Robert Sévigny
University of Montreal, Canada

Chen Sheying
Indiana University, USA

Elaina Y. Chen
Indiana University School of Medicine, USA

Explanatory Models of Illness and Psychiatric Rehabilitation: A Clinical Sociology Approach

Abstract

The notion of explanatory models of illness (EMI) epitomizes the theme of social representation in social psychiatry. This article illustrates a clinical sociology approach to the subject by revisiting the seminal work of Kleinman and reflecting on the use of EMI in studying severe mental illnesses, particularly in China. A general literature review is provided to show the complexity of the subject, and the work of clinical sociologist Sévigny over the past two decades is summarized. A case analysis is conducted to illuminate the many social factors that came to play in affecting the experiences and perceptions of schizophrenic patients and their significant others in the nation's capital Beijing in the 1990s. Diverse "explanations" in the experience of schizophrenia are explored, including the medical, the psychogenic, and the psychosocial models, among such others as inheritance and religious beliefs. Implications for research and clinical practice are discussed, including extending EMI study beyond illness interpretation to emphasize social rehabilitation.

Keywords

Explanatory Models of Illness (EMI); Social Psychiatry; Clinical Sociology; Rehabilitation of Schizophrenia; Case Study in China

Social psychiatry has been an understudied field in China, particularly since many ehavioral and social science disciplines were brought to a halt in the mid-20th century (Chen 2004). In contrast with scarce literature in this research field, the nation's rapid social change has produced mounting social and health problems,

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particularly in its densely populated urban areas (Guo 1987; Sévigny Chen and Chen, 2009), with a large number of people suffering from schizophrenia (Lai and Lee 2006; Cooper and Sartorius 1996; Saha, Sukanta, Chant, David, Welham, Joy and McGrath, John 2005). In order to understand the responses of the Chinese society, Western research on the explanatory models of illness (EM or EMI) among psychiatric patients and other people suggests a useful approach to the social processes in which such a mental illness is recognized, interpreted, and treated in China. Following Kleinman's seminal work on the subject (Kleinman, 1980, 1988), researchers have made important contributions by applying EMI analysis in China (e.g., Phillips, 1998; Pearson, 1993), as well as in other developing countries such as India (e.g., Bhui and Bhugra, 2004; Charles, Manoranjitham and Jacob, 2007). Still others have used the EMI notion in a multi-ethnicity context (Hinton, Franz, Yeo and Levkoff, 2005). There are not enough case studies, however, to help expand EMI research, especially in the area of social rehabilitation of severe mental illnesses such as schizophrenia.

This article aims at shedding light on the subject by using a clinical sociology approach with a historical understanding of mental health issues in urban China amid significant social changes in the 1990s (Sévigny, 2004). In order to position our analysis under the perspectives of EMI, we first provide a review of such approaches to severe mental illness (schizophrenia in particular) in the literature. Based on an examination of their cultural relevance to the Chinese context, we present evidence from a case study in Beijing on how those recognized as well as some potentially new models were found in the real life of the Chinese people.

Research Background and Methodological Considerations

This paper is the result of collaboration between the first two authors. Chen specializes in macro-sociology and research methodology, ranging from policy analysis to cross-cultural practice in social work and mental health, with a special interest in the general or quantitative representation of psychosocial problems in China (Chen 1997, 2002). Sévigny has been working in the field of mental illness and rehabilitation in urban China from a clinical sociology perspective, which is a more micro point of view. For a comprehensive and penetrating analysis of data accumulated in the post-Maoist 1990s, their complementary approaches combined do form a unique edge. In a previous article (Sévigny, Chen and Chen 2009), they studied the place and the impact of the *Danwei* (work unit) in the experience of severe mental illness (schizophrenia). The present study further explores the notion of EMI evolved out of medical anthropology in the representation of mental illness in China from the integrated micro-macro approach.

Such a multi-level approach is supported by the following perspectives: (a) Systems perspective: Personal history, family and living arrangements, wider informal social networks, work/employment and other formal organization participation, social institutions, stratification, population and environment, and social-cultural change; and (b) Disciplinary and interdisciplinary perspectives: Social psychiatry, social medicine, clinical sociology, social work, and public policy. The approach entails adequate epistemological thinking, including the micro vs. the macro, empirical vs. interpretative, qualitative vs. quantitative, objectivity vs. subjectivity, the validity of behavioral and experiential data, personal experience and its representation, and the nature or value of those actors' knowledge. While not without exception, the traditional "scientific" analysis stresses quantitative data,

logical empiricism, and objective knowledge independent of both researchers and subjects. In contrast, our analysis will emphasize interpretative, qualitative, and experiential data as well as subjective understanding on the part of the researchers (which does not preclude an analytical posture from the latter). The following will not follow the typical empiricist-positivist hypothesis-testing procedure but offer a psychosocial perspective in which detailed case study data are provided to explore what it meant to experience a severe mental illness in China.

Two previous research projects by Sévigny were relevant to this project. The first one was an analysis of mental health practice from a sociological, interpretative approach. In that project, Sévigny (1983, 1984) coined the notion of "implicit sociology" to illustrate how mental health professionals did not limit themselves to formal/explicit/expert knowledge to understand and communicate with patients. Especially, on many social dimensions of mental illness experience, psychiatrists would use their personal, experiential knowledge to conduct medical assessments, to make suggestions to a patient, etc. For instance, a psychiatrist who had worked most of his life in a poor urban area would understand the meaning (for a woman) of being depressed or extremely violent in his unique way. In studying schizophrenia in China, the idea of implicit sociology has been expanded to pursue the diverse meanings, interpretations, and languages each party (e.g., patient or relatives, work unit leaders or colleagues besides psychiatrists or psychologists) used to express the experience of mental illness. It is for that project that Sévigny formulated a clinical sociology analytical grid (Rhéaume and Sévigny 1988).[2]

More immediately related to the present study is a project conducted by Sévigny in the mid-1990s on social rehabilitation of patients suffering from severe mental illness in urban China. During that period of post-Maoism, he was asked to set up a research project with two objectives in mind: first, to propose a sociological approach to the process of rehabilitation of schizophrenic patients, and, second, gather some qualitative data on the experience of the patients themselves and the experience of other significantly related people (Sévigny 1993, 2004, 2008: 2-10; Sévigny, Weng, Yang, Loignon and Wang 2009). It was understood at the outset that the approach would be largely based on the notions of experiential knowledge, representation, and meaning. It was also agreed that the project would be a "collaborative" endeavor in the field of clinical sociology[3] and would use a case study approach. Case analysis stressed a few central experiences, in which the patient tried to understand and give meaning to such things as feeling alienation from his/her usual social environment (work situation, family life, etc.), effort to retain a positive self image, and ways of accomplishing relatively satisfying social rehabilitation. One of those central questions each patient (and those in his/her immediate social environment, or ISE) had come to deal with was: How can I explain to myself, and to others, what happened and what is still happening to me? For each patient in the sample, the theme of "explanation" was central to both the experience

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2 Clinical sociology is considered a sub-field of sociology that has its roots in many schools or trends in social sciences, mainly research-action, social psychology, interpersonal relationship, group dynamics, personality-culture-social structure, and social intervention. Clinical sociology always, in one way or another, deals with practice or action, either by studying the process of intervention or by studying factors related to action or practice, The term "clinical" is used here mainly by analogy ("to be or to go near the patient") and stress the intention to relate theory and practice, or concepts and empirical data. The other analogy implies the methodology of case studies. While some clinical sociologists work in the field of health, clinical sociology has been applied to all areas of action/practice (Sévigny 1996; Fritz 2008).
3 While all the field work was done in a research-action/collaborative perspective, most of the analytical work has been conducted by the first author and other contributors.

of illness <u>and</u> the experience of rehabilitation. And the question was central for all those who were concerned about the patient's experience.

More than 15 years have passed since the field work was done, but this background led us to a systematic inquiry into the EMI in a quest for more up-to-date and culturally relevant tools for research.[4]

Objectives and Approaches of the Present Study

The purpose of this article is to reassess the **core** of the of the original EMI approach by exploring its similarities and differences with Sévigny's approach. Sévigny's clinical sociology approach focuses on how the larger social system (LSS) is referred to by patients and their significant others[5] when they try to make sense of the schizophrenic experience. The emphasis on the LSS, supported by Chen's macro-sociology perspective with an "economic state in transition" model to highlight the Chinese public policy context (Chen 2002), pays special attention to the rehabilitation process from an experiential perspective. The authors also wish to inquire into the "medical explanatory model" from a non-medical or non-professional point of view. A working hypothesis here is that there are fundamental differences between the medical and the lay knowledge/language, as well as very important complementarities between them.

The research involves a broad range of concepts related to social representation or explanation. In view of those conceptual schemes, the article will use case material to illustrate the uses of and reasons for different EMI by the Chinese people in both the diagnosis-treatment of schizophrenia and the rehabilitation process (after single or repeated crisis) in a particular historical context, e.g., post-Maoist urban China. Based on such analysis, the study will provide some significant lessons to improve the understanding of explanatory models (EM) of severe mental illnesses.

The article contains three parts. First, it examines the "classical" notion of EM with regard to mental illness. A major use of the notion has been to highlight the idea that there are other types of explanations than the medical ones and other significant points of views than those of the psychiatrists (i.e., "lay", "folk" or "popular" explanatory models and idioms of distress). The non-medical explanations from the literature will be summarized before reviewing the EMI notion that Kleinman proposed in the late 1970's. The second part presents an analysis of a case study, which will illuminate how clinical sociology approaches the question of explaining or interpreting the experience of schizophrenia with a special emphasis on social

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4 In a pilot study Sévigny (1997), though not referring directly to Good' concepts (Sévigny 1977), used semantic indicators and identified three major EMI's in a complex theoretical system: a medical model, a personality of psychogenic model, and a psychosocial model. Sévigny also found that some informants – mainly family members – had referred to traditional Chinese medicine, though in a much more subdued or implicit way. For instance, a father would say "by the way" how he had taken his son to his old village to consult a traditional doctor, without elaborating on the subject, presumably because of the fact that his son had finally been hospitalized in a non-traditional institution.

5 This notion in sociology refers to any social actor adopted as a role model by another social actor (Jary and Jary 1991). Such a definition implies deep personal and emotional relationship with another social actor. In the context of this research project, we use a broad notion of "significant others" to include all social actors related to a person experiencing schizophrenia. The assumption is that even if some of them would not necessarily be considered as "role models", they had personally and emotionally "significant" relationships with the patient. For example, *Danwei* leaders or hospital staff were, at least potentially, "significant others" for the person experiencing a severe mental illness.

rehabilitation in a particular socio-cultural context. Finally, we will discuss how both the methodological approach and some interpretations of the data point to potentially significant improvement for further studies, particularly in the area of social rehabilitation.

Social Representation of Severe Mental Illness

Social representation of mental illness is a "classical" theme in social psychiatry (Jodelet 1991; Moscovici 1988). Here the notion is taken in its broadest sense to encompass many classic ideas in the social sciences: the definition of the situation, the perception of self and others, the meaning of experiencing, etc. Studying the social rehabilitation of psychiatric patients first requires understanding the representation of mental illness among different social actors involved in the process. Whether from the point of view of patients or those around them, attitudes and behaviors are based on such representation of mental illness.

EMI is a conceptual tool to help operationally define the idea of social representation of mental illness. A "model" is often used to classify the representation of professional (e.g., medical) knowledge, theory, practice, etc. But here we use the term in the same way as most medical anthropologists tend to use it, that is, representation of "non-professional" views and experiences. The explanatory models are commonly applied to both consequences (impact or outcome) and causes. In this article we use "causality" in a broad sense in order to understand the diversity of meaning of all the actors' experiences.[6] When one talks about what causes an illness, the "cause" may be understood in the context of scientific knowledge. In the biomedical world, for example, certain factors explain an illness and determine an appropriate treatment. The key word here is "to explain". The understanding that a lay person (e.g., a patient) has of her experience does not preclude reference to this scientific discourse: without belonging to the scientific world, the patient may well explain her/his illness in terms of genetics or psychosis. Today's "common knowledge" is very often yesterday's "scientific knowledge". On the other hand, a patient may also talk about a "cause" in reference to the symbolic or subjective world of "meaning". The search for answers to "why something happened", and "how", would be a part of the desire to understand and interpret illness. The patient may try to interpret what is happening to her without going into the realm of science. She/he may see it through the lenses of different sources of knowledge including science, the paranormal, spirituality, the universe of feeling, and personal motivation.

EMI: Diverse Approaches

By proposing the idea of EMI, Kleinman made a seminal contribution that influenced numerous other social scientists - by making it possible for patients and

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6 Common definitions of a "cause": (1) Things, persons, situations, events, historical moments, etc., which make something exist or happen; (2) Motivation, reason (*Le Grand Dictionnaire Encyclopédique de la Langue Française*, 1996). In the broad sense, "cause" is similar to "meaning. The English Oxford Dictionary defines "cause" as: "a person or thing that gives rise to an action, phenomenon or condition. (…) grounds for doing things, thinking or feeling something", while "explanation" is defined as: "statement or account that makes something clear. (…) a reason or justification given for an action or a belief." Such definitions do not refer to the methodology of establishing an "objective" relationship between a cause and a consequence, though one may refer to this "scientific" language in his or her own "non-scientific", lay knowledge.

other related people to have a say about the experience of severe mental illness.[7] Let us look at a sample of projects that have explored the views of people involved, directly or indirectly, with mental health and illness in various contexts and with diverse research strategies. The following are different ways of classifying research projects that have considered the views of the actors as an important base for the understanding of mental health/illness.

Classification of EMI based on different notions used. There are many "equivalents" for the notion of illness, and also for the notion of "explanation". For illness representation, the following terms may also be used: sickness, disease, disorder, distress, disability, severe mental illness, severe mental health problems, etc. Similarly, there are a number of notions related to social representation that may be used in generic or specific ways: perception (illness perceptions), interpretation (interpretative or comprehensive approach), attribution (social attribution, symptom attribution, etc., which usually refer to non-professional explanations of an illness, problem, etc.), reason (as opposed to "scientific" causation), meaning (e.g., "meaning-centered analysis of popular illness", see Good and Good 1982), social construction, and common sense. The main interest in this listing of "equivalents" is to stress the richness and also the complexity of the notion of EMI. Each of these related notions may point to a specific psychiatric practice and/or a different research purpose.

Classification based on populations or samples studied. Another way to organize or classify research on EMI is the type of population or sample studied. One of the basic insights associated with EMI is the importance of taking into account the views of all persons related to a specific case rather than using only the medical (or biomedical) frame of reference.

- Studies about singular cases: According to Kleinman (1980, 1988a, 1988b), an EMI makes sense only with regard to specific/particular cases. This is how he suggested studying the EMI for each person related to a particular case: the patient's EMI,[8] the mother's EMI, etc. If we stick to Kleinman's definition of an EMI, only this type of sample would satisfy his criteria.[9] Different yet still close to Kleinman's notion are those studies based on samples consisting of people directly related to a person suffering from mental illness (usually family members of a patient).

- Studies based on samples of persons directly related to mental illness: Phillips and colleagues (2000) used this type of sample, for instance. This is useful when each respondent refers at least implicitly to a patient personally known to him or her while the conclusions or interpretations cannot be applied directly to specific individuals.

- Surveys of general populations: Generally, the objective is to find out the "lay" or the "popular" knowledge of ordinary people toward mental illness, or toward a specific disorder like schizophrenia. Dear and Taylor (1982) used this type of research, for example. A sub-type includes comparisons between populations, such as Americans vs. Chinese. Such surveys, deviating from Kleinman's original notion, are nevertheless useful for the study of EMI if taken as a whole. The main justification for this is that they are a part of

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7 In this paper our reference to Kleinman's work concerns mainly or exclusively what could be called the core notion of EMI, and does not inten to to present a comprehensive review of his contribution of this notion.
8 The typical translation of a "patient" in the Chinese language is a "sick person".
9 This singular case approach was adopted by Sévigny in the Beijing project, hence the case analysis approach.

a cultural context.

Classification according to different aspects and time frames. The use of EMI may focus on different aspects/dimensions of mental health and illness, such as vulnerability-stress, "triggering" factors or conditions, expressed emotions (as a factor related to rehabilitation and to relapses), social stigma and stereotypes, help-seeking behavior, etc. Other categories may be based on different moments (e.g., a "before/after a specific event" or a state of vulnerability), or different phases (i.e., from diagnosis to treatment to rehabilitation),[10] in illness history.

Classification according to different research methods. Even though research may share the same purpose, the projects often differ from their methodological perspectives.

- Clinical approaches: The original work of Kleinman on EMI within the context of medical anthropology was concerned with immediate relationship between a patient and medical staff. Although this would not prevent generalizations later, the methodology used was basically clinical intervention. Kleinman used the usual tools of anthropologists, including the interview situation and participant observation (Kleinman 1980, 1988a, 1988b). Some others have based their research on clinical practice, such as the work of Phillips (1998).
- Statistical methodology: Many studies are based on statistics, which may not be considered as pertaining to the EMI field. They nevertheless provide clinicians with a useful contextual understanding of individual cases.
- Structured vs. unstructured data: The statistical approach implies structured data, and much of the research reviewed belongs to this type. On the other hand, others have used techniques more akin to classical social anthropology such as in-depth interviews or focus groups.
- Semantic data: As seen in the exchange between Kleinman and Good (Good and Good, 1980), semantic analysis is a complex field of study. Sévigny and colleagues (1999) also conducted a preliminary study based on similar but simplified type of EMI.

The above outline for identifying "representation" or "explanation" of mental illness underscores the complexity of both notions. Since the focus of this article is on the explanatory models of schizophrenia, we will refer to some but not all of the approaches mentioned above. In the following, we will examine Kleinman's definition of EMI, clarify its boundaries, and explore the use of EMI in the study of social representations that different actors have of rehabilitation (not just illness itself).

Kleinman's Notion of EMI

Kleinman proposed the notion of EMI at the turn of the 1980s. The following are notable regarding his seminal work and have been applied in numerous subsequent works:

- Kleinman and other medical anthropologists have applied the notion of EMI to three classical sectors of health intervention in terms of the knowledge and language referred to by a) medical professionals/formal interveners,

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10 The case study we present in the next section, for instance, was based on interviews collected about six months after hospitalization. In this context the collected data, even when the interviewee spoke of the crisis period, was always "colored" by the immediate experience of rehabilitation.

b) informal or traditional helpers, and c) the general population of a specific society (Kleinman 1980). While the study of the first two types of knowledge (medical and folk) had been a part of medical anthropology for some time, Kleinman's quite radical point was to allow for the exploration and understanding of the views of many other people involved with the experience of patients. Those viewpoints became a substantial part of the psychiatric theory and practice. At least in the modern urban context, Kleinman's contribution suggests that, besides the biomedical knowledge, there are other less formal views useful for approaching mental illness and rehabilitation.

- Those "explanations" were understood as being given by persons involved in the experience of mental illness: the patient him-/herself, family members, relatives, etc. Even if clinicians or health professionals in contact with a patient did not formally mention this aspect, they did constitute a significant addition to biomedical knowledge (Kleinman, 1981).[11] EMI was not confined to the "individual" aspects of the experience but included social conditions/contexts of the patient's experience. A set of "categories" were proposed to describe and analyze this patient-social environment connections. Examples often referred to by Kleinman were concerned with the patient's immediate social situation but also were relevant to his/her social environment

- The notion of "explanation" was defined in a very broad and comprehensive sense. Intending to explore other definitions than the scientific or biomedical definition of the "causes" of an illness, he proposed a broad notion of "explanation" that included "experience" and "experiencing"[12] on one hand and "meaning", "understanding", and "interpretation" on the other.

- The methodology proposed was an anthropological approach, mainly participant observation and unstructured or semi-structured interviews. The explanations were, by definition, those given about a specific case. Each case involved a specific set of EMI. Case analysis in that context was the main analytical tool to allow for the exploration of the experience of mental illness from the viewpoints other than that of the medical expert.

- The purpose of the EMI study was to contribute to different types of mental health services and different "moments" of clinical interventions (from diagnosis to decision making about hospitalization, to treatment, and finally to rehabilitation).

Without following strictly the original EMI idea, some researchers have stressed different aspects of mental illness experiences. Others, without being centered on the mental health experience, have proposed approaches that also stress or give priority to the actor's knowledge and have been sometimes applied to the mental illness experience. A few instances of them are the grounded theory with its notion of "substantive" knowledge (Strauss 1987; Glaser 1992), the lay knowledge as opposed to professional knowledge (Fabrega 2002, 2006), the EMIC-ETIC approach, which was first developed in linguistics but much applied to anthropology (For instance, Fabrega (1991), the local knowledge (Geertz 2000), the indigenous knowledge, and

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11 Having explored how psychiatric/medical professionals in practice referred to some non-professional knowledge about the social conditions – their own and their patients', Sévigny extended the notion of "implicit sociology" (Rhéaume and Sévigny 1988; Sévigny 1996) more specifically to psychiatric cases, including medical personnel, family members, neighborhood and local authorities and work units (*Danwei*) (Sévigny 2008, 2008a, 2009).

12 This is related to the notion of "experiential knowledge".

the implicit or tacit knowledge or etiology (Whitehouse, Maurer and Ballenger 1999). There are also other general concepts such as "attitude" or "belief" that are used in analyzing people's values in relation to mental illness. This brief list illustrates how innovative Kleinman's notion of EMI was, as part of a larger trend in the development of social sciences (particularly anthropology and sociology). Nevertheless, no clear answer has been found to the question arising from the Kleinman-Good exchange (Good and Good 1980): Does the EMI lead only to interpretation of a patient's individual illness, or should or could it be seen as an interpretation of a "larger" social or cultural meaning? This question is still debated and reminds us of another, classical debate about individual/society/culture relationship, which is relatively new in sociology and tends to postulate a more deterministic point of view.[13]

All these are important in considering the original conception of EMI. Featuring research on mental health in ensuing years, it indicates the value, both for clinical practice and for research, of exploring and analyzing the views of all those involved to fully understand the experience of severe mental illness. [14]

Case Analysis

Undoubtedly, Kleinman's contribution initiated a much more comprehensive approach to mental illness. Our assumption is that it may also be central to the study of social rehabilitation.[15] In order to show how Kleinman's contribution has benefited clinical sociology in this regard, we will present some case material in this section. But we will first explore whether and how different social actors personally related to a patient's experience of schizophrenia referred to any of the EMI reviewed above in their representation of severe mental illness, particularly to Kleinman's EMI.

Our empirical data were extracted from a qualitative research project conducted in China mentioned earlier (Sévigny, Chen and Chen 2009, Sévigny 2008, 2009, 2010). Between l988 and l997, the first author was involved as a sociological researcher in a large psychiatric hospital in Beijing. Twenty patients, as well as people from their immediate social environment (ISE) – family/relatives, neighbors, colleagues and leaders at workplace, and medical/hospital staff – were interviewed between 1990 and 1993. Most patients belonged to a major state-owned *Danwei* (work unit) and all were hospitalized in the medical facility. The research used a semi-structured technique of interview and focused on social representation by covering cultural, social, and organizational dimensions related to mental health interventions and rehabilitation. The analytical grid included basic concepts concerning the person-society relationship, which referred to the many "layers" of social conditions, ranging from personal experiencing to the interpersonal relations and to the larger social, economic, political and cultural systems. The case under study was chosen from this sample, which has been analyzed at length according to

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13 Martucelli (2002) offers a new approach to the individual/society relationship, which, when applied to the mental illness/health field, opens it up to a less deterministic point of view.
14 For an excellent presentation of the EMI notion in the context of public health, see Massé (1995)
15 Psychiatric rehabilitation may be seen as a part of treatment, or as the process that may follow the treatment or hospitalization. Either way, for a patient, rehabilitation implies coming back to his or her previous place of life, re-gaining a previous status or achieving a new one. It is a complex biopsychosocial experience. In that sense, any rehabilitation is social rehabilitation involving the family, the neighborhood, and social organizations (including workplace and medical establishments) (Sévigny et al., 1997). In the context of this research, social rehabilitation involves all aspects of social life outside the hospital after hospitalization

the general grid mentioned above (Sévigny 2010). The differences between the perspectives of medical personnel, *Danwei* colleagues and leaders, members of neighborhood organizations and the family, and patients themselves as well as Western and Chinese representations of mental illness are also illuminated. Here we focus mainly on the EMI as perceived and expressed by the patient and her ISE.[16] We will explore in what terms the patient and the people from her ISE underline explained their encounter with a severe mental illness. After a short presentation of the patient and her ISE, we will explore how the EMIs implied, directly or indirectly, by the meaning, reasons, explanation, and causes of the patient's experience of schizophrenia.[17]

Case Description

Lulu, female, was 24 years old when she was first interviewed. She completed graduate studies and, since then, had always worked in the private sector after refusing the job assignment given by her college. At the onset of her crisis, she had been living with her boyfriend Ceng for three years.[18] They met in secondary school. At home she had her mother and a younger sister who was also suffering from a severe mental illness and hospitalized when Lulu went through her own crisis. She had an older sister who seemed to be in control of her own life and was helping her family through their difficulties, which were aggravated by the fact that their father had taken his own life a few years ago. When the episode concerning Lulu happened, the mother was outside of home tending her younger sister. Some time before Lulu was hospitalized, her older sister had helped her finding a job: she was accepted as a trainee in a new department store. In the new market economy, the store was owned and managed by foreign investment.[19] Lulu was released from the hospital about a year before the interviews were conducted and had since been living with her family. Just a few weeks earlier, again with the help of her sister, she had found a new job.

Causality and Meaning : "What Is Happening to Me?"

This question, which she discussed at length with the doctor who treated her, was still present in her mind almost a year after the crisis that led her to the psychiatric hospital. And the question applied to many of the critical incidents that happened to her. Our case presentation will be limited to her meeting with a taxi driver at the beginning of her illness and her hallucinations about his father.

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16 Among the very few who have studied perceptions and representations of personal experiences of severe mental problems in China, Pearson (1995) and Phillips et al. (2000) dealt with the topic from different perspectives.

17 In the original, complete analysis, the case was analyzed under four headings indicating different but related approaches to the understanding of the patient's experience: a) the central or critical experiences in the patient's encounter with schizophrenia, b) consequences in his/her social rehabilitation, c) explanatory models (causes, consequences, meanings, etc.) and d) the patient's experience with the larger social system.

18 Note how she had accepted, and identified with, the new trend of the Chinese reform by the early 1990s: The absence of tight social control over her private life (her love affair) and her choosing a different job from the one assigned to her after her graduation.

19 In contrast to some other cases, Lulu found herself as a part of the trend characterizing the "new China" and felt very happy and motivated in that context.

She had been sent home by her department store manager who felt she was not feeling well at all and could not do her job. And she took a taxi, which her manager had called for her. A long story unfolded from there. She felt guilty for having had sex with this taxi driver because she felt she betrayed her boyfriend Ceng. At the same time, she was quite "shaken" because she remembered having more pleasure having sex with Fang (the taxi driver) than she usually did with Ceng.[20]

(1) Causes and consequences

Almost a year after this incident, she asked questions about love and sexuality with deep feelings. She remembered that Fang abused her, yet did not reject "those good feelings" when she was with him. At the same time, she could not see herself marrying Ceng ("I made love with another man...I belong to another man [than Ceng]..."). Another reason making it impossible to marry Ceng: "I am mentally sick and if we had a baby it would be a fool".

Lulu was interested in understanding the causes of her illness and its consequences. Concerning mental illness, this distinction led her to differentiate between having experienced her illness (such as her hallucinations) and the consequences for her social reinsertion and rehabilitation.

(2) The question of meaning: "What is happening to me?"

During her interview, Lulu recalled another event that left her with incomprehension and fear: "*I saw my dad on TV. He was navigating a space ship…*" At that moment, she remembered telling herself: "*What is happening to me?*" Her father had passed away a few years ago and there she saw him on the screen. This question expressed her feeling of despair concerning both what happened to her during that past year and in that particular event. In many ways, she tried to understand the reasons that caused her crisis and what had happened afterwards, but in the case of her hallucinations associated with her father, it was more meaning than consequence that still bothered her.

(3) Biomedical explanations

While biomedical explanations did not play an important part in her understanding of her illness, Lulu would still refer to them from time to time:

- She made allusion to genetics twice: First, she told the interviewer that she thought schizophrenia could only be passed on from father to son, yet she realized that her younger sister inherited the illness from their father. Second, she mentioned that because of the genetic factors she did not make the decision to bear Ceng's child.
- What she really tried to understand was why she had "hallucinations". She asked herself the question, stressing at the same time that she did not understand why (*What is happening to me?*). Interesting enough, she did not mention any of the medical staff comments on that issue.[21]
- She directly addressed the medical aspect of her illness only when she

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20 Even she knew she had some hallucinations while she was with Fang (for a few days), all this was not only hallucinations: Fang indeed was a "real" person who took her back to her home and met Ceng, Lulu's boyfriend. So the explanations she was trying to find were at those two levels.
21 In the entire interview, Lulu did not say much about her hospitalization.

made a connection between medication and sexuality ("*Since I've been medicated, I don't want to have sex anymore* (…) *Our sexual life is not as satisfactory as in the past...*"). Yet, after making that connection, she did not go further to conclude that things would be better if she were not medicated: for her, medication was only one of the many explanations. Her real preoccupation was her relationship with Ceng, not just the sexual aspect of it.

- She would sometimes use the concept of "illness", "psychosis", or "schizophrenia" to explain her situation, but generally s she tended to avoid naming her illness and would rather say "*this illness*" or "*this kind of illness*" as we saw in the following examples: The first medical explanation that she gave to make sense of what happened with a taxi driver[22] was that she was suffering from a heart disease (*I did not know that I had this kind of illness… I thought I was suffering from a heart disease*). Again, she lost her job because of her illness (*I lost everything because I was ill…*). And finally, she believed that she brought prejudice to Ceng "*because of this illness*".

Her illness became a way to understand her experience, yet she did not seek medical explanations as such. In other words, she saw her illness as the cause: knowing that she was ill enough to make sense of her experience. Finally, with the exception of her brief allusion to genetics, she did not try to explain her "illness" in terms of any biomedical or "scientific" knowledge.

(4) The paranormal explanation

Lulu used a paranormal explanation to understand how her father appeared in her hallucinations. As we saw from this statement:

 A newspaper that I read addressed the question: Can the spirit get out of its human shell? I read that Americans were conducting experiments on living humans, experiences that allowed the spirit to get out of its shell… I think that because of this illness [hers]*, I have earring and visual hallucinations. It's just the spirit that is going out of its shell…*

She did not explain her hallucination as a magical paranormal experience. Rather, she had a rational approach to the paranormal.

(5) Qigong and the release of energy

Lulu also talked about *Qigong*, which is seen by scientists as either a paranormal science or spirituality (particularly in terms of Chinese popular religion). As we saw in the excerpts from her interview, she talked about *Qigong* when she repeated how she left her job in a state of crisis ("*Some people were sending me energies…*"). The way she still talked about it, twelve months after the events, showed how this was a part of her belief system. Whether or not she had hallucinations, *Qigong* existed and she could use it to understand her experience.

(6) Her personality and her search for understanding

Her self-image played an important role in her understanding. When asked by the interviewer to describe herself, she gave a rather positive image. She saw herself as being "*superior to the average individual*", as "*intelligent*", and mentioned that she

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22 Lulu had intimate relationship with the taxi driver for a short period of time.

always did well in class ("*among the first ten students*"), she was "*extraverted*" and "*knows how to make friends easily*", she had a "*good sense of humour*". Yet, when she spoke of herself in those terms, it was not to "explain" her illness, but to express, by comparison, the consequences or "sequels" of this illness: her feeling of apathy, the absence of rules, the boredom and the isolation, her difficult relationship with Ceng, her suicidal tendencies, etc.

(7) Her feeling of guilt

Her feeling of guilt was also a part of her personality. This feeling punctuated her search for understanding. She did not dwell on it, but made allusions when referring to the key people of her experience. Sometimes, this feeling appeared during her hallucinations, as was the case when she was with the taxi driver. At other times, she expressed it clearly, as was the case with Ceng. First she felt guilty because she had "caused him prejudice", then she felt guilty because of the "genetic root of her illness". She also felt guilty for her relationship with the taxi driver. Finally, she felt guilty – or at least indebted – towards her mother. At the beginning of the interview, she was asked: "How does your mother treat you?" She answered briefly: "I have no complaint." Later on, she expressed herself in a more emotional way:

"I think it's not fair for my mother… It's not easy for her to take care of a daughter of my age… If it was not for her, I would already be dead… Her life is so miserable, she was so unlucky… I do my best to stay alive just for her…"

Her relationship with her mother and her feeling of guilt toward her were central to her understanding of her experience even though Lulu did not make any explicit connection in terms of "causality".

(8) Lulu's experience towards the Reform politics

The reader must remind himself/herself that we were in the early 1990s: the Reform had taken place for more than ten years, but was still in the midst of tremendous political and social change. Contrary to some other cases, Lulu was open and in favor of the social and economic reform toward a market economy. It is not clear if Lulu's political views had any impact on her illness, but it seemed clear that it had some implications for her rehabilitation process.

Although this is only a short summary of Lulu's case, it is important, as in most psychosocial analyses, to keep in mind three dimensions or levels of experiences: the individual level; the immediate entourage; and the greater social, political, economic, and cultural clusters. Lulu made references to them all; she would sometimes refer to one dimension and to another one later on. They remained present as important background of Lulu's actions.

Clinical Sociology and EMI: Discussions

Our review and analysis in this article and other publications suggests a number of ways to achieve a better understanding of the notion of "explanation" or the idea of EMI. All case studies from the original Beijing research project suggest that the clinical sociology approach, specially its operational methodology, may add meaning and complexity to the EMI notion. In the contest of this research, operational definition of EMI implied the following characteristics:

- To address more systematically the organizational, institutional, political and social dimensions of the experience of schizophrenia rather than focusing solely on the cultural perspective. Take a plural or multidisciplinary approach instead of a mono-disciplinary one, incorporating sociology, anthropology, political science, etc.

- To include important social actors that were almost never included in the analysis of EMI (the Danwei, its leaders and members, is a good example).

- To propose a broad definition of the notion of "explanation" or "explanatory": to include consequences as well as causes and consider personal motivations or intentions, desires or "wishes", as being potentially part of an explanatory model. Such a complex definition of causality was given in one of the previous papers (Sévigny, Chen and Chen 2009). Lulu's questions about her sexuality and love were of that type.

- To include, in the data to be analyzed or understood, the points of view of all the main actors from a patient's immediate social environment (ISE). Nothing in the original idea of EMI did preclude such an inclusion, but many other important social actors such as Danwei leaders and members, local authorities, hospital staff persons and others, were almost never included in the analysis of EMI.

- To give a more central place to the experience of social rehabilitation. Of course, as all psychiatrists have done in one way or another, Kleinman included rehabilitation as the ultimate end of treatment. However, compared to recent developments in the last two decades, rehabilitation in the 1980s did not have the central place that it now enjoys in the psychiatric field in China as elsewhere. From a methodological perspective, this has been achieved by gathering the relevant data between six months and a year after the hospitalization period. In other words, data have been gathered in the period during which social rehabilitation ("life after hospitalization and after the psychiatric crisis") was a central or critical phase. A good illustration of the place of social rehabilitation in relationship with other aspects of a patient's experience is this one: Lulu has a lot to remember, and to be concerned about, her hallucinations before and during her hospitalization, but it is clear that the remembering of that period was important about her future life, that is, her rehabilitation.

- Address the control issue we alluded to in the first section: Do social and cultural conditions determine only (or mainly) symptoms and illnesses, treatment and rehabilitation or, is it possible that patients and their significant others may use their personal and social resources to exercise some control over their personal and social experiences, or at least the representations of them? This question is still much debated in medical anthropology (Lock and Scheper-Hughes 1990). Lulu expressed the concern for the same "cause-consequence' issue. In her own way, on a very practical but also as an existential level, she was struggling with the question that Martucelli (2002) considers as characterizing one of the experience of "modern" individual: "how, in spite of my severe problems, do I stand up as a person and as a member of my society?"

The above points may be summarized in two general guidelines: a) Keep in mind the three dimensions of all experiences: the individual level, the immediate entourage, and the greater social, political, economic, and cultural clusters; and b) always include the rehabilitation process as one of the critical personal and social issues of

any experience of severe mental illness. In their representation of their experience of schizophrenia, Lulu and other cases studied all made explicit and implicit references to those three levels and to their psychosocial rehabilitation.[23]

Kleinman's original idea of EMI helped to advance the study of social representation in social psychiatry. It provides behavioral and social scientists with a useful paradigm to understand the meaning of mental illness from the perspectives of a patient and her significant others, as well as the impact of the patient's interactions with her immediate and larger social environment. On the other hand, clinical sociologists' work helps to validate the EMI approaches via detailed case studies that focus on various social factors affecting the experiences and perceptions of schizophrenic patients and their significant others. It also helps to identify the existing boundaries of the EMI approaches and expand their use in meaningful and operational ways. Sévigny's effort in the past two decades as reviewed in this article is a typical example of how clinical sociology research has approached the subject in similar yet different ways with an emphasis on relevance to the Chinese context. In that sense, the environment of a de-politicized "economic state" (Chen, 2004) is key to a historical understanding of the larger picture of mental health issues in China amid significant social changes since the late 1970s.

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23 Space limitation prevents us from presenting all cases and discussing at length the notion of clinical sociology. Interested readers may refer to related publications (Sévigny 1996, 2008, 2008, 2009, 2010).

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