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Que(e)rying the Clinic before AIDS: Practicing Self-help and Transversality in the 1970s

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Abstract In this paper, I offer a treatment of "the clinic" in which the clinic—as concept and space—is que(e)ried, that is, both questioned and made queer. I present two historical case studies that queer clinical thought and practices in the period before AIDS and before the full-blown arrival of queer theory on the western theoretical landscape. These two cases—the practice of self-help developed in the women's health movement in the United States and the practice of tranversality developed out of and beyond the Institutional Psychiatry movement in France—challenge the practice of medicine in the prehistory of both AIDS and queer theory, yet, they are not generally seen as precursors, or related in any way, to AIDS activism. In a sense, then, I also want to question and make queer the history of AIDS as we conventionally know it today by extending that history backwards and outwards to earlier queer critical and clinical practices like self-help and transversality.

Keywords Queer theory · Self-help clinics · Transversality · Feminist health activism · Félix Guattari · AIDS activism

In a piece on "AIDS, Activism, and the Politics of Health" for the Sounding Board section of *The New England Journal of Medicine* published in January 1992, Robert M. Wachter, at that time professor of medicine at the University of California in San Francisco and a frequent commentator on health policy, begins his look at the impact of AIDS activism on health policy and on movements fighting other diseases by first looking back at the "roots of AIDS activism" (1992, 128). I have written elsewhere about what I call the "origin story of AIDS activism" (Diedrich 2007b, 32), and Wachter's narrative relies heavily on this version, which has been repeated so frequently that it is now de facto the "authorized" version. The origin story of AIDS activism provides a neat and tidy narrative arc: a period of passivity—what Wachter calls in his article "a tragic period of hesitation" (1992, 128)—is replaced,

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finally if belatedly, by activism with the founding of the AIDS Coalition to Unleash Power (ACT-UP) in 1987. The passivity-to-activism narrative arc can be discerned even in the way Wachter formulates one of his article's key questions: "What are the roots of AIDS activism, and why was the epidemic 6 years old before the movement crystallized?" (1992, 128).

Wachter acknowledges in the opening paragraph of his analysis that "trends toward empowering patients and questioning scientific expertise antedated" the AIDS epidemic, noting increasing patient involvement in health care organizations and policy decision-making from the late 1960s and an even longer tradition of political advocacy by charitable groups devoted to raising money and awareness to fight particular diseases and counter the stigma often associated with them.[1] Still, for Wachter, AIDS activism brought something qualitatively different to "the health care scene"—"a jarring new dimension to what was previously a genteel dialogue between patient advocates and clinicians, researchers, and policy makers" (1992, 128). As I will show in this essay, Wachter's memory of a "genteel dialogue" covers over a much more contentious—and queerer—challenge to the discourses, practices, and institutions of medicine by feminist and community mental health activists, among others, in the period immediately prior to the emergence of AIDS.

I begin with Wachter's discussion of the emergence of AIDS activism in *The New England Journal of Medicine* to provide an image of how medicine sees itself before and after the arrival of AIDS. In Wachter's account, written just 10 years into the epidemic, and 5 years after the emergence of ACT-UP, what has already crystallized is a memory of AIDS and the early response to it founded on a forgetting of an other-than-genteel activism around health during the two decades prior to the arrival of AIDS. Wachter does mention the modern gay liberation movement whose origin he dates, as many historians do, to 1969 and the riots at the Stonewall Inn in New York City, and he also states quite explicitly that AIDS activism "evolved directly" from gay liberation. In Wachter's account, however, this particular lineage proves more detrimental than beneficial to the queer species when AIDS arrives. According to Wachter, the emphasis on sexual freedom in the 1970s "had two disastrous consequences when a new virus entered the gay community in the late 1970s"—the first consequence was that "the promiscuity in the community facilitated the rapid spread of the new sexually transmitted pathogen," and the second was that many in the gay community were unwilling to change their sexual behavior and, relatedly, were uninterested in "political militancy" (1992, 128). The gay liberation movement of the 1960s and 1970s, and its challenges to intimate, social, and political relations is not then a resource for AIDS activists in Wachter's formulation but a stage that had to be, and thankfully was, outgrown. For Wachter, gay liberation was a kind of pre-political adolescence preceding the political maturation that came with the sobering experience of AIDS and the activism that eventually emerged from this experience. In his analysis, Wachter also seems to suggest that sexuality is a domain separate from politics and that the struggle for sexual liberation is wholly personal and not political. Wachter's analysis fits into a general rhetoric of depoliticization—or, we might say, neoliberalization—of personal experience that gained momentum in the 1990s in a climate of increased deregulation and privatization under Reagan in the United States and Thatcher in the United Kingdom. As I will show below in my discussion of feminist self-

[1] In his influential analysis of stigma first published in 1963, Erving Goffman discusses "action groups" as offering a proto-political critique of stigmatization as a form of normalization. These action groups challenge stigmatization via the publication of counter narratives "that give voice to shared feelings" and help to "consolidate belief in the stigma as a basis for self-conception" (Goffman 1963, 27).

help clinics, interpretations of the feminist practice of "personal politics,"[2] a condensation of the phrase "the personal is political," have changed since the 1970s and are now most frequently used to describe an individual rather than a structural critique. My point is that AIDS activism was hardly unprecedented in its militant personal politics in general and sexual politics in particular, and yet this is not the story that tends to get told. While certain sexual practices (rather than promiscuity) facilitated the spread of AIDS in the gay community and, of course, other communities, other sexual practices invented in the gay community, like safe and safer sex, also very quickly facilitated a response to AIDS that would in time successfully slow the spread of the disease in the gay community (see, for example, Preston and Swann 1986).

Preexisting conditions

In order to uncover some of the forgetting that an analysis like Wachter's enacts, I am interested in attempting to discern what we might call the underlying—or preexisting—conditions in medicine and politics in the period before AIDS. While I am sympathetic to a desire to understand AIDS as representing a rupture in both the practices of medicine and the practices of queer politics, as well as in the everyday affective experiences of gay community formations, I also want to resist this interpretation by thinking more about what gets brought forward into AIDS activism from the health movements of the 1960s and 1970s and what doesn't. Or, we might ask, echoing and extending a question Julian Bourg (2007) asks about the ethical and political legacies of May 1968 in France: what aspects of the social movements of the 1960s and 1970s "never made it to the 1980s," and what aspects did? (Bourg 2007, 10).

I see this essay as one strand in a complex genealogy that will trace the continuities and discontinuities between AIDS activism in the early 1980s and several earlier transformations of discourses and practices of health and illness during the period immediately prior to the emergence of AIDS, roughly from 1960 to 1980. My genealogy includes transformations brought about by activism from inside and outside medicine. From within medicine, we see at this time the rethinking and restructuring of General Practice and the emergence of Family Practice as a new field of specialization as well as the institutionalization and codification of bioethics. It was also at this time that medical humanities was born, transforming medical education to include courses in health and human values and later, narrative medicine. From outside medicine, we see the emergence of several activist and advocacy movements—from the anti-psychiatry movement and the creation of community mental health clinics, to the women's health movement and the establishment of a network of feminist health centers, both of which I will discuss here, but also to the environmental justice movement and its counter-rhetoric to conservationism—all of which I argue impacted the dominant discourses, institutions, and practices of medicine before AIDS.

Along with discerning emergent practices of health activism in this period, I am also interested in the connection between these practices and the emergence at the same time of practices of thought now often labeled, imprecisely and sometimes dismissively, as post-structuralist. In particular, I am interested in the many attempts to link the "critical and clinical"—in Deleuze's apt juxtaposition from 1967—in the work of several thinkers

[2] This is the title of Sara Evans's (1980) important history of the emergence of the women's liberation movement in the United States out of the civil rights and new left movements of the 1960s.

associated with post-structuralism, including Michel Foucault, Gilles Deleuze and Félix Guattari, and Giorgio Agamben.[3] I consider the relationship of these political, methodological, and conceptual critiques from within and without medicine, and ask: how does what medicine is—its ontology—change during this time? Or, to echo the question that Foucault asked in his final lectures at the Collège de France in 1983: what is the present field of possible experiences of medicine at the beginning of the 1980s when AIDS arrived? My shift in terminology and objects—from "practices of health activism" to the "critical and clinical" to the "the experiences of medicine"—is intentional, suggesting a multi-directional movement between the domains of politics, aesthetics, theory, and medicine.

Queer clinics

The clinic is one place to look to help discern the "present field of possible experiences of medicine" in a particular historical moment, as Foucault understood well. In her introduction to a recent collection of essays that revisits Foucault's *Birth of the Clinic* as a jumping off point for a variety of ethnographic and historical treatments of "the clinic," Cindy Patton provides a genealogy of sorts of Foucault's own thought, suggesting the importance of the clinic to his later disciplinary and biopolitical formulations:

> Before Foucault treats the research-science disciplines of biology, economics, and linguistics (as he does in *The Order of Things*), he launches his argument about the emergence of modernity in the messy, deeply experiential space installed *by* and *as* "the clinic." Fifteen years before Foucault describes the panopticon and its extension as the carceral society, he elaborates "the clinic" and its extension as a relationship between science and people, between medical practitioners and patients, and between all of these elements and the state. (Patton 2010, xvii)

In this spirit, in the remainder of this essay, I want to offer my own treatment of "the clinic," in particular by thinking about how the clinic—as concept and space—might be que(e)ried, that is, both questioned and made queer. I present two historical case studies that might be said to queer clinical thought and practices in the period before AIDS, and, for that matter, before the full-blown arrival of queer theory on the western theoretical landscape.[4] These two cases—the practice of self-help developed in the women's health movement in the United States and the practice of tranversality developed out of and beyond the Institutional Psychiatry movement in France—challenge the practice of medicine in the prehistory of both AIDS and queer theory; yet, as Wachter's history of AIDS activism demonstrates, they are not generally seen as precursors, or related in any way, to AIDS activism. In a sense, then, I also want to question and make queer the history of AIDS as we conventionally know it today by extending that history backwards and outwards to earlier queer critical and clinical practices like self-help and transversality.

[3] In his introduction to Deleuze's *Essays Critical and Clinical*, Daniel Smith explains that Deleuze first links the critical with the clinical in his 1967 essay on Sacher-Masoch (Smith 1997, xi). See also (Deleuze 1989, 14).

[4] Contra Sontag (1979 and 1989), I am intentionally metaphorizing the experience of AIDS to help think about the relationship of a 1990s queer theory—read as full-blown—to earlier theoretical and political formations—read as not-yet queer.

1. Self-help

A glaring omission from Wachter's presentation of the roots of AIDS activism is his failure to mention the importance of the women's health movement in transforming medicine in the 1960s and 1970s. Such an omission is clearly necessary to sustain the portrait of a pre-AIDS "genteel dialogue between patient advocates and clinicians, researchers, and policy makers" (1992, 128). In Wachter's essay, feminists do appear, but only after he has discussed the roots of AIDS activism, in the section "Does the Model of AIDS Activism Apply to Other Diseases," in which he discusses the potential influence of AIDS activism on breast cancer activism. Here Wachter connects the emergent breast cancer lobby to "the earlier development of the feminist movement, which had been urging women for years to take control of medical decisions affecting their bodies" (1992, 131). In Wachter's genealogy, AIDS activism and feminist activism precede the organization of a potent breast cancer lobby, but there is seemingly no connection between health feminism and AIDS activism, and, relatedly, the earlier feminist impact appears to be solely on individual women and their bodies and not on medicine more broadly. I realize that my close reading of Wachter's genealogy may seem like little more than semantic quibbling, but I want to suggest that Wachter's history of health activism continues a long tradition of trivializing women's complaints in medicine in general and in *The New England Journal of Medicine* in particular.

Perhaps not surprisingly, the women's liberation movement is mentioned only very occasionally in the pages of *The New England Journal of Medicine*, and the women's health movement is mentioned even less frequently.[5] Two articles, one published in late 1974 and the other in early 1975, take seriously the attempts by health feminists to transform medicine—the first is the text of a talk given by Mary C. Howell (1974), a physician and Associate Dean for Student Affairs at Harvard Medical School at the Harvard Medical School Alumni Day in 1974 on a panel, entitled "What It's Been Like," to celebrate the 25th reunion of the first Harvard Medical School class to include women; the second is a contribution from Howard M. Spiro (1975) of the Yale School of Medicine to the Visceral Viewpoints section entitled "Myths and Mirths—Women in Medicine." I don't have space in this essay to read these articles closely, but I point to them here to show briefly how feminists figure in the journal and as an example of how they figure in medicine more generally before I take up the self-help clinic as one feminist remedy for the unsatisfactory treatment of women in medicine. Howell's article is a fascinating assessment of the practices of professionalization, and what she argues are mostly unconscious habits of discrimination against women in the field of medicine. She utilizes interviews with women medical students to diagnose the treatment of both women patients and women student physicians, and, despite many advances by women in medicine since the time of Howell's article, some of these comments still resonate today. Howell ends her article with reference to two positive effects of the women's liberation movement: changes to the law brought through implementation of Title IX of the Higher Education Amendments of 1972

[5] Keyword searches in *The New England Journal of Medicine* online database show the following: "women's liberation" is mentioned in 15 articles between 1960–1979, 7 articles between 1980–1999, and once between 2000–2010; "women's lib" is mentioned in 3 articles between 1960–1979; "women's health movement" is mentioned twice between 1960–1979, once from 1980–1999, and twice from 2000–2010; "feminist" is used in 19 articles between 1960–1979, 70 articles between 1980–1999, and 17 articles between 2000–2010. Search conducted at www.nejm.org on January 13, 2011.

and changes to attitudes of both doctors and patients as a result of the women's health movement (1974, 307).

Whereas Howell ends with the effects of the women's liberation movement on medicine and the law, Spiro begins there: "Of all the revolutions of the past few years, the one that seems most likely to have the longest life is that in sex, simply because people have a vested or, as appropriately, a 'bloused' interest. 'Women's lib' in medicine bids fair to be as permanent as any revolution can be" (1975, 354). What follows is a sympathetic assessment of the difficulties for women in medicine and an even-handed approach to the complex relationship between biology, psychology, and culture, an approach that allows Spiro to arrive at sensible assertions like this: "Regardless of whether they are culturally or biologically determined and regardless of whether society is mistaken in calling them womanly virtues, what are generally seen as psychic characteristics of women should be just what American medicine needs at present" (1975, 355). Yet, although Spiro expresses unequivocal support for "women's lib," the portrait of women's lib, nonetheless, relies on what in 1975 were already well-worn clichés, including that it is a movement that is "occasionally shriller than it need be" and that it "sometimes has a relentlessness that excludes humor" (1975, 356). And so, Spiro ends with this rather bizarre hope: that "women will laugh at jokes men make about women, or even that men physicians will laugh at the jokes women doctors make about men patients," which makes me wonder whether there will ever be any jokes about men physicians to laugh at (1975, 355). I point to Spiro's trivial conclusion in an otherwise serious take-up of women's liberation to suggest some of the reasons that, by 1992, the feminist challenge to medicine has been largely forgotten as a precursor to AIDS activism. Shrill people who can't take a joke are not generally perceived as having a positive impact on others.

And yet, although neither Howell nor Spiro mention them, feminist self-help clinics were up and running at the time of their articles, created across the United States beginning in the early 1970s as a structural response to the problem of the absolute authority of doctors, the objectification of women's bodies in health care, and the increasing specialization, technologization, and dehumanization of medicine.[6] In some instances, the clinics created were formal institutional spaces with permanent staff and funding, as in the case of the network of Feminist Women's Health Centers, while in other instances, these clinics were more informal and transient spaces for consciousness-raising around issues relating to women's often negative experiences of their bodies and the institution of health care. Some informal groups eventually became more formal, such as the Boston Women's Health Book Collective (1973), which began as a consciousness-raising group and would become increasingly influential with the publication of *Our Bodies*, *Ourselves*, the most widely-read articulation of the theories and practices of feminist self-help.

In a typical statement promoting the practices of self-help, the pamphlet *A Self-Help Manual for Women*, jointly authored by Louise Marshall, Valerie Vogel, and Aida

[6] For accounts of the women's health movement published at the time of, or just after, the women's liberation movement, see, for example, Boston Women's Health Collective 1973; Ruzek 1978; Dreifus 1977; Frankfort 1973; and Seaman 1969. For a selection of original literature from the women's liberation movement, including a section on Bodies with a subsection on Health, see Baxandall and Gordon 2000. For more recent histories of the women's health movement, see, for example, Davis, 2007; Morgen 2002; and Wells 2010.

Bogas in 1978, introduces the concept in this way, using "self-health" and "self-help" interchangeably:

> Self-health, in its broadest sense, means people educating themselves about their bodies and taking responsibility for their own health care. To us (as well as many other members of the women's health movement) self-help means groups of women getting together to share knowledge, to do research, to physically examine themselves for health maintenance, and to support each other. A self-help group can be any number of women of any age who are committed to working together, and to enjoying the excitement and power which comes with knowledge and self-awareness. (Boston Women's Health Book Collective Records, 1972–1997, no. 102.2)

The authors explicitly link the practices of self-help to the political transformation of women that began in the U.S. in the 1960s, and, importantly and somewhat paradoxically, they explain that *self*-help is most effective practiced in a group. Through group work on their selves and bodies, women created a critical and clinical method that challenged the exercise of medical sovereignty.[7] The state and medicine took this challenge seriously, calling into question the legitimacy of those leading self-help workshops and founding self-help clinics. In several celebrated cases, the women leading the movement were arrested for practicing medicine without a license; that is, they were arrested for being, in the eyes of medicine and the law, medical pretenders.

In an article in the *Medical Tribune* from 1973, Carol Downer, who founded the Feminist Women's Health Center in Los Angeles and was one of the women arrested for practicing medicine without a license, is quoted as stating, matter-of-factly: "'Physicians have not yet realized how angry women are about the treatment they've been getting and that we are working to change the situation'" (1973, 15; archived in Boston Women's Health Book Collective Records, 1972–1997, no. 102.3). The short article in the *Medical Tribune* ends with a comment from Dr. Mary E. Costanza who is identified as an Instructor in Medicine at Tufts University Medical School and as "herself active in a woman's self-help group" (Downer, 1973, 15). Because her identity seems to bridge the binary established in the article's title, "Physicians and Feminist Patients: Conflict Grows," her comments can be taken as at once sympathetic and authoritative, giving greater credence to her ultimate dismissal of the possibility of change coming to medicine from the outside (Downer 1973, 15). Dr. Costanza notes that self-help groups are useful in "making people aware of better kinds of communication between patients and professionals," and that "what is learned will be incorporated into existing institutions" (Downer 1973, 15). Nonetheless, she believes the medical usefulness of self-help groups is limited because they "aren't funded, and [because] depending on volunteers to provide comprehensive medical care is a pipe dream" (Downer 1973, 15). Costanza describes a powerful dynamic through which medical sovereignty is maintained and even extended

[7] I use the term "medical sovereignty" here to suggest the ways medicine participates in both modes of power —sovereign and disciplinary—that Foucault delineates in his work beginning in the 1970s. Although Foucault has often been read as arguing that disciplinary power replaces sovereign power in the 19th century, I think it is more accurate to understand these two modes of power in relation to each other, and to consider how the relation functions. Elaborating on Foucault's concepts, Agamben (1998) makes the very important observation that biopower is often exercised in support of a sovereign power.

through a dual process of both de-legitimation and incorporation of alternative practices of health.

In handouts from self-help clinics, women are addressed as practitioners and given step-by-step instructions on how to do a particular medical examination or procedure. The handout "How to Do a Pelvic Examination" from 1976, for example, is addressed to the woman doing the pelvic exam in the hope that a new approach to pelvic examinations will make the experience better—less traumatic—for the examiner as well as the woman being examined. The handout encourages a relaxed attitude and a pedagogical approach; the examination becomes an opportunity for teaching and learning on both sides of the practitioner/patient binary ("How to Do a Pelvic Examination, 1976"; archived in Boston Women's Health Book Collective Records, 1972–1997 (no. 102.1).

Many of the pamphlets advocating the self-help clinic as a practice of health point to the joy and wonder many women felt in discovering new knowledge about their bodies and themselves. The new knowledge is important but so too is the "transmission of affects"—both positive and negative—that happens in these clinics.[8] I would argue that it is through the facilitation of the transmission of affect between and among women that we might consider the feminist self-help clinics as queer. Adapting Foucault's "two great procedures for producing the truth of sex"—*ars erotica* and *scientia sexualis*, I want to think about a clinical *ars erotica* as a practice that contrasts with a clinical *scientia medicalis*, or, put slightly differently, we might say: the clinic is a domain where these two procedures for producing the truth of health might be brought together and sometimes into conflict through different clinical practices, although the increasing hegemony in the 21st century of a clinical *scientia medicalis*, in which laboratory tests and imaging technologies predominate, can hardly be disputed (Foucault 1978 [1976], 57).[9] In a newsletter from 1972 entitled "The Self Help Clinic," Colette Price describes what I consider a kind of queer clinical *ars erotica* of the self-help clinic:

> For all practical purposes, men have probably had more intimate contact with, and certainly far greater accessibility to the vagina than women ever had. The male organ, on the other hand, has always been exposed. The male organ, you see, is external and we really do seem to feel that seeing is believing. Thanks to the (Women's Liberation) Self-Help Clinic of Los Angeles, however, the same possibilities are now available to women. (Price 1972; archived in Boston Women's Health Book Collective Records, 1972–1997, no. 102.3)

Likewise, the handout "How to Do a Pelvic Examination" encourages the practitioner to help her patient see her own body as part of the examination because,

[8] "Transmission of affect" is the feminist philosopher Teresa Brennan's (2004) term from her book of the same title. For an influential analysis of the affective in relation to feminism, see Ahmed (2004). In the chapter "Feminist Attachments," Ahmed discusses how many women, including herself, come to feminism through positive affective experiences like wonder, as much as through negative affective experiences like anger.

[9] In diagnosing the relationship between *ars erotica* and *scientia sexualis* in Western culture, Foucault writes, "*Scientia sexualis* versus *ars erotica*, no doubt. But it should be noted that the *ars erotica* did not disappear altogether from Western civilization; nor has it always been absent from the movement by which one sought to produce a science of sexuality" (1978 [1976], 70).

as the handout intones in quasi-romantic, though not heteronormative, language: "it is a really exciting experience to see one's cervix and vagina, especially for the first time" ("How to Do a Pelvic Examination, 1976"). For Price and other self-help practitioners, the vaginal speculum becomes a technology of the self, allowing women to get "in touch" with themselves by viewing their own vaginas. Looking at the self intimately becomes a way of de-objectifying the self, because the process of looking at the self happens in a group of women and creates both a public health and a public sexuality. Or, put another way, a public is created in the practice of looking at one's body in a group of other women also looking at their bodies, and in the feelings of excitement produced as a result of this intimate—yet public—activity.[10]

Price and others, however, acknowledge one criticism of the practices of self-help: that they displace a structural analysis with a potentially solipsistic focus on the individual and advocate a "do-it-yourselfism" that encourages, first and foremost, greater consumption of health care (Price 1972 and Downer 1972; archived in Boston Women's Health Book Collective Records, 1972–1997, no. 102.3). On the one hand, I think it is clear that feminist health activism in general and the practices of self-help in particular effectively challenged medical sovereignty and influenced from the outside some of the key transformations occurring within medicine in the 1970s, including the formation of the new sub-fields of family practice, bioethics, and medical humanities. Yet, on the other hand, I also contend that health feminism's initial challenge ends up in many ways extending medicine's biopolitical and sovereign modes of power, as medicine appropriates one of health feminism's key tenets—that our relationship to our bodies and health must be an active, even vigilant, one. The active, or activist, patient—or what I called the "politicized patient" in *Treatments* (2007a)—morphs in the 1990s and 2000s into the consuming patient who is most adept at negotiating the seemingly limitless choices of Healthcare, Inc. In her analysis of the transformations and travels of the self-help manual *Our Bodies*, *Ourselves* (*OBOS*), Kathy Davis diagnoses a "shift in how knowledge and feminist knowledge practices are viewed in *OBOS*" (2007, 43). According to Davis, in later editions of the feminist classic "women are assumed to be, first and foremost, 'informed consumers'" (2007, 43).[11]

We can also see this shift from activism to consumption in the final section of Wachter's article on AIDS activism, which begins:

> Because AIDS activists have demonstrated the degree of influence that a well-organized, highly motivated advocacy group can have, we can be certain that the empowerment of patients will be a major part of the American social landscape of the 1990s. In this new order, some health professionals

[10] In his fascinating discussion of the clinic and/as tea room, Geoffrey Rees (2010) describes the "inchoate queer ethical potential of the clinical encounter." For Rees, the clinic itself is an intimate public space, and comparing how intimacy happens in the clinic with other intimate public spaces allows bioethics to draw on an elaborate discourse and practice of queer sexual ethics.

[11] In her discussion of *OBOS*'s transnational travels, Davis describes the aspects of the project's theories and practices that are emphasized, downplayed, or deleted in various locations. For example, she notes that the "editors of the Latin American adaptation were critical of the U.S. *OBOS*, which they regarded as individualistic, consumer oriented, and insufficiently political. In their view, the U.S. text over-emphasized the power of the individual woman to take care of herself as epitomized by the 'completely Anglo' notion of self-help" (2007, 180).

> will view a powerful consumer movement as a direct threat to their competence and power. (1992, 132)

In the new order that Wachter presents, the rather vague notion of the "empowerment of patients" of the first sentence narrows to a "powerful consumer movement" in the next. As Annemarie Mol (2008) argues, the logic of choice now dominates the contemporary practice of medicine in the West. "As if it were a magic wand," Mol notes, "the term 'choice' has ended the discussion. All the possible advantages and disadvantages of … [a] treatment, all its goods and bads, have been turned into private concerns" (2008, x). Mol offers an alternative to the logic of choice—the logic of care, noting that, "Care is not a limited product, but an ongoing process" (2008, 11). It seems to me that the promise of the self-help clinic was in offering a space for the ongoing process of care—of the self and of others, and to the self through others. Within the context of a medicine dominated by the logic of choice, this counter-logic of care is decidedly queer.[12]

2. Transversality

The second queer method I want to explore in this essay is the practice of transversality, a term first coined by Félix Guattari who is best known for his long collaboration with the French philosopher Gilles Deleuze, in particular on their two-volume magnum opus, *Capitalism and Schizophrenia* (Deleuze and Guattari 1983 [1972] and 1987 [1980]; see also Deleuze and Guattari 1986 [1975] and 1994 [1991]). Guattari's contribution to *Anti-Oedipus* and *A Thousand Plateaus* is often diminished or sometimes even overlooked entirely, yet his ongoing experience working with Jean Oury at the La Borde clinic in the Loire Valley of France and his many radical political interventions were key inspirations for the theoretical, methodological, political, and aesthetic innovations that came out of his collaborations with Deleuze.[13]

One formative influence on Guattari's critical and clinical interventions was the Institutional Psychiatry movement, which emerged in France out of the French experience of occupation during World War II. The theories and methods of Institutional Psychiatry—or what Guattari preferred to call Institutional Analysis—would eventually migrate into other domains in conjunction with the protest movements fomenting in France around May 1968.[14] As Julian Bourg notes, the Saint-Alban clinic in the south of France became an "incubator" for creative thought and therapeutic methods, bringing together a diverse group of individuals—including communists and Christians, surrealists and psychoanalysts, the healthy and the ill—who took refuge in the clinic and resisted the Nazi occupation (Bourg 2007, 126). After the war, both Frantz Fanon and Jean Oury interned at Saint-Alban in the 1950s, and they exported and extended the thought and practices they learned at Saint-Alban's to, in Oury's case, the La Borde clinic in central France, and, in Fanon's case, to the Blida-Joinville Psychiatric Hospital in Algeria. There is much to be said

[12] Mol shows that often taking care of oneself requires that one act strangely. She writes, "It is difficult to act strangely; difficult to do something that does not fit with the company you keep. Yet this is exactly what the logic of care wants you to do. In order to take care of yourself, you may need to deviate" (2008, 60).

[13] A recent biography of the two together goes a long way to restoring Guattari's primary not secondary influence on the thought of the pair (Dosse, 2010 [2007]).

[14] According to Julian Bourg, the "term Institutional Psychotherapy was first used in print in 1952 by the French psychiatrists Georges Daumézon and Philippe Koechlin" (2007, 125).

about Fanon's clinical and critical interventions,[15] but I am going to focus here on the clinic at La Borde, and what I take to be its queer method of transversality, which Guattari developed out of and in relation to the experimental clinical practices he participated in at La Borde from the 1950s until his death in 1992.

Guattari described transversality as a theory and practice of ranging across identities, disciplines, concepts, and milieus in order to keep open the possibility of desire. In an interview in 1973, Guattari suggests transversality as a means to get out of the trap of psychoanalysis and its habit of confining desire to the "small, secret domain of the couch." In the same interview, he then demonstrates transversality by making connections beyond and outside of psychoanalysis: "The problem of psychoanalysis is the problem of the revolutionary movement, the problem of the revolutionary movement is the problem of madness, the problem of madness is the problem of artistic creation. Transversality is, at heart, nothing but this nomadism" (2009, 147). The equation Guattari sets up—psychoanalysis plus revolutionary movement plus madness plus artistic creation—is both conjunctive and disjunctive: the autonomy of each practice is problematized when placed in relation to the other practices of thought. Guattari's concept derives from one of the definitions for the word "transversal," now rarely used, according to the *OED*, as something "lying athwart" or, figuratively, a "deviation" or "digression." A more common current use of the term comes from geometry and refers to "a line intersecting two or more lines, or a system of lines." Transversality activates and puts into motion a transversal, a line that deviates, digresses, and/or intersects across multiple lines, planes, and plateaus, in the terminology developed by Deleuze and Guattari.

All of these processes suggested by the concept of transversality will become key to the thought created in the collaboration between Deleuze and Guattari. Indeed, their thinking and writing together is infused with the spirit of a complex transversality between them. As they themselves have described it, the collaboration brought together a psychoanalyst influenced by Lacan but interested in overturning the orthodoxy in both the theory and practice of psychoanalysis and a philosopher interested in concepts and the means by which new concepts might be created rather than in expressing a proper deference to the history of philosophy.[16] Transversality leads away from the dead-end familialism of psychoanalytic and philosophical thought and practice and toward many of the key concepts demonstrated in *Capitalism and Schizophrenia*: "deterritorialization," "the body without organs," "nomad thought," "lines of flight," and "assemblages," to name just a few. In a conversation with Deleuze and Catherine Backès-Clément on *Anti-Oedipus*, Guattari explains that, at the start of his collaboration with Deleuze, he had "too many 'backgrounds,'" including leftist political work, Lacan's seminars, the institutional psychotherapy practiced at La Borde, and working with schizophrenics. He describes these backgrounds as more than just discourses but as "ways of life," and he describes being "to some extent torn between them" (Deleuze 1995, 15). Guattari's emphasis on conflicting "ways of life" anticipates Foucault's later turn to ethics or arts of existence, which itself anticipates a queer way of life as opposed to a gay identity.[17]

[15] For an insightful account of Fanon as "clinician and revolutionary," see Keller 2007, and for an interesting reading of Fanon with Deleuze and Guattari, see Musser 2012.

[16] For an interesting account of how they came to work together, see Catherine Backès-Clément interview with Deleuze and Guattari on *Anti-Oedipus* first published in *L'Arc* 49 in 1972, in Deleuze 1995, 13–15.

[17] See the interview with Michel Foucault first published in the French gay magazine, *Gai Pied*, in April 1981 (Foucault 1997, 135–140).

For Guattari, these diverse ways of life—combined with his writing with Deleuze—bring into being a "logic of multiplicities" that counters reductive logics, especially oedipal, Marxist, and scientific ones.

Both Deleuze and Guattari were interested in the how not the what or essence of an object, and Guattari especially understood the clinic as a space in which one might explore how psychological, social, political, and institutional discourses and practices work. Deleuze and Guattari's challenge to psychoanalysis, philosophy, and politics, then, was not simply a theoretical exercise but also a therapeutic one. Deleuze and Guattari argued that psychoanalytic thought and practice failed to be therapeutically effective because it did not go beyond the analytic scenario of a person on a couch talking about his or her childhood—the couch becomes a metonym for therapy as a reduction of desire and creative thought. In this conventional analytic scene, transference does not open up the machinic productivity of desire, but drives desire back into the nuclear household and the past. The problem was "the reduction of the social investments of libido to domestic investments, and the projection of desire back onto domestic coordinates," as Deleuze puts it in conversation with Guattari and Backès-Clément (1995, 17).

In his essay "La Borde: A Clinic Unlike Any Other," Guattari presents some of the background for the experiment in Institutional Psychotherapy that began at La Borde in the 1950s and continues to this day. The adjective Guattari uses to capture the treatment at La Borde is "baroque," which he glosses as "always in search of new themes and variations in order to confer its seal of singularity—i.e., of finitude and authenticity—to the slightest gestures, the shortest encounters that take place in such a context" (2009, 181–182). Let's not forget that the baroque is always also a little queer. If the feminist self-help clinic queered the clinic by extending knowledge and power to women in relation to their doctors and by highlighting rather than downplaying the transmission of affects within the clinic, La Borde queered the clinic by "[t]reating the institution as a whole" (Bourg 2007, 126) and transforming the interactions between doctors and patients even further. At La Borde, distinctions between the "presumably 'noble' tasks of the medical staff and the thankless, material tasks of the service personnel" were eliminated (Guattari 2009, 178). All staff—medical and service—performed all tasks in rotation, upsetting the doctor's usual position at the top of the institution's structure of authority by making decision-making a horizontal not vertical process. Guattari explained the logic of La Borde in this way:

> What we aimed for through our multiple activities, and above all through the assumption of responsibility with regard to oneself and to others, was to be disengaged from seriality and to make individuals and groups reappropriate the meaning of their existence in an ethical and no longer technocratic perspective. … The institutional machine that we positioned didn't simply remodel existing subjectivities, but endeavored, instead, to produce a new type of subjectivity. The supervisors created by the "rotations," guided by the "schedule," and actively participating in the "information meetings," gradually became, with training, very different people from what they had been upon arrival at the clinic. (Guattari 2009, 180)

The clinic becomes a space for the production of new types of subjectivity, not just among the patients but also among the medical and service staff as well, and this

inventiveness transforms—queers, we might say—the institution of psychiatry. More than this, the clinic becomes a kind of laboratory out of which "a collective critique of the power relations in society as a whole" is produced (Massumi 1987, x). In this way, the therapeutic effects go well beyond the boundaries of the clinic (never mind the couch) into society at large.[18]

Although Guattari's methods were often associated with the anti-psychiatry movement led by R.D. Laing and David Cooper in the U.K. and by Thomas Szasz in the U.S., he found that movement's sometimes "demagogic exaggerations" and overdetermined familialism to be reductive rather than productive of new subjectivities. Indeed, I would argue that one of the problems with anti-psychiatry, as formulated by Laing, Cooper, and Szasz, was that it was decidedly heteronormative in its analysis of family relations.[19] Or, put somewhat differently, we might say that much of anti-psychiatry presented, in the terminology of Eve Sedgwick, a paranoid critical practice in relation to psychiatry, whereas La Borde and Deleuze and Guattari offered a reparative critical practice. I want to conclude with a brief discussion of Sedgwick's (2003) essay, "Paranoid Reading and Reparative Reading, Or, You're So Paranoid You Probably Think this Essay Is About You," because, like Robert M. Wachter's piece in *The New England Journal of Medicine*, one of the things it does is look back at the early days of AIDS from a position in the 1990s. As literary critic, poet, teacher, and one of the most creative and influential forces in the emergence of queer theory in the 1990s, Sedgwick obviously approaches the 1980s from different backgrounds than Wachter. I think it is useful, therefore, to add Sedgwick to Wachter in order to multiply the logics circulating in the early years of the AIDS epidemic and in the hopes of ending my own analysis of AIDS activism and its clinical and critical prehistory on a reparative not paranoid note.

Sedgwick opens "Paranoid Reading and Reparative Reading" with a story about a conversation she had, "sometime back in the middle of the first decade of the AIDS epidemic," with her friend, the scholar activist Cindy Patton (2003, 123). Sedgwick asks Patton about the "sinister rumors of the virus's origin"; she wonders whether Patton believes any of the conspiracy theories about the making of the virus. Was it, for example, a biological weapon concocted in a U.S. military laboratory and tested on certain populations deemed expendable, or, even worse, was it invented to be used to kill those other populations: Africans, African Americans, and homosexuals? In Sedgwick's presentation of the conversation with Patton, she hopes Patton's expertise in the field will provide her with evidence for what she thinks must be true: that the U.S. government is somehow behind the spread of AIDS. And yet, Patton's response surprises Sedgwick. Although she doesn't deny that there could be a conspiracy, she tells Sedgwick she is uninterested in spending her energy determining whether such theories are

[18] The clinic as a kind of laboratory for social change was one of the tenets of the community health movement. For an insightful comparative analysis of two community health centers—the Delta Health Center in rural Mound Bayou, Mississippi and the Watts Health Center in Los Angeles—established in the 1960s as part of Johnson's War on Poverty program, see Loyd 2010.

[19] In *Psychiatry and Anti-Psychiatry*, for example, David Cooper focuses exclusively on the male child unable to establish an autonomous identity within his family, often as a result of an overbearing mother, who then becomes schizophrenic. In Cooper's assessment, it is often the case that families (really mothers) are psychotic, and "the identified schizophrenic patient member by his psychotic episode is trying to break free of an alienated system and is, therefore, in some sense less 'ill' or at least less alienated than the 'normal' offspring of the 'normal' families" (1967, 37). On the one hand, Cooper is critical of normalization, but on the other hand, his critique relies on a gender normativity in which boy children must break free of their mothers.

true, and this unexpected response for Sedgwick, "open[s] a space for moving from the rather fixated question Is a particular piece of knowledge true, and how can we know? to the further questions: What does knowledge *do*—the pursuit of it, the having and exposing of it, the receiving again of knowledge of what one already knows? *How*, in short, is knowledge performative, and how best does one move among its causes and effects?" (2003, 124). Sedgwick realizes that the paranoid practice of exposure often becomes an end in itself, forgetting or ignoring the important, further, questions about what knowledge does. Sedgwick returns to her surprising conversation with Patton in the mid-1980s to problematize what she sees as a "paranoid imperative" in criticism and politics in the mid-1990s. Although she acknowledges that "queer studies in particular has had a distinctive history of intimacy with the paranoid imperative," she worries that, by the 1990s, it has become *the* queer methodology, rather than one of many possible critical positions (2003, 126). She hopes to un-fixate queer studies by offering a call for other critical practices—reparative ones as well as paranoid ones.

We might consider, then, as an example of Sedgwick's paranoid critique the important work of the anti-psychiatry movement in exposing the horrors of many psychiatric institutions and practices. And yet, we also might—indeed, must—ask what have been some of the negative effects of anti-psychiatry on the mentally ill, especially as a result of the massive de-institutionalization that was first promoted by anti-psychiatry activists and later became a cornerstone of the state's progressive neo-liberalization of mental health care in the 1970s and 1980s. De-institutionalization was a sometimes literal exposure of the mentally ill on the streets of U.S. cities. For Sedgwick, the problem of the paranoid practice of criticism is that it is "averse above all to surprise," preventing us from glimpsing the "lineaments of other possibilities" (2003, 146) that might arise when we deviate, digress, or intersect. These lineaments of other possibilities were what the clinic at La Borde tried to open up for both its patients and staff. The desire was not simply to deinstitutionalize patients but to create alternative spaces for "a therapeutic social life" to happen (Guattari 2009, 189). In the contemporary neo-liberal logic of medicine, a "therapeutic social life" is difficult to imagine. Yet, I contend that it helps our clinical imagination to look back at earlier experiments—not necessarily as offering a one-size-fits-all model of the future, but as visions of the past that open up other logics in the present. We que(e)ry the clinic of the past in order to denaturalize the clinic of the present and to produce new clinics of the future.

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