That patients may become prophets: A study of madness in Anton Boisen, Sigmund Freud, and Deleuze/Guattari

Citation

Permanent link
https://nrs.harvard.edu/URN-3:HUL.INSTREPOS:37379257

Terms of Use
This article was downloaded from Harvard University’s DASH repository, and is made available under the terms and conditions applicable to Other Posted Material, as set forth at http://nrs.harvard.edu/urn-3:HUL.InstRepos:dash.current.terms-of-use#LAA

Share Your Story
The Harvard community has made this article openly available. Please share how this access benefits you. Submit a story.

Accessibility
That patients may become prophets:

A study of madness in Anton Boisen, Sigmund Freud, and Deleuze/Guattari

A Senior Paper Submitted in Partial Fulfillment of the Requirements for the Degree of Master of Divinity, Harvard Divinity School, Cambridge, Massachusetts

Paul Gillis-Smith

Graduation year: 2024

Advisor: Giovanni Bazzana, PhD

Teaching fellow: Dylan Nelson

5 May 2024
# Contents

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Introduction: a hermeneutic of psychosis</td>
<td>2</td>
</tr>
<tr>
<td>The Living Human Document: A biography of Anton Boisen</td>
<td>5</td>
</tr>
<tr>
<td>The reception history of Boisen</td>
<td>18</td>
</tr>
<tr>
<td>Boisen’s “special problem”: schizophrenia, creativity, mysticism</td>
<td>22</td>
</tr>
<tr>
<td>Boisen through Freud and Deleuze/Guattari</td>
<td>29</td>
</tr>
<tr>
<td>The problem of schizophrenia</td>
<td>30</td>
</tr>
<tr>
<td>Freud's schizophrenic: analytic anomaly</td>
<td>33</td>
</tr>
<tr>
<td>Schizo, Paranoiac, Schizophrenia: or, Deleuze-Guattarian analysis</td>
<td>40</td>
</tr>
<tr>
<td>Manufacturing catatonia</td>
<td>48</td>
</tr>
<tr>
<td>Conclusion: breakthrough or breakdown</td>
<td>52</td>
</tr>
<tr>
<td>Bibliography</td>
<td>54</td>
</tr>
</tbody>
</table>
Introduction: a hermeneutic of psychosis

In Sylvia Wynter’s “Unsettling the Coloniality of Being/Power/Truth/Freedom” (2003), Wynter illustrates the ways in which reason-makers construct the shape of irrationality. Wynter traces the theological categories of “Elect-Redeemed” and “Condemned” into notions of racialized hierarchy through a “Great Chain of Being.” The Chain’s hierarchy secures its own gradient for the possession of reason. Irrationality takes the shape of what sin once stood for, and the Black bondsman or bondswoman “will be projected as the by-nature determined…missing link between true…humans and the irrational figure of the ape” (2003, 304). Wynter follows this reproduction of irrationality in the Americas and the Caribbean along similar lines in Europe, where “the increasingly interned figure of the Mad would…come to function, within the terms of the same iconography, as the signifier of the ‘significant ill’ of a threatened enslavement to irrationality…” (304) Wynter pushes this further, tracing these categories of reason-making into the foundation of modern medicine; the Mad is the shadow-self of those who possess reason, and the Mad’s lack-of-reason that is simply part of their nature serves as the justificatory grounds for reason of the natural sciences.

Wynter argues that reason’s existence depends upon the existence of those human Others—the Mad, the enslaved “Negro,” the interned “Indian.” Reason grounds its power in asserting the un-reason in an Other, and Reason-keepers, whether the medical professional, the frontiersman, or the police, are engaged in the unending task of maintaining Reason’s bounds. It is with the Mad that I take up my argument here, and with one particular mad Other’s assertion of his own reason within madness.
Anton Boisen was many things, among them the “founder” of clinical chaplaincy (Asquith 1992; Eastman 1992), a researcher of psychiatric illness, and a prolific author. One designation that runs throughout his work is as mental patient himself, the “Mad” Other that Wynter highlights as where Reason draws its strength. Boisen held an ambivalent relationship with his condition and diagnosis. It was a resource in his interactions with patients in the asylums in which he worked, yet he also recognized that his status as “patient” proffered greater scrutiny to his research and elicited suspicion from colleagues. His own autobiography is even placed in that “genre of confessional literature” written by individuals who have been thrust into the patient-position (Hart 2010, 537), even as he expounds upon many other components of his life that do not seem to concern his diagnosis. Boisen could never escape his own patient status, even as he participated in the reason-making enterprises of modern medicine.

I am interested in Boisen’s work in part because of my own work as a clinical spiritual care provider, and because of the way in which he puts his own status as a mental patient to flight. Boisen saw his condition not simply as an obstacle to be overcome, but as a site of creativity, and even a source of mystical knowledge that could provide answers to questions that haunted him in a manner that medical professionals could only describe as “psychotic.” Boisen’s schizophrenia was not only a boon for insight into his own inner world, but it served as an endless fount of inspiration for research and study. From his bouts of psychosis, Boisen found inspiration to initiate a new discipline of chaplaincy within mental hospitals and prolifically published on schizophrenia’s expression and potential for cure.

Schizophrenia has long sat on the borderlands in the history of psychiatry. Since Freud founded his unique approach to the analysis of inner psychic states, schizophrenia was a problem
that the clinician was ill-equipped to address. Schizophrenia also was the site upon which those radically oriented psychiatrists, often associated with “antipsychiatry,” waged war with their discipline on its own inadequacies in diagnosis and treatment. In the work of the founder of psychiatric chaplaincy, we find a man who held a similar ethos to those in the history of psychiatry that led to the field’s reform, toward a more interpersonal and psychodynamic method of care. Yet, there are currents that Boisen and the “psychiatrists of antipsychiatry” released that have been both incorporated and resisted by their heirs, the chaplains and the psychiatrists. Through this hermeneutic of psychosis, where one centers the Mad as the potential site of novel forms of rationality, I hope to highlight the degree to which the Mad Other still stands as Reason’s foil, and reopen sites in the study of our interior life that may undo this Overrepresentation of Man that Wynter diagnoses.

What follows is a literary study of the role of psychosis in the founding of clinical chaplaincy by Boisen, Freud’s psychoanalytic diagnosis of schizophrenia, and Deleuze and Guattari’s an-oedipal schizoanalysis. This hermeneutic of psychosis follows Boisen’s commitment to “living human documents”—the assertion of the textuality of human life, and the vitality and organic quality of texts. Boisen’s notion of living human documents borrows from two convergent themes in the history of medicine in the beginning of the 20th century—a novel approach to diagnosis that insisted upon a more robust study of one’s entire social history alongside manifest physical symptoms, and a psychoanalytic method that interpreted symptoms with a literary quality. Boisen’s living human documents demanded an attention to the dynamic nature of these human texts. Alongside these inheritances from the history of medicine, the living human document was a sort of sacred reading practice with theological heft. Boisen held to a tradition of scripture-
reading wherein one’s understanding of human documents required a “faithfulness to the text”—one cannot interpret a human document to fit a predetermined meaning. As Boisen’s living human documents came from within asylums, I refer to this madness-centered approach as a hermeneutic of psychosis, a method inherited from Boisen and the antipsychiatrists. This hermeneutic refuses the assumed rationality of the clinician and the assumed insanity of the mental patient. Psychotic expression is rendered as such through diagnosis—the hospital is the site where mental illness is constructed as fact. Following R.D Laing’s *The Divided Self* (1960) and Thomas Szasz’s *The Myth of Mental Illness* (1961), the tradition of antipsychiatry reaches a fever-pitch in Gilles Deleuze and Felix Guattari’s *Anti-Oedipus* (1977), where we find many of the same techniques—an escape from psychoanalysis and psychiatry’s diagnostic conventions—that Boisen proposed several decades earlier, in his study of mental illness and religious experience. While *Anti-Oedipus* is often read as possessing a highly abstract notion of schizophrenia, it is brought back to the flesh and eccentricity of madness when read alongside Boisen. This tripartite conversation between Boisen, Freud, and Deleuze/Guattari elucidates the longstanding role of psychosis as challenge to psychiatry and the possibilities for madness, when given alternate containers for interpretation and action, to proffer creativity, insight, and religious experience. We do away with the psychiatric refrain, what must be done with the psychotics, and exchange it for a new question—what can the psychotic body do?

**The Living Human Document: A Biography of Anton Boisen**

Anton Boisen returns time and again to the need for the study of “living human documents” (1930, 235; 1936, 185 & 248; 1945, 292; 1952a, 296; 1960, 187 & 196). For Boisen, the living
human document is the alternative to the theoretical and scriptural-interpretive approach he found in seminaries, which he saw as inadequate in addressing the needs of parishioners in the aftermath of the first World War. Boisen positions the human subject as the very text to which seminarians must turn—fully alive with their suffering, contradictions, and referents. Further, he asserted that human experience should command the same attention and theological weight of one’s sacred texts (Gerkin 1984, 38). In a close reading of Boisen as living human document, one finds the citations that illuminate what he calls his “special problem,” his enduring fascination in the criss-cross between medicine and religion. Thus, what follows is such an account of Boisen as a living human document.

Anton was the eldest child of Hermann and Elizabeth. His father moved to the US from what is now Germany in 1869 to pursue an academic career. Both Boisen’s father and his maternal grandfather, Theophilus Wylie, were professors. In 1871, Hermann married his former student, Elizabeth. A year later, Hermann became a professor of German language at Indiana University, where Hermann’s father-in-law was also a professor of Languages and Chair of Natural Philosophy. In Boisen’s early life, he moved around with great frequency, following his father’s academic appointments. Just before Boisen’s fourth birthday in 1876, Hermann moved the family to Williamstown, MA, for a professorship at Williams College, then shortly after to the Boston area for another position, and then to New Jersey at Lawrenceville Preparatory Academy outside of Princeton. Hermann died when Boisen was seven years old, and he, his mother, and his younger sister returned to Bloomington, IN, to live with his mother’s parents. Boisen frequently reflected on this early loss of his father, feeling that his life was an expression of loyalty to his father’s memory (1960, 51), and often comparing his father’s life force to his own (1960, 84).
Boisen’s childhood milieu was both academic and ministerial. On both sides of the family, he was surrounded by reformed Presbyterian ministers and academics. His grandfather, with whom he lived from the age of seven on, became the president of Indiana University and had been trained as a minister. This period of his life was of mixed influence. He was deeply affected by the death of his young father, and the home of his grandparents was strict. Yet his mother was quite progressive for the time. She was one of the first women to attend Indiana University, and she held a more liberal theological position than her father Theophilus, who protested the use of instruments or the singing of anything but the psalms in church service.

Following the family’s connection to Indiana University, Boisen also attended there and completed a degree in Modern Languages in 1897. Upon graduation from IU, he taught French at a high school. He became fascinated with the work of William James, who had just published *Principles of Psychology* (1890) in the years prior to his time at IU, and *The Varieties of Religious Experience* (1902) just after his graduation. Boisen was introduced to James by a professor at IU, William Lowe Bryan, who was a founding member of the American Psychological Association. Boisen followed in James’s radical empiricism in his future studies of religious experience in asylum patients. Parallel to his academic investment in the founding figures of psychology, Boisen had a tumultuous inner world in regard to his sexual formation. Perhaps we should be grateful that he was introduced to the likes of James at this time, rather than Freud. In his autobiography, Boisen recounts his enduring feelings were “the shyness, the self-consciousness, the anxiety” (1960, 43), particularly around women. Women elicited a feeling of extreme awkwardness in Boisen, and he felt that he had “sexual interests [that] could neither be controlled nor acknowledged for fear of condemnation” (43). Rather than looking at the vulgar material that his friends exchanged, he
turned to the more explicit scenes in the Bible, the work of Shakespeare, and choice encyclopedia entries, which he claimed at the time was under the pretense of “seeking knowledge.” As a student of languages, his encounter with French novels was particularly evocative. While he resisted orgasm for years, a novel by Emile Zola at last did him in.

Perhaps in part due to this restless and conflictive relationship with French literature, he felt the need for a career change, and received a Master's in Forestry from Yale in 1905, working for the US Forest Service until 1908. While at the Forest Service, he worked for a man named Raphael Zon, a Russian expat who held an enduring influence on Boisen’s research methods. Forestry survey methodology became a cornerstone for Boisen's method of diagnosing spiritual problems and analyzing trends across patients. In 1902, he met a woman named Alice Batchelder, who became a perennial force in his life for the next 30 years. Boisen refers to Batchelder as the “Guiding Hand” in his life (209-210). He was immediately smitten by her, and he describes these feelings in retrospect that he “realized that [his] love for her was really a desperate cry for salvation and an appeal for a beloved person stronger than [himself]” (55).

It was also at this time that he first felt a call to ministry. Given his observations on the intertwinment of his feelings for Alice and a renewed sense of religious devotion, it seems the felt sense of this call had much to do with a pursuit of a relationship with Alice. Alice routinely shut down his advances. He would write her, and she would respond by asking that he leave her alone. At one point, Alice wrote Boisen back after a series of letters to her, telling him not to think of her or write her anymore, which brought Boisen to orgasm three times without an erection. At last, in 1908, she agrees to meet him, where she rejects him again.
In that same year, Boisen began to realize his ministerial calling and enrolled in Union Theological Seminary. He began his education there with an interest in James’s psychology of religion, but there was not yet much receptivity to James in seminaries anywhere, even a liberal seminary like Union. However, he did encounter the liberal theologian George Albert Coe who was invested in the psychological study of religious experience. Coe’s approach to individual experience continued to guide his work, and Coe and Boisen would exchange letters as Boisen began to formulate his “special problem.”

Upon his graduation from Union in 1911, he took a job in the study of church and school conditions in Missouri. Apparently, he was up for a pastoral position but was unable to secure the job due to his inability to elicit tears from parishioners when giving a trial sermon.

In 1912, he was ordained as a presbyterian minister, and began a position at a country church in Kansas, and briefly worked as a college chaplain in Iowa. Two years later, he took a new position in Maine, and at the beginning of the first world war, he took up work with the YMCA in France to serve the troops. He returned from Europe in 1917, and he took another pastorship in Kansas.

By 1920, at the age of 44, Boisen had worked as a French teacher, a forester, a sociological surveyor, a college chaplain, a wartime YMCA minister, and a pastor in several congregations across the US. The man was looking to settle down, and he was also still rapt by his feelings for Alice. He moved in with his sister in Arlington, MA, allegedly to prepare for a call in the Brooklyn Presbytery, but it seems likely it was also to be in proximity to Alice, who had consented to friendship. Boisen himself gestures to this ongoing linkage between his call to ministry and his view of women and marriage—he says of male ministers generally, “[t]heir only hope of salvation lay in their love for some good woman, and in that fact lay hardship and suffering for the woman, and a
real loss to society, since it would be only the finer type of woman who would be moved by such an appeal” (82). Boisen set to work on his Statement of Religious Experience and Statement of Belief in preparation for a ministerial call, and Boisen elucidates that this period of inner work led to the onset of a psychosis. He was committed to Boston Psychopathic Hospital later that year on October 9\textsuperscript{th}, and later was moved to Westboro State Hospital.

It was during this time in the hospital, which lasted fifteen months from October of 1920 until January of 1922, that Boisen clarified the intersection of madness and religious experience as his “special problem” (96). He notes that many of his delusions reflect a religious character, and the fact that there were no staff at the hospital to reckon with his religious problems in religious terms appropriately caused him distress. Thus—it is not the delusions themselves that are distressing, but the inability to find appropriate support for his experiences that is distressing. There was no appropriate container within which he could understand his own experience.

During his hospitalization, he discovers the work of Freud, who Boisen saw as pursuing a similar line of inquiry as himself. In January of 1921, he determines that his vocational future lay in the psychiatric hospital, specifically in order to seek a response to the problem “in which religion and medicine meet” (111). This realization coincided with Boisen’s interest in a transfer to Bloomingdale Hospital in New York. His primary interest in his transfer there was not for improved care, but because he heard that they used a Freudian method of treatment, and he was interested to witness their work “in order to watch the results” (108). Amid his own institutionalization, he sees his position within the asylum as one of research. Shortly after his discovery of Freudian analysis, Boisen resolves that he must take up the study of his “special problem” at Harvard Divinity School.
Boisen presents his autobiography almost in the form of a verbatim at times, the conventional teaching tool of spiritual care in its current form. He frequently includes letters that he wrote, and letters written to him to clarify points of the narrative. For example, in a letter to Norman Nash, then professor at the Episcopal Seminary, in September of 1921, he wrote the following:

“I hold that there is no line of separation between valid religious experience and the abnormal mental states which the alienist calls ‘insanity.’ The distinguishing feature, as I see it, is not the presence or absence of the abnormal and erroneous, but the direction of the change which may be taking place. For the most part the cases with which the psychiatrist is concerned are cases in which the patient is losing ground. Valid religious experiences, on the other hand, are unifying. The subject is gaining ground, even though there may be much disturbance and many morbid and erroneous ideas. Saul of Tarsus, George Fox and others I might name are classed as religious geniuses, not as insane persons, because the experiences through which they passed had a constructive outcome.

“It is worth noting that the procedure of the religious teacher has often been just the opposite to that of the present-day psychiatrist. The church has long taught that conviction of sin is the first step on the road to salvation. It seeks to make a man face the facts in his own life in the light of the teachings of Christ and to square his accounts, even though it may make him very uncomfortable. The psychiatrist, on the other hand, says, ‘Forget it.’ And very frequently he takes the position which one of our young doctors took in the only interview I have been granted since I have been here, that the trouble has been in my idealism and that the thing to do is to let nature have its way.

“I am unable to agree that further stay here is either necessary or wise. I am not unhappy. I am trying to forget myself in my work and I am fortunate enough to have plenty of interesting work to do. But I am well aware that so long as I remain here as a patient, I am by that very fact discredited. There is therefore little that I can contribute to the understanding of this problem. I would also be limited in my capacity to help others by the discouragement which might result from long-continued incarceration. It is also to be recognized that the longer I
stay here the harder it will be to re-establish myself when I do get out.” (135-136, emphasis added)

This passage illuminates how Boisen figures religious experience and mental illness alongside one another, from his earliest reflections on the subject. They are overlapping but not co-identical categories. The primary difference, at least in this moment, is that religious experiences reflect an experience of unification rather than disorganization. Boisen also points to the marginalized status of mental health patients—“as long as I am a patient, I am by that very fact discredited.” This follows an enduring theme in Boisen’s biography where his placement in the asylum setting corresponded with his own recognition of a worsening of his condition. When he was placed in a higher security ward, or when his freedom of movement or work responsibilities were diminished, he found that his psychotic symptoms also increased.

It is remarkable, then, that immediately upon his release from Westboro State Hospital, he enrolled as a special student at Andover-Newton Theological Seminary, affiliated with Harvard Divinity at the time. He took a course with a professor of medicine named Richard Cabot, who was a leading figure in patient-centered care and pioneered a new method of diagnosis. Cabot later founded the field of hospital social work which amounted to a rather similar position in hospitals to the chaplain in its earliest iterations, and Cabot served as the first president of the first clinical chaplaincy organization.

Boisen took up work at the very hospitals to which he had been committed just the year prior, at Westboro State Hospital and Boston Psychopathic, where he developed a research plan for how to introduce seminarians into the asylum. Boisen’s project of psychiatric chaplaincy ran parallel to a pedagogical project. Boisen saw that the state of theological education was chronically ill-equipped for addressing real human beings and the social worlds they carry with
them, whether in hospitals or in congregations, particularly after the horrors of the first World War. There was little attention paid to religious experience, and Boisen was specifically interested in introducing the scientific method for the study of such experiences (150). This train ran in two directions, as medical professionals also seemed to have little interest in studying the religious dimension of their patients’ lives.

In July of 1924, Boisen began work at Worcester State Hospital to “begin [his] experiment in the religious ministry to the mentally ill” (150). A key development for Boisen, diverging from his work in Boston, was that he was to have full access to the case records of the patients he was seeing. A year later, Boisen assembled his first cohort of clinical theological students—four in total. This 1925 class of students has been canonized in the history of spiritual care as the first clinical pastoral education (CPE) cohort, and the predominant CPE organization, the ACPE, celebrates 1925 as its inaugural year despite its own inception in 1967. Boisen’s contract at Worcester also entailed a teaching appointment at the Chicago Theological Seminary for one term a year, which allowed him to regularly present the research he conducted in the hospital setting and provide clinical instruction through case discussion in the academic setting. It was at this time that Boisen also at last relinquished his 23-year-long pursuit of Alice. Over the next three years, they fostered a new friendship, and entered a “covenant of friendship” on Thanksgiving Day in 1929.

In 1930, the first formal organization of clinical chaplaincy was formed as the Council for the Clinical Training of Theological Students, with Dr. Cabot as its president. The Council had three founding objectives for ministers under its training—
“1. To open his eyes to the real problems of men and women and to develop in him methods of observation which will make him competent as an instigator of the forces with which religion has to do and of the laws which govern these forces;’
‘2. To train him in the art of helping people out of trouble and enabling them to find spiritual health;’
‘3. To bring about a greater degree of mutual understanding among the professional groups which are concerned with the personal problems of men.’” (Eastman 1992, 134)

As is clear from these objectives, there is no mention of madness or in assisting patients with spiritual or religious understandings of their condition. These objectives gesture to the differences that would continue to develop between Boisen and Cabot, and Cabot’s interest in a hospital-wide chaplaincy, and Boisen’s more myopic commitment to asylum patients. While the incorporation of the Council seemed promising, 1930 was a turbulent year for Boisen. In June, his mother died at the age of 91, and Boisen again found trouble in his relationship with Alice. To Boisen’s telling, it was the result of “the shadow of another, younger woman [that] lay between [them]” (1960, 169), a fellow researcher working with Boisen, Helen Dunbar. This complication eventually led to Boisen’s second major psychotic break, for which Dr. Cabot had Boisen hospitalized. This stint in the asylum was much briefer than the first, and he was released after three weeks. Yet this came at a time when Boisen’s and Cabot’s theoretical differences were crystallizing. Cabot insisted that the patient population with which Boisen worked were helpless to the cure of their mental conditions. Boisen, on the other hand, insisted on a psychogenetic origin for many mental health conditions, and that their amelioration was possible if patients were given the right support. Cabot seized on Boisen’s own mental fragility, and he had Boisen’s oversight of instruction at Worcester revoked. Meanwhile, chaplaincy programs were expanding across the northeast in Rhode Island, Syracuse, and Boston. In response to the resistance Boisen experienced in Massachusetts, he
relocated from Worcester to Elgin State Hospital in Illinois, which would also allow for a deeper relationship with Chicago Theological Seminary. Boisen remained at Elgin until his death.

In 1935, as Boisen was completing his book *Exploration of the Inner World*, he discovered that Alice was facing eminent death from cancer. He determined to dedicate the book to her. While this dedication is no longer than three sentences, the writing process brought on another psychotic episode. Boisen’s comrades at Elgin were quick to recognize the symptoms, and they whisked him away to an asylum in Maryland, likely to be so far from Illinois or New England that it would go unnoticed by hospital staff familiar with him. This stint was another brief one, lasting only four weeks, and Boisen concluded that it was “another problem-solving experience” (177), which helped to clarify his own relationship to his recurrent mental illness, and to his view of madness more generally. For both himself and his patients, Boisen was sure that given the right social supports and knowledge of one’s condition, an increase in one’s symptoms might correspond to an un-investigated problem in one’s life, and one might be able to use such an altered state to bring the problem to light and address it in a new way. This became known as the psychogenetic approach to mental illness, the chief disagreement between Boisen and Cabot.

In subsequent years, Boisen’s research was acutely focused on schizophrenia. The American psychiatrist Harry Stack Sullivan was a strong ally to Boisen in this work and in assisting the publication of his research as founder of the journal, *Psychiatry*, in which much of Boisen’s studies on schizophrenia were published.

As clinical training for theological students expanded throughout the US, Boisen noticed a number of deviations from his initial formulation of the field. Boisen found that more attention was being paid to the verbatim format than to the more general, and extensive, case history as Boisen
had formulated. While verbatims provided a particular “slice of life” as an account of a singular conversation between patient and chaplain, the case history reflected Boisen’s commitment to the living human document. Boisen attributed this shift to clinical chaplaincy’s expansion into the general hospital setting, rather than just to psychiatric patients. He did not disagree with the method but expressed an interest in continued investment in the more robust analysis of case history. Boisen also found “a tendency to accept Freudian doctrine on authority without scrutinizing it closely, and a failure to ask the questions which are of first importance to the student of religion” (186). Boisen was also frustrated at the weak effort by theological schools to incorporate clinical training. He found the primary change that chaplaincy offered was in the form of an additional course simply on “personal counseling,” rather than a more general turn to scientific investigation of religious experience. Despite these transformations, Boisen did not seem to hold an egotistic attitude at deviations from his methods, so long as the focus was on “living human documents of persons in trouble” (196).

Boisen’s autobiography provides his own interpretation and analysis of his psychotic episodes in summary. This analysis of his own case history, of the living human document that is his person, gestures to the generative components that he considers to be foundational to mental illness and their relation to religious experience:

“A review of this record will show that I have passed through five psychotic episodes during which my thinking has been irrational in the extreme and my condition was such as to warrant the classification of ‘schizophrenic reaction, catatonic type.’ By that is meant that in sharp contrast to those forms of schizophrenia in which some adaptation to defeat and failure has been made and accepted, they were periods of seething emotion which tended either to make or break, periods in the development of the personality in which fate hung in the balance and destiny was in large measure determined. Of these five psychotic episodes
I believe I can say that, severe though they were, they have for me been problem-solving experiences. They have left me not worse but better.

“In addition to these five psychotic episodes there have been five major decisions which have been marked by deviation from the normal.

“All ten of these abnormal experiences began under the precise conditions which, for me at least, have characterized creative mental activity. There was intense interest in an important problem. There was also marked narrowing of attention, and prayer carried to the point of absorption. Such conditions are fertile in new Ideas, but the creativity is obtained at the expense of structured experience. Perspective may be lost and wide limits set for the validity of inner promptings. There is likely to be a radical change in the concept of the self, marked frequently by the sense of mystical identification, which leads some psychiatrists to explain such experiences in terms of ‘weak ego structure.’” (1960, 201-202)

In 1965, five years after the publication of his autobiography, Boisen died in Elgin, Illinois, at age 88, his ashes strewn at the Elgin State Hospital Cemetery. Ten years after his death in 1975, at the 50th anniversary celebration of ACPE, an odd scene of non-remembrance seems to exemplify the role Boisen has played in the history of clinical chaplaincy. Boisen’s cane is passed at each annual meeting to the incoming president, and it was at this meeting in 1975 that the tradition began. And yet, at that very meeting, Boisen was not mentioned anywhere in the program. One commentator puts it thus – “Boisen’s successors engaged in the ritual of handing down a holy relic of a founder they could not bring themselves to name” (LaBat 2021, 2). The question must be asked—why can Boisen’s successors not bring themselves to utter the name of the father, yet they commit to honoring his life through a relic? Put differently, how does a field reckon with a “mad founder”? As noted, Boisen held critiques of the field of spiritual care as it institutionalized. Boisen’s interest was primarily psychiatric in setting, the organization opted for hospital-wide chaplaincy. Boisen was committed to a psychogenetic notion of mental illness, Cabot rejected this
idea whole-cloth. And as will be elaborated below, Boisen saw the chaplain’s role as assisting in
the interpretation of a patient’s “psychotic thinking” as religious experience to enable creativity and
problem-solving, while the ACPE, with a big-tent approach for the training of “spiritual care
professionals of any faith and in any setting” now educates students to “develop new awareness of
themselves as person and of the needs of those to whom they minister,” and “enable students
to realized their full potential to strengthen the spiritual health of people in their care as well as
themselves” (ACPE 2020). As spiritual care institutionalized, its new focus required more general
methods for the diversity of sites that came under its purview—ICU’s, detox centers, prisons,
nursing homes, parishes, mental health facilities, or “any setting where ministry happens” (ACPE
2020). Perhaps Boisen’s particular “special problem” was all too specialized, even all too strange,
to account for at that celebration in 1975. Boisen was hardened into the ACPE’s legacy and
heritage—a name too weird be spoken, but an inheritance too looming to ignore.

The reception history of Boisen

Boisen offers himself to the reader as a diverse cast of characters—as a psychological
researcher, a founder, an unrequited lover, a devotee, an educator, a patient, a minister, a
theologian. Thus, when assembling the history of Boisen’s impact on the development of clinical
chaplaincy and clinical pastoral education, one can emphasize any set of these characters to
evoke a particular individual and agenda for clinical chaplaincy. Stephen King offers Boisen the
pastor as his first identity (2007, 29). For Henri Nouwen, who was a friend of Boisen’s, he reads
Boisen primarily as a patient. Boisen’s understanding of mental illness came out of his own
institutionalization as “one of them” (Nouwen 1992). To Susan Myers-Shirk, Boisen is an exemplar
of the liberal moral sensibility that served as the progressive reforming presence in religious communities in the early 20th century (Myers-Shirk 2009, 16-39). To Allison Stokes, Boisen exemplifies the uptake of Freudian analysis in 20th century ministerial practice (Stokes 1985). My interest in Boisen is as a student of William James, and as a predecessor and compatriot to later critics of the practice of psychiatry. Boisen commits himself to a radical empiricism in line with James, insisting that mental illness may have other functions than simply a mark for the Other—“we can say that Boisen’s own psychosis became the center of his identity” (Nouwen 1992, 159). As Stokes outlines, Boisen certainly was engaged with the work of Freud. Yet Boisen holds crucial points of resistance to Freudian doctrine, which will be outlined below. These points of resistance seem to take the shape of the antipsychiatric currents that will form decades later, but from a ministerial vantage point.

Stephen King marks the history of clinical pastoral education as split in two—the first involving personalities and peculiar characters, and the second “a chronicling of committee or board room actions” (2007, 23). Boisen’s own personality rests on this line, and in the institutionalization of the field, Boisen’s vision and influence was often pushed to the fringe. The shift away from Boisen’s interest in research and theological education reform was a product of clinical chaplaincy’s movement away from a “content-centered” approach—i.e. understanding the patient, a close study of the patient’s case history—and instead developing the pastoral relationship and the use of the self in the caring relationship. Two of these personalities King mentions are Boisen and Cabot. These years of a personality-driven history, from 1930 to 1935, were turbulent in the institutionalization of the discipline. From the Council’s inception in 1930, Boisen’s firing and move to Illinois brought the Chicago Council for the Clinical Training of
Theological Students on the scene, and a series of interpersonal conflicts in Boston led to the move of the original Council’s headquarters to New York, and a new organization called the New England Group to form in Boston. One schism was the result of a disagreement between Cabot and Boisen on whether there existed non-organic cases of mental illness, and whether religious interpretation of such cases could provide a patient an opportunity to integrate a so-called “psychotic episode” into an opportunity for re-organization and problem-solving. This was Boisen’s primary interest and method, and Cabot would have none of it. As mentioned above, during one of Boisen’s psychotic breaks, Cabot had him hospitalized and revoked his permission to supervise clinical students at Worcester State Hospital. The direction of clinical pastoral education became more in line with Cabot’s vision for the discipline than Boisen’s—non-psychogenetic, no longer focused on asylum patients, and insistent upon the role of the self in the chaplain’s work (Thornton 1970, 54). On more personal grounds, even students of Boisen and others sympathetic to his cause were unable to see past Boisen’s status as an “ex-mental patient” (Hiltner 1992, Pruyser 1992, Nouwen 1992). While there have been other publications to “provide a renewed understanding and appreciation” (Asquith 1992, 3) of Boisen’s legacy, he is widely considered the founder of the discipline, but oftentimes, as in the scene of non-remembrance above, the discussion ends there. Boisen speaks to this in his autobiography as he recounts the changes to the practice of chaplaincy later in his life.

One primary mode in which Boisen is understood is as a reformer to theological education. He was not alone or singular in his motives; at the turn of the 20th century, other educators leveraged similar critiques to Boisen’s in that the traditional seminary held too much of a focus on scriptural interpretation and understanding, and very little training on how to confront the human condition (King 2007, 14-18). Perhaps surprisingly, reforms underway in theological education
took cues from similar reforms in medical education. To refer to clinical pastoral education as clinical training was exemplary of such cue-taking, borrowed from reforms in medical education at the time. In the context of the history of CPE, the field that positions Boisen as its founder, his role is at times reduced to purely a matter of “feeling for”—Boisen's contribution to clinical chaplaincy is a matter of feeling for “the patients' struggles, their isolation, their being neglected, their being misunderstood and not taken seriously” (King 2007, 148). This softens the radical nature of Boisen’s approach. Boisen did not merely hold empathy for the patients with which he worked. He refers to his patients as “prophets on our hospital wards” (1936, 200), one from whom we may learn and who may even possess special knowledge.

Recently, however, certain scholars of spiritual care and pastoral counseling have attempted to recenter Boisen’s scholarly contributions in these fields. In Sean LaBat's *Anton Boisen: Madness, Mysticism, and the Origins of Clinical Pastoral Education* (2021), LaBat attempts at a revisitation to Boisen's life and research through the prism of Boisen's insistence on the shared resemblance of madness and religious experience. In another recent article, Glenn McCullough also works to reconsider the work of Boisen as an unrelenting force from within mental institutions to destigmatize patients’ conditions (2023). One must ask—why the discounting, or reduction of, Boisen’s centrality in the development of the discipline? And not only this, but how might his rigor in the analysis of schizophrenia, and his conjecture of the proximity of madness and mysticism, inform the practice of chaplaincy and the study of religious experience and its relationship to mental health in the present? As LaBat and McCullough demonstrate, Boisen’s work is often summarized through a polarity between mysticism and madness, or ministry and mental illness, in a more redemptive register. Yet there is trouble in working along such an identity binary—“Boisen
reminds us that even as we rework boundaries, we must also be aware that reworking is also always repetition, that as we adjust social structures, we also perform them, and this means taking on and re-erecting the very borders we rework” (Coble 2014, 417). In Boisen’s special problem, we find that schizophrenia is not simply misunderstood religious experience, but that schizophrenia, when granted permission to rework boundaries, is capable of novel activity—problem-solving, creativity, new syntheses.

**Boisen’s “special problem”: schizophrenia, creativity, mysticism**

With the genesis of Boisen’s special problem spelled out, and the subsequent (mis)understanding of the role this research played in his conception of chaplaincy, I will turn to Boisen’s special problem on his own terms—the shared resemblance of religious and schizophrenic experience, and whether a spiritually oriented cure might be found, or whether “cure” is even the appropriate end for schizophrenia. Boisen published a handful of papers on the subject, as early as 1928 and extending into the 1950s. Boisen’s research on schizophrenia and psychosis develops from his first major text on the subject, *Exploration of the Inner World* in 1930, through the 1950s in a series of academic articles.¹ Boisen’s work on schizophrenia was at a time

---

¹ The articles of note are as follows:
“The Sense of Isolation in Mental Disorder: Its Religious Significance” (1928) in *American Journal of Sociology*;
“Experiential Aspects of Dementia Praecox” (1933) in *American Journal of Psychiatry*;
“Types of Dementia Praecox—A Study in Psychiatric Classification” (1938) in *Psychiatry*;
“Economic Distress and Religious Experience” (1939) in *Psychiatry*;
“The Form and Content of Schizophrenic Thinking” (1942) in *Psychiatry*;
“Onset in Acute Schizophrenia” (1947) in *Psychiatry*;
“The Therapeutic Significance of Anxiety” (1951) in *The Journal of Pastoral Care*;
“The Genesis and Significance of Mystical Identification in Cases of Mental Disorder” (1952) in *Psychiatry*;
“What did Jesus Think of Himself?” (1952) in *Journal of Bible and Religion*
where the very diagnostic term was in transition. “Schizophrenia” as a diagnostic category does not surface until 1908, and its immediate predecessor, “dementia praecox,” emerges in 1886 in a German psychiatry textbook. The period of Boisen’s first commitment in 1920, through his research from the 1920s into the 1950s, was one of flux and further clarification of this diagnosis. We find this in his own work, with one of his earlier articles on the subject bearing the name “Types of Dementia Praecox,” while writing of “schizophrenic subtypes” in the same essay (1938, 233).

Their style is predominantly that of clinical psychiatric research in the texts he publishes in psychiatric journals, but they also include a flair for the theological. One encounters Boisen at his most theological in an essay titled “What did Jesus Think of Himself?” (1952b), where Boisen expounds upon the idea that Jesus did indeed think himself the messiah given his readings of the gospel accounts, and that his messianic consciousness “had...the entire constellation of ideas which characterize the acute disturbances which we see today in mental hospital patients” (1952b, 10). To Boisen’s analysis, this does not lead to discounting the messianic character of Jesus, but instead forces us to consider one’s messianism as a “problem-solving experience.” As Boisen puts Jesus into conversation and community with his patients, he sees Jesus as providing a model for healthy integration of messianic insight, reorganization, and problem-solving. Several of Boisen’s articles were published in early issues of Psychiatry. Much of these are his findings into clinical investigation of schizophrenia—its onset, its expression, and his conclusions on pathways to cure. These contributions to the clinical study of schizophrenia were in great part due to Boisen’s relationship with Harry Stack Sullivan, a landmark psychiatrist and founder of the journal (Hart 2001). Boisen’s special interest in schizophrenia and mental illness more generally was exemplary of his approach to the development of chaplaincy, and his differentiation from Richard Cabot,
trained physician and president of the first Council for the Clinical Training of Theological Students. While Cabot’s vision for theological education was toward those afflicted with bodily conditions, Boisen’s interest was in the mentally ill, and the role religion played in the expression of their psychosis, and in its amelioration (Eastman 1992). Thus, Boisen sees the task of theology as “to organize and test the validity of religious views in light of human experience” (Asquith 1990, 24). Boisen’s interest in religious experience is brought to bear in his studies of madness. Both peak religious experience and the experiences of mental patients are on the same plane.

Boisen seeks a redress of “certain types” of mental illness on the terms of religious experience, contact with the divine, and identification with the superhuman (1952a, 287). Boisen sets this argument out from a recognition of the shared resemblance of the two, mental illness and religious experience. Among his strongest convictions in his research on mental illness was that one could not make such hard and fast determinations between health and illness, or between pathological and mystical experience (Hiltner 1992, 141). Throughout his research of schizophrenia, he runs against a common understanding of schizophrenia as “split thought.” Schizophrenic expression is often discussed in terms of splitting or disintegration, but Boisen insists that there are certain expressions of schizophrenia that reflect a heightened engagement in life, not a disconnection from it (1952a, 290).

In Boisen’s early work, he highlights a process-oriented approach to the condition—it is a “way of life,” and a “reaction to a life situation” (1938, 235). Boisen is also quick to gesture to the importance of sociality in the development of these conditions, and this is a theme that endures throughout his studies. Boisen’s sensitivity to social factors, the role of one’s community in schizophrenic expression, and his insistence upon non-judgment from the clinician with respect to
the patient was absolutely radical in the theory of schizophrenia treatment in the first half of the 20th century. Only later did certain individuals from within psychiatry begin to catch up in their approach. From Boisen’s position as both a patient in this antiquated model of in-patient psychiatric care and as a chaplain and researcher, the antipsychiatry movement to come echoes many of the imperatives Boisen makes from within the asylum.

Boisen writes of schizophrenia as clustering into two distinct groups, generally speaking – the functional and the organic. Boisen described cases of organic schizophrenia as rooted in biological causes, and thus not applicable to Boisen’s investigation. Functional cases were where Boisen saw “reorganization” and “problem solving” was possible. Boisen identifies a theological/clinical trinity in creative reaction, schizophrenic experience, and mystical experience. The breaks, episodes, and subjective states that interest Boisen are simultaneously coded as all three, but they come to be understood through the clinical gaze as primarily, or exclusively, psychotic in nature. Boisen comes to this conclusion quite early through experiences of his own psychotic episodes during his first hospitalization at Boston Psychopathic Hospital. In a letter to his friend and confidant Fred Eastman, not two months into his commitment to the insane asylum, Boisen concludes the following:

“I see two main classes of insanity. In the one case there is some organic trouble, a defect in brain tissue, some disorder in the nervous system, some disease of the blood. In the other there is no organic difficulty. The body is strong and the brain is in good working order. The difficulty is rather in the disorganization of the patient’s world. Something has happened which has upset the foundations upon which his ordinary reasoning is based. Death or disappointment or sense of failure may have compelled a reconstruction of the patient’s world view from the bottom up, and the mind becomes dominated by the one idea
which he has been trying to put in its proper place. That, I think, has been my trouble and I think it is the trouble with many others also.” (1936, 10-11)

He addresses schizophrenia as typically “begin[ning] with intense preoccupation over one’s personal situation and with emotion so intense that one is carried, as it were, into another world” (1942a, 23). This is often understood as anxiety, but in the schizophrenic, it is anxiety carried to the extreme (1947, 1951). Boisen insists on the productive role of anxiety—“anxiety is not necessarily an evil but may be a condition of growth and of reorganization” (1952a, 292). Boisen locates the power of anxiety in the dissolution of self (1951, 2). Anxiety must not be considered an evil, or an enemy, but is “better interpreted as a manifestation of nature’s power to heal which is analogous to fever or inflammation of the body” (1942a, 30). This anxiety to the extreme in the early crisis stage results in an altered concept of a generalized Other, with the biproduct of an alteration in, or dissolution of, the concept of the self. It typically begins with a preoccupation of one’s thoughts and a period of sleeplessness. This preoccupation is then experienced as though one’s ideas are coming from an outside force—potentially a superhuman origin. Such an experience of these ideas from the generalized Other pushes one into utter perplexity, and potentially even a sense of profound self-importance. One may begin to feel their life as taking on cosmic significance. This sense of self-importance may bring one to a sense that they must sacrifice their very life for the cause in which their life is implicated.

After such an acute state of crisis, one may attempt a reorganization. It is here that Boisen presents the standard taxonomy for schizophrenia—the simple type, the paranoiac, the hebephrenic, and the catatonic (1947). The simple type is characterized by a withdrawal into phantasy. The paranoiac attempts to escape defeat through a perceived sense that this generalized Other is an enemy that is everywhere. In the hebephrenic, one finds the characteristic
features of speech alteration and word salad that seems intelligible only to the speaker. The catatonic, Boisen describes as engaged in a desperate struggle for reorganization, and the one type of the three who may have the best opportunity for breakthrough and problem-solving.

Boisen highlights the war between meaning and symbol in schizophrenic reaction—“In such states meaning outstrips symbol. Not only does the excited schizophrenic have to find new words to express the new ideas which throng in upon him, ideas for which the conventional language is inadequate, but he has no longer any language of which he is sure. Only one thing is certain: things are not what they seem. In everything that happens he sees hidden meanings” (1942a, 25). Boisen remains committed to the idea that these experiences are meaningful, even if to the observer or clinician, they appear irrational or nonsensical. Boisen finds the key to such meaning in the role of language—“the key to the understanding of schizophrenic thinking I find in the view that the use of language is the distinctive basis not only of human social organization but also of the structure of the personality” (1942a, 27). Boisen witnesses a bias to concreteness over abstraction in verbal expression. In contrast to the “normal man,” who typically works in terms of abstraction in order to “do his thinking in an accepted currency of ideas,” and “thus indulges in much that is mere verbalization and involves little emotional participation,” Boisen describes schizophrenic as highly emotive. He “finds himself face to face with what for him is ultimate reality. He is profoundly stirred emotionally and quickened mentally...New ideas come crowding in upon him for which the conventional language is inadequate. In everything that happens he sees meaning. This is but another way of saying that his thinking is characterized by concreteness and by directness of perception and feeling” (1942a, 32). It is on these terms, in the poverty of symbol
and the wealth of meaning in schizophrenic perception, that Boisen sees the close resemblance to mystical experience.

While Boisen’s work is often put into conversation with the development of pastoral theology (Hiltner 1958; Gerkin 1984), Boisen also functions as a quiet actor in the tradition of critical psychiatry, or antipsychiatry, and one of his biographers makes such a connection explicit. One biographer of Boisen describes his conclusions as running parallel to the work of Thomas Szasz, psychiatrist and author of *The Myth of Mental Illness* (Thornton 1970, 69-70); another recognizes Boisen as a “precursor to the ‘anti-psychiatry’ movement of the 1960s, and the more recent movements of ‘mad pride’ and ‘mad studies’” (McCullough 2023, 230). In Boisen’s own telling of his life’s work, his research into schizophrenia is some of his most important contributions to the production of knowledge (1960). How do these theoretical contributions to the study of madness fit into the historiography of Boisen? Does his title as “father of CPE” eclipse his own narrative sense as a scholar of madness? It is certainly the case that one informs the other, and the attempt at their extrication is not so easy. When read in such a manner, Boisen’s contributions to the understanding of schizophrenia, and the fundamental role of social determinants in both expression and interpretation of schizophrenic reactions, are highly prescient in the reforms to psychiatry in the second half of the 20th century. One also finds a comity with antipsychiatry in Boisen’s engagement with Freud and conventional psychoanalytic doctrine of the time. In his autobiography, Boisen writes of his first encounter with Freud during his first institutionalization, describing his reading of the *Introductory Letters* as if he were reading the answers in the back of a textbook, discovering that all of his responses were accurate. Yet as early as 1928, Boisen pushes back against the Freudian doctrine of the time on the necessity of a patient’s attachment to the
analyst for successful treatment (1928), and he became quite critical in other chaplains' turn to psychoanalysis and away from “the raw stuff of religious experience” (Gerkin 1984, 38). Boisen also expresses a resistance to Freudian doctrine in the role that the unconscious plays in analysis (1942a, 30). In Freudian parlance, the unconscious is the site of disharmony between one’s organization of meanings and one’s social self. While this may be pre-linguistic, Boisen does not consider this an unconscious process, but a “dissociated” one. It is something we may be aware of, even if we are unable to put it into words.

In order to see where Boisen’s own theory of schizophrenic reaction fits into the development of the concept, we must lay out Freud’s own understanding of schizophrenia, and compare this to later work from a landmark in antipsychiatry, Anti-Oedipus (1977). Chronologically, Boisen is nearly contemporary with Freud. Freud’s unique attention to the etiology and cure of troubling inner psychic states sets him as holding parallel interest to Boisen’s own project. While the argument has been made that Boisen himself was a psychoanalytic thinker, or at least owed a debt to psychoanalysis (Stokes 1985), Boisen’s work might be better placed in later theoretical developments. While much of antipsychiatry resembles a psychoanalytic method, there are certain key components of Gilles Deleuze and Felix Guattari’s Anti-Oedipus that diverge from psychoanalysis, specifically on the problem that schizophrenia posed to psychoanalytic conceptions of “cure.”

**Boisen through Freud and Deleuze/Guattari**

Boisen held an ambivalent relationship with Freud. In his early encounters, Boisen felt that Freud was a fellow traveler in the study of inner worlds. As his understanding of schizophrenia and
spiritual care for schizophrenics developed, he distanced himself from psychoanalytic convention and its influence on psychiatry. What follows is an attempt to situate Boisen’s unique approach to schizophrenia alongside Freud’s own treatment, to which Boisen relied upon and pushed against. I then offer Deleuze and Guattari’s schizoanalytic method as a landmark counterweight to Freud’s impact on psychiatry, which situates Boisen as both an inheritor of Freud’s legacy and an early contributor to the antipsychiatry movement. These three accounts of psychosis taken together—Boisen’s religiously inflected living human document, Freud’s psychoanalytic model, and Deleuze and Guattari’s schizoanalytic intervention—outline the challenge of determining what psychosis means, and insist on the potential for what psychosis may do.

The problem of schizophrenia

As Allison Stokes argues in Ministry After Freud, the field of clinical spiritual care owes a debt to Freudian psychoanalysis that often goes unrecognized. Like clinical chaplaincy, psychoanalysis marked a radical juncture in the history of psychology as an unrelenting commitment to the importance of inner psychic states, against the host of physiological explanations for behavior that had governed the nascent discipline. Psychoanalysis also pressed against later Rogerian currents of experimental psychology that surmised inner states could only be accessed by attention to external behaviors. Freud’s theoretical work provided several cartographical tools to map how these states develop, how they function, and how an analyst, in the work with a patient, might best access them and assist the patient in overcoming psychic blockages and neuroses. These tools have left an enduring legacy, even if the mainstream currents of psychology, psychiatry, and
pastoral care have sworn Freud off to various degrees. The case of schizophrenia and its history of treatment highlights this disavowal acutely; Tanya Luhrmann notes schizophrenia as the “poster child” of a “bio-bio-bio’ model of psychiatric illness: genetic cause, brain alteration, pharmacologic treatment” (2016, 2), borrowing this “bio-bio-bio” terminology from John Read (2005). Yet even as Freud pressed against neurobiological notions of etiology of mental illness, schizophrenia remains one of Freud’s enduring oversights, and this has held reverberating ramifications in the practice of psychiatry in its treatment. For Freud, schizophrenia becomes the antithesis to what treatable neuroses look like. Freud sees transference neuroses as the primary project for psychoanalysis. The transference neurosis is the “transformed and manageable form of the disease enemy” (Reed 1990, 447) —one holds libidinal conflict within oneself, and it is in work with an analyst that that conflict, or neurosis, is transferred onto the analyst. This transference may take many shapes; an analysand may transfer the conflict directly onto the analyst (the analyst is a stand-in for a parent with whom one has a conflict), or through re-experiencing the conflict in the analytic setting. The operative frame for psychoanalytic work is through the transference of one’s neuroses onto the analyst, and in this transferring to the analyst, the analysand might reach a momentary proper valuation of their repressed conflicts, or at least lay bare one’s resistance to those conflicts. However, if the analyst is unable to place “the bridle

---

2 Anecdotally, in my work in a psychiatric inpatient unit at a local hospital, the psychiatrist to whom I report works out of an office with a striking amount of Freud on the shelf. When I asked him about his relationship with Freud, and the role that Freud’s oeuvre might play for him in his work, he has said something along the lines of, “I mean, you can’t deny he got a lot of stuff right,” and “everybody has some sort of relationship to Freud.” While much of the work on psychoanalysis today seems limited to theoretical applications in media studies, ethnic studies, and literature departments, there is no doubt that psychiatry continues to reckon with the cartographical methods Freud provided.

of transference on a patient’s rampant drives,” (Freud 1914b, 398) the game is up. Analysis cannot be done. To Freud’s calculus, there are a few neurotic conditions that refuse to give themselves over to analysis—hysterics, obsessives, (1913, 46) narcissists, hypochondriacs, and paraphrenics (1914a, 359). Their neuroses are not a result of troubled object-libidos, the bread and butter of the analytic method, but of ego-libido, whose neuroses cannot be transferred. Thus, the schizophrenic is untreatable to analysis. While they are not ignored, they are seen as something quite separate from those with transference neuroses and are unable to reach any sort of proper valuation of their psychic states. This feature of schizophrenia has endured in the history of psychiatry. While subsequent developments of analysis have distinguished between disorders of affect—the neuroses—and disorders of thought—schizophrenias, for example—the latter are still judged as significantly harder to treat.

This institutional stickiness of the schizophrenic state, from Freud to my own experience as a chaplain in a modern Boston hospital, illuminates why Deleuze and Guattari’s project of an alternative analysis starts with the schizophrenic, and how Boisen’s schizophrenia-oriented project offers a divergence from mainstream psychoanalytic currents of his time. Like Boisen’s, Deleuze and Guattari’s Capitalism and Schizophrenia series is first and foremost a schizophrenic project, and with schizophrenia foregrounded, Freud’s psychoanalytic method begins to come undone. For if the schizophrenic and other “paraphrenic” conditions are left to the edges of psychoanalysis, one must ask what sort of values are being thrust onto the transference neurotics by this system. Freud points to the fact that there is not a dispositional separation between neurotics of the ego-libido and the object-libido; everyone is equally as likely to have a neurosis of
one or the other at some point. Thus, in an insistence of the impossibility for treatment of the ego-libido neuroses, Freud seems content in an inadequate method for neurotic treatment.

**Freud’s schizophrenic: analytic anomaly**

What comes to be concretized as schizophrenia operates throughout Freud’s work under three separate terms—first as dementia praecox, and then simultaneously as schizophrenia and paraphrenia. The designation of “dementia praecox” came from the earlier work of Emile Kraepelin, and paraphrenia was the term Freud suggested for this illness (1913, 46), while Swiss psychiatrist Eugen Bleuler and his new term for the condition eventually won out (Ashok et al 2012, 95-96). Thus, in tracking Freud’s theoretical understanding of this condition, we also see the disciplinary development of a nascent concept of this symptom cluster. For ease of understanding Freud’s usage and given the relatively stable symptom cluster to which he and other researchers refer, I will treat them each as synonymous, and merely as analytical developments along the same symptomatology, and thus refer primarily to schizophrenia.

While there is mention of schizophrenia as early as *Interpreting Dreams* and throughout the Great War period, Freud gives his most thorough-going treatment of schizophrenia in “On the Introduction of Narcissism” (1914a) and “The Unconscious” (1915c). In each, the distance between transference neuroses and neuroses of ego-libido are plotted, gesturing to the unique challenge that ego-libido neuroses pose to psychoanalysis. This distance makes clear that Freud’s analytic method fundamentally could not include the work of treating neuroses of the ego-libido. It

---

4 “Paraphrenia” intended to convey a beside-ness (Greek παρά), or contrary to, one’s mind, while Bleuler’s definition evinced the split-mindedness (German Schizein) of the condition.
is worth mentioning the consistent message that patients with schizophrenia are not worth an analyst’s time. At one point he recommends performing a trial analysis with every patient in the event that they have schizophrenia, in which case the analyst can terminate the relationship so as to avoid “wast[ing] his efforts and discredit[ing] his therapeutic method” (1913, 46). Freud also mentions that if he were to do more serious and extensive analysis of schizophrenia, it may call into question his theory of the primal drives (1915, 19).

In “On the Introduction of Narcissism,” Freud adds an injunction on schizophrenia because he sees both narcissists and schizophrenics as troubled by the same break from transference neuroses—they do not seek new objects to libidinally cathect. Instead, they abandon the world and cathect to/libidinally invest\(^5\) in their own egos. Freud notes the two fundamental characteristics of schizophrenics—megalomania and a withdrawal of interest from the external world. This withdrawal from the external world is what makes them “unamenable to psychoanalysis, it makes them incurable no matter how hard we try.” (1914a, 359) The obsessional and the hysterical resurface as those other challenges to analysis, but Freud reads these types as maintaining a connection to the external world; they still have erotic relationships with people and things. The schizophrenic, on the other hand, in their withdrawal from the external world, and in their megalomania, channel their libido into their own ego.

\(^5\) The use of the term “cathexis” is a fraught problem in Freud-translation. Freud’s original translator to English, James Strachey, selected this word (Freud 2006, 366), and is suggested by newer translators to have “nothing of the apparent simplicity of Freud’s metaphor Besetzung.” At first glance, Freud’s employment of Besetzung feels rather far afield from its more concrete uses in German—the occupation of a country, to occupy (as in, to squat) a building, or to cast actors in a play. Another translator opts for “investment” or “investment of energy,” (2005, xxii), but caveats; “‘charge’ is, admittedly, an equally strong contender, and one that has the additional merit of resonating with the ‘electricity’ imagery so fundamental to Freud’s metapsychology” (xxiii). Yet another translator admits that Freud’s Besetzung is not a matter of finding the right denotation in “charge,” “occupation,” or “investment,” but, citing Freud, that “the actual process denoted by this term is ‘something...of which we are totally unable to form a conception, but which, if it had entered consciousness, could only have been described in such and such a way’” (Solms 1999, 41).
While Freud may hold that the treatment of narcissism and schizophrenia by psychoanalysis may be impossible, he recognizes study of these types refines his notion of the ego, just as the analysis of the transference-neuroses informed his understanding of the libido. Neuroses, either of the libido or the ego, inform one’s “understanding of the normal” (1914a, 367). Just as the movement of transference neuroses, from introversion to regression, is the operative path for object-libido build-up, Freud sees something similar happening with these enigmatic neuroses of the ego—they must be the result of build-up of ego-libido as they introvert and regress from the people and things of the world. Megalomania, then, is a result of the disinvestment from the world as the libido chooses to instead invest in imaginative products. Hypochondria arises when this control process fails, when one is struck with the potential danger of one’s imagination. In each moment of the schizophrenic symptomatic development, Freud lines it up with how he has seen transference neuroses operate—megalomania as the transference move to cathect new objects (i.e., to exchange the self for new objects), and hypochondria as the “fear characteristic of transference neuroses” (1914a, 372). In the parallel paths of paraphrenia and transference-neuroses along ego-libido and object-libido, Freud notes that it is not a matter of two distinct human groups—one amenable to analysis and the other not, or one disposed to making an imitative object-choice in love relations (object-libido) and the other a narcissistic choice (ego-libido), but that both paths are open to all. Rather, we all begin with both sexual objects—oneself and one’s caretaker; we are born into a state of primary narcissism. It is even the case that we all occupy states of temporary cathected ego-libidos. For instance, when we fall ill, all our energy turns inward, obsessing on our inner state until respite comes, and we can divest from our own ego. In this way, it is not the case that some people are simply predisposed against analysis, but
that choices throughout one’s life and particular environmental factors might bend one away from the analytic enterprise, wrested from the bridle of transference.

This notion of two open paths leads Freud to the distinction between two drives—sexual drives and ego drives, the former informed by his work on transference neuroses, and the latter informed by his observations on the impossibility of reforming an ego-libido. In the impairment or depletion of the ego in transference neuroses, one might attempt a recovery in a schizophrenic move toward the ego. Yet it does not seem to work in the other direction—for Freud, a pathologically over-invested ego cannot be returned to the world of people and things.

Freud’s other primary site of investigation of schizophrenia is in “The Unconscious” (1915c). At the tail end of his investigation, Freud notes again the challenge that schizophrenia poses to successful work with transference neuroses. A period of repression is assumed—everyone is repressing—but for the schizophrenic, the post-repression libido does not seek a new object. Instead, it retreats into the ego into an infantile position, “a primitive objectless state of narcissism” (1915c, 79). The result is a “lack of a capacity for transference...their resulting imperviousness to therapy, their characteristic rejection of the outside world...the final outcome of complete apathy.”

Yet, the schizophrenic state offers something unique to the study of the unconscious, namely, that schizophrenics express consciously what psychoanalysis permits for expression in the transference neuroses. The schizophrenic seems to possess an unconscious that is always already present to them in their communication through language, even if muddled. In the early stages of schizophrenia, Freud makes note of how one’s speech resembles nonsense, the nonsense often clustering around a specific connection to a bodily organ. In reference to some clinical work by an Austrian psychiatrist, Dr. Tausk, Freud sees how a patient explained their own
utterances, which he and Tausk saw “amount[ed] to analysis.” (1915c, 80) This schizophrenic patient was able to render a comprehensible meaning from what an observer, in the initial utterance, might hear merely as nonsensical speech. More specifically, schizophrenic speech arises as “organ language” in the manner that the nonsensical directions all are rooted in a bodily particular. Tausk’s patient makes a series of comments about her eyes and about her lover as a deceiver, or Augenverdreher, “eye-twister.” The patient then speaks about being positioned, that she is being jerked about as if someone is moving her body against her will, followed by her analysis that her lover wishes she would act in a more dignified and refined fashion, attempting to make her like him. Freud draws a distinction between this patient and a hysterical, who rather than consciously feeling as if her eyes are twisted or feeling the impulse to or sensation of being jerked about, the hysterical would have twisted her eyes herself or performed the jerking movement unconsciously. Yet this schizophrenic patient holds all these thoughts consciously, linguistically, even if muddled or nonsensical.

Freud sees a parallel between the schizophrenic relationship to words and the dream process of moving latent dream-thoughts into dream images, a condensation together of many thoughts and investments, displaced into even a single word that is repeated or an image in a dream. Freud refers to this condensation and displacement of a schizophrenic’s thinking into a single word or phrase as a “substitute formation” (1915c, 81). The character of these formations is derived from the power of the word-relation over the thing-relation. In an adjustment to his conclusions on his essay on narcissism, object-investments are not abandoned, but are substituted by the word of the object. Thus, investments are made in word-ideas over thing-ideas. “The substitute is determined not be the similarity between two things, but by their identity when expressed in
words” (1915c, 82, emphasis added). What is conscious is not solely object-ideas, but rather two dimensions of the object in the word-idea and the thing-idea. This clarifies Freud’s difference between conscious and unconscious ideas—the difference is not a matter of psychic location, nor a functional distinction, but that conscious ideas are constituted by a thing-idea and corresponding word-idea, while unconscious ideas are thing-ideas lacking a word-idea.

This newfound notion of conscious and unconscious ideas plays out in a reformed understanding of repression, wherein the repressive act is the withholding of a translation of thing-ideas into words. An idea remains repressed if it not put into words, however Freud also notes that simply linking a thing-idea to words does not render it conscious. It allows for the possibility of making it conscious in the pre-conscious system. While Freud’s engagement with schizophrenia gets him no closer to making these patients amenable to analysis, they bear significantly on his understanding of the psychoanalytic process of uncovering repressions and the function of the unconscious system. The schizophrenic, on the other hand, has an ego that is in flight, with a total divestment from unconscious object-ideas, and total investment in word-ideas. The schizophrenic evades the repression of transference neuroses, and instead engages in something like a self-cure in linking their thing-ideas to word-ideas in speech. Freud is not content with this self-cure, for schizophrenics would then “have to content themselves with words instead of things” (1915c, 85). There is something about schizophrenic speech that still seems inadequate for Freud—it is not enough that a schizophrenic can give voice to their unconscious and thus circumvent the repressive apparatus. Freud’s understanding of the flight to words is tantamount to a flight from reality. The “abstract” nature of schizophrenic speech does not fit into either of the two paths of operation for psychic activity that Freud sees, in a) a movement from drives to the unconscious,
and onto conscious thought activity, or b) in the case of repression, from external stimulus to the conscious and preconscious systems, and into ego- and object-investments in the unconscious. In a peculiar detour, Freud sees the schizophrenic mind as not unlike the work of philosophizing, a way of thinking in the abstract—and that such thinking in abstract terms puts us in danger of “neglecting the relations between words and unconscious thing-ideas,” or in the reverse, that schizophrenic thinking is treating concrete things as if they were abstract.

In Freud’s much earlier thinking on schizophrenia in *Interpreting Dreams*, he comes to many of the same conclusions about the schizophrenic condition. Namely, patients with schizophrenia seem to have direct access to the meaning of their dream-symbolism. The random association and free play of ideas that the analyst might help a patient through, the schizophrenic is able to come to all on their own. This power of self-analysis to which Freud gestures, he also finds inadequate. While he does not seem troubled by the inability for psychoanalysis to approach their neuroses, he recognizes they fall outside of his system to some degree, even if research into their ego-attachment is informative to his understanding of ego and libido. A number of possibilities emerge as to why schizophrenia cannot be addressed through psychoanalysis. First, their capacity for self-analysis seems to undo the role of the analyst. Schizophrenics have a unique access to the symbolisms of their dream-lives and a power to analyze the incomprehensible speech acts they may commit, which is supposedly the intended task of an analyst. Second, and related to the first, the schizophrenic is able to circumvent repression in their direct access to conscious ideas, even if the word-idea may be divorced from the thing idea. Third, the libidinal investment in the ego, and thus a divestment from the world of objects, gestures to a psychoanalysis that cannot comprehend persons who simply refuse the social world, for whatever reason. The psychoanalytic reading of
such ego-investment is equivalent to a flight from the world. For Freud, social relations are taken as a given, an endless pile of things and objects for one to cathect. The schizophrenic position, at least to Freud, is one of refusal of this pile in an imaginative flight to the “I.” While Freud seems to abandon any attempt at treatment of schizophrenia the likes of which he finds for transference neuroses, later psychiatric developments provide an alternative treatment for the schizophrenic in a renewed attention to interpersonal dynamics and in a re-assessment of schizophrenia as a theoretical enterprise rather than a categorical assumption for diagnosis.  

Schizo, Paranoiac, Schizophrenia: or, Deleuzo-Guattarian analysis

Freud’s trouble with schizophrenia was not an outlier in psychiatric practice. In Donald Light’s sociological study of psychiatric training in the 1960s, he notes treatment of as the pinnacle of achievement in a psychiatrist’s career given the unique challenge that their cases provide (1980, 7). Schizophrenia has also been contested in diagnosis and noted as a near-untreatable condition. Tanya Luhrmann tracks the shift in diagnosis of schizophrenia through the development of the Diagnostic and Statistical Manual of Mental Disorders (DSM), noting that as the etiology of schizophrenia became increasingly biologized in the 1980s as a response to critiques of an overreliance on psychoanalysis by psychiatrists, its symptomatic cluster and characteristics shrunk. For those who may still be diagnosed under the regime of the DSM-III, “schizophrenia had now become the diagnosis of devastation.” Luhrmann paraphrases psychiatrists’ response to the

---

improvement of a schizophrenic’s condition thus—“if a person gets better, he or she didn’t have schizophrenia in the first place” (2016, 17). “Psychosis” became the more general category for anyone who does not seem to manage within the bounds of medicine at the time (British Psychological Society, 2014), and to this day there is no biological or diagnostic test to determine a schizophrenic condition; its diagnosis is based purely on the observation of the patient by the clinician. It is assumed that psychotic reaction is almost always a matter of delusion or hallucination—a disconnect with reality. However, a handful of clinicians and anthropologists have attempted at reforms to care for schizophrenics; a focus on interpersonal influences pertaining to the development of schizophrenic symptoms (Sullivan 1953), or an analysis of schizophrenia as “a special strategy that a person invents in order to live in an unlivable situation” (Laing 1967, 115). Boisen also belongs to such a tradition in his read of schizophrenic reaction through the prism of religious experience. Ronald Laing’s account of abuses of schizophrenics led to what became known as the antipsychiatry movement, and while Laing did not personally identify with antipsychiatry, his work was a pivotal point of departure for psychiatric practitioners and theorists alike. Gilles Deleuze and Felix Guattari’s project followed from the momentum of the antipsychiatry movement, and they lean on Laing for a clinical understanding of schizophrenic reaction (Woods 2011, 146 & 159). “Schizophrenia” is deployed far beyond the bounds of a diagnosis as Freud or the DSM had in mind, and becomes process, revolutionary figure, and relationship to desire all in one; “schizophrenia provides the primary conceptual vehicle for Deleuze and Guattari’s articulation of a radically decentered, desiring, and revolutionary form of (non)subjectivity, as well as the basis for a ‘materialist psychiatry’ that views desire in terms of production and production in terms of desire” (Woods 2011, 146). Schizophrenia is not a desired
state or goal, but the schizophrenic is included and recognized as person. While many figures with a theoretical background have attempted to sanitize Deleuze and Guattari’s schizophrenia of its clinical or psychiatric valences, Guattari’s life as a practicing analyst for forty years, and his work specifically with schizophrenic patients at the Clinique de la Borde, suggest that their deployment of this term cannot be wholly unmoored from the clinic. Rather, this serious engagement with the granularity of schizophrenia should put its clinical legacy, and its genealogical connection to Freud, at center stage.

First, in *Anti-Oedipus*, Deleuze and Guattari draw a clear line between their “schizo” and the pathological “paranoid” or “schizophrenic.” The schizo is a way of being anyone can take on for themselves, including schizophrenics themselves, meanwhile the pathological accounts—“paranoid,” or “schizophrenic”—they read as serving a specific function in institutional psychiatry. They place the schizo in stark opposition to the “artificial schizophrenic” of psychiatric institutions—“a limp rag forced into autistic behavior, produced as an entirely separate and independent entity” (1977, 5). Second, schizophrenia also comes to function as political-economic critique and intervention. For Deleuze and Guattari, schizophrenia resembles the logic of capitalism—it is a way of being that “is constantly breaking down codes and dismantling historically meaningful social structures to permit the free flow of capital and labour [sic]” (Woods 2011, 148). Yet schizophrenia also provides the potential for capitalism’s destruction—as capital must reinstate its own new codes, so the schizophrenic dissolution of codes may also map a path outside or against capital. For the purposes of a comparison to Freud and Boisen, I will focus on Deleuze and Guattari’s notion of schizophrenic *as person* and point to Deleuze and Guattari’s work in their deployment of this figure toward an alternative form of analysis. Deleuze and Guattari’s
primary targets are clearly Freud’s notions of the Unconscious and the Oedipus (or oedipalizing) complex. Yet Deleuze and Guattari’s interest in schizophrenia is precisely in schizophrenics’ resistance to oedipalization and to Freudian notions of the ego. In Deleuze and Guattari’s reading of Freud, the feeling was mutual: “Freud doesn’t like schizophrenics” (1977, 230). In their resistance to Freudian analysis, the schizophrenic becomes Deleuze and Guattari’s mode by which to leverage critiques of psychiatry and of Freud. Thus, through a comparison of schizo-to-schizo-to-schizo—Boisen’s, Freud’s, and Deleuze and Guattari’s, we note points of consistency, relays between each of their projects, and how Freud’s schizo laid the groundwork for a psychiatric practice that could render the schizophrenic with no other options than the asylum.

For Deleuze and Guattari, schizophrenia is an authentic and full engagement with reality, in direct opposition to Freud’s diagnosis of a schizophrenic who has vacated reality (D&G 1977, 87-88). Freud sees the schizophrenic as marked by a turning from the world of people and things, no longer cathecting objects as one “should.” Deleuze and Guattari see the unending chain of cathected objects not as the real encounter with the world, but as a representational engagement. The object-investment is but another repetition of the same, an oedipalized transference-neurotic playing out the same game on another person, or on another thing. Three figures are posed in the process of schizophrenia—the “schizo,” the “paranoid,” and the “schizophrenic”—the first (“schizo”) a successful breakthrough, an escape from the hospital as it were; the second (“paranoid”) defined by an introversion to the ego and insisting on a despot as source of meaning; and the third (“schizophrenic”) the unsuccessful breakdown (or a potential future successful breakthrough, for Boisen), “the clinical entity that ‘lacks’ Oedipus” (D&G 1977, 136). Deleuze and Guattari mark the schizophrenic, the third moment in their schizophrenic process, in essentially
the same way as Freud, only with an alternative view of the role of the hospital. Deleuze and Guattari’s schizophrenic shows the Freudian method for what it lacks, while Freud gestures to the schizophrenic as lacking the necessary mind for analysis, and in need of an institution for their own and society’s security. The nominal similarities (“schizo,” “schizophrenic,” process of “schizophrenia”) of the breakthrough and breakdown seem to be a purposive cause for confusion—“schizophrenia is at once the wall, the breaking through this wall, and the failures of this breakthrough” (136).

Angela Woods notes this tripartite structure as reflective of the three diagnostic categories of schizophrenia in the common parlance of psychiatry—hebephrenia (now called “disorganized” or “undifferentiated”), paranoia, and catatonia, of which Boisen also notes systematically. The hebephrenic, per some of the earliest work by Emile Kraepelin, is often filled with “childish silliness and senseless laughter,” they are not committed to keeping up appearances, they operate outside of the socially accepted times for activity, and often fail to participate productively within the bounds of capitalism (1915, 234 & 240). This tripartite view also parallels Boisen’s observation, where the catatonic schizophrenic is one who is engaged in a desperate struggle, and the one who may be able to take their expression of madness as an opportunity for problem-solving, even within the asylum (Boisen 1947, Boisen 1942a). Deleuze and Guattari’s account of a schizophrenia-process seems less to be a theoretical flourish or a sanitization of clinical concepts, but a commitment to medical history, from the earliest work on the subject by Kraepelin, for the sake of critique. In their account, the hebephrenic/schizo is free to abandon societal mores, and their failure to productively participate reveals social custom for the disciplinary regime that it is. The
catatonic, too, marks the hospital in the same way—it is not a place the schizophrenic can come to get well, but is instead where they are sent to be broken down.

In Deleuze’s “Schizophrenia and Society,” the schizophrenic process is simplified into a bipolarity—the organ-machine at one end, reflecting the hebephrenic total breakthrough, and the organless body on the other in a catatonic breakdown (2006, 17-19). The organ-machine is a response to a philosophical problem on the relationship between organisms and machines, which were typically pitted as opposites (Smith 2018). Organisms reproduce, machines do not. Organismic movement is unpredictable, machinic movement is calculated and determined. Organisms are not immediately teleological, machines are constructed for a purpose. Deleuze and Guattari insist upon the unity of these forces in the organ-machine—constructions that are unpredictable, non-teleological, and assessed based on what they might do, rather than on formal or substantial aspects—injecting the machinic into the organism. The organ-machine is a matter of putting disparate and unconnected elements together into new aggregates, generating a productive “nonsense.” It is a refutation of the “organization” implied in the organism. Deleuze and Guattari draw on Geoffroy Saint-Hilaire’s notion of organism as a particular form of organization, organizing and hierarchizing the organs into a self-regulating whole (D&G 1987, 45-47). The organ-machine is a productive disorganization of the organs in order that they might do something new.

The organless body, on the other hand, is another form of repudiation of organization that terminates in stasis rather than the productivity of the organ-machine—a stupor, a catatonia, a whole body operating with a single organ in mind. This organless body is the bodily experience of the clinical schizophrenic. It is not unlike Dr. Tausk’s patient whose whole expression becomes the matter of an eye, or a twisting of her limbs. In Deleuze’s account of the schizophrenic, we find the
radical commitment to the “polymorphously perverse” (2000, 57) as Freud describes in his account of the sexual drive—one drive, infinite directions. Freud shuts his own account of this polymorphously perverse drive into an erotogenic notion of normal development, yet he does not even seem thoroughly committed to such a “normal,” as one can only find a definition of the normal in relation to his numerous accounts of the aberrant. Deleuze picks up this thread where Freud drops it, and pursues where the drive might go, the schizophrenic lines along one might discover what a body can do.7

Deleuze and Guattari’s conception of the organ-machine shifts in their later text, into the “body without organs” (1987, 149-66). This body without organs is not a body that does not have organs, but a body without the imposed regime of organization, regulation, or hierarchization. They put the organization of the organism alongside two other systems of order that “bind us,” which they call strata (159): that of significance and subjectification. Just as one is ordered as an organism, one is also made to interpret and be interpreted—“otherwise you’re just a deviant.” And as one is ordered into meaning-making, into “making sense,” one is subjectified as citizen, student, parent, child, as “I”—“otherwise you’re just a tramp.” Deleuze and Guattari’s imperative to become a body without organs, then, is to attend to these stratifications, to experiment on a stratum, and to disorganize when possible. Perhaps in response to critiques of a too-glorified schizophrenic figure in Anti-Oedipus, they are just as quick to note the threats posed in the process of becoming such a body without organs—it is not a risk-free enterprise. The despot-inclined paranoiac and the

7 One might even go so far to say that all of Deleuze’s work is in response to one line in the third book of Spinoza’s Ethics—“For indeed, no one has yet determined what the body can do...This shows well enough that the body itself, simply from the laws of Nature alone, can do many things which its mind wonders at.” (III, P2, Schol., emphasis added) Schizophrenia, for Deleuze, is an incessant line of responses to the open possibilities of the body, to which the mind is only left to wonder at.
institutionalized catatonic of *Anti-Oedipus* become the “botched” or empty body without organs in *A Thousand Plateaus* (149). The risk of such botching requires that one must proceed with caution—

“how necessary caution is, the art of dosages, since overdose is the danger. You can’t do it with a sledgehammer, you use a very fine file...Caution is the art common to all three [organism, significance, subjectification]; if in dismantling the organism there are times one courts death, in slipping away from significance and subjection one courts falsehood, illusion and hallucination and psychic death...You have to keep enough of the organism, for it to reform each dawn; and you have to keep small supplies of significance and subjection, if only to turn them against their own systems when the circumstances demand it...Staying stratified—organized, signified, subjected—is not the worst that can happen; the worst that can happen is if you throw the strata into demented or suicidal collapse, which brings them back down on us heavier than ever” (160).

Making oneself a body without organs can be a dangerous affair, and the schizophrenic process highlights the precarity of one’s disorganization. Boisen’s own life testifies to it—his disorganization (or psychosis, as we may have called it before) led to his institutionalization on more than one occasion, and his institutionalization led to periods of such a botched organless body. Yet he could lodge on a stratum, identify a special problem, experiment with the meaning of this disorganization, he could generate novelty—chaplains in the asylum. The question, then, is how do we allow for our patients to become prophets?

Their centering of schizophrenic process and asubjectivity is not a celebration of transgression, but a “permission granted” for intensive forces that, when criminalized or pathologized, make them implode, turn back on themselves, or become destructive. If one is permitted to experiment in their disorganization, rather than thrust pathology upon them, we see what they can do. In one’s recognition as a prophet, their prophecy could be made legible. This is
their crucial move from judgment and interpretation, the regime of psychoanalysis, to one of experimentation—a materialist psychiatry (D&G 1977, 16-22), or schizoanalysis. The schizoanalytic break with psychoanalysis models the psyche on the schizophrenic state rather than the neurotic. A successful transference through adequate interpretation is abandoned, supplanted by psychic and corporeal experimentation. Schizoanalysis, then, as a commitment to experimentation, is a materialist psychiatry, a confrontation with the schizophrenic “as homo natura” (1977, 5), one whose culture is immanent to nature, not existing in a transcendent diagnostic and pathological category. This must necessarily entail an account of culture, and of its role in neurotic buildup. Culture cannot be limited to an analysis of relationship to mother and father, and the schizoanalyst does not abandon their consideration. The tripartite Freudian relation is but one actor in the wholesale evaluation that is to be done equally for all persons, no matter how aberrational in their behavior, as a machinic interplay of intensive forces in a life. A life is an experiment with an open field of possibilities, and Deleuze and Guattari’s schizo is the hallmark of this open field.

Manufacturing catatonia

I see Deleuze and Guattari working alongside Freud in as many ways as they also leverage critiques in his direction. The third movement in the schizophrenia process, the “schizophrenic” or catatonic, certainly resembles the Freudian account of the schizophrenic condition. Additionally, Freud’s assessment of schizophrenics’ ability to self-analyze, either of their dreams, their speech, or in their psychic structure as capable of circumventing repression, resonates with Deleuze and Guattari’s account of a schizophrenic capacity for self-experimentation in a “schizoid” life, or
hebephrenia. Yet they evaluate this moment in the process quite differently—Deleuze and Guattari seek to understand what can be learned from a schizophrenic state and their mode of production, how they might be included in the collection of bodily and psychic expressions, and what lessons they offer for successful destratification, while Freud sees schizophrenics as missing something that would allow for them to be amenable to analysis—namely, an object-libido. The schizophrenic’s capacity to self-analyze is seen as inadequate compared to the analyst’s power in uncovering repressions and providing moments of stability to a patient, and the schizophrenic is made out as irreparably unstable.

The processual nature of schizophrenia in Deleuze and Guattari make room for Freud’s schizophrenic to still have a place, in the break-down. Their analysis puts catatonic and institutionalized life into a new light—one that exposes the crisis that psychiatry has wrought in its diagnostics and treatment. Their schizoid, on the other hand, renders a positive evaluation of life on the limit, grants permission to their modes of production, and finds dignity in their aberrational activity. It is a response to the question that Deleuze takes from Laing—“what can we do so the break-through does not become a break-down?” (Deleuze 2006, 28) For Deleuze and Guattari, this positive valuation is also an invitation for anyone to take up aberrational, schizoid life, to make oneself a full body without organs, as an alternate political, social, and economic possibility.

Yet Deleuze and Guattari still abandon the catatonic, or at least overdetermine this third moment in the process. The clinical schizophrenic is only ever a patient, and he is where the process is put to an end, or prolonged indefinitely in the mental institution (D&G 1977, 5 & 136). Boisen offers an opportunity to Deleuze and Guattari’s catatonic figure. To Boisen, the catatonic is one who is engaged in a desperate struggle. They have move entirely “into the depths,” engaged
with an inner world that from the outside resembles madness, nonsense, or even threat. Following Boisen, Ronald Laing describes this catatonic state thus—

“The person who has entered this inner realm (if only he is allowed to experience this) will find himself going, or even being conducted—one cannot clearly distinguish active from passive here—on a journey. This journey is experienced as going further ‘in,’ as going back through one’s personal life, in and back and through and beyond into the experience of all mankind...In this journey there are many occasions to lose one’s way, for confusion, partial failure, even final shipwreck; many terrors, spirits, demons, to be encountered, that may or may not be overcome...We are so out of touch with this realm that many people can now argue seriously that it does not exist. Small wonder that it is perilous indeed to explore such a lost realm...This is where the person labeled catatonic has often gone. He is not at all here: he is all there.” (Laing 1967, 126-127)

Given such an outline of this state, it is no small wonder that Boisen insists upon the possibility for situating these experiences in the purview of religious experience. Laing goes on to state that the ceremonial of degradation in psychiatric examination and diagnosis must be exchanged for an initiation ceremony—one must be provided new containers for making sense of their inner voyage.

Deleuze and Guattari’s analysis also meets Boisen’s own assessment in their conclusions of schizophrenia as a process (D&G 1977, 352). Boisen’s primary touchstone with schizophrenics was in the asylum, and he notes that research on schizophrenia was also wholly on schizophrenia in the asylum. For Boisen, this meant that the subject of study was of a particular character: schizophrenia in its latest stages (1942a). Further, the schizophrenic’s interaction with hospital infrastructure itself affects the expression of one’s psychosis (1960, 136). For both Boisen and for
Deleuze and Guattari, the problem is not the reaction, or a schizophrenic event as studied (or potentially “treated”) in a hospital, but any other setting in which a schizophrenic process might be allowed to unfold, and the sort of support—religious, social, economic, medical, legal—that a schizophrenic process is permitted. Deleuze and Guattari along with Boisen share a primary question—*what makes the schizophrenic ill?* (D&G 1977, 352) They respond in unison: in many cases, it is the hospital itself and the mode of treatment that both creates and induces illness.

Tanya Luhrmann and Jocelyn Marrow’s engaged anthropology of schizophrenic experience makes note of the role that *acceptance* of the medical model of psychosis plays in how one interprets their psychotic symptoms. When one never accepts that their symptoms are expressions of illness, or that they are indeed an overdetermined Mad Other, they may make different sorts of sense of voices they may be hearing. Perhaps the voices are expressions of communion with a deity, or they as receivers of voices play a special role in interpreting and offering special knowledge to others (Luhrmann and Marrow 2016, 214-215). Boisen refused attempts to explain religious experience away with Freudian theories and psychoanalytic readings, quite contrary to the direction that Boisen saw chaplaincy as taking—for example, George Fox’s encounters with God could not simply be a matter of toilet training (Myers-Shirk 2009, 108). Boisen goes even further than the contemporary anthropology of Luhrmann and Marrow, who stop short of a commitment to the *reality* of what these voices are telling our patient-prophets. To Boisen, patients must be recognized as prophets, and given the space to experiment with their prophecies.
Conclusion: breakthrough or breakdown

As Sylvia Wynter offered a point from which to leverage a hermeneutic of psychosis, Wynter also presents a path forward, an invitation out of the hermeneutic. In “Rethinking Aesthetics: Notes Towards a Deciphering Practice,” Wynter offers a turn away from interpretation with respect to a particular meaning of texts, petitioning that we ask what it is texts might be able to do. Wynter is close to Deleuze and Guattari’s organ-machine, or body without organs—always experimenting, asking what else can this body do? Boisen offers a similar turn away from the literary conventions of psychoanalysis; his notion of “living human documents” demands the reader’s faith to the text in not extracting a predetermined meaning, and insists upon the inevitability of humans to always be on the move, doing, not offering up a meaning to the analyst. Deleuze and Guattari come to a similar point in their treatment of schizophrenia. They take up a critique of psychoanalysis as a literary tradition, where one’s symptoms, repressions, and transferences require an expert’s interpretation. A living human document is just such an organ-machine. Boisen asserts that a person may be understood just as they say they are, and can be engaged on their own terms; if they tell you they are a prophet, ask of their prophecy. If they tell you that the birds have made them promises, ask of these promises. When they tell you to sew shut their anus, ask them what they seek to keep out. If they tell you God has a certain destiny for them that has been in the works for 2,000 years, ask of this destiny. If they tell you that they have been enlisted for experimentation in the spirit realm, ask him of these experiments, and why it must be him. A patient on an in-patient psychiatric unit once told me this. His prophecy? Peace between Jews and Muslims. A patient in a psychiatric partial hospitalization program told me this, and she was most concerned with someone assuring her that she wasn’t “crazy.” An illustration from Deleuze & Guattari 1987, 152, borrowing from William Burroughs’ Naked Lunch. A case Boisen presents in “Onset in Acute Schizophrenia” (1947). A case Boisen presents in “The Problem of Sin and Salvation in Light of Psychopathology” (288).
mysterious hostile forces that are out to get them, ask them who they are, what they look like, and if they look like you. If they tell you they have not eaten for weeks, that they are deeply concerned with the fate of their people, and that their confidants insist they are the messiah, ask them of their concerns about the fate of their people and their experience in fasting.

Boisen provides a theological Anti-Oedipus, a religious interruption of the production of the mentally ill. In Boisen’s own Statement of Belief, the piece of writing he notes as plunging him into his first psychosis, he writes—“The divine has in consequence been coming into the world disguised in ugliness, crippled by disease, shackled by sin, and impotent with weakness” (1936, 296). To meet the demands of both Boisen and Deleuze and Guattari, we reject any declarations of heresy or madness, and invoke the organ-machine, or the living human document. Living human documents as sacred texts counters the distance made in interpretation—what does this text mean?—and supplants it with an embodied encounter toward what a text might do with its body—an incarnation. Boisen’s study of schizophrenia illuminates a clinical reality that Deleuze and Guattari maintain in an abstract register. Schizophrenia as process is alive and well in schizophrenics, it is simply unrealized clinically as process, only as reaction. In asking what these living human documents might do, for Boisen (1952, 294), Laing, and Deleuze and Guattari alike, the question is always, what brings a person to the breakdown, and what are the conditions for a breakthrough?

---

13 This is a common presentation of paranoid schizophrenia Boisen presents in “The Form and Content of Schizophrenic Thinking” (1942).

14 This case is that of Jesus Christ himself, who Boisen situates alongside his patients who express messianic projects in “What did Jesus Think of Himself?” (1952). He says of these patients, they “may not be wholly mistaken” (11).
Bibliography


  https://doi.org/10.4103/0019-5545.94660.


  https://doi.org/10.1080/0034408450400507.


