Clinical Sociology: Social Rehabilitation of Schizophrenia in China and Implications for Aging Research

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Abstract. This article illustrates a clinical sociology approach to psychosocial inquiry and a heuristic analytical grid as a methodological guide. Key concerns of clinical sociology including the notion of self, individual–society relationship, a priority on experience and meaning (including implicit language), action/intervention, and other theoretical and methodological issues are reviewed. The heuristic analytical grid is depicted in seven themes: the individual, the society, the time dimension, "levels" or types of communication, social representation (of mental health/illness), intervention, and organizational dimension of (medical) intervention. Relevance to the study of gerontology is indicated by highlighting the similarities between the study of personal experience of psychiatric rehabilitation and the study of aging. Implications for research and clinical practice are discussed.

Keywords: clinical sociology (CS), heuristic analytical grid (HAG. or HG), psychiatric rehabilitation, aging study, qualitative research in China

Résumé. Cet article illustre une approche de sociologie clinique pour la recherche psychosociale et propose un guide méthodologique sous forme d'une grille heuristique. Il présente et discute des thèmes centraux à la sociologie clinique comme la notion de self, la relation individu-société, l'expérience et le sens (incluant le savoir implicite), l'action et l'intervention, et d'autres enjeux théoriques et méthodologiques. La grille heuristique présente huit thèmes: l'individu, la société, la dimension temporelle, les "niveaux" ou types de communication, les représentations sociales (de la santé/maladie mentale), l'intervention et la dimension organisationnelle de l'intervention dans l'univers médical. Les auteurs indiquent la pertinence de cette approche pour la recherche en gérontologie en soulignant la similarité entre l'étude de l'expérience personnelle de la réhabilitation et le processus du vieillissement.

Mots-clés: sociologie clinique, grille heuristique, recherche qualitative, expérience, schisophrénie, Chine, réadaptation psychiatrique, étude du vieillissement

Introduction

This article presents a clinical sociology (CS) model and a heuristic analytical grid (HAG or HG) as a methodological guide in qualitative research. These have been primarily applied to social rehabilitation but may also be useful in the study of aging, an area that is often intertwined with but not necessarily emphasized in mental health or illness research. Their relevance to aging research is based on similarities between the study of personal experience of psychiatric rehabilitation and the study of aging (Sévigny 2000, 2004; Chen 2007, 2010).

The CS and HG have been an ongoing work for roughly three decades (Sévigny 1983a, 1983b, 1984, 1985, 1996; Rhéaume and Sévigny 1988; Sévigny 2007; Sévigny et al. 2009a). They were first developed at the turn of the 1980s for a study on the "implicit sociology" of mental health practitioners from Montreal (Canada). The notion of "implicit sociology" was meant to distinguish the health practitioners' formal, medical knowledge from their own, nonprofessional or laymen knowledge (and language) (Rhéaume and Sévigny 1988). These were further developed and adapted to the Chinese context when, in 1990, the leadership of a large psychiatric hospital in Beijing invited Sévigny to set up a research project on their patients diagnosed as suffering from schizophrenia in need of rehabilitation during the post-Mao period. At that time, the Chinese government - and the Communist Party - had already abandoned the Soviet model (even though its influence lasted for decades). Authorities in the field of mental health decided to emphasize the well-being of patients after their crisis period instead of concentrating on pharmacology. Social rehabilitation thus became a top priority in the field of psychiatric guidelines (Sévigny 2004). The purpose of the research proposal was to understand the experience of schizophrenia and of social rehabilitation from a clinical sociology perspective. Prior to commencing field work, Sévigny had provided extensive training on the clinical sociology model and on semistructured interview techniques to six staff members from the hospital. This team interviewed twenty patients, as well as people from their immediate social environment (ISE), namely relatives, neighbours, colleagues and work unit leaders, and hospital staff. The main methodology was personal case studies on the experience of schizophrenia with a monographic design.

In this Beijing project, Sévigny expanded the notion of "implicit sociology" to "implicit knowledge" to include all social actors and all aspects in the experience of schizophrenia. Key references on such work include Sévigny (1983a, 1983b, 1984, 1988c, 1993a, 1993b, 1996), particularly those applying to the Chinese (Sévigny, 1992/1993, 1997a,

2001, 2004, 2008, 2009; Sévigny et al. 2009a, 2009b). It should be noted that Arthur Kleinman's seminal work in the form of an analytical grid for mental health practice was the original inspiration for the model to be presented here (Kleinman 1988). Works by Lee were also an important source of information (Lee 1996, 2001; Lee and Kleinman 1997; Lee et al. 2005). We must also recognize the contributions of Michel C. Phillips and Veronica Pearson to the field of mental health and social rehabilitation in China. They studied the same post-Mao period and both authors were concerned with patients and their significant others expressing their own points of view. Mainly interested in the patient's family relationship, their efforts provided important groundwork for the Beijing research design and analysis (Pearson 1993, 1995, 1996; Pearson and Philips 1994; Pearson and Yiu 1993; Phillips 1993, 1998, 2001; Philips and Pearson 1996; Phillips et al. 1994, 1997, 2000).[1] There were others who also made important contributions (especially Luk and Shek 2006; Lai and Rance 2006).

As with any other field of social sciences, the clinical sociologist must be specific about his or her own set of definitions, assumptions, concepts, epistemological posture, and methodology. In the following, we present - in a rather simplified way - a series of definitions, basic concepts, and epistemological considerations relevant to the CS.

The Clinical Sociology Model

CS is a subfield of sociology (de Gaulejac 2007; Fritz 2008) with roots in many schools and areas of social and "human" sciences, including general sociology, psychology and psychosociology, personality-culture, personality-social-structure, interpersonal relationship, group dynamics, research-action and social intervention, and anthropology. CS always, in one way or another, deals with practice or action, either by studying the process of intervention or by studying dimensions related to action or practice. The term "clinical" is used here by analogy mainly with the medical field ("to be or go near the patient") and to stress the intention to relate theory and practice at any level and all areas of action/practice (Sévigny 1996; Enriquez et al. 1993; De Gaulejac et al. 2007; Fritz 2008).[2]

1. We limit this partial list of scholarly contributions to the period when the Beijing research was conducted.
2. In French as in English, the word "clinic" comes from the etymological Greek word: "being near the bed." CS may be applied to any personal or social experience or situation even though our original Beijing research focused on mental health.

A C.S. model implies that the basic theories and concepts of a given research study are coherent with its social and cultural context. Our CS model makes reference to a symbolic interaction perspective (Lester [1945] 1987, 22-46). Let us begin by considering an East-West issue concerning the self as a subjective approach to studying the experience of mental illness in China.

The Notion of Self

In line with the classical Chicago school of philosophy and sociology, the self, implicitly or explicitly, implies the relationships between the image of self and the image of society. We must then answer this question beforehand: Is there (or not) compatibility between this Western notion of self and the notion of self in the Chinese culture and society? Or, does this notion even have any relevance in Chinese culture?

With regard to Western - and American - humanistic psychology, the question about "meetings of the ways" was introduced by Welwood (1979). In a more intercultural context, this question has been explored by many others (Marsella et al. 1985; Marks and Aimes 1995; Bond 1996; Carrithers [1985] 1996; Elvin [1994] 1996). Yet it remains much debated. Bockover (1985), for instance, stresses the differences between the East and the West in revisiting the concept of emotion because "the subjective/objective did not cross Confucius' mind." On the other hand, Chu (1985), following Mead and the interaction perspective, considers "the changing concept of Self in contemporary China" as "a valid hypothesis."

A quick survey of important writings on that issue reveals multiple entry questions: Not only must we compare the East and the West, but also we must consider the specific Chinese conception of self (Buddhism, Confucianism, and Taoism) vs. the "modern," Western notion of self, in coherence with the last century's economic, political, social, and cultural life. Also, within the Chinese context, one should consider the urban-rural subcultures. Among the authors on this subject, Carrithers ([1985] 1996) and Elvin ([1985] 1996) specifically address the meaningfulness of the self in the Asian context. In discussing Mauss' conception of the person, Carrithers reminds us that Mauss proposed the "adequation," i.e., "person = self = consciousness." "Consciousness," or "awareness," is the basic concept in that East-West debate. Mauss finally proposed "An alternative social history of the self," which seems to "commit himself" (in Carrithers' expression) to solving the East-West debate with an observation of universality: "We all share the same precarious plight, between birth and death, subject to forces beyond our control." Elvin also discusses Mauss' notion of person by reviewing Chinese his-

tory. His observation is that "the self tends to find its ultimate meaning as a distinctive component of a vaster structure that extends across space and time: a society, a culture, or a future." He concludes that a notion of self in the Western sense of the word was present in certain periods of Chinese history, and absent in others. Finally, he considers that the self as a "carrier of conscious awareness" makes some sense in contemporary China. For our purposes, the two intellectual postures seem compatible with the clinical sociology model we present in this article.

An argument about the East-West issue may come from contemporary Chinese scholars who themselves attach great significance to Western psychology. For example, Qian introduces many Western psychological theories and practices: among them Carl Rogers' "person centered therapy" and his notion of self (Qian 1989, 268–291). She also includes a chapter on Freud (Qian 1989, 210–257), mostly based on Zhong You Bing's work. Zhong was one of the first in China to refer directly to the "therapy through insight," who did not hesitate to link Eastern and Western psychology. For instance, he translated the psychoanalytic notion of "insight" by a term from Buddhism: *lingwu*. The Western psychology published and taught at Beijing University in post-Mao reform indicates the possibility of studying the experience of schizophrenia in China through the notion of self and other related perspectives. Analyzing the "production" of *guanxi* (relationship) and of *ganqing* (feelings), Kipnis (1997) sees self formation as "immanent in practices of guanxi" and considers that "subjectivities lie … in feelings." For Kipnis, in the Asian context, the self or "subjectivities" are "recreated" through the practice of *guanxi* and the expression of feelings.

All these authors' perspectives are coherent with the CS model presented below.[3] Despite the debate on the notion of self, we may use Elvin's conclusion as a working hypothesis: When we consider Chinese philosophy and culture in the "modern" era, it is meaningful to employ the notion of self as used in the Western societies.[4]

3. Among other Asian nations outside China, Singapore is a good place to observe the co-existence of Western and Asian practices of psychological and social interventions. In Singapore, cultural and religious values, as well as modern and traditional medicine, are central to the definition of those interventions (Sévigny 1991).
4. It is noteworthy that one of the first related publications in the field of American psychology was John Welwood's (1979). He raised the East-West issue in connection with the humanistic psychology movement in US.

The Individual - Society Relationship

In CS, a basic assumption is intimate relationship between the individual and the society.[5] In term of academic disciplines, that implies the relationship between psychology and sociology. As will become evident to the reader, the model we present here contains both psychological and sociological perspectives that are at the foundation of CS. The individuals are both objects of social determinism and subjects who actively react to social situations. This starting point, i.e., the individual-society relationship, assumes a personal-historical perspective in which detailed case studies and other qualitative methods are the main "tool" to study the meaning of any experience.[6] The notions of "experience," "meaning," "subject," and "object" are at the centre of both psychological and sociological perspectives and at the core of our CS model.[7] The "individual-society" assumption also implies a set of theoretical and epistemological positions that we will present briefly in a simple and linear fashion even though they are all interrelated.

Uniqueness of personal experience

One way to illuminate the individual-society relationship is to focus on the uniqueness of any personal experience. The personal experience of mental illness or social rehabilitation is best suited for such an approach. There are, of course, common factors in all rehabilitation processes. Some of them are related to a) the characteristics of mental illness in general or to a specific illness such as schizophrenia, or b) the common norms and values within the patient's social environment. CS is based on the assumption that, beyond all the common determinants, each patient's experience is unique.

This uniqueness is theoretically related to four dimensions of the patient's experience. First, a patient is never entirely or totally identified with his "patient role." All mothers, nurses, work unit leaders, etc. do not fulfill their role entirely in the same fashion. The situation is the same

5. For lack of space, we do not elaborate here on the reason why we have opted for the concept of "individual" instead of "person." See Carrithers [1985] 1996.
6. The method used in the Beijing research was based on personal history of illness and case studies. The notion of "life story" or "life narrative" is often part of the CS perspective (DeGaulejac et al. 2007; Mercier and Rhéaume 2007).
7. In a view similar to the one presented here, Martucelli (2002) proposes a "sociology of the individual" and the notion of "individuation." In the same epistemological perspective, Kiipnis (1997, 9–11) refers to the notion of "subjectivation."

for psychiatric patients who still have specific or personal ways to be a patient. Second, it is almost impossible to imagine that a complex situation involving, for instance, the work unit, the family, and the hospital, would lead to completely identical experiences for different individuals. Third, uniqueness derives from the life history of each patient (who, in turn, is in contact with many people, each one having his own personal and social path). Finally, experiencing is always, at least in some way, a deeply unique experience, a uniqueness that is difficult to communicate to others. This assumption concerning uniqueness must not be considered a negation of the notion of "social fact." Another epistemological posture is equally important: social integration is a universal process that applies to all members of any society. The general assumption is that each patient's experience is, at the same time, or at different times and places, both a collective/social experience and a very personal/unique one. It is important to keep both perspectives in mind when studying mental illness patients - and elderly persons - who are often viewed as "nonperson" or "outside the real social world" even by mental health workers (Sévigny et al. 1999).

The concept of "total social fact"

The classical concept of a "social fact," as defined by Mauss ([1950] 1973), is another way to describe the individual-society relationship. This concept does not imply that there are some "nonfacts"; on the contrary, it assumes that all facts encompass all levels of social reality: from macro (or societal level) to micro (or individual level), through the intermediate levels of the group and the organization. In the study of a given social action, for instance, one has to understand the relationship between all these levels. Let us take psychological counseling or a psychotherapeutic treatment, for example, which are usually perceived as individual and personal experiences. Yet, from a clinical sociology perspective, these interventions take place in specific organizations (such as a hospital), they are indirectly influenced by larger social structures (for example, a national health system), and they imply shared sets of social values (voluntary work, for instance). In this broad sense, the clinical approach is interested in any specific social problem from a holistic or systematic point of view, which in a way resembles Mauss' approach to the "total social fact."[8]

8. In a critical essay about Durkheim and the French schools of sociology, Mauss reframed his notion of "totality" which explicitly includes the individual: "Whoever wants to explain a social fact … must describe the total social fact integrating the individuals who are themselves totalities, [must] take account of the complete individual…" (Fournier 1994, 536).

Multiplicity of Actors and Viewpoints with Sample/Case Studies

Any individual experience implies a complex social system of interactions. Anyone is, directly or indirectly, in interaction with some significant others: parents, friends, doctors, nurses, work colleagues, etc. Furthermore, many interactions take place among those significant others themselves. So, understanding someone's experience of rehabilitation or of aging implies taking into consideration this co-existence of multiple points of view.

Priority on experience and meaning

The specific interest of C.S. is to understand the meaning given by the actors (that is, their representations of reality, their personal motives, beliefs, purpose, reasons, etc.) rather than to give a "scientific" or semi-scientific explanation of the facts that would be considered as objective and without any relationship to the actors' meanings and intentions.

This priority given to meaning does not exclude "objective" data from the analysis. A clinical sociologist may have to take into account some objective facts, but his or her main concern will remain so that the research techniques (semi-structured interviews, letters, diaries, and other personal documents, direct observation of social exchanges, etc.) chosen will enable him or her to understand the meanings the actors give to those "objective" or "scientific" facts. In this context, all clinical analysis implies qualitative interpretation of them.

The implicit language

A mental health professional who has worked with psychotic patients from an underprivileged neighborhood of Montreal for the past ten years, for example, would have acquired an informal knowledge - and often not readily mentioned - on what constitutes an underprivileged neighborhood, what it means to belong to a milieu characterized by poverty and unemployment, the way in which a clinic is organized in a given type of neighborhood, etc. That mental health worker may also implicitly acquire some knowledge about social relations and culture in such a neighborhood, and about cultural differences between helpers and the helped.[9]

9. This implicit language is often - although not always - expressed in metaphoric or symbolic language. For instance, one of the Chinese words to express "implicit" is formed by two characters: *hanxu*. Han means "to keep in the mouth", and xu means "store up": *hanxu* is a good metaphor to describe the implicit language in the sense we use it in the C.S. context. Eberhard ([1983] 1990, 10) explains how Chinese culture often implies the recourse to the equivalent to our "implicit language" notion. About sexuality for instance: "Shame and virtue are as indissolubly linked in the modern Chinese

Here we summarize the position of C.S. in a few sentences: a) both explicit *and* implicit information is necessary to understand a person's experience; b) to fully understand how social actors give meaning to experiences and situations, it is essential to attentively listen to their implicit language; c) the kind of "implicit knowledge" applies to any social actors involved in an intervention or action (in any helping intervention, for instance, it applies to the "interveners" as well as to the "helped" persons and to anybody from his/her immediate social environment or ISE); d) and finally this implicit language or knowledge is also about the social actor's larger social system (LSS) within which the research or intervention is conducted.

The status of the actors' knowledge

Another question regarding epistemology needs to be addressed: What status does the clinical sociologist attribute the social actors' knowledge to? Are the social actors "competent" in describing their situation or their feeling, giving their own interpretation of a given experience? Or should the sociologist take for granted that when an actor explains or says something, s/he surely expresses a kind of misconception, a kind of "non-knowledge" or "false knowledge"? Different authors have taken different or even opposite positions on this issue. In Le métier de sociologue (The Sociologist Trade), Bourdieu and Passeron (1968) take a radical position: "It is perhaps the curse of the social sciences that they must deal with an object that speaks". Giddens (1981, 1991) argues from the opposite side: "...all (competent) actors in a society are expected to 'keep in touch' with why they act as they do, as a routine element of action, such that they can 'account' for what they do when asked to do so by others" (Giddens 1981, 294). Even though this position has been labeled "optimistic", it still seems fundamental in any interpretative sociology to date. Anthropologist Clifford Geertz takes a more radical stance when he considers that, as an anthropologist, he does *not* explain why a society functions the way it does, but rather *translates* for others the meaning to themselves or to their society. In Geertz's terms, this is a "local language" the sociologist will try to "translate" for others. Both Giddens' definition of the "competent actor" and Geertz's definition of "local knowledge" are useful to CS even if the researcher has to be more realistic than "optimistic" under certain circumstances.

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mind as they were in the days of Confucius. *Sexual matters can be referred to in symbolic form or in oblique metaphor, and in no other way*" (our emphasis).

According to the CS model, researchers and social actors (whether professional or not) are oriented toward problem solving and/or experiential decision. Most clinical sociologists would agree with this statement: CS research is not necessarily of an "action research" type, but the "action" dimensions are always present in one way or another. Moreover, it is possible (as in the Beijing study mentioned in the introduction) to consider that each individual "intervenes" in his or her own life or environment. Finally, some researchers study actions or interventions without being directly involved as a part of the happenings but mainly to help others in their own actions or interventions.[10]

At one stage or another, the sociologist will communicate with those s/he studies or "intervenes with": he or she has personal reactions to them and, conversely, they will also react to his or her presence. Thus, the clinical sociologist still has a personal involvement in this relationship. In that sense, the people s/he studies are not the only "objects" or "subjects" involved, but s/he is also a "subject" and "actor". The CS model provides a theoretical framework to understanding his or her own research-intervention, as a helper-researcher who must understand his or her relationships with those s/he studies. Such issues are more complex when teamwork is involved.[11]

Action, evaluation, and neutrality

Action is rarely neutral. Nor are debates and decisions value-free. In the long run, and often also in the short term, neutrality is also an important aspect of the personal relationship between the clinician and the groups studied, and plays an important role in the development of trust that characterizes the clinician-client relationship. For the clinical sociologist, neutrality means taking an unbiased perspective with respect to social issues. If the researcher identifies completely with the actors s/he collaborates with, or whom s/he studies, s/he can hardly make a scientific contribution.

Most social scientists now agree on the impossibility of neutrality. The clinical sociologist must pay attention to this dimension because, as we have seen above, s/he must be personably involved in the research process at different levels (e.g., "…going near the bed of a patient").

10. The Beijing research was a good example of diversity in the application of the CS model.

11. Although we do not elaborate on this here, the reader should realize that introducing a study on the personal experience of schizophrenia via a CS approach was in itself a social and political intervention in early 1990s' China (Sévigny, 2001).

However, this critical approach must remain on a general level and not interfere with the day-to-day research process. For example, no clinical sociologist would be able to conduct constructive research on social rehabilitation of aging psychiatric patients if s/he is fundamentally against the idea of rehabilitation, is opposed to psychiatric hospitals as social institutions, or believes that no social rehabilitation is possible in a given social context. A critical point of view does not necessarily mean to have a negative opinion, though one would accept such research only if s/he assumes some value of psychiatry and of social rehabilitation.

A frequently used technique to conciliate objectivity and personal involvement is to take into account the diversity of viewpoints, as discussed earlier. Neutrality then means to take into account the complexity of meanings that actors give to any specific situations. In the presence of different and even conflicting viewpoints among the people under study, the researcher must offer some interpretations for each one. S/he will also offer some interpretations as to why they differ or are in conflict, as well as the consequences of those divergences. To remain relatively neutral does not mean that the actors' understandings or representations should not be challenged – they are, after all, subjects who have their own personal points of view. Nor can it be assumed that individual actors are able to express *all* the dimensions (social or psychological) of given situations or experiences. The task of any clinical sociologist is to offer some interpretations in regard to the actors' experiences and representations. Finally, being only one actor among others, the researcher should be careful not to privilege his or her own biased interpretations of the situation and the people under study.

Other Theoretical and Methodological Considerations

Disciplinary and interdisciplinary inquiry

CS focuses on the individual-society relationship, which has to be studied at least along the psychological and sociological dimensions of an experience or situation. The interdisciplinary approach is not limited to the relationship between sociology and psychology, even when the research problem falls in the field of social psychiatry. CS often implies what Merton used to call "middle ground theories", for instance sociology of organizations, sociology of social movements, research on small groups, sociology of government, of family, of the workplace, of management, of trade unions, etc. CS demands crossing the lines of related disciplines in the social and behavioral sciences, e.g., economics, management, social work, law, and communications, to name a few. The only limits to multi- or interdisciplinary analyses are usually imposed by

external factors such as the expectations or demands of the actors (individuals or organizations) under study, or more concrete constraints such as deadlines and available resources.

Case studies and data gathering

Within the short tradition of CS, case analysis has often been the preferred methodology. Even before the development of CS, the Chicago School of sociology used case analysis and W. F. Whyte's *Street Corner Society* ([1943] 1993) was one of the most well-known examples. From the individual-society point of view, it applies to any personal experience: "society" referring then to any immediate social environment or any larger social, economic, political or cultural organization to which s/he individually belongs. Case analysis sometimes includes comparisons as a methodological tool, but those comparisons must be based on some meaningful central experiences (see below).

Data integration

In experimental or quasi-experimental research, the researcher exerts certain control over the situation. This is the scientific model in which most variables are "controlled" and comparisons are established on the basis of control groups. In such a methodological model, the research design isolates the specific, target variables to be studied. Moreover, the control is made possible through objective and standardized measurement. Clinical analysis implies a different form of control, one to be attained by the integration of data rather than by a process of reduction. The clinical sociologist's methodology is to take into account *all* the relevant "factors" that are part of the situation, even if s/he does not "control" them in the experimental sense.

Critical incident or central experience

The concept of a critical incident here has a broad meaning and includes everything that appears to be central to the understanding of one's experience. These central experiences can take different shapes. It could be a problem or a particular event around which the experience gains its full meaning; it could be a person who occupies a significant place in the patient's life; or a set of events that became central. Yet, no matter how these critical or central experiences appear, they are all both social and personal.[12]

The CS model described in the above was developed by Sévigny as a response to the research proposal put forward by the Beijing psychiatric

12. The notion of *critical incident* was developed by Margaret Cohen-Émérique (2000) in the context of intercultural relationships.

hospital mentioned in the introduction. It is not exclusive to other approaches in CS since even starting with similar ideas may lead to very different or divergent points of view. The general CS model is accompanied by a more "concrete" analytical grid. For the purpose of the Beijing project, it was intended for studying the experience of schizophrenic patients with social rehabilitation. Yet, as stated in the introduction of this article, it could be presented in general terms and the same grid may be used in the study of any personal experience, particularly aging.

THE HEURISTIC ANALYTICAL GRID

Any CS research project can be considered as based on one type or another of a heuristic grid (HG), whose purpose is to structure both the data gathering and the analytical procedures[13] and therefore to address important methodological issues.[14] This section illustrates a HG applied to the study of mental illness and social rehabilitation.

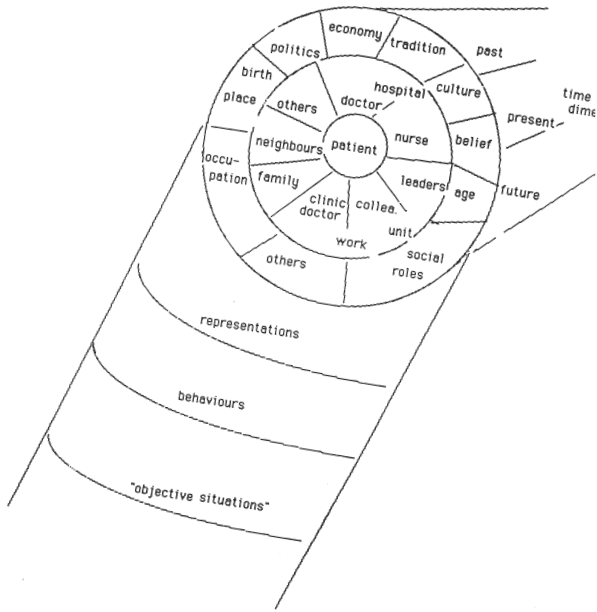
For a patient, rehabilitation is the experience of coming back to his or her previous place of life after hospitalization.[15] In this sense, any rehabilitation is social rehabilitation and, theoretically, it may involve social life in the family, the neighborhood, the workplace, etc. According to one's theoretical understanding or idea of rehabilitation, for example, being able to work may or may not be considered an important element for rehabilitation. Because rehabilitation will always take place in some social environment, the heuristic grid must provide some guidelines regarding the environment.

The HG presented in this section offers a systematic way to explore a) the different "layers" of social realities (for instance the distinction between the Immediate Social Environment (ISE) and the Larger Social System (LSS), b) different types (or "levels") of knowledge, c) the

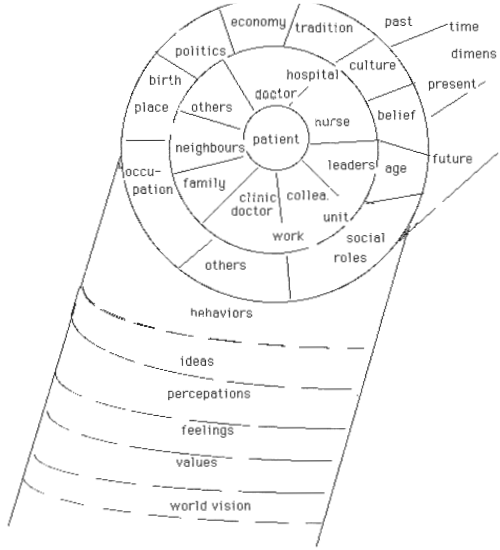
13. One of the pioneers in that field was Arthur Kleinman (1980, 1986, 1988) whose interest was social construction of illness in different social and cultural contexts but mainly in China. Following Leslie and Young, we consider Kleinman's grid "as part of the cultural background needed for understanding clinical interactions in the biomedical settings" (Leslie & Young, 1992:9). The "Comparative Cross-Cultural Grid" proposed by Kleinman (1988) was the basis for the grid proposed in the Beijing project.
14. The use of the term *heuristic* reminds the reader that this framework is not a pure theory, but more a tool to guide the researcher.
15. This is the usual definition when patients have been hospitalized, but there could also be situations where rehabilitation takes place outside any hospital system. Deva (1990), while president of the World Association for the Psychosocial Rehabilitation, often mentioned the importance of this notion of "rehabilitation without hospital" in the context of developing countries.

patient's representation of his/her social environment as part of his/her personal experience of mental illness and social rehabilitation, and d) a complementary point of view of all the social actors involved in each patient's experiences for the comprehension of the "clinical setting" (Kleinman's term). In short, the general objective of this heuristic model is to achieve a better understanding of the patient's experience. A secondary but important goal is to – at least implicitly – illuminate C.S. as way to understand the psychiatric patients' experience of rehabilitation. Two general graphs propose an even more concrete view of the whole grid.

Graph 1



Graph 2



The HG is divided into two sections and seven themes in the below. The first section directly addresses two major themes: (1) the individual and (2) the society. It also takes into account (3) the time dimension and (4) the "levels" or types of communication. The second section is specifically oriented toward the actions/interventions and includes three remaining themes: (5) representation of mental health/illness, (6) intervention with the "problem" (mental illness), and (7) organizational dimension of the (medical) intervention.

The Individual's Personal Self or Identity

The individual as part of a social system

In every society there are "expectations" toward any sick person, and particularly toward mentally ill patients. In this sense, being sick is a social role. Some patients tend to conform to those expectations spontaneously, while at other times do not readily. To understand a patient's experience also requires exploring a complex set of roles and their impact:

- As a family member
- As a part of the informal neighborhood (the next door neighbors, the formal Street Office or the Neighborhood Residents Committee in the Chinese context)
- As a member of a work unit (when it applies)
- As living in an urban or rural area, or in any specific setting
- As having a specific position in the larger social system (LSS) based on gender, education, occupation, financial situation (from very poor to very rich), social responsibilities, religious beliefs, membership in an organization, etc.
- As part of the whole political system or the economic system
- As part of the Chinese culture, tradition, and history
- As part of a social network (*guanxi*) (which may overlap with some other contacts already mentioned above)

The individual as the locus of a unique experience

This theme does not include a list of relevant items or dimensions because, by definition, uniqueness may happen to be linked to any other themes. The expression of uniqueness, for instance, may appear along with some explanation of the impact of a specific illness (theme 3), or information about the family or social status of a given patient (theme 2). For the same reason, a patient may express his/her desire to social integration while speaking of his/her family life as well as of the social welfare system. Among the terms that could be relevant to this theme are: meaning (through direct expression, implicit language, symbols, or metaphors), motivation, values, self-image, set of behaviours, etc.

The Social Context: ISE and LSS

An illness or rehabilitation experience may involve many social contexts. When someone (a patient himself or a person related to his/her experience) wants to explain, or comment about, for instance, the "cause" of an illness or of the rehabilitation phase as the consequence of this illness, those "causes" or "consequences" are related to a social context most of the time. For analytical purpose, we make a distinction between the ISE and LSS The former includes the family and relatives, neighbors, the work unit (called *Danwei* in the urban Chinese context), the hospital staff, etc. The latter refers to a more macro level of social life, which may be viewed in many ways. In sociological theory, the LSS is often considered as including three general areas: the social, the cultural, and the economic lives. At a more empirical level, the LSS may be viewed as

including many units or categories, such as: age and gender groups, rural or urban areas, different regions within a country, types of occupation and education, work units, the State and the political system in general, health system (both modern or traditional), economic and industrial organizations, religious beliefs and organizations, the family as a social institution (not only as a small group), etc. The last case - the family - reminds us of the groups already categorized in the ISE, which may also be looked upon as a social institution from a macro point of view. A family, a *Danwei*, a hospital, etc. may be referred to by interviewees (or any social actor) as part of the ISE or as part of the LSS.

The Time Dimension

Both diagrams include the past-future dimension, which is important to any content pertaining to the ISE or LSS. This dimension may have to be applied to individuals (e.g., a patient and ISE interviewees in the Beijing study). During an interview in the Beijing study, for instance, the Cultural Revolution might be mentioned as a "cause" or "starting point" of a patient's illness, or someone might express the hope that in the future the Reform would provide him/her with more social/societal support for rehabilitation.

Levels or Types of Communication

The notion of a level or type of communication applies to any individual experiences, to experiences situated in any ISE or LSS context and in regard to any themes such as a patient's illness, therapeutic intervention, or health establishment. Information, ideas, comments, attitudes, meanings, etc., may be expressed directly or by using a metaphoric or symbolic language. It may also be expressed by describing "objective" behaviors or personal facts. It may even be expressed by "meaningful silence" or non-verbal signs. It is important to keep those levels of communication in mind while interviewing a patient or a patient's ISE in order to understand - as much as possible - what we described earlier as their "implicit knowledge."

Below, we consider three remaining themes from their application to severe mental illness (schizophrenia in the Beijing study): (5) the representation of mental illness or health, (6) the representation of all types of therapeutic intervention, and (7) the organizational dimension of interventions.

Representation of Mental Illness/Health

This theme focuses on different sets of definitions of mental illness and of social rehabilitation. These definitions are diverse; they may refer to the causes or consequences of the illness, or to the criteria as to what is a success or a failure in the treatment of an illness, or what the ideal type of social rehabilitation is, or what the main obstacles to treatment and rehabilitation are, etc. Like the other themes in the HG, they are not only relevant to professional mental health workers (doctors, nurses, etc.) but also to all those involved in the patient's experience. Here are some elements of this theme:

a. Terms used to answer the question "what is mental illness and its rehabilitation": General terms, concrete descriptions, metaphors and images, concepts linked to biomedical categories, traditional Chinese medicine (TCM) categories, etc.;
b. Mental illnesses described as "problems" to be solved: Explanations given for the problems, references on consequences of mental illness in general and of a specific patient;
c. References to normality or abnormality: Specific attitudes, behaviors, and reactions that are generally said to be abnormal (for example: violence, non-conformity with the law and regulations, sexual misconducts, "strange" personal reactions like yelling, to be silent most of the time, etc.);
d. Normality or abnormality in other non-medical categories or metaphors more directly referring to social norms that are transgressed by a patient or members of the ISE;
e. Normality or abnormality in biomedical terms: Having such and such "disease", using traditional Chinese medicine (TCM) criteria, etc.; and
f. Causes and consequences: Social factors (events, organizations, situations) that are general or specific, and that are directly or indirectly linked to mental illness or rehabilitation – as the causes or consequences of mental illness or of the success or failure of the rehabilitation process.

Interventions

This theme focuses on different types of interventions about the mental health problem or about the rehabilitation process and raises questions such as: what is done about the problem? In general, there are four dimensions related to an intervention: a) some kind of planning, b) some "helping" mechanism, c) a communication process between the helper

or helpers and those who are to be helped, and d) an authoritative relationship. This broad definition of intervention applies to any person or organization involved in mental illness or rehabilitation. Here are some of the items relevant to "treatment" and "social rehabilitation", or about the relationship between them:

a. Intervention as a planned activity: form and degree of planning; goals of the intervention, decisions made, organized activities, evaluation of these interventions, criteria of success or failure of the interventions;
b. Helping mechanism: caring and/curing, medical and social interventions (such as family intervention), traditional Chinese medicine, etc.;
c. Support from institutions such as work units, neighborhood committees, social welfare institutions, financial support through salary, pension or other monetary means;
d. Different roles played by the patient's ISE; and
e. Aspects that remain non-planned or spontaneous in the interventions.

Some specific items to consider regarding intervention as a communication process:

a. Who communicates with the patient?
b. Who communicates with whom within the patient's environment?
c. Communication as a helping process: for example, references to some kind of psychotherapy, to some relationships that seem helpful (or not) for the patient;
d. Emotions expressed (or not) in these communications; and
e. Implication of intervention as a power relationship: People who represent the authority, forms of control from people in authority, formal and informal controls over people involved (patients, relative, etc.), degree of autonomy exercised (or not) by the patient (and by other persons involved), freedom to do things, pressure not to do things, etc.

Organizational Dimensions of Intervention

This last theme can be as inclusive as possible and is not limited to formal and biomedical interventions. The following four items are not exclusive either:

a. The professional and non-professional background of doctors, nurses, psychologists, layman interventionist, traditional healers, etc.;

b. The formal and informal support groups (including all types of support and self-help);
c. Types of organization: large hospital, factory clinics, private clinics, traditional Chinese medicine organizations, or any other sites;
d. Ethics and values: ethics code, traditional norms, etc.

The Heuristic Analytical Grid: Final Remarks

1. Personal and social change: Even if it is not stated more formally in the grid, each theme and sub-theme must be considered in a past-present-future time frame, and both personal and social history must be taken into account.
2. Multiple levels and types of communication: The themes and sub-themes in the grid are broad enough to include different types of languages (e.g., the everyday language, the formal medical or scientific language, the technical, political or administrative ones, etc.) and many forms of expressions (from subjective feelings to metaphors to objective facts).
3. A simple guideline: The grid should serve as a simple guideline that proposes categories that may not be mutually exclusive. During the data collection phase, for instance, a small number of open-ended questions are usually followed by probing questions.[16]
4. Prioritization among the themes, dimensions and levels of the grid: Not only is it necessary to take into account the relationship between the elements of the grid, but also it is important to understand the prioritization process. This prioritization will be influenced by the diversity of theories, concepts, objectives, etc.
5. As indicated earlier, the HG is relevant to both data collection and data analysis phases, which is most often in the case of qualitative research. The semi-structured interview, for instance, implies constant reference to the grid and the same happens during the analysis phase.

16. Here is, for example, a short list of open-ended questions for interviewing patients and members of their ISE: a) How is your relationship to the patient? b) What are your ideas on the patient and on his mental illness? c) What help have you provided the patient with? d) What measures have you taken to solve the problems that occurred? e) How do people around you feel about the patient and mental illness? f) How do you see the patient's future?

Implications for Aging Research

Clinical sociology offers many useful insights while the heuristic analytical grid instrumental to the study of psychiatric rehabilitation may also help with the study of any personal experience. The reader may have realized the connections between social psychiatric rehabilitation and various forms of helping the elderly. One of our main arguments here is that the CS model and its related grid may well be applied to aging research.

While the model and the grid were first introduced to study mental illness, gerontological researchers and practitioners will readily recognize their usefulness in helping to improve their work on aging. Historically, around the same time when the CS rehabilitation project on the experience of schizophrenia was taking place, the situation of aging in China also became a major issue (Yi et al. 1990; Sheng 1992; Wei 1992; Chen 1996; Chen & Chen 2009). A common theme in both research interests can be exemplified by Yuan's call for support of the elderly "in the Chinese way" (1990, 341-359). While citing Confucian thought on the subject of aging with various modifications since 1949, he described five "guaranties" - corresponding to five basic needs - that must be taken care of by all layers of society, from the State to the "grass-root units" and to the family itself. This actually reflects a worldwide need (Chen 2012a). Here, the relevance of both the ISE and the LSS of the CS model as presented in this paper is clearly shown. The model, thus, offers a conceptual tool to consider the same situation in studying the traditional Chinese medicine organizations.

The similarities between the study of personal experience of psychiatric rehabilitation and the study of aging have been shown in our previous work. Specifically, Sévigny (2000, 2004) highlighted the proximity between the two perspectives that the co-authors illustrated previously: proximity in epistemological choices and research paradigms, in the notion of rehabilitation, in factors affecting recent changes in Chinese society, and in mental illness as well as aging as a personal experience. Both authors have extensively studied this individual-society relationship from the two perspectives, respectively (Sévigny 1993a, 1996; Enriquez et al. 1993; Sévigny 1993b; Chen 1996, 1997, 2002, 2009, 2010). Eventually, their complementary approaches have led to direct collaboration about CS (Sévigny, Chen & Chen, 2009b; Sévigny, Chen & Chen, 2010). From the perspective of aging research, Chen (2010) provides a review of methods that gerontologists use in social and behavioral research. Qualitative approaches and their uses are summarized in terms of interpretive and critical social sciences that draw the insights of sociological

paradigms. The value and focus of qualitative research are highlighted with their epistemological roots. In reflecting on aging research in China, Chen (2010) illustrates the use of an integrated micro-macro model by illuminating the ideas of clinical sociology and a general public policy framework of an "economic state in transition" (Chen 2012b). For the former, its ideas guiding qualitative research can be very useful to gerontologists. These include the intimate relationship between the individual and the society, the uniqueness vs. the collective/social nature of personal experience, caution against viewing both mental illness patients and elderly persons as "non-person" or "outside the real social world," the "total social fact" approach to any specific social problem, recognition of multiple actors and views involved, a focus on the meaning given by the actors (that is, their representations of reality, their personal motives, beliefs, purpose, reasons, etc.) including their implicit language and knowledge, the debate on their "non-knowledge" or "false knowledge" vs. the "competent actor" or "local knowledge," the action dimension in research, the technique of conciliating objectivity and personal involvement by taking into account diverse viewpoints, and interdisciplinary case analysis as the preferred methodology. These should greatly help to enrich research methods in gerontology as commonly understood (Maddox 2001; Rowles & Schoenberg 2002; Jamieson & Victor 2002; Curry, Shield & Wetle 2006).

It should be noted that our presentation of the CS model and the related heuristic analytical guide does not pretend to be final, nor exclusive. Their development is still an ongoing work process. Our intent, therefore, is not only to review the "state of the art" of CS and HG but also to help aging and psychiatric researchers to collaborate and deal with current and future challenges to research and practice (Chen & Chen 2007). Hopefully, this presentation will help not only mental health workers but also aging researchers to use the clinical approach in their own fields. In this sense, it has not only dealt with CS *of* mental health and aging services but also with CS *for* mental health and gerontological workers.

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