



Career guidance for Persons with Intellectual Disabilities in the Emerging Social Inclusion Context in France

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Abstract

Social participation and citizenship are now at the forefront of care and support for disabled persons in France. Not being clearly defined, however, the terms do not provide professional caregivers with useful guidelines. The social inclusion that social participation implies represents a paradigm shift for most professional care-givers, the care and support for persons with intellectual disabilities having traditionally been structured around sheltered environments. They consequently have neither the models nor the experience to implement it. This paper proposes an approach to care and support based on social and narrative identities. Care and support in the social identity context involves developing the social identities the person needs to lead the life of their choice. An “anticipated” narrative identity serves to identify these social identities and the conditions required for successful alternation provide the bases for their construction. Professional care-givers have the opportunity of becoming de facto change agents and facilitating the transition between sheltered environments and social and professional inclusion. However, this transition is not easy as the paradigm shift towards social inclusion impacts care-givers as well, who need to rethink their roles within this new framework, develop new professional practises and manage the uncertainty that such situations entail. However, succeeding in the above would contribute to making persons with intellectual disabilities fully-fledged citizens.

Keywords: Career and vocational guidance, intellectual disabilities, social inclusion, social identity, narrative identity.

Introduction

In 2005, the French National Assembly introduced legislation making social participation and citizenship as a priority in the care and support of disabled persons (Assemblée Nationale, 2005). Social participation, and the social inclusion that it implies, represents a significant break from the existing approach to the care and support of persons with intellectual disabilities, traditionally centred around sheltered environments. As a result, new approaches to care and support need to be developed. Successful social

inclusion must include “professional inclusion”. As a large part of the skills required to work in society are developed in the care and support process, the two cannot be dissociated in the case of persons with intellectual disabilities, who have little or no work experience. The two, at this stage at least, are interdependent.

Training organisations in France consider *savoir* (knowledge), *savoir-faire* (skills) and *savoir-être* (social skills), to be important vectors of successful professional integration. They tend to focus on the first two, however, as developing social skills takes longer to develop than the time-frames they operate in.

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But social skills are important objectives of the care and support process, whence the need to closely associate vocational guidance and training with the overall care and support process.

This paper attempts to respond to the question “What kind of care and support would facilitate the social and professional inclusion of persons with intellectual disabilities?”

The response will be developed by linking the following terms together:

- social participation
- social identity
- care and support
- narrative identity
- personal projects
- alternation

The Current Situation

How was the care and support that social inclusion breaks from, defined? Surprisingly, *accompagnement* (accompaniment), which is French for care and support, has no clear definition in the official texts nor in the scientific literature. It has been described as a vague notion (Stiker, Puig, & Huet, 2014) or irritating, on account of being a catch all term (Paul, 2009). Several reasons explain this, but the question remains as to what guides professional caretakers when what is at the heart of their work is not defined.

The answer is a set of best practices that have evolved over time. According to the Agence nationale de l'évaluation et de la qualité des établissements et services sociaux et médico-sociaux (ANESM), now part of the Haute autorité de santé (HAS) – the High Authority of Health, that evaluates the social work sector, “the recommendations of professional best practices clarify values, give meaning, and provide common guidelines to help professional care-givers find the most appropriate course of action.” (ANESM, 2016). However, these best practices have evolved primarily in sheltered environments. They are not adapted to

social inclusion and a new set would take too long to develop.

There may be no clear definition for care and support, but the different approaches to “*accompagnement*” have in common the notion of “going with” and “going towards”. However, the question, “but going where?”, still remains. If we were to refer to the legislation, the response would be going towards social participation.

What do we mean by Social Participation?

Social participation isn't defined in the texts either, its meaning appears to be taken for granted. The International Classification of Functioning, Disability and Health (ICF) of the World Health Organisation (WHO) defines an activity to be the execution of a task or an action by an individual and social participation as involvement in a life situation, in other words, performing an activity in a real-life situation. Conversing with a person, using public transportation, and shopping are some examples.

Social participation thus defined represents means and not ends, and to that extent the definition is not operational. The list of activities the ICF provides, covering the full range of life areas, is useful for evaluating a person's capacities but carries no indication as to which activities need to be developed for a particular person. Do we develop them all? And if so in what order? Do we only develop some? And if so, which? And why these and not others? What is lacking is what those activities are for. In other words, one doesn't engage in a conversation with just anyone merely to have a conversation; one engages in a conversation to communicate with someone in particular; the conversation takes place in the context of a social interaction; and that social interaction brings social identities into play.

Every social participation situation implies social identities that vary with the context and the people involved. These social identities may be directly or indirectly linked to the activity in question. A social identity directly linked to the activity "to

cook" could be "a chef". A social identity linked less directly to the activity "to cook" would be "a parent", where preparing meals is a social role, or an expected behaviour, of a parent.

Consequently, I propose defining social participation as the expression of our social identities. Linking social participation to social identities introduces social ties into the equation. Social participation is the term used henceforth by international organisations and the WHO, as it is by French law, to refer to the lives of persons with disabilities and their place in society (Ravaud, 2014). The ICF's list of activities includes domains where this "place in society" is implicit, such as Communication or Interpersonal interactions and relationships. But it also includes Mobility and Self-care which reflect skills rather than the notion of social participation.

A social identity approach to participation also highlights the fact that we all have multiple identities. Currently, persons with intellectual disabilities tend to be referred to by this identity alone, which is limiting and occults the other facets of their personalities. Amartya Sen (Sen, 2008) states that the same person can be, without any contradiction, a Norwegian citizen, of Asian origin, with Bangladeshi ancestry, a Muslim, a socialist, a woman, a vegetarian, a jazz musician, a doctor, a poet, a feminist, etc. Defining the person by only one of those identities is an act of violence that begets violence (Sen, 2007). From Sen's viewpoint, reducing a person to their identity of "disabled person" alone would be an act of violence, albeit symbolic, which underlines the importance of multiplying the identities by which the person is known.

What is Social Inclusion?

Social inclusion, like participation, is a concept that remains unclear. The lack of clarity results from the numerous definitions of social inclusion which can make the concept interchangeable with social integration, social network, community participation and social capital (Simplican, Leader, Kosciulek, & Leahy, 2015)

Social inclusion is sometimes construed as the absence of social exclusion, which, in turn, has multiple definitions. The two are closely related and can be viewed as two ends of a single dimension (Hayes, Gray & Edwards, 2008). Some of the definitions express social inclusion or exclusion in terms of participation: individuals are socially excluded if they do not participate in key activities in the society in which they live, but would like to do so (Burchardt, Le Grand & Piachaud 1999.); they would be socially included by having the opportunities, resources and abilities to build and maintain relationships, engage in education and employment and participate in community events and organizations (Stain et al., 2012, as cited in Filia et al., 2018).

In the light of the notions of participation and social identity as expressed in this paper, we could also define social inclusion as the freedom to express one's social identities (participation) through combinations of personal development, human assistance, technical aids and accessible resources, without one's impairments being a hindrance.

The Importance of Social Identities in Social Inclusion.

The focus on identity is essential to the success of the disabled person's social inclusion. The transition from a sheltered environment to society is not merely a geographical move. It can put the person's identities and self-concepts at risk as the social identities of sheltered environments are not known outside of them. The identities of the sheltered environment, based on the person's administrative status, such as beneficiary, user and resident, don't have the same connotations in the outside world. To be recognised and accepted, one needs to develop identities that are known to and have the same meaning for the others of the group. Our identities have two components: Identity for Self and Identity for Others (Dubar, 2015). Identity for Self, expresses the kind of person we would like to be.

Identity for Others defines the kind of person you are (to the social group). In the event of a conflict between the two, “identity strategies” attempt to reduce the gap separating them and to merge the identity for Others with the identity for Self. We cannot do without others to forge our own identities.

A similar process operates in the case of social identification with a group, based on the cognitive integration of the ingroup and one’s self-concept, or “who we are”. Two complementary processes attempt to explain social identification: self-stereotyping and self-anchoring (van Veelen, Otten, Cadinu & Hansen, 2016). In self-stereotyping, the mental overlap between self and group emerges top-down, via the assimilation of the self to an ingroup’s prototype: “I am like my group”. Self-anchoring is an opposite process; information about the personal self-concept is used as an anchor to define an ingroup. This results in overlap between the self and the ingroup: “the group is like me”. The closer the match between self and ingroup, the higher the social identification.

The Stakes Involved

The move towards social participation, social inclusion and deinstitutionalisation, as recommended by the Committee of ministers of the European Union in 2010 (Comité des ministres, 2010), reflects a trend towards shifting the responsibility of the well-being of disabled persons from society to the persons and their families themselves. For example, the recommendations of the Committee of ministers state that “...parents have the primary responsibility for the upbringing and development of the child; they should choose how to meet their child’s needs. The role of the state is to finance and make available a range of high-quality services from which the families of children with disabilities can choose”, a transition from institutional to community-based services. Consequently, the autonomy of the person and the accessibility of services and resources become critically important.

Is Social Inclusion a Reasonable Objective for Persons with Intellectual Disabilities?

Social inclusion as an objective for persons with intellectual disabilities is not overly ambitious. Eight percent of persons with intellectual disabilities have mild impairments. They are relatively autonomous in different areas of their lives. Their access to social life can be improved by reducing the cognitive complexity of their environments or by providing them with technical aids (Courbois & Paour, 2007).

Defining Care and Support in a Social Inclusion Context

Legislation introduced in 2002 (Assemblée Nationale, 2002) requires the individualisation of care and support and the active participation of the person with intellectual disabilities, or their legal representatives, in drawing up their personal projects.

Taking into account our definition of social participation as an expression of one’s social identities on the one hand and the obligation to tailor the disabled person’s project to their expressed wishes on the other hand, I propose we define care and support as helping the disabled person to identify and develop the social identities they need to lead the life of their choice.

How Does One Identify these Social Identities?

Narrative identity as defined by Paul Ricoeur provides a solution. It is the sort of identity to which a human being has access thanks to the mediation of the narrative function (Ricoeur, 1988). The narrative constructs the identity of the character in constructing that of the story told. The identity of the story makes the identity of the character. In other words, we are the stories that we tell ourselves and others about ourselves.

To develop a personal project, we invite the disabled person to imagine themselves in a more or less distant future and to describe themselves and the life

they would like to lead then. Their personal project would then consist primarily of developing the significant social identities that emerge from the narrative. Among the situations described in the life the person would like to lead, would be those linked to work and the jobs the person would like to do. Getting them to develop their ideas in this area of their lives would help define their professional projects. The role of professional care-givers would then be to organise the acquisition of the technical and social skills required to achieve these objectives. The process needs to be iterative and be repeated at regular intervals in order to update the personal project periodically. It also needs to be put in place early. Research conducted in middle school on students' representations of the future showed that the number of jobs mentioned to complete the sentence "The job that I am going to do later is ..." was multiplied by three over the four years of middle school. In the special-education equivalent of those classes the number of jobs mentioned was reduced dramatically, to centre around manual work. It was a result of the students internalising their teachers' preconceived notions of what they were capable of.

How do we develop these social identities?

Alternation, as described by Berger and Luckmann (1991), provides a possible solution. Alternation is the process by which a person's identity undergoes a radical change, as in the case of a religious conversion. The social identities we refer to here do not represent such a radical change, but the conditions required for successful alternation could be useful in developing new social identities for persons with intellectual disabilities. Successful alternation requires three conditions: a plausibility structure, a significant other and the reorganisation of the conversational apparatus.

The plausibility structure is a social environment that confirms and reinforces the person's new social identity. The plausibility structures, in these cases, could be environments that overlap sheltered

environments and ordinary environments. It could be a sheltered workshop that functions like a "normal" one, or companies that take in interns from sheltered environments who are followed by a tutor and a caregiver. The significant other is a person who has strong emotional ties to the person and is the mediator between the person and the plausibility structure. The significant other would be one or more of the caregivers.

Conversation is the most important vehicle of reality maintenance. The conversational apparatus must hence contribute to reconstructing and maintaining the person's new social reality. The conversations in the person's social environment should reflect and reinforce their new identities. Support groups could also help in the process.

The Impact on Care Givers

The transition to social inclusion is not easy to navigate for the person with intellectual disabilities as it represents a radical change in their lifestyle and involves leaving behind the security of a sheltered environment for the uncertainty of society. But it is extremely difficult for professional caregivers too. They have no models nor the experience to adapt and to face up to the new demands of their jobs. They need to rethink their roles and develop new professional practices, all the while having to manage the uncertainty of the situation and the real and perceived threats to their jobs. This is largely due to the absence of a clear definition of care and support. Without such a definition, caregiver's jobs are defined by what they do and not why they do it. And best practices don't provide the why. What is missing is the bigger picture. As a result, when the context changes and the way things are done is no longer appropriate, it is as if one's job itself was being questioned and put on the line, which is extremely destabilising and is perceived as an existential threat. Having a conceptual framework that can guide caregivers' actions provides the bigger picture, and the approach laid out in this paper is an attempt at that.

Conclusion

We defined social participation as the expression of our social identities. We then defined care and support as helping the disabled person identify and develop the social identities they need to lead the life of their choice. These social identities are identified using an anticipated narrative identity. Developing those identities is based on the conditions required for successful alternation: a plausibility structure, a significant other and an appropriate conversational apparatus.

Although the transition may be difficult, professional caregivers become de facto agents of change in the lives of the persons in their care and of the institutions

that provide the care and the services. As we are at the threshold of a new approach to the care and support of persons with intellectual disabilities, care-givers have the opportunity to influence the systems that are put into place.

Hopefully, getting persons with intellectual disabilities to express their life choices would encourage them to voice their opinions on other aspects of their lives and on society at large, thus giving a voice to those who have been traditionally denied it. Successfully implementing care and support and providing appropriate vocational guidance would thus contribute to helping make persons with intellectual disabilities fully fledged citizens.

About the author

Girish Muzumdar is an associate member of the PROJEKT design and social innovation lab at the University of Nimes in France. His field of research is the care and support of intellectually disabled persons leading to social inclusion and the use of pictograms as technical aids in developing their autonomy.

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