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Introduction

Based on a double reading with sociological, historical and pragmatic perspectives, this chapter aims to give an account of some of the uses and reconfigurations of the clinic in the broad field of social intervention. The focus will be on the user/beneficiary (the helping relationship clinic), on the vulnerability of his social environment (the social clinic) and the professional challenges of the social workers who accompany the user (the activity clinic).

We will argue for a certain de-psychologization of the clinic in the field of social intervention, an area which is itself undergoing profound change. We will make the following two observations: the field of social work is now extending far beyond strictly psychological interventions; and there is increasing pressure on social services in terms of absorption capacity. These factors challenge the field’s fundamental stance, which consists in addressing the negative side of the situation.

Sociology put to the test in the clinic

Let us begin by specifying what type of sociological viewpoint we can adopt on the clinic depending on the degree of involvement of researchers, whose skills-sets are varied: they are, in turn, historians, analysts or practitioners. Since for sociologists the clinic can be both an object of investigation and a place of practice, we will start by opposing two distinct but complementary approaches: clinical sociology and the sociology of the clinic.

The sociological project of making clinical psychology an object of analysis is part of the tradition begun by Norbert Elias. It links psychological processes – such as psychological self-control or the self-regulation of affects – to a specific dynamic of civilization taking place at the time of the creation of modern states (Elias, 1991). More recently, there has been research on subjectivity as an object of public policy (Cantelli & Genard, 2007), on the increase of psychological suffering (Ehrenberg, 2010) and on the existential hardships of social vulnerability (Martuccelli, 2014). This research systematically analyzes, in the era of late modernity, the generalized social requirement of individual involvement and its processes of accountability, participation, activation or empowerment.

The contemporary individual is no more psychological today than he was yesterday. He has, however, since the advent of modernity, been beset by a series of hardships that can find, in psychology, a partial but fruitful language of analysis. (Martuccelli, 2007, p. 50)

The sociologist can also take as his object the clinic at work in given social configurations with a view to examining its practices. In this respect, Robert Castel's pioneering studies on 'psychoanalysis' (1973) and mental health (1981) paved the way for the criticism of the psychologization of social work (Bresson, 2006) in terms of analyzing spaces for listening (Fassin et al., 2004), 'self-help' (Vrancken & Macquet, 2006), clinical treatment for unemployment (Oriane, 2006) and contemporary psychiatry (Coutant, 2012; Otéro, 2015). Other studies, focused more on social work, have been conducted on the psychosocial clinic (Ravon, 2005), the clinical concern for integration (Laval, 2009) or the clinic of precarity (Pégon, 2011).

These sociologies of the clinic differ from each other with respect to their proximity to practicing psychologists. When the proponents of these different sociologies are unfamiliar with clinical practices and their systems of reference, and mainly guided by the all-out denunciation of social psychologization processes, they risk spinning out of control. On the contrary, when the sociology of the clinic is supported by a pragmatic approach that does not presuppose the meaning of clinical practices but rather interprets them on the basis of a concrete analysis of how they are implemented, it can fulfill its role of understanding generalized individuation processes without losing any

of its critical vigilance (Ravon, 2005).

The clinical sociology project is also supported by the analysis of the processes of subjectivation and by the critique of the psychologization of the social sphere. However, it differs from the sociology of the clinic in the type of relationship it maintains with the related discipline of psychology, at least in its clinical and psychosociological approaches of psychoanalytic or psychodynamic orientation. It is attentive to the unconscious issues of the subjects (individuals or groups) in order to better explore the 'psychological dimensions of social phenomena'. It is also multidisciplinary from the onset: 'It would be more appropriate to speak of "clinical social sciences", or even "clinical sociopsychology"' (Gaulejac et al., 2012, p. 10). 'The interest in integrating the clinical approach into a sociological perspective' is thus based on the ability to question 'the different forms of the production of knowledge', to redefine the 'conceptions of objectivity and subjectivity', to use 'subjective methodologies in the production of knowledge', to analyze 'the notion of subject in the face of subjugation processes', or to question 'the position of the researcher and the social worker (Gaulejac et al. 2007, p. 24).

Thus defined as an interdisciplinary approach, clinical sociology is characterized in particular as a method of intervention (Herreros, 2009). By placing at the heart of its practices and analyses the question of transference and counter-transference, that is, the subjective involvement of the researcher, but also by importing some key concepts from clinical psychology, clinical sociology can be criticized by sociologists themselves. Some of them highlight the dependence of clinical sociology on psychologists' categories such as 'neurosis' or 'narcissism' (Martuccelli, 2007), with the risk of a shift from sociological tool of analysis to symptom (Genard, 2015). At the same time, it can be criticized for its attachment to the notion of suffering, which tends to make conflictual social relations an object of compassion (Fassin et al., 2004), where other observers, no less critical, nevertheless make it a powerful indicator of the crisis of our advanced societies (Renault, 2004).

Beyond the various approaches and the controversies they generate, sociologies interested in the clinic are the object of frequent questioning addressed to the society of individuals. How can we understand the link between the process of subjectivation and

production of a subjugating society? How can we account for the individualized treatment of the social question? How can we conceive of social injunction so that it might become the actor of its own change?

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It is at the crossroads of these two complementary approaches that we will now conduct a sociological analysis of the clinical mechanisms at work in the broad field of social intervention in order to contextualize their different uses without reducing them to a single psychologization enterprise. Whether it is addressed to the beneficiaries of social intervention or to its professionals, or is part of the deficit paradigm of social integration at work since the end of the 19th century – or in the much more recent paradigm based on a capacity-centered anthropology that incites people to act – the clinic refers to different experiences that we will assign to three categories: (1) the helping relationship clinic, when the focus is on the beneficiary and the relationship associated with it; (2) the social clinic, when the vulnerability of the social environment of the person being cared for and the underpinning psychosocial supports are at stake; and (3) the clinic of professional challenges, when the issue concerns the institutional, organizational or ethical difficulties that social workers encounter in their job.

The helping relationship clinic: from psycho-pedagogy to relational work

If we follow the history of social work since its foundation at the beginning of the 20th century, psychology is the main discipline of reference. Since 1968, sociology too has made a number of breakthroughs and has emerged today as a discipline of primary importance, at least in training centers. With Binet and the implementation of advanced training courses (1909), a clinical model of social intervention developed under the name of psycho-pedagogy. Placed under the psychologist's gaze and measure, the deficient child is no longer 'abnormal' but 'delayed', no longer 'incurable' but 'irregular'; in a word, he becomes perfectible (Ravon, 2000). In a way, Binet invented what would become the very heart of the profession during the years of growth and specialization of social work in the 1960s and 1970s: namely, a technique for identifying and compensating for the

failings of social integration. What is at stake here is not so much the psychopathological measurement of disability as that of inequality relative to some kind of deficiency, which always measures an inferiority (Castel, 1981) or a (developmental) 'delay that can be observed so as to be able to make up for it' (Rancière, 1987, p. 198). Binet does not use the term, but the 'scientific pedagogy' he develops, in the form of psychological tests, is clinical throughout: visual descriptions of the schoolchild's body, psycho-physiological measurements and moral surveys of families combine to paint pictures of 'social and physiological poverty'. Daniel Lagache's later definition of clinical psychology, of which he is considered the founder, takes up the characteristics of Binet's psycho-pedagogical approach: 'the study of individual human conduct and its conditions (heredity, maturation, physio- logical and pathological conditions, life history) – in a word, the study of the total person in situ' (Lagache, 1949, cited by Ciconne, 1998, p. 10).

At the end of the 1960s, psychologists in social and medico-social institutions added to their objective assessment of the disorders of 'unsuitable' children and adults a more subjective focus. Rogers' non-directive pedagogy, to which we owe the very notion of a helping relationship (Laval, 2000), spread rapidly and widely within the field. Guided by an 'attitude of unconditional positive consideration' favorable to 'self-esteem' or 'raising oneself up' towards the person being cared for (Rogers, 1967, p. 248), the psychologist can then develop a subject-based clinic. The question of listening becomes central. This is shown by the success among social workers, especially specialized educators, of the work Summerhill by psychoanalyst A. S. Neill (1971). Against the model of 'instruction' producing 'shaped, conditioned, disciplined, repressed' children, and against a social system that manipulates individuals so much that they forfeit their 'free consent', the aim was to promote the conditions for their self-determination.

The function of clinical listening has taken various forms and has been recognized as a central competence of social workers (Chauvière, 1999); with a few exceptions, they orient their intervention based on interviews diagnosing the gaps and difficulties that need to be addressed. The extended use of this 'interventionist psychology' is no longer reserved for psychologists. It corresponds to a considerable transformation of social work at a time when, without a strong institutional program, without a real possibility of integration and without a precise educational future, social workers can only resort to

their capacity to listen to those they are trying to help (Ion, 1998). With the exponential development of social support practices, the relationship with the other becomes an essential reference point for social policies, and the helping relationship gives way to 'how to help relationships' (Laval & Ravon, 2005). It is therefore no longer a question of working on others, but of 'working with others' (Astier, 2007).

Didier Fassin has proposed a critical reading of what he calls a 'policy of listening', which he characterizes as a 'socialization of psychology': 'a process by which the notions of psychology can become the commonplace of social action, regardless of the agents that implement it: psychologists kept away from the know-how of their profession or social workers now more sensitive to the psychological approach of their public than to their sociological reading' (Fassin, 2007, pp. 67–68). Fassin sees in this reconfiguration of the helping relationship a change in perspective of the intervention, humanitarian rather than social, led by moral sentiments rather than a principle of social justice (Fassin et al., 2004), one where the professional is inhabited by an 'ethos of compassion' (Fassin, 2007), and where, despite the effort to render the helping relationship more symmetrical, it remains fundamentally unequal¹.

To summarize, we have witnessed a general transformation in the clinical framework of the beneficiaries of social work: initially identified as individuals whose delays or shortcomings must be objectified in order to better integrate them, and then as subjects to be listened to with an eye to emancipation, users now tend to be recognized as people with relational skills that must be associated with the production of the intervention itself (Ion, Laval & Ravon, 2007). This reconfiguration corresponds to a transformation of the clinic's places of practice: the Binet-style school-laboratory and its psycho-pedagogical experiments; the psycho-pedagogical consulting rooms of the psychologist and their rather closed space to promote the 'face-to-face bond'; and, today, practices of moving beyond the walls of specialized institutions and private practices. Indeed, new ambulatory practices have emerged since the 1990s: these include creating reception and listening areas, implementing mobile teams and making direct contact with people in the street. Listening is first and foremost about moving towards and meeting people (Ravon et al., 2000). The user now tends to be defined no longer on the basis of his status as a beneficiary, but rather on the basis of what is at stake for him at the very moment of

the intervention. It is therefore advisable to go to people to establish, in a given situation, what resources and means might be available to enable the social worker to define, with the user, the appropriate action (Ravon & Vidal-Naquet, 2016).

Social clinic: psychological suffering, social vulnerability and psychosocial support

The 'psychosocial clinic' (Furtos, 1999, 2000, 2005) provides a good example of this reconfiguration of social intervention. One of its main characteristics is that it addresses problems in the very places where they are expressed, that is, in areas of vulnerability where social precariousness manifests itself through severely deteriorated social living conditions (precariousness, sub-standard housing, life in the streets), through socially marginalizing situations (severed ties resulting from unemployment, divorce, the death of a loved one, exile), or by 'environmental defects' (violence or neglect within the family, occupational stress, urban and school segregation). This approach – initially called 'the clinic of salvaging' – emerged at the borders of social work and mental health at the end of the 1990s in a context strongly marked by the first projects to combat exclusion. It focuses on psychological damage (narcissistic fragility, self-deprecation or psychological collapse) resulting from negative socialization processes (Furtos & Laval, 1997). Based on Robert Castel's socio-logical analyses of disaffiliation (Castel, 1995), the psychosocial clinic focuses on psychological suffering but from a non-pathologizing perspective: this clinic does not construct 'psychological suffering' through a list of symptoms reflecting the psychological processes of the internalization of suffering, but rather from the relationship that is woven (or not) between the protagonists involved in the situation of help (Ravon, 2008).

Clinicians using this approach are thus characterized by their ability to travel to shelters, daytime reception centers, local centers, work welfare benefits request centers (French RSA) and so on². They are invited to actively 'hang out' in these places (Jourdan, 2005). Most of the time, they do not have an office, no name on a door and no predefined work schedules (Demetriades, 2002). It is a matter of reaching out to people in difficulty without waiting for them to come forward, thereby allowing them to solicit help as and when they wish via a system of 'free consent' (Furtos, Lahlou & Laval, 1999). Those

intervening are obliged to be there in person, on location – a place that is neither a traditional space for consultation nor an institutional establishment, but that place where the initial meeting itself occurred. These professionals do not establish a fixed position so as to explicitly maintain themselves in an intermediate, interstitial position (Lovell, 1996; Demailly, 2006). This serves to guarantee an optimal listening environment precisely because it is not structured by the institution; rather, it is defined by the uncertain, unprepared nature of the meeting (Roussillon, 1987; Fustier, 2000).

Unlike the psycho-pedagogue, who, constrained by the duration and relatively clear purpose of his mission, must implement educational strategies, and unlike the clinical psychologist, constrained by the temporality of the biographical narrative of the subject whose story he is listening to, the psychosocial worker here has only a tactical means of action that depends on the circumstances and is therefore inseparable from the situation in which it is used (Soulet, 2003). Such a position is particularly obvious when professionals, according to the situation, ‘de-specialize’ their behaviors. For example, psychologists accustomed to intervening on an outpatient basis routinely conduct the first interviews in such a way as to distance themselves from connotations associated with being a ‘shrink’ – without such distancing, no dialogue can take place. This is especially the case with users who, in a social assistance situation, identify interviews with therapeutic care and refuse to participate since they do not consider their request to be related to a need for care (Furtos, 2005).

The medical or therapeutic status is thereby neutralized, making it possible for users to formulate certain ‘non-requests’, be they requests that are impossible to make or cross-requests, when a user intentionally makes a request for care to a social professional and vice versa. There is no de-professionalization occurring here. On the contrary, de-specialization practices can be understood as an additional professional skill that opens up the helping relationship by creating a ‘benevolent environment’ (Vidal-Naquet, 2005), outside of which no negotiation is possible.

Thus characterized, the psychosocial clinic deviates doubly from the frame of reference of clinical psychology inherited from psycho-pedagogy. First, the psychosocial approach is not so much a clinic for the subject in need as it is a clinic for social deterioration. With

the models of social solidarity that emerged at the end of the 19th century, the right to assistance was conceived in the form of compensation and reparation. Aid was mainly conceived of in terms of redistributing rights to individuals who had been identified in terms of deficiencies, but with the promise of a place in an integrated world. The diagnosis of inferiority was therefore made in a progressivist manner, with educability as the guiding principle. The psychosocial clinic poses the problem in a significantly different way by referring to a 'malaise' linked to rocky social pathways rather than to initial inadequacies, disabilities or maladjustments that would conveniently explain the situation. First, the psychosocial clinic views negative social experiences expressed by the subject as they relate to social causalities. Therefore, it can no longer be the target of the usual criticisms made in terms of psychologization, insofar as it does not attribute the social dimension to the responsibility of those individuals who are most concerned. Second, the goal is more to support and care for vulnerable people than to heal or educate them (Hermant, 2004). Helping means reducing and managing the risks to which everyone is exposed, albeit in significantly different ways depending on the case. In a specific, localized context of social deterioration, the subject of help is immediately identified in terms of his autonomy, with his resources and his points of attachment and anchors. The challenge here is to support his capacities to manage his vulnerability in concrete ways. The solidarity model based on educability, where the inferiority of an individual is measured in terms of his possible progression, has given way to a new form of solidarity, where the diagnosis of vulnerability encourages supportive actions and perspectives for prevention or risk reduction. In this sense, protecting the vulnerable person also means promoting the activation of his role as an 'actor of his own change' (Ehrenberg, 2010).

Activation (Vrancken & Macquet, 2006), rehabilitation (Franck & Charrier, 2018), recovery (Rhizome, 2017), empowerment (Bacqué & Biewener, 2013): the challenge of strengthening the capacity to act now extends across the entire field of social intervention. Clinical practice is thus reconfigured in two ways. On the one hand, psychological suffering 'is now a reason to act on social problems and no longer just a reason to cure psychopathology. This change in the status of psychological suffering transforms this suffering into a distress signal, which then becomes a lever of action' (Ehrenberg, 2010, p. 302). The social question manifests itself as an existential problem

in that it makes it impossible for the person to meet the social requirement of self-realization in a world that is cruelly lacking in means of supports that allow autonomy (Soulet, 2005, 2007). The real focus of the clinic is therefore not so much the person's psychological antecedents as the consequences of the various processes of social deterioration. On the other hand – and contrary to traditional clinical approaches focused on the identification of deficiencies – the psychosocial clinic is oriented towards the search for unknown or untapped means of support, resources and capacities. In this respect, the psychosocial clinic can be considered a form of high-end social intervention that consists in supporting people who are actors of their own change and whose precarious, broken or diminished lives can nonetheless bring about new capacities to act. If we consider clinical activity as an 'attractor of negativity' (Pinel, 1996), we must therefore recognize its reconfiguration around a change of perspective, as though in neglecting the study of individual dysfunctions linked to the symptoms of the psyche, it was reorganized based on the analysis of societal deregulations attributable to neoliberalism. From this perspective, the psychosocial clinic is becoming politicized:

In recent decades, other forms of social suffering have spread, ones which in a way do not possess any precursors in the history of capitalist societies; they are much less accessible to empirical observation because they manifest themselves in the psychological domain, so that we have only clinical indicators to understand them. (Honneth, 2006, p. 322)

In doing so, the clinic makes it possible to document the criticism of institutions based on the 'feeling of injustice of those who are subjected to the social order' (Renault, 2004, p. 24).

The clinic of professional challenges: from expertise to deliberation

The initiation of an intervention in a psychosocial clinic often stems from a concern on the part of social workers who will call upon the psychologists in their professional environment. This clinic is thus initially conceived as a 'second-line clinic', which addresses users' problems based on the uneasiness of the social workers. According to Jean Furtos, the 'effect of psychological suffering' leads these workers 'to a degree of professional malaise and indeterminacy that requires self-reflection'. In the path opened

by the Strohl-Lazarus report (1995), where the question of psychological suffering of social origin is elaborated on the basis of alerts formulated by the social workers, he adds that 'the uneasiness of social workers is part of the psychosocial clinic; it is almost the condition for it' (Furtos, 2005, p. 12).

Social workers' sense of malaise therefore derives from the feeling of inability to cope with situations when they can no longer give meaning to their work, or when they can no longer learn from their experiences. Historically, this malaise has been problematized in two different ways (Ravon, 2014).

This malaise was first defined in the 1970s on the part of health professionals involved in user/provider relationships in terms of professional burnout syndrome resulting from excessive relational demands related to the difficulty in coping with patients' suffering and the inability to respond effectively. The sheer exhaustion of emotional capacities is well known in the field of social work, especially among workers engaged in helping relationships that are endless, pointless, devoid of progression and therefore have no discernable horizon. A great many clinical systems for analyzing professional practice or supervision have thus come into existence over the past 40 years, with the general idea of offering a space for professional reflection combined with the emotional regulation of practices (Ravon, 2009).

Additionally, since the 1990s this malaise has been understood based on certain damaging effects on the daily practice of the profession, resulting from the profound transformations of working conditions. These include rationalization, segmentation and flexibility of work, precariousness of professional status, an obsessive search for cost reduction, an increase in the amount and intensity of work, the proliferation of standard evaluations of an activity that is systematically regarded as the reflection of an individual. To these two problems (the helping relationship and working conditions), we can add a third, related to the individualization of care and the specific nature of each action – this implies seeking consent on the part of the user. In this case, the social worker does not know a priori what needs to be done; he is therefore constantly confronted with indeterminacies, especially ethical ones, which are never settled once and for all (Ravon & Vidal-Naquet, 2014).

Because of the structural uncertainty that governs the concrete activity of social workers and the immense role that their inner selves play in shaping it, they can never know if they are doing the right thing. Moreover, they know that, whatever they do, they cannot do justice to the paradoxes they face in the exercise of their work. [...] Required to adjust to the constraints of the situation, i.e. the constraints of the users' experience, social workers must build their own position in interaction with the user and agree not to control the framework of their intervention. They are confronted with a continuous problem of professional self-design of their intervention in situations to make it socially meaningful and effective. (Soulet, 2016)

These different professional challenges concerning the helping relationship, the working conditions – especially organizational conditions – and on-the-spot decision-making mobilize a different work clinic each time.

Generally speaking, it is clinical psychologists who lead the groups analyzing the practice of helping relationships, with quite varied analytical traditions, although the so-called 'Balint group' model is a strong reference in this area³. In any case, practice analysis groups provide social workers with an opportunity to present what can no longer be repressed (Henri-Menassé, 2009). Through collective development work, the elements that are not repressed are 'projected' into the group and, in the best of cases, 'deposited' or, better yet, 'recycled': specialists refer to 'metabolization' (Roussillon, 1987; Fustier, 1999).

With regard to the deterioration of working conditions, another clinical tradition, listed under the terms 'work analysis' or 'activity clinic', initially anchored in the industrial field, has become widespread in the past 25 years, and more particularly around the theme of suffering at work (Dejours, 1998). In the tradition of work ergonomics and psychopathology, this 'method for action' is based in particular on the ability of analysis to restore conflict in work collectives in order to revive the profession in its new contexts of realization (Clot, 2014). Distinct from practice analysis in that it is directed towards business transformation (Clot, 2007), this clinic is still marginal in the field of social and medico-social work.

This clinic can also be rivaled by the 'institutional regulations' that clinical psychologists are increasingly proposing in order to address organizational issues from the perspective of their negativity and from the institution that implements them. This approach, which is

reminiscent of the so-called ‘institutional analysis trend’⁴, ‘leads to not seeing any difference in level between professional practice and the institution in which it is carried out’ (Monceau, 2008). The analysis is therefore not reduced to a discussion between practitioners or their practices, but rather is the subject of a deliberation extended to the other actors of the institution, from technical and administrative agents to managers (Gaillard, 2017).

Finally, reflection on and analysis of one’s practices are unlikely to resolve a situation and to find new ground when addressing the ethical challenges related to uncertainties about the norms of good. Another clinic, which we will call the ‘meaning of activity clinic’ (Ravon & Vidal-Naquet, 2014), could be implemented to deal with action:

Not as the result of intention or the application of rules and standards, but as defining its objectives in its own right. [...] The ‘meaning of activity clinic’ could then have as its perspective to decide no longer on the notion of what is good in order to build new norms but, more modestly and in a dialogical way, on what is acceptable. (Ravon & Vidal-Naquet, 2014)

In this sense, the purpose of reflecting on action is not so much to arm the professional a little better as a subject of his practice as to help him to seek and find new directions in his work environment, ones which will enable him at least to maintain the possible action and at best to identify new approaches with an eye to acting differently⁵.

This inventory of the different social work clinics indicates a strong extension of professional self-reflection. It is of course impossible to detail all these analytical practices here. Beyond the disciplinary opposition between the psychological or sociological valence of the clinic, two conceptions of self-reflection can be distinguished.

On the one hand – and the Balint group is a perfect example of this – the ‘reflective practitioner’ model (Schön, 1994) developed in the early 1980s is based on the idea that the experience of action is the best place to learn professional intelligence. Knowledge, built up before the action and then reflected upon afterwards, is ‘mentalized’ by the professional, who, by the accumulation of experiences, solidifies his skills and professional action. On the other hand, to this ‘mentalist’ conception of knowledge which reinforces the dimension of expertise and control by the professional of his activity

(Mezzena, 2014), we will oppose a measured conception of self-reflection based on trial-and-error and deliberation (Champy, 2009); the meaning of intervention here is defined as the action progresses, situation after situation, according to the unforeseeable factors linked to encounters with users.

Thus, the request for reflective assistance does not lie in the search for a solution [...] but in the maintenance of a reflective space that makes it possible to continue to hold the possibility of a new outcome. In other words, the reflective exercise allows the action to continue, despite everything. Deliberation among peers does not return in the aftermath of problematic situations about what should have been done; it “rewrites” the action after the fact by extending it. By sharing the challenge of action, collective deliberation not only extends its understanding. It also transforms practice into experience, revealing both its limits and its new potential. (Ravon, 2016)

Whatever their specificities, these different work clinics have today become essential vectors of institutional regulation. They are essentially the only places of deliberation where social work can be thought of collectively on the basis of its actions and in an environment saturated with organizational constraints that take precedence over the job of helping – what the psychologists call the ‘primary task’ (Gaillard, 2017). However, such regulation can only be effective if the clinical analysis of practice, activity, institution or work can convert the identification of symptoms into critical indicators that can support the collective debate on the meaning of what we do, here and now. In other words, the generalization of clinical analyses, which have often developed only among specialists themselves, is decisive – be this critical clinic specialized, adaptive or subversive (Périlleux, 2015).

Conclusion

Although in no way an exhaustive inventory of clinical devices in the field of social intervention, the reasoned survey proposed in this chapter invites us to be very cautious about the lessons to be drawn, given the very plurality of objects and approaches to the clinic. That said, the extension of the clinic into social intervention shows above all the proliferation of situations of ‘psychological suffering’ linked to experiences of social vulnerability, and in particular those in which people are led to take responsibility for it.

The social injunction to become the agent of one's change is a challenge for clinicians, accustomed as they are to looking at the negative side of the situation. They must henceforth 'believe in' and 'hope for' the 'strengths of the individual person'. At the same time, suffering at work has spread among professionals, who have become powerless in the face of often hopeless situations, caught between the singular demands of users and standardized organizational constraints. Through its regulatory capacities, the clinic is also faced with the tricky challenge of having to ensure public debate on the meaning of social work.

Thus defined, the clinic, at least in the field of social intervention, cannot be reduced to a tool for producing evidence. Nor can it be reduced to the objectification of situations of vulnerability and of suffering on the part of professionals. Its ability to include individual cases in a collection of already-made observations has opened up to a new age of knowledge, one where we can 'finally discuss the individual in scientific terms' (Foucault, 1963). However, it has not yet led, as it has in the medical field, to nosographies. This is in spite of the fact that tools for assessing the risks of vulnerable populations seem – for the time being unsuccessfully – increasingly required by financing bodies. In other words, the inventory of the clinic in action in the field of social intervention shows above all relational situations of encounter and group situations of self-reflection. These are situations where the key material is the experience of vulnerability, whether professional or related to the users' life contexts. It therefore seems that the major contribution of the clinic in the field of social intervention is that it embraces the experience of life in all its vulnerability. Canguilhem pointed this out in his famous 1943 essay: 'We believe that there is nothing in science which did not first appear in consciousness, and [...] that it is the patient's point of view that is basically the true one' (Canguilhem, 1966, p. 53). By insisting 'on the fact that the patient is a conscious subject striving to express what makes him feel his experience by stating his illness through the experienced lesson that binds him to the doctor' (Canguilhem, 1966, p. 53), Canguilhem opposes the clinical posture to the positivist orientations that, since Claude Bernard, objectify this experience and make it a laboratory subject. What this means is that 'life makes itself known, and recognized, only through the errors of life which, in all living things, reveal their unfinished constituent parts' (Macherey, 1990, pp. 286–287)⁶.

Taking into account the point of view of the suffering subject in a clinical situation, whether a user or a professional, and recognizing him in all his capacities to experience situations as he sees fit, is what could ultimately define the clinic in and of social intervention.

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Notes

¹ Indeed, if the relationship is framed by the consideration of the other as a fellow human being, it cannot be the subject of reciprocity, compassion being by definition asymmetrical (Fassin, 2010).

² These places refer to different types of institutions for people who are marginalized, excluded, looking for work or receiving minimum social benefits.

³ The Balint Group, founded in England in the 1950s, is a professional support system initially intended for general practitioners. These 'research-training' groups are not designed to become a therapeutic place for participants, but a place for transforming their professional skills through a better psychological understanding of themselves and the relational situation in which they are involved (Balint & Balint, 2013).

⁴ 'Institutional analysis', at the crossroads of the critical sociology of organizations and psychoanalysis, immediately posits analysis as an act of intervention (Lourau, 1970). It is historically the result of the 'institutional psychotherapy' movement initiated by François Tosquelles and then developed by Jean Oury. Institutional psychotherapy refers to a particular moment of transformation in psychiatric care practices in the early 1950s, based on the 'pathological' nature of the institution, which needs to be taken charge of and cured in order to rebuild the relational network surrounding the patient (Tosquelles, 1995).

⁵ This clinic is still experimental. Following the tradition begun by Balint on the one hand and by institutional analysts on the other, it is based on the analysis of practice, but without making it a psychological question (individual or group) because it is above all interested in the sociological contextualisation of action. This is why we call it a sociological clinic (Ravon, 2012). At the same time, it borrows the dialogical approach of the controversy surrounding professional acts from the activity clinic, but without conducting an analysis of the work itself, in order to focus instead on the acceptability or unacceptability of the activity based on the analysis of problematic situations (Ravon, 2016).

⁶ I thank Numa Murard for bringing this text by Pierre Macherey to my attention.