Chapter 1
Introduction

In an urban area of Brussels, under the doorbell of a banal domestic townhouse, a small label declared the building a 'Day Center for Teenagers' (figure 1). Had someone rung the bell, a youth or adult wearing casual clothes would come to open the door. Or the secretary might poke her head out her first-floor window to see who had arrived, instead of using the intercom. Once past the threshold, newcomers would enter a vestibule where they would notice intensive traces of wear and hear the creaking of the floorboards above. After a few steps, they would find a small staircase, whose doors gave access to a living room, or to a dining room open to a kitchen and a yard. There, they would come upon people sitting or leaning against a table, addressing each other by their first names while they chatted about the daily news and shared their opinions. Some would sip at cups of coffee and, if it was late morning, they'd smell a meal being prepared. Such visits would have most likely occurred until 2014. That year, the day center moved to a new building located a few streets from the townhouse. The new place was an existing building on a much bigger site, freshly redesigned (figure 2). The name of the center was visible on its façade, without indicating that the teens were diagnosed with psychiatric disorders. At the entrance, large windows opened onto a view of the secretary who could see the visitors and open the door to let them in with a remote control. Newcomers who entered found a waiting area at the start of a long corridor. For them to reach the core of the day center, where caregivers and teens shared daily life, they had to walk down that corridor, pass another door, then

another corridor that led to the caregivers' office, after which stood the living spaces.

The differences between the entrances of the old house and the new building were small, but important. These spatial modifications induced caregiving in utterly different ways. This psychiatric day center for teenagers initially inherited the 'therapeutic community' model, in which everyone present in the center takes part in its everyday organization and social life. Although the center had made room for biomedical psychiatry about ten years earlier, when moving to the new location, the sharing of informal and ordinary moments of everyday life continued to be crucial to their care work. The old town house incorporated the values that have been constitutive of community psychiatry for decades. Its anonymous façade and public entrance avoided stigmatization of its occupants. Not only did it avoid displaying the psychiatric troubles that brought them there, but it also dismissed the idea that these troubles should be addressed by the disciplinary order of traditional institutions, such as hospitals, schools, or other welfare settings. Once inside, the building's domestic layout encouraged direct immersion and informality. As for the entrance of the new building, it induced quite different interactions with the space and between its users. The display of a logo, the glass entrance with its view of a secretarial office, the remote-controlled doors, the waiting room and corridors, all made palpable that this was a professional place primarily devoted to treatment.

These changes were far from trivial. The new entrance especially raised problems about the role of the secretary, who was not intended to be a hostess or, worse, a gatekeeper. Instead, she had to remain immersed in the everyday events of the group with the other caregivers and the teens. The team attempted to retain that sense of immersion for her. Details of her office arrangements then became of greater importance: her desk remained a large working table with chairs on both sides, rather than a higher, formal receptionist's desk with a counter. Plus, after moving to the new location, the caregivers and teens took care to involve the secretary's space in the group's daily life by often stopping by for a chat. The new entrance layout required effort to maintain these

casual interactions with teens that the caregivers deemed elementary in their work.

Matters of space

This book is an ethnographic study of the spatial arrangements in a care institution. It takes us into a specific place, the psychiatric day center for teenagers I introduced a moment ago, to better understand how a building and its interior spaces contribute to everyday care. This care center offers a specific entry for such an exploration because it speaks to significant changes that have been transforming the psychiatric field over the last fifty years. These changes entail a profound, ongoing questioning and reconfiguration of what a care institution might be. In terms of spaces, the most remarkable change across the diverse movements that established community psychiatry lies in the implementation of small facilities in houses outside hospital walls and their disciplinary organization. Yet these places were not only different due to their insertion in streets and neighborhoods. The materiality of the houses, their room layouts, and their disposition of furniture and objects also made a world of difference for the patients' daily experience of care. The original premise of my research is that there is a lot to learn from the spatial arrangements of such community facilities and from their usages. They offer insights not only to researchers and practitioners interested in psychiatric settings, but also into the spatial organization of other care institutions such as youth centers, group homes, or even nursing homes or schools, with respect to their specificities and differences. My hope is that you, the reader, will better perceive how material spaces subtly contribute to or hinder care after closing the book.

Certainly, that psychiatric day center can teach us about spaces of care, since its heritage carries a vivid reflection on institutional life. But it also deserves a closer examination, amid many other facilities I visited, because its move to a new building brought to the surface many matters of space that spanned concerns of caregivers, teenagers, architects, medical and administrative directors, and mine. The design project aimed at

providing caregivers and teens better conditions for their practice, while maintaining what was already working for them in the old house. Until then, in their ongoing care work, matters of space had always implicitly been diluted by other flows of concerns. As perhaps goes without saying, those concerns usually centered on the patients. But the transition created a rupture from a place populated by implicit habits, meaningful stories and histories, a place that required ingenuity when coping with inconveniences. This rupture raised the question, for both the caregivers and the teens, of how to retrieve what had rendered the original location so specific to them. Therefore, the transition required the caregivers to formulate the specific values and details of their spaces, to convey them to architects and directors. Each of us needed to learn about matters of space, although for different purposes.

As an anthropologist, my purpose is to relay what has been learned both from that transition and my ethnographic exploration of the everyday practice in that center, and to articulate these stories in order to bring novel insights about institutional spaces of care. In care ethnographies, at the crossroad of medical anthropology and studies of sciences and technology, I found research techniques and conceptual tools enabling a close look at spatial arrangements. These techniques and tools enabled me to probe how the materiality of spaces *works* in the care practice. Just as the story about the new entrance would lead us to suspect, spatial arrangements must be considered in how they induce everyday interactions and values in care situations, while none of these ingredients alone fully determine the others. The entrance story invites us to venture further into the building, guided by these questions: What do material spaces enable caregivers and teens to do? How do these tangible arrangements make them act? When do they succeed or fail? What tensions or contradictions do they generate? And, in turn, what does 'care' become when analyzed through a spatial lens?

This book offers some answers to these questions by bringing into view how specific spatial arrangements and their usages carry a form of care that has to do with the formation of patients' attachments. It recounts how material spaces, together with caregiving techniques, provide subtle conditions to bring out teenagers' affinities, even from their

slightest degree of existence. These community-based care practices and their spaces are critical in today's institutional landscape. They are all too often unrecognized, disqualified by biomedical knowledge, if not already devastated by the shifting landscape of deinstitutionalization and its discourses on management. By describing how matters of space are enacted in practice, this book invokes a further reflection on 'responsive care', namely, how caregivers' attentiveness to small and contingent occurrences gives room to what moves teenagers, to what matters to them. Before turning to this community care and the link I draw with the idea of attachment and its implications, I would like to describe how I studied the spaces in this research.

Figure 1: The old town house (2013).

Figure 2: The new building (2014).

An ethnographic take

This book follows the contours of *material spaces*. But what is a study of spatial arrangements? And how to look at these arrangements in relation to care? I started to pay closer attention to spaces when I was a scenographer. Although my work involved the drawing of plans, the building of models, and a certain knowledge of materials and construction techniques, the creation of theatre and exhibition sets induced another relationship to spatial design than that of architects. This became obvious when I started looking for monographs on contemporary psychiatric

buildings, and found them on the shelves of architecture libraries. In these books, I could see drawings, wide-angled photographs, and maps of architectural projects (Kovess-Masféty et al. 2004; Mens & Wagenaar 2010: 239–245; Laget, Laroche & Duhau (2016 [2012]): 459–471, 504–508). People were rarely depicted in them. Reading on, I learned about the themes that traversed these design projects. Buildings should look as 'normal' (that is, as non-medical) as possible. They incorporate arrangements for sociability. And prevention of aggression against oneself and others may also be considered. While these books allowed me to pinpoint recurring themes, my background as a scenographer prompted me to further understand how these spaces interfered with the dynamics of care as they played out in situations I observed.[1] Indeed, architects are trained to focus on design projects and seldom on post-delivery uses, while scenographers continue to modify stage sets throughout the rehearsal process. It is only when actresses and actors play with a set that we can observe if a scene works or not, and this process often demands modifications along the way. Consequently, I could hardly reduce my perspective to the conception of buildings and the themes inscribed in these spaces. I came to consider the ways in which they change over time, while being transformed in accordance with users' practices.

What's more, while moving my scenographer's gaze onto academic research, it was no surprise that it found its best translation in micro-ethnography. Rather than embracing an entire building, what fell under scrutiny were the spatial arrangements or elements with which occupants interacted.[2] In this way, the descriptions in this book go into

1 Note that geographers have also developed an interest in the spatiality of 'mental health' facilities. Rather than putting the materiality of buildings *per se* under the lens, they focus on mapping locations of care settings, distributions of people with mental disorders, as well as the significance of place for the patients. See Wolch & Philo (2000) for an overview.

2 For works that also put material spaces under the magnifying glass, and develop interactional perspectives on them, see Koolhaas & colleagues' (2014) robust monographic series about the 'architectural elements' that constitute a building (windows, ceilings, stairs, heating, etc.); the book *Usus/usures. État des lieux – How things stand* (Rotor, d'Hoop & Zitouni 2010) that renews an interest

the detail of interactions with the materiality of the spaces of the day center for teens. From Goffman's (1963; 1971) depictions of encounters in public places, I learned to seriously consider what can be at stake in people's interactions through their mutual, verbal and non-verbal responses.[3] Therefore, in this book, the 'material spaces' are the matter and texture with which one can interact in tactile and meaningful ways. They can take the shape of a room, a corner, a furniture element, or any other thing. I trace everyday interactions with the day center's tangible environment, as caregivers and teens move, sit, adjust their distance, establish eye contact, adjust their body position, orient themselves, pay attention to their surroundings, wander around them, touch them, manipulate things and display others, distribute their presence and, over longer periods of time, vary the spatial arrangements.

Therefore, if spaces are indissociable from interactions with them, how to understand the activity at hand? Goffman argues that spaces are not 'out there', external to people's interactions, and stresses the varying normativity of places (such as differing expectations for interacting in a restaurant versus a bedroom). Yet his works "built on a vision of space as a resource ready and waiting to be mobilized by conscious human agents" (Prior 1988: 89). Latour (1996 [1994]), following in interactionists' footsteps, tackles this problem. He calls for us to pay close attention to scenes of interaction equipped with objects, clothes, designed places, etc., by describing how they contribute to shaping actions. In other words, he contends that objects are delegated "to both replace human action and constrain and shape the actions of other humans" (Latour 2008: 151). In the care center, this means that material spaces make care-

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in architecture about the wear of materials, uses, users and construction practices; and see also Conein, Dodier & Thévenot (1993) for a collection of studies about people's engagement with objects in practices, beyond analyses of them as tools or symbols.

3 However, I do not share Goffman's aim in bringing up the acting out of social norms and the exclusion they delineate. In my fieldwork, these norms appeared much more indeterminate. Teens' behavior that failed to match social expectations could open opportunities to shake the local normativity (d'Hoop 2021a).

givers and care receivers act in particular ways. Each spatial element and human being plays a respective role as an actor in its encounters.

The materiality of care

A body of works has prolonged this ethnographic invitation to describe the agency of materiality on health and social care terrains. These authors investigate what constitutes "care in practice", as Mol, Moser and Pols (2010) titled a representative collection. They recount how care is *done* empirically, with its techniques, ways of doing, materiality, and events, and they conceptualize through these descriptions.[4] These care studies hold a particular view on things and technologies in care work. They cultivate a 'material semiotic' approach, meaning that they refuse to separate *a priori* the material world from that of ideas. In this approach, material objects do not reflect, represent or symbolize ideas, meanings, or values that people attribute to them. Instead, these studies contend that ideas take shape in and with the material world in ongoing practices.[5] They thus explore the relationships that weave between people and materialities, like technology or things, as well as what those relationships produce in an ongoing practice.[6] Think, for instance, of the modes of entanglement that take shape between wheelchair and

4 I can hardly encapsulate in one note the scope of studies that align with this approach. Those relevant for this research punctuate the book. Note, too, that in the fields of medical anthropology and nursing studies, many works have focused on practices as well, yet without articulating the active role of materiality. For a recent publication that discusses the approaches to the materiality of care, such as clothing or waiting rooms, see Buse, Martin & Nettleton (2018).

5 Nord and Högström (2017) provide a collection of studies about the architecture of care institutions (in the UK and Scotland) through a closely similar approach, which they label "non-representational theory" (10).

6 The material-semiotic approach does not posit foundational explanations. It gives descriptive details about how relations assemble or dissociate between humans and other beings. They do not propose general theories; these studies emphasize their situatedness as well as the transport of the knowledge they carry. For one account about material semiotics, see Law (2009).

the person it hosts (Winance 2019); or of the effects of telecare devices on how patients and nurses address problems, invent new routines, acquire knowledge, and form new webs of interdependence (Pols 2012).

In this view, the good, bad or ambivalent values at stake in care situations are not located in human minds and projected on neutral objects. Instead, these values pervade technologies, things, local strivings, routines, the application or shifting of rules, or the know-how particular to a practice.[7] Or, to put it another way, the values that matter in a care practice are neither subjective nor objective, neither universal nor essential, but they are dynamic within the specific situations where people and things interact (Pols 2015). The values and concerns embedded in the spatial surroundings animate everyday care practice. Therefore, in this book, I bring out how interactions with the spaces of the day center contribute to the emergence of attachments: when teens develop affinities as caregivers attempt to elicit them through mediation of the material environment.

Ultimately, I see the worth of these empirical care studies in their inheritance of pragmatic philosophy. They tell us about ways of doing and materialities that are not permanent, but involve persistent experimentation as caregivers attempt to improve the problematic situations they deal with. Rather than taking a strict critical posture, describing experimentation starts instead from the assumption that practitioners try to develop a good practice, or the best possible practice, without ignoring tricky aspects. This posture does not claim that objects and technologies can solve ethical issues, but rather shows how they cast these issues into sharper relief. In the practice of adjusting and continual experimenting, things and technologies, too, are 'attuned' (Mol 2008: 55; Mol, Moser & Pols 2010: 7–25).[8] In contrast to analyses that assign explanations to ex-

7 This empirical approach to care, then, differs from traditional care ethics because what care is, and what is good or bad within it, is not defined according to researchers' prescriptive criteria, but after having conducted situated inquiries and articulated them (Pols 2015).

8 Other ethnographies of care in non-Western hospitals have shown how improvisation is vital as well in biomedical practices (Street 2012; Livingstone 2012). Although adopting different conceptual frameworks, in medical anthropology

ternal forces or greater structures, such empirical care studies compel us as theorists to leave the protective shell of grand determinations, and to try to better report on and respond to situations that can hardly be limited by such certainties. The ethnography of spaces in care practices allows us to make visible how these arrangements are in turn involved in attentive experimentations, without deterministic or causal pretension. This non-deterministic view sidesteps a tale of the 'spatial influence' on users. Rather than merely impacting how caregivers and teens act, the spaces of the day center enact potentialities that open paths for their actions in ways that are unpredictable, but nonetheless consequential for the care work and its place (d'Hoop 2021b).[9]

In this sense, this ethnography of a building also adds a stone to architectural studies that are concerned with situated, embodied accounts of buildings and spatial arrangements (Doucet & Frichot 2018). These studies seek to resist a vision of architecture that claims to be autonomous, that is, supposedly disentangled from particular places, things, and people's lives.[10] There is indeed a strong tradition

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the subfield of hospital ethnography carves a path for microanalyses of various institutional lives in both social and professional aspects. Insights into this evolving specialty can be found in Long, Hunter & van der Geest (2008); Finkler, Hunter & Iedema (2008); and Street & Coleman (2012). The latter brings into focus the multiple spatial orderings, biomedical and others, at play in hospitals.

9 I can thus observe, as an ethnographer, how the spaces may enact or not teens' affinities in the daily care practice. The concept of 'enactment' puts the practice in question at the core of the inquiry: it is about the material and social activity that generates realities in practices (Mol 2002). This concept undertakes an ontological point: "If an object is real this is because it is part of a practice. It is a reality *enacted*." (44, original emphasis).

10 Most of these authors find a primary interest in the architects' design practices (for instance, Yaneva 2009a, or Houdart 2009), but they may also observe how actual spaces induce certain uses and social relations as Yenava (2009b) does with staircases, doors and conference rooms. According to Martin et al. (2015), an adequate social study of healthcare architecture demands exploring buildings both through their construction project and their experience by users.

in the architectural discipline that conceives buildings as the prestigious artworks of designers, drawn on white pages, and then built on empty sites. This framework excludes any counter-narrative that would welcome more marginal actors – such as existing lands, mundane infrastructures, or users and their words, practices and concerns. Of course, critiques within the architectural field have been calling for a greater sensitivity to users and their uses of spaces (Blundell Jones, Petrescu & Till 2005; Cupers 2013; Doucet 2015: 111–132). What ethnography can offer, then, is a fine-tuned description of how a specific material environment and its usage take shape, and with whom, and, over time, how they undergo necessary changes. I hope that such a situated account enables us to unravel the potential of an institutional place that is inhabited and arranged with care, and hence, to better perceive what it could be.[11]

The day center

The day center for teens belonged to an institution called *L'Équipe* that was created in 1964 as one of the precursors of the deinstitutionalization movement in Brussels. Its first facility was established in relation to *Brugmann*, a hospital affiliated with the Université Libre de Bruxelles. The aim was to move patients from its psychiatric unit and to host them in a 'therapeutic community'.[12] This care model is based on the idea that everyone present in the center takes part in its organization and social life, especially through mundane daily interactions such as sharing a meal, moving about, or improvising a chat. This was to help participants

11 On this speculative posture, that is, a posture that explores the transformative potentials of situated, empirical inquiries, their narrations, and relational perspectives, see Debaise & Stengers (2015). On the inspiration from this posture in architectural studies, Doucet, Debaise & Zitouni (2018).

12 The names of all facilities are real but, on their request, all the names of my interlocutors are pseudonyms. Majerus (2013) offers a micro-history of spatial organization in the Brugmann hospital (34–83), and of Brussels' context when shifting to community facilities, including to L'Équipe (ibid: 257–286).

learn how to better deal with their feelings and with the impacts of social interactions, as well as further consolidating their personalities.[13] During the five next decades, L'Équipe expanded into 19 other buildings, all located in urban areas. They included eight other centers, the location of the administrative and maintenance staff, a library, an art gallery, and ateliers. The day center for teenagers was created in the early 2000s. Since then, it has been hosting teens (aged 12–18) diagnosed with different kinds of disorder. All of them were school dropouts. When I joined them, more than half of the teens were sent by psychiatric units, most of them by mental health workers, and some by the juvenile justice court, youth welfare services, or their parents. A few of them were living in welfare institutions. In the day center's neighborhood, caregivers and youths regularly frequented public facilities, a park, bakeries, supermarkets, local shopping streets, a swimming pool, or the district library (figure 3).

At the time of my research, the team was still practicing the initial community model. The institution still worked in collaboration with Brugmann, where the medical director was based and from which she sometimes sent teens. The caregivers of the day center called their work "sociotherapy" and also referred to "institutional psychotherapy".[14] Baptiste, the coordinator, teamed up with five educators, three social workers, two artists, two psychologists, three nurses, two psychiatrists, a secretary, temporary external artists or trainees, and a medical director who came once a week as clinical staff. Besides the doctors, all

13 An initial reference in this school of thought is Jones (1953). For secondary sources: Fussinger (2011) provides a historical report of therapeutic communities; Spandler (2006) draws lessons from a historical case study (in the UK) for today's and tomorrow's social actions; and Smith and Spitzmueller (2016) give an ethnographic account of such a 'milieu therapy' from the caregivers' perspective.

14 The basic assumption of this French movement is that caring for people is done by caring for the institution. A vast literature has been written about it. For historical documents that offer in-depth reflections on the spatial dimensions of Institutional Therapy, see Guattari (1967); Murard & Fourquet (1975). For a philosophical reading of its therapeutic practice, see Rozier (2014).

members of the team were "sociotherapists". They came to know the teens by sharing a daily life filled with informal moments in living spaces (*le communautaire*) and diverse places for activities. Weekly community meetings gathered all the teenagers and some of the caregivers. Each of them was invited to bring issues they wanted to discuss. Relationships, or rather the conditions of togetherness in the center, were often dissected under a microscope during these meetings. Another important aspect of this care work was its opening to the external world by going outside, or by bringing experiences, things, or people from outside into the center.

As years have passed, the team has come to combine this community life with analytical work, inspired by psychoanalysis and systemic approaches.[15] Next to an individual focus, they considered patients' relationships and interactional dynamics in the group and with their own relatives (Vermeylen & Schouters-Decroly 2001). Since 2005, the care practice also integrated a biomedical approach. The caregivers were at first very skeptical about the inclusion of a nurses' office in the center, with its medicine cabinet and prescriptions. But they eventually accepted the biomedical work, provided that medication was used at the minimum necessary level. This was noticeable in the spatial organization as well. In both the old house and the new building, the living spaces and workshop rooms were located at the core. The infirmary was deliberately set back with the consultation rooms on the upper floors, unlike hospital wards where the nurses' station is often central (figures 4a-d; figures 5a-c).

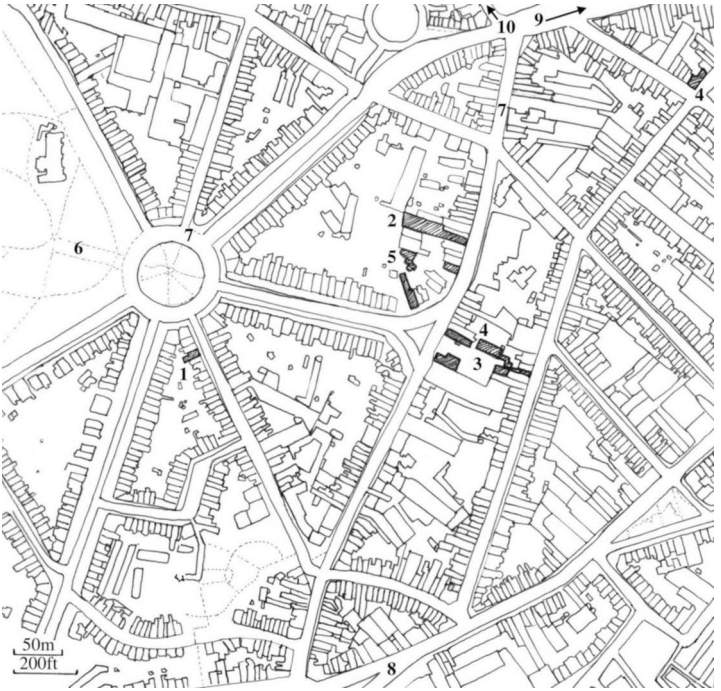
That combination of community work and both psychodynamic and biomedical approaches, it must be said, remained under debate in the ongoing practice. The differences between these frameworks were especially strained when they implied a hierarchy of knowledge about patients, and even more so when a decision about treatment involved un-

15 Though psychoanalysis mostly took place in conversations in consultation offices, its influence in the community work manifested when caregivers gave importance to what the teenagers said. Speech was a valued ingredient to better understand them.

certainty. This was the case with Samira. When she arrived in the center, she had been prescribed a high dose of Zyprexa, a medication used for schizophrenia. But after two months, the sociotherapists gave a report that cast doubts on that diagnosis, highlighting her intellectual vivacity in workshops, bodily attitude, relationship to her mother, and school reports. After having listened to the portrait presented by the team, the medical director rethought the diagnosis and changed Samira's medication to a much less strong one. That was a risky choice. The caregivers cautioned that they should all be attentive to Samira's response to this change.

Their decision involved a crucial process of craft: when caregivers were unsure of the way to continue with a youth, they used their different ways of knowing to address the issue. The team jointly composed a portrait of each youth. Day after day, they built an informal knowledge of the teens, notably by testing each of their responses with like and dislike. They revisited and refined this knowledge time and again, meeting after meeting. Tensions became palpable, though, when psychiatrists used their scientific knowledge in a way that silenced other caregivers' reports. But the story of Samira shows that it did not always happen that way. The complex portraits of each teenager that the team created enabled them to take careful decisions about treatment, whether it concerned medication or non-biomedical therapeutic propositions. Nothing less is at stake in how ordinary spaces help create mundane affinities, than what knowledge and which therapeutic possibilities can be explored in the course of care work.

Figure 3: The neighborhood of the day center.



1 The old house
2 The new building
3 Administrative and maintenance staff, art gallery and library of the institution
4 Others centers and ateliers of the institution
5 Clay Atelier
6 Park
7 Bakeries
8 Supermarket
9 Shopping street
10 Public library and swimming pool

Figure 4a: The basement of the old house.

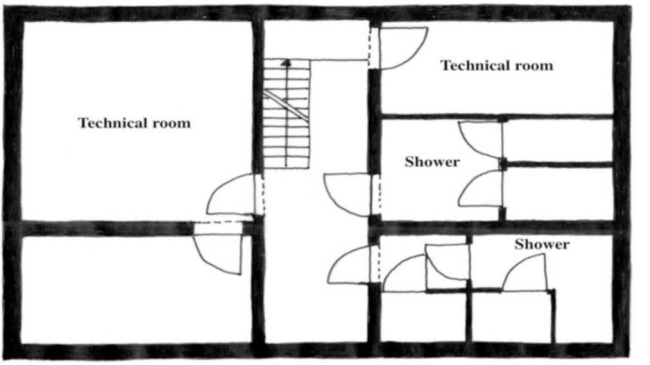


Figure 4b: The ground floor of the old house.

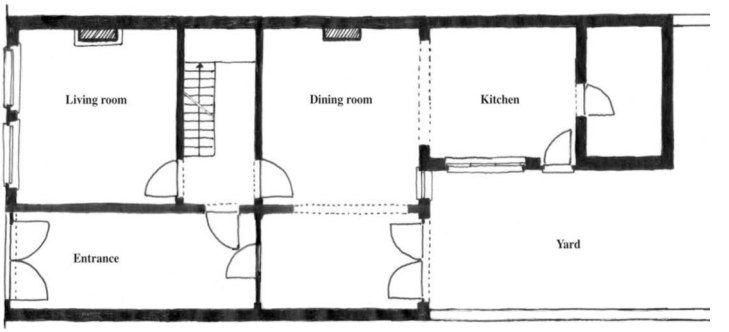


Figure 4c: The first floor of the old house.

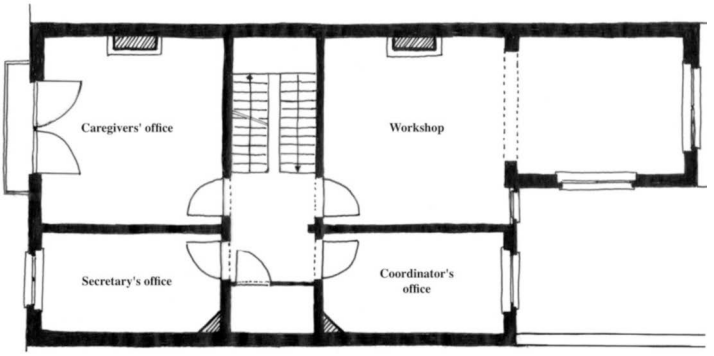


Figure 4d: The second floor of the old house.

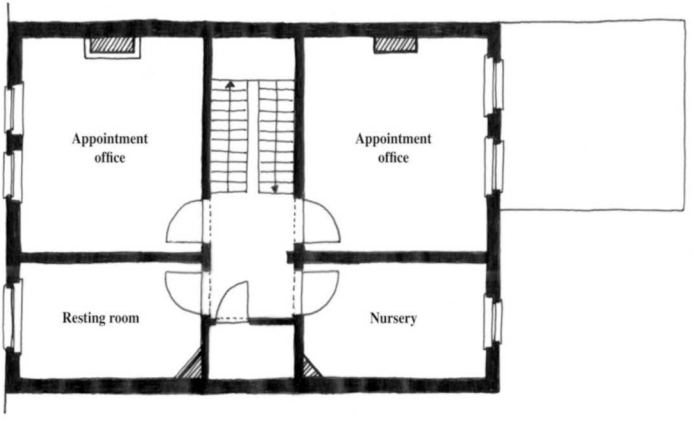


Figure 5a-c: The basement (top), ground floor (middle) and first floor (bottom) of the new building.

Slight attachments

The psychiatric day center for teens had a very special atmosphere. I was impressed by how, each time I was back, I felt caught up so quickly in its dynamic current, where everyone was intermingling and shared a set of concerns. "This place doesn't convey distress", I thought, comparing it to other stark settings, permeated with neglect and desolation, that I had visited elsewhere or read about (Rhodes 1991: 11–33). Of course, this place and its small community weren't intended to host acute crises, nor was its people exempt from suffering or tensions. But rather than reminding people of their own deficiencies, they seemed to succeed in bringing forth specific aspects of patients' personalities – what they liked or disfavored, their ways of interacting, their interests – through which each of them could experiment with who they could be. If that place related to care, it was through the creation of such affinities.

I learned to identify these affinities as attachments by reading the work of Antoine Hennion. For a little over two decades, together with his colleagues of the *Centre de Sociologie de l'Innovation* (Paris), Hennion (2017) has given a renewed and fertile meaning to the notion of 'attachment'. He seeks to understand the formation of passion: how does it happen that people come to strongly like something? As a French pragmatic sociologist, his challenge is to conceptualize how people develop tastes in practice, and how they become more and more sensitive to objects, which in turn gain finely delineated differences.[16] Gomart and Hennion (1999) proposed to speak of 'attachment' after having interviewed music lovers and drug users. Their interlocutors described how they completely gave themselves up to the constraints of sophisticated practices, like attending a rock concert or preparing a pipe for a crack high, and forged their sensitivities along with these techniques, objects, and collectives.

16 In the field of sociology of art, the focus on practices overtakes Bourdieu's critical view (social determinism), and distinguishes itself from sociologists who speak of beliefs, even when they closely describe experiences of tasting (such as Howard Becker's conventions). See Hennion (2004: 23).

In these studies on taste, when someone gets attached, it implies assessment conducted within a situation, during moments of attention where the qualities of an object unfold together with the person and body that comes to feel it. These moments of attention, Hennion and Teil (2004) detail about wine lovers, occur for instance when a guest at a dinner takes his glass of wine, drinks a small amount, stops for an instant, inhales, drinks again, slightly moves his lips, and sinks back into the flow of conversation. But the formation of attachment to objects goes beyond those acts of paying attention. They also entail the weaving together of a collective of people with whom taste is shared and debated. To develop a taste for something requires retrying the trial, questioning the object again. In this way, amateurs' sensitivities are revised, refined, and consolidated. Attachment, in this socio-pragmatic perspective, thus refers to the processes along which a person or group comes to hold on to things that hold them in return. When these affinities manifest, they entail the objects' feedback, bodily engagements, sensations, situations with their material devices, and collectives of people (Hennion 2005). Therefore, this notion allows us to describe how sensitivities come into being in situated practices, where the material equipment plays mediating roles in the way an attachment takes shape.[17]

17 The idea of 'mediation' helps the concept of attachment to blur traditional dualisms. In a nutshell, Hennion's concept of attachment draws inspiration to the Actor-Network Theory: after the object-as-network, it theorizes the subject-as-network. This implies that subjects are acted upon by objects as much as they activate their state of passion. Hence the concept of attachment renders it impossible to maintain oppositions between free agents or people determined by structures; between activity or passivity; or between a causality attributed either to a subject or to an object. Instead, as the stories in this book will reiterate, the attention paid to attachments traces a *middle path* where no one is active or passive, free or alienated. In this tale, material spaces do not hold by themselves, in their shape or substance, the power to create attachment. Instead they contribute to making an appreciation happen as mediators (among a chain of many mediators, like rehearsals, habits, rules, etc.) that stabilize, question, or transform the relationship between artworks and their passionate lovers over time (Hennion 2015 [1993]).

However, the affinities that I came to discern in the day center were, for the most part, not exactly passions enacted with great dedication. Most of these affinities were more modest and tenuous. They were less intense and less stable. They emerged from smaller things being liked, but diluted in the mundane flow of daily life, for only a few of these attachments grew more strongly. Teens became attached through familiar bonds in living spaces (chapter two), or ephemeral involvements in workshops (chapter three). Their likes and dislikes took shape when they responded to invitations from their environment, such as a corner to withdraw in, the smell of a dinner, or an inspiring artwork. Their attachments did not especially concern the place or its occupants, but anything else that a teen may come to like. Over time, some of these inclinations developed from everyday banality to long-lasting interests (chapter four), as when a fashion craze swept over a bunch of them. These interests, once shared within the group, led to new activities, and hence to the rearrangement of spaces. The institutional place then became 'lively', being animated by the temporal dynamics of those attachments (chapter five).

The idea that attachments are not always dearly cherished is not, in itself, a major discovery. Hennion already suspects that his descriptions resonate beyond the amateurs' techniques to get into peak condition and great sensations:

> Why not generalize this analysis of the amateur's competencies to far more varied forms of attachment? Can the amateur's meticulous, highly elaborate, debated knowledge not provide a model for analyzing more ordinary, lay, silent devices through which we are (and make ourselves be) present to the situations in which we live, throughout the day? What great amateurs enable us to see more easily, owing to their high level of engagement in a particular practice, is a range of social techniques that make us able to produce and continuously to adjust a creative relationship with objects, with others, with ourselves and with our bodies; in other words, a pragmatic presence vis-à-vis the world that makes us and that we make. (Hennion 2005: 142)

The important insight here is that many attachments may well be at stake in the ordinary techniques and devices that moderately enliven our ev-

eryday states. This insight opens our view on a far wider range of engagements with the things we hold on to in daily life. These seemingly mundane attachments in fact remain sensitive differences that matter once we have engaged with them. This book not only prolongs this insight by depicting how teenagers' attachments form at small doses, thanks to specific spatial arrangements and caregivers' techniques, but it also hones this insight by showing that these spaces and techniques trigger *the smallest of them*. The idea of 'slightest attachment' was brought to my attention when I figured out that the team attempted to foster the teens' affinities at any possible degree. They tried to spark the smallest of attachments through the mediation of spaces. The superlative 'slightest', then, emphasizes that the existence of these attachments is fragile, tenuous, because these affinities depend on caregivers' acute ability to notice their instant emergence. For them, every little attachment manifests as an embryonic sketchy possibility, as a lesser being that demands a greater achievement of its existence (Lapoujade (2021 [2017]).[18] This idea will culminate in the fourth chapter. Attachments of quiet intensity, we then realize, even in their most minimal expression, provide a fertile ground to become of greater interest. They then bear important consequences for the care work, institutional life, and its place.

Sparking attachments as care work

There is another difference between sparking attachments in amateur practices and here, in care work. Whereas amateurs seek to produce their passion, the teenagers who come to the day center most often do not aim at seeking them out. But caregivers do. They attempt to lure

18 Lapoujade (2021 [2017]) explores this ontology of beings of 'lesser existence' in his perceptive essay about Souriau's work on the 'modes of existence'. In French, the expression "slightest" (moindre) also echoes two movies that feature an attentiveness to the sensorial experiences of patients (Philibert 1997) or of autistic children (Deligny, Manenti & Daniel 1962–1971). In these movies, such an attentiveness grants these inclinations a central importance in settings alternative to traditional psychiatric hospitals.

the teens' responses to things or activities that could possibly appeal to them.[19] From one person to another, and from one day to the next, their responses remained unpredictable. An adolescent might be inclined to engage with the lure, or they might firmly resist it. Both kinds of responses, whether manifesting an attachment or a detachment, led caregivers to adjust their reactions in turn. Of course, I rarely met teenagers who were constantly eager to take up whatever was suggested to them. And most of them expressed, at least at some point, ambivalent feelings about the care setting and what it expected of them. Although this seldom happened, I also met a few teens who were nearly always left cold by most activities or occurrences in the day center. These young people had typically gone through an unstable life path, such as having spent years in juvenile institutions. In the day center, their overly chaotic attitudes made it hard for them to stay longer than a few months. To say the least, although they represented a minority of the teens, it was puzzling to witness that these adolescents didn't seem to find an anchor anywhere.

The fact that the adolescents' affinities were of primary interest to the caregivers calls for two clarifications. First, a word on the issue of power. There was indeed a necessary power circulating in the various lures to teenagers, which – as far as I could observe – emanated from their peers, from the staff, or from the material arrangements. Yet this power should not be *a priori* understood as negative per se, as a mere domination technique that disciplined, prohibited or regulated. Enticement could also transform those who let themselves be 'turned on' to some preference or disinclination.[20] Insofar as this form of power reinvigorated personal

19 This luring process can be understood as a technique of influence that involves the mediation of spaces or objects. I will return to this point in more detail in the second chapter. For more on the practical operations of influence in psychotherapy inspired by non-Western healers, see Nathan (1994).

20 Gomart and Hennion (1999: 220) underline this characterization of power in the concept of attachment. They recall Foucault's warning about our understanding of power (1995 [1975]): "We must cease once and for all to describe the effects of power in negative terms: it 'excludes', it 'represses', it 'censors', it 'abstracts', it 'masks', it 'conceals'. In fact, power produces; it produces reality; it produces

affinities, it could empower people when those affinities came into being. Of course, a structural asymmetry was playing out between the team and the teens. Yet when the spaces of the day center provided conditions for the creation of attachments, these conditions offered possibilities for teens to position themselves in practice, when developing relationships to others and to things at hand in the course of daily care (Pols 2005; 2010). In these conditions, power was not just an evil that must be denounced. It was there, at stake, in the luring processes that I describe, when teenagers and caregivers kept positioning themselves, negotiating, engaging, and resisting in their responses.

Second, an important theme that arose in this research was the informal knowledge that working with attachments generates.[21] Indeed, when teenagers positioned themselves relationally, this enabled the team to notice what moved them, and how each youth could have changed, or not. This informal learning forms part of the 'situated knowledge' that anthropologists have recognized in the psychiatric teams who work in close contact with patients (Rhodes 1991: 173–174; Floersch 2002; Brodwin 2013: 48–49). Such knowledge is homemade. It takes shape alongside an accumulation of ordinary experiences, and hence remains fragmentary, particular, local and hardly duplicable elsewhere. Above all, it is fragile when confronted with biomedical science.[22] Here, the "informal" quality of this knowledge denotes that it is gained,

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domains of objects and rituals of truth. The individual and the knowledge that may be gained of him belong to this production." (Foucault 1995 [1975]: 194).

21 I further explore this informal knowledge in the second and third chapters.

22 This situated knowledge takes root in different understandings. Floersh invokes a common sense developed by caregivers. For Rhodes, the references are Haraway (1988) and Foucault (1980). The latter speaks of "subjugated knowledge" to underline that it has "been disqualified as inadequate to their task or insufficiently elaborated: naive knowledges, located low down on the hierarchy, beneath the required level of cognition or scientificity.", and that "[...] it is through the reappearance of this knowledge, of these local popular knowledges, these disqualified knowledges, that criticism performs its work." (Foucault 1980: 82).

shared, and used in casual situations which necessarily involve interpersonal relations and engagements. When caregivers discussed teens' attachments, the informal knowledge base they created supported them in responding to each youth according to their inclinations or interests. This is what I call a "responsive" care practice: a practice in which care engages the teens, their caregivers, and their material mediations in a subtle play of personal and relational responses.

An enduring tension

The argument of this book – that spatial arrangements contribute to care as they generate a range of attachments, including the smallest of them – holds implications for contemporary conversations about psychiatric settings and, by extension, about institutional care. The issue that captures my concern is whether certain buildings and interior spaces hold potential to make room for the patients' personal responses, with their specificities, their struggles and their abilities. As the story of the day center indicates, the room made for biomedicine remains in tension with the sociotherapeutic work that considers patients as relational persons. In fact, this tension between the biomedical and social conceptions of mental illness and therapy has traversed psychiatry buildings for ages. While entire bookcases would be necessary to trace it along that history up till today, I would like to take a shortcut with the purpose of introducing how the present study addresses this tension and intervenes in the current context of the psychiatric field.

This leads us to take a brief historical detour. In the 19th century, psychiatrists and architects collaborated to design asylums for what was called 'moral treatment' (Markus 1993: 133; Quétel 2010: 74). Back then, they conceived the spaces through the lens of "environmental determinism" (Yanni 2007: 8). The idea that the architectural environment could shape behavior was pushed forward, with the suggestion that it would also cure diseases. Concretely, this meant the removal of patients from their everyday environment; the internal organizations of buildings based on classification systems, like galleries and cells organized in

rows; or hierarchical divisions of labor. In Europe, models of asylum spread as states mandated commissions to visit their buildings and to bring back their principles (Laget 2008). Since the early 20th century, though, a significant turn occurred as psychiatrists and architects started to lose their optimism. Asylums with their carefully determined arrangements did not prove to be a great remedy. On the contrary, the overcrowded services, in poor repair, with their meaningless routines, led to more damage than rehabilitation. Movements of "social psychiatry" started to envision care outside asylums, turning attention to the social condition of patients outside their walls (Lie and Green 2021). From the 1950s, antipsychotic medications started to be widely marketed and facilitated discharge of patients into their communities. Meanwhile, deterministic environmental convictions vanished, and architects' interest in conceptualizing care buildings dissipated (Yanni 2006; 2007: 145–158).[23]

From the mid-20th century, critiques increasingly shook the psychiatric field. They denounced, among others, its power relationships, institutional confinement, and the medicalization of mental illness. Several studies famously nourished these debates by drawing attention to spatial organizations. Foucault (1995 [1975]), in his historical analysis of disciplinary techniques, decorticated how the spatial partitions in institutions worked as power mechanisms. Buildings contributed to controlling docile bodies and transforming individuals' behavior while also making them observable for knowledge. His study became indispensable in the contestation of disciplinary architecture, for these spaces worked with a power mechanism and knowledge regime that dissolved the need for apparent corporeal violence (such as with chains). In 1961, Goffman foregrounded other issues in an ethnographic monograph of what he termed a "total institution" (4), a setting that fully takes

23 Perhaps it is less surprising, then, that historical research on the spatial conditions of psychiatry mostly focuses on the asylum era (in North America and Europe) and much less on its subsequent epoch of community care. See, for instance, Yanni (2007); Topp, Moran & Andrews (2007); Hamlett (2015); Ankele & Majerus (2020).

charge of the needs of inmates. Life within the psychiatric hospital, his study showed, led patients to experience a mortification of the self. While being isolated from the outside world, the inmates learned to see themselves through a ward system and had too few opportunities to build their personal territory within the institution walls.[24] This is how inmates, Goffman wrote, go through a dispossession from their personalities and from their ability to act in everyday situations. The book grew widely popular. It had a significant impact in anti-psychiatry movements, as well as on the public reforms that spread in many countries at that time.

In the wake of those critiques, among many others, psychiatric institutions underwent a thorough spatial reconfiguration. Deinstitutionalization policies aimed at moving away from long-stay psychiatric hospitals and promoted community-based facilities. Asylums were abandoned, hospital settings were reduced to acute care units and connected to a variety of new centers that were implemented within communities.[25] In contrast with traditional disciplinary architecture, these centers were often established in existing, small-scale buildings. They were entwined into neighborhoods and located at reachable distances by public infrastructure. From the outside, they were not clearly demarcated from other houses of the street. And their interior arrangements were often domestic while few, if any, of their features bore similarity to hospital institutions. Rather, as with the case we follow in this book, the arrangement of these houses wasn't rationally predetermined. The idea was that they remain flexible as to adapt to the possible upcoming uses of the particular people, including the patients, who frequented them (Baillon 1982).

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24 Despite the "underlife" of the institution, in which patients resist what is expected from them in an attempt to regain a sense of their selves (Goffman 1961: 171–320).

25 These moves from hospital to the community did not occur in a similar way across countries and regions. A review of the literature here cannot do justice to that diversity. Gijswijt-Hofstra et al. (2005) give an insight of those local developments.

But in the following decades, the face of deinstitutionalization changed along the way. Starting in the 1950s with the ideal of freeing patients from wards, it turned into reduction of costs through the implementation of less expensive settings, under the label of managed care or of mobile teams.[26] Managed care developed in the United States to reduce hospitalization and support individuals' recovery at home, as well as other 'needs' of 'clients', supposedly by coordinating community-based services. While case managers tinker with an individual knowledge of their clients, these frontline clinicians largely work under the predominance of bio-psychiatry (Floersh 2002; Brodwin 2013). Meanwhile, like most psychodynamic practices that need time, availability, and money, many settings like therapeutic communities have been driven out of psychiatry. In Belgium, where my fieldwork is, today's public policies largely favor the establishment of ambulatory care, in which patients are visited in their own living environment by mobile teams, not only in prevention of crisis but for long-term support as well.

Holding room for personal responses

In this shifting context, the vision of what the care landscape becomes seriously undermines institutional spaces where patients could be hosted as relational persons (Estroff 1981: 254).[27] Institutional reform

26 The failure of the deinstitutionalization reforms is well documented. It has often resulted in abandoning people living with mental troubles in the street. Knowles (2000) shows this in an ethnography of the spaces occupied by people who are neglected by the community mental health system in Montreal.

27 In Belgium this mental health reform began in 2010. A recent study has investigated how this reform has been working so far in Brussels (Walker, Nicaise & Thunus 2019). The authors note that, according to care professionals, too much means are devoted to mobile teams compared to other kinds of facility. More importantly for my argument, this study brings out that many people with psychiatric troubles do find greater support in "places of connection" (*lieux de lien*), where the medical discourse is not predominant, if not altogether absent, since these places rather belong to the cultural or associative sectors. This finding confirms how much the actual places of encounters and where personal

entails another materialization of space: there are fewer or no longer any buildings where caregivers and peers meet daily, albeit not without friction, and slowly grow into a better state thanks to the specific relationships and appreciations they weave *there*. In other words, the emplaced therapeutic techniques that were developed as alternatives to hospitalization for half a century are now devalued, if not suppressed, in the name of cost reduction and management discourses promoting efficacy. These discourses rely on the scientism of neuro- or biopsychiatry, or on rehabilitation programs based on a classification of mental disorders (Demailly 2011; Bellahsen & Knaebel 2020). This book responds to this corrosive situation by leaving no doubt about the crucial role of institutional buildings in community psychiatry, while their consideration seems all too often absent when envisioning the facilities of today and tomorrow.

But there is yet something more at stake in the erosion of spaces for community care and the devaluation of psychodynamic approaches in favor of biomedical ones. Lurhmann (2000), in her ethnography of psychiatrist training, points out that each approach implies a different way of conceiving mental trouble, of seeing patients, and of working with them. The loss of psychotherapeutic techniques, then, affects the way mental illness is conceived, narrowing it to be seen only as a disease, which impoverishes "our sense of human possibilities" (266). Such a disappearance entails the loss of close relationships with patients, loss of a deeper understanding of them, as well as loss of the complicated struggles and circumstances of each person. Above all, it implies the loss, within a care setting, of being able to provide *patients the possibility of responding* according to their unique, relational experiences.

Moreover, the problem is that in psychiatry and institutional care, the question of who or what a 'person' is cannot be easily solved. Along

affinities can anchor remain indispensable for care provision with the psychiatric landscape. A mobile team for young people in Brussels (Carton et al. 2020) makes a similar point. In their account of a youth's 'revolving door' trajectory (a succession of hospitalizations and discharges), they emphasize the great confusion that this discontinuous care causes for the youngster.

with Goffman's conclusion I mentioned above, medical anthropologists have brought to the fore how patients, once diagnosed with mental illness, see their status as person diminished, because they fail to act as unified and coherent centers of consciousness and of moral responsibility. These pathological diagnoses are formulated in ways that create a sense of the degradation of those capacities (Barham & Hayward 1991; Barrett 1996; Martin 2007).[28] The question of personhood in psychiatry remains quite tricky, insofar as it relies upon that conception of a 'person' with which patients have failed to align. In contrast, as we will see later, sociotherapeutic techniques and their spatial arrangements call for another conception of personhood. Here, it takes shape through a web of strong, intimate, reciprocal connections with others and with things that are crucial for restoring patients' personal and relational agency in the recovery journey (Troisoeufs 2009; Myers 2015).[29] The responses from teens that caregivers sought to provoke were not leashed to a conception of a person as an autonomous and rational individual. Quite the contrary, these community spaces and practice encouraged what a person

28 Martin (2007) writes that this Western conception of the person comes from the 17th century. It then included adult men, the 'men of reason'. During this period the 'mad' joined others who also did not possess full personhood, namely women, children, servants, and slaves. This is reminiscent of Foucault's (2001 [1961]) historical study that shows how madness was negatively defined as an absence of the work of reason. In her conclusion, Martin (2007: 277–280) takes up Foucault's argument: she states that this division is still at play nowadays, even though her descriptions of the experiences of people diagnosed as bipolar refute it. In the field of psychiatry, too, author-practitioners from distinct traditions narrate, and advocate for, patients who come to engage in a therapeutic work and in ways of living with their specific forces and abilities, instead of being defined as people with deficiencies. See Nathan (2001); Sacks (2012 [1995]); or Rogers (2020 [1967]) who inspired person-centered care frameworks in nursing studies.

29 In her ethnography of mental health care, Myers (2015) emphasizes the concept of 'moral agency' as it "suggests that in order for people to become the kind of person they want to be in the world, they must act in a way that helps others recognize them as the person they hope to be and holds them accountable for it" (156).

may be through the flourishing of their attachments, in much more livable ways.

In short, the disappearance of community work from the psychiatric landscape entails the loss of possibilities for patients to be able to respond as particular people, in particular relationships, building upon their specific affinities and their abilities to act with and upon the world at hand, rather than solely (or alongside) coping with a disease and its deficiencies. This tension has been at stake in psychiatric spaces since their establishment and throughout the history of their contestation. This book does not celebrate with nostalgia the heydays of social psychiatry or its therapeutic revolution. Nor does it provide an overview of, or comparison between, the facilities that compose the psychiatric landscape. Nor does it engage with the trajectories of patients in that landscape, their struggles, or their lived experience of treatment.[30] But it takes a partial perspective in order to revalue, among the different approaches that compose psychiatric and institutional care today, the community practice and its spatial mediations that still entertain the possibilities of both personal and collective responses in these places.

From fieldwork to a book

Between June 2013 and September 2015, I was intermittently immersed in the care center before, during, and after the transition between buildings. I began to take part in the care practice as most trainees do. Besides that, I documented my experience with lots of note taking, sketches, photographs, and recordings. During periods of two weeks to several months, I spent whole days at the center, attending informal

30 Velpry (2008) provides such an account of patients' trajectory and everyday life in France, Barham and Hayward (1991) in the UK, and Estroff's (1981) ethnography in the US remains a classic. Jenkins and Csordas (2020), inspired by phenomenological anthropology, have done such a study on adolescents' experience of psychiatry. They conclude that the possibility of "having a life" (207) is crucially at stake for those teens (ibid: 207–241). This resonates with the teens' attachments that I describe in this book.

moments, workshops, and team meetings. I progressively learned to adjust my responses in everyday interactions. I conducted 45 private interviews with caregivers of each function and with teens, starting with three questions: what they usually do with the surrounding spaces, what changes in that materiality they had noticed, and what comparisons do they make with other institutional places where they had been. Most caregivers and teenagers had experienced other settings in hospitals or welfare facilities. When the design of the new building was still in the conception phase, I also respectively met the architects, administrative directors, or former caregivers of this institution, to better understand the context and stakes of that project.

My ethnographic method took a peculiar, unexpected turn when the move was approaching. Some caregivers saw my presence among them and the observations I had collected so far as an occasion to collectively address the matters of space that then started to worry them and the adolescents. They proposed that I would accompany the transition. I thereupon attended caregivers' meetings with architects. I joined visits of the building site with small groups of caregivers and teenagers. I held a workshop with teens reporting on the relocation from the old house to the new building. And I partook in debates about spatial problems, which kept arising until the second year after their move. Along the installation phase, we also organized several staff meetings, for the team to react to my observations while also discussing choices for settling into the new building. During these meetings, we could figure out which rooms and issues had already gained a smooth consensus within the team or with the architects, or which arrangements caused debate to erupt, the values embedded in them, and the material details that counted for them. In short, when fieldwork turned into a companionship of the transition, the research topic of this book – the material spaces in a care practice – evolved together with my interlocutors' relationship to it as a practical problem.

Accordingly, the translation of that field experience into a book pursues a distinct analytic path. Each chapter starts with a spatial problem that rose in the everyday practice or with the transition to the new building. Each problem draws attention to words that I selected since they

mattered to caregivers in regard to the spaces, such as 'familiar', 'involvement', 'interest', or 'lively'. The teens sometimes seized on these terms too, for they pervaded the verbal world of the therapeutic community. However, they did not speak 'about' these words as concepts. Rather, the words point to values which played out in their interactions with the material spaces, creating opportunities to explore what these relationships entailed. My intention is to give more importance and nuance to these concepts by articulating my empirical descriptions and literature.[31] This analysis has led me to foreground the attachments of quiet intensity that now pervade this book.

In their everyday work, though, the team didn't explicitly speak with or about the term 'attachment' in the sociological sense, nor in a psychological sense. They did not refer to theories of attachment as formulated in the field of psychology and psychoanalysis, by Winnicott (1965) and Bowlby (1999 [1969]), among others.[32] However, caregivers' exchanges were dotted with words that pointed to the ways in which teens develop affinities, such as 'familiar', 'involve', or 'interest'. I came to understand these concepts as different forms of attachments that are brought into being by mediation of the spaces.[33] When I returned this

31 This does not mean depicting scenes as realistically as possible, but instead re-articulating the field experience, including the silent one, into written descriptions and insights. See Hirschauer (2006); Emerson, Fretz & Shaw (2011 [1995]).

32 This is another understanding of the notion of 'attachment'. It does not designate how appreciations come into being in socio-material worlds, but assumes that an individual's social and emotional development is enabled by the secure base provided through another's constant caregiving.

33 This is not to say that distinctive forms of attachment, like familiarity or involvement, are *ipso facto* bound to particular spaces. Rather my analysis refines the links between specific spatial arrangements and ways of attaching. This allows us to understand in detail how the former encourages the latter, and to further recognize these spatial subtleties elsewhere. For instance, as you will read the second chapter, you will learn that corners in the living spaces contribute to familiarization by suggesting the adjustment of one's comfortable distance. This enables us to recognize, in the third chapter, that corners in workshops suggest such distance adjustments too. In this second case, they also attempt to better involve participants in the activity at hand.

proposition to the team, they found it of keen interest. They emphasized that, although the quest for the teens' affinities was somehow diluted as commonplace in their everyday work, it was constantly at stake. Indeed, they added, their spaces played a crucial role in that dynamic.

What comes next

In the following chapter, I explore a first form of slight attachment with the living spaces where, most of the time, everybody stayed or passed by in a sort of casual, informal closeness. Such familiarity provided caregivers with an informal knowledge of each teenager, thanks to which they adjusted the care work to their personal and changing nuances. The chapter unravels three different ways that the living spaces fostered or hindered familiarization. Certain things, like games, kindled the clustering of adolescents and caregivers around hotspots. Other arrangements enabled them to adjust the contact between them, like everyday objects whose use implied indirectly addressing one another; sight lines that invited discreet glances across rooms; or corners that offered a chance to finding one's right distance from others. And familiarity was also enacted while 'hanging out' with furniture that afforded informal postures, or with a semi-open kitchen and its cook that mediated informal encounters. The living spaces encouraged familiarization through these 'material suggestions'. In contrast with clearly functional places, these material suggestions are ambiguous 'affordances' (Gibson 1966) that allow contingent influences. They ease the discomfort of institutional pressure on teens, and frame familiarity as an opportunistic, or circumstantial, form of attachment.

We will then travel to different locations inside and outside the building, where caregivers and teens engaged in workshops. 'Involvement' is a keyword throughout the third chapter. I explore the conditions under which material spaces can involve the teens in activities. By noticing these involvements, the caretakers expand their informal knowledge. They can better see what a young person likes to do, what their sensibilities are, and the accompanying enthusiasms and difficulties. The

adolescents' involvement in workshops is a highly uncertain form of attachment, for it happens between participants and things and requires specific practical and material framings. Through the setting of a pedagogical workshop that rejects the traditional classroom model, we learn how a space may arouse curiosity and allow caregivers to attune to teenagers' unsteady involvement in learning tasks. Meanwhile, the specific world of a clay workshop appeals to bodily senses and helps rekindle teens' engagement in modeling forms. Outings to sport fields and the city were porous to 'side slippage': unexpected disturbances that triggered collapse of the activity. But outside conditions also facilitated conversations. Beyond the contrasts between these different activities, these stories led me to see that workshop spaces, together with caregivers' techniques, facilitated teenagers' passage from indifference to greater involvement in what they were asked to do. Teen involvement, these passages show, is a form of attachment that comes into existence while remaining on the verge of fading.

When chapter four begins, almost a year had passed in the field. Material spaces varied over time as adolescents' and caregivers' interest in workshops declined and reawakened. Week after week, month after month, daily life activities carried a risk of boredom, and so required variation. New activities were set up, and the space was rearranged, evolving in response to the remaking of the teens' attachments. But how did all this happen? The chapter traces several strategies aiming at enrolling one another in interests current to the group. Such strategies became discernible in the hybrid arrangements of the buildings; in caregivers' exchanges about intriguing daily events; in their discussions with teens during community meetings – sometimes encountering their resistance; or in the adjustments of workshop frameworks alongside their realization. What's more, the interest and the spaces varied in less formal and verbal manners, along what we came to call 'waves'. As a workshop about bodily appearance exposed, this word evokes how participants' interest reshaped when taste for an activity spread within the group through interpersonal alterations. This chapter leads us to a turning point in the book. It brings into view that sustaining interest often relies on slight, furtive forms of attachment, such as the familiarity

of the teens or their involvement in the moment. The slightest of these attachments nourished the care work, for the team understood every little teen affinity as an emerging possibility that could engage them in care and in their own trajectories. It turned out, too, that sustaining interest increased the importance of these modest affinities to the point of materializing them in the institutional spaces, keeping this place specific to what currently mattered within the group.

A clash in a staff meeting opens the fifth chapter. The argument erupted as caregivers discussed that the aesthetic style of the new building should impart it with 'something lively'. Among different traits of the material environment, the exhibition of teenagers' artworks was especially at stake for conveying this liveliness. The guides in this chapter are thus drawings, paintings, frames, posters, mosaic tiles, and other artworks waiting to be thrown away. Some of these things emerged from workshops, and these anecdotes enliven them with concerns for those who are still aware of those special moments. Artworks could also incite group members to tell stories. These narratives expand the present time to past moments and keep track of teens' attachments. A chalkboard, meanwhile, sees tensions emerge as it appeals to brief, casual involvements in writing inscriptions. The stories about these artworks train our attention to the temporalities that they carry. These stories foreground how much the liveliness of the building rests on the artworks' temporal overlaps. They prompt me to expand the argument that attachment formation is bound to specific temporalities. From the slightest affinity to larger interests, each of them requires unpredictable paces to come into being. These paces can hardly be foreseen on a smooth, linear timeline, and even less in exhibitions organized with calendars. Hence, care work must operate with these different and overlapping temporalities.

The book ends by calling attention to the subtle character of crafting the attachments of teens. This subtlety relies on both caregivers' intuitive and contingent techniques, and on the material spaces that contribute to it. This notion of subtlety conveys some of the ethical implications that this responsive practice and its spaces carry in psychiatry and institutional care. My purpose is to point out what makes caregivers' practice and spaces vulnerable in the broader psychiatric landscape, while also

offering an acute sense of the vital role they continue to play as an institutional form of care in the community.