

Bureaucratically Split Personalities: (Re)ordering the Mentally Disordered in the French State

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Abstract:

The ability to (re)classify populations is a key component of state power, but not all new state classifications actually succeed in changing how people are categorized and governed. This paper examines the French state's partly unsuccessful project in 2005 to use a new classification—"psychic handicap"—to ensure that people with severe mental disorders received services and benefits from separate agencies based on a designation of being both "mentally ill" and "disabled." Previous research has identified how new classifications can be impeded by cultural and cognitive barriers to their adoption and struggles between professionals or administrators over their implementation. Drawing on 186 interviews, archival sources, and thirteen months of observations across different French bureaucracies, I expand on this literature in two ways. First, I use the case of psychic handicap to argue that a new classification can also fail to achieve its intended effect when it constitutes a *bureaucratically split personality*—a combination of classifications that imply that individuals belong to two, mutually exclusive kinds of people. I show how psychic handicap embodied contradictory expectations about the behavior, characteristics, and institutional trajectory of people with mental disorders. Second, I identify how bureaucrats resolved these contradictions through mechanisms of *refractory looping*, *outsourcing expertise*, and *classification by default*, which in this case led to the reclassification of this population as simply "mentally ill." This framework calls attention to how practical inconsistencies can limit the impact of new classifications, even absent overt resistance to their elaboration or implementation.

Key Words: Classification Struggles, Boundary Objects, Psychic Handicap, Diagnosis, Bureaucratically Split Personalities, France

In the government offices responsible for granting benefits and services to persons with disabilities in France, people with severe mental disorders¹ pose a continual classificatory challenge. Looking at the dossier of a 26-year-old man with schizophrenia, one evaluator remarks, "His medical certificate [written by a psychiatrist] says he has severe symptoms, but on the next page, it's written that he's 'autonomous in his activities of daily life'"—the latter being the primary basis for a disability determination. "In any case," another evaluator points out, "the certificate is old. He's probably psychotic again by now. We can't refer him for professional retraining if he's not stable." A final evaluator sighs, "He probably needs help with housing, but for some reason, he has crossed out all those boxes on his application."

¹ I use "severe mental disorders" to refer to the disturbances of thoughts, emotions, and behaviors usually associated with conditions like schizophrenia, bipolar disorder, or major depression; these disturbances are then typically classified as "symptoms" and labeled "mental illnesses."

Here, an individual whom everyone agreed was severely “mentally ill” was not recognized as “disabled,” despite the benefits in terms of housing, employment supports, and aid in daily life such a dual designation would bring.

These lower-level bureaucrats were attempting to apply the official classifications of the French state, whose centrality in the “certification [and] consecration [of] legitimate classifications” has attracted growing sociological attention (Fourcade 2009, p. 259; see, also, Bourdieu 2015; Loveman 2014; Norton 2014). Scholars have shown, however, how cultural or cognitive constraints (Mohr and Duquenne 1997; Steensland 2006) and professional or bureaucratic conflicts over jurisdictions and flows of resources (Barman 2013; Goldberg 2005; Strand 2011) can create barriers to the adoption and implementation of new classification schemes. In this paper, I expand on this literature in two ways. First, I elaborate another potential impediment, which emerges when an attempt to recategorize populations administered by different wings of the state creates a “bureaucratically split personality.” A bureaucratically split personality is a classification that implies that the same people belong to multiple categories that entail inconsistent behavioral expectations, principles of expert evaluation, and institutional trajectories. Second, I show the mechanisms by which bureaucrats resolve these unworkable and unstable combinations by favoring one side of the “split” over the other.

Until 2005, the French state directed people with intellectual or physical disabilities and those with mental illnesses into separate institutions, run by different sets of professionals, under the aegis of different bureaucracies. In 2005, however, legislators anointed a new classification, “psychic handicap.”² It established that a “substantial, durable, or definitive alteration of...psychic functions”³ caused by mental illness could create a “restriction of activity or of life in society” and thus constitute a “disability.” According to the President of the country’s organization for the families of people with mental disorders (UNAFAM), this transformation was “truly revolutionary.” People with severe mental disorders would continue to receive care as patients in the public psychiatric system, but also be incorporated into the state’s broader attempt to make people with disabilities into empowered actors capable of managing an autonomous “life project” (see Power et al. 2014). Psychic handicap thus seemed like a case of the dramatic shift in “biographical trajectory, memberships, or location” created when a new classification enters the “process of making people” in state institutions (Bowker and Star 1999, p. 223).

As the opening anecdote suggests, psychic handicap instead represents a case where a new classification scheme does not achieve its intended effect. Ten years after its codification in public policy, key actors were moving away from psychic handicap as a lever for radically changing the state’s response to people with severe mental disorders. They were instead proposing ways to advance individual autonomy and recovery without a designation

² “*Handicap*” in French can be translated as either “disability” or “handicap.” For clarity, I use “psychic handicap” (“*handicap psychique*”) to refer to the specific category advanced by advocates for people with mental disorders and “disabled” to refer to the broader administrative classification that could contain people with “physical,” “intellectual,” “sensorial,” or “psychic” handicaps. All translations are by the author.

³ République Française. 2005. *Loi n°2005-102 pour l'égalité des droits et des chances, la participation et la citoyenneté des personnes handicapées*. Retrieved October 4, 2017 (<https://www.legifrance.gouv.fr/>).

of psychic handicap.⁴ Compared to the United States, where the idea that “mental illness” causes “mental disability” has long been recognized,⁵ people with mental disorders in France remain primarily in services and institutions that serve people with illnesses (not disabilities) and under the jurisdiction of psychiatrists (Figure 1).

This outcome is puzzling. The introduction of psychic handicap had the support of the upper administration and civil society groups, overcoming the previous cultural and administrative separation of “mental illness” and “disability.” Moreover, rather than struggling over the new jurisdictions and flows of resources the classification would create, professionals and bureaucrats recognized that—in a context where France’s health system was facing budgetary austerity—a recognition of disability was crucial for providing housing, work, and social supports for the severely mentally disordered. In explaining the trajectory of psychic handicap as an instance of a bureaucratically split personality, I offer an alternative explanation that focuses on how a new classification scheme can be undermined by the unexpected but irreconcilable contradictions created when multiple classifications are supposed to be applied to the same people.

Empirically, this paper uses ethnographic observations in institutions tasked with applying and acting on classifications of mental illness, psychic handicap, and disability. I supplement this with 186 interviews with policymakers, advocates, medical professionals and bureaucrats as well as unpublished statistics, classification tools, and archives. I start by outlining the parallel development of France’s systems for the “mentally ill” and “disabled” and how the introduction of the category “psychic handicap” in 2005 appeared well-poised to allow someone to be both. The second empirical section analyzes, in turn, how psychic handicap emerged as a bureaucratically split personality as professionals applied for its recognition, bureaucrats sought to evaluate it, and disability service providers worked to integrate those so classified into existing institutions. At each stage, incongruities between the expected passivity and activity of people with mental disorders, the subjective or objective character of their troubles, and the variability or stability of these limitations made the notion of psychic handicap practically incoherent. Through three mechanisms, *refractory looping*, *outsourcing expertise*, and *classification by default*, these contradictions resulted in the return of responsibility for people with mental disorders to the health system, where they had a single bureaucratic identity as mentally ill.

In the conclusion, I reflect on how bureaucratically split personalities can be used to expand our understanding of the conditions that shape how official state classification schemes enter bureaucratic practice and reshape the definition of populations. Distinct resolutions of classificatory contradictions can result in profoundly different and consequential distributions of people across state institutions.

Theoretical framework

Cultural constraints and classification struggles

Modern states govern their populations through applying a dizzying and expanding range of classifications (Bourdieu 2015; Foucault 1991; Starr 1992). But while states can “forcefully remake social relations” (Morgan and Orloff 2017, p. 11) by obligating their

⁴ This shift is visible in the national ministerial strategy, which talks more about “avoiding” psychic handicap than giving benefits based on it. Secrétariat d’État chargé des personnes handicapées. 2016. *Stratégie quinquennale de l’évolution de l’offre médico-social: Volet handicap psychique*. Paris, France.

⁵ Comptroller General of the United States. 1977. *Returning the Mentally Disabled to the Community*. Washington, DC.

subjects to engage with official categories on census forms, for welfare benefit applications, or in courtrooms, the exercise of this classificatory power is neither automatic nor straightforward. The British state struggled for decades to stymie piracy, despite having the military might to do so, because it lacked the “cultural infrastructure” necessary to constitute pirates as a distinctive “social object” (Norton 2014, p. 1551). Doing so required finding a way of classifying pirates that resolved the contradiction between pirates’ rights as English subjects and the need of state agents to quickly identify, judge, and execute them in a coordinated fashion.

Existing scholarship, then, points to potential impediments to the introduction and institutionalization of new state classification schemes. In their study of the poverty relief organizations that constituted the American welfare state at the start of the 20th century, Mohr and Duquenne (1997) find a strict and consistent separation between the organizations and services offered to different categories of recipients, like the “worthy” and the “fallen.” Certain classificatory combinations may simply be cognitively unthinkable: for much of U.S. history, being recognized as a “woman” and belonging to the category “soldier” were, in the eyes of policymakers and administrators, mutually exclusive. Steensland (2006) examines what happens when enterprising reformers trespass these cultural separations, as with a proposal in the 1970s in the U.S. to provide General Income Assistance to all poor people. Opponents argued doing so would “symbolically contaminate” (2006, p. 1283) the deserving working poor by placing them in the same category as undeserving welfare recipients. Policymakers ultimately opted to create separate programs for people with disabilities and low-wage workers, which fit with prior divisions in the population. In short, *existing* state classifications create cognitive schema and cultural resources that constitute “symbolic constraints” (Mayrl and Quinn 2016, p. 2) to new classifications.

As this research shows, new categories are not just about making sense of the world, but also “sites of power relationships [and] political action” (Friese 2010, p. 148). A related literature on “classification struggles” explores contestation over not just the symbolic and moral implications of new classifications, but also their material ones (Barman 2013; Goldberg 2005; Mora 2014). For example, the “mentally ill” only came into being as a group once psychiatrists overcame the resistance of priests and judges, who saw them rather as morally deviant or criminally dangerous (Abbott 1988; Goldstein 1987). Today, classification struggles in the U.S. continue over whether jurisdiction over the mentally ill belongs to psychiatrists, social workers, or psychologists (Bosk 2013; Craciun 2016; Strand 2011). At stake in such struggles is which professional group will benefit from the authority, resources, and prestige for the management of the mad.

Classification struggles are not limited to the upper echelons of the state, where new classifications are elaborated and official criteria for their application defined. A separate literature has looked at classifications as deployed by “street-level bureaucrats,” the state agents who are in direct contact with citizens. While nominally bound by sanctioned categories, these bureaucrats have significant discretion in how those categories are used and in allocating resources attached to them (Lipsky 2010; Prottas 1979). Scholars have analyzed how bureaucratic resistance slowed welfare reforms’ efforts to convert benefit “recipients” into “workers” in France and the United States (Dubois 2003; Sandfort 2000; Watkins-Hayes 2009). Loveman (2007) similarly shows how census workers in Puerto Rico employed their own existing racial categories (based on appearance) in carrying out their surveys, undermining the official racial classification (based on ancestry). Struggles might be between bureaucrats and their superiors—for example, over a new classification that assigns them

responsibility for an undesirable clientele—or between bureaucratic groups—as resource constrained agencies push clients onto one another (Lara-Millán 2014; Seim 2017).

These literatures provide useful guidance for identifying where the process of using a new classification like psychic handicap to transform state interventions into the lives of the mentally disordered might break down. A deeply engrained cultural divide might make intermixing the “mentally ill” and “disabled” either unimaginable or morally suspect. Existing cultural divisions could be mobilized in classification struggles by professional groups threatened by the new repartition of resources and responsibilities. On the ground, street-level bureaucrats might more subtly resist implementing the new classification in an effort to shrug off a burdensome new obligation. Whether at the macro-level of policy, the meso-level of professions, or the micro-level or bureaucratic practice, each calls attention to various kinds of resistance a new classification might provoke.

From boundary object to bureaucratically split personality

This paper examines the trajectory of a new state category from a slightly different angle, emphasizing not struggles over classifications but rather contradictions between them. At times, new categories are fabricated out of whole cloth and layered on top of existing classifications, as was the case for “Hispanic” in the U.S. (Mora 2014). This paper focuses more specifically on cases where a new classification is intended to serve as a bridge through which previously mutually exclusive classifications come to apply to the same people. The recognition of the autism spectrum by health and human services agencies, for example, has taken children once called “mentally retarded” and placed in specialized institutions and enabled them to receive benefits on the basis of “disability” and access mainstream educational services as “students” (Eyal 2013).

The literature on classification in science and medicine has analyzed such recombinations as depending on what Star and Griesemer (1989, p. 409) call a “boundary object.” Boundary objects are categories which “live in multiple social worlds” and facilitates cooperation between them. A classification like the autism spectrum serves as a boundary object because it is flexible enough to be used by multiple communities (educators, psychologists, or autistic people themselves) without unilaterally imposing one group’s understanding of that object on the others (Bowker and Star 1999, p. 297). I conceptualize psychic handicap as an attempt to create a similar boundary object that would bridge the previously partitioned worlds of mental illness and disability.

In practice, however, psychic handicap was a *bureaucratically split personality*: an attempt to combine classifications that were, in practice, irreconcilable without a fundamental alteration to one or the other. Each term in “bureaucratically split personalities” captures a distinct feature of my approach. I use “bureaucratically” to differentiate from the literature on cognitive or cultural constraints. Bureaucratically split personalities are not so much “unthinkable” (Mohr and Duquenne 1997, p. 355) at the level of policymaking but rather “unworkable” in practice. Actors may be in agreement over what classifications should be used and how, but they may struggle to adapt existing tools and procedures in ways that allow them to integrate them into organizational processes. After all, “even the most dramatic change at the macro level comes to nothing if it is not collectively embraced in practice by those who must do their work in a new way” (Kellogg 2011, p. 7)

Second, I refer to “splits” to emphasize that bureaucratically split personalities stem from institutional divisions between the “many hands” of the state (Joyce and Mukerji 2017; Morgan and Orloff 2017). Different agencies develop distinctive practices for applying categories, expectations for those they classify, and processes for allocating resources based

on those classifications. Mol (2002, pp. 119, 138) points to how such radically different visions (in her case, of patients and of pathologies) can co-exist in a single organization as long as boundary objects remain “fuzzy” enough to allow cooperation without standardization. This paper, however, examines situations where the meaning of psychic handicap needed to be precisely defined and applied. In these moments, the distinctive visions of and expectations for the mentally ill and the disabled developed by different wings of the French state snapped into sharp relief. Such moments may create a process of “splitting” by which previously latent “perceived gaps” between classifications “widen,” “thereby reinforcing [the] mental separateness” (Zerubavel 1996, p. 424) of populations that a new classification was supposed to bring together.⁶

Finally, I use the term “personalities” to highlight that bureaucratic splits are most likely to be problematic when classifications imply that one is a certain *kind* of person. Hacking (1995, pp. 352, 360) describes “human kinds” as population groups about which experts claim “systematic, general, and accurate knowledge” that provides “principles through which [to] interfere, intervene, and improve.” A child can carry multiple psychiatric diagnoses—like “oppositional defiant disorder” and “ADHD”—without any contradiction. Both place them within a single human kind, “mentally ill” and imply a common set of interventions. But, as Eyal (2013) shows, diagnoses of “autism” and “mental retardation” are profoundly incompatible, because they imply different life trajectories, principles of expert intervention, and institutional homes. Discrepancies such as these, which are characteristic of classification schemes that I am characterizing as bureaucratically split personalities, are not easily reconciled with simple changes to diagnostic criteria or classification procedures.

Bureaucratically split personalities in practice

In this section, I consider in greater detail what differentiates a new state classification that serves as a boundary object from one that becomes a bureaucratically split personality, drawing on literatures that analyze *applying* to be classified, *evaluating* eligibility for a classification, and *institutionalizing* that classification into organizational processes. I then build on the literature on street-level bureaucrats, which already identifies a range of “coping behaviors and adaptive attitudes” (Lipsky 2010, p. 181) that state agents deploy when faced with contradictory mandates or inconsistent policy. As Lipsky (2010, p. 181) observes, these studies often leaves unspecified the “orientation of adaptive attitudes”—that is, how these behaviors aggregate into specific outcomes. I theorize three mechanisms—*refractory looping*, *outsourcing expertise*, and *classification by default*—that link individual responses to a bureaucratically split personality to the broader structure of the state, resulting in particular resolutions of the “split.”

Applying – State classifications vary in the extent to which they can be unilaterally imposed: states can conscript “soldiers” but generally not “patients.”⁷ Classifications that require some cooperation, then, must contend with what Hacking (1998, p. 21) calls “looping.” People “tend to conform to or grow into the ways they are described” in administrative or professional classification schemes, but this is in part because they themselves act in ways that change those categories. Paradoxically, this dynamic engagement actually makes those categories seem more natural and entrenched, as when racial classifications added to censuses became the basis for political mobilization in Latin America (Loveman 2014).

⁶ Maryl and Quinn (2016, p. 5) refer to this as “boundary activation” (see Lamont and Molnár 2002).

⁷ Forced treatment for mental illness is a notable exception.

This paper considers how the process of applying one state classification might impact the other classifications previously applied to the same people. That people might “loop” with respect to multiple classifications simultaneously is latent but not explicitly analyzed in existing studies. Hacking’s (1998) study of trauma victims shows how the way women responded to talk therapy but not to medication seemed to confirm that they had Multiple Personality Disorders—which meant that they were *not* schizophrenic, as many were previously diagnosed. I call *refractory looping* the process by which a population “growing into” one category implies them “growing out” of another.⁸ As I show, psychic handicap implied contradictory expectations for the way people would apply for benefits. Over time, the criteria for psychic handicap changed in a way that made it more synonymous with mental illness *and* clarified the meaning of disability in a way that increasingly excluded the mentally disordered.

Evaluating – A new classification scheme has little meaning unless some bureaucratic agency or professional group has jurisdiction for assigning it (Barman 2013; Kellogg 2014; Mora 2014). As Porter (1996) shows, the jurisdiction granted by states to bureaucrats increasingly comes with the expectation of “objectivity;” that is, that decisions stem from rules which appear impersonal, reliable, and publicly defensible (see, also, Bracci and Llewellyn 2012; Sandfort 2000). Psychiatrists, for instance, have responded to challenges to their jurisdiction by adopting new tools, criteria, and symptom scales intended to show the scientific basis of diagnosis (Horwitz 2001; Strand 2011; Whooley 2016). This paper analyzes how the professionals evaluating psychic handicap were supposed to “link together” (Eyal 2013, p. 864) a set of information about mental illness in a person’s application from the health system and evaluation tools from the disability system in order to perform an expert, objective evaluation (see, also, Berg and Bowker 1997; Mol 2002).

Psychic handicap was a bureaucratically split personality insofar as these two were a poor match for one another. Evaluators did not, however, respond by “burden shifting” (Seim 2017) responsibility for psychic handicap onto other agencies or “rubber stamping” (Lipsky 2010, p. 130; Prottas 1979, p. 68) psychiatric evaluations as their own, as the literature on classification struggles in bureaucracy suggests. Instead they *outsourced expertise*: achieving a semblance of objectivity by incorporating measures that were not supposed to be part of their evaluation. This collapsed one classification into another rather than linking them through a boundary object. Showalter (2019) shows a similar process in how early 20th century psychiatrists in New York prisons defined “psychopaths” using behavioral criteria produced by the justice system. Outsourcing expertise in this way meant that re-classifying people as psychopaths did little to transform them from being a “criminalized” to a “medicalized” population.

Institutionalizing – The application of a classification has concrete meaning only once it ties individuals into a broader infrastructure that acts upon that label (Bowker and Star 1999, p. 319). Public health surveys that identify many U.S. prisoners as mentally ill, for example, have little meaning so long as inmates remain in prisons without treatment. When the goal of a new classification is to help the classified population enter into extant institutions, the key bureaucratic task is one of “commensuration”: showing that new individuals are comparable to existing ones along some common relevant metric (Espeland and Stevens 1998; Lakoff 2005; Lamont and Molnár 2002). One successful example was the

⁸ Navon and Eyal (2016, p. 1426) describe how looping with respect to autism “disabled” other interpretations of children’s condition. This terminology would be confusing in this paper, and those authors’ use of the term does not consider competing classifications *per se*.

use of I.Q., which allowed parents in the U.S. to claim that their “learning disabled” children were close enough to “normal” to enter schools; the lack of a common measure in Germany left similar individuals in segregated institutions (Powell 2010).

A boundary object implies that a person has characteristics commensurate with the populations served by multiple sets of state institutions. When contradictions in these expectations emerge and a bureaucracy rejects someone as “incommensurate,” that person does not necessarily disappear into a classificatory vacuum. They instead tend to fall back into programs with more flexible criteria, which I call *classification by default*. In the U.S., people who do not fit the increasingly narrow eligibility criteria for welfare benefits on the basis of being “poor” wind up receiving services from emergency health, disability, or penal institutions that serve broader categories of persons (Hansen et al. 2014; Lara-Millán 2014; Seim 2017). This mechanism thus calls attention to how the resolution of bureaucratic “splits” depends on the mix between universal and targeted programs in different wings of the state.

Bureaucratically split personalities do not end in the wholesale rejection of a new classification as symbolically contaminated or through the triumph of one group or another in a classification struggle. Rather, this framework focuses on how, as a new classification scheme is applied, evaluated, and institutionalized, contradictions within that scheme can lead to *refractory looping*, *outsourcing expertise*, and *classification by default*. These processes gradually undermine its continued use.

Data and methods

Data for this paper were collected as part of a broader project on public institutions tasked with managing people with severe mental disorders in Paris, France. Through preliminary interviews and documents, I identified key sites in the health and disability sectors where consequential decisions in the lives of people with mental disorders are made (see Figure 2). This process frequently started in a Medical Psychological Center (“*Centre médico psychologique*,” hereafter “Psychiatric Clinic”). Over the course of seven months in 2016, I observed weekly triage meetings in which nurses would present new cases to psychiatrists, who would determine who received what level of psychiatric care. I also attended discussions between nurses, psychiatrists, and social workers of difficult cases who might apply to be recognized as disabled based on having a psychic handicap.

All applications for disability benefits are then processed by a multi-disciplinary team of generalist doctors, psychologists, and social workers in a Departmental Home for Disabled Persons (“*Maison départementale des personnes handicapées*,” hereafter “Disability Office”). I spent six months (also in 2016) observing evaluations of new demands, meetings to discuss employment of disabled persons, and sessions of the departmental commission responsible for making final determinations on complex cases and appeals.⁹ The Disability Office would then orient applicants towards providers of professional insertion, protected work, aid in daily life, or long-term housing, with whom I conducted interviews and site visits.¹⁰

⁹ I also obtained unpublished statistics from the Disability Office, which show that the cases I directly observed were representative of the broader range of demands treated by the Disability Office and of their outcomes.

¹⁰ Direct observation of decision-making over access to downstream services for housing and employment was not practical, because many structures (such as a fifty-bed nursing home) would only admit one or two new people per year.

In addition to asking for approvals from the directors of the Clinic and Office, as well as that of the teams which I was directly observing, this research was approved by the University of California, Berkeley Committee for the Protection of Human Subjects. In these settings, collective decisions are made outside of the presence of the applicants; the primary research subjects of this project were professionals, not patients/clients. I avoided recording any potentially identifiable information on the latter group. I show how people with mental disorders engaged with the category of psychic handicap through looking at bureaucratic traces and reports of their behavior, rather than direct interviews with them.¹¹

I contextualized my observational data from the Clinic and Disability Office through 186 qualitative interviews with professionals and policymakers. Among interviewees, 38 were involved in direct service provision in the health sector and 47 in the disability sector; questions focused on classificatory decision-making and their appropriation of official regulations and tools. I conducted interviews on the production of these regulations and tools with 25 people involved in public policies for health and 24 in disability. This included nearly all the key figures in the relevant national ministries who worked specifically on mental illness or psychic handicap, as well as those with the same responsibilities in regional and departmental agencies around Paris. The remainder were representatives of key advocacy organizations, professional groups (such as the psychiatrists' unions), research institutes, and the legal sector. Among the total, 50 were trained as psychiatrists, 39 as nurses or psychologists, 21 as social workers or special educators, 17 as generalist or public health doctors, 17 as lawyers, and 31 as administrators.¹² Interviews lasted between thirty minutes and two hours. I also examined official government reports, directives, classification scales and other tools, unpublished policy evaluations, and the archives of the Ministry of Health (which, to emphasize their separation from published academic sources, I reference in the footnotes).

I developed a coding scheme iteratively, starting by differentiating the various kinds of demands faced by the Psychiatric Clinic and Disability Office, then considering the range of possible responses to those requests. I subsequently developed codes that captured the reasoning professionals used to justify those decisions. I focused on 296 decisions at the Disability Office where decisions were made over the allocation of benefits or services, in particular the 206 cases in which someone did *not* receive at least one of the benefits for which they applied. In addition to the documentary evidence, I coded 9,000 separate units of texts from field notes and interviews in the software *Dedoose*.

Paris is undoubtedly a distinctive case within France. It is also the place where the introduction of psychic handicap would be most likely to succeed. The key actors that pushed psychic handicap (Ministries and advocacy organizations) are based in Paris. As many informants insisted, actors making classificatory decisions in Paris are thus subject to much greater oversight and scrutiny in their implementation of national policy. Moreover, services in both the disability and health systems are well-funded and widely available, suggesting that the limited impact of psychic handicap was not just a question of resources. Interviews and archives, combined with several weeks of comparative observation in a separate Disability Office outside of Paris and a different clinic and hospital, increased my

¹¹ This focus on observable responses to a classification rather than phenomenological experiences of being classified is consistent with other studies on “looping” (Eyal 2013; Navon and Eyal 2016).

¹² The remainder, mostly in advocacy organizations, had educational backgrounds not directly related to health, disability, or public policy.

confidence that the patterns I describe are reflective of the general bureaucratic challenge of using psychic handicap in the way policymakers intended.

Broadly, this project follows the extended case method (Burawoy 1998) in which the researcher attempts to understand concrete situations by looking outward to structural forces and backwards to the history weighing on those situations. My goal was thus to put theories of classification struggles, street-level bureaucracy, and medical sociology into dialog with my observations. The single case of psychic handicap cannot establish the necessary conditions for the success of a new classification or determine what would happen if a “split personality” appeared at the level of applying categories but not institutionalizing them. My goal, instead, is to elaborate theoretical mechanisms that can be applied and tested in other empirical situations (see Hirschman et al. 2016).

The politics of psychic handicap

Separating and recombining mental illness and disability

This section considers the separate development of France’s health and disability system and the divergent meanings they attached to “mental illness” and “disability.” Driven by the scandal of tens of thousands of asylum residents dying of hunger during World War II in institutions that were more holding-areas than hospitals, the post-War period saw a significant medicalization of social responses to mental disorders. In 1960, the state cut France into “sectors” of 70,000 people and assigned a public psychiatric team to each, responsible for providing universally accessible and free “prevention,” “cure,” and “re-insertion” for the mentally ill.¹³ In 1968, psychiatry was recognized as a medical specialty (Pinell 2004) and in 1971 psychiatric hospitals were designated “acute care” institutions subsumed under the regulations governing general hospitals. Nonetheless, at the end of the 1960s, the boundaries of psychiatry’s jurisdiction remained fluid: in addition to people with iconic mental disorders like schizophrenia or depression, psychiatrists were also variously tasked with addressing mental retardation and senility, adult “marginals,” and “inadapted children” (Chauvière 1980).

Psychiatry’s domain narrowed significantly in the 1970s. The 1975 Law in Favor of Handicapped Persons brought together two disparate sets of institutions: centers to retrain “invalid workers” and “wounded soldiers” as a matter of national solidarity, and residential schools created by the parents of “deficient children” as a matter of charity (Barral 2007, pp. 217–220; Winance et al. 2007, pp. 165–166). As the Health and Social Affairs Minister¹⁴ declared, the law “created a true social statute” (qtd. in Chapiro 2016, p. 5) for a new, state-recognized kind of person. These disabled people would receive non-medical interventions from protected workshops, supported housing, and services for aid and accompaniment in daily life. The law drove the removal of people with intellectual disabilities and the dependent aged from psychiatric hospitals.

The reform sparked a classification struggle over whether the “mentally ill” could also be “disabled,” which highlighted the different meanings of the two categories. The dominant image of a handicapped person was of someone with clearly-identifiable incapacities that would be stable over time. For the psychoanalytic currents dominant in

¹³ Ministère de la santé publique. *Circulaire du 15 mars 1960 relative au programme d'organisation et d'équipement des départements en matière de lutte contre les maladies mentales*. Paris, France.

¹⁴ Both “disability” and “health” are covered by the (frequently renamed) Ministry for Health and Social Affairs, but in separate directions. For simplicity, I speak of the “health” and “disability” ministries.

French psychiatry, lumping the mentally ill with the disabled was a form of unacceptable “symbolic contamination” (Steensland 2006, p. 1283). They saw mental illness as a troubled subjectivity that had a dynamic trajectory which could be treated and transformed, in contrast to a permanently broken body or brain (Lanteri-Laura 1972). As one psychiatrist active at the time told me, “The handicapped are people who have no more need for medicine, but just assistance and a bed. For psychiatrists to say, ‘We’re not going to treat these people anymore,’ that’s intolerable.” As the literature on professions and jurisdictional conflicts would predict, the struggle also had a material dimension. Psychiatrists’ unions feared that relabeling people as “handicapped” was a “modality of escaping the expensive designation of being a ‘sick person’” (Ayme 2002, p. 185).

The state sided with psychiatry, concluding that insofar as the law on handicap was a “correction destined...to cover up the holes in the social protection system,”¹⁵ the mentally ill did not need to be included, precisely because they were already protected by the French welfare state on the basis of being “mentally ill.” In the ensuing decades, mental illness and disability were “mutually exclusive” categories both in administrative practice and national discourse (Henckes 2011, p. 8). The disability and health systems had distinct financing streams, regulatory agencies, and logics of social protection (Table 1). Meanwhile, psychiatrists had near-undisputed authority to classify illness and intervene in their lives of the mentally disordered: as one researcher explained, psychiatric *secteurs* developed “therapeutic work, therapeutic lodging, therapeutic activities...but all around treating ‘our patients.’”

Growing budgetary pressures in the 1990s made a revision to this classification scheme seem increasingly necessary. Reports from the period identified many psychiatric hospitalizations as “inadequate” because stabilized patients who no longer required intensive medical care stayed for lack of a supported living situation outside.¹⁶ Although like most Western countries France was closing hospital beds by the 1970s, in the 1990s the transfer of funds was particularly stark: the state closed 33,000 beds in psychiatry and opened 30,000 in publicly-funded, privately-run supported housing establishments for the disabled (Figure 3). With no official recognition that mentally ill people could be disabled, however, their access to these new structures were limited. This exclusion was increasingly problematic because these same fiscal pressures meant that psychiatric teams were abandoning activities like managing apartments or helping patients find work that did not fit into a progressively more biomedical definition of treatment.

In 2001, the association of parents of the mentally ill announced a desire to “render existent a population” and “make real” that population’s rights within the disability system through the recognition of psychic handicap.¹⁷ The organization recognized not only the shift in financing from the health to disability system, but also strengthening European and international norms that promoted the rights of people with disabilities (Waldschmidt 2009). Thus, when the organization’s Vice-President described the initiative as a “demand to make a category of persons that didn’t exist before,” she meant that the new classification entailed

¹⁵ Ministère de la solidarité nationale. 1983. *Bilan de la politique en direction des personnes handicapées*. Paris, France.

¹⁶ Direction de l’hospitalisation et de l’organisation des soins. 2008. “Éléments d’analyse des inadéquations de prise en charge en hospitalisation complète.” *DGOS 2014 / 011 / 3*.

¹⁷ UNAFAM. 2001. *Le livre blanc des partenaires de Santé Mentale*. Paris, France: 12.

not just new services, but also a new “personality” for the mentally disordered as active players in increasingly autonomous lives.

Thanks in part to the organization’s lobbying, President Chirac called for public action to “remediate the difficult situation...[of persons] with psychic handicaps, who are currently without any solution.”¹⁸ This official recognition of this population was rolled into a 2005 law for the “equality, citizenship, and participation” of the disabled.¹⁹ It recognized that mental illness could create a “disability” insofar as it produced a “restriction of activity or a restriction of life in society” as a result of an alteration of “psychic functions.”

Psychic handicap as boundary object

After the 2005 law, UNAFAM changed its name to the “families of sick and/or psychically handicapped people.” This suggested their vision of psychic handicap as a boundary object: it allowed the mentally disordered to exist in the bureaucratic worlds of mental illness and disability simultaneously and created “durable cooperation” between them (Bowker and Star 1999, p. 297). One advocate explained their position at the time: “we don’t refuse psychiatry. We know that our family members need psychiatric care... We’re not hostile to them.” At the same time, though, UNAFAM’s Vice-President insisted that “for these citizens” with a psychic handicap, “everything like lodging, activities, professional help—they’re going to be accompanied by people not from the health sector. Not psychiatrists, not nurses, but social workers and educators.”

Numerous factors appeared to favor the success of this new classification system in transforming the institutional trajectories of people with mental disorders. The centralized French state used its power to “produce and canonize...social classifications” (Bourdieu 2015, p. 9; see, also, Carson 2007; Fourcade 2009; Porter 1996) to support this new scheme. The official responsible for implementing the 2005 reform stated that “psychic handicap will be the marker of whether our disability policies have succeeded.”²⁰ The President in 2014 declared it a “national priority.”²¹ A ministerial delegate for handicap insisted, “Clearly, at the level of people with disabilities, today, for the government, a big preoccupation—for the minister and her cabinet—is people with psychic handicaps.”

In stark contrast to 1975, medical professionals largely did not “struggle” to prevent the mentally ill from being classified as disabled. Two major psychiatric professional organizations actually co-signed UNAFAM’s original call. One psychiatrist who conducted trainings around the country stated, “We used to hear, ‘We’re not going to dump our patients in the disability system.’ Not anymore.” Of fifty psychiatrists I interviewed, only two expressed reluctance to call their patients “psychically handicapped.” While in the past psychiatrists feared contaminating the mentally ill with the hopeless-sounding label of disability, they now recognized that disability services offered their patients the best hope for “professional and social integration.”²² They further accepted that their jurisdiction over the

¹⁸ Chirac, Jacques. 2002. “Discours devant le Conseil national consultatif des personnes handicapées.” Paris, France. Retrieved August 19, 2016 (<http://discours.vie-publique.fr/>).

¹⁹ République Française, *Loi n°2005-102*, 3.

²⁰ Fédération d’aide à la santé mentale. 2016. “Égalité, citoyenneté et handicap psychique.” *Pratiques en santé mentale* 1 (February): 84.

²¹ Présidence de la République. 2014. *Conférence nationale de handicap: relève des conclusions*. Paris, France: Service de presse. Retrieved June 26, 2016 (<http://www.elysee.fr/>).

²² Massé, Gérard. 1992. *La psychiatrie ouverte: une dynamique nouvelle en santé mentale: rapport*. Paris, France: Ministère de la santé et de l’action humanitaire: 234.

new classification was limited: their role was to provide a medical certificate confirming someone's illness, which would accompany a written "life project" and application prepared with the help of a Clinic social worker. The expert determination of eligibility on the basis of a psychic handicap would fall to the Disability Office.

Finally, architects of the law had a vision for how mental illness and disability could be bridged at a bureaucratic level (Figure 2). Multi-disciplinary teams at the Disability Office would use standardized scales and evaluation tools to translate the mental symptoms characterized by psychiatrists into objective, functional impairments. The Disability Office would then convert these impairments into "limitations in everyday life," which would provide a stable rendering of psychic handicaps. This would make this population commensurable with those with physical, intellectual, or sensorial handicaps and thus admissible to institutions serving people with disabilities. Advocates further believed that the appeal of these benefits and services, increasingly only available through the disability system, would encourage applications from people with psychic handicaps. In so doing, they would join other people with disabilities in becoming active participants and self-advocates in their own institutional trajectory (Winance et al. 2007).

The law of 2005 did not just introduce a new category, then, but sought to create a new human kind: a "person with a psychic handicap." The prior symbolic distancing of disability and mentally illness would be broken down by a boundary object, facilitating a shared understanding of the limitations and challenges caused by mental disorders (see Star and Griesemer 1989, p. 393). Rather than provoking a classification struggle, this new scheme was backed by civil society organizations, professional groups, and the state, and appeared poised to enter bureaucratic practice.

Psychic handicap as a bureaucratically split personality

Application: passive patients versus self-advocates

The Law of 2005 envisioned that disability benefits would be granted based on the "aspirations of the handicapped person as expressed in their life project,"²³ a document that would be included in their application to the Disability Office. As I show in this section, however, the expected active self-advocacy of disabled persons was in contradiction with the passivity and recalcitrance of people with mental illness.

Most of the most severe patients served by the Psychiatric Clinic arrived through a hospitalization. Half of these hospitalizations were legally imposed without the consent of the person, who was deemed unable to recognize his or her own need for care (see Gong 2017). Social workers and psychiatrists who wanted their patients to receive disability benefits subsequently spent significant time cajoling obstinate patients to provide the minimum information necessary to make an application. One psychiatrist described:

To do a dossier for the [Disability Office], the person needs to be in agreement and for them to be in agreement, they need to be conscious of their handicap. And in fact it's variable with patients, because there are some who are conscious right away that they're not going to get there and that they can't get there, and then others not at all. I have a patient who is twenty-five, it's his second hospitalization in two years, he's had electroshocks, treatments that are very heavy—and he refuses the demand for handicap. And he tells me, several times, 'If I accept, that means I'm sick, that means I'm crazy, and there's nothing left but to die.' So what do you want me to do? For us, there are the criteria, for him, there aren't.

²³ République Française, *Loi n°2005-102*.

I once posited that perhaps manipulative people might come to the Psychiatric Clinic in the hopes of getting a medical certificate that would allow them to get the Handicap Allocation, which at €800 a month is €300 more than France's general minimum income. A social worker brushed me off: "I basically do handicap demands for people who don't think they are handicapped."

My observations of the social workers' weekly meetings at the Clinic confirmed that people often evaded the label of psychic handicap to their obvious detriment. Some patients remained involuntarily hospitalized because they would not apply to a less-restrictive nursing home that only accepted voluntary residents. While scholars have pointed to how fear of stigma can prevent people from applying for benefits to which they are entitled (Hasenfeld et al. 1987; Soss 2000), advocates in UNAFAM had presumed—probably correctly—that "handicapped" would be less stigmatizing than "mentally ill" (see Liu et al. 2010, p. 1393). What they missed was that "mentally ill" could be imposed on a person regardless of the stigma attached to it, while "psychic handicap" required a degree of cooperation and acceptance that was frequently lacking.

Even when patients were willing to support an application, they did not engage with the category of psychic handicap in a way congruent with the model personality of a person with disabilities. As one social worker laughed, "People don't give a shit!—for them, it's completely paralyzing to ask them what their 'life project' is. Often it's, 'survive with 800 euros a month' and so we just leave it blank. What's the point of writing, 'Be in care and eat' as a 'project?'" Another averred, "Their social demands are often not very linked with the state where they are. Some tell me, 'I'm ready to live alone, I can manage without psychiatry, I'm doing very well, thank you very much.'" Rather than increasing their patients' agency, for these professionals the goal was to render the mentally ill passive enough to accept the supports they needed but which the health system could no longer provide.

Psychiatric Clinic professionals' interactions with the Disability Office highlighted how the professionals expected very different behaviors from the same people, even when a shared recognition that they were dealing with the psychically handicapped should have served as a boundary object. One Disability Office official described, "Once, we actually did a visit to the home of someone whose application said she was 'autonomous in everything, handles eating fine, everything is fine, she just needs a little income' and we discovered that all she ate—breakfast, lunch, and dinner—were cans of sauerkraut." This behavior, she noted, was congruent with "mental illness" but not "disability": "For the nurse from the Psychiatric Clinic, that was fine—'at least she's eating!'—but for us, it was like, 'maybe this person could use some help making better choices.'"

The 2005 law envisioned that, after participating in the preparation of an application, an applicant's involvement would continue at the Disability Office. As one official in the Ministry explained, "What has really changed [with the law of 2005] is that our evaluations are participative. The person is at the center, and we do everything as a function of their life-project." Yet even when convinced to apply, people recently released from the hospital would still come to information-gathering interviews at the Office and declare "all is well." The head of the National Federation of Patients in Psychiatry told me: "When we have a meeting at the Disability Office, we're going to wash up, put on a tie, and say, 'I can do everything' and the evaluator is never going to ask, 'Is he saying this just to show he's still human, or because it's really true?'"

When the time came to create a "personalized plan of compensation" on the basis of the life project and medical certificate, the Disability Office was only allowed to make decisions on the specific benefits and services that the person had asked for, not what they

thought might be most appropriate. In the case of a 32-year-old man diagnosed with severe bipolar disorder, the head of the Professional Insertion Team asked, “Concretely, is this someone who can work in a regular company?” The person who had reviewed the dossier replied quickly, “No way. But he crossed out the box for a protected workshop.” “And,” added a psychologist who had interviewed him, “It’s a waste of time to even mention it to him.” Indeed, in 19 of the 77 cases of people with severe mental disorders that I saw adjudicated in the Disability Office, reference was made to either the person being in “denial” or having an “inadapted” life project. The latter might refer to someone with behavioral issues or a history of hospitalizations asking to live in a facility with the elderly or a person on numerous anti-psychotic medications requesting to operate heavy machinery.

The result of the growing awareness that psychic handicap was a bureaucratically split personality was a kind of refractory looping, by which psychic handicap was redefined as more and more a synonym of mental illness and further from “disabled.” Even when psychiatrists couldn’t see it, social workers in the Clinic recognized how the Disability Office had come to expect not just people who self-advocated, but people who accurately understood their limitations and asked for the “right” benefits. This excluded their clients. As one social worker laughed, “Oh, here’s a good one—they [the psychiatrist] wants us to send a new application for [patient name]. Do they remember that she was banned from the Disability Office for threatening an evaluator who told her she was disabled?”

As theories of “looping” suggest (Hacking 1995; Loveman 2014; Navon and Eyal 2016), the ways that people with severe mental disorders did (or did not!) engage with the category ultimately altered its official meaning. Two guides on working with and evaluating people with psychic handicap published in 2016 and 2017 noted an “absence of a demand”²⁴ and “lack of consciousness of needs”²⁵ as key components. Hypothetically, the disability system as a whole could be changed to account for this, allowing for legally mandating people with mental disorders to be evaluated by the Disability Office or to live in disability institutions like nursing homes (as is possible in the U.S.). But doing so would directly contradict the work of associations of handicapped persons to differentiate the disability system from the health one: as one proudly stated, in France “care without consent exists, but not [disability] compensation without consent.”²⁶

Instead, some associations developing innovative programs to encourage employment and provide housing for the mentally disordered were “looking for ways to promote access without an application to the Disability Office,” as one director explained. Although many of these programs still used the term psychic handicap,²⁷ they sought to return financing for these services to the health system. In so doing, they would evade the classification scheme created by the law of 2005, relying instead on a psychiatrist’s evaluation of mental illness—made with or without the cooperation of the patient.

Evaluation: subjective symptoms versus objective limitations

²⁴ L’agence nationale de l’évaluation et de la qualité des établissements et services médico-sociaux. 2016. *Spécificités de l’accompagnement des adultes handicapés psychiques*. Paris, France: 27.

²⁵ Caisse nationale de solidarité pour l’autonomie. 2017. *Troubles psychiques: Guide d’appui pour l’élaboration de réponses aux besoins des personnes vivant avec des troubles psychiques*. Paris, France: 16.

²⁶ Caisse nationale de solidarité pour l’autonomie. 2009. *Handicaps d’origine psychique: Une évaluation partagée pour mieux accompagner les parcours des personnes*. Paris, France: 64.

²⁷ Hardy-Baylé, Marie-Christine. 2015. *Données de preuves en vue d’améliorer le parcours de soins et de vie des personnes présentant un handicap psychique*. Centre de Preuves en Psychiatrie.

Even when applications reached the Disability Office, the evaluation of psychic handicap further detached it from the aspiration that it would serve as a boundary object between two worlds in equal partnership. Previous research on France's Disability Offices has shown how they struggle with the classic challenges of street-level bureaucracies: a seemingly-impossible mandate to offer individualized evaluations, despite limited personnel and time, in the face of an avalanche of demands (Baudot and Revillard 2015; Bertrand et al. 2014; Bureau et al. 2013). In my observations, the mix of generalist doctors, psychologists, and special educators there did not abdicate their role in evaluating psychic handicap through directly "burden shifting" responsibility back onto the health system. At one training at the Disability Office, new evaluators eagerly asked questions about the meaning of psychic handicap and nearly half the time was spent explaining how to qualify people with mental disorders as disabled. In a 2014 survey, 87% of departmental Disability Offices indicated that psychic handicap was the disability for which they most sought to improve evaluation practices.²⁸

Moreover, in interviews evaluators clearly evinced that determining whether someone with psychic handicap qualified for disability benefits required that they carry out an expert assessment separate from that made by psychiatrists. As the director of the Disability Office insisted, "You can have very different diagnoses [of mental illness] that result in the same consequences...The pathology is an element that is going to clarify things...but it's not the foundation of what we do." His discourse paralleled that of the referent for psychic handicap in the Ministry, who confirmed, "For disability, the diagnosis is not super important, what is important is the consequence. We don't need to know if someone is bipolar or schizophrenic. It was a conscious choice not to make that central to evaluation, because we're in handicap here, not in health." On the ground, the doctor on the evaluation team reviewing the medical certificate would frequently *not* mention diagnoses in discussions of individual cases, focusing only on the observable consequences of those diagnoses in functioning. From the administration to the ground level, disability professionals thus embraced the frequent critique of psychiatric diagnosis as unreliable, dependent on the subjective and inscrutable judgment of the psychiatrist (Craciun 2016; Strand 2011; Whooley 2016).

Indeed, looking at diagnosis alone would not help evaluators respond to pressures to objectify and justify their determinations. One member of the team needed to fill out the 40-page "guide of evaluation of needs for disabled persons" that precisely explained someone's limitations in daily life, independent living, or employment. These determinations could potentially be scrutinized by a departmental commission, composed of representatives of the government and associations for people with disabilities, which heard appeals and reviewed a random sample of dossiers in detail. That commission, in turn, faced oversight from the central state, which was seeking to standardize evaluations and eliminate "deviations in the interpretation of [regulatory] texts," as one ministry document put it. This goal was reaffirmed in 2017 in a new project to ensure "the objectification...[of] the needs of the person...and responses to them."²⁹ French disability evaluators were thus far from the old "politics of the administrative window" (Alexis 2008; Dubois 2003) in which low-level functionaries could exercise professional judgment largely free from outside surveillance.

²⁸ Haut Conseil de la santé publique. 2014. *Enquête quantitative sur les modes d'évaluation et de traitement des demandes de compensation du handicap par les MDPH*. Paris, France.

²⁹ Caisse nationale de solidarité pour l'autonomie. 2017. *Une réforme tarifaire pour faciliter les parcours des personnes handicapées*. Paris, France: 2.

Despite the stated commitment to using psychic handicap as a boundary object to establish disability as separate from mental illness, in practice it was a bureaucratically split personality because the tools supposed to use to produce “objective” evaluations were a poor match for mental disorders. For example, one benefit offered personalized aid for people with “severe” or “absolute” difficulties in one of sixteen different activities. The criteria reflected the vision of disabilities as something that could be precisely measured and documented: a simple set of procedures could show that a person who was paraplegic had an “absolute” barrier to feeding themselves or getting out of bed. The Law of 2005 included activities like “orient oneself in time and space,” “manage one’s security,” or “master one’s behavior in relationship with others” explicitly in order to cover people with psychic handicaps. But it was very difficult to show that limitations in these domains were “severe” or “absolute.”³⁰ The lead evaluator for this benefit explained, “We are trying to see what is possible or impossible for someone...for psychic handicap, that’s complicated.” In my coding of reasons for rejection from various benefits, I found that people with mental disorders were far less likely to be found to be concretely “insufficiently handicapped” or “too handicapped” to receive benefits (the latter most often referring to help finding employment), but more likely to have an application deferred because of a lack of clear evidence either way (Table 2).

Like most tools under the 2005 law, the medical certificate attached to each application was supposed to cover all handicaps, regardless of their origin. It included a series of checkboxes to be filled out by doctors about whether applicants were autonomous in various daily activities. To Disability Office evaluators’ frustration, however, medical certificates describing people with grave, treatment-resistant schizophrenia nonetheless frequently indicated that the person was “autonomous” in activities like “clothe oneself” or “travel outside the home,” thus disqualifying them from many benefits. The problem, one representative from UNAFAM pointed out, was that “physically they can get up, get dressed, cook dinner—but they don’t.” Disability has long served as an exemption from certain social expectations—like employment—based on what someone *cannot* do (Stone 1984). A psychic handicap, defined by limitations to the activities someone *will* do, was inapplicable within this framework.

A boundary object must “satisfy the information requirements” (Star and Griesemer 1989, p. 393) of each world. But the evidence psychiatrists supplied to show psychic handicap often spoke to a troubled subjectivity but not objective incapacities. In one debate over whether to give a Handicap Allocation to someone whose medical certificate described him as having “behavioral problems,” one evaluator commented, “Maybe this really isn’t a psychic handicap—it’s just someone who’s frustrated and compulsive!” The example displays how, in these evaluation situations, the “personality” of people who ostensibly had a psychic handicap was “bureaucratically split”: the fact that the issue was “psychic” seemed to conflict with the notion that it was a “handicap.”

These difficulties in conducting evaluations that satisfied bureaucratic requirements were particularly visible in cases of “anxiety-depression syndrome.” Mood disorders have been a central component of the rise of disability rolls in the United States (Berkowitz and

³⁰ 15.8% of these allowances were given to people with psychic handicaps, even though they constituted closer to 25% of total applicants for disability benefits. Amara, Fadéla, Danièle Jourdain-Menninger, Myriam Mesclon-Ravaud, and Gilles Lecoq. 2011. *La prise en charge du handicap psychique*. Paris, France: Inspection générale des affaires sociales: 30, 70.

DeWitt 2013, p. 223) and now account for 39% of new awards for disability income on the basis of mental disorders.³¹ But in Paris (no national data is available), mood disorders were only 21% of an already smaller portion of awards given for mental disorders.³² My observations suggest that this was not based on a stigmatizing belief that applicants were malingerers or that giving disability benefits would demotivate a search for employment (Table 2).

Rather, rejections stemmed from the way that, in an attempt to comply with the requirement that they document a clear justification for their decisions, evaluators chose indicators that widened the gulf between “people with depression” and “people with disabilities.” In particular, in the absence of concrete evidence of how anxiety or depression created functional limitations in everyday life, evaluators used two shortcuts: is the person treated by a psychiatrist in a public Psychiatric Clinic? Has the person been hospitalized? Explained one evaluator:

We’re obligated to grab onto something: is there a treatment, consultations, hospitalizations? Often, the people that show they don’t have treatments, that are not hospitalized...by definition are not handicapped. If it’s hard to find something in terms of a restriction [of activities], and we don’t have lots of elements of treatment, of [medical] following, then it’s not serious.

In discussing one case, a person wrote in her own application for a Handicap Allocation that, in addition to physical limitations, she also had “psychic fragility” and depression as a result of an automobile accident. One evaluator exclaimed, “We don’t know what that means!” Another cut in, “Well, is she being followed by a psychiatric clinic?” When the doctor looking at the dossier replied, “No,” the head of the team declared, “Okay, well, at a physical level she doesn’t meet our criterion, and she’s not being followed for her ‘fragility.’ We can reconsider this if she starts being followed at a [public sector] clinic.” The evaluator was *not* saying that she directly needed an evaluation by a psychiatrist that she could “rubber stamp” as a determination that the person’s depression constituted a psychic handicap. Rather, she was using a following by public psychiatry as an indicator of disability in and of itself in her own expert evaluation.

Ultimately, this heuristic *outsourced expertise* because it made evaluations contingent on the prior decisions of public sector psychiatrists over whether to treat someone in a psychiatric clinic, prescribe them medication, or hospitalize them. Psychic handicap did not serve as a boundary object which bridged separate classifications “without imposing...categories from one community” onto another (Bowker and Star 1999, p. 297). Instead, psychiatric diagnoses—which French psychiatrists did not have to objectify using formal tools or measurements, and which many in the disability system critiqued in the abstract as unreliable and subjective—in effect became disability evaluations. They thus excluded some people whose functional limitations were difficult to evaluate but which might formally qualify them for disability benefits.

In a sign of the state and civil society’s commitment to the spirit behind the recognition of psychic handicap, various state agencies discussed bureaucratic fixes for these evaluation procedures.³³ One option would be for evaluations to officially rely on psychiatric

³¹ Calculation based on Social Security Administration. 2015. *Annual Statistical Report on the Disability Insurance Program*. Washington, DC.

³² Unpublished statistics (see Note 8).

³³ A key example was “*Potentiel Emploi?*” a national experimentation in a detailed evaluation of working capacity centered on people with psychic handicaps. The experiment was not renewed.

expertise, which would defeat advocates' goal of moving beyond a purely-medical understanding of the challenges of people with severe mental disorders. Another would be to create separate tools and procedures for this population, which would make the challenge of commensurating them with other people with disabilities, discussed in the next section, more severe. In either case, the attempt to use psychic handicap in evaluations showed it to be a bureaucratically split personality. Illnesses that created difficult-to-document troubles of volition could not be easily translated into incapacities that the Disability Office could objectively establish.

Institutionalization: stable compensation versus unstable troubles

In some cases, the team at the Disability Office could evaluate the medical certificate and life project of a mentally ill applicant, recognize the existence of a psychic handicap, and directly grant a disability benefit (like the Handicap Allocation). The full aspiration of advocates, however, was that psychic handicap would enable people with severe mental disorders to enter an existing infrastructure of professional retraining centers, protected workshops, and supported housing for people with disabilities (see Figure 2). Institutionalizing psychic handicap, then, required establishing that people with psychic handicaps were commensurate with the disabled people these institutions already served. Here, a tension long embedded in the categories of disability and mental illness—that the former was fixed and stable, the latter unpredictable and variable—constituted another way that psychic handicap was an unworkable bureaucratically split personality.

This contradiction was evident to the “Team for Professional Insertion” at the Disability Office. They determined whether a person who had already been designated “disabled” would be offered help in finding employment through France’s Centers for Professional Retraining, which were created for people disabled by war or workplace accidents (Romien 2005). These centers operated a model of “compensating” for the limitations of a disability through a long trajectory of evaluation, pre-orientation, re-training, development of a “project for professional insertion,” internships, and only then job searching. These institutions’ requirement that people be “stabilized”—“a strict precondition” according to one government report³⁴—was at odds with the very definition of psychic handicap given by UNAFAM and other advocates, which emphasized its “variability” and “the need for constant adjustments.”³⁵ As one psychologist who worked on professional insertion observed at a training, “We should remember that we’re dealing with a population [mentally disordered] that at any moment could fall apart and we have to start again from zero.”

The delay with which the Disability Office treated applications was undoubtedly frustrating for all applicants but particularly problematic for those with mental disorders. One day, the team debated a 53-year-old woman whose two-year-old medical certificate described a “chronic psychosis” and “heavy treatment.” The team’s doctor commented, “If she hasn’t been in the hospital since then, maybe she’s okay...” But the psychologist from the retraining center replied, “No. She could be totally delirious. We’ve done this before and it hasn’t worked out. Can we just say she’s ‘still in care’ and give her a Handicap Allocation?” While evoked in only 5% of other rejected demands, the team used “still in treatment” as a justification 40% of the time in refusing a request from someone whose limitations stemmed

³⁴ Le Houérou, Annie. 2014. *Dynamiser l’emploi des personnes handicapées en milieu ordinaire*. Paris, France: Assemblée Nationale: 24.

³⁵ UNAFAM, *Le livre blanc*, 12.

primarily from a mental disorder (Table 2). Confronted with this observation, one psychiatrist working in a service for professional insertion admitted that “the notion of ‘handicap’ in psychiatry is not that interesting if you say that it’s something stable and fixed. ‘Stable’ means nothing, in terms of psychiatric pathologies...just call it a chronic illness.”

This same contradiction appeared in France’s extensive system of “protected workshops.” These are organized around the model of a disabled person (classically, someone with intellectual disabilities) who could produce predictably and reliably at some level lower than that of a “normal” worker, with the difference made up for by state subsidies. These facilities had an interest in taking people with psychic handicaps because prenatal screening and abortion meant the population of people with conditions like Down’s Syndrome was decreasing. Yet when the directors of these institutions actually brought people designated as having a psychic handicap into their establishments, they struggled to commensurate them with their institutionalized schema of “disability”:

These are people [with a psychic handicap] who are one day capable of taking lots of initiative, lots of responsibilities, very technical things, and another day, they can’t tie their shoes... That’s the difficulty, not because they don’t know how, not because they can’t do it, but because some days, they just don’t do it!

My interviews suggested these difficulties were more about practicality than stigma. Because protected workshops largely cannot fire workers once they have been hired, managers had to continue to pay mentally disordered persons even when they were on long sick leave due not to their *handicap*, but their *illness*. They thus declared that people with intellectual disabilities were preferable because the key metric against which they measured the disabled was their “capacity to maintain their work over time.” The result was that only 6% of places in protected workshops in the Parisian region were dedicated to individuals with primarily mental disorders.³⁶

In France, being psychically handicapped presents a disordered, contradictory split personality with respect to work. On one hand, France has long been seen as a leader in promoting the employment of disabled persons (Power et al. 2014). I observed that at least some of the gatekeepers of employment for persons with disabilities—the Disability Office, “ordinary” firms, and protected workshops—made genuine attempts to accommodate people with mental disorders. But, once admitted, they determined that they were a poor fit, and thus began turning around new candidates. By default, then, they made the primary bureaucratic identity of this population “mentally ill.” And, in contrast to its employment-focused disability policy, France’s generous paid sick leave means that it has among the highest proportions of the population among rich countries who are not working because of illness.³⁷ Thus, when government statistics show that very few people labeled as having a “psychic handicap” are employed, the reason is that, as one workshop director explained: “I’ve realized that these people aren’t really handicapped! They’re just sick!”

Difficulties of commensuration, rather than overt classification struggles, created problems for accessing long-term disability housing as well. Across the health and disability systems, nearly everyone I interviewed endorsed the goal of reducing the number of chronically ill patients languishing in hospitals. Ideally, these patients would go to disability housing establishments which were charged with promoting the active social participation

³⁶ Agence régionale de santé. 2011. *Projet Régional de Santé : Schéma d’organisation médico-social*. Île-de-France: 45.

³⁷ OECD Health Statistics. 2012. Retrieved September 13, 2017 (<http://www.oecd.org/els/health-systems/health-data.htm>).

and rehabilitation of their tenants. But, as the person responsible for handling housing placements at the Disability Office explained:

When you're at the hospital, everything is organized for you. They tell you when to get up, when you sleep, and the rest of the time, you do nothing. In supported housing, you have a collective life, activities all day. If you're not used to it, it's exhausting. And this constant solicitation to do things that you're not in capacity to do, it creates frustration and behavioral problems... and you go back to the hospital. A social worker from the Psychiatric Clinic recounted the case of a patient who had been involuntarily hospitalized for three years, and who would collect cigarette butts and eat them. Working with the Disability Office, they found a place for him in a nursing home but they "sent him back to us because they said that he wasn't willing to participate in group activities, he just wanted to eat cigarette butts. And I was like, 'yeah, that's the point.'" This back-flow was significant, equivalent to about 22% of the people leaving psychiatric hospitals for disability housing.³⁸

These challenges were not a matter of simple gatekeeping by housing establishments. The directors of the private associations that run them actually wanted to tap into a growing population. But, in a manner consistent with the idea of psychic handicap as a boundary object, they usually demanded that the public psychiatric teams sign a convention agreeing to re-hospitalize those individuals when necessary. The problem was that, when they did hospitalize patients whose symptoms flared, the homes were required to hold that person's bed, but were only paid one-third their usual rate by the state. The solution, the head of placements in disability establishments at the Disability Office explained, was that "now the establishments want a guarantee that the person is 'stabilized'...which means they [people with psychic handicap] are never going to make it." This refractory looping reaffirmed a meaning of disability that increasingly excluded psychic handicaps. In 2014 statistics for the Parisian region, 45% of the people who had been approved for residential services by the Disability Office but not found a structure willing to take them had a psychic handicap.³⁹

At the time of research, efforts were being made to facilitate the entrance of these populations into disability housing. Doing so, however, required a profound break with a model that provided the same daily payment for all categories of disabled persons. It thus entailed the slow process of building specialized institutions *only* for the "psychically handicapped"—which, increasingly, were simply converted pavilions of psychiatric hospitals. There, one ministry official admitted, "the color of the blouses has changed, but the practices are the same." As was the case when the Disability Office outsourced expertise, psychic handicap was being treated more as a synonym of severe mental illness than a true boundary object. Other innovative programs—like worksite "Job Coaching" or rapid-entry "Housing First"—relied on re-directing funding and expertise back into the health system, which was not bound by the expectation of "stability" around which the disability system was organized.

These findings speak to the role of the particular configuration of the French welfare state in shaping what happened when the contradictions of a bureaucratically split personality emerged. Unlike the targeted disability system, in which people needed an affirmative evaluation from the Disability Office and to be accepted by an institution, France's universal health system had no prerogative to refuse people (Bauduret and Jaeger

³⁸ Direction de la recherche, des études, de l'évaluation et des statistiques. 2013. *Les établissements et services pour adultes handicapés : Résultats de l'enquête ES 2010*. Paris, France: 269, 273.

³⁹ MDPH 75. 2014. *Rapport d'activité*. Paris, France: 61.

2005). Through *classification by default*, psychiatric hospitals became the home for mentally disordered people with irregular immigration statuses, criminal justice involvement, or, in some cases, a history of violence towards the staff at establishments for people with disabilities. Outside the hospital, the lower level Psychiatric Clinic staff remained the de-facto sources of advice in looking for employment, facilitators of social activity, and aids for daily life (“we’re nurses specialized in assembling IKEA furniture,” one joked). They encouraged people with severe mental disorders to eke out a living using public housing or the minimum welfare payment available all low-income people. These were clearly not the high-quality services envisioned for people in the disability system, but they required neither stability, nor self-identification, nor a clear documentation of functional limitations. They thus were the fallback source of solidarity for those deemed incommensurable with the disabled.

Conclusion

Why did the introduction of “psychic handicap” fail to effect the intended transformation of people with severe mental disorders from passive objects of medicine to individuals capable of managing an autonomous life project, aided simultaneously by both the medical and disability systems? For some advocates, the law of 2005 had not carried sufficient funding or political will for implementing the gamut of services official recognition of “psychic handicap” had promised. They blamed professional resistance and a mutual fear of symbolic contamination from psychiatrists and disability institutions, with each group seeing the people served by the other as undesirable. These explanations correspond to theoretical ones in the literature on classification struggles (Barman 2013; Goldberg 2005) and cultural constraints to the introduction of new classifications (Norton 2014; Steensland 2006) and are undoubtedly partly true.

I also, however, presented counterevidence to these explanations. Policymakers and administrators endorsed the change and psychiatric professionals acquiesced to it. My ethnographic observations show how, at the micro-level, social workers in the Psychiatric Clinic and evaluators in the Disability Office labored collectively to try to adapt the tools, procedures, and regulations given to them to a new population (see Kellogg 2011). The recognition of psychic handicap as a basis of disability, on top of an existing bureaucratic identity of mentally ill, entailed clear material benefits that ought to have driven requests for classification (Bailey 2008; Liu et al. 2010). This counter-factual of a transformative new classification is even more plausible given the success of French parents in the 1990s in establishing autism (which was ultimately called “cognitive handicap”) as the basis for a bureaucratic recognition of their children as disabled (Chamak 2010).

My analysis starts with the recognition that, in analyzing a state classification like psychic handicap, “although it is possible to pull out a single classification...in reality none of them stands alone” (Bowker and Star 1999, p. 38). In this case, the introduction of psychic handicap was supposed to serve as a boundary object that would facilitate the simultaneous classification of people with severe mental disorders as mentally ill and disabled. But both categories continued to bear the imprint of the different arms of the state in which they originated. Each limb had contradictory behavioral expectations, principles of expert evaluation, and typologies of persons they served which, suddenly, were supposed to apply to the same people. This prompted processes of *outsourcing expertise*, *classification by default*, and *refractory looping*. Although these mechanisms harken to classic street-level bureaucratic practices like “rubber-stamping,” “gatekeeping,” or “burden shifting” (Lipsky 2010; Prottas 1979; Seim 2017), they specify how a bureaucratic split personality led to a

specific outcome based on the particular structure of the French welfare state. As in the case of the clinical treatment of “split” or “multiple personality disorder” (now referred to as “dissociative identity disorder”), the ultimate solution was the “reintegration” of these contradictory bureaucratic personalities into a single, unified human kind: mentally ill.

These findings are surprising in light of research on “boundary objects” that claims that very different professionals can maintain radically different practices and visions of the objects of their work so long as they are linked by some common categories or tools (Bowker and Star 1999; Mol 2002; Star and Griesemer 1989). Why was the mighty French state unable to simply reconfigure psychic handicap to satisfy the needs of both the health and disability systems? My results speak to the issue of scale: psychic handicap really was a logically consistent boundary object in national policy and even, to an extent, for the heads of the Psychiatric Clinic or Disability Office. But for the nurses and social workers who bore the brunt of preparing applications or the psychologists and special educators responsible for filling in the tables and checklists of the Disability Office, that psychic handicap was a bureaucratically split personality was evident. Even once these problems filtered upwards, they were difficult to resolve because what was at stake was not just an administrative label but a personality. Interventions by the health and disability systems were organized by distinctive visions of the kinds of people they served. Trying to change those kinds—by, for example, suggesting that the preferences of people with disabilities could be over-ridden if, like people with psychic handicap, they lacked “insight” into their need and limitations (Gong 2017)—would most likely have undermined the consensus on which the 2005 reform rested and sparked a true classification struggle.

This negative case can point to reasons why the classification of disability has been much easier to apply to the mentally disordered in other contexts. In the U.S., the dominant system of psychiatric diagnoses—the Diagnostic and Statistics Manual—incorporates an evaluation of functional limitations (Whooley 2016). Disability evaluations are initially more purely medical (Powell 2010; Stone 1984) and diagnosis is thus deliberately “objectified” as disability. People with psychiatric disabilities are commensurate with other people with disabilities insofar as the category of “mental disability” was already in use by government agencies by the 1970s; mentally disabled persons formed an early part of the model around which the disability system is based (Bagnall and Eyal 2016). Moreover, as the U.S. has cut back even residual welfare programs, the mentally disordered have no option other than asking for the designation of disability, which gives access to a minimum income and Medicaid insurance (Hansen et al. 2014). Ironically, while the rising numbers of people receiving disability benefits on the basis of mental illness has provoked continuous political consternation in the U.S. (Berkowitz and DeWitt 2013), the classifications mentally ill and disabled have proven practically compatible, even without a bridge like psychic handicap. As this example suggests, we need greater attention to cross-national differences not just in the prevalence of classifications like disability but the meaning and nature of state categories that make them easier or more difficult to apply (see Carson 2007; Fourcade 2009).

This analysis thus focuses on the meta-characteristics of categories themselves and the relations between them as presenting a potential barrier to the reclassification of populations. Classifications may require validation from a single bureaucrat or demand information and collaboration of a network of experts. Institutions can vary in the extent to which they broadly or narrowly construct the populations they serve, and thus the degree of commensuration they expect between them. Crucially, categories can be to a greater or lesser degree ascribed. States can unilaterally incarcerate those they label criminals and intern those they label mentally ill, but new welfare programs that seek to “empower” or “make

autonomous” the poor require a greater degree of engagement, even if that engagement loops back to modify the meaning of the category. Finally, re-classification may take the form of a wholesale replacement of one classification by another, like relabeling people with autism as disabled and not mentally ill (Chamak 2010; Eyal 2013). Alternatively, it may consist of layering classifications on top of one another, as was the case with psychic handicap. The latter may be more likely to create bureaucratically split personalities; the former overt classification struggles.

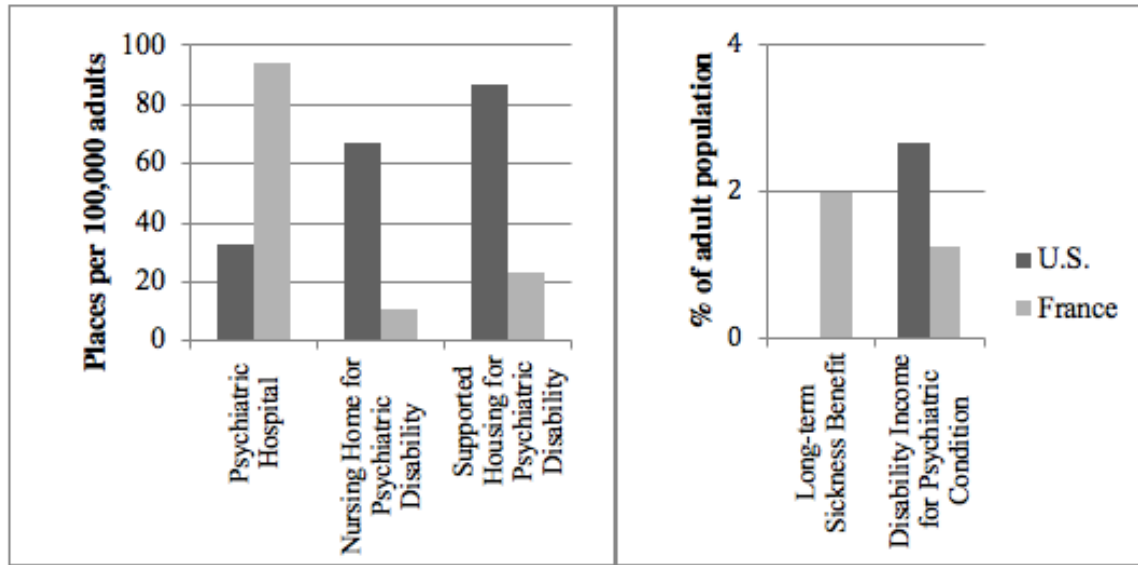
This perspective has important implications for a growing literature on how states establish key lines of division and social identities in their subject populations (Bourdieu 2015; Loveman 2014; Starr 1992). Psychic handicap could have been a case of the seeming buildup of classifications over time through projects that apply previously mutually-exclusive categories to the same people. Research points, for example, to the simultaneous management of the “poor” through both medicalization *and* criminalization, processes once thought to be opposing principles for state intervention (Bosk 2013; Lara-Millán 2014; Seim 2017). These analyses run parallel to work in the sociology of mental health that identifies an endlessly expanding accumulation of psychiatric diagnoses (Conrad 2007; Horwitz 2001; Rose 2006). Yet even if the state and medicine appear to construct an ever-more-elaborate “iron cage” of classification (Bowker and Star 1999, p. 320; see, also, Foucault 1991), this research helps identify the circumstances that limit attempts to layer and recombine classifications. Work that develops the now frequent recognition that the state’s “many hands” can act in ways that are “incoherent” (Morgan and Orloff 2017, pp. 3, 18), “contradictory” (Goldberg 2005, p. 342), or “ambiguous” (Mora 2014, p. 188) should consider how bureaucrats not just struggle over categories with one another, but struggle with the categories themselves.

What this case reveals is that it is precisely the state’s strength—its ability to marshal the “material and symbolic resources to impose the...classificatory schemes...with which bureaucrats, judges, teachers, and doctors must work” (Brubaker and Cooper 2000, p. 16; see, also, Loyal and Quilley 2017)—that made psychic handicap a contradictory bureaucratically split personality. There are no inherent characteristics to disability and mental illness that make them incompatible: rather, it was precisely the long process of forging true, distinct human kinds out of these classifications in state institutions that made merging one into the other so difficult. Orderly systems of population classification, then, must emerge from resolving the disordered systems that states themselves can create.

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Tables and figures

Figure 1: Medical and disability services for people with mental disorders in France and the United States



Sources: OECD Health Statistics; Davis et al. (2012); Direction de la recherche, des études, de l'évaluation et des statistiques. 2013. *Les Établissements et Services Pour Adultes Handicapés*. Paris, France.

Figure 2: The French health and disability systems and intended impact of the 2005 reform

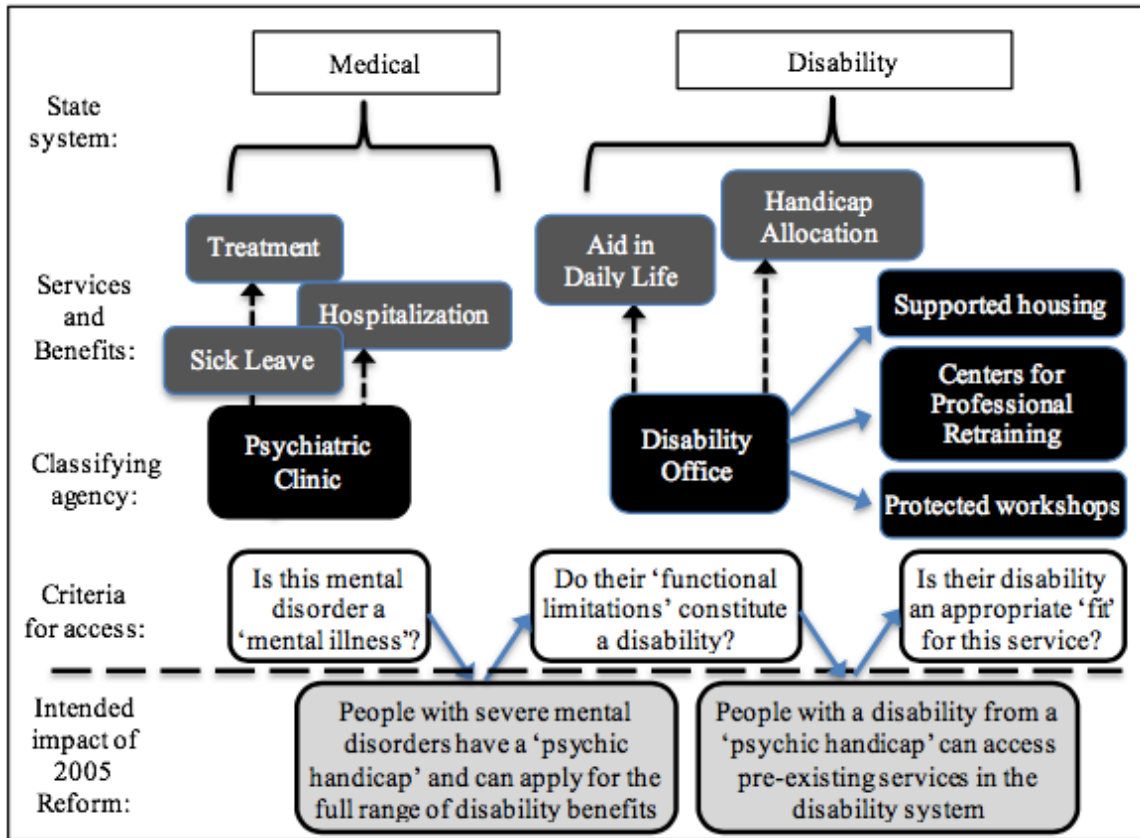
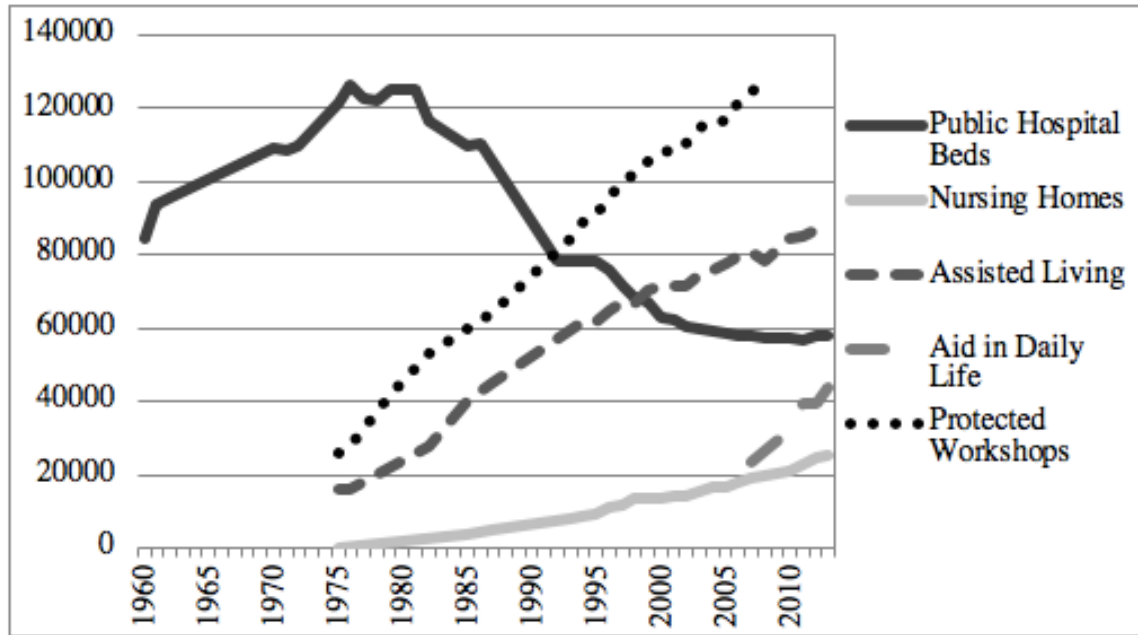


Figure 3: The decline in public psychiatric beds and rise in dedicated disability services in France (1960-2013)



Source: Institut de recherche et de documentation en économie de la santé. *Statistical Yearbooks*.

Table 1: Overview of France's health and disability systems

	Health	Disability
<i>Dominant Profession</i>	Psychiatrists, Nurses	Administrators, Educators, Psychologists
<i>Organization Type</i>	Public	Private Non-Profit
<i>Funding</i>	Central State, National Insurance	Sub-National Departments, Central State
<i>Access</i>	Universal; all people in a given Psychiatric Clinic's territory (with or without self-identification as "mentally ill")	Targeted; accessible only to applicants who self-identify with and are evaluated as "disabled" by the Disability Office
<i>Key Criterion</i>	Subjective symptoms; disturbances of thoughts, emotions, or behaviors	Objectively-determined limitations in daily life or participation in society; the life project of a person with disability
<i>Regulating Body</i>	Directorate of Health	Directorate of Social Cohesion
<i>Cost per Day</i>	€900 (Psychiatric Hospital)	€240 (Nursing home)

Table 2: Reasons for rejection from at least one disability benefit

	Mental Disorder (n=59)	Other (n=147)
<i>Administrative Ineligibility (Working, Migration Status)</i>	6.7% (4)	22.4% (33)
<i>Benefits De-Motivating</i>	3.4% (2)	4.8% (7)
<i>Incomplete Evidence of Handicap</i>	23.7% (14)	19.0% (28)
<i>Not in Treatment</i>	13.6% (8)	4.8% (7)
<i>Not Sufficiently Handicapped</i>	5.1% (3)	35.4% (52)
<i>Still in Treatment</i>	39.0% (23)	4.1% (6)
<i>Too Handicapped</i>	1.7% (1)	6.8% (10)

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