SIXTEEN

Critical, clinical

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The last book Deleuze published before his death in 1995 was a collection of essays entitled *Critique et clinique* (1993), which included articles devoted to "clinical" analyses of various philosophers (Plato, Spinoza, Kant, Nietzsche and Heidegger) and literary figures (Artaud, Beckett, Carroll, Alfred Jarry, Kerouac, D. H. Lawrence, T. E. Lawrence, Masoch, Melville and Whitman) (see ECC). The idea that artists and philosophers are physiologists or symptomatologists, "physicians of culture", was a notion first put forward by Nietzsche, for whom all phenomena are signs or symptoms that reflect a certain state of forces.[1] Deleuze took this Nietzschean notion in new directions in his writings, using it to explore the complex relationships between psychiatry and medicine, on the one hand, and philosophy, art and literature, on the other. "The critical (in the literary sense) and the clinical (in the medical sense)", he once wrote, "may be destined to enter into a new relationship of mutual learning" (M: 14).

Deleuze first posed the question of the relationship between the "critical" and the "clinical" – in his 1967 book *Masochism: Coldness and Cruelty* – in the context of a concrete question: why were the names of two literary figures, the Marquis de Sade and Leopold von Sacher-Masoch, used as labels in the nineteenth century to denote two basic "perversions" in clinical psychiatry? What made this encounter between literature and medicine possible, Deleuze suggests, was precisely the distinctive status of symptomatology within the context of medicine itself. The field of medicine can be said to be made up of at least three different activities: symptomatology, or the study of signs and symptoms; etiology, or the search for causes; and therapy, or the

development and application of a treatment. While etiology and therapeutics are integral parts of medicine, symptomatology marks a kind of neutral point, pre-medical or sub-medical, that belongs as much to art, literature and philosophy as it does to medicine. "I would never have permitted myself to write on psychoanalysis and psychiatry", Deleuze once admitted, "were I not dealing with a problem of symptomatology. Symptomatology is situated almost outside of medicine, at a neutral point, a zero point, where artists and philosophers and doctors and patients can encounter each other" (DI: 134, trans. mod.).

What accounts for this peculiar status of symptomatology? The medical diagnosis of a physician is always an act of judgement: it requires a genuine gift and an art, a "flair" that can only be obtained through long experience with numerous patients. Kant, however, had famously distinguished between two types of judgement, both of which are operative in the practice of medicine. In a "determinate" judgement, the general (the concept) is already given, and the problem is to determine the particular case to which it applies; in a "reflective" judgement, by contrast, only the individual case is given, and the problem is to find the general concept to which it corresponds. One might think that doctors make "determinate" judgements: they have learned the concepts of illnesses, and simply need to apply them to their patients. But in fact medical diagnoses are examples of reflective judgements, since in relation to an individual case the concept itself is not given, but is entirely "problematic". What a doctor confronts in an individual case is a symptom or group of symptoms, and his diagnostic task is to discover the corresponding concept (the concept of the disease). No doctor would treat a fever or headache as a definite symptom of a specific illness; they are rather indeterminate symptoms common to a number of diseases, and the doctor must interpret and decipher the symptoms in order to arrive at the correct diagnosis. If one seeks an example of a determinative judgement in medicine, it must be located instead in the therapeutic decision: here the concept is given in relation to the individual case, but what is difficult is its application (counter-indications in the patient, etc.).[2]

Although there is no less art or invention in determinative judgements than in reflective judgements, it is nonetheless in reflective judgements that Deleuze tends to locate the aspect of medicine that most interests him: the function of "concept creation". Illnesses are occasionally named after typical patients (e.g. Lou Gehrig's disease), but more often than not it is the doctor's name that is given to the disease (e.g. Parkinson's disease, Alzheimer's disease, Creutzfeldt-Jacob disease). The principles behind this labelling process, Deleuze suggests,

deserve careful analysis. The clinician obviously does not "invent" the disease, but rather is said to have "isolated" it. He or she distinguishes cases that had hitherto been confused by dissociating symptoms that were previously grouped together and juxtaposing them with others that were previously dissociated. In this way, the physician creates an original clinical concept for the disease: the components of the concept are the *symptoms*, the signs of the illness, and the concept becomes the name of a *syndrome*, which marks the meeting place of these symptoms, their point of coincidence or convergence (e.g. Tourette's syndrome, Asperger's syndrome, Korsakov's syndrome, etc.). Deleuze has defined philosophy as the activity of creating concepts, but the creation of concepts is equally evident in medicine, if not more so. When a clinician gives his or her name to an illness, it constitutes an important advance in medicine, in so far as a proper name is linked to a determinate group of symptoms or signs. If diseases are usually named after their symptoms rather than their causes, it is precisely because a correct etiology depends first and foremost on a rigorous symptomatology.

It is true that, in numerous instances, the symptomatological description of the cases themselves is sufficient, without the invention of a corresponding concept. The remarkable case of Phineas Gage, who survived severe destruction of his prefrontal lobes, initiated important avenues of research in neurology.[3] In the case of Johann Schneider, reported by Goldstein and Gelb (1918), the patient could scratch his nose but not point to it, which seemed to reveal a distinction between concrete practice and the "abstract attitude" (categorization).[4] Merleau-Ponty would take up the Schneider case while developing his theory of the "corporeal schema" in the *Phenomenology of Perception* (2002). Oliver Sacks's famous "Man Who Mistook His Wife for a Hat" seemed to manifest the opposite condition: he maintained the "abstract attitude", but had lost the concrete ability to recognize even his wife's face (prosopagnosia) (1970: 8–22). In all such instances, the symptomatologies of case studies pose specific problems for which neurology must seek the etiological bases. This is why Deleuze can write that "etiology, which is the scientific or experimental side of medicine, must be subordinated to symptomatology, which is its literary, artistic aspect" (M: 133).

The history of medicine can therefore be regarded under at least two aspects. The first is the *history of diseases*, which may disappear, recede, reappear or alter their form depending on numerous external factors: the appearance of new microbes or viruses, altered technological and therapeutic techniques, changing social conditions. But intertwined with this is the *history of symptomatology*, which is a kind of "syntax" of medicine that sometimes follows and sometimes precedes changes

in therapy or the nature of diseases: symptoms are isolated, named, renamed and regrouped in various manners. From the latter viewpoint, the plague and leprosy were more common in the past not only for historical and social reasons, but because "one tended to group under these headings various types of diseases now classified separately" (M: 16). The cultural repercussion of medicine tend to resonate most strongly in the domain of symptomatology. After the Second World War, for instance, there came the discovery of illnesses derived from "stress", in which the disorder is not produced by a hostile agent, but rather by non-specific defensive reactions that either run amok or become exhausted. Following the war, medical journals were filled with discussions of stress in modern societies, and new ways of grouping various illnesses in relation to it. More recently, there has been the discovery of "auto-immune" diseases, in which defence mechanisms no longer recognize the cells of the organism they are supposed to protect, or external agents make these cells impossible to distinguish from others. AIDS, Deleuze suggests, lies somewhere between these two poles of stress and auto-immunity (see N: 132–3). It is not difficult to see how these new "styles" of disease (diseases with carriers rather than sufferers, images rather than symptoms) end up getting reflected in arenas such as global politics and strategy, where the risk of war is seen to come not only from potential external aggressors (the terrorist as an "unspecified" enemy) but from defence systems going out of control or breaking down. In a similar vein, Susan Sontag has analysed the symptomatological myths that tend to surround diseases such as tuberculosis ("consumption"), cancer and, most recently, AIDS (see Sontag 1978, 2001).

The initial idea behind Deleuze's "critique et clinique" project is that writers and artists, like doctors and clinicians, can themselves be seen as profound symptomatologists. Sadism and masochism are clearly not diseases on a par with Parkinson's or Alzheimer's disease. Yet if Krafft-Ebing, in 1869 (in work that would culminate in his well-known *Psychopathia Sexualis* of 1886), was able to use Masoch's name to designate a fundamental perversion, it was not because Masoch "suffered" from it as a patient, but rather because his literary works isolated a particular way of existing and set forth a novel symptomatology of it, making the contract its primary sign. Freud would make use of Sophocles in much the same way when he created the concept of the "Oedipal complex", or of Shakespeare when he wrote about Hamlet. "From the perspective of Freud's genius", Deleuze writes, "it is not the complex which provides us with information about Oedipus and Hamlet, but rather Oedipus and Hamlet who provide us with information about the complex" (LS: 237). As Deleuze explains:

> Authors, if they are great, are more like doctors than patients. We mean that they are themselves astonishing diagnosticians or symptomatologists. There is always a great deal of art involved in the grouping of symptoms, in the organization of a *table* [*tableau*] where a particular symptom is dissociated from another, juxtaposed to a third, and forms the new figure of a disorder or illness. Clinicians who are able to renew a symptomatological picture produce a work of art; conversely, artists are clinicians, not with respect to their own case, nor even with respect to a case in general; rather, they are clinicians of civilization.
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> (LS: 237, trans. mod.)

At one point, Deleuze goes so far as to suggest that artists and writers can often go *farther* in symptomatology than doctors and clinicians, precisely "because the work of art gives them new means, perhaps also because they are less concerned about causes" (DI: 133). No doubt this explains why, in their writings on schizophrenia, Deleuze and Guattari frequently appeal to the writings of literary figures rather than the work of clinicians. "We have been criticized for over quoting literary authors", they commented. "But is it our fault that Lawrence, Miller, Kerouac, Burroughs, Artaud, and Beckett know more about schizophrenia than psychiatrists and psychoanalysts?" (ATP: 4).

One can readily see that Deleuze's approach to literature is almost the exact opposite of most "psychoanalytic" interpretations of writers and artists, which generally tend to treat authors as real (or at least possible) patients, whose work is then seen either (regressively) as a kind of "working out" of their unresolved conflicts, or (progressively) as a kind of "sublimation" of those conflicts. Artists are treated as like clinical cases, as if they were themselves patients, and what the critic seeks in their work is a sign of neurosis, as if it were the secret of their work, its hidden code. In such cases, there is no need to "apply" psychoanalysis to the work of art, since the work itself is seen to constitute a successful psychoanalysis, either as a resolution or a sublimation. "All too often the writer is still considered as one more case added to clinical psychology, when the important thing is what the writer himself, as a creator, brings to clinical psychology" (DI: 133). Part of the problem is that psychoanalytic interpretations are often tied to an "egoistic" conception of literature: "Everyone seems, and seems to themselves, to have a book in them, simply by virtue of having a particular job, or a family even, a sick parent, a rude boss … It's forgotten that for anyone, literature involves a special sort of exploration and effort, a specific creative purpose that can be pursued only within literature itself" (N:

130). Or, as Blanchot puts it, literature exists only in the condition of a third person that strips us of the power to say "I" (the neuter) (1993: 384–5).

Deleuze's 1967 essay on masochism, *Coldness and Cruelty*, provides one of the clearest examples of his symptomatological approach to literature. At a conceptual level, the book provides an incisive critique of the clinical notion of "sadomasochism", which presumes that sadism and masochism are complementary forces that belong to one and the same pathological entity. Psychiatrists were led to posit such a "crude syndrome", Deleuze argues, because they relied on hasty etiological assumptions (concerning the nature of the "sexual instinct"), and hence were content with a symptomatology much less precise and much more confused than the one found in Masoch himself. Because the judgements of the clinicians are often prejudiced, Deleuze's strategy in *Coldness and Cruelty* was to adopt a *literary* approach that attempted to provide a differential diagnosis of sadism and masochism based on the literary works from which their original definitions were derived. The results of Deleuze's analyses are twofold. On the clinical side, Deleuze shows that sadism and masochism are two incommensurable modes of existence whose symptomatologies are completely different from each other (a sadist would never tolerate a masochistic victim, nor would a masochistic torturer be a sadist). On the critical side, he shows that the clinical symptoms of sadism and masochism are themselves inseparable from the literary techniques and styles of Sade and Masoch. "Symptomatology is always a question of art", Deleuze writes.

> The clinical specificities of sadism and masochism are not separable from the literary values peculiar to Sade and Masoch. In place of a dialectic that all too readily perceives the link between opposites, we should aim for a critical and clinical appraisal able to reveal the truly differential mechanisms as well as the artistic originalities. (M: 14)

At the time, Deleuze saw *Coldness and Cruelty* as the first instalment of a series of literary–clinical studies: "What I would like to study (this book would merely be a first example) is a articulable relationship between literature and clinical psychiatry" (DI: 133, trans. mod.). The idea was not to apply psychiatric concepts to literature, but on the contrary to extract non-pre-existent clinical concepts from the works themselves. When asked in an interview why he had only treated Sade and Masoch from this point of view, Deleuze replied:

> There are others, in fact, but their work has not yet been recognized under the aspect of a creative symptomatology, as was the case with Masoch at the start. There is a prodigious table [*tableau*] of symptoms corresponding to the work of Samuel Beckett: not that it is simply a question of identifying an illness, but the world as symptom, and the artist as symptomatologist.
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> (DI: 132, trans. mod.)

Twenty-five years later, in 1992, Deleuze would finally publish an essay analysing the symptomatology of Beckett's work around the theme of "The Exhausted".[5] But Deleuze also pursued the project in his writings on philosophical texts. When he asked, somewhat rhetorically, "Why is there not a 'Nietzscheism,' 'Proustism,' 'Kafkaism,' 'Spinozism' along the lines of a generalized clinic?" (D: 120) he seemed to be indicating that he considered his monographs on each of these thinkers to fall within the domain of the "critique et clinique" project. *Nietzsche and Philosophy* (1962), for instance, shows how Nietzsche set out to diagnose a disease (nihilism) by isolating its symptoms (*ressentiment*, the bad conscience, the ascetic ideal), tracing its etiology in a certain relation of active and reactive forces (the genealogical method), and setting forth both a prognosis (nihilism defeated by itself) and a treatment (the revaluation of values). Similarly, Deleuze's secondary doctoral thesis, *Expressionism in Philosophy: Spinoza* (1968), presents an analysis of the composition of finite "modes" in Spinoza, which includes both a clinical diagnostic of their passive state (human bondage), and a treatment for their becoming-active (the "ethical" task) (EPS: 11). In a sense, Deleuze can speak in philosophy of Spinoza's "modes" or Nietzsche's "will to power" in the same way that one speaks of Alzheimer's disease or Tourette's syndrome in medicine, that is, as a non-personal mode of individuation indicated by a proper name.

In this regard, one can see Deleuze's first collaboration with Guattari, *Anti-Oedipus: Capitalism and Schizophrenia* (1972), as a new direction in Deleuze's "critique et clinique" project. The book takes as its object an acute psychotic phenomenon that poses numerous problems for the clinical method: not only is there no agreement as to the etiology of schizophrenia, but even its symptomatology remains uncertain. In most psychiatric accounts of schizophrenia, the diagnostic criteria are given in purely *negative* terms, that is, in relation to the destructions the disorder engenders in the ego: dissociation, autism, detachment from reality. Whereas psychoanalysis would retain this negative viewpoint, in *Anti-Oedipus*, Deleuze and Guattari attempted an inverse approach: "We tried to reexamine the concepts used to describe neurosis in the

light of the indications we received from contact with psychosis" (DI: 234). Following Karl Jaspers and R. D. Laing, they attempted to examine schizophrenia in its *positivity*, no longer as actualized in a mode of existence (an ego), but rather as a pure *process*, that is, as an opening or breach that breaks the continuity of a personality or ego, carrying it off on a kind of voyage through an intense and terrifying "more than reality" (AO: 24). They thus drew a sharp distinction between schizophrenia as a process ("breakthrough") and schizophrenia as a clinical entity ("breakdown"), which results from an interruption of the process. In short, Deleuze and Guattari attempted to *listen* to schizophrenic discourse, and to derive from it a "schizoanalytic" picture of the psyche. The result was their concept of the schizophrenic "Body without Organs", which has three aspects or components:

- *The anorganic functioning of the organs*. For the schizophrenic, bodily organs function primarily as unspecified elements of "machines", that is, they are experienced as parts that are connected to other parts: a tree, a star, a light bulb, a motor, another organ. In and of themselves, these organs or parts are completely disparate, foreign to each other, without any link, *pure singularities*; and yet they are made to function together in a complex machinic assemblage.
- *The Body without Organs*. In the midst of these organs-machines, a second theme appears: the Body without Organs as such, as it were, a liquid surface on which the anorganic functioning of the organs takes place; a non-productive or anti-productive surface that thwarts the productive activity of the organ-machines, at times making them stop dead in their tracks in a catatonic stupor. Yet the true enemies of the Body without Organs are not the organs themselves. The common enemy of both the organ-machines and the Body without Organs is the *organism*, that is, the organization that imposes on the organs a regime of totalization, collaboration, integration, inhibition and disjunction. In this sense, the organs of the organism are indeed the enemy of the Body without Organs, which attempts to *repulse* them, to denounce them as so many apparatuses of persecution. But the Body without Organs also *attracts* the organs, it appropriates them and makes them function *in another regime* than that of the organism. The organs are, as it were, "miraculated" by the Body without Organs, in accordance with this non-organic "machinic" regime that must not be confused either with organic mechanisms or the organization of the organism.

- *A relation in intensity*. But there is a third and final component to the description of schizophrenia: the theme of intensity. These two poles of the Body without Organs, never separate from each other – the vital anorganic functioning of the organs and their frozen catatonic stasis, with all the variations of *attraction* and *repulsion* that exist between them – translate the entire anguish of the schizophrenic and generate between them the various forms of schizophrenia: the paranoid form (repulsion), and its miraculating or fantastic form (attraction). This is *the intensive reality of the body*, a milieu of intensity that is "beneath" or "adjacent to" the organism and continually in the process of constructing itself. It is the proportions of attraction and repulsion that produce the various intensive states through which the patient passes, and thus the Body without Organs is something that is primarily *felt* under the integrated organization of the organism, as if the organs were experienced as *intensities* (or affects) capable of being linked together in an infinite number of ways. And in fact, as the organ--machines and the Body without Organs are really one and the same thing, Deleuze and Guattari's schizoanalytic model of the psyche is thus purely materialist: "In reality, the unconscious belongs to the realm of physics: the body without organs and its intensities are not metaphors, but matter itself" (AO: 283).

If, as Deleuze and Guattari suggest, schizophrenia appears as the illness of our era, it is not as a function of generalities concerning our mode of life, but in relation to very precise mechanisms of an economic, social and political nature. Our societies no longer function on the basis of codes and territorialities, but on the contrary on the basis of a massive decoding and deterritorialization. The schizophrenic is like the limit of our society, but a limit that is always avoided, reprimanded, abhorred. The problem of schizophrenia then becomes: how does one prevent the breakthrough from becoming a breakdown? How does one prevent the Body without Organs from closing in on itself, imbecilic and catatonic? How does one make the intense state triumph over the anguish, but without giving way to a chronic state, and even to a final state of generalized collapse, as is seen in the hospital? Is it possible to utilize the power of a lived chemistry and a schizo-logical analysis to ensure that the schizophrenic process does not turn into its opposite, that is, the production of the schizophrenic found in the asylum? If so, within what type of group, what kind of collectivity?

Anti-Oedipus thus adds a third and final component to Deleuze's conception of the "critique et clinique" project, an advanced symptom-

atological method that includes not only (i) the function of the proper name, and (ii) the assemblage or multiplicity of symptoms or signs designated by the name, but also (iii) the variations or "lines of flight" inherent in every such multiplicity, which account for the possibility of new discoveries and creations: "a process and not a goal" (AO: 133).

Like this direct engagement by Deleuze and Guattari with life through the symptomatological method, Deleuze's approach to literature is thus neither textual nor historical, but rather "vitalist", and as such is grounded in a principle of "Life" (Nietzsche, Bergson). It is always a question of evaluating, in a literary work, its possibilities of Life. But this also means that Deleuze's literary analyses are profoundly ethical, since it is Life itself that functions as an ethical principle in Deleuze's thought, and it is no accident that Foucault, in his American preface to Anti-Oedipus, called it "a book of ethics" (1983: xiii). Deleuze has frequently drawn a sharp distinction between morality and ethics. He uses the term "morality" to define, in general terms, any set of "constraining" rules, such as a moral code, that consists in *judging* actions and intentions by relating them to transcendent or universal values ("this is good, that is evil"). What he calls "ethics" is, on the contrary, a set of "facilitative" [*facultative*] rules that evaluates what we do, say and think according to the immanent mode of existence or possibility of life that it implies.[6] One says or does this, thinks or feels that: *what mode of existence does it imply*? This is the link that Deleuze sees between Spinoza and Nietzsche, whom he has always identified as his philosophical precursors. Each of them argued, in their own manner, that there are things one cannot do or think except on the condition of being weak or enslaved, unless one harbours a vengeance or resentment against life; and there are other things one cannot do or say except on the condition of being strong, noble or free, unless one affirms life. An immanent ethical distinction (good–bad) is in this way substituted for the transcendent moral opposition (Good–Evil). "*Beyond Good and Evil*", wrote Nietzsche, "at least that does *not* mean 'Beyond Good and Bad.'" (1968: 491). The "Bad" or sickly life is an exhausted and degenerating mode of existence, one that judges life from the perspective of its sickness, that devaluates life in the name of "higher" values. The "Good" or healthy life, in contrast, is an overflowing and ascending form of existence, a mode of life that is able to transform itself depending on the forces it encounters, always increasing the power to live, always opening up new possibilities of life.

Literature, likewise, is a question of health, and every literary work implies a manner of living, a mode of life, and must be evaluated not only critically but also clinically.[7] "Style, in a great writer, is always a

style of life too, not anything at all personal, but inventing a possibility of life, a way of existing" (N: 100). This does not mean that an author necessarily enjoys robust health; on the contrary, artists, like philosophers, often suffer from frail health, a weak constitution, a fragile personal life (e.g. Spinoza's frailty, Lawrence's hemoptysis, Nietzsche's migraines, Deleuze's own respiratory ailments). This frailty, however, does not stem from their illnesses or neuroses, but from having seen or felt something in life that is too great for them, something unbearable "that has put on them the quiet mark of death" (WIP: 172). But this something is also what Nietzsche called the "great health", the vitality that supports them through the illnesses of the lived. This is why Deleuze insists that writing is never a personal matter, it is never simply a matter of our lived experiences. "You don't get very far in literature with the system 'I've seen a lot and been lots of places'" (N: 134). Novels are not created out of our dreams and fantasies, our memories and travels, our sufferings and griefs, our opinions and ideas. It is true that writers are necessarily "inspired" by their lived experiences; but even in writers like Thomas Wolfe or Henry Miller, who seem to do nothing but recount their own lives, "there is an attempt to make life something more than personal, to free life from what imprisons it" (N: 143; cf. WIP: 171). Wolfe himself insisted that "it is impossible for a man who has the stuff of creation in him to make a literal transcription of his own experience" (1936: 22). For Deleuze, Life itself is an impersonal and non-organic power that goes beyond any lived experience, and the act of writing is itself "a passage of Life that traverses both the livable and the lived" (ECC: 1). In every great work of writing, then, one reaches the point at which "critique" and "clinique" become one and the same thing, when life ceases to be personal and the work ceases to be historical or textual: "a life of pure immanence" (DI: 141).

Notes

1. See, for instance, Friedrich Nietzsche, "The Philosopher as Cultural Physician" (1873), in Brezeale (1979: 67–76), although the idea of the philosopher as a physician of culture recurs throughout Nietzsche's writings. For Deleuze's analysis of the symptomatological method in Nietzsche, see *Nietzsche and Philosophy* (NP: x, 3, 75, 79, 157).
2. On the distinction between determinative and reflective judgements, see Deleuze's comments in *Kant's Critical Philosophy* (KCP: 59–60), where, not insignificantly, he makes use of these medical examples.
3. See Damasio's (1995: 3–33) analysis of Phineas Gage's case.
4. For a recent assessment, Marotta & Behrmann (2004).
5. Gilles Deleuze, "L'Épuisé", originally published as the postface to Samuel

Beckett's *Quad* (1992; translated in ECC: 151–74), a revised version from the original translation by Uhlmann (1995).

6. "*Règles facultatives*" is a term Deleuze adopts from the sociolinguist William Labov to designate "functions of internal variation and no longer constants" (see FCLT: 146–7, n.18).
7. For a broad assessment of Deleuze's "*critique et clinique*" project, see Bogue (2003b), which includes accounts of all of Deleuze's writings on literature, as well as the special issue of *Deleuze Studies* **4**(2) (2010), entitled "Deleuze and the Symptom: On the Practice and Paradox of Health".