THE CORPOREAL / THE CLINICAL / THE COLLECTIVE

An Architectural Schizoanalysis of Trauma

Research Plan AR3A010

Explore Lab / Delft University of Technology

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April 2021

Introduction

At the end of 2020, I was formulating a problematisation around the peculiar phenomenon of contemporary ruins in our built environment that, I hypothesised, had a paradoxical relation to decay (invisible, yet instant) and were a symptom of a disordered affective relationship between the retentive memories of the structure and its operations.

As if the pandemic wasn't enough illness to deal with, towards the end of 2020 I developed tinnitus, which turned out to be a symptom of the mental "disorder" I have been fighting for quite some time: complex posttraumatic stress disorder. It halted my exploration of the theoretical field and swung me back into the territory of the corporeal: my ear, my organs, my mind, my repressed memories. By taking care of myself and attending various therapies of a restrictive Dutch mental and physical health care system, I essentially underwent a process of my own problematisation.

Stepping back into the rhythm of graduation was not as difficult as expected for someone who spent the last three months thinking about just herself. My interest in problematising a dysregulation of association between memory and affect in urban environments did essentially not differ much from the difficulties I faced with my dissociative symptoms and how I am treated in the medical milieu. It made me wonder if the problematisation of my *corporeal* situation and *clinical* repressive trajectory could be applied to a *collective* situation, that of an urban milieu.

Problematisation

The clinical diagnosis of 'complex posttraumatic stress disorder' primarily refers to an individual's affective dysregulation caused by prolonged interpersonal traumatic events. Its pathological understanding is based on the study of its dissociative symptoms such as memory loss, alterations of attention or conciousness, somatisation, and fragmentation of self-perception. Only for the last twenty years, the medical field is learning the causes and mechanisms of trauma on a neuroscientific level. Before this, the 'complex' aspect of the disorder was often denied or misunderstood and until today is hardly found in "official" clinical treatments. (van der Kolk, 2015)

Most psychoanalytical diagnoses are based on the reflective judgements of its symptoms, instead of its actual causes, which makes psychoanalysis belong as much to medicine, as it does to art, literature and philosophy (Smith, 2011). After all, its function is that of "concept creation" (p. 205). Therefore the régime of the clinical can be as much problematised on its affective nature in relation to its history, as the artistic territory of architecture or the corporeal territory of the individual; especially when I happen to have a mental disorder that is unrecognised by the DSM-V (The fifth edition of Diagnostic and Statistical Manual of Mental Disorders), the bible of the psychoanalytical world; a work of art. The recordings of trauma on my body are a problem that miscommunicates with the ordered responses from the psychoanalytical territory. In order to heal, it even requires me to *become psychoanalyst, therapist, and pharmacologist*. Where is the line between the corporeal and clinical, when the patient has to educate the practitioner?

According to Chris Smith (2019), we experience a fragmented *self,* one of the C-PTSD symptoms, when we look at ruins; they act like mirrors showing an alienated identity that we have repressed to make sense of the world. "The body and the instrumental world have a reciprocal relationship" (p. 30), which makes architecture as much bodily as the interiorised body of the self. Specifically traumatypical memories, Stiegler argues, are not merely individual experiences, but constituted by recorded retentions in our surroundings, carried by technical structures. A traumatic upheaval of memories that disrupts the individual's organs is therefore as much a problem of the collective milieu as of the body itself. According to Stiegler's concept of a 'general organology', human organs can be thought of as co-

individuating with technical organs and social organs. Since the technical organs of our built environment are both impeding and allowing individuation towards the individual and social domain, architecture carries new possibilities of psychic and collective individuation that can offer the practice of care. (Hansen, 2017) (Stiegler, 2018)

Architecture is in this case considered a *pharmakon*—both a poison and a remedy—of which the therapeutic effects become a problem of liminality. Many people value the ruins of ancient temples, medieval monasteries, or early industrial buildings for their meaningful expressions. Yet when a contemporary structure becomes disused, its ruins appear a-symptomatic: decay is hardly noticeable, yet instantly present due to economically efficient precarious building methods (Bégout, 2018); they do not exteriorise a sense of the past, but instead a kind of haunting of the future (Rees, 2020). The empty warehouses, abandoned office buildings, haunting disused shopping malls of our present time swerve around in our surroundings like repressed memories because what is ruined is not their structures, but their potentials: a problem of affect dysregulation.

Now, as I am limited to a government certified amount of movement and relations, my territory is reduced to a constellation of my current mental health issues, the trajectory through the clinical field of mental healtcare, and my urban encounters. Therefore, this research aims to problematise trauma on the level of the corporeal, clinical, and collective, by critically operating the affects of dissociated (or traumatypical) structures. This will primarily touch upon affect dysregulation through the structure of repressed memory in architecture. In clinical fashion, the practices of aetiology, symptomatology, pharmacology, and therapy will be applied through the following questions:

1. How to break through dominant assumptions of the three territories in relation to trauma, i.e. how to (de-/*re-*)*diagnose*?
2. How to recognize the systemic nature of this diagnosis,
   i.e. how can the *symptoms* be described?
3. How to transform the memory-affect relation to one that is free from repression,
   i.e. how can territories become *therapeutic*?
4. How can spatial conditions support the process of healing,
   i.e. how can architecture, as *pharmakon*, become *medicine*?

Methodology

The main method for this research will be schizoanalysis, a term coined by Deleuze and Guattari (1983) in their collaborative work *Anti-Oedipus* describing a response to transcendental syntheses in psychoanalysis, those that ask "what does it *mean*?". They plead for schizoanalysis to be a materialist practice that can free desiring-production from affective constraints by instead asking "what does it *do*?".

For this analysis, the schizophrenic is taken out of the medical context to work with its emancipatory potential—"the ability to constantly break free from the dominant emotional controls" (Kingsmith, 2016, p. 1)—to locate its machinic flows and breaks in the social and to mobilise these processes to be productive of new affective resistances. There is no intent to romanticise the disorder, instead, schizophrenia is understood as a process that theorises the unconscious as machinic, rather than structural (Deleuze & Guattari, 1983, p. 108). In *Anti-Oedipus*, the production of desire is considered the same as social production, which means that schizoanalysis reveals similarities between processes in the different régimes of the political, social, corporeal, and economical.

Schizoanalysis works by breaking down the desires of the subject—deterritorialising the experience—and researching its intensities. Reciprocal to this is a process of reterritorialisation, a merging of newfound connections to a rhizome of knowledge, that offers a radically creative understanding of semiotic and subjective productions (Guattari, 2009), such as the territories of this research.

As a continuation of the *Anti-Oedipus* project, psychoanalyst Félix Guattari introduces the application of schizocartography: a diagrammatic mapping of the four planes of consistency as seen in *Figure 1*: the Machinic Phylum (Phi), Social domain of material and energetic Flows (F), Existential Territories (T), Universes of Value (U), with which he stresses the deterritorialised machinic nature of desire, that could be a catalyst for new productive reorganisations of connections through the four quadrants of the scheme. (Guattari, 2009) (Radman & Sohn, 2017)

If the affective relations of traumatypical structures can be mapped on the level of the repressed body, as well as in the domain of a repressed institution and ultimately the repressed collective, its opens up many paths of practical potentials. The method of

schizoanalysis is anti-psychiatric—and therefore maybe anti-methodological—by its freeing of desire as a revolutionary force from a presupposed methodological application. That's why this research will be an open exploration of the three territories, which will not conclude with an answer to "what does this all mean?", neither will it be reduced to a four-quadrant diagram, but aims to be productive in creating an assemblage of new connections regarding the corporeal, clinical, and collective in the face of trauma.

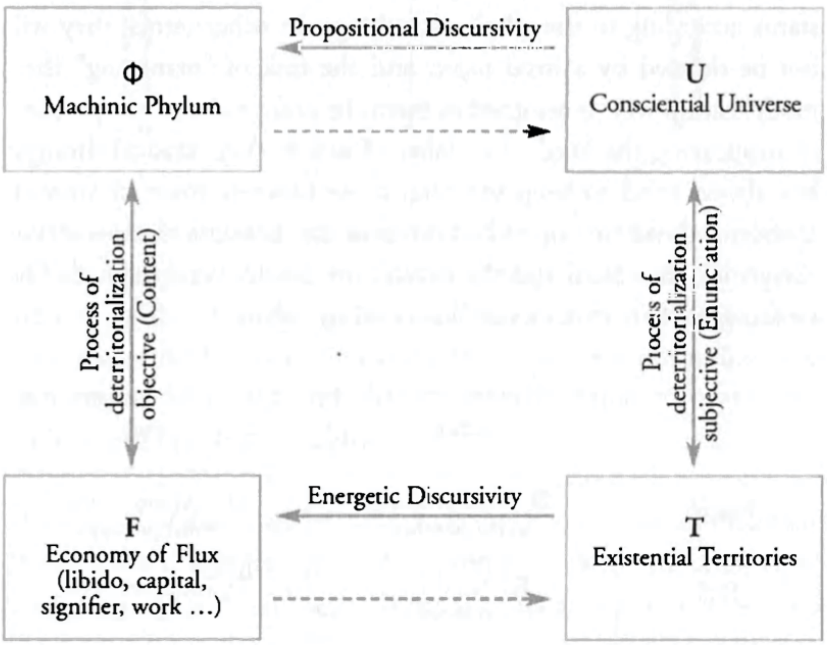
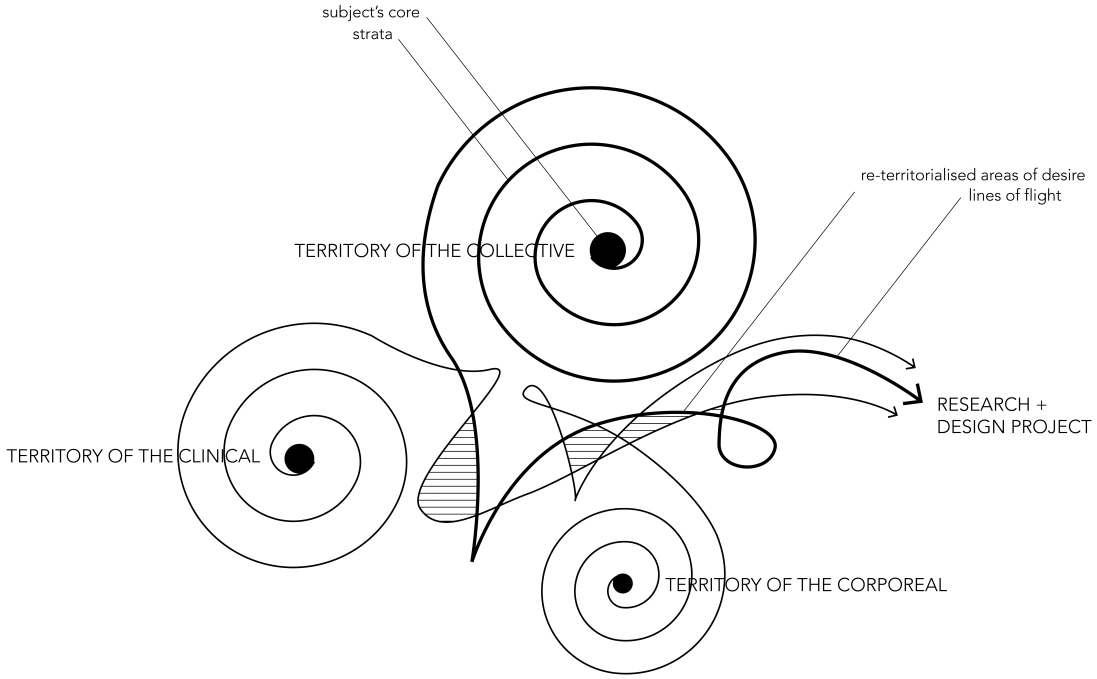


Figure 1. Schizocartography Diagram. Reprinted from *Soft subversions: Texts and Interviews 1977-1985,* (p. 219), by F. Guattari, 2009, Los Angeles: Semiotext(e). Copyright 2009 by Félix Guattari and Semiotext(e).

Diagram illustrating the Research Design



RE-SINGULARISATION OF SUBJECTIVE TERRITORIES
THROUGH LITERARY RESEARCH AND SCHIZOCARTOGRAPHY

Relevance to the Graduation Project

Schizoanalysis, through schizocartography, will ultimately become the first steps towards a design that considers the machinic relations between the corporeal, the clinical, and the collective. Problematising my mental health, my medical process, and my urban context through the lens of desiring-production is a way of opening up the affective processes of its spatial conditions regarding not just my personal situation, but the collective urban environment as well. A materialist understanding of trauma can be applied to architecture to radically change the dissociated state of what is built for healing affect-related psychological issues. Architecture as a virtual real territory can offer the therapeutic conditions for a psychiatric clinic of potentials, which is essentially a question of liminality between affect and memory.

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Self-Assessment

The 'Research Plan' course offered a deep dive into structured research design, which was quite difficult—yet necessary—when doing a more interpretive studio, like Explore Lab. The lectures covered various inspiring possibilities of research in architecture, which emphasised the importance of such early research design engagement. The lectures on 'the problem of problem-solving' and 'how to design a problem statement' were helpful to my topic interest. They were complemented by the masterclass 'Masterclass Disciplinary Mergers and Multi-Disciplinary Encounters', which I appreciated in its approach to research through an assembled exploration of various disciplines, offering some fundamental questions to support the research.

Unfortunately, I became ill l just a few weeks before the P2 presentation, which then had to be postponed. You could say I had the misfortune of having to retreat from my project for two months, but also the luck of being able to revisit the research design with a clean slate. Both my research and my potentials for a design project changed according to my personal experiences with having a mental illness. This could not go unnoticed, which felt initially very conflicting but showed potential for problematising mental health and architecture, as well as the territory of psychiatric institutions, something I did not expect to be able to do.

What I learned most is that there are many potentials in intuitive thoughts and operations, that I often seem to overlook when trying to control the research process. Topics with many misconceptions or taboos, such as trauma, are limiting when they are approached through restricted behaviour. Therefore, I am glad to apply schizoanalysis to my research, which fundamentally changed my perception of what is productive; having a noticeable change in being. Of course, I will continue to struggle with my mental problems, but the practice of schizoanalysis produced an understanding of the problem that is *collective* and therefore much more manageable.

Schizoanalysis does not ask for specific outcomes, but urges to produce a constellation of new insights, which means the methodology can itself become problematised through its practice. Yet this makes schizoanalysis vague, complex, and maybe still too wide of a spectrum of possibilities. Some clear boundaries should be defined in the research to protect myself from getting lost.

Overall, the course offered a summary of what the possibilities for architectural research are. Though, it was unfortunate that most information was either too superficial or repetitive to previous courses. It was essentially the practices of problematisation that have been the most helpful to this research as a strong fundament for further development. In hindsight, this required a period of personal reflection much earlier than my compulsory recovery break.