CORPOREAL	CLINICAL	COLLECTIVE
IN THE TERRITORIES OF...		
SCHIZ	SCHIZOID	SCHIZOPHRENIA
DEFENSE	DISORDER	DECAY
FEELINGS	FLASHBACKS	FRAGMENTS
CUT	CURE	CITY
POISON	PRESCRIPTION	PLANE

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ANTONIN ARTAUD

VINCENT VAN GOGH

READER'S GUIDE

LEGEND

MASTER OF
ARCHITECTURE
AND THE BUILT
ENVIRONMENT

EXPLORE LAB
JANUARY 2022

REMKE SEYBEN

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OF TECHNOLOGY

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LEGEND

P1 P2 P3 P4 P5

H0 H1 H2 H3 H4 H5

A0 A1 A2 A3 A4 A5

M0 M1 M2 M3 M4 M5

U0 U1 U2 U3 U4 U5

T0 T1 T2 T3 T4 T5

F0 F1 F2 F3 F4 F5

C

I realised that, out of the whole spectrum of my dysregulated emotions, it was rage that became the catalyst for making this graduation project. It is a rage fueled by the disregard society has for those suffering from mental health problems, that see themselves more represented in their surroundings, but painfully are still subjected to the structural harm of psychological and psychiatric institutions.

As much as we think the times of lobotomies are far behind us, the idea that the mentally “insane” should either be contained, removed from society, or cured to a level of “normalcy” is still engraved in general clinical practices. A cure can be offered, if that cure only asks improvement from the insane person, not society itself.

Ironically, I am a mentally ill not because of genetics, but because of the environments that I grew up in. Though my “Self” is continuously split into either a member of society or a clinical entity. Maybe I am not dissociating as much as society dissociates mental problems from the public sphere, when it is the same society that has produced many of the mental dysfunctions in the first place.

Yet as an individual writing my thesis, there is unfortunately not much I can do, other than to redirect my rage of sanism towards a mode of creative expression. By doing this, I am not pleading for more mental health awareness, I am advocating for a radical integration of mental illness into the built environment.

ANTONIN ARTAUD

Antonin Artaud offered a radical stance on art and mental illness in his critical essay “Van Gogh, le Suicidé de la Société”[1] on society’s treatment of the mentally ill, pointing out modern psychoanalysis as money-machine and the mistreatment of Van Gogh that, according to him, drove him to his suicide.

The theatremaker, writer, poet, artist, and sufferer from schizophrenia, probably felt a lot of empathy towards Van Gogh’s situation as institutionalised person, as he himself was also stripped of his being by the literary world he engaged with. “[They] either say Artaud does not belong to literature because he is schizophrenic, or since he belongs to literature, he is not schizophrenic.”[2]

But, by thinking of schizophrenia as puerile condition that excludes someone from literature, these critics themselves have developed a neuroticism. Yet this devision suits them, if that means they get to apply the novelties of his creative work, while keeping the insane person distanced from their territories. Mental institutions are kept in place, but allow craziness to evolve under the excuse of artistry for the “normal” people to enjoy. Who are the crazy ones?

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1 Artaud, Antonin, Van Gogh: *Le Suicidé de la Société*, (Paris: K, 1947).

2 Deleuze, Gilles, and Guattari Félix, *Anti-Oedipus: Capitalism and Schizophrenia*, (Minneapolis, Minnesota: University of Minnesota Press, 1983), 133-6.

VINCENT VAN GOGH

"…I will no longer put up with hearing someone say to me, as has so often happened, 'Monsieur Artaud, you are raving', without committing a crime.
Van Gogh heard this said to him.
And this is why that knot of blood which killed him twisted itself around his throat."[3]

Van Gogh during his life was not treated as full human, which is surprising to consider when we now know about the insane prices for which his artworks are sold. This paranoid fixation on the values of his work were in denial of his human integrity. It was either Van Gogh the psychotic, or Van Gogh the painter.

Society let Van Gogh's revolutionary perspectives break the rules of the art world, but simultaneously let him down by subjecting his being to the institutions of psychiatry. His work was an attack on insitutional conformism (Artaud, 1987, p. 8), but that revolutionary potential was not welcomed in his being of psychotic man, subjected to psychiatric practices of confinement and reduction of affect.

Society abandoned him by not really listening, not really allowing his mental capacities to flow as much as his paint. What's left of his mental suffering is a romanticised narrative of Van Gogh's life that is exhausted by museums and books, when they should've listened to the exhausted man himself, who saw no other way out then to kill himself.

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3 Artaud, *Le Suicidé.*

READER'S GUIDE

This work, as product of my masters graduation in architecture, is not conforming to normal standards of theses, architecture reports or analyses. This work is a combination of text, image, and design, through a diagrammatic mapping that the reader itself can engage in. A work like this I do not consider a product, but a productive process in itself.

Every segment consists of five small texts, all offering an exploration of three territories on the subject, followed by a deterritorialised perspective, and a reterritorialising conclusion.

1. corporeal
2. clinical
3. collective
4. deterritorialisation
5. reterritorialisation

This exploration will be repeated for the following chapters:

A. "prologue"
B. health
C. anti-method
D. machinic phylum
E. existential territories
F. material, energetic, semiotic flows
G. "conclusion"

The numbering of the texts offers a reading order, but does not have to be read as such. Various combinations of texts, referential anecdotes and diagrams can be combined per text. On the sidebar of every page, recommendations are given on which fragments to combine, but readers are encouraged to combine their own assemblages.

THE PROBLEM OF (CORPOREAL) HEALTH

Both my physical and mental health have always been a prevalent problem in my personal circumstances. We all have problems with our health to some degree, whether that be our own or someone else's. It is such an essential part of life to question the conditions of our health, since good health is a desireable state. During this graduation project, I was confronted with a problem of health, through the expression of tinnitus; ringing in the ear.

At the time, this sign of my body came out of blue, as much as it did for doctors and specialists, who diagnosed my hearing organ to be in perfect shape. That did not take away that tinnitus is an obvious sign of some kind of health problem, even when its corporeal mechanisms for suddenly developing where not so obvious. Health—or the lack there of—is reflected through our bodies, the mental and physical conditions of our being human. Though that does not mean one is skilled to associate the signs the body produces to what produced them in the first place.

With no corporeal answer to my development of tinnitus– while still being subjected to its ringing–the reading of my body's signs becomes not just a personal matter, but a critical exploration of a corporeal de-association. This dissection of corporeal signs is a literal work in progress, that problematises my health, through the mental process that is actively keeping me away from knowing what is going on.

H1

THE PROBLEM OF (CLINICAL) HEALTH

In 2017, I got diagnosed with Complex PTSD. Actually, I diagnosed myself, because no psychiatric institution was willing to acknowledge I have it, despite fitting all the symptoms. My clinical health was instead defined through the Diagnostic and Statistical Manual of Mental Disorders (DSM-V), which does not include Complex Posttraumatic Stress Disorder, but instead read the signs of General Anxiety Disorder, Depressive Disorder, and Post Traumatic Stress Disorder.

Until today, Complex PTSD is an informal and incomplete mental concept that is attributed to those that have endured multiple interpersonal trauma's over extended periods of time, often being the catalyst for dissociative disorders and personality disorders. Complex PTSD is a disorder all about abusive context, that produces mental dysfunctions according to the survivors prolonged coping mechanisms.

Yet psychiatry and psychology, that treat those who become rejected from societal norms, consider themselves to be separate from any context. In Freudian tradition, new kinds of innovation and research are often reduced to a problem of the individual, considering only the representational father and mother as psychological influence.

Can a dissociative person be cured by an institution that dissociates from the milieu it tries to cure? Can actual treatment be found from the hands of mental health practitioners that refuse to recognise the systemic repression of the clinical territory?

THE PROBLEM OF (COLLECTIVE) HEALTH

The problem of collective health has achieved more awareness than ever due to the Covid-19 pandemic. Over the entire world, societies have experienced anxiety, alienation, depression and emotional repression by the limitations of daily public and private life. However, these symptoms are not new to us, but merely symptoms of an economy intensified through a global crisis.

Form a Marxist perspective, the health of the working class is defined by their productivity and consumerism, that does not rely on their knowledge of their sensory-motor-schema's, but their fragmentation through automatisation and individualisation. Through a capitalist lense, as "[w]e not only lose our know-how, but also our knowing-how-to-live-well."[4]

As a collective we are subjected to capital-induced bodily, emotional and sexual repression, that causes the signs of illness, but are simultaneously pathologised for it. Poor health is defined through a personal lense, when in fact a symptomatology of a system should be read from the body of capital itself.

The built environment is one of the physical bodies of capital that can express the disorganised, desocialed and desymbolised effect of capitalism through mostly 'neat and orderly', but often precarious, fragile, commercial contemporary architecture.[5] That only leaves to wonder how humans can still associate themselves to their alienating habitats.[6]

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4 Bernard Stiegler, "Memory,"ed. W. Mitchell and Mark Hansen. *Critical Terms for Media Studies*, (2010), 68, https://warwick.ac.uk/fac/arts/english/currentstudents/undergraduate/modules/literaturetheoryandtime/ltt._steiglermemory.pdf.

5 Stiegler, "Memory," 82

6 Bruce Bégout, "Ruins in reverse," Switch on Paper, March 30, 2018, 1, https://www.switchonpaper.com/wp-content/uploads/2018/03/Ruins-in-reverse.pdf.

THE THREE SYNTHESES CONSTITUTING THE UNCONSCIOUS

According to philosopher Gilles Deleuze and psychoanalyst Félix Guattari, there are three syntheses that constitute the transcendental conditions of the immanent human unconscious.[7]

As human beings, we are not closed biological systems, but require a constant exchange of flows with our milieus. The body needs a precedent of desiring-production between organs: the connective synthesis. The process is feeding from its desires-produced and connections-made and therefore inscribes itself on the body to provide the system with points of reference for guidance: the disjunctive synthesis of recording. What is left are rest-products–anxiety, pain, tension–to be released through the conjunctive synthesis of consummation, a kind of self-fulfillment to reboot the reproductive process.[8]

Although these describe the transcendental conditions of the human unconscious, Deleuze and Guattari consider the mind to be immanent. Therefore in *Anti-Oedipus* they critique modern psychoanalysis on its repression of the immanent processes by the Oedipus complex.[9] However, they also use it to argument how capitalist existence, the body of capital we live under, subjects to the same conditions. Capital is not transcendental either–breaking with modern economic theories–but a system that connects its organs through labour, disjuncts itself through money and lets consumers enjoy its conjunction.[10]

The man-made body of capital and the biological body of a human are not so different after all. The man-nature dichotomy is in the past when we realise that technology is as much an organological machine as our own bodies. When I suffer from signs of dissociation, that does not mean my problem is reduced to my insides.

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7 *AO*, 22-35.

8 Ibid, 106-112.

9 Ibid, 22-35.

10 Ibid, 240-261.

PROBLEMATISATION

In the three territories of the corporeal, the clinical, and the collective, signs of disconnection, detachment, dissolution are overlooked by the disregard of the territorial bodies governing them. There is a mechanism at work that dis-associates from the conditions in the milieu that cause the precedents for a mode of bad health. But to resolve these symptoms in each their own territory does not use the full potential of the processes at hand.

Instead, these signs need to be resolved through a non-representational perspective that considers their immanence as unconscious processes. Health is not just a state to strive for, but "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." Health therefore implies a practice, insofar signs imply ways of living, forms of life.[11]

The paradox of health is that what is considered pathological is constantly influencing the concept of health itself, "making 'poor health' become the very condition for great health."[12] That is why a clinical concept of dissociation can be critically operated to overcome its affective problematic. As an architecture student, I am not resorted to a split being of either patient or architect. I can become a physician, a *care*-taker[13], by rethinking the relation between bodies and clinical signs through the revolutionary force of architecture.

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11 Daniel Smith, "Critical, Clinical," Essay, in Gilles Deleuze: Key Concepts, ed. Charles J. Stivale, 2nd ed. (Durham: Acumen, 2011), 212.

12 Andrej Radman and Heidi Sohn, "The Four Domains of the Plane of Consistency," Essay, in Critical and Clinical Cartographies: Architecture, Robotics, Medicine, Philosophy, ed. Andrej Radman and Heidi Sohn, (Edinburgh: Edinburgh University Press, 2017), 2.

13 Ibid, 3.

SCHIZ

The “schiz” of schizophrenia describes the tendency of the disorder to break from reality, referring to the schizophrenic’s interpretation of signs from its milieu. Signifying elements such as words, images, expressions, convey information that through a schizophrenic lense can either make hardly any sense (schizophrenic), or make too much sense (paranoiac). Both ends of the spectrum depict either extreme attachment or detachment from milieu-given information. However, by the chaotic nature of our own milieus, everyone experiences the misinterpretation of signs to some degree, making schizophrenic-paranoiac tendencies common corporeal experiences.

Dissociation as a mental process is the disconnection from one’s thoughts, feelings, memories or sense of identity as the result of a misinterpretation of trauma-related signs. The process has a schiz tendency to break from one’s corporeal reality in an attempt to protect the body from a harm that is not present. This makes a person with dissociation break from the Self, from others, from their environment, and their corporeal entity.

Having to deal with dissociation on a daily basis, I am not schizophrenic.Though this process produces schizophrenic experiences, which does not say anything about severity or suffering, but rather frame the “schiz” as more than a break(down). It is a limit of understanding, a limit that can be expanded for those that explore outside of the deviant norms of understanding.

SCHIZOID

The body keeps the score of traumatising events. Dr. Van der Kolk, who wrote a book on exactly this new neurological understanding of trauma, described how during his time as research attendant at a psychiatric hospital in the sixties, he noticed a certain pattern among the young people who had suffered a first mental breakdown diagnosed as schizophrenia.[14]

When symptoms of dissociation, catatonia and autism[15] are taken out of context, they have 'schizoid', schizophrenia-like, characteristics. Ironically, this becomes the problem when diagnosing Complex PTSD, a disorder that is all about context, an abusive and neglectful context that was denied, repressed, or normalised. Not just the sufferer dissociates from the harm, the perpetrators and witnesses do too.

When Sigmund Freud treated female patients who were abused over longer periods of time, he ignored the context of the bourgeois men that had inflincted the trauma, in favour of his theory of female hysteria. Freud tended to treat schizophrenics just as bad, by calling their resistance to being Oedipalised (a triangulation of mommy-daddy-me), "undesireable".[16] "Detachment from reality" then becomes a very subjective description of a symptom.

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14 Bessel A. Van der Kolk, *The Body Keeps the Score: Brain, Mind, and Body in the Healing of Trauma*. (New York: Penguin Books, 2015), 15-6.

15 *AO*, 23.

16 *Ibid*, 23.

SCHIZOPHRENIA

People who suffer from schizophrenia experience an abnormal reality that to them is shaped–or rather, unshaped–by the signs we structure our worldly understanding with. We are consciously and unconsciously aware that fields of information are related to certain levels of territories–how global conflicts have probably no correlation to my ringing ear. For the schizophrenic body, information becomes an assemblage of relations that don't make sense to us. The schizophrenic experiences no limit to the relations it can make, which can become overwhelming and lead to psychotic breakdowns.[17]

In clinical settings the disorder is described by symptoms that are productive of these breakdown and result in hospitalisation. But if we look at the immanent mechanism of schizophrenia, a constant destruction of relations, a web of break-flows, this could also have the potential for a breakthrough.[18]

This process is not alien to a collective experience, when we are alle subjected to the tides of breakdown and breakthrough of our economical system.[19] Capitalism is productive of sustaining its own conditions through a constant re-evaluation of limits and keeping as many break-flow relations in place, having quite the schizophrenic tendencies. Then, the question is not what schizophrenia actually is defined as, but instead what it does for us.

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17 Gregory Bateson, "Epidemiology of a Schizophrenia," essay, in Steps to an Ecology of Mind: Collected Essays in Anthropology, Psychiatry, Evolution and Epistemology (Northvale, NJ: Jason Aronson, 1987), 199.

18 Edmund Berger, "How Does Schizoanalysis Work? or, 'How Do You Make a Class Operate like a Work of Art,'" Deterritorial Investigations, May 17, 2013, https://deterritorialinvestigations.wordpress.com/2013/05/15/how-does-schizoanalysis-work-or-how-do-you-make-a-class-operate-like-a-work-of-art/.

19 Kingsmith, "High Anxiety."

SCHIZOANALYSIS

Deleuze and Guattari, in their collaborative work Anti-Oedipus[20], look at schizophrenia as a process of the immanent machinic unconsciousness that can be dissected to its transcendental material conditions of the machinic organs, the body minus all its organs (the Body without Organs), and the intensities between these two poles, productive of the various forms of schizophrenia.[21]

Deleuze and Guattari take the schizophrenic out of its medical context to work with its emancipatory potential—"the ability to constantly break free from the dominant emotional controls" [22]—to locate its machinic flows and breaks in the social and let go of representations, a practice they call schizoanalysis. This means that new non-dogmatic theories about our experiences should be produced, the systemic nature of our experiences recognised, our emotions transformed, and our creative voices expressed, in order to experience the health improvement from affective constraints.[23]

If the territories of economy and psychology can have similar processes, schizophrenia as process has the potential to deconstruct territorial limitations. 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.[24] Schizoanalysis is therefore an anti-methodological approach, by its freeing of desire as revolutionary force from a presupposed methodological application.

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20 *AO*, 75.

21 Smith, "Critical, clinical," 210.

22 Kingsmith, "High Anxiety."

23 Ibid.

24 *AO*, 108.

SCHIZOCARTOGRAPHY

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 newLY found connections to a rhizome of knowledge, that offers a radically creative understanding of semiotic and subjective productions[25], 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 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.[26] The diagram should not be read as a separative analysis, but as a materialist "cartography, meant to render visible a condition 'that changes itself with the conditioned and determines itself in each case along with what it determines'."[27]

The schizophrenic patient who is asked to help in the kitchen of the psychiatric clinic he stays in, happens to not use the general knowledge (Phi) of how a kitchen should be used. Instead, the aesthetic images of pots, pans, tiles, and cabinets she affords to perform an opera (U) in the territorial cut-out of the clinic's kitchen (T). Dough, words, spoons, music, screams and other patients flow through the space to express the spectacle. Not just this kitchen, but every kitchen from now on, has found a new understanding as theatre (Phi).[28]

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25 Félix Guattari, "The Schizoanalyses," essay, in: Soft Subversions: Texts and Interviews 1977-1985, ed. Lotringer Sylvère, trans. Chet Wiener and Emily Wittman (Los Angeles , CA: Semiotext(e), 2009), 204–28.

26 Guattari, "Schizoanalyses," 218; Radman and Sohn, "Four Domains," 4-10.

27 Radman & Sohn, "The Four Domains", 4.

28 Edmund Berger, "How Does Schizoanalysis Work?"

DEFENSE

When a mammal body is threathened by environmental factors, the Autonomic Nervous System (ANS) has a couple mechanisms in place that adress the right organs for the required response. The ANS is devided into the two branches of the sympathic and parasympathic nervous system. When danger is perceived, the emotional brain activates the sympathethic nervous system to either fight the danger, or flight the situation. Social or psychological threats have sympathic ANS responses through the tactics of freeze or fawn, that tap into the parasympathetic nervous system, also responsible for resting, digesting, and social interaction.

These four unconscious mechanisms are in place to make sure the body's integrity is protected and returned to a state of safety after the life threathening event. However, the body can get stuck in such responses, even when safety is re-established, but not directly experienced: the body has developed psychological trauma.[29]

But what if safety cannot be re-established? Defense mechanisms fall short when traumatypical upheavals are prolonged, interpersonal, and constitutive of a structural abusive environment. When constant (re-)traumatisations don't find resolution through one of the body's responses, the mind has no other option but to disengage from experience through disconnected perception, emotion and affect. Traumatisations can become complex relations in the victims milieu, structurally stopping the subject to associate with its milieu, even in safe conditions, through a continuous detachment from reality: dissociation.

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29 Pete Walker, *Complex PTSD: From Surviving to Thriving*, (CreateSpace Independent Publishing Platform, 2013) 29.

DISORDER

In clinical psychology, someone is considered to have a psychological disorder when a systemic behaviour, emotion, and thought have become an ongoing dysfunctional pattern. What is defined as dysregulation is depending on that person's culture or society. But relatively speaking, this means that the clinical world sets the limits for what is considered a mental illness.[30]

These limits are regulated through the DSM-V, the handbook for psychotherapeutic practitioners that provides lists of symptoms with rules and conditions for diagnosing. In contrast to medicine, concepts of illnesses are merely concepts developed by judgements, instead of having actual etiological groundings, making the practice of diagnosing mental illnesses as close to medicine as it is to philosophy.[31]

For those that suffer from childhood trauma, it means that they cannot be diagnosed and therefore treated for their symptoms, because of the regulations around PTSD that say that "your trauma is not physical, life threathening, or bad enough.", even though scientific developments have shown that the disorder is not a result of the events itself, but the conditions for returning to safety.[32]

With diagnosing being a clinical practice that is merely judgement based, the DSM-V could be considered a work of fiction, that keeps its distance to the material conditions of mental health. The denial of Complex PTSD from clinical practices is maybe one of the best examples of the structural dissociation in the clinical world it can not recognise from itself.

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30 Thomas S. Szasz, "The Myth of Mental Illness," American Psychologist 15, no. 2 (1960), 113–14, https://doi.org/10.1037/h0046535.

31 Smith, "Critical, clinical," 205.

32 Van der Kolk, *The Body Keeps The Score*.

DECAY

Historically, we have gone through all kinds of traumatisations. Wars, disasters, conflicts end in ongoing physical damage by the loss of bodies, ruination of the built bodies, the dismantlenent of government bodies: material decay. This we can recognise through the process of ruination of our built environement.

In the present day, the Anthropocene, we could consider material decay of the body of the Earth an ongoing process that is descriptive of our time. Ever since the advent of industrial technology by the invention of the steam engine, entropy is characteristic to an all encompassing milieu of material traumatisation that has been normalised.[33]

However, this system of material exhaustion and conflicts within production processes are the conditions under with our economical system moves forward. Over and over and over again, small traumatisations extend the limits of capitalism, deterritorialisng and reterritorialising its mechanisms.

Algorithmic capitalism has established such automised production of anticipations that defensive responses fall short; fight, flight, freeze, fawn, the conditions under which consumers and workers become alienated from their surroundings, are productive of their own agents in destruction.[34]

Decay is the prevelant process of our time, but the materialisation of this decay seems too big to grasp, too far away from individual understandings. We are left with dissociated milieus: industrially disorganized, desocialized and desymbolised spaces that leave consumers alienated from production processes.[35]

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33 Bernard Stiegler, “The Anthropocene and Neganthropology,” esay, in The Neganthropocene, ed. Daniel Ross, (Open Humanities Press, 2018), 39.

34 Stiegler, “Memory,” 69.

35 Stiegler, “Memory.”

DETERRITORIALISATION

The machinic phylum encompasses the knowledge of processes and mechanisms in place, that can be changed only through a deterritorialisation an reterritorialisation of connections made. When deterritorialising, a code of relations is cut from its territorial materialisations, for the code to be reapplied to another territory.

Through the processes of deterritorialisation and reterritorialisation, new relations are not just applied to new territories, like multidisciplinary research, but will add to the general understanding of how processes are built up from its relations, through a transdisciplinary lense. A machinic unconscious can therefore be understood not by just its territorial embedding by through its inherent relations between organs.

To understand the mechanisms in place, the organs are merely materialisations to a core set of relations. Therefore, we are more informed about the workings of processes through their diagrammatic explanation as through their anatomical dissection. To deterritorialise means to recognise the general organology of various territories, but not fixate on the organs themselves.

Dissociation as a mechanism has a territorial limit to understanding, if the process is not deterritorialised to a core of desiring-production. The diagrammatic set of relation that translates the knowledge behind a process is called an abstract machine. By reducing mechanisms to their diagrammatic connective relations, the connective synthesis of desire is completely untied from any material conditions and makes it possible to give insights into potentials to work its problematic.[36]

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36 Erik Werner Petersen, “Design as Seven Steps of De-territorialization,” Nordes: Nordic Design Research, no. 1 (2005), https://archive.nordes.org/index.php/n13/article/view/232.

DIAGNOSIS

The movement of deterritorialisation does not stay in the virtual, but always finds a reterritorialisation through the real. As much as abstract machines inform us about the core mechanisms at work and anticipate on its becomings, territories are where the desiring-production become present.

Reterritorialisation is productive of assemblages that are cartographic, which means that they are not reduced to a diagrammatic, but allow for the vastness of information to explore every corner of its milieu. Cartographies are visual mediums that are productive in themselves, because they open up the potential of connections through being navigated by the observer's desire.

Corporeal defense mechanisms are undiagnosed by its own psyche in the case of corporeal dissociation. In clinical practices this is not much different, as a diagnosis of dissociation is reduced list of judgment-based symptoms. Collectively, we are continuously experiencing the dissociative machine, as being a structurally normalised sign.

Problematising the mechanism of dissociation does not assume that there is something problematic about the process of dissociation itself, but with how diagnosing has been applied. The structural process of detachment, disconnection, and separation is therefore re-diagnosed as the dissociative machine.

Primary retentions, the memories produced by direct experience and perception, can become traumatypical when they cause an upheaval to an existing system of exchange between memories and affect.[37] If traumatisations happen structurally–especially during early childhood, when a coherent personality is not yet formed to deal with such traumatisations–dissociation fragments these primary retentions into new dissociated sub-personalities. Prolonged dissociation results in a structural fragmentation of the personality.[38]

As a result, primary retentions get scattered over a system of dissociated subpersonalities that each individuate around a segment of secondary retentions, the selective or imaginative reactivation of previous experiences.[39] Even though this is true for any human personality, those who have endured long periods of traumatisations express an intensification of this process through conflicting patterns of behaviour and responses, leaving a person to struggle with multiple identities, or none at all. This is possible by the tendency of traumatypical memories to remain fragmented in the brain, in comparison to stereotypical memories that can be integrated and archived according to space and time.

Though, the signs of a fragmented personality often go unnoticed for both the traumatised person and its surroundings, as each sub-personality has developed its own set of behaviours to mask any shortcomings. Dissociation is working when it is goes unnoticed, as its goal is to defend the body from harm by keeping the conscious Self in ignorance of its own memories through a constant splitting of its archived experiences.

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37 Mark B.N. Hansen, “Bernard Stiegler, Philosopher of Desire?” boundary 2 44, no. 1 (February 2017): 167–90. https://doi.org/10.1215/01903659-3725929.

38 Onno van der Hart, , Ellert R. Nijenhuis, and Roger Solomon, “Dissociation of the Personality in Complex Trauma-Related Disorders and EMDR: Theoretical Considerations,” Journal of EMDR Practice and Research 4, no. 2 (May 2010): 77, https://doi.org/10.1891/1933-3196.4.2.76.

39 Hansen, “Stiegler”, 2017.

FLASHBACKS

In the clinical world, trauma is diagnosable by the most significant symptom of flashbacks. These occur when primary retentions[40] are falsy connected to the brain's fragmented secondary retentions. Because their fragmentation, they get mistaken for new primary retentions, conditioning the body to believe that they are reliving a past event. The body unconsciously responses to the virtual threat by activating any of the defense mechanisms, hardly able to calm down because both cues of danger and safety are disorganised.

For those with structurally dissociated personalities, traumatic memories are more embedded into the affect-memory relation, becoming more stereotypical (reinforcing) rather than traumatypical (disruptive) in nature.[41] The emergency break on sympathetic defense mechanisms, dissociation, is therefore only strenghtened in its decision to protect the body from virtual harm. However, this also means that flashbacks are more removed from conscious experience. Flashbacks become only bodily unexplained responses of pure fear, anger or hopelessness, that are more difficult to dissect in relation to the trauma.

From a clinical perspective, flashbacks informs us that dissociation has failed. However, dissociation as a spectrum of intensities is not recognised as inherent process of trauma, but instead reduced to a symptom, only to be considered in the most extreme pathological cases. Those on any other part of the spectrum are diagnosed by their symptomatology (such as Borderline Personality Disorder, Simple PTSD, Major Depressive Disorder, Obsessive Compulsive Disorder, Bipolar Disorder) to receive treatment that hardly manages to go beyond symptom control of the conscious mind.

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40 Hansen, "Stiegler", 2017.

41 Ibid.

FRAGMENTS

Primary and seconary retentions do not stay experiences to the interior of our minds. We have a collective desire to exteriorise these memories into what becomes a tertiary retention: every kind of memory we record through our technologies, such as music, writings, and architectures.[42] Tertiary memory is as much a product as a producer of new primary and secondary retentions. It is our technologies–here specifically our built environment–that has tertiary memories enscribed that influence our affective responses.[43]

In fragments of architectures we can recognise the memory of the past through our sensory-motor-schemas. However, under hyperindustrialisation and algorithmic capitalism, this memory becomes hardly recognsiable through a standardisation of production processes and loss of affect knowledge. Contemporary ruins are often not the result of direct conflicts, but indirect traumatisations of a bigger economical force. They are, just as functioning buildings, grammatised objects; their processes have become discrete elements that are no different than the operating building next to it.[44]

These dissociated milieus brings up a question of agency. What are the acting forces within our built environement? Can the collective still be an agent in change of the environment? Capital is at every level an eerie entity: conjured out of nothing. Yet it exerts more influence than any subject can imagine.[45] The symptomatology of dissociated milieus goes unnoticed, because the traumatising repression is alienated from the collective and keeps the dissociative machine of capitalism in place.

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42 Hansen, “Philosopher of Desire?” 170.

43 Ibid, 181.

44 Bruce Bégout, “Ruins in reverse,” Switch on Paper, March 30, 2018, https://www.switchonpaper.com/wp-content/uploads/2018/03/Ruins-in-reverse.pdf.

45 Mark Fisher, *The Weird and the Eerie*, 4th ed. (London: Watkins Media Limited, 2016), 62-64.

BODY WITHOUT ORGANS

Even in a dissociative body, organs are essentially connecting, but not necessarily producing a production. What is produced is anti-productive, in the sense that it promotes disconnection, detachment, or fragmentation to keep any primary, secondary, and tertiary memories unproductive in relation to eachother, to protect the body from confrontation with self-induced traumatypical upheavals.

Anti-productive dissociative responses produce secondary retentions in themselves, which are again stored as scattered fragments to reinforce the discouragement of any singular individuation. Traumatic memories have become a virtual reservoir that are inserted to cut the process of becoming to one of becoming dissociated. This is the disjunctive synthesis at work, an anti-production that in itself balances productive forces with resistance.[46]

If we were to take a body and remove all its organs, what is left is a deserted in-between, yet all encompassing space that serves as a limit to becoming, an embodiment.[47] This 'Body without Organs'[48] (BwO) is out to resist the body's organological organisation, significance and subjectification. Dissociative mechanisms become dangerous when they retreat the body to modes of being that disregard organological structures around them. The body could become schizo, having an active struggle against the organs, at the price of catatonia. The body could become paranoid, believing that past abusive patterns are continually attacking the organs, at the price of amnesia. The body could become masochistic, inflicting harm to the organs in an attempt to distract from harm, at the price of analgesia.[49]

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46 *AO*, 9-15

47 Radman and Sohn, "The Four Domains," 3.

48 Gilles Deleuze and Félix Guattari, *A Thousand Plateaus* (London: Bloomsbury, 2013), 174-194.

49 Chris L. Smith, "Bodies without Organs and Cities without Architecture," essay, in *Architectural and Urban Reflections after Deleuze and Guattari*, ed. Constantin V. Boundas and Vana Tentokali, (London: Rowman & Littlefield International Ltd, 2018), 88-9.

FATIGUE

If symptoms of dissociation are produced by organs, they can best be described by their anti-productive enscriptions. They become structurally embedded into daily life through the complex insertion of traumatisations into the subject's body, a body that endlessly fragments itself in expression in order to survive[50].

Dissociative symptoms of catatonia, analgesia and amnesia are all the product of resistance to disruptive connections between primary and secondary retentions. The symptoms are not produced by the connections between organs, but instead are effects of the repulsions of desire, affect, and memory.

The symptomatology of dissociation is therefore best described as anti-production, that constitutes eerie feelings of detachment, disconnections, and disruptions. These expressions are not recognised through an aesthetic image, since traumatic affect cannot be recognised through for instance the materialisation of scars, since dissociation has made sure to limit any production of (mental) scar tissue.

Limiting dissociation to a description of corporeal symptoms can only lead to self-fulfilling symptoms[51] that become confirmations for clinical systems in place. Instead, we should be welcoming reorganisation–reterritorialisations–of symptomatology by recognising the anti-productive nature of traumatic disjunction. Philosophical concepts such as the Body without Organs are as much symptomatological judgments as the clinical concepts mentally disorder people are subjected to.[52]

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50 Bessel Van der Kolk, *The Body Keeps the Score*.

51 Guattari, "Schizoanalyses," 216.

52 Smith, "Critical, clinical," 205.

CUT

In dissociative states, either during traumatypical events or reproductions (secondary retentions) of them, the corporeal body has various ways to cut off the disrupting effects. The analgesic body cuts off primary retentions, the amnesic body cuts off secondary memories, the catatonic body cuts off affective responses.

However, these cuts are not always enough to keep traumatypical upheavals from disturbing the system, meaning that a dissociated body can be stuck in both repression and desire to respond to threat. In these situations the body's active defense mechanisms are in overdrive towards the passive dissociative feedback loop. In safe conditions however, no fitting exteriorisation can be found for this kind of active response. Dissociative patterns are produced as overrulers by redirecting the tension inwards, inflicting the affective responses on the body itself, through automutilation, suicidal ideation or self (re-)traumatisations.

Why would a body want to hurt itself even more? A dissociative personality tries to hold on to its own singularisation as a precedent for safety, which means that control of the process is found in the existing rhythms of trauma and fragmentation. These habits of complex traumatised people are not just consummations of their dissociative mechanisms, but therapeutic practices in an attempt to restore the neurochemical balance of the psyche. A desire to harm one's own organs, organism or psyche, the desire for a cut, should not be reduced to a "bad habit", when they are inherent attempts at expression. Dissociation as a repulsive mechanism cannot be understood without its counter acts of extreme exteriorisations.

CURE

A common misunderstanding of Complex PTSD is that there is merely a concious cognitive pattern at fault, marking the mind as "ill" and reducing the body to a mere messenger of symptoms, rather than inherent territory of the problem.

However, clinical practices of the ambulant care or psychiatric clinics designed to withdraw the mentally ill person from society not just by their locations, but through their interiorisation that is characterised as white, dim and plain as well. In here, patients are expected to find a "cure" in conditions that dissociate them from any of their affective responses. They become reduced to the problematic in the room, when they are still members of society.

Complex PTSD is as much a psychological as it is a physical problem. The clinical settings provided have a habit of repulsion to new individuations, rather than offer potentials for corporeal experiences. Therefore to problematise a mentally ill person should not be done through itself, but through the institution.[53] Instead of neurotically enforcing a generalised system of schematic therapies, it would be less risky to think about the material qualities of the clinical territory's expression.[54] The body of the clinical is as important as the mind of the institute. There is no cure in repression, neither for dissociation or complex ptsd in general. The only cure is to change the environment.[55]

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53 Susana Calo and Godofredo Pereira. "CERFI: From the Hospital to the City," (London Journal of Critical Thought 1, no. 2, 2017), 83–100. https://doi.org/ISSN 2398 - 662X.

54 Guattari, "Schizoanalyses," 217.

55 Cynthia Cruz, "Asylum," Commune, July 29, 2019, https://communemag.com/asylum/.

Those that have gone through clinical trajectories, have always encountered the moment when one is pushed back onto the streets. When you are discharged from the clinic, when a session time is over, when health insurance cannot cover your treatment anymore, there is a degree of urban intensities everyone needs to reallign themselves to.

The city has a machinic unconscious of its own, distinct from that of its inhabitants. The city is often linked to a sense of disconnection, because in the vastness of its interconnectedness, we can feel detached.The city has many infrastructural networks in place however to connect and disconnect its users, such as highways, bicycle lanes, sidewalks, subways, escalators, elevators, trains, any arrow in the ground. By simply moving through these systems, a lone inhabitant is still subjected to a collective rhythm of patterns that are automated, yet open. Even when movement is not desired, connections are enforced through a web of endless potentialities on a plateau of intensities.[56]

The unconcious collective of the city is produced by the similar, shared habits of our dissociated movements through the same dissociated milieus. At the level of the lone subject, the city is not just the reflection of its dissociative movements, but a milieu constitutive of both its repulsion and attraction to the collective; it is productive of a habit.[57]

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56 Andrew Ballantyne, “Schizoanalytic City,” essay, in Architectural and Urban Reflections after Deleuze and Guattari, ed. Constantin V. Boundas and Vana Tentokali (London: Rowman & Littlefield International Ltd, 2018), 36.

57 Combes, Muriel. “The Transindividual Relation.” Essay. In Gilbert Simondon and the Philosophy of the Transindividual, trans.Thomas LaMarre (MIT Press, 2013), 34.

The two poles of machinic organs and the BwO have their relation expressed in intensities: either as repulsion or attraction. It is this conjunctive synthesis that explains that a dissociative machine of mainly repulsive habits, is always in relation to something that is attracting: the tension, stress or anxiety it tries to defend the body from.[58]

Dissociation is in itself not inherently bad, but becomes an undesireable when producing a habit that is unbalanced to its attracting opposite system. This attractive intensity is a contraction of a future step, whereas the repulsion is a retention of past events. What is then produced happens in the present moment of repetition: an unbalanced habit of dissociation. An ongoing rhythm of retentional dissociation as habitual response to anxious attraction happens passively in the unconscious. Acting upon these habits makes the conjunctive synthesis unrecognisable, because the consummation of expression is watered down by the repitition.[59]

We are informed about the process when there is hesitancy by the system to act, when the habit fails[60]. In this delayed moment, conscious perception comes in. These moments can be produced by a caesura, a gap in time that distributes a retention of the past and the affective response towards the future. This cut refers to a symbolic event, a moment in which new information can enter the unconscious and is experiences through the experience of sudden recognition: ‘aha![61]

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58 Smith, “Critical, Clinical,” 211.

59 Tano Posteraro, “Habits, Nothing But Habits: Biological Time in Deleuze,” The Comparatist 40 (October 2016): 94–110, https://doi.org/10.1353/com.2016.0005.

60 Alia Al-Saji, “The Memory of Another Past: Bergson, Deleuze and a New Theory of Time,” Continental Philosophy Review 37, no. 2 (2004): 203–39, https://doi.org/10.1007/s11007-005-5560-5.

61 Daniela Voss, “Deleuze’s Third Synthesis of Time,” Deleuze Studies 7, no. 2 (2013): 199–206, https://doi.org/10.3366/dls.2013.0102.

COLLECTIVE

Complex trauma can be considered a habit of dissociation that nests itself into deep fragmented patterns and only inform us of it presence when the habits is interrupted in time. Affective responses such as anxiety, tension, or hesitation, are the consummations that show that the conjunctive synthesis is at work in these situations.

Through a clinical lense, these responses are understood as products of unconscious syntheses, yet are threated by therapies that try to minimise their frequency in clinical settings that repress any possibility to [oproepen] these affects. These cuts, schizzed, limits, gaps, or caesuras are what brings a subject to either breakdown or breakthrough of their own internal psyche. What makes the difference is if the tension can find a resolution through an exterior space.[62]

There is a membrane between interior and exterior, where the cuts are located, that make the difference between interior therapeutic dissociation of traumatised conditions, or external therapeutic practices of collective safety. The territory of the city already offers a plateau of intensities in which a lone dissociative individual can find resolution by recognising her own dissociative habits, through the lense of the collective experience.[63] Territories then become therapeutic, through an urban materialisation of the membrane.

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62 Anne Sauvagnargues and Jon Roffe, “Crystals and Membranes: Individuation and Temporality,” essay, in Gilbert Simondon: Being and Technology, ed. Alex Murray, Ashley Woodward, Arne De Boever, and Jon Roffe, (Edinburgh: Edinburgh Univ. Press, 2014), 57–72.

63 Combes, “Transindividual Relation,” 42.

POISON

The dissociative machine of my corporeal entity regulates the extreme exteriorisiations of defense mechanisms. Neurotransmitters are the messagers, produced in the brain to inform the mind what should be done to keep this system working. There is an opiod release when hurting, a dopamine release when indulging, a serotonin release when remembering good things. Those flows can become as addictive as drugs, but can also be therapeutic, like drugs.

To a dissociative body, primary and secondary retentions are like toxins, conveying a message of danger that causes disturbance to the system. So to keep a balance in place, I did not experience, remember, or act as much. That balance was, however, disrupted through a sign of tinnitus and the accompanying intuition that there was more going on than just tinnitus.

I was offered a new chemical balance through SSRI's, also known as anti-depressants, prescribed by my psychiatrist to provide not a cure, but a new conditioning to a brain that heavily relied on unproductive patterns. Sertraline provided that the neurotransitter serotonin was longer in use, which acted like a translator for my unconscious body's responses, providing me the right information in a carefully dosed manner.

I had a traumatic event happen to me that I did not know of for over a year. After years of therapy I thought I could be cured from all my dissociative patterns since childhood. But this was a hard realisation that the dissociative system in place that helped me survive my earlier traumatisations, provided the same conditions that brought me into a new traumatic experience. Dissociation is both an antidote and a venom.

PRESCRIPTION

Selective Serotonine Reuptake Inhibitors (SSRI's) are not pills that make you happy. Happiness–whatever that may mean–is an effect of certain behaviour. Anti-depressant medicine cannot change behavioural patterns single-handedly, but relies on establishing a new balance of serotonin in the brain, that set the conditions for new therapeutic habits. An SSRI is a technology that as a mechanism provides a break to the reuptake of serotonin, ultimately helping with depressive feelings, but simultaneously making make the brain become dependant on its usage.

Addiction is a mode of becoming, a habit, that is dependent from a certain stream of flows, however is always framed through a political, social and economical lense by clinical practices. The hypocritical pharmacological world has set its own restrictions to define who are addicts and who are not, when in fact, we all are.

Clinical institutions have the ability to reject those who suffer from trauma on the basis of them being addicted to an illegal substance as well. Hypocritically, they are the same institutions that won't acknowledge the systemic traumatisations the patients often deal with. An addict cannot be defined by its dependency of certain flows, rather it should be problematised what made them surpass the limits of its intoxication.[64] The pharmacological question is not one of value, but one of dosage.

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64 Bateson, Gregory, "The Cybernetics of 'Self': A Theory of Alcoholism," essay, in Steps to an Ecology of Mind: Collected Essays in Anthropology, Psychiatry, Evolution and Epistemology (Northvale, NJ: Jason Aronson, 1987), 315–44.

Medicine is not limited to what a pharmacy has to offer, a medicine is a set of conditions that offers the fertile ground for a rhythm of therapeutic habits. On a collective level, there are many rituals we participate in that are intentionally or unconsciously that set provide a framework of conditions to encourage or discourage certain practices. The functionalities of buildings, both from their interior and exterior, are material conditions to all kinds of collective experiences, such as raving, dancing, skating, watching sports, praying, drinking, socialising etc.[65]

For the sake of collective health, these material conditions of city life are also limited from overindulgence through the usage that is afforded. In the built environment, the structures that provides spaces for rituals are encompassed by a liminal space of transitions. Liminality is the intermediate state of an in-between condition (the cut between one architecture to another) in which the liminal entity is both separated from and part of the spaces is connect.

Liminality is habitual, not just because of the rhythms of people through them that use spaces, but through the conscious and unconscious collision of memory, values, and intentions. They are dissociative, but specifically because they inheret an associative quality as well. By being a transitional space, the material conditions bring a discontinuity, a cut or break, to the simultaneous shaping of urban flows.[66]

Prescribing the right dosage of architectural liminality through material conditions, means that the design of liminal spaces is a pharmacological practice. More importantly, the dissociated architectures of the city can become medicine through a rethinking of their conditions.

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65 Stiegler, “Neganthropology”, 35

66 Patrick Troy Zimmerman, Liminal Space in Architecture: Threshold and Transition, thesis, Tennessee Research and Creative Exchange, 2008, 5, https://trace.tennessee.edu/utk_gradthes/453.

PHARMAKON

In the clinical field, dissociation is always considered a symptom that needs to be overcome, a kind of poisonous condition to the system. But for a body that tries to defend itself, it is a medicinal practice. However, dissociation is not a condition, but a habitual mechanism that is constitutive a material conditioning based on a a traumatypical milieu. This does not mean that dissociation is a state of being that should be maintained, but instead says something about how treatment can be applied through the usage of the mechanism itself.

The material conditions that are produced by the dissociative machine, regulate the breaks in flows between organs to maintain an equilibrium. The effects of these conditions are defined by their limits, the dosage of cuts, which makes them a pharmakon: both a poision and a remedy.

The mode of relations that are essential to the dissociative machine can only be discovered through an ordeal of solitude, as working the dissociative machine is an individual endeavour. Paradoxically, this detached experience can only find its resolution of tension through the collective milieu, by the recognition of its own dissociative conditioning through the material limits of the technical environment.[67]

Architecture, a type of technics that has proven to relate as much to the individual as the collective individuation[68], can become a medicine for dissociation through a (re-)production of dissociative conditions.

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67 Combes, “Transindividual Relation,” 33-38.

68 Hansen, “Stiegler”, 183.

ACU-PUNCTURE

Material, energetic, and semiotic flows are conditions that can be redirected through technologies to either result in a poison, or a remedy to an ill system. These flows cannot be defined in their effect without their cut-outs, neither can the cuts (real or virtual) be productive without the constant flux of change that moves through them.

Architecture is here considered as pharmakon, that carries new possibilities of psychic and collective individuations. It requires therapeutic prescriptions to become medicinal, materialised by urban practices of care.[69] Liminal or transitional spaces, where habit, cuts and flows intersect in their highest intensities, are where the architectural dosage is defined.

The corporeal dissociative machine has produced the internal material conditions that offered medicinal qualities to keep its processes intact. For the mechanism of dissociation to step outside of its interiority–to find resolution in the collective territory[70]–architecture should not just reflect the dissociative process, but allow an intensification of dissociative conditions, to always be in proximity to corporeal experiences.

Architecture therefore becomes the practice of acupuncture, where the careful pinpointing of transitional knots through a therapeutic placement of needles that are discrete in gesture, are open to a vast network of urban potentials.

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69 Stiegler, “Neganthropology”, 35.

70 Combes, “Transindividual Relation.”

BIBLIOGRAPHY

Al-Saji, Alia. “The Memory of Another Past: Bergson, Deleuze and a New Theory of Time.” *Continental Philosophy Review* 37, no. 2 (2004): 203–39. https://doi.org/10.1007/s11007-005-5560-5.

American Psychiatric Association. *Diagnostic and Statistical Manual of Mental Disorders: DSM-5*. 5th ed. Washington, DC: American Psychiatric Publishing, 2013.

Artaud, Antonin. Van Gogh: *Le Suicidé de la Société*. Paris: K, 1947.

Ballantyne, Andrew. “Schizoanalytic City.” Essay. In *Architectural and Urban Reflections after Deleuze and Guattari*, edited by Constantin V. Boundas and Vana Tentokali, 29–44. London: Rowman & Littlefield International Ltd, 2018.

Bateson, Gregory. “The Cybernetics of ‘Self’: A Theory of Alcoholism.” Essay. In *Steps to an Ecology of Mind: Collected Essays in Anthropology, Psychiatry, Evolution and Epistemology*, 315–44. Northvale, NJ: Jason Aronson, 1987.

Bateson, Gregory. “Epidemiology of a Schizophrenia.” Essay. In *Steps to an Ecology of Mind: Collected Essays in Anthropology, Psychiatry, Evolution and Epistemology* (Northvale, NJ: Jason Aronson, 1987), 199-204.

Bégout, Bruce. “Ruins in reverse.” Switch on Paper, March 30, 2018. https://www.switchonpaper.com/wp-content/uploads/2018/03/Ruins-in-reverse.pdf.

Berger, Edmund. “How Does Schizoanalysis Work? or, ‘How Do You Make a Class Operate like a Work of Art.’” Deterritorial Investigations, May 17, 2013. https://deterritorialinvestigations.wordpress.com/2013/05/15/how-does-schizoanalysis-work-or-how-do-you-make-a-class-operate-like-a-work-of-art/.

Bogue, Ronald. *Deleuze on Music, Painting, and the Arts*. New York, NY: Routledge, 2003.

Calo, Susana, and Godofredo Pereira. “CERFI: From the Hospital to the City.” *London Journal of Critical Thought* 1, no. 2 (2017): 83–100. https://doi.org/ISSN 2398 - 662X.

Combes, Muriel. “On Being and the Status of the One: From the Relativity of the Real to the Reality of Relation.” Essay. In *Gilbert Simondon and the Philosophy of the Transindividual*, translated by Thomas LaMarre, 1–24. MIT Press, 2013.

Combes, Muriel. “The Transindividual Relation.” Essay. In *Gilbert Simondon and the Philosophy of the Transindividual*, translated by Thomas LaMarre, 25–50. MIT Press, 2013.

Cruz, Cynthia. “Asylum.” Commune, July 29, 2019. https://communemag.com/asylum/.

Deleuze, Gilles, and Félix Guattari *Anti-Oedipus: Capitalism and Schizophrenia*. Minneapolis, Minnesota: University of Minnesota Press, 1983.

Deleuze, Gilles, and Félix Guattari. *A Thousand Plateaus*. London: Bloomsbury, 2013.

Fisher, Mark. *The Weird and the Eerie*. 4th ed. London: Watkins Media Limited, 2016.

Guattari Félix. “The Schizoanalyses.” Essay. In *Soft Subversions: Texts and Interviews 1977-1985*, edited by Lotringer Sylvère, translated by Chet Wiener and Emily Wittman, 204–28. Los Angeles , CA: Semiotext(e), 2009.

Hansen, Mark B. N. "Bernard Stiegler, Philosopher of Desire?" *boundary 2* 44, no. 1 (February 2017): 167–90. https://doi.org/10.1215/01903659-3725929.

Kingsmith , A T. "High Anxiety: Capitalism and Schizoanalysis ." *CounterPunch.org*, 2016.

Kwinter, Sanford. "FFE: Mourning the Future." *ANY: Architecture New York. Memory Inc.: RETURN OF REPRESSED ARCHITECTURAL MEMORY* 15 (1996): 62. https://www.jstor.org/stable/41852177.

Petersen, Erik Werner. "Design as Seven Steps of Deterritorialization." *Nordes: Nordic Design Research*, no. 1 (2005). https://archive.nordes.org/index.php/n13/article/view/232.

Posteraro, Tano. "Habits, Nothing But Habits: Biological Time in Deleuze." *The Comparatist* 40 (October 2016): 94–110. https://doi.org/10.1353/com.2016.0005.

Radman, Andrej, and Heidi Sohn. "The Four Domains of the Plane of Consistency." Essay. In *Critical and Clinical Cartographies: Architecture, Robotics, Medicine, Philosophy*, edited by Andrej Radman and Heidi Sohn, 1–20. Edinburgh: Edinburgh University Press, 2017.

Rees, Gareth E. *Unofficial Britain: Journeys through Unexpected Places*. London: Elliot & Thompson Limited, 2020.

Sauvagnargues, Anne, and Jon Roffe. "Crystals and Membranes: Individuation and Temporality." Essay. In *Gilbert Simondon: Being and Technology*, edited by Alex Murray, Ashley Woodward, Arne De Boever, and Jon Roffe, 57–72. Edinburgh: Edinburgh Univ. Press, 2014.

Smith, Chris L. *Bare Architecture: a Schizoanalysis*. London: Bloomsbury, 2019.

Smith, Chris L. "Bodies without Organs and Cities without Architecture." Essay. In *Architectural and Urban Reflections after Deleuze and Guattari*, edited by Constantin V. Boundas and Vana Tentokali, 83–98. London: Rowman & Littlefield International Ltd, 2018.

Smith, Daniel W. "Critical, Clinical." Essay. In *Gilles Deleuze: Key Concepts*, edited by Charles J. Stivale, 2nd ed., 204–15. Durham: Acumen, 2011.

Smithson, Robert. "The Monuments of Passaic." *Artforum* 6, no. 4 (December 1967): 52–57. https://holtsmithsonfoundation.org/monuments-passaic-new-jersey.

Spinazzola, Joseph, and Bessel van der Kolk. "Complex Trauma and Disorders of Extreme Stress (DESNOS) Diagnosis, Part Two: Treatment." *Directions in Psychiatry* 21, no. 25 (November 2001): 373–414.

Stiegler, Bernard. "Memory." Edited by W. Mitchell and Mark Hansen. *Critical Terms for Media Studies*, 2010, 64–87. https://warwick.ac.uk/fac/arts/english/currentstudents/undergraduate/modules/literaturetheoryandtime/ltt._steiglermemory.pdf.

Stiegler, Bernard. "The Anthropocene and Neganthropology." Essay. In *The Neganthropocene*, edited by Daniel Ross, 34–50. Open Humanities Press, 2018.

Szasz, Thomas S. "The Myth of Mental Illness." *American Psychologist* 15, no. 2 (1960): 113–18. https://doi.org/10.1037/h0046535.

Van der Hart, Onno, Ellert R. Nijenhuis, and Roger Solomon. "Dissociation of the Personality in Complex Trauma-Related Disorders and EMDR: Theoretical Considerations." *Journal of EMDR Practice and Research* 4, no. 2 (May 2010): 76–92. https://doi.org/10.1891/1933-3196.4.2.76.

Van der Kolk, Bessel A. *The Body Keeps the Score: Brain, Mind, and Body in the Healing of Trauma*. New York: Penguin Books, 2015.

Voss, Daniela. "Deleuze's Third Synthesis of Time." *Deleuze Studies* 7, no. 2 (2013): 194–216. https://doi.org/10.3366/dls.2013.0102.

Walker, Pete. *Complex PTSD: From Surviving to Thriving*. CreateSpace Independent Publishing Platform, 2013.

Zimmerman, Patrick Troy. Thesis. *Liminal Space in Architecture: Threshold and Transition*. Thesis, Tennessee Research and Creative Exchange, 2008. https://trace.tennessee.edu/utk_gradthes/453.