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Refracting ‘health’: Deleuze, Guattari and body-self

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Abstract This article considers ‘health’ and issues of embodiment through the prism of Deleuze and Guattari’s framework of theory. Deleuze and Guattari speak of an embodied subjectivity, a ‘body-without-organs’ (BwO), which is the outcome of a dynamic tension between culture and biology. This BwO – or ‘body-self’ – is a limit, the outcome of physical, psychological and social ‘territorialization’, but which may be ‘deterioralized’ to open up new possibilities for embodied subjectivity. The question ‘what can a body do?’ is posed to address issues of health and illness. The physical, psychological, emotional and social relations of body-self together comprise the limit of a person’s embodied subjectivity, and as such delimit its ‘health’. ‘Illness’ is a further limiting of these relations, while health care may offer the potential to de-territorialize these relations, opening up new possibilities. This model suggests the importance of a collaborative approach to illness, health and health care.

Keywords Deleuze; embodiment; Guattari; postmodernism; subjectivity

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Introduction

Social theorists of health, illness and health care have struggled – as have other social scientists – with the problem of how to conceptualize the relationship between individuals, their bodies and their social context. In some studies (notably those looking at the ‘micro’ level of health and illness experiences), individuals’ accounts have been privileged, establishing a view of a person’s subjectivity that is apparently free and prior to social structures. This essentialist kind of approach to self-hood has been implicit in studies that have sought to understand the impact of illness, particularly chronic illness or disability (for example, Charmaz, 1983; Herzlich and Pierret, 1986; Baszanger, 1992). On the other hand, a range of studies have
emphasized the constructed character of illness, implicating social contexts such as poverty and deprivation, as well as ‘macro’ constructs of gender, ethnicity and cultural characteristics (for example, Fitzpatrick, 1991; Annandale and Clark, 1996; Daykin and Doyal, 1999). These structuralist or materialist studies often implicitly theorize people and patients as socially and culturally determined, with little or no potential to resist the forces and structures that impinge on them.

Intellectually, neither the notion of a prior, essential self nor that of a passive, determined subject seems adequate to understand fully the social and psychological character of health and illness. On one hand, essentialist models allow for an active, engaged subjectivity among people and patients, offering the potential to theorize resistance, for example to overbearing health professionals or to definitions of what it is to be ill, healthy or have a disability. Such studies may over-emphasize this freedom to act, at the expense of recognizing the social context in which health and illness are located. On the other hand, the social context of health and illness is central to structuralist accounts, yet where theorized as deterministic (for example, in exploring the impact of deprivation on well-being, or the gendering of patient–professional interactions) this model seems counterfactual to lived experience of resisting and refusing structures of power and inequality.

One solution for those who study health and health care is pragmatism, choosing essentialist approaches to address ‘lived experiences’ and non-essentialist frameworks to account for the social context of their subject. This strategy at least has the benefit of enabling studies at both ‘micro’ and ‘macro’ levels to flourish, although translation between these levels remains problematic. To give an example of where such translation between micro (experiential) and macro (social context) is important: in trans-cultural work on care and dependency, it is important to be able to explore and give weight to the lived experiences of patients or older adults, but to explore how these arise within a social and cultural context – for instance concerning family organization, systems of welfare and cultural norms and values (Fox, 1999). Understanding this topic should neither reduce people to constructions, incapable of resistance (Butler, 1990; Lash, 1991), nor discount the impact of context on experience by elevating subjectivity as prior and essential.

The quest for an approach which might transcend this divide has been revitalized by post-structuralist approaches to health and health care. Here the focus is upon the relevance of subjectivity and the biological and cultural construction of the body in experiences of health and care, and upon language as the mediator of both. The development of a sociology of the body (Featherstone et al., 1991; Turner, 1992; Williams and Bendelow, 1998) has drawn on such positions, identifying the body as a site of power, a node which is contested between forces of control and resistance (Foucault, 1979). This perspective has been productive within the context
of sociological reflections on health and illness (Lupton, 1995; Nettleton, 1995; Petersen, 1997; Fox, 1999; Cheek, 2000). Language and ‘systems of thought’ (Foucault, 1970) are the media within which both the body is disciplined and the self is constructed.2

Within this latter corpus, the work of Deleuze and Guattari is worthy of attention. Relatively ignored in Anglophone sociology, their propositions concerning the body, the self and the social world offer some interesting ways of thinking about illness, health and health care. Intrinsic to Deleuze and Guattari’s position is the recognition of the embodied nature of subjectivity, which is to say more than the trivial observation that having a self is impossible without having a body too! For Deleuze and Guattari, subjectivity is a consequence of the confluence between embodiment on one hand, and on the other, the physical and cultural worlds which impinge and limit, yet also make possible. Because of this, human embodiment cannot be reduced to physiology. Implicated in the construction of subjectivity, embodiment needs to be understood as an always-unfinished project, of conforming and transgression; while the true discipline of the body is political science, the study of diversity and resistance.

In this article, I want to examine how Deleuze and Guattari’s theoretical model of an embodied self, or a body-self ‘confluence’ supplies new ways to think about health. This formulation of body-self engages both with the active, experimenting, unfolding capacity of self to construct itself and the world about it, and with the contrary dynamic of a biophysical and social world which constructs and determines subjectivity. By asking the question ‘what can a body do?’ (Buchanan, 1997), I examine how body-self mediates what we call ‘health’ and ‘illness’, and how these notions become collaborative rather than individualized concepts in the context of health care.

Deleuze, Guattari and the embodied self

In this section I summarize the three key elements in Deleuze and Guattari’s theoretical position: the body-without-organs (BwO), territorialization and nomadic subjectivity. These abstractions will be explored to suggest how Deleuze and Guattari’s conceptions can be used to think creatively about the confluence of subjectivity and embodiment, and provide new understanding concerning health and illness.

The French philosopher Gilles Deleuze established his intellectual partnership with the psychoanalyst Felix Guattari shortly after the May 1968 revolt by students and workers in Paris. The corpus of their shared authorship includes the major works Anti-Oedipus (1984), A thousand plateaus (1988) and What is philosophy? (1994). Born in 1925 and a student of philosophy in 1940’s Paris, Deleuze’s influences included Nietzsche, Bergson and Heidegger, and resulted in such works as Difference and repetition (1968) and Logique du sens (1969). While this anti-rationalist
tradition coincided with French structuralism's emphasis on the centrality of language in constructing both the world and the self, Deleuze was critical of structuralist ontology as impersonal and over-deterministic (Bogue, 1989: 2–3). A n associate of Foucault's, he wrote a study of that writer's work (Deleuze, 1988) which is both a discussion of Foucault and of Deleuze's own perspective on the issues with which Foucault concerned himself.

Guattari was born in 1930 and following studies in pharmacy and philosophy became involved in oppositional politics, both as a member of the French Communist Party and in challenges to traditional models of mental illness and its treatment. During the 1960s he underwent psychoanalysis with Lacan and subsequently became a Lacanian analyst. However, it was his rejection of Lacan's blend of Freud and Saussurian structuralism, in favour of an effort to synthesize Freud and Marx, which provided the basis for his association with Deleuze (Bogue, 1989: 5–6). For both Deleuze and Guattari, the collaboration over their first joint work, Anti-Oedipus (published in France in 1972, and sub-titled Capitalism and schizophrenia) may be seen as synergistic from earlier (though different) commitments and intellectual influences, and as an innovative direction which was to be developed over the following decade. Their collaboration continued into the 1990s: until Guattari's death, which was followed shortly afterwards by Deleuze's own demise.

Deleuze and Guattari's first collaboration, Anti-Oedipus (1984) was both an attack on Lacanian psychoanalysis and the formulation of a radical ontology. As materialists, they sought to undermine Lacan's continuation of the Freudian focus on 'desire-as-lack' as the prime motor of psychodynamics. In this corpus, it is the lack or absence of an object (food, the mother, the phallus) translated into the realm of the 'symbolic' which may both lead to neurosis, but also supply the possibility of 'cure' once this symbolic desire is exposed. Deleuze and Guattari deny the latter proposition, arguing that it is only by challenging or changing the physical or psychological relations to real things or concepts (as opposed to their psychic symbols) that we may break free from the constraints of the social. Both psychotherapy and progressive political action must focus on the material roots of oppression rather than the psychic processes that are oppression's outcome.

Deleuze and Guattari do not deny the existence of a symbolic desire-as-lack, but propose in addition a conception of positive desire which is both real and productive, in the sense that it establishes real relations with objects and concepts (Deleuze and Guattari, 1988: 254). This desire can be understood as a creative affirmation of potential (M assumi, 1992: 174) akin to Nietzsche's will-to-power (Bogue, 1989: 23–4). By the exertion of this will-to-power, it is possible for humans to be creative rather than reactive, to meet their (real) needs and become free from oppression by capitalism.

The importance of Deleuze and Guattari's emphasis on this creative
potential is developed in their follow-up work A thousand plateaus (1988), which focuses less on the ills of psychoanalysis and more on the politics of resistance (Massumi, 1992: 82). Deleuze and Guattari develop their understanding of human beings as active and motivated rather than passive and determined, incorporating their engagement with the world through an ongoing work of ‘experimentation’ (Deleuze and Guattari, 1988: 149–51). The construction of subjectivity — they argue — is in the dialogical play of social processes and affirmative, creative and embodied experimentation/engagement with the world. The body-without-organs (BwO) is the locus of this dynamic encounter, territorialization and deterritorialization mark out the limits of the BwO as the social impinges and ‘writes’ the embodied self, and nomadology is the strategic resistance of territorialization.

The body-without-organs
The body-without-organs (henceforth BwO) emerges from Deleuze’s early work Logique du sens (1969), in which he sought to explicate the relationship between reality and meaning without recourse to an essential subjectivity. In Anti-Oedipus, the term becomes the pivotal relation between reflexive, embodied sense-making and the social environment. The BwO is not the physical body in any sense, indeed it is quite unlike what Deleuze and Guattari call the ‘organism’ or ‘body-with-organs’: the ‘common-sense’ understanding of physical embodiment which systems of thought in religion, law and biomedicine have constituted. Rather, the BwO is the outcome of what might be described as the ‘in-folding’ of the social and natural world. This process does not create a simple mirror-image of the environment, but more of a ‘refraction’ affected by the very physical and psychological nature of the medium being inscribed. For humans, this includes both the physicality of embodied subjectivity, and the sense-making processes which enable the establishment of reflexivity and thus a ‘self’.

To give an example: when a health professional ‘takes a history’ from a person with an infectious condition, she does not directly perceive the bacterium or virus, but apprehends through signs what that infective agent may be. Nor does she become the patient as she hears of the physical or emotional impact of the infection for the sufferer. Yet the health professional’s BwO is affected psychologically and emotionally by the natural and social elements in this consultation. She may locate herself as epidemiologist, or therapist, or carer, and her consultee as fellow-human, patient or public health risk. She may assign moral characteristics to her interlocutor and to herself, she may empathize or sympathize with her patient, or feel fear, anger or disgust. The meanings of the encounter redefine her BwO around new limits, opening up (or closing down) possibilities for her own embodied self. Needless to say in such an encounter, there will also be an impact on the BwO of the patient.

The BwO links (and allows the inter-penetration of) psychic experience
with the forces of society and of nature (Deleuze and Guattari, 1988: 150), creating a sense-of-self, and furthermore, the potential to resist such social forces. Within this dynamic struggle, the BwO may be thought of as a territory constantly contested and fought over. While the BwO is the site of cultural inscription, it is also the site of resistance and refusal, and is constructed and reconstructed (territorialized) continually. This dynamic model is of great significance for understanding the relation between body and self, and hence of health and illness as embodied processes.

An example will help to clarify the difference between Deleuze and Guattari’s perspective and an essentialist model of the human subject as prior (making sense of, and thereby constructing the social world around it). In the context of the experience of chronic illness, Charmaz suggests that

(physical pain, psychological distress, and the deleterious effects of medical procedures all cause the chronically ill to suffer as they experience their illness. However, a narrow medicalised view of suffering ignores or minimises the broader significance of suffering: the loss of self felt by many people with chronic illnesses. Chronically ill people frequently experience a crumbling away of their former self-images without simultaneous development of equally valued new ones. (Charmaz, 1983: 168, emphasis in original)

Deleuze and Guattari’s theoretical framework offers an alternative to this reading, in which there is not a prior, ‘interior’ self: a self to be ‘lost’. (Such use of metaphors of depth and surface are one tactic by which an essential, prior self has become commonsensical, Butler (1990) has argued.) For Deleuze and Guattari, such oppositions are swept away: the anatomical body is not the carapace of the self. The lived physical body and the self which ‘experiences’ itself as being ‘inside’ the body are both consequences of reflexive, normative ways of thinking (territorializations) about embodiment and individuality. The ‘self-inside-the-body’ is the BwO, the limit which is the outcome of a historical dynamic between psyche and the forces of the social.

Similarly, physiological ‘distress’ and the sensation of pain – which have no implicit meaning – come to signify because of further territorialization of the BwO by biomedical and human sciences systems of thought, into what Deleuze and Guattari call ‘the organism’ or ‘body-with-organs’. Once pain signifies in relation to the organism, it contributes to the subjectivity which has been territorialized on the BwO. In this reading, it is not the self which experiences pain or attributes meaning to it, the self is the pain, the self is an effect of the meaning of the sensations (Fox, 1993: 145).

In contrast with essentialist conceptions of the self, which bemoan the impact upon essential selves of chronic illness and suffering and the concomitant existential despair of embodiment, Deleuze and Guattari’s position offers the possibility for a subjectivity (and a ‘health’) not limited by the body-with-organs. Meanings are capable of transformation, with
possibilities for deterritorialization (see below). Part of that process may be the dissolution of systems of thought deriving from biomedicine, mind-body dualism (which sees the mind as ‘trapped’ inside the body), and the interior–exterior conception of subjectivity. The individualizing of pain and suffering by biomedicine (often with the collaboration of the human sciences) territorializes and limits the BwO as organisms or bodies-with-organs, which are then the natural subjects for the expertise of medicine.

Territorialization

Deleuze and Guattari see territorialization (deterritorialization and reterritorialization) as the outcome of dynamic relations between physical and/or psychosocial forces (Deleuze and Guattari, 1994: 67ff.). Territorialization is an active process, whose agent may be human, animate, inanimate or abstracted (society, God, ‘they’), as may the object of territorialization. Thus the force of the sun’s gravity territorializes the earth in its travels through space, acting on it through the exertion of a force. Air blown through a reed is territorialized to vibrate and produce a specific tone, and again into music by the designation of musician and audience upon blower and locutor.

Deleuze and Guattari apply this general conception to the specific arena of how meaning is ascribed within the social relations of human life. Re-reading Marx from this perspective suggests that the capitalist deterritorializes products into commodities, while labour is abstracted, becoming reterritorialized as wages (Deleuze and Guattari, 1994: 68). Territories and territorializations may be not only physical but also psychological and spiritual: philosophy and ideology have historically reterritorialized land as ‘nations’, Homeland or Fatherland (Deleuze and Guattari, 1994: 68). These systems of thought (what Foucault called ‘discourses’) possess authority, and as such may deterritorialize and reterritorialize how we think about the world and about ourselves.

Territorialization provides an explanatory framework for how the forces of the social impinge on individuals or cultures, from the stratification of class, gender and ethnicity through to the construction of subjectivities, for instance as ‘women’, ‘husbands’, ‘patients’ and ‘risk takers’. Usually (though not always) these social territorializations entail – somewhere in the process – some act of interpretation, of ascribing meaning to an act or action. Goffman’s (1968) description of the ‘stripping’ of identity (for instance when a person becomes a patient) may be better understood as a reterritorialization into a different identity defined by the cultural setting and achieved reflexively by the embodied self of the subject. Doctors, nurses and sociologists of ‘health’ deterritorialize patients according to their models of health, disease and illness, reterritorializing them in frameworks which match their systems of thought (Fox, 1993). Because meanings derive from a conceptual realm independent of the material world it seeks to represent (Derrida, 1978), there are endless possibilities for de- and
reterritorialization: language offers the potential for humans to interpret the world with infinite variety.

People are the continual subjects of deterritorialization and reterritorialization as their BwOs are inscribed by the forces of the social. From birth (perhaps – one could argue – from conception) every inscription is a deterritorialization of virgin territory and a reterritorialization in some new patterning. The BwO is the summation of all these myriad deterritorializations and reterritorializations of the embodied self: it is in this sense that we might agree with Foucault’s (1977: 148) description of the body as totally imprinted by (its) history. But – I would add – this is a history which has been enacted and engaged with, not simply imposed.

The nomadic subject and nomadology

Deleuze and Guattari identify the potential for resistance in this process of deterritorialization and reterritorialization, whether it is the outcome of an individual’s reflexivity or through the actions of another. Either way, it can provide what they call (Deleuze and Guattari, 1988: 9) a line of flight by which the BwO escapes from a territorialization. Often the deterritorialization is momentary and perhaps inconsequential: the BwO moves just a little from its previous position before reterritorializing in a new patterning. At other times, it may be substantial and life-changing, a line of flight which carries the BwO into unimagined realms of possibility and becoming-other. To give two examples: a patient’s BwO may be deterritorialized by the health care worker or friend who treats them as something more than a collection of pathologies; a child’s BwO may be deterritorialized (and reterritorialized) by the adult who treats her as an equal.

Such lines of flight can lead to what Deleuze and Guattari describe as nomadic subjectivity (Deleuze and Guattari, 1988: 55). Because the relation between a person and her environment is dynamic and challenging, movements of deterritorialization and reterritorialization are commonplace: part of the daily fabric of existence, part of the unfolding and becoming-other character of life and death, health and illness. Deterritorialization can be seen clearly in relation to sickness and mortality. Thus a risk to health from some environmental factor leads to a change in behaviour; an illness or impairment forces a person to adapt and exploit unused potentialities. In each case there is relative deterritorialization of the BwO. But these relative deterritorializations, even if they are very rapid or very extreme, rarely (perhaps never) result in an absolute line of flight, the absolute deterritorialization of the BwO which Deleuze and Guattari call nomadism or nomadology.

Deleuze and Guattari developed the concept of nomadology as an aspiration and an alternative philosophy to what they saw as the discursive straitjacket of western thought (1988: 23–5). In a narrower sense, nomadology is about replacing monolithic definitions of reality with a multiplicity of narratives. This enables an uninterrupted flow of deterritorialization that
establishes a line of flight away from territories, grand designs and monolithic institutions. Needless to say, this is not something which is achieved once and for all, there is always another and another deterritorialization ahead.

Thus nomadology must be thought of not as an outcome but as a process, as a line of flight which continually resists the sedentary, the single fixed perspective. A gain recall that Foucault (1977: 148) spoke of the body completely imprinted with history—that is, the forces of the social. Nomadology sets itself in opposition to this inscription: nomad subjectivity is one free to roam, untrammelled by the territorializations of power, and free to resist. As such, a commitment to deterritorialization and the nomad is intrinsically political, always on the side of freedom, experimentation and becoming, always opposed to power, territory and the fixing of identity.

This last concept from the work of Deleuze and Guattari seems pregnant with significance for our understanding of the social character of health and illness. Looking back at the earlier discussion of pain, it is possible to see the medicalized BwO as territorialized into the body-with-organs. The sick, the convalescent, the disabled are all part of this territorialization: the history of health has been written, and continues to be written within this territory. This can be recognized as the focus of critique in Deleuze and Guattari’s writing on mental illness, which began with the limited project of Anti-Oedipus and continued on the broader canvas of A thousand plateaus (a book conceived as a line of flight itself). What if there were to be a nomadological refusal of the territory of ‘health’? It is to this proposition that we now turn.

Refracting ‘health’: what can a body do?

In an essay which focuses attention on a key element in Deleuze and Guattari’s ontology, Buchanan (1997) suggests that theorists of the body (in philosophy, social science and biomedicine) have been asking the wrong question. Rather than considering what a body is, they should ask: what can a body do? This question is

the critical means of finding out what masochists, drug users, obsessives and paranolics are actually trying to do. The question works by staking out an area of what a body actually can do. This area is restricted by obvious physical constraints which must be respected. But this does not mean that there is no beyond, or that a beyond cannot be desired. And it is just this beyond—beyond the physical limits of the physical body—that the concept of the body-without organs articulates. . . . It is the body’s limits that define the BwO, not the other way around (Buchanan, 1997: 79, emphases in original)

Note that this approach is not functionalistic, indeed it rejects efforts to define the essential nature of a body. Deleuze and Guattari’s approach consists not in assessing bodily cause and effect (it has kidneys, so it can
excrete), but in counting what they call the affects or relations of a body (Deleuze and Guattari, 1988: 257): its psychological, emotional and physical attachments - which may be many or few. A asking 'what can a body do' recognizes an active, experimenting, engaged and engaging body, not one passively written in systems of thought. Bodies are not the locus at which forces act, they are the production of the interactions of forces. A body is the capacity to form new relations, and the desire to do so (Buchanan, 1997: 83).

A body can do this and it can do that in relation to the situations and settings it inhabits, and to its aspirations within an unfolding, active experimentation. In other words, it does this or that because of how it is territorialized (Deleuze and Guattari, 1988: 316). A blackbird sings inter alia because it has vocal chords (and neural pathways) that can form a relation with air that results in song. It has a relation to the dawning day or to predators in its environment. A and the singing-blackbird has serendipitous relations with other bodies (blackbirds and other animals) concerning mating, or warning, or marking territory (Deleuze and Guattari, 1988: 312).

For human beings, things are more complicated because of our capacity for reflexivity, but the principle is the same. We have relations which are proper to our physiology, to our environment and to our aspirations to talk, to work, to love, to reason or whatever. In this perspective, a person or a patient is defined not by essential conceptions of gender, age or ‘diagnosis’, but by their unfolding and changing relations. Rather than talking of their ‘experiences’, we can identify their myriad relations or affects: to air, to food, to their families, to walking, to their carers, to their homes and to their past and future lives. All of these relations establish the limits of a person’s body: what it can do. It is the forces - of biology, of environment, of culture and reflexivity and of the aspirational potential which all living things possess - which together make the body. They do this by defining (constraining, elaborating) the body’s relations or affects, what it can do. The forces and the resistances together constitute the becoming-body (as opposed to an essentialist being-body).

A asking the question of a body: what can it do? (which are its relations?) informs us about its BwO (the confluences of a body with its affects and relations), about territory and nomadism (the forces that make it what it is and what it may become), about deterritorialization and lines of flight (the trajectories which open up possibilities for becoming-other). For Deleuze and Guattari, this has both a theoretical significance and a practical utility, including the creation of a basis for their ‘schizoanalysis’. By encouraging patients (or people) to pursue an aspiration, it opens locked doors to new vistas (Buchanan, 1997: 85). Importantly, this does not result in the patient being restored to his or her former self, rather, using the newly awakened affect, he or she is encouraged to invent a new self...
Both ‘natural’ and ‘cultural’ forces comprise the relations which a body can have (and thus, what it can do), both are implicated in the ‘self-invention’ which is both a feature of schizoanalysis, and more generally of nomadology. Counting the relations (‘natural’ or ‘cultural’ – these terms become meaningless) of a body can indicate how it is territorialized; fostering new relations may open the way to a line of flight.

So let us ask this question about the human body. In Buchanan’s essay, he focused on some BwOs which are congruent with the Deleuze and Guattari project: the anorexic body, the paralysed body, the schizoid body (Buchanan, 1997: 85ff.), just as Deleuze and Guattari (1988: 150) considered the hypochondriac, drugged and masochistic bodies. I want to look at some less extreme BwOs, which may help map the limits of the ‘healthy’ body (including its implicit antithesis, the ‘sick’ body), and hence the lines of flight which might change those limits. In these sketches, think about relations/affects, about territorialization and about lines of flight into nomadic subjectivity.

The growing body
The body has a relation with time and with space. It aspires to have moved beyond where it is now, for time to have passed, for space to have been filled; alternatively it aspires always to remain the same, to return to what it was before. It tests its new capacities against the environment, and measures itself against what it has been, and what it will be in the future. Its relation to the environment is one of absorption: of nutrients and of experience.

The becoming-fit body
The body has a relation to gravity: it resists it and yet requires it for its creation and its sustenance. Gravity is an addiction, yet unlike a drug whose addict craves its ingestion, here the addiction is concerned with refusing its victory. The muscles of the body enter into new relations with the skin: pressing outwards, testing its limits. There are relations with fat and heart disease, which have become the enemy: the fit body wages poignant war on itself, denying (yet simultaneously admitting) its relation to time and to degradation.

The cancerous (cancering) body
The body subjects itself to censorship, to moralistic outrage. It appraises itself: ‘this part is good, it can remain; this part is bad, it must be excised or burnt or poisoned or overcome by positive mental effort’. The body is
conservative, it is suspicious of novelty, of otherness: it is a control freak because the worst consequence is to lose control.

**The slimming body**
The body enhances, concentrates and strengthens its relation with food, it thinks of everything it sees: ‘I can consume you, you can become part of me’. Life is measured in kilograms and days: the body becomes utopian, Puritan and millenarian, imagining a time and a remade, slim body which has yet to come into existence but which once attained will be free of pain and longing, gloriously released from the shackles of unconsummated desire.

**The valetudinarian body**
This body has been consumed by the diseases it fears. There is nothing left, it has been burnt out, it has become pathology. The BwO rattles, like an empty husk whose only contents are the ailments which began this hopeless territorialization.

**The dying body**
The body has a relation to time: it passes time by giving its capacities away, until there is nothing left to give, no more aspiration. It is engaged in giving up all that was once needed, saying ‘I no longer have a use for this or that, what do I want with that any more?’ When the body is emptied of all it contained, it no longer aspires to anything.

In writing these abstractions, I have tried to elaborate the ambivalence of the affects or relations, and their capacity to become all consuming. All these bodies are active, and they are all becoming-other (the exercising body is becoming-fit, the valetudinarian body is becoming-invalid, the dying body is becoming-moribund). They are all constitutive of BwOs as they conjoin with their affects (there is a food plus eating-body confluence and a medicine plus sick-body confluence and so on).

We can understand the ‘patient’ and her/his health/illness in terms of the affects or relations that are confluent to construct the BwO, the limit of what their bodies can do. This is not however, an exercise in assessing mobility or capacity to work or to reason or whatever. What a body can do is not a matter of health assessment or pathology diagnosis, but of the deterritorialization which the walking, working, reasoning-body makes possible: a glimpse of nomadic subjectivity. What a body can do deterritorializes the BwO, to open up new possibilities for her becoming-other.

But this cuts both ways. The intensification of an affect or relation can lead to a becoming which reterritorializes and inhibits further lines of flight. Buchanan offers the example of the anorexic (the ‘slimming body’ gone critical, perhaps), who
endeavours to obtain freedom, to become free, via the pathway of an intensive hunger, eliminating in the process all extensive demand (demands of the body-organism). Hunger that is not determined by the demands of the body is intense because it is now for itself; as such, it would be more correct to describe it as ‘hungering’ not hunger. The problem for the anorexic, however, and this is the inherent danger of all self-motivated becoming, is that far from accelerating becoming, what he or she actually does is deform it. Intensifying a particular [affect is] . . . a gross delimitation of becoming itself. It confuses the blissfully passive beyond of becoming which Nietzsche idealizes, with the passivity of the already become. (Buchanan, 1997: 87)

A body (BwO) that has become (rather than being in the process of becoming) has suffered territorialization, into a territory that cannot easily be escaped. The valetudinarian has become an invalid, the dementing body loses all sense of continuity. For some people, being a ‘patient’ or receiving care is just such a reterritorialization, one that closes down possibilities, creating a body-self trammelled by dependency. Having become, there is no becoming left to do. Singularity of purpose leads not to the beyond, but to death.

Becoming other requires the multiplication of affects, not the intensification of a single affect or relation. It is an opening-up to difference, to possibility and to the ‘rightness’ of the many rather than the few or the one. This is not an easy conclusion to draw: multiplication of affects and relations, particularly if – like some ‘patients’ – one’s resources are limited, may not be something which can be achieved independently: we may need all the help we can get (Fox, 1995). There is an agenda here which goes beyond the clinic and the academy and encompasses health and social policy, economics and the politics of welfare.

Conclusion

There are several elements which make Deleuze and Guattari’s model important for understanding health, both for the specifics of exploring the play of power and resistance in the embodied subjectivities of people and ‘patients’, and more generally to theorize an anti-essentialist yet resisting self.

First, the self and the body cannot be thought of as separate. The self-body confluence is the ontological entity which must be conceptualized as we consider embodiment and subjectivity. Further, the body upon which the social world impinges is not the physical body. The use of the term body-without-organs makes it clearer that the ‘in-folding’ of the social operates in a realm distance from the physical body, indeed that the sense we have of a physical body is a result of this patterning of the BwO. The BwO is the limit of what a body can do, not in a functionalist sense, but in terms of the affects or relations it possesses. For patients, people with disabilities, older adults and for anyone, the social may impinge to territorialize the
BwO, to establish limits from which it is hard to fly. But these limits can be redrawn, especially if one has a little help. For people with bodies everywhere, the BwO is the locus for confluences of relations, and these relations together establish what it can do. In studying ‘health’, the confluence of body-self that is the BwO becomes the focus of attention.

Second, body-self – this embodied subjectivity – is not the passive outcome of ‘inscription’, but a dynamic, reflexive, ‘reading’ of the social by an active, experimenting, motivated human being. For Deleuze and Guattari, the BwO is like an uncharted territory, but one whose possession must be fought over, inch by inch. The BwO is always in flux, as it is endlessly territorialized, deterritorialized and reterritorialized. Territorialization is a function both of the forces of the social and by the motivated, ‘experimenting’ BwO as it becomes other. The self is neither prior nor an outcome: it is processual, continually unfolding and becoming other.

Thus the discourses of biomedicine (along with law, religion and so forth) are not passively inscribed on the BwO, creating direct images or reflections. Rather these territorializations are resisted and subverted by an experimenting, ‘experiencing’ body-self, so that what ends up being inscribed is not a simulacrum, but a refracted patterning which bears some, but perhaps only indirect resemblance to the territorializing force. And what is inscribed may be deterritorialized by other forces of the social and natural worlds, ad infinitum (or at least ad mortem). This dynamic model of body-self can conjure the endless permutations of living, of ‘health’, ‘illness’ and ‘disability’, the multiplying, becoming-other BwO: the ultimate ‘reader’, always capable of a new interpretation, another nuance.

Third, we may understand ‘health’ as – at least in part – the resistance of body-self to forces of territorialization. Resistance is not only a possibility: it is the character of the body-self as it refracts the affects and relations which impinge upon it. As has been noted, these include physical and biological, psychological or emotional, social and cultural relations, and the body-self uses these strategically to define what it can ‘do’. So the ‘health’ of a body is the outcome of all these refracted and resisted relations, biological capabilities or cultural mind-sets, alliances with friends or health workers, struggles for control over treatment or conditions of living. Health is neither an absolute (defined by whatever discipline) to be aspired towards, nor an idealized outcome of ‘mind-over-matter’. It is a process of becoming by body-self, of rallying affects and relations, resisting physical or social territorialization and experimenting with what is, and what might become.

Inevitably, this perspective makes health and health care intrinsically political. For ‘patients’ and for everyone, the politics of health and illness are about engaging with the real struggles of people as they are territorialized – by biology or by culture, as they resist, and as they encourage others in their aspirations. Health is processual, and both at the level of the individual and the wider public health, this is a process that encompasses
natural and social science disciplines. For health care (as for education, citizenship and every aspect of social action), the analysis developed from the work of Deleuze and Guattari suggests an agenda for its practitioners that fosters deterritorialization in the body-selves of those for whom they care (Fox, 1995, 1999) and generates a politics of health that transcends economic and management perspectives. To engage productively with such agendas collapses disciplinary boundaries and establishes a pressing need for collaboration between medical and caring professions, social and political scientists, social activists, indeed everyone with a body.

Notes

1. Humanistic movements in psychology and sociology such as interactionism and phenomenology emphasize agency, and argue that individuals actively construct their own social world (Shutz, 1962; Berger and Luckmann, 1971). In essentialist models, the self is present, albeit in an unformed state, from birth. Other approaches have challenged this essentialism, and social theorists of health and health care have drawn on these perspectives. Turner (1968) described complex rites de passage in Ndembu healing rituals, while among the Cameroonian Bakweri, women’s seizures were healed by rites that reasserted the society’s gender roles (Ardener, 1972). Ethnomethodologists see humans as consummate actors, playing roles to achieve intended outcomes, such as doctors’ artful practices in managing consultations (Bloor, 1977; H eath, 1981; Silverman and Perakyla, 1990). Studies focusing on material and structural factors in determining health outcomes by-and-large discount experiential elements entirely.

2. The ‘post-structuralist turn’ in social theory has explicitly rejected humanism and concomitantly, any sense of an essential self (Mo i, 1985). In Foucauldian studies of clinical patients, the self is apparently nothing more than an epiphenomenon of the systems of thought or ‘discourses’ which structure subjectivity (Foucault, 1967, 1976; Armstrong, 1993; Nettleton, 1995). Unlike structuralists, in post-structuralism subjectivity and self are outcomes of a micropolitics of power mediated through systems of ‘knowledge’ and often focused on the body. The aspiration of post-structuralism is for a theory in which neither ‘the self’ nor the forces of ‘the social’ is prior or ontologically independent of the other. Despite this, post-structuralist approaches have been criticized for determinism: the reduction of the human being to a totally constructed cipher, incapable of resistance (Lash, 1991). No institution really is ‘total’ (G offman, 1968) or entirely discursive (Foucault, 1976); people choose to act despite clear risks to their health (Fox, 1999); patients reflect upon their circumstances and challenge and refuse definitions offered by professionals (Kleinman, 1988; Bloor and Mclntosh, 1990).

3. ‘Blackbird’ is itself a territorialization, achieved through the affects and relations humans have with these B wOs. There is a blackbird-human confluence which territorializes both elements!

References

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