Research report

*Conceptions of deinstitutionalisation in an institution: A comparative perspective*

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Introduction

The findings I will be presenting here are based on research conducted as part of an Erasmus + project entitled “Unlocking freedom through adult education”\(^1\). The title of the project is indicative of its underlying philosophy, the aim being to understand the means by which professionals and their institutions are able to “unlock” access to “freedom” for adults with intellectual disabilities supported by care and education institutions and “service providers”.

When I was first contacted, in my capacity as a researcher at Paris-Est Créteil Val-de-Marne University, to take part in this Erasmus + project, it soon became apparent to me that deinstitutionalisation meant, in the minds of the project promoters, the means by which institutionalised people with disabilities might ultimately achieve greater autonomy – or, to put it differently, empowerment – and even freedom. At the time, I was not unaware of the fact that deinstitutionalisation had, for many years, been advocated by a wide range of international organisations – and not least the European Union. A paradox then presented itself to me: how can professionals working in institutions which, in France, fall within the ambit of the ‘medico-social’ field subscribe to, and operate from, a deinstitutionalisation perspective? To what extent is it possible, from within an institution, to contribute to the empowerment of people living with an intellectual disability in the knowledge that such a process would require a break away from the institution, a process known as deinstitutionalisation? Better still, to what extent is it possible, from within an institution, to subscribe to the radical critique of institutions promoted by the deinstitutionalisation current?\(^2\)

This paradox lies behind the research question and proposed action I submitted to the project promoters.

\(^1\) Hereinafter referred to as “Unlocking Freedom”.

\(^2\) The example of Franco Basaglia, the father of Italian anti-psychiatry, shows, of course, that the answer can only be yes. Further on in this report, I will suggest that the work of the Italian psychiatrist – the father of the psichiatria democratica movement – should be seen as one of the intellectual foundations of deinstitutionalisation in Europe and throughout the world.
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The question might, at this stage, be summarised as follows:

**How do professionals working in the medico-social sector and, specifically, in a major institution – the Gabrielle Centre in Claye-Souilly near Paris – experience and represent this European recommendation? How are they able to reconcile the representation they have of their own role as educators with how they conceive of deinstitutionalisation?**

Keen, as I was, to take an inclusive approach by actively involving the users of the Gabrielle Centre in my research, a second question arises:

**What do the people with disabilities who are the beneficiaries of the services provided by the Gabrielle Centre have to say about deinstitutionalisation?**

I soon formulated a hypothesis about the first question, the roots of which I will return to in the following paragraphs: the way in which professionals working at the Gabrielle Centre view the disabilities (whether mental, psychological or cognitive) of the users of the centre for whom they work on a daily basis may constitute motivations or barriers to an empowering form of professional practice consistent with the requirements of deinstitutionalisation. In theoretical terms, my works falls within the field known as “clinical” research in education (in the sense of clinical psychology), which advocates the idea that educators are not always the masters of their own actions and that a not insignificant part of the core foundation shaping their professional behaviours and practices remain inaccessible (i.e. unknown) to them.

This basis is formed by unconscious representations and fantasies that infiltrate their professional practices and conceptions. Drawing on Freud’s contention that “the ego is not the master in its own house” (Freud, 1916), I suggest the following re-interpretation of his aphorism: the professional ego of educators, meaning the professional part of the ego, is not always the master of professional action and behaviour. Therefore, it seems important to identify the unconscious psychological
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factors shaping professional action and behaviour in order to establish whether they converge with, or diverge from, the ideals of professionals.

I will be delving deeper into these initial theoretical considerations in due course. For now, they are enough to provide a more specific articulation of the research hypothesis that I propose to develop and test in this report: I submit that while, ideologically, i.e. in terms of their professional ideals, educators may subscribe to the principle and process of deinstitutionalisation upon which the Gabrielle Centre is based, intimately, i.e. in terms of their subjectivity and the silent work of the unconscious, orepresentations or fantasies surrounding disability or the functions of an institution, may, in a differentiated manner according to the subject at hand, constitute: 1) sources of support promoting a form of professional action and behaviour consistent with the project of deinstitutionalisation; 2) barriers impeding the daily conduct of the project.

This working hypothesis is inspired by the main findings of my research in the field of educational inclusion (Ployé, 2016), where I was able to demonstrate, in the course of an investigation of collège (French middle school) teachers conducted as part of a doctoral thesis, the extent to which teaching professionals subscribe to the principle of educational inclusion, which represents, as I argue, the equivalent, in French education, of deinstitutionalisation in the medico-social sector. However, my observation of inclusion practices and my clinical assessment of the discourse of teachers surrounding the inclusion, in mainstream classes, of students with disabilities showed that there can at times be a significant gap between ideal inclusive practices and actual practice. Among the many factors behind this gap, I underlined the weight of the negative fantasmatics surrounding disability. Students are still largely seen and understood through a defectological interpretive framework that views them as being less capable than “ordinary” students and, therefore, less likely to benefit from schooling and education. On a daily basis, the effect of this fantasmatic is the euphemisation of inclusive education, a trend reflected in particular by lower cognitive objectives for students with disabilities in favour of an overemphasis on socialisation through educational inclusion: accepting their
These findings point to a discord between inclusive discourse and the daily reality of what I refer to as inclusion in and through action. In relation to their fantasies, students with disabilities are, ultimately, neither truly included nor really excluded. Following other researchers, I drew on the ethnological concept of liminality (Van Gennep, 1909) to describe the state of in-betweenness in which students with disabilities find themselves: though seemingly expected to be part of an inclusive educational approach, they continue to remain at the threshold of classrooms, pending a state of full inclusion that never materialises.

Given the background I have just set out, I am somewhat inclined to view with suspicion the idea that we might decree a generalised policy of deinstitutionalisation that is ultimately not conceived and designed in such a way that, in future, adults with intellectual disabilities, in our institutions, may be viewed as capable of independent living, a goal towards which they can simply be guided. Therefore, the first aim of this research and the report that concludes it is to examine how the actors of deinstitutionalisation – both professionals and users – speak about it and construct around it representations that serve to either promote it or impede it.

Understanding the concept of deinstitutionalisation is my second aim. The report is the result of an investigation based on a methodology designed to ensure scientifficity. In that sense, its ambition is not to support or subscribe to deinstitutionalisation as a political ambition. Rather, it seeks to understand the conditions of implementation on the ground, the reception given to it by professionals and users, and the hopes and threats it creates and suggests in their minds.

One particular episode from the last three years of the Erasmus + international partnership in which I have taken part as a researcher provides an indication of the gap between the position of the researcher and the position of several other partners involved in the “Unlocking Freedom” project. At a transnational meeting of project members in Tampere (Finland), I was invited to set out the state of my research-in-
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I will therefore present my position by articulating two points which may, for some, lie at the root of a conflict, but which, in my view, are capable of being discussed together through a fruitful dialogical interaction:

- I recognise that deinstitutionalisation is a whole set of practical recommendations, and that, philosophically, I am able to subscribe to it as a citizen: when they have powers of coercion over the subjects for whom they have responsibility, institutions can erect barriers to their development and restrict their access to full citizenship;

- I also argue that deinstitutionalisation is an ideology in the political sense of the term, but also in its Freudian sense: Freud examined the notion of ideology in connection with the idea of the ideal ego. Ideology “forms part of the set of ideal constructions (die Idealbildungen) and visions-conceptions of the world (die Weltanschauungen)” (translated from Kaës, 2012; 2003). The value and interest of this conception is clear to see when raising the question of its psychological function for the subject adhering to it (that is why, in my analysis of the collected corpus, I will seek to understand, behind the ideological positions of the subjects interviewed as part of this research, the affects they serve to cover up, conceal or reveal. As a clinician, it seems important to me to contend that when we consider the ideological discourse of
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This led me to setting out the following interpretive framework to my partners: deinstitutionalisation operates as an ideology in the group we form, enjoying considerable support and representing the canon of values that unites us in spite of our cultural and national differences. It serves to extinguish any controversies by pointing to a shared horizon, but it also serves to attack those who, among the partners, remain the least committed to the empowerment of people with disabilities. In short, it represents an ideal for the group and, in that sense, I am surprised that more time has not been spent discussing its history and foundations. I must say, therefore, that my position as a researcher compels me to question what we hold to be a self-evident fact – that is, to depart from a regime of ideological truth in order to construct a regime of scientificity around the notion. I included within my argument a question that has so far remained unanswered: why do we subscribe?

This realisation is what compelled me to understand more about the history of deinstitutionalisation, along with the reverberations to which my intervention gave rise within the group, enabling me to understand the psychological function of deinstitutionalisation as an ideology not only within our working group, but also in the group of professionals with whom I led talking groups over the course of one year at the Gabrielle Centre.

As I near the end of the problematisation stage, I must now set out the structure of this report:

- In part one, I will provide a dual analytical portrayal of deinstitutionalisation in 2018: how is it defined, notably by the European Union? I will choose one of the most recent recommendation texts as a point of entry to understand how the European Union conceives deinstitutionalisation and what path it is setting to enable member states to achieve it. I will offer a critical perspective on the text by examining the historical sources of deinstitutionalisation. My aim here
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will be to show that the idea is not new and that it draws on a range of sources that coagulated in the 2000s.

- In part two, I will provide a detailed description of the research methodology. In particular, I will show that my talking groups operated as groups enabling the clinical analysis of professional practice, during which a psychological fantasy or imagination surrounding daily work among persons with disabilities was able to unfold and develop.

- Part three will focus on the analysis of the material, and here I will take the liberty of developing some theoretical considerations in support of my argument.

Before going any further, I must thank my project colleagues for their patient attentiveness, their support and their acceptance of my intellectual frameworks. I also wish to express my gratitude to the professionals and the users of the Gabrielle Centre, who trusted me sufficiently to open up and speak to me.
Part one: Deinstitutionalisation: history, recommendations, oppositions

1. *Mise en abyme*: the historical roots of deinstitutionalisation

It seems wise, by way of introduction, to emphasise that deinstitutionalisation may seem, for the partners of the project, who are all involved in working with persons with intellectual disabilities, rather obvious – a self-evident fact: their involvement in the project was driven by a shared concern for the rights of persons with disabilities, for their empowerment and for their capacity to exercise their free will and choose their own life. In short: they experience deinstitutionalisation as a set of values that form a social ideal underpinning and driving their daily work and the set of European social policies in the area of disability. In a sense, these values are an extension of the humanist project that first emerged in the 16th century and in which subsequent discourses aimed at promoting the individual, defined by freedom and inalienable rights, find their origin. Deinstitutionalisation could also easily be thought of as the natural extension of the great democratic and emancipatory project that first emerged in the 18th century on both sides of the Atlantic. Thus, deinstitutionalisation might appear to be a natural process borne by the direction of history. From this point of view, deinstitutionalisation is seen as belonging to ideologies driven by a teleological vision of the history of humanity. In short, deinstitutionalisation is, and means, progress. How, then, can it be criticised, i.e. approached from a critical and theoretical perspective, if we succumb to such self-evident facts?

I propose not to see deinstitutionalisation as the product of a clearly mapped out path, and even less so as a self-evident concept. Rather, I will attempt to re-situate the idea within a network of intellectual currents that all contributed to its construction. By returning to the roots of the idea, I hope to enrich theoretical work on deinstitutionalisation and salvage it from the false and falsely self-evident assumptions that tend to sterilise it.
1.1. The legacy of anti-psychiatry in the formation of the ideological foundations of deinstitutionalisation

First, I argue that the European anti-psychiatrists of the 1960s and 70s and their radical opposition to psychiatric care institutions are an important source for a general critique of the institutions charged with caring for vulnerable populations, which had multiplied since the 19th century. The anti-psychiatrists represent a model of protest whose influence continues to be felt today.

By way of an introduction to the genealogical approach to deinstitutionalisation, let us consider the following quotation from Robert Castel, the great French expert on social policy in general and psychiatric policy in particular:

“The asylum system that began to emerge in the 19th century was built on a representation of the “lunatic” as a simultaneously irresponsible and dangerous being. As a source of significant threat, he must be neutralised but, since he is irresponsible, he cannot be punished. Therapeutic isolation – that is to say, compulsory internment – serves to overcome this contradiction. As the invention of the earliest alienists, it is designed to reconcile the interests of the lunatic, who thus becomes a patient capable of being treated in a therapeutic establishment, and the interests of society, which thus ensures its safety.” (translated from Castel, 1981, pp. 7-8)

With that opening sentence to his book, Castel summarises the main thesis, a thesis constructed and further developed in the post-war years up until the 1980s that condemns the psychiatric domain and, beyond that, medico-social institutions and their role: these emerged in the 1800s with the invention of the asylum which, under

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3 The French alienist physician Philippe Pinel (1745-1826) founded what he called “the moral treatment of madness” and, as an act of magnanimity, decided to lock up lunatics in places specifically designed for his revolutionary treatment method, the ancestor of modern psychotherapies: asylums. Prior to Pinel’s revolution, so Foucault’s central argument contends, lunatics were generally locked up in the kingdom’s general hospitals, where they shared the same fate as beggars and paupers. Whether viewed as places of care or dehumanisation, asylums were, from the very outset, at the heart of the controversies now embodied by deinstitutionalisation.
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the guise of treating madness, now seen as an illness, was first and foremost designed, according to Castel, to confine agents of social disorder in an “other” place, isolated and removed from humanity, an enclosed place – a place, therefore, of detention, of deprivation of liberty, described, deceitfully and euphemistically, as an asylum. Where madness produces disorder and disturbance, alienist medicine produces, from the early 19th century onwards, medical classifications claiming to rationalise the irrational and to devise therapeutic solutions delivered in specialist institutions where all that is missing is the effort of the law to confine lunatics. In short, treatment and prevention are the two functions of asylums.

My own hypothesis is that this thesis, put forward, in this instance, by Castel, but also defended by Foucault, Basaglia and the British anti-psychiatrists Laing and Cooper, lies at the root and source of this intellectual current – the current that lies behind deinstitutionalisation today, not least in France. Elsewhere, and especially in the English-speaking world, the proponents of deinstitutionalisation often refer to the work of Goffman and his view of total institutions – a view which Goffman articulates around his experience of asylums. The analysis of the asylum solution devised 200 years ago by the fathers of psychiatry in France represents, in my view, a fundamental matrix in the West for providing a basis for a radical critique of institutions and offering an ideological basis for deinstitutionalisation. It seems possible to draw a parallel between the lunatic, institutionalised in order, first and foremost, to protect the city and, secondarily, to treat him, and the person with disability who is institutionalised in the name of care and support, but perhaps also because he provokes, as the sociologist Alain Blanc puts it, a “disorder of appearances”, or even because he is a cause of fear. To substantiate this hypothesis, it seems to me useful to return briefly to the intellectual sources of deinstitutionalisation, which are, in my view, and in addition to the work of Foucault in France, the British and Italian anti-psychiatrists and Goffman’s radical critique of total institutions.
In order to unify disparate current of thought, I will borrow and extend Castel's hypothesis: all of these theories are shot through by what he identifies and defines as a “fantasy of liberation” (translated from Castel, 1981, p.26). Indeed, the various currents of thought involved in this process in the post-war period all set out to examine the social purpose of internment and confinement practices in asylum-type institutions. Books such as Michel Foucault’s *Madness and Civilization: A History of Insanity in the Age of Reason* (first published in French in 1961) soon began to serve as toolboxes for a fantasy of liberation which maintains that the claim to treat is nothing other than the mask concealing the repressive work of States. Thus, anti-psychiatry as a social phenomenon, as Castel writes, was not “an isolated (theoretical and practical) critique of a particular professional activity so much as the overdetermination of the meaning of this activity based on a generalised anti-authoritarian perspective” (translated from Castel, 1981, p. 29). Regardless of origin, anti-psychiatry is subtended by an exacerbated awareness of the repression operated by the State against mental health patients deprived of their rights.

I propose the view that anti-psychiatry is a figure that crystallises the generalised refusal, at the time, to provide a solution to the disorder created by “abnormality” by means of the institutionalisation of “abnormals”. Anti-psychiatry is used in particular by David Cooper (1970; 1967) as a means of justifying an all-out protest against the State – a protest that was, at times, also fostered by Marxist thought. For the British anti-psychiatrists, the idea is to denounce how psychiatric hospitals function. Therefore, they also denounce any institutions in which individuals find themselves under the authority of other individuals as a result of the violence, and the alienating effect of such violence, that those institutions direct against their patients: “If we are to speak of violence in psychiatry, a violence that is clear for all to see, that makes no attempt to conceal itself, that proclaims itself so loudly that it is rarely heard, it is the subtle and concealed violence that the others, “normal men”, inflict on those we call mad.” (translated from Cooper, 1970; 1967, p. 31). The work of such institutions, as Cooper argues, is not to treat or provide care, but rather to invalidate people in social and human terms. In that sense, they operate as effective relays of society as a whole and of the family in particular. They “mutilate”
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personalities: “It is not simply a physical bed that awaits a patient in hospital, but Procustes’ bed, formed of staff preconceptions with which the patient must comply, whatever the price he pays for such a mutilation of his personality” (translated from *ibid.* p. 48). Thus, psychiatry uses its concepts – with the author showing just how fallacious they can be, standing as the product of representations devoid of scientific basis – and its methods to promote a medical justification for the elimination of people whose only crime, as he ultimately emphasises, was to have manifested excessively independent behaviours. We find here a fruitful opposition between institutionalisation and independence that provides the foundation for deinstitutionalisation.

Mutilation of personality and invalidation of the patient as a person through the work of nurses and doctors: such is, in Cooper’s view, the reality of psychiatric institutionalisation, and, by way of resisting such violence, Cooper proposes a counter-model, elements of which have, as I argue here, been inherited by deinstitutionalisation.

Thus, Cooper’s argument ultimately leads him to recommending the creation of small-scale treatment centres, as illustrated by the example of Villa 21: “We had to establish a viable prototype of a small autonomous unit that could function in a large villa within the community, outside of an institutional psychiatric setting” (translated from *ibid.* pp. 126-127). What were the governing principles subtending Villa 21? It was an open community centre designed to ensure that care and treatment relations would not become relations of domination serving to invalidate patients as persons. Cooper rejected the implicit patient/carer hierarchisation, to the point that it was agreed as a team that patients would be granted the greatest possible degree of freedom: for example, Cooper described the wide-ranging collective reflection surrounding the question of waking patients affected by clinophilia: was it for carers to wake them when they felt patients had remained in bed beyond a reasonable rising time, or should that be the responsibility of the patients themselves? Should patients be allowed to remain lying down while awake for many hours during the daytime, avoiding any activity, or should the patients themselves be left to decide for
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themselves? A choice was made to go with the second of the two options. In tackling what he saw as their conscious and unconscious resistances, Cooper also forced the carers working at Villa 21 to work intensively on elaborating their professional position: “We decided therefore to explore in our daily work the complete set of ready-made ideas, prejudices and fantasies shaping the carers in their thinking about both themselves and their patients” (translated from ibid. p. 131). This last point speaks to me deeply, reflecting, as it does, my main working hypothesis, according to which the representations and fantasies observed among professionals working at the Gabrielle Centre may represent barriers to the adoption of practices consistent with deinstitutionalisation. Cooper justified this emphasis on professional self-reflection by demonstrating the extent to which negative preconceptions of mental illness form part of the history of psychiatry, representing defences against madness and the threats posed by madness to carers: “Disorder, disintegration, violence, contamination” (translated from ibid, p. 131).

In Italy, the work of Franco Basaglia⁴ – a psychiatrist, like Cooper – ultimately had more radical social and political implications than in Britain since, by adopting law 180 of 1878, Italy ratified the closure of psychiatric hospitals⁵. Basaglia, who was heavily influenced by Marxism, directed against asylums a humanist rhetoric based on respect for the rights of others. His aim was to promote the right to express difference, and it is for this reason that he saw it as necessary to break down the walls of asylums and re-introduce patients into the community: “For Basaglia, recovering the right to mental health – within the therapeutic community and then outside the asylum, in the polis – means restoring the right to express difference and to challenge power roles” (translated from Colucci and Di Vittorio, 2007; 2000, p. 12). In other words, the first challenge is to construct a discursive alternative to the master discourse of psychiatry, “a form of knowledge that is capable of challenging the false

⁴ While French academic work on Basaglia has tended to speak of anti-psychiatry, Italian specialists use other terms: Basaglia himself speaks of democratic psychiatry, while Colluci and Di Vittorio suggest the phrase anti-institutional movement, which has a more obvious connection to the notion of deinstitutionalisation.

⁵ Law 180 put an end to admissions to asylum-type psychiatric hospitals, calling instead for “local health units” providing the full spectrum of health services for a given population. The old psychiatric hospitals were converted into residential homes for chronic and homeless patients whose social reintegration remains problematic.
truths surrounding mental health” (translated from ibid, p. 13) in order to break away from the alienating dimension of psychiatric care in institutions. In other words, the anti-psychiatrists, whether British or Italian, were intent on denouncing the dehumanising representations of madness embedded in traditional alienist discourse and to offer instead a humanist discourse that restores and returns “patients” to a melting-pot common to all humanity and, more importantly still, to the very heart of the city. Here I propose to draw a parallel between this type of anti-psychiatric proposal and the declared intention of the proponents of deinstitutionalisation to remove traditional straightjackets in order that persons with disabilities are able to integrate, or re-integrate, the community. City and community need to be understood commonly in a political sense: Cooper’s and Basaglia’s lunatics and schizophrenics are, like persons with disabilities today, beings endowed with civil and social rights. What anti-psychiatry and then deinstitutionalisation share in common is a social critique of the notions of mental illness and disability: patients and persons with disabilities are “ordinary” individuals excluded from the circle of common social relationships by the designation of their difference (which lies essentially in others’ representation of it!).

In the 1960s and 70s, Basaglia and his associates in the Psichiatria Democratica movement contended that such a reversal of psychiatric discourse necessarily entails working from within the institution in order, first, to reform it and then, secondly, to dismantle it: “The fundamental aim of the future movement remains the struggle from within the asylum, starting from the unquestionable assumption that it is the very persistence of the asylum, built on the presupposition of the incurability and dangerousness of mental illness, that works to prevent the emergence of new knowledge released from supposed scientific neutrality and based on a daily practice of institutional transformation” (translated from Collucci and Di Vittorio, 2009, p. 39). Beyond this initial aim, the movement also conducted experiments consistent with the practices advocated by current deinstitutionalisation: the development of home-based care and treatment (particularly for psychotic subjects to avoid internment, which is thought to both deprive them of their rights as citizens and to aggravate their illness), the development of micro-structures within the city itself (for example, mental
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Health centres) designed to promote life outside the institution and maintenance within the city, and local networks of decentralised services.

These reforms “from within” – reforms that are highly representative of Basaglia’s work and thought – must be accompanied, according to him, by a political revolution, the outcome of which should be a new social realisation that institutions, regardless of their mode of governance and management, serve, inevitably, to construct relations of domination. If we fail to combat these relations of domination, any structural form of social care will prove meaningless.

Hence Basaglia’s warning that, by itself, breaking down the walls of institutions is not enough: breaking down walls of strain is pointless if symbolic walls (manufactured by prejudice, negative representations, social relations of domination, etc.) are re-created so quickly within the community: the supervision of an individual can be just as powerful in network-based care services, as scattered throughout the community as in the asylum, so long as the relationship between users and social services remains a relation of power. It is for this reason that Basaglia criticises how a policy of deinstitutionalisation was first implemented in the United States – a policy launched in 1963 with the Mental Retardation Facilities and Community Mental Health Centers Construction Act. Note that deinstitutionalisation in the United States is based, as it is in Europe, on converging critiques among liberal reformers and conservatives who “accuse asylums of being totalitarian, de-humanising and anti-therapeutic institutions, as well as places used to detain undesirables that create institutional neurosis” (translated from Lecomte, 2008, p. 35). The purpose of the 1963 law was to provide community mental health centres with federal subsidies designed to “empty out” the asylums. However, according to Basaglia, the real object of the law – which was not accompanied by a reflection on the social control of mental health patients – was, ultimately, nothing more than a reduction in the number of hospital beds in the name of cost-cutting, while maintaining, albeit with other means and at a community level, a strong degree of social control. He thus shows that the institution formed by the Mental Health Centers created a system of “capillary and invasive biopower demonstrating some vague therapeutic hopes but holding, above all, a strong social control mandate in everyday life” (translated from Basaglia,
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2007; 2000, p. 13). The key point for us, therefore, is that, as the father of Italian deinstitutionalisation was keen to emphasise, outside the condemned institution of the asylum, other more discreet and better tolerated forms can be re-created – more discreet and better tolerated because more consistent with the values of the period, the values of social control and therefore alienation, which are no less reprehensible than the oppression exerted by asylums. Goussot and Canevaro provide a nuanced view of Basaglia’s contribution to the culture of deinstitutionalisation, underlining its humanism: “Deinstitutionalisation, which Franco Basaglia was so keen to promote, implies a fundamental change: a person is recognised as a quality and not as a simply physical or nosographic quantity in a therapeutic system” (translated from Goussot and Canevaro, 2010, p. 269).

As defined implicitly by Basaglia’s critique, deinstitutionalisation is thus not a question of the space in which to house and attend to the needs of patients – the “living in an institution / living in the community” alternative is not sufficient to eradicate the situations of social domination of vulnerable persons – so much as a question of the restitution of an effective right to citizenship for all those whom society has tended to invalidate in the name of either an illness or a disability.

1.2 The legacy of the sociological critique of “total institutions” by Goffman in the 1960s and 70s.

Along with the European and American anti-psychiatry movement, of which I gave a double illustration above with the examples of Cooper and Basaglia, the so-called sociology of social control, represented primarily by Erwin Goffman in the 1970s, represents a second powerful theoretical anchor point for thinking about deinstitutionalisation in the present day.

Erwin Goffman was not a psychiatrist, but a sociologist. It was through an ethnographic observation of living conditions in an asylum that he came to address the question of total institutions. To understand the huge impact of his work in France, we need only consider that, for a long time, the term “total institution” used
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by Goffman in Asylums (1968; 1961) was translated as “totalitarian institution” (translated from Lainé and Castel, 1968) – a translation that goes beyond the common meaning of “total” and operates as a condensation, capturing not only Goffman’s thesis, but also the reception of the thesis by French critical thought of the 1960s. In a powerful summary of the text that unfolds this condensation, Robert Castel summarised Goffman’s thesis in the following terms:

“The totalitarian institution is therefore not only the hospital available for empirical observation, with its specific mode of organisation and its particular staff recruitment procedures, traditions, practices and ideologies. As a social institution, it combines most of the structural features that characterise a group of institutions specialising in the care of humans and the totalitarian control of their way of life: isolation from the outside world in an enclosed space, promiscuity among inmates, satisfaction of all the needs of individuals by the institution, mandatory compliance with internal rules that interfere in the intimate life of the subject and shapes every last detail of their daily existence, the irreversibility of staff member and resident roles, the constant reference to an ideology consecrated as the sole basis from which all aspects of behaviour are judged, etc. – all these features may be said to be true of hospitals, prisons, convents, military quarters and concentration camps” (translated from Castel, 1968, p. 11).

The use of terms such as “isolation”, “interfere”, “inmates”, “totalitarian control” and the implacable “concentration camp” captures the power of an imaginary framework that draws, as I argue here, on at least two sources in Castel and many of his contemporaries: religious closure and confinement (medieval monasticism) and the closure and confinement practices of twentieth-century totalitarian regimes, which share, among their common traits, an emphasis on the creation of concentrating structures. This imaginary backdrop therefore lies at the origin of a black legend of the institution that we might summarise thus: the institutions that take in persons whom we deem incapable of caring for themselves – mental patients, people with disabilities, the aged – under the guise of meeting their needs, arrange their isolation
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from the world (the community), deprive them of their freedom and deploy a medical discourse with a claim to scientificity motivated purely by self-legitimation.
Institutionalised subjects are discredited and invalidated (Cooper) as subjects endowed with rights and reason in order to legitimise the almighty power of a totalitarian institution.

However, we need to go back to Goffman to re-situate his description of total institutions⁶ in its original context. To define them, Goffman emphasises four chief characteristics:

- **Isolation from the world:** the separation between the inside and outside world is complete; a total institution is a “place of residence or work where a large number of individuals, placed in the same situation, cut off from the outside world for a relatively long period, lead together a reclusive life of which the terms are explicitly and carefully regulated” (Goffman, 1968; 1961, p. 41).
- **Full responsibility for meeting the needs of the people sequestrated by the institution,** contributing to a complete loss of autonomy: “The essential character of total institutions is that they apply to man a collective treatment consistent with a bureaucratic system of organisation that takes responsibility for all their needs” (translated from *ibid.* p. 48).
- **A bureaucratic mode of operation involving close supervision:** staff must “ensure that every person performs the tasks allocated to them in conditions such that any infringement committed by an individual will be perpetually conspicuous by virtue of its contrast with the behaviour of others” (translated from *ibid.* p. 49).
- **Limited contact between inmates and staff** marked by negative mutual representations: “Each group tends to form a narrow, stereotypical and hostile view of the other” (translated from *ibid.* p. 49).

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⁶ Therefore, I do not subscribe to the original translation by Lainé and Castel, preferring instead the translation currently in use among Goffman commentators.
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In addition to this summary description, it is also important to note what Goffman describes as the mortification of the self (the personality) of institutional residents. Here, a comparison can be drawn between the notion of invalidation used by Cooper to describe the silent work of the psychiatric hospital against the personality of patients and the notion of the mortification of the self: institutions produce effects on subjects which, to put it euphemistically, limit their personal development and their participation, as citizens, in social life.

However, Goffman emphasised that, despite these characteristics, the hold and power of the institution is never total. After all, “the inmate can always deviate from the role or character that the institution naturally assigns to him” (translated from Rostaing, 2015, online). Inmates produce “secondary adaptations”, to use Goffman’s term, and Bodin notes that these are likely to “contribute, in return, to an adaptation or modification of the institution” (translated from Bodin, 2017, p. 19). This kind of institutional adaptiveness is not compatible with the concept of total institution, suggesting that the earliest interpretations of Goffman’s work require qualification. It is also important to note that after the publication of *Asylums*, Goffman made little reference to the concept of “total institution” in his work. To understand the sources of current deinstitutionalisation, it is important to underline that the work of Goffman was received favourably among European intellectuals in the 1970s and 80s, who added to the powerful critique of institutions a reading of the institution as a site of total care (and, therefore, as a site of domination and alienation, to use the typical language of the 1970s). Therefore, I propose that deinstitutionalisation needs to be defined in a sort of broken mirror – that is, as an inverted image of what the institution (and the asylum in particular) is generally, and indeed metonymically, with both institutions and asylums becoming the target of extraordinarily negative perceptions and representations in the second half of the twentieth century. I will summarise my argument thus: deinstitutionalisation as it is currently being promoted (since the 2000s) is a response to the black legend of the institution.
This response is structured around the following core features:

- Care centres must be open because, if they remain closed, they restrict the potential of subjects who are likely to benefit from the services provided by the institution.
- The empowerment of persons with disabilities, who need to be given the means to cease being dependent on the institution: any care must be thought of as refusing to repeat any practices that lead to alienation and domination.
- The term “project” – found repeatedly in the prescriptive literature of the medico-social sector since the 2000s – summarises this ethical challenge for care and support.
- The promotion of diversity and the break away from the defectological categorisations that tend to belittle people with disabilities.

Against the grain of the real or fantasised practices of social exclusion that have affected people with disabilities in recent decades, the ethics of deinstitutionalisation appear to be on the side of a more inclusive society. In that sense, deinstitutionalisation aims to contribute to what we might term an anthropological rupture. Drawing on an interpretation of Foucault’s writings on madness and abnormality, Charles Gardou notes that history has often manufactured “atopos beings, with no place in society – expropriated [persons with disabilities], maintained in non-places. […] Made invisible, ontologically erased” (translated from 2012, p. 25).

The challenge now is to include them in the common good that is society.

1.3 Concluding the historical digression

To conclude, I will posit one final idea: in the 1960s and 70s, institutions – of which the asylum is the paradigm – were viewed as tools of alienation and social domination. In order to justify excluding certain members of society, institutions deployed a medical discourse with scientific pretensions. These elements of a radical critique that I have tried to illustrate correspond (to use Castel’s hypothesis) to a fantasy of liberation and social emancipation resembling, to a greater or lesser extent, libertarian thought. It is a fantasy that revolves “around the rejection of
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government by a master and [the] claim to individual knowledge-power” (translated from Veit, 2017, p. 24). According to some scholars, there is a direct link between the intellectual environment of the 60s and 70s and current neoliberal ideology which, in turn, is promoting a discourse of institutional critique. In other words, the assumption is that there is a fine line between calling for a subject liberated from oppressive institutional tutelage, the prime example of which is the institutionalised person with disability, and the neoliberal promotion of the citizen as the entrepreneur of his own self and “empowerment”. In his critique of neoliberal society, the philosopher Dany-Robert Dufour noted that the domination of the State over society, which had been widely denounced in the 1960s and 70s, has become, as a result of “the disappearance of the political”, the domination of civil society over an evanescent State (translated from 2015; 2007; p. 188). The regulatory role of the State is thus receding in favour of what has come to be known as good governance, in which the individual is the sole sovereign. The individual becomes the entrepreneur of his own self and, in the context of disability, becomes the “entrepreneur of his own mental health” (translated from Veit, 2017, p. 24).

In such a model, institutions in their traditional form are made to become useless and illegitimate. Veit describes the new model of the user called upon to be the actor of his own care, relying freely on decentralised technical services. The transcendent dimension of the institution, about which I will have more to say in due course, in connection with the etymology of the term “institution”, recedes behind the network-based and community provision of care. According to Dany-Robert Dufour, the replacement of a vertical model by a horizontal one is typical of postmodernity, which, according to the philosopher Jean-François Lyotard, amounts to “incredulity towards metanarratives” (translated from Lyotard, 1979, p. 9). What exactly does Lyotard mean by this? What he shows is that traditional institutions, such as schools or, as concerns the subject that interests us here, medico-social institution, are no longer able to legitimise their role and power by drawing on the narrative they have relied upon since the 19th century to justify their function in “instituting” the subject.
The grand narratives, so Lyotard argues, are disintegrating, and “there ensues what some have seen as the dissolution of social ties and the transition from social communities to a mass formed of individual atoms thrown into an absurd Brownian motion” (translated from ibid, p. 31). In other words, the definition of the citizen as individual, a veritable monad released from cohesive overarching institutions – a release that occurs in the name of the ideal of its self-realisation – constitutes the horizon of current neoliberalism, which is operating a recovery (which is also a form of diversion) of the anti-institutional emancipatory ideals of the 60s and 70s. In short: the individual pitted against institutions. The conjunction of the two systems of thought revolves both around the ideal of individual autonomy and suspicion towards old institutions.

Let us return to the question of the deinstitutionalisation of mental health, which concerns, first and foremost, our subject of intellectual disability: Veit shows that in the current neoliberal context, a constructed opposition has emerged between a “good outside” – the “outside” embodied by the community network – and a “bad inside”, the inside of the closed institution: “In contrast to the kind of collaboration promoted outside, where a range of solutions circulate and interact to support rehabilitation, the inside of psychiatric services is characterised by a discursive network associating it with a place of wandering for chronic patients struggling with recovery and reinstatement in the community” (translated from ibid, p. 24). Veit underlines an administrative phenomenon that illustrates the notion of anti-institutional suspicion: today, psychiatric institutions are seen as “sites of deprivation of liberty”, managed, as such, like prisons. What better description could there be of the total victory of anti-institutional discourse, which first emerged with the anti-psychiatrists and is now being endorsed by neoliberalism?

To summarise the argument: according to the hypothesis I have just put forward, deinstitutionalisation may be defined: 1) as the product of the radical currents of the 50s, 60s and 70s attacking traditional medico-social institutions, of which the asylum is the most emblematic example by virtue of its alienating dimension, but also by virtue of the ideal of the emancipation and social inclusion of persons with disabilities;
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2) and as the product of the neoliberal currents of the late 20th century, which developed a management model of disability care that gives prominence to the deinstitutionalised individual, seen as a user of decentralised care pathways, and liberated from costly institutional tutelage.

Having established this dual filiation – a filiation that serves to legitimise deinstitutionalisation – it seems necessary to me to take the remainder of this section on the theory of deinstitutionalisation in two directions:

- First, by presenting and analysing European recommendations in the area of deinstitutionalisation;
- Second, by analysing how a movement for the defence of the institution is resisting these very same European recommendations, with a particular focus on France.
2. Analysis of European recommendations: defining deinstitutionalisation implicitly

2.1 The European texts and reports constructing the case for deinstitutionalisation

In 2010, the Committee of Ministers adopted a recommendation “relating to the deinstitutionalisation of children with disabilities and their life within the community”. The text, at least in France, made a huge impact, inspiring hope and fear in equal measure among both professionals working in the medico-social sector and associations committed to the defence of people with disabilities. So began a European campaign, relayed by national governments, to promote deinstitutionalisation. So why did the text inspire such a movement?

Perhaps because the new European recommendation, enjoying the overarching authority of texts issued at a supranational European level, set the tone for a real denunciation of institutional toxicity: “The placement of children in institutions significantly increases concerns about its compatibility with the exercise of the child’s rights”. Thus, the conclusions of the text draw a clear link between life in an institution and violation of the rights of children. In other words, as early as 2010, deinstitutionalisation was immediately inclined towards a legal approach to the rights of persons with disabilities. The text then argues that the view of persons with disabilities needs to change “in order to encourage non-discriminatory inclusive practices”. The implicit message, therefore, is that institutions tend to be opposed to inclusion (representing, as they do, an ‘outside’ by contrast with the ‘inside’ embodied by the community, and the attack hints towards a continuation of the Foucauldian or anti-psychiatric critiques of the 1960s and 70s) and that, moreover, they discriminate against their users by depriving them, through institutional isolation, of the ability to exercise their rights as citizens. Such a claim renders the educational, caring and work integration dimension targeted by professionals working within institutions utterly unthinkable or aporetic.
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In France, arguments have been put forward to oppose the recommendation of the Committee of Ministers that children are sometimes best cared for and protected in an institution than within their family (French Senate debate), underlining, from an opposite perspective, that the family itself is an institution, and that it too can be toxic.

A second key moment was 2012, with the publication of a report criticising a number of Eastern and Central European countries (Open Society Foundations, 2012) – a long report expressing concern about the violation of the European and UN framework for the rights of persons with disabilities by countries using European subsidies to renovate their institutions: “we have seen that in some EU Member States, European Structural Funds are being invested in ways that perpetuate the unjustifiable institutionalization of people with disabilities”. In its introduction, the report notes that since the EU signed the United Nations Convention on the Rights of Persons with Disabilities, no Member State is allowed to spend European public funds with a view to perpetuating institutionalisation. Further on, the report notes: “Despite the widespread acknowledgement that the institutionalization of people with disabilities is a serious human rights violation and is an outmoded and an unacceptable form of “care” in the 21st Century, the inappropriate and unjustified institutionalization of people with disabilities remains prevalent across the CEE”.

Here I propose to focus on two key elements of the text:
- **The institution is not defensible under any circumstances.** Nothing can justify placement in an institution. Such a powerful statement may be seen as a way of foreclosing any debate and of situating deinstitutionalisation on the side of common sense and self-evident truth. Such is, in my view, a proof by contradiction of the ideological dimension of deinstitutionalisation. Ideology arises where potentially conflicting scientific arguments can no longer be deployed and discussed. The institutional position and its perpetuation by backward states is nothing if not scandalous;
- **The institution is not reformable under any circumstances.** The text is seeking for nothing less than its disappearance. No change or reform from within can be hoped for, since the institution is not only open to criticism in
terms of its method of operation and its deviances (i.e. those which lie at the root of the black legend) – its very foundations are also highly dubious. The radicalism of such a critique provides ammunition to those who, in France in particular, see deinstitutionalisation as a vast movement aimed at destroying the organisations making up the medico-social sector, and I will demonstrate, in the analysis that follows, the extent to which the accounts of professionals echo such a fear, which itself mobilises defences against the promotion of deinstitutionalisation from within the Gabrielle Centre itself.

What is the current status of the promotion of deinstitutionalisation in European circles? From an examination of the website of the EU dedicated to the question, it is apparent that, no doubt in an effort to take account of the different rates of progress across Member States, the European Union refers to a “transition from institutionally-based services to community-based services”, re-asserting that persons who live or grow up in an institutional setting see their ability and their willingness to participate in the life of their community as being extremely limited. The transition is, therefore, the focus of a long-term European strategy (2010-2020), promoted by the grant of “structural and investment funds” which “cannot fund the construction or renovaton of long-stay care centres, whatever their size”. The influence of the 2012 report can be felt here.

In other words, the position of the European Union has remained stable and consistent throughout this period – a fact I have illustrated here with three examples of texts. A detailed analysis of another document is needed in order to further our understanding of the core of representations, beliefs and values upon which deinstitutionalisation is constructed.

2.2 “European guidelines”: an analysis

In this sub-chapter, my focus will be a document of great value published in 2012 entitled “Common European guidelines on the Transition from Institutional to Community-based Care”. As the subtitle indicates, the document provides “Guidance
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on implementing and supporting a sustained transition from institutional care to family-based and community-based alternatives for children, persons with disabilities, persons with mental health problems and older persons in Europe”.

The foreword begins thus: “Across the European Union, hundreds of thousands of people with disabilities, mental health problems, older people or abandoned or vulnerable children live in large segregating residential institutions.” (p. 5). Further on, the text notes that “such institutions […] cannot ensure person-centred services”. Both quotations reflect the major intellectual influences I referred to above: first, there is the critique (which stretches back at least as far as when asylums were first introduced) that institutions serve to isolate and de-socialise under the guise of providing care and treatment or of responding to needs. Here, what prevails is the fantasy of closure and confinement. By associating the concepts of institution and exclusions, the European text creates an effective but simplistic intellectual framework: institutions confine and isolate; therefore, they exclude. Exiting the institution is a necessary condition for inclusion. We know that in France in particular such a geographical or topological view of inclusion was countered by the historical work of Swain and Gauchet, who came in the wake of, and opposed, Foucault’s thesis in *Madness and Civilization*. Reinterpreting the work of the French alienist Pinel (1745-1826) – that is, the mythical unchaining of lunatics and the invention of the asylum – Swain proposed a thesis which offers, in my view, a fertile ground for providing a more nuanced perspective on the European view of deinstitutionalisation: ultimately, that the asylum (and all of the institutions inspired from it) is an “other” place, a site of closure and confinement, that it constructs the detention of “lunatics” between four walls and under the supervision of a new power acting on behalf of the state – the power of doctors – is a given. However, for Swain, the more important point is to be found in the enterprise of care and treatment based on the argument first set out by Pinel, whose approach to therapy is premised on the idea that a lunatic is not fully subject to his madness, that there remains within him a man of reason – the man of reason of the 18th century and the Enlightenment; a partially lunatic man of reason with whom discussion and exchange is not only possible but posited by the alienist doctor as an act of care. Using the word long before its
modern sycophants, inclusion, so says Swain – “a passion of democracy” – is not only to roam the city in total indifference as an animal (she describes the little or lack of consideration for lunatics in the Middle Ages, particularly when they were free to wander the streets: were they even thought of as human?), but to be re-inscribed into the circularity of speech, even if it is within an asylum. The exclusion of lunatics – in the same way as the exclusion of disabled persons – was “to not belong to the circle of humanity defined by communication” (translated from Swain, 1994, p. 112).

To what extent is an institution capable of maintaining an inter-human circulation of exchange and communication between carers and patients, between those providing support and those receiving it? The European text does more than cast doubt on this, and it contains a second, and clearly visible, critique: the way in which the institution operates prevents respect for persons and their rights. The text reminds us of the theory of invalidation dear to Cooper, as well as the theory of mortifications and the depersonalisation of “inmates” described by Goffman. The EU text concludes thus (p. 9): “institutionalisation is increasingly acknowledged as poor policy and a violation of human rights.”

But just what kind of institution is the text referring to? It seeks to address the following:

“Thus, we can consider ‘an institution’ as any residential care where:
• residents are isolated from the broader community and/or compelled to live together;
• residents do not have sufficient control over their lives and over decisions which affect them;
• the requirements of the organisation itself tend to take precedence over the residents’ individualised needs” (p. 25).

The definition appears to retain only the “incriminating” elements, and what the remainder of the document describes (indeed, caricatures) and denounces is an entire “institutional culture” – a culture made up of the following elements, illustrated
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in the text: “Depersonalisation, rigidity of routine, block treatment, social distance, dependence, lack of accountability, etc” (p. 26). The list appears to be borrowed directly from the work of Goffman – that is, from a description of how asylums functioned more than 50 years ago. Were there not other characteristics to be considered, in Europe, amid the profusion of experiments that led to the more or less wide-ranging reforms of the institution, from Laing’s and Cooper’s Villa 21 to the La Borde clinic in France, where a complete overhaul of carer/patient relationships and institutional dynamics has been in place for decades?
Ignoring these counter-examples, the text continues its description of institutional culture in the following terms:

“Common factors marking institutional care are the removal of personal possessions, rigid routines that ignore personal preferences or needs and residents having little or no contact with people outside the institution. Children are often removed from one institution to another, losing any connection with their parents and siblings. […] Other reports have highlighted cases of physical and sexual abuse, the use of cage beds and other physical restraints, the absence of rehabilitative or other therapeutic activities, the overuse of medication and violations of the right to privacy and family life. Some reports have exposed inhumane living conditions, including lack of heating, malnutrition, unhygienic sanitation and otherwise poorly-maintained buildings.” (pp. 43-44).

Can the outrageous statements made here really be viewed as “common factors”? Furthermore, from the point of view of the scientific objectivity of the document (whose formal claims to objectivity are based on multiple references to a range of documents, surveys, articles, reports, etc.), why is it that the majority of the examples chosen to support the argument are drawn from Eastern European countries? Is the case of Romanian orphanages – which are referred to several times in the text, evoking the atrocities of what the West depicted on television at the fall of the Ceausescu regime in 1989 – really representative of the institutional movement in Europe? Does the decision to focus on such an extreme case, the denunciation of
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which is bound to attract the sympathy of all to construct a truth, not betray a lack of method or methodological care? Indeed, the case of the Romanian orphanages is indicative, in my view, not of any supposed institutional culture prevailing throughout Europe, but rather of the culture of “totalitarian state” connected to Romania’s affiliation with the pro-Soviet Eastern bloc for decades. Furthermore, when the bloc collapsed, is it not the case that the poor care and treatment delivered was due at least in part to the poverty affecting these countries at the time of their transition from socialism to unbridled capitalism rather than to the mere existence of the institution?

What conclusions might be drawn from these various texts?

In my view, they provide an implicit definition of deinstitutionalisation that operates based on a binary opposition between the anti-democratic dimension of institutional functioning and the humanist ideal borne by deinstitutionalisation. Such a hollowed-out framework, lacking, as it does, in any complexity, is useful for promoting the ideal of deinstitutionalisation and for illustrating it, but it hardly provides a full and accurate account of: 1) the sheer diversity of national contexts and circumstances – institutions, not least French institutions, cannot be compared to the misguided totalitarian ways of the formerly communist countries of Eastern Europe, where democratic culture is a more recent phenomenon; 2) the extremely diverse needs of institutionalised persons with disabilities: can it really be said of all of them that leaving an institution is the best way of meeting both their desires and aspirations (what do we know of them?) and their needs, particularly in terms of support?

In other words, what I want to emphasise here is the dual dimension of idealism and ideological reduction in the definitions of deinstitutionalisation so praised by the European Union. It is vital to re-work this definition and to put it to the empirical test of complexity. In my view, we are not doing a disservice to deinstitutionalisation by questioning and challenging it in this way: rather, we are giving ourselves the right and the means to deepen and explore it, to distance it from ready-made truths and to re-incorporate it into the space of democratic debate, which is alone capable of ensuring that it does not become a doxa bending different national realities to suit it.
2.3 Defending and illustrating the institution: a French counter-portrayal

In the final section of part one, I want to give the floor to those who, in France\textsuperscript{7}, challenge deinstitutionalisation, or at least challenge the anti-institutional critique which the idea implies. The French researchers in question, whose work I will merely touch upon here, have two targets in their sights:

- Deinstitutionalisation is wrong about the definition of the concept of institution, its role and its possible deviations because it fails to take account of the “institutionalising dimension”, which remains necessary; deinstitutionalisation is based on a terminological confusion between \textit{institution} and \textit{establishment} (\textit{établissement} in French, meaning the individual institution as a physical reality).

- To deinstitutionalise does not mean unravelling institutions, but rather conceiving and operating them differently.

In France, social work is underpinned by a long-standing and deeply-rooted framework of representations and perceptions, which François Dubet, who theorised the “Decline of the Institution” (2002), summarised thus: “The representation of the self as an institution is a fundamental representation of the profession; it is what makes it an institutional programme and something that is, quite literally, ‘magical’” (translated from Dubet, 2002, p. 239).

While in the minds of social workers relationship-building is thought of as an institutionalising mediation of the self for the other, any attack against the institution, even if based on a linguistic absurdity, is an attack against the “professional self” – that is, the very identity of social workers. Such a representation points to the main difficulty: in France, the term “institution” refers more to a social function (to educate, to treat, to care for, to support, etc.) than the establishments embodying the institution. The term “deinstitutionalisation” is, at first glance (and I will demonstrate\textsuperscript{7})

\textsuperscript{7}I trust readers will forgive me for the predominantly French background against which my thinking, and therefore my theoretical arguments, are set. Nothing should be inferred about any supposed superiority or inferiority.
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that this is the case in my analysis of the empirical material collected as part of this research), perceived by many social workers as an attack against these core functions and against the professionals who perform them on a daily basis in their relationships with others. This is, first and foremost, an attack against the quality of the educational, care and support relationships created by professionals – relationships which, in the professional’s own representation of his work, are designed to “establish” subjects. The implicit discourse subtending deinstitutionalisation underlines the supposedly inevitable totalitarian deviances of these institutional relationships.

Secondly, deinstitutionalisation proposes to operate as a “meta-framework” or “meta-discourse” replacing now defunct foundational discourses – that is, the discourses, in France, of critical sociology and Freudo-Lacanianism underpinning social work throughout the twentieth century. In that sense, deinstitutionalisation waves several red flags: it suggests a historic break with intellectual frameworks that have been the backbone of social work in France; in doing so, it brings discredit on social workers. There is a third key point in the critique of deinstitutionalisation in France: deinstitutionalisation is also fantasised as a Trojan horse – one that serves to import neoliberal management models into the very heart of the French social model. These neoliberal models are entering France through the medium of European regulations and recommendations (the Trojan horse) and the promotion of Anglo-American ways of thinking that are tending to colonise France’s national republican heritage.

Deinstitutionalisation – or rather the way in which it is represented and perceived, i.e. fantasised – may be said, in other words, to be casting a shadow of archaism over practices that are now seen, therefore, as being radically at odds with the new European framework.

Thus, deinstitutionalisation is presenting itself – or imposing itself – as a new discourse colonising the conception of social work in France. It is a discourse that is seen as aberrant – a discourse signalling a radical break with the secret and historical thread of professions devoted to work on/with/for others.
But what then is an institution in the tradition of French social work? Chambrier and Paturet (2014), like others, draw on the etymology of the word in a bid to entrench a meaning that has nothing to do with the meaning given to it by the discourse of deinstitutionalisation: “The Greek term “stauros”, from the Indo-European root "sta", the origin of the word “institution”, denotes the “pillar”, “pole” or “column” upon which an edifice is built” (translated Chambrier and Paturet, 2014, p. 7). An institution cannot be reduced to the walls of the physical institution or organisation that embodies it. It is an instituting principle, or, to put it differently, a principle that holds up and supports subjects within the social realm, a principle that ensures their stability. In other words, the institution (in the French sense of the term that I intend here) falls within the realm of the symbolic – a dimension not found in the English term. Chambrier and Paturet summarise the point thus: “Deinstitutionalisation amounts to the execution of the institution, without seeing […] how any institutional process, however imperfect it may be, is in fact fundamental to instituting subjects and human groups” (translated from ibid, p. 132).

It is, in my view, important to emphasise the significance of this question of terminology: although the French and English terms “institution” share the same etymology, they refer to radically different realities in French and English-speaking contexts. Because of the dominance of English-language culture, the French meaning of the term has receded in favour of the English meaning, and deinstitutionalisation has thus become a false friend: conceived as an opening or even a destruction of closed institutions in the English-speaking world, in France the concept is taken to mean an attack against the republican tradition of social work as a whole. How then might we construct a common culture of deinstitutionalisation given such a profound misunderstanding? Resolving the matter is, in my view, the first task. It is also important to note that the term “inclusion” allows for a similar misunderstanding: in French, the term connotes closure, particularly monastic closure, the idea of closing, or even the presence of an impurity in a diamond, while in English the term refers instead to the capacity for openness and reciprocal adaptation of hitherto closed systems to allow for the diversity of the human condition.
We might summarise the argument thus: irreducible, as it is, to the physical institution or organisation typically denounced by deinstitutionalisation, in France the idea of institution is thought of as “the full range of set-ups and arrangements that hold things together” (translated from Lebrun, 2010; 2008, p. 23) – specifically, that hold the subject and the social realm together. To attack this function is, by extension, to attack the social realm. Therein lies the substance of the main criticisms of neoliberalism, seen as a threat to the cohesion of social structures. However, as Francis Batifoulier notes, because they are not merely symbols but are also social structures, institutions in France must evolve, and indeed have already started to evolve: “We might think that many traditional institutions – the process is, in fact, already largely underway – will change beyond recognition to become service platforms. The new models of education, care and housing represent a radically new context when the ambition is to re-conceive the institution, hitherto identified with the walls of the physical institution” (translated from Batifoulier, 2012, p. 17). In other words, here deinstitutionalisation is defined as a reform of the organisational modalities of the institution and not as a destruction of it. Batifoulier concludes his argument by contending that we need to devise a new model of “institution-making”, which he defines thus: “Developing a project together means bringing together the various stakeholders – whether professionals, users or associated parties.

Developing something together is institution-making provided it is not limited to a sham participation but establishes a real process of involving all actors in the construction of compromise. Such communal doing, or making, is an acknowledgment of the fact that we recognise users as instituting actors” (translated from ibid, p. 141).

By way of concluding this line of argument, I suggest that when we speak of deinstitutionalisation in France, two imaginary frameworks are mobilised: the first constructs a black legend of the institution, confusing it with its physical walls and denouncing the work of the institution in the name of its totalitarian dimension. The second framework – the framework of social work – posits a golden legend of the institution, the essential function of which is to institute subjects. In short, a black
legend against a golden legend: it is between these two extremes that the users of
the Gabrielle Centre, but also the professionals who work there, must construct their
position and construct their own discourse.
Part two: Methodology

The purpose of this section is to provide a transparent view of the methods used to collect and analyse my research material, and to set out their epistemological foundations. My aim here will be to explain: 1) the nature of clinical initiatives and processes in education research and their scientific regime; 2) how I ran a talking group over a period of one year with 12 professionals from the Gabrielle Centre – a talking group which may be described as a group designed for the clinical analysis of professional practice; 3) how I ran two talking group sessions with users of the Gabrielle Centre prior to and after this first initiative with a view to collating their views, their representations and, sometimes, their experience of deinstitutionalisation.

1. Clinical research based on a psychoanalytic conception of the subject

The research I conducted at the Gabrielle Centre – the focus of this report – falls within a psychoanalytically-oriented clinical approach as defined and promoted by Claudine Blanchard-Laville in particular since the 2000s (Blanchard-Laville, Chaussecourte, Hatchuel, Pechberty, 2005). My aim in the following paragraphs will be to provide some brief epistemological and methodological perspectives on this research approach:

1) Psychoanalysis in clinical research encourages us, to quote the psychoanalyst Lagache, to focus on the “total person in situ”. What does Lagache mean by “total person”? He emphasises the importance of considering the unconscious processes at work in the observation of human behaviours – observations which need to see beyond the contempt for the “black box” advocated by behaviourists since the first half of the twentieth century. The first postulate of a researcher who favours psychoanalytic clinical practice is the existence of the unconscious, as theorised and described by Freud throughout his work and in the articulation of the two successive topics – an unconscious characterised chiefly by the fact that it escapes the Ego. The researcher must also have an interest in seeing the individuals he examines as subjects,
remaining attentive to their subjectivity. Herein lies the meaning of the term “clinic”, a term referring originally to the care and attention of the doctor standing at the patient’s bedside, intent on observing and listening to patients in all their singularity.

2) The clinical researcher recognises the division of the subject, whose words and actions are not transparent. This subjective division has a number of practical implications: the subject does not have a full understanding of the reasons for his actions (why make such a choice rather than another? Why use such a word, or what lies behind such an emotion? etc.), and a researcher cannot claim to understand them. In other words, clinical research initiatives must, first and foremost, and indeed somewhat paradoxically, base their epistemology on the postulate that there will always be a remainder that lies beyond or beneath what we understand in the knowledge constructed by such initiatives. The recognition of this remainder represents, in my view, the very foundation of the ethics of such initiatives, a valuable legacy of psychoanalysis. The latter and its corpus are not, therefore, merely another attempt to achieve a complete knowledge of man. Therefore, when analysing the utterances of professionals and users, I will always be guided by the idea that, through my intuitions, I will only ever arrive at an approximation of their meaning, at “potential meanings”.

3) There is good reason – indeed, a very specific good reason – for drawing on the psychoanalytic corpus in the field of disability. Credit should go, first and foremost, to Korff-Sausse, a scholar and psychoanalyst specialising in listening to subjects with disabilities and their families, for showing how psychoanalysis represents both an ethics and a method in a clinical approach to disability. First, it is an ethics in the sense that it posits that any human, even one with disabilities, has something to “say from their subjective position” (translated from Korff-Sausse, 2013, p. 176). Given this, both psychoanalysts and clinical researchers will have much to listen to – whether that be listening to subjects with disabilities (however much their speech may be impeded) or to those who support them, such as their families or those who care for them on a daily basis. Second, psychoanalysis in this sense is also a method since
listening inspired by psychoanalysis seeks to understand the latent behind the manifest. A person’s discourse is never transparent, as Freud once noted in speaking of the content of dreams: there is the obvious part of what is said – the manifest – and then there is that which is concealed – the latent – in which Freud sees displacements and condensations of mental content. The importance of taking account of this two-dimensional conception of discourse is further underlined by the fact that, as Korff-Sausse argues, disability is the domain of subterfuges and benevolent attitudes serving to conceal internal mental conflict. When dealing with such a sensitive topic, we cannot rely solely on what is said – i.e. that which is manifest in discourse. As Korff-Sausse notes: “what psychoanalysis enables is precisely to reveal the unconscious representations that lie at the root of these attitudes, often unbeknownst to their authors” (translated from Korff-Sausse, 2013, p. 177). Korff-Sausse concludes by arguing that psychoanalysis and the clinical approach that underlies it aim to understand the ambivalence of feelings, acknowledging the complexity and the plurality of meanings that characterise the situations they investigate, which is something that strictly technical approaches tend to overlook or smooth over. In the context of this research, the implication is that my approach to the participating users or professionals needs to go beyond their purely manifest statements by seeking to understand what these conceal or reveal in terms of unconscious content. For example, it cannot be a matter of simply reporting negative statements around the topic of deinstitutionalisation (such as “it doesn’t work”). If considered in the context in which it is uttered, such a statement could quite easily mean: “I really want it to work, for me it’s such a powerful ideal, but I don’t feel capable of contributing to it, etc.”. In other words, to unfold such meanings, the researcher’s strategy needs to involve seeking, in the utterance itself (slips of the tongue, choice of words, hesitations, repetition, tone, etc.) and the subject’s body language, for clues that provide a basis for hypothesising about the manifest meaning of the statement.

4) The final point is that we need to specify the scientific regime of the clinical approach adopted here. For the theoretical and ethical reasons outlined
above, what interests a clinical researcher is the subject of the discourse (i.e. the subject uttering the discourse) – in other words, the invariably singular way in which a subject inhabits language, but also the actions of the subject. Discourse and actions are examined in terms of their manifest and (above all) latent dimensions. The focus on the latent element of discourse and action underlines the need for an “in-depth” qualitative, rather than quantitative, investigative approach, the aim being to understand what is radically singular in the other, without, however, ruling out the possibility of constructing general (or generalisable) knowledge. As Pedinielli and Fernandez (translated from 2013, p. 6) write: “We maintain […] that patiently listening to a subject, to the narrative of their story and history, and the subjectivity-based approach are more heuristic, instructive and significant than quantitative abstractions based on surface elements unconnected to the subject”. In other words, the first characteristic of such research is to be situated in a specific time and place. Its aim is to seek to identify potential meanings in the situations that it investigates. No attempt is made to infer broad generalities. Case studies (here, the cases studied are the narratives constructed by the professionals and users of the Gabrielle Centre) allow for a kind of inferential reasoning which Canguilhem, cited here by Ciccone, explains thus: “The singular performs its epistemological function not by submitting itself for generalisation, but by forcing a critique of the prior generality from which it differentiates itself. The singular acquires scientific value when it ceases to be viewed as a spectacular truth and acquires the status of exemplary variation” (translated from Canguilhem, in Ciccone, 2014, p. 74). The cases analysed therefore have a dual dimension: they are singular and contextualised and cannot be said to be expressing any truth (for example, about how an institution operates), but they are set against a general backdrop and they do contribute to altering that general backdrop. Therefore, clinical research maintains a dividing line between respect for the singularity of the research fields investigated and a commitment to producing knowledge that serves to illuminate more general situations.
My first intuition upon joining the project was to assume that certain unconscious representations, certain fantasies (whether singular or shared), can constitute barriers to the action of medico-social professionals involved in supporting users with intellectual disabilities on the road to autonomy. Therefore, in order to verify this hypothesis, it was important to establish a methodology capable of ensuring that the research pays heed to these representations and fantasises, while allowing the professionals to conscientise them, to share them and, beyond that, to alter them in order to make them consistent with the deinstitutionalisation objectives of the Gabrielle Centre. Hence the suggestion I made to the professionals of leading working groups devoted to the clinical analysis of professional practice, which I will describe and justify here from a theoretical perspective. The talking groups I advocate may be likened to a research and training approach described (in French) by Claudine Blanchard-Laville as the clinical analysis of professional practice. The theoretical background of the approach is rooted in the practice supervision groups developed in post-war Britain by the doctor and psychoanalyst Michael Balint (1896-1970). By deploying a specific framework, the approach serves to contribute to the professionalisation of those who participate in it by inviting them to develop their “professional self” – in other words, the personal relation they develop with their work, their colleagues and their partners and with the users they care for. In the context of the Unlocking Freedom research project, it is this last point that appears to be the primary aim. In short, the approach has a transformative purpose. At this stage, it may be worth reminding ourselves of the central issue addressed in this research: the individual and social representations and fantasies surrounding mental and psychological disability can sometimes constitute unconscious barriers to the conscious commitment to promoting deinstitutionalisation. Professional action can sometimes involve an emotional dimension which, if not articulated or understood, may prevent a professional from achieving their ends. Thus, the strategies deployed in the clinical analysis of professional practice are capable of uncovering these unconscious representations, fantasies, emotions and affects. The
process of group articulation and understanding can help to instil a dynamic of professionalisation, a means of reaching beyond these obstacles, which it is the purpose of this kind of research to explain. Professionals engaged in such a process are made to become aware of factors that act upon them without them realising it and that impede or shackle them. In other words, the approach and strategies proposed here have a dual research and training dimension. As noted by the French researcher Clarisse Lecomte, who has used the framework of the clinical analysis of professional practice to support teachers in constructing their professional identity, the approach aims to “promote processes of subjectivation, in the sense of self-reflection and the autonomy of subjects” (translated from Lecomte, 2015, 2011, p. 78). Indeed, it is, in my view, vitally important to ensure that working groups within an institution, over which the possibility of a totalising and alienating agenda still casts a long shadow of suspicion, are able to have a space of articulation and elaboration in order to establish their autonomous thinking. A space such as this is also a space for hearing and transforming professional suffering. In my analysis, I will show just how much the participating professionals used the talking groups precisely for that purpose. Subjects use such opportunities to work on their inscription within the social network of the institution. Put differently, the approach enables a binding of the singular to the plural, a process that facilitates collective work: “The analysis of practice is aimed at subjects in professional settings confronted with the wear and tear of their daily work life. Its aim is to promote commitment to, and investment in, the professional identity they have opted for, and to provide group participants with an opportunity to engage in a “caring space” so that they too, by way of a domino effect, are able to implement a “caring” for those addressing them through the intervention of sites of practice to which they are attached” (translated from Henri-Menassié, 2009, p. 21).

Practice in an institution involves a coming together of social workers in the broad sense and persons with mental disabilities. Such an encounter, or coming together, is not insignificant or without consequence, and is in no way comparable to other encounters in which the question of alterity, or even of what Freud termed “the uncanny” (Unheimlich), is less present. The alterity or otherness of mental, intellectual or psychological disability is a cause of fatigue among professionals, and
the analysis of practice is a form of support and accompaniment in the encounter with the Other, since “what it activates is the site of internal conflict between the ego and the self, in institutional situations in which the encounter with the Other serves to produce effects of sideration, weariness and disengagement” (translated from *ibid*, p. 39).

Practice analysis groups are also intended to demonstrate greater tolerance of the internal conflictuality specific to each subject: the point is to put this conflictuality to work, i.e. to express and articulate it, in order to limit its action, to the detriment of the self, the persons supported by the professional or the institution itself. In that sense, practice analysis groups have a dual role: they serve to “fluidify” both how individual mental processes operate and how the institution operates.

2.1 Context of the sessions

Here, I will draw on the strategies used in the clinical analysis of professional practice as developed at Paris West University Nanterre La Défense by Professor Claudine Blanchard-Laville, strategies which I learned at the University of Vincennes in Saint-Denis (Paris 8).

The first session serves to construct the framework for which the researcher/leader has overall responsibility. This framework is based on the following foundations, set out to the participants during the first session:

- The discretion rule: the researcher and the participants are required not to disclose the content of the discussions outside the circle of participants. It is also agreed that any situations discussed during the session are not to be discussed by the participants outside of the sessions, even amongst themselves. If any such discussions were to take place, however, the conversations held must be reported back to the group as a whole at the next session. Insofar as the sessions form the researcher’s research material, the researcher may, with the prior consent of the participants, use the situations referred to during the sessions as part of his or her research question and focus, but may not record the conversations held, instead transcribing them from memory after the fact as part of a report for his or her eyes only that
constitutes the research material; the researcher must ensure that any situations reported by participants as part of the research are anonymised as far as possible.

- An attitude of benevolent listening: both the participants and the leader/researcher must endeavour to maintain an attitude of undivided attention towards the person speaking. Every participant is entitled to expect respect from the group and must therefore, in return, abstain from making any value judgments. The members of the group are required to approach the process from a perspective of understanding rather than prescription or evaluation; what is called for is a spirit of cooperation. Therefore, the role of the leader is, if necessary, to moderate the discussions if they deviate from the attitude of benevolent listening. To ensure they give their undivided attention to listening to others, the members of the group agree not to take notes.

- The members of the group, including the leader, are expected to sit on chairs in a circle, with no table, to ensure everyone can be seen and heard.

- The group constitutes a safe space designed to encourage and welcome speech and to create a sense of safety among its members.

- The group meets regularly (in this case, 10 times between the start and the end of the process) according to a pre-determined schedule. As a reminder, it was suggested to Senior Management that the meeting times coincide with the working hours of the group members.

- The main function of the framework set out here is to ensure collective thinking is an enjoyable process.

2.2 Description of a typical session

Each session lasted three hours, split as follows:

- 1: Reminder of context and moderation;
- 2: Recap of the situation presented during the previous session: the professional who spoke about a professional summarises what s/he worked on or or developed in the time between the two sessions. The group members
and the leader/researcher are also required to provide brief accounts of their thinking over the same period;

- 3: Presentation of a situation: one of the members of the group recounts a real-world work situation experienced at the Gabrielle Centre involving users of the Centre. It is important to allow sufficient time for the account to ensure the greatest degree of detail and accuracy, with as much emphasis as possible on the feelings experienced; the member in question is not to be interrupted during their presentation. They use a discursive form that suits them; the narrative can be disjointed or even incoherent, allowing for moments of silence. The narrator must bear in mind that they are not required to refer to a specific case, but to talk about their involvement in a situation. The affects and feelings experienced, whatever their kind, are not to be kept at arm’s length in an effort to rationalise them. Associations and digressions are de rigueur.

- 4: Clarificatory questions. The members of the group and the leader/researcher question the narrator to allow for new aspects of the situation to be explored; the narrator is not to be interrupted when answering.

- 5: The members of the group discuss the story. Now is the time for analysis – a collective analysis constructed as a group. They operate through association of ideas and are invited to draw connections with other personal situations. The various associations serve to revive the thinking of the member who presented the initial situation. That member concludes the discussion;

- 6 and subsequent stages: Presentation of a second situation depending on the time remaining;

- The session ends with a check on everyone’s ability to attend the next session.

2.3 How to analyse?

The job of the researcher is to articulate, from memory, the contributions of each session into a narrative. These retrospective writings are then revisited for the purpose of development and refinement, forming the research material. To analyse
these traces, I drew on the analytical frameworks of clinical research interviews, focusing not only on the situations recounted by the group but also the psychological tone of the group during the discussions and the effects that the situations had on each member, including the researcher. Each member of the group was emotionally invested in the situations presented, and these emotions provide an insight into the psychological worlds of each member.

The analysis does not give rise to an individualised treatment of each of the ten sessions devoted to the analysis of practice, but rather to a thematic treatment: the global perspective on the material as a whole serves to highlight recurrent themes in the discourse – themes that serve to arrive at a detailed understanding of what the professionals are experiencing. One example of a theme is the institutional paradox question, while others include the fantasies surrounding the institution or users.

3. Thinking deinstitutionalisation through listening to users

3.1. Listening to users: an ethical and scientific imperative

When I was considering submitting this research to the partners of the Unlocking Freedom project, it seemed doubly important to me to devote part of my work to collecting and analysing the accounts of users of the Gabrielle Centre. Indeed, it seemed to me to be an ethical necessity: persons with disabilities must be included in the research or policies that directly concern them. It also seemed to me to be a scientific and epistemological necessity since persons with disabilities can and should be regarded as experts in the subjects that concern them – and they are precisely at the heart of deinstitutionalisation policies.

Whether it be at the level of the European political authorities or within the academic community, an ethical framework has been developed since the 2000s. It is a framework founded on the idea that nothing which concerns people with disabilities must be done, thought about or implemented without people with disabilities being involved. Such an approach, supported by disability associations, draws on elements of law advocated internationally both by the European Union and the UN. In a 2007 resolution, the UN committed “states to involving people with disabilities, on
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an equal footing with others, in the formulation of strategies and plans, especially those which concern them directly” (translated from Nations Unies, 2007). Since the law of 11 February 2005, recent French legislation suggests that contemporary policies relating to the inclusion of people with disabilities must have, as their central and chief guiding principle, full and unfettered social and civil participation. In that sense, it would not have been tenable not to include the users of the Gabrielle Centre in my research protocol. Also, it seems reasonable to me to take the view that people with disabilities experiencing deinstitutionalisation will have a vital perspective on the value, limits and conditions of its optimisation.

From the point of view of the epistemology of this research, my thinking was also spurred on by various feminist arguments theorising the question of objectivity in research. I propose to draw on the perspective of the US scholar Sandra Harding, as developed by Elsa Dorlin (2016; 2008, p. 29), according to which social groups that are subject to discrimination are “best placed to produce highly objective points of view and knowledge”. Truly democratic research – that is, research that is not conducted unilaterally by the dominant on the dominated – is research that pays systematic attention “to marginal perspectives (outsiders) that serve to highlight the social values and interests (...) of those at the heart of the academic community” (translated from ibid, p. 31). Therefore, it seems to me important to collate the accounts of users with disabilities in order to counterbalance the accounts of the institution – i.e. of those embodying it, the professionals – in relation to deinstitutionalisation, not only because it is only fair and ethical that they be given a voice, but also because, scientifically and academically, it is an irreducible condition of the production of objective knowledge about deinstitutionalisation. But just how easy is it to collate such accounts?

8 The text refers to victims of sexism and racism, but, in my view, it is important to widen the discussion to include people with disabilities, in the sense that they too, because of a disability socially constructed in relation to a dominant norm, are discriminated against.
3.2 How should we listen to persons with disabilities?

I set up two talking groups with around ten users of the Gabrielle Centre. The groups were not led as practice analysis groups because that was not the intention at the outset. I now regret that decision. The groups were premised on a desire to encourage users to speak up, thereby reshaping and recasting their trajectory and story as users, the objects and subjects of a policy of deinstitutionalisation carried out by the “Gabrielle Centre” institution. In that way, they might be seen as providing an account “from within”, in their own words, but also their affects, their reference frameworks and their critical perspective on the system in which they are embedded. I convened the group on two occasions, before and after the 10 meetings held with the professionals, as if wanting, implicitly, to begin and end by listening to persons with disabilities.

On both occasions, participants were free to speak as they wished: some opening instructions and occasional cues when necessary or possible served to structure the sequence of interventions and contributions. The conduct of these collective interviews proved challenging because, as noted by Midelet and Scelles (2015), interviews carried out with persons with disabilities potentially amounts to “impeded communication”. It is sometimes necessary for the researcher to help participants to elaborate on a word or thought, a delicate exercise since there is always the risk of producing an interpretation of what users are saying that goes beyond what they actually intend to say. The researcher’s role in such a disharmonic group (i.e. able members versus people with disabilities) is to oversee the effects of language and posture that might serve, unwittingly, to reinstate the dominant/dominated relations that are ostensibly being rooted out, while supporting users. Such a challenge is, of course, a reflection of the difficulties experienced by professionals on a daily basis when their support work risks runs the risk, at any moment, of becoming a matter of dominating a vulnerable user, thereby defeating the very purpose of such support – i.e. their emancipation. The position of the researcher thus reveals a major paradox of the position of the carer.
Midelet and Scelles *(ibid)* warned against the possibility of other difficulties in this type of collective interview. For example, they emphasise that interviewees with disabilities may have internalised their experience of cognitive inferiority and therefore ‘self-discredit’ themselves (by identifying too powerfully with their status as dominated subjects). To protect themselves, they will tend to limit how much they speak (which is not without evoking the secondary adaptations described by Goffman among asylum inmates – i.e. adaptations designed not to lose face). I would add that researchers must be far more vigilant about their own personal affects when interviewing a person with a disability – what we might term their involvement or, to use psychoanalytic terminology, their countertransference. Indeed, more so than with other interviewees, researchers may deploy an unconscious defence mechanism against the otherness of a subject with disabilities involving a refusal or even an inability to view their words as being “of value”. There is also a risk of being incapable of listening and understanding a person with disability as we might any other subject – that is, a subject divided by their subconscious. Thus, Midelet and Scelles show that researchers, when faced with a subject with disability, are sometimes tempted to deny the perceptual or fantasmatic dimension of their words: “It is as if they (the person with disability) are only capable of talking about facts, about situations relating to their everyday life” *(translated from Midelet and Scelles, 2015, p. 75)*. To avoid these pitfalls, I have been careful throughout the analysis to consider the words of persons with disabilities as a reflection of their division and psychological conflictuality, as I did with the professionals.
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Part three: Analysis

Professionalisation: deinstitutionalisation, an idea caught between ideals, fantasy and the principle of reality

1.1 Introduction: changing the institutional “meta-framework”

At this initial stage of the analysis, I will attempt to summarise the thesis, which I will then unfold, and to set out the structure of my argument.

In France, as in the rest of Europe, medico-social institutions are bound simultaneously by the demand for deinstitutionalisation, the ancient historical roots of which I set out above, and by the rise of the management model. The management model may be defined, following Gaillard and Pinel (2011), as the tendency, in social work, to emphasise utilitarian goals and targets, standardised protocols which, while claiming to rationalise care and treatment, overlook their complexity, and a common core of values fuelling the institutional challenge or calling into question, of which hyper-individualism is one. The authors, who situate their work within a “clinic of the institution” perspective and are my main source of inspiration here, like Kaës, Gaillard and Pinel, show that this new model, to which I will add the new prospect – or horizon – of deinstitutionalisation, have, since the 2000s, constructed a new framework for the work of professionals, a framework which they describe as a “meta-framework” in order to emphasise its overarching dimension. It is the conceptual, pragmatic and legal environment, as well as the environment of values and ideals, which dominate practices, forcing professionals to situate their work and actions within its scope, but also their own values, their own ideals and their own representations of the profession and of the people they care for and treat. Pinel summarises the values promoted by the management model in the following terms: “The management model develops in specialised institutions and services by means of three instituting values: transparency, acceleration and individualism” (translated from Pinel, 2017, p. 19). These values are characteristic of what the author terms hypermodernity, which he defines thus:

“Hypermodernity is to be distinguished from postmodernity. While postmodernity corresponds to the moment when messianic narratives lost their
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Credibility – a loss which may pave the way for forms of shared melancholy – hypermodernity needs to be seen antagonistically, taking on the appearance of obsessive defence. Hypermodernity is seemingly situated in a direct line of descent from modernity, drawing on the same ideals (scientific progress, autonomy, contract, etc.) but it is also dedicated to a form of hype” (translated from *ibid*, p. 11).” (ibid, p. 11).

In this meta-framework, Pinel shows that the management model puts professionals in a difficult position because a wide gap can develop between the ideals and values borne by the model and those which drive professionals, particularly at the beginning of their career. This gap is synonymous with suffering, and I hypothesise that it may be the cause of resistance to change. This leads me to articulate the hypothesis which I propose to defend here in an analysis of the ten talking groups led with the professionals based at the Gabrielle Centre:

- Professionals are psychologically “shaped” by three factors or dimensions, the description of which chiefly draws on the second Freudian topic: 1) they operate under the “tyranny” of ideality, itself divided in two, with each professional having to compose with the professional ideal which he inhabits (which I will refer to, therefore, as the professional ego), which concentrates the set of values and models which he has integrated, while on the other hand he is subject to the dictates and prescriptions of society relayed by his institution: these form a sort of institutional superego. 2) Professionals, when supporting persons with disabilities, unconsciously mobilise representations and fantasies; this is the imaginary dimension of their professional identity. 3) On a daily basis, professionals are faced with the challenge of real encounters with others, whether colleagues working within the institution or users. Such encounters are liable to create crises because, for example, the fantasies surrounding disability may not necessarily coincide with the actual, real person with disability.

- “Psychological division” is liable to generate conflicts within individuals – conflicts which, as a result of the suffering they cause, encourage professionals to call on unconscious defences. Work then becomes a site of
“crisis” – of both individual and institutional crisis. In what follows, I will be referring to a powerful conflict, seen repeatedly in the majority of the professionals studied as part of this research, between, on the one hand, a strong adherence to the values of deinstitutionalisation (in particular the quest for autonomy) and, on the other, very negative representations and fantasies of psychological disability: subtended by a generally defectological perspective, they constitute major barriers to the ideal of deinstitutionalisation because subjects with disabilities are all too rarely viewed as being capable of growth and, therefore, autonomy and empowerment. Ultimately, the conflict tends to be swept aside by discourses opposed to deinstitutionalisation.

- It is important, therefore, to put in place institutional mechanisms and systems designed for professionals to enable them to re-mobilise the dimensions of their profession that have tended to be excluded – namely ideality, imagination and reality. In that respect, the clinical analysis of practices is one potential strategy since it serves to transform the unconscious elements that I have just described into discourse. However, we have, in some sense, stopped in midstream, just as speech was freeing itself and fantasies were emerging.

My position may therefore be summarised as follows: changes to the current framework governing the work of which deinstitutionalisation forms part places professionals in crisis, confronting them with a painful dynamic of change, which manifests itself differently in different people but which, generally speaking, causes them to doubt the effectiveness of deinstitutionalisation.

To further clarify my thesis, I will:
- show how the institution is fantasied among professionals as a place of paradox challenging the rationality of the process of deinstitutionalisation;
- illustrate how certain figures of psychological disability crystallise a fantasmatic universe impeding the work to empower users;
- describe the implications of these two points for the vision that professionals have of their profession.
1.2 An all-powerful and paradoxical institution in the minds of professionals

Much caution will be taken in using the corpus items I will be drawing on here to ensure the professionals who put their trust in me by speaking up in the group I supervised cannot be identified from the quotes I will be using. I will be remaining deliberately vague about both the identity of the participants, who will never be referred to by their names, and the situations they refer to and by means of which they might be identified. An approach such as the one I have adopted here is somewhat constraining, forcing me as it does to broaden the focus of the analysis to a group level – a group which, to use a strong hypothesis drawn from group psychoanalysis and first articulated by Kaës, shares a common and specific psychological reality, connected to the singular psyches of its members, during collective work phases. The primacy given to the group does not mean that I will not be pointing out areas of divergence and conflict. However, I will not be able to draw on the very finest texture of the analysis by drawing on the singularity and singular history of each member of the group. Thus, the members of the group will be referred to by the generic descriptors of educator or professional of the Gabrielle Centre.

Such a choice limits the diversity of the professional situations and statuses of the 12 members involved in the group, who are drawn from all of the Centre’s various departments and divisions, from sheltered housing to the Medico-Educational Institute and the ESAT. However, the benefit of such an approach is that it helps to maintain the principle of discretion, which was laid down during the introduction to the very first session as a fundamental law of group life.

Therefore, the focus of my analysis is on common themes running through the group, although they will invariably be themes manifested by personal accounts of clinical situations, as described when setting out the methodology of the clinical analysis of professional practice.
I will begin by describing and analysing the group’s fantasies about the institution in which they work. Note that these fantasies do not provide a description of any external and objective reality of the Gabrielle Centre. In the sense of the Vocabulary of Psychoanalysis, they are “imaginary scenarios” in which the subject is always present. In the context of the analysis of practice, such fantasies illustrate the one side of the psychological reality of a group of professionals at work during sessions. It is important, therefore, not to consider the fantasmatic accounts I will be quoting here as insider “indications” of, or “information” about, how the institution operates. The evidence I will be presenting is, first and foremost, indicative of the people who produced it. I will analyse it from the standpoint of a simple question: how do the fantasies surrounding the institution enable or prevent conceptions of the institution as a legitimate place consistent with the process of deinstitutionalisation in which the Gabrielle Centre is engaged through its institutional project? Do the two aspects – the deinstitutionalisation project and the fantasies of professionals about their own institution – converge or diverge?

During the first session, the research objective was clearly set out to the group: I described both the institutional elements (who is taking part, for how long) and the central theme of the Unlocking Freedom project. Having accepted the framework of my research, the senior management team of the Gabrielle Centre viewed it as an opportunity for some of its professionals to work on a central aspect of the Centre’s institutional project: deinstitutionalisation. The professionals were thus aware of the objectives, which does not mean that they interpreted them in the same way: one of the members reported, for example, that his assumption before I presented the framework was that he was going to be taking part, at the suggestion of management, in a “working group” devoted to deinstitutionalisation, while another member explained that her immediate understanding was that the group had been set up for the purpose of analysing practice, rather than as a simple discussion group focused on a set topic. The project I submitted to the group was therefore seen differently by different members: the protocol was inspired from the protocol of

Unsurprisingly, therefore, the first member who chose to speak during the first session did so by discussing the generic topic of the institution and of how it functions. His opening remarks can be summarised thus: the institution (he was referring to the Gabrielle Centre specifically) is "all powerful". The phrase was accompanied by an all-encompassing gesture designed to evoke control. A little later, a shift can be seen to occur in his discourse: "We know everything there is to know about them (i.e. the users), we do everything for them, we make decisions for them". The shift here is from the institution to the collective of agents operating within it, referred to by the personal pronoun "we". The use of such a pronoun is always significant for a clinical researcher when expecting a subjective account or subjective language: it may indicate the subject’s identification with something belonging to the group, or a defensive withdrawal of the subject behind the collective formed by the group. The unanimity of the members’ approving responses to the contribution suggests that the first hypothesis is valid: a shared fantasy runs through the group – a fantasy to which each member is able to relate: the fantasy of an all-powerful institution, meaning that the excess of power is due first and foremost to an excess of knowledge: we know everything.

The participant in question then proceeded to extend and develop the description, depicting a sprawling institution of which he and his colleagues are integral appendices, a giant institution – consider the explicit reference to the "gigantism" of the Gabrielle Centre campus – whose power is exerted primarily on its users. In this instance, the shared fantasy (shared in the double sense that it is common to the members of the groups and they have a stake in its articulation – the institution is all-knowing) is that of an institution whose professionals are the eyes and ears, from whom nothing about the life of users can possibly escape. As the professional in question remarked: “This creates a problem of intimacy”. Nothing is hidden, everything is visible.
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The fantasy underlines two points that are perfectly consistent with the description of scientific trends that some institutions proffer in the context of the promotion of deinstitutionalisation: at first, we might feel as if we are listening to an analysis by Goffman or Cooper of the effects of de-personalisation and mortification related to the “total” functioning of the institution. There is a fine line between evoking the supposed “omnipotence” of the institution and the use by some (e.g. Castel) of the epithet ‘totalitarian’ to describe the institution. In short, the first discourse used by the professionals is perfectly consistent with the traditional critique of institutions, meaning that professionals are likely to agree with the goals and expectations of deinstitutionalisation: deinstitutionalisation promotes the freedom and autonomy of persons with disabilities, while the mode of institutional operation described during the first session tends by contrast to destroy any space for freedom and considerably reduces the space which subjects have even for intimacy. As the contributor in question put it, users are even deprived of their ability to choose and to make decisions for themselves: “we make decisions for them”. Restoring the possibility, for persons with disabilities, of being the agents of their own lives – i.e. of being able to make choices and decisions that commit and bind them – is, in my view, one of the key objectives of deinstitutionalisation.

During the next session, the point about the lack of intimacy was taken up by another member of the group, but in relation, this time, to the question of free access to sexuality: the professional in question described a sort of contraband sexuality among some users who, in order to escape the snares and eyes of the institution, seek to hide in various corners of the campus – although, here too, they end up being seen and their actions become known to all. The (ultimately failed) attempt by some users to find expedients to engage in sexual practices that might escape the control of the professionals is not without evoking the secondary adaptations of "inmates" described by Goffman in Asylums.

The question of institutional omnivision leads me to evoke a second element that is consistent with anti-institutional discourse: the Gabrielle Centre, as it is fantasised and represented here, is evocative of the seeing/knowing/power triptych described by
Foucault when drawing on the writings of Bentham about the penitentiary institution referred to by the word Panopticon. The panopticon is the disciplinary system and mechanism by means of which everything can be seen (without being seen) and, therefore, by means of which we believe we know everything about inmates in a prison. Consider the following quote from Bentham describing the prison built on the model of the panopticon (1780, pp. 7-8):

“The entire structure is like a beehive whose every cell is visible from a central point. The inspector, himself invisible to everyone, rules like a ghost. However, he can instantly prove his physical presence if need be. This house of penitence is called a panopticon, in order to express in a single word its main strength, the ability to see everything at a glance.”

In his introduction to the French translation of Bentham’s book published in 1977, Foucault remarked: “it is a mode of functioning in which power is exercised by the mere fact that things will be known and people will be seen by a sort of immediate, collective and anonymous look.”

The unanimous agreement of the members of the group over the evocation of the all-powerful, all-knowing and all-seeing institution – a sort of total mother, of which they, the professionals, are the representatives – plays a key psychological role within the group: it is an “imaginary collusion” that serves to designate a “common enemy” (translated from Lhuillier and Litim, 2010, p. 156).

The value of the collective work we carried out around this fundamental idea of the almighty power of the institution was to operate a dual process: professionnels seek first to cease identifying with the globalising “we” of the institution; they then collapse the fantasy of almighty power by describing instances of institutional impotence or paradox.
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During the final sessions, many examples served to transform the initial idea of the almighty power of the institution, substituting for it the shared representation of the paradoxicality of the institution. Here are some illustrations:

- The professionals described the desire of the Gabrielle Centre to open up to the world, which they recognise as a positive move and which they emphasise as being a priority focus of deinstitutionalisation. Here I want to emphasise the conceptual agreement, in principle, between the senior management of the centre and the professionals around this notion of openness, which aims to transform a concentric institution into a platform of network-based services deeply embedded in the community – signalling, in a sense, a move from a model of closure to one of porosity. Yet, conscious as they are of this dimension of the project of deinstitutionalisation, they also point to the contradiction that creates the paradox: after all, it is from within, between its walls, that the institution creates a range of sporting opportunities aimed at residents, thereby reinforcing their ties to the establishment. I did not delve into the reasoning behind this choice, nor even sought to verify its truthfulness: that is not the purpose of an analysis of practice in which the only concern is the “psychological reality” of subjects and, therefore, the function, for them, of the discourse they hold.

- A second paradox arises, one that irreducibly opposes the drive to promote the empowerment of people with disabilities – another cornerstone of deinstitutionalisation and the first act of faith of all educators – and certain care and prevention practices. I will give two examples: one of the main phenomena observed among users was their morbid obesity, a fact that only serves to compound their difficulties. Seeing that obesity represents a major obstacle to social integration and personal autonomy, the institution was keen to put in place a prevention policy involving both patient education (learning to discriminate between foods) and consultations with a nutritionist present every week at the Centre. The professionals underlined the mandatory nature of the consultations and concluded by articulating the following paradox: it is impossible to reconcile the political stance of personal empowerment with the idea of forcing people to attend a medical consultation. As one educator put it:
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“We only want what’s good for them – so much”. Consider another example: another educator described a typical dilemma facing professionals in the mornings when helping certain users at breakfast time: some people struggle to regulate their appetite. Rather than speaking of desire, the educators referred instead to an uncontrollable impulse. In some users, this manifests itself as an excessive consumption of butter or too much bread and butter. The dilemma is the following: should an insatiable user be prevented from having more helpings when we know that eating so much is doing them harm, even if such damage is only done little by little and over time, or should we consider that this person has freewill, that, like anyone else, they make their own conscious choices, and that a professional ethics should require us to allow them such freedom? The dilemma is equivalent to asking the following philosophical question: should users be thought of as ontologically capable of self-regulation, or rather, since they are deprived of such a capacity by virtue of their disability (whether intellectual, mental or other), should we take an “interventionist” stance? The dilemma is the manifestation in the “field” – that is, the field of the care professional – of the institutional paradox. It is worth noting that the paradox is nothing new and that Cooper himself had already identified it: should the chronically ill resident of his psychiatric centre be forced in the morning to get up, have breakfast, wash, etc., or should they be left to look after themselves in the name of both their freedom and a refusal to give in to an alienating normalisation that merely serves to reproduce patterns of domination? Are those in “good health” capable by nature of putting those in “ill health” back on the right track? Asking such a question amounts to challenging the paradigm of the essentialisation of domination relations seen a thousand times in institutions. The assumption is that vulnerable people are naturally incapable of taking care of themselves and should therefore be placed under the vigilant supervision of people capable of better discernment. The members of the care team led by Cooper put up a great deal of resistance before accepting the wish of the psychiatrist to allow patients a significant degree of self-determination. What this no doubt represented, for a lot of these
carers, like many educators today, was a radical challenge to a norm embedded so deeply in their way of thinking about the world and about care.

- The third paradox, which incorporates the previous two at a higher conceptual level, is the paradox of the normality/disability relationship. Professionals ultimately capture the institutional paradoxicality at the heart of my argument here by showing that, on the one hand, the institution cares for people with specific needs who face profound and unique challenges and who therefore require support that takes into account their special needs, while, on the other hand, the institution is an entreprise of normalisation which they see as dubious. For example, one of the educators said: “they need to be as normal as possible”. So: normalisation or tolerance of difference? I am keen to underline the value of the issue raised by the users, which is, beyond them, the problem of inclusive society as a whole. How can collective norms and deep individual differences be articulated in such a society to ensure everyone has their place and is able to exercise their rights?

The focus on the normalisation of users by the institution creates, among professionals, a violent conflict between different ideals: while normalisation is the ideal of institutions, the ideal for professionals is instead to be found in the recognition of the otherness of people with disabilities, who cannot be reduced to normal behaviours. As one educator put it: “normalisation makes them suffer”. This conflict of ideals should, in my view, be a major priority in any such institution because it puts into play the very purpose of the institution: is that purpose to transform people in order to bring them back within the fold of normality, and by extension the community, the people it cares for, or is its sole purpose to provide support, even if the paths taken are not those of normality? Educators face a choice: normalisation is a form of violence, and deinstitutionalisation, if conceived of as a reintroduction into a social norm, is not a tenable horizon. It is important to remember that these debates deeply affected the psichiatria democratica movement in Italy: the return of mental health patients to the community should also serve to put in contact populations that have so far remained segregated in the hope of achieving a mutual acceptance and, therefore, an enrichment of what it means to be human.
What are the consequences of institutional paradoxicality for professionals? I propose to see in this function a dual positive and negative dimension. Paradoxicality is negative in that it brings about a defensive impulse in professionals: because they have a perception that anything they do will always “miss the mark”, satisfying one of the sides of the paradox but failing to meet the other, they no longer know how to situate themselves in relation to their profession. What should they do? The dilemmas they face on a daily basis, and the associated suffering, are the inevitable corollary of the paradoxes of the institution as they see them. In order to guard against such dilemmas, they seek refuge behind protocols, compliance with procedures and reliance on the leader. An entire session was devoted to the matter, the substance of which might be summarised by the idea that a service without a competent, full-time leader leaves its professionals completely helpless and unable to perform their duties. A leader is necessary to root out doubt. Such defensive strategies are exhausting and anxiety-inducing for professionals (a recurrent theme throughout the sessions), and professional creativity tends to disappear in favour of a rigidification of procedures. Consider the following example: one female educator, reacting to a colleague’s narrative exploration of a dilemma and, therefore, internal conflictuality, stated repeatedly that it was important not to be overwhelmed and that everything had to be “referred back” to senior management for her to take decisions. Here we see a psychological strategy aimed at helping the professional to avoid the suffering caused by the doubt and shame felt at the professional ego ideal being challenged by a failure with a user: the problem is symbolically evacuated by referring the matter back, in writing, to senior management. Yet it is only a short-term psychological evacuation strategy, which I do not believe is capable of helping professionals to reconcile themselves with their profession. However, I want to qualify the points made above which describe institutional paradoxicality by indicating, as a working hypothesis, the projective dimension of the accounts provided by the professionals. For they are the very institution whose paradoxes they criticise! Many of the statements made by the participants corroborate this hypothesis: “I’m not doing my job”; “I’m harming residents”; “I didn’t think this is what my job would be”; “we’re educators and we can’t do our job as educators”; “I’m not
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“competent”, “I don’t know how to manage crises”; “I don’t know when to call the emergency services or the on-call manager”, etc. Through their critique of the institution, the professionals project their own unbearable contradictions, and blame an overarching institution that does not give them sufficient resources, that contradicts itself, that does not understand what real work is, etc.

We may think that each professional is caught everyday in the paradoxes of caring for others because they are inseparable from the very notion of education and educational relationships. Educating the other, as Freud liked to say, is an impossible thing, particularly because the very act of educating creates a tension between his educational ideals and an old stock of values, norms and fantasies that make those ideals untenable. In short: educators express an ideal – to support users on their path to “disalienation” and empowerment. Therein lies the ideal of the professional ego. That is their “dream.” Yet, through their daily actions, they come to realise that their very actions (providing care and treatment, providing personal care, monitoring and supervising, sorting breakfast, taking their patients’ temperature – many specific examples were provided by the group) reproduce patterns of domination. The ideal does not hold up. The “intimate” conflict that arises from the violence of educational disillusion and the projection of the responsibility for this failure onto the institution is not to be morally challenged nor even to be conceived in reality (it could be but not in the context of a clinical analysis of practice that focuses on the psychological experience of professionals). Rather, it is to be understood as a defence mechanism deployed subjectively and inter-subjectively within the group to avoid yielding too much to depressive tendencies. In this respect, one of the aims and challenges of the sessions was listening to, understanding and accompanying the group depressivity, which must be thought as non-pathological: it is the development of the ordinary disappointment associated with the educational aporia.

10 The list is non-exhaustive, and each of the items quoted refers to a situation described by one of the professionals. Each statement is the starting-point of a personal story in which the group recognised themselves and their own experience, as if the singularity of a clinical vignette spoke of the plurality of the experience of educators.

11 I have opted to embolden the key points that I propose as suggestions for future action among professionals.
Finally, deinstitutionalisation is fantasised in two ways: it can both re-energise and revitalise the professional ideal because we see in it the core values of the educational profession, and because it adds a new layer of prescriptions that reinforces the impossibility of the profession, thereby confronting professionals with their inevitable failure. As one of the educators put it: “We are sold a dream”. The utterance can be understood in two ways: deinstitutionalisation is indeed a “dream” for professionals – that is, a real educational ideal: to enable people with disabilities to experience and enjoy their autonomy. However, the word “sell” here points to the element of illusion or event fraud that lies behind the dream – a term indicative of the ambivalence of professionals.

We see here just how necessary it is for the institution itself to deploy efforts targeted at professionals and aimed at: 1) supporting them in the notion that the ideals of professional educational practice and those of deinstitutionalisation do indeed converge. There need be no fear of a significant gap; 2) “positive reinforcement” by re-affirming the sense of individual and collective competence.

Mention of the paradoxes of the institution also had a positive effect during the sessions, subverting the fantasy of the almighty power of the institution. Ultimately, the fantasy is not tenable because the institution can neither know everything nor do everything: it is itself conflict-ridden and divided, just as professionals are. While hardly reassuring, it nonetheless enables play and discussion to be re-introduced.

Here, all I can do is to call again for the existence of inter-service measures to debate these paradoxes and the professional dilemmas they cause. Where such a debate is not possible, the policy driving the institution is immediately discredited. Such debates enable people to take a stance, subjectively and rationally, and serve to eradicate those defensive strategies that merely result in a sterile conflict between professionals and the institution they serve: as one educator put it, “deinstitutionalisation isn’t for us”, thus underlining his own feeling of exclusion.
The chief condition governing whether professionals are able to implement a deinstitutionalisation project in their daily work, the cornerstone of which is the empowerment of users, is that they perceive and represent users, both consciously and unconsciously, as being capable. What does the evidence point to?

In general terms, the corpus points to a conflict in the discourse surrounding users, and in particular those users suffering from a disability described as mental or psychological (psychosis first and foremost), between positive conscious representations and unconscious fantasies of a different kind. Indeed, in their manifest discourse, the professionals were found to subscribe entirely to the idea of educatibility at the core of their professional identity. It is because they believe in the educational project that professionals first “went into the profession”. In that respect, they align fully with both the project of their professional institution and with the ethics of deinstitutionalisation. For example, in the very first session, one professional stated that he was “up for” defining his daily support tasks in a different way, proposing that what he had previously done within the institution could be done from the institution and, in a centripetal fashion, from the inside to the outside. His discourse destroys the confined, walled space of the institution (which does not exist), with the educator seeing no conflict between his desires and his professional ethics and these new practices of openness consistent with the call for deinstitutionalisation. Here we see a consistency between positive representations of users (i.e. they are capable of leaving the institution and of benefiting from services – such as sports services as in the example used by this particular professional), the professional ideal of this educator (providing support to empower) and the “overarching” recommendations of deinstitutionalisation.

However, such positive representations were not often heard among the professionals during the sessions. By contrast, views echoing an unconscious negative fantasmatic of disability were in no short supply. I will attempt to provide
Let us consider a first type of negative fantasy that both points to a link between the theme of the paradoxes of the institution surrounding the idea of autonomy and serves to deepen our examination of this question. During one of the first sessions, one female educator said: “You have to have rules, users aren’t capable of controlling themselves on their own”. This professional justified her views by describing the insatiable appetite of one user. Others lent support to their views by describing a new development at the Gabrielle Centre: the care and treatment of children suffering from Prader-Willi syndrome, one of the characteristics of which, according to the participants, is, as they note, the inability to control food intake. I noted above just how this idea of the inability of some users to control themselves suggests the idea of the emphasis on prevention and restriction recommended by the institution – a form of work experienced by the professionals as an infringement of the principle of empowerment. Here I want to approach the problem from the point of view of what it reveals about a traditional fantasy: the impulsivity of people with disabilities is unlimited and therefore requires restraint strategies. To use a Freudian image, they are fantasised as “Ids” that are not subject to the “super-ego” shackles of rules and regulations. They escape the common lot of humanity, which involves integrating, and operating within, the law and within moral rules and standards, which constitute the oversight authority which Freud terms the Super-Ego. Thus, they escape the acquisition of social attitudes and therefore struggle with the process of hominisation. Such a fantasy creates an unconscious association between disability and animality – an association described as classic in clinical research surrounding the question of disability. In France, there is the well-known story of Victor of Aveyron, who was “found” and “captured” while living in the forest as a young

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12 The *Vocabulaire de la Psychanalyse* by Laplanche et Pontalis gives the following definition of the concept: “One of the authorities of personality as described by Freud in the context of his second theory of the psychic apparatus: its role is similar to that of a judge or censor in relation to the ego. Freud sees the functions of the super-ego as moral conscience, self-observation and the formation of ideals. Traditionally, the super-ego is defined as the inheritor of the Œdipus Complex, formed by the internalisation of parental demands and prohibitions.” https://psycha.ru/fr/dictionnaires/laplanche_et_pontalis/voc307.html
teenager, dirty, feeding on roots and food pilfered from nearby gardens and incapable of uttering a single word. In the early 1800s, he was taken in by a physician, Doctor Itard, who was keen to administer a civilisation programme and cared for the boy for five years, battling with his persistent mutism but ultimately giving up, disgusted by his failure, and returning the child “to his wild life”. The boy’s inability to learn language led the physician to describe him as wild – in other words, to deprive him of his humanity.

Korff-Sausse provides the following summary of the impulsivity-animality-disability link:

“Whenever we think of clinics of the extreme the category of animality comes to mind. Beings affected by a disability, a developmental abnormality, a deformity, mental deficiency, the terminal phases of illness, significant prematurity and old age inevitably evoke images of bestiality, in the sense of an excess of impulses indicating a crossing of the anthropological barrier that underlies the difference between humans and animals.” (translated from 2007, p. 85).

This idea of the overwhelming impulsivity of people with disabilities can also be found in the corpus and, specifically, in the references to sexual impulses that are difficult to control. The professionals referred to the problem of contraception, painting a picture, during the sessions, of the somewhat archetypical figure of a young woman with a mental disability incapable of normal sexuality and becoming pregnant without having the capacity to raise her children, who are invariably taken away from her by child protection services.

These two examples show just how difficult it is for professionals to avoid seeing users other than in terms of their differences with common norms and common humanity.

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A second kind of fantasy illustrates this point – a fantasy I term the “defectological conception of disability” and which involves representing fantasy purely in terms of an irreversible defect, a lack and a lessening and, therefore, ultimately, in terms of radical alterity. The themes of death, regression, frailty or even of the ill health of persons with disabilities operated as recurring fantasmatic focal points throughout the sessions:

1) For example, in the very first session, one participant made a case that a particular child could not attend school by using a term that betrays the power of the psychoanalytic and psychiatric culture in the construction of the fantasmatic universe of professionals: “he is too regressed”. The Larousse French dictionary defines the term as a “retrograde step” or “going backwards”. In other words, the users of the institution, despite the care provided to them, are seen as being likely to go backwards, to return to a former state characterised by an inability to learn and relations of significant dependence on professionals. In other words, users are represented as children who never grow up and even regress, make no progress and are unable to develop because of their disability and therefore remain dependent on professionals who are “parentalised” as part of the fantasy. In short: eternal children, and forever dependent. How then might their leaving the centre be seriously envisaged? One educator spoke at length to describe one of the users encountered several times in the course of our exchanges. The user in question was said to be “in full regression”, and participants repeatedly referred to the fact that he was ageing badly and very quickly. The educator in question then said: “He wets himself and soils himself”. The user is a man in his fifties. Such behaviour transforms the nature of daily work. Educational work recedes and even disappears and is replaced by a kind of mothering work that is as real (eating, hygiene) as it is fantasmatic. Some of the professionals within the group complained bitterly about such a downgrading of their roles. In the same way as a child, the incontinent user is incapable of describing his symptoms when he falls ill (an increasingly frequent occurrence), so much so that it took the emergency services to find that he was suffering from a very high fever which he had not complained about, or
indeed the A&E department to find that he was suffering from lung disease which had to far remained undiagnosed, undetected and absent in his discourse. The picture painted of his regression ended with a reference to his likely death – a quick (indeed, very quick) death, quicker than most people since “this kind of illness deteriorates very rapidly”. As the story unfolded, the group appeared to be shot through with generalised anxiety because, so the professionals reported, nothing had prepared them for dealing with the ageing – or, more accurately in this case, the wasting away – and death of users. One educator then spoke of the effect on her of the regression of one of “her” users, an ordeal that plunged her into a painful period of depression – a period which was not, however, altogether unhelpful: besides the fact that it enabled her to develop her own personal relationships with users, she was also able to mobilise her department to create a space for reflection on the subject of ageing. This points to an understated way of talking about death, a theme at the heart of two consecutive sessions. The example of this particular professional is illustrative of the usefulness of sessions devoted to the clinical analysis of professional practice, pointing, as she did at the end of the year, to the perceived benefits of expressing her fears in the way that she was able to during this experience and of sharing them with others, and then of finding a way of transforming them in her daily life and of reporting this transformation back to her colleagues in the group. We might, without fear of overstatement, hypothesise that her participation in the group enabled her to rid herself of anxiety in a safe and confidential setting and to articulate and understand it over time. Such a process contributes to her professional development, making her better able to support certain ageing users or patients.

Therefore, regression creates a fear of death and diverts the work of professionals away from its educational ends: as noted by one of the professionals, “with these users we’re not in educational mode, we’re in

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14 The following is an example of comments exchanged on the subject of ageing that betray the fantasy of the radical alterity of persons with disabilities:

Female educator: here, for some people 50 years old is equivalent to a hundred for normal people.
Male educator: it makes me think of cats.
support and assistance mode”. What this makes clear is that a fantasmatic scenario serves to structure interventions and utterances within the group around this topic: users are liable to regression, and so they need to be supported and to be provided with “primary care”, which has nothing to do with education. Support and assistance are the antithesis of autonomy: therefore, deinstitutionalisation is not possible.

2) Another participant, seeking to justify the inability of many users to acquire the skills necessary to leave the institution, used another term characteristic of common (i.e. untechnical) descriptions of people with psychiatric disorders: “we’re getting more and more lunatics here!”. He then went on to describe an opposition between two categories of users. There are those with intellectual disabilities whose characteristics are easier to understand and who can be more easily helped – a category described by the professional in question using a (French) term that dates back to the early twentieth century: “arriérés” (meaning backward or retarded). Yet he then remarks that this “traditional” profile is being gradually replaced by mental disabilities. He notes that the remit of the Centre was recently widened to include a new population summarised by a single word: psychotic. Again, the point is not to determine whether such a view is an accurate reflection of the reality of the institution. Rather, the point is to understand that the term is, first and foremost, a description of reality as perceived and fantasised by that particular professional – a perception and a fantasy that constitute his own psychological reality from which he forms a view of his own work. This new category of users is described using very harsh words such as “morons”, “dribblers”, “retards” and people “incapable of preparing their own food”. These terms should not be understood as insults directed against users and requiring unequivocal moral condemnation: if professionals allow themselves to use such words amongst themselves, it is because they unconsciously expect the expressive and transformative role of practice analysis to enable them to articulate an experience of radical strangeness with persons with disabilities. The use of such words is indicative of the intensity of the confusion and sense of the uncanny experienced by professionals. The fantasmatic encounter with mental
disability causes professionals to question the humanity of users, who are only perceived through the lens of the blatant signs of their difference, and the choice of such brutal signifiers highlights the difficulty for professionals of seeing the subject behind the disability, of seeing the dignity of the human being behind the lack and the impairment. To argue for deinstitutionalisation is to privilege an approach to disability founded on the idea of the common humanity we share with persons with disabilities, who are therefore entitled to share the same life spaces as any other human being and to enjoy the same rights.

To summarise this second point: as the key learning from the analysis of the corpus, I would emphasise the presence in the discourse of the participants of two similar kinds of fantasies surrounding persons with disabilities: the first kind describes persons with disabilities as being characterised by a largely “uncontrollable” impulsiveness that makes difficult any kind of educational work; the second kind suggests viewing disability in terms of an essentialised lack or absence, impairment and radical difference.

The effect of both types of fantasies is to discredit persons with disabilities as educable subjects capable of emancipation and autonomy. In that sense, the two types of fantasy share common ground, forming a considerable barrier to the acceptance of deinstitutionalisation as a possible horizon. Therefore, one major challenge for the institution is to embed strategies of psychical working out over the long term to ensure that the sense of the uncanny experienced by professionals do not result in exclusion or relegation in everyday practice.

1.4 Getting through the crisis

In this final section of the analysis of the sessions held with the professionals, I propose to view professionals as being in the midst of a crisis – a crisis that is perhaps representative or metonymic of a wider crisis, the crisis of the institution, and possibly even of medico-social institutions. While it causes tension and suffering, this
crisis is a positive process of change that points to the dynamism of professionals: what I saw was a group engaged in “psychological work”, in movement. While they may seek refuge, somewhat defensively, behind a certain rigidification and “protocolisation” of work, the professionals changed significantly during the year we spent together. It is precisely this change that I will be describing here, drawing, therefore, on the concept of crisis in its psychosocial sense.

The term ‘crisis” is in common usage in the social sciences and so my first task will be to attempt to outline its meaning. In Freud and, therefore, in psychoanalysis in general, a crisis in its subjective dimension is related to the division of the subject: the process of impulse inhibition and the difficulty for the ego to contain the “drive” of impulses are the coordinates of the ordinary psychological conflict that can become a crisis, as in hysteria “when the defective ego finds itself unable to transform and interpret the dynamics of impulse and instinct” (translated from Barus-Michel; Giust-Desprairies; Ridel, 2014, p. 26).

For classical sociology, and especially Durkheim, the notion of crisis is close to the notion of anomie: crisis is a social deregulation “that brings about disorganisation and the loosening of social bonds” (translated from ibid, p. 27). In France, should we not see the shift from the institutional model to deinstitutionalisation as a challenging process of deregulation affecting the realm of social care and having repercussions for subjects bound to that realm? The authors I cited above are keen to go beyond a strict separation between the social realm and the subject, which is why they argue that the notion of crisis combines both dimensions. I too want to situate my work in the conceptual waters of a clinical psychosocial approach to the notion of crisis that seeks to capture it in its social and subjective dimensions simultaneously by drawing on the Freudian framework of a subject divided by the unconscious. Crisis is a subjective experience with a strong “emotional impact” (translated from ibid, p. 33).

The theorizing of the authors cited here provides the basis for a strong hypothesis about what the professionals working at the Gabrielle Centre are experiencing subjectively within the institution in this period of change driven by the perspective (and prospect) of deinstitutionalisation: the argument is that they are experiencing
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these changes as a threat against existing balances – a threat that affects the sense they have of their own professional identity and of the identity of the institution. This is so because the identity of the institution is fantasised as being dramatically threatened by national and European recommendations.

A recurring example of a threat is this: on several occasions, the members of the group indicated that “Europe” – figured here as a cruel and tyrannical superego – is prepared to challenge France over its definition and uses of “sheltered work”, which it is assumed to be examining from a discrimination angle. Once again, the point is not to establish whether what the professionals are saying is actually true: rather, the point is to understand that by deploying such a critique (whether real or fantasised), they are talking about the threat that they perceive and which affects their professional practice on a daily basis. One of the services of the Gabrielle Centre, ESAT, is responsible for providing work to persons with disabilities, exposing it to having to admit defeat in the face of the European critique. The professionals believe that the identity of their institution and therefore, by extension, their own identity is awaiting a “catastrophic change” (translated from Bion) – a wait made all the more unbearable (and therefore likely to bring about a crisis) by the fact that its foundations in non-psychological reality are weak. This example underlines the dynamics at work during the sessions: an entire fantasmatic unfolds, informing the researcher of the anxiety experienced by professionals in the face of predictions (whether real or not) of change: therefore, “a core characteristic of the crisis is the experience (perception) of a grave threat to the continued existence of social unity, which may even affect individuals through their belonging to that unit” (translated from ibid, p. 33).

The psychodramatic dynamics of the clinical analysis of professional practices can act like a sounding board for the sense of crisis, which can manifest itself with surprising violence – manifesting itself in particular, as I will show, by a marked depressive state and a perceived loss of meaning to the work being performed. We may then ask whether it might not be preferable to spare the institution and the members of the group such moments. That would be to forget that allowing room for negativity in discourse is to enable the process of symbolisation and its
transformation, thereby lessening one’s ability to be a nuisance in everyday practice. Faith is placed in the containing and transformative dimension of the group and, therefore, of group psychological work. As noted by the authors I am drawing on here, a crisis is by nature creative if it has somewhere to express itself collectively. What then are the elements of the discourse of professionals, besides those relating to sheltered work, that are constituent of a general discourse on crisis?

As one female educator put it in referring to a level of institutional demand that is impossible to meet: “We’re at sixes and sevens”. The statement is reflective of a common mood among the group: the effect of institutional demands surrounding users and residents, the paradoxicality of which I have already underlined (i.e. empowerment versus emphasis on dependence), is to confuse and disorientate the professionals, who were found to exhibit a spectrum of responses when it came to assessing this effects of this disorientation:

- When it comes to having to take micro-decisions and shape daily practice, one female professional reported how she hesitates and feels guilty in advance of making any decisions, convinced as she is that the decision she will eventually take will not be the right one. According to her, these repeated hesitations are a cause of considerable anxiety (the situation she described occurred at night at a time of great solitude, thereby accentuating the sense of fear\(^{15}\)).

- Another female professional spoke of her mental exhaustion in the face of the repeated illness of one user, a case to which she devoted much time and energy before experiencing a sense of impotence in seeing the user’s declining health. I retrospectively described a state that is sufficiently serious to require time off work as a form of “affective drainage”.\(^{16}\) Consider also the case of one of her colleagues who spoke of her repeated disappointment at her perceived inability to perform the tasks that had driven her to join the

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\(^{15}\) The professional used the term ‘anxiety’, but ‘fear’ is, in my view, a more accurate description since one would be hard put – as she would be – to identify the object of her anxiety in her discourse. It was diffuse and elusive, escaping rational discourse. It is in that sense that I prefer to speak of fear in describing her experience.

\(^{16}\) I use the phrase to describe the experience of mental fatigue suffered as a result of interacting with users on a daily basis: the power of the narcissistic investments of the professional and the challenge of powerful affects (love, hatred, compassion, etc.) eventually exhaust the subject and prevent their ability to feel. A melancholic withdrawal can then be sensed in the professional’s discourse.
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institution in the first place. Though perhaps less “solid” than the professional referred to in the first example, both women exemplify the sense of depression associated with the climate of professional impotence caused, so the argument goes, by the institutional changes related to deinstitutionalisation.

Anxious hesitation and depression have a common effect: a decline in the power of professionals to act. They perceive (experience) themselves as pawns; decisions are made at the “L+2” level, and the reference to hierarchy (a recurring theme in the sessions) is indicative of a fear that the institutional relationship is broken. One final statement by one of the participants neatly summarises the prevailing feeling: “to include the people we work with, we exclude the professionals”. In other words: is deinstitutionalisation emerging and operating as a force opposed to professionals?

Two other powerful affects can be seen in the accounts provided by the professionals, and these feed into the crisis: shame and guilt. Researchers have emphasised just how omnipresent such feelings are in the clinical world of disability generally, among both families and professionals17. The psychoanalyst Serge Tisseron draws a distinction between the effects of the two affects. Guilt implies the possibility of reparation, while shame is “terribly desacralizing and destructuring” (translated from 2012, p. 39). Tisseron adds that shame is accompanied by the fear of loss. What is there to lose for a professional? “The love of those closest to them, their self-esteem and their links with the community of affiliation” (translated from *ibid*). We see that shame can even dissolve not only the sense of belonging to the institution, but also the professional’s own sense of competence. From a topical point of view, guilt and shame reflect different relations to the superego and the ego ideal. As indicated by Ciccone and Ferrant, guilt reflects “the demands of the superego, while shame reflects the dictates of the ego ideal” (translated from 2012, p. 19).

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17 I have observed these affects at work among teachers required to include students with disabilities in their classes: despite subscribing to the inclusive ideal currently reshaping the teaching profession, they see themselves as incapable of implementing it in their day-to-day work, with some teachers going so far as to view their actions as doing harm to the students with disabilities attending their classes and, ultimately, they feel shame and guilt. They often defend themselves against these painful affects by distorting the rationale of educational inclusion. The assumption is that the same process is at work in the medico-social world with the promotion of deinstitutionalisation.
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Professionals feel shame at not being up to the dictates of the professional ego ideal and feel a sense of guilt at being unable to meet the demands of an institutional superego committed to deinstitutionalisation. As noted by Pechberty et al., the sense of professional impotence that I have just described at work in certain female educators is potentially traumatic (Pechberty et al. 2012, p. 206) in that it is impossible for them to see themselves, in their relationship with persons living with disabilities, as good professionals. The result is a strong sense of self-disqualification.

One specific situation is particularly illustrative of what I have been discussing here – representing, in a sense, the height of the crisis, as recounted by one particular educator in one of the very last sessions. The topics discussed were the changes being made to the Gabrielle Centre’s organisation chart and their repercussions on one particular service. The discussion was an opportunity for the educator in question to look back with nostalgia on the time before the change, when real, competent leaders were in charge of the services and enabled everyone to do their job properly. Such a description is subtended by a vision that idealises both the figure of the leader, now disappeared, and a participatory model in which each professional can find his or her place and feel a sense of recognition.

Implicitly, she describes the (largely fantasmatic) coordinates of how she subjectively experiences change – that is, the coordinates of crisis: “What drives me crazy”, as she puts it, “is that I’m not able to do my job”. In her mind, the changes associated with deinstitutionalisation and the new management style put in place at the Gabrielle Centre are experienced as an abolition of the previous organisation, which worked. What she emphasises is the absence of a “good leader”, but also the lack of resources and other organisational or structural failings for which the institution is made responsible, preventing the kind of work fantasised by the educator: she is no longer able to fulfil the professional ego ideal and feels a sense of confusion – she claims to be going mad – and shame, causing her to consider changing profession. She then refers to a profession in which her educational vocation would not be put to the test: as she suggests, at least she would no longer suffer the disillusions of her
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day-to-day work and would be better paid. Nowadays, all she does is “dirty work”, well below her qualifications, performing tasks urgently and outside the confines of any institutional framework. She is unable to carry out these tasks effectively and to the correct standard and feels guilt at “doing violence” to users, by, for example, imposing a pace on them that they are unable keep with up. In short: guilt and shame, a sense of gradual de-professionalisation, of renunciation of ideals, a sense of being discredited in the eyes of patients’ families, a fear of criticism that her superiors could level against her, a sense of rebellion against authority, which she stifles. Ultimately, she referred to users three times as “declining”. There then followed a catastrophic description of one of the users whom she cares for and who was becoming increasingly dependent because he was not capable of attending to his own hygiene, to the point of being unable to drink without it “going down the wrong way”. As she put, there is “a zombie element to him”. Despite the fact that he sometimes threatens her, she claimed not to be afraid of him and ended by saying “I feel borderline”, thus using a psychiatric term, after the word “crazy” at the beginning of her statement, to describe herself.

Such a critical view is dangerous in that it results in the mobilisation of the set of defence mechanisms specific to each subject: “Depending on the moment, the contexts and the subjects concerned, the state of panic caused by the sudden occurrence of a catastrophic change will bring about the deployment of an entire arsenal of available defences, from the most archaic to the most elaborate. Inhibition, phobic avoidance, repression, paradoxical overinvestment or counter-investment, rejection, denial, negative hallucination, projection and division emerge as remedies for the fantasised or perceived danger” (translated from Diet, 2013, p. 25). As noted by Barus-Michel, Giust-Desprairies and Ridel (2014), the crisis is two-sided: it is both a moment of “outpouring of fear” (translated from p. 40), as I noted above in discussing the educator’s account, a moment of potential rupture from the institution, but also “a generator of drive” (translated from p. 41). It is an opportunity “to provide subjects with access to meaning, by means of which they are able to renew their dynamic of action” (translated from p. 40).
But what are the conditions of possibility of the positive side to the crisis? The positive side will only emerge:

- **If the institution does not view the effects of the crisis from the perspective of “resistance to change”**. Diet shows just how much the phrase has tended to pervade our thinking about work difficulties in recent years, the negative effect of which is to close off the thought that ‘any reaction is resistance’ and to point the finger at workers: change is necessary, we have no other choice, and so resisting it amounts to an individual moral failing that taints us all. The coordinates of the crisis as I have just described them should not be seen as a kind of resistance to change among professionals, but as barriers to the path to change (here, the horizon of deinstitutionalisation) that we need to break down together.

- **If the institution creates transitional and permanent mechanisms for the expression of critical experiences and perceptions** as I have just described them, while not being afraid of the discourse of crisis. While such discourse is shot through by a powerful imaginary dimension, it must be welcomed and included in order to be transformed.

- **If the institution supports professionality**: as we have seen, one of the main fantasies that will impede deinstitutionalisation is that, with deinstitutionalisation establishing new relationships with users, professionals will lose their original expertise and the values they associate with the education professions. Since there is no conceptual inconsistency between the values and expectations of the profession as embodied by the professionals and those of deinstitutionalisation (which have yet to find an embodiment), the institution must strive to close the fantasmatic chasm that has emerged between the two. What is needed is for senior management and professionals to construct a “shared culture” (translated from Chauvière and Plaisance) of deinstitutionalisation together. Perceived as external and possibly tyrannical, this watchword must become a subject of internal debate at the Gabrielle Centre. Therein lies one of the surest ways of re-establishing symbolic inter-institutional ties.
2. Deinstitutionalisation and the institution: the view of users

2.1 Methodology

Before I delve into the detail of this final section of the report, it is important to provide a brief outline of what I propose to do. It was not my intention from the outset to collect the accounts of young adults with disabilities having already embarked on a personal process of deinstitutionalisation when I first submitted my research topic to the Irish leaders of the Unlocking Freedom project. My identity as a trainer of specialist teachers and my previous research on French middle school (collège) teachers had directed my attention towards the question of educational professionalities in the era of the inclusive society. Although I devoted the closing chapter of my doctoral thesis (Ployé, 2016) to listening, in a clinical setting, to what students with disabilities had to say about their experience of school inclusion (Ployé, 2018), I must, in all truthfulness, say that it was only upon the request of my Irish partners that I modified the original protocol. Therefore, I want to emphasise both the modest scale of the work carried out among users as part of this research (since I devoted just two three-hour sessions to them on top of the ten sessions spent with the professionals), but also the pertinence of the request made of me in that it reflected a now inescapable research ethics governing work on people with disabilities, as I noted in the methodological comments made earlier in the paper.

This is what led me to consider prefacing and ending my work with the professionals with two work meetings with users of the Gabrielle Centre. The first talking group session was held before embarking on the analysis of practice with the professionals, while the second took place at the end of my work with the professionals. What the users of the Centre said on both occasions serves, therefore, as a useful counterpoint or contrast to the findings, providing me with a broader perspective,
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and, as I will indicate below, prompting me to submit a new proposal for research and action in cooperation with the Gabrielle Centre on the subject of peer education. It became apparent to me that the experience of users, fragments of which I was able to gather in the course of the two talking group sessions, qualified them as experts who must be involved in creating the shared culture of deinstitutionalisation that I am calling for.

Before embarking on the analysis, it is important to note a bias in the conduct of the two group interviews: two Gabrielle Centre professionals also took part. One of the participating professionals was involved in the Unlocking Freedom project and wanted to have the opportunity to listen to the users on the grounds that she had only recently been appointed at the centre and felt it was important for her to get to know them. I therefore agreed to her attending the sessions. The second professional, whose precise role at the centre I did not establish, although I am aware she holds a management position, also attended the first interview. I do not recall being alerted to this, which should not be taken to mean that I was not. However, upon re-listening to the recording of the first session\textsuperscript{18}, I was surprised to (re-)discover her presence and, even more so, to find that she eventually became heavily involved in the discussion. She was known to some of the users. The presence of the two professionals may have had an impact on the ability of the participating users to express themselves freely and openly and not to self-censor themselves. However, while they may have inhibited some of the participants, the manager’s interventions will serve as a basis for analysing an issue that extends beyond the confines of the group interview in which she took part. This is because she tended to intervene just as certain accounts from users might have brought discredit on the institution. Her interventions are, in my view, symptomatic of a specific relationship to users that I will attempt to describe below.

\textsuperscript{18} Unlike the groups set up for the clinical analysis of professional practice, the two group interviews were recorded (having obtained the consent of the users).
The two working sessions held with users of the Centre were an opportunity to hear from fifteen young adults. The group was set up by the senior management team of the Gabrielle Centre. I am not able to fully decipher their choice of users and the intentions underpinning their selection. However, I can emphasise two key points:

- Senior management invited young adults who had been, or still were, beneficiaries of its services and who were able to express themselves without major difficulties to take part, thereby enabling the group to run smoothly and with limited resources. It was not necessary to put in place adaptation strategies to collect the accounts of users. However, it is important to recognise that this amounts to a significant limitation and to a methodological bias. Without going so far as to speak of a representativity problem, the group was mostly composed of users less affected by intellectual disability than others also attending the centre. The group was constructed on the basis of a fictitious homogeneity, and we might argue that its members were better placed to undertake the work required by the process of deinstitutionalisation than many other users of the Gabrielle Centre, a fact that must not be overlooked. The relative artificiality of the group means that the results of the following analysis need to be seen in context;

- However, the members of the group were representative of the full range of the centre’s services, from the Socio-Medical Institute (IME) to the Medico-Social Support Service for Adults with Disabilities (SAMSAH). In that sense, the participants may be said to represent a wider range of experiences, with some being further down the road of deinstitutionalisation than others: some individuals are full-time residents within the institution, while others who live autonomously in nearby towns only attend the centre occasionally to benefit from specific services (medical or para-medical consultations, adapted physical education, etc.).
It is important to note that the composition of the group is indicative of a gap between the choices made by senior management in selecting talking group participants among users of the centre and the general discourse held by professionals in relation to the users of the Gabrielle Centre. While the users I interviewed presented difficulties, they did not reflect the typical profile depicted by the fantasmatic shared by the participating professionals, who often spoke of the increasing number of users suffering from mental disabilities, and I found that the figure of the psychotic patient served to crystallise that fantasy – a psychotic figure who is difficult to contain, who hampers educational work and causes professional distress. There was no evidence of this figure in the group of users who took part in this study. It is not for me to provide a medical description of the types of disability represented in the group of users. However, I do want to emphasise the significant element of social maladjustment at work in the discourse held by the users about their own experience, with examples including difficulties, poor financial management and life crises from which they struggle to recover, representing the anchor points of the difficulties perceived by users. With one notable exception, they did not discuss any psychological pathologies or intellectual deficiencies. In other words, where the professionals were found to have an interpretive framework shaping how they see the difficulties experienced by users of the Gabrielle Centre that is influenced by their professional psychological culture, the users tended to put the emphasis on the social factors at the root of their disabilities and the double process of maladjustment, seeing themselves as maladjusted to certain social expectations (for example, work in an ‘ordinary’ setting) that, far from being natural, are a result of the accidents of life. Another factor was the inability of society to adapt to their specific needs, causing them to feel excluded.

Therefore, I propose to argue that the institution is shot through by several competing definitions of disability:

1) Traditionally, professionals have relied on a biomedical definition of disability that I refer to as defectological. Their professional psychological culture and the infiltration of educational work by the kind of psychiatric thought that is characteristic of the French medico-social world results in a major focus on the
notion of deficiency. As noted by the sociologist Romuald Bodin: “relying purely on the biomedical criterion of deficiency to discuss disability will therefore imply seeing anyone who perceives themselves to have a deficiency as being disabled, meaning two thirds of the [French] population” (translated from Bodin, 2018, pp. 24-25).

2) Users draw to a greater extent (although the notion of deficiency is never far removed from their discourse) on patterns of thought associated with a sociocultural conception of disability. For them, disability is the product of an (acquired) maladjustment to social norms coupled with a maladjustment of society itself – meaning a double maladjustment that results in their exclusion.

3) It seems reasonable, therefore, to posit that the senior management of the centre is tending to approach the project of deinstitutionalisation from the perspective of an environmentalist conception of disability which posits that it is, first and foremost, a matter for the social environment to remove the barriers that society has tended, historically, to impose on people with disabilities in order to re-establish their full participation in society. Deinstitutionalisation is thus seen as being equivalent to creating accessibility: disability “is the product of the interaction between the individual (presenting a deficiency) and the environment that leads to ‘reduction in social participation’” (translated from ibid, p. 25). Yet I think it is worth specifying that each and every member of the senior management team was also prone – albeit in a less intellectualised fashion – to adopt a conception of disability close to that of the educators.

These three competing and very different definitions, shaped by different social positions occupied within the institution, are not compatible, and may even be said to be in conflict and to create spaces of incommunicability. As I have just indicated in the case of senior management staff, they are also increasingly likely to co-exist at an intra-individual level: each individual may draw on a specific conception when thinking about the objectives of the centre but express, in discourse or action, an altogether different conception in the daily relationships with users. The competing definitions of disability are therefore liable to give rise to conflicts between the various
actors of the institution, but also at an individual level. This double level of conflictuality is an impediment to sharing common views of the direction that social work needs to take with persons with disabilities. **In other words, creating a shared culture of deinstitutionalisation requires, first and foremost, an update of the different definitions and conceptions of disability in order to go beyond their sterile opposition.**

### 2.3 User awareness of institutional paradoxes

Whether expressed clearly and explicitly or emerging from their accounts, the Gabrielle Centre users interviewed as part of this research provided a basis for exploring the institutional paradoxes they experience on a daily basis. What I found is that they appear to be aware of certain contradictions in how the institution performs its roles and duties and in the resources that it deploys. To that extent, their accounts converge with those of the group of professionals and feed into the debate surrounding the element of constraint related to institutional domination and subjection, however much the institution is meant (and claims) to contribute to empowerment. Two examples taken from the discussions held during the group interviews will serve to illustrate the institutional paradox and, therefore, to show how deinstitutionalisation is not an impediment-free process.

The first example is the “control” exerted over food and obesity, which I evoked when discussing the views of the professionals involved in the practice analysis group. I use the somewhat controversial term control deliberately because, in my view, it crystallises a feeling (or possibly a fantasy) widely shared among the users who attended the group. Indeed, most of them had something to say about the consultations with the nutritionist and dietician based at the institution. One recurring claim, and one around which a “revolt” appeared to emerge against the centre, reveals the element of constraint associated with the consultations. One of the members of the group reported that users are required to have an annual consultation with the nutritionist. Once again, the point is not to determine whether such a claim is true (I also know the nutritionist in question holds patient education
sessions as part of an attempt to improve users’ knowledge of nutrition to encourage greater personal responsibility and therefore, ultimately, empowerment), but to understand that it reveals something about the fantasmatic world surrounding attendance of the centre by users. My findings indicate that they appear to experience certain practices as obligations. One of the members qualified the claim by saying that users are free not to attend consultations, but he was quickly told: “educators book appointments for you to see your nutritionist. The educators make a point of it [booking the appointments] during their working hours, so if you don’t turn up it doesn’t look great”. What transpires here is a degree of pressure exerted on users by the educators, who are no doubt keen to comply with guidelines and, alongside that, a process of superego integration of the need not to disappoint or oppose the work of the educators. While the obligation is external (in the sense that the institution, through the medium of the educators, arranges consultations that then become more or less mandatory), it is also internalised. The obligation is thus co-constructed, and we see that any process of user empowerment must involve, for users, a process of psychological permission in relation to the obligation, which then reflects back on their own superego controls. For example, one user spoke of how beneficial it was for her to receive nutritional advice, explaining that she did not feel capable, by herself, of sticking to a healthy diet. The daily menus she gets enable her to self-regulate her diet. This process of regulation appears to be impossible without the mediation of the institution. The same user also reported that she felt incapable of resisting her husband, who encouraged her to eat unhealthy foods. In other words, she disqualifies herself as a subject capable of moderation to further entrench the intervention of the institution upon which she remains dependent, despite not being a resident of the centre. This is where we see the extent to which deinstitutionalisation is not a question of knocking down walls or of openness. Beyond herself, this particular user has internalised the institution as

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19 We recall, however, that these very same educators, also when discussing the question of eating and obesity during the practice analysis groups, reported that they struggled with what they perceived to be injunctions of the institution and with translating these injunctions into daily supervision and even repression of certain eating behaviours at breakfast. These practices also represent a “constraint” for the professionals since they lie at the root of deep value conflicts between the establishment’s general policy and the ethics of educational work, with the emancipation of subjects being, for many professionals, the ideal to strive for.
a tutelary power exercising control over her, which she calls on when it is a matter of resisting the pressure exerted on her by her husband, who has little regard for the healthy eating advice given by the nutritionist. The account provided by this user (let us call her Claire) also shows just how much the institution tends to be fantasised by users as a world of containment and protection. Recounting her experience of the world of work, Claire showed how much her weight problems, coupled with weak ankles and her mental health problems (she stated that she was bipolar) make life outside the centre difficult: the world of ‘ordinary’ work is too violent and, without if the institution did not help her to manage “the highs and lows”, i.e. the moments of exaltation and profound depression associated with her condition, she would be constantly in and out of a psychiatric unit, in reference to which she described restraint and medication practices that disgusted her. In other words, she contrasts an outside threat that poses a risk to her health, her dignity and her freedom against an interior (the institution) that enables her to contain herself (by controlling her mood swings thanks to the psychologist and her weight thanks to the nutritionist) and protects her. She emphasised the need to maintain her ties with the centre, describing, in a reversal of common representations, ordinary society as dangerous and incapable of recognising her specific needs. To break her ties with the institution on the grounds that we deem it be to inherently bad for her, and indeed for all vulnerable people, would be to place her entirely in the hands of the community, which is to run the risk of marginalising her far more than she is currently. I suggest that such a profile is not uncommon among users.

A part of the group recognised their own experience in Claire’s account. It is precisely in relation to that kind of experience that the specialist French literature devoted to the subject of disability has come to express its distrust of deinstitutionalisation in the sense of a return, for the most vulnerable in our society, to schools and other “open” services incapable of taking into account their specific needs (Weibo, 2012). Weibo also notes, against the grain of the current prevailing view, that places “of special education must be spaces from which social participation must be driven” (translated) when a policy of inclusion by any means possible in a supposedly inclusive but
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‘ordinary’ environment ill-adapted to difference “can lead to even more radical exclusion” (translated from Weibo, 2012, p. 221).

To summarise, I suggest that the sense that some people with disabilities have of their own vulnerability and the fantasy that posits that the outside world will make them even more vulnerable (is there not an element of truth in that?) represent, among users, barriers to deinstitutionalisation as laid out in certain European texts and invite us to develop a finer understanding of the resulting fantasmat. Doing so also commits us to re-defining what good deinstitutionalisation practice might amount to: in my view, the point is not to call for the destruction of institutional walls (in the name of a violation of the rights of persons with disabilities) so much as to take a systematic approach to the needs of users in terms of autonomy of thought and psychological permission to think for themselves; in short: to support them in destroying the “walls in their minds” that constitute barriers to the construction of their autonomous life. Claire’s account, combined with others’, also suggests to me that what we improperly call deinstitutionalisation also requires society to work on itself to ensure it is capable of welcoming and integrating that which it rejects or marginalises. One of the members of the group noted that, without the centre, he would have ended up “on the street”.

Let us consider a second example of institutional paradox: the question of complying with schedules among residents of the Gabrielle Centre. Several members of the group spoke of restrictions in terms of individual freedom that contradict the institutional discourse on autonomy. One young man appeared frustrated at having to return to the centre at a fixed time every evening during the week and at weekends, adding that he is required to return earlier Monday to Friday. Two questions come to mind. First, why are residents, who are allowed to go “into town”, required to return at specific times? The answer to this question is, in all likelihood, connected to the responsibility of the Gabrielle Centre towards many of its residents under curatorship. The requirement to comply with schedules is also inherent to all institutions, enabling the organisation of shift handovers (for example). This is a typical example of the
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production of a constraint by the institutional system itself. The second question is this: why impose different times on weekdays and at weekends? In my view, the difference is indicative of the continuing weight of a hygienist dimension in educational practices, a fact also illustrated by the consultations with the nutritionist. The point is to ensure that on week days – that is, when the day is spent working – residents “benefit” from a sufficient quota of waking hours, while, on Saturday evenings, they can stay up later. The institution and its role in regulating the daily lives of residents stands in for the educational role of families and maintains residents in a position of disempowering marginality at complete odds with the ideals of deinstitutionalisation and the vital empowerment of thought I spoke about earlier. The same resident ended his account by noting that when he is “outside”, he is required to ensure his phone is switched on at all times, giving him the feeling of being watched. He then referred to the work of the night “guards” who “walk around with a torch”. A sense of unease then runs through the group; the image is an unpleasant one because it is a reminder of all the clichés surrounding the Goffmanian total institution. The sociologist was pointing to the security role performed by asylum nurses. The term was immediately corrected by the professional – a manager – present in the group: as she put, they are, in fact, “night watchmen”. So, watching rather than guarding. The nuance is not insignificant. It is important to delve deeper into this “critical” moment in the group in that it reveals a tendency to control the resident population. A conversation full of barbed remarques then ensued between the manager and the resident, Pierre, who said:

“When you're in a home you have to be in your bedroom by 10 p.m. The night watchman either stays in his office or he walks around with his torch. He goes round the house to check no one’s missing. At the home, if I go out and and I’m not back by 10 p.m., they call the cops”.

To which the professional responded:

“That’s a bit of an exaggeration. First, we call them on their mobile, if we can’t get hold of them, we leave it for a bit. If it’s someone who’s not very
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autonomous, we’ll be more concerned and we’ll ramp things up a bit. It depends on who it is and eventually we tell the police that someone who should be here isn’t here”

The exchange requires an analysis at two levels: Pierre’s experience and the tone of Karine’s response (Karine being the professional) to Pierre, and indeed all of Karine’s interventions in the rest of this collective interview.

The conflict between Pierre and Karine is rooted, in all likelihood, in her inability to understand the symbolic and fantasmatic element in Pierre’s account: Pierre is not talking about the “pure reality” of how the centre operates, particularly at night. To try to put him right is pointless. What he is discussing is how he interprets how the centre operates, and it is this interpretation, shot through with representations, perceptions and fantasises, that constitutes his psychological reality, which needs to be heard and understood, forming, as it does, an inalienable subjective experience that needs to be met with respect and consideration. Through his language and tone, Pierre evokes a world of control and deprivation of freedom: adherence to schedules, the feeling of being watched (and not protected), the tie created by the mobile phone and the reliance on the “cops” are all barriers to his freedom. His description of the night watchman’s work is enlightening: he does not say that his role is to ensure residents’ health or safety (despite it being one of the duties of the night watchmen); rather, he “checks” that no one is missing, as if his role is to ensure compliance with a curfew. In Pierre’s mind, in the fantasmatic world he has constructed around his presence at the centre, the price to pay to live in a home within the Gabrielle Centre is to be supervised and to be deprived of part of his freedom. His account calls for a detailed analysis of the symbolic significance and impact of the operation of the institution for residents, alongside an assessment of certain practices that may warrant a shared patient/institution reflection. **Would creating spaces for debate around certain professional gestures that cause such violent fantasmatic echoes among certain users not be a useful practice?**
Let us now consider Karine’s response and her interventions in the rest of the debate. Besides the fact that she responds “to the letter”, which is unlikely to help assuage Pierre’s feeling of being watched and controlled, Karine justified the institution’s practices by arguing that they are calibrated to match the greater or lesser autonomy of users. She speaks of concern. The correlation between the two terms (limited autonomy = quick concern) evoked in me a sense of maternal concern, which would have been appropriate if we were not talking about adults. What this reveals, in my view, is a persistent representation among professionals working within the institution of users with mental or intellectual disabilities as eternal children causing concern in their parents because of their immaturity and who need to be watched like a hawk. A number of details in the ensuing exchanges serve to corroborate my impression: users referred to the greater or lesser ability to have access to and spent their money (I wonder if they mean “pocket money”? ) or to presence of mixed bedrooms in certain parts of the institution. The conversations, their tone and the irritation they caused (see below) suggest that certain fundamental freedoms (being able to use one’s money as one pleases, enjoying a sex life that is clandestine but which is allowed to remain secret) are experienced by users as lessened by the Centre. A parent-child type domination relation was introduced by the rhetoric of autonomy used by Karine, who confused autonomy as the capital available to users and on the basis of which certain freedoms can be granted, and empowerment, as the long-term process that needs to be supported by creating spaces of freedom.

Pierre’s intervention unquestionable caused unease within the group, with the participants speaking more freely after him. One user of around twenty said:

“I live in the flats. We do our own shopping, we prepare our own meals. We don’t eat in the cantine, except at lunch time. Every Wednesday, it’s housework day. You have to do it because I don’t want to live in shit. Having said that, what’s annoying is the educators, you get the feeling we’ve got a lead up our arse (sic). They’re always on our back telling us ‘do this, don’t do that’, so I end up losing it, and tell them to piss off. I’m
We see in this passage a fundamental misunderstanding: this young man claims to be capable of a lot, and even of almost everything, since he and his fellow residents prepare their meals independently. However, they continued to be subjected to the educators and to the tyranny of their instructions (“do this, don’t do that”): while he sees himself as being autonomous, the educators do not acknowledge that autonomy, which he will therefore need to conquer by leaving. What better description might there be of the power of a dominant/dominated relation constructed on the basis of an imitation of parent/child family relations? Indeed, Karine unconsciously interpreted the intervention, which came after Pierre’s, as an attack and even a rebellion, going on, in the rest of the interview, to direct repeated acts of symbolic violence against the users, imposing her status as adult and manager of the institution: she first asks one of the residents to speak up, she then asks another resident to be quiet, she sighs, etc., thus also forgetting my role as moderator of the discussions and indeed the purpose of the group interview, which is not to right wrongs or to correct what the users say. In short, she goes from being a simple witness to being an educator, listening, admonishing and thus embodying the sense of irrevocable asymmetry between herself (and therefore the professionals) and the users.

While deinstitutionalisation cannot result from the tearing down of walls, it must, by contrast, involve the abolition of the parentalised relations of domination between those who are in a position to educate and those in a position to be educated despite being seen, by some, as being ineducable... This crisis, though short in its duration, remains illustrative of a possible perversion possible imbalance of the relationship between the institution and its users.
The height of negativity of the two talking groups is mirrored by the height of positivity found in a double intervention that began in the first session and was completed in the second. The intervention in question provides an insight into the kind of relationship that the persons with disabilities attending the Gabrielle Centre actually want, but it also provides a basis for seeing just how united they are in their view that the institution must continue and must continue to meet their needs.

The user in question is a young man I will call Mike. From the outset, Mike stated (and showed during the two talking group sessions) that he “likes” the Centre. What in his account does he associate with this sense of satisfaction? In my view, what Mike recounted is his journey on the road to achieving balance: he is involved in at least as many activities within the Centre as he is outside the centre. As a clinical researcher, I was particularly touched (and even moved) by the mental fluidity and the joy exhibited by Mike who, unlike more vulnerable users, saw no conflict between a protective inside and a dangerous outside. The absence of any such conflict in his discourse is indicative of his capacity to construct, to use a Winnicottian concept, a sense of continuity of being20 between the different spaces he frequents: the ESAT workshops after the IME services when he was younger, the apprentice training centre he travels to everyday to learn his job, not to mention the places outside the institution where he exercises and lives. As Jan Abram, a Winnicott specialist, writes, the sense of continuity of being is “the experience of a holding environment from the very outset of life”, which gradually enables us to “live creatively” and to “play” (translated from Abram, 2001, p. 149). Winnicott argues that the sense of continuity of being derives directly from the care of a good

20 There have been several different translations of “continuity of being” in French: Houzel refers to the “sentiment de continuité d’existence” (“sense of continuity of being”), while the reference book-length study in the field, Le Langage de Winnicott (Jan Abram), speaks of the “sentiment continu d’exister” (“continuous sense of being”).
enough “mother” (or environment) that enables the baby and later the child to evolve from a situation of absolute one maternal care to independence. Independence is acquired, Winnicott argues, when the environment no longer encroaches on the child’s mental experience.

Here I want to emphasis the heuristic potential of the Winnicottian concept for reflecting, through the experience of Mike, on what a good enough institution might be: indeed, we need not extend the maternal metaphor any further to understand the mothering role performed by the institution in relation to its users. I have already underlined its power in fantasies and representations of some professionals. What the metaphor does is to invite us to see the institution as the space where the subject, made vulnerable by his disability, experiences his relation of dependence on the environment and, even more so, gradually experiences, through the work of education (or culture, as Freud would put it) of which he is the recipient and through the support provided to him, a gradual process of empowerment at the end of which he is able to feel independent and to continue to exist. A good enough institution is one that enables a subject with disability to experience stability in such a way that he is able, to quote Houzel, “to arrive at representations of sufficiently stable representations of himself, of others and of the world around him” (translated from Houzel, 2016, p. 119). Institutionalisation is not the pathogenic maintenance of eternal relations of dependence legitimised by a fixation of the impairments of users; it is the fact of providing a subject with an opportunity to experience themselves as a subject, as a creative subject limited like any other, a subject connected to other subjects.

The positive role of the institution in this regard is clearly described by Mike, who told of how he was given the opportunity to transmit the knowledge and skills he had developed to the ESAT “interns” who had not yet acquired them. He was given an opportunity to be creative. The pride he expressed at that point in his story is a clear indication of the positive value of such an experience. Mike told us about a journey – a journey from dependence to
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Autonomy enabling him to say that he no longer needs the Gabrielle Centre (“I have nothing more to learn from the ESAT”) and to express his desire to work in a mainstream setting. And he too used the same word as Pierre: he will now feel less “watched”. We see just how much the term is a signifier common to all users, crystallising their painful experience of dependence on their environment. Mike’s account is valuable in that it shows that empowerment is a radical break away from these relations of dependence, but a gradual “de-encroaching”, a process in which the work of the institution is to support users in constructing an image of themselves as capable subjects and, in particular, as capable of growth and development.

Support, which is neither a form of control nor a letting-go, must lie at the very heart of the work of professionals. That it precisely what the two talking groups demonstrate. Users expressed their need for support and their fear of dependence. Therefore, the job of the institution is to find, for each user, and in a way that respects singularities, the right distance upon which to base educational work: supporting without dominating, recognising in the other not an irremediable disability but a desiring subject.
Conclusion
How else to conclude but by proposing what amounts to a personal definition of deinstitutionalisation – a definition arrived at on the basis of the experience of conducting research within a specific institution, the Gabrielle Centre?

But first, I will summarise the main learnings of this work. In this report, my aim was to show:

- That current recommendations in the area of deinstitutionalisation have been developed from the standpoint of a black legend of the institution that gives little credit to the social work carried out by institutions in France for decades.
- That deinstitutionalisation is a political and ideological project promoted by international bodies (UN, EU, etc.) that it embeds in a society that strives to be inclusive, inherently liberal and committed to reasserting the universality of human rights.
- That deinstitutionalisation promotes a “geographical” or topological approach to inclusion in ordinary society (Ployé, 2016), according to which the rights of persons with disabilities are better respected outside institutions as they currently exist rather than within them.
- That deinstitutionalisation, driven by Anglo-American and English-language currents of thought, contains within it a deep misunderstanding about the meaning of the term “institution” in French, confusing it with the term “establishment” (in the sense of an individual, i.e. discrete and physically embodied, institution). The result is the negation of the instituting function of institutions which, in the French tradition, consists in instituting free subjects capable of self-determination as part of the republican project.
- That deinstitutionalisation is a subject of concern among professionals working at the Gabrielle Centre, who may, on the one hand, subscribe ideologically to the goals of deinstitutionalisation, but also, on the other hand, betray representations of disability in their discourse that hamper the process of user empowerment.
- That while users refer unequivocally to the continued existence of relations of dependence and even domination at the heart of the institution, the violence of
which they bemoan, they also underline their need for an institution; what their experience implicitly reveals is that the theoretical and ideological dichotomy between an alienating institution and emancipatory ordinary society (the core framework of the discourse of deinstitutionalisation) does not hold up to the test of reality: ordinary society can inflict very powerful acts of symbolic violence on persons with disabilities, whether in the form of exclusion, social discredit or humiliation (to name but a few).

Given these various elements, I propose to argue that the definition of deinstitutionalisation needs to go beyond easy oppositions between the inside and the outside, the closed and the open, or liberal inclusiveness and totalitarian imprisonment. Rather, it needs to be defined as a new anthropological perspective in which disability is no longer seen from the point of view of the deficiencies, defects and other failings posited by the defectological approach, but from the perspective of the universality of human vulnerability. In social work, deinstitutionalisation must involve a displacement or movement of the gaze or perspective: the other, the other to be educated, is no longer to be viewed from the sole and reductive angle of a disability. A synecdochic approach such as this closes the world of persons with disabilities and prevents any development. The other must be seen, first and foremost, as a subject – that is, as a being endowed with speech, language (however difficult) and even desire. What is needed, therefore, is to see social work as a means of supporting subjects in their ability to speak and express themselves – and, in particular, to express their desires. In a sense, deinstitutionalisation, as it is capable of being implemented in France and at the present time, in a sociocultural context dissimilar to other countries, is, first and foremost, an ambition to see the subject as a subject first and not as a disability first and, therefore, to promote the full range of practices that will serve to re-include the other in the circle of fellow beings. Beyond deficiencies, the other is a subject who, like the educator, speaks and desires – a subject who must be recognised as such and as having that status – a status that is neither specific nor special, but is the status of us all. Before anything else, deinstitutionalisation must be an ethics of the subject.
To conclude, I propose to summarise the main arguments put forward throughout this report.

In the case of professionals and the institution:

1. Focusing on its staff, particularly those involved in providing daily care and support to people with disabilities, an initial work stream for the institution would be to mobilise the resources necessary to assure them that their professionalism and the ideals of deinstitutionalisation, as I have defined them here (support for autonomy, recognition of the other as a subject) are compatible and feed into each other. In their experience of everyday work, professionals must be made to feel that the institution wants and is able to see their actions not in terms of resistance to change but as being geared towards concerted change.

2. A second work stream would involve creating mediations and professional spaces in which professionals are able to continue developing their fantasmatic world that is constantly being mobilised in the encounter with the evocative power of intellectual and mental disability. Transforming silenced or repressed fantasies that nonetheless exert considerable power by contributing to the rejection of persons with disabilities as being ineducable and even inhuman through discourse and language is a major process of psychical working out. We may reasonably expect such work to appease the internal conflicts of professionals, thereby making them better able to see a person with a disability as a fellow human being, a brother in a position of vulnerability. More pragmatically, it is important to provide a space in which to debate the dilemmas of everyday life. When these are denied or prevented from being expressed, they result in a paralysis of thought and a protocolisation of action that undermines the capacity to adapt to the needs of users.

3. To address these various points, the return (or reinvigoration) of clinical analysis groups dedicated to inter-service professional practice seems necessary for two reasons: they allow for the creation of a space for articulating the experience and fantasies of professionals (articulation =
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detachment) and enable perspectives and practices to be brought together in such a way as to maintain a lasting and consistent institutional culture that goes beyond any division between the “base” (the “field”) and senior management.

4. To ensure the project of deinstitutionalisation is no longer fantasised as an injunction of a tyrannical institutional superego, we need to work, through dialogue, inter-agency work and inter-category work, towards creating a “shared culture” of deinstitutionalisation. In that sense, the creation of deinstitutionalisation days during which professionals, users and families of users can work together around the subject is a commendable initiative. It is important to note that the Gabrielle Centre itself developed the idea of holding such days and that it is currently taking steps to put them in place.

In the case of users:

1. It seems to me necessary to strengthen all the actions that enable user autonomy to be thought of not as a limited stock to which freedoms, which are themselves limited, are then granted, but rather as a process – empowerment – accompanied by strategies to make people responsible for their own actions.

2. Users must be listened to when expressing their needs. One such need – a need perfectly consistent with deinstitutionalisation – is to be able to develop their own place within the institution, beyond the usual binary oppositions of dominant/dominated, supervised/supervisee and parenting educators/forever infantilised disabled people.

3. Users can struggle to see themselves as competent and capable of making the right decisions for themselves. It seems necessary, therefore, to develop initiatives through which they can both mobilise certain skills they have developed and put them to good use among their peers. That is precisely the purpose and direction of the action I propose as part of the Erasmus + ILLICO project: to make users the agents of their own empowerment process, in the context of an institution that recognises them as experts.
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