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The scenes and spaces of anxiety: Embodied expressions of distress in public and private fora

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ABSTRACT

Psychological treatments of mental health issues have acquired a justifiable notoriety for their tendency to engage in generalisation and reductionism. By contrast, the emergent geographies of exclusion make visible the fine-grain material and spatial contours of the lives of individuals who experience mental health difficulties and distress. However, this can come at the cost of a relative neglect of the psychological. In this paper we propose a set of concepts for facilitating the study of intersecting planes of experience, which demonstrates the interdependency of the spatial, the psychological and the technological. Drawing on empirical work with participants who live with persistent anxiety, we demonstrate how online support networks mediate – that is transduct, intersect and transform – how experiences of anxiety are lived out. Attention to endogenous 'tactics' or 'modes of normativity' provides an interesting agenda for the emergent engagement of social psychology with social/cultural geography.

1. Introduction

The conceptualisation and treatment of mental distress have long served as a fault line in psychology, the source of heated and bitter ideological, philosophical and political debate. At stake is the question of the normal and the pathological, and the relationship between these two highly contested terms. As Canguilhem (1980) once proposed, these terms are greatly misunderstood in psychology. In biology and medical science, Canguilhem argued, the normal denotes not a fixed constant, but rather a continuous struggle of the organism to adapt its functioning in response to the challenges of the environment (for example, increases and decreases in neurotransmitter sensitivity in response to exposure to pharmacological stimulants). Norms are then mobile, changing and subject to ongoing revision.

The pathological is not opposed to the normal, but typically represents a special instance of the norm where the scope for changes in responses becomes limited (see Canguilhem, 1991). It is when the organism cannot respond 'normally' (i.e. adaptively, flexibly, and provisionally) that we speak of pathology. This is a point that has been raised by many psychologists and allied professionals working within the mental health field. The dimensional approach, as it is mainly referred to, aims to understand mental health difficulties as continuous with human experience as opposed to discrete categories of disorder.

However, the remaining danger in any psychological study of mental health is that it risks falling back into the error Canguilhem identifies. There are two forms this tendency typically takes. The first is the practice of reducing mental health to a single domain of expression (see Cromby et al., 2007). For example, mainstream psychology generally takes a cognitive approach to distress, where individual thoughts are the major focus of concern, leading to treatment approaches that emphasise the individual's responsibility to change (Smail, 2005). Although cognitive approaches acknowledge the importance of others in the development of individual interpretation and belief, the scope of enquiry nevertheless remains centred on the individual's processes of thought, systems of belief and errors in information processing (Bentall, 2003). Conversely, radical or critical psychology locates the source of distress firmly in the structures of society that lead to oppression and concerns itself with proposing interventions aimed at preventing these from occurring (see Hare-Mustin and Maracek, 1997; Newnes et al., 2000, 2001; Strakowski et al., 1995). That the one position is a structural inversion of the other is clear: wherein both contain the danger of returning to the same kind of reductive gesture.

The second danger consists in wanting to move as rapidly as possible from the particular to the general. The experience of ongoing anxiety, for instance, is subsumed within the overall diagnostic rubric of 'neurotic disorders' that include generalised anxiety disorder (GAD), obsessive compulsive disorder (OCD), panic disorder

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and social phobia (see APA: DSM-IV-TR, 2000 and WHO: ICD-10, 1992). The difficulty with this rush to generalisation is that since it washes out the particular at an early stage, it creates problems of differentiation and logical puzzles at a higher order. For example, although neurotic disorders are the UK's most common psychiatric diagnoses, affecting 16% of women and 11% of men (ONS, 2003), high levels of co-morbidity (co-existence of more than one mental health problem) have been found between different anxiety disorders (e.g., Magee et al., 1996; Yonkers et al., 1996) as well as with other psychiatric diagnoses, including depression, Tourette's syndrome, schizophrenia and eating disorders (Rasmussen and Eisen, 1992). Anxiety then seems to be everywhere and connected to everything precisely because the particularity of anxious experiences has been erased in their recognition and classification by psychology and psychiatry (Bentall, 2003).

How then can we speak of anxious experiences in a psychological framework without lapsing into reductionism or generalisation? In this paper we will argue that despite the many attendant problems in doing so, it is possible to envisage a form of psychological analysis that is capable of doing justice to the particularity of distress and, in our particular case, anxious experience. At the heart of this analysis is the notion, popularised in recent Deleuzian scholarship (e.g., Ansell-Pearson, 2004; Massumi, 2002) that experience is best grasped as a form of multiplicity. Whilst it is relatively straightforward to understand the contents of experience as multiple and possibly contradictory, it is considerably more challenging to see that experience is equally affective, spatial, embodied, material, technological and so on, and that what is usually called the psychological narrowly refers to only one set of planes of experience. The term 'plane' is derived from the philosophy of Henri Bergson and elaborated further by Gilles Deleuze. Amongst the several meanings of the term are the notions of a 'slice', a 'cut' or a particular perspective on the entirety of one's experience; a 'plan' or organisational principle at work in a particular mode of experience; and a grounding of experience in non-transcendental, immanent relations that cut across subject and object and are as such experienced without becoming directly a matter for consciousness (see Bergson, 1991; Deleuze, 1991; Deleuze and Guattari, 1988). Out of this heady brew we draw the particular meaning that experience is divided up into differing modes (e.g., the psychological, the affective; the technological) each of which have their own logic and patterning of relations, and are irreducible to one another. The difficulty is to keep this multiplicity – both difference and irreducibility – central to the analysis without prioritising one set of planes over another. In order to provide a check against this, we will use the term *mediation* to refer to the interdependency of one plane with another (e.g., the psychological with the spatial, the technological with the social). As we will go on to argue, the idea of experience as multiply mediated demands particular kinds of methodological responses.

2. Geographies of exclusion

Recent work in the social and cultural geography of mental health has done much to assist a return to the particularities, especially the material conditions, of the lives of mental health service users. Productive, public and political areas of our cities are hence clustered together in the centre, separated from domestic, private and 'reproductive' homes in the suburbs, a spatial configuration that compounded the political disenfranchisement of women (England, 1991). Similarly, those in distress have been excluded from public spaces; although no longer necessarily hidden away in asylums, as described by Foucault (1965), service users still tend to be concentrated in certain, generally inner city areas of cities (Rogers and Pilgrim, 2003) and find that the expression of their distress is only authorised in certain private (Pinfold, 2000) or medical (Parr, 1997, 2008) spaces. Creating and supporting this 'purification' (Sibley, 1995) of public space is the conceptualisation of distress and madness as 'irrationality'. In a society built upon reason (Foucault, 1965), where the ability to apply reason to understand and control one's own behaviour is a central tenet of how we understand the self (Rose, 1989, 1998), then those who display 'irrationality' are profoundly disruptive to both society and the modern concept of the self. Public space can be seen as the sphere in which these tenets of our society are secured; to enter successfully into public space, as well as into public and political discourse, a display of rationality is essential. Feminist authors have situated the experience of agoraphobia, for example, as a rational response to public spaces that are hostile and exclusionary towards women (McHugh, 2004).

David Sibley (1995), for example, has argued that public space is 'purified' of those who do not meet the standards of the self-regulating, 'reasonable' morally responsible individual. Exclusion, isolation and marginalisation are used as strategies to manage such persons, who are duly dispatched to prisons, hospitals and care homes. Given these alternatives, Sibley (1995) argues that those who experience mental distress may seek to withdraw from the 'geographies of exclusion' by retreating to their own homes. 'Pathological behaviour', such as social phobia, is then re-specified as a reasonable response to a disorientating and invasive experience.

Parr's (1999) work makes the similar argument that 'mad' behaviour is less acceptable in shared public spaces; the 'unreasonable' nature of distress renders it unwelcome in a society based on reason, since it presents a challenge to the idea that people are able to easily regulate and control themselves. She maps the intersections between those public spaces where such behaviour is not tolerated, and those designated spaces where it is allowed, such as mental health services and drop in centres. For example, Parr (1999), characterises delusional experience as involving a disruption of identities and a breakdown in the spatial boundaries between the self and the world; the experience of living with distress is characterised as a 'battle for the organisation of self' (p. 683). Retreat from public space is thus seen as an attempt to regain some 'ontological security' (Parr, 1999: 677).

Davidson (2000a) has duly noted the same phenomenon in her work with women diagnosed with agoraphobia, contrasting the security they felt at home with the increasingly unstable, dissolving sense of self in the outside world where, as outlined by Sibley (1995) and Parr (1999), distress is not welcome. Davidson (2000b) draws on Merleau-Ponty's concept of 'lived space', the subjective experience of 'objective space', to help understand her participants' need to practise going outside, explaining this in terms of them having to 'exercise' (pg 652) their establishment of a lived space if it were not to become 'hopelessly and debilitating contracted' (pg 652).

Finally, Segrott and Doel's (2004) investigation of OCD redefines the rituals and repetitious behaviour typical in OCD as reasonable coping strategies to living with a fear of contamination. Segrott and Doel draw on De Certeau's (1984) concept of 'tactical living' to capture what they conceived of as the active, constructive and potentially subversive nature of the ordering of space seen in OCD. As is well known, De Certeau distinguished between 'strategies' which create the structures and institutions of power and 'tactics' which are the practices through which individuals modify and adapt the structures produced without ever taking them over entirely. Segrott and Doel (2004) attempt to depathologise the symptomatology of OCD by redesignating it as a set of tactics operating subversively within power structures.

Now whilst we welcome the move in all these studies of geographies of exclusion and retreat to emphasise the material grain of the everyday lives of people who experience mental distress, we feel that this comes at the price of a relative effacement