# *Introduction – Schizoanalysis and Us*

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50 years of *Anti-Œdipus*. Legitimately, this year has been marked by a multitude of thematic events, but as obvious as the first statement is, it was still necessary to mark its impressive geography: it's rare that the subject allows such a transgression of the Anglo American tendency to dominate academic space. We – pedagogues, psychoanalysts, sociologists, philosophers, critics and activists, more or less oriented towards the ideas of the project of thought of which Guattari presented the first version (charming in its contradictory nature) with Deleuze in 1972 – are well aware that institutions, too, "speak", establishing transference relations while creating psychic defenses and so on. It seems that our series of meetings over the course of the anniversary year has reminded us of what we often forget behind the molarity of our day-to-day work: the institution itself appears as a subject in its unconscious. Observing our colleagues (and, of course, ourselves), we've seen that when we talk about the complex social and metaphysical abstractions of *L'Anti-Œdipus* from the institutional podium, we're actually talking about very personal things: local refractions of schizoanalysis where targeting transforms discourse into speech.

Schizoanalysis and us. Every year, researchers and critics come up with new truisms about the global relevance of *L'Anti-Œdipus* of year n. Without daring to join in this glorious tradition, we'll confine ourselves to a local observation that's close to home: two differently oriented but complementary processes are running in parallel in Russia. On the one hand, a specific movement towards singularity: Russia is currently trying to move from collective neurosis to individual neurosis; it seems that this process risks being reversed by the war in Ukraine, which brings us back to collective neurosis. On the other hand, a general movement in the West towards the reappropriation of agency, through, above all, collective arrangement (we remember Reddit's triumph over the big Wall Street traders and GameStop's stock price rise). Guattari himself would surely have welcomed such incoherence, but is relevance enough to make it possible to import schizoanalysis into Russia? What is the context of Guattari's thinking? We have tried to speculate on the clinical, institutional and social factors of schizoanalysis in Russia. The inspiration for this short presentation came from an article by Ian Parker (2021) on Guattari in the journal *Free Associations*.

A number of major works by Deleuze and Guattari, including *Capitalism and Schizophrenia* and What *is Philosophy?* have been translated into Russian for a very long time. Similarly, three translations of Guattari's texts, albeit modest, are worth mentioning in recent years: the essay *Les trois écologies* and the article "Machine et structure" appeared in 2019, and our joint translation of the article "Un changement de paradigme" was published in 2021 (Guattari 2019a; 2019b; 2021). But despite his fairly widespread popularity among philosophers, Guattari's clinical ideas remain almost unknown in Russian-speaking circles. The generic "schizoanalysis" is rare and increasingly replaced by "Deleuze's". Everyone thinks they know what schizoanalysis is, but doesn't want to understand it: reading Deleuze and Guattari is much more uncomfortable than simply reading Deleuze. We tend to forget that Guattari remained a clinician until his death, a psychoanalyst if you like, and that he not only worked as a psychotherapist at La Borde, but also conducted private analytical sessions in his office on rue Saint-Sauveur.

However, this is not a specifically Russian problem. In the Anglo-American world, the "clinic" is being successfully hijacked by Integrated World Capitalism. The vision of the mental health clinic, imposed by insurance agents, is today already being legitimately reproduced without their participation, by the people themselves, who have seen the source of cherished identification in the practices of mental repression: the scientific triumvirate of pharmacology, neurofascism and cognitive behaviorism (a reorganization of American Ego-Psychology that perverted psychoanalysis). With the victory of pharmacology over "anti-psychiatry", there seems to be no room left for another "clinic".

Is this the case in Russia? In some respects, Russia's historical context overlaps with that of Latin America: the development of medicine and mental health in Russia, as in Latin America, took place outside the orbit of the Anglo-American world for a considerable period. Another point of convergence is the significant social inequality in terms of access to psychotherapeutic care; in Brazil, Uruguay or Argentina, the public system is more conducive to the spread and establishment of psychoanalytic practices than in Russia, even if the "quality" of these psychoanalyses is called into question (Tupinamba 2021). To understand the particularity of the Russian clinical context, a number of factors need to be taken into account. In the West, mental health practice emerged from the hospital environment. For example, in England, the psychiatric hospital was once an "insane asylum", a prison, and in France, a local political refuge. This has, to a large extent, shaped perceptions of psy practice. If Parker derives the fate of schizoanalysis in the West from the inpatient unit, in Russia it should be derived from the outpatient unit. Since the 1920s, Russia has developed a network of public psychoneurological dispensaries – outpatient and semi-outpatient structures attached to psychiatric hospitals. The psychoneurological dispensary was considered a primary care facility, on a par with a general therapeutic polyclinic or gynecological clinic. In addition, psychotherapeutic practices were opened in adult polyclinics (albeit with a psychiatrist instead of a practicing psychologist), and psychoneurological practices were opened in pediatric polyclinics. This system was

intended to bring revolutionary psychiatric care to the masses without removing them from society. Hospitals, on the other hand, became the place where the most serious patients, either in crisis or in the throes of mental decompensation, were kept. This outpatient psychiatric system was the work of Nikolai Semashko, who was close to the ideas of social hygiene and introduced a psychiatric nosology rooted in the individual's social conditions. Russian psychiatrists were one of the first professional groups to support the Bolshevik coup d'état, which promised grandiose social and political change (Lavretsky 1998). The Bolsheviks kept their promise, but not in the way psychiatrists saw it – the late 1930s saw a grandiose and revolutionary unification of theoretical perspectives, including in the field of psychological care. Social hygiene also fell victim to this unification.

The situation did not improve after the war and the death of Stalin. While Western psychiatric hospitals opened their doors in the 60s and 70s, exactly the opposite happened in Russia, where the marginalization of psychiatric hospitals was launched. The ambulatory system began to ossify as it went along: the general practitioner, necessarily present in all polyclinics, was transformed into a distributor of patients to other doctors (Sheiman 2013). The psychiatric hospital was perceived as a special kind of prison. Any psychiatric problem, no matter how minor, was seen as a dangerous illness. A kind of metonymy took place: anyone seeking outpatient psychiatric care was now perceived as potentially dangerous and exposed to social expulsion and isolation in a special prison. To this day, psychiatric institutions are disparagingly, but carefully, referred to as "*durka*" (consonant with the Russian word "*durak*", mad). The words "schizo", "schizophrenic" and "autistic" are still common swear words in everyday language. The Soviet authorities' use of psychiatric services for political purposes (suppression of opponents) contributed to Russians' distrust of all forms of psychopractice. An essential clinical metaphor in schizoanalysis, schizophrenia, dementia praecox, contained explicit political connotations in the Soviet context, associated with repressive state practices and abuses. Slow-onset schizophrenia", referred to by Snezhnevsky as a "non-psychotic variety" (the phenomenon analysts today would call ordinary or white psychosis), became the hallmark of punitive psychiatry, used by the Soviet state from the 1960s onwards to combat dissidents. We should also mention another aspect of the Russian context. While in some parts of the world psychologists may have become a more "friendly" alternative to the psychiatrist, for Russians, any psy practitioner – psychiatrist, psychologist, psychotherapist, psychoanalyst – is perceived as a doctor and, therefore, as part of a frightening psychiatric machine. In hospital, patients periodically ask me (G.M.) to look at their stomachs or complain of coughing. The fact that, prior to the collapse of the Soviet Union, psychotherapy was largely perceived as therapy through suggestion or hypnosis also creates specific expectations in people. In such an environment, the general population is more likely to turn to life coaches, esotericism or a bottle of vodka than to a mental health system.

In addition to the clinical aspects of the Russian situation, there is also the social theme. Russia has not escaped the neoliberal ideology of excessive success, repressively imposed happiness, and guilt and despair over the impossibility of achieving it. In addition to the peculiarity of the Russian clinic, people not only feel broken, but believe they can be fixed like an automaton. What they expect from a shrink's practitioner is that he'll make them well: a position of passivity where a medical or magical manipulation will be performed on the subject. Simple and easy! Repaired, functional again. This explains the proliferation of psychotechniques of all kinds, in which the subject is spoken to by the Lacanian Other in the most malignant psychotic sense: the search for life scenarios in past lives, birth traumas, astrology, hypnosis, coding and other "urban magics", well monetized by late capitalism. It's hard to say whether there's a need for creative, liberating and ontological experimentation behind all this. There is also a pragmatic basis. Quality psychopractice remains, it seems, fairly inaccessible. The use of a highly qualified specialist (which, in Russia, often implies training obtained abroad) remains a prerogative reserved for the upper middle class, but the overheated market for psychology services is rife with practitioners of dubious qualifications, prone to dumping. The total absence of diplomas or other minimum barriers to entry into the profession does not improve the situation.

On the other hand, public institutions don't guarantee specialist qualifications either, and it can be difficult to get to them other than by "ambulance". What's more, people are not prepared to make a long-term contribution to their mental well-being. They'd be more willing to pay ten or a hundred times that amount to an esoteric guide or hypnotist if he promises to "fix" them in a single session. Common psychotherapeutic modalities, which were simply imported after the collapse of the Soviet Union in the 1990s, come into conflict with the particular social context. For example, due to high divorce rates and male mortality, the nuclear family had been in crisis for almost 20 years. Hence a common Russian anecdote: "Half the country was raised by a homosexual family consisting of a mother and a grandmother". Although the nuclear family is being reinvented in Russia, Anglo American psychoanalysis based on this phenomenon is unwelcome, and its followers resemble either a cargo cult or a Masonic lodge. Freudian psychoanalysis, which is more open and flexible, is better received in some circles, although it does not represent a remarkable social phenomenon. Family systems face similar difficulties. Cognitive behaviorism, on the other hand, only further perverts the already precarious state of the Russian psyche. In such a situation, "humanist" practices of social "caressing" have spread considerably: Gestalt, Rogerianism, positive psychology and their local variants.

Thus, the direct import of schizoanalysis into Russia is impossible, as is the direct import of any other analytic school. Schizoanalysis differs favorably from other schools in that the character of schizoanalysis contradicts the idea of a simple import. Schizoanalysis is an incomplete and contradictory doctrine, not a profound orthodoxy left by the master to his pupils. Nevertheless, it is not so much an analytical assemblage as a metamodel that can be deployed in a variety of fields. Guattari himself, at the start of his *Cartographies*

*schizoanalytiques*, does not present schizoanalysis as a new, more faithful brand of psychoanalysis, nor as a new alternative discipline to it. On the contrary, such a dialectic of contradictions for schizoanalysis is another unwelcome reductionism. Guattari writes that he seeks to liberate all the valuable elements that have been discovered by psychoanalysis from its reductionist layers. If, in a certain national context, it was important for schizoanalysts to distance themselves from psychoanalysis, this is not the case in Russia. Just as, for the Russian, everyone in the clinic is a doctor, any analyst – Guattarian, Winnicottian, Lacanian – will always be the same psychoanalyst. At the same time, in the context created by the trajectory of development of the Russian clinic, it seems more pertinent to distance ourselves not from psychoanalysis, but from psychotherapy: this denomination forms certain expectations in the Russian patient. He expects to be cared for, to have something done to him; he already accepts passivity before it takes place. The use of the root "schiz" as a common swearword also raises the issue of "branding". Schizoanalysis is really difficult to present. Schizoanalysis is actually made up of three projects: a program of philosophy and social theory developed by Guattari with Gilles Deleuze (materialist psychiatry and glossematic ontology); a metamodel; and a clinical practice. If it's not possible to present schizoanalysis as something unified, we suggest moving forward step by step, starting with the clinic – the clearest area of practice – preceded by theoretical research presented at academy-oriented thematic events.

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