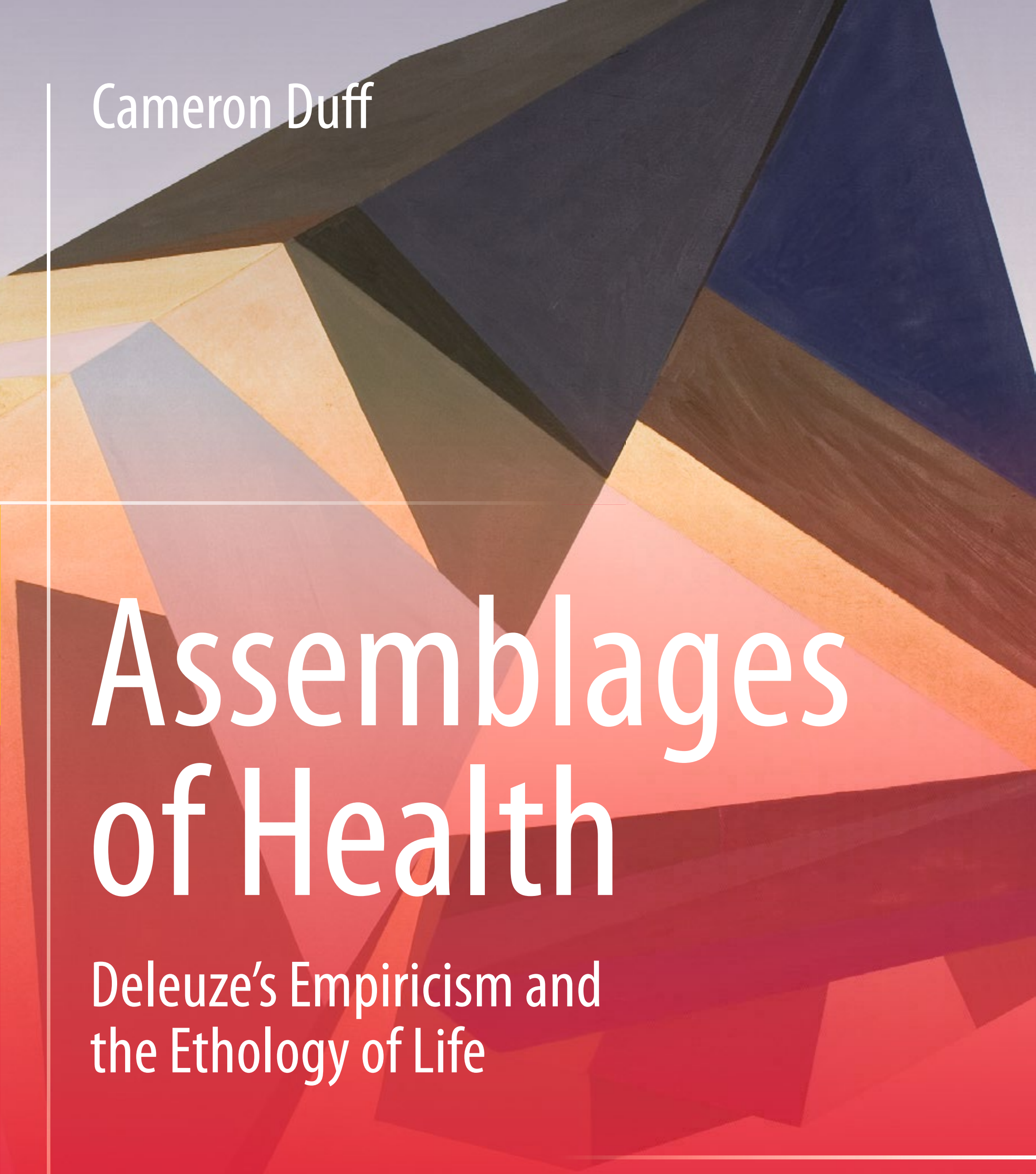

Cameron Duff

Assemblages of Health

Deleuze's Empiricism and the Ethology of Life

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This author wishes to thank Andrea Eckersley for permission to reproduce her painting ("Untitled # 5, 2008") on the cover of this book.

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Magic, magic, magic, the pair of them . . . like princelings in the dawn light

The environment enters into the nature of each thing.
– Alfred North Whitehead, *Modes of Thought*

In so far as the Cogito refers to a fractured I, an I split from end to end by the form of time which runs through it, it must be said that Ideas swarm in the fracture, constantly emerging on its edges, ceaselessly coming out and going back, being composed in a thousand different manners.
– Gilles Deleuze, *Difference and Repetition*

Whether we are individuals or groups, we are made up of lines and these lines are very varied in nature.
– Gilles Deleuze and Claire Parnet, *Dialogues*

Each line of life is related to a type of matter that is not merely an external environment, but in terms of which the living being manufactures a body, a form, for itself.
– Gilles Deleuze, *Bergsonism*

Preface

This book presents a study of health and illness derived in large measure from the writings of French philosopher Gilles Deleuze. It provides the first systematic assessment of the significance of Deleuze's thought for contemporary research in the health sciences, including work in public health, quality of life studies and human development. The book will introduce many of Deleuze's key ideas, exploring the application of his method, what he called "transcendental empiricism", to the analysis of select problems in the study of health and society. Of principal interest are the inventive accounts of subjectivity, embodiment and experience that Deleuze proposes, and the varied concepts that these accounts engender. In pursuing these interests, the book will confirm the need for a Deleuzian approach to research in the health and social sciences, along with the innovations in research practice that such an approach should inspire. Each task will entail a critical reading of several of Deleuze's most important concepts, including 'event', 'affect', 'relation', 'life', 'difference', 'immanence', 'becoming' and 'assemblage', in an effort to establish grounds for the more widespread adoption of Deleuze's ideas across the health and social sciences.

The book will focus on the treatment of subjectivity and the body such that the notion of 'human life' may be reframed in the health and social sciences. I argue that such a shift is critical given recent affirmations of the convergence of the human and the nonhuman in social, political and biological life (see Latour 2005). While for some, this convergence signals the need for a *posthuman* account of health and illness more alert to the imbrications of science, technology, politics and biology (Rose 2007: 1–8), I am just as interested in the implications of this 'decentring of the human' for research innovation in the health and social sciences. I aim to extend Deleuze's account of subjectivity and the body in order to sketch the most important implications of 'posthumanism' for thinking about health itself (see Wolfe 2010). The major problem the book seeks to confront, therefore, is the task of rethinking the ontological and epistemological status of health at a time when the 'human subject', to which the attribution of health necessarily refers, seems everywhere in retreat (Fox 2011). The book ventures to explain how health may be reframed in the absence of conventional ontological distinctions such as human/nonhuman, nature/culture and body/society. It asks what health may look like, and how it ought to be conceptualised, in the context of a posthuman, more-than-human, assemblage of spaces, forces and bodies. In addressing these questions, the book will present a number of case studies indicating how Deleuze's account of (human) life may afford fresh insights into enduring health problems such as addiction and mental illness.

I should note that problems concerning subjectivity and embodiment are central to a number of critical debates in the contemporary health sciences (Turner 2008). Of course, the very notion of a science devoted to health may be regarded as a peculiarly humanist enterprise, charged with the preservation of certain kinds of embodied existence to the neglect of others (Fox 2012: 2–7). The health sciences are certainly preoccupied with the body, with both its limitations and capacities, which combined with the demands of public health and the ministrations of clinical medicine effect a unique "government of the living" (Foucault 1997: 81). In Foucault's seminal reckoning, this 'governmentality' works to draw specific forces out of the body, installing a discipline of the flesh in the cultivation of its corporeal agency. Such insights have prompted a good deal of innovation across the health and social sciences (see Fox 2012; Petersen and Bunton 1997), although in analysing health problems scholars have sometimes exaggerated instances of domination and control at the expense of a more balanced assessment of the practices of resistance and self-fashioning central to Foucault's later writing. Recent examples of this tendency include debates regarding the rise of obesity and related health problems; the management of chronic health conditions such as diabetes, depression and HIV/AIDS; and attempts to reduce the use of alcohol and other drugs. Research in each domain typically endorses the 'governmentalities' expressed in the attempt to discipline certain kinds of subjects in an effort to preserve or restore particular kinds of embodied experience (Coveney 1998: 461–465). Health may, indeed, be usefully conceived in this fashion; as an exercise in endorsing specific forms of embodied experience in the interest of defending particular kinds of human life (Greco 2009).

Despite the impact of Foucault's work across the health and social sciences, scholars have often struggled with the methodological implications of his 'genealogy of the subject' for applied research (Turner 2008; Petersen and Bunton 1997). It may, in fact, be argued that the health and social sciences remain caught in the paradox of subjectivity; on the one hand committed to the study of meaning and individual experience, while increasingly aware of the 'illusion' of subjectivity, of its evanescent, mediated character (Law 2004; Mol 2002). The subject, like the body it seems, has lost the reassuring stability it once enjoyed. I argue throughout the book that the examination of human life presents an ontological problem, insofar as the 'subject' of the health and social sciences now evinces a bewildering ontological pluralism. This includes theories and perspectives that reject humanism altogether, treating it as a 'cultural fiction', to more moderate positions that regard 'human life' as a cultural and biological artefact supported within a web of social and 'natural' relations, through to traditional models which cling to the ideal of a sovereign entity endowed with inalienable rights and committed to their assertion and defence (Turner 2008).

Often this pluralism is treated as a convenient resource for the health and social sciences, affording diverse analytical strategies to suit diverse empirical challenges. Yet the antinomies that fracture human life cannot be dismissed so readily. The ‘subject’ of health cannot be both natural and artificial, body and society, without conceding an ontology of confusion that is forever revising the point at which nature and culture meet. Redrawing the boundaries between self and world may momentarily clarify the ‘being’ of human life, including those aspects which pertain to health and illness, but it usually serves to reintroduce a traditional subject, albeit within ever more onerous restrictions. Such moves retain the ‘subject’ and ‘culture’ as distinctive, reified things that shift and morph in their relations, retreating and advancing according to the predilections of observation and theoretical inclination. The health and social sciences have, in this way, settled for a fraught compromise, accepting both a ‘natural’ and a ‘cultural’ subject, a ‘natural’ and a ‘cultural’ body, forever arguing over the precise balance of this commingling, while ignoring the ontological tumult such a compromise entails (see Turner 2008: 1–5). The book rejects this fix, noting that the traditional subject cannot hold in the face of evidence confirming its historical and political contingency, just as the ‘cultural’ subject cannot account for the body without reducing it to artifice (Foucault 1983: 208). The subject, like the body, cannot be both nature and culture without confounding the very status of each. Human life must be explained, along with the full measure of its health.

I would add that the whole idea of health becomes hopelessly confused in this mix of bodies and worlds, subjects and cultures. Indeed, the ‘cultural’ subject that now rivals the ‘traditional’ subject in health and social science research opens up at least as many problems as it solves. For it asserts at the same time that health is a ‘normal’ property of a ‘naturally’ healthy body, just as it reflects the outcome of discrete structural interactions in the world. Yet how can health be both ‘natural’ and ‘cultural’? Which aspects pertain to the ‘nature’ of health and which aspects concern its ‘culture’? And how might the natural aspects of health be discerned among its cultural ramifications? Surely health must be denaturalised as soon as it is conceded that health is as much a function of historical, political and technological processes, as it is the expression of a hypostasised biology (Mol 2002: 56–60). The body, like the subject, becomes slippery and elusive in this commingling of forces, clinging to the assurances of the flesh as surely as it is distributed among the structures of a ubiquitous culture. So what does the health of a ‘natural/cultural’ body refer to; and what can it mean to describe such a body as healthy? Do such questions concern individual bodies; a particular set of salubrious practices; an especially conducive environment; an enviable genetic endowment; or do they concern all these things at once? The latter position merely confounds the ontological status of the embodied subject of health and illness, and the interactions which mediate it. It inevitably confounds causality and correlation in neglecting to consider whether the subject is a *party* to social and structural interactions, or *formed and modified* in them. Medical science usually endorses the first position along with the idea of a natural, healthy body, while the study of the 'social determinants of health' opts for the second, even as it retains a vestigial commitment to the 'natural' body of biomedicine (Fox 2012).

Foucault (1978) observed that the problem of determining the proper ontological status of the embodied subject haunts the human sciences because it renders uncertain the very object of their analysis. While each such science usually manages this matter internally, retreating to the certainties of long established disciplinary maxims, the epistemological challenges occasioned by the problem of 'human life' remain a source of enduring unease throughout the health and social sciences (Greco 2009; Rose 2007). This suggests that the time is ripe for a thoroughgoing reappraisal of the 'subject' of the health and social sciences in the interests of overturning the nature/culture, human/nonhuman dyads that bedevil so much contemporary work in these fields. The book proceeds from the conviction that Deleuze's philosophy provides the most coherent intellectual resources for this task.

The book will argue that Deleuze's transcendental empiricism furnishes a compelling basis for reorienting the study of 'human life', and the more specific investigation of the experience of healthy and ill subjects. Furthermore, Deleuze's empiricism offers a means of exploring the *territorialisation* of human life in ways that may revitalise accounts of the social dimensions of health. Abandoning the ontology of nature and culture, of nature *or* culture, Deleuze (1988: 104–122) prefers a "vital topology" of the "inside" and the "outside" in which the inside is always yet another fold of the outside, just as the outside is always a folding of the inside. Human life (the embodied subject) is involuted, "implicated" in this process of folding by which an "inside" (or interiority) like mind, consciousness or subjectivity is produced in a "differential synthesis" of an always present, always folded "outside" that includes the folds of habit, practice, sense data, food and water, other bodies, ideas and technologies (Deleuze 1994: 70–74). It follows that "the whole of the inside finds itself actively present on the outside" (Deleuze 1988: 119) such that subjectivity and embodiment ought to be regarded as *assemblages of the inside and the outside*, of forces and processes distributed in multiple, dynamic and recursive relations. Nature and culture, body and world, inside and outside can no longer be regarded as ontologically distinct and separable entities. As Alfred North Whitehead (1968: 21) observed in a sympathetic context, "we cannot define where a body begins and where external nature ends. . .exactness is out of the question. It can only be obtained by some trivial convention". Eschewing such conventions, Deleuze instead posits a pre-subjective, pre-individual field of forces, affects and percepts, of intensive and extensive singularities, out of which the assemblages which support or express human life are formed. Subjectivity is expressed in an assemblage, but cannot be reduced to any particular element, or set of elements, within it. The body is equally "multiple" assembled in the congeries of objects, actors and worlds (Mol 2002: 172).

The book contends that such logic presents a breakthrough in recent attempts to resolve the status of 'human life' in the health and social sciences (see Grosz 2011; Fox 2011). In developing this argument, the book will move from Deleuze's biophilosophy to consider those processes, events and relations that support the *vital expression of health in life*. This will involve an attempt to derive a 'developmental ethology' from Deleuze's writings, specifically his commentaries on Spinoza and Bergson. On the basis of these commentaries, I will emphasise the ethological composition of human life in order to identify the specific relations, affects and events that enable joyous, or healthy, encounters between bodies, and those that precipitate sad, or unhealthy, relations. The book will define health as a particular state of embodied subjectivity that is formed or produced in an assemblage of relations, affects and events. I will go on to argue that Deleuze's work provides a means of tracing the characteristic features of this assemblage, suggesting a basis for eliciting positive accounts of health by clarifying those relations, affects and events wherein a body's health is sustained or promoted. Having established a means of defining health in a more substantive way, the book will turn to consider the impact of various social and structural processes in mediating health outcomes in specific settings and populations. The purpose of this analysis is to advance a Deleuzian account of the social determinants of health, along with a novel causal analytics for studying them. Starting with those relations, affects and events that compose individual bodies, Deleuze's empiricism affords a method for discerning how broader social processes shape the everyday experience of health and illness. Transcendental empiricism should facilitate the identification of the specific individual processes that materially impact the health status of individuals and groups, including that bundle of relations, affects and events that constitute 'the social', as well as the more immediate relations typical of 'local' interactions (Fox 2011). The development of this argument will include the presentation of case studies designed to illustrate the innovations associated with the application of Deleuze's methods, as well as the most significant health policy implications that follow from their use.

Assemblages of Health is thus concerned to generate an account of health, subjectivity, embodiment and experience alert to the teeming heterogeneity of 'human life'. Taken from a Deleuzian perspective, health may be characterised as a discontinuous process of affective and relational becoming in which the *quality of life* is advanced in the provision of new affective sensitivities and new relational capacities. As Foucault (2001: 108) so cogently observed, this perspective remains in essence an ethical one. It supports a creative ethics of experience – of affects, relations and events, their encounters and resonances – equal to the vital expression of health. Yet this is not primarily an 'ethics of the self' akin to the one Foucault himself proposed. As I have noted, the traditional self all but disappears in Deleuze's mature philosophy, replaced by a 'swarm' of intensive singularities that coalesce in the assemblages that sustain (human) life. This is not to suggest an irredeemable antagonism between Foucault's and Deleuze's rival ethical postulates, only that the work of thinking through these postulates, and their various coherences and antinomies, has barely begun. *Assemblages of Health* contributes to this reckoning, finding in the quotidian logistics of Foucault's ethics a suggestive praxis for determining how Deleuze's ethological account of life and its becomings may be realised in an everyday pragmatics of health. The book is devoted to this life, to an ethics of the assemblage and the peculiar normativity proffered in it, along with the empiricism necessary for the practice of such an ethics. In this ethics lies the promise of an entirely new mode of health research, and a very different kind of life.

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Melbourne, August 2013 Cameron Duff

Contents

Chapter 1
Introduction

Few issues trouble contemplation quite like the paradox of health. It is at once the most natural of embodied states and yet remains forever vulnerable to the hostilities of an inclement environment. The formal study of health and its physical, social and political manifestations occupies huge swathes of the contemporary human sciences, demanding an ever increasing share of available research funding (Greco 2004). Public and private investment in the provision of health care grows too, albeit more reliably (Baum 2008). Recurrent investment in research, planning and policy development, infrastructure and service delivery illustrates what the sociologist Nikolas Rose (2001: 17–20) has called the "will to health" to describe one of the most distinctive features of contemporary Western life. In reviewing this "obligation" to be well, Rose (2001: 17) traces a shift in the ways health is conceived in modern societies from a problem of illness and dysfunction towards a dynamic and innately political process of "optimization". Exemplified in the promise of the genetic sciences; the emergence of population health and the identification of social and structural determinants of illness; the growing health literacy of a responsibilized and risk-averse population; as well as the everyday practice of self-help and the solicitations of the popular media, "optimization" reflects the various exhortations by which the modern individual is obliged to maximise his or her "biological destiny" (Rose 2001: 17). Comfortable in the assurances of organised health care, and confident that the risk of illness may be managed, the individual is *enjoined to be well*, while the promise of a life lived well takes on a kind of covenant of the governed (Foucault 2008: 227–230). It is against this backdrop of a profound shift in the meaning, practice and experience of health and illness that the present book ought to be situated.

The varied assessments of health and illness offered in the work of Michel Foucault, Nikolas Rose, Ulrich Beck, John Law and Annemarie Mol, among many others, suggest three enduring problems central to the concerns of this book. First, the obligations demanded by an emergent 'will to health' indicate the need for a substantive definition of health that goes beyond traditional understandings of "normal functioning" figured as the mere absence of disease (Blaxter 2004: 10). As the clinical advances associated with institutionalised

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health care render more and more conditions liable to treatment (if not outright cure), the challenge of defining the over-arching purpose of health and wellbeing has grown (Tengland 2006). Monica Greco (2004: 3–5) stresses that judgments about health go well beyond the issue of “normality” and the extent to which ill individuals might be said to differ from normal, healthy ones. Health inevitably invites normative judgements too regarding the character of the ‘ideal body’ and the various goals, values and practices to which such a body must accord. Greco (2004: 1–3) adds that efforts to clarify the normative character of health are a feature of contemporary debates in many parts of the world, even though these efforts rarely generate the desired consensus. More commonly, attempts to define the normative aspects of health merely propose more or less agreeable synonyms such as wellbeing, quality of life, vitality, capability or resource (see Gorin and Arnold 2006). This only confounds an already elusive and ill-defined notion, one that is routinely regarded as a taken-for-grant given, even as it takes on ever more significant moral, political, ontological, ethical and aesthetic baggage. The book takes up the indeterminacy of health, offering a kind of health in indeterminacy.

The second preoccupation of the book involves the ontological and empirical distinctions that have long sustained health care research, planning and service delivery in the West. It is routinely noted that distinctions such as natural/artificial, biology/technology, inside/outside and subject/object are beginning to break down in the health and social sciences in ways that have significant and far reaching implications, not only for the way health itself is conceived, but also for the way in which ‘human life’ is positioned in research and practice (Mol 2002). Although efforts to revisit the foundational binaries that subtend research and practice in the health and social sciences have a long history, the ‘subject’, ‘nature’ and ‘biology’ each retain a privileged position despite the threats to their hegemony that are everywhere apparent in scientific innovation (Protevi 2009). Examples include the prospect of a human genetics finally susceptible to manipulation and correction (Rabinow and Rose 2006: 212–214), alongside studies of the social determinants of health that dismiss the very idea of a natural, acultural subject (Baum 2008). Each of these developments undermines the distinctions between nature and culture, biology and technology that have informed the health and social sciences since their inception. Each suggests the need for a *posthuman account of health and illness*, more alert to the multiple, overlapping and endemic imbrications of biology and technology, the human and the nonhuman in contemporary life. It is no doubt true that offering such an account in the absence of a reified subject and its sequestered biology offends the primary methodological conventions governing the health and social sciences, their broader moral and ethical purpose too (see Mol 2002: 160–170). And yet Bruno Latour (2003: 78) has recently claimed that “a strong distinction between humans and nonhumans is no longer required for research purposes” in the human sciences. *Assemblages of Health* examines the implications of this claim, exploring the prospects of a posthuman account of health and illness, along with the value of such an account for research innovation in the health and social sciences.

The third and final organising theme of the book builds on the second in presenting a critique of the social and structural determinants of health. Recent analysis of the social determinants extends and deepens earlier studies which described a ‘social gradient’ in health outcomes between poorer groups and those with higher social and economic status (see Dawson 2009 for a review). Research in subsequent decades, undertaken in both the developed and developing world, has identified diverse social, economic and political conditions and their role in shaping health inequalities (see Scriven and Garman 2007: 34–40). Notable examples of these social determinants include income distribution, housing security, availability of essential services such as health care, transport and income support, social exclusion, education and employment opportunities, as well as gender, class and sexuality (see Marmot 2005 for a review). Each of these factors has been implicated in chronic health problems such as heart disease, diabetes, obesity and alcohol misuse, leading researchers to argue for comprehensive public health interventions targeting the social determinants in an effort to improve health outcomes in particular populations (Baum 2008). However, one of the longstanding problems with this research has been the challenge of documenting clear causal links between specific social or structural processes and the generation of health inequalities in particular instances, groups or places (Duff 2011; Fox 2012). This problem recalls enduring debates in the social sciences regarding the links between structure and agency, the macro and the micro, yet it also introduces new challenges for applied research.

At issue is the identification of the specific mechanisms or processes by which macro-structural factors may be shown to mediate health outcomes in particular settings among particular groups at particular times. Philosophers of science such as Bruno Latour, Isabelle Stengers and Annemarie Mol insist that ideas like the social determinants of health rely on a dubious logic of ‘social context’ in order to assert the links between structure and place (Duff 2011). To the extent that the health sciences now take social contexts to include factors and processes as diverse as employment security, access to essential public services, norms and culture, gender and class, it is tempting to conclude that there is nothing outside context, and hence little in collective life that doesn’t somehow mediate the health status of individuals and groups. This leaves social contexts seemingly everywhere and nowhere; everywhere involved in the organisation of interactions vital to the experience of health, and yet nowhere leaving a unique material trace, a domain that might be amenable to empirical inquiry. As a result, empirical assessments of the social determinants of health are increasingly bereft of novel insights, notwithstanding the delineation of social gradients in relation to an ever-increasing range of health problems and conditions (Marmot 2005). Even if one accepts the caveat that population health research is primarily concerned with quantifying risk and the probability of harm, the identification of associations between already complex social and structural phenomena does little to confirm how more direct causal relationships may be identified between social processes and the experience of health in discrete settings.

In the absence of a properly causal account of social context, amenable to application and analysis in a wide variety of settings, the whole notion of the social determinants of health risks being reduced to a rhetorical trope, useful for expanding the administrative purview of health and social policy but unhelpful as a guide for action in individual settings. For how is one to decide in a particular locale, at a particular time, how one should tackle social processes as diverse as employment trends, gender roles, cultural attitudes, economic fluctuations and poverty? Where should one's priorities lie? Where should one start? And how do the various social determinants already identified interact or compound one another such that the likely unintended consequences of proposed interventions might be assessed? In canvassing these issues, I am not seeking to undermine the broader aim of clarifying the social and structural aspects of health and wellbeing in particular settings. I am more concerned with the ethical, pragmatic and political implications of this work. The risk, illustrated so profoundly in recent analyses of the social determinants of health, is that the 'context' and 'structure' are installed as near monolithic constants in everyday life, impossible to ignore but equally resistant to remedial action. Indeed, recent assessments of the social determinants of health are so exhaustive that one is left wondering whether the task confronting health and social policy has simply become too daunting. The gap between 'structure' and 'locale', 'politics' and 'place' seems wider than ever, while there is little support in recent studies for determining how specific structural factors might be tackled at the local level, where presumably health is actually experienced as an inescapable fact of daily life. It is equally unclear how broad structural interventions, such as changes in employment, housing or welfare arrangements, actually impact specific health outcomes in particular settings. Arguably a more useful course for analysis is to devise a method for identifying how select local and non-local actors, entities and processes come to participate in, or otherwise meditate health related phenomena in particular places at particular times. This suggests the need to move away from the habit of differentiating particular health problems, conditions or phenomena from their putative social contexts.

The notion that health problems are mediated in a social context – the primary theoretical condition of all analysis of the social determinants of health – effects an ontological, epistemological and experiential disjuncture between the health status of individual bodies (or populations) and the settings, contexts or environments these bodies may be said to inhabit. This is a logic which presupposes health problems and their contexts as discrete axioms. The reading of Deleuze's methods provided in this book establishes an alternative logic to guide research into the social, political and economic dimensions of health. Modelled after the assemblage, I will argue that health cannot be methodologically, ontologically or epistemologically distinguished from particular experiential, social, political, economic or cultural factors, processes or 'determinants'. There is, in this sense, no social aspect of health distinguishable from economic or political ones in anything other than a particular species of epidemiological analysis. In what Deleuze (1994) calls "actual" or "real experience", biological, material, affective, social, semiotic, political and economic forces necessarily cohere in the articulation of an assemblage of health. As such, one should never speak of the social or political context of a particular health condition because this logic prematurely differentiates forces, processes or bodies without having first established the epistemological basis for