The moral life of doors in an open psychiatric center

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ABSTRACT

Doors are infamous in psychiatry for being used as instruments of constraint. Yet, while taking a close look at the doors of an open psychiatric center for teenagers in Brussels, I discover that doors play much more ambivalent roles beyond the issue of access and that their normativity shifts in the ongoing practice of care. While examining the moral life of these doors, I describe four modes of reflexivity that unfold with them. These reflexive modes are central to care work, since they put fraught issues on the table and enable a more livable everyday togetherness in institutional care.

KEYWORDS: Belgium, doors, empirical ethics, morality, reflexivity, psychiatry

Media teaser: In an open psychiatric center in Belgium, doors provoke reflexivity among caregivers and youths, expanding their moral dimensions beyond the issue of access.

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> The pleasure of grabbing one of those tall barriers to a room abdominally, by its porcelain knot; of this swift fighting, body-to-body, when, the forward motion for an instant halted, the eye opens and the whole body adjusts to its new surroundings.
>
> Francis Ponge, *The Delights of the Door*

In 2014, a psychiatric day care center for teenagers in Brussels, Belgium, moved to a new building. The design of the new place was prepared in numerous meetings. In one of these meetings, the architects, the administrative director, and Baptiste,[1] the coordinator of the center, discussed what they called "questions of access," implying the design of doors. They examined the plans and checked how each door of the new building would be technically equipped. According to the policy of the open day center, teenagers could leave at any time. Yet not all doors were to remain open. Some would open with magnetic badges, others with keys. Some would only have handles on one side of the panel, permitting an exit only. When the architects and director asked about the rule for each door, Baptiste's answers made them dizzy. It seemed that the question of whether certain doors could be opened, or not, when, how, and by whom, relied on particular circumstances rather than a general rule. In his daily practice, Baptiste was acquainted with doors that played roles other than providing and denying access. These roles sounded unfamiliar to his interlocutors, so he recounted anecdotes about minor incidents with doors, to which they listened, intrigued, and frowning.

In this article, I dig further into the roles of doors in the open psychiatric facility for youths. Doors have been and still are highly critical architectural elements in psychiatric places in terms of prohibiting or allowing entrance, and the resulting power dynamics (Markus 1993). That is, they inherit the moral issue of patients' constraint. Yet Baptiste drew attention to more specific situations than the bottom line of "allowing access" and its binary logic of entering or not, of freedom or constraint. So how do caregivers and youths engage with the doors? What are the moral issues of doors, and how do caregivers and the teens cope with them? Doors have strong implications regarding hierarchical relationships and caregivers' authority over the adolescents, but during my fieldwork in this center I noticed that they also provoked some reflexivity among the caregivers and teenagers. There were uncertainties over the rights and wrongs of doors, and over their specific equipment and usages. In such sensitive affairs, doors were caught up in some moral issues. Since caregivers had strong concerns about how to live well together with the teenagers, those moral issues were inextricable from an everyday politics of living together.

Infamous doors in psychiatry

Doors in psychiatric institutions are well known as disgraceful things, since they have been used to confine patients in wards. Historically, critical voices against these detention devices gave doors a prominent place in antipsychiatry and deinstitutionalization movements. Locked doors, Goffman noted in his famous book *Asylum*, like high walls or barbed wires, establish a barrier: a physical and social discontinuity between the "total institutions" and other places (1961:4). While studying the archives of the Brugmann psychiatric hospital (Brussels), Majerus (2011:111–113) exposed the different roles doors played until the 1960s. Their main role was related to

confinement, isolating patients from outside worlds, regulating professionals' movement throughout the building, and surveillance when doors were equipped with a windowpane. Since Majerus focussed on the nurses' observations of patients, he could witness how much everyday interactions with doors expanded the roles of these objects. Though seclusion was clearly confronting, like with a patient who wandered around in search of doors, or another who repeatedly shook doors in attempt to leave, other inmates felt protected by them, which seemed evident when they worried each time someone opened them. Interestingly, too, doors were not only dividers between rooms and people, but they were also spots for encounters: an interval, a space between.

Today, locked doors remain in acute units (Rhodes 1991:17; Barrett 1996:50; Luhrmann 2000:143) and in dementia care settings, where their technologies raise moral dilemmas about the restlessness of the residents that their constraint encourages (Driessen 2019; Wigg 2010). The traditional device consisting of a single key held by caregivers for all doors is still common. Magnetic badges can be programed to let certain caregivers into rooms relevant to their functions. Doors equipped with a windowpane incorporate an ambivalence between a need for privacy and the importance of not losing sight of patients who might be in a bad shape (Brenman 2021; d'Hoop 2019). Thus, doors do not get rid of the moral problem of the power of caregivers over patients, as they have long been and still are used as instruments of domination and repression.

Doors in an open facility

In the day center, doors were complicated matters of space given that it was an *open* care center: most of the doors were not there to prevent youths from crossing their thresholds, and permitted them to pass through. But that did not mean that the doors

were always fully open in the name of an unconditional freedom of passage. Rather, their normativity – the equipment, values, and uses of each door that were seen as appropriate for care – appeared much more intricate and less stable than anybody unfamiliar with the day center would expect.[2]

The history of the institution where I conducted fieldwork, L'Équipe, offers some clues about the reasons why these doors played intricate roles. It was created in 1964 in order to take patients out of the Brugmann psychiatric hospital and to host them in an open community home. "Open" did more than simply distinguish the center from hospital sites that hold patients within their walls. It also indicated that the houses where care was given were inserted in urban neighborhoods, where patients would live, come and go in an ordinary way, and hopefully join local social life without stigmatization. Since then, the institution has expanded into eight centers, including the psychiatric day center for teenagers. "Openness," a driving value of the deinstitutionalization movement, remains pertinent to its care philosophy.

Among the different forms of care, I became particularly interested in the "therapeutic community."[3] It is based on the idea that everyone present in the center takes part in its organization and the social life of the group, especially through mundane interactions during informal moments and activities. This approach is intended to help youths learn how to deal with the impacts of social interactions and their feelings, and also to regain confidence in their ability to engage in activities and life in their own way. Therapeutic communities aim towards "horizontal relationships" with patients, and this idea gave a special tone to hierarchy and authority in the day center. Caregivers and youths debated matters of daily life and rules about material spaces during weekly community meetings. About half of the adolescents I met at the center

had spent time in locked units before, so issues about doors were quite prevalent. They could easily trigger debate between caregivers and teens during their meetings.

I was immersed in the day center before, during, and after its transition from an old townhouse to a new building. Between June 2013 and September 2015, in periods spanning two weeks to several months, I took part in the center's daily life, attended and recorded caregivers' meetings, participated in workshops, and conducted interviews with caregivers and youths. My analysis focused on the workings of spaces in everyday practice. The transition to the new building rendered explicit the implicit role of spaces and doors in routines, such as in the meetings with architects. Doors manifested as intriguing objects, both in the everyday care practice and during the transition.

My positioning within the group evolved throughout fieldwork. From the start, although my research agenda was made clear to all, I was involved in community life as a caregiver completing an apprenticeship. When the move to the new building and the installation was in sight, at their suggestion I started to accompany caregivers and the teens in meetings and a workshop designed to address matters of spaces collectively. During these discussions my observation of spaces and theirs blended; they sometimes met, sometimes diverged. Sharing and confronting our observations invigorated their thinking on their spatial problems, and mine on my ethnographic material.

As a caregiver trainee, I learnt to attune my position to what was happening in the moment. In a therapeutic community, everyday situations may turn quite emotional, with bursts of laughter, anger, deep sadness, wild exaltation, disconcerting stillness, and so on. Caregivers discussed these emotional events in informal moments or meetings, some of them with the youths, and in doing so refined their abilities to find more adequate responses to others' experiences. Interestingly, this relational learning is part of the ethnographer's job as well. Lemos Dekker (2019) dissected how the emotions she

experienced in the field inclined her to attune to her interlocutors in sensitive situations (in her case, of someone dying). Such attunements, she noted, may well happen at doorsteps: whether the ethnographer might cross a threshold or not, stay there peering, or hold back, relies on their sensitivity to what distance is respectful. My apprenticeship in the day center also instilled my attunement to everyday events, both as ethnographer and awkward caregiver, sometimes reflecting on how I would employ a door.

The moral life of doors

But how should one study doors as a care ethnographer? In particular, how can one do justice to their delicate ethics as they emerge in the field? First, let's estrange the familiar: doors are spatial elements and technical objects that shape our everyday lives. Their main function is to enable us to go to the other side of a wall or prevent us from doing so.[4] Through these mundane interactions, doors have a "moral life." I borrow this expression from William James (1979), who prompted ethical philosophers to abandon dogmatic thinking, moral values of absolute nature, and judgments formulated a priori. Instead, an ethical analysis should truly touch the moral life: the goods and the ills in the concrete realizations of ideals and deceptions. A moral life takes shape as good and evil are experienced in the material world, bringing with them obligations, expectations, claims, refusals, scruples, disappointments, longing for appeasements, and so on (150). But, James stated, such moral relations exist when some sentient living minds feel them. So how could doors undergo the turmoil of a moral life?

My examination of doors as moral things finds further inspiration in an approach termed "empirical ethics of care" (Pols 2015). Despite having no explicit affiliation to James, this approach also embraces a pragmatist tradition: instead of predefining normative criteria that a care practice would meet or not, it investigates empirically

what care is and when it is good, in situated practices in which people interact with material things. In doing so, it redirects a "material semiotic" focus to ethics. Material semiotic studies explore the relationships between people and technology or things, as well as what those relationships produce in an ongoing practice. Once anchored into ethics, that ethnographic focus on practical engagements with objects enables researchers to learn the right or wrong ways to care, and for whom. In the field, everyday ethical issues emerge in practical tasks and things that contribute to shape specific care situations, such as technologies, routines, know-how, rules, and ideals, to name a few. Hence good and bad do not present themselves as crystal clear oppositions, nor do they stand as essential or universal values. Field stories usually lead researchers to describe ambivalences, the shifting of a local normativity, or the way negotiations and compromises are undertaken to address them as part of an attentive experimentation in care (Mol, Moser and Pols 2010:11–14). While aligning with this empirical ethics of care, I speak of the "moral life of doors" because it encapsulates how these objects make caregivers and teens capable of better and worse actions which, moreover, are not fixed but ongoing and changing. Moral virtues and demerits are traditionally attributed to human behavior, yet here these objects also appear as moral agents.

Several social scientists help to sharpen this perspective on doors. They look into people's interactions with them, into the sorts of interplay between a door and its users of which Ponge's poem makes us aware. Goffman (1971) described micro-situations in which doors contributed to the ordering of social encounters. Doors offer practical occasions for civility, he wrote, such as when a person might hold a door open for someone (15, 91). Within a social order, the morality of doors is fixed in normative rules that most people assume. But these rules are not always stable. Goffman (1963) depicted how a door may manifest a social disorder as well, such as when an individual

slams it and flounces through the frame (187). Doors also exacerbate tensions, for instance, when a dispute eruptes over whether a particular door should remain closed or open. Goffman (1956:72) told a story of a door in the restaurant of a hotel, between the dining room and the kitchen. The door was constantly opened by furious waiters who wanted to carry dishes through it, and shut by the manager who did not want the customers to see into the kitchen, where cooks' standards of service were much lower. Here, the frictions of that door concerned a matter of visibility, between the scene (the genteel dining room) and backstage (dirty practices in the kitchen), that interfered with a matter of practicability (being able to pass through the door easily with hands full).

But the very material and technical features of doors are also at stake in normative interactions with them. In the language of sciences and technology studies, a particular door incorporates a "script" (Akrich 1992): a program of actions envisioned by its conceivers about what is supposed to be accomplished with that door. The script of an object does not determine the user's actions, but it prescribes: it orients, it traces a normative path for certain action to be realized with it. Since the script envisioned in the technical device of a door can make us capable of better and worse actions when using it, the normativity of the technical object entails moral dimensions. Therefore, doors play tangible roles in people's social and moral lives. Back to the frictions that Goffman described, we could well imagine how a swing door with a porthole window would have helped to solve them. In this way, Latour (1988) dissected the delegation of the competence of "keeping a door closed" to a nonhuman door-closer. The action is distributed among people and the object, each being able to do different things, and each also requiring the skills of other interactants: though a door-closer may be easier to discipline than a doorman, the prescription of that object, according to the spring mechanism, also presupposes the skill of a passerby who does not let the door slam in

his face (157).

In the day center I observed how much the moral life of doors was inseparable from the details of their technical devices and interactions with them. In that care context, doors were anything but insignificant. These troublesome things brought obligations, claims, hopes, or refusals, sometimes in surprising ways. More than this, when caregivers and youths interacted with doors, they also engaged in an everyday politics of living together, since these positionings enacted attempts to live well with each other on a daily basis (Pols 2010).

Reflexivity in a care practice

Whereas doors in the psychiatric center reiterated moral concerns about power relationships, in the course of the care work these issues cast doubt. I discovered that apparently mundane interactions with doors in the care practice and during the center's relocation entailed different ways of being *reflexive*. These modes of reflexivity show that the morality at stake with doors can be quite supple, and can even be reshaped in a creative manner. This doesn't mean that these doors are devoid of power issues. Instead, these issues are dealt with in a broader and deeper moral questioning than the normative stiffness most doors inherit in psychiatric or institutional care.

It was while reading works by French sociologist Antoine Hennion that I started to better perceive the activity of being reflexive. He talked about the reflexive moments of wine or music amateurs when they experienced an object and "opened a parenthesis:" when they took a sip or listened to a piece, reflexivity emerged when their attention shifted from an ordinary state to a more perplexed one, sometimes shared collectively (Hennion 2009). These reflexive gestures are acts of paying attention to what is happening, and of interrogating it. Although these interrogations often occur through

verbal exchanges, the practical conditions of an activity may foster them, such as when the manipulation of objects makes us hesitate and re-evaluate them (a glass of wine, audio CDs, or in this case doors). During these moments of suspension, reflexivity does not concern subjects who reflect upon given objects, but rather both remain indeterminate through the encounter: objects may interrupt and unfold their qualities, while people refine their sensitivity to them.[5] Such a pragmatic conception of reflexivity allows me to observe it as it is done in practice, even discreetly, while being in touch with things, instead of assuming it in verbal, written, or mental operations. The reflexivity I consider here is "material:" it occurs when objects at hand resist what is expected from them and ask us to slow down.

The four modes of reflexivity I describe below show that doors are objects whose morality is not fixed once and for all. Rather they raise disturbances on several issues, beyond that of access. When door equipment materialized a rule without completely enforcing it, tension was left unresolved, and caregivers and youths muddled about that rule (first mode). But doors did not always enact a rule. The normativity of a door could also be collectively discussed. This led the team and teens to agree about a habit that they all in turn incorporated, and easily breached as well (second mode). Doors also mediated face-to-face encounters. In this sense, the way in which a youth opened or closed a door could trouble caregivers, who then wondered about the teen's state and how to respond to it (third mode). Surprisingly, doors also raised issues about their visual appearance. It takes us into a (fourth) mode of reflexivity through which teenagers and the team experimented with their debates in an unforeseen way. These modes of reflexivity are not exhaustive. They draw attention to some of the ways in which doors create moral disturbance and spark reflexive movements among professionals and care receivers, putting their everyday politics to work.

Doors materialized a rule: reflexivity with unresolved tensions

On some mornings I arrived at the old townhouse around 8.15 am and found one or two youths waiting at the entrance door. The center opened at 8.30, and not before. So, until we were let in, we chatted at the doorstep. During these moments my status approximated that of teenagers: none of us possessed the key, and we all had to wait outside. Once in the house, since I had been given the precious key that opened most of the rooms, my status shifted to that of a caregiver. This key drew a distinction between caregivers and teens, between those who could enter or not while standing on particular thresholds.

One of these thresholds, at the door of the caregivers' office, sparked tension on this matter. For years, the office had been open to everyone, youths included. But the team came to decide that they needed a space for informal chats, and a bit of rest from having teenagers around the whole day. So they equipped that door with a sign, in an attempt to implement a new rule that would prohibit entrance to the youths. Such a change made blatant the distinction between caregivers and teens. This way, it affected their relationships.

This decision was anything but easy. A salient issue was that of secrets. Whereas confidentiality in the day center was a clinical and legal obligation for team meetings and psychological consultations, secrets remained a debated topic within the team. Some of the caregivers repeated that they "don't like to hide from youths," perceiving secrets as a lack of respect. They wanted to be as clear as possible with youths about their views and intentions towards them, even though meetings where the team spoke about them without having them in attendance were a basic element of the therapeutic work. In contrast, for the psychiatrist secrets presented an imperative as strong as

confidentiality, and materialized in the acoustic isolation of walls and doors of consultation rooms, protecting the intimate character of patient confidence. The imperative of secrecy for the psychiatrist related to his psychoanalytic, introspective, and individualizing conception of care. Despret (2006) discussed how secrets in psychotherapy work on the assumption that the illness is confined in patients' interiority, for therapists who look for causes inside their psyche. In such a model, introspection provides key access to mental illness and therapeutic work, and legitimizes a hierarchy between the therapist and the patient. In this sense, secrets have a strong political dimension.

In my fieldwork, the political dimension of secrets was not only at stake between patients and therapists, but also between the psychiatrist and other caregivers who located therapy in their relationships with the teens more than they did in introspection. To those caregivers, the new rule prevented them from blurring apparent boundaries between patients and professionals. The sign on the door of the caregivers' office displayed, and recalled their different and hierarchical status: caregivers forbade the teens what they authorized for themselves. The tension about that door made palpable the moral and political dimension of secrets in psychotherapy, especially since patients and different caregivers had distinct understandings of the therapeutic work. What is more, the implementation of this rule relied upon a decision made by the caregivers only, without discussing it within the group. The issue touched, too, on caregivers' authority over teenagers.

Despite these debates, the team arrived at the decision to limit access to their office. They put a sticker on the door that left no doubt about the prohibition. It pictured an individual rushing to block the way, next to a sentence that made the message even more explicit (Figures 1a and 1b). But a sign often works less efficiently than its

delegation to a material device (Latour 2008:172). With the clumsy sign, that door became a source of tensions. From inside the room, caregivers often reminded others to keep it closed, and teenagers not to cross the threshold. From outside the room, it was rare that a youth took care to shut the door. Rather, many of them stayed next to it, some trying to enter, others to listen, intrigued or bothered by the secrets that the door guarded.[6] In other words, once a sign was delegated to implement the rule, the door sparked tensions in the everyday practice and impeded the relational easiness that caregivers sought to create.

[figure 1a and b here]

In the new building the door of that office was equipped with a magnetic keycard reader, a door closer, a doorknob that could not be turned from the outside, and an alarm that emitted a sound when the door remained slightly open. This aural reminder of the rule often irritated caregivers who deactivated it. All in all, the new device was much more competent at preventing entry. It was embedded in the door's technical features, without the need for a visual sign anymore. However, with that device in place, though it happened less often than before, caregivers continued to feel uneasy when they had to ban youths who exceeded the threshold. The electronic device reduced the team's work in keeping out intrusive teenagers. Yet the interdiction remained directly confronting when teens and caregivers interacted with the door. With the new door device, the tension remained partially unresolved.

This is a first lesson about the moral life of doors in the center: certain doors play ambivalent roles and, since they are sources of tension, they provoke reflexivity. The team office door somehow incorporated a rule that dealt with debates about secrecy and the problem of caregivers' authority over teens. But it incorporated the rule without applying it. With the move to a new building, technical solutions did not fully enforce

the rule, and so the reflexivity about it persisted. The device appeased the tensions but did not remove them. Teens and the caregivers continued to negotiate over the sore spot of the threshold, and hardly a day passed without their erratic choreography around that door.

Habits with doors: collective reflexivity

Caregivers did not always try to resolve the tensions with technological solutions. Another strategy was to turn rules into habits, and to discuss them together. The size of the new building brought new problems with doors, since it was six times larger than the townhouse. The greater surface area, with its two staircases and an elevator, challenged caregivers who did not want teenagers to spread out all around the place. By locking some doors, the team circumscribed the movement around the central staircase, to preserve their mundane, informal togetherness through spontaneous encounters.

Even so, one door remained problematic: it was located at the back of a corridor where, at certain times, teens went to consultation rooms. But, with that door open, the teenagers went on to scatter all over the place. Some of them got used to sitting in corners at the back of the corridor. On one hand, the teenagers' habit of withdrawing to the end of that corridor challenged caregivers' circumscription of their movements. On the other hand, the team did not want to block access to locations used less frequently than the living spaces. As Baptiste told me, they proceeded as follows:

> What we did was that we closed certain doors, but did not lock them…
> [Like] the door at the end of the corridor, we thought that if we left it open it

> was a call towards outside… That greatly played a part in youths not going out at any time, without asking… We had also told them in the community meeting: "If you need to take a breath of fresh air, the [new] building is sufficiently big, and we could imagine that you can go here, or there." But finally, teenagers did not ask [to withdraw]… Also, this circumscription gradually became obvious for adults, and for teenagers too.

In contrast to locking the door, the caregivers proposed that the door would be shut but not locked, and discussed the restricted area in the community meeting. The circulation was not prescribed by the technical object. It was progressively "built into" (Latour 2008:162) caregivers' and teenagers' routines as they became accustomed to a habit. The shifting of habits occurred as caregivers addressed youths with questions and invited them to imagine other ways to withdraw. This way, the reflexivity took shape in a collective mode. Once they had all agreed and came to practice these habits, simply closing the door was enough; there was no need to lock it. Everyone who spent a few days in the center would come to know that the door in question usually remained closed, even if it could be opened. It did not prevent the possibility of going through it for those who wanted to. If many of them had started to do so, the issue would have been discussed again in community meetings and other resolutions found.

With such "collective reflexivity," the moral and political questioning encompassed diverse participants and elements, where not all of them were known in advance. Together with caregivers' wishes to create casual togetherness, the zone of negotiation encompassed the teenagers, their need to withdraw, and other places where it might happen, or imagined ideas about where it might happen. These other elements entered the arena of debate to collectively create a new rule, which then translated into a habit. Through this translation, the "supportive points of power" came to lay less in the

material arrangement than in a habit, and in the collective reflexivity in which caregivers and receivers engaged.[7]

One can easily object that shifting habits, rather than continuing to debate a rule, is an insidious power tactic to produce docility among the youths. Instead, I see in that care practice that these rules and habits were interesting to caregivers and teenagers precisely because they could be transgressed. Rules and habits could both be breached, with breaches of either having the potential to nourish the care work, but with different consequences.[8] A breach of a rule could lead to it being recalled or, as I describe about the next mode, it could lead to reflexivity within face-to-face interactions. Changes in habits, as familiar patterns within the group deviate over time or when the group reshapes, might rather open on new areas of negotiation for further shifts. In other words, when the normativity lies within habits familiar to the group, it is easier to shift than with a rule, especially if this rule is materialized.

Doors mediated encounters: reflexivity in face-to-face interactions

Back to the meeting with the architects, a tension emerged about Baptiste's office door. In addition to a magnetic card reader, the administrative director and architects planned to install a bell, with which Baptiste could choose to answer with signs saying "busy/wait/come in." The coordinator convinced them not to install it. That device sounded entirely inappropriate to him because his door should be accessible even if youths were not allowed to enter. As he told me later:

> We [caregivers] know that we want this work to imply knocking, answering, and talking in order to know what's happening, and then we ask people to

> wait or not. In brief, we want to have that interaction. Without it, the teenager finds himself in front of a closed door and could just leave.

His door was a source of contradiction. On the one hand, a rule stated that teenagers could not enter that room when they wanted. On the other hand, most of the time teenagers came to the door with problems that needed to be addressed. Any teenager's problem required the coordinator to respond in an appropriate way to particular and unpredictable interactions with his door. "If a teenager throws himself at the door and then into the room, shouting," Baptiste continued, "I would welcome them very differently than a timid knock from a youth who stays there, waiting, a bit withdrawn…" The ways a teenager entered the room showed something about their state, to which the caregivers responded accordingly. The problem was that if a sign went up with that availability bell, it would restrict the door's possibilities for tuning into interactions with youths. Of course, the bell could also enable different actions, such as a nervous teenager continuously pushing it. But a naked door retained the possibility of being opened or closed in many ways, depending on the youths' reasons for coming and the mood or hurry they might be in. And a naked door avoided the bell's restriction of the many kinds of responses that the coordinator may offer within a face-to-face interaction.

This dynamic of breaching social expectations, of noticing it, and attuning the response – in short, working with the particularities of an unpredictable interaction – could also extend to the role of a door. Another caregiver told me:

> Doors are places where we necessarily have frequent contacts. They serve as funnels, in a way. So many doorframes are places like that… For example, Emil plays a lot with the door of the living room: he closes it, to make us

> react, so that we say to him: “Emil, you know that you can’t close it.” It is a game. But it is also his way to say: “I exist.” For Leo, it is often the door to the yard. (Slight laugh) This has a latch on the inside face, so youths close it regularly, when we are outside, of course!

When doors mediated encounters between caregivers and youths, they offered opportunities for youths to get the attention of others and to play cheeky games. They made some responses from teenagers noticeable, to which caregivers responded in turn as part of the everyday care work. But this did not happen with just any door. The door was also involved in these interactions because it was free from technical equipment narrowing its possible uses (badges or bell systems), which were instead extended (the latch enabling confinement in the yard). These unusual interactions, as they diverged from familiar usage with doors, augmented caregivers’ reflexive views in situations involving youths at particular moments.

The point is not that caregivers were against technological door equipment, but that they valued a door that enabled the noticing of particularities within face-to-face interactions. Doors, then, raised reflexiveness at the core of the interactions that were troubling for caregivers. This is a third mode of reflexivity, beyond trying to solve tensions with door accessories, or debating rules in community meetings that would translate into habits after its negotiation. Here, rules and habits are supposed to be integrated, and the reflexivity is enacted in the daily practice, surfing on discreet, implicit layers of common expectations that a youth’s response might challenge. This mode of reflexivity is very opportunistic: it depends on a situation as it happens in the moment. Since a naked door enabled a teenager to infringe rules or habitual usage, a caregiver could explore that breach and ask questions about what would trigger such a challenge of common expectations.

Caregivers' reflexivity on these transgressions of the norm draws an important difference. Rather than attributing such behaviors to a mental illness (an attribution that Goffman (1971:335–390) denounced), the team interrogated teens' attitudes as relational and ephemeral reactions within the group and their life circumstances. The caregivers' reflexivity contrasted with Garfinkel's (1967) "breaching experiment" in which the course of a social interaction and its expectations are ruptured: here, the breach also highlighted implicit shared understanding in a social group, yet the caregivers' responses did not aim at an immediate repair of the breach. That would have sounded to the caregivers like a ready-made answer, a normalization of a deviating behavior by, for instance, reminding those involved of a rule. Instead, caregivers called into question the problems that might have been at stake for those who breached common assumptions. This reflexive mode helped to particularize the caregivers' view on a teenager. Doors were their moral allies in these vital considerations for care.

Doors as visual things: experimental reflexivity

Finally, doors played a less expected role in the day center. They were panels hinged at doorways that stirred up the issue of their visual appearance. At the occasion of the move to the new building, the medical director proposed that doors would display a code with colors for teenagers: painted in red for forbidden ones, in orange for those allowed at certain times, and green for those with fully allowed access. The team opposed that proposition. They expressed reluctance to signify a rule between them and the teens with this sort of "traffic light" code. Eventually, some of the doors were painted in green, orange, or red, yet without applying the code to the whole building. Caregivers never explained the code to the teenagers. When I asked the latter about these doors, they just appreciated them as colorful. They barely identified a traffic light

code. The normative prescription of door colors remained weak if the team didn't activate it. Yet, what a door panel displayed manifested another way in which the object impacted its possible uses. Again, this sparked reflexivity.

Reflexive moments about the visual aspect of a door were rather occasional. But, as this final story relates, this issue can become critical enough to *forge* reflexivity; that is, to generate a reinvention of how it is done in an unforeseen way. Reflexive consideration is therefore practiced in an experimental manner, and this is a fourth mode. The door in question stood at a strategic location of the new building. Just after the street entrance, the reception desk, and a few consultation rooms, it marked the threshold of the day center area, where many external visitors were not allowed. Due to a technical problem, a wooden panel, not yet painted, replaced the former one. Caregivers seized the opportunity to run an artistic workshop for repainting the door. Two projects were set up with two different groups, each tasked with one side of the door: one visible from outside, and the other from inside. They sketched, researched, drew, and then assembled their work on a model. Participants found it easy to generate ideas, but it proved less easy for the group working on the external side to remain interested in the project in the long run. In contrast, the group for the inside panel became stronger: youths showed greater involvement, exchanges proliferated among them. In short, the project became arduous in one of the groups and worked surprisingly well in the other. After five months, the two models were presented to the caregiver team. And debates began.

The first matter that baffled the team was the style of the external side of the door. It pictured a very childish world – with rabbits or toys – rather than an adolescent one. This did not create the right image of the center, on a door seen by outside visitors

who never entered it. The other side's design much better reflected the aesthetic of the center, conveying a cheerful adolescent world.

However, the inside design, made by the stronger group, posed another problem. One teenager, let's call him Karl, suggested including his own nickname. The debate then started within the team about using the "signature" of a youth who would not be staying in the center for much longer. This touched upon questions that, for caregivers, were not yet solved: for how long should traces of an adolescent stay in the center? How could room be created for future teens? The door was a component of the building, and not a frame or an object that could be easily removed. But then Karl had put a lot into his drawing of the nickname. His increasing involvement had motivated him to start art education the next year. Caregivers could not just cut into that considerable interest. They knew it was counter-therapeutic to delete his work.

It was at that point that the controversy led to experimentation with the conditions of debate. The stronger group formalized as a "door committee." They requested the opportunity to defend their project at the clinical meeting, the weekly occasion for the team to address their most serious therapeutic concerns with the medical director. During that meeting, the door committee argued for the consideration of the time they had spent on the drawings, and took as evidence the other artworks displayed in the center that featured signatures. With these arguments, they enlarged the scope of considerations that came into the negotiation. Most caregivers endorsed this creativity since they valued that which could "bring a bit of fresh air" to their practice: to get new feedback or ideas. Eventually the door committee convinced the team to paint the door, with the signature a bit smaller and less centered (figure 2). The existence and action of the door committee were unforeseen in the day center. Youths diverted an existing device (clinical meeting) in a creative way, extending conditions for

the collective reflexivity usually done in community meetings. In doing so, they brought new conditions of debate, in which the door's visuality led a group of youths to enlarge their own thinking and that of the team.

[Figure 2 here]

And what happened to the other group, in charge of the external panel of the door? Their interests flickered and faded. Their side of the door was never painted. The team had a concern about that failed part of the project. They wondered whether they had overly segregated the youths who collapsed or succeeded to align, regarding the requirements of such a long-term project, and exposure to the critiques of whoever would see that door. If, in the successful group, a certain dose of strength was necessary to experiment with the collective mode of reflexivity, such strength, when absent, forced the team to question the adequate group composition in order to avoid repeating such a failure.

On modes of reflexivity in care

Doors of the day center entailed moral lives that went far beyond the provision or forbiddance of access. Their implicit, supple prescriptions relied on their technical details, on the rules they materialized, the habits incorporated with them, and their possible breaches, as well as on their visual aspects and the matters of taste they raised. With this range of issues under consideration, the right or wrong roles of those doors unfolded with different modes of reflexivity. The four modes I recollect manifest how "being reflexive" can take different forms with these moral things in a care practice.

To anthropologists, the concept of "reflexivity" resonates with important discussions about researchers' examination, in both ethnographic fieldwork and writing, of their own positioning in relation to their informants, and in the specific context of

research and its reception (Marcus 2015). Reflexive inquiry has since then incorporated the practice of ethnographers, as well as debates about the politics of knowledge. Sociologists have also taken interest in the notion of reflexivity when considering how to apply social analysis to themselves, or when people reposition as they integrate the social theory produced about them. In those trends, as in the care center, reflexivity is motivated by concerns about the reconfiguration of authority, and about putting the relationships between oneself and the others under scrutiny. As such, reflexivity boosts moral concerns.

In this article, reflexivity occurred in the practice I observed. As Hennion (2007) noted, when reflexivity is an activity on the field, it slips out of its strict definition. A significant slippage draws the notion away from its role in greater self-awareness and an individual's inner conversation. Similar to Hennion's pragmatic accounts (2007; 2009), the reflexivity with the doors manifested in an indeterminacy between an object revealing its qualities and people refining their sensitivity to their materiality, technicality, appearance, locations, appointed customs, and so on. Doors created room for disturbances, like breaches into habits, or troubling interactions with them. The reflexive dispositions in which these doors engaged reflect the "material reflexivity" that Thoreau and Despret (2014) discovered in their field inquiry with hard science researchers. A material reflexivity occurs when researchers hesitate or slow down in front of the objects or phenomena that resist what they expect from them. Instead of introspection into oneself, it is external feedback – in their case and mine, from material objects as much as people – that puts reflexivity into motion.

These reflexive modes enacted with doors carry implications for care institutions. Whereas doors inherit infamous roles in psychiatry, the stories above tell how it is possible for them not to obey strict and often detrimental norms. In my case

study, the aspiration for inclusivity in the "therapeutic community" model and the disruptions of a move to a new building amplified moments of reflexivity. But these reflexive modes provide inspiration for much more supple engagements with doors in everyday care than through the application of predefined norms. They teach us that transgressions are interesting in care for the perplexity and potential normative shifts they induce.

In this sense, the reflexive modes point to different ways in which care professionals may tune into the moral life of doors when paying attention to their usages. The door of the caregivers' office sharpens an awareness of the diverse devices that materialize a rule, and how each of them could fuel tensions and debate. Yet not all doors are equal candidates for such a fraught moral existence. The door located at the back of the corridor was not a secret-guarder, but it was useful in circumscribing the circulation, without constraining it. Hence materializing a rule would not have been appropriate. The collective discussion in community meetings rather oriented towards the adoption of a habit. Compared to a rule, a habit can easily be challenged and lead to the redefinition of a door's normativity. The third mode of reflexivity is much more discreet. It draws attention to the door equipment (or lack thereof) that allows unpredictable face-to-face interactions. The unexpected usages of a door can provide caregivers with opportunities to notice that something might be wrong and to interrogate it with the concerned person. And the door that sparked tensions about its aesthetic style does not only display that certain situations ask to experiment with the conditions of debate, but also that the unsuccessful part of that experiment calls for an extra dose of reflexivity on the conditions of that failure. Each in their own way, these different reflexive modes are forms of attentiveness that prevent the team from settling

for definitive verdicts. As such, they open paths for a more livable everyday togetherness in institutional care.

Lastly, the conditions of this reflexivity do not rely solely on care work. A few years after fieldwork, I presented these stories in a locked unit in Brussels that was about to undergo spatial redesign. The team, although interested in the doors' intricacies, held the view that directors did not listen to their advice on spaces, instead turning to architects. This is an old, well-known problem: the consideration extended by design decision-makers to the needs of users. However old, this problem still seems significant: the moral life of doors risks being all too easily ruined if directors, architects, or policymakers do not take seriously the first-hand experience and reflexivity that caregivers cultivate with these objects in their daily work.

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Notes

[1] On their request, all the names of my interlocutors are pseudonyms. The names of all facilities are real.

[2] The distinction between "morality" and "normativity" may be confusing. Here, the former refers to interactions with the object seen as good or bad, and the latter to the social standards seen as appropriate in the center. Whereas moral issues are hard to disconnect from normativity, norms may not always involve moral obligations or dilemmas.

[3] In Belgium, teams of psychiatric settings often combine several therapeutic orientations. Here, therapeutic community life blended with a biomedical practice and with analytical work, inspired by psychoanalytic and systemic approaches.

[4] The detail of door equipment is quite fascinating for its potential to discreetly afford (or fail to afford) ease to users, such as when inducing them to push or pull. See Norman (1998:10).

[5] Hennion associates reflexivity with the French grammatical form "reflexive." This form uses the word "se" to express that events arrive without active or passive actors at all, leaving the subject impersonal (for instance, "*cela se passe"*).

[6] In psychiatry, doors that exclude patients from the team's secrets easily provoke lots of anger among patients (Erstoff 1981:61). More broadly, one may remember that doors are conducive to arousing curiosity, for example while eavesdropping or spying through a keyhole.

[7] Foucault (2003:103) detected "supportive points" [*points d'appuis*] of power in the disciplining spaces of hospitals, as they distributed individuals and organized circulations and gazes.

[8] As Pols (2012:115–131) showed with the implementation of a telecare device, when certain changes gradually translate into routines, the innovative care practice can be experimented with more creatively than with normal application.

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