significant decrease in illicit drug use in the student population (14 to 17 years of age), and especially in the prevalence of cannabis use. However, the prevalence of ecstasy use seems to be stable. In 2004, the most important development was the decrease of drug-related deaths by 4.1% due to the increase of prevention programs and increasing number of places for medical detoxification because of the expansion of the existing network of methadone units (Ereunitiko Panepistimiako Institouto Psychikis Igiinis, 2004, 2005, 2006; Kentro Therapias Eksartimenon Atomon, 2006; Organismos kata ton Narkotikon, 2006).

Prevention in Greece

Prevention in Greece is focused on school-based and family interventions, as well as community prevention programs. There are also many selective prevention interventions addressed to vulnerable groups such as school dropouts, young offenders, juvenile delinquents, and students with psychosocial problems or problems in academic achievement. Prevention programs usually develop in places that are visited very often by youths, such as pubs, athletic clubs, and camping sites (Ereunitiko Panepistimiako Institouto Psychikis Igiinis, 2004, 2005, 2006). The mass media are used as a source of information about the means of prevention (Ereunitiko Panepistimiako Institouto Psychikis Igiinis, 2004, 2005, 2006). There also are other programs for professionals who work with youth, health professionals, Greek army representatives, and police staff (Organismos kata ton Narkotikon, 2006).

Greek Drug Rehabilitation

The main interministerial bureau for Drug Abuse and Treatment in Greece is the Organismos kata ton Narkotikon (OKANA). It is responsible for recording and dealing with illicit drug use at the national level, as well as for the adoption of a policy of prevention and treatment. Special attention has been given to the establishment of units addressed exclusively to teenagers and young drug abusers, as well as to the growth of the substitution (medical detoxification) programs network. Simultaneously, the continuing establishment of new units in rural districts point toward the attempt to cover the void in therapy at regional and local levels (Ereunitiko Panepistimiako Institouto Psychikis Igiinis, 2005).

The main types of therapeutic programs that have been widely used in Greece are drug-free adult residential communities, drug-free outpatient communities, drug-free adults units, drug-free youth units, and substitution (detoxification) units. A person may be referred from one unit to the other in order to maintain abstinence from drugs (Ereunitiko Panepistimiako Institouto Psychikis Igiinis, 2005; Kentro Therapias Eksartimenon Atomon, 2006; Organismos kata ton Narkotikon, 2006).

In Greece, the treatment capacity in drug-free programs is 1,119 persons and, in substitution programs, it is 2,804 persons. In 2004, there was a significant increase (30%) in places in the substitution units. However, the waiting list is still extensive (Ereunitiko Panepistimiako Institouto Psychikis Igiinis, 2005; Argopethenoun perimenontas sti lista, 2006; Malliori, 2006; Gazgalidis, 2007).

There are fifteen substitution programs in Greece that administer methadone, buprenorphine, or naltrexone (Organismos kata ton Narkotikon, 2006). These substitution programs, all provided by OKANA, are the prevailing form of drug treatment. The process of drug addiction recovery involves a detoxification program tailored to the specific needs of the patient. Detoxification of the patient is a necessary part of the drug addiction recovery process in order to prepare the body for any medical treatment that may need to be administered (Organismos kata ton Narkotikon, 2006). Medical detoxification, a process of allowing the body to rid itself of a drug while managing the symptoms of withdrawal (Willis, 1969; Leech, 1987; Davison and Neale, 1997; National Institute on Drug Abuse, 2006), can be considered as the first step in drug rehabilitation. It is not a treatment of addiction in itself, because it only involves withdrawal from the drug (Willis, 1969; Royal College of Psychiatrists, 1987; Liappas, 1992).

Reintegration

One of the most important responses to social correlates of drug addiction in Greece is the establishment of forty specialized social reintegration and vocational integration units for former drug users. The aims of the units include providing job-hunting skills, improving educational levels, increasing vocational training, and increasing opportunities for entering the labor market by special subsidy schemes (Ereunitiko

Panepistimiako Institouto Psychikis Igiinis, 2004; Organismos kata ton Narkotikon, 2006). Within the third community support framework (CSF) and, taking into account the principle of equal opportunities between former drug abusers and the rest of the population, many operational programs have been implemented. Most of the programs involve vocational training, counseling services, accompanying supporting services, and promoting job-matching services (Organismos kata ton Narkotikon, 2006).

Approaches to Drug Rehabilitation in Greece

The holistic nature of clinical sociology or the psychosocial perspective allows the study of multidimensional problems, such as drug rehabilitation. Here, we focus on the psychosocial interventions used by mental health professionals in the rehabilitation of drug users in Greece. We base our analysis on a review of the literature and information provided by two experienced psychosocial counselors who have been employed in Greek drug rehabilitation facilities. Sparse information exists about Greek drug rehabilitation interventions and, especially, psychosocial interventions. This analysis contributes to that literature.

General Psychosocial Approaches

Motivational Interviewing

Motivational interviewing was proposed by Wanigaratne et al. (1990) and focuses on resolving a patient's ambivalence surrounding substance abuse and the major changes that are involved in moving from drug abuse behavior to abstinence. Based on principles of motivational psychology, this kind of interview aims to have drug users produce internally motivated change.

This approach is based on the transtheoretical model, which posits that actual change occurs through an internal process in which a person begins to see that the benefits of changing behavior outweighs the benefits of maintaining behavior. Through this process, individuals come to believe that they are capable of changing their problematic behavior (Prochaska et al., 1994). The professional's role is to assist patients in making their own changes by facilitating the individual's movement through the stages of change toward successful sustained behavior (Miller and Rollnick, 1995).

Prochaska et al. (1994) state that the path from addiction to rehabilitation is a long process composed of six stages: precontemplation, contemplation, determination, action, maintenance, and relapse. Individuals move through these stages, the "cycle of change," as they progress in modifying the problem behavior. Each stage requires certain tasks to be accomplished and certain processes to be used in order to achieve change.

In the *precontemplation* stage, users do not perceive drug abuse as a problem or do not realize the problematic side of their drug abusing behavior. As Velleman (1993) suggests, in this stage the therapist should employ techniques that can increase the time that users think about their drug use in order to assess themselves and their behavior. In the *contemplation* stage, users acknowledge the link between behavior and problems, and begin to consider both the existence of the problem and the feasibility and costs of changing the problematic behavior. It is possible for individuals to remain at this stage indefinitely. People at this stage tend to respond to feedback and educational information about substance use. When ambivalence is resolved, people move to the stage of *determination*, in which they have decided to change. In the next stage, *action*, individuals are committed to changing their behavior by their own efforts or by each choosing and entering a therapeutic program. In this stage, individuals seem to need considerable support in order to sustain a drug-free life. While struggling to maintain the new changes, users proceed to *maintenance*, the final stage, in which positive reinforcement is less important, and behavioral strategies such as employing alternative behaviors and a well-supportive environment are vital (Velleman, 1993).

This transtheoretical model is a circular one (Wanigaratne et al., 1990; Velleman, 1993; Prochaska et al., 1994). If people relapse, they can go through the same stages a number of times until maintenance is achieved.

Cognitive-Behavioral Techniques

The underlying assumption of these techniques is that the learning process plays an important role in the development and continuation of drug use and that behavior is learned or unlearned while influenced by environmental factors. While cognitive therapies reduce substance use by changing the way that the patient thinks, cognitive-behavioral therapies work by changing what the patient thinks and how he or she acts (National Institute on Drug Abuse, 2006). Some of the most widely used cognitive-behavioral approaches in drug addiction treatment are self-monitoring, relapse prevention, solution-focused, and contingency management.

Self-monitoring entails having patients keep a detailed record of their substance-taking behavior. This intervention enables patients to gain insight into their behavior and eventually change it. The underlying principle of this intervention is for patients to consciously focus on the behavior they wish to change by identifying possible triggers and high-risk situations and by calculating the emotional, physical, and financial costs (Wanigaratne et al., 1990). Keeping *craving diaries* and making a *cost-benefit analysis* are the most common applications employed in drug addiction treatment using the self-monitoring approach.

The *relapse prevention model* (Marlatt and Gordon, 1985) is a collection of cognitive-behavioral strategies and lifestyle change procedures that aim to prevent relapse in addictive behaviors. The model emphasizes behavioral self-control and intends to teach individuals who are trying to maintain changes in their behavior how to anticipate and understand the nature of relapse and, finally, cope with the problem of

relapse. Drawing on social learning theory, it focuses on coping with situations that pose a threat to the individual's sense of control and that increase the risk of relapse, and also on managing the experience of re-feeling the positive emotions associated with the drug-using experience (Marlatt and Gordon, 1985; Marlatt, 1996; McCrady and Epstein, 1999; Parks and Marlatt, 2000). The goal of this treatment approach is for individuals to become aware of their own high-risk situations and to learn effective coping skills and cognitive strategies to deal with situations in which they would have previously used substances, resulting in greater self-efficacy and confidence (Marlatt and Gordon, 1985). Wanigaratne et al. (1990) point out that relapse prevention and self-monitoring methods are aimed at the maintenance phase in the cycle of change as well as at getting a person back into the cycle following a relapse.

The *solution-focused approach*, according to Berg and Reuss (1998), is "a difference that makes a difference; solution building is more effective than problem solving because solution building focuses on a patient's resources and successes while problem solving focuses on a patient's weaknesses and deficit." This technique views patients as competent and helps them to visualize the changes they want, and builds on what they are already doing that works. Specifically, the therapist asks a user to guess how his or her life would have been if a miracle had happened and the problem that the user faced had been solved. This process of goal building attempts to trigger patients' potentials, motivation, and internal resources to actualize their vision by making the dream come true (Berg and Reuss, 1998; Pichot and Dolan, 2003).

Contingency management is widely used in hospitals or therapeutic communities. It is a behaviorally based, psychosocial intervention that uses various rewards, or contingencies, to reinforce abstinence. Patients earn points or vouchers as rewards for drug-free urine tests. These points can later be exchanged for items that encourage healthy living such as joining a gym, seeing a movie, or going out for dinner. In this way, behaviors that are inconsistent with drug taking (as well as job-hunting and social skills) are reinforced (Davison and Neale, 1997; Gross, 1997; Budney and Higgins, 1998; McCrady and Epstein, 1999; Kaminer, 2000).

Many studies have found that contingency management interventions produce large reductions in illicit drug use when compared with standard drug treatment counseling or other interventions (Chutuape et al., 2001). However, there is a concern that such approaches do not promote long-term abstinence, because individuals cannot be rewarded for their entire life when they resist the urge to take drugs (Davison and Neale, 1997) and because the underlying problems of addiction are not addressed (Andrzejewski et al., 2001; Kirby et al., 2006).

Therapeutic communities for drug addicts were first established in the early 1970s in the Netherlands, England, and Italy. Various types of therapeutic communities exist in Europe; some operate on an outpatient basis offering medical detoxification, while others provide residential accommodation offering drug-free programs. Some are stricter and more authoritative, while others promote discussion (Stewart, 1987; Poulopoulos, 2005).

In Greece, therapeutic communities are often very well organized programs of rehabilitation in which patients live in residential units for six to twelve months.

The units are for individuals who have been using drugs for a long time, have been involved in other illegal acts, and have serious problems in social functioning (Poulopoulos, 2005; Medlook.com, 2007). Therapeutic communities aim to reintegrate individuals into society without their being dependent on drugs or performing illegal acts (Poulopoulos, 2005). These communities help their members define their personal and social identities, and that is achieved through the implementation of assigned duties and working (Stewart, 1987; De Leon, 2000; Battisti, 2001; National Institute on Drug Abuse, 2006; U.S. Department of Health and Human Services, 2006).

Systematic family therapy considers drug dependency a symptom for the family, and needs to be dealt with in order to bring balance to the family. Consequently, the practitioner intervenes in the family by changing, for instance, the way family members relate and communicate with each other in order to address a drug problem.

A system is an organized collection of interdependent and interacting parts, not a random aggregation of items, and it is separated from its environment by a boundary (Minuchin, 1974; Paritsis, 2000). We cannot study a part of a system by isolating it from the system to which it belongs. This means that any human behavior is an exhibiting behavior of a system (such as family or society), has a purpose for existing, and cannot be studied separately from that system. Thus, if a behavior is problematic and the system that we are studying is the family, then we are talking about a symptom of the family, and not a problem of a family member (Minuchin, 1974).

Systemic family therapy suggests that some family factors protect an individual from chemical substance abuse. These factors include a warm and positive relationship with an adult who cares about the individual, a supportive family environment, parents' expectations that their children will not use drugs, positive parental models, orientation to achievement, and the existence of rules and roles in the family. These factors can be the aims of the therapeutic intervention. Additionally, factors in the family's life cycle, such as changes in family structure, family composition, nationality, socioeconomic factors, and place of residence, can be considered (Minuchin, 1974; Paritsis, 2000). It has been found that systemic family therapy can be effective with drug addiction and can be used on in its own or in combination with other psychosocial interventions (Asen, 2002).

Interviews of Drug Rehabilitation Counselors

Two experienced drug rehabilitation counselors were interviewed to obtain additional information about psychosocial interventions with drug users in Greece. Neither of the counselors had experienced personal drug problems in the past. The first counselor, a 35-year-old man, had several years of experience as a psychosocial counselor. He had previously worked in a residential (drug-free) therapeutic community for five years, and for the last two years he has been working in a counseling unit for adolescents that provides individual and group counseling services for drug abusers and their families. The second counselor, a 44-year-old woman, has been

working for the national organization against drugs (OKANA) for the last eleven years as a psychosocial counselor. OKANA is the only organization in Greece that offers medical detoxification in combination with counseling services. The confidential interviews were video recorded, with the participants' consent, to have an accurate record of their accounts.

Questions and Responses

Semistructured interviews were conducted for this study. The interview schedule consisted of three questions.

Interview Questions

First question: In what kind of organization(s) or therapeutic center(s) for drug rehabilitation have you worked? What was the organization's philosophy regarding psychosocial intervention?

Concerning his experience in the residential therapeutic community, the first counselor reported that the facility was drug free; for example, the community did not offer medical detoxification, and things were quite strict and authoritative. He stated, "You have to be strict because if one falls out of line, the other complains or relapses. The community life aims to build the person's responsibility under authority. It places you under authority and you have to cope with it."

Residents could organize their lives gradually, starting from the safety of the therapeutic community: "They have certain hours that they work, they participate in encounter groups, and they have their own free time. They learn to balance duties and fun."

The therapeutic aim is for the subjects to achieve a gradual exposure to the real world. For example, "As soon as one comes in the community, no contact with the family or friends, not even telephone contact, is allowed. Then, gradually, limited telephone contact is allowed and after some months, a day out or, later, a week out is allowed. Then, they come back, on their free will and can talk about their issues."

The respondent referred to the community as a new kind of family, and to the social and emotional skills gathered from interaction with other members: "[This is] a new family; you can learn to have a family again. The authoritative persons in charge may be considered as the parents and the other addicts as your brothers and your sisters. Residents learn to cope with all of them and build relationships."

It was important that friendships could develop in the therapeutic community. However, group dynamics were easily disrupted. As he mentioned, "People in charge are very careful about who comes in the community. One's activities affect everyone else."

Although both group and individual interventions were provided in communities, more emphasis was given to group sessions: "The place of individual therapy in treatment is mostly to prepare individuals for (different kinds of) group therapy.

Only if there is an issue that cannot be taken to the group, or in the case of relapse, will the individual be seen individually."

The counselor reported that the counseling unit setting is usually radically different from that of communities, because therapists mainly work one to one with patients. He reported that the drug addiction counseling unit where he now worked was providing only emotional and psychosocial support, not medical detoxification.

The second counselor, the woman working for the national organization against drugs, reported that every drug abuser who walked in the door was sent directly to the doctor and assigned a counselor. The organization provided both medical and social support. She stated, "Psychosocial intervention is not considered as the most important treatment offered by the organization. Great importance has been placed on medical detoxification programs." She also said that individual sessions were conducted more often than group sessions. Social and emotional support was provided, as well as help in practical matters such as finding housing and employment.

Second question: Were there any specific interventions you adopted as a psychosocial counselor?

Both counselors have an approach to treatment that fits within the organization's guidelines. They use a combination of a person-centered and a cognitive-behavioral approach. They try to respect the user and develop a therapeutic relationship.

In regard to the nondirective, person-centered approach, the first counselor mentioned that he has deep misgivings about this approach being applied in a patient group. He thought that relating to drug abusers in a more intimate way was not efficient, at least at the initial stage of intervention. As he noted, "Carl Rogers suggested to increase self-trust and to manifest subjective experience. But these areas of self-trust and subjective experience are problematic areas for drug addicts. It can lead one to the wrong way." Most intervention programs train substance dependent individuals not to trust themselves and to have a sober distancing from themselves. As the counselor stated,

> The worst enemy of drug addicts is themselves. They cannot trust their perceptions because they are shaped and misshaped by drugs. On the other hand, I see that building a relationship is good. When patients are at a point that need to work on themselves and let some issues to come to the surface, then yes, be pure, person-centered; let it come out.

Motivational interviewing was used by both counselors. As one of the counselors noted,

> It is pretty much designed to help people who are thinking about life changes and weighing the advantages and the disadvantages of these changes. It is very good in helping people address situations they find difficult to weigh and make a decision. There has to be some reason to come off drugs, something you really want to achieve.

The cognitive–behavioral techniques that were used by the counselors were the solution-focused approach and various self-monitoring techniques. One of the counselors reported, "I try to make [the drug abusers] believe in themselves and think that there is something worth living for; any effort they make, even if it is not successful, is worth doing. Positive thinking is very important as well as setting goals and finding motives for living."

Both counselors complimented their patients for their achievements, "Affirmation really works in this patient group. Self-assurance is needed, in order to develop the inside strength and the belief in personal ability."

According to both counselors, self-monitoring interventions are used in the first stage of treatment, in which you mainly concentrate on the actual abuse. As one counselor noted, "I usually ask [the drug abusers] to keep a craving diary. They write, for example, the day and the place of drug using as well as what triggered them to relapse." Both counselors were, in a sense, in charge, by making drug abusers evaluate the consequences of their actions and make a cost-benefit analysis.

The counselors mentioned that each patient has different specific needs and, consequently, they were treated differently. As one counselor said, "Patients will directly or indirectly tell you what they want from treatment. You cannot force anything; you must wait until they ask for it. Something has to come from the patient. They have to reach out to you and say that is what I want."

It was very clear that treatment interventions depended on the therapeutic setting where these counselors worked. For example, when you work for a community, you have to be quite authoritative and strict.

Third question: How would you describe your attitude toward this patient group in terms of the therapeutic relationship?

The relationship between the patients and counselors was described as quite supportive and understanding. The counselors try to get as close to the patients as they can. They offer their genuine valuing, concern, acceptance, care, and empathy. Additionally, they are transparent, gentle, and tolerant figures of authority by giving indirect advice. As one counselor said,

> If you do not work in a community, you do not have to be very strict. You can be gentle and build an understanding and respectful relationship. The way I work is to get close to [the patients]; develop an accepting relationship without sort of censuring, judging, or criticizing. Confrontation does not work. Interestingly, direction, in the form of advising, does not work. If users do not want to do something, they will not do it.

The second counselor pointed out that it was not always easy to develop a relationship:

> It may be that in a statutory organization, where you are providing medical detoxification, there is big demand by the users for the prescription drug. A lot of them just wanted that. I often felt that some users came to me because they had to do it in order to get the drug from the doctor, or because others, such as an employer or a relative, pushed them to do it.

The counselor also noted, "Working in such setting [a statutory organization], patients may not trust us anyway."

Discussion: Interviewees' Comments in Light of the Literature

The counselors reported that addiction treatment was not a simple matter and should address the many aspects of each individual's personal needs. This belief is supported by the literature, wherein addiction is considered a very complex, multifaceted

disease that involves problems, such as diverse biological changes in the brain and a myriad of social, familial, and environmental factors (Willis, 1969; Leech, 1987; Royal College of Psychiatrists, 1987; Liappas, 1992; Velleman, 1993). Drug dependence disrupts physical, medical, and spiritual aspects of an individual's life. In response to the holistic nature of drug dependence, many different approaches have been developed, some of which work for some people while others do not.

Psychosocial intervention plans should be sufficiently receptive and flexible to match the individuals' needs (Leech, 1987; Royal College of Psychiatrists, 1987). Any good treatment plan needs to assess the psychobiological, social, and pharmacological aspects of the patient's drug abuse (National Institute on Drug Abuse, 2006). If, for instance, the counselor considers the relapse risk to be high, relapse prevention techniques will be added to the prevention program. Finally, the rehabilitation program may vary according to the abuse substance and the transitional stage of the patient's addictive behavior (Wanigaratne et al., 1990).

Psychosocial Interventions Used by the Counselors

The counselors used a variety of therapeutic interventions, adopting them according to the patient's stage of change. They found that certain approaches, such as motivational interviewing and cognitive-behavioral techniques, are quite effective with substance-dependent individuals.

Motivational Interviewing

Motivational interviewing was used by the counselors as a tool for assessing drug-dependent individuals' needs and motivation and, consequently, for resolving their ambivalence concerning drug abuse. In this way, the patient's stage of change was explored. This model was adopted in order to encourage internally motivated change (Wanigaratne et al., 1990; Velleman, 1993; Prochaska et al., 1994).

Motivation for drug use treatment, measured by factors such as patient's perceived need for treatment, resistance to treatment, as well as a willingness and commitment to participate (Longshore and Teruya, 2006), is regarded by both counselors and by the literature as crucial to the patient's engagement and successful abstinence from drugs (Fiorentine et al., 1999; Shen et al., 2000; Longshore and Teruya, 2006). The counselors emphasized that adopting this intervention technique enabled them to obtain a delicate balance of directive, educational, and patient centered components (Miller and Rollnick, 1995). It should be noted, however, that a lack of motivation or a patient's denial or resistance to change might not be considered a trait of the user but rather feedback regarding the counselor's behavior (Miller and Rollnick, 1991).

The counselor working for OKANA stated that most of the individuals who were referred for counseling did so because it was considered by others to be essential, and they were not interested in therapy. Indeed, many individuals are referred to drug

rehabilitation services from doctors, employers, or relatives (Fiorentine et al., 1999). Participating in a rehabilitation program may be the best way for some individuals to keep their job and preserve their marriage (Hammersley, 1995). Therefore, it is essential for the counselor to assess the patient's readiness and resistance to treatment, especially when they are not self-referred (Longshore and Teruya, 2006).

Cognitive-Behavioral Techniques

The cognitive-behavioral techniques used by the counselors were *self-monitoring* and *solution-focused*. Although the literature review showed that relapse prevention and contingency management are particularly promising in drug rehabilitation (Davison and Neale, 1997; McCrady and Epstein, 1999; Pichot and Dolan, 2003; Kirby et al., 2006; National Institute on Drug Abuse, 2006), the counselors did not report using these strategies.

    Self-monitoring, a skill promoting abstinence, is used by both counselors. Specifically, one referred to *diary keeping* and the other to the *cost-benefit analysis. Craving diaries* are widely used and may include the date, place, and time of relapse as well as positive and negative consequences, thoughts, and feelings at the time, and action taken after abusing the drug (Velleman, 1993; McCrady and Epstein, 1999). The counselor pointed out that craving diaries are aimed at the maintenance phase in the "cycle of change" as well as at getting a person back into the cycle following a relapse (Wanigaratne et al., 1990).

    Cost-benefit analysis was reported to have helped users realize some of the difficulties of drug dependence. Drug abusers were confronted with the task of considering the consequences of their drug-taking behavior and making a decision one way or another. There are some cases, however, in which drug users considered only the good things associated with drug use and just neglected the dangers (Saunders et al., 1995).

    A solution-focused approach, according to the counselors and the literature, was helpful for some drug-dependent patients. This approach promotes positive thinking and short-term goal setting. The counselor focuses on positive behavior, rather than the negative, and compliments users for their positive behavior. The counselors did this for every achievement, because they acknowledged affirmation as a way of empowering patients and giving them the strength they need to cope with their problems. Thus, the individual's esteem is enhanced. As reported in the literature, the drug-dependent individual's esteem is an area of weakness that must be addressed. Experts agree that genuine direct or indirect compliments are quite appropriate with this patient group (Berg and Ruess, 1998). Miller and Rollnick (1991) also emphasize the importance of affirmation, but without being excessive.

Therapeutic Community Setting

The counselors stated that the therapeutic community setting is a good choice in the treatment of addiction. This is also supported by the research literature, since the

community model is considered one of the most effective ways to return drug users to the straight world, supporting a long-term change in the individual's life (Leech, 1987; Stewart, 1987; Matsa, 2001; Poulopoulos, 2005; National Institute on Drug Abuse, 2006).

The first counselor noted that the Greek rehabilitation communities that are drug-free offer residential accommodation and do not admit severely disturbed individuals who might disrupt the group's dynamics. He pointed out that people who enter the therapeutic communities have to be emotionally committed to them.

Another interesting finding that evolved from the interviews was that although Greek therapeutic communities may impose strict rules, they also promote a climate of mutual support and understanding between the members of the community. Community members can find a lot of support in "coming off" drugs from those who have had similar experiences and face similar problems. They can deeply empathize with each other and learn to look at themselves in a different way through others (Willis, 1969). Individuals not only establish new relationships, but also distance themselves from any previous peers. As one of the counselors viewed it, the community may be a family in a very large way.

According to the research literature and to the counselors, the role of the psychosocial counselor in this setting is to facilitate a harmonious coexistence and the resocialization of the community members by attaining social skills. These skills include relating effectively with other individuals, being cooperative, and being responsible for one's actions. The residents are expected to eventually transfer this learning into the wider social context of the society (Battisti, 2001).

Counselors' Attitudes Toward the Patient Group

The counselor's task is to create a climate that enhances the patient's own motivation for and commitment to change (Miller and Rollnick, 1991, 1995; Miller, 1998) by communicating respect and conveying their acceptance of patients (Rogers, 1951, 1961). Nevertheless, the interviewed counselors did not accept that these qualities are sufficient in themselves with this patient group at the initial phase of drug rehabilitation. As one of them said, "Drug addicts cannot trust their perceptions because they are shaped and misshaped by drugs." Indeed, physical dependence on a drug involves an alteration of the brain functioning and, in such cases, the major concern of the individual is to take the drug (Willis, 1969; Hammersley, 1995; Gross, 1997).

Both counselors considered it appropriate for the counselor to be a gentle, directing figure rather than an argumentative one. They claimed that when the therapist gently challenges drug-dependent individuals, he or she assists them to resolve their ambivalence. The counselor should be quite persuasive and challenging but not coercive because coercive methods may result in patients' resistance. On the other hand, wholly nondirective methods may leave the drug abuser confused and floundering (Miller and Rollnick, 1991, 1995). Both counselors also implied,

however, that the attitude of psychosocial counselors cannot be seen independently from the setting and the philosophy of the organization that employs them.

Social Support Network: Family Support

The counselors reported that the existence of a social support network plays a major role in the life of drug users. A relationship is important, not only with the counselor, but also with significant others, and with a respectful person who empathizes with and believes in them. Also, the counselors suggested that a supportive environment outside the rehabilitation setting is vital to drug users who attempt to get off drugs, while individuals who are not well supported may be at a high risk of relapse.

According to the counselors, family interventions in the rehabilitation units in Greece include group counseling, parent (individual) counseling, mutual support groups, support in parental issues, and seminars concerning issues such as communication and roles in the family. Encouraging family involvement can help the recovering person create a more knowledgeable support network, solve underlying problems, and improve treatment results (Bekir et al., 1993). It also makes it easier for the counselor to intervene in any problematic family situations that might foster a relapse as well as to explore strategies through which significant others can help patients remain abstinent.

The family can be a factor that contributes to the development and the presentation of a problem, and it can be a factor that contributes to its solution. In Greece, the family institution is an intrinsic and strong part of the society (Katakis, 1994). The vast majority of adolescents live with their parents, which implies that family involvement in the therapeutic process is essential. The engagement of the parents in dealing with the problem of substance abuse is a decisive factor for the successful treatment of their children.

Conclusion

Based on the research literature and the information provided by the counselors, it was found that the counselor's approach to drug addiction in Greece has to combine elements from motivational psychology, existential-humanistic psychology, cognitive-behavioral approaches, and family systemic therapy.

In the first stage of drug addiction treatment, the patient–counselor relationship is often conceptualized by the metaphor of the hiker and the guide; the counselor (indirectly) guides the subject through at least the earlier stages of recovery. At this stage of the treatment, the drug-dependent individual needs to be enabled to find his or her own way again by "becoming a person" because every person on earth has the ability to self-actualize (Rogers, 1951, 1961).

Individuals have a desire to reach their full potential, but motivation for change should not be taken for granted. Being aware that most drug users are initially quite ambivalent about stopping, the psychosocial counselor gently, respectfully, and insightfully encourages the patient toward motivation while finding a balance between gently coaching and allowing the patient to be self-directed.

It is important to recognize where the patient stands in relation to the model of change proposed by Prochaska et al. (1994) in order to plan the psychosocial intervention. However, interventions used in Greek rehabilitation units depend not only on the individual's needs at the time but also on the type of facility and the philosophy of the organization.

Recent developments in Greek drug rehabilitation services tend to consider drug dependency and abuse as a problem of the Greek modern society that needs intervention at multiple levels, such as the individual, group, family, community, and society. However, as Miller and Rollnick (1991) have noted, "As in the game of chess, there are no standard scripts that can be followed. Each case is novel and poses unique challenges."

References

Andrzejewski, M. E., Kirby, K. C., Morral, A. R., and Iguchi, M. Y. (2001). Technology transfer through performance management: the effects of graphical feedback and positive reinforcement on drug treatment. Drug and Alcohol Dependence, 63, 179–186.

Antoniou, D. (2006, December 22). Afksithikan Thanati apo Narkotika [Increase of Drug Related Deaths]. Kathimerini, A15.

Asen, E. (2002). Outcome research in family therapy. Advances in Psychiatric Treatment, 8, 230–238.

Battisti, F. M. (2001). Life stories and psychosocial interventions: the case of therapeutic communities. In: A. V. Rigas (ed.), Psychokinonikes Paremvasis se Organismous, Omades Kai Atoma [Psychosocial Interventions in Organizations, Groups and Individuals] (pp. 123–138). Athens: Ellinika Grammata.

Bekir, P., McLellan, T., Childress, A. R., and Gariti, P. (1993). Role reversals in families of substance misusers: a transgenerational phenomenon. International Journal of the Addictions, 28, 613–630.

Berg, I. K., and Reuss, N. H. (1998). Solutions Step By Step: A Substance Abuse Treatment Manual. New York: W. W. Norton.

Budney, A. J., and Higgins, S. T. (1998). A Community Reinforcement Plus Vouchers Approach: Treating Cocaine Addiction. Washington, DC: National Institute on Drug Abuse.

Chutuape, M. A., Katz, E. C., and Stitzer, M. L. (2001). Methods for Enhancing Transition of Substance Dependent Patients from Inpatient to Outpatient Treatment. Drug and Alcohol Dependence, 61, 137–143.

Davison, G. and Neale, J. (1997). Abnormal Psychology. New York: Wiley.

De Leon, G. (2000). The Therapeutic Community: Theory, Model, and Method. New York: Springer.

Ereunitiko Panepistimiako Institouto Psychikis Igiinis (EPIPSY) [University Mental Health Research]. (2004). 2004 Ethniki Anafora tou Euroapaikou Kentrou Parakolouthisis gia ta Narkotika Kai thn Ousioeksartisi (EMCDDA). Ellada: Ekspaplosi Kai Geniki Tasi Kai plhrofories se epilegmena themata [2004 National Report to the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) Greece: New Development, Trends and in-depth information on Selected Issues]. Athens: Reitox National Focal Point.

Ereunitiko Panepistimiako Institouto Psychikis Igiinis (EPIPSY) [University Mental Health Research Institute]. (2005). Etisia Ekthesi 2004: I Katastasi ton Narkotikon Kai ton Inopneumatodon stin Ellada [Annual Report 2004: The State of Drugs and Alcoholic Drinks in Greece]. Athens: National Centre of Reasoning and Information for Drugs and Addiction.

Ereunitiko Panepistimiako Institouto Psychikis Igiinis (EPIPSY) [University Mental Health Research Institute]. (2006). Etisia Ekthesi 2005: I Katastasi tou Problimatos ton Narkotikon stin Europi [Annual Report 2005: The State of the Drugs Problem in Europe]. (Online) Athens: National Centre of Reasoning and Information for Drugs and Addiction. http://www. epipsy.gr

Ethniki Statistiki Ipiresia Ellados (NSSG) [National Statistical Service of Greece]. (2006). Athens. http://www.statistics.gr

Eurobarometer. (2004). Young People and Drugs, Flash Eurobarometer 158, Taylore Nelson Sofres. European Commission Brussels: Directorate General Press and Communication.

Fiorentine, R., Nakashima, J., and Anglin, D. M. (1999). Client engagement in drug treatment. Journal of Substance Abuse Treatment, 17(3), 199–206.

Gaulejac, de V. (1997). Clinical sociology and life histories. International Sociology, 12(2), 175–190.

Gazgalidis, C. (2007, January 5). Diktio Ipiresion kai Therapias [Network of services and therapy]. Eleytherotipia, A30.

Glassner, B., and Freedman, J. A. (1979). Clinical Sociology. London: Logman.

Gross, R. (1997). Psychology: The Science of Mind and Behaviour. London: Bath Press.

Hammersley, D. (1995). Counseling People on Prescribed Drugs. London: Sage.

Kaminer, Y. (2000). Contingency management reinforcement procedures for adolescent substance abuse. Journal of the American Academy of Child and Adolescent Psychiatry, 39(10), 1324–1326.

Katakis, C. (1994). Tris Tautotites tis Ellinkis Ekogenias [The Three Identities of the Greek Family]. Athens: Kedros Laboratory for the Study of Human Relationships.

Kentro Therapias Eksartimenon Atomon (KETHEA) [Therapy Center for Substance Dependent Individuals]. (2006). KETHEA 2005. Athens: KETHEA.

Kirby, C. K., Benishek, L. A., Dugosh, K. L., and Kerwin, M. E. (2006). Substance abuse treatment providers' beliefs and objections regarding contingency management: implications for dissemination. Drug and Alcohol Dependence, 85(1), 19–27.

Kokosalakis, N. (1998). Politics and sociology in Greece, 1950–98. International Sociology, 13(3), 325–343.

Leech, K. (1987). What Everyone Should Know About Drugs. London: Sheldon Press.

Liappas, Y. (1992). Narkotika: Eksartisiogones Ousies, Klinika Problimata, Therapia [Drugs: Addictive Substances, Clinical Problems, Treatment]. Greece: Patakis Publications.

Longshore, D., and Teruya, C. (2006). Treatment motivation in drug users: a theory-based analysis. Drug and Alcohol Dependence, 81(2), 103–206.

Malliori, M. (2006, December 10). Ousiodi alla anapantita erotimata [Main but unanswered questions]. Kyriakatiki Eleytherotipia, A52.

Marlatt, G. A. (1996). Models of relapse and relapse prevention: a commentary. Experimental Clinical Psychopharmacology, 4(1), 55–60.

Marlatt, G. A., and Gordon, J. R. (1985). Relapse Prevention. New York: Guilford Press.

Matsa, K. (2001). Psaksame anthropous kai vrikame skies: ToEnigma tis Toksikomanias [We Looked for People and we Found Shadows: The Riddle of Drug Addiction]. Athens: Agra.

McCrady, B. S., and Epstein, E. E. (1999). Addictions: A Comprehensive Guidebook. Oxford: Oxford University Press.

Medlook.com. (2007). Eksartisi apo narkotika: therapeutikes methodi [Drug Addiction: Therapeutic Methods]. http://www.medlook.net/article.asp?item_id=2206

Miller, W. R. (1998). Toward definition and understanding of addiction. Minuet, 5(3), 2–6.

Miller, W., and Rollnick, S. (1991). Motivational Interviewing: Preparing People to Change Addictive Behaviour. New York: Guilford Press.

Miller, W., and Rollnick, S. (1995). What is motivational interviewing? Behavioural and Cognitive Psychotherapy, 23, 325–334.

Minuchin, S. (1974). Families and Family Therapy. Cambridge: Harvard University Press.

National Institute on Drug Abuse (NIDA). (2006). Therapy Manuals for Drug Addiction (Online). Bethesda, MD. http://www.drugabuse.gov/TB/clinical/clinicaltoolbox.html.

Organismos kata ton Narkotikon (OKANA) [National Organization Against Drugs] (2006). H Poria mas 2004–2005 [Our Progress 2004–2005]. Athens: OKANA.

Paritsis, N. C. (2000). Systems and Intelligence: An Introduction to the Subject. Heraklion: University of Crete.

Parker, H., Measham, F., and Aldridge, J. (1995). Drug Figures: Changing Patterns of Drug Use Amongst English Youth. London: Institute for the Study of Drug Dependence.

Parks, G. A., and Marlatt, G. A. (2000). Relapse prevention therapy: A cognitive-behavioral approach. The National Psychologist, 9(5). http://nationalpsychologist.com/articles/art_v9n5_3.htm

Pichot, T., and Dolan, Y. (2003). Solution-Focused Brief Therapy Its Effective Use in Agency Settings. New York: Haworth Press.

Poulopoulos, C. (2005). Eksartisis—Therapeutikes Kinotites [Addictions—Therapeutic Communities]. Athens: Ellinika Grammata.

Prochaska J. O., Norcross, J. C., and DiClemente, C. C. (1994). Changing for Good. New York: William Morrow.

Rhéaume, J. (1997). The project of clinical sociology in Quebec. International Sociology, 12(2), 165–174.

Rigas, A. V. (1997a). Karkinos: Apo ti mana stin kori. I dynamiki its Epanalipsis [Cancer: From the Mother to the Daughter, The Dynamic of Repetition]. Athens: Mavrommati.

Rigas, A. V. (1997b). Maria T. Istoria Zois. Psychobiographiki Prosegisi [Maria T. Life History: Psychobiographical Approach]. Athens: Mavrommati.

Rigas, A. V., and Triadafyllidou, S. (2001). Prooptikes Prolipsis Kai Psychokinonikis Paremvasis: I periptosi tis chrisis Ecstasi [Perspectives of prevention and psychosocial intervention: the case of ecstasy use in Greece]. In: A. V. Rigas (ed.), Psychokinonikes Paremvasis se Organismous Kai Omades [Psychosocial Interventions in Organizations, Groups and Individuals] (pp. 111–122). Athens: Ellinika Grammata.

Rogers, C. R. (1951). Client-Centered Therapy: Its Current Practice, Implications and Theory. London: Constable.

Rogers, C. R. (1961). On Becoming a Person. Boston: Houghton Mifflin.

Royal College of Psychiatrists. (1987). Drug Scenes: A Report on Drugs and Drug Dependence. London: Caskell.

Saunders, B., Wilkinson, C., and Phillips, M. (1995). The impact of a brief motivational intervention with opiate users attending a methadone program. Addiction, 90(3), 415.

Shen, Q., McLean, T. A., and Merrill, J. C. (2000). Clients perceived need for treatment and its impact on outcome. Substance Abuse, 21(3), 179–192.

Stewart, T. (1987). The Heroin Users. London: Pandora Press.

Thliveri Hellenic protia sta narkotika [Afflictive the Greek Premiership in Drugs]. (2006, November, 24). Vima, A13.

U.S. Central Intelligence Agency. (2007). The World Factbook: Greece. https://cia.gov/cia//publications/factbook/print/gr.html

U.S. Department of Health and Human Services. (2006). (NCADI) Substance Abuse and Mental Health Services. Rockville, MD. http://ncadi.samhsa.gov.

Velleman, R. (1993). Counseling for Alcohol Problems. London: Sage.

Venizelos, V. (2006, November 28). InsertSinechis Ayksisi ton Thanaton apo Narkotika sti Thessaloniki [Continuous increase of drug related deaths in Thessaloniki]. Avghi, A16.

Wanigaratne, S., Wallage, W., Pullin, J., Keaney, F., and Farmer, R. (1990). Relapse Prevention for Addictive Behaviours: A Manual for Therapists. London: Blackwell.

Willis, J. H. (1969). Drug Dependence: A Study for Nurses and Social Workers. London: Faber and Faber.

World Health Organization. (1964). In: K. Leech (ed.), What Everyone Should Know About Drugs (pp. 18). London: Sheldon.

Selected Readings

Addiction. (2006). http://www.addiction.com

AntiDrug.com (2006). http://www.theantidrug.com

Argopethenoun perimenontas sti lista. [Deaths while awaiting in the waiting list]. (2006, November 26). Kathimerini, A21.

Dryden, W. (1994). Questions and Answers on Counseling in Action. London: Sage.

Ethniko Kentro Tekmiriosis kai Pliroforisis gia ta Narkotika kai thn Toksikomania (EKTEPN) [National Center of Documentation and Information for Drugs]. (2007). http://www.ektepn.gr

European Association of Professionals Working in the Drug Field (ITACA). (2006). Rome, Italy. http://www.itacaeurope.org

European Federation of Therapeutic Communities. (2006). Oosterzele, Belgium. http://www.eftc-europe.com

European Monitoring Center for Drugs and Drug Addiction (EMCDDA). (2006). Lisbon, Portugal. http://www.emcdda.europa.eu/.

Fritz, J. M. The Development of the Field of Clinical Sociology. (2006). http://digilander.libero.it/cp47/clinica/fritz.htm

Fritz, J. M. (1985). The Clinical Sociology Handbook. New York: Garland

Hawton, K., Salkovskis, P. M., Kirk, J. and Clark, D. M. (1999). Cognitive-Behavioural Therapy for Psychiatric Problems: A Practical Guide. Oxford: Oxford University Press.

Kassimati, K. (1998). Development of social research in Greece. International Sociology, 13(3), 345–358.

Kentro Therapias Eksartimenon Atomon (KETHEA) [Therapy Center for Substance Dependent Individuals]. (2007). http://www.kethea.gr

Kokkevi, A., Loukadakis, M., Plagianakou, S. Politikou, K., and Stefanis, C. (2000). Sharp increase in illicit drug use in Greece: Trends from a general population survey on licit and illicit drug use. European Addition Research, 6, 42–49.

Meulenbeek, P. A. M. (2000). Addiction problems and methadone treatment. Journal of Substance Abuse Treatment, 19, 171–174.

Organismos kata ton Narkotikon (OKANA) [National Organization Against Drugs]. (2007). Athens. http://www.okana.gr

Rigas, A. V. (1999). Sigkrousiaka modela stin Kliniki Kinoniopsychologia: Theoritiki Prosegisi [Conflicting models in clinical sociopsychology: a theoretical approach]. In: I. N. Nestoros (ed.), Epithetikotita sthn Ikogenia [Aggression in the Family, School and in Society], (pp. 82–89). Athens: Ellinika Grammata.

Rigas, A. V. (ed.). (2001). Psychokinonikes Paremvasis se Organismous Kai Omades [Psychosocial Interventions in Organizations, Groups and Individuals]. Athens: Ellinika Grammata.

Siafakas, V. (2006, December 10). Dialogi gia ta Narkotika [Dialogues for Drugs]. Kyriakatiki Eleftherotypia, A30, A51.

United Nations Office on Drug and Crime. (2007). http://www.unodc.org

Watts, W. D. (1989). Reducing adolescent drug abuse: sociological strategies for community practice. Clinical Sociology Review, 7, 152–171.

World Federation of Therapeutic Communities. (2006). http://www.wftc.org

10
The Patient's Personal Experience of Schizophrenia in China: A Clinical Sociology Approach to Mental Health

Robert Sévigny

The Chinese Context and Clinical Sociology[1]

In most parts of the world, psychiatry has experienced dramatic and drastic changes in the last half century. One of those changes is a general movement toward the social integration, in the largest sense, of persons suffering from severe mental illness. Since the Reform period or the post-Maoist era, which commenced with Deng Xiaoping's ascent to power in 1978, China has been included in this trend. In the Chinese context, the development of the idea and practice of social rehabilitation has been a significant aspect of overall social transformation.

In China, as elsewhere, many factors influenced this development toward the increasing social integration of psychiatric patients: new drugs made it possible to help or control patients, clinical professionals and researchers began stressing the social dimensions of mental illness, and social movements heightened awareness of the social and personal situations of people experiencing severe mental illness. Indeed, the introduction of the notion of mental health, as opposed to mental illness, emerged during this period and included a focus on the quality of life of those suffering from severe mental distress. Since the Reform era, psychiatry, like all of Chinese society, has experienced a period of important changes. After focusing exclusively on medical treatment and sociopolitical reeducation, nowadays psychiatry is more oriented toward a bio-psycho-sociopolitical approach that sees psychiatric social rehabilitation as an important factor in treatment. In so doing, it moves slowly toward a practice that emphasizes the consequences of severe mental illness on the patient's personal experience. Psychiatry and Chinese society at large have become a vast laboratory of social change.

This chapter explores the patient's personal experience (or experiencing, to use a more technical term) of schizophrenia in the context of a changing Chinese society,[2] and presents a few important aspects of clinical sociology. The clinical sociology approach is based on a two-part psychological and epistemological hypothesis: the private personal experiences of the individual and the individual's experience of the wider society are one and the same, and this applies to people who have been diagnosed as mentally ill and viewed as alienated as well as to people who are considered normal in their social integration and interactions. According to this working hypothesis, experiencing schizophrenia implies experiencing the society as understood by patients. Patients are affected by the reality of such forces as a market economy and globalization, internal migration, and the gap between the wealthy and the poor, and not only purely through their individual personality. So, to understand how mentally ill persons give meaning to their experiences, we must understand how, explicitly or implicitly, they take into consideration their social environment.

The Immediate Context of This Research Project

This research was carried out between 1992 and 1997 in a large Beijing psychiatric hospital. The sample included twenty patients. For each patient selected, about ten were interviewed, as were people from the patient's immediate social environment (relatives, neighbors, doctors, and nurses who had been in contact with the patient, and work colleagues and leaders of the patient's work unit, where applicable). All of the patients included in the study had been diagnosed with severe schizophrenia by the hospital medical staff. The sample was stratified according to relevant factors, such as the patient's age, education, marital status, gender, previous job, whether or not the individual had been attached to a work unit (and, if so, the type of work unit), whether or not other organizations had been involved (especially the residential committee [*jiaweihui*], the street committee [*jiedao*], and the subdivision of the Public Security Bureau [*paichuuo*]. Age and length of hospitalization also were controlled in order to limit the sample to those between 25 and 45 years of age. The interviews were conducted by six members of the research group from the hospital, made up of two psychiatrists, two nurses, and two psychologists.

The fieldwork was preceded by an intensive training session led by the author. Semistructured interviews were used, including both open-ended questions and

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[2] As I will mention in the next section, those data are from interviews realized some years ago. They are nevertheless a fair illustration of the changes I just mentioned. I am presently doing a secondary analysis of the same data in order to propose a more formal typology of attitudes and representations of, and attitudes towards, those social, economic and political changes. It seems that some patients experience those changes in reference to the pre-reform past, and others in terms of models of a "new" China.

probing questions. These questions allowed the interviewees to "move" among the themes and subthemes related to the heuristic grid presented below. Most interviews took place at the patient's residence or work place. They were recorded and later transcribed and translated so that both Chinese transcription and English translation of the interviews were available to the researchers. The hospital leaders and the members of the research team agreed to the following ethical norms: everyone should be assured of confidentiality, everyone should have the freedom to refuse to be interviewed, and no harm should result from participation in the research.

Methodology and Concepts

As a relatively new field in sociology, clinical sociology includes general characteristics shared by most researchers and practitioners. Within the general framework of clinical sociology, a few conceptual or methodological issues strike me as particularly noteworthy and applicable for the study of the personal experience of schizophrenia in China. The issues most relevant to my methodological approach are the related notions of *implicit sociology* and *experiential knowledge* (for example, giving priority to objective data or to the meaning or the representation of experiences). Additional relevant issues include the action research aspect of clinical sociology as well as three important preliminary definitions: *person/experience, society*, and *social rehabilitation*. I conclude this section with a brief presentation of the use of a heuristic guide and the notion of "critical incident" or "central experience" for generating useful data.

Implicit Sociology and Experiential Knowledge

In some of my previous studies, I used the notion of implicit sociology. When I wanted to apply this notion to my Chinese data, I began to refer to a larger and more comprehensive idea: experiential knowledge.

The notion of "implicit language" was first applied to Canadian mental health workers and their representations of their practices. Previous analysis showed that mental health workers, whose principal task is explicitly to understand and to help or care for individuals, made numerous references to the social dimensions of their interventions (Rhéaume and Sévigny, l988a,b). In other words, when these practitioners wanted to give meaning to their experiences or intervention practices, they would refer explicitly, for example, to psychological or psychiatric theories. They also would refer, at least implicitly, to their patients' social environments, to the social context of their practice, and sometimes to their own personal and social experiences.

For example, I interviewed a psychiatrist who worked with psychotic patients in an underprivileged neighborhood of Montreal for the past ten years. To explain to himself, and to others, what he does and why, he refers not only to psychological theories but also to the knowledge that he has acquired in his contacts within the

milieu in which he works. He has acquired practical expertise on what it means to live in an underprivileged neighborhood, and on the specificity of the helper-helped social relations, which can be maintained in this type of neighborhood. His practical knowledge, gained through experience, is at the heart of his implicit knowledge and language. But the notion of implicit has a deeper meaning or at least a more personal and intimate one: he has his own feelings about his relationships with his clients or patients. There are also some experiences in his own private life that he implicitly employs in his understanding of his clients or patients.

A female psychoanalyst, during a long interview about her practice, came to express a similar view (Sévigny, 1983a,b). While describing her practice in a very concrete and detailed way, she realized the importance of her own experience as a child in the small village in which she was raised. As she expressed this in her words, "I realize something I have never told any one of my colleagues or during academic seminars. Of course, when I listen to a patient, I use my conceptual knowledge, but my understanding, my interpretation, is often based on my own experience as a child in a small village."

This type of experiential knowledge is also an important aspect of what I have come to call implicit sociology. This implicit language is often referred to in terms of common sense or in terms of the layman by opposition to learned language. It is important to realize that this everyday language is used by everybody (including, for instance, doctors, leaders, and intellectuals) as it is most often the language of emotions, feelings, opinions, and impressions that, for whatever reason, cannot be so easily expressed in a direct or overt manner.[3]

In the previous Canadian study (Rhéaume and Sevigny, 1988a), implicit language was applied to medical practitioners, but all social actors use explicit and implicit languages. This implicit/explicit dichotomy is related also to the formal/informal dichotomy. When someone uses a formal type of knowledge, the person may be communicating very explicit information, but part of the information may be difficult to express that way. Work unit leaders, for example, may use a very formal and explicit language to discuss why a mental patient has some difficulties with the job requirements. On the other hand, when work leaders want to express how they personally feel about the situation, or how they understand the patient's medical problem, they may resort to images, metaphors, nonverbal signs, and even silences. Or they may limit themselves to describing their own behavior without trying to elaborate on their feelings (which does not mean that they have none concerning the whole situation). Everybody, at one point or another, is confronted with such a complex experience. In all those cases, the language used is relatively implicit. I extend this notion of implicit sociology to all social actors including the schizophrenic patients and to all types of knowledge that referred to those actors' personal and social experience.

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[3] All in all, one is confronted with an important epistemological and social problem as it is not possible to separate "learned" people who would know, understand and explain the social world, from those, who would only be able to express naïve or even mistaken representations about their own experiences.

The Action/Research Issue

In my own version of clinical sociology, two different types of objectives, though intimately interrelated, may be pursued: intervention and research. The main thrust of this chapter is research, not intervention; it is based rather on classical qualitative concepts and analysis. On the other hand, it is also intimately related to the intervention dimension of clinical sociology for three reasons. First, all the fieldwork has been produced in conjunction with the management and staff of hospital X in the context of a research-action methodology. Second, all the patients and the other interviewees from their immediate social environment (ISE) were considered as social and personal actors. In other words, as a clinical sociologist, I study persons who, in diverse ways and degrees, intervene in their own experience. The ultimate objective of such research is to propose to psychiatric practitioners a clinical sociological model for the treatment and social rehabilitation of the severely mentally ill.

Three Preliminary Definitions

Person and Experience: A Rogerian Approach

The clinical sociology approach calls for a conceptual and theoretical understanding of the person. Many studies, especially those in the French tradition, borrow from psychoanalysis to conduct this type of analysis. The present monograph fits into the classic Rogerian approach to personality and experience.[4] Using this conceptual approach, the person is mainly formalized in terms of the intimate connection between experience and self or self-image. In this conceptual framework, *experiencing*, to use the technical word, implies a holistic reaction; it is the whole organism that acts and reacts to its environment. In this perspective, all the most central representations of one's experience should be taken into consideration during the analysis, making it possible to consider the uniqueness of each personal experience. I will apply this perspective to the experience of severe mental illness and more particularly to schizophrenia.

Definition of Society

A clinical sociological approach also calls for an operational term for society. The intent is not to start with an ad hoc definition of a certain society, but to use a heuristic scheme that encompasses the main dimensions of any society: interpersonal

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[4] In drawing from this perspective, I developed a concept of self-image and the representation of one's environment as early as my first works on religious experience (Sévigny, 1970).

relationships, relationships to close circles of family and friends, and relationships to organizations and greater sociocultural clusters. Again, as such, this multilevel notion of society is nothing new; what is new is (1) the application of these categories to narrations of people directly or indirectly related to a severe mental health problem, and (2) the consideration of people's personal private experiences and people's experience of society as one analytical unit.

Definition of Social Rehabilitation

Although clinical sociology may apply to any particular field or sector of society, each case implies a set of operational definitions. This is no less the case with the mental health field. Mental health implies many different types of practices, many varieties of unit of analysis (from overarching public health policies toward mental health/illness; to the different organizations involved; to the personal experience of illness, treatment, and social rehabilitation). The ultimate goal of this research project, the social rehabilitation of patients, necessitated a preliminary definition of social rehabilitation. In very general and simple terms, *rehabilitation* was defined as the experience, for patients, of returning to their previous places in life, of regaining a previous status. In that sense, any rehabilitation is a *social* rehabilitation and, theoretically, may involve the family, the neighborhood, local organizations, and (especially in this case) the work unit (*danwei*), the first level of political structure in urban China. According to one's theoretical ideal of rehabilitation, the capability to return to the world, for example, may or may not be considered an important part of rehabilitation. To understand the social rehabilitation of psychiatric patients, we have to take into account the relationship between mental illness and rehabilitation.

A Heuristic Grid

To make sense of the information generated in the interview process, the team employed a heuristic grid. To demonstrate how this was used, let us suppose a clinical sociologist interviews work unit leaders about how they think and feel about mental illness and rehabilitation in general and, more specifically, about a member of their own work unit who suffers from a severe mental disorder. A first goal of the grid is to allow the sociologist to follow the leaders' stream of consciousness without imposing a personal point of view. A second goal is to allow the sociologist to check if he or she is getting relevant information about the main significant aspects of the work unit leaders' experience with mental illness. The latter does not necessarily have something to say about each item of the grid, but it is important to be certain that the sociologist had the opportunity to comment on each included element. A third goal is to check that the researcher is not imposing his or

her own representations on the leaders but rather aiding the leaders in genuinely expressing their point of view. In other words, the main purpose of such a general model is twofold: first, to structure the interaction process between researchers and actors (the work unit leaders, in our example); and second, to ensure the validity of the data.

In the Chinese project, the grid included, as fully as possible, most of what could be implicit or explicit answers to the following questions: What are the *representations* regarding the experience of mental illness? What *interventions* took place? What happened in the patient's ISE? Was the larger social system (LSS) involved in the experience of the individual? What was expressed about each actor's personal identity? This grid also allowed me to focus on the interactions between those five questions and answers.

Critical Incident or Central Experience

In this study, the notion of central experience was borrowed and adapted from Cohen-Émérique (2000). It includes everything (events, facts, experiences, situations, behaviors) to which the main actors refer when they want to give meaning to the patient's experience. For example, these might include an event or a situation that a patient feels is the cause of the illness, a violent behavior that is perceived by most of the patient's entourage as a sign of illness, a relationship with a significant other, the difficulties encountered in returning to work. Each of these central experiences takes us back to the self–society relationship, and most of the time the focus on these central experiences is shared by most of the people in the patient's ISE. The analytical process was a very flexible one. While keeping in mind both the heuristic grid and the critical or central experiences, each element of each interview that was relevant to a theme or subtheme of the heuristic grid was considered a *unit of analysis*.

Understanding Schizophrenia in China: An Illustration

This section presents four vignettes to give a general idea of how patients and those in their ISEs represent their experience of being a mentally ill person. Each of these vignettes focuses on the patient's experience. Among other findings, these examples suggest that an individual's most intimate feeling or self-image does sometimes relate to the LSS. Furthermore, what an interviewee (a patient or someone from the ISE) considers a central experience may sometimes seem very minute, superficial, or accidental from an outsider's point of view. The objective of the following vignettes is to convey how patients organize some key events of their experience and how they talk about this experience to themselves and to others.

Pang Shi

Pang Shi, a worker born in 1951, is married. He does not hold a diploma, but passed exams at the first-year level of secondary education.

She has had many relapses. The last, in 1992, happened not long after he was refused admission to the Communist Party. He attacked the secretary of the Party with an ax. The director of the factory where he worked said he would rather pay him his salary to stay home than allow him to come back to work, even at a lower salary. In 1978, while he was on sick leave for hepatitis, his work unit refused to give him a wage increase. Everyone around him remembers those negative events associated with his work unit.

According to Shi's family, there were no other major events in his life that could be seen as contributing to his condition. Although family members mention his wife's desire to divorce him, they say that since Shi and his wife have a child and because of his condition, his wife did not go through with it, and, instead, was very nice to him and took good care of him. On the other hand, everybody around Shi, even those from his work unit, think he was deeply affected by not having been admitted as a Party member. During his interview, Shi does not mention either his rejection by the Party or the episode where he attacked the secretary of the Party with an ax. In his mind, though, many of his problems arise from his relationship with his work unit.[5] "After all," he told the interviewer, "I was sent to the hospital by the factory." At the same time, he does not seem to have heard, or to remember, that his work unit leader told others that he would never have him come back to work at the factory. On the contrary, when asked by the interviewer about his plans for the future, he answers, "I just want to go to work. I want to work after I am recovered." His work situation, therefore, is really at the center of his experiencing and its representation. At one point, Shi mentions another event related to the work unit where he became very aggressive:

> I couldn't bear it when they mocked me… They just meant to make jokes with me sometimes, but I couldn't accept it. Thus, my mind and my psychology couldn't stand such a heavy burden. I broke the windows. I was working as the gate guard, so I broke all the windows of the gate-guard room.

A few minutes before, when asked by the interviewer, he had already mentioned this feeling of "being mocked" and his confusion about this experience:

Interviewer: Why were you hospitalized?
Shi: Because they always mock me (*lao ji dui wo*).
Interviewer: Why do they always mock you?
Shi: I don't know myself. They always treat me as if they were investigating me.

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[5] The reader must bear in mind that the Chinese work unit (*danwei)* is the first level of the Communist Party organization: the work unit is not same employer it would be in the Western world.

He has the deep feeling that he is accused of something he cannot understand ("I don't know myself"). Furthermore, he has the feeling that nobody is really communicating with him directly. In his own words, this is how he describes his relationship with others:

> None of them said anything to me in person. They didn't say to me that I have problems…
> I could hear them talking, as far as I know. They talked to me (*gen wo dui hua*) through other people. Sometimes I could hear when they talked to me directly.

Beyond his problems with the work unit, he still hopes that the traditional situation (i.e., since 1949) in urban China will apply to him: each person must be part of a work unit and the work unit must take care of its members. This is the iron rice bowl that Mao had promised to all Chinese.

When questioned about the meaning of what is happening to him, he says to himself and to the interviewer that he does not know.

Interviewer: What do you think of your disease?
Shi: I think of my disease… I don't have any ideas.
Interviewer: You don't think you are sick?
Shi: No, I don't think I am sick.

But not knowing is only one part of his feelings about his experience. He has another explanation; he considers that his illness is related to his own "nature" (his word). He portrays himself as being "eccentric," "solitary," "suspicious," and "overly sensitive." Shi says, "Because of this, people look down on me."

Things may not be completely clear in his mind, but there are elements that he makes sense of either by referring to some aspects of his personality or to some elements of his environment. His feelings or fantasies of being "investigated" could also, at least symbolically, refer to the state police and even to the political context in general.

Weng Yan

Weng Yan is a worker. She was born in 1952 and is married. She did not finish secondary school.

A series of events marked Weng Yan's experience: First, according to the politics of the day, she was one of those sent back to work in her native village, in the countryside. While working in a factory, Yan's roommate accused her of stealing 10 yuans. According to Yan and people close to her, that was the first moment of tension. Yan had to leave and had to find a job at Tianjin, the region's big city. She was hospitalized for the first time shortly thereafter, in 1975.

In 1976, an earthquake struck Tianjin and had a big impact on Yan. Most people from her close environment (ISE) consider the accusation of stealing and the earthquake as important events in her life, even though no one makes a direct connection between them and her illness.

Another important event happened shortly before our interview with Yan: she and her husband were forced to leave their home to go in a *dazayuan*.[6] Because her neighbors said that she was fighting and breaking things, she was forced to leave. She considers this eviction to be a determining factor in her life because it made her realize that she did not like either her family or her in-laws and that she wanted to break all connections with them. These difficult relationships with others, at the end, include everybody around her. This is how she describes her contacts with her neighbors and how she comes to feel she does not fit their expectations of a normal person:

> I cannot have contact with others. I stay at home all day long. I don't think my mental state can be balanced. In the compound, the relationships with the neighbors are complicated, not friendly… I don't go to their homes. I just shut my door and live my own life.

Yan regrets this situation. All she has left is solitude and confinement. Why, according to her, does she find herself in this position? She believes that her mental state is "not balanced." She looks for an answer within herself rather than in the attitude displayed by her neighbors. She never forgets that she is not normal: "For a normal person, if she doesn't think anything when something happens to her, then this is a normal person. As for me, I just cannot get rid of it. For instance, I also think about it even on the public bus."

She dreads other people's opinions of her and feels that she does not belong. She associates this feeling of rejection with the effects of medication on her behavior or attitudes. The core of her problem seems to be the reaction of others toward her. She does not feel weak or unqualified, but in front of others she is ashamed of herself. She has probably internalized the lack of understanding other people have of her condition, or applies to herself the reaction she would apply to somebody else in her condition. In her mind, she makes a distinction between the way she must behave and her inner feelings: "People in this courtyard have no such requirement about how you feel. The key point is how you do things."

This allusion to the philosophical distinction between being and seeming, between reality and appearance, sums up the patient's experience: the loneliness, the lack of social bounds, the rejection and lack of understanding from others, and the shame or fear of being looked down on. In a way, this is her daily reality. These difficulties do not prevent her from keeping in touch with another reality, the reality of her social conditions. Here again the work-unit association comes into play. Upon learning from a newspaper that her *danwei* was about to build an apartment building and sell condos to the members, Yan went to her work unit's office to get information about this opportunity.[7] She found that it was out of the question that her family could not afford to buy one.

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[6] Dazayuans are those old traditional homes in China built around a small garden. One characteristic of this type of residence is that people lived very close to one another and usually had to share common spaces. At the time of the field work, many of those dazayuans still existed.

[7] At the time of the field work, there was a new policy: work units, instead of renting housing to their members, would try to sell apartments to the members. This was a step towards a market economy system.

> Hey, we still are not [financially] a "comfortable" family… I went to the work unit. Isn't there a house-project? I read a pamphlet in the newspaper. So, then, I went to the work unit. In fact, they wanted you to buy a house. How can we afford to do it? At the moment, we just make do with this one. Three of us in a single room.

Yan is well aware that the *danwei* is trying to relegate its responsibilities to its members; instead of offering an apartment at a low rental cost, work-unit members might purchase one. Yet this new social system is not conceived for people like her. Despite the economic development around her, the money she receives does not allow her anything beyond "fitting three people in the same room." Here, her confinement and marginality are not linked exclusively to family members, neighbors, and people she met in public places. This marginality is no longer exclusively linked to her being mentally ill, but also to the experience of being poor. The poverty of her family does not allow them to benefit from the homeownership program launched by her *danwei*. The feeling of isolation from her neighbors is made even more difficult to bear. She is not pointing to any direct relationship between her family's poverty and her mental illness, but in her exchanges with the interviewer she makes it clear that in her experience the two go together, that is, her mental condition reinforces her poverty, and her poverty makes her mental condition more obvious to those around her.

Li Wan

Li Wan, a nurse, was born in 1962. She studied nursing and music at the college level. Wan's parents were moved to a rural zone and were still living there when they divorced. Wan and her brother were young then. Wan's father initially had custody of her, but later Wan's mother took her along when she moved to Beijing. Her father still lives in the country. After her mother remarried, Wan went to live with her brother, but when his wife had a child, she went back to live with her mother and stepfather. She has worked twelve years in a hospital, first as a midwife and then as a senior nurse. Additionally, she has musical talent, and her work unit, taking great pride in her success, gave her the privilege of singing lessons in a famous institute. They also gave her a less tiring job in the supply department, so that she could spend more time on music. After receiving her music diploma, she continued working in the supply department. Her mother, who owns a clothing store, provided additional financial support for her music lessons.

According to her relatives, the occurrence of certain abnormal behavior at home and at work led to her hospitalization. Yet here, too, it happened in a very unusual way. First, a few years before her hospitalization, her family had consulted a doctor without telling her work unit, which went against the usual procedure. Then a psychiatrist who did consultations at her hospital decided that she should be sent to a psychiatric hospital rather than be treated at the hospital where she was employed. It seems that the nursing department was anxious about allowing a mentally ill person to work as a nurse. She was then transferred to hospital H. without anyone telling her why. Thanks to her mother's financial resources, Wan was given preferential treatment: she had a private room and nurse.

After Wan's hospitalization, her work unit refused to let her continue working, but continued giving her a salary. The fear of being rejected or discriminated against was very present in Wan's mind. As for the hospital where she was treated, Wan said, "The attitude of the hospital is quite standard. One is to comfort you; the other is not to discriminate against you."

In this statement, Wan expressed both the fear of rejection and the need for care. She has the same anxiety concerning her job. Since her hospitalization, Wan has not gone back to work, yet when she thinks about it, she expresses her concern of "being looked at as scum." Her previous quotation continues:

> If I go to work, I just hope people won't treat me unequally. Of course, I haven't worked yet. I just hope after I go to work, they won't look down upon me. Just give me more encouragement. So long as I make some achievement, praise me more. Encourage us.

From this excerpt, we realize how Wan perceives her environment being divided between "us" and "them," with "us" being the patients and "them" being the others. The others represent an identity that she wishes to recover or not to have lost. The "us" she sometimes perceives as a threat, as it means being different from the others; it is also the part of her that needs help and comfort. In this "us," she expresses a collective identity based on her mental illness.

A few minutes earlier in the interview, she had explained what "comfort" meant to her. Here again she makes a very significant distinction between her overt behavior in daily life and her inner feelings. Wan said that her family is "concerned about my daily life and my mood… In general, they are careful with the words they use with me." Wan's craving for comfort, for encouragement, for being looked at as a normal person, is similar in both the context of her daily life and of the job she still hopes to regain one day.

Lu Hua

Lu Hua, a male, was born in 1968. He did not finish secondary school and is without a regular job. Some dramatic events shaped Hua's path. When he was a child, his mother committed suicide. As a consequence, he lived with different families on his mother's side, and later lived with his father, a hemiplegic who was sick for a long time and died when Hua was about twenty. His only sister already was married. He found himself living alone. Even before his father's death, he traveled a turbulent path. In secondary school, shortly after failing all his exams, his father kicked him out of the house. He lived as a homeless person and was considered delinquent. He had to spend three years in a "reeducation through work" center and then was employed for a while by a work unit where one of his relatives worked. After he quit, Hua displayed aggressive and violent behavior. He broke things belonging to a neighbor, who complained to the Public Security Office. Hua's behavior was found to be abnormal, so the Office contacted his sister and asked her to give permission for Hua to receive psychiatric care. She agreed, and Hua was made aware of her decision. He spent one month in Hospital H. When he left, his

sister helped him find a temporary job selling videos. Hua has experienced violence, aggressiveness, shame, and confinement for a long time.

During the interview, Hua clearly states his shame at having been temporarily committed to a psychiatric hospital, a feeling aggravated by the fact that he does not see himself as mentally ill. When conversing with the interviewer, Hua probably revisited his past. When he expressed his anger, he did not speak to the interviewer per se, but to everybody at the same time:

> Face is as important to a man as bark is to a tree. A dog will leap over a wall in desperation. Damn it, if I lose my temper, I can gamble… Just don't drive me crazy. Are you going to let me live? Damn it, I am also a human being anyhow. I am not an animal.

Hua has a strong reaction to the marginalization he experiences. To him, social rehabilitation should mean being treated like a human being, especially by the social institutions around him. His worst feelings of resentment are directed toward the institutional environment that shaped his youth. Hua had been rejected by two local institutions, the Street Committee (*Jiedao*) and the Residents Committee (*Juweihui*) that could have helped him before the reform period. Hua was hoping for their help, but he hadn't received any assistance. As Hua said, "The Neighborhood Committee doesn't care about me. Neither does the Office. I just find my way outside."

The only other institutional resource available to provide help in the face of mental illness is the work unit. As Hua never experienced stability at work and never became affiliated with a specific work group, he does not have access to this kind of help either.

Hua talked about his current employment and the role his sister had played in his job search. When Hua was helpless, he received some support from his sister; but he is still ambivalent toward her because she was the one who agreed that he should be sent to the hospital. At first, Hua discusses his job as a sales representative in an essentially business-like manner, but he then speaks aggressively of his sister:

Interviewer:	What are you doing now?
Hua:	I am just helping them, not a permanent staff.
Interviewer:	How are you doing with your work now?
Hua:	Very well.
Interviewer:	You get a salary every month?
Hua:	I am a sales representative. I get whatever commission based on my performance. Just depends on your skill.
Interviewer:	What are you selling now?
Hua:	Videos.
Interviewer:	Is the place you work a private shop?
Hua:	State-owned. My older sister introduced me there. Who could I depend on after I came out? It was she who sent me to the psychiatric hospital. Who else should I go to for help? I went to see her at her friend's. She said, "How could they send you back?" She said such a thing. I was really angry. She said, "Let me find you a job." I said, "OK. Where?" She said, "When you go to see our relatives, if they ask who found you the job, you say 'my elder sister.'" I'll remember you, bitch, all my life.

Even when there is aggressiveness and resentment in his narration, Hua also shows pride when he talks about his job. This job requires "skills" and he performs well. At the same time, he is aware of his fragility and dependence ("Who could I depend on?"). Hua also is aware that his marginality is exacerbated by the fact that he does not belong to any work unit. In his mind a work unit would normally help him. He nevertheless, in an indirect way, expresses this need or dream to belong to a work unit. As we have just seen, he is sure no work unit feels responsible for him. Yet, he still feels that the work unit is an important factor in the image he has about the world around him. To the interviewer (who is a member of the medical staff), he says, "I am really happy you can come to see me. It makes me feel I am in a work unit. Once a worker has some accident in the work unit, the leaders go to see him at home, right? I am really very happy."

For a short moment, he feels he belongs to society. He knows that no work unit leader will ever come to his place because he fell ill. He knows that this interviewer works as a nurse in the hospital where he spent some time. He thus realizes that this interviewer does belong to a work unit and this gives him the feeling of not being left out.

Discussion

The objectives of this chapter have been to present clinical sociology as a particular approach to study schizophrenia in urban China, and to understand schizophrenia in the Chinese context. I will make four very brief concluding comments, each of them relating to both objectives.

Patients are Able to Say It in Their Own Words: An Experiential and Implicit Knowledge

Many people—professionals and laypeople alike—often see people with severe mental illness as "nonpersons" unable to express their experiences, so it is worth noting that patients and members of their close environment are indeed able to "say it in their own words," to borrow an expression sometimes used to describe the impact of psychotherapy. Their knowledge includes their understanding of their personal experiences as well as their interpretations of the changing context of urban Chinese society. People involved in the mental health/illness experience are all real persons. Additionally, in our sample, they were not just patients, mothers, or work-unit leaders; they were specifically Chinese patients, mothers, or leaders. Shi expresses very well the ability to give sense to his experience: he refuses the idea that he is sick, but at the same time he hopes to go back to work when he "recovers." He does not know why he is sick, but he has deep feelings about his personality (in his words, his "nature" and his "psychology"). And he refers to going back to work, implying that working (in his *danwei*) would be part of a rehabilitation process. Yan, for her part, even has elegant words to express the differences she feels between

herself and "normal" people: when something happens to her, she cannot stop thinking of it, "even on the public bus." Wan, in her own words, makes the distinction between the overt behavior her relatives expect from her and her own inner feelings. When Hua exclaims, "I am not an animal," he uses very strong, clear words to express his experience.

The Experience of Illness and Rehabilitation as a Collective Construct

The experience of mental illness and its complex meaning are truly a collective construct. Each patient is part of a network that contributes to his/her experience and this collective production becomes, in a way, an integral part of the patient's experience and its representation. This network ceases to be solely a social context and becomes an actor in and of itself. On the other hand, this network, or the immediate social environment, is not the only collective actor. There is also the larger social system that is mentioned by many interviewees. Of course, those references evoke a specific period (1993–1997).

Many macro social changes already have transformed this collective construct. For instance, there has been rapid change in the implementation of a market economy, the changing role of the work unit toward the social welfare of its members, and the massive migration of people from rural areas to large cities. All those factors, and others, are bringing significant changes for individual patients, but even for the most isolated ones, the experience of mental illness will remain a collective construct, although perhaps a more complex one that we have yet to understand. In a way, Wan's experience is, in good part, the result of her immediate environment. Her family consulted a doctor without giving her the reason for their concerns. The same doctor transferred her to a psychiatric hospital, again without telling her the reasons. The preferential treatment she enjoys at the hospital is because her mother is financially well off, and the *danwei* continues paying her salary without offering her any job. In Hua's case, the local political world (for example, the neighborhood committee, the *danwei*) is part of the world in which he feels rejected. These are only a few illustrations of the concept of collective construct as part of the patients' personal experience.

Actors Feel and Act According to Their Representation of Normality

Medical professionals and social scientists often make a distinction between social and clinical normality. The patient finds himself or herself at the center of this distinction. Medical personnel, for instance, tend to stress (exclusively) their intervention at the clinical dimension of abnormality. The directors of a work unit, who

control the sociopolitical and work environment of their members, often judge situations in terms of social normality. But this distinction between clinical and social normality is never completely clear in the actors' minds. When the mission of a work unit involves contact with medical authorities, its attitudes, decisions, and actions sometimes are based simultaneously on these two types of normality: clinical and social. Besides, patients and relatives, for example, often have the feeling that the medical diagnostic gives a new meaning to what they tended to perceive as a social abnormality. From a patient's point of view, both types of normality are an intimate part of their experiencing.

An Implicit Definition of Social Rehabilitation

All in all, the implicit knowledge carried by all the actors involved in social rehabilitation leads us to an implicit definition of social rehabilitation. Not only do actors have words to tell their story and give it meaning, they also foresee some elements that, in their view, should serve as the basis of any social rehabilitation process. According to the patients, social rehabilitation interventions should avoid a radical break between the hospitalization of a patient and her or his social milieu. Among our four interviewees, there is a clear unanimity: the road to rehabilitation should be through work and mainly through *danwei* support. In that sense, their views reflect very well the beginning of the 1990s. At that time, reform had already taken place in urban China; particularly, the market economy had started to change the role of the *danwei* as the main social welfare support system in regard to health services. While all the patients in our research project did not express the same view, those four and those in their immediate social environment quite clearly were expressing an identification reflecting the recent past rather than the changing urban China. According to them, working within the *danwei* organization was still the only—and the ideal—type of social rehabilitation they could contemplate.

Clinical Sociology: A Tool for Rehabilitation Intervention?

In reference to the practice of psychiatry, the primary aim of this chapter was to present clinical sociology as an approach that can be applied to the experience of severe mental illness with all its complexity: the personal, interpersonal, organizational, social, political, and cultural dimensions. The second objective was to offer a perspective that would take into account the context of modern urban China. Through my very brief introduction and the illustrations provided by a few cases, I hope to have partially illuminated the understanding of so complex an experience.

References

Cohen-Émérique, M. (2000). L'incident critique [The critical incident]. In: G. Legault (ed.), L'Intervention Interculturelle (pp. 161–184). Montreal: Gaëtan Morin.

Rhéaume, J., and Sévigny, R. (1988a). Sociologie Implicite des Intervenants en Santé Mentale [The Implicit Sociology of Mental Health Paractioners] (2 vols.). Montreal: Éditions Saint-Martin.

Rhéaume, J., and Sévigny, R. (1988b). Pour une sociologie de l'intervention en santé mentale [For a sociology of mental health interfentions]. Sante Mentale au Quebec, 13(1), 95–104.

Sévigny, R. (1983a). L'intervention en Santé Mentale: Premiers Éléments pour une Analyse Sociologique [Mental Health Intervention: First Step for a Sociological Analysis]. Montreal: Les Cahiers du CIDAR, Département de Sociologie, Université de Montréal.

Sévigny, R. (1983b). Théorie psychologique et sociologie implicite [Psychological theorie and implicit sociology]. Santé Mentale au Québec, 8(1), 7–21.

Selected Readings

Bond, M. H. (ed.). (1996). The Handbook of Chinese Psychology. Hong Kong: Oxford University Press.

Chen, S. (2002a). Social problems of the economic state: historical roots and future directions. China Report, 38(2), 193–214.

Chen, S. (2002b). Economic reform and social change in China: past, present and future of the economic state. International Journal of Politics, Culture and Society, 15(4), 569–589.

Chow, N. S. W. (2000). Socialist Welfare with Chinese Characteristics: The Reform of the Social Security System in China. Hong Kong: Centre of Asian Studies, University of Hong Kong.

Cooper, J. E., and Sartorius, N. (eds.). (1996). Mental Disorders in China. London: Gaskell.

Corin, E. (1990). Facts and meaning in psychiatry. An anthropological approach to the life world of schizophrenia. Culture, Medicine and Psychiatry, 14, 153–188.

Enriquez, E., Houle, G., Rhéaume, J., and Sévigny, R. (1993). L'Analyse Clinique dans les Sciences Humaines [Clinical Analysis in Human Sciences]. Montreal: Éditions Saint-Martin.

Gendlin, E. T. (1996). Focusing-Oriented Psychotherapy. A Manual of the Experiential Method. New York: Guilford.

Kleinman, A. (1988). Rethinking Psychiatry: From Cultural Category to Personal Experience. New York: Free Press.

Kleinman, A. (1996). China: The epidemiology of mental illness. British Journal of Psychiatry, 2, 129–130.

Kleinman, A., and Kleinman, J. (1999). The transformation of everyday social experience: what a mental and social health perspective reveals about Chinese communities under global and local change. Culture, Medicine and Psychiatry, 23(1), 7–24.

Lee, S., and Kleinman, A. (1997). Mental illness and social change in China. Harvard Revue of Psychiatry, 5, 43–46.

Pearson, V. (1995). Mental Care in China: State Policies, Professional Services and Family Responsibilities. London: Gaskell.

Pearson, V. (1996). The Chinese equation in mental health policy and practices: order plus control equal stability. International Journal of Law and Psychiatry, 19, 437–458.

Phillips, M. R. (1993). Strategies used by Chinese families coping with schizophrenia. In: D. Davis and S. Harrell (eds.), Chinese Families in the Post-Mao Era (pp. 227–307). Berkeley: University of California Press.

Phillips, M. R. (2000a). Services de sante mentaux en Chine [Mental health services in China]. Epidemiologia e Psychiatri Sociale, 9(2), 84–88.

Phillips, M. R. (2000b). Causes of schizophrenia reported by patients' family members. British Journal of Psychiatry, 227, 20–25.

Sévigny, R. (1979). Le Québec en Héritage: La Vie de Trois Familles Montréalais [Quebec Heritage: The Life of Three Montreal Families]. Montreal: Éditions coopératives Albert Saint-Martin.

Sévigny, R. (1984). L'intervention en santé mentale et la notion de sociologie implicite [Mental health intervention and the notion of implicit sociology]. Culture, Health, 11(3), 12–19.

Sévigny, R. (1993). Psychiatric practice in China, some preliminary elements for further analysis. Culture and Health, 9, 253–270.

Sévigny, R. (1996). The clinical approach in the social sciences. International Sociology, 12, 135–150.

Sévigny, R. (2001). Une expérience de recherche-action: la réinsertion sociale de patients psychiatriques en Chine [A research-action experiment: Social rehabilitation of psychiatric patients in China]. In: Revue Internationale de Psychosociologie (pp. 139–158). Paris: Editions ESKA.

Sévigny, R. (2002). Expérience [Experience]. In: J. Barus-Michel, E. Enriquez, and A. Levy (eds.), Vocabulaire de Psychosociologie (pp. 128–133). Paris: Eres.

Sévigny, R. (2004). Social welfare policy: social rehabilitation of psychiatric patients in urban China. International Journal of Social Psychiatry, 50(3), 241–261.

Sévigny, R., Weng Y., Yang, Z., Loignon, C. and Wang, J. (in press). Jingshenbingxue Kangfu: Youguan Lingchuang Shehuixue De Tansuo [Psychiatric rehabilitation: A clinical sociology approach]. In: W. Yongzen, R. P. Liberman, and X. Yingqing, (eds.), Jingshenfenliezhen Kangfu Caozuo Shouce [A Handbook of Rehabilitation for Patients With Schizophrenia]. Beijing: People's Medical Publishing House.

Sévigny, R., Yang, W., Zhang P., et al. (1999). Attitudes toward the mentally ill in a sample of professionals working in a psychiatric hospital in Beijing, China. International Journal of Social Psychiatry, 45, 41–55.

Tang Y., Sévigny, R., Pei-xian, M., and Feng, J. (2007). Help seeking behaviors of chinese patients with schizophrenia admitted to a psychiatric hospital. Administration Policy in Mental Health and Mental Health Services, 34(2), 101–107.

Tsang, W. H., Weng, Y. Z. and Tam, P. (2000). Needs and problems related to mental health services in Beijing. Psychiatric Rehabilitation Skills, 4(1), 1–21.

Weng, Y. Z. (1998). Jinshen canji ji jingshen Kangfu. [Psychiatric handicap and psychiatric rehabilitation]. In: S. Zhou and C. Fan (eds.), Shiyong Kangfu Yixue [Applied Medical Rehabilitation] (pp. 818–832). Nanjing: Dongnan University Press.

Weng, Y., Liberman, R. P., and Xian, Y. (eds.) (in press). Jingshenfenliezhen Kangfu Caozuo Shouce [A Handbook of Rehabilitation for Patients with Schizophrenia]. Beijing: People's Medical Publishing House.

Yip, K.-S. (2005). An historical review of the mental health services in the People's Republic of China. International Journal of Social Psychiatry, 51(2), 106–118.

11
Art and Science in Italian Clinical Sociology

Giuseppe Gargano

The mounting social pressure for the utilization of sociological knowledge points to the necessity for the development of the field of clinical sociology in order to demonstrate the role of social-cultural factors in accounting for certain types of behavior that are not acceptable to a given cultural system. With such development, sociology would have a valuable tool to point more specifically to the manner in which social-cultural factors influence, modify, shape, arrest, and change personality organization and behavior. Thus, clinical sociology becomes an essential tool for comprehending the central processes involved in a given social system. [Dunham, 1982]

This chapter defines clinical sociology in practical and theoretical terms, and discusses its areas of application and the cultural theoretical background of such a professional perspective. It is important to define "sociology" in order to understand its clinical perspective and the practical applications deriving from it, but it is not easy to define sociology, especially in Italy, as the sociological knowledge used in performing a variety of institutional and cultural roles has not been formally recognized and this has resulted in a lack of identity for sociologists. This is the opinion of many professionals employed by the Italian Social and Medical Services, who are regarded as mere technical surplus, and not as interdisciplinary figures, in the planning projects aimed at improving the well-being of individuals and the community. Through a process of intellectual pillage of notions and methods, sociology—the so-called "science without boundaries"—has been confined to the regions of minor disciplines, while sciences, such as medicine and psychology, have asserted their hegemony. It's enough to say that social psychology, criminology, and even educational science have acquired the patrimony of all the theoretical knowledge developed by sociology without due recognition of its historical and intellectual roots.

The Italian experience, different from that in other European countries, is characterized by the exclusion of sociologists and their knowledge from all sorts of interventions, limiting their role to the analysis of social phenomena without contemplating possible contributions to proposed activities. University professors have failed to promote the "culture of social intervention", concentrating instead on the intellectual aspect of the field. This has made sociology one of the borderline intellectual professions without specified contributions of use to the social services system except for its confused and marginally speculative aspects.

This situation has affected all of the social professions. There is now a battlefield where social assistants, educators, and others are fighting to assert fragments of competencies, under the cover of the so-called scientific knowledge, with negative effects at the professional level. This results in therapeutic actions that may cause more damage than not intervening at all.

Italian sociological practitioners are not recognized members of an institutional setting. They wander in search of their own roles and domains, forever changing their professional identity, adapting themselves to operative contexts that are different from their specific competency. They often become journalists, teachers, and evaluation experts, but more often are unemployed, regretting the choice of a course of study that did not lead to a socially recognized career. This is the battlefield for professional sociologists, who believe in the practice of theoretical notions of sociology and wish to claim their own legitimate operative domains at the cultural and scientific levels.

Professional Sociology: The Contributions of Individuals and Organizations

Leonardo Benvenuti, a university professor in political science at the Università degli Studi di Bologna, is one of the pioneers. In the 1990s, he founded the Italian Association of Socio Therapy (AIST). Benvenuti (2002) defines sociotherapy as a discipline using "a sociological perspective, [about] the specific case [that] makes generalizations that are true for situations beyond the individual sphere." Benvenuti's work begins with the belief that between the macro-sociological approach, concerned with the institutions as preexistent to the individuals, and the micro-sociological approach, concerned with analyzing minor social configurations as the setting of formal/informal interactions, there is room for the application of sociological knowledge to situations of individual malaise.

Many of the sociologist's considerations in the research field start from the individual and end up as generalizations, thanks to a series of techniques and theories. Why should this constitute a limit to sociological activity? Is it possible that sociologists deny themselves the right to apply their findings to individual situations as other professional figures do? Should it also be noted that their conclusions are doomed to arrive late due to the time required or their elaboration?

Since the 1990s, some Italian social scientists, although still a minority, have been interested in a type of intervention-oriented sociology that is a practical, humanistic, sociological specialization similar to sociology as defined in the United States as "clinical." Besides Benvenuti, the university professors who have been interested in a practical sociology and in the study of single cases are those belonging to the Italian group of clinical sociology, such as Michelina Tosi, Francesco M. Battisti, and Massimo Corsale. The development of clinical sociology, however, is still incomplete, notwithstanding the many attempts by the Italian Society of Sociology (SOIS), headed by Lucio Luison, to devise places for its formation and growth.

In 2002, I worked together with a small group of professional sociologists to establish the Italian Association of Clinical Sociology (ASC), an Onlus (a charity association). The idea was to establish a place where it was possible to develop theoretical knowledge as well as services conceived as sociological actions. The ASC organizes basic clinical sociology courses for its many associates, and runs a home for people with social problems and two multifunctional centers for children: the Clinical Sociology Study and Research Center, and an orientation and counseling center staffed by junior sociologists. In 2003, the Italian Association of Professional Sociology (AISP) was founded. President Lucio Luison's aim was to certify sociologists' professional competencies at both the political and cultural levels.

In 2004, these three organizations—the AIST, ASC, and AISP—founded the Italian Federation of Sociology Association, and I became the president. The organization's structures and procedures aim to improve the sociologist's professional qualifications and the professional respect granted sociologists in accordance with Italian laws. The federation is setting a new political and cultural course aimed at encouraging the work of sociologists in the different areas of intervention. Italy has hosted international conferences in clinical sociology and, in 2005, members of all three associations, as well as international practitioners, were faculty members for the first graduate program (master level II) in clinical sociology.

Sociology: A Dialogue with the Human Experience

Zygmunt Bauman (Bauman and Keith Tester, 2001), the father of contemporary sociology, defines sociology as follows:

> A reality, and not a proposal…, a continuous dialogue with human experience, and such experience differently from the universities is not divided into faculties and certainly not into watertight compartments. Scholars may refuse or neglect to read the works of their neighbor, keeping intact their idea of separate identity. But this is not the case of human experience, where the sociological, political, economic, philosophical, historical aspects are intermixed in such a way that they lose their identity when they are separated.… I dare say that sociology won't win the "independence war" no matter how hard it tries. More precisely it won't survive in case of victory, let it be possible. The discourse structure bearing the name of sociology is porous all over and it is well known for its enormous and never satisfied absorbing power.… I personally believe that there lies its strength and not its weakness.… I think that the future of sociology is safe just because more than any other academic discipline it is able to embrace the human experience as a whole.

The task of sociology and the importance of social thought must be reasserted. According to Bauman (Bauman and Tester, 2001), sociology "has not and… cannot have meaning or utility unless it is a comment on the real experience of men…, a comment transitory as the experience itself.… To practice sociology makes sense according to the help mankind receives." In the end, "human choices… make all the difference between lives human and inhuman." Bauman thinks the practice of sociology is linked to values beyond sociology itself that speak to all the people and not only to the community of the social thinkers.

Bauman is motivated by a deep concern for people and is committed to the defense of their dignity. Some of Bauman's concepts and ideas are the best way to introduce clinical sociology. Indeed, since sociology's founders have underlined its practical-humanistic dimension, the main task of clinical sociology has been to conceive of sociology as "a science close to the needs of [people]."

Pure Sociology and Professional Sociology

The definition of *pure sociology* raises the issue of eternal debate about theory and practice in sociological science. Since its origins, sociology has employed the method of the physical and natural sciences to account for social phenomena. This method is scarcely adequate to understand people's complex social experience, especially if we consider the possible generalizations made to build "general theories." This means there can be a lack of correspondence between theoretical knowledge and a possible empirical application.

Sociology, like the other sciences, has a theoretical base and an interest in pure theory. However, sociological theory and pure sociology should not be considered to be intellectual or even sublime moments, but rather phases of a process of continuous dialogue and evaluation when considering selected phenomena. The Weberian question of how to explain particular events with the help of general principles is the starting point of a pure sociology that also can be useful.

Another aspect of the relationship between praxis and theory is language. Through research, meaning is obtained that becomes part of the common language. The use of matter-of-fact language, devoid of inaccessible technical words, makes science useful to human experience. Sociologists should take into account that the display of knowledge is a linguistic code able to help people understand what happens to them during social interactions. The linguistic comprehension of phenomena has cognitive and emotional aspects that promote new social representations. In this context, it is interesting to evaluate the evolution of such terms as *alcoholic, drug addict*, and *pathological gambler* in everyday language and the negative and positive connotations these words can suggest when their meaning is not properly understood. Reality is transformed by the language that defines it, so it is important that sociology use language to communicate its knowledge and create levels of self-consciousness and well-being at the same time.

Professional sociology is commonly distinguished as applied and clinical. The Sociological Practice Association (SPA), founded in 1978 as the Clinical Sociology Association, introduced the term *practical sociology*, a significant and operative combination of the clinical and applied approaches. This new, broad framework included an emphasis on practical research but also retained a strong interest in the diversity of intervention approaches.

Clinical sociologists must define their instruments of intervention, based on classical sociology, and adapt them to the society's new requests and needs. A sociology of intervention, is not improvised but proposes intervention schemes.

Professional sociologists analyze social facts, define a scheme to evaluate the situation, plan a course of action (that may be interdisciplinary) to overcome the malaise that originates in the society and, if possible, keep records of the effectiveness of their interventions.

A Sociology Close to the Human Experience

A nonacademic, useful sociology must be close to the human experience. The image of closeness or of bending, deriving from the Greek word *cline*, has been used in the medical field for treatments near the sickbed. In sociology the word *clinical* has a similar connotation, expressing the need to be close, even if the intervention is not related to a specific pathology. Sociology becomes clinical when its method is centered on the study of the individual case and it produces a change in the person that is part of the intervention. The individual, the community, the organization, and the society can be assisted in resolving situations of conflict, suffering, and isolation. Social research in clinical sociology does not aim at verifying hypotheses, but it becomes diagnostic when, together with the client, it defines the factors influencing or determining the modes of interpreting reality or the conception of reality.

Clinical sociology aims at changing the situation of an individual, a group, a community, or an organization. Clinical sociology is not just a possibility; it is a perspective, a direction for analysis and intervention. The practical humanistic specialization of this perspective is centered on the study of human action and the importance of human will. As Rebach (1991) noted, "The stress is on *working with* more than on *working for* or *doing something* to the client."

The clinical sociologist explores, by means of a mutually accepted action, the situation as it is perceived by the client, and together they plan a possible solution to improve a difficult situation. The diagnostic framework and the resolution are sociologically oriented; every piece of information is decoded by sociological knowledge, and personal problems are considered to be social problems. Straus (1989) defines such problems as "intimately tied to cultural and subcultural factors, located in history and society, reference groups, family dynamics, and the social construction of reality."

The sociological clinical approach must not be confused with other ways of intervention such as psychological, pedagogical, psychosocial, and psychosociological approaches, as it aims to apply sociological knowledge to the specific situation and to propose different solutions to the problem. The variables considered to define the problem or the situation are the user, the group, the organization, and the community that have determined the sociogenesis of the behavior of individuals and the group. In addition to the classical variables such as age, sex, and education, variables such as the following are taken into consideration: relationships, conception of reality, interpretative model of the representation, and the individual's interactions with others. These factors are examined within a sociological model

and through sociological instruments such as the interview, explorative talk, narrative analysis, or biographical analysis. The analysis of the situation is essential to finding the appropriate solutions. Determining the options that can be put into practice should be the result of an examination of a list of theoretical solutions developed through techniques such as brainstorming.

To understand how sociologists perform a "sociological mission," I will present an example of an intervention—the establishment of the Casa (House) of Giona—that goes beyond the limits of a "pure" science which aims only to verify a hypothesis connected to a disciplinary paradigm. Before presenting this intervention, I want to discuss sociology as a dynamic process, a continuum of different sociological possibilities, in which pure, applied and clinical sociology contribute to a sociological science that is useful to people.

From Empirical Research to Social Intervention

The analysis and clinical intervention methodology of a social intervention has, as its most congenial expression, qualitative research. Qualitative research has developed significant epistemological and methodological definitions. In Italy, in the 1980s, the rediscovery of the qualitative approach in empirical research methods applied to the studies of poverty represented the beginning of the appreciation and consolidation of empirical research methods in contemporary sociology. The introduction and increasing use of qualitative methodologies such as life stories, active observation, the study of documents, ecological analysis, the study of organizing cultures, and action research are linked to an earlier beneficial era: the sociology of the 1950s and the modernization of the south in Italy.

The first connection between theory and empirical research developed outside the academic context. The research undertaken in the 1950s was about conditions in the south of Italy. The first research by Danilo Dolci on the condition of southern Italy cities was action research, which started with participation from the bottom strata of society and used qualitative research instruments. Dolci is a significant example of those who used qualitative approaches to decode the social and cultural context in search of a more integrated relationship between the society and its setting (Dolci, 1974; Fontanelli, 1984).

Qualitative methods, such as life stories, interviews, and biographies/autobiographies, stimulated the social research that originated from the context and social network. Dolci's ethnographic work that aimed to analyze and understand the Sicilian society not only used narrative research as the basis of the empirical approach that also emphasized the participation of community members in the research. Individuals' experiences and personal life were given their full value because of the horizontal participation processes.

These experiences produced, for the first time, a synthesis of the social transformation of the lower strata, starting a debate about the agrarian reforms and the development of south Italy in the 1950s. The innovative character of contemporary

social policies concerning social development is expressed by the promotion of the participation of the community in decision-making processes. Social actors are no longer the passive object of social policies; they are actively involved in the production and management of social services. In this decentralization process, there is an acknowledgment of citizens' autonomy and participation.

Interpersonal Dimensions, Shared Objectives, and New Social Policies for a "Net"

Social policies aimed at bottom-up interventions involve the citizens and organize an articulated net of actions for their well-being. The new way of organizing and working with resources, organizations, and services (that are usually separated by institutional domains) is the answer to meeting the real needs of individuals.

We must not forget the significant examples of integration from the bottom up that were carried out in Italy in recent years: the experiences of volunteering and the multiethnic associations and other organizations connected to social cooperation and local development. The third sector has been an example of how to make changes and carry out projects. It is possible to underline the interpersonal dimension and to pay attention to people's real life, as a starting point, without separating this perspective from other dimensions.

Choosing such an approach does not necessarily mean ignoring the social system as an economic organization and political administrative apparatus, or underestimating social complexity. Oral history, for instance, helps us avoid models and patterns conceived in advance that are often contradicted by the evidence, and to evaluate the relation between individual and collective facts. Oral sources give voice to communities, and interpersonal reasons and their meaning are reconstructed through language, memory, and imagination.

Social Services and the Multiethnic Society

The substantial difference between traditional social services and a community organization lies in the adoption of two very different reference models regarding the individual. With traditional social services, the individual is dependent on the service, with the administrators playing the central role and the users the passive role. In the community organization model, the administrators power decreases, information is shared, and the users' competencies improve. In this case, the users have a more independent and autonomous role as active and conscious community members. The latter approach changes the intervention model, the users' role (which is now central), and the definition of the concept of change and responsibility.

As a consequence of the directions and new social policies concerning immigration, for instance, social services have been given the status of special services and are expected to respond to the particular needs of immigrants. After an intermediate phase, social services will be the same for everybody, acknowledging equal rights for immigrants and the local population as well. In this phase, social work is a meeting point for different cultures, developing a possible common ground for reducing the social distances among the different social groups. It is then correct to define the social services as structures in which people communicate with each other. These structures promote people's autonomy and improve their abilities.

New operative strategies are necessary to achieve a greater development of the administrator–user relational area, the organization's procedures, the administrative apparatus, and the intervention strategies. This confirms the need for administrators' training concerning cultural and social dynamics, qualitative methodologies, flexible institutional structures, and procedures that may encourage proposals for social intervention in the locality. All of this will help create structures that are open to change.

Biographic Discourse and the Achievement of Well-Being

Acknowledging the therapeutic function of sociological intervention, considered as the promotion of individual well-being, it is impossible to ignore the limits of the therapeutic value of autobiography. This makes it necessary to establish some conditions: (1) remembering must not be a painful act, as the will to remember enhances the therapeutic power of mental and emotional detachment; and (2) narrating the past helps us to affirm our identity.

To reconstruct the different dimensions of our experience, decoding our story is apt to evoke an internal tableau of images, stories, and events, more than just a simple involvement in past experiences or trivial memories of people and facts. These same experiences will be transformed through the individual and personal construction of an existential exercise that invites us to imagine ourselves and to think of ourselves with the others. The possibility to remember (while connecting the experiences of one's own individual story with one's overflowing personal and social background and, at the same time, examining memories closely) is proof of our ability to evoke and produce original, unedited constructions that can be distant from emotional implications.

Identity consciousness is achieved through the development of a self-conception driving the temporal cycles of everyday life. Identity is a multidimensional process, not a never-changing fact. One's personal autonomy is elaborated in relation to the social groups with which one identifies. The groups affirm and reinforce identity together with the sense of originality that characterizes an individualized process. The production of an autobiographical discourse is the meeting point of different identities and is an opportunity to observe, describe, and interpret interacting biographies that help us to define ourselves.

The experience of a changing social story, of our evolving social trajectory related to other experiences, inspires an autobiographic work: the essential balance of our lives and of our existential condition. Using the clinical sociology approach, the autobiography helps actors attain a high level of self-consciousness, which in turn, helps to develop autonomous paths. The introspective movement is made much easier by the use of life stories. These stories give back to the creators themselves the biographies that are still being developed. The reconstruction of a period of their lives makes people conscious of their direction.

Narration: A Path for Inclusion

Life stories and the needs and resources of specific community realities have great significance in regard to problems such as citizenship rights and integration in local communities. Life stories make it possible to analyze society's structures and functions and, in the course of the interviews, we can verify how the story and the life, the public and the private experiences, are intertwined. Narrative analysis allows individuals to consider their relations and cultural models while their is direct observation, involving open and personalized questions.

Life stories narrations and narrations of family groups can be instruments to start inclusion processes in social and daily life. Identify has roots in the past that anchor and support the present. When individuals and groups have a relationship with their past, it is possible to establish development processes that encourage individual self-esteem and affirmation.

The modern person-uprooted from her or his own past, separated from a multitude of social and cultural links and having lost the value of memory and story–lives in a condition of weakness resulting in traumatic situations. To be a stranger or to be estranged from the social and cultural context causes behavior unsuitable to real social integration.

Through my own socioclinical practice, I have noticed that the use of life narrations is not only a valuable research method but, above all, a method to produce changes. Sociological approaches encourage individuals to compare their experiences and future paths; they are basic supports for adaptation and inclusion.

Sociologically-Oriented Treatment Centers

The aim of a useful clinical sociology is also to create sociologically oriented treatment centers where it is possible to test and apply the methods and the techniques of the practical approach. It is important to activate liberation processes from a situation of malaise and to offer services of sociological nature.

In this section, I am going to analyze the Casa di Giona (House of Giona), a therapeutic treatment center that is under the care of the Italian Association of Clinical Sociology. Here, clinical sociologists live their sociological mission, every day facing the difficulties and critical moments of applying theories to practical intervention.

In this regard, it is important to define the concept of "setting" as assumed by clinical sociology. It is considered to be a dynamic process, including both structural and relational elements. It is a place where the sociologist is fully immersed and explores, together with the user, the modes of interpreting reality, influenced by a person's belief and biography. Sociologically oriented treatment centers are relational and communicative spaces, useful in decoding the different expressions of malaise. Clinical sociologist must keep their researchers' "soul" to understand what happens and to plan an accepted intervention of resolution from a painful situation.

The instruments the clinical sociologist uses are not limited to those the sociologist typically uses. The clinical sociologist must take part in the lives of the individuals and groups involved in the intervention. The creation of a "treatment center" makes it possible for the clinical sociologist to understand the biographies of the excluded in a reciprocal way. The objective is not to be peers, but for the clinical sociologist to stimulate a person's interest in her or his own condition.

With the clinical sociologist's participation and science, the street, the house, the neighborhood, or the town can become the treatment setting. Real communication is basic to this approach, especially as we are beginning to hear the stories as perceived and lived by the actors.

The Sociologically-Oriented Casa di Giona

The Casa di Giona (a guest house), established in 2005, is located in the city of Angri in the province of Salerno. Its residents are adults who are (1) disabled and need social and educational interventions to maintain and recover levels of autonomy and support in their families; and (2) affected by psychosocial problems and need continual social assistance. These are individuals who do not have the necessary family support or whose presence in the family is temporarily or permanently impossible.

The house becomes a *place*, a material and symbolic construction with an identity and a relational and historical function. This house is an inhabited and humanized place. It provides residents with the keys to interpret and make sense of reality. The place puts the people inside a story, a memory, a project for the future, and offers the information that makes its residents behave in a certain way and have primary and secondary relationships that are as normal as possible.

The other places, or "never places," even the curative ones, do not provide their inhabitants with an identity, do not include them in any story, and just perform a

function. The "never places" foster weak individuals in terms of their personal, historical, and cultural identities. The anonymous and impersonal relational patterns in "never places" have symbolic systems that do not offer meaningful keys and give peculiar interpretations of reality.

The House of Giona has become a place with a strong symbolic content where the administrators use a series of motivational strategies to foster real change. The strategies involve institutional and family resources. To participate in and listen to the biographic narrative becomes the intervention methodology.

Even a small pause is helpful for people to start clarifying their own lives and, above all, to define personalized treatments. The inclusion of the guest becomes social therapy in a process where the person affected by the malaise is the protagonist of his or her story and in the stories of the other people living in the same condition. To participate means the guest belongs to a community, generating and increasing the solidarity, responsibility, and availability.

According to the principles of clinical sociology that have inspired the methodology of inclusion, the main target of a program for the guest is to acquire competencies to decode one's own biography in relation to its setting and culture. The aim is to work with people who have serious problems with the support and the involvement of different actors having a role in their lives (e.g., family, school, institutions) and to include them in the processes, which encourages them to take an active part in planning the solution. The structure is not the classical place of diagnosis and protocols, but it takes the form of a flexible and open intervention process, in both phases—sorting out the individuals to be involved and implementing possible answers. The scheduled actions are intended to co-explore the settings (family, society, school, institutions) where the symptoms of the malaise are displayed and to activate the individuals and the existing contextual resources.

The therapeutic laboratory becomes a physical place, a relational setting, a climate where one plays an active role in the linguistic, cognitive, and affective decoding process of the malaise. The place seeks to be an interface, an instrument for the social and educational institutions of the geographic area to organize specific support and intervention activities. The timing and modality for these objectives are planned by the team together with the guest and the people that have sent the guest, and they are continuously verified and defined anew. The best therapeutic course of action is defined little by little as affective and cognitive competent behavior is developing.

The House of Giona offers the following:

- Day and night reception (even for one night)
- Meals and personal care
- A cozy and home-like atmosphere, with rooms that have an individual character

- "Therapeutic" laboratories and activities related to every aspect of daily life, from personal care to house management and specific work activities
- A warm and stimulating relational setting that encourages friendship within the house and helps to maintain the long-lasting relationships that already exist outside the house
- A project aimed at the guests' autonomy, starting from the personal care
- Social, recreational, artistic, cultural, and sports activities

The house is open to marginal and abandoned people, those facing a critical situation due to their condition who cannot find solutions within their families or the institutions. People can support and enjoy a warm and a stimulating place where they can find a rich relational network, social and medical care, and a flexible attitude of protection and personal autonomy. The "therapeutic laboratories" offer a socioeducational and recovering intervention of great value to those who need gradual contact with reality through small responsibilities and constant effort to achieve a greater personal autonomy. The admission of a guest is based on the evaluation and decoding of the individual's malaise.

The duration of an individual's stay is determined in advance, but is renewable in agreement with the person or organization that referred the person. A period of review also is agreed to by those who referred the guest.

The house's organization and management are entrusted to a team composed of a scientific supervisor; an administrator of the house; a therapeutic program supervisor; a person guiding and organizing family management; three managers—two for the day shift and one for the night, supporting and sharing the daily management; an administrative secretary; and volunteers.

The administrators accomplish all the tasks in the house:

- A guest and an administrator are in charge of the kitchen, the meals, and food purchases. One of them is responsible for the menu after taking into account the needs of the team and the advice of a dietitian.
- A guest and an administrator are in charge of the housework, from washing and ironing to supervision of each guest's' wardrobe.
- Volunteers run the recreational, cultural, and sports activities.

The guests can plan and verify their life experiences through individual or group sessions with a clinical sociologist and a psychologist who cooperate with the administrators and support the guest in his or her daily activities. The activities are checked weekly in relation to the individual's project that was developed with the team. Every week the team meets to review the experiences of individual guests. This meeting encourages dialogue between the administrators and improves the definition of the guests' individual projects.

A program manager organizes training meetings for the administrators three or four times each month. These sessions help the administrators control

the emotions and reactions triggered by the relationships with the guests. They also provide the administrators with the necessary professional training and information relative to pathological states and the sociopedagogical interventions.

The Welcome Program

The program's duration depends on the psychological and social conditions of the guest and on the objectives previously agreed to by the guest and those who referred the guest to the program.

The welcome program has four phases: (1) an initial definition and decoding of the problem, preparatory to entering in the house; (2) individual evaluation; (3) an individual project; and (4) social reintegration.

First Phase: Admission Process

This phase starts with listening to and acknowledging the request by the institute or the person referring an individual and ends with the assessment and possible admission to the house. The assessment is of fundamental importance regarding expectations and for the subsequent intervention. The assessment is coordinated by the area services and includes the contribution of different professionals. The objectives are as follows:

1. To consider the guest's request and his or her expectations.
2. To first collect information about the problem from the guest, illustrate the main features and the objectives of the assessment and the first phases of the intervention, elicit from the relatives and other significant figures (a guardian, for example) their points of view and expectations, guide them in cooperating with the general definition of the intervention project, define the problem anew, make an initial contract that is fully understood and accepted by the guest, and, if necessary, ask other significant figures (such as relatives) to participate in the general program.
3. To get the guest's written permission to collect and use personal information and allow video recording.
4. To motivate the guest to enter the second phase of the program.

In this phase a tutor is assigned to the guest. The main function of the tutor is to act as a reference for the guest and the therapeutic team in multiple ways related to the guest. Among other things, the tutor is responsible for keeping a diary of every significant detail regarding the guest. It is possible that at the end of this phase the guest may get a new tutor. In this way, according to the theoretical model of reference, the guest can test himself or herself within different "relational styles."

Second Phase: The Individual Evaluation

This phase encompasses the first three months of observation and interaction. During this phase there is (1) a personal and relationship assessment; (2) an exploration of personal difficulties and available resources; (3) a clinical diagnosis and restatement of the problem; and (4) the development of a detailed intervention program based on the information that has been obtained. In this phase, the guest can test the setting and get acquainted with the other guests and team members.

Third Phase: The Guest's Individual Project

The guest's project is approved by the referring organization/individual and the guest. In this way, the intervention is sufficiently structured and intensive. The guest takes part in the life of the house, respecting the organization and the rules previously negotiated as well as those being negotiated (self-organization) along the way.

   Life is organized on the family model; the atmosphere is informal and every guest is involved in the organization of the day, which is planned and directed by the guests and the staff. Daily life is designed to be for social and cultural reintegration. For that reason, guests and staff eat meals together. The guest's program activities are finalized based on core considerations: acquisition or reacquisition of autonomy; regular habits and rhythms of life, such as responding to the requirements of any social action, rules, regular hours, and rhythms; and capacity of cooperation and coordination in order to attain a common aim.

   The social interaction system of a common life, together with reflective and evaluative moments concerning one's own and others' behavior, expectations, and emotions represents a resource. The person assembles the necessary instruments to recognize one's own identity, which is often undergoing a crisis, and makes representations of an autonomous self that is able to decode one's self, the setting, and one's self in the setting.

Fourth Phase: The Reintegration

At the end of the residential program the guests have two possibilities according to previous planning and the guest's resources: go back to the family (context of origin) or enter a structured program. In the first case, the discharge is based on the conditions agreed to in the discussions with the family. The aim is to find the necessary supporting resources in the family's geographic area that fit with the guest's program and guarantee gradual and coherent phases toward the person's ultimate autonomy. In the second case, the guest would be included in other specialized

structures selected together with the territorial services. In both cases, the client can keep in touch with the administrators in the house and will be invited to undergo follow-up tests.

Conclusion

Clinical sociology, as a practical discipline, must use the instruments at its disposal for intervention and, above all, for the improvement of a personal or collective situation. The methodology accompanies the different phases of the research, making it possible for the observer to live with the situation in order to reproduce the conditions necessary to modify the biographies of the clients. A variety of techniques, such as life stories, biographies of the "excluded", and life experiences conveyed through interview and active observation, offer the possibility to conceptualize the sociological malaise whose origins can be found in the cultural system of one's own social environment. The aim is to apply our scientific knowledge to improve people's lives.

In the clinical sociologist's experience of "action and participation," the starting point (to analyze, observe, compare, and interpret the actors' behavior) must be to distinguish the behavior that is noted by the clinical sociologist from the behavior that is perceived and described by the actors themselves. As a consequence, the clinical sociologist has to leave the position of a detached observer, external to the field. Observing directly and informally the social situation where the interaction itself takes place and recording directly the findings based on these observations, without the pressure of preordained patterns, it is possible to conceptualize in an improved way. Through the reconstruction of the logic of the actions from within, such as what is perceived and experienced by the actors themselves, the clinical sociologist will be able to discover the *implicit data*, knowledge that makes it possible to account for behaviors that might seem meaningless.

This research procedure moves between two poles, from a critical approach of the researcher acting autonomously to *taking the place* of the actors at the same time. This may clarify the logic of the clinical sociology procedure, which, through the analysis of the participants, puts into practice a way of breaking into the actor's inner self and into the actor's real world of perceptions and interpretations.

References

Bauman, Z., and Tester K. (2001). Società, Etica, Politica: Conversazioni con Zygmunt Bauman [Conversations with Zygmunt Bauman]. (L. Burgazzoli, trans.). Milano: Raffaello Cortina Editore, 2002.

Benvenuti, L. (2002). Malattie Mediali, Elementi di Socioterapia [Mental Illness, The Basics of Sociotherapy]. Bologna: Baskerville.

Dolci, D. (1974). Racconti Siciliani [Sicilian Stories]. Torino, Italy: Einaudi.

Dunham, H. W. (1982). Clinical sociology. Its nature and function. Clinical Sociology Review, 1, 23–33.

Fontanelli, G. (1984). Danilo Dolci. Firenze, Italy: La Nuova Italia.

Rebach H. M. (1991). Intervention in Clinical Sociology. In: H. M. Rebach and J. G. Bruhn (eds.), Handbook of Clinical Sociology (pp. 49–64). New York: Plenum Press.

Straus R. (1989). Changing the definition of the situation: toward a theory of sociological intervention. Sociological Practice, 7, 123–135.

Selected Readings

Avanzini, B. B. (2002). Devianza e Controllo Sociale [Deviance and Social Control]. Milano: Franco Angeli.

Berzano, L., and Prina, F. (1999). Sociologia della Devianza [Sociology of Deviance]. Roma: Carocci Editore.

Blumer, H. (1968). Symbolic Interaction: Perspective and Method. Englewood Cliffs, NJ: Prentice Hall.

Blumer, H. (1975). Comments on "Parsons as a Symbolic Interactionist." Social Inquiry, 45, 68.

Bruhn, J. G. (1987). The clinical sociologist as a health broker. Clinical Sociology Review, 5, 168–179.

Cooley, C. H. (1902). Human Nature and the Social Order. New York: Charles Scribner.

Crespi, F. (2002). Il Pensiero Sociologico [Sociological Thought]. Bologna: Il Mulino.

Demetrio, D.(1995, May). La ricerca autobiografica come cura di sé e processo cognitivo [autobiographical research as a cure and the cognitive process]. Presented at the IRRSAE convention, Apprendere dalla Memoria: Il Metodo Autobiografico Nella Formazione e Nella Didattica, Milano.

Demetrio, D. (1997). Pedagogia Interculturale e Lavoro sul Campo, in I Bambini Stranieri a Scuola [Intercultural Pedagogy and Fieldwork, Foreign Children in School]. Firenze: La Nuova Italia.

Dollard, J. (1935). Criteria for the Life History. New Haven, CT: Yale University Press.

Du Bois, W. E. B. (1899). Philadelphia Negro: A Social Study. Boston: Ginn.

Fritz, J. M. (1992, June). Seminar in Sociological Practice, Current Issues in Clinical Sociology: History, Case Analysis and the Sociological Profession. Presented at the Dipartimento di Scienze Sociali, Università degli Studi. Torino, Italy.

Fritz, J. M. (1996). The Clinical Sociology Resource Book (4th ed.). Washington, DC: American Sociological Association Teaching Resources Center and the Sociological Practice Association.

Gaulejac, V. de, and Roy, S. (1986). Pour une sociologique clinique [for a clinical sociology]. Bullettin de Psycologie, 39, 377.

Gaulejac, V. de, and Roy, S. (1993) Sociologie Cliniques [Clinical Sociology]. Paris: Hommes et Perspectives.

Goffman, E. (1959). La Vita Quotidiana come Rappresentazione [The Presentation of Self in Everyday Life]. (M. Ciacci, trans.). Bologna, Italy: Mulino, 1969.

Luison, L. (ed.). (1998). Introduzione alla Sociologia Clinica—Teorie, Metodi e Tecniche di Intervento, Sociologia Professionale [Introduction to Clinical Sociology—Theory, Methods and Intervention Techniques]. Milano: FrancoAngeli.

Park, R., and Burgess, E. W. (1921). Introduction to the Study of Society. Chicago: University of Chicago Press.

Straus R. (1977). The Life Change Process: Weight Loss and Other Enterprises of Personal Transformation. Doctoral dissertation, University of California at Davis.

Tosi, M., and Battisti, F. (eds.). (1995). Sociologia Clinica e Sistemi Socio-Sanitari: Dalle Premesse Epistemologiche allo Studio dei Casi e Interventi [The Comparative Analysis of Socio-Sanitary Services in Europe]. Milano: FrancoAngeli.

12
Socioanalysis and Clinical Intervention

**Jacques Van Bockstaele, Maria Van Bockstaele, Jacques Malbos,
Martine Godard-Plasman, and Nathalie Van Bockstaele-Theilhaber**

Our team of analysts[1] has shaped its path in clinical sociology over more than thirty years through the development of a technical instrument: socioanalysis. The term *socioanalysis*, which was an early replacement for the longer term *psychosocial self-analysis*, turned out to have a number of meanings. Socioanalysis can be described in various ways, depending on whether one adopts a pragmatic, technical, or theoretical point of view.

From the pragmatic point of view, a socioanalysis is addressed to social entities desiring to work together to improve their control over their own action, or who request help in dealing with problems for which they see no solution. These entities must have sufficient weight in institutional negotiation to be able to contract with the collective analyst constituted by the socioanalysts and to commit their time and resources for the appropriate time period.

From the technical point of view, socioanalysis is grounded in its acquired experience of how, in specific conditions, the basic mechanisms governing the action of a social entity are reproduced. Because of this experience, socioanalysis, as a technique, provides insight into the origin, structure, and functioning of an entity under specified conditions.

From the theoretical point of view, socioanalysis circumscribes an object—the entity that generates and supports the action. This object contains the elements that constitute the action and the forces that carry it. Its formal definition results from the conditions under which it can be accessed from the different perspectives—internal and external.

By identifying elements that make up the action and the forces that carry it out, socioanalysis makes it possible to grasp the factors that determine the action of a particular entity. The technical conditions of the socioanalysis allow us to obtain a sufficiently faithful and precise reproduction of the mechanisms by means of which actions are produced and relations are generated within that entity. Finally, the contractual relation established with the entity in question legitimates the possibility, for the socioanalysts, of intervening and interpreting, and, for the

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[1] The "Centre de socianalyse" was founded in 1957. The "association d'analyse praxéologique et cognitive" (CAP) was established in 1986 to replace the "Centre d'analyse socio-économique" (CASE) founded in 1960.

requester, of carrying out, with our help, an analysis of the entity and the action. In the domain of research on human and social action, identifying the elements that constitute an action and understanding how they fit together remain major theoretical goals, marked by the absence of a consensus about the object of investigation. This absence shows both the inadequacy of the theory and the lack of tools appropriate for studying action.

A socioanalytical team is composed of at least four members—the minimum, based on our experience, to ensure the socioanalytic situation, which is defined below. A clinical intervention always takes longer than one year because of the time that is needed for change in the institution or in social processes. The time frame of more than a year is specified in the contract, as no definite duration can be decided a priori.

The core concept (Imagine-Co-opt, IC), which is discussed below, establishes the identity of a socioanalytical team. A well-formed team can only be recognized by the Association Française de Socioanalyse (AFS).[2] The Association's objectives are the theoretical development of socioanalysis, the development and control of didactic training of socioanalysts, the deontological control of the activity of socio-analysts, and the protection of socioanalysts' professional interests.

Some Preliminary Remarks

In the 1960s, two of our articles appeared in the French review *L'Année Sociologique* in a new editorial category that we had suggested in order to establish the specificity of our approach: Travaux de Sociologie Clinique (Works in Clinical Sociology)[3] (Van Bockstaele et al., 1963, 1968). Even if clinical sociology is defined as means to achieve social change within society and to respond to social requests, it still has not well-defined boundaries or clearly specified attributions.

In clinical research, what we are seeking to understand eludes direct inquiry, due to both the observer and the observed status. Can resistances be bypassed so as to yield access to what the requester and the intervening clinician endeavor to know? We have elaborated a specific approach in which the link contracted with the object of observation (i.e., a social entity) gives the observer (i.e., us) the right to observe, intervene, and interpret, and enables the entity to start an analysis of its action (Van Bockstaele, et al., 2000).

Socioanalysis arose from the initial choice to use a collective analyst for the purpose of interpreting the intra/intergroup relations of an institutional client entity. That early resolution (Van Bockstaele, et al., 1977) originated in experimental work on intra/intergroup relations. Empirical exploration of social reality during that period took two forms. The first, clearly dominant, refers to the type of exploration,

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[2] The Association Française de Socianalyse (AFS) is located at 50 rue des Carrières, 92150 Suresnes, France.

[3] *L'Année Sociologique* is the review once founded by Emile Durkheim. In the following years, the category Works in Clinical Sociology eventually was dropped.

which seeks access to the social reality by observation, more precisely, through an observation that is supposed to gather data without intervention or manipulation by the observer (survey by questionnaire or interview). The second form, extremely rare, consists of the different types of active exploration, which refers to an observation in which the observer intervenes technically and deliberately and does not presume an experimental or clinical form. The exploration leads to attributing a crucial rule to the interaction observer/observed.

Our conception of clinical sociology was formed through our experimentation during our laboratory research in the early 1950s as members of the Centre d'Etudes Sociologiques. Our work, entitled "Expérience des Groupes Radio," followed the experimental tradition, which aimed at modeling historical data (e.g., democratic versus autocratic; Lewin, 1938). Inspired by this tradition, the idea arose to study the world division of East/West and its effects on the minority/majority relations within the French political scene. This study of the Cold War was achieved by introducing an intra/intergroup relation and an intragroup division between a majority and a minority, with members of the minority being strictly confederates (or "stooges") of the experimenters. The work of Festinger and his colleagues (1950) inspired our methodology in laboratory research.[4]

In the experimental setting, the intergroup relation, a simulated outsider (selected as the independent variable) was channeling different kinds of external pressures to affect the intragroup relations and decisions. The intergroup relation thus implied that the effects observed would be measured on the dependent intragroup variables (perceptions and communications). At that time, the experiment was not backed by any prior consensus because of a lack of scientific support or lack of evidence. Therefore, the implementation of the experiment met with considerable resistance. In the long run, different problems in the procedures affected the statistical analysis of the results. We encountered some discrepancy between the cognitive and behavioral measures for which we could not account at the time. Moreover, there were questions by members of the research team about the use of confederates.

It was precisely at this point that we were introduced to "group diagnostics." This new resource led us to embark on a clinical venture, though we risked appearing as renegades of experimental research. The group diagnostics, according to Lewin (1938), proposed a critical distance vis-à-vis experimental work, in our case particularly our distinctive manipulation of social relations. Many years later, as we had progressed in our clinical research, we returned to the cognitive measurements taken on the minority parameter (perceptions of the height of individuals) and found that they confirmed the soundness of our first clinical innovation, which had amounted to confer, by analogy, to the clinical observer (the team of socioanalysts) a status of minority parameter (Van Bockstaele and Van Bockstaele, 2002).

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[4] A key political book debated at that time of intense anti-Communism was George Orwell's *1984*, the antitotalitarian counterutopia (Orwell, 1949). (Orwell had just died in London in 1950.) In the France of the C.E.D. (Communaute Europeenne de Defense) and in light of the trial of Julius and Ethel Rosenberg, the choice of a "minority parameter" was bound to be interpreted as representing the political minority of the PCT (the French Community Party).

This chapter discusses two essential points. In the first section, we introduce the characteristics of the socioanalytic task—its practice and its purpose. The purpose is to handle spontaneous external requests, that is requests originating from social entities having the capacity in whatever domain in order to make political, technical, social, and financial decisions. In the second section, we account for the links between that specific situation and our practice of clinical intervention, which has never been separated from research on the same practice, its technical tools, and its underlying concepts.

Socioanalysis and Imagination: A Co-optation Task

Socioanalysis, understood as the practice of an analytic situation, is conducted under the responsibility of the Centre de Socianalyse (established in 1957). The originators of the Centre decided to create, outside of the university, a permanent group of analysts who are dedicated to the development of socioanalysis. The practice of socioanalysis is characterized by the application of instructions that have been explicitly formulated and are proposed beforehand, in conditions where their prescription is possible and desirable. The socioanalytic technique has taken twenty years to develop, its transformation arising from our clinical practice. Thirty-two successive instructions have been formulated between 1957 and 1972. These instructions were called "rules" beginning in 1958. The socioanalytic task is unchanged since 1976 and is defined as follows:

- Imagine the life of the group of socioanalysts.
- Co-opt (choose or elect) relevant representatives.

Participants assume the obligation to

- express, with no omissions, what belongs to the task of imagination-co-optation, and
- refrain from any statement about the task that does not have as its object the realization of the task.

We will distinguish four methodological and interpretive principles that give access to the observation of social entities. According to our experience, their application allows analysis and interpretation of the actions of these entities (Van Bockstaele and Van Bockstaele, 2004).

Co-Investigation: A Necessary Condition for Access to Observation of a Social Entity

One of the difficulties of investigation in the social sciences comes from the limitations imposed by institutional structure and functioning. The problem is as much practical as it is technical, but it is a major obstacle to investigation, since what we

wish to investigate is made inaccessible by the very reality we are trying to study. Our response to this specific situation is to associate with the investigation those very individuals who are its subject matter, and who, by the self-investigation they engage in, become also its addressees.

The consent cannot be considered a simple precondition to the investigation that holds once and for all. For us, obtaining consent takes the form of a negotiation that makes it possible to start a co-investigation, whose maintenance is a permanent object of reflection and analysis. Furthermore, this co-investigation is not reducible to simply making it possible to obtain and keep the consent of the actors. The modes of action and organization of everyday life are developed and perpetuated by regulation and observation at all levels of responsibility. Those who have this responsibility for directing people and things dispose of multiple resources for control and evaluation codified implicitly or explicitly within power practices.

Thus, co-investigation must take as its goal accessing the entity's capacity for self-observation. The first requirement for co-investigation is to have a tool that will allow, without harming the individuals or institutions, penetration of the defense and protection mechanisms. At the same time, the entity that has expressed the request should be protected from the spontaneous temptation to indulge in a self-investigation not guided by explicit rules. That would put it at risk of oscillating between different extreme positions that would be more or less damaging or useless. It might develop a spirit of conformity in which the dissuasive force of hierarchical relations would directly affect the production of information internal to the entity. It might favor a spirit of contestation in which verbal freedom would take on the appearance of abolishing hierarchy, and thus not reveal normal functioning. Or it might produce a utopia that reconstructs the entity independently of the real institutional constraints, social or economic, sheltering everyone from actual responsibility.

If the socioanalysts let such self-investigation develop, they will be faced with a situation in which they do not have enough evidence to evaluate the versions of the facts produced by the requester. If they then intervene in order to verify the statements, they become censors, and thereby trigger reactions of defense and protection in the requester. Our experience has led us to conclude that the lever cannot be found outside of the relation of co-investigation; it can only emerge out of that relation.

For socioanalysts, the goal is not to unmask their interlocutors by surprise, to trick them, or to prescribe an illusory or cathartic freedom of speech. The group of socioanalysts must assume the consequences of the choice implied by the notion of co-investigation, and become an object of investigation themselves for the entity they are investigating. Because of this, the socioanalysts find themselves obliged to take all information produced about them or for them as significant. Their task is to decode its meaning, probable or evident, for themselves. They refrain from confirming or contesting its correctness. They interpret this production, if they judge that it is appropriate to do so, in order to make the investigative work the requester is carrying out intelligible to the requester.

Investigation Reversal: The Condition for Reproducing the Mechanisms Underlying the Construction and Functioning of the Entity

The socioanalytic situation is designed so as to produce a confrontation between two poles: the group of socioanalysts and the requesting entity. These two poles are linked by the co-investigation and have explicitly differentiated functions. This differentiation generates a relational process that yields the raw material for the analysis. This raw material, like the relational process that produces it, has a specificity that reflects the entity's own history and the characteristics of its construction, its structure, and its functioning. This specificity is manifested by the particular exploratory procedures the entity uses in the co-investigation to carry out its self-observation. Its capacity for self-observation is then transposed as the entity explores what it wants to formulate as it observes and describes the group of socioanalysts.

In "A Crucial Event in the Development of the Rules of Socioanalysis" (Van Bockstaele et al., 1996b), we describe how, in the course of an intervention in a printing shop, we observed a transposition of the shop problems onto the difficulties met in the socioanalytic situation, particularly in relation to the comparative hierarchical structures of the shop and of the team of socioanalysts, and how the participants increasingly appropriated this shift as a means for dealing with their own conflict and differences. The various ways in which the workers in the shop made use of our collective analyst revealed the need for us to revise the formulation of the task and to propose, instead of talking in the group of the various problems of the shop, to "imagine the functioning of the group of socioanalysts." This early experience actually remained a constant source of insight as we specified the adequacy of the task to subsequent contexts in which we conducted socioanalysis.

In such an approach, observation is oriented, shifted toward an external object. Development of the relational process is regulated. This regulation exists because of our control over one of the poles of the interaction, that of the socioanalysts. The target-switch in the investigation, that is, the instruction to the requester to confine itself to exploring the group of socioanalysts, and nothing else, supplies the technical means of regulation without destroying access to observation of the entity we are analyzing. This exclusive exploration gives us the possibility of understanding and interpreting what is said, while also guaranteeing protection of the individuals and institutions concerned with the request.

The relational process is established *in* and *by means of* the shift. In practice, it is obtained by an instruction to the requester to carry out the following task: "Imagine the life of the group of socioanalysts and co-opt the relevant representatives." The result of this instruction is that the requester consents to be observed while it is being, explicitly, an observer, and that the socioanalysts receive the information produced about them and directed to them as a means of access to the action problems of the requester.

Because of the structure of the technical situation, the representatives of the entity in analysis speak of the socioanalysts in their presence, with the group of socioanalysts being represented by one, several, or all of its members. In ordinary social life, speaking of others when they are present, or absent, is an activity governed by the spontaneous use of implicit rules. These rules organize the conditions under which it is possible, legitimate, or customary for complex social relations to be created or manifested: historical, hierarchical, formal, and functional.

A second step in the formulation of the socioanalytic situation has been the introduction of the second part of the task: co-opt relevant representatives. With this introduction, the boundaries of the project are no longer merely extended beyond the situation; they have a life-sized presence within the analytic situation. During the whole analytic process, the limits of the group of people representing the entity can change, according to what has been discovered or clarified about the common project. For each socioanalytic session, the names of the individuals who will represent the entity in that session is communicated in advance to the socioanalysts. The choice, by the socioanalysts, of their own representation is conceived as an interpretation of the image of the project introduced at a certain time in the process of analysis. It is experienced by the representatives of the entity as an interrogation. This affects the information produced about the socioanalysts. The group of socioanalysts is not simply an imaginary object, like a gratuitous act or a stylistic exercise; the group provides mediation for important stakes specific to this entity. The entity itself attributes to the socioanalysts imagined details of relations, production, and regulation, and thus, gives them information about these stakes and their dynamics.

By "stakes" we mean here the elements active in the field of forces internal or external to the entity: power, resources, anticipations, regulation, relation to their environment—that is, things that are not directly accessible to those who are not within the entity. These stakes are closely related to group membership and history. They are reference points in the memory of action, a memory whose identification is a condition for the entity's existence. It is on this basis that the elements of the field of forces that determine, at each moment, the state of the entity, are structured: power relations, links between different networks, use of equipment and facilities, deployment of resources, choice of programs, anticipation of conditions of maintenance and development, and control and regulation of the flow of energy and information (work, finances, exchanges, management, planning).

The group of socioanalysts is not exempt from the problems just mentioned. This community of experience between the group of socioanalysts and the collective requester provides a basis for the target-switch, yet without establishing its validity. Clinically, what ensures the validity of such an explorative procedure is the observation that it is possible to interpret the reality of the entity under analysis from the information that is produced, as well as how it is produced and progressively transformed. This is because the characteristics attributed to the socioanalysts, and out of which the hypotheses are constructed or the successive versions of the life of the group of socioanalysts are elaborated, are not merely products of the individual imagination of one or another participant. These attributions manifest the particularities of the entity and the

characteristics of its own life, both in their form and content, in the order in which they are emitted (and by the order of who emits them), and by the composition of the group of socioanalysts and of the group representing the entity.

The reversal in the investigation allows the mechanisms that govern the entity's functioning to be reproduced. This makes these mechanisms accessible, allowing the socioanalysts to carry out their interpretive role. The discrepancies that they observe between the range of possibilities that the target-switch authorizes them to explore, and the exploration process actually carried out by the successive groups representing the entity, give a measure of the defense mechanisms it can muster. Sensing it is the object of the investigation because of the interpretations it is receiving, the entity constructs its exploration of the group of socioanalysts while protecting its own identity.

These protective mechanisms have not been invented for this specific occasion. Experience indicates that they reproduce those that are spontaneously activated by an entity in every exchange or confrontation with outsiders who are not strictly involved in fulfilling its goals. They also represent a regulation of the construction process that allows conception of the entity's own identity. The defense or protective mechanisms and the construction process are inseparable; they determine the characteristics of the entity's action and, in particular, work together in the permanent task of setting its boundaries.

Finally, the differentiation between the functions of the two poles and the task instructions creates an asymmetrical situation that calls for a set of rules to be assigned that will allow the co-investigation to proceed on a basis of equality. These rules should apply to both poles, and be their reference for what they are supposed to do. These rules are the following: "Express, leaving nothing out, what is relevant to the imagination-co-optation task. Abstain from saying anything about the task that is not aimed at carrying it out." As reference, these internal rules give rise to procedures, govern both production and interpretation, and are obligations both for the entity's representatives and the socioanalysts.

The socioanalysts, because of the rule of non-omission ("leave nothing out") cannot in any event reject an attribution, whatever its content and form, nor can they do their interpreting on the basis of information other than that produced in the sessions. Even in the case where the socioanalysts have information about the represented entity, they can only use it if it is evoked explicitly enough in the imagination–co-optation task for the interpretation to implicitly include it.

The way the link is established between the reference rules and the procedures is itself an object of observation and interpretation. The relation between the non-omission (leave nothing out) and abstention rules and the practice of imagination–co-optation transposes this link to the analytic situation. This transposition illuminates the process by which the rules emerge: the use of the rules becomes established and the mechanisms for incorporating them develop. To avoid disturbing the equilibrium in their relations and changing their conception of how the entity functions, the representatives who are present try to retain control over what they allow others to see. But they cannot escape the logic of the socioanalytic situation, since their carrying out of the task makes manifest how they are using its rules.

The orientation of the work induced by the target-switch and its interpretive use is to be seen on two levels. On the one hand, the task, the rules, and the variations in which socioanalysts are present reflect the production of the entity's representatives toward an exploration of the life of the group of socioanalysts in its most descriptive aspects, for example, the relations between the socioanalysts and the intentions behind the successive choices of who is present. On another level, the interpretive activity leads to questioning. In particular, the relation between the grounds for the interpretation and the function of the task and rules is viewed in different ways. The descriptions about the socioanalysts leave room for interrogations that are spontaneously more abstract. These attempts to understand the interpretive activity explore the relations linking the socioanalysts to their work tool.

The reversal of the investigation, or switch in the observed/observed relation, gives direct access to the problem of the entity's action, both within its internal system and in its relations with an external system. A dynamics of construction of social alterity (exchanging one's own perspective for that of the other) is reproduced by the work of analysis, thus making it possible to explore reciprocity.

Reciprocity: A Window on Power Relations

By construction, the socioanalytic situation is asymmetric. On one side, there is a technical offer of analytic intervention, which asserts its capacity to handle problems relating to the action of a particular entity. On the other side, there is a request made by an entity that has a contracting capacity; that is, it is able to commit, to a sufficient degree, an institution or relevant membership or covering structure so as to guarantee the presence of representatives at each socioanalytic session, over a sufficiently long period, and the corresponding funding. Each side must demonstrate the legitimacy of its position. Those offering the intervention must give proof of their technical capacity, and the requesters must justify and maintain their commitment.

The socioanalysts are in charge of the technical aspects of the situation. They prescribe the working conditions that give access to the functioning of the entity in its institutional environment proper, which itself is situated in a broader field of interactions. This contractually admitted access means that the group of socioanalysts is responsible for receiving the request for what it claims to be, without prior inquiry, or any systematic questioning, either individually or collectively. However, even before the formal start of the socioanalytic sessions, the group of socioanalysts is a potential repository for the entity's secrets. Because of this, the question of confidence is central. In a sense, for the socioanalysts, it is the equivalent of consent for the requester. However, just as consent is not a sufficient condition for access to the real questions the entity is asking itself, confidence alone does not give what is needed to conduct the analysis. Fluctuations in consent, like those in confidence, are a permanent background aspect of analytic work. The degree of confidence or

acceptance is never something that can be agreed on a priori, except for those aspects that are fixed by the contract.

At first, the constituted entity consists of the members of a partition on the systems in which they are actors. The boundaries of this partition are generally vague, even when there exists an initial kernel of strong and determined requesters. The decision to begin a socioanalysis expresses the partition and makes the requester accountable for this initiative. This tension is political in nature, in the sense that any definition of a boundary is a political act, implying for instance, options, values, or plans. It expresses a balance of power perceived and anticipated with more or less skill and precision.

The articulation created between the position of those offering the intervention and that of the requester implicitly raises the question of the technical legitimacy of the socioanalysts and the political legitimacy of the requester. Through this confrontation of their respective positions, a reciprocity of exchanges is established based on the asymmetry of their roles and the right of each to judge, exercising the functions assigned to them, the legitimacy of the other.

In the socioanalytic situation, the entity is legally dispossessed of its capacity to speak of what ordinarily concerns it, since, given the definition of the imagination–co-optation task, it does not have sufficient information, or appropriate criteria, to back up what it says about the life of the group of socioanalysts. No hierarchy present within it is entitled to use arguments of authority to justify the truth of what is being imagined. This dispossession does not prevent the social relations that exist in the entity from being expressed in all sorts of ways, through imagination or co-optation. The partition triggered by the socioanalysts introduces a new boundary for the entity within its systems. This boundary shows up in the fluctuations in who is chosen to represent the entity. The capacities to imagine and to co-opt, as they are manifested, provide information that can be used to evaluate the political legitimacy of the project undertaken and of those who are responsible for it.

We can thus see how the political legitimacy of the requester is progressively expressed in carrying out the imagination–co-optation task. But co-optation is also an evaluation of the technical legitimacy of the socioanalysts. It expresses the requester's sense of what is being understood or recognized. The members representing the entity are judges of what the socioanalysts see and understand that is not overtly visible and is, more or less, voluntarily left unsaid.

The reciprocity, created by the task and its interpretation, between the two parties engaged in the analytic task creates a disconcerting situation for the entity's representatives. It is experienced as disarming, in the sense that the arms normally used in the exercise of power, and the resulting order of social relations, are deprived of their ordinary basis, hence of their capacity to control a situation. This absence of means favors a process of exploration of the resources of the socioanalytic situation. By observing and understanding this exploration, the socioanalysts gain access to the rules that govern attribution, to the socioanalysts and their group, of characteristics that belong to the entity's representatives and the life of the entity under analysis. This symbolic substitution, which occurs via the imagination–co-optation task, concerns, in particular, the rules governing speaking order and

position, the choice of interlocutors, who takes the initiative in imagining, the appearance of certain themes, whether they are accepted or rejected. The entity's problems with action are re-created in transposed form: the legitimacy of power, the relations of ordering within the entity, the field of forces for judgment and its exercise in the network represented (the communication channels).

Reciprocity is a tool that gives the socioanalysts access to the dynamics of action; it also offers the entity the possibility of understanding its own dynamics. The imagination–co-optation task is the operating force in this, but how does it fulfill this function in the socioanalytic situation?

Imagination–co-optation: A Manifestation of Social Alterity

This reversal, "imagining the life of the group of socioanalysts," has two functions: it shields the entity from self-investigation that could be harmful or useless, and it gives access to the rules and modes of functioning of the entity. The co-optation of relevant representatives requires handling of the boundaries of the entity, and hence calls for consideration in the analysis of the relations between what is inside and what is outside the entity. This handling of the relation between the internal and the external is not possible unless the entity's representatives imagine the repercussions of the partition created by the decision to engage in socioanalysis, as well as the effects of the variations in its limits, broadening or narrowing, according to the co-optation chosen.

Thus, for both imagination and co-optation, we see that each implicates a number of interdependent and complex operations, closely linked to social alterity. In the technical conditions of a socioanalysis, the confrontation between two disjoint entities, the socioanalysts and the social entity represented, leads the entity's representatives to engage in complex operations and triggers imagination–co-optation.

These complex operations have their counterparts in social life. Negotiation, in the broadest sense, involves a confrontation aimed at exchange or decision, between parties or entities whose interests are shared, conflictual, or opposed. This confrontation, whatever its frequency, duration, extent, or object, cannot exist without prior anticipatory work: imagination of optimal compositions and organizations, presences or absences that are desired or desirable, functions and roles, imagination of balance of power, attack or retreat routes, and imagination of opposing scenarios. This anticipatory work, preceding the encounter, is continued and transformed once it is exposed to reality in situ.

At that point, the work is broken down into multiple concomitant, interdependent levels: at first, the whole set of anticipations remains an implicit background reference; next, the relations that are established and the content produced are incorporated into the negotiation process; later on, recognition of discrepancies between the initial picture and the reality of practices observed in situ leads to reconsideration of the anticipations in light of the reality; finally, a permanent effort of imagining regulatory procedures and ways to resolve tensions and shift goals allows exploration

of possible or desirable co-optations, with the goal of forming coalitions and changing positions and the balance of power. The dynamics of the negotiation develops in this way by articulation between these multiple levels implicitly set up by each of the entities involved in the confrontation.

Similarly, the choice or designation of the people involved in the action is the outcome of a more or less lengthy process of maturation in which there is a tangled web of anticipations, requests, and affinities that result, according to specific rules and appropriate procedures for using these rules, in integration and promotions within the system, or restructuring of this system. The boundaries internal to the system and those external to it are active elements whose fluctuations indicate changes in the orientation of action.

In the socioanalytic situation, imagination and co-optation appear as two sides of a single task. Open with respect to co-optation, and free with respect to imagination, the socioanalytic situation is nonetheless strictly delimited by the rules of non-omission and abstinence. These rules apply to the domain of imagination–co-optation explored in the task: they fix the boundaries within which interpretation is possible and licit, they regulate the internal and external information modes as well as the way the task is carried out, and they provide explicit criteria for self-evaluation, since they are directly connected to the output of the represented entity.

In reality, the apparently simple, or even nonserious, formulation of the task and of the prescribed rules hides a complexity that is only revealed as it is carried out, by the extent of the problems arising from the need to carry out the same task at each session. The multiple levels of reference, procedures, and practices, found in the negotiation and the choice of people, are materialized by the exercise of imagination–co-optation, and by the function played by the rules of non-omission and abstinence in the definition of references and the determination of the possible procedures and practices.

Carrying out the imagination–co-optation task leaves very little room for anticipation, whether about when themes will emerge, how long they will be relevant, or of how the co-optation will evolve. The variations in the makeup of the group of socioanalysts and the frequency and content of their interpretations often cause surprise. This elimination of the reference points that normally allow anticipation forces the entity to re-create a capacity for anticipation, within the technical conditions specified by the task and its rules. All the analytic work, both in production and in interpretation, aims at detecting the hesitations, attempts, refusals, repetitions, and transformations through which a dynamic of anticipation is rebuilt.

To reconstitute this anticipation function, the entity has no other means than to build the action system, to use and reproduce the mechanisms it uses in its daily life to manage its capacity for action. Through the evolution of the content produced, the actors simultaneously make explicit the genesis of this capacity. In a word, the history of the entity is replayed. However, this actualization is not a narration of past circumstances and events. It is manifested in the particular ordering that comes to exist between the generation of the acquired references and their transmission. The articulation of positions and anticipations forms the

content, the procedures, and practices, while internal and external boundaries are being constructed.

The co-investigation (which is made possible, on the one hand, by the imagination–co-optation task and the rules for carrying it out, and on the other, by the interpretation) itemizes, evaluates, and processes the data that arise from the entity in action. The entity, getting used to the prescribed conditions and testing the limits on what is possible in the analytic situation, gradually reconstructs a capacity for anticipation, to the extent that the resistances that block its self-understanding and its self-management are overcome. These resistances are scattered throughout the exploration process. As the analytic work progresses, their interpretation becomes clear.

When the entity's self-interpretation capacity begins to anticipate the interpretations of the socioanalysts, it becomes perceptible that the analytic work brings about transformations in the degree of mastery of the elements constituting the action of the particular entity; distancing is achieved with respect to the major latent or explicit conflicts that affect its performance. These transformations increase the entity's aptitude for inventorying, integrating, ranking, and collecting its action resources, and to evaluate their productivity at the different levels of control and regulation. Thus, the entity's mastery of its capacity for strategic action is progressively favored.

The reproduction, through the imagination–co-optation task, of a substitute partition revives and updates, little by little, the most obvious, but also the most repressed, or the most conflictual, aspects. These supply the raw material for a reconstruction of the entity's social alterity. This reconstruction, or socioanalytic *diapoesis*[5] generates progressive mastery of the rules and norms constraining the imagination–co-optation, and, in so doing, gives access to the implicit references in relation to which judgments are made about situations and individuals, and evaluation of performance is expressed.

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[5] The term *diapoesis* in socioanalysis rests on the idea of a "poetic" creation of things. This notion of creation related to the role of the imagination in the genesis of institutions has an illuminating precedent in the "new science:" "The first men of pagan nations, children of the human race as they were … created things themselves according to their own ideas…, which is why they were called 'poets,' which in Greek means 'creators' " (Vico, 1744). Note that Comte (1851–1854) enters Vico (whom he claims not to have read) in his "positivist calendar" (Comte, 1830–1842, Vol. IV) and that Michelet translates from Italian (Vico, 1710), indicating in the "metaphysics" of this idea that truth and fact are convertible ("*verum et factum convertuntur*"). This convertibility, a crucial aspect of the problem of "natural" action in opposition to "divine" action, is based, in Vico, on the complementary claim that "a thing is true insofar as it results from a doing." In the opposition between reason and faith, Vico's statement contradicts that of Comte according to which experimentation, that is, doing in the domain of rational knowledge, "is only appropriate for physics" (Comte, 1830–1842/1975, Vol. I). Taking his distance from scientism in general, Musil pursues a quest for "doing" that remains unfinished without contesting the application, at the "crossroads" of faith and probabilistic reasoning, of the "*experimentum cruces*" (see Bouveresse, 1993, 1998). Socioanalytic diapoesis can be profitably understood in this context.

Socoianalysis as a Reference for Clinical Intervention

Intervention in situ in Complex Social Systems

Our interventions originate in the socioanalytic model and the use of the socioanalytic rule. These interventions are designed for institutional requesters who wish to address a particular aspect of their activities either within their own institution or in association with other institutions with which they have interdependent activities, whether complementary or related. The specific nature of each case determines the most suitable form of intervention for attaining the aim of analysis. The purpose of intervention in situ is to contribute to the improvement of the capacities of regulation and self-observation and, as a consequence, the strategic capacity of the system concerned (Van Bockstaele, et al., 2000).

The social sciences have always been knit into a political context via their institutionalization and financing, as well as the use made of them. What interests the social scientist also interests the decision maker, who is, in return, the possible object of the sociologist's study (Van Bockstaele, et al., 1994).

When actors within an organization or complex system decide to seriously question the value and effectiveness of a given project, several possibilities are open to them. They can seek the opinions of all those involved in the project, either by opening up a debate during meetings or by individually approaching the interested parties within the hierarchy. They can call in a supposedly qualified external observer to assess certain aspects of the project, whether well-defined or not, and ask for possible solutions to problems that have been identified. Any appeal to external observation for the purpose of investigation involves the risk of dispossessing the actors, either partially or almost completely, of their powers of diagnosis and initiative. External observers are often used in a way contrary to their aims. They can find themselves bearing the responsibility for internal decisions that can only be assumed by those actually in charge. That is why our work has been founded on the development of tools of intervention that have to meet, above all, an important technical constraint of clinical intervention: the satisfactory integration of the processes of diagnosis, change, and evaluation.

In socioanalytical intervention, the negotiation between request and supply develops around three poles:

1. The mutual commitment objectified by practical decisions concerning the length of the contract, the fees, and the scheduling of the sessions.
2. Coherence between the conditions of the analytical role and the contractual obligations must be ensured. The contractual obligations can only be obligations of means and diligence, and in no case obligations of results.
3. Technical means are set up: a process of open investigation, produced through verbal exchanges on the object of investigation and by means of appropriate compositions of the groups, in and between which the exchanges take place.

The rules of the investigation are the following: the parity of opinion; the anonymity of any comments and remarks brought up for discussion; and the exclusion of any decisions except those relating to the advancement of the analysis. These rules must be set out prior to the investigation. Some internal evaluation criteria for the analysis also have to be determined: a criterion for ensuring exhaustive exchanges in the particular field of investigation; a criterion for recognizing different points of view; and a criterion for involving other categories of agents or relevant members.

A sample, sufficiently large, significant, and variable over time, of the members of the entity (or group of related entities) and its constituent categories is selected, while the requesters have to identify the categories concerned and take on the responsibility for bringing together chosen members of each category, that is, a stable intermediary, acting as an interface between the political will of the entity (or entities) and the need to regulate the work. A team of analysts, external to the entity (or entities) is present, designing the most appropriate form of intervention, providing continued professional assistance in implementing the program of analysis, and offering an interpretation of the material produced and of the factors and obstacles limiting it.

These elements together are designed to create an open entity (or group of related entities) with all attributes of autonomy. This entity (or group) handles its frontiers and, by drawing upon its background and memory, develops its experience through its activities and exchanges. By construction, the habitual modes of recognition, management, and protection of autonomy are here reproduced. The flow of transmissions that develops gives rise to specific material: new ideas open the way to discussion, challenge positions, and enrich argumentation.[6]

An Approach to a Situation Involving Strong Relations Between Categories

The relationship between government agents and their industrial counterparts has been the object of a clinical intervention that began in 1970 and is still in progress. This intervention was initiated at the request of some agents to reflect on their action and that of their administrations in order to change the type of relations with their counterparts. We suggested adjusting our technical apparatus. We had to define how to ensure durable participation of both civil servants and their industrial counterparts in a given field. This approach was later called "multicategorical."

Our first concern was to specify the bearer of the request: a group of civil servants able to change their usual ways of acting and relating, able to deal with non-government agents on an equal basis for extended periods of time. This group was called *groupe Méthodes*. Over the years, nongovernment agents showed their

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[6] The detailed description of our technical apparatus "Action-Simulation, Cognition" (ASC) can be found in the fourth edition of *The Clinical Sociology Resource Book* (Van Bockstaele, et al., 1996a).

determination to participate in the action. Such an intercategorical relation has allowed a double collective subject to arise via a joint request and given birth to increasing multicategorical debates among civil servants, members of different branches of industry, environmental protection agencies, and elected local representatives.

At first, our investigation was restricted to a field that until then was seen as relatively marginal, a plan for the development of small or medium-size businesses. Then our work expanded into new fields: security, safety, environment, and risk in heavy industry (1980); regional development, local development, and transnational issues (1985); bank and finance (1990); pensions (1994); paid shareholders (2002); and aging of the population (2004).

Government generates power relations, especially manifest when its action is carried out by means of regulations, inspections and penalties, as is the case in some of the domains we have explored. An analytical approach requires a technical device for capturing power relationships without concealing or agitating relations of domination and subservience. Practically this requires elaborating a set of articulated tasks, based on a set of explicit rules.

In any given field, a "test program" is initiated jointly by the requesters. The authorities concerned are informed, and must have agreed to engage the process. The object of the program is to carry out a multicategorical action research on the government and its action. Three rules direct the whole process:

1. Parity between persons and categories: authority cannot be invoked as an argument
2. Relativity: there is no unique solution to a problem nor a single valid method
3. Historicity: time is an operator of change through transmission and evaluation

The technical apparatus rests on the hypothesis that representations, images, and connections deriving from action and specifying it, are reproducible (transferable) under appropriate conditions. A clinical intervention involving the government is characterized by the fact that this administration is the object of a mental representation, inside any other system. Indeed, some of the regulations defining and constraining those social systems are set, modified, and checked by the central administration. This structural property makes exploring the mental representations explicitly or implicitly involving the central administration, a paradigm for gaining access to the processes, which are usually not perceived, due to the presence of observers or power relations. They become perceptible to the different categories of actors.

This simulation springs from a situation symbolically circumscribed by the specific social system, its action, its connections, and its rules of parity, relativity, and historicity. These rules are often perceived as the opposite of what goes on in organizations as they imply: no definite exercise of power, no decision or conclusion, no stated agenda, and no pressure from deadlines or prescribed goals. This inversion elicits results unexpected by the participants: the situation is protected, exchanges are more open, the choice of topics is free, and it is possible to co-opt categories with which debate seldom occurs.

Conclusion

Previous work in the laboratory has taught us that only a deliberately constructed situation would allow us to delimit an object accessible to the researcher. As we adopted the clinical route, we remained faithful to the orientation of experimental research, the basic reference for "active" observation. This conviction has guided the technical approach to the problem of social functioning that gave birth to the socioanalytic task and to our tools for clinical intervention. Practice of intervention cannot be separated from research on that practice, its technical tools, and its underlying concept.

References

Bouveresse, J. (1993). L'homme probable. Robert Musil, le Hasard, la Moyenne et l'Eescargot de l'Histoire [The Probable Man: Robert Musil, Chance, Average and the Snail of History]. Paris: Editions de l'Eclat.

Bouveresse, J. (1998). Le Philosophe et le Reel [The Philosopher and Reality]. Paris: Hachette.

Comte, A. (1830–1842). Cours de Philosophie Positive [The Positive Philosophy of Auguste Comte (freely translated and condensed by Harriet Martineau)]. M. Serres, F. Dagognet, & A. Sinaceur (eds.). Paris: Hermann, 1975.

Comte, A. (1851–1854). Système de Politique Positive ou Traité de Sociologie, Instituant la Religion de l'Humanité [System of Positive Polity, 4 vols., London, 1985–1877]. In edition, "Conforme à l'Édition de 1851". Paris: Au Siège de la Société Positiviste, 1929.

Festinger, L., Back, K., Schachter, S., Kelley, H., and Thibaut, J. (1950). Theory and Experiment in Social Communication, Report of Studies Under Office of Naval Research Contract. Ann Arbor, MI: Research Center for Group Dynamics.

Lewin, K. (1938). Experiments on autocratic and democratic atmospheres. The Social Frontier, 4, 316–319.

Musil, R. (1930). Der Mann ohne Eigenschaften [The Man Without Qualities] (1st ed.), (S. Wilkins, trans., and B. Pike, ed.). New York: Knopf, 1995.

Orwell, G. (1949). 1984 (A. Amélie Audiberti, trans.). Paris: Gallimard, 1950.

Van Bockstaele, J., and Van Bockstaele, M. (1977). Preliminary note on socio-analysis (R. A. Carter, trans.) Bulletin de psychologie, 12, 6–9, 277–290. (Original work published 1959.)

Van Bockstaele, J., and Van Bockstaele, M. (2002). La patience expérimentale: de l'expérience des "groupes radio" à la socianalyse [On patience in experimentation: from the "group-radio experiment" to socioanalysis]. In: J. M. Donegani, S. Duchesne, and F. Haegel (eds.), Aux Frontières des Attitudes en Hommage à Guy Mélanges Michelat (pp. 241–260). Paris: Editions de l'Harmattan.

Van Bockstaele, J., and Van Bockstaele, M. (2004). La Socianalyse: Imaginer-Coopter [Socioanalysis: Imagining and Co-opting]. Paris: Edition Economica/Anthropos.

Van Bockstaele, J., Van Bockstaele, M., Barrot, C., and Magny, C. (1963). Some conditions on intervention of an analytic type in sociology (V. Lisacek, Trans.) L'Année Sociologique, 1993, 238–262.

Van Bockstaele, J., Van Bockstaele, M., Barrot, C., Malbos, J., and Schein, P. (1968). Nouvelles observations sur la définition de la socianalyse [New observations on the definition of socioanalysis]. L'Année Sociologique, XIX, 279–295.

Van Bockstaele, J., Van Bockstaele, M., and Godard-Plasman, M. (1994). Some remarks about the dyad observer-observed and the relationship of the observer to power. Clinical Sociological Review, 12, 1–16.

Van Bockstaele, M., Van Bockstaele, J., and Godard-Plasman, M. (2000). Observing action in situ (N. Mellott, trans., and C. van Dijkum, F. Geyer, and R. Lee, eds.). Electronic Journal of Sociocybernetics ISA-RC 51. http://www.unizar.es/sociocybernetics/Journal/dentro.html.

Van Bockstaele, J., Van Bockstaele, M., Schein, P., and Godard-Plasman, M. (1996a). A tool of analytic intervention: Action-simulation-cognition (ASC). In: J. M. Fritz (ed.). The Clinical Sociology Resource Book (pp. 231–240). Washington: ASA Teaching Resource Center.

Van Bockstaele, J., Van Bockstaele, M., Schein, P., and Godard-Plasman, M. (1996b). A crucial event in the development of the rules of socioanalysis: the printing shop intervention. Clinical Sociology Review, 14, 14–43.

Vico, G. (1710). De Nostri Temporis Studiorum Ratione [On the Study of Methods of Our Times], (E. Gianturco, trans.), with as an addendum, The Academies and the Relation Between Philosophy and Eloquence (1737), (D. P. Verene, trans.). Ithaca, NY: Cornell University Press, 1990.

Vico, G. (1744). Scienza Nuova Seconda [The New Science] (3d ed.). (T. Bergin and M.H. Fisch, trans.). Ithaca: Cornell University Press, 1948.

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Focus Groups in the Context of International Development: In Pursuit of the Millennium Development Goals

Janet Mancini Billson

> The central thought is that of a true science of society, capable, in the measure that it approaches completeness, of being turned to the profit of mankind… in its practical character of never losing sight of the end or purpose, nor of the possibilities of conscious effort. It is a reaction against the philosophy of despair that has come to dominate even the most enlightened scientific thought. It aims to point out a remedy for the general paralysis that is creeping over the world, and… it proclaims the efficacy of effort, provided it is guided by intelligence. [Ward, 1906]

The legacy of the twentieth century and the promise of the twenty-first century were on the minds of leaders, change agents, and ordinary people around the world as the new millennium approached. The most far-reaching aspirations—the Millennium Development Goals (MDGs)—were adopted in 2000 by all 189 member-states of the United Nations General Assembly, the International Monetary Fund (IMF), the Organization for Economic Cooperation and Development (OECD), and the World Bank (WB). The Millennium Declaration was designed to throw into relief the values of various organizations concerned with international development and to stimulate concerted action (United Nations, 2000). As the culmination of several major international meetings and summits, the adoption of the Millennium Declaration "was a defining moment for global cooperation in the 21st century" (United Nations, 2002).

Talking to People Systematically

When most of the world signed on to the MDGs, it became more apparent than ever that international development agencies would need to talk to intended beneficiaries about the intended consequences of aid and technical assistance. This has been a large part of our work at Group Dimensions International (GDI) since 1993, as it became clear that much international aid was not "reaching the ground," but rather was lining the pockets of emerging elites, and that the social dimension of development had not been fully recognized or integrated into projects (Cernea, 2004). Corruption, lack of transparency, and insufficient aid coordination surfaced as major stumbling blocks in achieving national development goals. Lack of understanding

about how culture and context affect development, inattention to the powerful forces of gender and ethnicity, and disregard for social impacts (as opposed to economic gains) characterized most development interventions (Billson and Mancini, 2007).

The MDGs were intended to help both countries and donors/lenders focus not simply on the amount of aid ("disbursements") but also on outcomes. For example, has poverty been reduced? Are school completion rates for girls catching up to those for boys? Has infant mortality been mitigated? Has maternal health improved? While these and other indicators are certainly susceptible to (and best measured by) statistical means, the *how* and *why* of progress toward goal achievement lends itself admirably to focus group and key informant interviews. Talking to people, rather than simply measuring dollars or kilowatts, has steadily gained currency in development evaluation.

Focus group research was developed in the post–World War II period by sociologists Paul Lazarsfeld (who used the term *focus interview*) and Robert K. Merton (who coined the term *focused group interview*). Merton and Patricia L. Kendall wrote about the method in a 1946 article that was later expanded upon by Merton, Gollin, and Kendall (1956). The methodology was almost immediately submerged by the discipline's intense efforts to prove itself a "hard science" through increasingly sophisticated survey and statistical work, but the market research community rediscovered it during the 1960s. Since the 1980s, focus groups, as part of the resurgence of qualitative methods, have gradually become a respected tool that reflects the practice orientation and more qualitative nature of early twentieth-century sociology.

Focus groups can be defined as structured, guided discussions that have as their sole purpose the gathering of data for scientific purposes (Merton et al., 1956). Their success depends on a well-trained moderator who facilitates the discussion through guided interaction so that ideas generated by the group can be pursued. The moderator draws out motivations, feelings, and values behind verbalizations through skillful probing and restating responses but, just as importantly, participants stimulate each other through "discussion, debate, dialogue, and disagreement"(Billson, 2007b) that cannot occur in individual interviews or on questionnaires.

Why focus groups? Of all social science methods, focus group discussions excel in engaging the participation of those who are the intended beneficiaries of various programs and projects. In an era of increasing attention to participatory research and involvement of local stakeholders in program design, implementation, and evaluation, focus groups stand out as a logical vehicle for structured, systematic discussion. Focus groups enable researchers to develop a picture of how things work and then to take that analysis to ensuing focus groups in order to verify, expand, and possibly revise assumptions (Billson, 1991). For example, Mosavel et al. (2005) used a series of focus groups with black South Africans in Cape Town to explore the (perceived) need for cervical cancer screening. By using focus groups and individual interviews to engage community stakeholders in interpretive analysis, the team "developed a research framework that incorporated the community's concerns and priorities, and stressed the intersecting roles of poverty, violence, and other cultural forces in shaping community members' health and wellbeing." The interviews led the researchers

to refocus away from "cervical cancer" screening toward "cervical health" screening, which was a concept that the community related to more immediately as having a direct impact on women's lives.

Using focus groups for early-point and midpoint monitoring can uncover problems before they sabotage the intervention. Asking about lessons learned and best practices at the end-point evaluation can help to shape more effective programs for future implementation. The key point methodologically is that group interaction generates insights through the cross-fertilization of ideas, affording depth and insight into the research question and helping contextualize quantitative data (Krueger and Casey, 2000; Puchta and Potter, 2004; Billson, 2006b, 2007b). Like any other method, focus groups have limitations, especially when researchers or moderators lack training and experience in the approach or the recruitment lacks rigor, but their power as generators of complex analyses is difficult to match.

Focus Groups in the International Context

Qualitative approaches to understanding differences in behavior, attitudes, and values among various cultural groups within a country's borders and between countries are now used (and respected) virtually worldwide (Billson, 2007c). Focus groups are especially popular in education and health, but are also used as a vehicle for participatory research, rapid appraisals, monitoring, evaluation, and case or comparative studies in sectors such as water and sanitation, urban development, human development, private sector development, agriculture, and environment. Focus groups also have become popular in accessing critical data for crosscutting issues such as food security and gender.

One impetus for the recent interest (and confidence) in focus group research stems from the insistence by local beneficiaries that quantitative methods cannot adequately capture their lives or the true situation "on the ground" when it comes to needs or to the performance of development projects. International development organizations are discovering the limitations of quantitative methods for studying vulnerable populations (such as the poor and the elderly) or for evaluating programs intended to reach such populations. Increasingly, focus groups have become institutionalized, especially by international development organizations. For example:

- The World Health Organization and many other U.N. and international entities have established international standards for conducting focus groups (Hawthorne et al., 2006).
- The World Bank has commissioned its own "guidelines" for conducting focus groups (Billson, 2006b), which were disseminated to one thousand resident missions worldwide.
- Organizations, such as the Wilder Foundation, have developed their own focus group and community meeting guidelines (Hoskins and Lucas, 2003).
- One of the most influential studies of the late twentieth century, *Voices of the Poor: Crying Out for Change*, utilized focus group methodology (Narayan et al.,

2000; World Bank Group 2000/01). This study asked poor women and men in twenty countries, "How do you define well-being or a good quality of life, and ill-being or a bad quality of life?" (Billson and Fluehr-Lobban, 2005).

Furthermore, focus groups have matured to the point that some researchers are integrating unique strategies into the traditional focus group context (eight to ten participants sitting around a table and responding to a set guide for about two hours). For example, Barata et al. (2006), asked Portuguese and Caribbean Canadians about their attitudes toward participating in research. Then, they role-played a fictional recruitment and informed-consent agreement process with respondents in the focus group, which revealed very different reactions when the two cultural groups were compared.

Atkinson et al. (2006) used Internet focus groups (IFGs) to explore patient-reported outcome measures (PROs) in both Germany and the United States, and then used thematic coding methodology to develop culturally sensitive question-naire content using the natural language of participants. Then they asked participants to return for an evaluation of the PRO (survey-type) questions. According to the researchers, "Overall, the IFG responses and thematic analyses provided a thorough evaluation of similarities and differences in cross-cultural themes, which in turn acted as a sound base for the development of new PRO questionnaires."

Hermalin (2003) conducted focus groups in four Asian countries to explore the well-being of aging citizens. Everywhere, focus groups are held under trees, in community halls, in government conference rooms, or in homes—wherever benefi-ciaries and other stakeholders can reasonably be expected to gather for a structured group interview.

Using Focus Groups to Advance Well-Being

Group Dimensions International is dedicated to building capacity for group effective-ness through research, training, organizational development, and facilitation with the goal of achieving positive social change. Our work in international development has involved clients such as the World Bank Group, the United Nations, the Foundation for Advanced Studies on International Development (FASID—Japan), and the European Commission. Our purpose is to assist communities and organizations in becoming more effective internally and externally; to foster organizational insight; and to help organizations shape their programs, policies, and products through knowledge and expert application of social science concepts, theories, and methodol-ogies. This entails guiding organizations and communities in better understanding the needs of their constituencies, evaluating their work, and envisioning their futures. Always, the overarching goal is to advance well-being among individuals, organiza-tions, communities, and societies.

We take "development" to imply movement toward well-being for those who are affected by projects; this means that evaluation must go beyond financial auditing

and expenditure reporting to focusing on actual impacts on the intended beneficiaries. Our mission is in keeping with the underlying values of the MDGs—to achieve poverty reduction and improve well-being. In that sense, we take our research to be practice. Our work contributes to uncovering the complexities of development effectiveness, to the extent that it is possible, in order that future projects will be more likely to succeed (Billson and Fluehr-Lobban, 2005).

In keeping with this mission and in concert with sophisticated quantitative methods (Bamberger, 2000), our corporate strategy is to advance the use of qualitative methodologies, especially individual and focus group interviews, as legitimate, powerful, and systematic research tools. Group process theory undergirds our facilitation, organizational analysis, and strategic planning functions. Thus, we employ focus groups in evaluation research, needs assessments, and strategic planning. We often harness the rich data from focus groups to data generated by key informant interviews, surveys, secondary analysis of census or other statistical data, and direct observation. Our work typically lays the foundation for client decisions regarding program development, policy analysis, organizational improvement, enhanced insight into challenges and contexts, and, ultimately, positive social change. Examples of our work are provided in the sections that follow. To protect client confidentiality, specific challenges in conducting focus groups could only be discussed in a general way.

Needs Assessment, Strategic Planning, and Program Development

Needs assessments help shape a project or program directly and responsively to the expressed concerns of a target population. They precede project implementation and monitoring and evaluation (M&E), but may uncover indicators that should be incorporated into the M&E processes. For example, in 2006, GDI conducted focus groups on tourism development with private and public sector respondents in Savannakhet Province, Laos (Billson, 2006a). Abbott et al. (2002), used focus groups to design communication campaigns for a forestry project in Russia.

Strategic planning also involves the process of assessing the needs of stakeholders (usually in an organization, community, or government agency) in relation to their stated goals and detailed outcomes for the future. Strategic planning may involve a situation analysis before the session (generated by key informant interviews, desk review of annual reports and other materials, and a survey of stakeholder satisfaction with the current situation and preferences for future directions). Strategic planning sessions can result in concrete ideas for program development and the decision to do a formal needs assessment with those who are slated to implement the plans. For example, GDI's work with the Canada–United States Fulbright Program involved a needs assessment for training and professional development that included a survey of all fifty Fulbright directors worldwide, development of the training agenda for their annual retreat, evaluation of the retreat, and generation of ideas for future program structure and directions (Billson and London, 1999a,b).

Monitoring and Evaluation

The OECD defines monitoring and evaluation as follows: *Monitoring* is a continuous function that uses the systematic collection of data on specified indicators to provide management and the main stakeholders of an ongoing development intervention with indications of the extent of progress and achievement of objectives and progress in the use of allocated funds. *Evaluation* is the systematic and objective assessment of an ongoing or completed project, program, or policy, its design, implementation, and results. The aim is to determine the relevance and fulfillment of objectives, development efficiency, effectiveness, impact, and sustainability. An evaluation should provide useful and credible information that enables the incorporation of lessons learned into the decision-making process of both recipients and donors (Kusek and Rist, 2001).

Group Dimensions International has carried out three major studies of the M&E processes, which are critical in determining to what extent development programs are in fact achieving their intended outcomes. These discussions took place within the context of the growing stress on results-based management (RBM), an emphasis that has become even stronger in the quest for achievement of the MDGs. Results-based management has to do with how governments and other development entities achieve or fail to achieve results. Focus groups provide an excellent way to explore this question with both stakeholders and beneficiaries, although triangulation of methods or differential use of methods is indicated according to stakeholder needs for information, the complexity of collecting data, political sensitivity regarding the collection of data, and intended uses of the information (Kusek and Rist, 2001 [p. 17], 2004; Kusek et al., 2004; Lefevre et al., 2004).

Results-based management depends on an efficient feedback loop that sends M&E information into stakeholder communication streams so that reform, transparency, and programmatic changes can be engineered. This process usually involves capacity-building on the part of those who are managing change and may involve participation of intended beneficiaries in helping to determine how effective interventions are and what could make them more effective in the future. Focus groups can be useful during the monitoring process to ensure that mechanisms for accountability are in place (and in use) and to gauge beneficiary satisfaction and impacts. They are not used just during formal evaluation, which usually occurs toward the end of a project or program, or even years after its completion.

For example, GDI conducted one of the earliest stakeholder evaluations of the World Bank's evaluation methods and practices (Billson, 1996a). The purpose was to elicit perceptions of the image, mandate, performance, processes, and products of the World Bank's Operations Evaluation Department (OED), and to generate ideas for OED's future work in enhancing development effectiveness. Six groups were conducted at bank headquarters with operations division chiefs, managers from central vice-presidencies, operations directors, and task managers. Six groups were held in three borrower countries—Colombia, Zimbabwe, and Indonesia—with government ministries, national planning departments, nongovernmental organizations (NGOs),

and Bank resident mission staff. Respondents suggested the use of more participatory methodologies, heavier reliance on community-based qualitative data-gathering techniques, broader dissemination of findings, and mechanisms for introducing results in a timely fashion so as to impact future projects.

With international development agency board members, executives, and task team leaders, we have conducted focus groups on issues such as resettlement policy implementation, the World Bank's evaluation methods and practices, attitudes toward monitoring and evaluation, and the impacts of Bank lending. One study (Billson, 2004) involved focus groups and key informant interviews with World Bank task team leaders, sector managers, and division chiefs. The purpose was to explore views of the bank's M&E performance, barriers to conducting effective M&E, and the extent to which M&E furthers development effectiveness and results.

A later GDI study (Billson and Steinmeyer, 2006) focused on the perceptions of staff and management regarding the bank's M&E system; how staff and management view the use and usefulness of the Bank's internal Independent Evaluation Group (IEG; formerly OED) evaluation results, products, and information; and the challenges staff and management encounter as they attempt to incorporate monitoring information and evaluation results into design of future development projects. Focus groups and executive interviews were conducted with the World Bank task team leaders, sector managers, country directors and coordinators, board members who serve on the Committee on Development Effectiveness, and IEG staff. This study contributed to IEG's *2006 Annual Review on Operations Evaluation* (2006). The study focused on the use and usefulness of monitoring information and evaluation reports; the application of M&E information to manage for results; challenges, incentives, and disincentives in using monitoring information and evaluation results; and the possible disconnects between perceptions of those who use M&E information and those who produce it.

Program Evaluation and Impact Assessment

The capstones of M&E are program evaluations and impact assessments (Baker, 2000). Both require careful research design (best prepared in advance of program implementation) and often involve comparison groups. In development, however, the availability of comparison groups may be ethically or logistically impossible to arrange. For example, if the Asian Development Bank determines the need for a power dam in two provinces of the Philippines, it cannot decide to build a dam only in one province, but not in the other, simply to measure comparative impacts.

A second challenge in conducting program evaluations or impact assessments lies in identifying indicators—before a project begins—that are measurable and trackable by local or national authorities through the end of the project. Statistical records (e.g., of funds dispersed, number of kilowatt hours generated, or number of people served by a new dam) also may not provide a meaningful picture of the project's true impacts or relative success. Issues of displacement, resettlement

because of flooding lands along the river, or insufficient infrastructure to transmit power to those who need it most could confound a project's positive impacts.

Group Dimensions International has used qualitative methods to carry out many program evaluations, both domestic and international. In 2007, GDI led a thematic evaluation of Emergency School Feeding Programs (ESF) sponsored by the U.N.'s World Food Program (WFP) (Steinmeyer, 2007). The evaluation used group interviews and key informant interviews in Pakistan, Sudan, and Congo (Steinmeyer, 2007). The purpose and objective of the evaluation was to draw lessons for future implementation of ESF in the various emergency contexts in which the WFP operates; to identify aspects of ESF on which further guidance is needed; to inform the preparation of the WFP's policy paper on food for education; and to refine the 2004 Guidelines for School Feeding in an Emergency Situation.

The perceptions from the field of current WFP practices with regard to emergency situations and protracted relief and recovery operations led to exploration of four general aspects of ESF operations: (1) the *relevance* of objectives generally associated with ESF operations in the various emergency and operational contexts of WFP projects; (2) the *efficiency* and *effectiveness* of ESF operations for contributing to these objectives; (3) the *constraints and opportunities of managing* ESF operations in the different emergency and operational contexts, and how these influence project *performance*; and (4) the factors influencing the *sustainability* of ESF benefits in the various contexts encountered by WFP. These evaluation elements—relevance, efficiency, effectiveness, constraints and opportunities, performance, and sustainability—can be used in any program evaluation.

Impact assessments present even greater challenges when the period under examination covers many years and a multiplicity of interventions has occurred. In this case, statistical analyses are limited; gathering the perceptions of those who have closely watched the passing of history may be more fruitful in exploring impacts. For instance, in 1996, when the World Bank performed a public expenditure tracking study of funds earmarked for schools in Uganda, it was determined that less than 30 percent of the money was making it down to the local level. The majority was being siphoned off by administrative costs at the central government level or into the pockets of the elite (ESSDN, 2003). This raised general questions about the impacts of donor lending and the extent of (and need for) aid coordination among donors. It was in this context that GDI was asked to conduct seven focus groups in Kampala, Uganda's capital, to help determine the impacts of donor lending since the fall of Idi Amin in 1979. The report (Billson, 1999) became part of the World Bank's participatory evaluation for the Uganda Country Assistance Review.

Over seventy stakeholders from the Government of Uganda, donors, parliament, NGOs, civil society, media, and the private sector participated. Participants were asked to discuss both successes and shortfalls in country and donor performance, as well as "lessons learned" that might improve future performance. Respondents deplored the fact that only a small portion of aid funds was making it to the intended populations; they stressed the importance of "plugging the holes" in the system and empowering civil society to ensure better implementation of projects.

They were positive that decentralization would lead to greater accountability and better project implementation at the local level, but agreed that capacity building at the district level is also crucial. Agricultural modernization and land reform, capacity building in the government and media, and better research facilities and more current statistical/census data were identified as key building blocks for future development.

Policy Analysis

Group Dimensions International has employed focus groups to explore policy issues and policy implementation. For instance, as part of the move from development as a "bricks and mortar" exercise toward the broader goal of improving lives through poverty reduction, GDI was asked to conduct focus groups with task managers (now called task team leaders) and economists at the World Bank (Billson, 1996b). Respondents were invited to define social development—in the sense of social integration, poverty reduction, social justice, human resource development, political stability, and beneficiary participation—and relate it to the concept of development in general.

The World Bank respondents reported that "social development" tends to merge with images of social sector work to create an amorphous picture that is hard to separate from "economic development." Many respondents believed that, for the most part, good economic development (and analysis) produces (and therefore subsumes) good social development (and analysis). Social sector work and the broader category of social development "go beyond individual human resource development and sustainability" to include stakeholder participation and a notion of growth. Furthermore, respondents said they were unsure of how to find sociologists or anthropologists to contract regarding work on social development issues.

Along these lines, GDI's focus group study of task managers revealed that when the World Bank's policy regarding involuntary resettlement (designed by sociologist Michael Cernea) was not consistently implemented, it was because of lack of knowledge of *how* to manage the social dimension in development work rather than out-of-hand rejection of the resettlement policy itself (Billson, 1993). Another focus group study showed that task managers were unclear about how to engage sociologists and anthropologists effectively in studying girls' education in Asian and African countries (Billson, 1995b).

These and other studies led to intensified efforts to integrate the social dimension into Bank projects, policies, and processes through a variety of internal mechanisms incorporated into the project cycle (including identification, preparation, appraisal, and supervision). As Cernea (2004) argued,

> At each and every "stage" in the Bank's project cycle, there is a different set of socio-cultural variables and issues that must be addressed, there are values, attitudes, and expectations to be known and taken into account. … A good *social* specialist would have specific, and distinct, functional tasks to perform.

Enhancing the social dimension of development is an ongoing policy initiative in the World Bank and remains at the core of GDI's work.

Conference, Workshop, and Product Evaluation

Merton's original conceptualization of focus group discussions was to garner impressions from respondents who were exposed to a common stimulus, such as a radio show. This is still an excellent use of focus groups—evaluating conferences, workshops, or products to which a group (or category) of respondents has been exposed. Billson and Steinmeyer (2005) evaluated the flagship publication of the United Nations Economic and Social Commission for Asia and the Pacific (UNESCAP), based in Bangkok, Thailand (the largest of the five U.N. Commissions). UNESCAP's annual *Economic and Social Survey of Asia and the Pacific* had been produced for fifty years without a formal evaluation. Focus groups were held with UNESCAP staff and managers, and individual interviews were held via telephone throughout the ESCAP region with readers in think tanks, universities, governments, and corporations.

In the middle of the Asian Economic Crisis of 1997, the Asian Development Bank and the World Bank sponsored a week-long Asian Development Forum in Manila. Group Dimensions International used on-site focus groups with a random sample of participants from the region, along with post-session surveys, to evaluate the conference (Billson and London, 1997a). Similarly, we used focus groups in evaluating the World Bank's Global Knowledge Conference in Toronto (Billson and London, 1997b), and the WB/Foundation for Advanced Studies on International Development program, "Development Effectiveness: The Environment and Urban Development," which was held in Malaysia and Japan (Billson, 1997). Evaluating conferences and workshops involves perceptions of content and organization, but also of how people learn best in this type of setting.

Challenges to the Integrity of Focus Group Research

Most cultures engage naturally in small group discussions within families, neighborhoods, and political entities. This renders focus groups especially appropriate as a methodology for exploring development issues. For instance, in Laos, focus group participants said they enjoyed the interview and found it a comfortable format because they participate in "morning chitchats" (a tradition among men but increasing among Laotian women as well).

Strong recruitment and moderation for balanced participation are essential. Careful planning and preparation help minimize misinterpretation and maximize participation, but caution must be employed at every step of the way. Challenges to conducting professional, systematic focus groups include the following:

Communication

Because of the liabilities of communicating across great distances during the preparation stage, errors in communication are likely when organizing focus groups in the international context.

- Communication surrounding recruitment and logistics can be clumsy and inaccurate.
- Email is the preferred way to communicate and leaves a "trail," but it is also an informal mechanism that is subject to technological glitches and misunderstandings.

Recruitment—Obtaining Balanced Stakeholder Viewpoints

Validity of the data depends on acquiring a reasonable distribution of all stakeholders in the focus groups to avoid biasing results.

- Recruitment in small or rural communities raises questions of duplication of results (by inadvertently recruiting inside kinship or friendship groups) or of politicizing the process. Although it is desirable to involve local residents and train them in neutral recruitment techniques (a step toward participatory research), close supervision is necessary to help recruiters resist pressure from local networks.
- Focus groups in the international development context often involve government agencies and other large bureaucracies as key stakeholders. It is possible for mega-organizations to overshadow the viewpoints of other stakeholders. Governments may for convenience overrecruit government personnel versus NGO respondents. Separation of these stakeholders into separate groups helps to avoid this problem.
- Inadvertent politicization of the research can occur when prestigious governmental officials are invited to a focus group, rather than those who are specifically knowledgeable about the topic. Holding separate focus groups with beneficiaries, NGOs, and other public groups will help balance government viewpoints.
- Stakeholders and intended beneficiaries, like citizens of developing countries whose taxes probably support international development funds, may be unaware of projects, hostile toward them, or supportive of them (Department for International Development, 2002). It is essential to select those who are aware of the development intervention and are in a position to evaluate it.

Moderation

Strong moderation involves balancing participation and staying on the client's key research question.

- Especially in politically charged situations, it may be difficult to keep the group focused on the topic at hand rather than allowing the interviews to devolve into gripe sessions. Dominators may overtake a focus group if the moderator does not exert appropriate control and employ special moderation techniques.
- Retaining respondents for the full time allotted (generally two hours) may be hard when the temptations of email and telephone messages—or of other meetings—are only a few steps away. This is especially true for members of bureaucratic organizations.
- Inconsistencies in moderation occur because of the need for multiple moderators (in large studies) or the lack of moderator training, which can confound the data and data analysis. It is important that all moderators on a research project be retrained to the current guide, population, and research question (Billson, 2007a).
- Weak moderator guides with poor questions that fail to generate interaction may result in thin, off-target data. Clients often want focus group researchers to employ survey-type questions, which is inappropriate and must be addressed up front.

Cultural Issues

Cultural sensitivities must be anticipated and addressed in doing international focus group research (Billson, 1991, 2003, 2006b, 2007a, 2007b, 2007d, 2007e; Knodel, 1995). Participants bring varying expectations and habits regarding small group interaction. Ground rules and procedures must be established at the outset, while taking into account what will work better in one culture versus another.

- In some cultures, the concern for harmony and aversion to criticism strongly affect group discussions. Moderators must be certain in the "preamble" to reassure participants that it is not only acceptable but also essential for them to give their most honest opinions and ideas—even if others might disagree with them. We find that taking extra care to create a safe environment in which genuine disagreement can be expressed helps reduce the press toward harmony and agreement.
- The research design must compensate for difficulties that surround conducting focus groups in cultures in which critical or negative remarks are considered impolite. Stratifying the groups by gender, socioeconomic status, role in the community, and place of residence may help participants speak more honestly. It is preferable to compose the groups of nonacquaintances who use fictitious names, and to reassure participants that their names will not be used in reports, publications, or discussions with local authorities.
- In some cultures, making direct eye contact with participants might be considered rude. We acknowledge this cultural difference and stress the need for eye contact as a part of skilled moderation.
- Language barriers and interpretation difficulties always occur in cross-cultural interviews, and raise special problems in focus groups. We find that whenever researchers work outside their linguistic/cultural communities, meaning is lost

and confusion occurs over the exact intention of the research and the questions. Technical support with professional translation of the guide (in advance) and interpretation (during the interview) is essential. Interpreters should not simply be someone local who is interested in the project and speaks the relevant languages; training is essential (Maynard-Tucker, 2000). As with moderators, interpreters can bias responses; they should be apprised of the project's purpose, the critical role of neutral interpretation, the nature of the participants, and the logistics. The moderator should anticipate spending at least two hours reviewing the moderator's guide with the interpreter well before the first group. An appropriate interpreter must have full command of both languages, be able to interpret simultaneously or quickly—the "one-second rule"—and be able to concentrate and stay in role (Billson, 2007a). The moderator should not also be the interpreter, because the moderator needs to pay close attention to group process, as well as to content.

Each of these challenges must be met head on before the sessions (in the case of recruitment and politicization issues) or during the session (in case of facilitation and retention issues) if the research is to be conducted systematically.

Strategies for Conducting Focus Groups in a Comparative Mode

Questions of comparability of data arise when focus groups are conducted in several cultures (or communities) for the same project. For instance, a study of female urban micro-enterprise owners in four countries should yield a clear picture of these women in each country, but should also afford a comparative view across countries. This requires a *structural approach* to conducting the research that involves (1) developing solid case studies based on the data for each country, and (2) systematically comparing data across all project countries (Table 13.1).

The Group Blueprint

If you place the key variables on a grid, you create a group blueprint that helps you visualize the ways in which major variables interact with each other (Billson, 2007b). Group blueprints not only help determine the number of groups, but also help shape the direction of the research. Especially when it is necessary to curtail the number of focus groups, a blueprint helps you decide rationally rather than randomly which groups to eliminate (Table 13.2).

Sagasti (2004) had a professional market firm conduct focus groups in Peru. The focus groups were stratified by socioeconomic status and gender. Other variables (which would have yielded more focus groups) could have been urban vs. rural

Table 13.1 Nine critical strategies for comparative cross-cultural research

1. Craft a *common, required* research design and "group blueprint" (segmentation of the population according to key variables).
2. Set aside ample time for careful preparation for the focus groups (including recruitment strategies and mechanisms, incentives for participation, and determination of who will make the best recruiters).
3. Thoroughly train recruiters and recruit without biasing samples.
4. Develop a uniform moderator's guide with a preamble that reiterates the research purpose and ethical concerns (such as anonymity, use of the data, who will receive the report).
5. Thoroughly train moderators and interpreters (professionals trained in policy research interviews rather than in market research are preferable in development venues).
6. Organize close, on-site supervision of the entire research process. (This is especially crucial for ensuring comparability when working across communities, cultures, or countries.)
7. Create and follow a common structure for data analysis (e.g., global coding, interrater reliability mechanisms, and developing agreement on emergent themes).
8. Create and agree upon a common structure for report presentation (including headings, subheadings, and use of direct quotes).
9. Follow basic strategies for conducting ethical qualitative research.

Adapted from Billson (2007a).

Table 13.2 Group blueprint for Peru: two key variables

	Income	
Gender	Low income	Low-to-medium income
Male	Group 1	Group 3
Female	Group 2	Group 4

residence, education level, age band, occupational type, or participation in or beneficiary of a particular program.

Limited funding, time, and the burden of managing enormous amounts of qualitative data discourage conducting a large number of focus groups. Most projects can generate sufficient data by holding from four to twenty focus groups, although many larger projects exist. A solid research design makes sure that respondents reflect the profile of the population from which they are drawn. Weak design inevitably results in poor research and possibly unusable results; strong design supports the generation of valid, reliable, and useful data.

The Moderator's Guide (Protocol)

Designing focus group questions is as much an art as a science. The moderator's guide should always be developed in collaboration with the clients (and beneficiaries, stakeholders, and key informants) and then piloted *in each community/culture/country* with respondents who are essentially similar to intended respondents. Several iterations of the moderator's guide will occur, especially when concepts must be translated from one language into another. Working

closely (even electronically) helps eliminate misunderstandings. Developing a uniform moderator's guide provides *project integrity*; ensuring that the guide is identical across countries (or regions/districts within the same country) provides *data consistency* (Billson, 2007a). In spite of these efforts, implementation of the guide *identically* in multiple settings and often with multiple moderators remains a challenge (Hawthorne et al., 2006). The highest standards of supervision, guidance, and auditing are essential if data are to be compared with rigor.

Framing the Questions Across Cultures

The moderator's guide for a cross-cultural study should contain the same core questions for all groups and all countries, but tailor-made questions for each culture can be placed in add-on modules.

- Core questions can include "identical" (no wording differences) and "parallel" questions (that tap the same material but with slightly different terminology). Example: In Bangladesh, women might refer to contraception as "birth control," and in Thailand women might use the term *contraceptives*. As long as the wording is identical except for these interchangeable terms that have to do with local usage, it is a parallel question.
- Tailor-made questions address specific issues and should not constitute more than about 10 to 15 percent of the entire guide, if the project goal is to make meaningful comparisons across cultures. Example: A tailor-made question might address unique programs or events: "The Ministry of Health conducted an education campaign in your district regarding contraception. How did women react to that?"

Certain concepts might not easily be translatable into some languages. For example, we found that Canadian Inuit women did not relate to a question about "problems"—a word that does not appear in Inuktitut, their language (Billson and Mancini, 2007). Comparable terms must be negotiated during the process of developing the moderator's guide—not during the focus groups.

Coordinating Logistics

The opportunity for true comparative research also presents multiple opportunities for failure of the data-collection process. If focus groups are held with women in very informal, freewheeling settings in one country, with husbands and children wandering in and out of the room, but in a very formal setting in another country, without interference, the results may be quite different.

Similarly, if community leaders are allowed to observe the focus groups because the local logistics person cannot prevent them from entering the focus group setting, the data may look very different from data gathered in a more neutral setting. Close, on-site supervision of the process by one central coordinator will strengthen

consistency of processes and procedures across sites and serve as a sounding board for solving problems unique to each country.

If logistics and data collection processes are kept as uniform (and controlled) as possible, then comparative analysis is protected. Consequently, there is a particular need in cross-cultural focus group research for the following:

- Training of all logistics and support staff
- The assignment of one person in each country who is responsible for and present for all focus groups in that country; preferably, the person coordinates logistics and observes at least one focus group per moderator to ensure consistency of style and approach
- The presence of at least one representative from the project's central headquarters (or a consultant who oversees all country research activities); if this is not possible, then a videotape of at least one focus group from each set should be reviewed for consistency, along with a review of logistics
- Email reports on logistics and the progress of the research to be sent before, during, and after the focus group session

Even when researchers do not moderate the focus groups themselves, they can be intimately involved in the research process. As Sagasti (2004) writes about the Agenda Perú project, "We frequently stood behind a two-way mirror to observe the progress of the focus groups and spent a considerable time reading the detailed transcripts of each session." This increases the likelihood that the entire data-gathering process will be carried out in a consistent, systematic manner.

Recording the Data

Regardless of the method used to record a session, it must be accurate and thorough. Audio-taping sessions protects data that are needed for most social and policy-related research; note-taking is acceptable as the primary means of documenting the interview, to avoid the necessity of formal transcription, but the session also should be tape-recorded. Later, the note-taker should check notes against the tapes for accuracy. Group Dimensions International has experimented with a variety of systems; the results definitively suggest the value of having tapes. In our view, even though transcribing adds to project costs, tape-recording with formal transcripts provides the most accurate and reliable data. It also is essential in doing cross-cultural work because of translation issues.

The Importance of Training

The group interview offers a lens through which we can see a wide variety of experiences and opinions. This presents both advantages and disadvantages because moderators serve as the "instrument of research," which makes it is easy for their biases to

influence the data. All moderators must be trained particularly on the core questions that will be used across cultures—how and when to probe, how to restate the questions without changing them if respondents do not immediately contribute, and how to avoid biasing respondents by their own reactions to participant responses.

Group Dimensions International has trained community-based recruiters/moderators in many countries—for example in Canada, for studies of gender relations in seven cultural communities (Billson, 1993); in Laos, for a tourism project (2006); in Trinidad, for Ministry of Public Information and Administration studies; and in Bolivia, for the improvement of public education. Trainees can be extremely helpful in the design and recruitment stages, and, with supervision, can serve as effective moderators.

Conclusion

Focus groups constitute a universal methodology, but they must be reshaped for each cultural context without losing the depth of data associated with local, regional, and national sensitivities, their scientific nature, or the capacity for cross-cultural comparison.

By asking critical questions of all parties involved in attempting to create positive social change and improve well-being, sociologists help development practitioners avoid the fatal disconnect between theory and policy. Focus groups, as a type of in-depth interviewing, can provide invaluable insights into the complexities of development implementation and impacts.

Through *triangulation*, focus groups can amplify other methods to reinforce the advantages and strengths of each method while minimizing their disadvantages and weaknesses. For example, participant observation and key informant interviews could explore how people frame the key research questions; focus groups could generate debate and collaborative interpretation; a face-to-face survey of a larger sample of community members could broaden the base of understanding; and preliminary conclusions and hypotheses could be discussed in focus groups to contextualize data as part of a "progressive verification method" (Billson, 1991).

Focus groups harness our collective understanding of the complexities of human interaction and help uncover layers and types of information that are not easily accessed through other methods. Used properly, this maturing social science technique can produce rock-solid data regarding many different questions or settings.

Through many methods, but especially through focus group research because it is so well suited to exploring the worlds of interest and experience that exist in every society, sociologists make unique contributions. We work actively in shaping policy and programs that address the most pressing problems of this century by helping to evaluate the progress so far toward achievement of the MDGs and similar aspirations. Group interviews, which were developed by sociologists in the last century, have grown in both popularity and misuse. The challenge of this century is to bring more discipline to the method, use it responsibly, and present findings creatively.

References

Abbott E. A., Gouverniuk, K., Liamets, L., and Ukhanova, T. (2002, August). Using cross-cultural focus groups as a tool for communication campaign design: An example from Russia's Forest Project. Paper presented to the Research Special Interest Group, Agricultural Communicators in Education (ACE), Savannah, GA.

Atkinson, M. J., Lohs, J., Kuhagen, I., Kaufman, J., and Bhaidani, S. (2006). A promising method for identifying cross-cultural differences in patient perspective: the use of Internet-based focus groups for content validation of new patient reported outcome assessments. Health Quality Life Outcomes, 4, 64.

Baker, J. (2000). Evaluating the Impact of Development Projects on Poverty: A Handbook for Practitioners—Directions in Development. Washington, DC: World Bank Group.

Bamberger, M. (2000). Integrating Quantitative and Qualitative Research in Development Projects—Directions in Development. Washington, DC: The World Bank.

Barata, P. C., Gucciardi, E., Ahmad, F., and Stewart, D. E. (2006). Cross-cultural perspectives on research participation and informed consent, Social Science Medicine, 62(2, January), 479–490.

Billson, J. M. (1991). The progressive verification method (PVM): toward a feminist methodology for studying women cross-culturally. Women's Studies International Forum, 14(3), 201–215.

Billson, J. M. (1993). Complexities of involuntary resettlement policies in World Bank projects. The World Bank, Environment and Social Policy Division.

Billson, J. M. (1995a). Keepers of the Culture: The Power of Tradition in Women's Lives. New York: Lexington Books/Boulder, CO: Rowman and Littlefield, 2007.

Billson, J. M. (1995b). The research process in World Bank projects: the perspectives of task managers. The World Bank, Asia Technical Division. Unpublished report.

Billson, J. M. (1996a). Perceptions of evaluation methods, processes, and products—Washington, Colombia, Indonesia, and Zimbabwe. The World Bank, Operations Evaluation Department. Unpublished report.

Billson, J. M. (1996b). Social development in World Bank work: perspectives of task managers and economists. The World Bank, Task Group on Social Development. Unpublished report.

Billson, J. M. (1997). Evaluation of the EDI/FASID Joint Seminar-Study Tour Program (Development Effectiveness Program on the Urban Development and Environmental Management—Malaysia, Japan). The World Bank, Economic Development Institute, and the Foundation for Advanced Studies in International Development. Unpublished report.

Billson, J. M. (1999). Participatory evaluation: country assistance review—Uganda: focus groups for public and private sector stakeholders. The World Bank, Operations Evaluation Department. Unpublished report.

Billson, J. M. (2003). El Poder de los Grupos Focales, un Manual de Entrenamiento para Investigación Social y de Políticas Públicas, e Investigación de Mercados [The Power of Focus Groups: A Manual for Social, Political, and Market Research], 2nd ed. Barrington, RI: Skywood Press.

Billson, J. M. (2004). Making Sense of SPSS and Surveys: From Design to Analysis. Barrington, RI: Skywood Press.

Billson, J. M. (2006a). Public sector and private sector perspectives on tourism in Savannakhet Province, Laos. Foundation for Advanced Study on International Development and the Japan International Cooperation Agency. Unpublished report.

Billson, J. M. (2006b). The World Bank Institute Guidelines for Effective Focus Group Research. Washington, DC: World Bank Institute Evaluation Group.

Billson, J. M. (2007a). Conducting Focus Group Research Across Cultures: Consistency and Comparability. Bath, England (Online): University of Bath, Economic and Social Research Council, Research Group on Well-Being in Developing Countries, WeD Working Paper No. 27. http://www.bath.ac.uk/econ-dev/wellbeing/research/workingpaperpdf/wed27.pdf

Billson, J. M. (2007b). The Power of Focus Groups: A Training Manual for Social and Policy Research (5th ed.). Barrington, RI: Skywood Press.

Billson, J. M. (2007c). The Power of Focus Groups: A Training Manual for Social and Policy Research—Focus on International Development (4th ed.). Barrington, RI: Skywood Press.

Billson, J. M. (2007d). The Power of Focus Groups: Focus on Health. Barrington, RI: Skywood Press.

Billson, J. M. (2007e). The Power of Focus Groups: Focus on Education, Barrington, RI: Skywood Press.

Billson, J. M., and Fluehr-Lobban, C. (2005). Female Well-Being: Towards a Global Theory of Social Change. London, England: ZED Books.

Billson, J. M., and London, N. T. (1997a). Evaluation of the Asia Development Forum (Philippines). The World Bank, Economic Development Institute. Unpublished report.

Billson, J. M., and London, N. T. (1997b). Evaluation of the Global Knowledge '97 Conference (Canada). The World Bank, Economic Development Institute. Unpublished report.

Billson, J. M., and London, N. T. (1999a). Fulbright executive directors worldwide: Needs assessment, program structure, and final evaluation. Canada–U.S. Educational Foundation. Unpublished report.

Billson, J. M., and London, N. T. (1999b). Perspectives of board members: a needs assessment, situation analysis, and strategic planning report. Canada–U.S. Fulbright Program. Unpublished report.

Billson, J. M., and Mancini, K. (2007). Inuit Women: Their Powerful Spirit in a Century of Change. Boulder, CO: Rowman and Littlefield.

Billson, J. M., and Steinmeyer, M. (2005). Evaluation of the UNESCAP flagship publication, Economic and Social Survey of Asia and the Pacific. United Nations Economic and Social Commission for Asia and the Pacific, Bangkok. Unpublished report.

Billson, J. M., and Steinmeyer, M. (2006). Perceptions of monitoring and evaluation among World Bank Staff, Management, and Board Members. The World Bank, Independent Evaluation Group. Unpublished report.

Cernea, M. M. (2004). Culture?… at the World Bank? Letter to a friend. Culture and Public Action. http://www.cultureandpublicaction.org/pdf/cernealet.pdf

Department for International Development (DFID). (2002). Increasing Levels of Understanding and Support for Development within the UK. London: DFID.

Environmentally and Socially Sustainable Development Network (ESSDN). (2003). Case study 5—Uganda: Participatory approaches in budgeting and public expenditure management, Social Development Notes, 74.

Hawthorne, A., Davidson, N., Quinn, K., et al. (2006). Issues in conducting cross-cultural research: implementation of an agreed international protocol designed by the WHOQOL Group for the conduct of focus groups eliciting the quality of life of older adults. Quality of Life Research, 15(7), 1257–1270.

Hermalin, A. I. (ed.). (2003). The Well-Being of the Elderly in Asia: A Four-Country Comparative Study. Ann Arbor, MI: University of Michigan Press.

Hoskins, L., and Lucas, C. A. (2003). The Wilder Nonprofit Field Guide to Conducting Community Forums: Engaging Citizens, Mobilizing Communities. St. Paul, MN: A. H. Wilder Foundation.

Independent Evaluation Group. (2006). Annual Review of Operations Evaluation. Washington, DC: The World Bank.

Knodel, J. (1995). Conducting comparative focus group research: Cautionary comments from a coordinator. Health Transition Review, 4(1), 99–104.

Krueger, R. A., and Casey, M. A. (2000). Moderating Focus Groups: A Practical Guide for Group Facilitation. Thousand Oaks, CA: Sage Publications.

Kusek, J. Z., and Rist, R. C. (2001). Building a performance-based monitoring and evaluation system. Journal of the Australasian Evaluation Society, 1(2), 14–22.

Kusek, J. Z., and Rist, R. C. (2004). Ten Steps to a Results-Based Monitoring and Evaluation System. Washington, DC: The World Bank.

Kusek, J. Z., Rist, R. C., and White, E. M. (2004). How will we know the Millennium Development Goal results when we see them? Building a results-based monitoring and

evaluation system to give us the answers. Africa Region Working Paper Series No. 66. Washington, DC: The World Bank.

Lefevre, P., Suremain, C., Rubin de Celis, E., and Sejas, E. (2004). Combining causal model and focus group discussions: experiences learned from a socio-anthropological research on the differing perceptions of caretakers and health professionals on children's health (Bolivia/Peru). The Qualitative Report, 9(1), 1–17.

Maynard-Tucker, G. (2000). Conducting focus groups in developing countries: skill training for local bilingual facilitators. Qualitative Health Research, 10(3), 396–410.

Merton, R. K., Gollin, A. E., and Kendall, P. L. (1956). The Focused Interview: A Manual of Problems and Procedures. New York: Free Press.

Mosavel, M., Simon, C., van Stade, D., and Buchbinder, M. (2005). Community-based participatory research (CBPR) in South Africa: engaging multiple constituents to shape the research question. Social Science Medicine, 61(12), 2577–87.

Narayan, D., Chambers, R., Shah, M. K., and Petesch, P. (2000). Voices of the Poor: Crying Out for Change. Oxford: Oxford University Press.

Puchta, C., and Potter, J. (2004). Focus Group Practice. Thousand Oaks, CA: Sage.

Sagasti, F. (2004). Agenda: PERÚ, personal communication. http://www.agendaperu.org.pe.

Steinmeyer, M. (2007). Evaluation of the UN WFP Emergency School Feeding Program: performance, effectiveness, and lessons learned. United Nations World Food Program. Unpublished report.

United Nations (UN). (2000). Road Map Towards the Implementations of the United Nations Millennium Declaration. New York: United Nations.

United Nations (UN). (2002). The United Nations and the MDGs: A core strategy. http://www.undp.org/mdg/core_strategy.pdf.

Ward, L. F. (1906). Applied Sociology: A Treatise on the Conscious Improvement of Society by Society. Boston: Ginn.

World Bank Group. (2000/01). Participation in poverty diagnostics—methods. In consultations with the poor: methodology guide for the 20–country study for the World Development Report 2000/01. http://www.worldbank.org/participation/web/ webfiles/fgd.webfiles/fgd.

14
Clinical Sociology and Community Mediation: Training Grassroots Leaders in Multiethnic Malaysian Communities

A. Halim Wan and P. Melati Wan

Clinical Sociology and Ethnic Relations

The field of ethnic relations has traditionally been an integral part of a basic sociology curriculum. Typically, students of sociology are introduced to the concepts such as race, racism, ethnicity, minority, prejudice, and discrimination early in their sociology courses. Sociologists in general, with the exception of some Marxist or radical sociologists, see ethnicity as a social *phenomenon* that needs to be studied in its own right rather than as an *epiphenomenon* that can be reduced to some other social manifestation, as a purely economical, political, cultural, religious, and psychological phenomenon. This means that, as a social phenomenon, ethnicity does not lose its social relevance just because members of different ethnic groups practice the same culture and the same religion; or when intermarriages result in genetic pooling and physical and racial homogenization; or when economic inequality between ethnic groups disappears; or when peace is achieved and maintained through political alliances and cooperation between ethnic groups.

Clinical sociologists are those performing *direct sociological intervention* in planned social change efforts for the purpose of achieving a particular objective. This objective may be to promote a particular social trend *(promotion intervention)*, prevent the occurrence of an impending social problem *(prevention intervention)*, minimize or arrest a downward spiral of an occurring social conflict or crisis *(conflict resolution intervention)*, or reestablish social relationships in a postconflict situation *(rehabilitation intervention)*.

Sociological interventions are usually collaborative in nature. Working with other practitioners and empowering the clients and the stakeholders of the social situations, sociologists are working to assume the role as collaborators and allies. Applying this promotion–prevention–resolution–rehabilitation perspective to the field of community ethnic relations, clinical sociologists may institute programs for bringing members of ethnic groups together to participate in cooperative community activities (promotion intervention); organize interethnic group discussions for issue clarification and community problem solving before the problem reaches the point of conflict (prevention intervention); intervene in situations where an occurring social conflict is perceived to be "ethnic" in nature for the purpose of minimizing

its negative consequences (crisis intervention); or reestablish social relationships in postconflict situations where members of different ethnic groups are reluctant or slow in reestablishing their preconflict relationships (rehabilitation intervention).

Like all forms of social reality, ethnicity or ethnic identity is a form that is socially constructed. Emphasizing the subjective aspect of ethnicity, Everett C. Hughes (1971) explained that what is important for ethnic identity is not so much the externally visible ethnic markers, such as physical appearances, cultures, and social traditions, but rather the fact that "the people in it and the people out of it know that it is one; because both the 'ins' and the 'outs' talk, feel and act as if it were a separate group." This means that although there are often clear ethnic markers and criteria of group affiliation based on racial characteristics, religion, social class, political orientation, language, culture, physical location, or a combination of the above, what is central to the concept of ethnicity is psychological feeling of "we-ness" or "we-consciousness" of being part of an ethnic entity.

The dynamic process of ethnic formation, transformation, or metamorphosis that scholars term as "ethnogenesis" (Wan, 1979) shows how the concept of "social constructionism," elaborated by Peter Berger and Thomas Luckman (1966), works in determining the nature and dynamics of ethnicity in society. Individuals in groups "construct" their ethnic identity over time as a way of making sense of the human diversity around them as well as a basis for organizing appropriate strategies for survival and advancement. On closer examination, a social phenomenon such as ethnicity is not a monolithic or rigid imposing social structure existing "out there." Rather, it is a complex, multilevel dynamic interrelated and interdependent social construct with meanings that are contingent upon the specific social situations perceived by social group. The implication of the idea of *social constructionism* to clinical sociologists is clear: If social reality, which is the basis of human action, is constructed, then it can be *reconstructed*. The role of social intervention involves the process of reconstructing part of the perceived reality relevant for affecting social change.

Ethnic Relations in Malaysia

Judging by the unfolding events occurring around the world, it is ethnic conflict, and not class conflict, that appears to be the main cause of social conflicts. As the globalization process unfolds, movements of people across regions and national boundaries have escalated transforming most countries previously with homogeneous population structures into heterogeneous ones. According to Pran Chopra (1974), Malaysia, in particular, has been considered as being among the most ethnically diverse society in the world, and it therefore offers "an ideal laboratory for a student of contemporary national-building techniques." A renowned anthropologist, Clifford Geertz (1963), was impressed with the way Malaysia managed its ethnic diversity since "judging on the mere surface of things, it [the Malaysian society] ought not to work."

Geographically, Malaysia is situated in Southeast Asia, with its western part on the Asia mainland and its eastern part on the northern portion of Borneo. Malaysia is a multiethnic country of 25 million people, with 61 percent belonging to the indigenous (*bumiputera*) category and the others mainly being Chinese and Indian. Historically, the original population of the region consisted almost wholly of indigenous groups until the beginning of the British colonial rule in the second half of the nineteenth century. The colonial government introduced an influx of immigrants from China and India, dramatically reducing the status of the indigenous population to that of a minority category by 1931. The use of different languages, cultures, and religions further limit the opportunities and the need for interethnic interaction and exchanges.

Independence from the British in 1957 was followed by phenomenal economic growth. This resulted in a high rate of social and geographical mobility among the population, and, together with the adoption of a common national language, the various diverse ethnic groups were brought closer together as they sought educational and employment opportunities. While there were opportunities for economical and political cooperation and compromises, occasionally the closer contact generated interethnic competition, tension, and conflict. The latter created a perceived sense of insecurity and threat, exacerbating ethnocentrism among all the ethnic groups as each began to strengthen their ethnic identities, traditional values, and distinctive cultures.

The Neighborhood *Rukun Tetangga* Program

Under British colonial rule, ethnic tensions were generally kept under control by the presence of the colonial authority who moderated, conciliated, or mediated between the interests of various ethnic groups whenever the need arose. In postindependent Malaysia, however, the newly emerged government had to find new ways of dealing with conflicting ethnic demands and dissatisfactions. These ethnic tensions had begun to accumulate even at the anticipation of the approaching independence—before, during, and after the Second World War.

Throughout the 1960s, the first decade of the postcolonial Malaysian society, ethnic demands dominated public debates and political bargaining. The main point of contention was about "special status and privileges." The economically backward indigenous groups thought that they should be allowed to maintain the special status and privileges that had been granted by the British colonial government in the past, while the immigrant groups demanded an equal status as Malaysians to the one granted to the indigenous groups.

Ethnic tension reached its climax following the general elections of 1969, when a major ethnic riot broke out, known as the 1969 May riots. As an immediate response to this rather traumatic experience for such a young nation, the Malaysian government immediately established the Ministry of National Unity in 1971 whose function was to ensure a more harmonious interethnic relations (without violence)

in the future. With no other similar agencies in other countries to emulate, the newly established agency gradually and incrementally developed strategies that it hoped would promote interethnic relations in the society. In an effort to further enhance its effectiveness, the Department of National Unity and Integration, initially a ministry on its own, has been relocated under the direct auspices of the prime minister's Department of Malaysia.

The Department of National Unity and Integration focuses on both *macrolevel* national and societal integration issues as well as *microlevel* community relations. The latter can be viewed as *horizontal integration* involving social groups at the community level, while the relations between the different social levels or classes, such as between the government and the people, would be *vertical integration*. At the societal level, social restructuring and poverty-reduction policies were adopted as national policies, besides forming political and economic alliances between ethnic elites. At the community level, the main strategy is to increase the opportunities for interaction between ethnic groups through activities, such as organizing social gatherings on festive occasions, community night watches in crime-prone areas, kindergartens serving children of all ethnic groups, and recreational activities for all age groups.

To plan and execute these community programs, a community organization, *Rukun Tetangga* (Peaceful Neighbors), was introduced, initially in a few areas in the 1970s but gradually throughout the country. Most of these neighborhood organizations are established in urban areas where crime rates and ethnic diversity are more prominent than those in the rural areas. According to the department, by May 2006, as many as 3,146 *Rukun Tetangga* neighborhood committees have been set up, staffed by 78,650 committee members serving about 10 million of the urban population. These neighborhood committees are supposedly nongovernmental organizations (NGOs), but the government does play a major role in determining the committee members, mainly to ensure that they are representative to some degree of the various social groups and are also capable of promoting community unity. The idea of *Rukun Tetangga* itself was probably not indigenous to Malaysia since there has been in existence a similarly named program in neighboring Indonesia, a program introduced by the Japanese in their brief occupation of Indonesia (1942–45) during the Second World War (Dick, 2006).

Varshney (2005) considers the *Rukun Tetangga* program to be one of the most important mechanisms helping the Malaysian society achieve an impressive "intercommunal peace" after the ethnic conflicts of the late 1960s. Despite Varshney's praise for its relative success, the Malaysian situation remains somewhat fragile. Minor conflicts do occur from time to time since the 1969 May riots, sometimes erupting into open violent conflicts, although on a somewhat smaller scale when compared to the 1969 riots. Two of these incidents were the 1998 Kampung Rawa incident in the state of Penang, and the more serious 2001 Kampung Medan riot in the state of Selangor. In the latter case, out of a population of about 100,000, six people died and twenty-four were hospitalized. The incidents were warning signs that despite relatively harmonious relationships between the ethnic groups, more needs to be done to prevent violent ethnic conflicts in the future.

The establishment of neighborhood committees is an essential first-step toward monitoring and enhancing community integration. In this part of the world, as in other developing societies, a *gemeinschaft*-type community relationship characterized by intimacy and durability (as envisioned by Ferdinand Toennies) has always been a traditional social ideal. This ideal is termed *masyawarah-mufakat* (consultation and consensus), in which a community to expected to deal with conflicts through the process of community consultation until some form of cooperative spirit and consensus is reached.

In reality, *gemeinschaft*-type communities generally grew out of culturally homogeneous communities of the past and are not easily replicated in the kind of culturally heterogeneous ones found in present-day urban Malaysia and Indonesia. Out of the consultation and consensus process of the past generations emerged the *adat* (custom), which emphasizes social harmony and nonviolent coexistence. When communities transform into ethnically diverse entities, the appropriateness of the *adat* comes into question, leaving community leaders and public officials at a loss as to how to respond to interethnic conflicts in an appropriate and effective manner.

This ineffectiveness is noted by Claire Q. Smith (2005) in her study of the 2002 Dayak-Madurese conflict, which occurred in neighboring Indonesia. This incident is highly relevant to Malaysia because of the similarities in the urban multicultural dynamics between the two neighboring countries. In Smith's study, the two main ethnic groups involved in the conflict in Kalimantan (Borneo) were the indigenous Dayaks and the Madurese who migrated there from the nearby island of Madura. In the urban areas, the two groups maintained their separateness by practicing self-segregation, a practice that was somewhat less pronounced in the rural communities.

According to Smith, when conflicts broke out between the groups in 2002, and on a smaller scale for years before that, the police could not play the role as a third-party mediator. The local military officers, even when approached by the locals, seemed to consider the role of mediator as outside their jurisdiction. The local leaders reacted to the conflict by using other methods, such as making public appeals for the groups to cool off, a method that was clearly ineffective when the communities were bent on seeking revenge using violence and destruction. The traditional leaders were not able to play the role as intergroup mediators because they were too embedded and were too emotionally involved on the side of their own ethnic groups to be able to adopt a more impartial stance. The conflicting groups did not seem to trust the local government authorities to mediate in the situation since, according to Smith, there were no existing mechanisms that can be activated to mediate conflicts when they occur. The ethnic groups resorted to evoking the assistance of the spirits and supernatural powers through the mediating magical powers of traditional *shamans* as the trusted traditional alternative that they have always resorted to in the past every time they need to deal with violent conflict situations requiring superhuman powers and physical invincibility.

Community Mediation Training

The incidences of ethnic conflict in Malaysian society, although sporadic and easily controlled thus far, have left deep scars on the Malaysian psyche. The have created doubts and pessimism in the minds of many Malaysians about what the future may hold for the country. (The vast majority, however, may simply brush the incidences aside as insignificant events.)

Sociologists take these occurrences as reflecting some basic social structural conditions that are capable of generating future ethnic conflicts that are perhaps even more intractable and tragic in their consequences. Clinical sociologists are not merely content with describing the present and predicting the future, and seeking more funding for more research, but instead focus on what concrete social interventions need to be taken based on the sociological understanding already obtained. Research findings for the clinical sociologist are based on actual action taken and on its outcomes, rather than merely observing the actions of others. In the case of Malaysia and other countries facing a similar predicament, clinical sociologists need to establish effective conflict resolution mechanisms to deal in particular, but not exclusively, with ethnic conflicts.

This chapter focuses on the initiation of a community mediation training program involving the *Rukun Tetangga* community leaders in urban Malaysian society. The training of community leaders as community mediators was a component of a broader proposal for the establishment of the Social Relations Management System (SRMS) within the Department of National Unity and Integration (Wan, 1984). This idea of training community leaders to perform community mediation is based on the realization that managing conflict in a culturally diverse community is a new social skill that usually is inadequately acquired in homogeneous traditional societies. The setting up of *Rukun Tetangga* committees alone is inadequate if they are not equipped with the complex and demanding skills of how to deal with culturally diverse communities.

The committees (with one exception) were established in most of the areas in Kampong Medan, a suburb of Kuala Lumpur, only *after* the riots had occurred in 2002. This meant that the incident could not be attributed to the failure of the committees to prevent ethnic violence for the simple fact that they did not exist in the main area where the riots occurred. Even if the *Rukun Tetangga* committees were already in existence then, it was not clear how they could have coped with the situation if their committee members were not adequately equipped with community mediation skills beforehand.

One of the roles that a clinical sociologist interested in ethnic relations can play is to provide a community mediation training program to help community leaders acquire these necessary skills. Community mediation in ethnically diverse settings is a particularly challenging role that reflects the extent to which extensive sociological analysis and research in ethnic relations can be translated into specific community management skills.

Clinical sociologists can help in developing a conflict management system, one that monitors community relationships and trends, and, most crucially, provides

community members with an early warning system and the relevant skills to perform social intervention when or even before the need arises. The idea of conflict management is based on the assumption that conflict is not always avoidable or negative in its impact. This means that it can have a positive role in social life. To do so, it must be productively channeled through constructive collaboration, negotiation, and compromise and avoid destructive and violent means of resolution resulting in unnecessary human suffering and loss.

Some sociologists believe that it is the overall dominating network of social structures, social institutions, and social classes that produces conflict. They argue that the nature of an ethnic relationship is determined by *macrolevel* governmental policies and practices, and that ethnic leaders are the cause of conflict, and, therefore, only they can resolve these conflicts through political agreement and compromises attained at the societal level. Based on this argument, focusing on the microlevel of social interactions and relationships between individuals and groups in communities is bound to be futile and unfruitful.

Clinical sociologists are usually not convinced by this line of argument because they recognize the importance of intervening at the microlevel (interpersonal behavior) since, they would argue, ethnicity exists primarily in the minds and action of individuals and groups. Ethnicity is not regarded as something that is totally invented and manipulated by ethnic leaders, although the latter may well exploit ethnic issues for personal gains. Ethnicity is socially constructed but it is a process that involves all levels of society, not something that is imposed from above. This "macro-micro" dichotomy in explaining social dynamics and the effectiveness of social intervention is labeled as track one versus track two approaches in conflict management.

A track one approach, according to Anthony Baird (1999), is that of a "power-based mediation" where governmental or institutional officials from a third party, such as from a friendly neighboring country or from organizations such as the United Nations, play the role as mediators with the objective of achieving political settlements. Similarly, David Baharvar (2001) sees the track one approach as involving government-to-government negotiations that are done officially, where the governments involved are "responsible for negotiating, signing, and ratifying treaties and other agreements." Baharvar (2001), however, points out that a weakness of a track one approach is that it does not acknowledge the importance of involving all the antagonists in an ethnic conflict. By focusing on the role of the elites, it de-emphasizes the fact that ethnic conflicts are the result of poor communication and relationships between the individual members of ethnic groups themselves.

While a track one approach may be considered effective for resolving international conflicts and claims *between* countries, some writers argue that this does not apply so well to ethnic relations *within* a country. According to Bram Peper and Frans Spierings (1999), community mediation takes place in the *life-world* of people, more specifically, in the neighborhood, and that community mediation is part of the process of "social renewal," which enhances the quality of social life especially in the urban society.

A track two approach, on the other hand, considers conflict as situations that should be dealt with at the grass-roots level, rather than something involving conflicts between governments. As they put it, it is the individual and the groups with their "socially constructed identity and meaning shared" that result in the development of negative ethnic stereotypes and the perception of ethnic differences as "a clash of cultures." Similarly, Baharvar (2001) advocated that conflicts should be dealt with "directly and personally" by the groups themselves and not be something that is dealt with by nation-states or governments. He sees the involvement of NGOs in the efforts of "capacity-building, consultation, dialogue, and training" of ethnic groups as a good example of a track two approach.

In line with a pro–track two approach, Varshney (2005) believes that effective community peace committees should emerge from below rather than being imposed from above. According to Varshney, expecting political leaders to impose peace from above does not work well because the political leaders are "normally already committed to polarization and violence for the sake of electoral benefit."

Claire Q. Smith (2005), reflecting on her Kalimantan study, notes that ignoring the grassroots or community level in conflict mediation, reconciliation, and peace-brokering processes can produce disastrous results. Discussions concerning peace among the top echelon of the government hierarchy involving political, military, and religious leaders, without genuine community involvement, are unlikely to achieve genuine and lasting conflict resolution. Smith concludes with a broad recommendation that development policies should incorporate the possibility of the outbreak of community violence, since conflict is a fact of life, rather than treat violence as a rare and unforeseen occurrence.

The proponents of clinical sociology generally favor the adoption of a *systemic* approach toward social intervention. A systemic view of society suggests that social intervention can start at any level or point chosen for its strategic advantage since the interdependence between components and levels of society will mean that change at any level will affect changes in other parts of the system as well. This means that social intervention can be initiated at both the macro- and microlevels of social systems. Anthony Baird (1999) wants to see a combination of both approaches—the official track one level with the interpersonal track two levels.

Tom W. Milburn (2006) poses an interesting question: "What can we learn from comparing mediation across levels?" He feels that the practitioners of international (track one) and interpersonal mediation (track two) do not interact and exchange their ideas and thoughts as much as they should. The outcome from this lack of sharing of clinical experiences is that few new insights are gained that can benefit both parties in the development of a more holistic mediation theory and practice.

Conflict resolution methods can be categorized into three types of responses: one-party, two-party, and three-party (third-party intervention). Mediation is one of the responses in the third category. For the purpose of this chapter, there is a need to use the term *mediation* in two different senses. The first is using the word with a capital *M* (such as *Mediation, Mediator*, and *Community Mediation*) to refer to a specific technique in conflict resolution that is performed by people trained and

recognized as official Mediators. This would include Family Mediators within the court system or Community Mediators who are officially or socially appointed to deal with community conflicts. When seeing Mediators as professionals, it is useful to see Mediation in this specified form so as to differentiate their services from those of the others. Mediation as a specific third-party technique involves the active role of a third party in establishing an open communication channel through which disputants in a conflict can arrive at some form of agreement regarding their grouses and claims. Even if Mediation results in an agreement to disagree, to break off relationships, or to switch to for legal litigation, it can still be considered as a positive outcome of mediation if it is done in a spirit of mutual respect for each other's rights and wishes.

The second use of the term *mediation* with a lower-case *m* (such as *mediation, mediator,* or *community mediation*), in this chapter, refers to a broader use of the term in which a mediator is any form of third-party involvement dealing with any social situation. Thus, community leaders act as community mediators when they perform their daily tasks by bringing together different parties for the purpose of fulfilling certain community needs or achieving certain community goals, even if their roles are, for instance, merely that of a chairperson, moderator, or referral agent.

In other words, the *mediator* is not officially appointed or recognized as a *Mediator*, but who may unofficially practice specific Mediation approaches when deemed appropriate. The community mediator may eventually transform into a Community Mediator once such a role is officially recognized, sanctioned, and rewarded, often monitored by some form of professional bodies that regulate their membership and the quality of their services in society.

The training of *Rukun Tetangga* committee leaders as community mediators is used in the second sense of the term *community mediator* rather than as professional Community Mediator. The long-term objective is to move toward the latter as this role become recognized officially and professionally within the Malaysian society.

The broader usage of the term *mediation* as any means of resolving conflict is reflected in the ideas of Bethuel Kiplagat (1998) when she referred to the practice of promoting community unity in African societies. Kiplagat sees mediation simply as "a process of restoring broken relationships," whether it is at the level of interpersonal, community, groups, or nations. This is an interesting definition since it focuses on the *relationship* rather than the nitty-gritty *contents* or *substance* of conflicts. Kiplagat (1998) thinks mediation is practiced differently in different societies. For example, as part of an African heritage and tradition, versions of mediation on that continent involve the participation of the whole community, including even passersby and, consequently, there is no clear or definite boundary differentiating the delegates from other stakeholders. Kiplagat says the African process is transparent, as opposed to being conducted behind closed doors; and music, dance, story telling, and poetry are used as vehicles for conveying a peace message injected with spiritual values and goals. Since mediation deals with

restoring relationships, Kiplagat sees it as a healing process not only between people but between people "with their God" as well.

William Lury (1999) describes the Bushman system for managing conflicts, where, when a problem appears, "everyone sits down, all the men and women, and they talk and talk—and talk." This process continues at a leisurely pace until finally the point of consensus is reached and the conflict is "literally talked out." The elders, as a sort of mediator, voice this emergent consensus in order to reduce ambiguity and miscomprehension. According to Lury, if a dispute occurs between people from different groups, an initiative will be made to involve the person from the out-group to come for the talk. If this invitation is not responded to, efforts are made to approach the out-group's village and engage in a discussion there. Lury sees a similar process in the Semai community in the Malaysian rain forest, who arrange a "community *bcaraa*" where people "sit down in a circle, discuss what happened, and talk about how to resolve the issue and repair the injured relationship." This approach, according to Lury, allows the community to see how peaceful means of handling frustration and differences benefits everyone in the community.

Among other Malaysian groups, the idea of reaching consensus, under the supervision of a mediator, is relatively rare. Ronald S. Kraybill and his colleagues (2001) note that in another rural Malaysian community, the idea of face-to-face talk about a conflict is believed to "only make things worse" as parties are offended by the direct show of emotions and antagonism. As an alternative, some groups avoided a face-to-face confrontation with their opponents, choosing to let their "intermediary" talk to each party simultaneously but separately, and are "so careful that the second person may not even realize that the first person is unhappy" until the problem is finally resolved.

The idea that both parties can be right in some ways (the "right-right" paradigm), and that the outcome should benefit both parties (the "win-win" paradigm) through compromises and consensus is not as common and as widely practiced in many developing societies as it is thought to be, even if it is cherished as a social ideal. According to Martha G. Logsdon (1978) for most Indonesians, not unlike many of their Malaysian cousins, social harmony is considered to be more valuable than "winning." Logsdon studied the *Rukun Tetangga* in some areas in Indonesia in order to see whether decision making in the neighborhood is based on the *majority-rule model* or the *unanimous-consent model (musyawarah-mufakat)*. She found a trend of moving away from this traditional idea toward adopting that of the majority rule model of decision-making process, one that does not try to bring conflictive ideas toward a consensus.

Clinical sociologists, in introducing community mediation for community leaders in contemporary developing societies, simply cannot assume that the idea of mediation is something that is readily understood or acceptable. The dominant idea currently in vogue even in many traditional societies may well be that conflicts are resolved by third parties judging and pronouncing the "right" party from the "wrong" party and by giving rewards and imposing penalties according to that judgment.

A *Rukun Tetangga* Training Program for Community Mediators

Beginning in 1990, I initiated a training program to equip *Rukun Tetangga* committee members with basic mediation skills. The bulk of the participants were active members of the *Rukun Tetangga c*ommittees, while the others were officials from government agencies. At first, this program was offered on an ad hoc basis, whenever the agency overseeing the *Rukun Tetangga* program deemed it necessary. Then, a more concerted and continuous training program was finally approved by the agency in early 2005. This program ended in late 2006.

The participants came from four zones: north, south, east coast, and east Malaysia. Each training session involved between fifty and one hundred participants, depending on the size of the communities in the different zones. Although this number is unusually big for a workshop, training methodologies were selected that allowed and enabled all attendees to actively participate through experience-sharing and role-playing sessions. A total of 1200 participants attended, with some attending two workshops and a few attending three. Each training session lasted for a period of four days.

The training began by introducing a broad or general idea of community mediation (lower case *m*), which highlighted the participants' role as the "link" or "mediating agency" facilitating the communication and problem-solving processes among the various groups and the levels of society. In this initial part of the training program, I discussed twenty different but complementary role options that the participants could play as a general mediator in their communities. These options are useful for clinical sociologists who want community leaders to be able to deal with a larger variety of social situations rather than merely be able to play the role of a third party in a specific conflict situation. (I refer to that kind of Mediation with a capital *M*.) These twenty options are presented on a kind of conceptual continuum, ranging from responses that do not require a third party to those that do.

In reviewing the options, I place Mediation somewhere in the middle (at number 10) to clearly indicate the moderate stance of the Mediation technique in relation to the other options. Mediation is presented to community leaders as a middle ground situated between the simpler one- and two-party responses on the one hand, and the more formal and complex three-party responses such as arbitration and litigation. Alternatively, the twenty responses can be seen as separate alternatives rather than placing them on a continuum. Clinical sociologists will have to choose an approach that works for them when working with a particular group of community leaders.

The twenty types of responses are briefly described here. Since they are all specific techniques of conflict resolution, the first letter in each word is capitalized. The first six responses are something that one or both parties can initiate without or with minimal help from a community mediator. These responses are as follows: *Restitution*, offering apology and ways of correcting something as one admits to the other party as being at fault; *Deferment*, adopting a wait-and-see stance with the hope that the situation normalizes; *Retreat*, psychologically or physically distancing from a conflict situation; *Entreatment*, making an honest or credible appeal or plea

to one's opponent to abandon the latter's demands or accusations; *Negotiation*, direct bargaining with one's opponent until a compromise is reached; and *Contestation*, to engage directly in counterarguments and counterattacks for the purpose of weakening, demoralizing, and putting the opponent on the defensive until the latter admits defeat.

The next five responses require the involvement of a third party: *Facilitation*, where the conflicting parties are involved with other stakeholders in a nonconfrontational problem-solving focus group discussion under the guidance of a facilitator; *Moderation*, where two opposing parties present their respective views in a debate with the intention of influencing the stakeholders in the audience; *Conciliation*, where a third party brings the opposing parties together to communicate and interact directly, but with minimal intervention by the conciliator except at the point of a serious communication breakdown; *Mediation*, where a third party actively influences and steers the direction of the communication and problem-solving process, usually with the help of a structured or semistructured methodology, focusing on both the process and contents of the conflict toward some form of agreement; and *Caucusing*, a form of "shuttle" mediation where, for a variety of reasons, the third party deals with the parties separately, often repeatedly, until an agreement is reached.

The next five responses involve a third party that claims professional and legal expertise and power to help guide parties in a conflict toward the right solution to their problems. This begins with *Counseling* or *Therapy*, where professionals claim expertise in helping the disputing parties to understand more clearly their motivation for the conflict as well as for its resolution; *Representation*, where proxies are selected by the conflicting parties to negotiate and make decisions on the latter's behalf; *Advocacy*, where a third party assumes a moral or legal responsibility to fight for or speak on behalf of a party, often seen as a weak or victimized party, deemed deserving to be defended; *Arbitration*, involving the role of an officially appointed third party (arbitrator) who is given the power to make legally enforceable decisions after considering the views of the conflicting parties, following a simplified and less formal variation of a court procedure; and *Litigation*, an official and legal procedure where the third party is a judge who, sometimes in collaboration with a jury, makes a legally binding decision usually of a "win-lose" nature, and the process is open for public scrutiny.

The last four responses deal with intractable conflict and postconflict situations, usually after the failure of the above options to address a conflict: *Termination*, where parties agree or are ordered to sever the relationship official or legally, including obtaining court injunction that forbids close association; *Reconciliation*, where those whose relationship had been terminated wish to establish new ones based on a new understanding or contract; *Social Inclusion*, where a party who has been physically, socially, or psychologically excluded, such as having been institutionalized or expelled from a community, is helped by a third party to reestablish new relationships, or "normalizing" past, old, and broken relationships; and finally, *Referral*, where a third party seeks the help of other third parties to intervene in a conflict situation.

Community mediators may need to seek a combination of the above twenty responses rather than sticking to a single response in complex and protracted conflict situations. For example, before choosing Mediation as the main strategy, the conflicting parties may need help to decide on a one-party response, such as on how to ignore one's opponent or learning how to "let go" of a particular demand or claim. Failing that, the parties may wish to give direct two-party negotiations a try, and perhaps, only if this fails, will third-party options be considered.

The Community Mediation Process

The second part of the training program focuses on the role of the participants as a community Mediator (with a capital *M*). To help provide some form of structure for the Community Mediation process, I have identified twenty components of the Mediation process, or twenty main tasks. If the twenty tasks are arranged in a particular order, based on a hypothetical or "ideal type" in the Weberian sense of a Mediation process, the outcome is a twenty-stage model of Community Mediation. According to this model, the trainees are prepared to deal with the specific challenges, tasks, obstacles, and solutions that they are likely to encounter at every step of the process. By having trainees face rather complex and challenging conflict situations where *all* twenty tasks may be required to be performed, the community leaders will be prepared for the worst and are likely to be relieved when real-life conflict situations are not so demanding or complicated. In these simpler cases, not all twenty tasks or stages need to be performed by them. The systematic approach provided as a guide is never meant to be a blueprint to be adhered to in all situations.

Each stage of my twenty-task model examines the role of the parties involved, the tasks that the community mediator faces, the issues and obstacles, and the ways of overcoming them. While one stage is completed before moving to the next stage, each case is unique. Because of this, a simple conflict may require the Mediator or mediator to perform only a few of the following tasks, or the sequence of the tasks may to be reversed or rearranged. A brief description of the twenty tasks for the Mediator or mediator is as follows:

Task 1, establishing a close rapport with all the social groups within the community: Without establishing a strong rapport prior to the appearance of issues and conflicts, community leaders are unlikely to be readily accepted as credible third parties once these issues and conflicts have surfaced and have reached a particularly critical stage.

Task 2, setting up an informal monitoring mechanism indicating changes in the state of intergroup relations within the community: Community leaders need to mobilize their committee members to identify the mood within the community; and keep records of issues and incidents, especially those involving different ethnic groups. Leaders also need to observe the way the community responds to these issues and incidents.

Task 3, initiating promotional and preventive programs and activities to be participated by all the diverse social groups: Based on the above monitoring process, community leaders and their committee members are able to plan for and execute proactive preventive outreach work in their communities.

Task 4, approaching group leaders on the verge of a conflict outbreak to gauge the seriousness of the imminent conflict and their willingness to allow intervention in the community: Should the promotional and preventive prove to be "too little, too late" to prevent the possibility of a violent conflict, community leaders need to approach the potential disputants to gain insights into the current situation. This active solicitation, instead of waiting to be approached, is important since it allows the possibility of intervention before a conflict has already reached a critical stage.

Task 5, obtaining an agreement from the disputants on the appropriate means of conflict resolution: Using the twenty alternatives to conflict resolution mentioned earlier, community leaders, together with the main players in the conflict, can consider the available and appropriate options, either choosing a single option or a combination.

Task 6, identifying another third party to mediate should the community leader fail to gain the approval of both conflicting parties: The failure of the initial offer on the part of the community leader to help may be due to the lack of confidence of the disputants in the ability of the local leader to be impartial. The leader may be accepted by one party but rejected by the other because of the leader's close association with one party in the past, disqualifying him or her as a credible and impartial third party.

Task 7, upon choosing Mediation as the option, deciding on the specific role the community leader plays in the process: Community leaders should be prepared to play a role in the Mediation process, but this does not necessarily mean that their role must be that of the principal Mediator. It may be more appropriate in some situations for the leader to play the role as a co-Mediator or supporting Mediator, if this is in the best interests of all parties concerned and it enhances the possibility of making the Mediation successful.

Task 8, upon accepting the role as a principal Mediator, deciding on a tentative yet appropriate Mediation strategy: Planning a Mediation strategy helps Mediators to be more confident and prepared to face the conflict situation, even if as events unfolds, this preplanned strategy turns out to be inappropriate. It is therefore important that whatever strategy adopted should be flexible enough to enable it to respond to changing situations as the Mediation process unfolds itself.

Task 9, performing separate pre-Mediation sessions with each disputing party, if deemed necessary: In many situations, pre-Mediation sessions may not be possible or feasible due to time and other constraints. The community mediators may also not feel the need to undertake this task since it is not seen as particularly helpful especially in relatively uncomplicated cases. Those who feel a need to hold premediation meetings may believe that it would provide a deeper (but not necessarily truer) perspective on the conflict at hand when certain information may be provided by the disputants that they might not disclose when they are in a face-to-face situation.

Task 10, preparing for the first Mediation session: Community Mediators need to pay close attention to the details of the physical and social environments within which the first session will take place. This is especially crucial for conflict situations that involve large groups of disputants and where the tension is anticipated to be high. The first session is particularly critical because it is capable of creating impressions and ambiences that enhance the disputant's ease, confidence, and trust in the Mediation process or otherwise.

Task 11, starting a session: Starting a Mediation session is usually more challenging than the normal commencement of a run-of-the-mill meeting due to the unusually high level of tension, and a sense of uncertainty, insecurity, or even doubts that invariably accompany intense conflict situations. The disputants probably suspect the sincerity of their opponents, the usefulness of Mediation, and the impartiality and capability of the Mediator. The task facing the Mediator can be particularly demanding at this early stage, including the task of making the disputants feel safe and protected in the company of their opponents, demonstrating genuineness and openness in order to quickly gain trust from both disputing parties, and making the parties feel that they are there voluntarily without being pressured to do so.

Task 12, allowing emotional ventilation to occur: Community Mediators need to provide opportunities for the parties to ventilate their feelings and emotions directly to their opponents before they are capable of communicating more calmly and rationally. This is one of the benefits or advantages of Mediation since such free emotional expressions or even outbursts are not tolerated in the formal courts. The Mediator needs to possess the ability to allow this to happen while at the same time ensuring that it does not inadvertently sabotage the process.

Task 13, allowing both parties to present their claims and demands: After the occurrence of emotional ventilation, both parties should feel more ready to press for their demands and counterdemands, if there are any. At this stage the Mediator needs to ensure that both parties are able to present their demands in terms that are as clear, specific, and concrete as possible in order to make it possible for their opponent to respond accordingly. Mediators need to make sure that demands that are vague and too conceptual or moralistic are capable of being translated into specific actions, solutions, and goals.

Task 14, locating a middle ground for conflicting positions: The Mediator needs to help the parties to be involved in a continuous bargaining process, beginning with their original demands and claims, which may be calculated to be somewhat "excessive" as a bargaining strategy, until both parties are prepared to move toward some form of compromise. Should the parties refuse to make any change from their original demand, the Mediation process will come to a stalemate. The Mediator needs to be able to make the parties feel that making concessions are in fact winning moves rather than losing ones.

Task 15, facing a stalemate: When the Mediation process can no longer move forward, the Mediator needs to be able overcome the initial sense of disappointment and instead to regard it as a mere *hiatus* in the process that is still capable of recovering and eventually succeed. The Mediator should reassure the parties that

impasses are normal in the Mediation process and that they are not signs of failure as much as a time for contemplation and repositioning.

Task 16, scheduling caucuses: If the Mediators feel that a short break is not sufficient to ensure that the Mediation process will be back on track, there should be caucus sessions where they meet the parties separately. The objective is to convince the parties, without trying to exert force or to make them feel guilty, that the gains from a successful Mediation process will exceed their perceived loss if they be prepared to move toward a middle ground. This middle ground may not satisfy all parties but is at least an option where everyone gains.

Task 17, drafting an agreement: Upon reaching a verbal agreement, the Mediator needs to help put this agreement into some form of a document. Although is not legally enforceable, it will help to guide the future behavior of the disputants towards resolving substantive issues in the conflict. A well-prepared, clear, and concise agreement should clearly highlight the gains obtained by parties as well as their responsibilities in terms of concrete and measurable actions and goals that they need to achieve within a clear time frame.

Task 18, monitoring the implementation of the agreement: Some Mediators end their involvement in the Mediation process once an agreement that is accepted by both disputing parties has been drafted. However, for Community Mediation where the Mediator and disputants are long-term members of a local community, it is more appropriate if the implementation of the agreement is considered as an important part of the Mediation process since the reputation of the Mediation process and that of the particular Mediator are at stake if the agreement is not implemented and the parties resort to their pre-Mediation behavior.

Task 19, ending Mediation: The Mediator, with the concurrence of the disputants, should agree to end the Mediation process once the stated objectives of the effort have been satisfactorily achieved or, in the case of total or partial failure, when it is felt that the process has exhausted its potential. It is important to reiterate that after Mediation has ended, regardless of whether it has been successful or otherwise, the disputants are free to embark on other conflict resolution options that both parties consider as necessary and appropriate.

Task 20, normalizing overall post-Mediation community relations: Although Mediation may help to resolve specific issues, demands, and claims, many stakeholders in a community are not direct participants within the process. Community Mediators need to carry out other postmediation activities that bring together the larger community to normalize its overall social relations, which might have been badly affected or traumatized by the conflict. The activities are monitoring and promotional in nature, providing opportunities for social groups to be engaged in cooperative and communicative community efforts, with the objective of improving the overall social ambience in the community. This means that community leaders are performing, once again, the first two of the twenty tasks outlined above, which will enable them to undertake proactive measures to prevent conflicts from getting out of control.

This second part of my training workshop was particularly interactive and practical. The participants were placed in small groups in order to role-play. Real

conflict situations that had been experienced in the past by the participants were introduced and simulated to enable the participants to experience the practical dynamics of Mediation. Initially, simple conflict situations involving two persons—perhaps colleagues or family members—were introduced. Gradually the role plays become more complex and, by the end of the training, they involve six or eight people who usually belong to different social groups. I avoided using the usual "games" or hypothetical situations that are commonly used in management training for fear that it might be "unreal" and irrelevant for the participants.

Role reversals were used so that participants could play the roles of other social groups, usually those of their ethnic out-groups, in order to enhance interethnic empathy. Due to the different nature of the Mediation cases that were discussed in the different training programs, each training experience was unique. The participants who attended the training course more than once learned to deal with a wider range of community conflicts.

Conclusion

Mediation is an approach toward conflict resolution that appears to focus on resolving substantive issues and claims, but, in fact, focuses on how to enhance and restore *relationships* between people involved in conflicts. It is done in a spirit of human compassion and voluntary choice, empowering people to meet at a middle point of social compromise and goodwill. The same cannot be said about the litigation, arbitration, and advocacy processes that are becoming so dominant in human societies worldwide including traditional societies and those once labeled as primitive.

It is nothing short of a catastrophic human tragedy when conflict resolution solves conflicts but weakens or destroys relationships in the process—when a party has to "lose" in order for another party to "win" or when solutions are imposed by a third party while the combatants harbor grudges and seek revenge. Mediation, as Jan Fritz (2004) put it, has a "magic" behind it, something that Mediators and participants in Mediation can experience for themselves, especially when the process is able to transform gradually situations where there has been animosity and hatred into ones of friendship and comradeship, or at least where there is mutual respect for differences in values and need.

The objective of establishing a community mediation program needs to go beyond the focus on resolving specific conflicts involving specific persons toward the larger objective of bridging the social, cultural, and economic gaps between diverse social groups in a community. The long-established view in postcolonial Malaysian society was that community leaders should concentrate on promoting economic development. It has been generally assumed, somewhat erroneously, that economic development will naturally and automatically result in social development and integration. The argument is that ethnic conflict is basically due to economic inequality and competition over scarce economic resources. This line of argument

results in community leaders being appointed with few skills on how to promote social integration in their communities. The objective of equipping leaders with community mediation skills is an effort to redress this lack of interpersonal skills to promote and strengthen social *centripetal* forces and social synergy among diverse social groups. It is hoped that this will counteract the *centrifugal* forces that are always present which leads the community in the opposite direction, toward social segregation and polarization, which will eventually provide fertile grounds for social conflicts.

While many professions may enter the mediation field, mainly to deal with limited interpersonal conflict, clinical sociologists are particularly suited to deal with the wider social conflicts. Clinical sociology's contribution to the practice of social mediation is to add a social systemic perspective to the process, a sociological perspective that sees social conflicts as involving whole communities, societies, or the world at large. Adopting an open comprehensive systemic approach, clinical sociologists recognize the interconnectedness of all aspects and levels of social reality, ranging from the individual all the way up to the global level. Communities are usually, after all, mere *microcosms* of the wider society, where conflicts in the former generate interests and responses from the latter, especially if the conflicts are seen to be inadequately, ineffectively, and unsatisfactorily managed.

In becoming involved as Community Mediation specialists, the easiest option for clinical sociologists is merely to make minor and superficial changes to already existing interventional approaches practiced by other professionals. Clinical sociologists can offer additional insights and tools that can be combined with those of others in a team-based collaborative approach in social intervention efforts. More radically, clinical sociologists can develop alternative approaches, which question some of the basic assumptions held by other professionals due to their tendency to sometimes underemphasize the significance of the social context and social structures while overemphasizing the psychological and physiological ones. Clinical sociologists can be of service by providing more effective intervention strategies that will make the increasingly heterogeneous and diverse societies throughout the world into more peaceful and harmonious places.

References

Baharvar, D. (2001). Beyond mediation: the integral role of non-governmental approaches to resolving protracted ethnic conflicts in lesser-developed countries. Online Journal of Peace and Conflict Resolution, 4(1). http://www.trinstitute.org/ojpcr/4_1baharvar.htm.

Baird, A. (1999). An atmosphere of reconciliation: a theory of resolving ethnic conflicts based on the transcaucasian conflicts. Online Journal of Peace and Conflict Resolution, 2.4. http://www.trinstitute.org/ojpcr/p2_4baird.htm.

Berger, P. L. & Luckman, T. (1966). The Social Construction of Reality: A Treatise in the Sociology of Knowledge. New York: Doubleday.

Chopra, Pran. (1974). Malaysia's strategy for survival. Pacific Affairs, 47(4), 237–454. http://links.jstor.org/sici?sici=0030–851X%28197424%2F197524%2947%3A4%3C437%3AMSFS%3E2.0.CO%3B2–M&size=LARGE.

Dick, Howard (2006). State, Politics, Society and Institutional Learning: Lessons of the 20th Century. http://www.iisg.nl/research/ecgrowthdick.pdf.

Fritz, J. M. (2004). Derriere la magie: models, approaches et theories de mediation [Behind the magic: mediation models, approaches and theories]. Esprit Critique 6(3). http://www.espritcritique.fr/0603/esp0603article01.pdf.

Geertz, C. (ed.). (1963). Old Societies and New States. New York: Free Press.

Hughes, E. C. (1971). The Sociological Eye: Selected Papers. Chicago: Antherton.

Kiplagat, B. (1998). Is mediation alien to Africa? Online Journal of Peace and Conflict Resolution 1.3. http://www.trinstitute.org/ojpcr/1_3tt1.htm.

Kraybill, R. S., Evans, R. A., and Evans, A. F. (2001). Peace Skills: Manual for Community Mediators. San Francisco: Jossey-Bass.

Logsdon, M. G. (1978). Traditional decision making in urban neighborhoods. Indonesia, 26, 95–110. Originally presented at the Association for Asian Studies Meeting, 1978.

Lury, W. (1999). Getting to Peace: Transforming Conflict at Home, at Work and in the World. New York: Viking Penguin Group.

Milburn, T. W. (2006). What can we learn from comparing mediation across levels. http://www.gmu.edu/academic/pcs/milburn.htm.

Peper, B., and Spierings, F. (1999). Settling disputes between neighbours in the lifeworld: an evaluation of experiments with community mediation in the Netherlands. European Journal on Criminal Policy and Research (Online), 7(4), 483–507. http://www.springerlink.com/content/t106t36460217k41/.

Smith, C. Q. (2005). The Roots of violence and prospects for reconciliation: a case study of ethnic conflict in Central Kalimantan, Indonesia. (Social Development Papers: Conflict Prevention and Reconstruction Paper np.23) The World Bank. http://www.worldbank.org/conflict.

Varshney, A. (2005, December). Social policy, conflict and horizontal integration. World Bank Conference, New Frontiers of Social Policy: Development in a Globalizing World, Arusha, Tanzania.

Wan, A. H. (1979). Ethnogenesis: A Case-study of the Malays of Peninsular Malaysia. Doctoral dissertation, University of Bristol, England.

Wan, A. H. (1984). A Monitoring System for Ethnic Relations in Malaysia. Kuala Lumpur, Malaysia: Department of Rukun Tetangga and Ministry of National Unity.

Selected Readings

Banton, M. (1985). Promoting Racial Harmony. London: Cambridge University Press.

Bercovitch, J. (1984). Social Conflict and Third Parties: Strategies of Conflict Resolution. Boulder, CO: Westview Press.

Fritz, J. M. (2006a). L'approccio al conflitto: il ruolo della teoria nella mediazione [Approaches to conflict: social theory and mediation]. In: L. Luison (ed.), La Mediazione Come Strumento di Intervento Sociale (pp. 24–36). Milano, Italy: FrancoAngeli.

Fritz, J. M. (2006b). Contributi della sociologia clinica alla mediazione [Clinical sociological contributions to mediation]. In: L. Luison (ed.), La Mediazione Come Strumento di Intervento Sociale (pp. 81–93). Milano, Italy: FrancoAngeli.

Killian, L. M. (1966). The social scientist's role in the preparation of the Florida desegregation brief. In: A. B. Shostak (ed.), Sociology in Action: Case Studies in Social Problems and Directed Social Chang (pp. 129–134). Homewood, IL: Dorsey Press.

Kriesberg, L. (1981). Peace promotion. In: M. E. Olsen and M. Micklin (eds.), Handbook of Applied Sociology: Frontiers of Contemporary Research (pp. 538–560). New York: Praeger.

Miller, J. S. (1991). Clinical sociology and mediation. In: H. M. Rebach and J. G. Bruhn (eds.), Handbook of Clinical Sociology (pp. 247–257). New York: Plenum Press.

Morland, J. K. (1966). Race relations activities of sociologists. In: A. B. Shostak (ed.), Sociology in Action: Case Studies in Social Problems and Directed Social Change (pp. 123–128). Homewood, IL: Dorsey Press.

Oppenheimer, M., Freedman, J., Lang, K., and Kirk, J. (1966). The sociologist-activist in the civil rights movement. In: A. B.Shostak (ed.), Sociology in Action: Case Studies in Social Problems and Directed Social Change (pp. 135–140). Homewood, IL: Dorsey Press.

Shostak, A. B. (Ed.). (1966). Sociology in Action: Case Studies in Social Problems and Directed Social Change. Homewood, IL: Dorsey Press.

Wan, A. H. (1983). The Need for Monitoring Social Relations in Malaysia. Negara, 7(1), 11–15.

Wan, A. H. (1990a). A Social Relations Management System. Monograph Series: No. 10. Centre for Policy Research. Malaysian Science University (Universiti Sains Malaysia, Penang).

Wan, A. H. (1990b, July). A management and monitoring system for ethnic relations in Malaysia. Presented at the 12th World Congress of Sociology, Madrid, Spain.

15
Mexico's Street Children

Elvia Taracena

This chapter examines the problem of street children in Mexico from a clinical sociology point of view. In Mexico, we have developed a socioclinical perspective based on French clinical sociology and psychology, adapting it to the reality of the complex social phenomena of our country with its strong economic and social contradictions. We have carried out this work for the last fifteen years, at the National Autonomous University of Mexico (UNAM). Our faculty's curriculum, from the beginning, has involved the linking of teaching, research, and service via clinics and community interventions. The work with socially excluded populations that is carried out in this program involves simultaneous research and intervention. It is in this context that the Secretariat of Public Education called upon us, as a team of university researchers with experience in intervention involving street children, to submit an educational model that takes into account the cultural characteristics and way of life of these young people (Taracena and Albarrán, 2006).[1]

Clinical sociology concerns itself with examining complex social problems; it analyzes the subjective dimension in both its individual and collective aspects. On the subjective level, the categories suggested by Bourdieu (1984) have proved very useful to us. In particular, those referring to symbolic, cultural, and economic capital permit us to locate the position of a person or group of people.

It is also important to reconstruct the historicity of the phenomena, for which Castoriadis's (1975) perspective is indispensable. Considering his work, we have spared no effort in trying to understand social exclusion as an expression of the socio-political reality of our country, and, with that, the reasons for no solutions being found that would reduce the number of children who work and live in the streets of our nation's biggest cities. Equally, we have worked on the imaginary and actual social representations of different social sectors in relation to street children, as well as the representations that the children have of themselves (Taracena and Tavera, 2002).

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[1] There is no official program of elementary education directed toward street children. The closest experience has been the programs for 9- to 14-year-olds that are designed as a flexible educational alternative and directed toward child and adolescent workers. The programming has been applied in an exceptional manner in some schools. The government has shown, and currently shows, interest in the street children problem, but, until now, has taken no concrete steps toward developing a remedial educational program for all age levels.

According to Gaulejac et al. (2005), clinical sociology has the objective of analyzing the existential dimension of social relationships. In particular, it focuses on the relationships that exist between the person and the society. It deals with comprehending the dynamic and the contradictions of human destinies, based on readings from the intersection of psychoanalysis, sociology, and phenomenology. From this, two questions arise: In what measure do individuals contribute to producing their own history? And in what measure do they contribute to producing the history of the societies in which their own history is written? These problems lead to the analysis of the social genesis of psychic conflicts and conflicts of identity. In doing this analysis, clinical sociology has made an important contribution to characterizing the phenomenon of street children at the intersection of social reasons and personal reasons.

Economic and Social Factors that Favor the Appearance of Street Children

The phenomenon of street children is frequent in many countries in Latin America, such as Uruguay, Argentina, Brazil, and Mexico (Lucchini, 1993; Taracena, 1995), as well as in Central Africa (Kuyu, 1998) and Egypt (Payva, 1995). Despite their cultural differences, the groups of street children in the different countries share some characteristics, such as illicit drug consumption and the survival culture.

In the majority of Latin American countries, young people are found working, and some living, on the streets. They organize themselves in peer groups, which, in some way, substitute for the family group, devising their own rules and modes of socialization. In Mexico, we found that there are now two or three generations on the street, given that many of these young people procreate at an early age, and their children live on the street with them (Saucedo et al., 2006).

Some of the elements explaining the presence of the street children are social exclusion and poverty, although we cannot establish linear causal relationships between poverty and street life. In our opinion, the migration to the great metropolises in search of job opportunities produces a cultural eradication within the families, without finding methods of insertion into the urban culture. This, in turn, produces indispositions in the relationships and the identity, and often there are situations of violence that are significantly associated with the expulsion of the youths from their families. Economic, political, and social aspects undoubtedly favor the excessive migration to the urban areas.

The difference between the living standards and incomes of the different populations in Mexico has been great, and the gap between rich and poor is ever widening. Julieta Campos (1995) observes that the gap widens as a result of political movements and adaptation to the neoliberal economic model. The combined income of Mexico's twenty-four wealthiest families is equivalent to that of the 25 million poorest Mexican individuals. According to a document published in 2002 by the

World Bank, "Poverty in Mexico: An Evaluation of the Conditions and Tendencies, and the Governmental Strategy," half the population lived in poverty while a fifth lived in extreme poverty.

In a recent period of Mexico's history, faith was placed in an economic miracle. Between the 1930s and 1960s, Mexico achieved spectacular growth in the gross national product (GNP), practically doubling it.[2] This produced a wave of migration toward the cities, in particular toward Mexico City, which, in about forty years, saw its population increase fivefold.[3] Such rapid growth has impeded the absorption of the newcomers, and thus we witness the proliferation of belts of misery. These new entities have altered the city's forms of organization. The people that arrive in Mexico City develop strategies for land appropriation and demanding services, and create new forms of acculturation.[4]

One of the consequences of the aforementioned phenomena—economic crisis and migration to urban areas—is the number of people who subsist on street vending. Several categories of vendors can be distinguished, some of them playing an important role in the informal economy, and others located on the edges of disguised begging.

The Street Children

The street represents different possibilities for young people, for whom it constitutes a living space. The street children may ask for money or carry out small jobs that allow them to survive. They also discover the possibility of trying illicit drugs or initiating sexual activity. The street is a place where they may establish relationships, either with peers or with adults, which determine their forms of socialization. And when they choose a place to live, they do so in areas close to the open-air markets or subway stations, in other words, in places of certain affluence that give them the opportunity of obtaining food.

In Mexico, three situations are identified with regard to the so-called street children. There are those who live at home with their families and even continue to attend school, albeit in an irregular manner due to their need to work. There are those who have lost all contact with their families, who live alone in the streets, and who perform activities that could better be described as begging rather than work. Lastly, there are those who live between the street and their homes, that is, in a transition stage on their way to a life in the streets.

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[2] According to numerous studies, the GNP went from 3.6 to 6.7 percent during this period.

[3] The metropolitan area of the Valley of Mexico in 1960 had 5.4 million inhabitants and, today, has more than 25 million.

[4] An interesting example is the city of Netzahualcoyotl, which over a period of twenty years, went from being a large belt of misery to a popular neighborhood with services and an identity of its own.

Some governmental research carried out in Mexico focuses generically on the boys and girls who work in the streets. A 1999 study by the Secretaría de Desarrollo Social (SEDESOL; Secretariat of Social Development), the Secretaría de Educaión (SEP; Secretariat of Public Education), and the Secretaría de Salud (SS; Secretariat of Health) in the nation's one hundred main cities (excluding Mexico City), indicated that 114,497 minors under the age of 18 worked in the streets (DIF-UNICEF, 1999).

With respect to Mexico City, United Nations International Children's Emergency Fund (UNICEF) and the Sistema para el Desarrollo Integral de la Familia del Distrito Federal (System for the Integral Development of the Family in that City; DIF-DF) performed two censuses of street children, one in 1992 and another in 1995 (DIF-UNICEF, 1996). In the latter, 13,373 boys and girls under the age of 18 were accounted for as being *on* and *of* the street, which translated into a 20 percent increase with respect to the data recorded in 1992. In each case, the populations found in the streets and public spaces were recorded, and later a comparative statistical study was made of the children who worked in the streets and those who lived in, or were from, the street. In like manner, the 1995 census found 270 girls and 1,580 boys on the street, together representing 13.84 percent of the total, a figure that was 9.13 percent greater than the one obtained three years earlier. In absolute numbers, this population's total changed from 1,020 in 1992 to 1,850 in 1995, an increase of 81 percent. Globally, the following findings were concluded to have occurred from 1992 to 1995:

- The number of minors in the street grew 20 percent, with an annual average rate of 6.6 percent.
- The existence of children dedicated to prostitution was recognized.
- Gathering places for street children increased 135.73 percent.
- A new generation of children born on the streets was observed.

The 1995 census provides this statistical sketch regarding the street children in Mexico City:

- 85.40 percent are males, and 14.60 percent are females.
- The characteristic economic activity is windshield washing.
- Most of the children are adolescents; 85.4 percent are between 12 and 17 years old.
- 75.35 percent came from Mexico City and the contiguous state of Mexico.
- 70 percent use illicit drugs, mainly paint thinners, glue, and marijuana.
- The principal illnesses reported were respiratory (64 percent), gastrointestinal (14 percent), skin infections (3 percent), and eye problems (1 percent).
- 49.46 percent engage in sexual activity and, of those, 43.02 percent began that activity between the ages of 7 and 14.
- 11.90 percent are illiterate.
- 40 percent began their life in the street between the ages of 5 and 9; 60 percent between 10 and 14.

- 44.09 percent reported living in the street to escape abuse, and 23.66 percent because they like it.[5]
- Among street risks reported: 28 percent mistreatment by non-street dwellers and 20 percent police extortion.
- 62.37 percent have been arrested on drugs, vagrancy, or theft changes.

There are serious and recent studies that enable us to calculate a precise figure for street children in Mexico today. Additionally, a number of studies use different categorization methods for defining the different types of young people on the street, and, depending on the source, the data differ to a significant extent. There are also difficulties in making this count, related to the mobility of the youth, and quite often the numbers cited are just estimates. The data presented here are, in our judgment, those that best approach reality, and those that we consider the most reliable as far as sources are concerned.[6]

One of the possible explanations for the presence of street children who are searching for food, shelter, and the possibility to make money is the failure of the usual spaces of socialization, with respect not only to the families, but also to the governmental institutions. This phenomenon also contradicts the image that has been constructed in Western society of children as fragile beings; even in their marginalized position, the children show the possibility of fighting back, their thirst for life, and their need to find spaces of socialization.

It is necessary to perform a more detailed analysis of the failure of the social spaces. Regarding the changes in public space, Tessier (1995) clearly shows that the large cities tend to reduce the public spaces to those essentially designed for transit purposes, and that that other use may represent a transgression that reinforces the processes of social exclusion.[7]

The violence in the big cities only increases and reinforces the conviction of the citizens respecting the need to find ever more sophisticated ways of overseeing and repressing everything that could be seen as delinquency.[8] Thus, the spaces of socialization in the streets that for generations represented the possibility of

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[5] It is important to mention that many street children said that they liked living on the street. We consider it fundamental to take into account that such affirmations speak to the methodological device employed in the study, the type of questions asked, and the context in which those questions were asked. It is very probable that faced with a family situation usually touched by marginality, poverty, abuse, and other conditions of vulnerability, the street becomes the only space possible for the child or youth situation. Also this is a space where the child has the real possibility of co-constructing, with peers, a system of life with new rules, priorities, habits, and relationships. In this way the child doubtless arrives at a feeling of acceptance and affability, inasmuch as it distances the child from a childhood history almost always tainted by violence.

[6] We are fundamentally interested in performing a qualitative analysis of the phenomenon in order to discover ways to confront it.

[7] In this sense, an interesting attempt has been made to prohibit the playing of soccer in spaces not especially designed for that activity.

[8] In that sense, the initiative to have police control over all young people found in the street after 10 p.m. only heightens fear and feelings of repression, and does nothing to resolve delinquency.

constructing social ties, disappeared overnight, to be replaced with distrust and fear. The new measures contribute to the heightening of the processes of marginalization, and to the construction of an image of the street as a dangerous place.

In this chapter, we analyze the processes of violence—social violence, symbolic violence, and family violence—through accounts given by street children. Family violence is one of the most important acts that children cited as a motive for taking to the streets. We are convinced that this type of violence is an expression of social violence, examples of which may be found in the accounts of the street children who are HIV positive. This analysis also revisits other works carried out in Mexico, in particular, the 1996–1998 work in the Mexico City neighborhoods of Indios Verdes and Tacuba.

Theoretical-Methodological Considerations

We decided to develop drafts of different cases of street children using a clinical sociological approach. Our objectives were as follows:

1. To characterize each of the different social actors in the phenomenon of working street children.
2. To determine the living and working conditions of the children, in order to establish the risks, but also the potential for learning on the street.

We consider it important to go beyond the tendency to present a single image of the street children and solely concentrate on what they lack and their difficulties. We have sought to determine their living conditions and their modes of structuring and constructing their identity, as well as their psychic reality.

To this end, we have chosen a clinical and social approximation that gives an account of the social reality of the street children and their relationship to the urban space, the informal economy, and power relationships. We carried out in-depth interviews with street children from different groups and of different ages. We also used drawing as a way of accessing the reality of the young people. Over the course of our interventions, we interviewed approximately one hundred youths (Taracena and Tavera, 1998; Taracena et al., 1993; Jayme and Juárez, 1995; Martínez and Melgarejo, 1996; Márquez and Ordóñez, 1996; Macedo, 2003).

With respect to the children who live on the street permanently in Mexico City, we have maintained contact with them. We also have performed interventions in different institutions that deal with street children, carrying out, in various places, educational activities that permit us to contribute something, while, at the same time, extending our observations.

We also have assisted in the work of a nongovernmental organization (NGO) by accompanying HIV-positive children, with a view to ensuring continuity in the use of adequate medication and the use of preventative measures such as condoms during sexual relations. The majority of these children continue to live on the street. In some cases, they return to their homes occasionally or go to institutions for street children. Two of them have gone before a children's court.

From the methodological point of view, we found it interesting to base our study on the accounts the children give of their life histories. This approach helped us construct theoretical categories that permit a better understanding of life on the street.

The Demand

From the clinical sociological viewpoint, an important question to clarify is that of *demand*. In many cases, there is no explicit demand on the part of the street children, at least at first. However, we are certain that there exists a social demand that can be because of the increase in the numbers of street children and the escalating degradation of their living conditions. This acknowledgment of a social problem as a demand may be the basis for other institutional or personal demands that are outlined in the course of this work.[9]

In our research and intervention work, we insist on continually listening to street children, and trying to limit their difficulties. We do not work with the notion of normalization. In general, we offer the children activities that permit us to maintain a dialogue with them and to understand their experiences. Sometimes, the contact with the children allows a personal demand to arise that is expressed in a desire for relationship and recognition.

When our interventions are made in institutions, those entities establish the initial demand. Later, the individual demand of the children is obtained during interviews.

Reconstruction of Trajectories Through Interviews

Working with life trajectories involves adopting a theoretical and methodological position where the reconstruction of the children's life story is kept at the forefront. In this case, we think the fact that children are HIV positive leads them to agree to reflect on the history and events that led to acquiring the illness. Hurtubise and Roy (2003) observed the same phenomenon in the case of the *sans-abri* (homeless) in Quebec, where the fact of being HIV positive gave them

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[9] The National Autonomous University of Mexico (UNAM) has always recognized a social burden and has a commitment to the country's less-fortunate people. In the UNAM, there is a social service that connects the professional practices of all disciplines with working with the populations that have the greatest needs. In our case, groups of students who, having finished their studies, dedicate between six months and one year to making interventions with the street children through nongovernmental organizations or directly in the children's living spaces. This permits the students to produce a reflective work on their practice, with the aim of obtaining a bachelor's degree in psychology, and permits us to carry out research projects and interventions, with a view to confronting our nation's complex social problems.

the desire to explore and organize their history. In different observations and interventions, we have noted that the street children experience difficulty in evoking their family histories. There have even been indications of a desire to forget. However, in the interviews we conducted, we have formed the impression that once a dialogue and trust in the relationship have been established,[10] there surfaces a need in young people to recognize the causes underlying their situation. We may consider that in the case of a serious illness that is associated with dying, this appears as a destiny toward which the children's trajectory directs them and the account is constructed around this idea.

The reconstruction of a trajectory by an individual involves a subjective viewpoint based on the individual's perceptions and emotions. The biographical approximation that we work with (Gaulejac, 1999) is based on the Freudian concept of *family novel*. Freud proposed this concept to describe the tendency for some children to invent a history. Generally, it deals with fantasies linked to the need to ascribe more prestigious origins to one's self, although clinical practice has shown that all individuals employ a subjective fantasy mechanism at the moment of constructing a story about themselves. The biographical approximation in the social sciences must take this into consideration when interpreting the data.

It is evident that the reconstruction of a life story involves an intersubjective game between the person who recounts and the person who facilitates the interview. In this sense, the context in which the discourse is produced has to be taken into consideration.

The interviews for this research project were carried out in a therapeutic space, constructed in a house where HIV-positive adolescent-age street children were assisted with becoming aware of and taking responsibility for their illness; they were being taught how to look after themselves. The two themes given priority in the interview were (1) the family and (2) the ways of engaging in prostitution. The house for street children is financed by a religious organization and, although its operation is secular, the religious affiliation, in our opinion, determines the weight given to the family and its dysfunctionality as the cause of the children taking to the streets.

Analysis of the Interviews

We will look at six interviews with HIV-positive adolescents in order to analyze the social and personal elements that mark their trajectories, and the illness as an expression of their existential situation. Basic information about those interviewed is presented in Table 15.1.

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[10] This act was not readily achieved with all of the young people interviewed. In particular, one girl rejected the possibility of relating her story and of working with the psychologists in the interrogation of a life history.

Table 15.1 Basic information about the interviewees

Name	Age	Schooling	No. of years living on the street	Parents' occupations	Siblings' characteristics
Rodrigo	22 years	None	Thirteen years	Father: taxi driver Mother: homemaker	Four siblings, two sisters and two brothers (one married and one still living at home)
Omar	24 years	Junior high school	Eight years in the street, with a period in prison	Father and mother: street vendors	One brother studying at university and one sister at home
Pablo	14 years	Third grade	Four years, with periods in children's institutions	Father: mechanic Mother: absent	One brother, a mechanic
José	21 years	Third grade	Six years in institutions; today he lives with a partner; one period in prison	Father: taxi driver Mother: absent	Two sisters who work in the home
Consuelo	17 years	Fifth grade	Nine years in prostitution, several periods in children's institutions	Father: market vendor. Mother: absent	One sister living on the street
Lidia	15 years	Seventh grade	In either youth institutions or the street for the last two years	Father and mother: absent	One brother and one sister who left with the mother

The common element in the accounts of the street children is violence, both within the family and on the street. Social ties with the individuals who were able to substitute for the paternal and maternal roles also are plagued with violence. The institutions were not capable of offering protection, socialization, and construction of a life project. We consider it important to not only make a psychological reading of this violence, but to maintain various readings: sociological, anthropological, and psychological. Even though the figures of the parents appear in the accounts as imparters of this violence, we are not dealing with an individual pathology, but with a social violence expressed and aggravated by illicit drug consumption and alcoholism.

If we revisit Bourdieu (1980) with regard to the idea of trajectory, we see that there are few possibilities for these young people to escape from the spaces of violence. It is interesting to note that not all the members of the families of each of these children are on the street, and there is even one case where the brother of one of them is attending university. This means that each individual may construct himself or herself in a different manner in similar spaces. These accounts show that within a single family, certain children may be more exposed than their siblings to the processes of violence.

Our analysis was performed with the idea that in each life history there exists a social irreducible and a psychic irreducible (Gaulejac, 2003). We began from the premise that the social precedes the psychic, but, at the same time, that we cannot reduce the psychological to social determinations. Each history represents the interaction of those two registers in order to produce the singularity of each person, a fact that may help us to understand the different destinies in a single group of human beings.

In the accounts analyzed, we found two cases of rape, one within the family and the other outside of it. We found three cases of prostitution, two homosexual and one heterosexual. In all six of our cases, the paternal figure is a violent and abusive figure and, in three of the cases, the maternal figure is absent and nobody has been available to replace her.

What is notable is that the processes of violence within the family are found to be reinforced by processes of violence outside the family, or vice versa. Consuelo's story adequately illustrates the situation:

> I believed my mom abandoned us because she didn't love us or my dad, and how was she going to love him if he always beat her. My dad always beat the three of us. My mom didn't bother about me, and the only one I got along with well, sometimes, was my sister. My dad told me that I was 3 years old when my mom abandoned us.

Consuelo decided to leave home after someone in the family raped her. She lived with her sister on the street for a few weeks, until they were found by a woman, who promised to take them in, but who also exploited them:

> One day, a woman passing by began to ask us stuff—where were we from, where our parents were, if we had eaten. We told her that we hadn't eaten and she asked us if we wanted to go to her house. She told us that she would give us food and a change of clothes, so we went with her.

I only stayed with her a while, because she kept my sister and took me to a house where they look after children.

I didn't like it there, so I ran away and went to live with some children in the subway who got high sniffing glue. I went to look for my mom in the Merced [a very large wholesalers' market area in Mexico City], because my dad had said that she worked as a prostitute there. But I never found her. I began to work as a prostitute there at the age of 10. I asked the women in the Merced how they did it and learned as I went along. I made more money than I would have if I had been begging, or even stealing.

I stayed there in the Merced. I met other kids who offered me cocaine, and since they stole in order to eat, I began to steal with them. There, you have to do something. If you don't, you don't eat. The Merced is very hard.

What is remarkable in Consuelo's story is the lack of a substitute maternal figure. This differs from other street children's accounts in which they have many others arriving who are close to them, but who are not relatives. In Consuelo's case, neither the group of children, nor the institutions, nor the individuals that she met offer her a sense of protection and support.

In our earliest interviews with working children (Taracena et al., 1993), we found female figures who protected the children and helped them construct projects of greater autonomy. In another study (Taracena and Tavera, 1998), we discovered that the peer group could fulfill the function of the family with regard to norms and possibilities for recognition and affective relationships. A common element in the accounts we analyze here is the lack of spaces and a support structures for each child.

Often, we get the impression from these accounts that the children suffer violence to the point where they begin to reproduce it as a survival mechanism. Rodrigo's story exemplifies this mechanism:

Well, my father arrived home and beat [my mother], and, well, he abused her. He raped my mother and took the money she had, and, well, not content with abusing my mother, he abused my sisters also.

I told my family that I didn't want to live at home any longer, that I wanted to leave for good, that I didn't want to see them again, that I hated them. And they said, "You're going to stay in this house and that's that." When I left, they looked for me, and when they found me, they beat me. I always went to the Northern Central bus terminal and they knew I always went there. If they wanted to find me, they knew where to look. I was really worried and scared about finding a new place to live. And well, for me, the Central was where there was light, so that's where I went. I was attracted to it like a moth.

That's when I first got involved in prostitution. Look, I went out on the street and, well, a guy offered me a ride. I didn't want to go and I fought him. But anyway it didn't matter. He took me away in his car and he raped me. He did whatever he wanted to me, then threw me out like an old rag.

Well, I cried and cried about what had happened and, well, I saw my mother down the street who had come looking for me and, well, I told her what had happened to me, and my mother instead of… Well, I thought that she would hug me, that she would say that there was no problem, that she would be with me in those times. I looked for something like that. However, do you know what I got? I got a real hard slap on the face, and she told me: "You know what? You're a son of a bitch! A fairy! You've no shame. I never want to see you again. You're a disgrace."

Rodrigo made a living from homosexual prostitution for several years, and, at a certain point, began a relationship with a man who offered him protection. However, this man was murdered:

> Look, do you want to hear a good one? A little queer who was good to me… He was a doctor. I say "was" because he's dead now. The first times he, well, we had relations and everything, and I told him he was a nice guy, because, because he treated me well and never hit me. He never humiliated me, never made me feel less than anyone else, which is what happened with all the guys I went with. They'd go: "Move it, idiot, I'm paying for this," or "You're a real son of a bitch." You're this, or you're that. In other words, they looked for a thousand and one ways to humiliate me. I'll be honest with you. I really liked that guy and have good memories of him. And every time I could, I went to talk with him. He gave me a lot of advice. He told me that he was going to get me out of the street and that he was going to adopt me. I mean, that we weren't going to have sex any more. He told me, "I don't want to have sex with you any more" many times. Anyway, if we had sex four times before that it was a lot, and, afterward, we didn't have sex. He said, "You know, I don't want to have sex with you, I like you a lot and want you to get on… I don't want you to prostitute yourself…" I don't know why they killed him. They shot him, and that was the end of the dream.

In both Rodrigo's and José's cases, although we do not present details of the interview with José here, a figure appears in their lives whom they trusted and with whom they managed to establish a significant affective relationship, despite having met them in the course of engaging in prostitution. These were men of a certain age who could have played, in a certain sense, the role of a paternal figure. However, in both cases, these men had been murdered, which illustrates the violence associated with the context of those who can represent important figures for these children.

At the time of the interviews, Rodrigo lived with a girl as a couple, and had given up prostitution. He also talked of his desire to have a child. It is frequent that contact with illness and the proximity of death produces in these adolescents the need to make projects, sometimes for the first time in their lives.

From the anthropological point of view, Le Roy (1995) insists on not negatively analyzing the relationship between the law and the street children. This author proposes four categories for analyzing social order: the imposed order, accepted order, negotiated order, and discussed order. The imposed and accepted orders are those of the laws and the institutions that normalize socialization. The negotiated order is that of mediation, and the discussed order is that of the marginalized young people. The author places emphasis on the fact that the discussed order may correspond to a moment in the socialization of the youth. Nevertheless, in the cases at hand, the degree of marginalization does not permit thinking in terms of a moment of socialization, since marginality dominates and, throughout the life of the youth, is accentuated. The relationship to the law is transformed into continuous transgression and socialization by way of violence.

In the children's stories, they do not demonstrate a rebellion against order, and, in that sense, a consciousness of marginality. Instead, they feel more like victims of violence in a circle in which they generally pass from being victims to being aggressors. It is only through their accounts that the youths can begin to become aware of their place in the social institutions.

If we position ourselves in psychoanalysis as a frame of reference, it is convenient to analyze the relationship to the law, and to the symbolic. It is evident that these figures of cruel and abusive fathers constitute a destructive image that implies

the impossibility of fulfilling a parental function. The law, with regard to street children, is abusive and corrupt.

For Winnicott (1979), the father represents law and order in the family, and, for the family to function, the father must be a strong and strict figure, while, at the same time, be understanding, friendly, and sensitive. This would allow the child to be able to hate and fear him, but also love and respect him. Thus, the father can impose limits and indicate the norms necessary for the functioning of the family.

In the socialization of the child, institutions, schools, churches, and sports clubs represent the possibility of a substitution with respect to accepting the norms as necessary for respecting the law. This permits children to accept their destructive impulses and the possibility of channeling those impulses, by a process of sublimation, toward creativity and socialization.

What the street children's stories show is that all of the figures of identification are figures who transgress the law. They do not have control over their own destructive impulses, which produces a lot of confusion and a terrible fear in the children.

The case of Lidia is interesting for the reasons mentioned before. She herself requested that she be placed in an institution, as her family could not deal with her. The problem was, however, that the institution was similarly incapable of doing so. As Lidia said in her interview:

Lidia: She scolded me, she yelled at me in front of everyone. Then, I remember that I yelled at her, too.
Interviewer: She yelled at you and you yelled at her?
Lidia: Yes, and it got worse. Until one day I couldn't stand it and asked my grandma to take me to an institution.
Interviewer: What made you ask her to do that?
Lidia: Well, when I was on drugs, I got very aggressive with her and I didn't want that. After all, she was my grandma.
Interviewer: And she took you to an institution?
Lidia: Yes.
Interviewer: What happened there?
Lidia: Well, it was run by nuns and they were very strict. Honestly, I didn't like it and, after eight months, I ran away.

This happened when Lidia was going through adolescence, when the problem of limits presents itself with the greatest intensity. Lidia was frightened of herself and desperately sought a structure that could help her control her aggressive impulses.

Based on Winnicott (1979), we wish to underline what, for the author, is the principal function of the parents, consisting in the contention and holding that would permit the children to accept their aggressive impulses as nondestructive. The examples of Lidia and Omar show us to what point young people need limits, and that the fact of not finding them acts as a propellant toward a life on the street, or away from the family.

However, the violence exercised by these youths against themselves and others evokes complex processes that articulate psychological and social dysfunctionalities. The interviews show that sexual abuse within the family is another important driving force with regard to an exit to the street.

Sirotta (2002) shows how incest, as a reality or as a fantasy, is an element that seriously perturbs the social order and symbolic foundation of the psyche. Discussing violence in schools, the author shows that acts of vandalism, theft, arson, rape, and diverse aggressions and serious uncivil acts may represent the social effects of individual defenses. These effects function in group resonance, create an area without reference between itself and the other, which, paradoxically, is destined to conjure the resurgence of intimate scenes of the incestuous, bodily and psychic exploitation that those children have suffered within their family.

In the case of the street children, we think that exercised and sought violence expresses the difficulty of elaboration of the violence linked to sexual abuse within the family. This is true whether inflicted upon themselves, the mother, or the brothers or sisters.

Conclusion

The stories analyzed here illustrate extreme cases where these children have been the victims of unacceptable violence. They represent cases that are converted into the expression of social, familial, and individual violence. In our work, we have always insisted on recognizing on the street child the lessons and abilities that they have learned on the street. In this way, we avoid reducing the experience on the street to a single image of risk. Nevertheless, it is important to recognize that, in certain cases, the street represents a space that duplicates the violence received in other spaces.

The fact that these young people have contracted AIDS between the ages of 14 and 24, demonstrates how their trajectory leads them to a dramatic exit as a consequence of a chain of physical, sexual and symbolic violence. Although we must not conclude all street children follow the same trajectory, we cannot deny the impact that these stories have on what the street represents for us.

The making of life accounts requires respect particularly for certain rules of ethics, where the involvement of the person who gives the account and the professional who takes it requires a recognition of the affective dimension as a central process. The question of the demand, the analysis, and the recognition of the affective dimension requires an understanding and cautious attitude. In the types of cases discussed here, it is important that the processes of violence experienced by the young people are not renewed by means of intrusion or commentaries that could be converted into abusive interpretations. It is important also to respect the rhythms of young peoplen, and their willingness or unwillingness to relate certain experiences of their life. Finally, the professionals who conduct the interview must take care to analyze, with the help of a

third party, the impact that these stories have on them, and the form in which the professionals' own trajectory is located in their listening.

We believe that clinical sociology provides us with a rigorous framework for the analysis of the involvement of the researcher and the processes of transference and countertransference. The work pertaining to these aspects is intimately linked to the ethical position of the researcher and also permits the construction of the distance necessary for the young people who were interviewed for this research. The accent that we have placed on the constant interrelation of the social, culturally historic, and affective processes on the reading of the life story is in accord with clinical sociology's openness toward different disciplines and to the complex reading.

References

Bourdieu, P. (1980). Questions de Sociologie [Sociological Questions]. París: Les Editions de Minuit.

Bourdieu, P. (1984). Homo Academicus [Homo Academicus]. París: Les Editions de Minuit.

Campos, J. (1995). Que hacemos con los pobres? [What Do We Do With the Poor?] México: Aguilar Nuevo Siglo.

Castoriadis, C. (1975). L'Institution Imaginaire de la Société [The Imaginary Institution of Society]. París: Editions du Seuil.

DIF-UNICEF. (1999). Estudio de Niñas, Ninos y Adolescentes Trabajadores en 100 Ciudades. Resultados Definitivos [Study of Children and Working Adolescents in 100 Cities. Definitive Results]. México, México: DIF-UNICEF.

Gaulejac, V. de. (1999). L'histoire en héritage: roman familial et trajectoire sociale [The heritage of history: The family novel and social trajectory]. París: Desclée de Brouwer.

Gaulejac, V. (2003). Historias de vida y sociología clínica [Life Histories and Clinical Sociology]. Proposiciones. Historias y relatos de vida. Investigación y Práctica en las Ciencias Sociales, 29, 89–102.

Gaulejac, V., Rodríguez, S., and Taracena, E. (eds.). (2005). Historia de Vida, Psiconálisis y Sociología Clínica [Life History, Psychoanalysis and Clinical Sociology]. Querétaro, México: Universidad de Querétaro.

Hurtubise, R., and Roy, S. (2003, May). Risque, santé et maladie chez les SDF [Risk, health and disease at the SDF]. Presented at the Colloque Sociétés en crise et recherche de sens (Conference of the Societies in Crisis and in Search of Direction), Athens, Greece.

Jayme, A., and Juárez, M. (1995). Los hábitos de alto riesgo en la infección por VIH en el menor de la calle [High risk habits in HIV infection in the street child]. Unpublished undergraduate thesis, The National Autonomous University of Mexico, Campus Iztacala, Mexico.

Kuyu, C. (1998). Otages dans la rue. [Hostages in the street]. In: S. Tessier (ed.), A la Recherche des Enfants de Rue (pp. 276–286). Paris: Editions Karthala.

Le Roy, E. (1995). Espace publique et socialisation dans le métropoles: quelques préliminaires à une problématique interculturelle [Public space and socialization in the metropolitan areas: some preliminaries to an intercultural problems]. In: S. Tessier (ed.), L'enfant des Rues et Son Univers Ville, Socialisation et Marginalité. Enfances et Sociétés (pp. 31–46). París: Centre International de l'Enfance, Editions Syros.

Lucchini, R. (2003). Enfant de la Rue, Identité, Sociabilité, Drogue [Street, Child, Identity, Sociability, Drugs]. París: Librairie Droz.

Macedo, M. (2003). Niños de la calle con VIH-SIDA [Children on the street with HIV-AIDS]. Unpublished undergraduate thesis, The National Autonomous University of Mexico, Campus Iztacala, Tlalnepantla de Baz, Estado de México, México.

Márquez, A., and Ordóñez, E. (1996). Un acercamiento al niño de la calle y el grupo operativo como alternativa de intervención [An approach to the street child and the operations group as

an intervention alternative]. Unpublished undergraduate thesis, The National Autonomous University of Mexico, Campus Iztacala, Tlalnepantla de Baz, Estado de México, México.

Martínez, L., and Melgarejo, J. (1995) El niño de la calle y la cultura popular [The child of the street and popular culture]. Unpublished undergraduate thesis, The National Autonomous University of Mexico. Campus Iztacala, Tlalnepantla de Baz, Estado de México, México.

Paiva, V. (1995). Communication et santé. Résultats préliminaires de recherche en Egypte et au Brésil [Communication and health. Preliminary results of research in Egypt and Brazil]. In: S. Tessier (ed.), L'Enfant des Rues et Son Univers Ville, Socialisation et Marginalité. Enfances et Sociétés (pp. 171–176). París: Centre International de l'Enfance, Editions Syros.

Saucedo, I., Rábago, M., Ramírez, V., and Bertado, G. (2006). Diferencias entre niños y niñas en situación de calle del Distrito Federal. Una aproximación cualitativa [Differences between boys and girls living in the street in Mexico City]. Mexico City, México: Yolia, Niñas de la calle A.C.

Sirotta, A. (2002). Faces of war in school. Psychosomatic Field, 28, 147–167. Grenoble, France: L' Esprit du Temps.

Taracena, E. (1995). Enfants de la rue et enfants dans la rue à Mexico [Children of the steet of Mexico City]. Revue Lien social et politiques—RIAC 34 (pp. 101–108). Montreal, Canada.

Taracena, E., and Albarrán, I. G. (2006). Un Modelo Educativo para los Jóvenes en Situación de Calle [An Educational Model for Children Living in the Street]. Mexico City, México: Secretaría de Educación Pública.

Taracena, E., and Tavera, M. L. (1998). La fonction du groupe chez les enfants de la rue à Mexico [The function of the group for Mexico's street children]. In: S. Tessier (ed.), A la Recherche des Enfants de Rue (pp. 70–87). París: Editions Karthala.

Taracena, E., and Tavera, M. L. (2002). El teatro como una alternativa para el estudio de la relación identidad-cuerpo en niños de la calle [Theater as an alternative for the study of the identity-body relationship in street children]. In: I. Aguado, C. Fernández, and M. L. Tavera (eds.), Subjetividad y Lazo Social (pp. 125–142). Mexico City, México: UNAM FES-Iztacala.

Taracena, E., Tavera, M. L., and Castillo, G. (1993, December). La répresentation de famille chez les enfants qui travaillent dans les rues de Mexico [The respresentation of the family in children who work in the streets of Mexico City]. Presentation at the colloquium L'approche clinique dans les sciences humaines: possibilités et limites (The Clinical Approach in the Human Sciences: Possibilities and Limitations). Montreal, Canada.

Tessier, S. (1995). L'enfant des Rues et Son Univers Ville, Socialisation et Marginalité. Enfances et Sociétés [The Street Child and His Universe, City Socialization and Marginality. Infancies and Societies]. París: Centre International de l'Enfance, Editions Syros.

Winnicott, D. W. (1979). L'enfant et sa famille: Les premières relations [The infant and her or his family: First relations]. París: Petite Bibliothèque Payot.

Selected Readings

Gaulejac, V. (2002). Lo irreductible social y lo irreductible psíquico [The social irreducible and the psychic irreducible]. Perfiles Latinoamericanos, Revista de la Facultad Latinoamericana de Ciencias Sociales. Sede México N° 21, 49–72.

Taracena, E., and Tavera, M. L. (2001). El trabajo de los niños en México. La representación del problema de acuerdo a diferentes sectores sociales [Child labor in Mexico. The representation of the problem according to different social sectors]. In: M. C. Rivera, R. Eisnberg, O. Contreras, and M. Landesmann (eds.), Investigación Educativa (pp. 309–315). Mexico City, México: UNAM.

Winnicott, D. W. (1992). Escritos de Pediatría y Psicoanálisis [Through Paediatrics to Psycho-Analysis]. London: Karnak.

Winnicott, D. W. (1986). El Niño y el Mundo Externo [The Child and the External World]. Buenos Aires: Hormé.

World Bank. (2006). La pobreza en México una evaluación de las condiciones, las tendencias y la estrategia del gobierno resumen y mensajes principales [Poverty in Mexico: An Evaluation of the Conditions and Tendencies, and the Governmental Strategy]. World Bank. http://www.siteresources.worldbank.org/INTMEXICOINSPANISH/Resources/b_resumen.pdf.

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Building Environmental Justice in Brazil: A Preliminary Discussion of Environmental Racism[1]

Selene Herculano and Tania Pacheco

The environmental and social costs of Brazilian economic development have been paid by displaced populations in rural areas and poor residents of shantytowns in urban and metropolitan regions. These population segments mainly consist of blacks and "pardos" (mulattos). In spite of Brazil's supposed lack of racist policies, the country has inherited certain aspects of the culture of slavery that create inequalities, including environmental ones that are largely accepted as "natural."

Some efforts have been made to denounce this situation and create real sustainable development. These efforts aim at the empowerment of vulnerable populations so that recognized formal rights of citizenship may be actually obtained. This chapter focuses on cases that exemplify such efforts including the Brazilian Forum of nongovernmental organizations (NGOs) and Social Movements for Sustainability (1990), the Brazilian Network for Environmental Justice (2001), and the First Brazilian Seminar against Environmental Racism (2005).

A Geographical, Historical, and Socioenvironmental Introduction to Brazil

Brazil was colonized by Portugal in 1500 and is currently the only country in South America where Portuguese is spoken. The Brazilian population is formed from the descendants of the Portuguese colonizers, the several native tribes (which have been decimated over the centuries), and the black slaves brought from Africa. During the colonial period (1500–1800), French and Dutch invaders tried to conquer Brazil. Although they failed, they left behind settlements and cultural traits that also have been absorbed into the nation. Finally, since the mid-19th century, other extracontinental ethnic and national groups (including Germans, Italians, Japanese, Arabs, Lebanese, Polish, and Spanish) have been added to the Brazilian mix. The result of all this has been a population composed of diverse cultural groups but united by territory, government and language.

By any measure, Brazil is a big country; its 3,300,000 square miles (8,547,000 square kilometers) make it the fifth largest country in the world, occupying almost half of the South American continent. The country's demographic density is low, but social inequalities are high. There are some 182 million inhabitants of Brazil and the country has a demographic density of nearly 20 people per km^2. The nation's fertility rate has declined to 2.28 children per adult woman; in the richer southeastern region, this rate has dropped to 1.99. But, if the present size of our population is not a problem per se, it is in relative terms, having almost doubled since the 1970s, growing from 70 to 182 million people.[2]

Habitation and life patterns have changed drastically over the past few decades. While Brazil could have been considered a rural nation in the 1950s, with the greater part of its population situated in the countryside (33 million of 51 million Brazilians), today 81.25 percent of the country's inhabitants (136 million of 182 million people) can be found in urban areas. Difficulties have arisen due to the nation's high degree of unequal income distribution (Brazil has a Gini Index of 0.609),[3] poor levels of education (an average of 3.9 years of formal education), and unbalanced population distribution. The vast majority of Brazilians are concentrated along the coast and in metropolitan regions such as São Paulo (16 million inhabitants) and Rio de Janeiro (11 million inhabitants). In these cities, unsanitary and "under-urbanized" slums and poor suburbs abound.

Brazil has been wracked by difficulties arising from its external and internal debts.[4] The Brazilian workforce is distributed as follows: 11 percent in agriculture, 39 percent in industry, and 50 percent in tertiary sectors of the economy (both developed sectors, such as banking and administration, and in the underdeveloped sectors of nonformal economic activities, such as street vending and domestic labor). These debts drain the country's resources, channeling them away from meeting the basic needs of the population and into the hands of the national and international banking system.

In 1822, Brazil became an independent empire separated from Portugal. In 1888, slavery was abolished and the Brazilian republic was proclaimed the following year. At that time, rights of citizenship were limited to only 10 percent of the population (wealthy men). Women got the vote in 1932, but illiterates only achieved the franchise some 30 years later when the vote became a universal right protected by the constitution.

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[2] These data come from the Instituto Brasileiro de Geografia e Estatística (IBGE) [Brazilian Federal Bureau of Geography and Statistics] (2000) and the Instituto de Pesquianas Economicas Aplicadas (IPEA) (2004), a federal institution for economic studies situated in the Ministry of Planning.

[3] The Gini Index measures inequality number closer to 1 indicates the country is more unequal.

[4] There is an external debt (2002) of USD 332 billion and an internal debt of 476 billion dollars (1 trillion Brazilian Real).

It was only in the 1940s, under the government of President Getúlio Vargas, that the country's industrial development[5] finally began to take off, particularly in the steel and oil sectors. The Companhia Siderúrgica Nacional (CSN, National Steel Company) was founded in 1940 and Petrobrás, the national petroleum giant, opened its doors in 1954. Both enterprises were state owned. Between 1955 and 1960, development continued under President Juscelino Kubitschek, whose electoral slogan was "50 years [of economic advancement] in five." During this period, the federal capital moved from Rio de Janeiro to Brasília (an entirely new, planned city in the country's hinterlands), the automobile industry was launched (with German technology) and roads and expressways were built (but the railway system was abandoned). Dams producing electricity, such as Furnas, began to be erected, along with many other modern industrial infrastructural projects.

In 1964, a U.S.-supported coup d'état removed President João Goulart (Jango) from government. According to several scholars (Skidmore, 1975; Dreifuss, 1981; Fausto, 2006), Jango's sin, in the eyes of the Brazilian elite and the U.S. Central Intelligence Agency, was that he tried to accomplish several reforms in sensitive areas such as land tenure, thus enabling him to be painted as a communist. From 1964 until 1979, Brazil was ruled by a military dictatorship, as were many other countries in South America. Due to "petrodollars" (available Arabian money in the form of bank loans), this period also was one of economic expansion and development, with huge infrastructural facilities, such as dams, expressways, bridges, nuclear plants, subways, and skyscrapers, being projected and built throughout the country. This period came to be known as the *"Brazilian miracle,"* with the country's gross national product (GNP) growing by 10 percent annually. Unfortunately, this so-called miracle would be paid for in the future, as it was also the period in which the Brazilian external debt[6] (Instituto Brasileiro de Geografia e Estatística, 2000; Fundação Getúlio Vargas, 2002) was created. The ideology of national integration prevailed throughout the country during the dictatorship, but the most apparent aspect of this could be found in the form of a TV channel monopoly that broadcast throughout the national territory. The channel spread consumerism as a way of life to the upper classes while simultaneously suffocating local and regional cultures.

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[5] The internal debt passed the R $1 trillion mark (US$ 476 billion); it increased from R $857.47 billion (in December 2004) to R $1.002 trillion in December 2005. In other words, in one year, the national internal debt rose by an incredible R $145 billion: R $276 thousand per minute! The cost of servicing debt in the federal sphere (the sum of interest and principal payments for both the internal and external debts) reached R$ 139 billion, significantly higher than the R $99 billion total earmarked for all social welfare expenditures: health, education, relief, agriculture, public security, culture, urbanism, housing, sanitation, the environment, science and technology, agrarian reform, energy and transportation (Fórum Brasil do Orçamento, 1992). Current Brazilian development indicators can be summarized as follows: a GNP (2000) of US $434 billion; GNP per capita (2001) of US $3,229; a Gini index of 0.609; adult illiteracy at 13%; a HDI (Human Development Index - 2001) of 69 in the global ranking.

[6] This grew from 3,523 billion dollars in 1968 to 40,215 billion dollars in 1979 and 137,180 billion dollars in 2000. (FGV- Fundação Getúlio Vargas/ Conjuntura Econômica, 2002).

In 1985, a civilian president was elected by indirect vote via an electoral college, and, in 1989, the population regained the right to vote for the country's president. In 1988, a new Federal Constitution was put in place that consecrated the principles of citizenship, liberty, equality, and human and social rights (such as the right to education, public health, welfare and environmental quality). Nevertheless, an enormous gap continues to exist between the spirit of the Federal Constitution and life as it is now lived in the streets and fields of Brazil.

Brazil is generally understood to contain six ecosystems: (1) the Amazonian rainforest in the northern region, which makes up almost half of the country's territory; (2) the *pantanal* (or wet lands) of the Central West; (3) the *cerrado*[7] (or scrub lands) of the Central West; (4) the Atlantic forest in the Southeast and parts of the South and Northeast (several isolated coastal systems are located along the Atlantic margin, where 9 percent of the former Atlantic rain forest still exists); (5) the *caatinga* (a sort of thorn and bush-filled badlands) in the northeastern outback; and (6) the pampas (a savannah-like environment) in the South.

All of these ecosystems suffer from increasing environmental impacts due to the types of development that Brazil has pursued since the 1950s and, in particular, the unequal urbanization, defined as "swelled urbanization" by geographer Milton Santos (1980), that has resulted from this process. This kind of urbanization has been caused by intense migratory movements toward the metropolitan regions of the Southeast,[8] resulting in lowered levels of quality of life in the urban areas in the most populated southeastern coastal region, the depletion of the coastal ecological systems, poor sanitation, slum growth, and the establishment of polluted industrial zones.[9]

This pattern of uneven development in Brazil is marked by the following traits:

- A monopoly of rural and metropolitan land that has impeded a more balanced pattern of land use and has pushed significant portions of the population into shantytowns (Singer, 1975)
- Neglect of social policies (mainly in the areas of health and education) (Pochmann and Amorim, 2004)
- Encouragement of the automobile industry and individual transportation to the benefit of upper middle class and to the detriment of an effective policy of public transportation, with goods being delivered by trucks on highways instead of by rail, sea, or river (Furtado, 1974)
- An impoverished democratic system, with representatives elected mainly from the rich oligarchy and a Congress that does not act as if it is as really committed to the people's needs and opinions (Demo, 1991)

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[7] The *cerrado* is an ecosystem that forms Brazil's largest water reservoir. Many of the country's rivers are born there. It covers 25% of the Brazilian national territory and is being menaced by agrobusiness.

[8] These days, migration has moved towards the Central West, drawn by work in soy production in the cerrado.

[9] According to the 2000 Census (IBGE – Instituto Brasileiro de Geografia e Estatística), Brazil has 37.8 million urban homes: 34.8 million of these have access to water supplies, but 21 million are not linked to the sewage system. About 3.7 million urban homes lack bathrooms and sanitation.

- A slow, unjust, and ultimately inaccessible justice system (Arantes, 1997)
- Explosive boom/bust cycles (in areas with rubber, mining, and gold) with consequent detrimental impacts on rivers and forests, as well as upon social arrangements (Alencar et al., 1996)
- The expansion of soy cultivation and cattle raising in areas of the pampas, moving toward the *cerrado* and (recently) Amazonia, following a pattern of monocultivation and involving the intense use of pesticides (Ministeriodo Meio Ambiente, 2005)
- A human fertility rate that is higher among the poorest and most neglected social segments, especially the teenagers of the city streets, a fact that contributes to a vicious cycle of poverty and ignorance (Pochmann and Amorim, 2004)

Brazil, then, is a country characterized by structural and geographic imbalances, ritualistic democracy, draining of resources by the financial system, demographic increases among the poorest, and general neglect, by the government and its representatives, of any sort of sustainable social policy. This situation has turned the country's endemic poverty and ignorance into an almost insoluble problem.

Whenever foreigners (or even most Brazilians) think of Brazil's environmental problems, the deforestation of the Amazon springs immediately to mind. The world's largest rain forest is indeed being depleted by the timber trade (specializing, for instance, in mahogany, cedar, and massaranduba Brazilian redwood), mining activities, cattle raising, and expanded agriculture. In the 1970s, a federal plan to settle 100,000 families in *agrovilas*,[10] combined with cheap credit policies for big cattle ranches, encouraged a flood of immigration to the region from the South. The military government also was concerned with occupying the Amazon for reasons of national sovereignty and geopolitical strategy. Policies of integrating Amazonia with the rest of the country were created, with the military government inaugurating the Transamazonian Highway in the 1970s. (This road already has been swallowed by the forest along some stretches.) Mineral exploitation in Serra dos Carajás, although very profitable (producing gold, copper, nickel, manganese, tin, and bauxite), also had harmful effects on the environment. Gold mining reached its apex in the 1980s, when half a million transient miners (*garimpeiros*) flooded the region in search of the precious metal in the alluvial deposits of the Tocantins Valley at the Serra Pelada, polluting local waterways with mercury.

The Amazonian Region, as legally defined, contains almost 60 percent of Brazil's national territory.[11] In spite of the undeniable importance of the Amazon, its problems have long overshadowed the fact that the Brazilian environmental crisis is far more complex and varied. It has been said that Brazilian socioenvironmental problems are a form of *pollusery* (pollution and misery) because they bring

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[10] Agrovilas are urban new settlements in rural areas in Amazonia.

[11] The Amazonian Forest has about 6,5 million km, 5 million of it in Brazilian land and the Amazonian basin has 7 million km, 4 million of these in Brazilian territory (Instituto Brasileiro de Geografia e Estatística, 2000).

together not only industrial pollution, deforestation, toxic chemical waste, nuclear waste, the green agricultural revolution, and pesticides, but also high urban concentration and disastrous urban demographic growth patterns, shortage of urban infrastructure (sewers and sanitation), and lack of housing policies for the poor. The environmental debt and environmental impact of the huge development projects of the past half century have been unequally distributed and fall most heavily on the poorest Brazilians, who lose their health, culture, and land for the sake of economic increases that do not improve their lives.

Menaces to the Amazonian Rain Forest and its river basin also arise from unsolved social-environmental problems in other, more populated, regions of the country. These problems may be summarized as follows:

1. The expansion of agribusiness and agricultural frontiers—soy and cattle-raising—in the Central Western *cerrado* and *pantanal*, ecosystems that are now menaced by agricultural pesticides; desertification brought on by overgrazing and monoculture in the southern pampas, in the South; and mercury poisoning from gold mining in the rivers of the Central West (Comissão Interministerial para o Meio Ambiente, 1991a,b; Fórum Brasileiro de ONGs e Movimentos Sociais para o Ambiente e o Desenvolvimento, 1992)
2. Desertification in the northeastern outback, a perennial problem, due to deforestation begun by colonizers in the sixteenth century (Pádua, 2002)
3. Pollution of our generous fresh water resources (rivers and underground waters)[12] caused by agricultural pesticides, the use of mercury in open mines, and industrial and urban domestic effluents as well as physical and social disturbances caused by the building of huge hydroelectric dams and the unequal distribution of irrigation systems (Comissão Interministerial para o Meio Ambiente, 1991a,b; Fórum Brasileiro de ONGs e Movimentos Sociais para o Ambiente e o Desenvolvimento, 1992)
4. The technological risks and hazards created by the nuclear plants at Angra dos Reis (Rio de Janeiro) and by the establishment of chemical industries (and their subsequent hazards) throughout the country
5. The replacement of native trees in the Atlantic forest by pine and eucalyptus, used as raw material by the cellulose plants of the Aracruz firm in the states of Espírito Santo, Bahia, Rio de Janeiro, and Minas Gerais
6. The low level of the quality of life in metropolitan shantytowns

Meanwhile, cities throughout Brazil still lack adequate sewage systems, and in the metropolitan regions, shantytowns are scattered all over. They are called

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[12] According to the Instituto Brasileiro de Geografia e Estatística (IBGE) (Instituto Brasileiro de Geografia e Estatística, 2000), the Aquífero Guarany is a large underwater reservoir with an area of 1,200 million km and is located under Brazil (840,000 km), Uruguay (58,500 km), Argentina (355,000 km) and Paraguay (58,500 km). Its size is the equivalent of England, France and Spain, taken altogether. The reservoir's water volume is estimated at 40 km/year (Forum Brasil do Orcamento, 1992), 30 times more than the needs of the local population (15 millions inhabitants).

favelas[13] in Rio de Janeiro or *mocambos* in Bahia, and are officially defined by the Instituto Brasileiro de Geografia e Estatística (2000) (Brazilian Federal Bureau of Geography and Statistics) as "poor, ramshackle settlements with more than 51 houses." Some, however, are bigger than towns, containing more than 200,000 residents. The cities with the highest number of shantytowns are, in fact, the most well-off and developed in the country: São Paulo (612 *favelas*); Rio de Janeiro (513); Fortaleza (157); Curitiba (122); Campinas (117); Belo Horizonte (101); Salvador (99); Belém (93) (Instituto Brasileiro de Geografia e Estatística, 2000). Poor people tend to settle near their better-off fellow citizens in an attempt to survive in the urban environment.

The very presence of these shantytowns becomes a tragic indicator of economical dynamics, as well as the result of a lack of effective social policies over the last five decades. In the city of Rio de Janeiro, hundreds of slums, most of them on hillsides, are found in the remnants of the Atlantic Forest, occupying mangroves and riverbanks and creating risky living conditions (for example, because of mudslides and floods). They also destroy the fauna and flora, which, together with the beaches, make Rio one of the fairest cities in the world.

The city of São Paulo receives around 200,000 migrants a year. These people have no access to regular urban lots, and settle in the poor periphery and along the edges of the rivers and dams that make up the city's water supply system. In Vila Socó, a neighborhood of the city of Cubatão, in the state of São Paulo, houses have even been built alongside Petrobrás's oil pipelines. More than a hundred residents died in an accident in 1984 when the pipeline caught fire and exploded (Ferreira, 1993).

Another chronic environmental problem on the coastal margin is the spilling of oil and other poisons. About 600,000 liters of petroleum leaked into Guanabara Bay from Petrobrás pipelines in 1997, and another 1.3 million liters leaked in 2000. In 1991, in Salvador, fifty tons of ammonium were poured into Aratu Harbor, killing the fauna and flora and severely damaging the nearby mangroves where the poor population earn their living.

Pollution hits poor people first and makes them ill; inequalities in urban policies make poor people live in hazardous sites. Poor people are displaced whenever new developmental facilities arrive in their areas. But who are these poor people?

As mentioned above, the Brazilian population is a mix of ethnicities, colors, and cultures. According to the national housing survey (Instituto Brasileiro de Geografia e Estatística, 2004), the country is 52 percent white, 6 percent black, and 42 percent

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[13] The first "favelas" appeared in the city of Rio de Janeiro at the end of the XIX century when ex-slaves and ex-soldiers returned from the Canudos war. (Canudos was an utopian community in the Northeast which was razed by imperial troops.) The name "favela" comes from a typical northeastern plant and it was first used to describe the squatter settlement established on Providence Hill in the city of Rio de Janeiro. Since 1888, when slavery was abolished, ex-slaves who were not entitled to land had began settling in unwanted corners of Brazil's cities – typically in the forests and the mangrove swamps. In the city of São Paulo, the first shanty-towns appeared during World War II as a result of expanded industrialization and the urbanization process.

"mixed" (this category is made up of *pardos* (mulattos), Indians, descendants of Indians, *caboclos, cafusos*,[14] and others).[15] The richest 1 percent of the population is 88 percent white; by contrast, 70 percent of the poorest 10 percent of Brazilians define themselves as black or mixed.

A current debate in Brazil regarding social exclusion is around whether this exclusion is primarily created by racism or by poverty (Fry, 2005; Hasenbalg, 2005; Kamel, 2006). Those who claim that racism does not exist in Brazil point to legal equality and miscegenation itself as evidence of their position, concluding that the country's very evident social problems must thus be rooted in poverty. Those who affirm racism's existence use both anecdotal evidence and the statistical data that link poverty and color.

But there is a third way to look at the question. According to this third view, racism and prejudice are not solely directed against blacks, natives, or mixed people, and they are not simply a matter of color or "race." Rather, these prejudices are employed in order to justify existing inequalities, defining riverside populations, traditional forest people, those who traditionally fish, natives, peasants, and others as "naturally" inferior. This, in turn, enables their exclusion and displacement to be seen as a natural and acceptable price for national progress. In a similar fashion, even poor whites who migrate from the impoverished Northeast to the urbanized Southeast are likewise considered by many Brazilians to be an inferior "race."

Searching for a Sustainable Society by Building Citizenship

In 1988, the United Nations decided that it would hold a world summit (United Nations Conference for Environment and Development, UNCED) in 1992 in Rio de Janeiro to discuss issues of environmental protection and development. Beginning in 1990, preparatory meetings were held by environmental activists and their allies in Brazil. They wanted to create a coalition to represent civil society in the ongoing UNCED and give voice to the point of view and wishes of the Brazilian people (in contrast to the official voice of the country's government). That was how and why the Fórum Brasileiro de ONGs e Movimentos Sociais para o Meio Ambiente e o Desenvolvimento (FBOMs, Brazilian Forum of NGOs and Social Movements for the Environment and Development) was launched.

The FBOMs brought together associations of trade-unionists, indigenous people, black and women activists, students, urban resident associations, people affected by dams, Amazonian rubber tappers, environmental activists, professors, and others in national meetings throughout the country. According to FBOMs, the depletion of

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[14] The ancestry of mulattos is both white and black; caboclos have white and Indian ancestry; and cafusos have black and Indian ancestry.

[15] Some activists of the Brazilian Black Movement, Dojival Vieira, founder of the NGOs Afropress and ABC sem racismo (ABC without racism), argues that there are 91 million black people (50% of the entire population). By this measure, Vieira counts as blacks also the "pardos".

natural resources has the same causes that have been responsible for social inequalities in Brazil, a model of development based on lack of democracy and a huge and unfair Brazilian foreign debt. To transform this evil model of uneven and often false development and create a truly democratic society, one that is both less unequal and more ecologically sustainable, FBOMs proposed an agenda of twenty-three points as the organization's set of political guidelines:

1. Effective international cooperation based on a new pattern of relationships between nature and human beings, women as well as men
2. Redefinition of the Brazilian role in the international context; elimination of inequalities and the creation of real citizenship and democracy for the population
3. Payment of the Brazilian foreign debt to a thorough investigation of its origins
4. A new energy model based on decentralized production, alternative sources of energy, and democratic consumption
5. A strict reform of the Brazilian nuclear program following public hearings
6. Sustainable exploitation of Brazilian mineral resources
7. The creation of national policies for the country's fresh water supply
8. Defense of biodiversity, with the encouragement of scientific research that addresses the welfare of the people
9. Adequate and specific treatment for each of the Brazilian ecosystems, including conservation measures that seek to improve the quality of life of local populations
10. Agrarian reform, with new agricultural policies addressing the needs of "smallholders" and domestic producers as well as the nutritional needs of the Brazilian people in general, encouraging the use of soft technologies
11. Fishery policies that support small-scale fishermen
12. The redefinition of the Brazilian industrial model, encouraging consumption of popular commodities and the use of soft technologies to create employment, redistribute revenues, and enlarge the internal market
13. Urban reform based on three issues: social function of property, citizenship rights, and democratic management of cities
14. Health and sanitation policies for urban and rural human settlements
15. Guaranteed accessibility to contraception and reproductive health care, as well as respect for free individual choices
16. Priority investment in education, science, and technology
17. Promotion of environmental education at all levels
18. The democratization of mass communication and mass media
19. Increased work against racism
20. Definition of the legal boundaries of indigenous lands
21. Definition of extractive reserves, settlements for small land owners, and solutions for the survival of poor mineral prospectors
22. Increased NGO and social movement access to official studies and research concerning the public interest
23. The full participation of NGOs and social movements, as expressions of civil society, in any discussion and decision-making processes involving the environment and development

One of the main contributions of the Brazilian Forum was to define as environmental protagonists those social activists who were not generally considered as such: for instance, people affected by dams, small farmers, and the homeless. Environmental struggles also began to be conceived as a quest for democracy, popular participation and accountability. As social and environmental activist Rubens Harry Born (1987) emphasized:

> There is another aspect of environmental struggles, which is the population's wish to be respected by the authorities; their desire to really practice their rights and to have a better quality of life.… It is the task of the Brazilian environmental movement to make people active in defense of their quality of life.

Below, we give a brief overview of the Movement of People Affected by Dams, Extractive Reserves, the Brazilian Network for Environmental Justice, and the Working Group on Racism. These examples of activism are evidence of the convergence of social and environmental struggles in Brazil.

The Movement of People Affected by Dams

The huge hydroelectric dams (UHE or Usina Hidroeletrica) built throughout the world since the 1960s are considered to be the cleanest, safest, and most definitive solution to the search for energy. Brazil's ample water resources seemed to make dams the logical choice for energy generation, and the image of turbines at work soon became a symbol of modernity and good government throughout the country.

Following the erection of Furnas, a hydroelectric dam, in the 1950s, the military government created Eletrobrás in 1970, a state-owned energy enterprise. Intensive planning for the construction of huge UHEs began: *Itaipu* was built from 1973 to 1977 in the Paraná river basin, covering an area of 1,350 km^2 and drowning the beautiful Sete Quedas waterfall; *Sobradinho*, built from 1976 to 1978 in the São Francisco river basin, formed a lake of some 4,214 km^2 and dislodged around 50,000 peasants in seven municipalities; *Itaparica*, built between 1974 and 1978, also in the São Francisco basin, covered an area of 834 km^2 between Juazeiro and Paulo Afonso, dislodging 5,000 families, drowning three cities and one village, and directly affecting some 120,000 people; *Balbina*, constructed between 1987 and 1989 in the Amazon Basin, formed a lake of 2,346 km^2; *Tucuruí*, built between 1975 and 1985 on the Tocantins River, covered an area of 2,830 km^2.

Taken together, these five dams cover an area of 11,574 km^2 (an area larger in size than Lebanon). According to A. Vianna (1992), Brazilian UHE construction policy in the twenty years from 1973 to 1993 resulted in the formation of a water surface of 24,000 km^2, an area bigger in size than Israel. The Eletrobrás Plan for 2010 calls for the building of 300 more dams.

Dams have been planned and built without listening to the voices of the populations that would be affected by them. These people generally received a notice that they needed to move and, if they were lucky, some small amount of compensation.

Sometimes, as was the case in Bahia, they were given bus tickets to São Paulo. In Balbina, the UHE was built on the land of the Waimiri-Atroari Indian tribe. In Tucuruí, clouds of mosquitoes have appeared due to the drowning of the forest. Trying to meet the problem, local governments have sprayed highly poisonous substances and planned to remove the human population from the area.

The Movement of People Affected by Dams (Movimento dos Atingidos por Barragens, MAB) was launched, advised, and supported by the Catholic Church and various Protestant churches. It began to denounce the fact that, in many areas of Brazil, the local population had no electricity, while the energy produced by neighboring dams went to distant cities and also transnational enterprises such as aluminum plants (Alumar, for example, in Maranhão State).

According to the MAB, the struggle against dams means more than the mere defense of the land. The MAB's activities include (1) changing current patterns of energy consumption and energy, economic, industrial, and urban policies; (2) denunciation of technocratic, authoritarian policies that see the Brazilian backlands as empty space sparsely inhabited by a population understood to be a hindrance to economic progress and, as such, not worthy of consideration; (3) denunciation of the irrationality of policies that flood fertile lands, pushing regional populations into urban shantytowns, and poisoning water supplies; (4) analysis of the role of cement lobbyists in policy making; and (5) denunciation of the destruction of natural resources and soil desertification caused by changes brought about by dams.

The movement's growth at a national level began in Altamira and in the city of Goiânia, where the Goiânia Letter was signed during the First National Meeting of Workers Affected by Dams in 1989. In 1991, the First Congress of Workers Affected by Dams was held in Brasília and on March 14, 1991, the Movement's Brasília Letter was signed. March 14th became, in fact, the National Day of Resistance against Dams in Brazil, focusing attention on the sociopolitical methods used to exclude and displace populations (Brasília Letter, I Congresso Nacional de Trabalhadores Atingidos por Barragens, March, 14, 1991).

Extractive Reserves

The *Reservas Extrativistas* (RESEX, Extractive Reserves)[16] were inspired by Brazil's Indian Reserves, with the right of Indians to the land having been legally recognized by the Federal Constitution of 1988 in article 231.[17] The aim of the RESEXes is to preserve forests and ecosystems and encourage extractive culture by

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[16] The website for Reservas Extrativistas is http://www.redegoverno.gov.br/defaultCab.asp?idservinfo=20371&url=http://www.ibama.gov.br/resex/resex.htm.

[17] The Federal Constitution of 1934 already recognized the right of the Indians to their land. In 1960, the first indigenous area was created, the Xingu National Park. During the military dictatorship, the concept of "indigenous reserves" was fully accepted. In 1988, the new Federal Constitution recognized Indian rights to their domains and the full use of their reserves. These, however, have been continuously invaded by squatters, timber harvesters, and prospectors.

giving native fruit collectors and rubber tappers the means to survive and to pro-duce, freeing them from their current state of partial slavery. According to the Ministério do meio Ambiente (MMA) (2005), RESEX is

> an area occupied by a population which traditionally uses resources extracted from their surrounding environment for immediate survival and trade. [The RESEX] is a state-owned area, managed by local communities through concessions, being at one and the same time a unit of conservation and production.

The RESEX is typically envisioned as a territory within forest environments, but it also can be instituted in other ecosystems, such as the *babaçuais* of the states of Maranhão and Ceará, or the *carnaubais* of Paraíba state.[18]

In December 1992, the National Council of Rubber Tappers (Conselho Nacional dos Seringneiros or CNS) organized a seminar in which it put down on paper the guidelines of the Programa de Reservas Extrativistas—RESEX. One of the main points of these guidelines was criticism of the traditional model of agrarian reform proposed for Amazonia, which settled families in standardized lots of land without considering surrounding environmental conditions. By contrast, the CNS proposed the collective use of land.

The RESEX concept also motivated the Quebradeiras de Coco Babaçu (*babaçu* coconut breaker women) in the state of Maranhão. These women traditionally collect the *babaçus* coconut, which is used to make soap and oil. Working in open native *babaçuais*, the women began to be persecuted and killed in 1985 by neigh-boring farmers who fenced the *babaçuais* in order to raise cattle, enclosing common land and transforming it into private property. An alliance of church members, anthropologists, sociologists, and feminists came to the aid of the *quebradeiras*, who now have financial and technical support from foreign NGOs and from the federal government.

Traditional fishing communities also make use of the RESEX idea to defend their extractive and living areas against such menaces as urbanization, beach development, new roads, and resort tourism. They have established RESEXMARs (sea RESEXes), the best known of which are Pirajubaé (in Santa Catarina State), Corumbaú (in Bahia), and AREMAC (in Arraial do Cabo, Rio de Janeiro State).

In 1989, the Commission on Health, Work and the Environment (COMSAT) of the Chemical Worker's Trade Union of ABC/SP launched a campaign entitled "No to the Contamination and Pollution of the Chemical Industries of ABC."[19] This campaign sought to publicize cases such as those in which the trade union was fighting against the mercury contamination of the Billings water reservoir and the clandestine dumping of dangerous chemical leftovers. COMSAT's main goal was the substitution of technological procedures, and they were successful in getting

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[18] "Babaçuais" and "Carnaubais" are native forests of Babaçu trees and Carnaúba trees, respec-tively. Both are kinds of palm trees.

[19] "ABC" is an acronym for one of the most industrialized areas on the outskirts of the São Paulo Metropolitan Region. It is formed by three municipalities: Santo André, São Bernardo and São Caetano.

new regulations promulgated by Assembléia Legislativa do Estado de São Paulo (ALESP).

The Central Única dos Trabalhadores (CUT), the nation's largest federation of trade unions) also founded a national committee on environment in 1991. The CUT instituted a data bank on Amazonia (including management of social-environmental community development projects); developed maps of hazardous waste sites; and conducted research on industrial activities and their environmental impacts on worker's health. CUT's Instituto Nacional de Saúde no Trabalho (INST, National Workplace Health Institute) developed a program for managing and following-up on collective technical environmental risks in the three biggest industrial zones of the country. This program has encouraged and organized collective memory regarding incidents where malfunctions, accidents, or releases of polluted effluents have had major environmental impact. These include oil and ammonia spills in Candeias; oil spills in Todos os Santos Bay and Guanabara Bay; arsenic and sodium hydroxide poisoning in São Paulo; mercury dumping by the Solway Company in São Paulo; lead poisoning caused by Ferro Enamel; and benzene poisoning at Matarazzo Chemical Industries.

The struggle against benzene poisoning (overexposure to benzene, which causes leukopenia, leukemia, and anemia) is another case where trade-union efforts have addressed both workers' health and environmental issues. This struggle began in 1983, when the Metalworkers Trade Union of Santos diagnosed the first cases of benzene poisoning in the Camaçari petrochemical zone. Unfortunately, in this case, the local media started complaining that the trade union's points about benzene poisoning were simply a strategy utilized by the industrialized South to hinder the economic development of the Brazilian Northeast.

The Brazilian Network for Environmental Justice

We were among the forty cofounders who launched, in September 2001, the Rede Brasileira de Justiça Ambiental (RBJA, Brazilian Network for Environmental Justice). The RBJA focuses on the linkages between social inequalities and environmental depletion. In its 2001 Declaration of Principles, the Network (Rede Brasileira de Justiça Ambiental, 2007) states:

> We understand environmental injustice to be those social and economic mechanisms which unequal societies use in order to channel the lion's share of the environmental damage caused by development towards low-income populations, discriminated groups, traditional ethnic groups, working class neighborhoods and, in general, towards marginalized and vulnerable populations.

The RBJA is an attempt to create alliances between trade unions and environmental activists in the fight against environmental class inequalities and in the struggle to develop policy-building strategies. For instance, when SINTAEMA (the Brazilian trade union for the water, sanitation and environmental facilities workers of the State of São Paulo) first created its committee on sanitation and the

environment, it hoped to take part in the development and application of sanitation national policies. The country still lacks such policies.

Though made up of a relatively small number of participating organizations (less than 100), the RBJA has played an extremely significant role in the day-to-day struggle for environmental justice in Brazil. The organization has led several battles on its own and has also connected isolated movements into networks spanning both Brazil and Latin America. This linkage strategy has meant that the association's secretariat has been able to bring together diverse social actors and orchestrate multifront, political campaigns across the country, as well as widely publicize the demands of groups that have been the victims of environmental injustice. This strategy has strengthened the network's associated movements and allies through the construction of a wide political agenda.

One important change that has taken place within the network has been the formation of a Work Group on Chemicals in a partnership with the FBOMs. This work group was set up with the RBJA in response to demands made by the Associações de Trabalhadores Contaminados ou Expostos a Substâncias Químicas (Associations of Workers Contaminated by or Exposed to Chemical Substances). The Network's secretariat played an important role in bringing together groups from different states that have been victimized by this sort of environmental injustice. This work group creates policies for environmentally safe chemical use in Brazil and also promulgates an informed debate regarding the exposure to and naturalization of chemical contamination risks, focusing on the workers and communities most subject to these risks. The group has participated in several debates involving government and the society at large regarding the implementation of international chemical safety treaties, and has also organized campaigns against the transportation and dumping of toxic residues, in favor of the prohibition of dangerous materials and for the recognition of the rights of groups exposed to chemical contaminants.

Equally important has been the work developed by the network in support of the Reporting Group on Human Rights and the Environment (*Relatoria para o Direito Humano ao Meio Ambiente*), within the National Reporters for Human Economic, Social, and Cultural Rights Project (*Projeto Relatores Nacionais em Direitos Humanos Econômicos, Sociais e Culturais—Plataforma DhESC Brasil*). Since this project began in Brazil, the RBJA has contributed to the Reporting Group on the Environment, forwarding accusations regarding environmental injustice within the country.

Other significant work has been developed together with the Osvaldo Cruz Foundation (FIOCRUZ). It is well known that big corporations commonly attempt to defuse environmental justice controversies by issuing reports signed by scientists they have hired. Brazil Sustentávele Democrático (BSD) (representing the RBJA) and FIOCRUZ have signed a cooperation agreement to provide communities and social movements with independent research, capable of serving as a counterpoint to corporate studies and reports. Within the scope of this agreement, foundation researchers prepare technical reports that can be used in hearings in conflicts between corporations and communities. A pilot study, under the auspices of the agreement, is now being conducted that evaluates the Aracruz Cellulose Company's

use of pesticides and other toxic agricultural chemicals and how these affect the communities bordering the company's plantations. These communities have suffered a series of health problems that have been linked to the contamination of the water table by the kinds of agrotoxics that Aracruz uses on its plantations.

The partnership with FIOCRUZ also includes the construction of a databank, largely made up of documents that have come out of conversations with the RBJA. These include news clippings, accusations, articles, campaign material, reports, event posters and flyers, technical cooperation agreements, meeting minutes, technical reports, and academic research papers. The main objective of this collection is to facilitate access to the documentary material produced by environmental groups in their struggles against environmental injustice and encourage data sharing among the member groups. The databank also serves to aid researchers, communities involved in environmental justice issues, and governments by promoting greater understanding of historical struggles against environmental injustice. It is hoped that the wider distribution of this information will contribute to the recruitment and effective training of new actors and groups as protagonists in the attempt to create new development models and ensure democratic access to environmental resources and their sustainable use. The database can be accessed by local groups via the Internet site of the network (Rede Brasileira de Justiça Ambiental, 2007) and is a powerful tool for the education of groups and communities engaged in the struggle for environmental justice.

The RBJA has also been one of the main developers of the *Rede Alerta Contra o Deserto Verde* (Green Desert Alert Network), another example of the efforts that are being made to deal with environmental justice issues. This network brings together some 100 different groups in four states (Espírito Santo, Bahia, Rio de Janeiro, and Minas Gerais) and aims at limiting the expansion of the eucalyptus monoculture, and denouncing the social-environmental impacts of the Aracruz Cellulose (including deforestation of native forests, expulsion of native and traditional groups from their lands, dismantling of peasant cultures, and water and soil poisoning). The immediate aims of the Green Desert Alert Network are (1) to achieve legislation forbidding new cultivation until an agro-ecological zoning plan can be completed; and (2) to guarantee native and traditional group lands, as well as the return of lands that have already been taken from these groups.

In August 2005, the Sustainable and Democratic Brazil Project (*Projeto Brasil Sustentável e Democrático*) decided to organize a workshop, inviting several of its partner members to discuss and analyze strategies for working against environmental racism. One consequence of the workshop was the foundation of the Working Group on Environmental Racism (GT Racismo Ambiental) within the RBJA. At the end of November of that year, we held the First Brazilian Seminar Against Environmental Racism (*I Seminário Brasileiro contra o Racismo Ambiental*) at the Federal Fluminense University (*Universidade Federal Fluminense*), a co-sponsor of the seminar. The seminar united Brazilians from several different regions and states, including scholars who had already conducted research about environmental injustice and vulnerable populations, NGO researchers who were likewise involved in these conflicts, representatives of social movements engaged in the network's struggles and, most

importantly, leaders of traditional, *quilombo*, and indigenous groups as well as urban groups that were likewise excluded from full citizenship rights. Also, a few international guests, including sociologist Robert Bullard (2006) and clinical sociologist Jan Marie Fritz (2006), were invited to join the discussion.[20] Event participants began with the presumption (which, in fact, underlay all of the network's activities) that only collective participation in constructing alternatives to current developmental paradigms would allow for a successful struggle against environmental racism and the factors that underlie it.

The seminar participants defined environmental racism as "those social and environmental injustices which fall disproportionately upon vulnerable ethnic groups," observing that environmental racism was not limited to racist intentions, but is also present in "actions which have racial side-effects, regardless of their original intent." As the stories presented during the seminar clearly showed, racism was not simply a function of skin color or ethnic origins. Originating in inequality and prejudice, it was, in fact, part of a scenario whose underlying issues were much broader. As the seminar continued, it became clear to participants that the development model currently in existence in Brazil and other countries was based on the notion that certain human beings in both rural and urban areas are "disposable" and can thus be used as a exploitable source of labor, kicked off their land with little or no compensation, assassinated by hired gunmen, or simply rendered "invisible" (Rancière, 1996).

During the seminar, activists from the black and indigenous movements from different regions of Brazil described cases in which their populations had been victimized, particularly in those cases where the economic frontier has expanded over these populations' living areas. Certain Brazilian indigenous groups, the true and original "owners" of the land, have suffered from nothing less than genocide. The representative of the Coordinating Council of Indigenous Organizations of the Brazilian Amazon (Coordenação das Organizações Indígenas da Amazônia Brasileira), for instance, denounced the fact that Cintas Largas women had been contaminated with sexually transmitted diseases, including HIV. A Tremembé shaman from Varjota village in Itarema, Ceará, talked about his fight against the Du Coco Company (which he said had invaded and was destroying his group's lands) and the ranchers who had pushed the group off their beaches and poisoned the waters of the surrounding region. Seminar participants were told that an alcohol company had been draining waste water into the Encantada Lagoon in the Jenipapo-Kanindé Indigenous Reserve (likewise in Ceará). This body of water is considered by the Indians to be sacred, but the company's pollution did not end there; toxics also had seeped into the region's groundwater. A Kaiowá leader from the Tey'ikue Indigenous Reserve in Caarapó

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[20] Clinical sociology contributions in Brazil cover a number of areas (e.g., juvenile delinquency, psychosociology, work, health, and action politics), but there has been very little work on environmental justice and environmental racism. Prominent work in clinical sociology includes the publications by Norma Missae Takeuti (2002b) and Teresa Cristina Carreteiro (1993, 2006). The second International Colloquium on Psychosociology and Clinical Sociology was held in Belo Horizonte in 2007.

township Mato Grosso do Sul asked for aid in fighting the drug dealers on his reservation who were "beating fathers, raping schoolgirls, and hooking boys on drugs." Finally, a Baré Indian, representing the Barcelos Indigenous Association of Amazonas (Associação Indígena de Barcelos, Amazonas) related how his people were fighting against disrespectful and predatory tourism.

The statements of *Quilombola* (descendants of the *quilombos*, the village/republics created by escaped slaves) also were heard during the seminar. The participants were told that in Santo Amaro da Purificação, Bahia, a French company had exposed the local population to lead poisoning for some thirty years, donating lead slag for pavement for schools, parks, and roads, while the company's used filters were given to women to be used as rugs in their houses. *Quilombolas* from Amapá recounted their victory against an attempt by the ICOMI company (Indústria e Comércio de Minérios S/A) to bury manganese mining waste on the group's lands in the Serra do Navio. Members of urban black movements talked about how they were forced off their original lands, in high-risk zones, such as shantytowns lacking water and other services, and were exposed to the violence of drug gangs.

In at least one case, indigenous peoples and *quilombolas* said they had fought together against a common enemy: the Aracruz Cellulose Company. When the company came to Espírito Santo state in 1967, promising jobs and progress for everyone, some 2,000 *quilombola* (numbering 10,000 families) existed in the north of the state. Today, there are only thirty-five communities and 1,300 families. More than forty indigenous villages were destroyed, and the three that have survived (Comboios, Pau Brasil, and Caieiras Velha) are now surrounded by the eucalyptus desert. The main toxin used in the cultivation of eucalyptus is Tordon 2.4 D, the base for Agent Orange, a highly illegal carcinogen that was used in Vietnam.

In Brazil's highly mechanized soy cultivation belt, those traditional people who have not been forced off their lands have been condemned to subsistence agriculture on contaminated soil. Others are forced by their survival needs to work carrying barrels of herbicide or producing charcoal under unsanitary conditions. In exchange for the promise of a better tomorrow, both Indians and *quilombolas* have ended up destroying not only nature, but their own means of survival as well as their culture, traditions, connections to family and friends, and the right to practice their own religions.

According to a representative of the Tupiniquin Indians of northern Espírito Santo state, "when we destroy the forests, we also destroy the gods who live within them." In the same way, when indigenous peoples or *quilombolas* are driven from their lands, they are also forced to break with their traditions and, consequently, lose their collective identities. These groups are being weakened with no apparent violence being involved. They are being "annulled," turned "invisible" and condemned to disappearance, either through physical death or through emotional and spiritual extermination. Our society and culture is practicing what we ourselves should recognize as "cultural genocide" against these traditional people.

How to face this state of affairs and, ultimately, change it was the key question debated during and after the seminar. It was finally decided that work needed to be directed not only at disseminating but also at widening the notion of environmental

racism, and, to this end, seminar participants began investigating the origins of the phenomenon. As a first step, we collected the issues and testimony presented and discussed at the seminar and published a book (Herculano and Pacheco, 2006). The release of this volume was used as an opportunity to engage in debates, networking, and group building in several different cities and townships throughout Brazil. In November 2006, we participated in the 1st Cearense Seminar Against Environmental Racism (I Seminário Cearense contra o Racismo Ambiental) and other seminars are planned.

Over the last two years, a wider conception of who is victimized by this sort of racism also has been formed, This approach takes into consideration the *caiçaras, babaçu* nut breakers, *geraiszeiros*, small fishing groups, shellfish harvesters, rubber tappers, and even Northeastern immigrants seeking employment and better living conditions in other regions of the country.

Conclusion

Aside from the perennial lack of resources, the struggle against environmental racism continues to face two great challenges: first, many members of the environmental justice movement, influenced by orthodox Marxist beliefs, do not themselves understand environmental racism to be a major issue; second, some wings of Brazil's black movement believe that "slapping adjectives onto racism" may end up minimizing our understanding of racism's impact our society. The authors of this chapter believe that both of these views are incorrect, as they seem to forget that, going beyond our specific collective and individual needs and visions, we must forge a vision of a greater utopia that unites us and serves as a common denominator for our struggles. More specifically, we need to work toward a vision of a just and democratic planet. Without such a vision, we will continue to be hostage to the same logic that currently holds us down and prevents any one group from being even partially victorious. This view, in fact, was the general conclusion of the Cearense Seminar, as well as that of another meeting, organized by the Brazilian Network for Environmental Justice together with Ibama, regarding environmental racism and restrictions affecting African-Brazilian religious practices in the Tijuca National Park.

Meanwhile, the Brazilian Network for Environmental Justice has embarked on a very ambitious project: the creation of a map showing environmental racism in Brazil, to be used as an educational tool and weapon in the struggle for justice. The work is based on the information received by the Working Group on Environmental Racism as well as Internet research and wide-ranging studies that seek to create new partnerships across new states and regions in an attempt to widen the network's base while information is being collected.

To focus even more public attention on the issue, the network is making available videos of the testimony given by seminar participants. These are being distributed privately via the Internet to researchers, academics, NGOs, and other interested

groups. Through the writing of articles and the organizing of seminars, the network and its Working Group on Environmental Racism seeks solutions and examples of alternatives. Success is copied and failures are analyzed so that the errors that caused them will not be repeated in the future.

The network also has been expanding its activities to the wider sphere of Latin America, working with networks and movements located in other countries in the region, especially in overseeing and criticizing the activities of the Brazilian state petroleum company, Petrobrás, as it engages in prospecting in neighboring nations. Petrobrás has had an unusually good record of environmental activities in Brazil, where it has created several environmental education programs and activities. In the rest of Latin America, however, and especially in Bolivia and Ecuador, the Brazilian company has acted like most privately owned, multinational firms—ignoring environmental safety guidelines and the needs of traditional populations. The network also has begun criticizing the Initiative for Integrating the Infrastructure of South America (IIRSA), claiming that Brazil's insertion into the international market and the development of major entrepreneurial projects have increased disputes for territory within the nation, negatively impacting the country's most vulnerable groups.

The Brazilian environmental and social movements are not large. On the contrary, they are quite small, with a low number of affiliated members and activists and do not have the participation of many sociologists.[21] Nevertheless, the Brazilian environmental and social movements have been successful over the last few decades in influencing the creation of state agencies, legislation, and regulations. For instance, the movement in favor of Extractive Reserves was responsible for the creation of Centro Nacional de Populações Tradicionais (CNPT, National Center for Traditional Populations) inside the Instituto Brasileiro de Meio Ambiente e Recursos Hídricos (IBAMA, Brazilian Institute of Environment and Water Resources).

Environmentalists were successful in creating units of conservation, but are too weak to achieve effective management of these units and to prevent their invasion by urban expansion. Furthermore, when social and environmental regulations do exist, they are seldom applied.

Against what and whom do the environmental movements struggle? They are against the dominant ideology of progress and those who charge environmentalists with being antiprogress (the worst sort of accusation that can be leveled in a country that is so enamored of the idea of development); against governments who fill in mangroves and bays, open roads within national parks, straighten rivers, and do not obey their own laws and decrees; against companies and their waste; and against real-estate speculators, mines, and capital intensive plantations.

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[21] Leila da Costa Ferreira (2002) has detailed the contributions of Brazilian academics to environmental sociology. Some academic sociologists also are members of ANPPAS, a small national association of social researchers and scholars concerned with the environment and society. Few academic sociologists, however, are involved in the movements concerned with environmental justice and environmental racism. The sociologists who are involved with the movements are more likely to be professional staff members of NGOs, non-profit institutes and organizations working to empower the poor often with the support of foreign foundations.

Brazilian social and environmental activists still need an organization or coalition that can provide them with technical and legal support as well as financial resources. A factor hindering organization is the political parties' constant infiltration of citizens' movements. Parties try to draw these movements into their sphere of influence, but in practice only end up driving citizens away from these movements in droves, seeing as how the average Brazilian despises politics in general and political parties specifically.

Dialogue with the government has become a common event these days, because new governments (which seek to give themselves a democratic patina) need partnerships with civic associations in order to prove their commitment to public opinion and the public interest. Owing to a kind of symbiosis, then, part of Brazilian civil society and fractions of the Brazilian State end up sharing the same fragilities and wind up mutually supporting one another. The best result of this symbiosis has been the legislation and state agencies that the legislature has created; its weak point is its lack of efficacy.

This chapter has described the sources of some of the main environmental and developmental problems Brazil faces, emphasizing how both are deeply linked. It also has described cases of success in citizen organization, attempting to analyze which factors have helped the most in these instances. We understand the problems, but we still lack prescriptions regarding what to do. In fact, what can be done when the churches do not support a movement, the judiciary is not available, judges' decisions are not obeyed, and newspapers are unreachable?

References

Alencar, C., Capri, L., and Venicio, M. (1996). História da Sociedade Brasileira [History of the Brazilian Society]. Rio de Janeiro: Ao Livro Técnico.

Arantes, R. B. (1997). Judiciário e Política no Brasil [Judiciary and Politics in Brazil]. São Paulo: IDESC- EDUC-FAPESP.

Born, R. H. (1987, November 25). Pastores e ovelhas [Shepherds and sheep]. Folha de São Paulo, B32.

Bullard, R. D. (2006). Varridos pelo furacao Katrina: reconstruindo uma "nova" Noa Ornleans usando o quadro teorico d justice ambiental [Washed away by Katrina: rebuilding a new New Orleans using the theoretical framework of environmental justice]. In: S. Herculando and T. Pacheco (eds.), Racismo Ambiental (pp. 126–147). Rio de Janeiro: FASE.

Carreteiro, T. C. (1993). La citoyennete appauvrie [Impoverished citizenship]. In: V. Gaulejac and S. Roy (eds.), Sociologies Cliniques (pp. 143–152). Paris: Desclee de Brouwer.

Carreteiro, T. C., and Enriquez, E. (2006). Le modele American of la violence [The shape of American violence]. Revue Internationale de Psychosociolgie, 179–186.

Comissão Interministerial para o Meio Ambiente (CIMA) [Interministerial Commisssion for the Environment]. (1991a, September). O Desafio do Desenvolvimento Sustentável—Relatório do Brasil para a Conferência das Nações Unidas sobre Meio Ambiente e Desenvolvimento [The Challenge of Sustainable Development. The Brazilian Report to United Nations Conference on Environment and Development (UNCED)1992]. Brasília: Comissão Interministerial para a Preparação da Conferência das Nações Unidas sobre Meio Ambiente e Desenvolvimento (CIMA), [Inter-ministerial Commission for the Preparation of the United Nations Conference on Environment and Development].

Comissão Interministerial para o Meio Ambiente (CIMA) [Interministerial Commisssion for the Environment]. (1991b). Subsídios Técnicos para Elaboração do Relatório Nacional do Brasil para a CNUMAD [Technical Notes for the National Brazilian Report to the United Nations Conference on Environment and Development]. Brasília: CIMA.

Demo, P. (1991). Cidadania Menor—Algumas Indicações Quantitativas de Nossa Pobreza Política. [Minor Citizenship—Some Indicators on our Political Poverty]. Petrópolis: Vozes.

Dreifuss, R. A. (1980). 1961–1965: A conquista do Estado: ação política, poder e golpe de classe [State, class and the organic elite (microform): The formation of an entrepreneurial order in Brazil 1961–1965]. Doctoral dissertation. Petrópolis: Vozes.

Fausto, B. (2006). Getúlio Vargas, o Poder e o Sorriso. [Vargas, Power and Smile]. São Paulo: Companhia das Letras.

Ferreira, L. C. (1993). Os fantasmas do Vale—Qualidade Ambiental e Cidadania [The Ghosts of the Valley—Environmental Quality and Citizenship]. Campinas: Editora da Unicamp,

Fórum Brasileiro de ONGs e Movimentos Sociais para o Ambiente e o Desenvolvimento (FBOM). (1992). Meio Ambiente e Desenvolvimento Uma Visão das ONGs e dos Movimentos Sociais Brasileiros [A Report on Environment and Development – The Point of View of Brazilian NGOs and Social Movements]. Rio de Janeiro, Fórum de ONGs brasileiras, (A Report that Summarizes Eight National Meetings from 1990 to 1992).

Fry, P. (2005). A Persistência da Raça—Ensaios Antropológicos Sobre o Brasil e a África Austral [The Persistence of Race—Anthropological Essays on Brazil and Austral África]. Rio de Janeiro: Editora Civilização Brasileira.

Fritz, J. M. (2006). Confrontando o racismo ambiental: boas ideias, vozes femininas, perspectivas globais [Confronting environmental racism: good ideas, women's voices, global prospects]. In: S. Herculando and T. Pacheco (eds.), Racismo Ambiental (pp. 148–163). Rio de Janeiro: FASE.

Fundação Getúlio Vargas (FGV). (2002). Conjuntura Econômica [Economic Conjuncture Studies]. http://www.fgv.br/principal/idx_principal.asp.

Furtado, C. (1974). O Mito do Desenvolvimento Econômico [The Myth of Economic Development]. Rio de Janeiro: Paz e Terra.

Hasenbalg, C. (2005). Discriminação e Desigualdades Raciais no Brasil [Discrimination and Racial Inequalities in Brazil]. Rio de Janeiro: IUPERJ, Belo Horizonte, publishing company of the UFMG.

Herculano, S., and Pacheco, T. (eds.). (2006). Racismo Ambiental. [Environmental Racism]. Rio de Janeiro: FASE.

Instituto Brasileiro de Geografia e Estatística (IBGE). (2000). Censo Demográfico [Demographic Census]. Rio de Janeiro. http://www.ibge.gov.br/home/.

Instituto Brasileiro de Geografia e Estatística (IBGE/PNAD). (2004). Pesquisa Nacional por Amostra Domiciliar [National Survey by Housing Sample]. Rio de Janeiro. http://www.ibge. gov.br.

Instituto de Pesquisas Econômicas Aplicadas (IPEA). (2004). http://www.ipea.gov.br/default.jsp.

Kamel, E. (2006). Não Somos Racistas [We Are Not Racist]. Rio de Janeiro: Nova Fronteira.

Ministeriodo Meio Ambiente [Ministry of the Environment]. (2005). http://www.mma.gov.br.

Pádua, J. A. (2002). Um Sopro de Destruição: Pensamento Político e Crítica Ambiental no Brasil Escravista (1786–1888) [A Blow of Destruction: Politics and Environmental Criticism in Brazil During Slavery (1786–1888)]. Rio de Janeiro: Jorge Zahar.

Pochmann, M., and Amorim, R. (2004). Atlas da Exlusao Social no Brasil [Atlas of Social Exclusion in Brazil]. San Paulo: V. Cortez.

Rancière, Jacques. O desentendimento [Le mésentente]. São Paulo: Editora 34, 1996.

Rede Brasileira de Justiça Ambiental. (2007). http://www.justicaambiental.org.br.

Santos, M. (1980). A Urbanização Desigual—a Especificidade do Fenômeno Urbano em Países Subdesenvolvidos [Unequal Urbanization—Urban Phenomena in Underdeveloped Societies]. Petrópolis: Vozes.

Singer, P. (1975). A Economia Política da Urbanização [Political Economy of Urbanization]. São Paulo: Brasiliense/CEBRAP.

Skidmore, T. E. (1975). Brasil: de Getulio Vargas a Castelo Branco (1930–1964) [Brazil, from Vargas to Castelo Branco (1930–1964)]. Rio de Janeiro: Paz e Terra.

Takeuti, N. M. (2002b). Inconsistência simbólica e fragilidades indentitárias [Inconsistent symbols and fragile identities]. Psicologia em Revista, Belo Horizonte, 8(12), 32–44.

Vianna, A. (1992, December 28). A População e as Hidrelétricas [Population and hydroelectric plants]. Jornal do Commercio, p. 27.

Selected Readings

Bullard, R. D. (1990). Dumping in Dixie: Race, Class and Environmental Quality. Boulder, CO: Westview Press.

D'Aesky, J. (2001). Racismos e Anti-Racismos no Brasil [Racism and Anti-Racism in Brazil]. Rio de Janeiro: Pallas.

Dean, W. (1996). A Ferro e Fogo—A História e a Devastação da Mata Atlântica Brasileira [With Broadax and Firebrand—the Destruction of the Brazilian Atlantic Forest]. São Paulo: Companhia das Letras.

Ferreira, L. (2002). Brazilian environmental sociology: a provisional review. Ambiente and Sociedade, 10, 27–43.

Herculano, S. (2002). Resenhando o debate sobre Justiça Ambiental: produção teórica, breve acervo de casos e criação da rede Brasileira de Justiça Ambiental [Theory, case studies and the foundation of the Brazilian Network of Environmental Justice]. Revista Desenvolvimento e Meio Ambiente, 5, 143–149.

Landim, L. (1998). Sem Fins Lucrativos—as Organizações Não-Governamentais no Brasil [Nonprofit Organizations in Brazil]. Rio de Janeiro: Iser.

Movimento dos Atingidos por Barragens (personal communication, March 14, 1991). Brasília Letter, I Congresso Nacional de Trabalhadores Atingidos por Barragens.

Pacheco, T. (2005). Linha da Dignidade [Line of Dignity]. Rio de Janeiro: FASE.

Pacheco, T. (2007). Desigualdade, injustiça ambiental e racismo: uma luta que transcende a cor [Inequality, environmental injustice and racism: struggles beyond color]. Rede Brasileira de Justica Ambiental. http://www.justicaambiental.org.br/_justicaambiental/pagina.php?id=1363.

Pinto, L. A. Costa. (1998). O Negro no Rio de Janeiro—Relações de Raças Numa Sociedade em Mudança [Blacks in Rio de Janeiro—Racial Relationship in a Changing Society]. Rio de Janeiro: Editora da UFR.

Takeuti, N. M. (2002a). No Outro Lado do Espelho: A Fratura Social e as Pulsões Juvenis [On the Other Side of the Mirror: Social Breach and Youth Drives]. Rio de Janeiro: Relume Dumará.

Urban, T. (1998). Saudades do Matão [Missing the Forest]. Curitiba: Editora da UFRJ.

Urban, T. (2001). Missão (quase) Impossível—Aventuras e Desventuras do Movimento Ambientalista no Brasil [An Almost Impossible Mission—Adventures and Misadventures of the Environmental Movement in Brazil]. São Paulo: Peirópolis.

Viola, E. (1987). O movimento ecológico no Brasil: do ambientalismo à ecopolítica (1974–1986) [Ecological Movements in Brazil: from Environmentalism Towards Ecopolitics (1974–1986)] In: J. A. Pádua (ed.), Ecologia e Política no Brasil (2nd ed., pp. 63–109). Rio de Janeiro: IUPERJ/Espaço e Tempo.

17

Globalization and Community Organizing: Building Today's Local-Global Movement in the United States

Walda Katz-Fishman and Jerome Scott

Movement Building: The Strategic Question of Our Times

Economic, political, and social crises are deeply affecting communities throughout the United States. In the United States the long history of genocide of indigenous peoples, enslavement of African peoples, the economic exploitation of working people including many immigrant communities, the inequality of women of these communities and classes, wars of conquest and expansion of the continental U.S., and ecocide (the destruction of the ecosystem through harmful political, economic, and social policies) have shaped the economic and political system of global capitalism in the United States since the country was founded, and some of these practices predated the country's founding by over three centuries. This system is rooted in white supremacy and gender oppression as part of the overarching domination of society and the state by the rich and powerful—by those who own the economic resources across the country and the globe and form today's global corporate class (Zinn, 1995; Hennessy and Ingraham, 1997; Smith, 2005).

These forms of injustice and inequality have been reproduced in every century since the late 1400s. In each century resistance and resilience have been a consistent part of daily life. Those communities and classes most adversely affected have organized and struggled against their oppression and exploitation, seeking freedom, liberation, justice, and equality (Kelley, 2002; Mohanty, 2004; Project South, 2004a).

The communities made up of Indigenous peoples and African runaway slaves—known as Maroon communities—fought against genocide, displacement, and the slave-based plantation system in the U.S. South for several centuries. They were finally defeated by the U.S. army in the Seminole Wars and were driven from the South to Oklahoma in the Trail of Tears in the mid-1800s (Katz-Fishman and Scott, 2004b). The black freedom struggle challenged slavery and Jim Crow—U.S. racial apartheid—until the reforms of the modern civil rights movement of the 1950s and 1960s were achieved. The trade union movement fought for the right to organize and for fair wages and working conditions for working people, giving rise to the New Deal reforms of the first half of the twentieth century and the early years of the social contract and welfare state in the United States. Women across race and even class challenged gender oppression in the economic, political and social institutions of U.S.

society for centuries and finally won reforms in the twentieth century—the right to vote and the end to economic discrimination. The enforcement of these reform policies has left unfulfilled many promises of equal treatment under the law for people of color, women, and workers, and is a huge part of the unfinished agenda of the twenty-first century (Martinez, 1998; Project South, 2004a; Project South, 2005).

This legacy of centuries of movement building, and especially its deep roots in southern resistance to Indigenous genocide and African slavery with the powerful voices of women, led many of us in the early twenty-first century to struggle for establishing the United States Social Forum (USSF) in the U.S. South. Within today's context of building a transformative and liberatory movement, organizing the USSF—as part of a world social forum process linking social movements locally, nationally, and globally—was the strategic next step in gathering together the various fronts of struggle and creating a shared vision of the United States and the world we are fighting for. Project South's commitment to movement building for liberation informs our work and brought us to the USSF, held in Atlanta, Georgia, in the summer of 2007, as a process for networking, visioning, and developing strategies for social change (www.ussocialforum.org).

Twenty years ago, when Project South got started, we organized, trained, and developed leadership for movement building. We took a long-term view of things. We were at the beginning of these deepening economic, political, and social crises that demanded that our social struggles and the organizations involved in the various fronts of struggle develop a critical consciousness, political analysis, and political independence from those in power. We also had to figure out our relationships to one another as part of a national movement and to the emerging global justice and equality movement.

The work of Project South, and our communities, organizations, and struggles exist within the objective realities of social history—the electronic revolution, the transformation of work, and the destruction in every aspect of social life and the environment; a powerful global capitalism and its repressive and deadly neoliberal policies; and a violent U.S. empire spreading war, militarism, rape, and violence against women, and abusive prison systems at home and abroad (Katz-Fishman and Scott, 2005a; Project South, 2005; Robinson, 2005). In today's movement building moment, the USSF offered the space to grow our bottom-up justice and equality movement deeper and stronger, and to envision the world for which we fight. We are using this process to build a movement worthy of uniting with our sisters and brothers in the Global South.

Movement Building Through the Lens of Project South

Project South Values: Vision and Mission

Because we discuss our participation in and understanding of movement building over the last twenty years through the lens of Project South, an institute for the elimination of poverty and genocide, we offer a brief history and context of our

origins and our work. We start with our values, vision, and mission statement since it is our political analysis and our vision for humanity and the planet and that guides us in our day-to-day work and especially our decision to help build the USSF (www.projectsouth.org).

Values

Project South is a values-led organization. Our values demand that we "walk our talk." This means that the power and leadership of people and communities at the grassroots are central in the process of creating liberation. We believe that leadership needs to be collectively held and continually developed. For us, justice requires the elimination of exploitation and oppression on local, national, and global levels, and within ourselves and our organizations. To do this work, Project South is committed to movement building that requires financial and political independence.

Vision

The world we are fighting for will evolve from the continuous struggle of liberated people. Cooperative, globally interconnected communities protect, produce, distribute, and sustain the resources of the earth on the basis of need. Our society values the power of diversity and difference, which allows all humanity to develop to our fullest potential.

Mission

Project South is a leadership development organization based in the U.S. South creating spaces for movement building. We work with communities pushed forward by the struggle to strengthen leadership and provide popular political and economic education for personal and social transformation. We build relationships with organizations and networks across the U.S. and global South to inform our local work and to engage in bottom-up movement building for social and economic justice.

Who We Are and the Work We Do

In 1986, our political worldviews and our political practice brought several of us together in the western Alabama Black Belt where the Federal Bureau of Investigation (FBI) had launched an attack on the voting rights of blacks and of poor and rural residents of Alabama (Slaughter, 1992). We came from different but convergent

political histories, from the black freedom struggle—the League of Revolutionary Black Workers in the auto plants of Detroit and the Student Nonviolent Coordinating Committee; and from the anti–Vietnam War/anti-imperialist, and health care movements (Georgakas and Surkin, 1998; Ransby, 2003). We shared a revolutionary outlook and movement building practice that we strived to make part of the growing bottom-up struggles in the closing decades of the twentieth century. At that time we agreed to form Project South as a political and economic education organization to take the story of what was happening in the U.S. South to the country, and to lift up the historic and strategic role of the South in radical and liberation movements in the United States.

From our beginning, we were a multiracial organization including communities of both low income and people of color as well as grassroots activists, and scholar and student activists. We brought these diverse communities together on the basis of equality to do the education work necessary to build a movement for social and economic justice. This was rooted in our understanding that the movement we were building was a broad and deep social movement—a movement of all sections of society who shared a transformative vision that addressed the needs and interests of those most adversely affected and a liberatory practice to make it a reality. Since we ourselves came from these diverse communities, we thought it important to create a space located in the community where scholar and student activists could join with low-income community activists to begin to model another way of creating and sharing knowledge and of political practice for fundamental systemic change (Freire, 1970, 1992). We see Project South's work as consistent with the tradition of clinical sociology, especially activist interventions and analysis to transform communities and improve people's lives (Fritz, 2005, 2007).

Project South began with two volunteers who had other jobs—flexible ones—and could spend time doing this essential political education and movement building work. We had no formal offices and had no budget other than our own resources. Grassroots fundraising (e.g., memberships, donors, selling T-shirts, fee-for-service workshops, and organizing) was our primary means of raising funds.

Along the way in 1991, Project South became a 501(c)(3), community-based organization. This refers to Project South's status as a nonprofit organization. In the United States, organizations can apply to the Internal Revenue Service—the government's tax-collecting agency—for nonprofit or tax-exempt status. Many types of organizations are eligible, such as charitable, educational, service, advocacy, and research. To qualify for nonprofit status, organizations cannot run candidates for political office or support political parties, and cannot spend over 15 percent of their budget on political lobbying. But organizations can run educational campaigns around political issues, and many do. The advantage of 501(c)(3) designation is that organizations are tax-exempt; they pay no business taxes (except payroll taxes), and donations made to them are tax-deductible for the donor. Most charitable foundations that fund grassroots organizations require that the organizations have 501(c)(3) status or have a fiscal agent that has it. Many nongovernmental organizations (NGOs) in the United States are part of the growing nonprofit sector. In Project South we never let

the fact that we were a 501(c)(3) organization compromise our political worldview—our mission, vision, and movement-building work.

As we were preparing the application for our 501(c)(3), we had a political discussion about what the full name of Project South should be. After much thought and deliberation we agreed on Project South: Institute for the Elimination of Poverty and Genocide. For us this meant that we were an education organization and that if we could get rid of all forms of poverty and all forms of genocide in the United States and the world, then we would be moving closer to our vision of a just, egalitarian, collective and cooperative economy and society.

Project South has five full-time staff in our national office in Atlanta, Georgia, and a small volunteer-run office in Washington, DC. We have a working board of fourteen members from across the United States. Project South's board and staff meet twice a year in Atlanta to plan and evaluate our program work, approve the budget and fundraising activities, and do political and popular education for our own internal leadership and organizational development. We always have developed and used a strategic plan, currently a three-year plan, to guide our program work, fundraising, and board, staff, and organizational development. We try to operate by consensus, though, if necessary, we vote and a simple majority decides. Between meetings the board carries out its work through four standing committees—executive, fundraising, board development, and program—that meet monthly through conference calls. The personnel committee is on-call if needed, and, as we are going through a transition, there is now a transition committee to guide that process. The staff collective in Atlanta meets monthly to plan and evaluate all aspects of Project South's daily work: program, fundraising, and staff development.

Our annual budget is around $300,000. While Project South now gets about two thirds of its funds from progressive foundations, we still emphasize grassroots fundraising—memberships, donors, sales of our popular educational publications, and fee-for-service workshops—as key to our survival over the long term. We are a membership organization with over four hundred individual members and several organizational members as well. Project South's offices are in the Southeast U.S. and much of our work is concentrated there, but we are a national organization and do popular education and movement building work throughout the country.

Project South staff and board do our popular education and leadership development work largely through workshops and the writing and sale of our curriculum. Our most recent popular education toolkits are *Today's Globalization: A Toolkit for Popular Education in Your Community* (Project South, 2005); and *The Roots of Terror: Yesterday's Struggles, Today's Lessons, Tomorrow's Victories* (Project South, 2004a). Our "Building a Movement" popular education retreats (BAMs) bring together community, scholar, and youth activists for an intense two-day popular education experience to understand the lessons of history, develop an analysis of root causes of our daily problems, create a shared vision of the society and world we are fighting for, and begin to think about long-term political strategy for liberatory practice. In 2000, we began working

with youths in the Atlanta area and formed the Youth Council. So we have added an intergenerational dimension to our leadership development and movement building work (www.projectsouth.org).

Consciousness, Vision and Strategy: Stages of the Movement Building Process

From the perspective of Project South, we understand the movement-building process as unfolding through definite, but overlapping, stages of development: consciousness, vision, and strategy (CVS). We identify these stages through people's actions and thinking about the problems they are confronting, the proposed solutions to their problems, and their plan to get there. In the consciousness stage, people experience more and more problems and crises in their lives because of the objective conditions of global capitalism—including racism, and gender and other oppressions—and join organizations to fight back, to hold on to what they have, or to make short-term gains. Eventually people and organizations look to connections among problems and systemic root causes. In the vision stage, people and their organizational leadership understand systemic root causes and begin to envision the world we are fighting for—that is, what our communities will look like when we have resolved our problems and have fundamentally transformed societies worldwide. The final stage, the strategy stage (including tactics), is a movement-wide coordinated plan for organizing and educating the long-haul struggle to make the vision a reality (Lenin, 1902; Freire, 1970, 1992; Project South, 2004b).

Based on our participation in the social struggle, we observed that movement building was in the consciousness stage in the late 1980s, 1990s, and into the first years of the twenty-first century. So the primary work we did was consciousness-raising—deepening people's understanding of the root causes of the problems affecting our communities locally, nationally, and globally, their systemic and historical nature; and developing the leadership to think about solutions—short-term and especially long-term. In July 2004, Project South held the Midnite School, our first popular education gathering to explore vision and to strengthen the emerging leadership, both individual and collective, that would guide the movement to the vision stage and be able to bring into the movement in an organized way the thousands of new people and organizations being pushed forward by the struggle. Since then, some movement leaders have been requesting and we have been creating and using more vision tools in our popular education work (Project South, 2004b). In 2005 and 2006, more and more organizations and their leadership in local-global justice and equality struggles are at the beginning of the vision stage, though many individuals and organizations are still in the consciousness stage. Our task—through continuous analysis, practice, and education—is to be part of advancing the movement building process.

Movement-Building Moments Along the Way

The Voting Rights Struggle Continues

For Project South, the first concrete indication that the reform era was over and the era of intensifying repression and struggle was on the rise was in 1986 in the west Alabama Black Belt. The FBI had launched the largest investigation of alleged vote fraud by historic civil rights activists who helped author the 1965 Voting Rights Act (Slaughter, 1992). The U.S. government's attack on the very fundamental political right of so-called "democracies"—the vote—had begun. The "I'll Vote On Campaign" lifted up the struggle to defend voting rights that had been won only twenty-one years earlier (Slaughter, 1992). We saw this attack become pervasive in the 2000 and 2004 presidential elections. While we joined the voting rights struggle, we have always taken the position that democracy is not just about the vote. Rather it is about in whose interests society is organized. At the same time, this struggle marked for us the beginning of the consciousness stage of today's growing bottom-up movement for justice and equality.

Up and Out of Poverty Now!

Those most adversely affected by the slashing of the social safety net, the dismantling of the welfare state, and the passage of neoliberal policies were stepping up in their own defense and taking leadership in new bottom-up grassroots organizations and struggles. The National Welfare Rights Union, the National Union of the Homeless, and the Anti-Hunger Coalition came together in Philadelphia in 1989 to form the Up and Out of Poverty Now! Campaign, led by the victims of poverty. Project South committed, along with others, to building and educating the Up and Out of Poverty Now! Campaign in the Southeast, and especially in Georgia. Over the next few years, Project South helped organize two Up and Out of Poverty Southern summits as well as *Street Heat* magazine, to identify the needs and demands of our struggles in the Southeast and to develop collective grassroots leadership.

Indigenous and People of Color Struggles Challenge Global Capitalism and Oppression

In 1992, Project South was part of the struggles of indigenous and African peoples in resistance to over five hundred years of genocide, exploitation, oppression, and ecocide taking place around the globe. The 1994 passage of the North American Free Trade Agreement (NAFTA) and the Zapatista uprising in Chiapas, Mexico, in

response to NAFTA, were critical movement-building moments. The Zapatista struggles sparked, in many ways, the current phase of the global justice movement because they understood and experienced first the impact that NAFTA would have on the peoples of North America. NAFTA, a key neoliberal policy in the economic integration of North America (Canada, United States, and Mexico), intensified the race to the bottom that profoundly affected job loss, economic and environmental destruction, and immigration to the United States—especially the U.S. South—from Mexico and elsewhere (Committee of Indigenous Solidarity, 2005).

In many ways, neoliberal policies, such as NAFTA, operate in North America much as Structural Adjustment Programs (SAPs) instituted by the International Monetary Fund (IMF) and World Bank in the 1980s and 1990s operate in the developing world. They are designed to open up commodity markets for all goods and services, including intellectual property; to weaken or gut labor and environmental protections, cheapening the cost of production; to slash government spending for social welfare and social goods and to privatize them, creating crises in the lives of working people and, at the same time, creating new markets for the private sector in what were formerly public goods and services (Lechner and Boli, 2004; Katz-Fishman and Scott, 2005a; Project South, 2005; Robinson, 2005; Blau and Iyall-Smith, 2006).

Confronting Neoliberalism at Home: The Justice and Equality Movement Takes Root

Welfare "reform" in 1996 was designed to eliminate "welfare as we know it," while structural poverty, underemployment, and unemployment continued their upward trend. This, along with a mushrooming prison-industrial complex, was a real marker for the breaking of the social contract that had been in place since the New Deal reforms for labor and working people enacted in the 1930s and 1940s. It brought home to the American people the harsh economic and political realities that peoples across the world often suffered at the hands of U.S. empire and global capitalism. This set the material basis for a new kind of solidarity and for the emerging local-global movement for justice and equality that is reflected in the World Social Forum process (Peery, 2002; Roy, 2004; Katz-Fishman and Scott, 2005a; Project South, 2005; Robinson, 2005).

Project South realized that the growing movement required a large number of leaders and took up popular education as a leadership development tool in popular education institutes, workbooks, workshops, BAMs, and a youth council. We also realized that the globalization of capital and neoliberal policies meant that our bottom-up movement had to be locally grounded, nationally networked, and globally connected.

We partnered with the Highlander Center in organizing Southern Strategies to build the southern base for the growing justice and equality movement. The Highlander Center, founded in 1932 by Myles Horton and Don West in the mountains

of Tennessee, created a critical space for folk or popular education during two very important phases of U.S.-based social movements. The Highlander Center did much of the political and economic education for the Congress of Industrial Organizations (CIO)—the more radical section of the trade union movement—in the South in the 1930s and 1940s. In the late 1940s and early 1950s, Horton and Highlander made a strategic assessment that the next upsurge in social struggle in the U.S. South and the country as a whole would be around the black freedom struggle and its challenge to U.S. racial apartheid or Jim Crow. Literacy and popular political education were combined in the Citizenship Schools that indigenous educators from around the South conducted in their communities—raising consciousness and developing literacy at the same time (Horton et al., 1990).

Highlander's collaboration with Project South in the Southern Strategies project was a continuation of this tradition of movement-building work in the South. Southern Strategies addressed two key aspects of movement building: the historic and strategic importance of bottom-up struggles in the South to anchor national movements, and the changing face of the South from a black–white dynamic to a black–immigrant–white dynamic.

The terrorist attacks of September 11, 2001, and the subsequent U.S. Patriot Act interrupted the movement-building process in the South and throughout the country. The Patriot Act was quickly enacted into law specifically to stop terrorism, but the government used it to step up government surveillance of grassroots political activity and to challenge constitutional rights surrounding arrest, detainment, and imprisonment. The ensuing war on terrorism became the excuse to seriously erode civil liberties and thus also represented an attack on the bottom-up movement. But these events and their aftermath clarified the injustice and repression of the U.S. government at home and abroad (Ahmed, 2002; Zinn, 2003; Project South, 2004a).

In the early 2000s, grassroots–, low-income–, and people of color–led organizations were coming together with increasing intentionality and frequency to share experiences, develop relationships, and help build the emerging local-global justice and equality movement. Project South entered this process through Globalizing Civil Society from the Inside Out, the Convergence of Movements of Peoples of the Americas (COMPA), the Grassroots Global Justice Alliance (GGJ), and the World Social Forum (WSF) process (Grassroots Global Justice Alliance, 2005).

The Grassroots Global Justice Alliance consists of fifty-eight U.S.-based grassroots organizations committed to local-global movement building and the USSF as a strategic opportunity to grow our social justice and equality movement in the United States (www.ggjalliance.org). These events and processes in the first decade of the twenty-first century marked the beginning of the vision stage of the movement-building process. Organizations and their leadership that were already highly conscious were increasingly clear that global capitalism and its global oppressions was the systemic cause of their myriad social ills. They were starting to reflect on "another world"—on the society they were struggling to create that would resolve their problems. The social forum process became a gathering space for deepening analysis and for visioning; for networking and relationship building; and to begin strategizing.

The Rising Local-Global Justice and Equality Movement and the U.S. Social Forum

The First Intercontinental *Encuentro* (encounter) for Humanity and Against Neoliberalism organized by the Zapatistas in Chiapas, Mexico, in 1996 inspired the World Social Forum (WSF) process. The WSF, occurring every January since 2001, is a popular (civil society) gathering of the world's worker, peasant, youth, women, and oppressed people. They meet in response to the World Economic Forum in Davos, Switzerland—a gathering of the global corporate and political elites. The WSF is an extension of the ongoing movement-building process that struggles against global capitalism, its neoliberal policies, and the U.S. empire and war. Its mantra, "another world is possible," challenges us to envision the "other" world that we want (Katz-Fishman and Scott, 2004a; Mertes, 2004; Scott et al. 2005).

The WSF process brought forth the call for the U.S. Social Forum. The GGJ answered the call, organizing a consultation process and the National Planning Committee (NPC) for the USSF in 2004–05. The NPC selected Atlanta, Georgia, as the site for the USSF, recognizing the strategic importance of the South for movement building. Project South stepped up as the anchor organization for the process.

The USSF, originally scheduled for summer 2006, was rescheduled for 2007 in response to the devastation and destruction of Hurricane Katrina, the failed levees, and a government that is broken and cannot be fixed. Moving forward, the NPC identified five critical fronts: the struggle to rebuild the Gulf Coast, immigrant struggles and building black–brown alliances, struggles to end war and militarism at home and abroad, the struggle for indigenous sovereignty and an end to ecocide, and workers' rights and struggles.[1]

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[1] These five fronts of struggle represented movement-building moments and challenges. Some showed lost opportunities, but also the potential to have an impact on people's lives. The continuing devastation of New Orleans and the Gulf Coast more than two years after Katrina hit, and the inability of the government to rebuild poor and working-class communities is a challenge to our movement to grow stronger and more effective in defending those most in need. The explosion of millions of immigrants onto the streets of the United States in 2006, demanding their human rights and opposing anti-immigrant legislation, is the basis for real debate in the growing movement about immigration, its roots causes, and what a progressive solution and policy might look like. The need to build unity between African Americans and immigrants is key for the movement to defeat the "divide and conquer" strategy of the elites. The U.S. occupation of Iraq and Afghanistan sparked protests for over three years and declining support for the war and U.S. intervention elsewhere. This militarism abroad, when linked to growing repression and the prison-industrial complex in the United States, offers great challenges and opportunities for building a unified voice in the movement. The legislative push to open up the Arctic National Wildlife Refuge to energy corporations is a battleground around indigenous sovereignty and the assault on Native-American community control over energy resources. Not only indigenous sovereignty, but also energy policy and global warming are all part of this key struggle. Finally, working people, both organized and unorganized, are facing deepening crises in their lives—jobs, wages, working conditions, and even the right to organize are under attack. Taken together, these struggles and moments were central to the USSF and movement- building vision and strategy for the grassroots in the United States.

In building toward the USSF in 2007, the Southeast Regional Organizing Committee organized a powerful Southeast Social Forum in June 2006 in Durham, North Carolina. It brought together over 700 activists and organizers—80 percent working class and from communities of color, and a majority women—to deepen relationships, to share experiences and analysis, and to begin to envision another United States. Workshops explored the historic and contemporary expressions of white supremacy, economic exploitation and poverty, gender oppression, and political and ideological domination by elites, and the grassroots vision and struggles before us. The opening plenary put a spotlight on the horrific devastation of New Orleans and Gulf Coast communities in the aftermath of Hurricane Katrina and the role of the government at all levels in helping create this destruction. Another looked at building black–brown alliances in the Southeast, especially among black and immigrant communities that were being pitted against one another. And the final plenary examined the complex interrelations between militarism and war, male supremacy, and all forms of gender oppression (Van Gelder, 2006).

The Southwest Regional Organizing Committee, anchored by the Southwest Workers Union, organized the Border Social Forum in Ciudad Juarez, Mexico, in October 2006. About 1,000 grassroots activists from organizations on both sides of the U.S.–Mexico border gathered to discuss the economic, political, cultural, and daily challenges of life at the border. They marched to protest plans for the multimillion dollar wall at the border proposed by the U.S. government, calling it the "wall of death" because so many immigrants driven from Mexico by the neoliberal policies of global capitalism die trying to enter the United States in the territory that was once Mexico (before the Mexican-American War of 1848). Cultural celebrations, workshops, and networking were powerful steps to the USSF and the local-global movement we are building. Similarly, Regional Organizing Committees throughout the country were busy educating and organizing their communities (www.ussocialforum.org).

Building the Movement: The U.S. Social Forum and Beyond

The United States in the Early Twenty-First Century

In the opening years of the twenty-first century the daily realities in working-class and low-income communities across race, nationality, gender, and generational lines were harsh indeed in the richest country in the world. Of the nearly 300 million people who lived in the U.S. in 2005, 38.2 million, or 13.3 percent of the 2005 population, lived at or below the poverty level (Webster and Bishaw, 2006). In the nation's capital, Washington, DC, the poverty rate was 19 percent, and it was 18 percent or higher in five states in the South and Southwest: Mississippi, Louisiana, West Virginia, Texas, and New Mexico. The poverty rate was 44.9 percent in Puerto Rico (Webster and Bishaw, 2006). Among blacks and Latinos nationally, the poverty rate was almost double that of whites.

On the face of it, this was a huge economic problem, but it became even worse when we looked at the very low level of income set as the poverty line. For instance, the U.S. Census Bureau's *American Community Survey* calculated the poverty line as only $15,423 for a family of three with a child under 18 years of age (Webster and Bishaw, 2006). Such a family could escape poverty with this income, but surely could not secure the necessities of life. The cost of housing, food, clothing, health care, education, and transportation for this family of three far outstripped this poverty-level income. Activist communities estimated that roughly 45 million Americans were without any health insurance and a similar number experience hunger or very low food security throughout the year. These economic crises disproportionately affected communities of color and especially the women and children in these communities.

How did having a job affect these realities? If you were a minimum wage worker, the answer is, not much. The minimum wage in 2006—$5.15—had not increased for over nine years. The value of the minimum wage, adjusted for inflation, peaked in 1968 at $7.71 and has declined ever since to $5.15 in 2006. Since 1997, its real value declined 20 percent and has not been able to lift a two-person family out of poverty since that time (Yourish and Rivero, 2006). (Congress finally raised the minimum wage in 2007 when the Democrats took control, with additional raises to come over the next two years.) Again, workers of color and especially women disproportionately worked in minimum wage jobs or those close to the minimum. Median earnings looked better than the minimum wage—$41,965 for all men and $32,168 for all women, or 76.7 percent of men's earnings (Webster and Bishaw, 2006). But even these earnings left many working families in debt to pay the house note, the car note, the student loan, and health care.

Given these deep systemic economic crises in the lives of so many millions of women, men, and children, we should not be surprised that this had profound political implications as well. Perhaps the most striking was the booming prison-industrial complex in the United States. By the end of 2005, 7 million people were in the criminal injustice system—incarcerated, or on parole or probation. Of these, a record 2.2 million were in prison or jail, 4.1 million were on probation, and just over 780,000 were on parole. The imprisonment of women was on the rise; and women now represented 7 percent of all state and federal inmates. Blacks and Latinos were also over represented among the 7 million. Just over 8 percent of black men and 2.6 percent of Latino men aged 25 to 29 were incarcerated, but only 1.1 of white men of this age group. Black women were two times as likely as Latina women and three times as likely as white women to be in prison (Associated Press, 2006).

On the other side was the vast accumulation of wealth—the billionaires who made up the richest people in the United States. In 2006, the Forbes 400 members were all billionaires, so having $999 million did not get you on the list. At the top of the list was Bill Gates, the richest person, with $53 billion; and at the bottom was Sehat Sutardja, a semiconductor mogul in Los Angeles, with a mere $1 billion (Ahrens, 2006). To make this concrete, consider the wealth accumulated by Google's founders Sergey Brin and Larry Page, who had $14.1 billion and $14 billion, respectively. For every day over the last two years they each accumulated

$13 million a day (Ahrens, 2006). This certainly is more than most working people make in a lifetime.

This mega-wealth accumulation by corporate magnates is matched only by the merger mania that has again overtaken the private sector. On two days in November 2006, mergers and acquisitions worth more than $75 billion were announced. *Thompson Financial* reported that deals valued at $3.2 trillion were already made public in 2006 as of November. It is likely the record set in 2000 of $3.4 trillion will be surpassed (Pearlstein, 2006).

Lessons from Social History for Building Today's Movement for Justice and Equality

We identify six key lessons from social history and social struggle. These lessons inform our movement-building processes in the early twenty-first century.

The Centrality of Oppression and Exploitation in the U.S. Context

The United States was forged in the oppression and exploitation of Indigenous and African peoples, peoples of color, immigrant and working-class communities, and women and children. This oppression and exploitation was reproduced in new ways in every century since the late 1400s; and those most adversely affected have consistently resisted and struggled for their freedom and liberation. These realities are central to our social history and movement-building practice.

We Only Get What We are Organized to Take

Whenever gains were made, it was because of the popular struggles of those most adversely affected. The reforms addressed the demands of that section of society leading the movement; for example, the New Deal addressed the demands of the powerful trade union movement—mostly white male workers in industry—but excluded the agricultural and service workers, including most blacks, other people of color, and women. So the demands we put forward in today's movement-building moment have to answer the problems of all of those at the very bottom of society—the poorest and most oppressed among us.

We Need a Long-Term Outlook

The ruling class takes a long-term view; for example, in 1944 it put in place the major international financial institutions (e.g., International Monetary Fund [IMF], World Bank [WB], General Agreement on Tariffs and Trade [GATT] of the

Bretton Woods Conference) that today, sixty years later, dominate the economic and political landscape of capitalist globalization and its neoliberal policies (Project South, 2005). Our bottom-up movement also needs a long-term strategic outlook that informs the tactics of our day-to-day struggle.

Unity of Theory and Practice

Whenever our struggles converged into a powerful movement, it was because people united theory and practice. They acted, reflected, and were intentional about the intellectual and subjective side of the movement as well as the action side. Our movement needs to have study circles and popular education to ensure the broadest and deepest popular participation in the movement and to develop collective leadership from all sectors of society.

There are No "Good Old Days": What is Our Vision and Strategy for the Future?

The major victories and reforms of the twentieth century—labor, civil rights, gender, sexuality, ability, the environment, and peace—were won through great struggles on the part of the people, and made a difference in people's lives. But poverty is still with us, as are white supremacy, patriarchy, ecocide, and war. And today we find our hard-won gains under attack and rolled back. This is because we reformed the system but did not change it fundamentally. Today's movement needs a vision looking forward; there are no "good old days." We also need to reflect on what it will take to hold onto our victories over the long haul. What is our consciousness and analysis of the system? What is our vision? What is our strategy and how will we implement it in our daily work?

Electronic Technology Creates Abundance: Our Movement Can End Poverty and Misery

Today's capitalist globalization is happening in a new objective moment in social history. The global electronic age is based on electronics, which is labor-replacing technology. This means several critical and new realities. Working people are needed less and less in the production, distribution, and communication processes of the market. With fewer good jobs and lower wages, working people the world over often cannot afford to buy the necessities of life. Because of this, it is harder and harder for global corporations to sell all the goods and services produced by this highly productive technology. Within the context of the capitalist market, workers are in a spiraling crisis of poverty and all its social effects, and even global capital is facing a crisis of glutted markets. On the other hand, today's electronic technology (computers, robots, all forms of automation) makes it possible to create

an abundance of all the things we need—food, housing, clothing, health care, education—while protecting the earth. Our movement needs to embrace the potential of this new technology that can truly liberate humanity if we transform society organized around private property and maximum profits into a cooperative and collective society organized to meet human needs (Katz-Fishman and Scott, 2005a; Project South, 2005; Robinson, 2005).

Lessons Learned from Project South Experience for Political Practice and Organization

This is Very Hard Work Over the Long Haul

Across race, nationality, class, gender, sexuality, age, region, and religion, we are building a transformative movement that has human liberation and protection of the planet at its center. This movement is anticapitalist, anti–white supremacist, antipatriarchal, and opposes all forms of oppression, inequality, and degradation of the environment. We are trying to do this from inside the "belly of the beast" within the context of centuries of "divide and conquer" by the ruling class; the twentieth century anti-Communism of the McCarthy period[2]; today's resurging economic and political crises; and practices and ideologies of racism, sexism, nationalism, and homophobia. Needless to say, history and context makes theorizing, visioning, strategizing, and funding antisystemic struggles very hard work. It also means we have to be in this work for the long haul.

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[2] The McCarthy period ushered in an intense era of widespread anticommunism, and government political repression and intimidation. McCarthyism and the U.S. Red Scare, as it was known, were most extreme in the post-WWII years from the 1940s to the 1960s. This period took its name from Senator Joseph McCarthy, who accused the U.S. government of being infiltrated by Communists at a time when the Soviet Union was a powerful adversary, when communism and socialism were popular political worldviews in the United States, and when the Cold War was gaining ascendancy. But anticommunism and government repression were not new, and this period got started in earnest during the hearings of the House of Representatives Committee on Un-American Activities (HUAC) held by Representative Martin Dies from 1938 to 1940. It lived on through U.S. government infiltration and disruption of the bottom-up popular movements in the 1960s and 1970s—for example, the Black Panthers, the anti–Vietnam War movement, the American-Indian Movement, and radical women's groups—in a program known as COINTELPRO (counterintelligence program). At the height of McCarthyism, the pervasive and punitive search to root out communists and all "subversives" from the government and the country gave rise to the term *witch-hunts*, and caught in their web government officials, ordinary workers, scholars, and the famous Hollywood Ten. These investigations resulted in "blacklists" of all those deemed "un-American," and in this way destroyed thousands of careers and lives. The total disregard for and violation of civil and constitutional rights of the American people during McCarthyism anticipated today's war on terrorism in the post-9/11 era. Its legacy, even today, is a profound anticommunism and a deep divide between radical scholars and cultural artists, and low-income working-class communities (Fried, 1997; Project South, 2004a).

We Have to Challenge Historic Divides Inside the Movement

The powerful ruling-class strategy of "divide and conquer" is so much a part of society across the globe that it too easily enters our political work and our movement. Divides and privileges based on race, class, nationality, language, culture, gender, sexuality, age, religion, and more are embedded in and reproduced by the economy; political and legal structures and processes; educational institutions; ideology, culture, media, and the arts; and all aspects of social relations. Often those with power, privilege, and resources in the larger society (e.g., whites, those with more money, those with more formal education, men, heterosexuals, adults, citizens) bring their privilege and power into their organizations and the larger movement. In addition, working and low-income people bring ideologies and practices into their organizations and the movement that reproduce divisions from the larger society—such as white supremacy and racism, anti-immigrant stereotypes and actions, male supremacy, heterosexism, and ageism. Inside our movement, within and among organizations, we have to intentionally challenge these divides through dialogue, popular and theoretical education, and action; and have internal processes for accountability and dealing with issues as they arise.

We Have to "Walk the Talk"—Model the World We Are Trying to Create

People often ask how we are ever going to build a movement to fundamentally change society when things are so unjust and unequal. It is essential that we strive inside our organizations and movement to "walk the talk"—to model the world we are trying to create. Concretely this means the power and leadership of people and communities at the grassroots are central in the process of creating liberation, and that leadership needs to be collectively held and continually developed through education and practice. This leadership needs to be diverse in terms of race, gender, class, nationality, sexuality, and age, and we have to be very intentional about developing and lifting up the voices and leadership of those most adversely affected who are pushed forward in struggle. We also have to be intentional about creating structures and processes in our organizations that are collective and cooperative. This requires building relationships and trust within our organizations through dialogue and practice across divides. All this takes time and patience.

Politics Leads and Requires Financial Independence

Much has been said about the relationship between money and politics, especially that those with the money set the political agenda. This is truly problematic for today's organizations that say they are committed to social justice and social change, but are part of the vast array of 501(c)(3) organizations with government tax-exempt status, and funded in large measure by foundations and in a few cases by university affiliation. We are having conversations and even conferences about

the "501(c)(3)–ing" of our justice and equality movement, and often repeat the slogan "the revolution will not be funded."

Two of the most obvious challenges and contradictions are that funders set agendas, and they foster turf issues and competition among organizations rather than cooperation and collaboration. As a result community-based organizations have lost the culture of grassroots fundraising and resource gathering, and find their very survival financially in the hands of external funding sources most of which do not really want social transformation and human liberation. Also, as a result of these dynamics, building collective and egalitarian structures and processes within our organizations and movement are very difficult.

We share a brief story from Project South's early years to illustrate how we are dealing with our politics and our financial independence. Though Project South has always had as part of its mission to bring scholar and low-income activists together on the basis of equality and a shared analysis and vision, we intentionally are not a university-based organization. Early in our organizational life, following the 500 Years of Resistance gathering at a Washington, DC–based university, it became clear that if we were to pursue a formal relationship with the university, it would be on their political terms and not ours. Because we were just as clear that our long-term vision and strategy was to build a bottom-up movement to transform global capitalism—inclusive of white supremacy and gender oppression—rather than to just critique it and call for reforming it, we made the conscious decision to be an independent community-based organization. To this day we know that was the correct decision and see the extensive political strings that come with university-based funding of organizations that profess to do community-based work.

At the same time it is true that foundation grants also come with political strings attached. Even progressive foundations most often have a reform agenda and even more specific funding guidelines that constrain the political worldview and practice of their grantees. So in Project South we have always taken the position that we will take foundation grants, but will not alter our vision and our work because of these grants. For this reason we continue to develop our grassroots fundraising as the only way to maintain our political independence, and believe that we can and must "sell" our political analysis and our popular education and movement building work to our members and supporters as a long-term strategy for our survival and for the larger project of human liberation.

Unite Theory and Practice

Another challenge to long-term and liberatory movement building is that inside many of our organizations theory and analysis are less valued and given less time than direct action, campaigns, protests, providing services, and advocacy to address immediate needs or fight for short-term policy changes. Clearly both short-term fixes as well as long-term transformative movement building need to be part of our agenda. Theory has to guide practice both strategically and tactically, and practice needs to inform theory development and application.

For Project South theory is "living theory"—not theory as doctrine or dogma, but theory as the intellectual side of political struggle and movement building for liberation. We took up popular education within the movement building process to address this need of the movement and our organizations for reflection, analysis, and, as the movement developed, for visioning and political strategy. It remains a challenge to get organizations to take time for reflection, education, and theory. But as crises have intensified and the movement has grown, organizations are a bit more willing to take the time to do this intellectual work of movement building.

Another challenge is the historic campus–community divide, particularly given the separation between radical and revolutionary activists and scholars as a result of the McCarthy era anticommunism and witch-hunts. For Project South, the challenge is connecting university-based intellectuals and movement-based intellectuals in a meaningful way within the movement-building process so that theorizing is rooted in political practice, practice is grounded in living theory, and both sections of society are part of the emerging social movement. As an organization that, from our beginning, intentionally sought to create a space to bring scholar and grassroots activists together on the basis of equality, we struggle to be a bridge between these communities and to the larger movement. We do this through relationship building and popular education in both movement spaces and campus and scholar spaces. Twenty years ago this was very difficult work and is still difficult today; but as activism and the movement have become more visible, more people in both communities are willing to take time for the intellectual work of uniting theory and practice.[3]

Think Outside the Box, and Have a Bold Vision and a Long-term Strategy

The ideological hegemony of the economic and political elite permeates people's formal education and mass culture, and thus their consciousness. So the critical work, through popular education and living theory, is vital to guide the movement through the consciousness, vision, and strategy stages. Understanding social history and the crisis of global capitalism in the electronic age moves those most adversely affected to begin to en vision a world and a United States that is not capitalist, not white supremacist, not patriarchal, and not homophobic. We have seen this need and desire for visioning and a growing need for concrete next steps. Through the theoretically grounded popular education tools Project South developed, we are able to be part of pushing the movement-building process forward in this historic moment.

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[3] Because of our commitment to uniting theory and practice, to bringing scholar and grassroots activists together, and to bridging the campus-community divide, the authors received the American Sociological Association Award for the Public Understanding of Sociology in 2004. The award recognized our work in Project South and the larger movement for justice, equality, and liberation. While there are different understandings of public sociology, ours is from the bottom-up, and is organically connected to the struggles of those most adversely affected by global capitalism and all forms of war and oppression (Brewer, 2005; Burawoy, 2005; Katz-Fishman and Scott, 2005b; Blau and Iyall-Smith, 2006).

Another United States Is Possible

The mantra of the social forum process—"another world is possible"—takes on new meaning for the United States in the historical context of having hosted the first U.S. Social Forum in 2007 (www.ussocialforum.org). Another United States is possible. It is the ongoing task of the U.S.-based bottom-up movement to envision it and develop the political strategy necessary to make it happen.

References

Ahmed, N.M. (2002). The War on Freedom: How and Why America was Attacked, September 11, 2001. Joshua Tree, CA: Tree of Life.

Ahrens, F. (2006, September 22). The Super-Rich Get Richer. The Washington Post, A1, A8.

Associated Press. (2006, December 1). U.S. Prison Population Sets Record. The Washington Post, A3.

Blau, J. and Iyall-Smith, K.E. (eds.). (2006). Public Sociologies Reader. Lanham, MD: Rowman and Littlefield.

Brewer, R. (2005). Response to Michael Burawoy's Commentary: The Critical Turn to Public Sociology. Critical Sociology, 31, 353–359.

Burawoy, M. (2005). The critical turn to public sociology. Critical Sociology, 31, 313–326.

Committee of Indigenous Solidarity. (Personal communication, September 10, 2005). Chronology of the Zapatista Uprising 1994–2005.

Freire, P. (1970). Pedagogy of the Oppressed (M.B. Ramos, trans.). New York: Continuum, 1995.

Freire, P. (1992). Pedagogy of Hope: Reliving Pedagogy of the Oppressed (R. R. Barr, trans.). New York: Continuum, 1994.

Fried, A. (ed.). (1997). McCarthyism: The Great American Red Scare—A Documentary History. New York: Oxford University Press.

Fritz, J. M. (2007). Clinical sociology. In: C. Bryant and D. Peck (eds.), The Handbook of 21st Century Sociology, vol 2 (pp. 353–359). Thousand Oaks, CA: Sage.

Fritz, J. M. (2005). The scholar-practitioners: the development of clinical sociology in the United States. In: A. Blasi (ed.), Plural Histories of American Sociology: Essays at the Centenary of the American Sociological Association (pp. 40–56). Leiden and Boston: Brill.

Georgakas, D. and Surkin, M. (1998). Detroit I Do Mind Dying. Cambridge, MA: South End.

Grassroots Global Justice Alliance. (Personal communication, May 2, 2005). Founding Meeting Report.

Hennessy, R., and Ingraham, C. (eds.). (1997). Materialist Feminism: A Reader in Class, Difference, and Women's Lives. New York: Routledge.

Horton, M., Kohl, J. and Kohl, H. (1990). The Long Haul: An Autobiography. New York: Doubleday.

Katz-Fishman, W., and Scott, J. (2004a). A movement rising. In: An Invitation to Public Sociology (pp. 53–55). Washington, DC: American Sociological Association.

Katz-Fishman, W., and Scott, J. (2004b). The black radical traditions in the South: confronting empire. In: R. Coates (ed.), Race and Ethnicity Across Time, Space and Discipline (pp. 191–222). Leiden, The Netherlands: Brill.

Katz-Fishman, W., and Scott, J. (2005a). Global capitalism, class struggle, and social transformation. In: B. Berberoglu (ed.), Globalization and Change: The Transformation of Global Capitalism (pp. 123–140). Lanham, MD: Lexington.

Katz-Fishman, W., and Scott, J. (2005b). Comments on Burawoy: A View from the Bottom-up. Critical Sociology, 31, 371–374.

Kelley, R. (2002). Freedom Dreams: The Black Radical Imagination. Boston: Beacon Press.

Lechner, F., and Boli, J. (Eds.). (2004). The Globalization Reader. Malden, MA: Blackwell.

Lenin, V.I. (1961) [1902]. What Is to Be Done? Burning Questions of Our Movement (J. Fineberg and G. Hanna, trans.). New York: International Publishers, 1969.

Martinez, E. (1998). De Colores Means All of Us. Cambridge, MA: South End Press.

Mertes, T. (Ed.). (2004). A Movement of Movements: Is Another World Really Possible? New York: Verso.

Mohanty, C. T. (2004). Feminism Without Borders: Decolonizing Theory, Practicing Solidarity. Durham, NC: Duke University Press.

Pearlstein, S. (2006, November 26). What's Under All Those Acquisitions? The Washington Post, F2.

Peery, N. (2002). The Future is Up to Us: A Revolutionary Talking Politics with the American People. Chicago: Speakers for a New America.

Project South (ed.). (2004a). The Roots of Terror: Yesterday's Struggles, Today's Lessons, Tomorrow's Victories (2nd ed.). Atlanta, GA: Project South.

Project South (ed.). (2004b). The Midnite School: Creating a Vision for Our Movement. Atlanta, GA: Project South.

Project South (ed.). (2005). Today's Globalization: A Toolkit for Popular Education in Your Community (2nd ed.). Atlanta, GA: Project South.

Ransby, B. (2003). Ella Baker and the Black Freedom Movement: A Radical Democratic Vision. Chapel Hill, NC: University of North Carolina Press.

Robinson, W. (2005). A Theory of Global Capitalism: Production, Class, and State in a Transnational World. Baltimore: Johns Hopkins University Press.

Roy, A. (2004). An Ordinary Person's Guide to Empire. Cambridge, MA: South End Press.

Scott, J., Katz-Fishman, W., and Brewer, R. (2005). Global Movement on the Rise: World Social Forum 2005—Brazil. As the South Goes…, 13, 10–11.

Slaughter, J. (1992). New Battles Over Dixie: The Campaign for a New South. Dix Hills, NY: General Hall.

Smith, A. (2005). Conquest: Sexual Violence and American Indian Genocide. Cambridge, MA: South End Press.

Van Gelder, S. (2006). Southern Revival. YES! Magazine, Fall, 50–52.

Webster, B., Jr., Bishaw, A., U.S. Census Bureau. (2006). Income, Earnings, and Poverty Data From the 2005 American Community Survey (ACS-02). Washington, DC: U.S. Government Printing Office.

Yourish, K., and Rivero, C. (2006, August 13). Razing the Minimum Wage. The Washington Post, B2.

Zinn, H. (1995). A People's History of the United States, 1492–Present. New York: Harper.

Zinn, H. (2003). Passionate Declarations. New York: HarperCollins.

Selected Readings

Grassroots Global Justice Alliance. (2006). http://www.ggjalliance.org.

Project South: Institute for the Elimination of Poverty and Genocide. (2006) http://www.project-south.org.

United States Social Forum. (2006). http://www.ussocialforum.org.

About the Contributors

Janet Mancini Billson, Ph.D., C.C.S., a certified clinical sociologist, is adjunct professor of sociology at George Washington University and director of Group Dimensions International (16 Otis Shores, Woolwich, Maine, 04579, USA). With a focus on cross-cultural research and the impacts of rapid social change on gender identity, Billson is the author of eight books, including *Female Well-Being: Towards a Global Theory of Social Change; Inuit Women: Their Powerful Spirit in a Century of Change; Keepers of the Culture: The Power of Tradition in Women's Lives; Cool Pose: Dilemmas of Black Manhood in America*; and *The Power of Focus Groups*. She is the lead focus group trainer for the World Bank's International Program for Development Evaluation Training. Billson has served as evaluator for a wide range of U.S. and international organizations since 1981, including the World Bank, the United Nations, universities, and think tanks. Her email address is jmbillson@gdiworld.com

Sarah Callaway Brabant, Ph.D. C.C.S., a certified clinical sociologist and fellow in thanatology, is professor emeritus of sociology at the University of Louisiana at Lafayette, Louisiana USA. In 1981, she designed the first course on death, dying, and bereavement at the university and, although retired, continues to teach this course as an adjunct. She is the author of *Mending the Torn Fabric: For Those Who Grieve and Those Who Want to Help Them*, and has contributed over fifty articles to professional journals. She has worked in her community for over thirty years to provide resources for men, women, and children suffering from a variety of negative circumstances, e.g., bereavement, AIDS, abuse, and homelessness. Her email address is sbrabant@bellsouth.net

Jan Marie Fritz, Ph.D., C.C.S., a certified clinical sociologist, is professor of health policy and planning in the School of Planning at the University of Cincinnati (POB 210016; Cincinnati, Ohio 45221-0016, USA) and affiliated with the Department of Women's Studies and the Department of Sociology. She has been president of the Clinical Sociology Association, president of the clinical sociology division of the International Sociological Association (ISA), and chair of the Sociological Practice Section of the American Sociological Association. She is vice president for finance and membership policy of the International Sociological Association and the ISA

representative to the United Nations (New York City). She was a member of the U.S. Environmental Protection Agency's National Environmental Justice Advisory Council's Health and Research Committee, and she has been a mediator and facilitator for over twenty years. She is the author or editor of more than eighty publications including six editions of *The Clinical Sociology Resource Book*. Her email address is jan.fritz@uc.edu

Giuseppe Gargano, M.A., a clinical sociologist specializing in addictive behavior and related diseases, is director of citizen services for the council of Acerra in the Naples province in Italy (Associazione di Sociologia Clinica ONLUS; via Ponte Aiello; 12-84012 Angri Salerno, Italy). He is the founder and president of the Italian Association of Clinical Sociology and is a cofounder and president of the Italian Federation of Sociology Associations. He also is responsible for the scientific and therapeutic department of the House of Giona in Angri. He previously directed the therapeutic community at M. Fanelli of Pimonte for individuals who were addicted to drugs. He is an expert in planning and social intervention, and he teaches basic courses in these areas for public and private organizations. He is a member of the drug fund committee of the Campania region and was a faculty member for the first graduate clinical sociology program in Italy. He has published sociological analyses of the world of young people and pathological addiction. His email address is info@sociologiaclinica.com

Vincent de Gaulejac, Ph.D., is professor of sociology and organizational sciences and director of the Laboratoire de Changement Social (Social Change Research Center) at the University of Paris 7 Denis Diderot (9, rue Joffre, 78110, Le Vesinet; Paris, France). He is the author of numerous publications, including *La Névrose de Classe* (Class Neurosis), *Les Sources de la Honte* (The Sources of Shame), *Le Coût de l'Excellence* (The Cost of Excellence), *Sociologies Cliniques* (Clinical Sociology), and *La Société Malade de la Gestion* (The Society Afflicted with Management). He also has edited several collected works in French: *Sociologies Cliniques* (Clinical Sociology, 1993), *La Sociologie Clinique, Enjeux Théoriques et Méthodologiques* (Clinical Sociology: Theoretical and Methodological Issues, 2007); in English: an issue of *International Sociology* (No. 12, 1997); in Spanish: *Historia de Vida, Psicoanalisis y Sociologia Clinica* (Life History: Psychoanalysis and Clinical Sociology, 2005); and in Russian. His email address is gaulejac@paris7.jussieu.fr

Martine Godard-Plasman is a socioanalyst and associate member of the Centre de Socianalyse and the Association Française de Socianalyse/French Association of Socioanalysis. She also is a researcher-consultant with the Association d'Analyse Praxeologique et Cognitive (Association of Praxeologic and Cognitive Analysis, CAP-11bis rue Alfred Roll, 75017 Paris, France). She participates in clinical interventions with industrial groups, groups in public and private admin- istration, and associations. She has coauthored several publications on the technical, practical, and theoretical aspects of socioanalysis. Her email address is martine. godard-plasman@wanadoo.fr

Selene Herculano, Ph.D., a sociologist, is an associate professor at the Universidade Federal Fluminense, Rio de Janeiro (UFF/ICHF/GSO—Campus do Gragoatá, Instituto de Ciências Humanas e Filosofia, 24230-320 Niterói, Rio de Janeiro, Brazil)**.** She teaches environmental policy to graduate students and coordinates Laboratório de Estudos de Cidadania, Territorialidade e Ambiente (LACTA, Laboratory for Studies on Citizenship, Territoriality and Environment) (www.uff. br/lacta; www.professores.uff.br/seleneherculano). She is the author of *Em Busca da Boa Sociedade* (In Search of a Better Society), published in Brazil by EDUFF in 2006, and coeditor, with Tania Pacheco, of *Racismo Ambiental* (Environmental Racism). Her email address is seleneherculano@hotmail.com

Walda Katz-Fishman, Ph.D., a scholar-activist and popular educator, is professor of social theory and social inequality at Howard University (Department of Sociology and Anthropology, 2441 Sixth Street, NW, Washington, DC 20059, USA). She is author of over fifty chapters and articles and a contributing editor to four popular education toolkits and books, including *The Roots of Terror: Yesterday's Struggles, Today's Lessons, Tomorrow's Victories; Today's Globalization: A Toolkit for Popular Education in Your Community,* and *Readings in Humanist Sociology: Social Criticism and Social Change*. As board chair of Project South: Institute for the Elimination of Poverty and Genocide, she serves on the coordinating committee of Grassroots Global Justice and on the National Planning Committee of the U.S. Social Forum. She is also an executive committee member of Sociologists Without Borders and was co-recipient of the American Sociological Association 2004 Award for the Public Understanding of Sociology. Her email address is wkatzfishman@igc.org

Jacques Malbos is a socioanalyst and founding member of the Centre de sociana-lyse (21 rue de Javel, 75015 Paris, France) and the Association Française de Socianalyse (French Association of Socioanalysis). As an action-researcher and as a researcher-consultant*,* he has used socioanalysis in working on problems of development, structuring of different associations, relations with foreign associations, and processes of regulation in environments with great inequalities. He is a past president of the scientific committee of the Club Alpin Français (The French Alpine Club). His email address is cnd@ffcam.fr

Yuji Noguchi, M.A., is professor of sociology at Tokyo Gakugei University (Department of Social Science; 4-1-1 Nukuikita-machi, Koganei; Tokyo, 184-8501, Japan). He is the author of several books, including *Narrative Based Clinical Sociology* and *Caring as Narrative*. He was a past member of the editorial board of the Japan Sociological Society and is now the director of the Japanese Society of Health and Medical Sociology. He has worked in the mental health field as a social worker and has studied in collaboration with experts in a variety of clinical fields. His email address is noguchi@u-gakugei.ac.jp

Tania Pacheco, Ph.D, an historian, coordinates the Environmental Racism Program at the Federação de Órgãos para Assistência Social e Educacional (Federation of

Agencies for Social and Educational Assistance), FASE (www.fase.org.br; Rua das Paimeiras, 90, Botafogo, 22270-070, Rio de Janeiro RJ, Brazil). She has been a frequent consultant to other Brazilian NGOs, social movements and the Brazilian federal government. She also has done consulting work for UNICEF. She is the author of many award-winning theatrical plays and nine books. She also is the coeditor, with Selene Herculano, of *Environmental Racism* (2006). Her email address is tania.pacheco@superig.com.br

Andriani Papadaki, M.A., MSc, teaches in the School of Social Work in the Department of Health and Welfare at the Technological Educational Institute of Crete and is a psychologist in a high school for children with special needs (Ksirokampos, 72100; Agios Nikolaos, Crete; Greece). She also is a counselor for groups of parents working for the Parents Counseling III Program at the Institute of Continuous Education. Her research interests include substance abuse, children's aggression, peer-rejected children, children with special needs and family systemic interventions. She is member of the Greek Psychological Society and registered with the Greek Support Services. Her email address: andrianipapadaki@yahoo. gr<mailto:andrianipapadaki@yahoo.gr>

Jacques Rhéaume, M.Ps., Ph.D., sociologist, is professor of psychosociology and clinical sociology of small groups and organizations (theory and practice) at the University of Quebec in Montreal (Département de Communication Sociale et Publique; Université du Québec à Montréal; C.P. 8888, Succursale Centre-ville; Montréal, Québec, H3C 3P8 Canada). He is the coeditor of *Life Stories and Clinical Sociology*. His research interests and publications are about models and practices in social intervention and community development; life stories as a research and training approach for change; and issues of mental health in the workplace. He is the director of the Research and Training Center within the Social and Health Services Center de la Montagne, a multiethnic Montreal neighborhood. He also is president of the clinical sociology division of the International Sociological Association. His email address is rheaume.jacques@uqam.ca

Anastasia-Valentine Rigas, DESS, DEA. PHD, is a full professor in social clinical psychology and qualitative methodology and also is the director of post graduate studies in health psychology and social psychology in the Department of Psychology, School of Social Sciences at the University of Crete (Rethymnon, 74100, Greece). She is an author and editor of 14 books about soical clinical psychology and has written several articles on cancer and psychosomatic diseases. She has organised many international congresses, seminars and symposiums in Greece about clinical social psychology methodology and intervention. Her research interests include female social identity, violence and divorce, social representation in family life, inter-group relations, psychosocial interventions and substance abuse. She is the president of the Greek Association of Social Representations and Methodology and also is the president of the International Association of Qualitative Methodology.

Jerome Scott, a labor and community organizer and educator, is executive director of Project South: Institute for the Elimination of Poverty and Genocide (9 Gammon Avenue, Atlanta, GA 30315, USA). He is the author of over thirty chapters and articles on political economy, race and class, globalization, and popular movements for justice, equality, and popular democracy, and is a contributing editor to four popular education toolkits, including *The Roots of Terror: Yesterday's Struggles, Today's Lessons, Tomorrow's Victories* and *Today's Globalization: A Toolkit for Popular Education in Your Community*. He serves on the Coordinating Committee of Grassroots Global Justice and on the National Planning Committee of the U.S. Social Forum. He was co-recipient with Walda Katz-Fishman of the American Sociological Association's 2004 Award for the Public Understanding of Sociology. His email address is jerome@projectsouth.org

Robert Sévigny, Ph.D, is an emeritus professor of sociology at the Université de Montréal (P.O. Box 6128; Centre-ville Station; Montreal, Quebec, Canada H3C 3J7). He is a founding member and first president of the clinical sociology division of the International Sociological Association. He also was a founding member of the clinical sociology division of the Association des Sociologues de Langue Française. He was the scientific director of a research center that specialized in the cultural and ethnic aspects of social and health services. He is still involved in research, training, and consultation with education, business, trade unions, and research organizations. A monograph of French Canadian families—*Le Québec en Héritage* (Quebec Heritage)—was among his first clinical sociology studies. Mental health is his main area of research and he introduced the idea of implicit sociology to study both mental health practitioners and clients/patients. He presently writes about schizophrenia in a changing China. His work has been published in Canada, France, England, China, Brazil and the United States. His email address is robert.sevigny@umontreal.ca

Elvia Taracena, Ph.D., is a professor of psychology in the Faculty of Professional Studies Iztacala at the Universidad Nacional Autonoma de Mexico (UNAM) (Avenida de Los Barrios #1; Colonia Los Reyes Iztacala; Municipio de Tialnepantla; 54070 Estado de Mexico, Mexico). She also is a level II researcher with the National System of Researchers (SNI) in Mexico. She received her degree in the science of education from the University of Paris VIII in France. She has written a number of articles and chapters as well as two books about clinical sociology. Professor Taracena is president of Metafora A.C., a civil association dedicated to undertaking clinical sociological and psychoanalytic interventions and investigations as well as to writing life histories. She recently received the Sister Juana Ines de la Cruz award for her important work at UNAM. Her email address is etaracena@hotmail.com

Jacques Van Bockstaele is a socioanalyst and founding member of the Centre de Socianalyse (21 rue de Javel, 75015 Paris, France) and the Association Française de Socianalyse (French Association of Socioanalysis). His work at the

Centre d'Études Sociologiques (Center for Sociological Studies) of the Centre National de la Recherche Scientifiques/National Center for Scientific Research (Paris) in experimental sociology on intra-intergroup relations led him and his colleagues to develop an intervention technique, socioanalysis, aimed at client social entities. Socioanalysis has been the subject of several coauthored publications and a 2004 coauthored book, *La Socianalyse: Imaginer-Coopter* (Socioanalysis: Imagining and Co-opting). As a researcher-consultant, he co-manages interventions, as carried out by a team, involving industrial groups, groups in public and private administration, civilian and military groups, and groups in public and religious associations. His email address is: jm.van-bockstaele@wanadoo.fr

Maria Van Bockstaele is a socioanalyst and founding member of the Centre de Socianalyse (21 rue de Javel, 75015 Paris, France) and the Association Française de Socianalyse (French Association of Socioanalysis). She originally was involved in institutional clinical work with emotionally disturbed children, an experience that heightened her awareness of the influence of multigroup interests (such as institutions, family, and therapists). The realization of the importance of intergroup relations in social life prompted her and her colleagues to create an intervention technique, socioanalysis, for institutional clients. Socioanalysis has been the subject of several co-publications and a 2004 coauthored book, La Socianalyse: Imaginer-Coopter (Socioanalysis: Imagining and Co-opting). As a researcher-consultant, she co-manages interventions, as carried out by a team, involving industrial groups, groups in public and private administration, civilian and military groups, and groups in public and religious associations. Her email address is maria. vb@wanadoo.fr

Nathalie Van Bockstaele–Theilhaber is president of the Association d'Analyse Praxeologique et Cognitive/Association of Praxeologic and Cognitive Analysis (CAP, 10 Sacramento Place, Cambridge, MA 02138, USA). She also is a member of the Association Française de Socianalyse/French Association of Socioanalysis. She has been associated with the various stages and aspects of socioanalytical research and has attracted colleagues from a number of fields to work with the Association d'Analyse Praxeologique et Cognitive. Based in the United States, she contributes to making socioanalysis known to an international community. Her email addresses are nvb@media.mit.edu and nvb@cogsci.berkeley.edu

A. Halim Wan, Ph.D., is the head of the Clinical Sociology Consultancy, a private enterprise in Malaysia (Number 40, Jalan Athinahapan 1, Taman Tun Dr., Ismail, 60000 Kuala Lumpur, Malaysia). He previously was a dean and a professor at the School of Social Sciences, as well as a former director of the Centre for Policy Research, at the Science University of Malaysia, Penang. He has developed intervention methods in a number of areas including family (marriage and divorce), community development (ethnic relations), organizational development (human resources), problem solving, and conflict resolution. He has been a consultant, trainer, and evaluator for numerous organizations including the United Nations

Population Fund, World Bank, Konrad Adenauer Foundation, Asia Foundation, Singapore AMP and Malaysia's Social Development, and National Unity Ministry as well as the Ministry of Education. He is a member of the Clinical Sociology Research Committee of the International Sociological Association. His email address is wanhalim@gmail.com

P. Melati Wan, MSc., has a graduate degree in sociology from the University of Oxford (Number 40, Jalan Athinahapan 1, Taman Tun Dr. Ismail, 60000 Kuala Lumpu, Malaysia). She has worked with juvenile delinquents, transgendered individuals, single mothers, seniors with disabilities, children of low-income households, and abused women and their children, and has conducted research about a riot in a Malaysian community. She has assisted the Institute on Aging (San Francisco), Women's Aid Organization (Kuala Lumpur), Malaysian British Educational Co-Operation Services (Kuala Lumpur), and Pintas Child Development Center (Kuala Lumpur). Her email address is wanpuspamelati@gmail.com

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