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THE PARADOX OF PANIC
A GEOGRAPHIC ANALYSIS OF AGORAPHOBIC EXPERIENCES
by
RUTH BANKEY, B.A.RCH

A Thesis Submitted to
the Faculty of Graduate Studies
in partial fulfillment of
the requirements for the degree of

Master of Arts

Carleton University
Ottawa, Ontario
May, 6, 1999
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**" THE PARADOX OF PANIC:
A GEOGRAPHIC ANALYSIS OF AGORAPHOBIC EXPERIENCES "**

submitted by **Ruth Bankey, B.Arch./M.A.**
in partial fulfillment of the requirements for
the degree of Master of Arts

Chair

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GEOGRAPHY & ENVIRONMENTAL STUDIES

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ABSTRACT

This thesis investigates the geographical, social and gendered experiences of women with agoraphobia and panic disorder (PDA). I critically analyse and review various literatures and discourses on agoraphobia. I argue that clinical literatures define agoraphobia as PDA, while non-clinical literatures define agoraphobia as an organization of specific social and spatial anxieties. These various approaches to the agoraphobic condition are interconnected, particularly when we understand PDA/ agoraphobia as a fear of the hysterical body, which is bound within the construction of femininity as a pathology. The experiences of PDA/agoraphobic women challenge both clinical and postmodern/poststructuralist subjectivities; in favour of a feminist geographical approach that reconceptualises the links between space, place, bodies and illness within the context of those researched. This study aims to open up areas for further study and investigation, and in so doing, increase an awareness of PDA/agoraphobia within academic and public consciousness.

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Chapter One - Introduction

Thus they (city planners) think of the modern city according to the model of the antique city, which is at the same time identified with the ideal and rational city. The agora, place and symbol of democracy limited to its citizens, and excluding women, slaves, foreigners, remains a particular philosophy of the city, the symbol of urban society in general (Lefebvre, 1996:98).

The agora has left an indelible mark on the structure of cities today. The agora was a space of meeting, a marketplace and a space of the polis or city where landholding men would govern and assume the privileged role of citizens. It was also a space which imprinted the deeply rooted gendered divisions of western society onto the structure and organization of city planning. The term agoraphobia is derived from the term agora and through this, an association with its history and geography. It is not incidental that agoraphobia is continually referred to as a female ailment that specifically concerns the spatial patterns and the mobility of women. This 'coincidence' of gender, geography and illness attracted me to the study of agoraphobia. Agoraphobia, defined as a fear of public places in lay terms - agoraphobia without panic or, in clinical discourse the fear of fearful thoughts - panic disorder with agoraphobia (PDA), currently afflicts one out of twenty North Americans, over three quarters of whom are female (Carlson et al., 1996; NIMH in Doctor and Kahn, 1989:13). Yet, very little research has been done on PDA/agoraphobia outside the disciplines of medicine and psychology and there is even less that focuses on the concerns and perspectives of agoraphobic women. Given that such research informs the work of educators and practitioners who deal with PDA/agoraphobia, there is a vital need for scholarship that acknowledges the multiplicity

of PDA/agoraphobic experiences. There is little discussion and exploration of the cultural construction and spatiality of PDA/agoraphobia, and yet PDA/agoraphobia is connected to issues concerning the divisions of gendered spaces, places, identities and the production of space vis-a-vis bodies. PDA/agoraphobia is traditionally understood as a clinical condition, but it can also be explored as a spatial and gendered production.

This thesis examines clinical models of PDA/agoraphobia that construct and reproduce 'disorders' for women exclusively within the confines of those discourses. How do PDA/agoraphobic women as medicalised and feminized subjects work through problematic representations of themselves, thereby constructing new social spaces and subject positions? I seek to discover what strategies are employed by PDA/agoraphobic women to subvert, accommodate or reinforce representations of femininity, corporeality and the construction of gendered geographies. I am intrigued by the implications of a PDA/agoraphobic space and what meaning is invested in space for a PDA/agoraphobic person. What and how does the study of PDA/agoraphobia contribute to an understanding of geographical spaces and processes? What do agoraphobic women reveal about the nature of space-making, the gendered construction of space and the importance of women - their bodies and experiences - in mediating, understanding and producing space? How can PDA/agoraphobia be thought about within feminist geographical theory? Is the 'agoraphobic body' a result of medical normalizing practices and representations of the body; lived experience; a lack of understanding that "space and place matters" in the general public. Or is it a combination of all of these factors? Agoraphobia exposes how the division of private and public spheres, spaces of

production and consumption, their representations and lived realities are all part of gendered relations and the nature of 'place'. The agoraphobic condition is deeply concerned and affected by space, and by the shaping of gendered identities. Potentially, there is a wealth of spatial and gendered insight to be gained from individuals who invest such profound and extreme meaning in space.

The etymology of the term agoraphobia reveals a genealogy intertwined in how the agoraphobic condition is experienced today. The agora was the central zone of the city, grounded in the daily scene of social life, business and politics (Morris, 1994: 41-42). It was a place of assembly, a place of festival and a marketplace - the dynamic centre of the city. It was a space where people came to congregate and interchange opinions, news and goods. Although one part of the agora was often reserved for housewives and prostitutes, the agora was pre-eminently a man's precinct (Mumford, 1989: 148-151). As a marketplace the agora was one of the few places that free citizens, artisans, slaves and mercantile foreigners could interact with one another, but only during particular times and within specified areas. But, while various groups of men occupied the market and meeting space of the agora, very few women were permitted to do so. As a political forum the agora served as a multipurpose gathering place for able-bodied, middle or upper-class male citizens and as a space in which elders and neighbours gathered and met, a form of city hall (Ibid, 1989: 134). The agora has become an architectural model for the development of political, economic and social gathering spaces within western culture. In the Greek city the agora was the arena for public debate and self government. It was a space in which to foster democratic ideals

and the polis (state). Indeed it was a manifestation of the polis in spatial form. Over time, the agora has been a space of power and resistance, a space of articulation for the exchange of goods and ideas and for political safety and freedom, as well as a space of dissention, fear and most importantly exclusion (Kostof, 1985: 133). As such, the agora from its inception was deeply imbued in the division of gendered roles, identities and geographies.

Agoraphobia, within popular culture, has come to be understood as a fear of the marketplace, an of public or open spaces, primarily because of its etymological connection to the spaces and history of the agora. In fact today clinicians do not understand agoraphobia as a fear of the agora, but rather as a fear of fearful thoughts, or as a fear of panic. Rather than being directly connected to the experience of place, agoraphobia, as understood clinically, is directly connected to the experience of panic.

Agoraphobia is defined by the Dictionary Of Anxiety Disorders and the latest edition of the Diagnostic and Statistical Manual as:

A: Anxiety about being in places or situations from which escape might be difficult or embarrassing, or in which help may not be available in the event of having an unexpected, or situationally predisposed panic attack or panic-like symptoms. Agoraphobic fears typically involve characteristic clusters of situations that include being outside of the home alone; being in a crowd or standing in line; being on a bridge; and travelling in a bus, train or automobile.

B: The situations are avoided (e.g travel is restricted) or else endured with marked distress or with anxiety about having a panic attack or panic like symptoms, or require the presence of a companion.

C: The anxiety or phobic avoidance is not better accounted for by another mental disorder such as social phobia (e.g avoidance limited to social situations because of a fear of embarrassment.), specific phobia (e.g avoidance limited to a single situation like elevators), obsessive compulsive disorder (e.g., avoidance of dirt in someone with an

obsession about contamination), post traumatic stress disorder (e.g., avoidance of stimuli associated with as severe stressor), or separation Anxiety disorder (e.g., avoidance of leaving home or relatives) (DSM IV, 1994: 396-397).

More specifically though, agoraphobia within clinical discourse is identified in two ways: panic disorder *with* agoraphobia or PDA, and agoraphobia *without* panic disorder. Panic disorder with agoraphobia is defined and identified as a fear of fear itself, a fear of having a panic attack and is characterised by the reoccurrence of unexpected, situationally bound or situationally predisposed panic attacks. The criteria for agoraphobia without panic disorder is related to a fear of developing panic-like symptoms without actually experiencing panic attacks. Clinical models of agoraphobia tend to focus almost exclusively on PDA and little is known about the course and experiences of agoraphobia without panic according to various clinical literatures (Ibid, 303-404).

Although agoraphobia was recognised as far back as the ancient civilizations of Egypt, Greece and China, until the latter half of the twentieth century, the term agoraphobia and the agoraphobic syndrome were not well defined or identified (Doctor and Kahn, 1989: 13; Thorpe, 1998). In fact agoraphobia appeared for the first time as a distinct category in the 1980 Diagnostic and Statistical Manual (Thorpe, 1998). Some theorists speculate that agoraphobia was not well defined until the end of the twentieth century because of the socialization of gender roles and spatial restriction of groups of individuals, such as women (Brehony, 1983; Thorpe and Burns, 1983).

PDA/agoraphobia and its conceptualization have been significantly transformed over the past century and have recently come to be defined as a fear of panic (Antony et

al., 1992, Barlow, 1988; Cox, et. al., 1995). Prior to this, agoraphobia was defined more etymologically as a fear of the marketplace or public spaces and therefore seen to be a fear more directly associated with the spaces avoided, as opposed to being defined as an avoidance behavior (Gardener, 1995). Before the 1970's, agoraphobia was not typically identified as a “discrete syndrome”. When patients sought treatment they were often treated for other symptoms instead (Garbowsky, 1989: 31). Since the 1970's and particularly in the 1980's an intensive period of research on agoraphobia led to a more clearly delineated description and diagnostic criteria for the disorder (Lindemann, 1989; Thorpe, 1998, Walker et al., 1991). As a result, it is claimed that PDA/agoraphobia is now more reliably treated (Aceierno et al., 1993 Barlow, 1988; Thorpe, 1998). While most books written in the early 1980's and before assert that panic disorder with agoraphobia is one the most difficult anxiety disorders to treat, books, periodicals and manuals written after the mid eighties more positively claim that the treatment of panic disorder is highly effective and the treatment of agoraphobic avoidance behaviors, while more difficult to treat than panic, has grown more successful (Cote et al., 1994; Thorpe, 1998; Walker et. al, 1991). This shift has profound implications for the treatment and development of PDA/agoraphobia, as well as important geographical significance . By defining agoraphobia/PDA as an avoidance behavior more closely connected to a panic reaction, or an internal mechanism as opposed to a reaction directly related to and caused by the outside environment, many clinical etiologies and approaches to agoraphobia have become more firmly rooted in understanding the body separately from its environment. Various medical and psychological models of agoraphobia/PDA have differing

perspectives on the relationship between the body and geography but, typically, these discourses either negate or attempt to separate the agoraphobic body from its environment to further clarify and examine each sphere as distinct.

The clinical discourse on agoraphobia and the term itself, as understood today, began around the end of the nineteenth century. Agoraphobia comes from the Greek words *agora*, meaning marketplace, and *phobos*, meaning fear of. Dr. Alexander Karl Otto Westphal, a German neurologist, coined the word in his 1872 publication entitled *Die Agoraphobie*. Westphal described agoraphobia as “ the impossibility of walking through certain streets or squares, or possibility of so doing with resultant or anxiety ” (Westphal, 1872). Alternately, Moritz Benedikt, a contemporary of Westphal’s, named this disorder as *platzschwindel* meaning dizziness. This suggested that the central feature of the disorder was not anxiety but dizziness. In 1871, Westphal observed that anxiety or panic disorder is based on ideas, cognitive factors, and not brought about by external stimuli. In other words, space and place were not directly connected to the experience of agoraphobia; they were understood and conceptualised separately from the agoraphobic mind and body. The connection between space and anxiety was thought to be a conditioned response, a process by which fearful reactions become associated with particular things or places. Westphal based his models of therapy on the ability to distinguish between experience and space, which in turn, informed the discussion of agoraphobia in European circles of psychiatry.

Freud was another important figure in the development and history of agoraphobia, though he was more interested in all-encompassing theories of

psychosexual development than he was of any specific syndrome (Thorpe, 1998). His writings on agoraphobia, “such as the architecture of hysteria” revolve around a discussion of one particular case study - the case of little Hans. Following Freud’s analysis of little Hans, agoraphobia was interpreted as a form of castration anxiety for men and an anxiety of repressed libido, manifest as “promiscuous urges in the street” which “seems to depend on a romance of prostitution” for women (Freud, 1897 in Vidler, 1993: 35). According to Freud, the traffic and publicity in the streets evoke in the agoraphobic woman fears of illicit incestuous desire (See Brown, 1987:154-55 and Freud, 1974(1909)). Following Freud’s and Westphal’s studies of agoraphobia, many physicians and psychiatrists studied agoraphobia, particularly in the United States. Interest in agoraphobia waned until the 1970's (Thorpe, 1998).

American clinicians were quick to identify agoraphobia as an instinctual nervous disorder akin to hysteria and melancholia (James, 1873 in Brown, 1987: 154). Alternatively, critics, writers and architects of the time, blamed the emergence of agoraphobia on the architecture of the city. Georg Simmel saw the modern abstract spaces and geometry of the city as a direct cause of agoraphobia (Vidler, 1993: 34). The Viennese architect Camillo Sitte, was particularly interested in the connections between the fashionable open spaces of the Ringstrasse and the emergence of agoraphobia. His city plans for Vienna reflected this disdain of open, ‘modern’ architectural planning in favour small scale enclosed squares (Da Costa Meyer, 1996: 143-45). Other architects, eager to reconstruct the foundations of urban space, argued that the pathology of agoraphobia was precisely the “product of urban environments, and that their cure was

dependant on the erasure of the old city in its entirety ” (Vidler, 1993: 36). From the early 1920's these architects projected images of a city transparent, infinitely extended and thereby cleansed of all mental disturbance: “the site of healthy and presumably aerobically perfect bodies ” (Ibid, 1993: 36).

During the nineteenth and early twentieth century, most individuals who reported agoraphobic episodes and analysed and investigated within clinical discourses were men (Doctor and Kahn, 1989). For example, all of Westphal's and Freud's original agoraphobic patients were male. In 1885, a single description of a female agoraphobic patient appeared in the literature with a comment that the condition was uncommon amongst women. Despite the predominance of male agoraphobics, agoraphobia was thought of as fundamentally female in character (Vidler, 1993: 35). Now however, various statistics indicate that agoraphobia/PDA is much more common in women than men (Carlson et al., 1996; Fredrikson et al., 1996; Health Canada, 1996). For example, some practitioners argue that for every three female agoraphobic/PDA persons, one male is diagnosed with PDA/agoraphobia, while others estimate that upwards of 85 percent of PDA/agoraphobic individuals are women (Burke et al., 1990; Carlson, 1996: 477; Chambless and Goldstein, 1992; Wolman and Stricker, 1994).

In the twentieth century agoraphobia has become inextricably linked to women and gender. Early twentieth century writings on agoraphobia, typified by the writings of Helene Deutsche, dramatically shifted the focus of agoraphobic investigations from men to women. PDA/agoraphobia was a female condition. It expressed a woman's fears and tensions about straying outside traditional domesticated gender roles (Deutsche, 1929).

From this work and exploration grew a literature that attempted to link women and agoraphobia to genetically and biologically determined factors, suggesting that women are more naturally prone to panic and agoraphobia (Macdonald and Murray, 1994).

There also emerged an entire literature about the female condition of PDA/agoraphobia: as a housewives disease, as a crystallization of cultural sex-role stereotypes for women and as fundamentally linked to marriage - women who marry houses rather than men (Brehony, 1983; Chambless and Goldstein 1982; 1992; Seidenberg and DeCrow, 1983; Symonds, 1973). This body of literature focused on the incidence of agoraphobia after marriage and the prevalence of agoraphobia in recently married women. Current statistics no longer support the argument that PDA/agoraphobia is a condition most often found in married women, although married women form a large percentage of those diagnosed with agoraphobia (Health Canada, 1996). According to current statistics PDA/agoraphobia is most common in women aged 18-35, the majority of whom have never been married (Carlson et al., 1996; Eaton et al., 1991; 1994). What is reported in all of the literature on PDA/agoraphobia is that women experience PDA/agoraphobia more frequently than men for a variety of personal and cultural reasons (Bourdon et al., 1988).

This thesis focuses on PDA/agoraphobic women, because women form the predominant group diagnosed with PDA/agoraphobia. The men I interviewed informally during my research appeared to express similar concerns and issues to those expressed by the women. In fact, the men seemed to be more conflicted over the gendered associations of PDA/agoraphobia with the feminine, so that they developed coping and

spatial strategies that were similar to but more intense and oppressive than those expressed by PDA/agoraphobic women. Thus, despite the focus on women, the thesis materials and analyses are also relevant for agoraphobic men.

'Bodyspace' and Chapter Outline

The body has become an increasingly popular site for academic investigations- "theory shops at the body shop" (Cunningham in Callard, 1998; Parr, 1997; 1998). This pun is useful because it indicates that:

Behind the ostensibly untainted sophistication of theory as a rigorous labour of the mind lies a more grubby perusal of wares. If theory is indeed shopping at the body shop, it is useful to think both about how the body has been materialised as a desired object within academic practice and about which shops, and wares therein, have become appealing within the circuits of theory (Callard, 1998: 388).

Bodies have become the objects and subjects of intense cultural, philosophical and feminist fascination within a remarkably short time (Grosz, 1997: 1). This does not mean that bodies were ignored as academic subjects in the past. On the contrary, many recent histories of illness, sexuality and medicine have demonstrated that bodies have always been objects of theoretical and pragmatic concerns. It is just that only recently has 'theory' developed terms complex enough to do justice to the complexity of bodies (Ibid, 1997: 2).

In human geography in particular, the body is increasingly being considered as a subject for theoretical reflection (Parr, 1998: 28). This is because human geographers have acknowledged the permeability of body, social and spatial processes - the dynamic

quality of our environments and our bodies that affect one another. Our physical and psychological bodies produce a sense of place and affect the way in which we understand and inhabit imagined and physical spaces. Various geographical writings have focused on the interconnection between body, space and social process. For example, some writings have focused largely on the gender politics of bodies within western culture (Bell and Valentine, 1995; Cream, 1995:33; Duncan, 1996; McDowell and Court, 1994; Rose 1992; 1993; 1996), while other writings focus on the discussions of the physical presence of the body and its effects on geographical relations (Moss and Dyck, 1996; Chouinard and Grant, 1996; Dear et al., 1997; Butler and Bowlby, 1997; Parr, 1997; 1998: 28).

This thesis involves an exploration of the body within a variety of clinical and non clinical discourses, which approach the body from several perspectives. Mainstream medical and some psychological theory and practice is based on the body as a biological object and the subject of scientific inquiry and knowledge, to normalize and standardize our understanding of our bodies and thus, prevent disorder. Foucault defined this exercise of power as the creation of a “docile body” or rational subject. This “docile” body is enmeshed in a functional system of clinical representations and practices concerning the body that reinforce and reflect mainstream clinical thought (Bordo, 1993). The body is often understood to be a site of clinical information and as such, clinical models have isolated the body from outside environments to reinforce its power over the understanding of bodily processes. Bodies are reinscribed as clinical subjects as their processes and components are given nomenclature, explanation and

diagnostic criteria. This “docile body” or rational subject is caught up in the desire to maintain and establish disciplinary control and order.

Feminist critics focus on the regulation of the body within western medical tradition, because the body is seen to be trained, shaped and impressed with prevailing patriarchal forms of identity and subjectivity (Bordo, 1993: 165-66). Feminist geographers concerned with issues of health politicize the body as an agent of social justice and resistance. The body is seen as a site of struggle that negotiates and reveals the tensions between lived experience and clinical normalizing practices. The notion of a body as a discontinuous, non totalizeable series of processes and parts, may be of great value to feminists attempting to re-conceive and rethink bodies and places outside of the binary oppositions imposed on the body by mind/body, nature/culture, subject/object, private/public, interior/exterior oppositions. They provide an altogether different way of understanding the body in connection with other bodies and other spaces, challenging various clinical discourses on the agoraphobic body and the rational subject (Grosz, 1994: 164).

Much of the focus of the study of the body, outside of clinical discourse, has been structured around a celebration of the body and its pleasures. “The preferred body was one under control, pliable, amenable to the subject’s will: the fit and healthy body, the tight body, the street smart body, the body transcending itself into the infinity of cyberspace” (Grosz, 1997: 2). Grosz describes how the body as an object of play simultaneously becomes an object of self-exploration and self-regulation. This pliable body is a “docile” body, but this body is not simply obedient to the will of others, in

respect to power structures, but more a body docile to personal will. But, unlike bodies that are stimulated by the confusion and play of corporeal boundaries, bodies with PDA are tormented by their physical sensations of shifting boundaries. The rethinking and resituating of the body, that many critical theorists celebrate, “should be celebrated for its unsettling effects on knowledges that are devoted to erasing traces of the corporeality of their own processes of production and self- representation ”, but not without caution and always in context (Ibid, 1997: 2).

The thesis involves a rethinking of the implications of the body in theory. More modestly, I am attempting to make some initial connections between panic disorder with agoraphobia and a larger discussion of bodies within a variety of subject matters. I believe that the study of agoraphobia and panic disorder with agoraphobia has something to add to other discourses on the body. Therefore the study of PDA/agoraphobia needs to claim a more recognised space within academic and public consciousness.

This thesis attempts to widen the scope of discussion about PDA/agoraphobia, and thus, it investigates a wide variety of themes and topics. The thesis was written as an additive process, each chapter is its own story and alludes to its own set of possibilities, but is also clearly related to the next chapter and enhances an understanding of the other chapters. The thesis is presented as a series of separate yet intertwined themes and layers. These layers illuminate, add to, and sometimes disrupt and confuse the others. An attempt to consolidate a singular understanding or model of PDA/agoraphobia is fraught with contradiction and is moreover problematic. I hope to provide a polyphony of voices and insights into the agoraphobic condition. I provide a

variety of ways in which PDA/agoraphobia has been explored as a social condition and clinical disorder to open up possible venues and areas for discussion.

This thesis adopts a feminist, geographical, postmodern, poststructuralist approach and yet, my analysis is also a critique of a particular type of postmodern, poststructuralist theory. The thesis contains many ideas and approaches that are in tension with one another, that do not resolve themselves into neatly organised packages. The thesis argues against the separation of ideas and experiences into simple organized, dichotomous categories and structures, thus, pretending that resolution has come. And it is hoped that in so doing these ruptures will provoke further questions and possibilities for research. This first chapter, which consists of a background introduction and chapter outline, introduces the direction that the thesis will take and situates the work within the context of its history and literatures. Chapter two explores my research methodology. The discussion within the methodology chapter positions my work in relation to a wider understanding of feminism, and what a feminist research project involves. This thesis combines and links quantitative research, literature reviews and theory to semi-structured interviews to critically examine and discover the matrix of competing and complementary discourses that shape the lives of agoraphobic women from their perspective and voices which have typically remained silenced or unheard (McDowell, 1996: 42). My research methodology adapts and incorporates contemporary feminist geographical perspectives on reflexive research and the importance of insuring that applied research is both practical and accessible to those who would benefit from the research (McDowell and Sharp, 1997).

The third and fourth chapters are structured as discourse analyses and literature reviews of some of the ways in which agoraphobic experiences are approached. The third chapter focuses on a literature review and analysis of clinical agoraphobic discourses, where agoraphobia is diagnosed as PDA, as a fear of fearful thoughts, a fear of panic; while Chapter four analyses literatures that do not approach the agoraphobic subject clinically, that use agoraphobia to express a set of historical and geographical conditions. In Chapter three, I argue that many clinical models do not sufficiently reflect and address a notion of spatiality and spatial process into an evaluation of PDA/agoraphobia and, thus, miss potentially useful insights about PDA/agoraphobia and its geographical implications. Yet, it is also important to acknowledge that many clinical approaches are successful in addressing PDA/agoraphobic concerns and queries, and that the separation of activity from space is potentially enabling for many PDA/agoraphobic individuals. Thus, these clinical models provide a caution and highlight the observation that the celebration of and desire for a fluid subject is sometimes a harmful and problematic proposition.

In the non-clinical literature review and discourse analysis of the fourth chapter, it is clear that non clinical and clinical literatures speak about two different agoraphobic subjects: agoraphobia as PDA (clinical) and agoraphobia as a social condition or the 'geography of women's fear' (non clinical), though there is some overlap between them. Agoraphobia as a social condition involves: the history of gendered spaces - issues of public safety and harassment; economic, political and cultural constructions of the feminine and womanhood; and the exclusion of women from specific power structures.

Throughout these two chapters and this thesis, I suggest that clinical and non-clinical approaches to the agoraphobic body and subject can be integrated into a model that recognises the lived experiences and consequences of PDA/agoraphobia, and incorporates more complex understandings of spatial relations and processes. This model is informed by spatialised feminism, in other words, a feminist postmodern, poststructuralist geographical approach that incorporates geography and the content of its spatial and social processes (McDowell, 1996).

The last two chapters synthesize the material of the previous chapters with my field work research, to present possible ways of approaching the PDA/agoraphobic condition. Chapter five explores the argument that PDA/agoraphobia can be seen as a fear of the hysterical through my interview subjects' own words and experiences, while chapter six explores how PDA/agoraphobia as a fear of the hysterical is manifested within a variety of geographical spheres experienced by those interviewed. I argue that PDA/agoraphobia can be thought of not just as a fear of having a panic attack or a fear of losing control over the body, but also as a fear of being seen as losing control - a fear of the hysterical body. This understanding of PDA/agoraphobia as a fear of the hysterical is informed by clinical literature that links social phobia and agoraphobia to one another (Mannuzza et al., 1990). It is also informed by psychoanalytical writers who implied that a fear of going out into the streets was a fear of being seen as out of place and transgressive (Freud, 1974(1909)) and within the work of some non clinical authors such as Brown, Bordo and Turner who compare the history of agoraphobia to hysteria and to anorexia.

This also involves an understanding of how disorder and madness have been constructed into an image of immobility and helplessness directly connected to the construction of the feminine within western culture. Chapter five intertwines the genealogies of hysteria and PDA/agoraphobia and, in so doing, explores how ‘women’s’ disorders experienced today are bound up in the construction and images of women and illness. The hysterical body is an example of how the feminine has been pathologised, how the female body has become an arena for visual spectacle and disciplinary measures, and that a logic of visibility has often been used as a means of objectifying and oppressing women (Chow, 1992). I argue that historically the ailments pertaining to women are not separate pathologies. Rather, they form an intertwined genealogy and contribute to the production of one another. I provide and provoke new ways of approaching and discussing PDA/agoraphobia by combining the experiences of women diagnosed with PDA and the history of gendered identities. As a subsection of a larger issue of women and mental health, the study of PDA/agoraphobic women simultaneously challenges and reveals the interconnectedness of medical, feminist and geographical discourses on women’s bodies.

Chapter six acts as a conclusion to the thesis. It integrates a variety of themes and challenges into an analysis of agoraphobic geographies at the scale of the body, home and city. For all three agoraphobic geographies, the agoraphobic individual’s attempts at self-empowerment become highly problematic and self-defeating. Drawing on Chapter five, I argue that PDA/agoraphobic spaces are territorialised as private or public, based on the presence of others and the possibility of a scrutinising gaze, rather

than on how public and private spaces have traditionally been identified. Over time, and after recovery, the 'home' and 'body' come to take on various spatial meanings and geographies. Traditionally public spaces that are empty become private spaces, while private spaces that are full of people or activity become public. Yet, while it may appear on the surface that PDA/agoraphobic experiences challenge the dualistic divisions of the rational subject, more accurately PDA/agoraphobic women re-inscribe public and private spheres onto other spaces and moreover, reiterate the separation of place based on the visual. Public and private spheres have been traditionally separated and categorised according to the visibility of subjects or activities within that sphere.

In Chapter six, I extend the discussion of connections between disorders predominantly diagnosed in women. I compare PDA/agoraphobic homescapes and anorexic spatial strategies because both anorexic and PDA/agoraphobic women use these spaces as a site in which they can restrict and monitor access to foreign substances such as food or people, and both sites become tragically self-defeating forms of protest.

Chapter six highlights the importance of a sense of stability in order to be mobile. This chapter shows how transgressive bodies are an unliveable ideal for certain groups of individuals. The desire to understand social and spatial processes as fluid and dynamic is successful when somatic boundaries are stable, but otherwise the body becomes a medium of fearful confusion and physical torment. Yet, this celebration of shifting spatial/corporeal boundaries suggests the possibility of understanding permeable bodies and spaces as a part of the human condition, not something to be thought of as deviant or abnormal. By breaking down conventions and distinctions that are oppressive

and that perpetuate an PDA/agoraphobic woman's sense of abnormality and deviance PDA/agoraphobics may not perceive of their problematic panic sensations and agoraphobic responses as abnormal therefore develop a greater sense of security, and become more geographically mobile.

At the end of Chapter six I present possible areas for future directions within agoraphobic research and activism. As a part of my research process, I have actively worked with agoraphobic associations in the Ottawa area. The research was structured not only to ask questions of academic scholarship, but also to challenge support groups to move beyond self-help counseling to focus on cultural, political and economic issues, by directly asking agoraphobic women and men what resources they need and think they should have.

In summation, I structured this thesis with a number of aims in mind. These can be traced and found in its chapters. They include: opening up areas of investigation and discussion about the agoraphobic condition to promote an awareness of this disorder by the general public and in areas that have not explored the possibilities of the PDA/agoraphobia to gain additional insights. Therefore, I will provide alternate ways of approaching and understanding agoraphobia. I want to open up possible ways in which academics, clinicians and the PDA/ agoraphobic individuals may themselves understand the agoraphobic condition. I found during my research, that the women whom I interviewed expressed amazement at the idea that someone outside of clinical circles was interested in their lives and experiences. This prompted many of the women to rethink and question how 'geography' affected their PDA/ agoraphobia. I want to suggest that

the divisions between mental health and illness are based on dualistic constructions such as rational/deviant, self/other, that are more indicative of the desire to identify and label bodies than of any essential deviance or irrationality.

PDA/agoraphobia is problematic and debilitating, but is not a sign of madness. I want to challenge the notion that PDA/agoraphobic concerns must remain within clinical disciplines or discourses and I therefore, challenge and critique models and theories of the body that do not sufficiently reflect on the lived realities of those individuals, either within traditional clinical discourses or academic postmodern/poststructuralist theory. I want to suggest that issues of health include, and are contingent on geographical issues such as place, space and mobility. I want to highlight the idea that PDA/agoraphobia has a lot to offer to an analysis and understanding of the construction of the feminine, gendered relations, the genealogy of women's illnesses and disorders, and issues of the feminine and of gender . I believe that space may be viewed as a social construction, constantly in the process of transformation; and that social relations have spatial forms and spatial contents and contexts which, in turn, produce new social and spatial effects. The primary reason for this thesis is to demonstrate the need for an increased awareness of PDA/agoraphobia - its consequences, realities, and the resources that need to be made available to these individuals, because it can result in substantive change in how clinicians, academics, the general public and PDA/agoraphobic persons themselves approach and understand agoraphobia. The content and experiences of this thesis should not be entirely unfamiliar to those reading the text. Many of the experiences of those interviewed should resonate in the lives of even those who have not been diagnosed with

PDA. Though there will be some notable differences, the study and investigation of PDA/agoraphobic women not only opens up possibilities for greater awareness of these women's experiences. Simultaneously it informs our own experiences. We need to recognise the connections and the discrepancies between PDA as an immobilising disorder and agoraphobia as a part of the everyday experience of the human condition connected to the construction of feminine ideals and spaces within western culture. For all these reasons, I am politically committed to a feminist project that explores the lives of women and the power relations that shape those lives and to opening up areas in which women, and more specifically marginalized women such as PDA/agoraphobic women, can be heard.

Chapter Two-Methodology

As a challenge to contemporary clinical perspectives I would like to explore PDA/agoraphobia and my research process through the use of feminist research and methodological practices, and at the same time explore this contested terrain. In the remainder of this chapter I will identify three concepts commonly used in feminist research: feminist epistemology, stressing the power relations involved in the research process (D. Rose 1993: 58 in Madge et al., 1997: 87); methodology recognising the social relations of research; and research methods linked to feminist goals (Ibid, 87).

Much of feminist political impact has been as a “theoretical critique and political movement in the context of a wider range of social movements that are based on what has become known as identity politics ” (Hall, 1994: 120). Feminist politics disrupt the idea of a centered subject in a variety of ways: by opening up political contestation to whole new arenas of social life particularly within the domestic sphere; exposing the issue of how women and men are produced as gendered and sexualized subjects, that is, politicizing both subjectivity and the process of identification; and finally focusing on issues of sexual difference and thus challenging the notion that women and men were part of the same identity (Ibid, 125). Feminist research explores notions of gender, masculinities and femininities and the way in which these categories and identities are negotiated and produced.

Feminist epistemologies variously refer to women’s ways of knowing, women’s experience or simply women’s knowledge, all of which is unacknowledged by male-biased

professional philosophers and to epistemology proper- “that is, alien to a theory of knowledge in general” (Alcoff, 1996: 23). But this latter conception of proper epistemology leaves unchallenged the premise that a general account of knowledge, one that uncovers justificatory standards *a priori*, is possible. This is precisely what feminist epistemologies have brought into question (Hankinson-Nelson, 1993). Feminist epistemologies have insisted on the significance and particularity of context to theory. This has led to the skepticism about the possibility of a general or universal account of the nature and limits of knowledge, an account that ignores the social context and status of knowers. Feminist epistemologies reveal the progressive political possibilities of situating theory (Harding, 1993). Moreover, developments in feminist theory have demonstrated that gender as a category of analysis cannot be abstracted from a particular context while other factors are held stable; gender can never be observed as a pure or solitary influence. Rather, gender is an abstract category linked to multiple dimensions and feminist epistemology and should not be isolated from other axes of oppression (Bondi, 1992; McDowell, 1996; Rose, 1993).

Alcoff argues that feminist theory (and consequently its methods) is a reactive project to critique existing theories and notions of theory itself, as well as to identify the ways in which sexual difference has both been constituted by and constitutive of existing knowledge. It is also a constructive project to develop alternative theories and theoretical norms, not simply as a reversal but as a transformation of existing norms and standards (Alcoff, 1996: 13-27). Feminist methodologies often combine multiple feminist research methods and are understood to be processes guided by feminist theory that may be

interdisciplinary and aim to create social change (Reinharz, 1992: 240). In a different vein, Shulamit Reinharz identifies feminist research methods as methods used by people published in journals and/or that have received awards from institutions, and individuals that define themselves as feminist (Ibid, 6). Feminist research methods become a means of designating and displaying one's political and academic commitments (Westcott, 1979; Gottfried, 1995).

Feminist research practices and methods also involve a challenge to orthodox or conventional academic work . This challenge is outlined by the Women and Geography Study Group (1997):

First it involves rethinking categories, definitions and concepts, used to formulate theories within a geographical discipline. Second, it involves examining the methods (and the theories underlining them) used for exploring defined problems. Third, it involves considering the process of selecting problems deemed to be significant for geographical enquiry, in particular through using gender (with all its multiple meanings and intersections with other aspects of social identity) as a key analytical category in studies of space/place, environment and landscape (Madge et al., 1997: 86).

Feminism does not promote methodological elitism but instead encourages a plurality of methods where the choice of method is what is deemed to be appropriate, comfortable or effective (Tuana, 1993). Part of a feminist research project is an awareness of limitations, contradictions, non-universality, subjectivity, and an acknowledgement of positionality and the use of power (Minh-Ha, 1989; Warren, 1988). Other key aspects of feminist research are “reflexivity within the research process, consideration of the relationships between researched and researcher, as well as a commitment to challenge oppressive aspects of social identity ” (Madge et al., 1997: 109).

Feminist research does not necessarily have to be on, by and for women; it can explore notions of gender, masculinities and femininities and the ways in which these categories and identities are negotiated and produced (Hekman, 1990). There is a growing body of postmodern/poststructuralist feminist research methods that engage in these questions of shifting subjectivities and identities (Butler and Scott, 1992; Ferguson and Wicke, 1994; Nicholson, 1990; Stanley and Wise, 1990; 1993). According to Jane Flax postmodernist/poststructuralist feminist methods call into question the concept of innocent knowledge and the rational subject that predominates in the history of Western Philosophy (Flax, 1990;1992). In this respect postmodernist feminist theory challenges clinical PDA discourses structured by “innocent knowledge- the discovery of some sort of truth that can tell us how to act in the world in ways that benefit or are for the (at least ultimate) good of all.”, which is the knowledge produced by the rational subject (Flax, 1992: 447). Instead of structuring feminist thought around the presumption of ‘truths’ and ‘facts’, postmodern/poststructuralist feminist research methods are structured as a discourse that traces “the effects of power relations which simultaneously enable and limit the possibilities of that discourse ” (Ibid, 453). In other words, postmodern/ poststructuralist feminist research involves an examination of the politics of location, a politics which recognises that discourses are only partial perspectives based on “situated knowledges” or contextual experiences (Haraway 1988a, cited in Lal, 1996: 188).

A central dilemma for contemporary feminist researchers, in particular researchers who adopt postmodern or poststructuralist feminist research methodologies and practices, is power and the “unequal hierarchies or levels of control that are often maintained,

perpetuated, created, and re-created during and after field research ” (Wolf, 1996: 2).

Power is mediated throughout the research process before field work is initiated, during the field work process, and after the field work is completed. The research process is not a linear one; aspects of research practice often overlap and transform one another. During the research process power differences stem from the different positionalities of the researcher and researched. For example my position as a mobile person who has never experienced panic has affected the relationship between myself and those agoraphobic women whom I have interviewed as well as the interview structure itself. Power is exercised within the research process, when defining the research relationship, and throughout the negotiation of insider/outside self/other. Power is also an issue during the post fieldwork period, when it comes time to writing and representing, thereby constructing the research subject (Ibid, 2). Some feminists and others have argued that what is needed is a research method that develops the art of conversation, of “listening to” and not just “talking with”; that acknowledges that subjects of research are simultaneously responding to the researcher’s agenda while actively engaged in “shaping their presentations to suit their own agendas of how they wish to be represented”(Lal, 1996: 204-205). Here, the researcher and researched shift positions from self to other. What such feminist researchers advocate is a sensitivity, honesty and awareness of the power relations that ensue during research (Nielsen, 1990).

My examination of PDA/agoraphobia throughout the entire research process has been informed by feminist research agendas and a critique of the foundations, presumptions and methodological criteria governing knowledges about women within a

male-biased construction of knowledge. The research process has been a dynamic one, where the thesis material has continually been transformed over time and with insight. My research on PDA/agoraphobia, and the geographic perspectives I have adopted have challenged, rather than reproduced clinical literatures by extending the analysis and construction of this panic disorder outside of the domains and disciplines of the physical and psychical body, and thus, provided new insight into the PDA/agoraphobic condition. The research for this thesis has lasted over a period of two years, in which I have worked with organizations that deal with PDA/agoraphobia, have formally interviewed ten women who were either diagnosed with or believed they had PDA/agoraphobia, and informally interviewed at least thirty other men and women diagnosed with panic and agoraphobia. The process began through contacts with the Agoraphobic and Panic Support Network, which has become the Anxiety Disorders Association of Ontario. Through this organization I contacted other PDA/agoraphobic support groups and individuals who expressed interest in my research. Several other individuals also approached me personally to be interviewed. The formal interviews began with a process of constructing a letter of introduction and an informed consent form to be approved through the ethics committee of Carleton University (See Appendix I, II). Once this was approved the formal/ transcribed personal narratives and semi-structured interviews commenced. All of the interview subjects signed and dated their informed consent form, and received a letter of introduction. The interview subjects were also asked to verify whether they had been formally diagnosed with PDA/agoraphobia by a clinician or, if not, to answer questions in a self-diagnosis questionnaire for PDA (See Appendix IV). All of the women had been

formally diagnosed and/or indicated through the questionnaire that they had/have PDA. Due to time restrictions, and at the request of several interview subjects, the plan for family interviews and questionnaires as described in the letter of introduction was subsequently abandoned in favour of more in depth interviews and personal narratives. Often interview subjects contacted other people with PDA/agoraphobia, whom they knew, to be interviewed. The women and men interviewed ranged from 18 to 60 years of age, and all of those interviewed had lived in the Ottawa area for the majority of their lifetimes. All interview subjects had received some form of treatment, depending on their employment and income status, which varied from person to person and over time. The majority of the ten formally interviewed women do not know the others interviewed, nor were they informed of who had been or would be interviewed. In addition to the formal interviews, several focus groups were informally organized to raise viewpoints and discussion that may not have arisen within the interview/personal narrative process.

Over the course of the research I have also engaged in an analysis and exploration of literatures on PDA/agoraphobia that form an interesting counterpoint to the field work. The literature analysis and review highlighted questions such as: how are the lived experiences of PDA/agoraphobes represented textually? Are there discrepancies between varying literatures? Through the study of PDA/agoraphobic literatures and discourses, issues and aspects have emerged. These issues include: why is PDA/agoraphobia defined and used differently in popular literature than clinical literature? How does the literature on PDA/agoraphobia construct PDA/agoraphobic identities, subjectivities and geographies? What are the analytics of power in the PDA/agoraphobic condition- how is

power negotiated and mediated within PDA/agoraphobic discourses? And what other disciplines could contribute to a discussion of PDA/agoraphobia?

This chapter will be subdivided and structured into several sections that reflect the negotiation of power relations throughout the research process. There will be an exploration of the politics of location/positionality/consciousness-raising in my own research, an investigation of methodology and methods, and finally a discussion of the ethics and politics of representation and reflection within the final documented post-fieldwork. There are several key themes that have informed my methodological approach: feminist approaches, methods and politics; the insider/outsider, self/other dilemma; issues of friendship and exploitation- the researcher and her persona, representing one self; ethics of consciousness raising within action- research and empowering methods; and reflexivity and positionality.

1)Feminist approaches, methods and politics

Audrey Kobayashi makes explicit the relationship between the recognition of the power relations and the methods feminists use.

The politics of involvement, for feminist researchers, require research methods that recognize the relationship of others as one of (ideally) mutual concern and trust...Methods that stress mutual respect and involvement, shared responsibility, valuing difference, and non-hierarchical ways of achieving ends are not simple or shallow gestures of accommodation, nor are they just an alternative methodology. Such methods (and the way they are used) define an approach to political change. They raise the question of "who speaks with whom?". This question occurs before we enter into the field and remains with us as we engage our subjects across the space of social engagement (Kobayashi, 1994:76).

My reasons for pursuing agoraphobic research are similar to those of Jenny

Williams, in her study of women and post natal depression:

I wanted to explore women's own experiences both of their depressions and the treatments offered. Rather than accepting typical masculinist scientific knowledge I sought to present a "view from inside". Deciding to utilize qualitative research methods to contemplate this emotive topic, it seems appropriate to work with a small group of women over an extended period (one year) collecting detailed information then presenting the data by analysing women's own words" (J. Williams, 1994; Madge et al. 1997: 102).

The experiences of marginalized groups, such as agoraphobic women, have traditionally been devalued or ignored within the power structures of medicine (Bordo, 1993; Jaggar and Bordo, 1989; Russell, 1995). The consensus from PDA/agoraphobia support networks is that PDA/agoraphobia is marginalised within the medical profession, and as a result many of these women feel isolated and are unable to receive funding from medical and government sources of funding (ADAO, 1999; APSN, 1997; 1998). Most of the literature and studies on PDA/agoraphobia are directed towards women. Therefore, researching the lives of PDA/agoraphobic women themselves permits a critique and analysis of the working power relations in clinical and non clinical literatures on PDA/agoraphobia, treatment and clinical practice. PDA/agoraphobic women are labelled, diagnosed and treated by a system of knowledge constructed, in part, through the beliefs and activities of those people at the centre who make policies and engage in social practices that shape agoraphobic lives (Harding, 1993; Holloway, 1992). In this sense Dorothy Smith argues that the many various lives and experiences of women can provide the starting point for asking new, critical questions about those women's lives as well as the lives of men and women in general (Smith 1987; in Harding, 1993: 55).

I intend to draw on the experiences of this marginalised group of

PDA/agoraphobic women through a variety of approaches/methods. Throughout the research process I have consulted and worked with various PDA/agoraphobia networks and support groups. I have conducted personal narratives and then interviews with PDA/agoraphobic individuals as a way of stimulating more questions about the discourses and literature surrounding PDA/agoraphobia. I have also interviewed and spoken with many PDA/agoraphobic men and women informally, in order to juxtapose a broader range of experiences and circumstances onto my formal semi-structured interviews and personal narratives. I began the initial meeting process with personal narratives that allowed the interview subject to express to me what they considered an important starting point for discussion. These personal narratives then informed more specific semi-structured interview questions. The interviews and personal narratives were then transcribed, utilized and included, in part, in the research thesis text.

I began the conversational process with personal narratives to establish what experiences these women feel comfortable talking about and to get a sense of what these women understand space and place to mean. Sidonie Smith endorses personal narratives as a research technique where “these respondents insist on their own voices, their traditions, their histories, and their identities... In this way they turn the forms of personal narrative to their own purposes ” (Smith, 1993: 407). The personal narrative acts as a more fluid power relation between researcher and researched (Personal Narratives Group, 1989). The interviewer responds to the twists and turns of their subject and the subject’s agenda. In this way, these women may be marginalised, but are not devoid of power within the research relationship (Smith, 1993; Smith and Watson, 1992). It is important

not to place these women in a static position. This is what the varying detailed experiences and contexts of agoraphobic lives have revealed through personal narratives. In other words: “in reading personal narratives we find ourselves immersed in complex issues of representation, ideology, history, identity, and the politics they bear on subjectivity” (Smith, 1993: 393).

The personal narratives were then followed by more structured interviews with questions informed by opinions and information in the personal narratives. Key themes, experiences and or desires were identified within the personal narratives and structured into a set of more directed and specific questions about the construction of space. I divided my semi-structured interviews into three sections: PDA/agoraphobic geographies at the scale of the city, community and home; personal histories and experiences within and around the body; and future directions and possibilities for PDA/agoraphobic research and study. The questions in the section on agoraphobic geographies included questions on geographical issues such as: a discussion of what meanings are invested in “home”; what is home and how is it geographically manifested; and the split (or lack thereof) between the private and the public sphere. The second section focused on personal experiences and histories involving the geographies of PDA/agoraphobic body politics? That is, how do PDA/agoraphobic women understand their bodies and the relationship between their bodies and their environments? The third section of interview questions prompted some serious reflection and contemplation on how and what needs to be done to increase an awareness of the agoraphobic condition. A wide variety of literatures were also incorporated into the interview process that oriented and produced other interview

questions. These literatures came from disciplines such as women's studies, sociology, geography, architecture-art history, philosophy and psychoanalytic thought. The multiple perspectives and approaches to PDA/agoraphobia that I have used have provided an interesting critique of how PDA/agoraphobia is constructed and understood differently by various 'groups'.

Due to the sensitive subject matter of the personal narratives and interviews, the questions and topics of study were directed to ensure that the research subjects were comfortable discussing their PDA/agoraphobic experiences with me. It was clearly stated on the informed consent form, that the women not only had the right not to answer any questions they were uncomfortable with, but to stop the interview process at any time. Fortunately this did not happen; all of the women were very comfortable talking to me about their experiences. Jenny Williams describes how her methods transformed themselves throughout the research process. Williams explains:

... how some of her subjects involved in a research program of post natal depression in northwest England preferred the use of semi structured questionnaires rather than informal interviews : However during the projects several women telephoned me with similar requests (for questionnaires). Explaining they wanted to participate, but their experiences were too distressing to verbalize, I was asked to compile a written questionnaire for them to complete. Thus, I altered my original plans and designed a semi structured questionnaire based on open ended questions. This provided a source of rich data in a way which was neither too disturbing nor embarrassing for the women (J. Williams, 1994; cited in Madge et al., 1997: 95-96).

It is important to develop a series of backup methods to supplement or as an alternative to methods which may fail or be problematic during the course of the research thesis. Nevertheless, it was important to have contingency plans in the event that the interviews or personal narratives are poorly received. Thus, I compiled a five page list of

possible questions and topics that addressed many different areas of study ranging from the highly personal to highly general, as well as, questions which involved elaborated narratives, or that were highly structured, focussed, one sentence responses (See Appendix III). The focus group was another method juxtaposed with other research methods to provide another means of conversation, discussion and support for the participants. It was an option for those individuals who were uncomfortable with in-depth interviews. The focus group raised viewpoints and issues that may not have arisen during the interview/ personal narrative process. Some of the interview subjects were more comfortable sharing their experiences in a group setting with other PDA/agoraphobics who can directly relate to the experiences and sensations of PDA/agoraphobia. Focus groups introduce a problem for maintaining confidentiality. As a result, the focus groups were organized within the dynamic yet structured forum of the support groups, which have an ethic of confidentiality to begin with. The focus groups were also set up and approached as informal, and I took general notes rather than taping the conversations, to ensure that my information would not be too anecdotal. The focus groups introduced these women to other PDA/agoraphobic individuals which has resulted in networking amongst the participants.

Currently there is little research available on the spatial implications of PDA/agoraphobia and, as a result, the interviews in the field work portion of the thesis were pivotal in directing questions and insights about agoraphobic space. Feminist methodology understands that there are power relations, ethical questions, and dilemmas to face in the ways we choose to ask, in order to construct knowledge (Fine, 1992). This means that

feminists argue that people know as much about their lives and the meanings that they live with, as those who attempt to study them (Madge, 1997: 106).

2) The insider/outsider - self/other dichotomy

The simple dichotomy of insider/outsider - self/other is often an arbitrary one that fails to recognize the complexity of the research process and the movement of the researcher and researched between worlds and identities, disrupting the traditional boundaries of self and other. Many feminist scholars have questioned postmodern and poststructuralist notions of difference (See Lal in Wolf, 1996; Mohanty and Alexander; 1997). J. K. Gibson-Graham question the play of identity, specifically gender identity, in feminist theory:

If we are to accept that there is no unity centre or actuality to discover for women, what is feminist research all about? How can we speak of experiences as women? Can we still use women's experiences as resources for social analysis? Is it still possible to do research for women? How can we negotiate the multiple and decentred identities of women (Gibson-Graham, 1994: 206 in Madge et al., 1997: 98)?

Gibson-Graham respond to the question by detailing how their own research in Queensland opened up a "space for the emergence of new forms of alliances based on alternative subject positions for gendered subjects, and of different forms of political resistance based on undermining the hegemony of binary gender discourse" (Ibid, 98). Acknowledging the interchangeability of self-other identities can allow for a space of common ground and other ways of understanding. It cautions the researcher from making assumptions about solidarity, empathy based on identity or how assuming that those who do not share those identities cannot contribute or offer critical insight to other individuals

and groups (Wolf, 1996:18).

Within my own research process I have simultaneously been identified as both insider and outsider. During the initial contact phase with the research subjects, I was often asked “have you ever had agoraphobia or panic? ”. Because I have not experienced PDA/agoraphobia I was automatically identified as an outsider. One PDA/agoraphobic woman stated “I’m afraid you can never really understand agoraphobia unless you’ve had panic”, which was not an uncommon response. Many feminist researchers find that insider status is advantageous because it leads to a more balanced view of the researched (Abu-Lughod, 1988 in Wolf, 1996). In response to these statements and viewpoints, I volunteered for a series of experiments at the Royal Ottawa Hospital to induce a state of panic in trial subjects. Not only was this experience futile, because I experienced no panic sensations, but my attempt to gain some insider awareness was beside the point. One experience of panic in a controlled situation was not going to provide me with a more balanced view of the PDA/agoraphobic women and their situations. I became aware in the process of working with PDA/agoraphobic groups and women that an insider status did not necessarily entail an ability to empathise with experiences of panic, but could be gained through direct involvement within PDA/agoraphobic communities and the genuine desire to learn, help and assist PDA/agoraphobic individuals. I also came to realise over the course of the research that I could establish bonds and insider status within the community based on shared political or social viewpoints and experiences. These women were PDA/agoraphobic, but they were also students, and women with similar backgrounds and life experiences to my own, and in this way I was able establish a form of insider status.

We all live in contradictory positions, thus, though an examination of “politics and accountability by questioning where and how we are located”, feminists may challenge thinking that pre-figures the subject as unitary and stable, in western hegemonic discourses (Abu- Lughod, 1993:41 in Lal, 1996: 200). Multiple identities and shifting positions of the researcher and researched are “reflected through decisions and outcomes influenced by and arising from theoretical frameworks, ideological underpinnings, personal identity and material social location of the research ” (Mbilinyi, 1992: 35 cited in Hovorka, 1997 :29).

3) Issues of Friendship and Exploitation- The Researcher’s Persona, Representing One Self

Earlier feminist works suggested that developing friendships between the researched and the researcher was desirable and necessary for productive feminist research (Oakley, 1981; Finch, 1984). These works were a critique of interviewing methods that favoured detachment and rigid divisions between the identities of researched and researcher. More recent feminist scholarship suggests that friendship within the research process is not always possible, and does not always result in a balanced power relation between individuals (Cotterill, 1992). If friendship is sought after by the researcher, friendship needs to be specifically defined as a mutually respectful and reciprocal relationship during the research process. Striving for empathy and intimacy should not be confused with friendship (Reinharz, 1992).

The power differentials between those in the research process can be exploited by either the researcher or the researched. Therefore it is pivotal to identify what privileges

one brings to the research process. In my own research many of the women I have investigated are in vulnerable positions and might like to establish a friendship that continues beyond the research process. Judith Stacey argues:

That the friendship that may develop between a feminist researcher and her subject could end up being more manipulative than traditional positivist methods... Friends end up knowing more about each other than conventional researchers and their subjects; this closeness can expose research subjects to far greater danger and exploitation (Stacey, 1991:114 in Wolf, 1996: 20).

When the researcher engages in the life of the research community, the researcher's multiple identities of friend and researcher can become exploitive. For example, in the case of Clare Madge's forestry based fieldwork in Gambia:

Informants may disclose information to the friend which they would rather not reveal to the researcher...Rather I suggest that participant observation involves playing out a multiplicity of changing roles during the course of the research. These roles which are sometimes complementary, sometimes clashing and which are contingent on our positionality, will influence the data given/gained and our subsequent interpretations. In other words will influence what we produce as knowledge (Madge, 1994:94-95 in Madge et al., 1997).

There are also instances where the researcher is at a disadvantage with respect to issues of friendship and exploitation. As Pamela Cotterill experienced, some of the women whom she identified as friends had difficulty taking the research process seriously (Cotterill, 1992: 598). Other researchers such as Lila Abu- Lughod felt that she could not force people to discuss issues that were unimportant to them, and as a result it was very difficult to complete her research (Wolf, 1996: 21). She felt dependent and vulnerable in this situation. The powerlessness a researcher may feel when her subjects will not discuss their experiences may be frustrating, but this does not mean that the researcher is

powerless herself.

One crucial issue as a researcher pursuing research on PDA/agoraphobia is not to assume the role of therapist (Burman, 1990; Squire, 1989; Ussher, 1989; Zanardi, 1990). Invariably, certain individuals are looking for someone to assist them, and to talk to. I am not comfortable being seen as an expert in this research process because I believe that while I have studied this 'disorder' extensively, the researched themselves are the experts who will disseminate their knowledge and experience to me (Cotterill, 1992). The therapist or peer supporter is often placed in a judgemental and prescriptive role. While I agree that the researched should ask questions of the researcher, even questions of a personal nature, I am uncomfortable being placed in the position of the 'knower' and of being expected to fulfill that role. Therefore, it was important to clearly inform the researched, that I am not an expert, that the research findings themselves are contingent on the interviews and personal narratives of the researched, and that the thesis has been derived, in part, from those conversations.

Ultimately, I as the researcher must leave the field work and compile a thesis document. From this moment the researched are vulnerable. It is the responsibility of the researcher who is concerned with issues of friendship, that is, engaged in a mutual respectful relationship, not to use one's own ideas and arguments to simplify the experiences of those researched. Rather, the issue is how one works against the appropriation of other voices and experiences, works against resolving the research into neatly packed wholes, for work which is continually in tension without pretending to achieve resolution (Stanley, 1997). This involves acknowledging how power is negotiated

between researched and researcher and how these positions have transformed themselves in order to maintain honesty between the researcher and the researched (Du Bois, 1983: 95).

4) Empowering methods- Ethics of consciousness raising

“Conducting ethical research does not involve a simple set of formulae; rather it entails thinking through the process of working and living with people and attempting to challenge unequal power relations upon which differences rest” (Madge, 1994: 98 in Madge et al., 1997: 103). Is a feminist research project geared towards the empowerment of others? Some feminist theorists insist that a feminist project is concerned with the redistribution of power amongst women and men (See Reinharz, 1992; Wolf, 1996). Other feminists insist that if the work is to be truly feminist, someone other than the researcher should be empowered by the work (Geiger, 1990 in Wolf, 1996: 24). The question that then arises is how can research empower the research subjects? Personal narratives and interviews are considered to be unobtrusive methods used to study dis-empowered women (Abu-Lughod, 1993; Geiger, 1986; Personal Narratives Group, 1989; Shostak, 1989 in Wolf, 1996). These methods are preferred as a means of writing women’s worlds and lives with as little editorial intervention as possible. Some feminists have contended that the interview and personal narrative process may in fact benefit those who are interviewed, increasing their feelings of self worth (Personal Narratives Group, 1989). Unfortunately, many of these feminist theorists assume that the researched are being empowered, yet fail to ask the research subjects themselves if they are benefiting

from the process (Patai, 1991 in Wolf 1996).

Who the research is empowering is a pivotal research/ethical consideration and question. Are we concerned with the empowerment of our research subjects, or do our good intentions mask that the only individuals we are empowering are ourselves (Moss, 1993). Is the research about “giving voice” to others as a means of empowerment, or is it about allowing others to speak and be heard in their own voices? Maria Mies detailed a similar experience where the women who had been taken into a women’s refuge/safe home did not want to be politicized through the researchers’ consciousness raising projects which tried to explain their position as a manifestation of patriarchal power (Mies, 1983). Women with whom one is working may not share the same feminist agenda and the question must be asked “whether the researcher is justified in imposing their agenda on the researched ” (Madge et al., 1997: 93).

Consciousness-raising is often entangled in issues of empowerment. For Maria Mies it is the primary motivator of feminist research (Mies, 1991). Consciousness-raising implies that someone is less than fully conscious and needs to have their consciousness raised by someone else, with a superior knowledge (Gorelick, 1991:467 in Wolf, 1996). The researcher must continually ask and question what the ethics of consciousness-raising are? Is consciousness-raising, and the imbalance of power it presupposes, ethical? Does a researcher enter a community, such as the Anxiety Disorders Association of Ontario, conduct their research, raise consciousness and leave? Can raising consciousness potentially harm the women being studied? What are the impacts on these women’s lives (CRIAW, 1996)?

Nevertheless, it is important to work with groups and institutions that are supportive of the research and the researched. The Anxiety Disorders Association of Ontario, and Panic and Anxiety support group are organizations whose interests are focused on PDA/agoraphobic sufferers and their well being. Through working with these groups I have constantly questioned whether my research interests are in tandem with the interests of flesh and blood PDA/agoraphobic women. The research has developed with the assistance of this organization, and there has been the potential for these organizations to re-address issues that have arisen over the course of the fieldwork. My connections to the ADAO and Panic and Anxiety support group make it possible to contribute to the inner workings of this organization, which may potentially have long term benefits for those organizations. My research work aims to promote an awareness of other ways of exploring PDA/agoraphobia within the anxiety and panic disorder community; to promote an awareness that the experiences of these women do not isolate them from other women, while recognising the severity and struggle present in the lived realities of the PDA/agoraphobic woman.

5) Reflexivity/ Positionality- The Politics of Representation.

“A central part of the interpretive process is reflexivity. We need to think about our assumptions, our part in the research process and the ethical considerations we make during that process ” (Dyck, 1993: 53 in Madge et al., 1997: 106). Reflexivity involves evaluating the methodology, methods and products of the research critically, throughout the process of study. We should evaluate our research critically, reflecting on and learning

from past experiences. The multiple interpretations that arise over the course of the research need to be investigated and written in such a way that the “diversity, complexity and contradictions” of the research are given a space (England, 1994: 82). Reflexivity provides an opportunity for the researcher to consider whether our research, and our representation of research subjects, will perpetuate damaging stereotypes, place the participants in some sort of danger, or expose practices of politically powerless people to those who may use this knowledge to oppress them (Madge et al., 1997: 108). Reflexive methodologies, ideally, are used to negotiate and learn from power relations within research. Paradoxically, the good intentions of those who use self-reflexive methods do not always result in the disruption and redistribution of the balance of power in the research process (England, 1994). Within debates on feminist research, self reflexivity has become more of a focus, and thus has displaced and obscured the research subject in favour of the researcher: “it gives voice to the already speaking author” (Lal, 1996: 206).

Who then has authorship over the research? Some feminist researchers have given joint authorship to their research subjects (Mbilinyi, 1989 in Wolf, 1996: 33). Other feminist researchers find this to be problematic, impractical and risky because some research subjects may remain anonymous, while others may not (Opie, 1992 in Wolf, 1996: 33). I would also find co-authorship with research subjects problematic, because most of my research subjects to-date insisted on remaining anonymous. Within my research the majority of women interviewed requested that their narratives remain anonymous and confidential. One woman specifically asked that “she didn’t want to be able to recognise her own experiences when reading the thesis document.” As a result I

have used the interview material, so that the experiences of those women are obscured and fragmented. I have not used names or other personal identifying features in my transcript information.

Yet, at all stages throughout the research process, the researched have had an active role in the construction of questions or the inclusion of questions and aspects of the agoraphobic condition that they believe need to be discussed. The research subjects will also have the opportunity to see the final thesis document after it is defended and provide me with constructive criticism that might transform or redirect the research at a later date. The field work commenced with a negotiated consent form. Both the researcher and researched negotiated, agreed upon and wrote down the terms of agreement, and standards of ethical conduct, such as confidentiality. The majority of women required that the content of their interviews remain confidential, and that the transcript and tapes not be revealed to anyone other than myself. Agreeing to this not only built trust between the those in the research process, it outlined standards of conduct I had to abide to.

The form of representation whether textual, visual, or using auditory mediums also plays a significant role in the politics of representing the researched. For example Annie Opie states “that the intensity of the spoken word can convey what a spirited page cannot and there must be some way of acknowledging this, indicating the emotional content or tone of the response ” (Opie, 1992 cited in Madge et al.,1997: 107). In the case of PDA/agoraphobic research, Constructing Panic the Discourse of Agoraphobia by Lisa Capps and Elinor Ochs addresses this by creating a transcript language that conveys Meg’s (research subject) emotional overtones. In transcribing my own interviews and

personal narratives, I conventionally transcribed the information, and then reviewing the material on the tapes, I wrote notes over the text that would indicate, inflection in voice, speed or volume of the conversation as well as significant pauses between words or statements. And while I do convey some of these expressions and emotions within this thesis, I have not fully used the “overtones” of the information in my transcripts.

Ultimately, “we have to acknowledge that as researchers we have the last word, final editorial control over the work. It is in this arena that we must assure our feminist politics and those of the research community, and conflicts between these two, are reflected in the final written version whatever form that may take ” (Ibid, 108).

Positionality is concerned with the privileges of the researcher and researched. In questioning and being accountable for where we are located a more productive engagement in our relationships to those whom we study and represent may ensue. The questions and concerns that may arise from exploring one’s location relative to the research may be disturbing, but these questions fundamentally need to be asked. Kim England’s initiates her field work by questioning her position as researcher:

Could I be accused of academic voyeurism? Am I trying to get on some cheap package tour of lesbianism in the hopes of gaining some fleeting understanding of, perhaps, the ultimate ‘other’ given that lesbians are not male, heterosexual, not always middle class and often not white ? In the midst of academic discourse on the problems of appropriating the voices of marginalised people and the perils of postcolonialism, I worried that I might be, albeit unintentionally, colonizing lesbians in some kind of academic neo-imperialism (England, 1994: 84).

I might ask a similar question of my own work. Could I be accused of using the painful lived realities of PDA/agoraphobic individuals as a means of colonising their experiences and sensations , thus, exploiting the subjects of my research? When I suggest

that these PDA/agoraphobic women are not powerless, will others assume that I am suggesting they are powerful? Will this work be perceived of as a celebration of PDA/agoraphobia? How can I frame it so that it is not? These questions must be asked over and over during the research because “What we ask, who we ask, where we ask, and when we ask invariably inform us of our shifting positions” and this “depends upon certain ethical decisions which present multiple dilemmas during the research process” (Madge, 1997: 102). Reflexivity and positionality are not ends in themselves. “A reflexive and self critical methodological stance can become meaningful when it engages in the politics of reality and intervenes in some significant way, otherwise we risk the charge of self absorbed navel gazing or ‘soul searching’”(Harding, 1987: 9 in Lal, 1996: 207).

Conclusion

The feminist methodology that I have incorporated into my research is a feminist postmodern/poststructuralist geographical approach. I am interested in the possibility of what Linda McDowell has called spatialised feminism; which embraces the complexities, political strategies, struggle and marginality, fluidity, in short a discursive set of positionalities (McDowell, 1996). The use of a spatialised feminism may help to construct contextual theories of difference in which the associations of gendered identities such as agoraphobia, with place and location are seriously addressed. It is an understanding of space/place that takes into account the changing geography of changing social relations from multifarious positions and perspectives. The identity of space is constructed from social relations with a spatial form and spatial content which is derived, in part, precisely

from its interactions with the outside (Massey, 1994). Attempts to fix the meaning of place or human subjects as a singular bounded inside/outside identity do not permit the geographies of dissolving boundaries to provide an opportunity to recognize our interconnectedness.

Within feminist geographical thought mobile subjectivities are not ones necessarily defined by their psychical and physical movements, but by the ability of subjects to theorise difference and multiplicity. PDA/agoraphobic identity moves towards a definition of both geography and identity as a network of relations, which challenges essentialist and objective forms of subjectivity that fix the forms of place and being as separate. Multiple subject positions produce multiple knowledge where meaning and spatial relations becomes both contextual and discursive. There is a complex interrelationship “ between material, symbolic and discursive constructions of space in situated theory, in imagined communities, in the social construction of different visions of space and in the performative and fictive nature of subjectivities and social relations ” (McDowell, 1996: 41).

I would suggest that irony is an important political tool for a spatialised feminist approach, that has informed my research methodology and process. It is an important political tool in the study of PDA/agoraphobia and the dismantling of the rational subject. The ultimate irony of agoraphobia is that PDA/agoraphobia is assessed by the criterion that the panic attack cannot be located in space, that it is placeless and yet the experience of agoraphobia is rooted, transformed and affected by space. Irony embraces this contradiction and figures in the form of a question, or a riddle. According to Kathy

Ferguson, irony is a political condiment that enhances the other commitments of a feminist project. It is a way to keep oneself in a research situation that resists resolution without pretending that it has come (See Ferguson, 1991; 1993 and Haraway, 1991). Irony is about contradictions that do not resolve into larger wholes, it engages in a project that embraces complexity, throughout the research process (Ferguson, 1993). It “provides multiple vantage points without erasing or denying difference”. Thus, the research is continually in a state of tension which provokes further questions (Ibid, 35). An ironic stance brings together elements in the research which initially may be viewed as incompatible in order to continually rethink the work produced.

While irony may be about serious play, there is little humour in the often painful lived experiences of agoraphobic individuals. And while irony is a political and academic stance that I adopt, it is used as a means of investigating the spatial relations of agoraphobic women's lives. Throughout this thesis issues of contradiction and conflict will arise. Many of the ideas and experience which I explore do not resolve themselves into neat and organized categories, theories or wholes and it is through these ruptures that I have been able to connect theory and experience within a complex matrix of personal geographies, political strategies, various identities and subject positions, issues of power/knowledge and resistance (McDowell, 1996).

Chapter Three- Clinical Agoraphobic Discourse Analysis And Literature Review

“Theory is anything but disembodied ” (Donna Haraway, *The Promises of Monsters*).

The crisis of the rational subject as indivisible, contained and isolated has not only been unravelling over the past century within critical spatial and social theory, but it is also at the centre of a critique about the manner in which clinical discourses on agoraphobia have structured, understood and treated this ‘disorder’ today. The rational subject is the marker of traditional science, medicine and objective knowledge, and is defined as a bounded individual, whose identity and subjectivity are clearly delineated and maintained through normalising spatial and somatic boundaries. Various clinical agoraphobic, that is, panic disorder with agoraphobia (PDA), discourses of medicine and psychology adopt the rational subject as a body to be sought after within agoraphobic treatment- a body which is self-contained, separable into a coherent internal and external environment, and, thus, able to ‘master’ its surroundings. This is antithetical to the aims of current critical theories that want to fragment the rational subject into a series of dislocations and ruptures. Within these approaches, attention is drawn towards notions of subjectivity and identity as fluid and permeable. It is hoped that if “we move towards a definition of identity and place as a network of relations, unbounded and unstable, rather than fixed, we are able to challenge essentialist notions of place and being ” as well as identity and subjectivity (McDowell, 1997: 36). What has become a serious point of contention in this celebration of transgression and fragmentation is how to define what a fluid or permeable subject is. Is the blurring of boundaries between bodies and spaces

characterised by a celebration of displacement, dislocation and movement; or by a recognition that multiplicity and difference produce discursive spaces. In other words, that spatial networks and positionalities are contextual in nature, and thus incorporate a complex web of relations of domination and subordination. Both definitions challenge essentialist notions of identity and place as fixed. And while the first definition tends to celebrate movement as a concept, the second definition explores the consequences and experiential realities of a mobile subject.

I believe that recognising that subjectivities and identities are in a constant process of remaking and renegotiating exposes the limits of any claim to a singular or autonomous subject, and that the transformation of the boundaries or limits of human subjectivity and identity brings geographical or spatial analysis to the centre of discussion. But how can PDA/agoraphobia be rethought so that it privileges an understanding of the boundaries between bodies, spaces and social processes as fluid and dynamic, when it is precisely this permeability that is problematic for PDA/agoraphobic individuals according to anecdotal evidence as well as medical and psychological research on PDA? How can the blurring and projection of PDA experiences into spaces be theorised as positive, when this transformation of bodies and spaces results in excruciating immobility? Ironically, the decentring of the subject results in her immobility. An exploration of PDA thus necessitates a rethinking of critical postmodern and poststructuralist thinking in favour of a critical spatial theory that recognises that “spatial configurations and connections between places are significant only in the context of a specific investigation of particular sets of relationships” (McDowell and Sharp,

1997: 31). Thus, we must investigate the meaning of place and its multiple meanings, subjectivities and positionalities or what Linda McDowell describes as a spatialised feminist politics.

An exploration of PDA/agoraphobia also requires a critique and exploration of how clinical PDA/agoraphobic discourses problematize the intersection/encounter between bodies and use the rational subject as a model for treatment and management of the disorder. Neither the rational subject nor the fragmented subject fully acknowledges the intricacies and complexity of PDA/agoraphobic experiences, and in this respect neither vision of the 'subject' approaches the PDA/agoraphobic individual as a person. Rather she becomes an object who is constantly in a state of renegotiating her identity and positionality. My approach throughout this chapter is twofold: first, to provide a critique of the celebration of the body as fluid and permeable, by providing more insightful theories of the body that are sensitive to the consequences of this transgressive body; and second, to expose how the clinical discourses of medicine and psychology have dealt with PDA individuals by separating that subject from her/his surroundings in order to secure that subject's psychical and physical competency. In other words, through a literature review of clinical literature on PDA/agoraphobia, I will explore how the rational subject has been adopted, or modified within clinical practices. This rational or Cartesian subject has seemed to many contemporary theorists, in particular feminist theorists, to be held "accountable for the subjugation of women and the psychological illnesses of western individuals" (Kirby, 1996: 45). Contemporary feminist theorists challenge the claim to represent subjects as rational Cartesian selves in order to propose more responsive forms

of social and spatial relations. It is widely held amongst current geographers that space is relational and constitutive of social processes, and I would add that bodies are equally relational and constitutive of both social and spatial processes (Lefebvre, 1991; Massey, 1993; 1994). The manner in which we come to understand the spaces which surround us is not only a result of how others have defined space, but is equally a result of our experiences and how we internalise and spatialise our surroundings. In this respect, we produce or create the spaces around us vis a vis our corporeal feelings and lived realities. Interrelationships between objects and bodies occur in space and time and it is these relationships themselves which create/define our histories and our geographies (Massey 1992: 79).

The body has become a site of increasing geographical fascination within recent years. I am interested in how the body has been adapted and fetishised as a desired object within academic practice, often through the obfuscation of postmodern and poststructuralist theory. This fetishisation demands that it be unravelled in order that its potency, both academic and otherwise, can be diluted (Callard, 1998: 388). Several spatial and critical theorists have adopted the interrelationship between body and environment, self and other, as a theoretical premise without sufficiently reflecting on how those theories are reflected and negotiated within a person's life (Baudrillard, 1983; Deleuze and Guattari, 1972; 1987; Foucault, 1986; Lyotard, 1984; Marcus, 1992). While more often postmodern/poststructuralists' subjects are based on a mishmash of watered down and ill digested work without reflecting critically on or situating the work within its context (Callard, 1998:388). This applies to the taking up of work for example by Judith

Butler (1990, 1993), Donna Haraway (1991, 1992, 1992a, 1997), Michel Foucault (1970, 1970a 1986) and Homi Bhabha (1994) (Callard, 1998: 392). A good example of both is Deleuze and Guattari's celebration of the schizophrenic as a transgressive postmodern/poststructuralist subject. As Elisabeth Grosz argues "Deleuze and Guattari invest a romantic elevation of psychoses, schizophrenia, and becoming, which on the one hand ignores the very torment of suffering individuals and on the other hand, positions it as an unlivable ideal for others" (Grosz, 1994: 163). And while this example does not typify the entire body of Deleuze and Guattari's work, it is a particularly good example of how mental illness and pathology has been used to showcase postmodern/poststructuralist theory. Alternately, this plasticity of limits in the postmodern era is considered by many critical spatial theorists to be precisely the opening that political, or social, or economic criticism, needs to achieve a radical reformation of subjects (Kirby, 1996: 54). This radical reformation of subjectivity, through mobility and fluidity, is often discussed not at the scale of the body, but at the scale of capital or information flows, the shift from global to local scales and technological processes such as cyberspace, where the cyborg becomes the medium in which technological processes and fantasies are merged with human subjectivity (Jameson, 1984; Baudrillard, 1983). And while cyborgs in their science-fiction sense have become examples of the possibility of transformation between the body and its surrounding contexts, the incorporation of outside societal and social processes is not seamless; it is fraught with contradiction and struggle.

Donna Haraway has used the cyborg in her writings to challenge and subvert the dualistic thinking that has formed the rational subject (Haraway, 1991; 1992; 1997). Her

cyborg is not only a combination of both imagination and material reality, but an ontology of the subject. A cyborg world is about lived social and bodily realities where people are not afraid of their joint kinship with animals and machines, not afraid of partialities and contradictory standpoints. Her cyborg is a critique of scientific and medical models of the body and subjectivity that fails to take responsibility for the social relations of these discourses. Embracing her cyborg manifesto means embracing the task of reconstructing boundaries of daily life in partial connection with others. It is a way out of the maze of dualisms in which medical and scientific discourses have explained our bodies to ourselves (Haraway, 1991 :223).

Haraway's discussion of the cyborg body and the biopolitics of the body is a useful critique and analysis of clinical discourses on PDA/agoraphobia, because her project aims to break down the categories and distinctions that structure the western rational self, while recognising that we must take responsibility for the construction of any limits or boundaries that we create or transgress (Haraway, 1991: 191). In this respect a cyborg ontology is a refutation of the abstraction of bodies or of knowledge which can be characteristic of postmodern and poststructuralist theory as well as the universalising claims of the Cartesian subject.

This chapter will explore how literature of the clinical discourses on PDA/agoraphobia, both medical and psychological, have either incorporated, modified or rejected the rational, Cartesian subject as a model for treatment, and/or, how spatial relations have been problematicized for PDA/agoraphobes through these clinical models. For example, within certain forms of psychological therapy individuals are taught to

separate themselves and their feelings from their environments, or to restrain from projecting those feelings into the spaces around them. What this form of treatment and management implies, in one sense, is that the PDA/agoraphobic's fear of specific places and spaces is an unhealthy mis-attribution. And while the projection of panic into an imagined landscape is problematic and for the PDA individual, it simultaneously informs that person that spaces and environments must be understood separately from the mindful actions of her/his bodies. The ability to control one's self, through the separation of one's thoughts from one's surroundings is a sign of mental competence and in this respect the production of spaces vis a vis our bodies is problematic. In an ever changing state of flux, the rigidity and solidity of our somatic boundaries is seen to be a sign or form of normal behaviour.

Even though these clinical discourses problematicize the PDA person's relationships with their surroundings, they clearly make evident that the body does have a role to play in the production of space and the ways in which we understand and live in the spaces which surround us, though this role may be a negative one. Within the study of PDA, 'geography does matter' but, the production of space vis a vis our bodies can be problematic and therefore can not simply be celebrated. Because some clinical discourses problematicize space for the PDA/agoraphobe, medical and psychological literature on PDA poses a challenge to refine and redefine postmodern and poststructuralist conceptualisations of space that celebrate the interrelationship between bodies and spaces. Therefore the pivotal question of this chapter is what kind of a theoretical and practical approach to PDA addresses the concerns, geographies and lived experiences of PDA

women without diminishing the struggles and conflicts those women experience in an attempt to live 'normal' lives again. I will argue that feminist approaches to postmodern and poststructuralist theories, such as 'spatialised feminism', provide a different understanding of PDA/agoraphobia because they acknowledge and explore the consequences of geographical movement within lived experience. I will conclude this chapter by discussing and elaborating on how spatialised feminism is an important and insightful approach to PDA/agoraphobic subjectivities, identities and geographies.

A staggering amount has been written within the clinical discourses of panic disorders and anxiety disorders over the past decades. The study of these disorders, which includes PDA, has increased exponentially over the past decade, as has the variety of ways in which these disorders are approached (Acierno et al., 1993; Antony and Barlow, 1992; Cox, 1995). I have separated clinical discourses into two primary disciplines of medicine and psychology, for the sake of clarity and conciseness. I have not included a discussion of self-help discourses which often adapt and reinforce clinical methodologies and approaches to PDA/agoraphobia, because this literature involves a specific discussion and analysis of its own. Both medicine and psychology are subdivided into hundreds of subdisciplines, all of which have a partial perspective and approach to PDA and panic disorders more generally. I have chosen to focus on the predominant forms of therapy and study within the disciplines of psychology and medicine and to interrogate them with a focus on a geographical or spatial analysis. It is also important to note that the clinical theory, treatments and approaches to agoraphobia I am exploring do not necessarily translate verbatim into clinical practice. Every practitioner picks and chooses from a

variety of approaches and interprets those choices into a treatment model.

Within clinical discourse, agoraphobia is more properly understood as PDA or panic disorder with agoraphobia (Health Canada, 1996). Agoraphobia without panic disorder is rarely explored here. Even the Diagnostic and Statistical Manual IV describes that relatively little is known about the course of agoraphobia without panic and that the few patients that are diagnosed are often re-diagnosed with specific phobias and not agoraphobia (DSM IV, 1994: 405). What is treated within medical models of PDA is the panic itself, which is seen to have a biological component (Fyer et. al, 1991; Laden, 1991). Within these models PDA has some form of biological etiology, such as biochemical changes, hormone levels, neurophysiology, genetics or brain imaging to name a few possibilities (Ballenger, 1984; McNally, 1994). PDA results in physiological responses such as gastrointestinal upset, palpitation sweating, hyperventilation, blurred vision or dizziness (de Beurs, 1993; Wittchen and Essau, 1991). And as a result, PDA can be treated through pharmacological or biological means such as tricyclic antidepressants, benzodiazepine, monoamino oxidase inhibitors and natural peptides such as CCK-4 (Asnis and van Pragg, 1995; Klein, 1991; World Psychiatric Assoc., 1993). Medical treatments of panic vary in their effectiveness, and often while the medication will alleviate sensations of panic, there will be undesirable side effects such as weight gain and lethargy. It is generally agreed that medical treatments are most effective when combined with other forms of treatment (Health Canada, 1996).

Medical approaches and treatments of PDA/agoraphobia are based on a specific model of the body, which is why so many individuals find medical treatments ineffective

(Hubbard et. al, 1982). Medical models operate on the assumption of a standardized body, thereby reinforcing the ideal of a singular standardized rational subject (Bohan, 1992).

Within a medical approach to PDA, the body and its processes become the source of panic (Barlow and Craske, 1991). The hierarchal body of old traditional medicine has given way to a network of amazing complexity and specificity (Haraway, 1992: 323) .

Treatment of PDA is primarily aimed at blocking panic attacks. It is assumed that after full remission of panic for most patients the anticipatory anxiety diminishes and the avoidance component of the disorder subsides on its own (de Beurs, 1993: 18).The avoidance behavior, which is perceived to be secondary to the panic itself, will simply subside once the panic responses have ended (Barlow, 1988). Medical approaches, in their current form, do not address issues surrounding avoidance behaviors because they are outside of the domain of medicine or of the physical body (Bohan, 1992). Though the rational subject is a contained organism, the domain of the interior of our bodies and the struggles within the body, or what Haraway describes as the biopolitics of the body, become biomedical apparatuses for visualization. The body itself becomes a site of contestation between bodily systems such as the genetic, immune, endocrinological and neurological systems. Our interiors becomes the means by which we sustain our integrity and individuality. We are invaded not only by the presence of foreign contagions, but by our own strange parts and processes (Haraway, 1992: 320). Haraway's discussion of biopolitics, is centered on the immune system which becomes a landscape of warfare or microcosm of battles between alien pathogens and our immune processes (Haraway, 1991). Within PDA discourse, the body is not structured around the immune system, but

rather the endocrine and neurological systems, and our bodies are not being invaded or transgressed by foreign organisms, but turned on themselves through the deviance of our genetics, natural hormones and neurophysiology. In a variety of self help books and medical texts the bodily processes of the PDA/agoraphobic are presented as a battlefield, as a disorienting landscape, images which are not only drawn from warfare, but from discourses and images of madness (Dumont, 1995; Rapee, 1996). Medications and drug/peptide therapies police or check the disorderly nature of the PDA/agoraphobic body. Similar to Haraway's discussion of the immune system, the PDA/agoraphobic process is written of as " everywhere and nowhere, its specificities are indefinite if not infinite, and they arise randomly; yet these extraordinary variations are the critical means of maintaining bodily coherence" (Haraway, 1992: 323). In the case of PDA, the body is not being attacked by another, but is being transformed by an uncontrolled self. What exactly is disorderly within the self is not yet known, although there is much research and research funding directed towards those questions (APSN, 1996;1997;1998). Despite this, medical literatures still refer to the body as a disorderly internal landscape (Gurguis et al., 1991). Rational subjects must be able to control both their actions and their bodies in order to prevent the possibility of contagion and disorder. This involves the regulation of the body so that actions are not perceived of as transgressive or impure.

The PDA/agoraphobic person disciplines and consequentially punishes her/himself geographically by self- imposing walls which, more often then not, are the same as the physical walls of their house or backyard fence. This is reminiscent of Foucault's description of the panopticon and its process of discipline and consequentially

punishment in the text Discipline and Punish. Foucault describes how the structure of the panopticon prisons facilitated a surveillant gaze, which was then internalised by the prisoners themselves. “Hence the major effect of the panopticon: to induce in the inmate a state of conscious and permanent visibility that assures the automatic functioning of power ” (Foucault, 1970: 201). In this view, both the prisoner or agoraphobe no longer needed the physical walls to imprison themselves; the suggestion of a gaze was all that was necessary to discipline- “ visibility is a trap” (Ibid, 200). The PDA/agoraphobic individual self-imposes a similar consciousness of permanent visibility. Walls and visual barriers allow PDA/agoraphobes to conceal the possibility of losing control and thus, these visual barriers simultaneously become a haven and crutch. Ironically, the walls and barriers that isolate so many individuals transform themselves into the PDA/agoraphobe’s means of identification. The prisoner needs the prison to maintain her/his identity and in this sense space is pivotal within the construction of PDA/agoraphobic identity and subjectivity.

What distinguishes PDA behaviour from other reactions to panic is that the self is disciplined spatially and an identity is constructed from these spatial experiences. The rational subject, as normative ‘mentally stable’ figure, is not only defined by its somatic boundaries, but also by its ability to control or ‘master’ the spaces around it (McNab, 1993). Since PDA individuals do not feel that they either have control over their bodies or their responses to particular spaces, they restrict themselves to the situations and spaces in which they know they can maintain control (Ibid, 1993). The creation of safe spaces, spaces in which the individual perceives her/himself as powerful and stable, is a pivotal

geographical aspect of rational subjectivity.

Psychological models of PDA/agoraphobia, similar to medical models, incorporate and problematicize the spatial relationship between PDA/agoraphobics and their geographies. These models facilitate the rational PDA subject's ability to control and define her/his spatial and physical boundaries (Rachman and Maser, 1991). While medical discourses on PDA/agoraphobia focus on PDA/agoraphobia as a physiological response separate from activities outside of the body and outside environmental factors, psychological approaches to PDA/agoraphobia are far more nuanced in their approaches and perspectives on the body and its geographies. In general, psychological models of PDA attempt to understand psychological mechanisms of panic and its consequences (Thorpe, 1998). Similar to medical models of PDA/agoraphobia certain psychological perspectives locate the site of PDA/agoraphobia within the physical body as opposed to an environmental response (Barlow and Cerny, 1988). However, within the behavioural perspective, PDA results from a stimulus which may be external or internal and results in a panic response (Craske, 1991). The permeability of PDA experiences beyond the boundaries of the body is seen to be problematic because it restricts the mobility of the PDA individual and produces more anxiety. The avoidance behaviour of PDA is understood to be a mis-attribution of panic symptoms that are projected outside of the body (Wolman and Stricker, 1994). That is, the panic sensations are attributed to the particular places and events where the panic occurs, as opposed to a recognition that the panic is separate from the spaces in which they occur. The panic responses are somatic in nature and not spatial.

The goal of psychological therapies is for the PDA/agoraphobic individual to realise that her/his somatic anxiety responses are internal and need not be projected into surrounding spaces (Cote and Barlow, 1993). From a psychological perspective we begin as bounded subjects, and when those boundaries are transgressed we must learn how to reinstate our rational selves again, otherwise our identities will become compromised and unstable (McNally, 1994). Psychological treatments and approaches to PDA/agoraphobia aim to mobilise PDA/ agoraphobic persons by separating and delineating the boundaries between self and environment; treatment can only be successful when this demarkation and de-territorialisation of body and space is accomplished (Walker et al., 1991a). Therefore the production of space vis a vis the body becomes problematic because during PDA, divisions and associations between internal and external spaces are blurred. PDA/agoraphobia makes an individual acutely aware of their environment and the role that perceptions have in the creation of safe and unsafe spaces (McNab, 1993). This heightened awareness of one's surroundings often produces a feeling of fear and disorder which is disorienting and anxiety provoking.

Most texts that include psychological perspectives on PDA/agoraphobia compare and contrast multiple psychological approaches, medical models and the phenomenology of panic with one another (McNally, 1994; Thorpe and Burns, 1983; Walker et al. 1991). Each of the psychological perspectives that I examine here include a variety of competing methodologies and studies within each model. This chapter will not focus on the debate between and within each of these approaches, but will instead highlight the major aspects of each approach and analyse how it contributes to an understanding of the

body and the geographies of PDA/agoraphobia. These dominant approaches include: psychodynamic and psychosocial models, psychophysiological models, cognitive models, behavioural models, and cognitive- behavioural models of treatment (Seligman, 1991). Not all of these models though support the rational subject as a prototype for learning and behaviour.

Psychodynamic/ Psychoanalytical Models-- The psychodynamic/psychoanalytical models of PDA/agoraphobia directly challenge the impermeable subject in favour of a subject who is more fragmented and dislocated. The ruptures in human subjectivity are not seen as problematic, in the sense that ruptures in subjectivities are failings in and of themselves, these ruptures in personality and behaviour on the other hand, need to be understood and retranslated into a comprehensive language, often based on the social or personal experiences of agoraphobic individuals (Nemiach, 1981).

Psychoanalysis plays and has played a role in the development of PDA/agoraphobic research and studies (Shear, 1991). Psychoanalytical/ psychodynamic conceptualisations of the body and its relationship to environments outside the body are far more fluid than other psychological models. Freud's 'discovery' of the conscious poses a challenge to the rational subject by arguing that our identities and desires are not rational but function very differently. Modern psychoanalysis has built on Freud's work to argue "that self as whole and united is something which has to be learned: it is formed in relation to others and is seldom achieved but rather is an ongoing process involving imagination and fantasy" (Hall, 1994 in McDowell, 1996). Psychodynamic or psychoanalytical models of the body not only figure a physical but a psychic body,

separated as conscious and unconscious realities (Shear et al., 1993). The body is not only understood to be a repository of biological components but residual or repressed memories, geographies and experiences. The conscious and unconscious minds are merged together, and coexist to produce reactions within one's lived experiences. Spatial experiences as well, are understood to be permeable in nature. Landscapes of fear and memory from the past are often retraced and projected within PDA. These imagined geographies within a psychodynamic model are understood and treated as real landscapes which do exist, but must become untangled and explored for other meanings (Ibid, 1993).

The psychoanalytic approach involves talking about one's fears to an attentive and understanding listener. By going deeper and trying to find the subconscious sources for the symptoms of PDA/agoraphobia the psychoanalyst uses subconscious cues and responses to form a diagnosis and treatment (Walker et al., 1991b). The psychoanalyst then aims through psychodynamic methods to unravel unconscious desires and memories from conscious realities, but not in a fashion where the traces of the unconscious are suppressed or viewed necessarily in a negative fashion (Klein et al., 1983). The aim within psychodynamic approaches to PDA is to understand and analyse one's experiences and unconscious fantasies or desires in order to come to terms with one's avoidance behaviour and its hypothesized cause (Walker et al., 1991a).

Approaches to PDA/agoraphobia that are incorporated within psychodynamic models are based on Freud's bio-psychosocial theories and writings on anxiety, where anxiety is defined as the mental reaction to anticipated dangers whose origins can be physiological, psychological or responsive to a real danger (Cote and Barlow, 1993).

Psychodynamic treatment may be conducted in several forms as psychodynamic psychotherapy, exploratory psychotherapy, in the long term as psychoanalysis proper, hypnotherapy, regression treatments and psychoanalytic dream analysis. The psychodynamic approach is based on the development of insight by association (Ibid, 153). The panic is a marker of repressed experiences, often childhood experiences which need to be analysed and explored. Events that precede the panic attack are recalled and associations are made with repressed impulses that allow the panic and anxiety episodes to diminish (Shear, 1991).

According to psychodynamic theory what is key to emphasize is the importance of unconscious determinants of thoughts, feelings and behaviours (Shear et al., 1993). The psychodynamic therapist listens to the patient by tracking verbal productions and behaviours with a view to understanding how they represent symbolic transformations of underlying themes (Walker et al., 1991a). The therapist here is concerned with the development and management of the patient's sense of self, intuitable forces and the quality and stability of object relations. Psychodynamic theory predicts that anxiety is generated when the unconscious instinctual or real danger situations are activated which is why the anxiety is experienced spontaneously (Klein et al., 1983). This is accomplished by free-floating techniques and the encouragement of patients to not censor their thoughts.

This approach is not as prevalent as other psychological models in the treatment of panic disorder with agoraphobia and there is little clinical research data that supports psychodynamic models (Cote and Barlow, 1993:153). This can be explained fairly

concisely: psychoanalytical approaches to panic and agoraphobia do not focus their research on clinical trials. Psychoanalysis is a highly subjective process with several grand narratives that structure its approach (Chodorow, 1989). Though there are many forms and approaches to psychoanalytic thought, typically panic and agoraphobia are understood and constructed in terms of very subjective symbols, images and terms, many of which are phallogocentric, inherently biased and sexist, and non accommodating to diverse notions of gender and pathology (Grosz, 1994; 1997). Psychoanalytic therapy is a form of interpretation, which may not accurately reflect the lived experienced of PDA individuals.

Psychoanalysis tends to a single explanatory paradigm, a single regime of explanation, the reduction of current adult factors to infantile precedents, the reduction of the relations between the sexes to those regulated by a respect for the phallus, the reduction of sexuality to genitality, the reduction of body to erotogenic sites, the need to be endlessly read symptomatically, to read events and impulses about being something else (Grosz, 1994: 181).

So while on the one hand, I have positively described psychoanalysis for its recognition of the possibilities of movement between landscapes, spaces and bodies, simultaneously imagined and real, on the other hand, in some documented applications problematic aspects are emphasized. Psychoanalytical methods are criticised by a large number of clinicians, academics and patients because of manner in which events and objects are interpreted and analysed, in this respect psychoanalysis is extremely dependant on the manner in which lives are interpreted and analysed (Cote and Barlow, 1993). Psychoanalysis subjective approach to the agoraphobia/PDA is indicative of a model which views the subject as partial and subject to interpretation.

Psychosocial Model— The psychosocial approach combines psychological theory with social constructions and relations over a period of time (Hallam, 1991). This model is more prone to accept and investigate the role that environmental and spatial relations play in the lived experiences of PDA (McNally, 1994). Psychosocial practitioners do not accept that panic disorders, as defined by the DSM, are a qualitatively different type of anxiety complaints (Walker et al, 1991). Panic complaints may have direct antecedents and phenomenology but this is not the same as constructing these observations into an entirely other theory and demand a separate causal explanation for panic attacks or PDA/agoraphobia (Ibid, 1991). Causes and consequences of PDA/agoraphobia, such as the coping strategy of staying at home, are difficult to untangle from pre-existing personality predispositions, from patterns of marital interaction, and from the theorist's stereotypical views of the female role (Ibid, 1991). In this respect, an investigation of the nature of home and gendered geographies is figured more prominently within psychosocial analyses (Klein et al. 1987; Roy-Byrne et al., 1986; Salzman; 1982; Seidenburg and DeCrow, 1983). Psychosocial approaches are not common in the research of PDA/agoraphobia, in part because this approach extends itself beyond the accepted psychological and medical discourses on PDA/agoraphobia that focus on the body as the site of disorder.

There are a variety of psychosocial models of PDA/agoraphobia in practice (Thorpe and Hecker, 1991). These models incorporate sex role stereotyping, tension in family relationships, obsessions and nightmares, in addition to phobic fear and avoidance to demonstrate that psychological models can be combined with social scientific

perspectives (Chambless and Goldstein, 1982 in Hallam, 1991). Psychosocial models explore the relationship between gender, sexuality and marital status and domestic spaces and suggest that the feminization of sick roles and the gendered nature of private and public spaces are important points of departure for further study and analysis of PDA/agoraphobia (Brehony, 1983; Chambless and Graceley, 1989; Chambless and Mason, 1986). Various models propose an integrative model based on functional analysis of behaviour, encompassing physiological, cognitive behavioural and interpersonal factors; for example, that the PDA individual's social learning experiences have resulted in low self esteem and dependency which results in a high level of stress, which in turn is increased by panic attacks (Brehony and Geller in Thorpe and Hecker, 1991), and/or that PDA often develops within the context of general stress (Ibid, 1991). These models also question whether internal or external stimuli are a more dominant locus of control for agoraphobes (Hallam, 1991; Mathews et al., 1981). That is, what role does one's environment play in the experiences of PDA/agoraphobia?

Fundamental to understanding psychosocial aspects of mental health is the inclusion of multifaceted factors such as age, class, gender, ethnicity and spatial relations which leaves data open to a host of competing interpretations that can bridge the gap between clinical psychiatric and social science disciplines (Rapee, 1996). There is hope for more study in this methodology since the definition of panic and panic attacks has consistently changed over the past twenty years (McNab, 1993). With new definitions come the possibilities that the larger social issues will become a part of medical literature. According to psychosocial research, social correlations help to stimulate and validate

theoretical notions within the dominant discourses of PDA/agoraphobia (Thorpe and Hecker, 1991).

Notions that the PDA/agoraphobic individual is a production of both societal constructs and personal experiences, desires and memory, challenge the idealised rational individual. But, neither psychodynamic/analytical or psychosocial discourses dominate the understanding, treatment and management of PDA/agoraphobia, primarily because these models are either viewed with skepticism, or involve resolving social and cultural issues that may be much more difficult to deal with (Walker et al., 1991). Psychosocial models involve larger societal transformations about the nature of illness or gender roles. And while these models generate self awareness about the manner in which we come to understand ourselves contextually they do not provide individuals with more immediate and direct solutions to their difficulties, which other psychological models such as psychophysiological, cognitive, behavioural or cognitive behavioural attempt to accomplish (Shear et al., 1993).

These latter discourses on PDA/agoraphobia are more favourable of rational subjects in the sense that the individual wants to express a “coherent, consistent rational space paired with a consistent, stable and organized environment ” (Kirby, 1996: 45). This involves “restoring the interior to homeostasis ” a process in which PDA/agoraphobic individuals attempt to reclaim a sense of self through separating the self from outside stimuli (Ibid, 45). In other words, in the changing and sometimes unstable world of the agoraphobic person, the ability to control spaces and sensations through a rigid sense of self, identity and subjectivity is seen to be pivotal to mental

health.

Paradoxically, psychological methods are based the ability to control one's self by separating one's thoughts from one's surroundings in order to establish a sense of what is inside and outside the body and to re-establish as sense of self. This separation of body from environment allows the individual to reflect on how they can become a united self once again. Ultimately the aim is to unify the rational self through the establishment of boundaries between body and environment, self and other. The separation of body and space as problematic implies, in one sense, that the projection of feelings into space is a mis-attribution and moreover unhealthy. And while the projection of panic into an imagined landscape is problematic and unhealthy for the PDA/agoraphobic individual, it simultaneously establishes a precedent for PDA/agoraphobic individuals where spaces and environments must be understood separately from bodies and their processes. In other words the recognition of the direct relationship between our bodies and the production of spaces precipitates instability and needs to be corrected.

Psychophysiological Model-- In any psychological disorder there are a number of choices in therapeutic methods. One of the most frequent combinations of methods is medication in conjunction with cognitive and behavioural therapies- the psychophysiological model (Michelson and Mavissakalian, 1985; 1988; Mavissakalian and Michelson, 1985). The choice of combination depends on the patient's etiology and treatment effectiveness. More commonly it follows personal preference, experience and habit of the practitioner (Walker et al., 1991a). The general theory behind the combination of methods is, since no one treatment has been shown to always be effective,

the likelihood of success increases as more approaches are used (Swinson et al., 1991). This model is very similar to medical models in its approach to the body and spatial relations. The use of drug therapy helps to stimulate the effectiveness of psychological approaches and treatments (Jacob and Lilenfield, 1991). The mind is understood as contained within and a component of the physical body. The etiology of PDA/agoraphobia still remains within the physical body and the trained behaviours of those with PDA (Telch, 1991).

Psychophysiological approaches are often also described as psycho pharmacologic or psychobiological (McNally, 1994). There are advantages and disadvantages to such pharmacological and behavioural combinations. The possible positive effects of combined therapies include: drugs make compliance with psychological therapy more likely (Zuercher-White, 1997). A treatment regime such as medication demands little effort on the patient's part which makes the more arduous demands of psychological therapy more yielding (Ibid, 1997). Psychological therapy enhances compliance with the drug treatment, support and encouragement from the psychological therapy can motivate the regularity of drug taking by fostering positive attitudes in the patient (Ibid, 1997). And psychological and drug treatments may act on different parts of the disorder (Ley, 1992).

The possible negative effects of combined therapies include: while it may be simple and direct for a practitioner to prescribe a drug, the patient may have hesitations or desire not to take the medication at all. This may cause unforeseen confrontation which brings up more issues in the patient- doctor relationship (Cross National Study, 1992). Drugs can produce state-dependent learning where something learned in one drug state

may not transfer to a changed state and when the drug is removed. Those skills may reverse or may not be visibly apparent (Michelson, 1991; Michelson et al. 1985; 1988). Drugs can reduce anxiety to a point at which exposure therapy no longer simulates real life situations (de Beurs et al, 1995). The drug may have a negative placebo effect by increasing dependency and allowing the patient to assume a passive role in therapy (Rachman, 1991). The patient may also attribute positive changes to the medication without making any progress in therapy; and drugs may cause increased anxiety and stress in the patient or even a relapse (Rickels, et. al, 1993). In addition the withdrawal of medication may produce a rebound effect, with increased anxiety and panic as an outcome (de Beurs et al., 1995a).

In summary, psychophysiological models of PDA/agoraphobia incorporate both drug treatments and cognitive or behavioural therapy because both psychological and biological factors are understood to cause PDA/agoraphobia (Ley, 1992). This model suggests that stressful environmental events, abnormal behavioural reactions or defective psychological processes interact to produce panic and agoraphobic symptoms (Telch et al., 1995). The environment is thus a stimulant that produces reactions within the mind and body. PDA/agoraphobia can either exist as a manifestation of sudden anxiety or fear or as a manifestation of the disturbance in brain functioning (Shear, 1991a: 55). Some physicians believe that medication is useful for blocking panic attacks or necessary if cognitive and behavioural therapies fail (McNally, 1994: 81). The literature on these forms of treatment explores the co-morbidity of drug treatments and psychological treatments which often include comparative drug trials, as well as a comparison of the

effects of combining drug therapies with psychological ones (Telch, 1991). This model is the most common and frequently used model because of its effectiveness, yet many individuals are still uncomfortable with taking medication and for those individuals other psychological methods are preferred (Health Canada, 1996).

Cognitive Model--The primary assumption in cognitive therapy is that PDA/agoraphobia is caused by certain cognitions or beliefs that are held by patients (Clark, 1991). PDA/agoraphobia is triggered by a perceived threat or stimulus, either internal or external, which creates apprehension that result in bodily sensations that are then interpreted catastrophically, triggering further perceived threats. In this way cognitive theory assumes that panic responses are due to the misinterpretation of bodily sensations in a catastrophic way (Clark, 1986; 1991). Cognitive models allude to one of the geographical implications of PDA/agoraphobia. That is, in the case of PDA the panic responses are often concealed by the individual and remain within the body as catastrophic "misinterpretations", compared to being a visible somaticised response (Hoffart, 1995).

The aim of this therapy is to change the cognitions of the patients (de Beurs, 1993: 25). Within a cognitive model two types of disturbed thinking are assumed: negative automatic thoughts such as I am having a heart attack, I am going to faint, I am going crazy; and dysfunctional assumptions and rules, that is the general beliefs patients hold about the world or themselves, such as feelings of panic that can lead to sudden death (Beck et al., 1988; Clark, 1991). The aim of treatment is to change this negative thinking, without the therapist moralising or lecturing the patient (Beck, 1991; Beck et al., 1985;

1992; 1994). David Clark describes the style of cognitive therapy as “collaborative empiricism” where the view of patients and their problems are regarded as hypotheses and patients and therapists collaborate to determine whether these hypotheses are helpful or accurate (Clark, 1991: 66). Avoidance behaviours are seen to sustain negative beliefs, because they prevent the patient from experiencing that the anticipated catastrophes will not happen (de Beurs, 1993: 26) .

What this implies for a geographical analysis of PDA/agoraphobia is that the relationship between perceptions of environments and our bodies are interconnected, and that PDA/agoraphobia is a negative outcome of this relationship. But it also implies that spaces themselves have no intrinsic qualities or meaning unless meaning is projected onto them. An exploration of the history of particular spaces that are typically avoided is not investigated within clinical trials or cognitive literature in general. The gendered nature of spaces that are avoided, or what meanings are attributed to those spaces, is not as important as the process of changing thought patterns and separating one’s feelings and projections from the spaces themselves.

Many of the texts on PDA/agoraphobia speculate that PDA and social phobia often overlap, that the spaces agoraphobes avoid are spaces in which they could potentially be humiliated in, lose control, or have no control over (Kendler et al., 1992; Mannuzza et al., 1992). The aim of cognitive treatments is to change the thinking patterns of PDA/agoraphobic individuals so that they can regain control over such spaces (Lang, 1985). Patients are encouraged to expose themselves to situations in which a panic is likely to happen, but unlike behavioural therapy , patients expose themselves to these

situations once or twice instead of repeatedly as they would in traditional behavioural treatments (Clark et al. 1994). The focus on cognitive treatments is more concentrated on making sure that one's thoughts and somatic experiences are not confused with the spaces in which they occur in contrast to exposure treatments (Beck et al, 1985;1988). In short, bodily responses should remain within the body and be understood as somatic and not spatial (Lang, 1985). The spaces which surround us are understood to be more of a stage on which we act than precipitators of action- I am projecting, as opposed to reacting to (Chambless, 1991; Clark, 1991). Alternatively, space is presented as a stimulant and trigger for action, it provokes particular reactions based on our personal perceptions of those spaces and when those spaces and our understanding and sensitivity to space becomes acutely noticeable, our environments become problematic. It is almost as if an awareness of our environment is problematic, that when we do not think of our geographies and their relationship to us, we are in a normal healthy state.

Behavioural model- In the Behavioural model the sufferer is brought face to face with their fears and is left exposed to them for fairly long periods until the panic lessens and dies away (Thorpe and Burns, 1983). The controlled exposure will desensitise the agoraphobic person (Barlow et al, 1989). Space becomes a medium of both torment and treatment within a behavioural model. Space is utilised as a tool, somewhat analogous to a pharmacological treatment or relaxation exercise. Behaviourists, unlike other therapists, have little or no interest in underlying psychological causes but seek only to change behaviour patterns (Walker et al., 1991). Behavioural theorists tend to focus on learning experiences involving classical and operant conditioning that lead to the development and

maintenance of fear (Health Canada, 1996). Within a behaviourist model, the PDA/agoraphobic person has learnt to react wrongly to certain stimuli and must be retrained to react correctly, without fear (Vose, 1981). This assumes that there are normal and correct responses to our geographies and while it makes sense that avoidance behaviours negatively impinge on the mobility of agoraphobics and this needs to be aided, a panic reaction is not an abnormal response to particularly fearful places (McNally, 1994). Many places induce fear for a wide range of women and are consequently avoided, and yet the actions of these women are often praised for being sensible as opposed to abnormal. But according to these practitioners, there is a difference between healthy panic responses and panic attacks (Barlow et al, 1989; Barlow and Craske, 1991; Craske et al, 1991). The primary goal of behaviour therapy in the treatment of PDA/agoraphobia has been to modify the 'unadaptive avoidance behaviour by means that were tested in laboratory paradigms on avoidance learning' (de Beurs, 1993: 21). The object of behavioural models is to separate the association between stimuli and the response of anxiety (Walker et al. 1991a). Again the delineation between body and environment must be kept separate because of the catastrophic consequences of their interconnectedness.

Exposure, which is the most common form of behavioural therapy, is a generic term which describes a complex set of therapeutic procedures that expose patients with PDA to anxiety producing stimuli (Michelson and Marchione, 1991: 100). The most usual exposure- behavioural techniques include: desensitisation- the patient is exposed very gently to the feared situation (Zuercher-White, 1997); flooding- the sufferer is

thrown in at the deep end and exposed immediately and completely to their greatest fear; implosion-patients are asked to imagine themselves in their most frightening situation for an hour or more with the assistance of a therapist; exposure in phantasy- the assistance of films or slides of the feared situation are used (Ibid, 1997); modelling- the therapist acts as a model for the patient; shaping- the therapist encourages the patient to confront their phobic situation with them; operant conditioning- the patient is rewarded when they succeed in overcoming a difficulty; simple relaxation (Vose, 1981); and respiratory control techniques (Walker et al., 1991).

The protocol for and order of behavioural treatments include: diagnosis and accurate description of problems; assessment of current level of functioning; introduction of principles and nature of treatment; cognitive restructuring- overestimation of probability; cognitive restructuring- overestimation of consequence; instruction for breathing retraining (Cox et al, 1988); introduction of principles and practice of exposure in vivo (in live patient); extension of exposure to internal cues; continued practice of exposure; relaxation techniques (Out et al. 1993); utilizing cognitive and breathing skills (De Ruiter et al, 1989); regular homework assignments (Edelman and Chambless, 1993); additional skills- communication, assertiveness, social; termination and discussion of maintenance; post treatment assessment; and finally follow-up or booster sessions (Walker et al., 1991a). Once this protocol is in place it is important for the behaviourist to assess its reliability and productiveness since it is important for the treatment to be effective, for the patient to have productive feed back , and to provide clinical statistics and examples for future patients (Gould and Clum, 1995). The patient is assessed by

physiological measures such as respiratory rates and behavioural measures such as the behavioural avoidance test (BAT), which develops a hierarchy of feared situations or events (Walker et al., 1991). The BAT then specifies that patients perform tasks in order of increasing difficulty, fear and avoidance hierarchy measures, then patients should monitor measures and responses in a diary (Craske and Barlow, 1991; Ghosh and Marks, 1987; Gould and Clum, 1995). This protocol is performed in patient-doctor sessions and is a long range treatment for most PDA/agoraphobic persons and different or modified packages are prevalent (Walker et al., 1991a).

Cognitive-Behavioural Models- Behavioural techniques are sometimes combined into more complex methods for behaviour treatments called cognitive-behavioural treatment packages that are monitored and tested for their effectiveness depending on the particular individual (Michelson and Marchione, 1991; Zuercher-White, 1997).

Cognitive-behavioural approaches to agoraphobia state that agoraphobia with panic is a disorder of the mind based on misinterpretation of bodily symptoms similar to cognitive models of PDA/agoraphobia (Cote et al., 1994; Michelson, 1991). Cognitive behavioural treatments involve identifying patient's negative interpretations of their bodily experiences, then suggesting alternative non catastrophic interpretations of the sensations, then helping the patient to test the validity of these alternative interpretations through discussion and behavioural experiments (Clark, 1986: 465; Telch et al, 1995). Often the interpretation of bodily responses is considered to be the result of stress induced hyperventilation (Clark, 1986: 465). There are several components to cognitive behavioural approaches to PDA/agoraphobia which include breathing retraining because

it is believed the hyperventilation may produce somatic sensations that are perceived of as panic (Rapee and Barlow, 1991; Shear et al., 1994); cognitive re-attribution, where the misinterpretation of somatic responses result in an escalation of anxiety ; and interoceptive exposure (Barlow, 1988; Pollack et al., 1994) where the conceptualisation of panic attacks as ‘conditioned’ or learned produce body cues that trigger further panic attacks (Cote and Barlow, 1993: 154). According to Clark, the treatment for cognitive-behavioural treatments is structured into five steps: brief voluntary hyperventilation; explanation and discussion of the way in which hyperventilation induces panic; training a pattern of slow breathing to be used during attacks; training more ‘appropriate’ cognitive responses to bodily symptoms; and the identification and modification of panic triggers in order to make the panic attack a more understandable and comprehensible event (Brown and Barlow, 1995; Clark, 1986: 466). Additional relaxation techniques, such as applied relaxation training have also been used within a cognitive-behavioural model (Cote and Barlow, 1993: 157; Out et al, 1995).

There is a great deal of overlap between cognitive-behavioural, behavioural and cognitive approaches to PDA, most practitioners seem to prefer a combination of cognitive and behavioural techniques, because this allows for greater flexibility when dealing with individual patients (Thorpe, 1998). The effectiveness of each of the specific forms of these treatments vary depending on the study and the perspective of the researchers involved in the study. An overwhelming number of studies indicate that combining cognitive-behavioural treatments with medication is the best of all possible solutions (Health Canada, 1996)

Cognitive- behavioural, behavioural and cognitive approaches to PDA/agoraphobia may vary in approach but all three isolate PDA/agoraphobia as a somatic response. The behavioural approach is possibly the most directly geographical or spatial approach to PDA/agoraphobia , because it incorporates spatial relations into its methodology. All three approaches also allude to the importance of approaching PDA/agoraphobia as a somatic response. More generally, all of psychological approaches allude to the need for some sense of stable somatic boundaries prior to investigating how those boundaries are permeable and interconnected with social and spatial processes. In this respect, clinical discourses on PDA/agoraphobia provide a criticism of postmodern/poststructural analysis or approaches with a positive emphasis on plurality and elasticity. These latter theories often promote instability and fragmentation as instruments of political subversion and cultural transgression but do so from a privileged position. Many of these academics display callous regard for marginalized others, such as PDA/agoraphobic women, who are more inclined to seek security, comfort and the pleasures of everyday life than to pursue the thrills of transgression and break (Mcleod, 1996: 20-21). It is easy to talk about subjectivity as permeable and constantly changing, but for some, it is much more difficult to live and it is those lived experiences that we must be sensitive to and structure our theory around. What is pivotal is to distinguish between the blurring of subject boundaries as a ideal and as a material set of relations and thus, to establish a ground in which both theory and experience are taken into account. For many PDA/agoraphobes the decentring and fragmentation of the subject is a frightening reality which only results in immobility and fear. The manners in which

psychological and medical models have approached PDA/agoraphobia are not unwarranted because it has been successful in the treatment and management of this disorder. These models encourage us to rethink subjectivity as contextual, situated and positioned and to focus on the connections and links between processes and people at a variety of spatial scales. This is what is meant by a fragmented/ partial identity and fluid subjectivity within feminist geographical thought today.

Clinical approaches to PDA/agoraphobia may provide a useful criticism of the limits of particular forms of critical spatial theory, but they are by no means unproblematic themselves. The integration of geographical relations into these medical models may help to provide an understanding of the body which is more sensitive to the lived realities of PDA/agoraphobic individuals. In addition to interdisciplinary approaches to PDA/agoraphobia there is another approach to psychology which actively theorises and utilises postmodern/poststructuralist theory in a manner similar to feminist geographical approaches. These (feminist) postmodern, poststructuralist psychological perspectives form a separate and contested literature within psychology, and unfortunately I was unable to find approaches to PDA/agoraphobia described as a postmodern/poststructuralist psychological model. I would like to briefly summarize how postmodernism and poststructuralism are seen to complement psychological theory, because ultimately I believe these approaches have much to offer psychological discourses on PDA/agoraphobia. Often postmodern/ poststructuralist psychological models fit under the heading of psychosocial, psychoanalytic or psychodynamic models and concentrate on issues of positionality, bias and context (See Hare-Mustin and

Marecek, 1994; Sherif, 1994 ;and Riessman, 1992 for an extensive list of sources). These 'critical models challenge both the traditional roles of practitioners as advice givers, and their theoretical, epistemological and research biases (Chodorow, 1992; Sherif, 1994). These approaches are structured as a critique of various psychological models and methodologies and the implicit hierarchy within psychology based on scientific principles (Birke, 1992; Matlin, 1987). These approaches are also structured around a critique of the rational subject that subjectivity necessitates (Hare-Mustin and Maraceck, 1994; Sherif, 1994).

As these critical psychological perspectives show, contrary to much of the thinking around identity politics and medical/psychological discourses, a stable and unified identity and body is not a necessary basis for a progressive politics. It is on the other hand a component, a part of the process for PDA/agoraphobic women to develop a sense of agency and security (Duncan, 1996a: 246). Thus, in addressing the lives and geographies of PDA/agoraphobic women feminist theory must incorporate both clinical discourses and social processes while being sensitive to the concerns and powerlessness many of these women experience.

Various clinical discourses on PDA/agoraphobia fail to address the complexity of spatial and corporeal interrelations, and in so doing they pose the interconnectedness between environment as a general problem. There are also some clinical discourses that neglect to address overarching social and gendered histories that have developed and structured the manner in which bodies, spaces and illness are understood. In short, these discourses are based on the conception and maintenance of a rational subjectivity that is

gendered, isolated and structured as a part of a clinical and social hierarchy.

The next chapter focuses on non clinical discourses on agoraphobia that actively theorise the relations between social processes, geography and the body. Both chapter three and four are structured in response to one another because I believe that various approaches to agoraphobia and PDA are complementary and result in a greater awareness of the PDA/agoraphobic condition. Ultimately what is important about a comparative analysis of PDA/agoraphobia in clinical and non clinical discourses, through a feminist geographical lens, are the possibilities not only for PDA/agoraphobic individuals, but for knowledge claims in general. What is needed is a strategy to incorporate PDA/agoraphobic individuals as subjects of study in fields that are diverse and affect the lives of women with or without PDA. One of the aims of spatialised feminism, feminist geographical theory is to begin to forge alliances between different groups and communities of women who are differently positioned. This is what Chandra Mohanty describes as an imagined community between groups with similar struggles. “Imagined not because it is not ‘real’ but because it suggests potential alliances across divisive boundaries, and ‘community’ because in spite of internal hierarchies it nevertheless suggests a significant, deep commitment to what Anderson, in referring to the idea of nation, calls horizontal comradeship” (Mohanty, 1991: 4). In this respect PDA/agoraphobic discourse needs to question not only what the difference between PDA/agoraphobic women and non agoraphobic women are, but also what are the commonalities. What needs to follow is: how does the study of the PDA/agoraphobic subject and PDA/agoraphobic spatial relations contribute to the larger discourse on

women, gender and geography? This is what the non clinical literatures on agoraphobia directly address. As Dorothy Smith argues “that the many different lives and experiences of women can provide the starting point for asking new, critical questions, not only about those women’s lives , but about other women’s lives and men’s lives and most importantly the causal relationship between them ” (Smith 1987; in Harding, 1993: 55).

Chapter Four- Non Clinical Agoraphobic Discourse Analysis and Literature Review.

Metaphor and metonymy, then. These familiar concepts are borrowed of course , from linguistics. Inasmuch , however , as we are concerned not with words but rather with space and spatial practice, such conceptual borrowing has to be underwritten by a careful examination of the relationship between space and language (Henri Lefebvre, 1991).

The previous chapter concluded with a fundamental question about the agoraphobic condition- what are the differences and commonalities between PDA, agoraphobic women and women more generally; how are these differences and commonalities expressed geographically, and how do agoraphobic spatial relations contribute to larger discourses on women, gender and geography? I will argue throughout this chapter that agoraphobia can be explored and approached: as a disease/disorder (PDA); or as an organization of specific social anxieties. The clinical literature or discourses of the previous chapter primarily focus on agoraphobia as Panic disorder with agoraphobia (PDA). In this chapter the focus will be on agoraphobia as a social disorder, or a metaphor for gendered social, economic, political and spatial relations and histories. Agoraphobia as a metaphor does not imply that these agoraphobic experiences are fictive or imagined. They simply do not directly address or focus on the experiences of those diagnosed with PDA. Metaphor throughout this chapter is approached not as an illustration of bodies but as constitutive and grounded within and through corporeality or “body-matter”(Best, 1995: 187). Metaphor does not simply illustrate agoraphobic spaces and places but actively produces agoraphobic geographies. This rewriting of metaphor as grounded in lived experience is meant to challenge the binary opposition of

materiality/ideality on which the rational subject is predicated (Ibid, 189).

The critical literature review of the previous chapter focussed on the construction and understanding of PDA/agoraphobia through clinical practices and professional terminology, as well as the limitations of those clinical practices and language. Yet, the chapter simultaneously acknowledged the importance of particular clinical perspectives because they tend to investigate and explore the lived consequences of PDA/agoraphobia. This not only fosters further critical analysis within and of those clinical discourses but, encourages a critique of particular postmodern and poststructuralist celebrations of illness. In this respect, the chapter was both a critical literature review and a critique of metaphoric rhetoric and language in contemporary postmodern/poststructuralist theory.

Issues of metaphoric and material language are of primary importance to the study and definitions of PDA/agoraphobia in a variety of ways: a celebration of the dynamic and permeable qualities of bodies, illness and spaces; the construction of a medicalised language of PDA; issues of language within the construction of an PDA/agoraphobic's own identity and subjectivity; and finally, the term 'agoraphobia' which can be used as both a material, lived condition experienced by those diagnosed with PDA, and as a metaphor for larger spatial, social and gendered constraints on women, agoraphobia without panic. The bulk of this chapter will analyse and develop geographical relations that pertain to both clinically diagnosed PDA individuals and to women and men in western culture in general. How do larger gendered, geographical and social issues impact the lives of those with PDA? And how do the lived experiences of those

diagnosed with PDA refine and reveal widespread gendered, spatial and social metaphors? I am suggesting the possibility of a historical and spatial project that takes into account both geographic metaphors and the content of their social relations themselves, to unveil the layers of oppression that those relations and metaphors create (McDowell, 1996; Rose, 1996).

With the reassertion of space in social and cultural theory, an entire spatial language has emerged for comprehending the contours of social reality (Smith and Katz, 1993: 67). Language, specifically metaphor, helps to mediate the intersection between personal experiences and larger cultural, spatial and social ways of understanding the world. Space has provided an attractive lexicon and grammar for many feminist, and postmodern/poststructuralist, thinkers. In this respect spatial metaphors have become a predominant means by which social life is understood:

But perhaps surprisingly , there has been little, if any attempt to examine the different implications of material and metaphorical space. Metaphorical concepts and uses of space have evolved quite independently from material treatments of space, and many of the latter are cast in ways which suggest equal ignorance of the productive entailments of spatial metaphors. Yet if a new spatial politics is to be both coherent and effective, it will be necessary to comprehend the interconnectedness of material and metaphorical space (Ibid, 68).

How the symbolic and lived experiences of 'space' and 'place' are marked by the juxtaposition of 'materiality' and 'metaphor' alludes not only to the problematic polarities of these terms, that have often divided discussions of space and place, but also, to a desire to scrutinise diverse signifying practices through which space is organized and articulated (Aiken et al., 1998). It is key that notions of metaphor and material are not understood

dualistically because it is precisely the interconnectedness of metaphor and materiality that I seek to explore.

Metaphor works by invoking one meaning system to explain or clarify another. The first meaning system is apparently concrete, well understood, unproblematic, and evokes the familiar; in linguistic theory it is known as the 'source domain'. The second 'target domain' is elusive, opaque, seemingly unfathomable, without meaning donated from the source domain... metaphors assist in reducing the unfamiliar to the familiar; they reinscribe the unfamiliar event, experience or social relation as utterly known. It is precisely this apparent familiarity of space, the givenness of space, its fixity and inertness, that make a spatial grammar so fertile for metaphoric appropriation (Smith and Katz, 1993: 69).

Metaphors, in particular geographic metaphors, are "representational strategies that help us to think and articulate certain ways of being, in Elspeth Probyn's words: "they [organize] the field of the thinkable. " In so organizing, they open up some avenues of thought and necessarily close down others (Pratt, 1998: 13). But the construction of worlds based on metaphor are embedded within a paradox. While we "make worlds through metaphors" in the context of personal perceptions and experiences, those metaphors derived from lived experience are most powerful when resonant of some larger cultural construction. Thus, successful metaphors often bifurcate the expression of individual human experience in favour of the reflection and refraction of larger social, gendered or geographic strategies used by our cultures to make sense of the world. Therein lies a fundamental question about the utility of metaphors- the legitimisation of knowledge and distribution of power to those who set the standards of signification; and a caution to continually remind ourselves of what we are closing off, or opening up through metaphoric geographies and language. The 'givenness' or familiarity as discussed by Smith and Katz which is presumed of spaces and places is problematic because spatial

experiences, such as PDA/agoraphobia, are often not transparent or reducible to a common language, but rather are often based on projection or assumption, and not well informed study or consideration of spatial experience.

When space itself is seen as amenable to social construction, the taken for grantedness of the source domain for spatial metaphors is denied, and the metaphors are opened for scrutiny. The point here is to enable an explicit consideration of the meaning and politics of metaphor by investigating the connectedness, the imbrication of material and metaphorical space. Our argument [*as is mine*] is not against spatial metaphors as such; rather that by recognising that space is problematic, we seek to undermine some of the assumptions that render spatial metaphors seemingly reflexive and thereby to enrich the reservoir of meanings available for politicised spatial metaphor (Smith and Katz, 1993: 80 *Italics mine*).

Therefore, metaphors contribute to an understanding of spatial experiences. Yet, the use of metaphor more often reflects the desires and political aims of those constructing language instead of the experiences and desires of those studied. What I am attempting to differentiate between is the textual use of agoraphobia as a fear of public or market space and the lived experiences of PDA women. The argument that agoraphobia can be understood as a metaphor is reliant on the distinction between a clinical definition of agoraphobia as a fear of fearful thoughts as opposed to the non clinical traditional definition of a fear of the marketplace or of public spaces. The agoraphobic trope or metaphor does contribute to an understanding of the gendered nature of agoraphobia, but more accurately reflects a desire on the part of academics to discuss and explore gendered geographies, and the practices and territorialities of exclusion that have accompanied those geographies and histories.

Just as geographical metaphors such as centre, margin, border, ground,

positioning, placelessness, dislocation, and mapping have become fetishised rhetoric in a variety of academic discourses, agoraphobia, I would argue, has likewise become a popular metaphor or trope that signifies problematic aspects of gendered geographies and their histories. Similar to other geographical metaphors, agoraphobia's utility depends on the specific circumstances in which the term is used and how these metaphors are intertwined with material relations to produce identities and subjectivities. An agoraphobic metaphor is an extremely useful and poignant one in that it 'unpacks' an entire history of gendered spaces and can lead to the exploration of other geographical metaphors, such as mobility and rootedness.

This chapter is structured, in part, as a literature review of non clinical writings on agoraphobia in order to develop an analysis of non clinical discursive language practices. These literatures, which are few in number, tend to be structured within the disciplines of sociology, gender studies, cultural studies, psychoanalysis, linguistics, architecture and art history, and geography. Agoraphobia is often described, within non clinical discourses, as a fear of public spaces, and more specifically a fear of situations within the public arena. Indeed, the bulk of agoraphobic episodes do occur within the public sphere, but not exclusively within that realm. These literatures and discourses, with some exceptions, tend to draw their insights and material from other non clinical disciplines or older (and outdated) sources of clinical literature on PDA/agoraphobia, and often structure their arguments and analyses on agoraphobia in response to these older clinical approaches without very much information on current approaches and advances in the study of PDA/agoraphobia.

As a result, I have come to realise that a good percentage of non clinical literature on agoraphobia does not reflect the experiences of those I have interviewed, but reflect the manner in which gendered spaces and spatial relations have been socialised and politicised. Agoraphobia is a powerful symbolic form and allegory that exposes how the division of private and public spheres, spaces of production and consumption, are all part of gendered relations and the nature of 'place'. This chapter will argue that agoraphobia without panic which 'is rarely if ever seen' by the DSM and other clinical practitioners, is in fact far more prevalent and longstanding than PDA. There is such a thing as a fear of public or market spaces for many individuals, but these fears and anxieties are a part of the acculturation and socialisation engendered in western societies.

The underlying question of this chapter is how the literatures and insights of agoraphobia as material (PDA) and agoraphobia as metaphor (socio-cultural) contribute to an understanding of one another, and in particular to an understanding of the lived realities of those diagnosed with PDA. This chapter aims to develop how agoraphobia as a metaphor and as a material set of relations are not in opposition to one another. Rather there is a great deal of overlap between the histories of gendered geographies and the individual perceptions and experiences of PDA/agoraphobes. Both definitions and uses of the term agoraphobia have something to contribute to an understanding of the experiences of agoraphobic individuals, and to one another. The compartmentalization of agoraphobia into several distinct approaches and definitions is more a reflection of disciplinary boundaries and the professionalization of knowledge than it is the lack of mobility between varied uses of the term agoraphobia. I want to emphasize and explore

the connectedness of various agoraphobic discourses in order to suggest the different critical possibilities affected by a mobility between different voices and various disciplines, and thus reveal the interconnected and oppressive aspects of each.

The exploration of agoraphobia as both metaphor and material opens up venues for analysis and discussion where agoraphobia is not simply a pathology, but a complex combination of social, spatial and gendered practices. As Da Costa Meyer explains “ If gender is the product of social practices and institutions we must historicise and contextualise agoraphobia, not just pathologise it” (Da Costa Meyer, 1996: 149). The definition, etiology and conceptualisation of PDA/agoraphobia does not have to be limited by and to clinical discourses. I want to suggest that the agoraphobic condition is interconnected to larger discussions on women, bodies, illness and spaces, and that the reaction of PDA/agoraphobics to spaces should not necessarily be viewed as abnormal or irrational, but as an extension of the socialization and spatialization of gendered subjects.

A variety of agoraphobic metaphors are explored within this chapter: the agoraphobic as heroine- consciously or subconsciously resisting and protesting phallogocentric language and patriarchal culture as a whole; agoraphobia as a metaphor for the feminization of women and the use of the body in the reproduction of femininity; agoraphobia as a metaphor for the fear of assuming a political identity and subjectivity; agoraphobia as a metaphor for the gendered division of economic geographies and the gendered assignment of work; agoraphobia as a metaphor for nineteenth century bourgeois middle class values, and how that family structure has resulted, in part, in the breakdown of emotional and erotic social problems; and agoraphobia as a metaphor for

the sexualisation and gendered history of spaces, which includes the public/private split as well as issues of public harassment, assault and public safety. All of these metaphors contribute to a definition of agoraphobia without panic and support its existence as a concrete phobia. Many individuals are afraid of certain spaces, of public spaces in particular, and not simply the events that happen within them. It is difficult for those with and without PDA to dissociate spaces from the actions associated with them, because this collapse of action and spaces reveals the importance of place within our daily lives.

Language and Identity

I lived on Dread-
To Those who know
The stimulus there is
In Danger- Other Impetus
Is numb- and Vital less-

As 'twere a spur- upon the soul
A Fear will urge it where
To go without the spectre's aid
Were Challenging Despair. (Dickinson, poem 770, fasc.23, Garbowsky: 1989, 118)

One predominant agoraphobic metaphor belongs within the discourse of feminist psychoanalytic thinking. French feminist psychoanalytic thinkers, such as Cixous, Clement, Irigaray and Kristeva, have theorised much of their work around female figures such as the hysteric and agoraphobic individual who circumvent 'phallogocentric' language (language predicated on the phallus within patriarchal structures) in favour of a language of the body. These feminists adopted the agoraphobic and hysteric woman as symbols and metaphors of resistance to the male-oriented representations of women's bodies and the subordination of women's bodies in patriarchal culture (Grosz in

Neuman, 1993: 11) . Agoraphobia becomes a metaphor for and a means of actualising an authentic feminine language. This metaphor is fraught with contradiction and conflict because protesting the stifling of the female voice through one's voicelessness-that is, employing the language of femininity to protest the conditions of the female world- will always involve ambiguities (Bordo, 1993: 177). Agoraphobic protest is more of a fantasy of rebellion that neglects the practical life of the disordered body. Therefore, French feminist psychoanalytic theories of agoraphobic protest are obscured by too exclusive a focus on the symbolic dimension and insufficient attention to praxis (Ibid, 181). Within this section I would like to explore this metaphor of the agoraphobic as 'anti-phallogocentric heroine' through an exploration of how language is used in the construction and maintenance of PDA/agoraphobic identities and to reveal PDA/agoraphobic forms of resistance and oppression.

Several of the most comprehensive non clinical books and discussions of PDA/agoraphobia are found within the disciplines of literary analysis and linguistics. Among the most noteworthy are Lisa Capps and Elinor Ochs Constructing Panic- The Discourse of Agoraphobia and Maryanne M. Garbowsky's The House Without the Door. Both books explore the ways in which language can reveal or reinforce PDA/agoraphobic identities and subjectivities. More interestingly, both books have something to say about the use of PDA/agoraphobic women as symbols or metaphors of women as heroines who are actively engaged in the process of rejecting a patriarchal, phallogocentric culture and language. Capps and Ochs' text uses this metaphor to construct their protagonist as engaging in an act of resistance, using her panic and agoraphobia to redirect and refuse

the actions of others. They simultaneously develop and analyse the consequences of this form of resistance and its self defeating nature in the protagonist's personal life. On the other hand Garbowsky's text is a refutation of the PDA/agoraphobic as metaphorical heroine or symbol with a focus on Emily Dickinson who has often been used as a figurehead or symbol for creative and resistive possibilities of madness (Berg, 1980). Through the careful exploration of how her writings reveal her agony and struggle, Garbowsky highlights that the celebration of madness only serves to disservice the genuine emotions and pain that has made her work so memorable and brilliant.

Capps and Ochs' book focuses on the detailed interview of a year in the life of an individual PDA woman, and the manner in which this woman, Meg, uses language to reinforce her identity as irrational and emotionally unstable, thereby reinforcing her belief that she is mentally ill, and in need of assistance. Garbowsky's book is quite different, and has a very different purpose. The book hypothesizes that the poet Emily Dickinson was PDA/agoraphobic, and that her PDA can be revealed not only through her life history, but more convincingly, through her letter writings and poetry. Both books convey the importance of language, storytelling and metaphor in the construction and description of the self, suggesting that the PDA/agoraphobic self is partially made through the constant use of metaphors of helplessness. Capps and Ochs' book is perhaps more helpful to this thesis in several ways: its information and analysis reflects some of the interview material and responses within my own research; the book uses more current research on PDA; it is a more thorough examination of PDA; and unlike the majority of writings on agoraphobia in non dominant discourses, seriously considers and integrates

the lived experiences of PDA into its analysis.

Interestingly, the French feminist psychoanalytic thinkers I have mentioned would support my argument against their celebration of the PDA/agoraphobic condition, insofar as my analysis examines how language is used to reinforce a sense of powerlessness and oppression. For them, verbal language is bound within constructions of patriarchy and confine women to specific representations of themselves. The manner in which language is used by Meg and Emily Dickinson is confined by conventions of how women must behave and present themselves to others, but, this is where I differ from these feminists because I believe that this should not diminish the sensations and feelings of oppression and fear that underlie those words. For example, Kristeva alludes to the agoraphobic's use of visual imagery and spatial clues instead of language to develop their sense of self and place as if in the pre-oedipal phase. Kristeva is suggesting that somatic and spatial "speech acts" are as important to the development of knowledge and self awareness as are conventional symbolic language systems. For Kristeva, the agoraphobic failure to communicate in conventional language systems is not a failure, but rather a response to the inability of phallogocentric language to accurately communicate the desires of women; alluding to the potential and possibility of spatial language systems, not only for agoraphobics , but for men and women in general. Agoraphobia is "body talk" for Kristeva. She sees phobia as a failure of the subject's "signifying system" (Kristeva, 1982). The agoraphobic personality, she writes in her analysis of little Hans case study, is "incapable of producing metaphors by means of signs alone... the only rhetoric of which he is capable is that of affect, and it is projected, as often not, by means of images "(Da

Costa Meyer, 1996: 151). What Kristeva does not explore is that spatial and visual codes are as much imbued with patriarchal codes, as are symbolic language systems. Learning by 'means of images', does not return us to a period of empowerment. Visual languages and imagery are constantly transformed through the structures that transform language systems.

In Constructing Panic, Capps and Ochs elaborate on how language practices can be problematic for PDA/agoraphobic women. Meg's experiences are structured as a story with a plot structure of panic narratives. According to the authors, this is because:

Through narrative we struggle to bridge our past, present and future and even imagined lives to formulate coherent identities... Through this storytelling process, we reshape these identities in keeping with who we feel or hope ourselves and others to be at the moment. In this way, our present identities evolve out of complex temporal, linguistically and interactionally organized communicative encounters (Capps and Ochs, 1995:14).

Within French feminist psychoanalytic theory, agoraphobic and hysteric narratives were symbolic of the ways in which women could be silenced within the institutions of language, culture and psychoanalysis (Showalter, 1997:56). For Irigaray in particular, it is precisely the silence of the female produced by the absence of femininity in representational systems of language and logic which has created agoraphobic and hysteric narratives (Whitford, 1991 and; Irigaray, 1974; 1985). Meg's stories are "mined" for their theories of panic in order to gain insight not only into her experiences but PDA experiences more generally. According to Capps and Ochs, Meg's panic narratives present two different theories of panic. One portrays the PDA/agoraphobic person as behaving irrationally in response to a particular location, where the physical location

becomes a reference point for the panic. The other portrays Meg as a rational individual, who legitimately reasons why she should not engage in a proposed activity, but accommodates others, participates in the activity and subsequently panics. In this case, PDA is linked to a communicative language problem and an inability to express negative feelings when faced with an undesirable proposal (Capps and Ochs, 1995:17).

French psychoanalytical feminists would describe Meg's communicative language problems as a part of a larger silencing of women's voices and the pathologising of femininity (Kofman, 1985; David-Menard, 1989). They have chosen to view hysteria and agoraphobia as a rejection of phallogocentric power, the refusal of masculine norms of feminine behaviour surfacing in the form of the speaking feminine body (Strong, 1988:12). The alternative available to the agoraphobic woman is to use her body and mind as messages of desperation and alienation (Moi, 1985). In Cixous and Clement's feminist analysis, agoraphobic symptoms are not the result of pathology but rather the only mode of empowerment open to them. (Cixous and Clement, 1986) The agoraphobic's pathology is therefore reinterpreted by the French feminists not as a case of individual neurosis or disorder, but rather as a structural necessity in a patriarchal order in which the phallus monopolises all value.

Irigaray states that the maternal/woman's body is designated as void, because woman is defined as lack or absence in phallogocentric logic, language and culture. Thus the woman has to mimic herself in order to cope with the discursive norms of femininity (David-Menard, 1989). In so doing the hysteric exposes the normal masquerade of femininity and its complicity with discursive norms (Chisholm, 1994). Thus, Irigaray

sees hysteria and agoraphobia as culturally induced symptoms. “ What is left for woman is both mutism and mimicry, miming a language which is not her own- a masculine language, that caricatures and deforms that language, it lies, it deceives as women have always been reputed to” (Irigaray in Whitford, 1991a: 77).

Irigaray suggests that the silence of the female is produced by the absence of femininity in dominant Western representational systems of language and logic that have defined women as pathological. For Irigaray the origin of that failure does not lie with the agoraphobic but with the symbolic system. Because women are outside of language they must find other means of expression. In other words the agoraphobic is condemned to use her body to represent herself as woman, in a language that does not really consider what woman is, which presents the woman with hyper-real presentations of femininity. Converting their bodies into the site of another language, women communicate in a pantomime mode of fits and starts (Evans 1991: 214).

The woman learns from the hysteric and agoraphobic to assume the feminine role deliberately in order to recognize it and thus to thwart it. The woman does not suddenly escape the patriarchal culture which has produced the hysterical or agoraphobic body, she transforms it for herself and thereby engages in a process of resistance. Irigaray explains:

To play with mimesis is..., for a woman, to try to recover the place of her exploitation by discourse, without allowing herself to be simply reduced to it. It means to resubmit herself... to ideas. In particular to ideas about herself, that are elaborated in and by a masculine logic, but so as to make visible, by an effect of playful repetition, what was supposed to remain invisible: the cover up of a possible operation of the feminine in language (Irigaray in Chisholm, 1994: 268).

Both Capps and Ochs acknowledge that the subjective, multifaceted nature of

narrative is critical to understanding how people perceive themselves and their worlds, but is also reliant on the subjective analysis of others. The authors argue that PDA/agoraphobics spend much of their time ruminating over past experiences with panic and imagining potential panic experiences, and that in doing so PDA is kept alive through these repeated reconstructions of panic (Capps and Ochs, 1995: 21).

According to Capps and Ochs, each of Meg's panic narratives focuses on a central problematic experience, referred to as an inciting or initiating event (Ibid, 39). Meg has constructed a grammar of helplessness, which she is aware of, as did many of the women I interviewed who considered themselves to be plagued by continual and unexpected panic attacks. Meg uses grammatical constructions that frame her panic experiences as irrational by:

Consistently referring to herself in semiotic roles other than agent or actor, 2) using grammatical forms such as modal verbs that frame her action as arising out of necessity rather than a voluntary act, (3) using grammatical forms that imply a failure to achieve a goal, and (4) using grammatical forms that intensify her vulnerability and de-intensify her ability to cope and control (Ibid, 67).

This grammar of constructed helplessness is used in two very different ways, to achieve several different means, as a source of accommodation and non-accommodation to the desires of others. Meg struggles between her desire to satisfy her own wants and to accommodate the wishes of others. The accommodation of others is not a trait exclusive to Meg. In western societies many women have been socialised to adopt certain feminine roles. Popular nineteenth and early twentieth century rhetoric reinforced the view that a woman's worth resided in her contribution and unselfish goodness to men and children

and hence to society more generally (Woolf, 1929). And while this image of feminine goodness was established firmly amongst middle class women of the nineteenth century and early twentieth century, the continual resurgence of social conservatism in the late twentieth century still makes this image of femininity an issue that women such as Meg, and a number of interview subjects within my own research, face today. Meg's communicative language dilemma and accommodation as a source of panic is also discussed within the writings on PDA/agoraphobia as an example of sex role stereotyping, where the socialisation of stereotypical feminine behaviour as helpless, dependent, and unassertive contributes to the development and maintenance of the characteristics of PDA/agoraphobia (See Seidenberg and DeCrow, 1983; Symonds, 1978). Meg's narratives show that she delays revealing her displeasure about a situation until she is well into her panic attack and it is only after the panic attack occurs that a language of reluctance and agony ensues. Then Meg refuses to accommodate, issuing immediate cease and desist orders to co participants in the ongoing activity (Capps and Ochs, 1995: 93).

Alternately, Meg uses her PDA experiences as a source and excuse for non accommodation. There are several narratives where Meg very clearly voices her disagreement about proposed action before the incident occurs. In each of the narratives, Meg sets the agenda, using her panic as a threat to others to take heed.

Meg: I *begged* William, ' *don't* get on the freeway when we take her back to the Marriot. Let's just take the surface streets. Please. I can't *risk* that we might' -(4 pause)... I said I just cant. I *cannot* live through another episode like what I just *endured*. And if we get on that freeway, and we get stalled again in traffic- (.4 pause) I- I just can't *bear* that" (Ibid, 97).

Recently some clinicians and researchers have suggested that one of the payoffs of PDA is that it provides a medical rationale for not leaving an undesirable marital relationship, as well as a reason for not complying with the demands or desires promoted by others (Ibid, 100). In this respect PDA is a means towards avoiding confrontation and disappointment by not having to accommodate to a potentially unpleasant experience.

For Irigaray there is revolutionary potential in this non accommodation of agoraphobia. “Even in her paralysis the agoraphobic and hysteric exhibits a potential for gestures and desires... a movement of revolt and refusal ” (Whitford, 1991a: 47). Mimesis is a form of self awareness and in this respect a subversive tactic. The agoraphobic, within feminist psychoanalytic thinking, is rebellious (Evans, 1991; Moi, 1985). While situating the agoraphobic as heroine can be viewed as disturbing, offensive and callous, it is also productive in that it does not continually place the agoraphobic as victim, rather as an active resistant agent. Seidenberg and DeCrow, whose writings are psychological but widely adopted by non-dominant agoraphobic discourses, describe agoraphobia “as a strike against the renunciations usually demanded of women and the expectations of housewifely functions such as shopping, driving the children to school, accompanying their husband to social events ” (Seidenberg and DeCrow, 1983 in Bordo, 1993:175). Sometimes Meg is actively engaging in resistance in trying to control her surroundings , which has unfortunate consequences (APSN 1997; 1998; Da Costa Meyer, 1996; Seidenberg, 1973). Yet, Meg’s non-accommodation narrative portrays her as constrained by her boundaries, and this sense of confinement is not only physically confining but emotionally confining because Meg does not allow herself to engage in open-ended

negotiations. Meg's stories link her panic to an inability or unwillingness to communicate negative reactions in an effective and appropriate manner. Meg's communicative problems exist across all her relationships. She uses her PDA to set boundaries on her social relations and interactions as well as her physical boundaries. Emily Dickinson's situation is in many respects similar to Meg's. She also has personal communicative problems within her relationships, but unlike Meg communicates her feelings and desires through poetry and writing.

Emily Dickinson is a prime example of a woman who has been celebrated for her madness, in spite of the overwhelming evidence of powerlessness and sadness within her life. Dickinson has written over seventeen hundred poems and a thousand letters, yet she is still considered to be one of the most elusive writers of all time. Garbowsky's book The House Without The Door details the manner in which language and metaphor conveyed Dickinson's illness and agony. Emily Dickinson lived the majority of her adult life, her last twenty years, in the upstairs room, or attic, of her father's house until she died. Her PDA became so overwhelming that by the end of her life she could not leave the attic. For Dickinson language, poetry and letter writing in particular, became her means of expressing, conveying and working through periods of panic and anxiety. And while her poetry is celebrated as brilliant and empowering it is paradoxically tragic and written from a place of perceived powerlessness.

Her poems are filled with metaphors of prisons and images, of pain and darkness, which simultaneously describe her PDA experiences of depersonalization and

derealisation, which are characterised by feelings of detachment from one self, and temporary spatial dislocation:

I saw no way- The heavens were stitched-
I felt the columns close-
The earth reversed her hemispheres-
I touched the Universe-

And Back it slid- and I alone-
A speck upon a ball-
went out upon Circumference-
Beyond the dip of bell- (Dickinson, poem 378, fasc.38, in Garbowsky, 1989: 120)

Numerous other poems accurately describe the various experiences of PDA. In various poems the reader can sense the inherent difficulty of recovery and the delicate balance of her mental health (Garbowsky, 1989: 125). Garbowsky convincingly explores the ramifications of PDA for the individual, using Dickinson's letters and poems to investigate the experiences and consequences of this disorder. She hypothesises that Dickinson knew that because of her PDA the only way she would leave her father's house was through death and yet in her isolation and loneliness she often experienced moments of transcendence. It is through her poetry and writings she "would experience the "paradise" denied her in life" (Ibid, 151) .

The House Without the Door not only develops a literary analysis of Emily Dickinson's writings, but explores the relationship between representations of femininity, madness and authorship. Garbowsky cites the book The Madwoman In The Attic (1979) written by Sandra Gilbert who describes how Dickensian literally and metaphorically became a madwoman. Gilbert believes that "women writers used metaphors of starvation,

madness and enclosure both consciously and unconsciously to describe their struggle with the male dominated literary world” (Ibid, 145). These metaphors were used to dramaticise the high price of creativity for women of the nineteenth century. In this instance agoraphobia is characterised as a defence rather than disorder negotiated through extreme positions. And so while many feminists see Dickinson’s seclusion as a symbolic gesture, a slam on the door of her repressive patriarchal society, these feminists “interpret agoraphobia primarily as a metaphor and ignore that it is an illness with debilitating effects ” (Ibid, 145). The power and control Dickinson was able to exercise over her family, since they were forced to do her bidding, came at the high price of depression and loneliness.

The poet transformed her weakness into strength, transcending her limitation of space through the liberation of words. However if we disregard her illness and interpret her seclusion as a symbolic act, then Dickinson becomes a parody of herself and the force behind her poems is lost (Ibid, 146).

Likewise, when agoraphobia merely remains a decontextualised metaphor or symbol, we trivialise the potency and power of the real life struggles of PDA individuals and the agoraphobic condition, in favour of a staged gesture.

French feminist psychoanalytic thinkers fail to take the real flesh and blood pain and suffering of the person herself into their celebratory accounts of hysteria and agoraphobia. Cixous, Clement, Irigaray, and Kristeva’s comments should be understood as a metaphorical critique, a form of resistance to Freudian and Lacanian hysteric discourse which is predicated on the phallus and woman’s presence mediated by that phallus. However, simply affirming what has previously been negative is not enough for a

feminist project and does not constitute substantive change or progress (Strong, 1989: 24). The resistance that the agoraphobic exhibits is not usually effective or productive and a more detailed investigation of the context and manner in which resistance is displayed is necessary in the theorising of the hysteric and agoraphobic, as has been analysed through the experiences of Meg and Emily Dickinson. It is important to investigate the contexts and consequences in which hysterical and agoraphobic mimicry/ resistance is produced so as not to confuse acts of power and defiance where there are acts of powerlessness and/or elements of both .

No rack can torture me-
My soul - at liberty-
Behind this mortal Bone
There knits a bolder one-

You cannot prick with saw-
Nor pierce with cimitar-
Two bodies- therefore be-
Bind one- the other fly-

The eagle of his nest
No easier divest-
And gain the sky
Than mayest thou-

Except thyself may be
Thine enemy-
Captivity is consciousness-
So's liberty. (Dickinson, poem 384, fasc.31, in Garbowsky, 1989:150)

History Of Gendered Spaces

Illness has symbolic and metaphorical meaning; it is not simply symptomatic of

medical problems. Our bodies are deeply inscribed with ideological and normalised constructions of gender, sexuality, class, and so on. If we treat and understand illness as a symbol not only of disorders in the patient but also as metaphors of social arrangement gone awry, then we need appropriate methods for reading the discourses of disease (Sontag, 1978; Turner 1982 in Turner, 1992: 216). Susan Bordo suggests that the continuum between female disorders and constructions of femininity is revealed through a reading of those disorders to which women have been particularly vulnerable, such as anorexia, hysteria and agoraphobia. The symptomatology of these disorders reveals themselves as textuality: loss of mobility, loss of voice, inability to leave the home all have symbolic, gendered and political meaning (Bordo, 1993: 168). Working within this framework we see that whether we look at agoraphobia, anorexia or hysteria, the body of the sufferer is deeply inscribed with a construction of femininity emblematic of a particular historical period (Ibid, 168). These constructions of femininity are homogenising and normalising, erasing factors of race, class and other constitutive differences, insisting that all should aspire to a standardised ideal. In this way the bodies of disordered women offer themselves as an “aggressively graphic text for the interpreter. A text that insists, actually demands that it be read as a cultural statement, a statement about gender ” (Ibid, 169). In the context of current western culture, where mediums of information are predicated on the visual, rules for femininity and the construction of the feminine have come to be culturally transmitted more and more through standardised visual images as a literal form (Ibid, 169). As a result “femininity has come to be largely a matter of constructing, in the manner described by Irving

Goffman, the appropriate surface presentation of the self” (Ibid, 162). Women learn rules of femininity through bodily discourse, as well as through behavioural discourse, in which we are told where our bodies can move and occupy space. “Neither the appearance of agoraphobia nor the escalating number of victims is accidental. As Bordo has forcefully demonstrated, psychopathologies that emerge within a given society , far from being exceptions to the rule are in fact, products of that culture ” (Da Costa Meyer, 1996: 153).

For Bordo and Turner, agoraphobia is a tragic parodic metaphor of twentieth century constructions of femininity. In particular, agoraphobia is argued to be a metaphor for gendered geographies which have arisen and developed as a result of cultural sex role stereotypes or the feminization of women. This metaphor which is centred on the gendered division of private and public spaces, and how those binaries have created a geography of women’s fear and harassment, has contributed to, as Gil Valentine states, a ‘spatial expression of patriarchy’. “ The notion of a public/private dichotomy has structured much feminist analysis and has attracted a great deal of attention within feminist studies because it relates closely but problematically to distinctions and divisions between women and men” (Bondi, 1998: 160). Inequalities between men and women of various ethnicities, races and socio-economic status are seen by many feminist scholars to be deeply embodied and embedded within the design and organization of space (Peake, 1993; Greed, 1994).

It is commonplace to argue that gender inequalities in late twentieth century urban societies are bound up with an interweaving between gender class and the dichotomies of city/suburb and public/private. To elaborate, feminist geographers and feminist historians have emphasized how, from the first moments of suburban development, the distinction

between city and suburb was imbued with ideas about separate spheres for men and women in which the public domain of the urban centre was both deeply masculine and associated with social, economic and political power. Conversely, the suburb came to be associated with middle class domesticity, femininity and dependence (Bondi, 1998:161).

Public, or 'open', 'democratised' space is often described within the binary as a masculine space of both economic and political production and consumption, while the private space is defined as a 'woman's proper place' - a domestic feminized space of consumption and reproduction separate from the public sphere. Rosalyn Deutsche draws on the political nature of private and public spheres to construct a metaphor of agoraphobia, not simply as a fear of public spaces, but a fear of the democratising of public spaces. Deutsche has taken the literal meaning of agoraphobia, as a fear of the polis where political action occurs, to analyse issues of concerning public art and its democratisation (Deutsche, 1996: 316). Agoraphobia becomes a metaphor for a fear of capitalist, patriarchal systems that reflect and negotiate an understanding of democracy that is grounded in difference rather than commonality (Marion-Young in Deutsche, 1996: 321). This is linked to a rigid private/public divide that consigns differences to the public realm and sets up the public as a universal sphere, a privileged space of politics and a space of social regulation and standardised image (Ibid, 326). Agoraphobia, is, in this respect, a fear of the forms of identification or image that patriarchal structures have constructed and standardised for public consumption. The logic and strength of Deutsche's argument is based on the premise that within a patriarchal capitalist system, democracy's corollary is public space and that "what is recognised in public space is the legitimacy of debate about what is legitimate and what is illegitimate" (Ibid, 273).

Consequently, public space has historically been perceived as “a realm between society and the state, a sphere in principle open and accessible to all, ” where people emerged from their private lives and cast aside private concerns to commit to more common concerns (Ibid, 287). But, as the historian John Barrel is careful to point out: “women were denied citizenship, and denied it absolutely in the republic of taste as well as in the political republic of Greece” because they were believed incapable of generalising from particulars and therefore of exercising either detachment, rationality or public vision (Ibid, 311). Agoraphobia becomes a metaphor of the fear of engaging oneself within a political process, a fear of assuming a political identity or stance. The boundaries of the private/public dichotomy produce a public sphere as a privileged political realm and simultaneously produces a privileged space outside political debate from which the citizen can observe the social world, that is, it produces the agoraphobic private subject whose existence it presupposes (Ibid, 309).

This theme is reiterated within other feminist analyses of gendered spaces where the public or city realm is defined through masculine qualities such as rationality, strength and rigidity, while the private domestic suburban sphere is defined as feminine for its comfort and passivity. In this respect the public domain has come to be more highly valued than the private realm, precisely because of its masculine connotations. The dualistic division of spaces and their gendered associations are more of an ideal or ideology of nineteenth and twentieth century social conservatism than they are the contemporary reality of cities for women and men. It is an ideal which has had, and continues to have, powerful effects on the lives of individuals today by legitimating the

exclusion of women from the polity as well as particular, notably public, spaces during particular times of day. This is one reason why agoraphobia has become such a powerful metaphor amongst feminists.

The interconnections between gender and the dichotomies city/suburb and public/private are understood as ideals or ideologies rather than descriptions of reality. Feminists have long argued that there was a considerable gap between nineteenth century ideal of separate spheres for men and women, which was deeply middle class in its origins, and the daily lives of the majority of the population, numerically dominated by the working classes. (Mackenzie and Rose, 1983; Mackenzie, 1988) In other words feminists have insisted that representations of city and suburb, and of public and private, misrepresent gender divisions, and must be distinguished from the everyday lives of women and men. Thus there exists a rich tradition of feminist analysis that exposes how the spheres of public and private and city and suburb are 'really' interlinked in the lives of women and men (e.g., Gamarnikow et al., 1983; Siltanen and Stanworth, 1984; Pateman, 1989; Morris and Stina Lyon, 1996) A central theme in this tradition concerns the ways in which private and public interconnect differently in the lives of those different classes, ethnicities, races, ages, and so on (Bondi, 1998: 161).

Various feminists have analysed the multiple meanings and gendered associations which have been attributed to the public/private dichotomy, often because these binaries are structured within larger structures of capitalism and patriarchy which construct and facilitate misrepresentations of gendered divisions (Ibid, 161). Thus, the public and private dichotomy simultaneously influences and obfuscates issues of gendered relations and gendered geographies. For many feminist writers agoraphobia is not only bound up in the construction of a spatial and visual feminine ideal, but also in gendered economic structures and the validation of public and private spaces in terms of paid and unpaid work respectively. For writers such as Gillian Brown and Ester Da Costa Meyer, agoraphobia is a spatial expression of the restricted economic geographies that women are consigned to within a patriarchal structure. Thus, agoraphobic metaphors are theorised

in relation to capitalism as well as gender. The semiotics of this anxiety disorder include powerful markers of economics, class and ethnicity, as well as gender that vary from culture to culture, and are articulated differently in terms of space. According to Da Costa Meyer the synchronicity of agoraphobia within the rise of the metropolis anchors it firmly within capitalism. “ Non discursive, symbolic agoraphobic protest through the body ends up by subserving the hated establishment and reproduces sexual division of labour by keeping women at home; which is to say it reproduces capitalism ”(Da Costa Meyer, 1996: 151).

With the spread of a consumerist ideology, the boundary between house and marketplace has eroded. Hence the need for an ideology of domesticity: middle class women were encouraged to consume but also to stay out of the labour market. Agoraphobia can thus be said to allegorise the sexual division of labour and the inscription of social as well as sexual difference in urban space. It speaks after all the same symbolic language as in patriarchal society: the gendered antimony between interior and exterior space reasserts the economic (active) function of the male, and the “non productive” (passive) one of the middle class female. Agoraphobia represents a virtual parody of twentieth- century constructions of femininity. The parodic femininity of agoraphobia is based on a literal interpretation of domesticity as immobility, helplessness and infantilisation- the main stereotype fabricated in the west as a role model for affluent women (Ibid, 149).

Further, Gillian Brown argues that agoraphobia is not only an expression of the dichotomy of gender roles in public and private work and public and private space, but more fundamentally an way in which affluent women can subvert western consumerist societies (Brown, 1987).

Going back to the etymology of agoraphobia, Gillian Brown has reinterpreted it as the fear of the marketplace (or agora), that is, the fear of consumption. In her view agoraphobia epitomises the plight of the individual in a market economy and thus can also be seen as a painful and pathologic attempt to circumvent the consumerist role assigned to middle class women in affluent societies (Da Costa Meyer, 1996: 149).

In particular, Brown focuses on the role of women as consumers, as opposed to productive workers within a patriarchal capitalist system. She maintains that the withdrawal from the marketplace is also a desire to be domestic, and to domesticate the space around her (Brown, 1987: 143). Brown focuses on the role played primarily by middle and upper class white women as the targeted consumer source and the restrictive possibilities this has left for women as a whole, who are stereotyped and generalised as consumers without a recognition that the majority of women are neither white nor upper or middle class, and have been employed within the public sphere for centuries. According to Brown, Da Costa Meyer and Bordo, agoraphobia has become a metaphor for the gendered geographies and economic geographies of white middle and upper class women. This symbolic language of femininity, which belongs to a very specific group of women has been transposed as the 'feminine' ideal par excellence, without the recognition by many historians that this form of femininity is a homogenising representation with little to say about the lives of women from a variety of class, ethnic, and racial circumstances. Both Brown and Da Costa Meyer argue that the presence of women in the public economic sphere has been underscored by historians, who would prefer to structure their history as an organized simplified dichotomy:

The industrial revolution required, among other things, the sexual division of labour and the separation of dwelling from workplace. As a result the social identities of men and women came to be constituted differently. Yet the doctrine of separate spheres- a male public sphere and female private sphere- cannot be excepted today aside from ideology. Numerous historians have underscored the continual presence of women in the public realm throughout the centuries; it was only to men that they had been invisible (Da Costa Meyer, 1996: 147).

The agoraphobic metaphor is enmeshed not only within structures of capitalism

and patriarchy, but moreover, within issues of privilege. As Susan Bordo notes “agoraphobia and anorexia are after all, chiefly disorders of middle and upper-middle class women - women for whom the anxieties of possibility have arisen, women who have the social and material resources to carry the language of femininity to symbolic excess ” (Bordo, 1992 in Da Costa Meyer, 1996: 148-9).

These ‘anxieties of possibility’ are not only evidenced within the public sphere but the home as well. For de Swaan, agoraphobia is a metaphor for the conflictory relationship between western society, sexuality and intimacy. Thus the ideal nineteenth century bourgeois family is compulsively reproduced by contemporary agoraphobic couples (de Swaan, 1981: 367). The agoraphobic metaphor is predicated on the cultural constructions of middle-upper class femininity and ‘family values’ and in this respect agoraphobia is reduced to a cultural stereotype. Yet, as previously mentioned, this disease cannot be universalised, due to its circumscribed nature of social distribution. It does not represent the female condition nor does it address the purely psychological or individual suffering of its victims (Da Costa Meyer, 1996: 153).

de Swaan’s analysis of agoraphobia bridges issues of gendered economic geographies, with issues of family relations and public safety. Agoraphobia becomes a metaphor for woman as symbolic capital enmeshed in the regulation of women according to restrictive, immobilizing social and sexual norms. de Swaan situates his metaphor during the nineteenth century, in the initial phase of widespread industrialization across Europe and North America, when cities went through a period of accelerated growth which created both new opportunities and problems for the bourgeoisie. It ,thus, became

increasingly difficult to maintain both social and physical distance between social classes and as a result, the limitations placed on bourgeois, middle and upperclass women increased, so “that they might avoid dangerous or degrading contact with the lower classes ” (de Swaan, 1981: 362). To the bourgeois mind, the public space of the urban street and marketplace was a space of roughness, violent menace and erotic seduction (Ibid, 363). The limitations of movement for bourgeoisie women accentuated differences in economic and social standing, thus underlining the respectability of these ladies, their families and their husband in particular. Imposed restrictions on women soon acquired added meanings of respectability, chastity and dependency which transformed into collective fantasies about public order, sexuality and violence in the street and about the family as the “haven in a heartless world ” (Ibid, 368). Domesticity demonstrated these women’s economic and erotic dependance on their husbands (Ibid, 363). Agoraphobia becomes a metaphor for the values of a repressed, repressive industrial society reliant on patriarchal structures.

The twentieth century agoraphobic, according to authors such as de Swaan and Da Costa Meyer, reiterates remnants of the “conscious misperceptions of her grandmother”, reproducing the restrictions of nineteenth century patriarchal values, while denying any other motive “except an inexplicable anxiety” (Ibid, 368). The agoraphobic is a woman managing relational conflicts, such as marriage, through the fantasy of nineteenth century bourgeois life:

Significantly the vast majority of cases of agoraphobia develops after marriage. Transition from a state of total dependency on parents to one of expected independence precipitates a crisis, which may result in agoraphobia... agoraphobia is known, to no one’s

surprise, as “housewives” disease (Da Costa Meyer, 1996: 150).

For de Swaan, agoraphobia is moreover a metaphor for the “repudiation of sensuality and the privatization of bodily functions and emotional conduct within societal transformations that have affected the modes of relational and emotional management in intimate networks ”(de Swaan, 1989: 377-8). While standards and restrictions imposed on women and family models spatially and behaviorally have become far more relaxed and fantasies of the home as haven have become less entrenched in the twentieth century, these themes, fears and values are reproduced and reiterated within the lives of agoraphobic men and women , particularly women who are married.

While fears of the public or urban sphere can no longer be legitimated for their potential socio-economic consequences, they are legitimated because of the potential violence and sexuality within public- urban spaces; public harassment, vandalism theft, assault, and rape. Rules of behavior for economic reasons merge into rules of behavior for safety reasons. Management by command is transformed into management by negotiation.

Gardener’s aim in her article “ Out of Place: Gender, Public Places and Situational Disadvantage” and book Passing By - Gender and Public Harassment is in part to suggest that the socialisation and normalisation of a geography of fear is part of all western women’s lives, in the hope that PDA women and non PDA agoraphobic women will join together to politicise their struggles. The metaphor that Gardener draws on to politicise her message is the historical spatialization of patriarchy. Gardener emphasizes that because agoraphobia delineates the ways in which women and men come to

understand public spaces, where women are socialised to distrust public places and the strangers in those places, their fears are something which western culture sustains by supplying a “psychologically stigmatising label for those who have this extreme fear ” (Gardener, 1995: 38) Moreover, because agoraphobia is often described as an irrational phobia of public spaces, a fear of space itself is seen of as baseless and unauthentic, despite overwhelming evidence to the contrary.

Women and situationally disadvantaged groups, in particular, are socialised to be cautious and anxious of entering space. Fearful responses to these situations, far from being disorderly, are regarded as healthy ‘normal’ responses (Gardener, 1994;1995). Carol Brooks Gardener postulates in her writings that public spaces accord greater rights and freedoms to men, and as a result women have to modify their behaviour patterns accordingly to avoid public harassment or injury. In this respect she suggests that agoraphobic reactions which are labelled as pathological are in fact rational emotions, given the extreme lengths and behaviours that non PDA women go to, to protect themselves. Agoraphobia, thus, is a metaphor for the consequences of the socialisation of spatial fears. During particular times, in particular spaces most men and women are agoraphobic without panic. “In the case of rape victims, public space does not exist except as part of a topology of fear. And time not just space is constituent element of agoraphobia; at night in most large cities, all women are agoraphobic ” (Da Costa Meyer, 1996: 152-3). During the night, ‘stranger danger’ and a heightened sense of environmental awareness, which is similar in many respects to the heightened sense of PDA environments during a panic attack, becomes particularly acute for women.

As a result, most women, especially at night, have a heightened consciousness of the micro design features of their environment and they run past crossing the roads to avoid alleyways, indented doorways, over grown bushes and other perceived shadowy areas (Valentine, 1989:386).

Many individuals are fearful of entering dark alleys or unfamiliar public spaces at night, not only because they fear impending danger, but simultaneously because they fear that they will be blamed for the consequences of their actions. This, according to Gil Valentine, is detrimental for women in a variety of ways:

The inability of women to enjoy independence and freedom to move safely in public space is therefore one of the pressures which encourages them to seek from one man protection from all, initially through having a boyfriend and later through cohabitation. This dependence on a single man commonly limits women's career opportunities and general life world. This in turn results in a restricted use of public space by women especially at night, allowing men to appropriate it and hence making women feel unsafe to go out, reinforcing their comparative confinement in the home. Consequently this cycle of fear becomes one subsystem by which male dominance, patriarchy, is maintained and perpetuated. Women's inhibited use and occupation of public space is therefore a spatial expression of patriarchy (Ibid, 389).

Consequently, women are told, and soon learn through experience, and historical precedent, that it is inappropriate and potentially unsafe to be alone in male dominated space, especially at night (Ibid, 389). According to Valentine's study on the geography of women's fear, victims of violence in the public sphere are publicly blamed for being in a dangerous or inappropriate place when they were attacked. This encourages all women to transfer their fears from men to certain public spaces where they may encounter attackers. The other side of this fear of being in public space is for women to adopt false assumptions about their security when in places deemed safe for women, such as the home (Ibid, 385). The house has been both a symbol and haven of safety and privacy and women have consistently been relegated to that domestic sphere. Women are advised "to

make homes their symbolic cities or fortresses ” against the outside world (Gardener, 1994:335). And yet, many current studies and writers have shown that violence towards women is more prevalent within the private home, than in public spaces (Stanko, 1995).

When in public places many women are subject to public harassment such as catcalls, challenges, advice, evaluation, the threat of physical violence and the possibility of being slighted or barred from particular places and service situations. Many other groups of individuals are equally situationally disadvantaged, such as those who are disabled, racially or ethnic minorities or gay/lesbian/bisexual. Gardener argues that women and men are culturally predisposed to understand public territories in different ways, and that, therefore it is not surprising that many of the geographical patterns of PDA and non PDA agoraphobic women are similar. By examining the responses of non phobic women, the tactics of both non agoraphobic and PDA/agoraphobic women can be illuminated. PDA women devise strategies to limit or diffuse interaction with public life. One woman describes that when she leaves the house, “she shakes to the extent that she is forced to crawl along the pavement, she spend her days and nights in the room furthest away from the street which has become her zone of safety, she can’t even look out of a window facing the street without blacking out ” (Gardener, 1994: 337). The non PDA woman’s strategies for dealing with public space are not as dramatic, but are often just as meticulously thought out and executed. Certain non PDA women as well report feeling safer in particular rooms because of limited access to the street for prowlers. Thus typical non PDA responses highlight phobic ones because both groups are concerned with issues of safety.

Women, and young women in particular, are constantly advised by rules of etiquette and civility to discipline their activities both outside of and within the home. For women, changes in appearance beginning with puberty and leading to changes in fashion and public appearance trigger different responses (Ibid, 1994). Thus, women from a young age are constantly aware of the possibility that someone will scrutinise their appearance and draw some conclusion from that. These verbal and visual clues often suggest that women are out of place in certain public spaces. This verbal and visual harassment seems to diminish for many women when they are accompanied by another person, particularly a man, which establishes another precedent for remaining at home, unless accompanied by a trusted individual (Ibid, 1994).

Women are also advised by crime prevention agencies such as the police, to make their homes into greater prisons, by remaining home, at certain times of the day, or by erecting barricades and thinking of their homes as potential battle zones (Ibid, 340). When both non PDA and PDA women are encouraged to securely barricade themselves against public threats, it is easier to understand why certain tactics are shared amongst both groups. Both crime prevention and etiquette, then, converge in the recommendations that there are certain reasons for keeping to one's house if one is a woman. PDA/agoraphobia draws on and exacerbates these tendencies (Ibid, 341).

When women are alone they are counselled to employ protective strategies such as the avoidance of public places, bringing along a companion either animate or inanimate, or careful territorial planning. These are strategies used by both PDA and non PDA women. The advantage of avoidance as a strategy for PDA women is that it limits

the possibility of appearing ridiculous in public. Yet, many non PDA women avoid public spaces to preserve their self image when they believe that they appear untidy, or during periods of low self esteem. Companionship is another means of security, or a buffer to public harassment. Women use objects such as books, walking sticks, or bags to provide refuge, and to avoid being spoken to or addressed, or to act as talismans. But the use of objects differ from PDA and non PDA women. The PDA woman hopes that her object will cap her fear and panic and carries her object knowing that her fear will occur, while the non PDA woman uses her assortment of objects to avoid interacting with others and limit intrusions by strangers.

In both cases there is a shared concern with crime prevention and the necessity to plan strategies. Non phobic women use regional restrictions and mappings as tools to reduce their vulnerability while in public (Ibid, 348). The elaborate mental mapping of city spaces is also common amongst PDA women, but these maps are designed not with an eye to reducing rape, crime and abuse, but instead to alleviate their stress and avoid other individuals. For example, non PDA women will map out the city to avoid criminal perpetrators, while PDA women also avoid sites which may perpetuate panic. And while non PDA women tend to map out larger distances, PDA women map and often think through every step of the journey. In both cases the experiences of particular places, or reactions to those places can become universalised and typologised as landscapes of fear.

Conclusion

What I have attempted to show throughout this chapter is that the experiences of

PDA are connected to a much wider set of social, gendered and geographical relations, and that agoraphobia without panic is a part of the socialisation of gender roles for women in particular. Women with PDA agoraphobia should not think of themselves as isolated or as abnormal, but as a part of a larger community of women. Yet there are some notable differences between the experience of PDA and the experience of agoraphobia, notably panic. These panic sensations entirely change the dynamic of how agoraphobia is manifested and experienced. They become less about the surrounding spaces and more about the body. As a result particular spaces are not only avoided to curtail panic attacks, but also avoided so that one will not be seen to panic. Unlike agoraphobia without panic, spaces are not avoided because one fears that one will be harassed and attacked by others, but because one fears her own response within that space. It is a fear of harming others, or more precisely, a fear of losing control and being seen as unstable in front of other people. So while agoraphobic women tend to avoid spaces for reasons of public safety and harassment, PDA women avoid spaces for fear of public condemnation and contagion.

Agoraphobic women for example typically avoid poorly lit spaces in the dark, while many PDA women find poorly lit spaces at night comforting. What connects these two histories, as will be explored in chapter five and six, is the history of the construction of the feminine, gendered spaces, the female body and its representation, and feminine behaviours in western culture. How does agoraphobia as metaphor and material affect or contribute to an understanding of the lives of those diagnosed with PDA? All of the metaphors identified in this chapter provide some explanation for the experiences and

rationale behind PDA avoidance behaviours, but the metaphor that is most important in understanding the lives of those I have interviewed is that agoraphobia is the reproduction of femininity through the body. The women interviewed all expressed one common theme- a fear of being thought of as ill or mad and, thus, being found out by others through panic sensations. This is, as I will argue in the next chapter, a fear of the hysterical body and its implications as an expression of the feminine. I believe that the feminine has been constructed as a pathology through associated images of madness and instability, embodied in the hysterical woman. Hysteria has become emblematic, the embodiment of hyper-femininity. I believe that PDA women are afraid of appearing hysterical, afraid of the image of the hysterical woman and its negative connotations of weakness, contagion and instability. To some extent this way of approaching agoraphobia provides a new perspective on the experience of both PDA and agoraphobia without panic. I believe that this fear of the hysterical could be applied to an understanding of agoraphobic space more concretely. I am interested in how the visibility of hysteria underscores what is already visible about agoraphobic women: her removal from the public sphere.

One need not be a Chamber- to be Haunted-
 One need not be a House-
 The Brain has Corridors- Surpassing
 Material Place-
 Far safer, of a midnight meeting
 External Ghost
 Than its interior Confronting-
 That Cooler Host.

(Excerpt from Dickinson, Poem 670, Garbowsky, 1989:130-131)

Chapter Five- Constructing the Irrational Woman

Women are frivolous

Women are changeable

Now they adore you, Now they ignore you

Women are lovable

Women are dangerous

One day they kiss you, then they dismiss you

Women are fickle

ever capricious

Truly so charming you'll be deceived

Ah yes, deceived! - La Donna e mobile (Duke of Mantua, Rigoletto, trans. from Italian).

These phrases are not merely the ravings of a forlorn lover, they succinctly address and reinforce a mythology of the feminine which permeates western society and in particular western medicine. *La donna e mobile*, translated from the Italian as the woman in motion, does not refer to spatial mobility, rather it is a reference to the instability and disorder of women's bodies and minds. In the case of both agoraphobia and hysteria the body is caught between movement in excess and paralysis. The woman has no control over her body and thus is rendered immobile. The feminine, and consequentially women, have been pathologised as unstable, deceitful, naturally inferior and irrational. This is a recurring theme within traditional western medical culture and practice. And while twentieth century medical practice has done much to dispel itself of this patriarchal legacy, traces and ghosts of this pathology remain and are reinscribed onto contemporary subjectivities, identities and bodies. Bodies, in particular women's bodies, are reinscribed and stamped by historical and contemporary representations of the feminine. These inscriptions further re-write and re-produce these bodies as sites of struggle evidenced in the daily life experiences of PDA/agoraphobic individuals.

Therefore in order to understand the PDA/agoraphobic condition it is important to draw upon the histories of other disorders and diseases attributed to women because the history of these ailments form an intertwined genealogy; they affect and contribute to the histories of one another. Whether we look at “disorders” such as agoraphobia, hysteria, menstruation or anorexia “we find the body of the sufferer deeply inscribed with an ideological construction of femininity emblematic of the period in question”, the symptomatology of which reads itself as textuality, laden with symbolic, cultural and gendered meanings that help to construct the irrational woman (Bordo, 1993: 168).

The previous chapter analysed the relations between gendered geographies and mythologies, such as the dichotomous split between male and female spheres into private/public, production/consumption, and safe/dangerous. These relations and their history poignantly reveal that agoraphobia without panic, which is rarely discussed within clinical discourses on agoraphobia, not only exists, but is a more common form of agoraphobia within western society which has been socialised and normalised as appropriate behaviour. This history of gendered spaces can be traced within the lives of those who are diagnosed with PDA both spatially and somatically. But the gendered spaces discussed in the previous chapter do not neatly explain the fears, and spatial experiences of PDA women. Instead I believe that PDA geographies can be more usefully situated within a “logic of visibility” that has bifurcated men and women’s bodies, spheres and spaces from one another (Chow, 1992: 105). PDA, rather than being defined as a fear of fear itself, could be defined as a fear of the hysterical image, in other words a fear of the hyper feminine, the irrational incapacitated woman- a fear of losing control in

front of others. This chapter explores how constructions of femininity have affected those individuals diagnosed with PDA.

There are many fears and experiences associated with PDA/agoraphobia.

PDA/agoraphobia is experienced and internalised in as many different ways as there are persons with panic, yet there are underlying themes, which can be traced throughout the narratives and lives of PDA/agoraphobic individuals. PDA/agoraphobia as a fear of fear, or a fear of losing control of one's self, is a predominant theme which emerges within panic narratives, but a more important and less obvious theme that I found in listening and reading PDA/agoraphobic narratives was not simply a fear of fear or panic itself but a fear of the hysterical image. This fear of being perceived of as out of control by others not only emerged as a theme within my research on PDA/agoraphobic women, but moreover links a history of the construction of the feminine to those lives and narratives, and expands the possible insights to be gained from investigations of PDA/agoraphobia. My exploration of PDA/ agoraphobia as a fear of the hysterical image is not meant to provide a set definition or answer to the PDA/ agoraphobic condition. Instead, it is meant to evoke possibilities for discussion and analysis of PDA/agoraphobia, and in so doing establish connections between women and histories of women's illness to one another. Furthermore, as I illustrate in chapter six, there are additional insights to be gained by linking the histories and experiences of 'women's illness', such as anorexia, and PDA/ agoraphobia because they illuminate other connections between women, illness and geography.

I have chosen to focus on the genealogy of hysteria because it encapsulates the very essence of the mythologising of the irrational woman. Hysteria has been linked and conflated with women in many unflattering ways (Showalter, 1993: 286). As Edward J. Tilt, a Victorian physician, notes in his handbook of Uterine Therapeutics “ Mutability is characteristic of hysteria because it is characteristic of women ”(Tilt, 1881 in Showalter, 1985). The hysterical body has become emblematic of all the traditionally negative characteristics considered to be feminine; irrationality, duplicity, theatricality, suggestibility, instability, weakness, passivity and excessive emotionality. The hysteric “is the preeminent figure of immobility for the nineteenth century, whose strange postures freeze normal bodily motion and activity ” (Brown, 1987: 135).

This chapter will unpack what is meant by a fear of the hysterical, through the discussion of what the hysterical image is, and how that image has been traced onto the lives of those diagnosed with PDA/agoraphobia. The hysterical image is simultaneously a symbol of the feminine as spectacle, irrational behaviour, losing control, and excessive femininity, which leads to being visually scrutinised, judged as abnormal/deviant and subsequently punished. The cure advocated for hysterics was in the form of a ‘rest cure’, in a conventional form of domesticity. The domestication of the hysteric in a sense “represents the mobilization of immobility” that characterises nineteenth century western culture and economics (Ibid, 139). Yet, the hysterical body is more than a metaphor for femininity within a patriarchal society. It has become a living shadow or simulacra of womanhood. Because western medical mythology and the literature and art it influenced neglected to sufficiently reflect on the everyday lives and experiences of the hysteric,

these discourses have created an image of the hysterical body, which “becomes indistinguishable from that which it images”; the image and the lived reality of hysteria have been mistaken for one and the same thing (Micklem, 1996: 90). PDA/ Agoraphobia is a fear of the hysterical body and its associated imagery. It is a fear of being thought of or thinking that oneself is losing control and slipping into madness. It is a fear that one’s own experiences are not quite authentic (authenticated) and therefore not legitimate (legitimated). In other words it is a fear that the PDA/ agoraphobic woman will not be taken seriously, that she is just ‘acting up’ and misbehaving. As Edward Shorter describes: “ by defining certain symptoms as illegitimate a culture strongly encourages patients not to develop them or to risk being thought ‘undeserving’ individuals with no real medical problems. Accordingly there is great pressure on the unconscious mind to produce only legitimate symptoms ” (Shorter in Showalter, 1997: 15).

I have also chosen to focus on the genealogy of the hysterical body and its associated representations of femininity because the mythologising of hysteric medical practices have contributed to representations and spaces of womanhood that more closely represent the ideology of patriarchal practices than they do of women. Clinical practice often distinguishes itself by implying a hierarchy between fact and fiction; “clinical ‘truth’ can be ascertained through familiar clinical paths of symptomatic facts and findings” (Micklem, 1996: 106). The distinctions between myth and fact are far more blurred than certain practitioners would like to admit. The mythologising of clinical discourses surrounding the hysterical body and woman cannot be separated from the practices they created. Clinical myths and treatments of women’s disorders contribute to

the production of one another, to images and geographies of women within western culture more broadly, and the popularisation of the image of the hysteric body and the term hysterical. In the previous chapter I argued that agoraphobia has been variously defined and understood as both a clinical practice and a metaphor for a set of gendered geographical histories. Similarly, hysteria can be understood as a clinical practice that affects the lived experience of those diagnosed with hysteria, or as 'hysterical' - a trope for the irrational woman.

Hysterical literature and artwork, popularised in the eighteenth and nineteenth century, are the primary media by which the hysterical body is known in contemporary popular culture. They represent the expanding influence of an eighteenth and nineteenth century medical profession whose scientific knowledge gave it both social and political power, including power over representations of women, where the:

otherness of women and the differences of women became transformed, under the influence of a male, scientific, medical profession, into a pathological disorder-madness- that resulted in the control, confinement and silencing of women. Madness as Elaine Showalter has argued, became a "female malady" in the nineteenth century, the symbol of not just conformity or rebellion but of an 'essential feminine nature'- frail, emotional, melancholic or neurotic- that was observed and controlled by scientific male rationality " (Prestwich, 1993: 114).

Unfortunately, this literature and imagery, which is linked both to gender prejudices of eighteenth and nineteenth western society and the institutionalisation of power over women's bodies, is one dimensional. It fails to address the controversy and criticism of medical practice. Hysterical imagery and literature cannot be taken as complete or even realistic portrayals of the treatment of mental illness in the period. The

images and literature that were distributed and adapted in the nineteenth century failed to show that interments in the asylum were relatively short, and that asylums treated both men and women, which may have helped to transform women from “alluring symbols of madness into ordinary, unfortunate and complex human beings” (Ibid, 115). For example, the paintings that portray the lunatics of the Salpêtrière under both Pinel and Charcot, two of the most infamous nineteenth century hysteric physicians, are propaganda on behalf of a late nineteenth century French clinical profession that was insecure in its power (Ibid, 114).

The genesis of the term and image of the hysterical today is the result of an exercise in eighteenth and nineteenth medical professional power. These images and writings were designed to maintain and control representations of women and the feminine as irrational, morally corruptive and weak and therefore, in need of the moral guardianship of a ‘rational’ clinical or scientific system for care. It is these representations that PDA/ agoraphobic women deal with on a daily basis today. As Judith Butler argues, the particular manner in which something is identified names it into being and often, these identifying practices are governed by authoritative presentations of the subject (Butler, 1993: 13-16). Subsequently, the history of madness and hysteria is not well known; instead the mythologising of hysteria and its associated static medical representations and images are what remain to colour and influence popular culture.

I have provided this background analysis as a challenge to the simplistic images and writings on hysteria generated by clinical professions. I will now analyse and explore how a fear of this image of femininity has affected the complex and diverse lived

experiences of PDA/ agoraphobic women themselves. PDA/ Agoraphobia, a fear of the hysterical, is a subset of PDA as a fear of losing control. The hysterical image of the fear of losing control it is not only a fear of losing control over one self, but of being perceived of as frail, out of control or vulnerable by others, and thus being judged or scrutinised. PDA/ agoraphobia as a fear of the hysterical triggers a panic spiral. Being thought of as unstable only confirms for that person that they are unstable. This makes that individual feel less in control and more vulnerable to the sensations of panic, which are often thought to be heart attacks. Often, PDA/ agoraphobic avoidance behaviours develop from this fear of being seen as abnormal, and the resultant restrictive spatial patterns are more a result of avoiding judgement as opposed to avoiding particular spaces in which the event happened. The women I interviewed were more afraid of being seen in a state of panic, than of actually having the panic attack itself. Many of these women understand their environments as backdrops in which they can camouflage themselves, or stand out to be purveyed by others. It is not that the PDA individual wants to be isolated, but anonymous, and therefore out of public scrutiny. This fear of being seen as abnormal or deviant by others precipitates a fear of panic itself - "this is not normal, and now that someone else knows and I'm going to be found out, I have more to worry about, and a better reason to panic." I am arguing that PDA/ agoraphobic women are not helpless victims, rather they are often placed and place themselves in problematic positions and locations that require struggle to get out of.

The PDA/ agoraphobic woman desires a subjectivity that is autonomous, anonymous and that does not threaten norms of what is respectable or orderly. The public

realm is regulated by banishing from sight behaviours that are considered repugnant, such as madness, or deviance. As Tim Creswell notes, “ it is difficult to get people to recognise normative geographies until these are transgressed... the occurrence of out of place phenomena leads people to question behaviour and define what is and what is not appropriate for a setting ” (Creswell, 1996). The public sphere is seen here as a place of discipline and scrutiny, where one’s identity comes to be characterised as abnormal, deviant or transgressive. And while in today’s society PDA/ agoraphobic behaviour, exemplified by not interacting within the public spaces of a culture, is considered abnormal and unhealthy, occupying public spaces and revealing one’s abnormality or deviance is considered equally if not more unhealthy. The PDA/ agoraphobic woman is faced with a dilemma: remaining in seclusion and isolated are unhealthy activities, which she must strive against; and yet exposing herself to a public which might view her body and actions as mad or abnormal is also taboo.

The individual logic behind PDA/ agoraphobia as a fear of the hysterical varies: The fear of the hysterical may be caused by a feeling of isolation and loneliness, a fear that when one is seen to be out of control or abnormal, one will be abandoned. It may arise because of expectations of motherhood- to be the strong unwavering mother figure. A third logic is related to expectations within the workplace. Finally and more commonly, it can be a fear of visual scrutiny and spectacle. Trying to avoid spectacle is not uncommon amongst individuals with or without panic. The fear of being labelled and categorised as mad and unstable is a normalised response in western culture. PDA women want to be perceived as strong willed, independent and in control. The image of the

hysterical woman is antithetical to their desires. The fear of the hysterical may arise because of expectations to be a composed and strong modern woman. It could be argued that for women in a patriarchal system, PDA/agoraphobia has been an 'acceptable' means of expressing one's anxiety because it reinforces and confirms standards and stereotypes of femininity. But today, these stereotypical images of the feminine as overemotional and prone to outbursts and spectacle conflict with the image of the 'modern woman' of the twentieth century. All of the women and men that I interviewed, formally and informally, expressed some fear of the hysterical image, and the importance of being seen as normal. For them, having others see you as abnormal confirms, validates and reinforces one's own sense of uneasiness and powerlessness.

The Good Woman

The fear of the hysterical may be a result of a feeling of isolation and loneliness, a fear that, when one is seen to be out of control or abnormal, one will be abandoned. This fear of abandonment is often a result of the PDA/ agoraphobic's need to be validated, to be told that they are 'normal' and acting in an appropriate manner. Several of the women, rather than avoiding the gaze of other people and public places, actively sought out spaces where people would be, in order to confirm that they had not been abandoned . These women are afraid that their panic or abnormal behaviour will isolate them from other people, who will then abandon them:

My fear is that I'm going to be judged and I'm not going to have friends because I got angry or said nasty things. Or if I have a panic attack they'll think I'm losing control, I'm not a good person to be around, or a good friend. People are not going to like that because

I'm not some perfect model of whatever, and that I'm not going to have any friends because of it.

Therefore, these women actively seek out people to keep them company and described themselves as outgoing extroverted persons, who enjoyed social situations, and always over-compensated for their vulnerabilities in public. Being around people, strangers or friends were effective strategies for relieving anxiety. It reminded them that they were not alone and most people had no awareness that they were secretly terrified of these individuals:

The only reason I seek out people is because it makes me feel less anxious. I don't seek them, I mean, if they are walking by. It's just because it helps me feel less alone, the idea of not having friends, being abandoned. There are a variety of things that contribute to anxiety I just discovered the major ones that allow me to function. Basically it makes me feel less panicky. I'm a very social person, very comfortable.

These women are not afraid of the hysterical body, because it is a visually scrutinised body; they are afraid of the stigma that the image of the hysteric has left on western culture. These women are afraid that their panic episodes and behaviours are not appropriate and offensive to others, but unlike the majority of PDA women who avoid social settings and strangers, choose to surround themselves with strangers to feel as if they have not been abandoned. These women typically have relied on the validation of others in order to judge the merit of their conduct. They have tried to be good daughters, good wives, good friends and good mothers, but their sense of what makes them good is judged by how others perceive and respond to their actions. This is not only characteristic of their personality types as perfectionists, but reflects the societal norm that women must be accountable and responsible for the welfare of others before their

own. Capps and Ochs describes this role as the socialising of anxiety. According to Capps and Ochs, for their protagonist Meg the housewife is subservient to her husband. Like many other family dynamics, Meg often seeks validation from her husband by directing her stories, questions and concerns directly to him for advice and approval. She uses her narratives not only to make sense of the unnerving events of her life, but to portray her events and emotional responses that she is unsure of as positive in an effort to obtain validation from other members of her family, particularly William her husband (Capps and Ochs, 1995: 121). Meg frequently directs stories about experiences to William. In this way she establishes him in a key position to evaluate her rationality and competence. These interactions rarely help her to make sense of her confusing and distressing experiences. More often than not her storytelling to William and her family leaves her with the sense that her point deviates from the norm and that she is an irrational woman in need of further validation (Ibid, 132). In doing so, Meg positions William her husband as a panopticon- the all seeing eye of power. As used by Foucault in Discipline and Punish, the panopticon refers to a type of institutional or prison architecture, in which spaces both confine inhabitants and expose them to surveillance from a central watchtower or viewing space (Capps and Ochs, 1995: 121). In this way Meg sets herself up to be monitored, when it is exactly the fear of being evaluated as irrational or abnormal that she seeks to avoid. In seeking validation from others she loses her authority to reframe her own experience.

The Good Mother

Meg's instincts to appear normal not only maintain the traditional patriarchal family values which structure her household, but are also meant to protect her children. One of Meg's worries is that when she is anxious she will frighten her children, or set a bad example for her children to follow. Meg, as well as other mothers that I interviewed, expressed a fear of creating anxiety and negative examples for the child. These women attempt to conceal their panic not only within the public sphere, but also within their own homes. One woman described:

I think, no I am, was afraid that someone would find out, that I was losing control, and I was mostly afraid that my daughter would find out; a sense that something was wrong and be scared. I didn't want to frighten my child. I didn't want her to see me losing control. I also didn't want anyone else to know or to worry about me. I wanted to take care of my daughter by myself. I didn't want people to think I was a weak frail single mother who couldn't handle her responsibilities and lost control.

Another of the women interviewed told her children about her PDA when they were teenagers. She told me, that she "tried to keep it from them when they were little because, she didn't think they would understand what was happening to their mommy, and that would frighten them." She decided to tell her children about her history of PDA when they were teenagers because of research that suggested her panic might be hereditary. She felt that her children would be well advised to know that if they had panic, it was a natural, non life threatening event that could be overcome. Nevertheless, for many years she feared having her children know that she had PDA. Similar to Meg, she would try to maintain daily routines that her children came to accept. And whenever she could not fulfill her role as a 'normal' mother, her husband would take over driving

their children to school and after school activities, all the while telling her children that “mommy needed to be at home baking, mommy needs to clean the house, that’s what mommies do”; using the stereotypical mid twentieth and nineteenth century housewife as a way in which to legitimate her housebound activities. Several other women did not have the luxury of a husband to help complete chores. One of the women interviewed is a single working mother with one child. For fear of having someone else see her as vulnerable, this woman did not mention that she had PDA experiences to anyone in her family, despite constant questioning. Not only was it pivotal for her to remain in control for her child’s sake, but also to appear strong and competent in order to show others that her non traditional choice of single parenthood was legitimate. She was often told and reminded of the difficulties and stresses placed on single mothers, and she was advised against it. If others could see her panic, it would confirm her worst fears that she wasn’t strong enough to be a single parent, that indeed single parenthood was problematic both for the parent and child. To aggravate this situation, this woman was a single parent with a full time demanding job. In her situation the fear of the hysterical did not only arise because of expectations of motherhood- to be the strong unwavering mother figure- but because of expectations of her within the workplace.

The Good Worker

All of the women that I interviewed were afraid of the repercussions of their PDA within the workplace. The most common strategies for the women interviewed was to take a leave of absence, to quit their jobs entirely and pursue employment that could be

accomplished within the house, or rely on their partners to supply the family income. In the case of the woman who was a single parent, these options either did not exist for her or were not accessible at the time. She was a woman who had worked for many years at the same job, slowly working herself up the corporate ladder. She describes her experiences within her company and the repercussions of appearing frail in a world that thrives on the appearance of invulnerability, control and strength:

The repercussions for my work... the company viewed me as being weak psychologically... I had to defend my stability and the fact that I was mentally competent and so on and forth... I think they were doubting my confidence because of the time off. So there were repercussions, now I did get recognition for excellence ...But there was that seed of doubt planted by the time off, that wasn't forgiven and was always something that raised caution.

When I asked if other people had experienced similar dilemmas or problems at her workplace she explained that the treatment of female workers may have been more hostile, but both men and women who acted in a 'hysterized' or feminine manner were outcast in a similar way:

Yes, I mean I think there were lots of people who felt a lot of stress I don't know anyone else who discussed it. First of all people don't discuss these problems in this environment because if you do you're labelled. I do know a number of colleagues who took time off because they were stressed overworked but no body ever talked about it. If you want to stay home and hide under the bed you just couldn't cope. It's not spoken off you have to be completely competent at all times. You have to be *allowed* not to be not fully competent at all times. You are not allowed any natural feelings you have to keep it steady you have to be straight.

Many of the other women also described to me the conflicts they had over taking a leave of absence, and the repercussions of that absence within the workplace. Most of the women did not inform their co-workers or supervisors of the Panic and agoraphobia, and instead described themselves as very ill. One woman told her co-workers that she was

recovering from surgery, to avoid the embarrassment of being labelled with a mental disorder, because if they thought she “had some disease, that was a reasonable reason for leaving work.” Thus, even when outside of the workplace, these women wanted to portray their time off as legitimate. Another woman who worked outside of her home prior to her PDA episodes, has set up an home office in case she has to remain at home for a period of time again:

I remember the last time, they kept on phoning me, asking when I would come back. I told them I had panic and agoraphobia, but they figured it would be over in a month or so... When they realised that I wasn't coming back any time soon, I started getting phone calls, 'are you sure this job is what you want, are you going to be able to work again.' So I said to myself, now that I'm feeling better, I'm going to make sure that they know I'm committed to the job... I've turned my basement into a home office, which I use occasionally now anyway. I have my computer and fax and filing cabinets and desk. The Internet is great, I don't have to worry about falling back on my work, I can contact everyone through fax and Internet, I don't have to worry about someone seeing me or even hearing my voice for that matter. But in case it happens again, I'm prepared.

Fear Of The Gaze, Spectacle And The Feminine

The most common theme throughout my interviews and reading was that PDA/agoraphobia is also a fear of the feminine as spectacle, that somehow because one is watched, one's panic will be 'found out', judged as abnormal/deviant and subsequently punished. As one agoraphobic woman described it: “the person who might be there while you panic is just too terrifying so you avoid everyone as much as possible.” One of the aspects of the hysterical body is the extent to which it has placed the body, in particular female bodies, under the watchful eye of others. The history of hysteria is bound within constructions of the feminine as spectacle. The image of the hysterical body as spectacle is reinforced within the history of clinical treatment surrounding hysteria. Sander

Gilman's work on hysteria focuses on the visual representations of treatment and practice. His argument is that the hysteric clinic and asylum were organized primarily around the visual "dominant scopic regime" of the clinical profession, itself derived from a long standing western medical tradition of representing the insane (Gilman, 1993: 359). From the ancient Greeks to contemporary western clinical practice, observation has been the primary way of identifying clinical problems in the body. Hysteria must be 'seen' to have observable symptoms in order to be diagnosed or classified as a disease:

To see the patient means to develop a technique for seeing, a technique that is scientific; the patient in turn, as the object of the medical gaze becomes a part of the process of the creation of the ontological representation of the disease, a representation that is labelled hysteria. This does not deny the underlying pathology of the hysteric; it reflects only the meaning attributed to the symptoms created to represent the pathology as a disease (Ibid, 353).

Even in contemporary medical practice , both clinician and patient shape the beliefs of the patient and define their symptomatology. The techniques for seeing and representing hysteria are based on a theorising of female bodies which have classically been associated with materiality, and with the body, as opposed to men , who were primarily defined by their "rational mastery" (Butler, 1993: 34). This binary tradition confined women to their "fleshly limitations" while men could transcend the realm of the body into spheres of logic and reason (Alcoff, 1996). Women provided the flesh, while men provided the form (Grosz, 1994).

According to Gilman, the Salpetriere encapsulates the connections between the primacy of the visual in medicine and the construction of visual representations of femininity. In 1870, Martin Charcot set up a clinic specifically for hysterics in the Paris,

Hospital La Salpetriere. His work became infamous throughout Europe and North America and physicians flocked to the Salpetriere to see his hysterics on display. The majority of patients that he placed on display to be poked and prodded at, like a petting zoo, were women hysterics. In comparison, the male hysterics he diagnosed and observed did not warrant the same visual scrutiny (Showalter, 1997: 70). Charcot wanted to control the image of the hysteric as a young female in need of the ‘healing gaze’ of a physician, such as himself or his male students (Prestwich, 1993: 111). The women Charcot displayed as subjects were constantly, but not for extended durations of time, subjected to the (male) medical gaze of his students. These hysterics became the object of pathological scrutiny. Many physicians contemporary with Charcot and including Charcot believed that the women hysterics could be cured by exposing them to images and photographs of themselves:

The realism of the photograph was assumed to have a therapeutic function because of its mode of representation...Seeing one’s own difference provided the healthy aspect of the mind with the juxtaposition between the normal and abnormal... He presented his patients with images of themselves that seemed to startle them into an awareness of their madness, because of the radically realistic image of them as demented (Gilman, 1993: 354).

The patients of the Salpetriere learnt from representations of the hysteric how to appear as hysteric. The hysterical woman needed to observe herself in a hysterical state in order to identify and replicate a hysterical symptomatology, which included the arc en cercle position, a position associated with sexual seduction. The image of the hysteric in the medical literature of the nineteenth century is an “essential image of deviance” (Ibid, 362). This image served several purposes: it allowed other clinicians to readily identify

hysterical symptoms and to identify overt female sexuality as deviant, at the same time as it allowed the hysterical woman to shape her identity in an identifiable manner. It is the dominant representation of the hysteric which defines the disease, the treatment of the disease and the patients response (Ibid, 367). These images of the hysteric always assume that there is a normal image of a productive healthy human, and that the deviant is marked by external signs. These signs and movements were often associated and conflated with representations of the feminine, thus, excessive femininity is simultaneously understood as deviant behaviour. Controlling one's body and repressing somatization or feminine gesturing becomes a strategy to appear normal.

The list of tactics and strategies that PDA/agoraphobic women have developed to prevent being gazed at is extensive and revealing. Agoraphobic women have internalised strategies for appearing 'normal', despite their understanding that panic, while catastrophic for the individual, is often not seen by other individuals. As discussed in the previous chapter, these strategies include bringing along companions or items that will conceal their bodies and facial gestures; avoiding spaces and places at particular times of the day where other people tend to congregate or inhabit; constructing elaborate walking paths to avoid being seen; and avoiding forms of transportation that may make them visually vulnerable.

Typically the women I interviewed avoided spaces during the daytime, or used spaces that were concealed from view, exactly what is opposite to conventional safety instructions for women in public spaces. These women were aware of the dangers of walking alone at night or in less visible spaces, but the fear and terror of visible spaces

seemed to outweigh the possibility of attack and danger in public spaces at night. As one of them discussed:

I feel the discomfort, like what if John Doe jumps out at me and tries to assault me, I was abused as a child so I know its a frightening thing. But I'm aware it can happen in any hour day or night, so to me it is less of a concern walking at day or night... So I like night because nobody can see me, I feel more anonymous... I just feel safer its like a blanket protecting me. If I do get into danger there will be fewer people to help me, but I don't think if it that way.

This woman did not exclusively avoid spaces during the day. Her logic for choosing spaces to inhabit and visit were based on the numbers of persons, particularly men, that would be present in the space. She frequently meditated and relaxed in a popular Ottawa park during the day, when the men employed in the area were busy in their surrounding offices:

Yup, I think its called the Remicks Rapids I go to. I sit there for hours. I prefer the day rather than the darkness because during the night its frequented by a lot of people who just want to get off in the bushes and it bothers me. I don't stay too late there when it is dark. All the guys from the government offices are coming out there for quickies.

This woman, and most of those I interviewed, tended to avoid spaces in which male strangers were commonly found, though crowded centres such as shopping malls were also frequently avoided. Another woman described her preference for spaces at night for similar reasons as the woman described above, but she also described a fear of being around others for fear that they would cause her to panic, loose control and possibility hurt someone:

I don't know why I'm usually better in the evening. I think its because I can be alone and I don't have to worry about being seen by other people, being thought of as losing control by others. There's this bog that I like to go to, Its peaceful and serene, and very quiet. I'm more comfortable there, nobody is watching me, and there is nobody around that I could remotely hurt.

Although avoiding places was the most common avoidance behaviour, other tactics for moving through public spaces such as the place or time of day in which one walked were just as important to conceal one's self. Another woman explained:

I like to be close to buildings , or behind trees, off the sidewalk away from the traffic where I can't be seen. When walking down Carling where there are houses, it is hard to run from house to house, so I hide.... I prefer street lamps so I can see where I'm going. But, I walk in a way where people in apartment buildings or in cars can't necessarily spot me because I feel people are judging me. Over the years I managed to put it aside but I guess it was part of my upbringing, but I kind of imagine people and their minds picking me to pieces. It drives me crazy. I prefer not being with somebody in the dark.

Several of the women described their anxieties around classroom experiences.

One woman avoided classroom spaces by taking correspondence courses. Her feelings about exam taking and her presence within the classroom revealed a common theme: " I used to get real nervous just before exams I didn't know if it was more than other people did, I probably felt that way because it fed into ' I'm not going to be able to do this.' and be judged feel like I'm failing." In another situation, one of the women avoided being seen in her classroom by locating herself in the least visible seat, or in the seat closest to the exit, which is a common tactic for most agoraphobics in movie theatres, lecture halls, restaurants and meeting rooms. She describes the process and rational of how she coped with her lectures:

I would sit anywhere somebody couldn't see me, but I was terrified and so sick I couldn't get out of my chair half of the time. I would go into class knowing I would be sick, so I had to set up my environment so I could feel safe. I would sit by a window, always have to have it open, at the back of the class near a door. But even though it was the middle of winter, I would still open the window, but nobody knew.

The environment would be safe if she was able to easily move from one space to another and if no one noticed her within the room. Both of these conditions assured her

that she had control over her situation, and control over the responses of others in relation to her. Generally this woman needed to have control over all of her situations, and that control involved her ability to maintain anonymity. She deplored and avoided when possible:

situations that I don't have as complete control as possible. I find myself having little control and I'm forced to take the bus. I can't stand the bus, thinking about taking the bus makes me worse and anticipating taking the bus when the winter hits is worse. I'm worrying today about the bus ride I'll have to take in January, so I try to block it out. I don't have a problem driving and traffic not a problem, because I still have some control, but if I were on a bus I don't.

Many of the women I interviewed preferred certain modes of transportation. The bus, as a form of public transportation, was particularly feared because the individual neither had control over the driving of the vehicle or how many people would appear on the bus. These women were particularly afraid of being stared at on the bus, fearing that some 'lonely man' would approach them for conversation or gaze at them for the duration of their bus ride. Walking is another feared form of transportation because walking is a slow activity, thus, the ability to get out of a situation could be problematic. The presence of other people walking along the sidewalk and potentially being stopped for directions or conversation was another drawback of walking. These reasons suggested, for those interviewed, an inability to control their surroundings and provoked much anxiety. Car driving seemed to be a preferred mode of transportation, because it provided a protective shield against visibility, conversation, and it allowed the driver to go wherever she wanted at the speed she desired. The car becomes an effective coping strategy that allows these women to move through the city while still remaining anonymous.

Fear Of The Hyper-Feminine: Discipline And Punish.

It seems logical that most people, agoraphobic or not, fear the hysterical body or being labelled as hysteric because the hysterical body is not a pleasant or positive image. What differentiates PDA individuals from people who are not is that PDA individuals fear the hysterical body to the extent that they avoid the possibility of becoming that body by restricting themselves spatially. The PDA/agoraphobe disciplines and consequentially punishes her/himself geographically by self-imposing walls and boundaries. As discussed in chapter three, the agoraphobic fear of the hysterical body is reminiscent of Foucault's description of the internalisation of the panopticon through inducing a self-conscious and permanent state of visibility and surveillance (Foucault, 1970). Walls and visual barriers allow PDA/agoraphobes to conceal the possibility of becoming a spectacle and thus these visual barriers simultaneously become a haven and crutch. Ironically the walls and barriers that isolate so many individuals transform themselves into the PDA/agoraphobe's salvation.

Foucault defined this exercise of power as the creation of a docile body- a body which is simultaneously isolated and connected to a society of 'normalised' bodies. This body is a direct locus of social control where "the movements of our daily lives are trained, shaped and impressed with prevailing forms of identity and subjectivity" (Bordo, 1993: 166). One manifestation of the docile body is the intelligible body, a body made intelligible by normalizing representations and practices of a society. The hysterical body is a specific kind of intelligible body, with its specific histories and representations. The specific form of hysterical body or image feared by the agoraphobic woman is that of the

capricious female. The hysterical body has often been described as a “no-body”: it is a body which draws attention to itself through simulation. Hysteria is often described as a disorder which mimics other diseases and disorders. It has no true legitimacy in and of itself and has come to imply behaviour that produces the appearance of disease (Showalter, 1997: 14). The hysterical body becomes a screen, a tabula rasa, onto which other disorders are projected and inscribed. The hysterical body is therefore problematic in that it can be adopted as a medium to project whatever the interpreter wishes and has been adopted within western culture to project an image of the fickleness of female nature. This capriciousness is linked traditionally within patriarchal systems to processes that minimise the women’s voices and protest.

The fear of the hysterical body is also a fear of being perceived of as excessively feminine, therefore weak and unstable. Theorising disorders attributed to women, such as hysteria and agoraphobia, has involved theorising the feminine and female body. The construction of the irrational woman, vis a vis hysteria, is lodged in the traditions of patriarchal western philosophical and medical discourses concerned with corporeality and knowledge. These discourses have been critiqued by a variety of feminist scholars such as Elizabeth Grosz, Judith Butler, Denise Russell and Elaine Showalter, as problematic for women, primarily because of the close connection between these discourses and patriarchy and because the label hysteria has always been used to discredit women’s political protest (Showalter, 1997: 10).

Patriarchy underlies much if not all traditional western clinical and philosophical traditions. The genesis of western science, philosophy and medicine is rooted in a logic of

patriarchy which necessarily separated women and men into particular hierarchies. The two dichotomously opposed characteristics, mind and body, are further complicated by the inclusion of male /female, masculine/ feminine, outside/inside, self /other and reason/passion dualisms. Lateral associations link the mind/body dualism to these other binary terms, enabling them to function interchangeably within certain contexts.

Dichotomous thinking necessarily ranks and places into a hierarchy these two polarised terms so that one becomes the privileged term and the other the suppressed, subordinated, negative counterpart (Grosz, 1994: 3). Body is thus what is not mind, the feminine is necessarily what is not masculine. Women are placed in the conundrum of being outside reason and logic, by virtue of their sex and the association of body with feminine.

Typically femininity is represented in several ways in this binary system: either the mind is rendered equivalent to the feminine, thus ruling out women a priori as possible subjects of knowledge, or each sex is attributed its own form of corporeality (Ibid, 14). But instead of granting women an autonomous and positive corporeal form, women's bodies are judged in terms of a natural inequality in comparison to men. By extension, women's bodies and minds are not fully normal. They naturally lack the self control and mastery of the male mind and thus are inferior (Russell, 1995: 19). The sex of bodies is further used to explain and justify the different, unequal social and cognitive abilities of men and women. Women are their bodies, more biological, more corporeal, more natural.

Women's bodies are weaker, plagued by irregularities, unpredictable and thus prone to madness.

These beliefs and constructions of female bodies have come under a barrage of feminist criticisms and revisions. More positively, Judith Butler argues that “bodies never quite comply with the norms by which their materialization is impelled”, and thus, there is always a possibility of resistance against normalising practices of the body (Butler, 1993: 2). Bodies are understood within a matrix of regulatory relations and lived realities. This matrix provides a theoretical framework for the reformulation of bodies and identities. It also provides a practical framework of study in suggesting that the complexity of living as an embodied subject must be included in a conceptualization and understanding of agoraphobia, and women’s bodies and experiences more generally. The hysterical body is a constant reminder to agoraphobic individuals that “our bodies are a site of struggle, where we must work to keep our daily practices in the service of resistance to gender domination ” (Bordo, 1992: 184). This necessitates an awareness of the contradictory relations between the ‘intelligible body’ and the transformative experiences and beliefs of women themselves, what I call the lived body. The lived body treats the perspectives of agoraphobic individuals “not as subjugated and disruptive, but as primary and constitutive of our world ” (Hartsock, 1990: 171; in McDowell, 1996: 42). This is done by shifting from the voices of clinicians to those agoraphobic individuals themselves and through an exploration of the interactions between medical practice, representations of women and lived experience. The body of the PDA individual needs to be conceptualised as a site of power, resistance and struggle which has been invested with meaning by outside clinical, social and gendered forces which are then internalized, creating further tensions between the lived body and its context. The body is also re-

written by the lived experiences and life histories of individuals themselves. The PDA/agoraphobic condition expresses and reveals these forms of inscription on the body as well as the power relations they negotiate or reproduce.

It is important to 'listen to' and not just 'talk about' the agoraphobic condition: Why shouldn't a history of hysteria (and agoraphobia) be written? Not one expecting to unearth a micro toxin as vera causa, nor even one tracing progress from medical confusion to medical clarification. But a history of hysteria (and agoraphobia) experiences , that is, of people labelled as hysterical (agoraphobic), or identifying themselves as suffering from the condition , and embodying it in their behaviour: one taking into account all the intricate negotiations , denials and contestation bound to mediate such multifarious sickness presentations... We should expect not a single , unbroken narrative but scatters of occurrences: histories of hysteria(agoraphobia) in fact (Porter in Showalter, 1993: 226).

We need to build an account of the world as seen from those who inhabit and live within it, particularly from the perspective of those whose voices have remained unheard or silenced, such as PDA/agoraphobic and hysteric individuals themselves. It is important to investigate the contexts and consequences in which hysterical mimicry/resistance is produced so as not to confuse acts of power and defiance with acts of powerlessness. In the hopes that PDA/agoraphobes who have acquired (through struggle) the means to speak for themselves will transform/ redefine both the centre and the margins (McDowell, 1996; Rose, 1996).

The history of hysteria is a history of representations of the feminine. When western patriarchal medical practices construct woman as a changeable irrational 'other', they are tracing a self portrait. Indeed the mythologising of hysteria and the feminine do more to reveal the underlying nature of masculinist medical practices, than of any essential female characteristics. It is a mythology which attempts to make " women the

passive, inert objects of a medical will to power” and has some success in doing so (Foucault in Showalter, 1997: 19). It is not dissimilar from the Duke of Mantua’s aria, presented at the beginning of this chapter. The aria “La donna e mobile” is an expression of his frustration with a woman who will not succumb to his will. He is unable to comprehend that women, and in particular Gilda, the opera’s heroine, are complex, embodied social actors. Because the duke is frustrated that he has not secured the admiration of a woman he is sexually interested in, he represents and stereotypes women as fickle and changeable instead of conceding that maybe he needs to work on his own personal skills. In fact when he sings that woman is fickle and changeable he is tracing a self portrait. He is neither self-aware nor reflexive; instead he projects his own flawed characteristics onto others. If he cannot physically control or possess Gilda, he certainly intends to discredit her and her gender. His construction of the irrational woman utilises gender bias and stereotypes in order to strengthen his argument in a patriarchal social context. Yet, his description of women, and consequentially of Gilda, is completely inaccurate. Gilda is presented as independent, brave and thoughtful. Tragically, “La donna e mobile ” is also inaccurate because Gilda is confined to her house by her father, who is afraid that she will be harmed if leaves her home. Similar to so many other agoraphobic individuals, she is trapped, immobile, within a culture which perpetuates her sense of powerlessness. The Opera’s ending is bleak despite its heroic overtones. Gilda defies her father’s orders, exercising her autonomy for the first time by leaving the house and escaping into the city. Tragically she dies while protecting her lover during this empowering act. Gilda’s character was devised as a cautionary tale for women of that

time, but it was also written as a political and social commentary on the gendered politics and geographies of the period. Today it remains as a commentary and marker of the injustice of the gendered divisions of cities and geographies. Gilda's tragedy highlights that patriarchal structures and mythologies need to be questioned and unpacked because they fail to acknowledge and respond to the complexity of agoraphobic women's experiences, desires, interactions and relationships.

Chapter Six- Conclusion - Agoraphobic Geographies.

I guess if there was one place you could go to be you it would be your home, right (HGTV motto)?

Throughout this thesis I have challenged the simplistic divisions that inform the rational subject, such as material/ideal, rational/irrational, private/public, interior/exterior. I have not only challenged these conceptually, but I have explored how everyday experience is negotiated and lived in a more complex manner than those dualisms imply. Unlike the other dualisms I have analysed throughout this thesis, I have consistently argued that the dichotomy between deviance and normality needs to be questioned and dismantled for PDA/agoraphobic individuals, because it is problematic and immobilising. This final chapter will examine how the dualisms that inform the rational subject, particularly normal/abnormal, are part of agoraphobic geographies, and present some future directions and possibilities that PDA/agoraphobic research might take.

It is necessary to understand the gendered and social relations of ideas, spaces, bodies and illness as interconnected and contextual. In this respect, geographical concepts, such as “spatialised feminism”, are useful in situating the social and gendered relations of agoraphobic individuals (McDowell, 1996). Spatialised feminism is another way to describe a feminist geographical approach that has integrated gender-based analysis without fixing a notion of identity, subjectivity or spatiality as static, or separating the category of ‘gender’ from that of race, class, ethnicity, sexuality and disability in an attempt to sustain and elaborate on an integrated feminist politics.

Spatialised feminism represents a broad theoretical critique and political

perspective. It aims to destabilise and to transform gender and spatial relations and hierarchies. It situates theory and research as products of lived experience and place relations. Feminist geographers who question concepts and theory that are taken for granted as gender neutral or universal in character have come to see this as necessary (Duncan, 1996b: 225). Therefore, in my analysis and my exploration of the construction of PDA/agoraphobic geographies the traditional boundaries between private/public and interior/exterior spaces will be remapped and re-examined. While my spatialised feminist analysis is both a process and a project that aims to politicise knowledge claims and geographies as grounded and negotiated within daily lived experience, I do not suggest that daily lived experience is devoid of dualistic divisions. The dualisms that I have challenged and fought against still remain in contemporary western society, not simply as simulacra, but as concrete divisions and ideologies in the structures of western culture and reflected in the spatial organization of cities and bodies. The division between private and public is still among the most important of spatial ordering principles in North America today. The distinction between private and public spheres is deeply rooted in political and social philosophies that construct, discipline, exclude and suppress the actions of individuals thereby encouraging conformity to traditional power structures. For example, the idea of privacy is deeply embedded in western political theories of freedom, personal autonomy and private property (Duncan, 1996a: 128). Moreover, private spaces are regarded as those that are hidden from public view and consequently it is here that autonomy is most effectively enacted, widely respected and maintained.

The private as an ideal type has traditionally been associated and conflated with: the domestic, the embodied, the natural, the family, property, the 'shadowy interior of the household', personal life, intimacy, passion, sexuality, 'the good life', care, a haven, unwaged labour, reproduction and immanence... The public as an ideal type has traditionally been the domain of the disembodied, the abstract, the cultural, rationality, critical public discourse, citizenship, civil society, justice, the market place, waged labour, production, the polis, the state, action, militarism, heroism and transcendence (Ibid, 128).

Thus, the geography of the city is structured into public spheres of debate and exchange while the private sphere is seen as a space of relative non-interference by civil society and the state.

In this thesis I have explored the implications of the spatial construction of gender and identity by revealing how the spatial practices of a marginalised group, such as PDA/agoraphobic women help simultaneously to undermine and to reinforce the deeply rooted divisions of normal/deviant, private/public, interior/exterior, and body/environment. Throughout this chapter I would like to undermine the underlying structures and ideas that form the boundaries between corporeal and spatial public/private spheres, because these boundaries, these dualistic relations of the rational subject, are employed to exclude, control, confine and suppress gendered and all other sorts of difference in favour of traditional patriarchal power structures and hierarchies. At the same time, it is important to acknowledge that while PDA/agoraphobic experiences and geographies challenge and critique the simplistic world of the rational subject, PDA/agoraphobic individuals still yearn for a rational subjectivity where they understand their bodies as contained and controllable. In this respect, a spatialised feminist analysis of PDA/agoraphobia will not only unveil social and gendered geographical relations, but

will explore the layers of oppression that those relations and geographies create (Massey, 1994: 163).

This chapter will examine how tensions within geographical relations of the PDA/agoraphobic women I interviewed are exposed at three scales: the city; the homescape, which often includes both the home, house and the surrounding community; and the individual spaces of and around the body proper. I want to explore how PDA/agoraphobic experiences challenge, modify or reinforce the dichotomous categories of the rational subject within these scales. The previous chapter argued that PDA/agoraphobic women are hyper-sensitive to the ideas, images and structures of western culture and that these impressions are then traced and re-inscribed onto PDA/agoraphobic bodies and identities. These women are informed by the normalisation and medicalisation of histories, images and geographies of women and illness, which are then internalised. This chapter will explore how PDA/agoraphobic women are hyper-sensitive to the sensations and experiences of their own bodies and environments. PDA/agoraphobia, in this respect, becomes a powerful and poignant example of how a person's environment can affect their life. PDA/agoraphobic identities and subjectivities are simultaneously specific, based on individual perceptions and lived experience and multiple, based on a history, imagery and geography of the construction of the feminine and the irrational woman. Furthermore, this chapter identifies connections between PDA/agoraphobia and other illnesses regarded as feminine - in this case anorexia. The construction and territorialisation of PDA/agoraphobic geographies is all about empowerment and the ability to construct a space in which the individual feels secure and

powerful. In this respect, the anorexic body provides an interesting comparison to the PDA/agoraphobic home scape. The anorexic body is an appropriate comparative figure because of the ways in which both PDA/agoraphobic home scapes and anorexic bodies are employed as strategies of protest, that are ultimately detrimental to both the anorexic and to the PDA/agoraphobic.

Agoraphobic Cityscapes

A spatialised feminist analysis asks how social relations, particularly gender relations, are negotiated and embedded in the spatial organization of places (Duncan 1996: 4). The city is a geographical sphere that all of the women I interviewed defined, with some trepidation, as a landscape of fear. Within the PDA/agoraphobic cityscape these social and gendered relations are embedded in the categorization of spaces as private/public, work/leisure, materiality/ideality, male/female, rational/deviant, and self/other. Many feminist geographers suggest that these dualisms do not reflect the multiple ways and patterns in which the city is inhabited and used. Some suggest that these dualisms have changed and adapted themselves over time in a manner which is often insidious and concealed and yet others argue that the dualistic separation of cityscapes is apparent and obvious. What all these writers do agree upon, which is one of the aims of spatialised feminism, is that webs of power/knowledge and power structures must be linked into the social construction and significance of space in feminist geographical theory (McDowell, 1996: 37).

PDA/agoraphobic cityscapes must therefore include a discussion of how these

geographical experiences are linked to the power/knowledge structures within private and public spheres. There are three issues or themes that reoccur throughout this chapter and section. First, PDA/agoraphobic cityscapes challenge the rigid boundaries and categorization of spaces as either public or private. PDA/agoraphobics recognise that spaces can be both private and public, safe and unsafe depending on the time of day, activities within the space, or the stage of recovery.

I know that certain spaces can be dangerous at night, but they can be equally dangerous during the day. You can be assaulted anywhere, that's why I don't mind going out at night so much. It's not that I'm not careful, but I'd prefer to be alone where no one can see me, develop defensive techniques, and go out at night, rather than wander around to do things in the day.... Maybe I'll go out more often during the day when I feel better.

Second, PDA/agoraphobic cityscapes re-inscribe the division of public and private spheres onto other spaces and patterns of movement. PDA/ agoraphobic women categorise public and private space as either belonging to others or belonging to the self. In public spaces their experiences are open to contest, public scrutiny and debate. In private spaces their experiences are maintained as autonomous, proprietary and personal. This division of space into private and public realms is based on the presence of other people, the gaze of others and the ability of those others to judge and articulate their opinions. Thirdly, an analysis of PDA/agoraphobic cityscapes challenges the celebration of fluid boundaries, when those boundaries are de-contextualised. Understanding spatial and corporeal processes as unbounded and in a state of flux does not serve any progressive purpose when those processes reiterate traditional patriarchal power structures, hierarchies and oppressive situations.

Spatialised feminism incorporates an analysis of the structural constraints of everyday experience, the power/knowledge networks and structures that inform social, gendered and spatial relations. Feminist geographers see the identification of oppressive power structures as a step towards the possibility of a progressive spatial framework and politics (Bondi and Domosh, 1992; McDowell and Sharp, 1997). PDA/agoraphobic cityscapes reinforce the traditional divisions of public and private places and spheres. The avoidance of traditionally public places such as schools, universities, civic buildings, marketplaces and city squares, is connected to issues of being seen and recognised as 'spectacle' within those spaces. In the Ottawa-Carleton area all of the women that I interviewed avoided spaces that were sites of festival and celebration including: Parliament Hill and the downtown area during Winterlude, Canada Day, and festivities during the summer. Other sites that PDA/agoraphobic women avoided were places where these women felt that they did not have control over their actions and their spaces, or other people's actions and perceptions of them. Such spaces included shopping centres, cinemas, theatres, large grocery stores, galleries, museums, the Congress and Civic Centres. They frequently avoided celebratory functions such as community get-togethers, friends' parties, school celebrations and work related parties during periods of intense PDA/agoraphobia. It is not surprising that these women would avoid spaces of celebration and festival where people congregate around some form of spectacle.

Nor is it surprising that they avoid spaces such as shopping malls and grocery stores, since the fundamental design goal is to create spaces that maximise the time spent walking around so as to pass by every available product. One woman stated that she

avoided shopping malls because they do not have quick exits and she felt that she could be trapped in the mall. Subjects preferred smaller shopping establishments with a quick access to an exit, and a large parking lot. Several of the women commented on how important it was for them to park as close as possible to the main entrance and to the exit at any of these spaces. But when I asked if they had ever considered applying for a handicapped permit, to allow them to park as close as possible to the entrances and exits, all the women either replied that they had never looked into the matter or were far too embarrassed to do so. They did not want to have a handicapped sticker because this would confirm their fears of being seen as different and abnormal.

Another aim of spatialised feminism is to deconstruct essentialist notions of space and gender by examining the ways in which subjects and places are constituted as multiple and diverse. The PDA/agoraphobic cityscape oscillates between private and public spheres and spaces. Spaces that are full of people and activity become public, while uninhabited places become private. In this respect, activities do not simply occur within a space, but transform the way that space is understood. Conversely, the settings for activities also change the way in which those activities are perceived and discussed. Geographic space is not a 'Cartesian stage on which rational subjects act'. It is in a constant state of transformation, and it cannot therefore be understood as static. Public parks that are uninhabited are a good example of how a traditionally public space can come to be experienced as private. For example, Hog's Back Park, a large public park in Ottawa, was described by several of the women as a haven during the winter or at times of the day when people are not visible within the park. However they described it as a

space to avoid during the summer when the beaches teemed with people. Many of the women described specific public places in a university, shopping mall or civic building, such as a library, as private havens when those spaces were uninhabited or had places that could be isolated and separated from the rest of the building or complex. One woman described how she liked walking on Parliament Hill, possibly the most 'public' space in Ottawa, late at night when nobody was around because it felt safe and private. What is understood as private and public within an PDA/agoraphobic cityscape is not only dependent on the presence of other people, the activities within that space, the time of day or time of the year, but personal experience. The same woman who had described Parliament Hill at night as a safe private space, described another part of Parliament Hill used as a 'make- out' spot at night as public and frightening because of her previous negative experiences with relationships.

The blurring of private and public spheres is also apparent within the coping strategies of PDA/agoraphobic women. One coping strategy that I observed was for PDA/agoraphobic women to plan their chores and errands around the route from work to home, in order to develop a routine and a territory of safe spaces. There were two distinct ways in which the PDA/agoraphobic women I interviewed re-territorialised the city: either along a pathway from home to work, or in a series of concentric, radiating spaces. Many of the women did not work outside of their homes. As a part of the process of their recovery, they travelled from the confines of their immediate homes, to neighbourhoods, to the wider community, and to other communities. However, it should also be noted that many of those I interviewed who were in a process of recovery and re-

territorialising Ottawa's cityscape were still reluctant to leave the Ottawa-Carleton region. One of the women would try to walk an additional two blocks from her house every day, slowly circling out from her house. Her process of recovery was to diminish what she perceived to be a landscape of fear. As the boundaries of the PDA/agoraphobic cityscape subside, PDA/agoraphobic women can begin the process of transforming spaces thought of as public into private. More specifically PDA/agoraphobic women can come to understand that public spaces do not automatically imply a loss of control. The ability of the PDA/agoraphobic woman to walk to her local park may result in that park becoming a private refuge thereby challenging the rigid categorisation of that space as public. The private and public spheres of the city are always in a process of transformation: what was re-territorialised as private safe space one day, might revert back to a landscape of fear the next day when an unexpected panic attack occurs.

The most intriguing discussion of the merging of public and private spaces was a discussion around the safety of automobiles as a form of transportation. As discussed in the previous chapter, many of the women commented that they had little difficulty moving through the city in a car, which they felt both concealed and liberated them. Some of the women felt more comfortable driving or being a passenger; this seemed to be dependant on the person's mood and state of anxiety that day. The Queensway, a major freeway that connects the Ottawa-Carleton Region, was cited by several of the women as a preferred street of transportation, with few traffic lights, high speeds and drivers concentrating, focusing in a tunnel-like fashion on the road as opposed to looking into the passing cars. But, when the car would stop at a traffic light, stop sign, or be caught in

traffic, not only did this produce anxiety because it signalled a lack of control on the part of the PDA/agoraphobic woman but, because of the possibility, that during that period, other people would look into the car. Several women, as a coping strategy for this problem, had a spare set of sunglasses and scarves in the car to conceal them in such a situation. Unlike other forms of transportation such as the bus, or train, the car is a symbol of private property; it is in effect a 'mobile home'. Unlike modes of transportation like walking, the car provides a layer of protection and a quicker escape from a situation. The automobile as a form of transportation has often been associated with notions of personal freedom, individuality and mobility. The automobile has been celebrated and mythologised as emblematic of progress, democracy and liberty. In this respect, for many PDA/agoraphobic women, the automobile has come to embody virtues of the public sphere within a private space, an ideal way to experience the city without losing control - the agoraphobic mode of transportation par excellence.

This exploration of how PDA/agoraphobic cityscapes are experienced , understood and constructed serves as a constant reminder that the celebration of the interchangeability and permeability of spatial categories and places themselves must be informed by how those geographies come to be experienced. The movement of boundaries enables the PDA/agoraphobic individual to feel powerful and mobilised. PDA/agoraphobic individuals aspire to have permeable spatial boundaries in the city, to be mobile subjects, to re-territorialise spaces, because this mobility is enabling. Yet, this analysis has also shown that the manner in which spaces are re-classified is based on gendered ideals of the public and private spheres and the oppressive power relations that

structure the separation of those spheres, such as the logic of visibility - the belief that one must constantly monitor one's body (Chow, 1992). Upon closer inspection and examination, the dualisms of private/public, seen/unseen, normal/abnormal, and self/other are re-inscribed and re-placed onto other spaces and places. The gendered division of private and public spheres and spaces traditionally encouraged women not to inhabit or to be seen within the public realm. PDA/agoraphobic women, in an attempt not to be seen and subvert the disciplinary gaze of others, become compliant to established norms and geographies of femininity and feminine behaviour. PDA/agoraphobic individuals are, thus, simultaneously subversive and compliant to patriarchal structures. The traversal/transgressing of boundaries does not automatically result in a progressive or positive outcome, particularly when this process is linked to oppressive structural relations and experiences.

Agoraphobic Homescapes

Similar to the PDA/agoraphobic cityscape, the divisions of private and public spaces are transformed over time and stage of recovery as the 'home' comes to take on a variety of spatial meanings and geographies. The perception of what one's home is may change from day to day, over a period of months, years, or decades. The 'home' also can be identified as a collection of spaces or as a particular space within the house such as a bedroom, attic or office. The isolation and confinement of the PDA/agoraphobic woman in a particular room often occurs after severe panic sensations, or disputes with members of the household. As discussed in the section on cityscapes, the 'home' can be identified

within the spaces and places of the neighbourhood. Most of the women I interviewed extended their safe homespace into their surrounding community and several of the women mapped out pathways that they would have to walk through every week, as a part of their recovery. Alternatively, neighbourhood areas were perceived as potentially dangerous spaces, because neighbours might think that something is wrong, judge and spread gossip about their “strange neighbour”, according to those interviewed women. One woman drew the blinds and curtains in her house, specifically during her period of agoraphobia and panic, so that her neighbours would not peer into her house:

It is an older neighbourhood, so we are a tight knit community, and you know stuff, gossip gets around. There are a lot of elderly people working in their front yards, surveying the neighbourhood for problems. I don't want them to turn me into a problem, I know they'll talk. So I close the curtains and blinds when I'm in the house, that way they can't see me if I panic, and I can't see them whispering.

The ‘home’, for some PDA/agoraphobic women, may only exist in the memories of childhood homes. Several of women explained that they did not feel they had a home. They did not feel that there ‘was any personal private space for them’ or a space that was secure enough to for them to regroup their thoughts and experiences:

What does home mean to me, well nothing right now, I don't really feel like I have a home, I'm always at odds with places because I'm always afraid of having a panic attack, I don't feel that any space is secure or safe. I guess when I think of home, I think of where I grew up, not to say that where I grew up was always pleasant or safe, but its what I think of when I think of home. I guess they were just safer, more innocent times

When these women were asked to identify what home meant to them, home was often described as the space of pleasant childhood memories involving parents or other family members. Finally, the ‘home’ may be located in specific places of refuge outside of the house, such as a workplace office, a friend's home or park bench:

For a while, my home was in my office. I could shut the door and close the blinds and get some sense of composure. I didn't want to go home to my husband, to hear him complain about how I need to get over the panic and run errands. Here in my office, I can control my paperwork, I'm the boss and I don't have to deal with constant criticism.

Ultimately, the home scape in its various manifestations, implies a space of comfort, control and pleasant associations or memories.

The meaning of 'home' itself as a private space is contested amongst some of the women interviewed. For some women, the home is just as publicly oriented and understood as the traditionally public space of the street or the city square. One of the women interviewed described how the experience of having to celebrate her birthday at home, transformed her house into a public and fearful place. When her guests arrived, she could barely remain in the room, and spent most of the evening upstairs or in the washroom trying not to panic. As she thought about her friends asking questions about her behaviour she began to have a panic attack. When the party was over, and her friends had left her house, the house became a private and safe place again.

A more complex investigation of how place and space are constituted, also involves an exploration of how those spatial relations are embedded in the organization of spatial structures. Most women during their initial panic and agoraphobic episodes reinforce a stereotypical division between private and public spaces, where the private is located within the house or home, and the public outside of the home. This has been seen as problematic for many feminists, who see the designation of the home as private as limiting the role of political institutions and social movements in changing oppressive power relations within the family, and household (Duncan, 1996a: 131). More

importantly, PDA/agoraphobic home scapes similar to non PDA cityscapes are informed by the separation of self/other within private and public spheres. This separation of self/other reflects a desire on the part of the PDA/agoraphobic woman to establish and maintain control over a specified domain. This desire is not dissimilar from the anorexic's desire to control her body.

One of the aims of a spatialised feminist analysis is the ability to forge alliances and connection between groups who are differently positioned in the hopes that this will open up new areas for the discussion and create alternate discourses which would provide more interactive, dialogic and potentially enabling ways of understanding the identities, subjectivities and geographies of PDA/agoraphobic women and other marginalised groups (Duncan, 1996:37). In this respect, a comparison of anorexic bodies and PDA/agoraphobic homescapes is not only a good point of comparison, but may ultimately open up venues for the discussion of women and illness. The anorexic body is discussed in a variety of ways: as a crystallisation of constructions of femininity within western culture, as an available arena of control, and as an act of protesting one's personal situation (Bordo 1992; 1994; Brumberg, 1988; Bruch, 1978; Caskey, 1986; Chernin, 1981; 1985; Orbach, 1986). The PDA/agoraphobic homescape, like anorexic bodies, can be approached in a variety of ways: as an example of the 'feminine' or domesticated nature of the private home, as one of the spaces in which PDA/agoraphobic women can exercise some form of control over their lives and situations, and as an act of protest.

Both the PDA/agoraphobic homescape and the anorexic body constitute radical refusals to participate in a world always in a state of flux. Both PDA/ agoraphobics and

anorexics secure the boundaries between self and world and self and other, fulfilling the ideal of domestic privacy that has often been associated with constructions of femininity and motherhood (Bordo, 1992;1993). While the anorexic devotes all her energy to the enterprise of controlling desire, regulating the passage of food to and from her body, the PDA/agoraphobic regulates the passage and presence of people and activities within her home. Both the PDA/agoraphobic and anorexic, while denying themselves and foregoing access to food or to the outside world, are often consumed and dedicated to the consumption of others (Brown, 1987:148). In this way, both assume the traditional role of woman as nurturer and care-taker of others. Anorexic practices, like PDA/agoraphobic strategies, manifest domestic functions in extreme forms. The literature of PDA/agoraphobic sex-role stereotyping and PDA/agoraphobia as the 'housewife's syndrome' focuses on this interpretation of PDA/agoraphobia as an embodiment of the domestic ideals and cultural dictates placed on women's bodies, functions and spaces (Brehony, 1983; Fodor, 1974; Seidenberg and DeCrow, 1983; Seidenberg, 1973; Symonds, 1973). One of the women I interviewed explained to me how her PDA/agoraphobia was a good example of the tensions experienced within the 'housewife's syndrome'. For her, the house in which she lived was her refuge from panic but also her prison. She described how she had been socialised to believe "how being a good mother and good wife were the most important duties a woman could aspire to." Shortly after marriage she began to experience sensations of panic and could not comfortably leave her home. She convinced herself that this was a blessing in disguise because it focussed her attention on her husband and children. She felt that in her home she could control and

monitor her own actions as well as the actions of her family through withholding or allocating household chores:

All of my life, I was led to believe, that I should be a good mother, but when the panic first came, I thought there was no way I could be a good mother and wife. I knew I was losing it, but I needed to show my husband and small children that I could still handle things... I began to realise that maybe this agoraphobia was a good thing. I mean this way I had to remain at home and take care of the house. I soon realised that this also meant that I had power in my house. I mean I could tell people what to do, out there, out of the house, I have no control, I'm just a middle aged woman. But inside here I'm in control, I tell my boys what to do and they listen. My family knows you don't mess with me in the house.

Through embodying the role of a traditional middle class housewife this woman felt that she had some sense of power in her household, which distracted her from her overwhelming fear that she could lose control over her body at any moment.

Both anorexia and PDA/agoraphobia are immobilising disorders, but unlike the anorexic whose coping strategies of withholding food can prove to be fatal, PDA/agoraphobic coping strategies are problematic but typically not fatal. Because the separation of private and public spaces has incorporated the separation of women and men as a cultural norm, coping strategies for PDA/agoraphobic women within the private sphere are built into traditional family structures. Several other women I interviewed had their PDA/agoraphobia precipitate after marriage as well, but in those instances, the women had supportive husbands, who took over tasks outside of the house, actively encouraged and supported their wives and families on their single income. These married women had all worked in a stable job before their episode and were on sick leave during the period of their PDA/agoraphobia, thus they could look forward to having a stable income in the future.

Most of the women that I interviewed were not married. For these single women being confined in the home presented similar problems, such as how to generate income or complete tasks outside of the home. These women relied on the generosity of friends or partners to run errands outside of the household. Several of the single women had very little or no money during their PDA/agoraphobic periods. They survived on student loans, odd jobs close to their homes, or had to ask friends and family members for money. One woman described her coping strategies at the time when her PDA/agoraphobia was most acute. She was housebound, more precisely room bound. By this point she had lost contact with most of her friends and family because she could not see them socially and as a result she had no available immediate support system to assist her with errands. At the time she lived in a house in the downtown area. In order to run her daily errands, she would ask homeless teenagers, walking in the downtown area, to run these errands for her for a small fee. She described this arrangement as very successful. These and other coping strategies allowed the PDA/agoraphobic women I interviewed to function and survive despite their overwhelming sense of immobility.

The length of time spent isolated in the homescape was a period when some of the women were able to regain a sense of self. By having a space in which they felt empowered, they allowed themselves to focus on the personal repercussions of their panic episodes. The PDA/agoraphobic home scape became a stepping stone, a place to regroup thoughts and feelings in order to move out of the house and into the landscapes of the city. In this respect, PDA/agoraphobic home scapes also can be understood as a space of resistance to panic sensations where the individual can reflect on the barrage of images

and messages that PDA/agoraphobic women receive. It is a space of protest against the excesses and sensations PDA/agoraphobic women must filter everyday. This space of protest, unlike the anorexic body, is not always debilitating over the long term because it can result in the increasing mobility of PDA/ agoraphobic identities and subjects.

However, the PDA/ agoraphobic homescape can also be a space of self-defeating resistance/protest. One woman that I interviewed, whose panic and agoraphobia occurred at a point in her marriage when the relationship was deteriorating, used her panic and agoraphobia to show her husband that she needed his help and encouragement and to protest his “abandonment” of her. Unfortunately, the panic attacks did not have the desired effect of gaining her husband’s attention. Instead, they precipitated more resentment, fear, thus, more panic attacks. This led to a minor depression which further exacerbated her fears of abandonment and helplessness. Another woman described a similar situation. When her panic began she felt she was telling her husband “I’m gone, what are you going to do about it.” She was fed up with her husband’s unwillingness to help with tasks around the home or with the children. This woman stated that “she probably subconsciously began the panic attacks because she wanted to punish her husband” for his negligent behaviour, by forcing him to be attendant to her, her needs and the needs of their family. Her husband responded to her panic attacks mockingly. This led to further panic attacks, insecurity and anger. Here the PDA/agoraphobic homescape became a counterproductive site and medium of protest.

This analysis of the PDA/agoraphobic homescape has highlighted several key issues. Whether we look at a rational or postmodern/poststructuralist subjectivity and

geography, the central issue is whether spatial, social and gendered relations are restrictive and/or dis-empowering. Within PDA/agoraphobic homescapes we must recognise that PDA/agoraphobic subjectivities and spatial networks are contextual in nature, and thus incorporate a complex web of relations of resistance, domination and subordination. For example, PDA/agoraphobic homescapes are always in the process of transformation, and in this way they have no fixed character or set boundary. At the same time however, the PDA/agoraphobic homescape can reinforce the stereotypical gendered nature of the 'home' or domestic sphere, repeating patterns of oppression within the history of gendered spaces. By remaining immobilised in the home and by the boundaries of that home, PDA/agoraphobic women re-inscribe those places and their family relationships through domesticated ideals that further immobilise them. Ultimately, these geographical experiences of PDA/agoraphobic women are tragically self defeating. Ironically, if not tragically, PDA/agoraphobic women, who fear and attempt to avoid stereotypes of femininity, of being seen as spectacle, or being perceived as feminine, retreat into the spaces historically attributed to the feminine, and in so doing produce a subjectivity which is inexplicably linked to femininity. By remaining out of the public sphere, away from other people, PDA/agoraphobic women reinforce the patriarchal belief that a "woman's place is in her home", even if that home produces and results in problematic circumstances. It is the spaces of the home and the private which come to define and produce the image of a 'mainstream' PDA/agoraphobic subject. The domestication and immobilisation of PDA/agoraphobic identities and subjectivities suggests the importance of the ability for these women to be physically and psychically

mobile - to move beyond the dualistic and prescribed boundaries and geographies of the rational subject.

Agoraphobic Bodyscapes

It is at the scale of PDA/agoraphobic bodyscape, the spaces both inside and immediately outside the body, that the initial conflicts and problems of PDA/agoraphobia begin and thus, inform the geographies of PDA/agoraphobic women at the scale of the home and city. It is at this scale that ideals of a postmodern plasticity are problematic, but it is also at this scale that a 'postmodern plasticity' might be most enabling and important for PDA/agoraphobic women. The PDA/agoraphobic bodyscape unintentionally disrupts the divisions between self contained body and environment in a variety of ways: the para-sympathetic experiences of depersonalisation, de-realisation and a heightened awareness of the PDA/agoraphobic's body and environment. In ways that parallel the impulses behind PDA/agoraphobic home scapes and cityscapes, PDA/agoraphobic bodyscapes challenge, reinforce and embody the dichotomous separation of spaces and bodies as either public/private, internal/external, rational/abnormal, and real/imagined. And bodyscapes question theory that does not interrogate questions of difference and context within the reconceptualisation of health and illness. The body is not simply a medium of theory, "a surface to be mapped or inscribed, a boundary between the individual subject and that which is other to it, a container of individual identity, but fundamentally a boundary which is permeable and penetrable" (McDowell and Sharp, 1997: 3).

The PDA/agoraphobic body is in many respects a “no-body” because the traditional boundaries of the body become blurred and intermingled with one’s internal and external environments. This is not the “no-body” of the hysteric described in the previous chapter that is thought to mimic the appearance of disease, it is literally a “no-body”, literally the sensation of a loss of corporeal and environmental boundaries. The three ways in which this “no-body” is experienced and produced are: depersonalisation, the feeling that of being disassociated or detached from the body; de-realisation, the sensation of being detached, “slipping away” from the environment; and an increased awareness of external and internal sensations (Health Canada, 1996). All three are often experienced simultaneously or within a specific panic attack. The sensations of depersonalisation often result in perceptions where the body is no longer understood to be there. One PDA/agoraphobic woman I interviewed described this process as unreal:

Do you remember ever having a feeling, you look in the mirror and you think about leaving yourself and it is scary, like you were fading out... I seem unreal to myself. Cause when I’m on the phone and suddenly I start having a panic attack and I look down at the receiver. I look at my hand but, to me it is not really my hand. It’s essentially the same, it’s like stepping away from my own conversation.

The PDA/agoraphobic woman becomes a “no-body” because she no longer has a sense of her body as real or concrete; it exists as a “two dimensional image” which is disconnected and foggy; and/or the PDA/agoraphobic woman experiences a separation from her body - as if she has two unreal bodies, a phantom body which overlooks a two dimensional body. The experience of depersonalisation is manifested as a loss of control over the body. “I feel like my body has a mind of its own and I don’t feel connected and I panic, its like it decides for itself what it is going to do.” All of the women

described how their depersonalisation was accompanied by other physical sensations of panic such as breathing problems, chest pains, headaches, irritable bowels, increased blood pressure, a general sensation of loss of control over bodily functions, accompanied by a “feeling like there is nothing you can do about it.” Through depersonalisation the PDA/agoraphobic body scape becomes a space of powerlessness and fear.

Impurity is often attributed to this instability over bodily functions and is anathema to the rational subject. As Mary Douglas explores in her text Purity and Danger, the clear demarcation of corporeal boundaries is necessary in the functioning of a ‘rational’ society (Douglas, 1966). Her work focuses on the movement of bodily fluids and substances beyond the human body which become sites of contagion that are impure and dangerous. Analogously, the attribution of aspects of the self and mind outside of the body possibly signals contagion and danger, not only for those individuals but for others. Rational subjects who function in these societies must be able to control and isolate their bodily processes as well as their actions and thoughts, and thus become accountable for polluting spaces and persons outside of their body. Depersonalization is a form of this impurity which results in the attempt to re-establish a rational subjectivity in the form of avoidance behaviours.

The experience of de-realisation produced a similar sense of oppression and anxiety for those interviewed. The feeling of slipping away from one’s self - the PDA/agoraphobic woman feels that she is slipping away from her environment, that her environment is becoming unreal. De-realisation is another way in which the boundaries between self and environment become intertwined:

As I was approaching the building, I suddenly felt as if I was... the buildings were no longer there...the streets became blurred, I felt dizzy and yet I know that I wasn't falling down or walking strangely... I wasn't happy... I was moving at a different speed I was just going by, I couldn't focus on myself anymore, and the space was no longer even there. I felt as if I was moving at a slow motion pace, that everything around me was faster and more intense. I felt as if I was no longer there, it was just speed and space.

De-realisation is not dissimilar from aspects of Homi Bhabha's 'third space', an in-between space where the negotiation of time and space relations and perceived incommensurable differences creates a spatial tension (Bhabha, 1994:218). Bhabha, in relation to global and local social movements, identifies a 'third space' as a space continually opening out and remaking boundaries. The PDA/agoraphobic 'third space' is one of fear, struggle and resistance. This in-between space of de-realisation also results in a "no-body". So much attention is focussed on the transformation of the surrounding environment that the PDA/agoraphobic woman forgets that she has a body. During de-realisation, all of the women I interviewed described a heightened awareness of sounds, smells, colours, textures in their environments. These women described spaces around them getting foggy or darker, tunnelled, constricting, spinning, dropping, and unbalanced: For instance I walk out of my door, and I'm downtown near Catherine Street. The street would seem kind of foggy and the dark down the street looked so much further than it really was. The street would feel off kilter, you would feel unbalanced. Sometimes the road in front of the sidewalk would feel like it was dropping and your next step you were going down. The noises were louder and more profound and upsetting, petrol smells and that kind of thing got worse. Everything is intensified.

During a heightened sense of both internal and external environments, PDA/agoraphobic women blur the boundaries between self and environment, where they literally become the sensations of their body or the sensations of their external environment. The PDA/agoraphobic body scape becomes a series of organs, processes,

pains or sounds, smells and sights, but not a coherent body. The PDA/agoraphobic bodyscape is subsumed into the sounds and sensations of bodily processes and/or external stimuli:

I leave my body and somehow I actually am worked into the noise of my body and the outside, and it's overwhelming - the noises and the sounds. I know it is not a right feeling and I couldn't walk if I had to during the panic, it's strange. Voices and sounds are heightened and I slide into a feeling that I'm no longer connected to myself. I don't know why it happens and it happens everywhere.

Interestingly, while the heightened internal/external sensations or depersonalisation of the PDA/agoraphobic bodyscape typically blurred and transformed what was perceived as inside and outside the body, several of the women used this heightened awareness to re-establish a sense of somatic boundaries:

Did I have a heightened sensitivity to my own body and body functions? Absolutely!. My heart - I could hear it the rushing sounds and my body noise. Like I said the outside environment kind of goes away. There's recognition of what's going on but I don't care what's going on around me. I'm there but I'm not. But, I have a heightened sense of sounds, it's almost a desire to focus to what's going on inside of yourself and anything that distracts you from it is annoying...I don't care what is going on around me.

Conversely:

What happens to the space around me? I remember pretty much to notice what is happening in the moment when I am panicking. I'm thinking this is my environment and I will notice everything that's going on, and I will panic in that environment and try not to avoid the things I see and hear outside in order to avoid the things I feel in my body. As much as I am noticing everything, I have this shield going on, I don't want to be more focused on my body. It's scary, so I focus on what's going on in my world that I shouldn't be noticing, because it's all too much, but I'm searching for something to distract me.

In the first scenario the PDA/agoraphobic woman focuses so exclusively on her body that she becomes those sensations. In the second scenario the body and its

sensations are avoided. De-realisation, depersonalisation and a heightened sense of one's body and environment occur at the geographical scale of the body. All of the ways in which the PDA/agoraphobic bodyscape is experienced attest to the importance of understanding the way in which we produce space and perceptions based on somatic experiences. The experiences of a heightened sensitivity to the PDA/agoraphobic body scape, depersonalisation and de-realisation are all part and parcel of the para-sympathetic nervous system's response to fear. While traditionally the experience of agoraphobia with panic has been a marker for the disordered, unwell body - a signal that there is something wrong with the body, and a way in which to reify the bounded self of the rational subject as a marker of mental health and normality - it should be understood as an excessive natural response. Panic is associated with a "flight or fright" response to immediate danger, in which the body is prepared for immediate escape from the situation" (Health Canada, 1996: 4). This "flight or fright" response is described by clinical practitioners as an intense period of fear, but this response is neither limited to panic sufferers nor uncommon amongst individuals generally. Without a "flight or fright" response, individuals would not respond to immediate danger. In this respect, the dissolution between boundaries of the self and environment, or self and other for the PDA/agoraphobic, is not unnatural, but highlights what the majority of individuals fail to recognise in their own lives. The fluidity of boundaries between the body and its surrounding spaces, the production of space vis a vis our bodies is not exclusively the property of the 'disordered.'

The painful and frightening near heart attack-like experiences of panic cause

PDA/agoraphobic women to question whether they are in control of their bodies. The belief that they have lost control or may lose control is perceived by these women not simply as unhealthy, but as abnormal. Given this insecurity, any indication of acting strangely reinforces the fear that one is losing control. Thus, the fear of losing control simultaneously becomes a fear of being seen as out of control or deviant. In this way, PDA/Agoraphobic bodyscapes reinforce and embody distinctions between private/public and self/other which results in further anxiety and the labelling of their bodies and identities as abnormal or normal.

In a world where the rhetoric of ever increasing permeability and movement through information technology, global economic systems and the fear of millennial breakdown is ever present, the body becomes a space of assured control. When that space is violated, when one's body is seemingly penetrated and transformed not through one's desires or one's choice, but through some other inexplicable means, the sense that order needs to be maintained through one's body is heightened. The implication and underlying assumption about an individual who desires transgression or the traversal of boundaries is that this individual has been able to maintain some sense of stability. To break down boundaries, boundaries must have been established. Thus, rational and postmodern/poststructuralist subjects are not dualistic, but presuppose one another. PDA/agoraphobic individuals, who assumingly had some sense of coherent somatic boundaries at a point in their lives, are faced with the dilemma of 'losing control' over their bodily boundaries without the personal desire or choice to do otherwise. So while the PDA/agoraphobic embodies the desires and processes of a postmodern culture, they

do so problematically.

The mobility of subjectivity and identity, in other words a recognition that we come to be constituted through multiple subject positions and a matrix of gendered social, personal, cultural, economic, political and spatial relations, does not always translate positively at the scale of the body. The attempt to break down ideological boundaries, thought to be restrictive and damaging, cannot always be accomplished through the breakdown of somatic boundaries. The confusion of PDA/agoraphobic boundaries, between self and environment, is a physically traumatic experience and it would be callous to celebrate this form of permeability. Yet, the recognition that these bodies are interconnected to their environments highlights how our bodies are integral to the production of imagined and material spaces, and how those spaces are interchangeable and interconnected. Theorising and discussing permeability as a natural bodily process may help to dislodge the perception amongst PDA/agoraphobics that their experiences are abnormal, irrational and deviant, and does cautiously challenge the dualistic divisions of internal body and external environment. Certainly, PDA/agoraphobic experiences are unhealthy and problematic. The physical sensations of panic would certainly still be feared, but they are not uncommon or unnatural. In this respect, PDA/agoraphobic bodyscapes ground and inform the celebration of fluid bodies by analysing and investigating the consequences and constructs of a volatile body.

We have to get at the causes of power and oppression in the PDA/agoraphobic condition by noting how power relations are manifested within PDA/agoraphobic lives and locations. At all three scales, city, home and body PDA/agoraphobic geographies and

patterns of movement unveil layers of restriction and patriarchal power that structure spatial relations, while simultaneously suggesting possibilities and lived realities of resistance and empowerment within those structures. Cityscapes, homescapes and bodyscapes provide a critique and challenge to both rational and postmodern/poststructuralist subjectivities and geographies. These 'scapes' unveil the problems which may occur when traditional 'rational' spaces and territories of the body are transgressed, but they also imply that rational subjectivities are often an unlivable and damaging ideal. This chapter has noted the importance of what postmodern/poststructuralist thinking has to offer, while reminding the reader that it is not enough to celebrate a mobile subject, but to celebrate the progressive and enabling possibilities of that movement.

We have to situate and position our own relations, as academics, to the PDA/agoraphobic condition. For those of us, privileged to be in a position where our somatic stability is not perceived to be at risk, PDA/agoraphobic experiences allow us to self reflect critically on how our imagined geographies become lived reality, or alternately, how we can come to understand our identities and subjectivities as both multiple and specific, diverse and individualised. I have argued that a spatialised feminist approach provides a way of interpreting postmodern/poststructuralist celebrations of the body and space within the daily lived realities and geographies of PDA/agoraphobic women. What a spatialised feminist analysis of PDA/agoraphobic geographies indicates is that spatial relations need to be investigated contextually. For in doing so it is shown that while spaces and places may be territorialised and re-territorialised, traversed and

transgressed with a postmodern ease, the underlying concepts and ideologies which formed those boundaries still remain. For PDA/agoraphobic individuals to celebrate their plasticity of limits, they reinstate those limits through the conventions of a rational 'normalised' subject. The theoretical desires and underpinnings of a postmodern plasticity are not always accompanied by the reformation of subjectivity or identity. Nor are those ideals necessarily progressive or helpful. Academics must acknowledge issues of privilege and power within academic theorising itself. The PDA/agoraphobic condition may enable postmodern or poststructuralist thinking, but that does not mean that postmodern/poststructuralist theory enables the PDA/agoraphobic woman.

Identifying what normative geographies are and how they are theorised and constructed is a first step towards destabilising, and eventually overturning, repressive dualistic geographies of gender and illness. I believe that the spatial/corporeal boundaries of both the rational and postmodern subject need to be actively questioned for their usefulness and placed within a larger public consciousness (Duncan, 1996a: 141). Openly contesting dualistic spatial divisions will open up venues for discussion and analysis of the lived geographies of struggle and possibility for PDA/agoraphobic women. A sensitivity to the place-specificity of process/struggle and to the play of differences in those places permits more sophisticated explanations of the politics of creating and recreating 'otherness' which is constitutive of deviance. In this respect spatialised feminism also implies a progressive view for the future that recognises and acknowledges diversity and a commitment to change when necessary. A focus on the gendered and social relations of geography forces us to reflect on our own positions in processes of

creating and using knowledge, a reminder to us that we are a part of larger pervasive power structures and that we are likely to become entangled in our own interpretive webs (Chouinard and Grant, 1996). We have to get at the causes of power and oppression within PDA/ agoraphobic lives, as well as noting their diverse manifestations in those lives and locations, if we are to speak to and act on issues of social change. If we do not, not only do we impoverish diverse knowledges and help silence voices but we also risk an academic atmosphere in which it is unclear why academics should be speaking for anyone rather than stepping aside and letting people speak for themselves (Ibid, 192). I am trying to act as a facilitator for change and further inquiry into the PDA/agoraphobic condition by providing some additional insights and contributions for discussion, such as the fallacy that there are clear-cut divisions between abnormality and normality. The PDA/agoraphobic condition affects not only those with PDA, it affects us all in the manner in which we come to understand, identify and (re)- territorialise space.

Future Directions And Thoughts

This thesis has not only been written and constructed to inform academics and practitioners, but PDA/agoraphobic women and men themselves. In conclusion I would like to present some of the key concerns identified by those I interviewed, concerns which have fuelled and informed this thesis generally. One fundamental issue throughout this thesis, which needs to be re-addressed, is how the thesis is helpful , progressive and enabling for PDA/agoraphobic persons and individuals in general. As a part of my semi-structured interviews, I asked all those interviewed, formally and informally, to discuss

the future directions and possibilities for PDA/agoraphobic awareness. There were several key issues and methods of implementation that were mentioned by almost all of the women and men interviewed. The most commonly discussed issue was that of increased awareness of the PDA/agoraphobic condition in western societies. An increased understanding and awareness of agoraphobia can be facilitated through educational and media campaigns that explain the many ways in which panic and agoraphobia takes over a person's life. Many of those who were interviewed felt that a discussion of panic and agoraphobia should be included into public school curriculums in Ontario. But unfortunately, there has been no movement on the part of the Ontario school system to include this into health education classes, which have focused more exclusively on issues of sexual and reproductive health. There are some attempts being made to provide more information on agoraphobia in Ontario. Organizations such as The Anxiety Disorders Association of Ontario in Ottawa and the Anxiety Disorders Network in Pickering, Ontario, have actively been engaged in the process of increasing awareness about agoraphobia for many years. Unfortunately, funding for these organizations is hard to come by, and is constantly cited as a major obstacle in spreading and disseminating information about anxiety or panic disorders.

This lack of funding for organizations that assist and support PDA/agoraphobic individuals was another point of contention amongst those whom I interviewed. The lack of funding available to causes involving PDA/agoraphobia was seen as problematic because those organizations need financial support for awareness campaigns and to run the day to day organization and support structures of those associations. These

associations are not only a source of information about PDA/agoraphobia, they provide services for PDA/agoraphobic women, such as: a volunteer companion program, which assists PDA/agoraphobic women and men in completing chores and providing encouragement; referrals to therapists; as well as the compiling of newsletters, support groups, management workshops and educational presentations. Currently the Anxiety Disorders Association of Ontario, which has grown tremendously in the two years of my research project, is working on establishing public education seminar programs for youth in grade seven; and beginning in the fall of 1999 the association will set up stress management/ self esteem/assertiveness/emotional intelligence workshops for the workplace.

During this research project I have witnessed the struggles of support groups and associations in trying to receive funding. These groups and organizations have had some success in securing funds from individual donors, but by and large municipal, provincial and federal government funding is minimal. As a part of my involvement within these organizations, I have been trying over the course of my research to seek possible sources of funding and have found relatively few. This has been very discouraging. I was informed that money for research and education of gendered disorders such as anorexia is available, as are a network of shelters and associations that address issues around anorexia and bulimia, but not for PDA/agoraphobia women and men. Anorexic organizations have been effective in securing funds, providing services and maintaining public awareness of eating disorders. Some of the credit of this effectiveness must go to those individuals who have analysed, explored and written about anorexia, bulimia and

other associated eating and body disorders, thereby bringing the topic into the public arena and consciousness. Eating disorders such as anorexia, unlike PDA/agoraphobia, are much more apparent within western culture. But, I believe that a similar pattern of education and awareness could occur for PDA/agoraphobia if it was discussed and explored more readily within a variety of discourses, thus bringing this disorder into larger discussions of gender and health.

Another monetary issue that was strongly raised by the individuals interviewed was the funding available for treatment by the Ontario Health Insurance Plan (OHIP). OHIP will only cover visits to doctors and one psychiatric visit, thereby encouraging individuals with PDA/agoraphobia to seek particular types of treatments, treatments that I have analysed within this thesis as highly subjective and ineffective in dealing with the PDA/agoraphobic condition. Most of those interviewed expressed dissatisfaction with general practitioners and psychiatrists in dealing with their PDA/agoraphobia and most of those interviewed wanted a psychological consultation. Unfortunately, most of these individuals could not afford to see a psychologist for prolonged periods of time. The funding of medical etiologies and models of treatment of PDA/agoraphobia is reflected within the larger scale of funding for panic disorders within Canada. While pharmacological approaches to PDA/agoraphobia receive thousands of dollars in funding for clinical trials, of which I was a part, psychological or support group funding is minuscule in comparison. If we are to begin to dissolve the binary categories of abnormal/normal for PDA/agoraphobic individuals, these individuals need access to forms of treatment and information that either challenge or modify these dichotomies.

There are a wide variety of psychological approaches to PDA/agoraphobia that address the issues raised throughout this thesis, that incorporate 'postmodern/poststructuralist' thought, or more specifically a feminist geographical approach, into clinical practice.

In addition to psychological consults, PDA/agoraphobic individuals should not simply come to understand their PDA/agoraphobia through treatment from clinical professions, but through discussions with other PDA/agoraphobic individuals, and in sharing experiences develop a sense of community, sociability and normality. This is another reason why support groups and organizations that support and assist those with panic disorder and agoraphobia are important and require more funding. Alternately, developing a sense of community does not have to involve remaining within PDA communities. This thesis strongly argued that agoraphobic women with panic disorder have much to offer by way of discussion and experience to other women with gender based illnesses and women in general who experience agoraphobia without panic. Therefore alliances between groups that deal with disorders that women experience, such as anorexia/bulimia, or other women's groups, might not only foster mutually beneficial discussion and treatments, but will invariably increase an awareness of PDA/agoraphobia in the public at large. One caution though is to identify PDA/agoraphobia as a woman's disease. PDA/Agoraphobia is predominantly diagnosed in women, but is not exclusive to women. Though this thesis did not focus on the experiences of men and PDA/agoraphobia, through my conversations with many agoraphobic men, I came to realise that agoraphobia and panic affects their lives in very similar ways, and for very similar reasons to PDA/agoraphobic women. PDA/agoraphobia is not simply a woman's

issue, but an issue concerning gender and the construction of the feminine.

Similarly, anorexia is more commonly seen amongst women, but is not exclusive to women. Therefore, while these alliances can be potentially positive, they may also be misleading and exclude or discourage many men from having their voices heard.

Therefore it is pivotal that these alliances between illness groups do not exclude a discussion of men's PDA/agoraphobic experiences, because these experiences may serve to reinforce and compliment the experiences of various PDA/agoraphobic women.

In summation what was most important for those I interviewed was to develop effective therapies and approaches for the management of PDA/agoraphobia with panic. I hope that by opening up venues and areas of investigation the complex matrix of PDA/agoraphobic experiences can be more effectively understood and dealt with.

I have often felt that there is an entity within me which is beyond my control. This entity (other being or creature) seems to have the ability to take over my life at any time, often without warning and certainly in an aggressive manner. I call this entity the alien within. I cannot see it or hear it, but I feel it pounding at me sometimes day after day in its attempts to direct and control my life. My coming and goings have been limited as a result, my thought processes and emotions have been equally disturbed, often rendering me into a state of complete confusion and explicit grief.

It is important to become one with this alien... But as I was denied the many opportunities for self expression, self determination, independence and so much more, it had no choice but to create a place for itself that was independent of me. A place where it would eventually make itself known when it became strong enough to retaliate. For years I did to it what had been done to me since birth. I ignored its needs beyond subsistence. When I can learn to love it, respect its place in my life and allow it to share with me what it wants me to learn, I will no longer need to fear it and get angry at its presence. It will no longer be alien."

-- (Anonymous Agoraphobic Woman.)

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**Suggested (ADAO) Agoraphobia, Panic And Anxiety Book Titles For People With
Agoraphobia And Support Persons**

Agras, S., Panic -Facing Fears, Phobias and Anxieties
Auger, L., Help Yourself
Babor, S. And Goldman, C., Overcoming Panic Attacks
Barlow, David. Anxiety and its Disorders
Barlow, David. Mastery Over Anxiety and Panic
Bassett, Lucinda. Panic to Power
Beck, A., Anxiety Disorders and Phobias
Benson, H., The Relaxation Response
Berent, Jonathon. Beyond Shyness: How to Conquer Social Anxieties, 1994
Boer, L., Getting Control: Overcoming your Obsessions and Compulsions
Bourne, E. The Anxiety and Phobia Workbook
Burns, D., Feeling Good
Burns, D., The Feeling Good Handbook
Carnegie, D., How to stop Worrying and Start Living.
Dumont, Raeann, The Sky is Falling, 1996
Dwyer, D., Pulling Your Own Strings
Dwyer, D., Your Erroneous Zone
Geist, J., Jefferson, J. Et al., Anxiety and its Treatment.
Gold, M., The Good News about Panic, Anxiety and Phobias.
Goldstein, A., Overcoming Agoraphobia
Handley, Robert and Neff, Anxiety and Panic Attacks, Their Cause and Cure, 1985
Handley, Robert, Beyond Fear
Halas, C., Matteson, R., I've done so well, Why do I feel so bad.
Harper and Ellis, A New Guide to Rational Living
Harvey, J., If I'm so successful why do I feel like a fake?
Henley, A., Phobia the Crippling Fear
Hunt, D., No more fears
Jeffers, S., Feel the fear and do it anyway
Kabat-Zinn, Jon, Full Catastrophe Living
Kabat-Zinn, Jon, Wherever you go there you are.
Kushner, H., When bad things happen to good people.
Levenkron, Steven, OCD: Treating and understanding Crippling habits, 1991
Levinson, H., Phobia Free
McCullough, C., Mann, R., Managing your Anxiety
McCullough, C., Always at Ease: Overcoming Shyness and Anxiety in Every Situation, 1991
Marks, I. Living with Fear
Matthews, Gelder and Johnson, Programmed Practice for Agoraphobia
Maxmen, J., The New Psychiatry.
Neff and Handley, Anxiety and Panic Attacks

Neidhardt, Weinstein and Conry, No Gimmick Guide to Managing Stress
Neuman, F., Fighting Fear.
Peale, N.V., You can if you think you can.
Peurifoy, R., Anxiety Phobias and Panic
Robins, J., Fisher, D., Tranquillity without pills
Ross, Jerilyn. Triumph over fear. 1996
Seagrave and Goldstein, Free from Fear
Selye, H., Stress without Distress
Sheehan, D., The Anxiety Disease
Sheehy, G., Passages
Stainback and Goldstein, Overcoming Agoraphobia
Swede and Jaffe, The Panic Attack Recovery Book
Vines, R., Agoraphobia Fear or Panic
Weekes, C., Hope and Help for your Nerves
Weekes, C., Peace from Nervous Suffering
Weekes, C., Simple Effective Treatment for Agoraphobia
Wilson, R., Don't Panic
Wilson, R., and FAO, S.T.O.P Obsessing

APPENDIX I- LETTER OF INTRODUCTION

Ruth Bankey
(613) 234-3283
rbankey@chat.carleton.ca

Dr. Fran Klodawsky
Department of Geography
(613) 520- 2600 ext 8689

Letter of Introduction

Date:

Dear Participant,

I am a graduate student in the Department of Geography at Carleton University who is involved in a research thesis in order to fulfill the requirements of my degree. I am interested in the diverse experiences of agoraphobia and how those experiences affect a person's environment. I am focusing my research on women with agoraphobia because I am interested in the lives and experiences of women in space. I believe that I will learn and discover more about this subject from interviewing persons who consider themselves to be/ or have had agoraphobia as well as a family member or friends.

The aim of this research study is to gain a better understanding of how agoraphobia transforms a person's perceptions of their environment as well as that environment itself. I will be asking you as a person with agoraphobia/ family member/ friend to talk about how agoraphobia has affected the way that you move around your household, your community and the city of Ottawa. I will ask your permission to interview a family member or friend, either in your presence or on their own.

I am asking you to participate in a series of interviews and also, possibly, a focus group discussion with other female agoraphobes and/or a questionnaire. I will ensure that your words and experiences will remain confidential. Identifying features may be removed from the transcripts and the tape may be returned to you or erased to ensure confidentiality.

If you agree to participate in the research, I ask you to read and sign an attached interview consent form which will further outline your rights and provide more details of this study. Signing this form lets me know that you are willing to be interviewed and that you understand that the information you provide will be treated confidentially. Signing this form does not constitute a waiver of your rights. It is meant to inform you of what the research will entail and to let you know that you will be informed of the results and progress of the research throughout the thesis process.

If you are interested in participating or have any questions or concerns please feel free to contact me. My phone number and e-mail address are provided for you at the top of the page. If you require further information, you may contact Professor Fran Klodawsky, my thesis supervisor, at the Department of Geography, Carleton University. Please leave your name and telephone number so that I may contact you. I appreciate your taking the time to consider participating in this study.

Thank-you.
Sincerely,

Ruth Bankey.

APPENDIX II- INFORMED CONSENT FORM - PERSONAL NARRATIVES AND SEMI-STRUCTURED INTERVIEWS

Informed Consent Form- Women and Agoraphobia. (Interviews)

I have spoken with Ruth Bankey concerning her research proposal and have read the letter of introduction informing me of the research. I, _____, agree to participate in the thesis research study conducted by Ruth Bankey, for her graduate work, that will examine the experiences of women and agoraphobia, in order to express my views on the subject. I will participate in the interview under the following terms:

- I understand that I have a right to withdraw from the research process at any time regardless of the reason.
- I understand if the interviews are inconvenient or discomforting that I may withdraw from an interview or choose not to respond to certain questions. If this is the case, I understand that the interview questions will be modified to suit my needs and feelings.
- I understand that the research process will involve a number of interviews and, possibly, a focus group and/or questionnaire.
- I understand that the time and place of the interview will be mutually agreed upon.
- I understand that a family member/friend may be asked to be interviewed.
- I Understand that my confidentiality will be protected by eliminating or disguising any identifying details from the transcript, report or thesis document and that the audio tape will be returned or erased at my request. I understand that the tapes will be placed in a locked container during the research process.
- I understand that I have a right to receive and review a written transcript of the interviews or focus groups and that I can suggest modifications for accuracy or to add new information.
- I understand that the information from the interviews, focus group, questionnaire may be used in the construction of a thesis document which may be used in further research and/or published.

- I understand that I will be informed about the research process as well as the findings progress of the research thesis process. I understand that a summary of the research findings will be made available to me if I request it, and a documented copy of the thesis will be available at Carleton University's Library.
- I understand that my contributions to this research project are valued and important.

Participant:

Researcher:

Date:

APPENDIX III- SAMPLE OF INTERVIEW QUESTIONS AND TOPICS

Examples of Possible Personal Narrative Directed Questions.

Friends/Family:

- Do you have dependents?
- How has that affected your agoraphobia, your mobility?
- Do you have family members/partners in the area who have witnessed your agoraphobic episodes?
- Have you changed the spatial patterns of your friends/family? How? An experience you can recall?
- Would they be willing to participate in the study? Are you comfortable with this? Why/Why not?
- Are you willing to participate in focus groups/ questionnaires? Why/why not?

Preliminary Questions/ Agoraphobic Experiences:

- How long have you lived in the Ottawa area?
- Have you experienced agoraphobia while living in Ottawa? If not where?
- When can you first recall an agoraphobic/panic experience?
- When were you diagnosed with agoraphobia?
- What triggered the onset of agoraphobia?
- Where did you restrict yourself to? In your home? Your community?
- Can you describe the space?
- How do you, have you, territorialized, marked off your space?
- Why did you remain in that space?/ why did you avoid other spaces?
- Did your mobility change? When? What triggered it?
- Where did you allow yourself to go, move around?
- Have you had other panic attacks, if so can you detail when these attacks occurred?
- Can you describe the progression of changes in your spatial mobility and why they changed?

Ottawa/ Preliminary questions:

- What are your spatial patterns in the city?
- Does this change during the year? During the time of day? If so when?
- Why do you avoid/ inhabit these spaces?
- What triggered those responses?
- How have your spatial patterns in the city transformed over time? Explain, discuss?

- What are the safe spaces in the city? Have those safe spaces changed? been affected by your experiences of agoraphobia?
- How do you move around in the city, to keep yourself safe? Has your agoraphobia influenced this?
- Are there specific places in the city that you have to go to, for work, leisure, school, children's activities?
- Do you have any special or particular ways, things that you avoid, to get to these places?
- How does your agoraphobia affect your working schedule? Leisure schedule?

More Personal/ Sensitive Questions:

- When I ask you to describe your spatial experiences, what does that mean to you?
- What does home mean, indicate to you? What does community?
- Where is home, your community, physically located, has that changed? Has that changed during a period of panic or agoraphobia? Do you have a different sense of where home and community are during/after a panic attack?
- How has that transformed your understanding of your environment?
- Did that change during an agoraphobic panic episode?
- Can you describe your panic experience? How does it change your perceptions of the environment?
- How does it change your perceptions of yourself and your body?

APPENDIX IV- SELF DIAGNOSIS QUESTIONNAIRE

Self-Diagnosis Questionnaire

The following questionnaire is designed to help you identify which particular anxiety disorder you may be dealing with. It is based on the official classification of anxiety disorders used by all mental health professionals and known as DSM-IV (Diagnostic and Statistical Manual of Mental Disorders - Fourth Edition).

1. Do you have spontaneous anxiety attacks that come out of the blue? (Only answer "yes" if you do not have any phobias.) Yes _____ No _____
2. Have you had at least one such attack in the last month? Yes _____ No _____
3. If you had an anxiety attack in the last month, did you worry about having another one? Or did you worry about implications of your attack for your physical or mental health? Yes _____ No _____
4. In your worst experience with anxiety, did you have more than three of the following symptoms?
 - Shortness of breath or smothering sensation
 - dizziness or unsteady feeling
 - heart palpitations or rapid heartbeat
 - trembling or shaking
 - sweating
 - choking
 - nausea or abdominal distress
 - feeling of being detached or out of touch with your body
 - numbness or tingling sensations
 - flushes or chills
 - chest pain or discomfort
 - fear of dying
 - fear of going crazy or doing something out of control

If your answers to 1,2,3 and 4 were Yes, stop. You've met the conditions for *panic disorder*.

If your answer to 1 was Yes, but your anxiety reaction involved three or fewer of the symptoms listed under 4, you're experiencing what are called limited symptom attacks, but do not have full-blown panic disorder.

If you have panic attacks *and* phobias, go on.

5. Does fear of having panic attacks cause you to avoid going into certain situations? Yes___ No___

If your answer to 5 was Yes, stop. It is likely that you are dealing with **agoraphobia**. See question 6 to determine the extent of your agoraphobia.

6. Which of the following situations do you avoid because you are afraid of panicking?

- going far away from home
- shopping in a grocery store
- standing in a grocery store line
- going to department stores
- going to shopping malls
- driving of freeways
- driving on surface roads far from home
- driving anywhere by yourself
- using public transportation (buses, trains, etc.)
- going over bridges (whether you're the driver or passenger)
- going through tunnels
- Flying in planes
- riding in elevators or on escalators
- going to a dentist's or doctor's office
- sitting in a barber's or beauticians's chair
- eating in restaurants
- going to work
- being too far from a safe person or place
- being alone
- going outside you house
- other

The number of situations you checked above indicates the extent of your agoraphobia and the degree to which it limits your activity.

If your answer to 5 was No, but you do have phobias, go on.

7. Do you avoid certain situations *not* primarily because you are afraid of panicking but because you're afraid of being embarrassed or negatively evaluated by other people (your embarrassment could subsequently lead you to panic) Yes___ No___

If your answer to 7 was Yes, stop. It's likely that you are dealing with **social phobias**. See question 8 to determine the extent of your social phobia.

8. Which of the following situations do you avoid because of a fear of embarrassing or humiliating yourself?

- Sitting in any kind of group (for example, at work, in school classrooms, social organizations, self-help groups)
- giving a talk or presentation before a small group of people
- giving a talk or presentation before a large group of people
- parties and social functions
- using public washrooms
- eating in front of others
- writing or signing your name in the presence of others
- dating

- any situation where you might say something foolish
- other

The number of situations you checked indicates the extent to which social phobia limits your activities.

If your answers to questions 5 and 7 were No, but you have other phobias, continue.

9. Do you fear and avoid any one (or more than one) of the following?

- insects or animals, such as spiders, bees, snakes, rats, bats, or dogs
- height (high floors in buildings, tops of hills or mountains, high-level bridges)
- driving
- tunnels
- bridges
- elevators
- airplanes (flying)
- doctors or dentists
- thunder and/or lightning
- water
- blood
- injections or medical procedures
- illness such as heart attacks or cancer
- darkness
- other

10. Do you have high degrees of anxiety usually only when you have to face one of these situation?
Yes___ No___

If you checked one or more items in 9 and answered Yes to 10, stop. It's likely you're dealing with a specific phobia. If not, proceed.

11. Do you feel quite anxious much of the time but do not have distinct panic attacks, do not have phobias, and do not have specific obsessions or compulsions? Yes___
No___

12. Have you been prone to excessive worry for at least the last six months? Yes___ No___

13. Have your anxiety and worry been associated with at least three of the following six symptoms?

- Restlessness or feeling keyed up or on edge
- being easily fatigued
- difficulty concentrating or mind going blank
- muscle tension
- sleep disturbance (difficulty falling or staying asleep, or restless unsatisfying sleep)

If you answered to 11, 12 and 13 were Yes, stop. It's likely that you're dealing with generalized anxiety disorder. If you answered Yes to 11 but No to 12 or 13, you're dealing with an anxiety condition that is not severe enough to qualify as generalized anxiety disorder.

14. Do you have recurring intrusive thoughts such a hurting or harming a close relative, being contaminated with dirt or toxic substance, fearing you forgot to lock your door or turn off an appliance, or an unpleasant fantasy of catastrophe? (You recognize that these thoughts are irrational but you can't keep them from coming into your mind.) Yes___ No___

15. Do you perform ritualistic actions such as washing your hands, checking, or counting to relieve anxiety over irrational fears that enter your mind? Yes___ No___

If you answered Yes to 14 but No to 15, you are probably dealing with **obsessive-compulsive disorder**, but have obsessions only.

If you answered Yes to 14 and 15, you're probably dealing with **obsessive-compulsive disorder**, with both obsessions and compulsions.

If you answered No to 14 and 15 and most or all of the preceding questions, but still have anxiety or anxiety-related symptoms, you may be dealing with **post-traumatic stress disorder** or a **non-specific anxiety condition**.

Co-Occurrence of Anxiety Disorders

In the five years that have passed since the first edition of The Anxiety and Phobia Workbook was published, it has become increasingly apparent that many people are dealing with more than one anxiety disorder. For example, one survey of people with panic disorder found that 15-30 percent of them also have social phobia, 10-20 percent have a specific phobia, 25 percent have generalized anxiety disorder, and 8-10 percent have obsessive-compulsive disorder. People with agoraphobia quite often have social phobias and/or obsessive-compulsive difficulties. If you find that your particular condition fits the description for more than one anxiety disorder, you are not alone.

This questionnaire was taken from the book, "The Anxiety & Phobia Workbook" written by Edmund J. Bourne, PhD.

APPENDIX V- ADDRESSES AND CONTACT NUMBERS FOR PANIC AND ANXIETY DISORDERS NETWORKS IN THE OTTAWA-CARLETON REGION.

Anxiety Disorders Association of Ontario. 797 Somerset Street West, Suite 14 Ottawa, Ontario, Canada, K1R 6R3, 1-613-729-6761
1-877-308-3843. contactus@anxietyontario.com
www.anxietyontario.com

The Anxiety Disorders Network. 1848 Liverpool Road, Suite 199, Pickering, Ontario, Canada, L1V 6M3, 1-905-831-3877

The Anxiety/Panic Disorders Support Group Of Ottawa. For more information and contact number contact the ADAO.