Clinical Sociology Review

Volume 12 | Issue 1 Article 4

1-1-1994

Some Remarks about the Dyad Observer-Observed and the Relationship of the Observer to Power

Jacques Van Bockstaele
Centre de socianalyse

Maria Van Bockstaele
Centre de socianalyse

Martine Godard-Plasman
Centre de socianalyse

Some Remarks About the Dyad Observer-Observed and the Relationship of the Observer to Power

Jacques Van Bockstaele

Maria Van Bockstaele

Martine Godard-Plasman
Centre de socianalyse (Paris, France)[*]

The historical research that has accompanied the reappearance of the term of *clinical sociology* in the United States[1] and its wider acceptance, marked by the creation of a research committee within the International Sociological Association, has revealed, above and beyond a use of the term that goes back to the thirties, roots that go outside of the academical and sociological fields as such.

Publications and bibliographies would seem to show that the term itself has not been used in Europe, at last not until very recently. We ourselves proposed the term of *clinical sociology* in the sixties, as a means of describing the field work we began in 1956.[2] Yet, if clinical sociology is defined as the study of the functional problems of society with the goal of social change and help to populations in difficulty, the question may cover a wide and complex field. Empirical studies are many and varied, but their relation to theoretical developments is largely unknown or ignored.

[*]We thank Gladys Bournique and Joseph Bournique for their major contribution to the translation of this text.

This is what this article will attempt to show, basing its demonstration on several examples that seem to us to be authentic episodes in the history of clinical sociology. These examples reveal similarities despite differences in the approaches, diversities in the objects of investigation and varied historical contexts.

We have chosen to describe three European examples and three examples taken in the field of American sociology. These examples seem to show that a double question, both implicit and explicit, is permanent in this type of investigation. There is first the question of the relation of the observer to the power that requests, facilitates, or favors the observation, and second that of the relationship between the observer and the object he observes.

It is easily seen that the dyad observer-observed is usually separated; the relationship between the two terms is not taken into account explicitly.[3] The object observed is treated from the point of view of its own characteristics, which make it a specific domain or population. Until most recently, theoretical reflection did not much consider the observer. Growing demand for evaluation brought forth the questions of formation and deontology; but the question of the practical and technical conditions under which a relationship between the observer and the observed can be established has not yet become a central issue for sociologists.

The relationship of the observer to power is usually implicit or hidden. It nevertheless plays an essential role in the determination of the limits and accessibility of the objects of observation. The choice of these objects is made within a field of forces, the constraints of which can be explored. This exploration may even be the condition, if not of complete liberty in, at least of control of the sociologist's intervention.

It seems probable that the permanence of both questions is an indication of difficulties inherent in observation and intervention. These difficulties are perhaps more visible in a clinical approach than in areas where quantifying tools can mask them. If this is so, it is worthwhile to study these difficulties more closely, since the clinical field seems called to a new development. This is precisely the approach that we plan to take.

I. Experiences from two worlds and through two centuries

We will first recall, without excessive comment, six moments in the history of clinical sociological work. Some of them are already familiar to most readers. Two of them are most likely unknown.

1. In Europe

1a. The Royal Medical Society[4]

Louis XV died of smallpox in 1774. Turgot, his general comptroller of finance, noticed that tax revenue decreased during the years of the epidemic. He also realized that the medical schools, saddled with rigid doctrines, were unable to put the newest discoveries to use for the general good. It seemed to him of first importance to increase the quality and quantity of medical services available in rural areas; to do this, he conceived the idea of a medical society which would put its knowledge at the disposition of the economy. Vicq d'Azir, physician and member of the *Académie des Sciences*, made this idea reality.

The Royal Medical Society, once founded, recruited physicians as correspondents. They were requested to send in their observations and descriptions regularly. These *missi dominici* doctors, like most educated people at the time, thought at first that rural populations, who lived more naturally than urban populations, would be healthier. In fact, they discovered populations not only in worse health but with disorders not found in the cities. It was all the more scandalous in that it was unexpected.

So these physicians, as they cared for these populations, studied and accurately described symptoms, illnesses, and epidemics as they appeared; they also observed and described living conditions at work and discovered, to their surprise, that representations of the body and of illness existed, and they thought about and discussed the repercussions of all these elements.

The abundant correspondence (Peter 1967) between the Society and its correspondents covers all France, and it builds a detailed picture of the sanitary situation in each place, month by month. This generalized system of medical information modified the very nature of medicine and its practice:

> Doctrine recedes into the background, and observation is given first priority. It is observation which gives contact with reality. . . . They want to see and record everything: collective diseases and individual cases, beliefs, the influence of surroundings, climate, resources. It is authentic rural sociology, based on the standard of living, medical practice and its associates, assistance institutions, ideas and feelings about life, sickness and death. (Peter 1967, 748)

The descriptions of these physicians modified the classification of diseases and transformed clinical observation; even their language changed during this experience as their perception of causes and consequences was transformed. They

thus helped develop a new medical practice, based on different criteria of interpretation of symptoms. And their work was one of the reasons mortality decreased in the following years.

1b. Beatrice Webb (1858–1943)

Beatrice Webb's written contribution to clinical sociology is a half-century of social observation presented in autobiographical form (Webb 1938); it may seem to be a compromise between literature and science. Her project was to gather on the spot precise descriptions of social facts about human reality; her goal was political reform. Research on society constituted in her mind a major lever for such reform. Halfway between philanthropy and politics, between human compassion and social militantism, Beatrice Webb's research was influenced both by Herbert Spencer and by Charles Booth. It was through the comparative physiology of the former that she grasped the bases of scientific sociology and through the monumental surveys on "The life and labor of the People of London," which the latter partially financed, that she discovered the importance of field work. She did surveys herself, often under an alias; in fact one could say she practiced spying, somewhat like an ethnologue or a detective.[5]

Three important facts color Beatrice Webb's global project. She had a social position, in the sense of status and political influence; Sidney Webb founded the Fabian Society, a group of socialist reformers, and he was (Labor) Prime Minister twice. She made an explicit decision to produce a scientific work, based on observation of men and facts, and indicates some elements of her methodology; for her, observation requires a sympathetic link with the object of research, and all research notes must be carefully filed. She was involved in public institutional activity, as cofounder of the London School of Economics, intended to provide training in the basic disciplines necessary for the collection and classification of societal data, as cofounder of *The New Statesman*, and as coelaborator of a report on the law on poverty. After 1917, however, she concentrated on her autobiography and abandoned the project of a learned work in sociology. The less formal mode was, she thought, more appropriate to her experience and her knowledge.

1c. Marienthal unemployed

In 1931, Paul Lazarsfeld, Marie Yohada, and Hans Ziesel studied the effects of unemployment in Marienthal, a small town in Austria.[6] The stated goal of the

survey was to "fill the gap between official statistics and the random impressions of social journalism, and define a methodology which combines the use of quantification and participant observation" (Lazarsfeld 1981, p. 23). The only important employer in the town, a textile factory, had closed two years before the survey began, and the entire community had been affected. At that time there was no sociology department at the University of Vienna. The research was subsidized by the party in power, the Austrian social-democratic party, which was anxious to prove its capacity for governing and to "prepare the working class for its historical role" (Lazarsfeld 1981, p. 19).

The research team decided that a complete inventory of life in Marienthal was necessary in order to face reality truthfully and completely. Their first object was the village itself, and the major fact to be faced was massive unemployment. All kinds of data were collected: biographies, personal data (including a diary kept by an unemployed man), schedules, accusations and complaints, essays written in school or for competitions, menus, historical information, demographic statistics, information about family budgets; in fact any information, formal or informal, which promised to be relevant was included.

One methodological principle was constantly imposed: "no one . . . could be simply journalist or observer, . . . everyone was to enter into the life of the community as naturally as possible, if possible by fulfilling some useful function" (Lazarsfeld 1981, p. 28). Among these "useful functions" were the distribution of clothing, political work, sewing lessons, medical consultations, gymnastics for girls, educational counseling. The researchers collected information while fulfilling the roles from December 1931 to mid-january 1932. Some 60 lbs. of documents were produced, and they gave birth to a small book which attempted to cover the ground opened by the question of how, and how long, people and communities are able to resist when faced with this kind of adversity.

2. In the United States

2a. The Community Surveys

The first major Community Survey, that of Pittsburgh, was carried out in 1907. Since the 1870s, philanthropic and social reform movements, following Ch. Booth, undertook sociological surveys integrating the search for ways to provide social help. A department of sociology had existed at the University of Chicago since 1892. A notice presenting the university said that "the city is one of the most complete social laboratories in the world." Philanthropic groups

furnished the possibility of field work to university students. Field sociologists were often priests or pastors. The respective weight of sociology and philanthropy, however, changed progressively in favor of the former; ethnology and sociology developed together, with no strict academic separation between them. Social workers, journalists and sociologists combined their efforts and contributed toward social control.

2b. The Yale School of Medicine project

The next example is the story of a failure. Winternitz[7] was a physician; in the late twenties he was named dean of the Yale School of Medicine. His experience had convinced him that traditional medical training alone was insufficient for complete analysis of patients and proper understanding of the origin and evolution of disease. Doctors, he felt, should be able to evaluate the importance of social influences on health, and, if possible, be prepared to suggest appropriate remedies. he wanted to enlarge the medical point of view and open a new field of data which he felt indispensable if practice were to be better adjusted to social reality. he was therefore determined to provide Yale medical students with training in clinical sociology, so that they would be able to apply its techniques in their medical practice. However, when, in 1929, he tried to found a department of clinical sociology in the medical school, he encountered opposition. His perseverance during his whole term as dean failed to convince the administrators, and his project was stillborn. Some later analysts attributed this failure to the 1929 depression, but this explanation is certainly not sufficient.

2c. Alinsky

Saul Alinsky trained at the University of Chicago, where he took Burgess's courses in clinical sociology. It is therefore not surprising that he should be primarily interested in sociology as a means toward social change. One of his early publications in 1934, an article titled "A Sociological Technique in Clinical Criminology,"[8] indicates that this orientation was present in his work from the beginning.

For Alinsky, power is the central dynamic element in society. He believed it to be constitutive of social relations, and therefore felt it essential to teach those who have no power to win some. Far from being given, or linked to a situation, power, he maintained, is conflictually won. Persons and groups have their own individual interests to defend and to promote. Those interests are fundamentally

the only social motor. Change is produced when power is seized by previously uninfluential groups who then impose the promotion of their interests. Sociological intervention which aims at change must therefore be forceful, intentional, and public. He considered himself a social leader, if not exactly a social agitator.

Alinsky proclaimed that, as sociologist, his goal was to point out and explain the contradictions present in the current political system and to help those who suffer from these contradictions to change political structures. His method was to create community groups among the marginalized minority groups of the major cities and to help them organize their self-defense. His interventions were deliberately provocative. Some have become famous. They aimed at forcing those who hold the keys of change to satisfy the demands of populations' victims of poverty and discrimination.

II. Characteristics and epistemological problems

In spite of their small number, these examples are quite typical not only of the way practice of clinical sociology grew, but of the way it was and is exercised. We will try to show that they indicate some of the major aims and constraints in the field.

1. The clinical function

The French Royal Medical Society physicians present a particularly revealing example of a movement that appeared in the second half of the 17th century in England, Germany, and France and continued until the beginning of the 19th century.

Physicians were the first to gather concrete data on the society they lived in. Their purpose—explicit or not—was to find out new criteria that they could offer to the Princes for a better way of governing their people.[9]

All of these doctors made systematic observations that were qualitative as well as quantitative and aimed at solving what we would call "problems of society." They proved unexpectedly capable in the accomplishment of the task of counting, observing, predicting, curing, and reforming individuals and groups. All were convinced that the results of their exploration were transmissible, and that this transmission participated in the construction of science and the transformation of medical practice. They found part of the resources necessary for their exploration in the problems normally encountered in medical practice: living conditions, conditions of death, demography, epidemic flow, etc.

The physicians' clinical way of looking at society's functioning and dysfunctioning and the tools they invented were passed on later to the men of science who replaced them (Condorcet, Laplace, Lavoisier, Quételet).[10] Engineers came next, who were engaged in industrial development and promoted practice of statistics and surveys. They would withdraw only at the beginning of the 20th century. Philosophers and historians would then hold the first rank.

Yet, in the last period, physicians have pursued clinical work and some of them figure among those frequently cited as having conducted interventions aimed at social change, such as J. L. Moreno (1934), E. Jacques (1951), W. R. Bion (1961) and F. Tosquelles (1966).

In all the examples that we have considered in the first part of the paper, we find the desire to help—linked to that of reform or of change. The desire to increase knowledge, to promote science in order to reach these goals, is everywhere present and fundamental. That group of goals, linked in that particular fashion, is characteristic of the way clinical function—whether applied to the human body or the social body—has been, and is, defined in most cases. But this definition remains incomplete because it does not include the conditions in which the defined goals have been or can yet be reached.

2. Legitimacy and the link to power

The doctors' exploration was first of all legitimate because of their therapeutic competence. Yet this professional legitimacy would not have sufficed to permit them to accomplish their task of observation and intervention. Official recognition and mission were necessary. And, in fact, we observe that all of these doctors as well as the men of science later on were close to political power, either because they personally exercised a political function or because they had special relationships with those in power.

It is this political legitimacy that gave them the right to observe, count, and advise the prince. Without this intention and recognition of the loyalty and competence of the emissaries of power, they would have been able neither to count people, places, and things, nor to observe customs and material and moral living conditions, nor even to treat sick people not specifically confided to their care.

Beatrice Webb and her husband were politically engaged social scientists, institutional innovators, members of official Committees. At the time they were working at Marienthal, Paul Lazarsfeld, as well as Marie Yahoda and Hans Zeisel,

were active members of the Austrian Social-Democratic Party and the party was subsidizing the survey. S. Alinsky was not working on behalf of an established power but he viewed his intervention as a way of counter-acting this power and wrote, "If Machiavelli wrote *The Prince* to tell the wealthy how to preserve their power, I write Rules for Radicals to tell the poor how to get hold of it" (Alinsky 1971, p. 67).

Epidemiology and vaccination favored a certain type of health control; the modes of social control slipped progressively into this model. Clinical social action became a governmental assistant as industrial and scientific development changed society. The medico-political initiative of study of the human body as the source of life and death became a technico-political initiative of study of the social body as source of wealth and poverty.

Postrevolutionary France was marked by philosophers, such as Saint-Simon (1760–1825) or Fourier (1772–1837), who had been brought up by the ideas of the Enlightenment and had witnessed the Revolution upheaval.

Both were in search of new social rules and new ways of government. Part of the systems they had conceived of were put into action by their followers, the "Saint-Simoniens" and "the Fouriéristes." Part of these systems gave birth to new theories, either by philosophers or politicians. One should remember that Auguste Comte who coined the term "Sociologie" was secretary to Saint-Simon for some time and was working on the editing of the latter's writings.

Reform and change no longer belong exclusively to established power. 19th-century Europe produced a wide gamut of remedies systems, theories, and surveys with strong institutional repercussions. Europe has passed through a century of doctrinal hegemony. The resultant political ideologies separate observers according to whether they seek consensus or social struggle, are religious or anti-religious, believe or not in the possibility of a science of society.

The link to power remains necessary; it is a condition for financing and access to publicity, but it splits observers even more than it divides the regions of observation. The specifications, financing, and destination of investigations are determined within a field of forces in which the powers that control resources, admission, and constraints concerning the object play a large role.

3. The image and status of the observer

The physicians from the *Société Royale* acted openly as observers. They had therapeutic competence and they could lay on official recognition. Yet they came from the big city and were viewed with a distrust of which they were conscious. People feared taxes and unusual cures.

Indeed, an individual who is aware of being observed reacts: he builds an image of his observer by identifying social signs and thus locates him in a field of forces. He tries to identify his own possible gain or loss from feedback. A community, family, town, or particular social category in the same situation similarly responds by putting into action its structure, communication modes, and defenses.

All sociological observers, clinical or not, are involved in the question of their status. In each of our examples, the question is evident, whether or not it is raised explicitly.

Beatrice Webb conducted her surveys under aliases; the researchers in Marienthal disguised themselves. Priests and pastors helped survey work in problems areas of Chicago and observers worked under cover of charitable organizations. Alinsky presented himself as an activist, not an observer, building situations in which he encouraged groups to assume responsibility for themselves by actively facing power relationships. He held a power apt to challenge current established powers.

Winternitz was acting as dean of the School of Medicine and as such wanted to broaden the training and view of the physicians. There may be a number of reasons why he failed, among which are the difficult time and the depression. But there was resistance on the part of medical school senior faculty due to the novelty of his idea and to its underlying conception of the medical profession's social responsibility, and above all a conflict between academic disciplines.

The history of the medical clinic is also the history of the growth of institutions—legal, scientific, pedagogical, and therapeutical—which make possible its practice and progress. For Foucault (1963), all social sciences have much the same architecture, from medicine to sociology.

Both in Europe and in America, the universities have gradually established their prerogative in the determination of professional legitimacy in sociology. The link to power has thus been masked to a certain extent. Yet the specifications, financing, and destination of investigations are determined within a field of forces which usually remains uninvestigated.

4. The object of observation and status of who is observed

The *Société Royale* physicians were mandated by a royal institution which chose and delimited their field of study. The choice was motivated by the perception of a need, and the need was certainly real. And, since dysfunction is likely to be most visible among poor and marginal populations, it is not surprising

that for a long time empirical studies, whether aimed at knowledge or at change, were dedicated to working men and peasants. Other categories of poor and marginal people formed a complementary group which was gradually included in the investigative field (Leclerc, 1979).[11]

This is, however, the same as to say that the field of observation or intervention was limited to those categories judged most accessible or least equipped to resist investigation. If to some extent this choice was justified, it remains true not only that those in situations of power, and those holding the purse-strings, could resist being subjected to this kind of inspection, but that this opposition was occult, usually unsuspected even by would-be observers. Interest for the study of power-holders is a relatively recent phenomenon, and the possibility to impose or negotiate its possibility even more so.

At first, the persons and groups studied, insofar as they were studied, were considered more or less ethnologically as *object*. But as the observational field widened, two influences worked in the same sense. When individuals or groups observed occupied positions or ranks that forbad considering them as simple objects of investigation, the observers felt the need to consider them as subjects; those observed, and the relationship with those observed, help the observer discover to what extent it is a relationship of domination which permits the investigation. As consciousness of the autonomy of all subjects emerged, this need extended to all persons and groups. The practice of feedback of survey results[12] illustrates one response to this need, and all clinicians face the problem, which is intimately connected with the observer's link to power.

This rapid trip through two centuries and two worlds of sociological observation and intervention has shown that the reality of clinical approach has been active for a long time and that it exists and flourishes even where the name "clinical sociology" is not honored.

But even more important is the light it throws on some of the questions which are at the center of present developments in clinical sociology.

Alfred McClung Lee in 1979 stated some of these questions in the following terms: "Is clinical sociology merely another name for applied sociology, for practical sociology, or sociological practice? . . . Is not the use of "clinical" another example of scientism, of trying to give an impressive "scientific" appearance or repackaging to stock sociological research techniques, theories and consultation?" (McClung Lee 1979, p. 487). How can the examples sketched

above help to answer some of these questions and give some indications for further developments?

To clarify this point, we will first advance a tentative definition of clinical research: for us, clinic research requires the conjunction of several components:

- a subject asking or agreeing to be observed;
- an observer, well defined and responsible, with a defined object and a tool for observation;
- the simultaneous presence of the specified subject and the observer, contracting for an obligation of "diligence."

We have seen in our examples that some observers announced, others hid their position as observer. We do not think this difference of attitude is determined by the characteristics of the persons and the situations involved; we feel that it is each observer's way of adapting to a constraint that is universal in clinical sociology. If some legitimate power, be it political, scientific, or academic, does not impose, or justify the observation, it can only be undertaken in a concealed manner. It is certainly not an accident that recent clinical sociology is above all present in the field of medicine, or health in a large sense.[13] It would seem that clinical sociologists have, to a certain extent, been able to profit from the right to clinical observation that doctors have.

If a clinical approach is to be extended to other areas, however, and if clinical sociology is not to be defined by specific fields in which it can easily be exercised, it would seem necessary to define the conditions that can make clinical approach[14] possible at a sociological level.

In clinical research, indeed, what we are seeking to understand eludes direct inquiry, because of both the observer and the observed status. Can we yet bypass resistance and have access to what both demander and the intervening clinician endeavor to know? Our conviction is that a possible recourse is to elaborate a specific mode of approach in which the link contracted with the object of observation, a social entity, gives the observer the right to observe, intervene, and interpret, and enables the entity to start an analysis of its action. Indeed, our conviction is that such an instrument cannot just aim at assessment, but is part of the process of change from the very beginning, and as such is a tool for active intervention.

We have developed over twenty years such a technical instrument that we call *socianalyse* and the *socianalytical task.*[15]

We were interested in the examples we mentioned in the beginning of this paper because they typified, whatever the period or the object, a permanent

challenge of clinical approach: exploring the limits, constraints, and accessibility of observation.

NOTES

1. Cf. Jan M. Fritz (1988), (1991) and A. McClung Lee (1979).

2. Before publishing an article on Socioanalysis in *L'année Sociologique* in 1963, we discussed with the editor under what group title it should appear. We agreed on "Work in Clinical Sociology." Five years later, our second article appeared under the group title "Problems in Clinical Sociology." Between the two there was no mention of clinical sociology, and the use of the term had disappeared. In 1952 René Clémens published an article in *Cahiers internationaux de sociologie* entitled "Sociologie et applications cliniques de la sociologie." The author pleads the cause of the recognition of empirical clinical studies.

3. A chapter of the *Handbook of Clinical Sociology*, Howard Rebach and John Bruhn, ed s. (1991), is dedicated to "Communication and relationship with clients." The central question is developing an effective working relationship with clients. McClung Lee (1966) offers a description of the relationship between a clinician and his observed object:

1) Through critical discussion with practical observers of spontaneous social behavior in problematic situations
2) Through scientific utilization of available clinical data
3) Through participation directly in clinical situation.

However, the conditions necessary for this participation are not discussed in the article.

4. J-P. Peter has analyzed 20 years of the archives of the *Société royale de Médecine*. Quotations are taken from his 1967 paper. Lécuyer (1977) drew a plan of the stages of empirical social research in France, beginning in the middle of the 17th century with the Instructions of Colbert, Louis the XIV's minister for a large description of the French "Provinces," including military, church, judicial, and financial topics. At the same period Vauban, who intended to build fortified places on all frontiers of France and needed precise information about the population, proposed "a simple and general method for taking a census."

5. That is, at least, how W. Lepenies (1985) describes her survey work.

6. The small book that presents this research was published in Germany in 1932; it was published in Great Britain only in 1970 and in France in 1981. It has been little cited, even by Lazarsfeld himself.

7. Winternitz's attempt has been presented several times. For more information, see in particular, *Clinical Sociology Review* (1989, 7).

8. In 1932, Alinsky used the term "clinical" to define his approach to criminology: "A Sociological Technique in Clinical Criminology" (in proceedings of the Sixty-Fourth annual Congress of the American Prison Association). He was at the time part of the staff of the Illinois State Penitentiary.

9. In addition to the Societé Royale physicians, a more complete study would mention Hermann Conring (1606–1682), Sir William Petty (1623–1687), François Quesnay (1694–1774), J-P. Süssmilch (1707–1767), Louis Villermé (1782–1836), and many others. Prior to other functions, all these men had been physicians or surgeons. They produced meaningful advances in demography, economics, and surveys which have been most beneficial to further development of social observation (Lazarsfeld 1961).

10. At the end of the 18th century in France, chemists, agricultural engineers (Lavoisier, Turgot), or mathematicians (Laplace, Condorcet, later on Fourier or Quetelet) would pursue the project of systematically describing the country. Using the results of mathematical progress, they would develop social statistics that physicians had began in their time to gather—pragmatically—by counting deaths and births. The idea of reform was never absent from their work. Lavoisier wrote for the French Revolutionary Assembly, a treaty on population and economic situation in which he recommended the creation of a central bureau for statistics.

11. The French sociologist Halbwachs declares in *La classe ouvrière et ses niveaux de vie* (1913) (The working class and its levels of life): "We are going to study the working class because we have abundant data, because we have data available which we do not have about other classes. It would be quite impossible to study, at the moment, with the same methods, the needs and expenses of other groups. The facts about the working class are the most simple." What had been at first a consequence of the historical development of sociology is there described as a technical constraint. This alleged constraint is political rather than methodological and suggests above all the current legitimacy of social control over lower social classes.

12. The practice of feedback of survey results has been introduced by Floyd C. Mann and his co-researchers of the *Survey Research Center* at Michigan University (Floyd Mann 1954). By reporting through the line personnel of the organization, the data collected in the initial exploration, the researcher can have the people he addresses to react, asking for more data or giving more. People are incited to propose changes in their services, inferred from the diagnosis proceeding from the initial exploration. In *Applied Sociology*, edited in 1965 by A Gouldner and S. N. Miller, the practice of survey with feedback of results is presented as the main available approach for a clinical sociology.

13. It is most striking when looking at the Clinical Sociology Section of the *Sociological Abstracts*.

14. To our knowledge, there has been little or no attempt to develop specific tools, adapted to the particular constraints imposed on the field of clinical sociology. The last 10 years have been marked by a growing interest in biographies and life stories. Another trend can be found in William Foot Whyte's PAR (Participatory Action Research): a powerful strategy to advance both science and practice involving practitioners in the research process from the initial design of the project through data gathering and analysis to final conclusions and actions arising out of the research (W. F. Whyte 1991: 7).

15. We cannot develop here the construction of our work. For more information see Van Bockstaele, Van Bockstaele *et al.* (1959, 1963, 1966, 1968, 1971, 1992). An English version of some of these papers is available.

REFERENCES

Alinsky, Saul. 1971. *Rules for Radical*, Trad. fr. 1976, *Manuel de L'Animateur Social, Une Action Directe Non Violente*. Paris: Seuil.

Bion, W. R. 1961. *Experiences in Groups*. Londres: Tavistock publications. Trad. fr., 1965, *La Recherche sur les Petits Groupes*. Paris: Presses Universitaires de France.

Clemens, R. 1952. "Sociologie et Applications Cliniques de la Sociologie," *Cahiers Internationaux de Sociologie* XIII.

Foucault, Michel. 1963. *Naissance de la Clinique*. Paris: Presses Universitaires de France.

Fritz, Jan-Marie. 1988. "The History of Clinical Sociology," *Clinical Sociology Review* Vol. 6.

___. 1991. "The Emergence of American Clinical Sociology." In Rebach Howard M. & Bruhn John G., ed. *Handbook of Clinical Sociology*, New-York and London: Plenum Press.

Hoggart, Richard. 1988. *A Local Habitation*. Londres: Chatto and Windus. Trad. fr., 1991, *33 Newport street, Autobiographie d'un Intellectuel Issu des Classes Populaires Anglaises*. Paris: Gallimard-Le Seuil.

Jaques, Elliot. 1951. *The Changing Culture of a Factory*. Londres: Tavistock Publ. Trad. fr., 1972, *Intervention et Changement dans l'Entreprise*. Paris: Dunod.

Lazarsfeld, Paul. 1961. "Notes on the History of Quantification in Sociology: Trends and Problems." *ISIS* Vol. 52.

Lazarsfeld, Paul, Marie Yahoda, & Hans Zeisel. 1932. *Die Arbeitlosen von Marienthal*. Leipzig: Hirsel. Trad. fr., 1981, *Les Chômeurs de Marienthal*. Paris: Editions de Minuit.

Leclerc, Gérard. 1979. *L'Observation de l'Homme, Histoire des Enquêtes Sociales*. Paris: Seuil.

Lécuyer, Bernard-Pierre. 1977. *La Recherche Sociale Empirique en France Sous l'Ancien Régime*. Paris: Ecole Pratique des Hautes Etudes, miméo.

Lee, A. M. 1966. *Multivalent Men*. New-York: George Braziller.

___. 1979. "The Service of Clinical Sociology." *American Behavioral Scientist* 23(3):487–512.

Lepenies, Wolf. 1985. *Die Drei Kulturen: Soziologie Zwischen Literatur und Wissenschaft*. Munich. Trad. fr., 1990, *Les Trois Cultures. Entre Science et Littérature: L'Avènement de la Sociologie*. Paris: Editions de la Maison des Sciences de l'Homme.

Mann, Floyd. 1951. "Human Relations Skill in Social Research," *Human Relations* IV(4):341–354.

Mann, Floyd & H. Baumgartel. 1954. *The Survey Feed-Back Experiment: An Evaluation of a Programm of the Utilization of Survey Findings*. Ann Arbor:Institute for Social Research.

Moreno, Jacob L. 1953. 2d édit. révisée, lère édit. 1934. *Who Shall Survive*? New York:Beacon House.

Peter, Jean-Pierre. 1967. "Une Enquête de la Société Royale de Médecine 1774–1794: Malades et Maladies à la Fin du XVIIIème Siècle." *Annales E.S.C.* :22–4.

Tosquelles, François. 1966. *Pédagogie et Psychothérapie Institutionnelle*. Numéro Spécial de la Revue de Psychothérapie Institutionnelle.

Van Bockstaele, Jacques & Maria Van Bockstaele. 1959. "Note Préliminaire sur la Socianalyse." *Bulletin de Psychologie* XII:6-9:277–290.

___. 1966. *Quelques Remarques sur le Transfert Sociologique et ses Conditions d'Observation* Evian: Association Internationale de Sociologie, VIème Congrès Mondial de Sociologie, miméo.

Van Bockstaele, Jacques, Maria Van Bockstaele, Colette Barrot, & Claude Magny. 1963. "Quelques Conditions d'une Intervention de Type Analytique en Sociologie." *L'Année Sociologique* :238–262.

Van Bockstaele, Jacques, Maria Van Bockstaele, Colette Barrot, Jacques Malbos, & Pierrette Schein. 1968. "Nouvelles Observations sur la Définition de la Socianalyse." *L'Année Sociologique* XIX:279–295.

Van Bockstaele, Jacques, Marie Van Bockstaele, Tewfic Benkritly, René Carron, Martine Godard-Plasman, Jacques Malbos, & Pierrette Schein. 1992. "Clinical Sociology: An Approach Based on Multicategory." Paris, Conference of ISA Research Committee on Clinical Sociology, miméo.

Van Bockstaele, Maria & Pierrette Schein. 1971. "Limites des négociations et négociation des limites." *Sociologie du travail* 13:1–24.

Webb, Beatrice. 1938. *My Apprenticeship.* London: Penguin Books.

Whyte, William Foot. 1991. *Participatory Action Research.* Sage Focus Edition.