Making people autonomous: a sociological analysis of the uses of contracts and projects in the psychiatric care institutions

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Abstract:
This article aims at describing the tensions arising from working on and with someone in psychiatry, in order to make this person more "autonomous". First, through the example of the recovery, it acknowledges, the normative horizon of what is considered today as "good care": a negotiation between partners, aiming at increasing the possibilities for everyone to follow their own lifestyle. It then seeks to describe how this definition of good care is endorsed and applied in two institutions (in Belgium and in France) hosting people with severe mental health issues where the care teams are using three words ("contract", "project" and "autonomy"). The article analyses the difficulties encountered while putting into practice these demanding ideals and shows how and to what end the care teams take action in defining the "good" projects and, in a more general way, what patients can or should expect from themselves and from their future.

1. Introduction

> *In a French institution where people with mental health issues are treated, a meeting (called partner meeting) is organized on a monthly basis and supervised by a systemic therapist[1]; it includes a patient[2], the referents of this person in the care team of the institution (psychiatrist, social worker, educator…) and a certain number of people, who are important to this person (friends, family, social and medical actors…). After a few minutes of din, the systemic therapist starts the meeting by directly asking the patient: "So, Mrs. X, how are you doing since last time?". The patient is taken aback by this trivial question and mumbles in a moment of attentive silence from the twelve participants: "How am I doing? That's what you're asking? Well, I am doing fine, I don't know, it's not up to me to say this, I think". Then the patient turns to her referent psychiatrist from the institution and says: "It's up to you to answer that question, I think. So how am I doing ? ".*

The worlds of mental health are social mechanisms in which we can observe people (the caregivers) take some action on others (the patients, residents, clients) who have been more or less driven (if not forced) to share decisions which should ultimately come back to them according to social norms and

[1] Systemic psychotherapy implies working not at the level of the individual, but at the level of the relational system in which the patient evolves.

[2] In this article, people being treated for mental health issues and staying in institutions, where the fieldwork has been done, will be called "patient" or "resident" to apply the indigenous terms used within the institutions where the study was done. This designation is in no way a value judgement.

expectations : choosing where to live and with whom, organizing the day but also knowing what is good for you or plainly "how you are doing", "how you have been", as in the above quoted extract[3].

The social sciences literature about psychiatry has been focused on this specificity for a while, first from the perspective of power relationships, constraint, social control and domination of a (group of) individual(s) (Sharp (1975), Goffman (2017) or Foucault (2014)), then from the perspective of negotiated orders (Strauss *et al*, 1964, Ogien 1989) and negotiation process, especially about what is "good care" (Pols, 2003), or the "orchestration" of the autonomy of the patient (Bloor, 1986).

1.1. Mental healthcare in the context of the "autonomy as a condition"

In the moral context of societies with "autonomy as a condition" (Ehrenberg, 2010), working on (and potentially with) someone is no trivial activity. This context is characterized by the value given to the individual autonomy (which is both a right and a duty for individuals) on one side and on the other side by the presupposition that each person, whatever the age or the condition, has a capacity to be autonomous, even if it may be temporarily impeached (it is the ideal of the hidden potential – see Ehrenberg, 2018, Marquis, 2014). This configuration creates controversies about what is "good care" in mental health, and about the legitimate and non-legitimate, acceptable or non-acceptable forms of the patient-caregiver relationship.

The general trend of this reconfiguration is that a care relationship which is too asymmetric (Delmar, 2012) seems today less legitimate. In particular, the practice of any form of constraint applied to a patient becomes much more problematic than it was, at least theoretically. This primarily concerns the different types of physical constraint practices (solitary confinement, restraint, drugs), but also, on a larger scale, the more varied and less visible forms of suggestions or coercions, that may invite the patient to consider specific therapeutic solutions or lifestyles as more desirable than others.

The search for a care relationship that is as symmetric as possible is legitimized on a therapeutic side as well as on a moral side. On the therapeutic side, it is expected that putting the individual at the center of his/her care, in an active position (or, at least, getting his/her consent) will make the care more efficient and the outcome – that is allowing and training the person with mental health issues to operate (again) in the society – more relevant. Examples of this trend can be found in field actors' and scholars' growing interest for the incorporation of a "shared decision-making" process in the relation between the patient and the caregiver (Hamann et al, 2003; Adams et al., 2007). More generally, a "client-centered care" approach is considered much more effective: "efforts to enhance patient-centered communication and promote clients' active involvement in mental health treatment decisions can improve outcomes, including engagement in treatment" (Krevenbuhl et al., 2009: 699). On the moral side, the creation of a less unequal relationship possible between the caregivers and the patients is in line with the social representations which value the autonomy and the possibility for everyone to be able and to have to decide ultimately what is good for him/her. As Drake and Deegan (2015: 1007) express it, "It is time to take the high road and heed the ethical imperative upon which the practice of shared decision-making rests: autonomous adults have the right to determine what happens to their bodies and minds".

In the English-speaking world, the social movement of psychiatry survivors (Crossley and Crossley, 2001, Crossley, 2006, Morrison, 2013) has, among others, criticized for a long time the forms of unequal relationships. In the last three decades, the Voice-hearers movement (see the seminal article of Romme and Escher, 1989), has also advocated for a better acknowledgment of the ability of people

[3] The author would like to sincerely thank the two anonymous reviewers of *Culture, medicine and psychiatry* as well as Nicolas Henckes for their useful comments on previous versions of this paper.

hearing voices to cope with it. Voices should not be considered anymore as a symptom of schizophrenia to be suppressed, but as a personal feature with which patient and caregivers should work (Coleman, Smith, 2002). These topics appeared more recently in the public discussion in French-speaking Europe (France, Belgium, Switzerland[4]). But the idea of a (more) equal relationship between caregivers and patients is growing there too. Above all, it is from now on not exclusively supported by associations of patients, relatives, or other social actors in an advocacy perspective. It is gradually becoming a criterion which is integrated and defended by actors of the professional caregiving environments themselves.

The *recovery* perspective, which draws on studies demonstrating that the course of severe mental illness is not an inevitable deterioration as well as on several first-person accounts by people with mental illness who managed to cope or recover (Jacobson, Greenley, 2001 : 482), has tried to implement in the psychiatric practice the idea of working *with* the patient rather than *on* the patient (Davidson *and al*., 2009). In the French-speaking Europe, the increasing importance of this perspective, set itself into the trend of psycho-social rehabilitation (Massé, 2006), exemplifies this logic very clearly and shows how the therapeutic and moral justifications are combined. As A. Ehrenberg (2018: 85) puts it, "recovery is the key concept of the care of the psychotic subject in the city as well as the concept by which he/she *emancipates him/herself as an individual*, the reference which makes him/her become a moral and social partner. The recovered patient is a capable patient, meaning that he/she may have symptoms, but he/she can take the responsibility of his/her life at some level and under variable forms."

Proponents of this view see recovery as a "paradigmatic shift in mental health care" (Pachoud, 2018), and vow to transform the relationship they have with their patients into a relationship of co-construction, of partnership, or even as a contract, where the patient is a partner and an actor of his/her care. As a "first-person perspective", which seeks independence from the medical model, recovery aims at overcoming the sick/cured antagonism in a context of chronicity for numerous pathologies, where the question is not to live beyond the illness but to live with it or maybe even *thanks to* it, as in the resilience perspective (Marquis, 2018). Here also the therapeutic and moral sides are dually linked: first by the consideration that efficient care, essentially defined as *progress*, is always possible ; then by the idea that the efficiency measurement of the care consists in gradually giving back to the patient the control of the different parts of his/her life, so that he/she can choose a form of life in which he/she has defined a maximum of parameters and which matches his/her expectations. As Bernard Pachoud, one of the main advocates of this movement in France, defines it : "recovery is less considered as a goal, a desirable or ideal final stage of which it remains to establish and promote the ways to achieve it, than an approach, a process in which what is important is to commit to progress" (Pachoud, 2012: 259). The perspective of the recovery is thus building a practical anthropology of the patient, i.e. a particular way of representing a patient so as to define what kind of care should be applied to her/him (see Marquis, 2014: 153). The main features of this practical anthropology are first that it is progressive instead of binary (autonomy is not present or absent, but a matter of levels); second that it is democratic instead of elitist (nobody is excluded from the opportunity to progress, even in the slightest way); and third that the focal point of good care (and thus the definition of a life worth living it) is not only health but "the re-engagement into a work life, the optimization of the daily life and social life conditions" (Pachoud, 2012: 258).

[4] Even if the movements of the institutional psychotherapy are advocating such ideas for a while (cf. Clinique de La Borde, etc.), their perspective mainly stayed dissenting.

1.2. The ends and the means: a (theoretical) division of labour between patients and caregivers

This search for a more symmetrical care relationship as well as the recovery movement and the practical anthropology of the patient it develops fall within a new way to address the mental pathology, which, in the French-speaking world, refers more and more frequently to the disability category (Sicot, 2006, Lovell *et al.*, 2009), precisely at a moment of change in the way (mental) disability is perceived.

The understanding of the mental illness from the disability category leads to a shift of the attention from the nature of the illness to its consequences in terms of (loss of) activity and autonomy, especially in the day-to-day life (Ehrenberg, 2005). In France, the law from February 11th 2005 hereby describes the situation of psychic disability as an "extended or occasional situation of difficulties in the completion of domestic, social and civic activities in a given environment and due to a persistent or durable health problem, linked to […] a development disorder or a mental illness." The functional consequences of the illness can then be assessed with scales (for example the GAF – *Global assessment of functioning* – from the DSM, or other measurement instruments such as the WHO-DAS II – *Disability assessment scale* of the World Health Organization – and the LIFE-H – *Assessment of life habits* – scales), and the actions therefore focused on the restoration of the life conditions.

This shift takes place at a particular moment. The recent passing of the Convention on the Rights of Persons with Disabilities by the UN in 2006 also marks another transition: from a substantial conception to an ecological and relativist conception of the disability (Ravaud and Stiker, 2000), which changes the nature of the disability by not making it an inherent characteristic of the individual but a consequence of a maladjustment to the environment, creating a "disabling" situation (Blanc, 2012). In this perspective, the care work towards the people in this situation of (psychic) disability has to be above all a work of support in order to allow these people to make decisions which concern them, to develop their abilities, and to give them tools to assess the necessary means to pursue their goals.

An interesting consequence of this double evolution is that it tends to organize in the care relationship a division of tasks and responsibilities between the caregiver and the care receiver which should theoretically allow to avoid any form of constraint, coercion or suggestion – not only physical, but also moral – by forestalling any situation where a caregiver would define for a patient, if not despite this person, what would be good for him/her[5]. This division can be synthetized as follows: the person concerned defines his/her *ends* and goals and the care or support team decides the implementation of the *means*[6].

The hypothesis on which is based this article is that this division of tasks and responsibilities constitutes the normative horizon regarding which good care is thought through and assessed. This division of tasks is expected to lead to the disappearance of the asymmetric relation in which decisions are made by someone on behalf of someone else and its substitution by a partnership in which the decision is shared. It should also substitute the vertical relationship of care for a horizontal relationship of support and coaching. It should finally avoid the enforcement of standardized solutions to prefer the encouragement for everyone to create their own solution and their own lifestyle. In this perspective, the institutions for mental health care are places where a specific work is practiced: to allow individuals

[5] For a very clear example of this consequence, see the way the CRPD was included into the Brussels law, in the decree "Inclusion" (Marquis, 2015).

[6] The role of the caregivers can maybe include helping with formalizing decisions to be made (what do I *really* want to do?) and assessing these decisions (what are the conditions to make it happen?), with tools such as the CASIG (Client Assessment of Strengths Interests and Goals) scale, for example.

to adjust means to their ends, which are supposed to be defined independently (beforehand) and formalized into a project, to make them more and more capable than they are now without reducing them to a label, and by allowing them to create the *lifestyle* they want and need.

Far from being just an abstract perspective, this normative horizon is embodied in very concrete aspects of the relationship between caregivers and care receivers. Promoting patients' *autonomy* and ability to intervene in their own care, avoiding any form of constraint, transferring responsibility of its own well-being to the patient him/herself through the development of a *personal project*, establishing between patients and team members *contracts* which are to be understood by both parties are very common examples of attempts to implement this division of tasks. All of these attempts suppose, in a way or another, to *involve* the patient in its own care. Yet, even when caregivers emphasize their support to this normative horizon and try to translate it into practice through such devices and attitudes, this division of tasks seems extremely complicated to apply. I would like now to show how and why by studying concrete attempts in two psychiatric institutions.

1.3. Methodology and structure

The following analyses are based on an ethnographic study made in two institutions which treat people with severe mental issues, where I spent about a year doing fieldwork. I also interviewed each time about thirty patients/residents and about fifteen care team members. Observations and interviews required the obtention of the (written) consent of the institutions' respective administrative and medical boards, as well as of patients implied in both methodologies. Participants always had the right to refuse being observed or interviewed, or to stop their involvement in the research process at any moment. This process as well as the ethical protocols were approved by two institutional review boards[7].

The main goal of such a qualitative investigation is, as Barrett writes it, the understanding of "the way people interpret and make sense of their world" (1996: 7). I thus would like to show now how and why this normative horizon and the division of tasks that embodies it are extremely present in both institutions, but also to highlight the tensions they create. First, I will describe the characteristics of these two institutions and will explain in what way they make two interesting cases, completing other studies already done. Then, I would like to show how the caregivers who are working there, share this normative horizon and try to implement the division of tasks by *involving the patients* in their own care. Three indicators will support this demonstration. First, the will from the caregivers to avoid constraint and inequalities in the care relationship with patients and to favor a collaboration, a partnership, a contract. Secondly, the hyperpresence of the "project" category. Thirdly the promotion and the assessment of the patient's autonomy.

"Contract" (or collaboration and partnership), "project" and "autonomy": these indigenous terms and their daily and performative uses define the normative space from which the "good care" is thought through and applied, being seen as respectful and efficient. However, I will show how the application of these principles on each of these points creates difficulties if not failures: the caregivers create forms of constraints precisely while trying to avoid them, intervene themselves on the goals pursued by the patients and seek to have patients internalize a wish for autonomy. The division of tasks between patients (only responsible of their ends) and caregivers (sharing with the patients the planning of the means) is not really applied. The conclusion finally discusses the reasons why this application may simply not be sustainable.

[7] Comité d'Evaluation Ethique de l'INSERM (IRB00003888, n° 15-268, France) and Comité d'Ethique Hospitalo-Facultaire (CEHF) UCL-Saint-Luc (IRB00001530, 2016/10FEV/046, Belgium).

2. Studying language games in two care institutions for people with severe mental health issues

This study was carried out in two institutions which, despite some differences, undergo the same tensions linked to the work of remaking a daily life in order to give the individuals “more autonomy”, because they share several structural characteristics.

The first institution is a therapeutic community set in the French-speaking part of Belgium. It has 18 beds for adult patients, who are called “residents”, and who may stay for a maximum of 2 years. Inspired by the principles of institutional psychotherapy (Oury, 2001), the care team and the residents, who are not distinguished by their physical appearance, are living in the community every day. They eat together and share household maintenance tasks (however only the residents are staying overnight). It defines the following objectives in its therapeutic project:

> *[extract from the therapeutic project] “the objective of the non-profit association "La communauté" is to ensure the welcome, the treatment and the social reintegration of adults and young adults suffering from psychiatric pathologies. […The community is] an experimentation field to try something new, an institutional place able to mobilize the creative potential, generate a stimulation and provide a “revival” of responsibility and autonomy; which enables then the repossession of a position in the social world. […] By trying to give a short-term treatment (2 years maximum), it is about helping people with a psychiatric issue to reach a personal “better-being” and to regain a satisfying social life”.*

The second facility is a psychiatric institution situated in the Ile-de-France region, nearby Paris. It has 65 beds for "patients" considered to be in a therapeutic or institutional dead end. In theory, the patients may stay for a maximum of 6 months. These patients are often coming from other institutions, which encounter difficulties in coping with them. Inspired by the systemic principles following which therapists should act on a system of relations rather than on individuals, this institution aims, via a stay of “break”, at resetting the connections between the patient, his/her caregivers and his/her relatives, including by organizing “partner meetings” where the patient actively participates:

> *[extract from the website] “It is a simple idea: break away from the usual care focused on the patient and his/her issues to mobilize the resources provided by the interactions between the patient and his/her environment. [… The institution] will propose to the clinicians and the caregivers, to the closed ones and the relatives, to come and share their perspectives about the situation.”*

The two institutions are dealing with quite similar patients, because of their quite similar diagnoses (severe psychotic illnesses, spectrum of psychosis) but also because of their comparable career (Goffman, 2017): most of them already have a quite long career in psychiatry (despite their young age), made of hospitalizations, going back home, times being homeless, or previous stays in other institutions.

On a theory and practice side, the two institutions share a psychodynamic background. Whether they borrow from systemic or institutional psychotherapy, the projects of these facilities advocate to treat “through” the institution and the life in the community. In both cases, these are semi-open facilities: unless there is an exceptional and temporary restriction (called “inclusion” in the therapeutic community, to underscore at the same time the proximity and the distance with a potential further move of temporary or definitive “exclusion”), people can come in and go out of the buildings as they please, under the condition to stay overnight (except with an exceptional authorization). Patients have each their own room (sometimes shared with someone else) which they occupy as they please as long as they follow certain rules.

Finally, the most important common point of these two institutions concerns the place they want to have in the path of the patient and the mission they give themselves or receive according to this. Only patients considered "stabilized" (out of a crisis state) are accepted, the goal being to improve their "autonomy". Like almost all the institutions of the Belgian and French medical landscape, these two institutions are for a very large part financed by the social security public system and are accountable for their activities. The two institutions consider a stay (necessarily temporary) in their facility as a stepping stone to ensure stabilization and improve the autonomy. Practically this implies on one side to help each patient to identify a satisfying solution for the longer-term (for example a life in a supervised flat, going back to work in a protected context, etc.) and on the other side to gradually give back to the patient the control over the different parts of his/her life. Fulfilling these two missions can be achieved not only with strictly speaking "therapeutic" actions (clinical interview with psychologists or psychiatrists, taking some drugs, group discussions about "the illness"…) but even more with activities (sport, art, leisure, body treatments, daily life activities like cooking, tidying up, etc.) offered by the teams and in which participation is up to the patients.

This place in the path of the patient, and the fact that the stay is always time-limited imply that the question of "what is next" arises as soon as the patient or resident checks in. In the French institution, during the first meeting with the referent educator, each new patient gets an agenda where he/she is asked to clearly circle the date of his/her release. This shortened temporality creates a permanent tension between two logics (Velpry, 2008). On one side it is about trying to "attach" the patient, allowing him/her to settle, open up, find his/her way around, evolve at his/her own pace: the patient needs to feel *good* in the institution, better than s/he felt before so that new therapeutic possibilities arise. On the other side, it is about "detaching the patient" during the stay, offering him/her to gain new skills, avoiding him/her to stall, and preventing that he/she likes the institution so much that he/she indulges in the situation: it is then important that the patient *doesn't feel too good* in the institution so that he/she can prepare to leave and to continue his/her path towards new horizons. The following interview extract with an educator from the Belgian institution shows how this tension creates inevitable and perpetual hesitations or even arguments about the good ways to interact with a patient who needs to be kept in balance : between the language game of pleasure and well-being on one side and the one of efficiency and realism on the other side ; between the willingness to follow the patient's rhythm on one side and the concern of the team members when things are not going fast enough, stall and even regress on the other side ; in a more general way, between the wish of not doing anything which outreaches a request from the patient on one side, and the feeling of the necessity to sometimes force things and thus bypass the will of the patient to make him/her good despite him/her.

> *(Interview with the educator after staying in an institution on the seaside): "This year we have a very sluggish group and it really feels like nothing bothers them, nothing moves them, and even when I talk in a more personal way, and I say that it does bother* me*, (she insists)* me *and not only the institution, it doesn't make a difference. But all this mess, I can't take it anymore! And you feel like it doesn't make a difference for them. They are driving me crazy and I feel like the rest of the team doesn't support me. One day, the director told me: what is important [for the patients]? what is important is being "well" [frowns on] here." But what is it "being well" ? Does that mean that we have to let it go when they don't wake up, when they never go out, when they live in the filth, so what, we let them do as they please? Last time we had to force a patient to go out of his room, just like a child, I swear. So, yes, you can see that he is not happy, but I told him "you don't leave me any choice". Really, what else do you want us to do?"*

How can we unfold the implications of these tensions? Numerous works from these past 40 years have dealt with care institutions of this type (being open onto the city, wishing to care "through" the institution, welcoming people with severe mental health issues, involving the patient, etc.) This is notably the case in the Anglo-Saxon countries of the Therapeutic communities, discussed mostly by practitioners or advocates (e.g. Campling & Haigh, 1999, Gale *et al*, 2013). On a more general way, the process of deinstitutionalization has been subject to very complete studies, in particular about the way daily practices of the new facilities create (normative) categories of knowledge and action for the care teams, organizing then new forms of application for an institutional power which creates insanity and schizophrenia (e.g. Barrett, 1996, Estroff, 1985, Rhodes, 1995).

This article is more in line with the works of Bloor *et al*. (1988) on the therapeutic communities. The subject of this study is mainly constituted by what we could call ordinary social ideals (of which Manning (1989: 184) and Barrett (1996: 12) have already showed the importance in the therapeutic work in mental health) or, with Wittgenstein (2010), language games used by the different actors. These must be understood as institutional resources, in Wittgenstein's or Durkheim's sense (Douglas, 1986). These resources which are used to qualify and assess what is happening, don't depend on specific individuals, but are part of the particular cultural and moral context (which Wittgenstein calls a "form of life"): the one of autonomy as a condition, described earlier, which organizes the good care in a certain way. Autonomy, projects, contracts, as well as the rejection of constraint share, in this regard, what Wittgenstein calls a "family resemblance", or a "complicated network of similarities overlapping and criss-crossing" (2010, §66).

The first major advantage of the language games notion is that it forces to take the categories (such as contract, project and autonomy) and ordinary social ideals used by care receivers *and* caregivers seriously, without straight away disqualifying them as ideologies. The second advantage is to consider language and words not as theoretical categories that subsequently apply to reality, but as elements that bear should not be studied separately from their concrete uses in specific situations. Therefore the interesting question to ask is not "what does autonomy (or any other category) *really* mean?" (which Wittgenstein consider as a philosophical disease, see Sass, 1994) but "what do people *do* when they use this category? What difference does it make? What kind of performative effect does it have (see Austin, 1975 and Potter, 2001)?". To rephrase Wittgenstein's engine metaphor about the study of language (2009, §132), social and moral issues thus should be studied when they are "doing work" (in concrete situations), not when they are idling (as object of abstract philosophical investigations).

Endorsing a Wittgensteinian view thus implies studying how, in the very fragile environment of psychiatric institutions, people try to find it worthy to keep on giving or receiving care. In this perspective, the use of the word « institution » refers to these mutually constituted communication and sense-making patterns, and it differs here from the acceptation of the institution as a "social structure", mobilized for example by the symbolic interactionism (see e.g. Strauss *et al*, 1964: 351). However, both aspects of this category are clearly intertwined: the way people make sense of their world also depends on and resonates with the positions that they occupy in a social structure (see below 3.1). The next part of the article shows how professionals put to work and into practice these ordinary social ideals, in what ways these are used to give sense to their practice and assess their efficiency, but also how this application can lead to tensions when the day-to-day reality of the psychiatric institutions seems to compromise it. It is then about how, inside these language games using the contract, the project and the autonomy, the caregivers try to create ways to stay worthy and to keep away any feeling of futility concerning these ideals and the work being done, despites the difficulties and failures they experience (Brodwin, 2013).

3. The normative horizon of good care faced with the day-to-day

3.1. The avoidance of constraint: care as a collaboration between partners with a *contract*

In both institutions, constraint is considered as an unwanted last resort solution. Unless for very exceptional cases (individuals under the influence of psychoactive substances for example), there is simply no physical constraint. On a larger scale, asymmetry is theoretically avoided as much as possible and both institutions are working to reduce the gaps between patients and caregivers. Thus, nobody is wearing a uniform (except the kitchen staff in the French institution, i.e. the people in charge of cleaning and cooking). In the French institution, each individual has a magnetic card around their neck, giving them different accesses to the different places, which tends to give a professional (or patient) look to everyone. In the Belgian community, the lack of differentiation is even more present: caregivers and residents not only eat in the same place but they also prepare and share the same meal at the same table; familiarity is authorized and the caregivers are gladly "giving of themselves" by sharing with the patients their own daily problems, games or moments of silence together while smoking a cigarette, etc. This lack of differentiation tends to be established as an informal rite of passage for the interns who are joining the team temporarily and have to guess gradually if they are talking to a resident or to a worker, which gives some fun and pride to the team.

However, this relationship obviously stays asymmetrical and these different elements cannot erase the fact that these institutions are living spaces for the residents and workplaces for the caregivers. Similarly, if patients are theoretically never in a situation where they would have no choice but to follow the rules of the institution (because they can indeed leave and get free from these), the consequences of such breakup would be so significant for patients with very little room for maneuver (no other place to go, etc.) that they wouldn't dare taking the risk. Consequently, most of the time, patients do follow the rules or restrictions which restrain their desire (for example the obligation to ask and get an authorization when they want to spend the night outside). The caregivers are well aware of the asymmetrical nature of this relationship, in which patients need them more than the opposite. How do they handle together this obvious asymmetry and the willingness, supported by moral and therapeutic perspectives, to reduce constraint as much as possible?

It is interesting to note that, when patients are positioning themselves as being constrained by external rules, for example by using the words "I have to clean my room better", "they told me I should be more present in the common spaces of the community", etc. caregivers are trying, sometimes systematically, to rephrase the words of the patients. The proposed rephrasing aims at replacing a heteronomous understanding (a life in terms of "should" and "they") by a shared understanding on the basis of a prior agreement (a life in terms of "will" and "we").

For example, while having an informal conversation sitting at the table, when I asked him how the trial day in a future institution went, a resident of the Belgian institution answered: "It went well. I will maybe go to this housing but here they want to test me about living in a community before. This is only why I am here, it is to show that I can do it. Afterwards, I will have the right to get my own apartment." A member of the team who heard our conversation replied directly to the patient: "this is not about having the right or not, it's just that, all of this needs to be done gradually, and we agreed on this, we said that you would need more substantiation at the beginning, remember?" In the same way, while a resident was complaining publicly that the institution would refuse her to change her trustee, a social worker replied: "Nobody here is forbidding you to do this, nobody can prevent you from doing it, this is your life and your choices. But the institution [the team] thinks that it is too early to do it, so you do as you want, but we will not support you in this process."

In a general way, this retranslation process is about involving the person in the reasons why it is necessary and relevant to practice some form of constraint or restrictions. In the words of the teams, it is about "sharing responsibilities" with the patient, by making him/her understand that the measures taken doesn't appear as arbitrary fads from the team but are being deduced from a logic the patient should also understand. Two ways of legitimating this logic, which can be alternatively or simultaneously used by the caregivers are easily noticeable. The first is the patient's well-being, progression, health, mood, and future. The second is the quality or the possibility of living in a community.

The preferred tool to share the common endorsement of these logics between patient and caregiver is the *contract*, which is most of the time very informal (such as the "remember?" example above), but sometimes well formalized on a sheet of paper. For example, someone who is not clean enough, or whose mess in the room has become problematic, someone whose presence in the institution is too weak or not constructive enough or someone whose substance consumption has become a threat for the individual or the community can be asked (or forced) to set up a contract in which the patient commits to take certain measures, or he/she would bear the consequences (often, being excluded from the facility). The contract is different from order and constraint as it is precisely supposed to be understood, accepted, and assumed by both parties who have freely agreed on it and find an interest in it. In other words, the goal is that you cannot refer to it as a practice of a heteronomy.

> *Extract from a conversation in the French institution:*
> *Patient: why can't I go spend the night at my girlfriend's parents? I have asked and it has been refused.*
> *Educator: Sir, we have already explained it to you during the partner meeting: last time we agreed to try as long as you would come back the next morning and you would not consume any alcohol. That was our contract and it didn't work out, so we are now drawing the conclusions. We need to be in this together if we want to go forward.*

As shown in the previous extract, it happens frequently that contracts are broken in practice by acts from patients or residents. It is even more frequent that the logic of the contract cannot bring the expected effects of shared responsibilities and of a common vision of the situation, where parties would act together for a shared goal (the better-being of the patient and/or the life in community). The caregivers then go back to imposing or at least apply a set of constraints on certain aspects of the daily life, while trying to remove the idea of "punishment" from the situation. The consequence of a broken contract, if not being excluded, often consists in limiting the freedom of movement of an individual by removing the authorization to leave the facility – what the Belgian institution calls inclusion (making it sound quite like exclusion) – even if it doesn't change anything in the facility (the buildings are still open).

But it is also possible to apply a systematic constraint which would be prior to the establishment of a contract. That's what I observed in the Belgian institution where the care team was complaining about the lack of involvement from the patients regarding the organized activities. By comparing the multiplication of contracts agreed individually between a resident and the care team, and the fact that it very seldom paid off, this institution has eventually decided to make the participation in two activities per week compulsory. This decision, which is a breach in the representation of the care to the psychotic patient (historically supported by the institutional psychotherapy) as essentially letting the patient come on his/her own without saturating him/her with propositions (Sassolas, 2009), is justified, according to the team, by the double fact that on one side it is necessary to help patients to get out of themselves and their stagnation, and on the other side that their time in the institution is counted.

3.2. The *project*: a goal beyond the stay in the institution

If the terminology of the contract is frequently used, the one of the project is absolutely ubiquitous in both institutions.

The use of the project category allows the caregivers to implement the ideal of a patient as a partner rather than an object, and the division of tasks arising from it (cf. supra). The project is an exterior entity of which the patient is seen as the depositary: caregivers are not working *on* the patient but *on* the project *with* the patient. The project becomes the workable doppelgänger of the patient on which both caregivers and patients take action. As a goal pursued by the patient, the project allows to justify and assess the several actions taken by everyone. The pursuit of this desired state, located somewhere in the future, justifies indeed the creation of a temporary discomfort. Chasing autonomy can even substantiate a temporary limitation of autonomy. In this sharing of tasks and pursued goals, the role of the patient is to wish for something and to help the caregiver to help him/her get it, while the role of the caregiver is to act on the actions of the patient, to increase the room to maneuver and the agency of the patient – shortly, to make the patient the actor of his/her own change. The following interactions with patients were often coming back in the partner meetings of the French institution and illustrate this idea: “Miss, if you have a focus point, we can help you to go forward but you have to show us the way”, “tell us how to help you”, “what can we do for you?”, etc.

The category of the project first has a democratic aura: *each one* can have a different project because the same normative horizon should not be imposed to everyone. The project is gradual and adaptable to each of the situations. Its uses thus rest on an axiom which is more moral than empirical: whatever its basic state, each one has room to maneuver to wish for something at least a little better and to go towards it. Beyond its congruence with a morally respectful vision of care including a partnership with the patient, the project also offers a practical efficiency about an inherent tension to the functioning of the two studied institutions, and probably of numerous institutions, which are welcoming people in situation of liminality (Turner *et al.,* 2017, Troisoeufs, 2009) : it is about living a daily life as close as possible to the “real daily life”, while knowing very well that the environment where it takes place is artificial (in particular because it offers supports which don’t exist on the outside) and also limited in time.

In institutions which are above all marked by the pervasiveness of the daily life, the project is an exceptional leverage of problematization for the caregivers (especially in front of patients who anticipate the different attempts of creation) because of its capacity to translate and integrate any element of the daily life (from a study done in similar institutions, Bloor et McKeganey (1986) already saw in the ability to retranslate the ordinary elements in a therapeutic logic, a minimal definition of therapeutic work; also see Corrin, 1990). You don’t cook “just like that”, because you are hungry or because it is your weekly institutional task, but because it is an essential step in retrieving your autonomy. You don’t get up earlier “just for fun” or because “you have to”, but to regain a rhythm compatible with a professional activity. You take some medication not (only) to feel less ill but to “get better”, etc. With the project, the most ordinary elements are transcended and are no more autotelic. They have a meaning, a direction and therefore cannot be overlooked anymore because they are insignificant. In other words, everything can be subject to a conversation with the patient, create an action of reflexivity from the patient, even constitute an element to assess how the patient “is doing”, as the following excerpt from my fieldnotes in the Belgian institution shows:

> *A resident doesn’t have enough money to buy cigarettes and no one among the residents wants to give him cigarettes anymore. He talks about it to a psychologist, who is sitting there in silence with other residents, while saying that he will receive his allowance tomorrow, and asks the psychologist if he could lend him some money. The psychologist*

tells him: "OK, Jean-Paul, I can give you a cigarette, but you need to know that this is the last one, so what I can offer you is to try to wait the longest as possible, and when you really cannot wait any longer, you can come and ask me about that cigarette. That way, you can manage what is left. But you can ask me for this cigarette whenever you want." The resident is not really listening to the explanation and answers with a smile that the psychologist will find sardonic: "OK, thanks, well I want it now, right now, it is right now that I cannot wait any longer". The psychologist is in an awkward position, hesitates, and finally gives it to him while saying: "Too bad, you could have learned something great for your project regarding budget management."

In the Belgian institution, the definition of the project was supposed to happen at the end of the first year in the institution. During the time when I made my observations, the attention given by the teams to the project has been strongly reinforced: the project of the patient, its definition, and its adequacy with what the institution thinks it can offer, have gradually and preponderantly interceded into the selection process of patients, via the procedure of "applications" and "trial days". In these selection processes, the projects of the potential future residents are less judged upon their content than upon their simple existence and the fact that the patient presents it "authentically". As the extract from the interview with the psychiatrist of the Belgian community shows, the extent of the project, the final goal is considered less important than being on the way, moving.

"The patient can get in with a minimal project: 'I want to learn again the things from the daily life, I want to get back to a normal rhythm of life and learn how to take care of the papers, the (administrative) stuff', for us, it is a project. Afterwards, during their stay, we try to move things forward. At the end of the first year, we ask them to think about the future and to say: 'well, where do you want to go now? An apartment on your own, a protected housing, another therapeutic community?', […] This is how it is : they can come with a simple basic project – well for them it is not that simple to get back to a normal rhythm of life, learn again the things from the daily life, cook, do the laundry, some people are not able to do it when they arrive here, they don't know how to peel an onion! It happens! And when they peeled an onion for the first time on their own, well, we are happy."

Since the project needs to belong to the patient, it is essential that the patient shares its meaning and doesn't live this in a heteronomous way. The existence and the investment into a project are a way for the teams to make sure that they will deal with this patient as a partner, that is someone who will not create conflict in a sterile way, or who will not show a complete inability to enter the logic of projection. Even if team members do expect difficulties, fatigue, dissenting if not destructive behaviors, only the patient who will be able to help people to help him/her will be welcomed. In a team meeting in which the decision to admit or not new residents is made, someone talking about a case has everyone agreeing when he mentions about a candidate suffering from the Korsakoff syndrome and drowning into relationship issues: "Honestly, this person is very nice and her story is very sad, but really, I have the feeling that everything is so broken and I don't see how she could invest herself into something like a project. For me, there is nothing we can do for her, I don't see what we can offer her here."

In summary, the practical use of the project falls well within the tension between attachment and detachment. The patients need to feel well in their new living environment that is the institution, for a quite long, but always limited, amount of time. Mentioning the project at the very beginning of the stay enables the team to make sure that the patient is aware that his/her stay here is limited in time. Patients are encouraged to "settle in" (temporarily) but it is out of the question to move in (permanently). More than an opportunity to make contact and problematize every moment of the day, speaking the project language in the relationships between caregivers and patients gives the caregivers the opportunity to assess if the patient is still in a dynamic of change, and to ensure that he/she is not

going to stay, that he/she plays the game to be attached then detached. The project is a movement operator, a guarantee against the status quo providing with the assurance that the patient is still trying to continue his/her way beyond this limited stay.

Do the caregivers really think that the patients really believe in their projects? Even the most passionate supporters of the notion of project are able to see the practical, if not strategic, aspects of its use. In the two surveyed institutions, an interesting moment to observe is the period, not long before the patient's release, during which he/she applies for another living space (whether it is a care institution with a full management staff, a supervised flat, or a rented flat on the normal real estate market) This period is considered as crucial in the journey of the patient. The care team members, mainly the educators and the social workers, are really committed to support, or even coach the future released ones, for example by training them to give some calls, to show the expected behaviour an application interview. During these sessions, it is common to observe that the caregivers invite the future released ones to deeply consider the strategic aspect of the project: to use the good words, look motivated, not too detached or passive, not hesitate sometimes to overdo their wishes or accomplishments to reassure the teams where they apply or the owner of the flat… The shared undertone is that it is more important to look like you believe in it than really believing in it. However, in the daily life of the institution (that is before and sometimes at the same time as the step we just mentioned), these same caregivers are putting themselves into the position of asking to be convinced by the patients' genuine investment into their projects and will show dissatisfaction if a patient pretend to have a project which reveals to be a smoke-screen and is not genuinely invested in something s/he really desires.

In the ideal of the division of tasks described above, the development of a project by a patient is supposed to put the therapeutic team in a position of support which consists in working on the means and empowering the patient to reach the goals s/he had autonomously sketched beforehand. However, we can only be amazed by what Ellen Corin already called the "conformist normative position" of the projects developed by patients (Corin, 1990: 167). At the end of the stay, the definition of the good life seems much more ordinary than exotic: it is above all about the vague idea of being more "autonomous", which means concretely to search for your own apartment (or a more autonomous housing), try to reduce your treatment, have a paid, adapted or voluntary job, be in a relationship and possibly start a family. These four criteria may be found in most projects of patients. It is also interesting to note that, very often, patients disqualify themselves regarding these criteria after mentioning them.

> *I: According to you, is it possible to have a great life with schizophrenia, but also with some medication?*
> *R: Well, the problem is that as soon as there is some stress, we react in a more negative way, more strongly, with each cause of stress whether it is a positive or a negative one. This is my schizophrenia. Everything stresses me out. So, I tell myself, what will it be when I will have my apartment, a job, a family life with a wife, kids and so on.*
> *I: Do you want those things?*
> *R: Well, yes, but I already know that it sucks for me.*

Yet, in the beginning of patients' stays, projects are much more varied than the quadrilogy "autonomous housing – less treatment – paid job – being in a relationship". Here are a few examples I was told by entering patients: open a breeding farm in Africa, start a business in buying and selling of collection comics, travel around the world by foot, go to New York to perform in a concert, or simply

isolate oneself as much as possible to play videogames. How can we explain the loss of this initial variety and its retranslation in the aforementioned four criteria?

In the daily interactions between team members and patients as in the more formal meetings, the dialogues are actually not only about the *means* to use to attain objectives in a project which has been predefined by the patient. On the contrary, the caregivers negotiate with the patients over an "acceptable" or "reasonable" project, that is a project they think they can reasonably support, according to their system of relevance (Schütz, 1987: 140). As seen before, this system of relevance is mainly focused on the release of the patient, on the more or less short term. The acceptable project must be about securing the now: where will the patient go and live? How to be sure that the patient will not be socially isolated? How to organize a follow-up and forestall the crises? How to make sure he/she will provide for him/herself? Etc. The caregivers are looking to be reassured on these questions and they have to decide between the projects they think they can support and the other ones. So, while the reasonable or acceptable projects can be in theory quite varied, they are in reality limited by two unacceptable or unreasonable extremes. On one side, there is the *too ambitious* project which would put the future of the patient at risk while not at all ensuring the immediate after-stay (it doesn't prioritize properly). For example, this can be a form of autonomy which the patient cannot handle yet, according to the team. In this case, the team can surely reply to the patient that he/she is not "ready yet". Other projects are sometimes simply considered as crazy, like a symptom of the illness. Rather than formally forbidding the continuation of the project, the team offers then to not support the patient, even let reality crush his/her desires. During a team meeting of the Belgian therapeutic community, the referent of the patient, whose project is to become a singer in New York, talks about the announcement of the resident taking action:

> *For the moment, he talks a lot about this New York thing, that he is very talented and that he is going to leave with a friend who will be his manager. I definitely have the feeling that the "friend" wants to get a free plane ticket! So, will he or will he not go? I am taking the bets that he won't do it. In any case, I made it clear that the team would not support him in this project and that there were more urgent matters to deal with. I would like to remind everyone that, last time, we found him in his pajamas, with his guitar, walking alongside the train rails in France because he wanted to find his father and that Michael Jackson was reincarnated into him. So really, I don't see the point of supporting this.*

On the other side, the acceptable or reasonable projects must be *ambitious enough*. A project lacking ambition happens when the patient is satisfied with a status quo (stay as long as possible in the institution). Even worse, it can be a project that would lead to a regression on important points for the team (isolate oneself, eat only processed food, etc.). Then the team reacts either by saying that it is not recommended or simply not possible, or by insisting on the fact that the person is capable of much more than he/she thinks.

In that sense, the negotiations which are taking place between caregivers and patients are not only about adjusting the means to predefined ends, but also about working on those ends, even adjusting these ends to the means. The projects which are not supported by the team are considered unreasonable or unacceptable precisely because they don't provide the caregivers with the guarantee of a movement (either because the patient claims not being moved by anything, or because what moves him/her doesn't include how to handle the immediate after-stay). This is how, in a breach with the division of tasks described ahead, a negotiation about the acceptable ends takes place. In this process, one can see gradually emerging the good life that the patient can or should hope to have.

3.3. Promoting *autonomy* (and the love for autonomy)

The (theoretical) rejection of constraint and the promoting of the project category are elements which give form to a larger mission which is written in the statutes of both institutions: the stimulation of autonomy. Undoubtedly even more than for the contract or the project, it is striking to see how frequent this category of autonomy is used by the caregivers as much as by the patients.

Why is autonomy so important in these institutions? Probably, at least partly, because beyond the conflicts of theories, of positions, … it seems to get everyone agree. No one is against promoting the autonomy of the patients and certainly not the patients themselves, at least in theory. Promoting autonomy is what the sociologist Bourdieu (1997) would call the *illusio* of the psychiatric field, especially in the context described above: a commonly endorsed principle for which people fight, even against each other. Of course, there are very different understandings of autonomy, according to the different theoretical approaches. Nonetheless, autonomy can have such an importance because it qualifies the general logic of care without specifying more: it is about gradually giving back to the person the relative control over several parts of their life by removing the therapeutic scaffolds.

In its use by the teams, the category of autonomy is set between on one side, a certain will of formalization and on the other side its essentially unclear and pragmatic use. In the French institution, the incoming patients need to answer a questionnaire about several functional competencies (the questions are dichotomous, for example: do you know how much things are worth? Yes/No). The same way, the teams can use formalizing scales like the GAF scale from the DSM. However, in the daily life of the institutions, autonomy is used essentially in an operative way and actually qualifies the fact that a patient "is better" (meaning some progress) or that he needs less support (meaning a decrease of dependency). In a sense, autonomy is nothing other than what the care of the functional rehabilitation centers can improve. The acknowledgment of this better-being or this tendency to autonomy is observed through clues from the day-to-day life and communicated, during team meetings or interactions with patients, via lots of vague phrases about the daily interactions: "being there", "share something", "looking good", "feeling good", "being present in the interaction", "being smiling and nice", or on the contrary "being absent", "being elusive", "not looking good", "not feeling good", "being overwhelmed", "slouch", "frown", "being worn out",…

Nevertheless, the everyday uses of autonomy are not as vague and contingent as they appear at first sight. We can highlight three criteria that the caregivers use to assess the degree of autonomy. First the attitude of *being active*, which means participating to the activities and the daily life, not sleeping too much or slouching, moving instead of standing by, etc. The second criterion is about being *properly socialized*, meaning encouraging and having social relationships but also being able to be alone without wildly searching for contact, being present in the common spaces, being nice during an interaction, for example by using humor and conventions (greeting, wishing people to enjoy their meal, etc.) while avoiding hostility, being attentive to your looks, etc.

Finally, the most essential criterion (while being the most nebulous) is *being oneself* and/or feeling good with oneself. This means firstly not being (too) overwhelmed or delusional, but well in line with the world, being able to use the pronoun "I", to confide and to share about your inside life. Secondly this implies investing in yourself as an object of interest (for example through a good hygiene or the search for pleasures which are not deadly nor excessive – eating a healthy meal, doing an activity). Thirdly this implies showing a certain reassuring stability or predictability: not having important mood swings, or unexplainable changes of attitude, knowing what you want, keeping your engagements, fulfill your actions, etc. Fourthly and more fundamentally, the teams will consider a patient as reassuring and "feeling good", a patient who is invested in his/her project and demonstrates a desire for autonomy. Each institution has its ideal patients or residents, who are characterized, in the

discourse of the caregivers, less by their compliance than by the fact that, according to the famous phrases, “they really want it”, “they really want things to get better and are working hard to do so”. The appreciated position is close to the resilient one (see Marquis, 2018) which, despite the difficulties and the sufferings, “has resources” and genuinely *desires* to pull through.

In the daily practice of the institutions, autonomy has been subject to several forms of investment which might be paradoxical. It is both presupposed and expected, while being practiced and made desirable.

In a way consistent with the moral environment described earlier and with the institutions’ missions, autonomy is very often presupposed to be “in the patients”, at least under the form of a potential to activate. In the team meetings, it can be noticed through frequent mentions of patients which have more room for maneuver than they (strategically want to) show : “this one, he has some resources”, “don’t be fooled by his slouching, there is some thinking going on inside his head”, “it’s true that nothing is scheduled for her but I am not worried, even if we are heading to an early release, she will end up back on her feet, I am not worried”. In the relationships between caregivers and patients, the first ones willingly use the language game of inside abilities and hidden potential in the formal and informal moments (therapeutic moment, daily conversations, sport or art workshops), which are frequently designed to reinforce self-esteem and self-trust. It is about revealing to the person the existence of a prevailing but under-used competency by encouraging a change of perspective of the individual about him/herself. The first extract reports an interaction, in the French institution, between the systemic therapist and a patient. The second extract, in the same institution, describes an interaction during a yoga session between the psychologist (who is organizing it) and a patient:

> *Extract 1:*
> *Therapist: (about the pathology of the patient) “It is not only biological Mrs., you can also have some control”*
> *Patient: “Yes, I understood it thanks to the cognitive remediation at the Sainte-Anne hospital: they were showing me graphs about my mood and it helped me”*
> *Therapist: “Well I do encourage you to continue. You have some resources and there is no inevitability for your difficulties and your problems.”*
>
> *Extract 2:*
> *Patient: I will stop this exercise now, I cannot take it anymore, it hurts everywhere, I can’t do it.*
> *Psychologist: Mrs., you’re saying that you can’t do it but did you see everything that you’ve done already?*
> *Patient: With my weight, I am blocked [to move]*
> *Psychologist: But this has nothing to do with weight, everyone can do it with some practice. [He helps her doing the pose]. See, you did it, you, not me. And it feels good, right.*

If autonomy in its embryonic or potential form is presupposed with each of the patients, it is also expected: the patient must behave in a consistent way with the presupposition of its ability to be not an object or a passive receiver of the care, but a partner and an actor of the said care. The Belgian therapeutic community presents its therapeutic project in this way: “it is expected that the residents are not passively receiving care but are the actors of an active participation to the functioning of the therapeutic community through taking responsibilities in its daily management.” It is obviously not expected that the patient must do anything on his/her own. Being actor of the care means, in a minimalist way, being willing to receive it. In the case of the institutions which are trying to rehabilitate the patients by practicing tasks from the daily life and by organizing activities with and for the patients, it is at least about showing compliance to or interest in these activities. When the patients are not

meeting these minimal expectations, caregivers do not hesitate to communicate to the patients that they find it inconceivable. The following situation describes this: in the Belgian therapeutic community, during a meeting between patients (called 'club') in attendance of a social worker (the aim of the club being to involve the patients in the definition of the activities for the coming months and to have them deal with the allocated budget), the social worker shouts, facing the lack of suggestions or wishes from the residents: "Don't tell me that you don't want to do anything! I cannot believe it! Let me remind you that activities are an essential part here, otherwise what is the point [of being here]?".

On the other side, autonomy is obviously practiced and trained. The most visible work, perfectly normalized and advocated by the caregivers, is about empowering the patient, restore the conditions of a possible action on one side by offering possibilities of development (work on the meaning), and on the other side by doing exercises, role-playing, trainings, activities (work on the competencies). The caregivers are trying to increase the control of the patient over the different parts of his/her life by following the logic of first doing *for* (in place of), then doing *with* (support), and finally *get* him/her to do (setting up the conditions of an autonomous action) (see Floersch, 2002). Making and following up on contacts with external professionals (trustee, reception desk for a future living space, legal actors, etc.) exemplify perfectly this logic. In a first time, the caregivers accept to do most of the work: they call *for* the patient, while the patient is here. The patient will call him/herself, as quickly as possible, *with* the caregiver who will have reminded him/her when is the best moment, etc. Eventually the caregiver will ideally just have to make sure that the patient *did* correctly the necessary procedures, in the most autonomous possible way.

By following this logic and increasing the power of people to act on the different parts of their life (administrative procedures, personal care, medication management, food, sociability, time management of a day, etc.), the caregivers are trying also to gradually give back the control over these different parts, according to the logic "if you are able (to cook, to do some administrative procedures, etc.), then it is now up to you to do it." Both institutions have therefore created places and facilities where the "most advanced" patients/residents can – and, to a certain degree, should – cook for themselves.

If promoting autonomy has sometimes been denigrated in a perspective of social sciences as a fake and neoliberal form of empowerment asking the most from the weakest people, this terminology is assumed and valued by the caregivers (who incidentally are claiming to be very sensitive and critical towards massive phenomenon such as the "new forms of management", "capitalism", etc.), due to its congruence with the moral environment mentioned earlier. In this environment, giving the means to allow the patient to get a form of desired autonomy is considered as the most efficient and respectful form of care. Providing patients with the tools to live the life they have chosen without imposing a lifestyle which doesn't emerge from the patients' wishes is, in caregivers' view, the noblest part of their work. The pursuit of this goal helps them going through daily difficulties or failures. It justifies their investment in trying again and again, without ever losing hope in making patients more autonomous.

However, as in the case of contracts and projects, its application raises difficulties, not only because of the inabilities of the patients, but much more interestingly because of the lack of interest in autonomy. I have observed that a meaningful part, but less visible and assumed, of the work on autonomy didn't consist in working on patients' capacities or knowledge but more fundamentally on desire and willingness. It is about giving the taste for autonomy, that means not only showing that life is worth living for (or at least it can be bearable despite the suffering), but also convincing them that on one side an autonomous life is better than an administered life and, on the other side, that this (at least a bit) more autonomous life is totally reachable, in particular thanks to the presupposition of internal

resources needed to be activated. This last point is visible for example in the way the person responsible of the theater activity in the Belgian therapeutic community describes his workshops in the activity report of the institution:

> *"I could notice from my own experience within this workshop but also by observing the residents, that this moment enables to develop one's self-trust, imagination, memory but also to surprise and to surprise oneself ("I didn't think I was able to do this") and to unwind oneself. […] 'Oh my god… I will never be able to do it… What am I doing here?' 'Of course, you will make it! You have to let go and be natural! And we are all in the same boat and together we support each other!' "*

This work is above all (but not only) done by paramedical members of the team (social workers, educators, etc.), who are close to patients on a daily basis and support them in their projects. We can see numerous examples of a work that D.W. Winnicott (1971) could have assimilated to the creation of a good enough environment, where it is about presenting the outside world as not only a bunch of threats but a source of potential satisfactions, to make an element of personal achievement out of an ordinary event. This is the case of the following interaction in the "release group", where an educator replies to a resident, who was sharing his preference for short evenings, alone, spent eating processed food:

> *Resident: in the evening I just want to sleep so [when I will live in a protected housing] I will go to sleep early after having a pizza or something, if I even feel like going to buy one…*
>
> *Educator: But while you're sleeping, you are forgetting yourself. [lively tone] You could invite some friends over! And cook lasagnas for everyone, you can even prepare them in the microwave. You go buy your lasagnas, you set the table and all… It's so fun to prepare an evening like that! And then it is nice when you eat well! You feel good when you take good care of yourself.*

In these interactions which insist on the fact that life is worth living for, it is about creating a taste, even an excitement for a particular form of life: autonomy, a less possible administered life and which matches the criteria of being yourself, active and properly socialized. This activity has inevitably a normative dimension because, like what we could observe in the process of building projects, it is not about supporting *any* type of lifestyle (for example a dissocialized existence made of risky or inactive behaviors), but lifestyles which are, on one side, in line with the ideals of autonomy as condition, and, on the other side, which will very concretely allow the individuals to deal with what's expected in this moral context.

This work, aiming at developing a preference for autonomy and the idea of one's inside abilities, is not subject to a systematic reflection. It is not written in any document. On the contrary, it inserts itself in the gaps of the daily life and has a fundamentally craft dimension, left to the "feeling" of the caregivers. Therefore, if the project and contract categories give tools to the caregivers to help the patient to develop autonomy, caregivers nevertheless remain powerless in situations where people have no interest, no desire for autonomy, ruin more or less deliberately their own project, or are feeling pessimistic or too realistic about the meaning or the weak possibilities that the ideal of autonomy is representing in their case. In the terminology used by the caregivers, it is sometimes said that these patients "don't buy it" (a project, an increased autonomy, etc.). It is then interesting to observe that the conversations can take very ordinary forms which sound as much like motivating again a depressed friend after a breakup ("you will be fine, you'll see"), as the capability mantra of self-help ("your life will be changed in a way you cannot imagine"). The following extract is a concrete example of the

difficulties raised by this work. It is a conversation between a patient and his two referents in the care team, the beginning of a "mini-team", which is a monthly meeting in the Belgian institution.

> *Member of Team A (Psy): so, it's been a month since we met, and if I look at my notes, last time we had questioned a bit your way of being present in the institution, and it is true that we were saying with the team that there is not much change.*
> *Member of Team B (technician): we don't see you downstairs very often.*
> *Resident: ah yes, I remember. But we are here to propose things, right?*
> *A : yes*
> *R: so, I would like to propose something, you will have to make it mandatory. If I can give my opinion, it is that you need to make me do things. I know I will go downstairs if it is mandatory for me.*
> *B: Um…*
> *A: and how often do you us to make things mandatory?*
> *R: as you want, really, how often you want it. You are the team and me, you know I really need the opinion of everyone.*
> *B: But why do you want us to make things mandatory? You can go downstairs whenever you want, right?*
> *R: Yes, but I really have to force myself to be downstairs. Honestly, downstairs, there are only David and JL, and it's not always, well you know, fun. So, if you give me the choice, I stay upstairs. But since you say that you need me downstairs, well I propose you make me do it.*
> *A : it is also for the community.*
> *R: yes, but they also spend a lot of time in their room.*
> *[Long silence]*
> *R: but ok, I will think about it*
> *[…]*
> *A: Being downstairs is not only our request, it is yours too. You came into a therapeutic community. Afterwards, in the protected housing, they will ask you to be active, to go out, you will need to have a rhythm and being downstairs, it is also a way to prepare for that.*

This situation, in which the caregivers assess the autonomy of the patient from his desire of sociability, brings an echo to the scene described at the beginning of the article. In both cases, it is about situations where patients are reluctant to take an active part in their care. They remain in a position seen as passive, administered from the outside, delegating to someone else the responsibility of telling how they are (extract 1) or obligating them, forcing them. To a certain extent, in a logic with reversed fronts, these patients want to endorse a classic role of patient and ask the caregiver to assume theirs as well as the part of heteronomy it bears. They re-establish the unequal relationship that the caregivers are trying to avoid (without really succeeding) for moral and therapeutic reasons. These two extracts finally show how much an essential dimension of the caregivers' work consists in making the patient the starting point of actions, thoughts, feelings, hopes and expectations. When the patient doesn't buy it (for example, in a team meeting, a caregiver mentions about the condition of a patient's room: "his mess doesn't bother him, that's what worries me"), this work of introjection can take very visible forms, like in the extract we just mentioned: it is about introjecting "into" the patient a request or an expectation, otherwise the empowering good care will not be considered as valid.

4. Conclusion : a quixotic horizon ?

This paper first described the normative horizon of the "good care" in a moral context where asymmetric relations are less legitimate and where empowering patients to help them become (once again) autonomous is perceived as morally respectful and therapeutically efficient. This horizon, clearly

exemplified in the ideology of the recovery movement, organizes a division of tasks in the care relation between patients (responsible for the ends) and caregivers (responsible for the means). While the first ones are expected to wish for something better and more autonomy for them, the caregivers are expected to limit their intervention on the empowerment of patients and not choose on their behalf the life they should live. This representation of the care relation forms a language game, in which three categories take an important place (contract, project and autonomy), while others are expected to disappear (constraint, status quo, etc.). By examining the uses of these categories in two institutions welcoming people with severe mental health issues, this article showed how caregivers endorse and embody this division of tasks, but also how their concrete practice continually brings a breach into it. Caregivers indeed practice some forms of constraint and don't respect the theoretical symmetric aspect of the contract. They do not accept *all the* projects but only some of them which they find reassuring, and this causes a drastic reduction in the original variety of the projects developed by patients. Finally, they do not only work on patients' autonomy, but also on their very wish to be more autonomous.

I would like to briefly discuss here why this is so. A first structural reason for not fully meeting this division of labour is the tension in the institutions aiming at sending back the patient into the society in a better condition, between the attachment and the detachment, the well-being and the efficiency, the rhythm of the patient and the short temporality of the stay. While the caregivers agree to let patients make their own attempts for a while, they feel they have the moral duty, when the end of the stay is near or when the evolution of the patient is considered too slow, to accelerate the changes and even sometimes force things to happen. In other words, caregivers who try to empower patients experience a tension between, on one side, a representation of the good care as a limited intervention on the means (letting the goals and the rhythm of changes under the patients' responsibility), and on the other side the fear that, if they limit their intervention in this way, a patient may have spent two years in the institution without making sufficient progress that could help her/him in the outside world – which clearly represents a failure for an institution with such a mission.

A second reason, more fundamental, for which this division of tasks (at least in its strong application) is destined to fail in a certain amount of cases, results from the fact that the anthropology of the patient it presupposes is as democratic as demanding, and the patients can fail because of it, when they don't meet the expectations: take an active part into your care, prefer an autonomous life to an administered life, etc. Without this response from the patients, the logic of contract, project and autonomy promotion can't hold. The problem is seen most vividly in the world of mental health because the anthropology of the person, who has a project and is on his/her way to autonomy, doesn't paradoxically always take into account the psychopathological aspects of mental illnesses. The members of the care teams, who are aware of this tension, are then trying to adapt and lower their own expectations, for example, by settling for "small evolutions", like the psychiatrist we mentioned earlier, following the logic of "it is already something". Moreover, by giving a lot of importance to the hidden potential and by refusing to confine the people in labels or atavisms, this logic values talking to the patient like anybody else. However, theorists of psychosis, which are readily mentioned by the care teams of both institutions, show that severe mental illness (Oury, 2001, Sassolas, 2009), because it qualifies a disorganization of intentionality (Lovell et Ehrenberg, 2001), affects precisely the ability to be in a project, to bring stability into the interactions, to act upon yourself, but also the way to perceive if these elements simply have some meaning and are worth being pursued. This second aspect raises important questions which may be stated as follows. Contract, project and autonomy; the division of tasks they try to put in practice, and the recovery ideology on which it is grounded: are all these elements only suited for good patients able to meet the criteria of the demanding anthropology? What do caregivers do with patients who do not show the ability or even the expected interest in being more

autonomous? What place is left for patients who just want to be treated asymmetrically in the old way? The present study shows either way that caregivers feel quite lost when patients do not endorse the language game of the patient who is an actor of his/her own care, and that they return to a classical form of asymmetry, while feeling uneasy about it.

On a theoretical point of view, the paper allowed us to understand better that if psychiatric institutions are to be dealt with as "negotiated orders" (Ogien, 1987), what is negotiated on a daily basis in the different interactions is not only about definitions of situations or rules. To use a fundamental term of sociology from Marcel Mauss (Tarot, 1999, Théry, 2003: 50), what is negotiated is also and maybe, above all, *expectations*. What the patient can or should expect from the caregivers, what the caregivers can or should expect from the patients, what each can or should expect from oneself, what "society" (understood as an indigenous category) expects from each one and vice-versa, and finally what the patient can or should expect from the future.

Negotiations about expectations, projections into the future, hopes and about definitions of the life which is worth living for also entail negotiations about the ways to assign the *responsibilities* – what Douglas (2010) would call practices of social accountability. These practices assign responsibilities of the encountered problems (who or what is responsible for the trouble I'm in?) but also of getting out of them (who or what is responsible for the improvement of my own situation?). In their day-to-day practice described in this paper, the care teams can't help continually evaluating patients on their ability to assign responsibilities to themselves instead of waiting for external solutions.

These negotiations about expectations have a very practical aspect: for the teams, it is about introducing qualifications and distinctions between patients, or between different moments of the evolution of the same patient to know what to do and to interact with this patient (Strauss *and al*., 1966: 353). But they also have a moral aspect. Henceforth, it is the investment of the moral (or normative) plan by the caregivers, who give them criteria to empirically verify the more or less good efficiency of their care practices: is the evolution of this patient meeting the expectations he/she or the staff had? Are we able to keep him/her moving? Does the given care continue to make a *difference*? Is the form of life he/she develops matching an autonomous life one way or another? Etc. In this way, the division of tasks pretending to limit the caregivers work on the means while letting the patient dealing alone with their goals seems to be a quixotic representation of the care relation.

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