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Published online: 12 Jul 2016.

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The psychiatric treatment of 'behavioural problems' in adolescence: Between coercion and socialisation

Isabelle Coutant

CNRS (Iris), Paris, France

ABSTRACT

A 2005 report from the French Institute for Medical Research highlighted factors likely to prompt 'behavioural problems' in children and adolescents, and recommended early identification of at-risk families. A number of mental health professionals rose up against such medicalisation of social issues. This ethnographic study was conducted in this climate, in a psychiatric unit, located in a disadvantaged area in the outskirts of Paris, that specialises in adolescents with such problems. The research emphasised how professionals resist being instrumentalised by juvenile counselling services and the justice system, the observed practices bearing traces of critiques of psychiatric institutions since the 1960s. Psychiatrists thus try to justify and legitimate their interventions, which are co-constructed by relevant counselling and mental health professionals and, as much as possible, adolescents and their parents. Consequently, full understanding of institutionalisation, beyond its aspects of constraint and subjection, also requires consideration of its potential as a step in the socialisation process, especially for adolescents from working class backgrounds bereft of social and cultural capital. Contact with professionals may confer a kind of power, 'the power to speak'. At least, that is what the professionals try to give them using the 'pedagogy of reflexivity'.

Introduction

Our service often provides care for what might be considered a 'new pathology' at the edge of psychosis and neurosis: serious personality structure problems where disordered behaviour is not accompanied by disordered thought. These problems are especially frequent among the youth of our suburban housing estates (where other more classic problems, like anorexia, are rare), and are often expressed through violence, delinquency, and drug use. The existence of these problems is definitely connected to socioeconomic insecurity, the lifestyle in housing estates, family breakdown, and the severity and frequency of traumatic events experienced in childhood. Their treatments are different than those for more classic pathologies.
(Dr. B., child psychiatrist in charge of an adolescent unit)

This presentation of a psychiatric unit for adolescents in a disadvantaged area on the outskirts of Paris echoes a discourse heard across the field of troubled adolescence, among care professionals and counsellors alike: they must assume care of 'new pathologies' for

which the usual institutional responses are no longer appropriate (Rassial 2002). They are also referred to by other terms: in counselling services they speak of 'borderline' youth, psycho-analytically oriented child psychiatrists speak of 'pathologies of the act' (a term designating a tendency to impulsive acts), and still others indicate an increase in 'behavioural problems' stemming from 'deficiencies in upbringing' (Delaroche 2005). Generally speaking, definitions are vague because these problems are difficult to categorise and have few indications for treatment.

In 2005, a report from the French Medical Research Institute (INSERM) linked these 'pathologies' to the category of behavioural problems, deferring to American psychiatry as codified in the DSM IV (the diagnostic manual of mental problems).[1] It defines behavioural problems according to how they are expressed, in this case 'a palette of behaviours ranging from fits of anger and recurring disobedience in the difficult child to serious aggressive acts such as rape, assault and injury, and flight of the delinquent. Its primary trait is an attack on the rights of others and social norms.' It is said to concern 3 to 9% of youths aged 13−18, mainly boys. Among girls, risky sexual behaviours are more typical manifestations of such problems. The report's review of international literature on the subject led it to identify multiple risk factors, including family history of behavioural problems, criminality in the family, a very young mother, and/or consumption of psychoactive substances during pregnancy. They recommended early identification of 'at-risk families' and the implementation of a counselling and psychotherapy programme for them, reserving pharmacological treatment in principle for secondary recourse.

This report raised an outcry among more psychoanalytically oriented professionals, an approach that is still relatively influential in France. They launched a public appeal and petition, entitled 'No poor marks for bad behaviour for three-year-olds' that quickly obtained nearly 200,000 signatures. Their appeal stated, 'By medicalising phenomena of child-rearing, psychological, and social orders to the extreme, INSERM's area of expertise leads to a confusion between social malaise and mental suffering, and even hereditary illness.' The signatories were, furthermore, worried about a drift toward exclusive reliance on the prescription of medication for lack of human resources for non-pharmaceutical therapies. The presidents of INSERM's ethics committee and the National Ethics Consulting Committee co-signed an article along the same lines (Erhenberg 2006).

These issues touched on wider concerns about the rising prominence of public safety logics in the French political field since the late 1990s. The degradation of living conditions in working-class housing estate neighbourhoods (known as *cités*) on the outskirts of major cities came with a radicalised street culture and exacerbated tensions between the stable fractions of the groups and youth experiencing insecurity, often from the most recent waves of immigration (largely from North and sub-Saharan Africa) (Beaud and Pialoux 1999). A portion of these insecure young people also exhibits increasing hostility toward institutions that fail to deliver on their promise of integration into mainstream French society. The extreme political right owes some of its success to the exploitation of these tensions, and all political parties have gradually converted to a security discourse in the hope of correcting these problems. Political elites have turned away from sociological explanations for delinquency, accusing them of being mere excuses, and have demoted social counselling while reinforcing the repressive

arsenal (Coutant 2005; Terrio 2009). This context coloured mental health professionals' perceptions of the INSERM report on behavioural problems, and opponents signalled the risk that mental health professionals were being made into instruments for social control.

But this controversy is also part of a longer history. Michel Foucault notably demonstrated psychiatrists' role in pathologising juvenile deviance in the 19th century. When working-class children started entering the public school system, teachers were faced with students far from meeting their institution's expectations, and the children's social and cultural distance, manifested in scholastic deviance, was made into a pathology. This led to the emergence of new figures of abnormal childhood − the unstable and the retarded (Foucault 1999; Pinell and Zafiropoulos 1978). Their instability in school was interpreted as a sign of impending delinquency to be prevented by diagnosis and rehabilitation. Nikolas Rose extended this analysis to the English case as part of a wider consideration of the effect of psychological disciplines on forms of government in advanced, neoliberal democracies (Rose 1989). However, he distanced himself from an exclusively critical approach to social control to develop another branch of Foucauldian thought: attention to what institutional mechanisms mobilising psychological knowledge do to us as individuals and affect how we perceive and understand ourselves. He makes a connection between psychological knowledge, power as exercised in contemporary society, and the kind of subject they produce.

This article pursues this last approach based on research conducted in the aforementioned psychiatric unit. It analyses several case studies that represent these 'pathologies' to find the effects of psychiatric care on the concerned populations. The article first shows that although such care work does partially fall under the psychiatrisation of the social (which is to say, an intervention by mental health professionals relating to problems and suffering that are at least partly engendered by living conditions), it would nonetheless be reductive to think of it only in terms of social control. This is because mental health professionals are not simple adjuvants of State power, as has already been demonstrated (Estroff 1985; Rose 1989; Rhodes 1991; Brodwin 2008). Professionals in the studied unit do resist the instrumentalisation to which they are subjected and are aware of the living environment's impact on their clientele's problems. Moreover, while it would be an oversimplification to interpret the situation in terms of social control, the ways in which the public uses and appropriates the institution are nevertheless overlooked. Psychiatric facilities are sometimes the last resort for families or financially strapped institutions for youth that are faced with the growing insecurity of the population they serve, so in addition to its treatment function, the studied unit also offers social and counselling services for youth with the fewest resources. This article aims to comprehend what is at stake and what is taught in exchanges between caregivers and working-class adolescents, and what kind of subjectivity is built in the process. It also more specifically considers the resultant transformation of the working classes, since the young people concerned (in this field site, at least) are from this background: the governmentality by speech and relationship to emotions transmitted and disseminated in these institutions contribute to an acculturation to middle- and upper-class norms. To the extent that many institutions serving young people are rife with this form of governmentality, analysis of this kind of intervention is part of a more general consideration of the ongoing reconfiguration of working class−State relations in western societies.

The fieldwork

The studied unit was established in the early 1990s in an underprivileged area on the edge of Paris. It specialises in adolescents from 12 to 18 years old. There had been no inpatient services for adolescents in the vicinity since the 1960s, when all beds had been eliminated because psychiatric institutionalisation, judged to be harmful, fell into disfavour. Concurrently, the local population rose significantly with the construction of large housing estates attracting more families, often immigrants, to the area. When the unit opened, one in three local residents had been born in a foreign country, and one-third were under age 19. The unit opened with the main mission of admitting adolescents with behavioural problems for a so-called 'crisis' hospitalisation period. Staff psychiatrists in this unit are all around 60 years old and are influenced, to varying degrees, by psychoanalysis; they believe in the potential benefits of hospitalisation but also denounce its possible drift, a position consistent with the mainstream institutional psychiatry they learned while in training (Henckes 2009). The interdisciplinary team consists of youth counsellors and a social worker, in addition to mental health professionals.

Observations were conducted in the unit an average of three times a week between November 2006 and June 2007. The researcher attended nurses' daily briefings, weekly recap meetings, and meetings outside the hospital with a variety of partner organisations, as well as therapeutic sessions and meetings with families when the care team and patients permitted it. Formal interviews were conducted with 30 caregivers of all grades, complemented by many informal everyday conversations with mental health professionals and adolescents. Altogether 30 therapeutic cases were followed, with medical file access.

Young people are directed to the unit following paediatric hospitalisation or by referral from an outside psychiatrist, counselling service, or magistrate. After psychiatrists evaluate their situation, they are admitted as either in- or outpatient for a period ranging from a week to three months (the average being a month). One annual report highlights one characteristic of its clientele: 21% of the young people admitted to the unit 1991−1994 had received court orders for social counselling assistance. Observations suggest that this percentage is distinctly higher among inpatients, half of which were in this situation between October 2006 and June 2007.

Psychological problems, social problems

Of the 30 young people in care concerned by this study, only four came from the upper classes and five from fractions of the lower middle classes and upper working classes; the rest (21) came from the lowest fractions of the working classes − mostly children of immigrants (seven from sub-Saharan Africa, six from North Africa, one from Asia) or immigrants themselves (a girl from Algeria, a boy from Morocco, a girl from the Congo). This is linked to the socio-economic characteristics of the local population as well as the strategies of the higher classes, which do not usually call on this kind of public institution. Half of the studied cases are those of adolescents that are hospitalised for 'behavioural problems', and all the young people concerned are from the working classes.

The 'social' dimension of behavioural problems

The weight of social variables cannot be overlooked when considering the life histories of young people in care for behavioural problems. Their trajectories are marked by insecurity and broken families, even abandonment and foster placements in a majority of cases. For at least some adolescents, psychological 'destructuration' seems to result from a disjointed and painful personal history.

Daniel's situation exemplifies this well. His parents were undocumented immigrants from the Republic of the Congo. He was separated from his underage mother while she was still breast-feeding, shortly after the deportation of his asylum-seeking father. Since social services could not find housing for both mother and child, they placed the mother in a youth home and the baby with a childminder. They kept in touch for a while, but the young woman's legal and material insecurity prevented her from being able to see her child regularly. Daniel's child-minder had to cut his work short because of a serious health problem, so Daniel was placed in a children's home, resulting in decreasingly frequent contact with his mother. Behavioural problems got worse over the years and he was hospitalised at age 12.

Some young people who were socialised in working-class neighbourhoods internalise street-culture values. These values hold that you should never 'let your guard down' and must always seem both physically and psychologically strong without facing the risk of being denigrated by the group. Souad thus describes how she became violent shortly after starting middle school, because she was being mistreated by other adolescents and had no brother or father to take her defence. To stop being treated like a 'jester', she began to react to insults and get into fights. She was obeying the fundamental principal of 'never getting down on all fours like a dog'. What institutions categorise as behavioural problems happens to correspond to what is valued in the street: violence, aggressiveness, talking back, and refusal of subordination are all ways of defending your honour and reputation and being labelled an 'aggressor' rather than a 'victim' (Bourgois 1995; Lepoutre 1997). What is seen as normal among peers is re-interpreted as a symptom of suffering in the institutional field.

The trajectory of Jonathan, barely 13, illustrates this. From the age of nine he found himself in front of the school's disciplinary board. His 'problems' worsened upon starting middle school (extortion, carrying knives, violence, theft), and he consequently started seeing a counsellor and a public psychiatrist. He attended four middle schools between September 2005 and December 2006. By January 2007 he had quit school, and was referred to the facility's day clinic, where he signed up for several therapeutic activities. He proved to be rather subdued and shy. A month later Jonathan ran away and his father brought him to the hospital's paediatric emergency service, hands tied. He was transferred to the psychiatric centre, with the main goal of removing him from his environment. He was in a gang of older adolescents and thought to be easily influenced; his parents worried about the company he kept. His parents were migrants from sub-Saharan Africa; his mother worked in food service and his father was a mechanic. They had no problems with their three other children. Jonathan was aware of his aggressiveness but did not have much more to say on the subject: 'Someone insulted me a little, I responded and I fought.' He asked to be kept away from 'the bad people who influenced' him. His parents agreed to a placement. Although the psychiatrists wondered about the psychiatric dimension of his problems (along neurotic lines, they thought), their etiology (lack of 'holding' following the

mother's depression/something 'unspoken' in the father's story) led them to agree that the environmental dimension had to be taken into consideration and that the priority was to respect the request to be removed from his present conditions. As he was very close to his family, the team recommended finding a small facility that could take him in during the week and allow him to return home on the weekends. They also planned to 'work with the parents'.

There are also situations where the problems seem to be partly related to a gap between strictly juvenile socialisation and the values of the family. Adolescents from immigrant backgrounds are especially prone to difficulties interpreting their experiences using their parents' explanatory systems. The dispositions children internalise in their diverse circles of belonging may thus come into contradiction and be the source of different kinds of identity crisis. This is all the more true because parents do not always recognise themselves in these 'children of France', 'illegitimate children' (Sayad 1979a, 1979b) over which they sometimes feel they have lost control (Coutant and Eideliman 2015); this theme will be picked up in discussion of Malis's situation in the following section.

Justifying intervention

In situations where social and psychological problems seem intertwined, the facility's evaluative function justifies inpatient admission, should they wish to choose that option. Psychiatrists can then consider which pathologies might underlie behavioural problems, and whether a diagnosis would help with prevention.

Hospitalisation is also intended to protect adolescents that repeatedly run away ('stop the self-destruction'), which justifies it for professionals. For girls, counsellors and caregivers tend to worry about potential sexually 'dangerous situations'. During this study, six teenaged girls were prescribed a pregnancy test and anti-HIV therapy. Three had been raped. For boys, professionals are more fearful that delinquency might develop. In the studied cases, this psychiatrisation of behavioural problems concerned girls of a wider age-span than boys: after a certain age it seems that such problems may be re-interpreted in the register of confirmed delinquency in boys (and penalised), whereas girls they may be connected with the expression of suffering for a longer period. This is probably related to a representation of girls as potential assault victims. Girls' violence and rebellion might also be more pathologised, because society and people in the girls' lives see them as more socially abnormal than comparable behaviours in boys (Cardi and Pruvost 2011).

Malis, age 16, was referred by her high school to a public-sector psychiatrist for depression and suicidal thoughts. Her family was from Cambodia and her parents speak little French. She was the youngest of four daughters, one of two born in France, and the most restive. She wants to go out with friends, hangs out with boys, and spends time on social networks. Her psychiatrist and parents decided to hospitalise her after she was the victim of a gang rape, because she was 'putting herself in harm's way' by not taking her retroviral treatment, skipping school, and loitering in the housing estate. She seemed 'very detached from the event'. The unit psychiatrist agreed to hospitalisation for fear that the girl would 'give in to the whims of just anyone': 'That's the aspect that I see. Because we aren't here to stop young people from being assaulted, that's up to the police.' A three-week hospitalisation was planned to evaluate her problems. Malis confided to a counsellor that she felt she did not get enough recognition and affection from her parents, felt like 'the ugly duckling'. She had overheard her father tell her uncle on the telephone, 'She's not my

daughter. She says bad things, she's never done anything good.' Her psychiatrist from before her hospitalisation emphasised the 'division in the family': 'there is a major problem of connection, an intra-familial psychopathological aspect. The Cambodians on one side, the French on the other. The two daughters born in Cambodia speak the language. The youngest two are considered to be foreigners. For the parents, the difficulties with the latter two are not from them, but from France'.

The work mainly consisted of mediation between father and daughter. At the first family interview, father and daughter did not greet each other. The psychiatrist would not allow her sisters to play the role of linguistic interpreters, calling instead on a nurse of Cambodian heritage to help. She wanted to arrange it so that father and daughter spoke directly to each other. The father expressed his worry, his difficulties speaking with his daughter. Initially Malis remained silent, eyes downcast, but she was listening. She finally spoke up, in French, to mention problems communicating with her father and to explain that she felt 'invisible' at home. Initially she was 'in denial about putting herself in harm's way' — at least this is how the youth councillor interpreted Malis' attitude in her record based on her observation of the encounter — but her speech changed over the course of the interview and she acknowledged that she would not let her own daughters go out as they wished. She ultimately understood her father's perspective. At the end of the interview, she spoke to him in Cambodian. The father embraced his daughter, teary-eyed. In the following days, Malis said she was becoming more aware of the cultural divide in how people are brought up. The psychologist noted, 'Malis is questioning who she is, is thinking both about her relationship to her parents and about herself'; 'she can finally admit that she was very sad.'

Resisting youth services' requests

The psychiatrists admit they treat the 'malaise of the housing estates' and recognise that 'if youth foster homes were better equipped, a lot of situations could be handled without resorting to psychiatrists'. They are particularly careful to define the parameters of their interventions. For instance, a year after nationwide rioting (Fassin 2006), psychiatrists would respond to certain policies addressing adolescent disruption of scholastic and public order by asserting, 'We aren't here to stop car-burning! That's the police's job, not ours!' They have been known to resist requests from counselling and legal services and condemn Prefects or Magistrates' tendencies to make their own diagnoses when dealing with adolescents.

The unit ends up having to pick up the slack of other under-resourced youth-oriented institutions that tend to off-load their missions onto them. This is regularly demonstrated (or at least glimpsed) in evaluation interviews, much to counsellors and adolescents' distress.

It was particularly evident in the case of Jessica, a 14-year-old girl brought in by the director of the foster home where she had been living. He described her 'aggressive and violent' attitude, her absenteeism in school, and her acting out (suicide attempts, attacks, running away, opposition). He mentioned the family setting (a violent step-father, her mother's rejection) that was behind her foster care, and commented, 'Jessica is lost'. The psychiatrist was not easily convinced, so the director insisted, 'We thought we had to give her a place where she can be depressed.' The psychiatrist, joking a little, replied 'So you've taken classes with us!' The director, who knew the institution well, having brought other

adolescents, admitted, 'Perhaps, having come here…' He even outlined some avenues her therapy might follow, based on his perception that her family was harmful. The psychiatrist wondered, 'And why do you think we will do that better than you?' to which the director responded 'We don't have the skills, and we don't have the space to manage crises…,' then sighed that he was rather at loose ends with Jessica himself.

Indeed, psychiatric institutions have to deal with a demand for care that they helped to build by creating categories and institutions for addressing behavioural problems and by socialising counsellors to their worldview, although it might not always be the most appropriate institution for addressing a given situation. This was especially true in this case, where Jessica firmly refused their suggestions and was not admitted.

There was a similar exchange a few weeks later. A 15-year-old named Latif was brought in by his counsellor. He had just been expelled from two middle schools for behavioural problems and insults, and had been taken into police custody for throwing rocks at a car. The counsellor explained that he had been born in Paris and grew up in a bigamist family from Mali. Latif was the eldest of the second wife's children. A year previously the father had decided to separate his wives because of their conflicts, and henceforth Latif lived with his stepmother. The counsellor had trouble discussing these subjects with the boy, who she described as 'very closed'; she was at a loss, despite having a good working relationship with the father. During the interview Latif was silent, his head low. 'Attitude of passive opposition, gives evasive responses, refuses care', the psychiatrist wrote in his file, before concluding, 'Few therapeutic solutions. Perhaps the day clinic in relation with the middle school?' But his father, attending the following session, insisted that Latif be admitted to the day clinic so the situation would improve. Wearing traditional African clothing and struggling to express himself in French, he expressed his confidence in institutions but inability to understand his troublesome son, so unlike his other children.

To justify the admission, the psychiatrist filled out a protocol with a diagnosis supporting the request: 'Risk of development of serious personality disorder.' He added clinical arguments: 'Violence in school and in the street. Several expulsions, in police custody once. No truly utilitarian motive, rather depressive rage. Perhaps a therapeutic approach possible, in addition to counselling measures.' The advising doctor approved 'personality disorder'. The day clinic team set the following objectives: 'Support education, participate in orientation plans, time for evaluation, try to get engaged in care.' Latif came in three half-days per week, and caregivers noted improved school behaviour, despite the emergence of some learning difficulties. Surprising day-clinic adults, Latif (who had always said he wanted to work) quite actively sought an internship, and found one himself in food service. Gradually, though, the team developed a care plan combining institutions for care and schooling. In fact it is surprising that his case was qualified in a pathological register to justify his admission, given the psychiatrist's initial uncertainty that such care was necessary. The unit's paediatrician signalled this in her way in a meeting: 'Just what is his pathology, other than slacking in school?'; 'borderline condition,' replied the psychologist. Enquiries into his situation a year later revealed that Latif had refused the suggested plan, but had enrolled at the Apprenticeship Centre, his employer having agreed to let him follow a programme alternating school and work.

Analysis of the cases presented here confirms that they all fall at least partly under what is usually designated as the psychiatrisation of delinquency. At the same time, psychiatry must increasingly deal with other institutions that are confused when confronted with

young people they cannot handle (Sicot 2007). This might lead one to think that growth of the category of new pathologies is less due to the supposed novelty of the problems than it is to a concurrently growing interest in adolescent suffering within the political field and among psychological professionals (Fassin 2004; Rechtman 2004) and the recent transformation of youth counselling systems, compounded by the context of growing public insecurity. Especially at middle-school level, rising school attendance levels, resistance to holding students back, and recognition of the family's place orienting children's studies has meant a decline in teachers' power. In fact, they have to deal with adolescents who are obliged to attend school through age 16, but without having the marks necessary to get an apprenticeship. Counselling services have also undergone significant changes since the 1970s, mainly the closing of large, strictly supervised foster homes and the shift to more relaxed supervision, such as providing counselling assistance to non-residential youth. Moreover, the degradation of living conditions touching young people from 'the estates' may lead to a variety of problems, from drug use to the radicalisation of street culture.

This approach tends to overshadow professionals' resistance to the instrumentalisation of psychiatry for the ends of social control and the entire ethical dimension of their reflections about their function, as illustrated by the doubts they express in the presented examples. Furthermore, it masks the fact that the category of 'behavioural problems' clumps together young people with very different profiles. Problems can be significant and debilitating, preventing them from being fully functioning members of society or putting the adolescent in serious risk. In some cases the behaviour problems relate to pathologies that include loss of contact with reality (hallucinations, delirium), leading to diagnostic hypotheses in terms of psychosis.

Limiting analysis of this kind of institutional work to the psychiatrisation approach would be to underestimate the co-construction that takes place during interventions. It also gives short shrift to what happens when professionals and their publics meet.

Psychiatric intervention as co-construction

Although psychiatric work is partly based on restraint through confinement and medication, it also inherited the vocation of assuring a transformation permitting its patients to join society. In this sense it is an attempt to modify the person, self-transformation work (Darmon 2009) or self-cultivation (Mahmood 2005; Matza 2009; Zigon 2010). For the psychiatrists in this unit to see their work as 'well done', adolescents not only need to have changed and progressed, they must also have acquired new forms of self-management through specific emotional work (Hochschild 1979) — they must appropriate the undertaking. The influence of psychoanalysis in France, the internalisation of criticism of psychiatry over the 1960s to 1970s, and the more recent emergence of the recognition of psychiatric patients as legal subjects have together created a model for normalisation practices that are subject to negotiations between patients and caregivers. Ideally one should obtain consent, not 'do in the place of', and ultimately allow patients to gain greater self-control, which here seems to be based on the 'power to speak'.

'Working on the alliance'

To begin psychiatric work in which professionals set out to transform someone with the objective of independence, they must first be perceived as moral authorities. This position of authority presupposes that the caregivers believe that their mission is valid, and that they can get it recognised as legitimate. It is important to get the confidence of the family (when there is one) from the moment an adolescent is taken into care, and some form of engagement from the adolescent. They call this 'working on the alliance'. They must then constantly both justify and supervise the violence of confinement and discipline (Gansel and Lézé 2015), so although medical power tends to ultimately assert itself, this does not happen without some discussion.

During the study, the team was concerned about a 14-year-old girl named Souila, who had been hospitalised in paediatrics following an attempted suicide by medication. She had been in sporadic contact with the unit for two years. In early 2005, at age 12, she had already been hospitalised in paediatrics after drinking bleach during a conflict with her mother. They fought over Souila's clothing and going out. In spring 2005 her middle school indicated behavioural problems. Shortly thereafter Souila was taken into police custody for assaulting a young man with other adolescents: her panicked mother once again appealed to their services. The social worker 'works with the mother on a request for counselling help, which she has trouble accepting but seems necessary for bringing in a third party.' The mother allowed the unit to speak to the juvenile judge, who issued a court order for social counselling. Things worsened, however, when Souila was expelled from school for insulting a teacher. Her mother, who worked a late shift as a hospital service employee, could no longer control her comings and goings. Distraught, she contacted Souila's father (separated since her infancy) in the hope that he might take her in. He refused, fearing he might 'hit her and find himself in prison'. The service fruitlessly suggested several care plans. The mother finally accepted the idea of a hospitalisation in January 2006, but after the admission interview, as she was being taken away, Souila screamed and begged her to not leave her there. Her mother collapsed in tears and cancelled the hospitalisation. The team heard nothing more for a year.

When they next saw Souila, in January 2007, they learned that a juvenile judge had placed her in foster care two months earlier, but she had run away from the foster family after three days. The team was worried. Her mother agreed to psychiatric hospitalisation in February 2007 but rapidly expressed reticence, especially concerning medication-based treatments. Unsure of her engagement, the team wondered if they should request a ruling for provisional placement from the judge, in case she decided to withdraw her daughter against medical advice. The unit's directing psychiatrist retorted that this raised ethical issues and it would be better to 'take a chance' and wait for the next interview before planning the next step. The psychiatrists felt that 'the alliance is fragile' and should not be 'broken'. Since the young woman was also hostile to the idea of foster placement, one of the psychiatrists suggested a 'middle position': 'it's ridiculous to force a kid to go elsewhere, she'll run away. But the father needs to be supported and reintroduced so there's a third party between mother and daughter. We have to work on the mother and daughter's separation, without rushing.'

This case is revealing because the question of alliance work is made quite explicit. The professionals wonder how best to go about it, so as not to undo previous work or overstep

their role. The 'right way' is consequently structured around ethical issues and criteria for therapeutic effectiveness: avoiding the authoritarian imposition of medical power while trying as best as possible to get its legitimacy recognised implies considering the patient and family as people whose opinions should be taken into account and increasing the likelihood of a consistent intervention. It also means taking some risks, mainly that the adolescent might 'put herself in harm's way'. Although this kind of intervention makes sense given how psychiatric institutions developed over the latter half of the 20th century, it is more broadly in line with transformations in State action in recent decades: in all institutions, work 'with' families has replaced work 'on' families (Astier 2007). This corresponds to considerations that are both moral (users are seen primarily as subjects, responsible individuals) and, increasingly, economic (in view of transferring State costs to families).

Transmitting the 'power to speak': the pedagogy of reflexivity

Once they decide to hospitalise, the care team's mission is to guide adolescents toward newfound self-control by getting them to speak more, particularly about feelings. In this regard, hospitalisation is the occasion for a specific institutional socialisation, as paradoxically it may be a time for acquiring or re-enforcing interactional skills or communicational capital (Schwartz 1998). This happens through apprenticeship in new forms of self-management, which is to say through identification of an individual's disorders (relative to dominant social norms), affects, and needs. This is what makes it self-transformation work. As one nursing auxiliary explained it to an adolescent, 'It's you who does the work', to which the adolescent shot back, 'Just what do I have to work on?' This aspect of the work is not always easy to implement, since it presupposes adolescents accept the idea that they have work to do, which implies that they acknowledge the problems that brought them into care and recognise them as such, instead of being in 'denial' or 'trivialisation'.

Most often, especially at the beginning of care, the caregivers do most of the talking and suggest emotional states ('you are angry/sad/worried…') and possible interpretations of the supposed feelings. Service staff, nursing auxiliaries, nurses, and counsellors sometimes pull adolescents aside during the day; psychiatrists and psychologists intervene in a more ritualised manner in scheduled individual sessions. The logbook shows how each intervenes: caregivers note particular interactions during which they 'verbalised' the adolescent's feelings. For example, of a girl who was dealing with a failed placement in a foster family, it read, 'I verbalised her disappointment for her'. Gradually, adolescents integrate this vocabulary along with the habit of putting moods into words. Although the relationship to speech varies with cultural capital, it is not the only criteria, as pathology type, gender, and the habit of institutional relationships also play a role.

The work to be done differs according to pathology and social background, however. For adolescents that present behavioural problems, the objective is to teach them greater self-control. When tensions rise in daily interactions caregivers may take adolescents aside to ask what is wrong. Emotions are considered legitimate, but they have to be expressed in an appropriate way. Caregivers thus make the difference between saying and doing explicit ('you've got a right to be angry'/'you have no right to go smashing things'). They suggest acceptable self-management methods (talking, moving away). This work on emotions is based on explanation as well as discipline: a rebellious adolescent may be sent to

her room, while observable progress is met with encouragement ('You could handle what I said to you'; 'you were able to…').

Daniel, the minor in foster care introduced earlier, was hospitalised for suicide risk and then monitored for hyperactivity and behaviour problems. During an interview with his counsellor a few months later, the psychiatrist spoke of his 'considerable progress'. By day, the 13-year-old attended a clinically supervised educational institute, and he stayed at the hospital for nights and weekends while waiting for a foster family. The psychologist weighed in, adding, 'Now when he can't stay put he can ask to leave. And in an interview he was able to say that he's been more agitated lately.' She continued, 'He said that you'd found traces of his mother and that got him really worked up.' Daniel arrived. The psychologist repeated what she had just said, 'You listen to adults more, you manage to talk.' The psychologist put into words what she imagined he felt, the impatience stemming from an endless hospitalisation despite progress. Daniel listened and smiled, his head down. He concluded by speaking of his joy and anxiety at seeing his mother again. After their reunion some time later, the psychologist said she was pleased the boy 'could say' that his mother had been 'moved': 'I am happy that he was able to use that word.'

Teaching the language of emotions is transmitting a 'power to speak'. The value placed on this power to speak is linked to unit professionals' objective: making it so that the patient can make his or her own decisions and eventually gain more control over relations with others. This interpretation of psychiatric work could be considered a pedagogy of reflexivity (Coutant 2012). Regularly commenting on adolescents' observable progress is a way of guiding them out of themselves. The psychologist defined her role after a 'clash' this way: 'My role, that afternoon or the next day, is to see the kids and say 'What happened? What happened so you lost it? How could that happen differently?' The passage of time offers conditions conducive to reflexivity. Patients should also be helped to formulate their own will. Sessions with psychiatrists and psychologists manifest this distinctive and separate space dedicated just to 'I', and caregivers encourage adolescents to wait for this particular setting to make certain requests. The interview session is the ultimate space for mentioning 'personal things', marking the boundary between the intimate and the non-intimate.

Alongside the 'I' aspect of identity, professionals also intervene on the 'we' side (Elias 2001), whether it be what they call family-relations work (interviews with parents, interventions to influence family relations) or work down the line (discussions with patients, families, and various institutional partners to set up return to ordinary life). All these interventions — leave time, using the day clinic, and in some cases returning to school part-time — are intended to gradually make the adolescent independent.

Dilemmas: caregiving without undermining responsibility, taking youth in without it becoming chronic

To guide adolescents in a process of subjectivation that is not a simple subjection (according to Foucault's definitions), the psychiatrists grant them a certain degree of autonomy and, once the acute problems have been treated, the ability to make decisions about things concerning them. Nonetheless, this conception of 'good work' is regularly challenged, posing dilemmas for the professionals (Rhodes 1991; Brodwin 2008; Fassin et al. 2015).

It is not always easy for them to 'provide care without undermining responsibility'. The topic of contraception for girls is a good example, as the prescription of an implant is controversial whenever the possibility is raised. Some caregivers believe that prescribing implants symbolically condones some girls' 'risky' sexual behaviours and negates the idea that they can be guided toward relative control over their existence. This kind of dilemma (caregiving without undermining responsibility) may also be found when psychotic adolescents with delinquent behaviour are taken into care. The psychiatrists do not automatically equate the delinquent acts with the pathology. The psychiatrist responsible for the unit interpreted the fact that one of his patients had joined a gang of delinquents in his housing estate as a sign that psychologically he was doing a lot better, because he had previously been very isolated but had developed the ability to connect with other adolescents. After the boy was re-hospitalised at his own request, the psychiatrist decided to release him upon learning that he boasted of his crimes every time he returned from leave. 'The problem that arises with him is when do we stop? […] You do stupid things, but it's not because you do stupid things that you're in therapy − you're in therapy because you're unwell. We've had several patients like that, who we improved in psychological terms, who raised some problems but of a rather different order, the social order. They cross the line in other ways. It's going better in their heads.' According to him, other institutions may be more relevant for these adolescents, potentially even prison, which is a complicated situation given the failure of the prison healthcare system should they need care.

Mental health professionals also have to deal with contradictions when the hospital ends up being seen as a refuge for the most underprivileged youth. The professionals have integrated the idea that hospitalisation over a given length is bad for the patient, 'becoming chronic' when it lasts too long. In this under-resourced sector some adolescents in conflict with their family or placement may show up at the hospital, where they have a routine, as if it were a 'second home'. Caregivers may hesitate before agreeing to some of their requests for re-admission. The psychiatrist in charge of the unit, more pragmatic than his colleagues and less permeated by psychoanalysis, tends to think that it might be important to offer refuge to patients to 'allow them to breathe'. One of his colleagues is more reticent, fearing the establishment of a downward spiral. Young people reliant on social services do often spend longer in psychiatric care than deemed necessary for their therapy, for lack of institutional solutions down the line from the hospital. In situations like this, it is as though psychiatry once again finds itself in the role of confiner, despite the fact that its practitioners, aware of its history and the challenges it has faced, resist the development.

Conclusion

This study of the uses of public psychiatry in a disadvantaged part of greater Paris reveals the distress of social workers and magistrates confronted with situations that are unmanageable for lack of means and appropriate facilities, in a context of increasing population vulnerability. Injunctions for the protection of children may thus lead to the confinement of errant adolescents. When the young people manifesting 'behavioural problems' happen to come from the working classes, their problems are additionally cast as an issue of public order, in line with the logics demonstrated by Michel Foucault. This is somewhat controversial among mental health professionals (as discussed in the introduction) and raises

questions during the everyday practice of psychiatric activities: how legitimate is the intervention? How far to go? It is thus hardly surprising that psychiatric interventions with a powerless public are for pathologies that are not always entirely confirmed in the nosography, a situation that does not seem to occur in higher social categories.

Once the 'alliance' is strong enough, the first objective is to envisage the hospitalised adolescents' re-integration, meaning increasing their capacity for self-control. This undertaking is based on self-transformation work, where the self is understood as a configuration connecting the 'I-identity' to a 'we-identity': in the studied unit, it was a matter of strengthening the 'I' with a pedagogy of reflexivity and transmitting emotional and communicational capital while at the same time re-articulating a 'we', familial and social. Professionals tried to pass on the power to speak, an integral part of a psychiatric power that also intends co-construction.

Although the way in which psychiatric power is practised in this institution is probably specific in some ways to the field site, it is nonetheless in line with a broader trend in governmental population transformation. In societies valuing independence and individual emancipation (for reasons as much economic as moral, as costs are shifted from the State to families), many institutional actors are led to work 'on' patients by working 'with' them. In this regard, decision-making is partly co-constructed between institutional actors and the people who are the object of interventions. This might be even more evident when the working classes are concerned, as in the cases presented here, because their norms may be somewhat different from institutional norms, and this distance has to be reduced through specific pedagogical work in which speech has taken a prominent place. Regardless, the situation should not be interpreted as the opposition of a disciplinary past with a non-disciplinary present − partly because the State's 'domestication of the dominated' has always been as rife with discipline-as-philanthropy (Bourdieu 2012), and partly because current forms of intervention are still about discipline, albeit practised in another way. Discipline speaks and makes speak because it is surrounded by ethical prescriptions and a certain conception of the human being, overlapping moral concerns and neoliberal injunctions.

Institutions are places to socialise the working classes more than other social classes, because their norms are the furthest from dominant norms. The psychiatric institution is no exception. The most helpless may see it as a refuge, not just a place of confinement, once their initial resistance has been disarmed. Their requests to return, which are the price of the care teams' success, speak volumes of such adolescents' living conditions outside the hospital: not all have the resources to live as 'subjects' without support (Castel 2002).

Note

1. Inserm Expertise Collective. 2005. *Troubles des conduites chez l'enfant et l'adolescent*. Paris: Editions Inserm.

Ethical approval

A Convention has been signed with the hospital studied, who approved the research and precised its ethical features. Oral consent for observation and interviews was also obtained from each study participant.

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