

# CLINICAL SOCIOLOGY

by Jan Marie Fritz

## Introduction

Clinical sociology is as old as the field of sociology and its roots are found in many parts of the world (Fritz, 1985, 1991b). The clinical sociology specialization, for instance, often is traced back to the fourteenth-century work of the Arab scholar and statesperson Abd-al-Rahman ibn Khaldun (1332-1406). Ibn Khaldun provided numerous clinical observations based on his varied work experiences such as Secretary of State to the ruler of Morocco and Chief Judge of Egypt.

Auguste Comte (1798-1857) and Emile Durkheim (1858-1917) are among those who frequently are mentioned as precursors to the field. Comte, the French scholar who coined the term sociology, believed that the scientific study of societies would provide the basis for social action. Emile Durkheim's work on the relation between levels of influence (e.g., social compared to individual factors) led Alvin Gouldner (1965:19) to write that "more than any other classical sociologist (he) used a clinical model."

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

Let us go about our business with the understanding that within the scope of scholarship there is first science, and second something better than science. That something

better is first prevision by means of science, and second intelligent direction of endeavor to realize visions.

I would have American scholars, especially in the social sciences, declare their independence of do-nothing traditions. I would have them repeal the law of custom which bars marriage of thought with action. I would have them become more profoundly and sympathetically scholarly by enriching the wisdom which comes from knowing with the larger wisdom which comes from doing.

Clinical sociology, one of the fields that pairs science and action, is a humanistic, creative and multidisciplinary field that seeks to improve the quality of people's lives. Clinical sociologists assess situations and reduce problems through analysis and intervention. Clinical analysis is the critical assessment of beliefs, policies and/or practices with an interest in improving the situation. Intervention, the creation of new systems as well as the change of existing systems, is based on continuing analysis.

Clinical sociologists have different areas of expertise – such as health promotion, sustainable communities, social conflict or cultural competence – and work in many capacities. They are, for example, community organizers, sociotherapists, mediators, focus group facilitators, social policy implementers, action researchers and administrators.

Many clinical sociologists are full-time or part-time university professors, and these clinical sociologists may undertake intervention work in addition to their teaching and research or they may focus on providing some combination of research and advice to

those who do take actions (e.g., policymakers, the public, administrators, corporate boards, unions). If the focus of clinical sociologists is on advice/analysis for the public sector, this emphasis, in the last few years, has been referred to as public sociology (Fritz, 2005; Burawoy, 2004).

The role of the clinical sociologist can be at one or more levels of focus from the individual to the inter-societal. Even though the clinical sociologist specializes in one or two levels of intervention (e.g., marriage counseling, community consulting, national policy development), the practitioner will move among a number of levels (e.g., individual, organization and community or micro/meso/macro) in order to analyze and/or intervene.

Sociological practice is a general term that includes two areas, clinical sociology and applied sociology. Clinical sociology, as practiced in the United States, emphasizes hands-on intervention while applied sociology emphasizes research for practical purposes. Both specialties require different kinds of specialized training. Some sociological practitioners only describe their work as “clinical” or “applied,” while others say they work in both areas.

Those clinical sociologists who conduct research may do so before beginning an intervention project to assess the existing state of affairs; during an intervention and/or after the completion of the intervention to evaluate the outcome of that intervention. For some clinical sociologists, the research activity is an important part of their own clinical work. These sociologists have appropriate research training and look for opportunities to conduct research. Other clinical sociologists prefer to concentrate on the interventions and leave any research to other team members.

In the following sections, the development of the field of clinical sociology is discussed in terms of: (1) the history of American sociology; (2) intervention; (3) theories and methods and (4) international settings.

## **THE HISTORY OF AMERICAN CLINICAL SOCIOLOGY**

American sociology emerged as a discipline in the 1890s at a time when the nation was struggling with issues of democracy, capitalism and social justice. Frustration led to public protests and the development of reform organizations. In this climate, it is not surprising that many of the early sociologists were scholar-practitioners interested in reducing or solving the pressing social problems that confronted their communities.

### **Clinical Sociology as a Concept**

While many of the early sociologists were interested in practice, the earliest known proposal using the words “clinical sociology” was put forward by Milton C. Winternitz, a physician who was dean of the Yale School of Medicine from 1920 through 1935. At least as early as 1929, Winternitz began developing a plan to establish a department of clinical sociology within Yale’s medical school. Winternitz wanted each medical student to have a chance to analyze cases based on a medical specialty as well as a specialty in clinical sociology.

Winternitz vigorously sought financial support for his proposal from the Rosenwald Fund, but was unable to obtain the necessary funds for a department of clinical sociology. He did note, however, the success of a course in the medical school’s section on public health that was based on the clinical sociology plan. In 1929 Winternitz

wrote about his effort to build a department in a report to the university president and the report was published in the Yale University *Bulletin*. Also published in 1930 was the speech Winternitz gave at the dedication of the University of Chicago's new social science building in which he mentioned clinical sociology.

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

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

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

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

The various activities that have grown up around child-guidance clinics, penal and correctional institutions, the courts, police

systems, and similar facilities designed to deal with problems of misconduct have increasingly turned to sociologists to become members of their professional staffs.

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

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

In 1944, the first formal definition of clinical sociology appeared in H.P. Fairchild’s *Dictionary of Sociology*. Alfred McClung Lee, the author of that definition, later used the word clinical in the title of two articles – his 1945 “Analysis of Propaganda: A Clinical Summary” and the 1955 article “The Clinical Study of Society.” Lee was one of the founders of the Society for the Study of Social Problems, the Association for Humanist Sociology and the Sociological Practice Association and also was, from 1976-77, president of the American Sociological Association.

Also appearing in 1944 was Edward McDonagh’s “An Approach to Clinical Sociology.” McDonagh proposed establishing social research clinics that would use groups to study and solve problems.

In 1946, George Edmund Haynes’ “Clinical Methods in Interracial and Intercultural Relations” appeared in *The Journal of Educational Sociology*. Haynes was

a co-founder of the National Urban League (1910) and the first African American to hold a U.S. government sub-cabinet post. His 1946 article, written while he was executive secretary of the Department of Race Relations at the Federal Council of the Churches of Christ in America, discussed the department's urban clinics. The clinics were designed to deal with interracial tensions and conflicts by developing limited, concrete programs of action.

### **The First University Courses**

The first clinical sociology course was taught by Ernest W. Burgess at the University of Chicago. In 1928 and 1929, the course was considered to be a "special" course and did not appear in the catalog. The course was offered as a regular course from 1931 through 1933. The clinical sociology course continued to be listed in the catalog for the next several years but was not taught after 1933.

The university catalogs did not include a description of the clinical sociology course, but it always was listed under the social pathology grouping. All courses in this section dealt with topics such as criminality, punishment, criminal law, organized crime, and personal disorganization. Many students enrolled in these first clinical sociology courses were placed in child guidance clinics. Clarence E. Glick, for instance, was the staff sociologist at the Lower North Side Child Guidance Clinic and Leonard Cottrell was the clinical sociologist at the South Side Child Guidance Clinic.

Two other universities offered clinical courses in the 1930s, namely Tulane University and New York University. The Tulane University (1929) course was

designed to give students the opportunity to learn about behavior problems and social therapy.

The New York University course, taught by Harvey Warren Zorbaugh, provided undergraduate and graduate preparation for visiting teachers, educational counselors, clinicians, social workers and school guidance administrators. The major focus of the program was the solution of educational problems and other social dilemmas.

Zorbaugh, a faculty member in the School of Education, along with Agnes Conklin, offered a “Seminar in Clinical Practice” in 1930. The course was intended to qualify students as counselors or advisers dealing with behavioral difficulties in schools. From 1931 through 1933 the clinical practice course, titled “Seminar in Clinical Sociology,” was open to graduate students who were engaged in writing theses or conducting research projects in educational guidance and social work.

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

During the 1953-54 academic year, Alvin W. Gouldner taught a “Foundations of Clinical Sociology” course at Antioch College in Ohio. The college bulletin provided the following description of the course:

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

### **Contemporary Contributions**

While publications mentioning clinical sociology appeared at least every few years after the 1930s, the number of publications increased substantially after the founding of the Clinical Sociology Association in 1978. The Association, which later became the Sociological Practice Association, made publications a high priority, particularly in its early years. The *Clinical Sociology Review* and the theme journal, *Sociological Practice*, were published by the Association beginning in the early 1980s. These annual journals were eventually replaced by *Sociological Practice: A Journal of Clinical and Applied Sociology*, a quarterly publication.

The Clinical Sociology Association/Sociological Practice Association had a central role in the development of American clinical sociology. The Association helped make available the world’s most extensive collection of teaching, research and

intervention literature (e.g., Fritz, 2001; Straus, 2004) under the label of clinical sociology and it introduced the only clinical sociology certification process.

The Sociological Practice Association's certification process for clinical sociologists was available at the Ph.D. and M.A. levels. The Ph.D.-level process was adopted in 1983 and certification was first awarded in 1984. The Association began to offer M.A.-level certification in 1986. The Sociological Practice Association, along with the Society for Applied Sociology, also put in place the Commission on Applied and Clinical Sociology. The Commission has set standards for the accreditation of clinical and applied sociology programs at the undergraduate and graduate levels.

The Sociological Practice Association and the Society for Applied Sociology merged in 2005. The name of the new association – the Association of Applied and Clinical Sociology – once again gives name recognition to clinical sociology.

### **INTERVENTION AND INTERVENTIONISTS**

The basic intervention process with a client system, as outlined by Ronald Lippett and his colleagues (1958), is divided into seven stages: (1) The client system discovers the need for help, sometimes with the assistance from the change agent; (2) The helping relationship is established and defined; (3) The change problem is identified and clarified; (4) Alternative possibilities for change are examined and the goals of the change are established; (5) Change efforts are actually attempted; (6) Change is generalized and stabilized and (7) The helping relationship ends or a different type of continuing relationship is defined.

Three points can be made about the stages: (1) Initial assessments of the situation may be conducted during the third stage, and process and outcome evaluations may be conducted during a number of the stages; (2) It is possible not only to progress through the stages but to cycle back through them as necessary; and (3) The length of time required for each stage will depend on a number of factors including the kind of change under consideration.

Clinical sociologists do differ in their areas of expertise and consultation models (e.g., control or influence, extent of citizen participation). A practitioner also may use a general consultation model in her/his practice to analyze, reduce or solve problems or she/he may use certain approaches depending on the particular areas of application and/or the specific set of circumstances. Bruhn and Rebach (1996:31-67) note that the “creative problem solver” can choose from a number of approaches including ones they describe as social systems, human ecology, life cycle and clinical.

It is useful to outline the principles, attitudes and tools needed by clinical sociologists in conducting interventions. While these may differ somewhat depending on the level of intervention (e.g., individual, community, nation), the following would be among those included: having an ethical framework; practicing inclusiveness; working with the people’s interests and opportunities; encouraging recognition of the viewpoints of others; demonstrating interdependence as a factor in the change process; encouraging capacity building; and having a long-term perspective. Change agents need to be open-minded, have courage and be able to work well with others.

The characteristics of the client system are particularly important during a period of change. The largest share of work in any change initiative generally must be

undertaken by the client system. Therefore, the extent and quality of the change will depend, in large part, on the energy, capability (including available resources) and motivation of the client system.

The context in which change takes place is also very important. The change agent and the client system need to identify and review the internal and external forces that foster or resist change at the onset as well as throughout the process. These forces might be seen as biological, psychological, social/cultural, historical and/or environmental. This is a particularly creative part of the change agent's work, whether the interventionist is facilitative or directive, and is basic in the selection of intervention tools and techniques for effective, sustainable change.

### **Intervention for Socioeconomic Development.**

As an example, let's consider intervention in the area of socioeconomic development. Development is defined here as a planned and comprehensive economic, social, cultural and political process, in a defined geographic area, that is rights-based and ecologically oriented and aims to continually improve the well-being of the entire population and all of its individuals (Fritz 2004a). Economic development is the process of raising the level of prosperity through increased production, distribution and consumption of goods and services. Social development, on the other hand, refers to the complexity of social dynamics (the interplay of social structures, processes and relationships) and focuses on (1) the social concerns of the people as objects of development and (2) people-centered, participatory approaches to development. The individuals would be actively involved in open, meaningful participation in development

and in the fair distribution of benefits. The comprehensive definition of development (or socioeconomic development) has three components – social development, economic development and environmental protection.

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

There has been a growing recognition that economic development is a source of dynamic changes and generates wealth, but it will not, by itself, create prosperity for all. Intervention is required for socioeconomic change. Four points about intervention, as outlined below, are specific to socioeconomic development intervention:

(1) Harmony between social and economic interventions. Social interventions should contribute in a positive way to the economy, and economic interventions should improve the quality of people’s lives. A review of this situation is particularly important when one or more parts of a client system assume that economic changes will inevitably lead to social progress.

(2) Rights-based development. Rights-based development emphasizes the primacy of human rights law and people's ability to determine or strongly influence state policies. Including "rights-based" in a definition of development is one way of underscoring the importance of human rights in the development process.

(3) Protection of vulnerable populations. These groups could include refugees, immigrants, victims of war, racial/religious/ethnic minorities, children, elderly and women. Women, for instance, have been gaining formal rights but this progress has not been matched by an improvement in their quality of life. The hidden barriers and ceilings to women's participation are still in place and the shift to more responsibilities for families and communities has been an increasing burden for women.

(4) Appropriate level of intervention. Many countries have had, at some point, national social planning agencies but the planning approach has weakened or been abandoned over the years because of factors such as indebtedness, lack of resources or political pressure from groups that were politically conservative because they thought that planning should not be done at a national level as well as from advocates of community-based planning. These advocates thought that state agencies often had an inappropriate, top-down style of planning. Development requires a participatory approach to planning; because the levels are interconnected, it is necessary to involve, to some extent, most if not all intervention levels.

Clinical sociologists who work on socioeconomic development issues recognize the need to be able to have access to policymakers and/or work with those interest groups that can effectively lobby for change. Interventionists have to be knowledgeable about the substantive areas under discussion and be culturally competent, able to effectively

work with teams and knowledgeable about how to encourage public participation and media coverage. They recognize the importance of working on all relevant intervention levels to help foster an effective, sustainable, rights-based development process.

## **THEORIES AND RESEARCH METHODS**

Clinical sociologists frequently have training in more than one discipline and a great deal of experience in working with intervention teams whose members have a variety of backgrounds. Because of this, clinical sociologists integrate and use a broad range of theoretical approaches and, if they conduct research or collaborate with researchers, also have exposure to or use a range of research methods.

Epistemology, theory and research methods are linked. The kind of research methods used and the ways in which they are used will generally reflect the epistemology and theories held by the interventionist or those responsible for the intervention.

### **Research Methods**

Clinical sociologists who conduct research use a wide variety of research methods and techniques such as participatory action research, geographic information systems, evaluations, focus group analysis and surveys. But clinical sociologists probably are best known for their case studies. Case studies involve systematically assembling and analyzing detailed, in-depth information about a person, place, event or group. This methodological approach involves many techniques such as document analysis, life histories, in-depth interviews and participant observation.

Sometimes the cases are directly related to intervention work (e.g., a critical evaluation of program outcomes) and sometimes they are analyses of situations (real or based on reality) that will be of assistance to policymakers and administrators who are considering interventions. An example of that kind of work would be the analysis of the tobacco control interventions in “Well City” (Fritz, Bistak and Auffrey 2000) which included a list of lessons/ intervention considerations.

### **Theories and Models**

Clinical sociologists, in good part because of their interdisciplinary training and work experience, use a wide range of theories. Among the theories frequently used by clinical sociologists: grounded, standpoint, multicultural-liberationist, systems, conflict, interactionist, critical and social exchange. Theories, implicitly or explicitly, are a basis for the models that explain how practitioners should function. According to Lang and Taylor (2000:101), “models represent appropriate, aspirational, or best practices; they include guidelines for implementing them.”

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

Each of the areas of practice can have their own models. It might be useful to take one area of practice – mediation, for example - and briefly examine the theories and models used by practitioners coming from different disciplinary backgrounds.

## *Mediation*

Mediation, an area of expertise for some clinical sociologists, is a semi-structured, creative process in which one or more impartial individuals assist disputants (Fritz 2004b, Vraneski 2006). Mediators usually “learn a particular model and approach to mediation that encompasses guidelines, rules, procedures, and ways of understanding mediation practice” (Lang and Taylor 2000:101).

Stage models are frequently used for organizational and community disputes. One such model, according to Jennifer Beer (1997), has seven stages: opening statement; uninterrupted time for each person to speak; exchange; setting the agenda; building the agreement; writing the agreement and closing. Beer notes that separate meetings (small caucuses of some participants and/or the mediator and one or more participants) can be held at any time during the mediation. Another model, developed by Jacqueline Morineau (1998:83-88), has three stages: theory, crisis and catharsis. Lascoux (2001:161- 67) discusses a six-stage model with the first stage (creation of context) being “the most delicate and the longest.” Haynes (1994) describes a five-stage family mediation model in which the mediator continues to cycle through the stages as often as necessary. During the first stage of this model, the mediator gathers, verifies and shares the data.

The stages in the stage models are frequently not distinct and will differ depending on factors such as culture; mediator, sponsor or party preference; specialization; type of mediation and complexity of case. Some models may be ones in which no or few stages are specified or expected while other models have many stages. A complicated community environmental dispute, for instance, might begin with a period

in which possible participants are identified and discuss the likelihood that all will participate in some kind of conflict analysis. This group might then hold a series of facilitated sessions in which procedures are developed and approved that would be used in a mediation. All this preliminary work would take place before what one might think of as the actual mediation. Christopher Moore (2003:67-69), in his 12-stage model of mediation, devotes the first five stages to the period *before* the meetings to discuss the problem/situation actually takes place.

Even if there was one model that could be used in all or most situations, there can be differences, at times, in the order of the states or in the length of time devoted to certain stages. There also will be differences in the way mediators and organizations that hire mediators rely on the models. The models each provide a general flow for cases but there will be a range in their use by practitioners - from those who rigidly follow a prescribed model to those who would not think of doing so.

The model or models used by American mediators are related to their approaches to mediation (participant-centered, solution-oriented, transformative, narrative and humanist/integrated process) (Fritz 2004b). The models and approaches are grounded in theory. The theories would include those that are biologically-based (e.g., social Darwinism, ethology, sociobiology), focused on the individual (e.g., social learning, social exchange, psychotherapy) and focused on social/political situations (e.g., sociotherapy, systems, conflict, multicultural/liberationist, land ethic, humanism).

The humanist/integrated process (HIP) approach, the preferred approach of some American clinical sociologists, emphasizes humanism, cultural competency, empowerment, respect and creativity (Fritz 2006). The mediator is reflective in

continually assessing the interaction between/among the parties and among the parties and the mediator. The HIP mediator is participant centered but flexible in terms of stages and approaches. Depending on the circumstances of the mediation, the mediator may integrate aspects of any of the other mediation approaches (e.g., transformational, solution-oriented).

Frequently the HIP approach is multicultural/liberationist and based on a particular view of humanist theory. This humanism, focusing on free and responsible individual choices, includes respectful consideration of the natural environment and fits very well with Aldo Leopold's (1949) land ethic theory. Leopold (1949:204) indicated that "a land ethic changes the role of Homo sapiens from conqueror of the land-community to plain member and citizen of it."

Mediation, like other areas of clinical practice, has a variety of theories and models that may be used as guideposts. Creative dispute intervention means that theories, models and intervention strategies may be adjusted as the work proceeds; new or refined models, theories and intervention strategies are seen as a normal part of the creative process.

## **GLOBAL CLINICAL SOCIOLOGY**

Interest in clinical sociology has been growing in a number of countries. For example, French is the predominant language of many, if not most, of the current international clinical sociology conferences and books and articles have appeared with clinical sociology in the title in France and French-speaking Canada. The French-

language clinical sociologists emphasize clinical analysis although some also are involved in intervention. They have a solid international network and have done an excellent job of attracting non-sociologists to that network. Their literature is substantial. Particularly notable is the work of Jacques van Bockstaele and Maria van Bockstaele (1963, 1968); Robert Sevigny (1997, 2005); Eugene Enriquez (1992, 1993, 1997); Vincent de Gaulejac and Shirley Roy (1993) and Jacques Rheume (1993, 1997). The van Bockstaeles (2004), who have worked as organizational consultants for many years, have published a book on socioanalysis and Jacques Rheume and his colleagues in Montreal are completing a book on the development of clinical sociology in Quebec.

For many years, Italians have hosted clinical sociology conferences, published clinical sociology books and articles and hosted numerous clinical sociology training workshops. If one is interested in learning about clinical sociology in Italy, one would want to review the work of Michelina Tosi and Francesco Battisti (1995) and publications by Lucio Luison. Luison's 1998 book, *Introduzione alla Sociologia clinica* (Introduction to Clinical Sociology), contains thirteen chapters written by Americans. Everardo Minardi, an editor of a book on action research (Minardi and Cifiello, 2005), is the head of a new graduate program in clinical sociology. The Clinical Sociology Association in Italy, which has been headed by Gieuseppe Gargano and Massimo Corsale, is one of four sociological practice organizations.

Clinical sociology also is found in other parts of the world such as Greece, Brazil, Mexico, Japan and Malaysia. According to Yuji Noguchi (2005), clinical sociology was first noted in Japan in 1994 and the first textbooks were published in 2000 and 2001. Noguchi says there still is discussion of the definition and theoretical frameworks, but the

Japanese also share with Americans “a practical concern with problem solving.”

Japanese clinical sociology focuses on health and illness. In Malaysia, Halim Wan (2004a, 2004b) has started a professional organization of clinical sociologists and is writing two books about the field. One of the volumes focuses on the development of clinical sociology and the other is about his extensive experience as a practitioner.

The international development of clinical sociology has been supported primarily by three organizations. The clinical sociology division of the International Sociological Association (ISA) was organized in 1982 at the ISA world congress in Mexico City. Clinical sociologists also are members another ISA section - the sociotechnics – sociological practice division. The other major influence is the clinical sociology section of the Association internationale des sociologues de la langue française (International Association of French Language Sociologists).

American scholar practitioners, with their focus on intervention, have had a strong role in the development of the field of clinical sociology, but now are only one of many national influences shaping the emerging global specialization. World-wide, clinical sociologists continue to be interested in health care, quality of life, national social policy, organizational development, conflict intervention and individual development. More recent clinical areas of analysis, research and intervention include public participation, environmental protection, tourism, globalization, rights-based socioeconomic development, and security – all major issues in an at-risk world.

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