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Contesting stigma and contested emotions: Personal experience and public perception of specific phobias

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Abstract

This paper draws on interviews with members of the United Kingdom National Phobics Society to explore the implications of the contested nature of specific phobias for their experience and perception. In common with other chronic and contested conditions such as Chronic Fatigue Syndrome, phobias are stigmatised and subjected to widespread judgmental attitudes in both medical and lay populations. In contrast, however, phobic experience is rarely characterised by difficulty in describing symptoms and obtaining a diagnosis: core fearful reaction to and avoidance of particular objects is usually obvious and *uncontested*. The crucial difference is that phobias are constituted by emotions and behaviours considered irrational and inconsequential, and it is their (perceived absence of) significance that raises questions and eyebrows. In other words, what does it matter and *who cares* if you happen to be scared of snakes? Using phobics' own words as far as possible, the paper explores the processes through which phobic emotions are constructed as contested, and examines phobic means of managing experience and perception of these emotions. It reveals that many respondents are resourceful and resistant, continually renegotiating their positioning as irrational, incapable and emotionally weak.

Keywords: Stigma; Emotion; Phobia; Contested illness

> People who haven't got phobias or *say* they haven't got phobias tend to dismiss people who have. […] And they'll say the—well the same thing that everybody says—'oh you're being silly' […] 'there's nothing to be afraid of, come and have a look'. (Mharrie)

Stigma and contested emotions: an introduction

Unlike other chronic and contested conditions which have been the subject of recent research—for example, arthritis, environmental illnesses and multiple sclerosis (Kroll-Smith & Floyd 1997; Moss & Dyck, 2002)—specific phobias involve widely recognised symptoms and patterns of behaviour that are rarely difficult to diagnose (APA, 1994). While there may be some debate and confusion surrounding the cause of their disorder (Merckelbach, de Jong, Muris, & van der Hout, 1996) and perhaps complications associated with commonly co-morbid symptoms of depression or generalised anxiety, the distinctively fearful reaction to and avoidance of particular objects is usually obvious and uncontested (Antony, Brown, & Barlow, 1997). In contrast, to site one further and much publicised example, chronic fatigue syndrome (CFS)—otherwise known as myalgic encephalomyelitis (ME)—is notoriously difficult to 'pin down' diagnostically. The sheer

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range and disputed nature of both 'physical' and 'psychiatric' symptoms mean that sufferers struggle to obtain recognition as being 'legitimately' ill, and are often denied access to appropriate treatments and accommodations as a result (Clarke & James, 2003; Moss & Dyck, 1999). Phobias, however, are positioned very differently and arguably more prominently in the popular imagination, and most of us would know a phobic reaction if we saw one. Similarly, those who themselves suffer from blind panic at the sight or even the thought of a cat or a rat know exactly what the matter is, but they too find it difficult to get help, and they too are faced with such difficulty precisely because of the contested nature of their condition.

One reason why questions of legitimacy and so contestation are raised in both cases is that neither phobic nor fatigue symptoms can be directly 'seen' or measured—as one could see and measure, for example, the extent of fracture on a bone. In the case of phobias, however, sufferers find that it is not so much that the *existence* or 'reality' of their symptoms are subject to question by lay and professional others: their fears are, in some senses at least, understood to be 'real'. The crucial difference is that phobias are constituted by emotions and behaviours considered irrational and inconsequential, and it is their (perceived absence of) significance that raises questions and eyebrows. In other words, what does it matter and *who cares* if you happen to be scared of snakes?

As respondents quoted in this paper powerfully attest (see below), their pathologically fearful reactions to and debilitating avoidance of such common environmental objects and situations as spiders and bridges, thunder and fog, tend to 'provoke' unhelpful responses from non-phobic others (Davidson & Smith, 2003). In stark contrast to the kinds of reaction one might anticipate to other less contested illnesses—reactions such as sympathy, understanding and support—phobias are likely to be met with dismissal or even laughter. After all, and almost by definition, irrational fears are rarely considered a serious or 'reasonable' matter, and that which lacks reason in contemporary constructions frequently lacks legitimacy (Lloyd, 1984). Given the powerful and pervasive dichotomy between and supremacy of reason over emotion, emotions deemed least reasonable are positioned lowest of all and so subject to greatest contestation. (If in doubt, take a moment to imagine a range of potential responses to a publicly expressed horror of a seemingly innocuous object, say, a feather.)

That such dismissive, denigrating attitudes are widespread, and contribute to the secrecy, shame and stigma surrounding experience and perception of phobias, is particularly troubling when we consider that they are among the most common mental health problem presented at the level of primary-care; Mind (2000, p. 4) estimates there are currently 10 million sufferers in the UK, a figure including significantly more women than men. Gelder, Gath, Mayou, and Cowen (1996, p. 170) estimate lifetime prevalence rates to be 13, and 4 per cent respectively. Despite the commonality of phobic disorder, discussion of its experience—and particularly personal, first hand accounts—has been largely absent from social science and health literature (Davidson, 2003b). Similarly, while it is widely recognised that stigma has negative impacts on illness experience and treatment outcomes for mental health problems of all kinds (Fink & Tasman, 1992; Rosenfield, 1997), and while qualitative research has taken place on the effects of stigma on, for example, experience of schizophrenia (Schulze & Angermeyer, 2003), there is, to date, no comparable research on stigma and specific phobias. This paper goes some way towards addressing this gap in research, and aims to contribute to understandings of the complex realities of living with contested and stigmatised illness, focusing on subjective experience and personal narratives of phobias.

Available studies of stigma and mental illness frequently draw on Goffman's (1963) highly influential treatise on the 'deeply discrediting' attribute that impacts on the subject's sense of identity and self-worth, and their ability to interact socially with others (Byrne, 2000; Camp, Finlay, & Lyons, 2002; Corrigan, 1998; Prior, Wood, Lewis, & Pill, 2003). Research reveals that stigma is pervasive, powerful, and difficult to contest, but that is not to say that those 'stained' by its presence uncritically accept the construction of themselves as—in the case of phobias—irrational, ridiculous, or 'stupid'. While the phobic individual is marked by the 'flaunting'—through embodied expression—of discredited, 'inappropriate' and contested emotions, they are also, as we will see, capable of challenging such constructions. Few if any are immune, however, to stigma's undermining effects, and many are hyper-aware of and frequently hurt by the negative judgements of others, whether strangers, friends or family, colleagues or employers, or those health professionals ostensibly in a position to help. To repeat, few, if any, are immune.

In what follows, I draw on qualitative research to demonstrate the extent to which phobias are routinely trivialised and subject to widespread ridicule, and to explore how the contested and stigmatised nature of phobic emotion affects their personal experience and public perception. Using phobics' own words as far as possible, the paper explores the processes through which phobic emotions are 'belittled' and constructed as contested, including discourses of infantilisation and feminisation. It then examines phobic means of managing experience and perception of their phobic emotions, considering the consequences of ostensible 'acceptance' of stigma through 'failing' to disclose and 'keeping up appearances'—often using less contested conditions as a covering front—in contrast with contesting stigma by