'The very opposite of calm':
A socio-cultural history of agoraphobia

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For my family...

Abstract

Scholars have written very little about agoraphobia outside of the psychiatric disciplines. Because women comprise the majority of agoraphobics today, what *has* been written tends to focus on their historical inequality with men, especially their tenuous relationship to public urban space. Although these social explanations illuminate the historical importance of women's structural oppression, they do not account for the fact that up until World War I, agoraphobia was a disease diagnosed primarily among middle-class urban-dwelling men.

The argument of structural oppression also overlooks crucial disciplinary and epistemological shifts within psychiatry since the 19th century that have had significant implications for agoraphobia's production as a psychiatric object. These include the rise and fall of psychoanalysis, the development of a formal classification system known as the *Diagnostic and Statistical Manual of Mental Disorders* (DSM), and a subsequent (re)turn in recent decades to the positivist and biopsychiatric approach to treating mental illness that was dominant in the late 19th century (prior to the psychoanalytic ascent). Finally, structural accounts tend to take the disease concept of agoraphobia as a uniform and stable category. A close reading of the psychiatric literature reveals, however, that efforts to contain the disorder within a scientific system of classification fail to note the variability in the conceptualisation and treatment of the disorder.

In light of these problems, one must interrogate agoraphobia through its representation in biological, psychoanalytic, and behaviourist clinical publications since the disorder was first named in 1871. The problem of classification,

exacerbated by the DSM, remains a central theme in this history and illuminates how the category of pathological "Other" – racialised, gendered, and classed – has been constructed through relations of power enabled and reinforced by an exclusionary and regulative discourse of disease. Clinical narratives are read in the context of social processes in order to destabilise the sharp distinction traditionally drawn between psychiatric and cultural discourse. From the outset, a normative theory of social order lurks, embedded in the concept of agoraphobia, shifts in psychiatric and cultural terrain notwithstanding.

Acknowledgements

The saying "it takes a village to raise a child" strikes me as relevant not only to child-rearing but to dissertation writing as well. So many people have contributed to the completion of this work – it is indeed the product of a collective effort.

Several years ago Roberta Hamilton modestly claimed that as my M.A. supervisor she had already taught me everything she knows. As I suspected at the time, she was wrong about that. With a challenging but gentle hand she continued throughout my doctoral studies to be a mentor in the fullest sense. I owe her an immeasurable debt. David Lyon and Annette Burfoot also guided me with questions that proved to be among the most important: David's inspired me to think about agoraphobia as social theory, while Annette's encouraged my interest in embodiment. Bart Simon, who became an official member of the committee as Head's Delegate for the defence, has since the beginning been generous with ideas, references, and insights from his own experiences. Jacalyn Duffin helped me more than she knows, not least in teaching me how to think critically about the concept of disease. I am also very grateful to my external examiner Anthony Synnott of Concordia University, whose enthusiastic and insightful questions and comments have given me much to think about as I go forward with this work.

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Patients are not concerned with how we classify them,
they only want to get better.

~ M.A. Jenike et al., 1988

The surest road to health, say what you will,
Is never to suppose we shall be ill;
Most of those evils we poor mortals know,
From doctors and imagination flow.

~ D.K. Henderson, 1941

"Is everyone mad, do you think?" Sybil asked, recovering her poise. "One way or another, do you think it could be so?"

Jung gave one of his shrugs and said: "there are degrees of madness, of course. I have found some traces of it in myself, I do confess." He waved his hand. "But madness is a crafty beast and cannot be caught with theories. Over time, I have learned not only to be distrusting of theories, but to actively oppose them. Facts are what matter. And the facts regarding each individual's madness are all we have. General theories regarding madness merely get in the way of discovering its true nature in each patient, one by one by one. My own madness is quantified by parentheses – just as all madness is. And because of that, I have learned not only to deal with it, but to live with it. And most importantly, as any person must, to function in its presence. It is mine – my own and only mine.

~ T. Findley (*Pilgrim*), 1999

Chapter 1
Introduction

> **agoraphobia** (ăg″ō-ră-fō′bē-ă) [Gr. *agora*, marketplace, + *phobos*, fear]. Overwhelming symptoms of anxiety, often leading to a panic attack. This may occur in a variety of everyday situations (e.g., standing line; eating in public; in crowds of people; on bridges or in tunnels; while driving) in which a person might have an attack and be unable to escape or get help, or suffer embarrassment. Panic attack symptoms often include rapid heartbeat, chest pain, difficulty breathing, gastrointestinal distress, faintness, dizziness, weakness, sweating, fear of loss of control or of going crazy, dying or impending doom. People with these symptoms often avoid phobic situations, even to the point of staying at home for their entire lives.
>
> ~ *Taber's Cyclopedic Medical Dictionary*, 17th edition, 1993

Zoom in, floor level. Figaro is playing in the background. A heavy steel apartment door opens. An arm comes out, feels around the floor. It's obvious from how low the arm is, that the person attached is on hands and knees. The camera moves slowly up the length of the doorframe, revealing half her face, one eye peering nervously out. She can't reach the newspaper.

"Not again!" she exclaims, and slams the door.

Zoom out.

The door opens again. Still on her knees, she's got a broom in her hands. She avoids actually looking out the door. Her diaphragm heaving, she's breathing fast and hard. She crouches down, reluctantly looks at the newspaper, suddenly swings the broom out. She tries to drag it in, her torso and arms outstretched, knees remaining well inside the doorway. Damn!

No luck.

Out of breath she pulls back, aggravated, muttering, tossing aside both broom and eyeglasses. Quietly, she begins reciting the names of US presidents.

She's not giving up.

Hugging the doorframe, one eye peering anxiously out, she leans forward again. The camera switches perspective: she's no longer the object of its gaze, but its subject. Now we see the newspaper lying what seems miles from her door. Slowly the camera pans upward, capturing the length of the corridor. A different strain of music – scary, crazy, ominous music – dubs in overtop of Figaro.

The camera flips back. She's an object again.

Still whispering the presidents' names, she slowly gets up on her feet, holding onto the doorframe, averting her eyes. Suddenly, with her feet still inside the door, she hurls herself towards that newspaper, landing on the floor face first.

I jump a little.

Wait – she's got it!

She slithers quickly backwards, looking down. She's inside. She's safe. She shuts the door and sits, relieved, breathing hard, back against the wall.[1]

I realise I'm leaning forward in my chair and I exhale.

It's just a movie.

Maybe not.

Many people – mostly women – go through this type of ordeal every day. One study estimated the prevalence of agoraphobia to be as high as 5% of the population.[2] In the United States that translates to millions of people too terrified of public spaces to leave their homes, some even just a few feet to their mailbox.

Most people seem to know someone with agoraphobia, at least those with whom I have discussed my research. Famous people with agoraphobia include Marilyn Monroe, Kim Basinger, and Howard Hughes. Sigmund Freud told a colleague he suffered from agoraphobia for a time, and there are related debates about Emily Dickinson and Charles Darwin.[3]

Agoraphobia has also become something of a lucrative cottage industry – in only a few minutes surfing the internet, I found videos to buy with titles like "Agoraphobia: A Prison without Bars" and "Fight or flight?: Overcoming panic and agoraphobia," and audiocassettes such as "Pass Through Panic." A quick search at <barnesandnoble.com> turned up over fifty books on agoraphobia – for sufferers, by sufferers, for friends and family of sufferers, and for therapists. But agoraphobia is big business for pharmaceuticals too: In 1998 the Upjohn company made $321 million (US dollars) selling Alprazolam, a minor tranquilliser commonly used in the management of agoraphobia.[4] Anti-depressants, widely prescribed (for a range of mental disorders), have yielded a tidy sum as well. The global antidepressant market is expected to increase from its current value of $11.1 to $13 *billion* USD by 2005.[5]

Agoraphobia is not just profitable, however. It occupies significant cultural space, both in terms of the social support networks generated and in terms of culture qua entertainment. For example, an Internet search (<www.google.com>) for the term "agoraphobia" gets over 35,000 hits, some of them shopping links, but they are also links to sufferers, to reams of personal statements, and websites for support groups and information resources. In the spirit of support, agoraphobia has been featured on ABC's newsmagazine 20/20, and in *The Globe and Mail.*

And as recently as April 5th *Time* magazine did a special feature on phobias as well, including a self-test based on the *Diagnostic and Statistical Manual of Mental Disorders*. Interestingly, nearly all of the questions in the test pertained to agoraphobia. Some samples: "Do you [h]ave a persistent and excessive fear of ... being in a public place from which there is no escape?" "Do you [h]ave an excessive and ongoing fear of social situations, such as going to the mall, the movies, or a restaurant?" "Do you [f]ear traveling [sic] without a companion?"[6] Even the Loblaws grocery chain, in *President's Choice Magazine*, tucked a short piece on agoraphobia between its recipes and advertisements not long ago.[7] And as entertainment, agoraphobia has been featured in novels (*That's Fine, Spin Dry*), on the silver screen (*Copycat, The Fear Inside*),[8], and as a plot-line on ER.[9] Agoraphobia has a considerable presence on the cultural landscape.

Within the world of psychiatry, agoraphobia has been an even bigger concern for well over a century. Phobias in general have occupied space in the minds of doctors (and patients, of course) since even earlier than that. Hippocratic physicians wrote the earliest descriptions of "men who feared 'that which need not be feared'":

> ...The morbid condition of Nicanor. When he used to begin drinking, the girl flute-player would frighten him; as soon as he heard the first note of the flute at a banquet, he would be beset by terror. He used to say he could scarcely contain himself when night fell; but during the day he would hear this instrument without feeling any emotion. This lasted a long time with him.
>
> Damocles ... appeared to have dim vision and to be quite slack in body; he could not go near a precipice, or over a bridge, or beside even the shallowest ditch; and yet he could walk in the ditch itself. This came upon him over a period of time.[10]

Phobic symptoms were associated with melancholia until well into the 18th century, when emphasis was being placed on their classification.[11] The surgeon Le Camus (1722-1772), for example, sought to classify phobias according to the sense most affected – sight, hearing, touch, taste, or smell.[12] Sauvages (1706-1767), a botanist, classified his observations by symptomatology, identifying vertigo as the most striking characteristic of phobias.[13] Pinel (1748-1825), reluctant to replace the earlier Hippocratic system, preferred to elaborate upon existing classifications while Esquirol (1772-1840) introduced the term *monomanie* to refer both to patients with classical phobias and patients with more delusional fears.[14] Interestingly, Esquirol also pointed out "how the dominant ideas of a century might influence the choice of objects feared."[15]

The remarks of Beauchêne (1783), Brück (1832), and Benedikt (1870), however, spoke most directly to what would ultimately become the diagnostic category "agoraphobia". Beauchêne observed that in his patients the presence of a companion often relieved phobic symptoms, and this would remain an observation cited regularly throughout the history of agoraphobia. Brück described symptoms he observed as "schwindel angst"[16] while Benedikt, described by some as the first to describe agoraphobic symptoms proper, used the German term *platzschwindel* (dizziness of places) to describe a patient he had seen who was "' unable to cross wide streets or open spaces.'"[17]

But it was German physician Carl Otto Westphal's pathbreaking article "Die Agoraphobie" (1871), published in the German (Prussian) journal *Archiv für psychiatrie und Nervenkrankeiten*,[18] which is widely seen as the starting point of the history of agoraphobia, and possibly even the modern literature on phobias.[19]

Following his paper and several others that were published immediately in response, the clinical discourse of agoraphobia developed a life of its own and has continued to expand. A recent search on Medline turned up nearly 2000 references published in the last 30 years alone.

Based on English-language clinical representations published since Westphal's "Die Agoraphobie," I offer in this dissertation a critical socio-cultural history of agoraphobia in the context of developments and shifts in culture and society, in medicine and psychiatry, and in social theory. I examine the problem of classification, a central thematic in this history that presents a critical point of connection between the medical and the cultural. By examining the exclusionary discourse of this disease, I attempt to show how the "Other" is constructed through relations of power that inform a range of classifications, including gender, race and ethnicity, class, sexuality, and physicality. Finally, I also consider how agoraphobic subjectivities become embodied, through the practices associated with agoraphobia, namely its enactment or representation in journals, and the discursive reiteration of normative cultural and disease classifications.

Reading agoraphobia in these terms permits an examination of clinical narrative in the context of cultural processes. I argue that from the outset a normative theory of social order has been embedded in the discourse of this disease, notwithstanding crucial shifts in cultural and medical-scientific terrain. Agoraphobia is more than simply a disease phenomenon. Following Bordo, I take the "psychopathologies that develop within a culture, far from being anomalies or aberrations, to be characteristic expressions of the culture; to be, indeed, the crystallisation of much that is wrong with it."[20]

I both benefit from and hope to contribute to several disciplinary literatures, including history, cultural studies, psychiatry, and especially sociology. Although health and medicine have long been a central area of specialisation within sociology, only a few sociologists have actually pursued the study of agoraphobia, perhaps because it has seemed to be only a problem for the individual and hence more appropriate to psychological study. But I consider agoraphobia a sociological problematic in several respects. As Durkheim demonstrated in 1897, suicide – that behaviour which seems to encapsulate individual distress par excellence – is in fact profoundly social.[21] Following this example, I shall demonstrate that the study of agoraphobia belongs squarely within sociology. Second, agoraphobia was not always a pathology of women. From its early days, through the First World War, agoraphobia was a disorder diagnosed primarily in men. This raises the sociological question of how a disease could be(come) gendered, and then subsequently *re*-gendered. Related to this are issues of race and class, insofar as agoraphobia, like hysteria and neurasthenia, has largely been perceived a white, middle-class phenomenon. Third, it is also evident from the medical literature that the question of what it has meant historically to be "normal" has been informed by capitalist imperatives of production and consumption, with diminished working and shopping always serving as a revealing sign of pathology. Fourth, both medical and sociological evidence suggests that agoraphobia may have emerged in response to the sea changes of modernity, that modern urban *social* conditions gave rise to the individual(ist) need for self-preservation. In this sense, then, the symbiotic relationship between sociology and modernity calls for a sociological study of this *modern* disorder. Finally, the study of indi-

vidual problems in social and historical perspective is fundamental to the sociological imagination itself. As C. Wright Mills argued, an accumulation of "personal troubles ... must be understood as public issues – and in terms of the problems of history-making." Sociologists must know that "the human meaning of public issues must be revealed by relating them to personal troubles – and to the problems of the individual life."[22] As he also stated, "Without the use of history and without an historical sense of psychological matters, the social scientist cannot adequately state the kinds of problems that ought now to be the orienting points of his [sic] studies."[23] Rigorous sociology depends upon the examination of individual "biographies" in the context of larger histories and social issues.

Mills' point constitutes one of the ties that also binds this work with the discipline of history, whose traditional methods and assumptions I both adopt and challenge. I agree with Mills that sociologists do not do enough history (nor historians enough social theory, for that matter). We tend to avoid primary materials and skim the surface of secondary works, failing to realise that these are merely interpretations, evidence *generated* rather than evidence *found.*[24] I attempt to problematise this ambiguous relationship between history and sociology by approaching agoraphobia as an "event" – as a "moment of becoming at which action and structure meet."[25] As Philip Abrams argues:

> [W]e have to find a way of living with the fact of the mutual interdependence and contamination of theory and evidence without resorting to either the anti-theoretical fetishism of history-as-evidence ... or the a-historical fetishism of theory-as-knowledge ...[26]

But in problematising this relationship, I ask what it means to do history and sociology and in this respect my work draws on and contributes to cultural

studies as well. Following Michel Foucault, I seek to examine the practical, epistemological, and discursive production and regulation of embodied medical subjects in the context of a history of ideas. A poststructuralist critique of traditional historical method offers to explode claims to fixed meaning and obvious categories of knowledge, and the relations of power that order our lives. As Foucault states, "It's a matter of shaking this false self-evidence, of demonstrating its precariousness, of making visible not its arbitrariness, but its complex interconnection with a multiplicity of historical processes."[27] By taking a poststructuralist approach, I hope to reveal how the dominant rationality of psychiatry has been deployed as a technology of power, "how forms of rationality inscribe themselves in practices or systems of practices, and what role they play within them."[28]

In this thesis I explore how agoraphobia has been a shifting category of knowledge, changing very much in response to a shifting psychiatric gaze that, save for psychoanalysis, has always taken for granted the possibility of a unified, rational subject. I also seek to underscore the politics, contestations and conditions of possibility in which this disorder has historically been embedded. The very act of representing agoraphobia (and really the people that have it) has been a key constitutive component of its production as a meaningful and powerful psychiatric entity. It is the representation of agoraphobics as classifiable and deviating from the *normal* and the *orderly*, that I call into question.

Finally, although I do critically examine some of its practices and assumptions, my interest here is decidedly *not* in alienating psychiatry and psychiatrists. Should even one practitioner have occasion to read this dissertation, my hope is that it will be seen as a step towards bridging the deep fault-line that appears to

divide our respective understandings of what the other's scholarship entails. Sociologists of medicine would do well to see medical writing as an untapped resource for their work, but psychiatric thought would also benefit from a more sociologically informed understanding not only of the pathologies with which it is concerned, but of the culture in which these pathologies exist.

With these questions and objectives in mind, the dissertation is arranged according to several overlapping themes. Following a review of the literature that has informed this work (Chapter 2), and an outline of my methodology (Chapter 3), I turn to the medical literature. In Chapter 4 I focus especially on doctors' late 19th and early 20th century (up until 1949) efforts to discern what this disorder was all about. This chapter discusses how doctors explored the best ways to treat and classify agoraphobia, as well as the important shift in the prevalence of this disease from men to women.

In Chapter 5, I turn to the psychoanalytic literature, from Freud's first foray in 1892 into a theory of the unconscious and its relationship to the development of phobias, through to literature published in the 1970s. Although, chronologically speaking, Freud's early work overlaps with the early medical literature, I treat psychoanalysis separately because, after his investigations, a tendency towards more specialised and psychodynamic approaches to mental pathology emerged. Indeed, by the end of the 1930s, psychiatry was *defined* by psychoanalysis, which remained the dominant approach for several decades. Its influence was apparent in the first and second editions of the *Diagnostic and Statistical Manual of Mental Disorders* (the DSM), the official classification and

nomenclature of the American Psychiatric Association (APA), released in 1952 and 1968 respectively.

Behaviourism is the subject of Chapter 6. The roots of this approach were established in the late 19th century, and scattered evidence of behaviourism is present in the early years of agoraphobia's history. Eventually constituting something of a bridge between a declining psychoanalytic presence and a resurgence of positivism, its *real* moment in this history only came after the 1960-70s. With its assumption that biology, cognitions, and environment all played a role in the development of agoraphobia, behaviourist methods, seen as efficient and economical and officially approved by the APA in 1970, focused less on deep, unconscious problems, and more on the practical management of agoraphobia.

In Chapter 7 I sketch the history (and politics) of the DSM, from its early 20th century precursors that led up to its first edition of 1952 through an outline of the events leading up to its various revisions (in 1968, 1980, 1987, 1994, 2000). This chapter reveals what a contested psychiatric presence this manual has had, especially since its third edition of 1980. The DSM-III especially set in motion a paradigm shift in psychiatry that involved nothing less than a professional and epistemological turf war. In the course of this struggle, the earlier psychodynamic conception of mental illnesses as psychosocial reactions was trumped by a biopsychiatric, research-oriented, descriptive, and scientistic approach to psychiatry more compatible with the medical model. Indeed, with its wide acceptance by government, judiciary, pharmaceutical and insurance companies, and mental health care providers, the DSM-III both represents and has played a central role in the transformation of the discipline. Hypothesis-testing,

drug trials, and large-scale multi-authored studies was the new face of psychiatric *science*. Its successful excommunication of psychoanalysis for failing to conform to the standards of validity and reliability had come to define psychiatry vis-à-vis the APA and its DSM system.

Against the backdrop of this paradigm shift, I turn in Chapter 8 to the literature on agoraphobia that has been generated since then. We will see how the biological and positivist tendencies evident in early psychiatric literature from a century ago have been revived in concert with a burgeoning pharmaceutical industry. This chapter reveals how behaviourism has managed the APA's wholesale (re)turn to biology by packaging its scholarship in conformity with the categories of the DSM and the normative positivism of contemporary psychiatry. Finally, despite these relentless efforts to implement standardised psychiatric classifications, in practice, the category of agoraphobia has been patchy at best, largely because the official criteria for agoraphobia have changed with each DSM, and because they've been deployed inconsistently by practitioners and researchers.

In Chapter 9 I reflect on agoraphobia's representation in medical literature and agoraphobia in the light of cultural texts and its social conditions of possibility. Seeking to disrupt the privilege normally accorded to scientific knowledge and its penchant for classification, psychiatric science is presented as both practice and culture. Moreover, as an exercise that can exclude the social, science constitutes a legitimation of the positivist representations of agoraphobia so standard in this period. Within these psychiatric narratives that presume to be able to classify *people* is, I will argue, a deeply embedded normative theory of social order. The binary of normal and pathological entrenched within concerns about in-

dividual mental health also reflects an implicit concern with society's health, assumed to be jeopardised by any and all deviations from medical (and cultural) norms. These standards – gendered, classed, and racialised – have had far-reaching implications to the extent that medical notions both draw from and reinforce the social fabric.

I conclude in Chapter 10 with thoughts on agoraphobic bodies. I argue that agoraphobic bodies are enacted by practices associated with the disorder, practices that derive their meaningfulness from normative cultural categories. I attempt to account for the multiplicity of agoraphobic bodies, as well as challenge the presumed distinction between the discursive and the material.

As a final point, I note one caveat. As I have already mentioned, the chapters overlap in their chronological considerations because they are arranged thematically. The three major perspectives that I consider (medical, psychoanalytic, and psychological) co-exist throughout this history, but each has reached its zenith at a different point. Thus, I begin with the medical literature that tended towards biological explanation, which was overtaken by psychoanalysis, which in turn was overtaken by behaviourism, which in turn has found a way in the past two decades or so to function contemporaneously with a rejuvenated positivism and biologism in psychiatry.

Turning now to the literature review, I outline the non-clinical literature on agoraphobia that has emerged, as well as some of the historical, sociological, and cultural literature that has informed this project.

Notes

[1] A scene from the movie *Copycat*. Sigourney Weaver plays an agoraphobic forensic psychiatrist.
[2] See Rosenbaum et al., 1995:A4.
[3] Adler, 1997; Barloon and Noyes, 1997a, 1997b; Colp, 1997; FitzGibbon, 1997; Fuss, 1998; Garbowsky, 1989; Gordon, 1997; The Insane Asylum, 1998; Reik, 1949. (Re: Marilyn Monroe, Kim Basinger, and Howard Hughes – my sources here are unrefereed websites. Whether or not the information is accurate, it signifies agoraphobia's presence in the cultural imagination.)
[4] Pharmacia & Upjohn. 1998. *Powering the Turnaround: Annual Report, 1998*. Bridgewater, NJ: Pharmacia & Upjohn, p. 35. The report also shows that in 1998 $1.199 billion dollars were spent on research and development, though it unfortunately does not break these figure down by product (p. 62). These figures are especially remarkable when compared with those of 1982 when Upjohn Co. reported earnings of (only!) $12 million USD (Orr, 1990:466).
[5] Jarvis, 2000. Much of these profits have been earned in the US, as Foote observes that antidepressant sales there have grown from $2 billion USD in 1993 to over $7 billion USD in 1998 (Foote, 2000). The increase is attributed to improvements in existing technology, namely the development of SSRIs.
[6] Kluger, 2001:59. The online version of the article contained a link to quiz entitled "Are you a phobia expert?" Intended to increase non-phobic readers' sensitivity to these conditions, a preamble to the quiz reads: "Phobia, schmobia. Why can't people just get over themselves?" And later: " Everybody knows about claustrophobia (confined spaces), acrophobia (heights) and agoraphobia (public spaces), but there's a lot more out there to worry about. Here are 10 other everyday phobias you might not even realize you have – until now" (Gregg, 2001).
[7] ABC News, 1999; Daigle, 1999; Hollingshead, 1992; Huang, 2000; Underwood, 1999.
[8] Interestingly, both of these movies are thrillers; the agoraphobic women featured in them are both afraid of violent harm being done to them. In the medical literature, agoraphobia is *never* about fear of violence. Rather, patients are afraid of *themselves*.
[9] A recent issue of *The Globe and Mail* had a nearly-full page ad for Saab convertibles that read: "Saab vs. claustrophobia. The antidote for that restricted feeling" (2001:A10). (As we shall see later in the dissertation, claustrophobia and agoraphobia are often conflated.)
[10] Cited in Errera, 1962:327. For the Hippocratics the symptoms of phobia came under the category of melancholia (black bile), one of the three major types of insanity delineated at that time.
[11] Errera, 1962:328. Actually, the association with melancholia persists, to the extent that debates over the relationship between depression and agoraphobia continue.
[12] Errera, 1962:329.
[13] Errera, 1962:330.
[14] Errera, 1962:331.
[15] Errera, 1962:331.
[16] Cited in Van Horn, 1886.
[17] See Knapp and Schumacher, 1988:25.
[18] Westphal was known for his work in both psychiatry and neuropathology. His interests within these areas included obsessive-compulsive neuroses, periodic mania, hypochondriasis in children, paralysis in syphilis and other mental illnesses, "contrary sexual feelings" (homosexuality), brain disorders, infectious diseases of the nervous system and spinal cord, and the proper form of psychiatric training, (Knapp and Schumacher, 1988:17-20).
[19] Lewin, Errera in Knapp and Schumacher, 1988:2.
[20] Bordo, 1993:141.
[21] Durkheim, 1951 [1897].
[22] Mills, 1959:226.
[23] Mills, 1959:143.
[24] Goldthorpe, 1991:214.
[25] Abrams, 1982:192.
[26] Abrams, 1982:333.
[27] Foucault, 1991:75.
[28] Foucault, 1991:79; 1982:210.

Chapter 2
Literature Review

Introduction

As I have noted, agoraphobia has garnered surprisingly little attention from sociologists. This lacuna is significant if we consider how much work sociologists and others have done on, for example, Anorexia Nervosa.[1] There has been especial interest in linking women's oppression and the gendered imperative of beauty to its emergence,[2] yet little interest in agoraphobia whose prevalence is also among women.[3] Perhaps anorexia has seemed more relevant to non-medical and feminist scholars because it is more immediately apparent than agoraphobia. That is, agoraphobia, except maybe in actual moments of panic, is not "written on the body," as we could say of malnutrition. It may simply be the difference between a disappearing-but-still-present body and a body-already-disappeared – a body housebound. Still, one would think that the *complete absence* of some bodies from public spaces would be at least as compelling. Instead, people – mostly women – who do not venture outside pass relatively unnoticed and overlooked, in this literature as in life.

Fortunately the dearth of literature on agoraphobia has not been entirely unmitigated. Turning now to a review of what *has* been published, I offer an overview of this scholarship, focusing on how my work both departs from and contributes to it. In addition to the literature on agoraphobia proper, I shall also briefly consider texts in related areas. Though not all of these ultimately appear in the thesis, they nonetheless helped shape my thinking and the questions informing this research.

Agoraphobia

Women's inequality is a central theme in the literature on agoraphobia. In general, the arguments tend to be variations on the idea that agoraphobia is caused by and reflects women's diminished status relative to men, their restricted mobility, and their tenuous relationship to the public sphere.

The first to consider agoraphobia in these terms was Abram de Swaan. In 1981 he examined the relationship between "large-scale societal transformations and shifts in relational and emotional management within intimate circles," focusing in particular on the rise of professional psychotherapy and the development of psychic problems in the late nineteenth century.[4] He uses the case of agoraphobia as a vehicle for describing how intimate relations between people were altered in the late 19th century such that the difficulties they experienced within themselves and with each other were transposed into the vocabulary of psychotherapy. De Swaan argued that it was not until this time that people came to describe their difficulties as psychic problems. Indeed, the proto-professionalisation of psychotherapy encouraged people to recognise and organise their anxieties according to professionally delineated categories and to present them as problems suitable for expert psychic treatment.

De Swaan makes his case, in part, by observing that even when bourgeois restrictions on women's movement in public space were diminishing near the end of the 19th century, psychiatrists were reporting cases of agoraphobia. As he writes, "Actions that had been socially prohibited before, remained unfeasible to some even after they had become permissible."[5] Later he writes that the restric-

tions imposed on women were transformed into collective fantasies about public order, sexuality, and violence, as well as notions of family as sanctuary. When sanctions against women's movement were lifted, these fantasies vanished from public discourse, "but survived in the intimate family circle as available themes to be elaborated into a particular agoraphobic relationship", becoming the "cultural heritage of later generations."[6] In other words, agoraphobia was a particular way of managing relational conflicts within the matrimonial family, a method that recreates the 19th century bourgeois family, as well as "an inexplicable anxiety to guide its actions and to protect its ways."[7]

As we shall see later in the thesis, de Swaan is quite right to make a link between agoraphobia (at least in its earliest formations) and 19th century bourgeois sensibilities. Yet de Swaan's argument is also somewhat narrow in that he glosses over some important details that otherwise are not explained by his argument. Specifically, he talks about the proto-professionalisation of psychotherapy, but tends to limit his definition of psychotherapy unproblematically to psychoanalysis, sans any professional and disciplinary struggles. In the period that de Swaan emphasises, i.e., the last decades of the 19th century, Freudian psychoanalysis was only just emerging, and was met with widely documented resistance. De Swaan also states that after Westphal's article in 1872, an article concerned entirely with men, "women patients soon followed, constituting a large majority of agoraphobic patients at that time."[8] Perhaps this strong majority was evident in non-English-language publications, but in the English-language literature this was decidedly not the case, given that the increase in prevalence among women did not begin until well after World War I. His argument that the current preva-

lence of agoraphobia in women is a cultural inheritance of 19th century sexual mores does not account for the four decades that men displayed these symptoms more than did women. Finally, the notion that agoraphobia reflects an inherited collective preoccupation with 19th century ideas about gender and class-appropriate behaviours glosses over the important shifts in psychiatry and society that have taken place over the last century. The agoraphobia of today is presented as though it was merely a cultural hangover. De Swaan's analysis is nonetheless incisive in its connecting emotional and intimate relations with societal change, or in the words of C. Wright Mills, private troubles with public issues.

Another publication released shortly after de Swaan's was also concerned with gender inequality, but was less persuasive. Robert Seidenberg and Karen DeCrow wrote their *Women Who Marry Houses* in order to highlight "the point of why people, especially women, ... might be agoraphobic."[9] That point, they argued, was that in a culture that "has consistently doled out punishment to women who travel away from home," some women, "sensing the existential irony of their situation," refuse to leave home altogether. As a "paradigm for the historical intimidation and oppression of women," agoraphobia may well be a "work strike" against the expectations of the housewife disguised as a "caricature of femininity."[10] Indeed, agoraphobics may be "the most completely uncompromising feminists of our times [...] Sensing that they are not welcome in the outside world, they have come to terms with their own sense of pride by not setting foot on land that is deemed alien and hostile."[11] Critical of drug and behaviour therapies (Seidenberg, not surprisingly, is an analyst), they contend that until gender oppression, sex role stereotypes, and societal intimidation of women are addressed, ago-

raphobes will continue to respond with "their so-called neuroticism ... a strong personal political statement about their own plight in a restrictive society."[12]

Seidenberg and DeCrow touch on many important aspects of agoraphobia, including, for example, shopping, marriage, the different therapies, private and public spheres, and the role of experts in the construction of gender. It is clear that their way of thinking about women and mental disease served an important purpose at the time they were writing; the DSM had made its mark by then, and an increasing social consciousness of the politics of women's treatment in the hands of psychiatrists was emerging. Unfortunately, their dogmatic and polemical approach obscures their argument. They draw very little on the actual medical literature, and imbue "woman" (who has no race or class) with an invariable set of essential characteristics, not the least of which is her docility, even as she engages in agoraphobic (if petulant) dissent. Their world is simplistically bifurcated into victims and oppressors, rendering their argument for agoraphobia as protest somewhat contradictory and unsophisticated. I hope to demonstrate that the gendered politics of agoraphobia were and are more complex than this.

Joy Reeves and Stephen Austin's argument also concerns gender inequality, but theirs is not quite so one-dimensional as Seidenberg and DeCrow's. Reeves and Austin contend that the models used by health practitioners who treat agoraphobia could be improved by incorporating a feminist sociological perspective because what is fundamentally at issue is the degree of sex inequality in society. Following C. Wright Mills' emphasis on biography and history, they start by examining the early days of agoraphobia, when agoraphobics were predominantly men, concluding that this "perception may have existed because the

gender stereotype of women was consistent with the behavior of female agoraphobics." Women "who exaggerated their feminine roles were perceived by others as within the 'normal' range of acceptable behavior."[13] Reeves and Austin's insights continue when they suggest that 19th century women were more likely to seek comfort from their women friends rather than from male doctors, "thus obscuring objective recognition and official recording of her condition."

Although it is a minor point, I take issue with their uncritical equation of doctors with objectivity. Still, to their credit, they do underscore the point that diseases do not exist meaningfully until doctors name them. Additionally, given the significant body of historical literature on female friendships in the 19th century, I do think Reeves and Austin's explanation for the gender disparity in reports of this disease is at least plausible. Where their argument deteriorates somewhat is, as with Seidenberg and DeCrow, in their unproblematic assumption that femininity and agoraphobia are uniform and stable categories and that power can only be oppressive, working only to victimise women. They are correct to emphasise structural considerations otherwise not entertained within psychiatry, but they do so at the expense of certain other, more fundamental issues. These include the process of dichotomous classification of both disease and gender, as well as the need to understand power differently, as productive and not only oppressive, as they present it. I agree with Reeves and Austin when they say a psychiatry inclusive of social and political issues would be more effective in the treatment of agoraphobia.[14] I contend, however, that these social and political issues have to go beyond a bifurcated model of sex stratification.

Ann Toni Brown also works within the same framework, arguing that agoraphobia in women is due to decreased rights relative to men.[15] Brown examines how 70 agoraphobics (62 women, 8 men) cope with their agoraphobia through different help-seeking behaviours based in the separation of modern social life into private and public spheres. She demonstrates that agoraphobia can "be better understood through exposition of the social meaning and determinants of the sufferers' characteristic fears and coping strategies."[16] Her study illustrates the fact that "agoraphobic individuals suffer from profound anxiety about the subsequent problems for their normatively proper behaviour and role duties." The tactics they employ "aim to avoid risky ... public situations with the minimum of normative contravention."[17] Brown contends that no woman, let alone agoraphobic women, has an easy time entering public life and that this is why more women become agoraphobic in the first place:

> Obviously ... women's greater vulnerability to agoraphobia will be solved in the long run by changes in gender ideologies and arrangements allowing women to participate fully and equally in public life. But this is something of a universal panacea, meaning so much that it means almost nothing, and certainly nothing for agoraphobic women trapped in the here and now.[18]

As a solution she offers, however cautiously, "a judicious measure of feminist consciousness raising in the social management of agoraphobia." She stresses "'judicious' because it is important not to replace one set of alienating practices and ideologies (medicine) with another (radical feminism), which will not be accepted by the majority of women sufferers.[19]

Like the others, Brown is correct to consider agoraphobia in the light of gender politics, and especially with evidence from the sufferers themselves. Jux-

taposed together, her work and mine constitute an interesting contrast, considering that the voice of patients is almost never heard in the literature that I examine.[20] Our work also differs in another respect: Brown's objective is to facilitate improved treatment through the redress of the "sick conformity to gender stereotype[s]" that constitutes agoraphobia. I too hope to have a positive effect on women's lives, however I contend that the category of agoraphobia itself and the practices surrounding it need to be challenged. Specifically, there tends to be in all of the texts discussed so far an uncritical acceptance of these bifurcated categories – the normal and pathological, private and public, masculine and feminine – as stable and monolithic.

The complexity and instability of this kind of thinking begins to be addressed by Carol Brooks Gardner who observes some striking similarities of attitude and activities between agoraphobic and non-agoraphobic women.[21] Using participant-observation and in-depth interviews, Gardner studies how these two groups modify their behaviour in public places – agoraphobics in the name of panic prevention, and non-agoraphobics in the name of crime prevention. She finds that both groups use similar behavioural tactics, including absenting themselves from public places, bringing a companion, mental mapping of safe and unsafe areas of the city, and using cover stories so as not to appear ridiculous. Gardner argues that "the similar conduct of individuals labelled 'pathological' and 'normal' indicates both the rationality of agoraphobics and the extreme behaviors that nonphobic women must enact."[22] Women and men "are culturally predisposed to understand public territories in different ways and ... there is ample warrant for women's distrust of public places."[23] Thus agoraphobic avoidance

of public places simply highlights the typical measures that non-agoraphobic women take, for there are good reasons for staying home if one is a woman and "agoraphobia draws on and exacerbates these tendencies." She goes on to say that "although the source of fear is different ... women's descriptions of their actual practices often blur the boundaries between the nonphobic and phobic."[24]

Indeed, Gardner's calling into question the private and public, and the normal and pathological – central dichotomies at work in both the experience and classification of agoraphobia – is a great strength of her study. Her finding that non-agoraphobic women employ many of the same tactics that agoraphobic women do underscores the cultural bind that women find themselves in: to be afraid of public places is a proper gendered fear and women should conduct themselves accordingly. (It is ironic that women tend to accommodate more readily the informal controls on their movement, even though it is men, having more freedom to walk the streets and therefore a greater presence there, who are actually more likely to be attacked in public space.[25]) Thus, agoraphobia illustrates the cultural sanctions against women's freedom of movement and destabilises the rigid split between the "normal" and the "pathological." I am not sure, however, how well the argument holds in the reverse. That is, in none of the medical literature is there any suggestion that what agoraphobic women are afraid of is crime. Rather, they generally seem to be more afraid of themselves and especially the possibility that they will panic in an "unsafe" place. Still, Gardner's work does provide a place to begin critically assessing the question of what is "normal" gendered behaviour and what this might have to do with the category of agoraphobia.

In her sociology thesis on agoraphobia, Kathleen McSpurren also takes up the issue of gender roles, arguing that agoraphobia is an expression of different psychiatric perspectives on gender.[26] Tracing the history of agoraphobia through some of the same medical literature that I do and situating it within a medical and cultural context of rampant hysteria and neurasthenia, McSpurren argues that the normative construction of gender has changed over the lifetime of this disease. Each of the branches of psychiatry (medicine, psychoanalysis, cogntive-behaviourism), moreover, has mobilised these culturally and historically-specific constructs differently (in form but not in content) within their respective literatures. She takes issue with the tendency of all of them to interpret agoraphobia in ways that render these women passively compliant with the rules of femininity, as reproducing ideal feminine behaviour. In other words, she argues that the diagnostic category has "served to confirm the social construction of femininity."[27]

Following Susan Bordo's thesis on anorexia and clearly influenced by Seidenberg and DeCrow, she contends that agoraphobia ought to be seen as an embodied "protest against the limits and confinement of femininity by taking the ideals of domesticity and dependence" to the extreme.[28] McSpurren's is a definite advance over Seidenberg and DeCrow in that she avoids polemic and marshals much convincing evidence from the psychiatric literature to support her argument. But I hope to show in my own thesis that while normative ideas about gender have certainly played an important part in the history and embodiment of agoraphobia (both in terms of its invention and re-gendering), other critical factors are important to consider as well. Not the least of these is the history, influence, and politics of the DSM and the cultural and psychiatric imperative of clas-

sification imposed by and reflected therein. Bordo, and by implication McSpurren, conceptualise anorexia and agoraphobia as embodied expressions of a pathological culture. I agree that pathology is a reflection of culture – indeed, I quote Bordo's insightful remark to this effect in my introduction. But I hope to show that agoraphobia is also an expression of certain practices, namely, classification and representation, and that these practices have been inconsistent and unstable. McSpurren recognises the link between shifts in psychiatry and shifts in the construction of gender, there is still a tendency in her argument, however, to accept the category of agoraphobia itself as uniform and stable. As well, she utilises psychiatric literature to make her case, but takes for granted the role played by the very act of writing up publications about patients. I interrogate that role, especially in terms of the embodiment of patients as agoraphobic subjects, an issue I take up in Chapter 10. I hope to show that these documents are not merely sources of evidence about agoraphobia (and gender). As representations, they are also among its conditions of possibility.

Gender inequality is not the only concern among writers interested in agoraphobia and Lisa Capps and Elinor Ochs, a clinical psychologist and a linguist, examine the important relationship between representation and the category of agoraphobia. They argue that by "simply attending to how persons around them are representing and constructing their world through language,"[29] it is possible to understand agoraphobia as a socialised communicative disorder. Sensing that "more attention needs to be paid to how agoraphobic persons talk about themselves and their experiences," the authors closely following the life of one agoraphobic woman – Meg – and demonstrate that the "stories people tell construct

who they are and how they view the world."[30] In other words, the agoraphobic person uses language to construct her own abnormality, to participate in her own *agoraphobi-fication*, both reinforcing and drawing on extant psychiatric categories and assumptions: "We describe Meg as agoraphobic because she consistently labels herself in this way. She even chooses descriptors that match criteria found in the *Diagnostic and Statistical Manual of Mental Disorders*..."[31] They add later on:

> Listen to Meg's words for the dominant version of her suffering, but probe beneath the surface to apprehend a subjugated version, one that articulates an alternative, conflicting world view. This subjugated world view is not recognized in the official discourse of *The Diagnostic and Statistical Manual of Mental Disorders*. Nor is it fully recognized by the storyteller herself.[32]

The stories Meg told them contained within them "socializing messages about fears, control, dependence, irrationality and/or other symptoms of this most debilitating disorder."[33] Capps and Ochs conclude that agoraphobics construct and reconstruct themselves in the ways that they talk about and make sense of themselves, and that this is how anxiety is passed along through generations. Capps and Ochs also demonstrate the sense that agoraphobia is a category of knowledge and the DSM its "official version" through which patients are filtered, something I also pursue in this thesis. In contrast with their examination of how Meg sees herself through the lens of her own representations, my aim is to examine how medical representations serve a parallel and related purpose, that is, in the construction of agoraphobia as a normative category.

Other Literature Informing The Research

The Social Conditions of Modernity

De Swaan, McSpurren, and Reeves and Austin underscore the need to study agoraphobia in historical perspective. Like them, I also examine how agoraphobia was enabled in the first place, and I focus in particular on the social conditions of modernity. Classical social thinkers such as Emile Durkheim, Karl Marx, Max Weber, Georg Simmel, and Ferdinand Tönnies demonstrate in their writing a generalised anxiety about the changes of modernity and their effect on the individual psyche. Implicit in these ideas is a sense of nostalgia for more pastoral earlier times, a sentiment echoed within the psychiatric literature.[34] Building especially on Freud and Simmel, Benjamin describes (though in more positive terms than the others) the fast pace of modern urban living, with its crowds, displays, and commodities available (and necessary) for purchase. He reflects on the bourgeois demarcation of private from public life, the establishment of the family home as a sanctuary, away from the perils outside its walls.[35]

All of these ideas are suggestive of the possibility that the sea changes of modernity were accompanied by a difficulty of adjustment. Individual citizens had substantive reasons to become anxious, and out of their anxiety doctors and social theorists accumulated the evidence they needed to bolster their concerns about the direction in which society was heading. Indeed, at the core of this discourse about individual anxiety was an anxiety about social order and the notion that with all these social changes the health of society itself was becoming increasingly jeopardised.[36] Critical factors in this discourse were issues of race, class, and gender; as Rebecca Herzig and Laura Briggs demonstrate, notions

about civilisation and savagery were profoundly interconnected with normative medical conceptions of health and pathology.[37] Bert Hansen and Mary Poovey also show how written medical discourse served as an important and powerful forum for constructing the Other,[38] while Michèle Barrett and Kathryn Montgomery Hunter together underscore the nebulous boundary between (medical) truth and (cultural) narrative.[39]

The Classification and Representation of Disease (Concepts)

This study of agoraphobia draws on several other analyses of specific diseases, as well as the concept of disease itself. Briefly, my point of departure is the idea that disease concepts are socially constructed, shifting, contingent, and plural. Annemarie Mol's work on atherosclerosis[40] and hypoglycaemia[41] (this with John Law), alongside that of Marc Berg and Geoffrey Bowker,[42] demonstrate the plurality of disease. As Mol argues, for example, "Atherosclerosis isn't one, but many [...] The ontology incorporated and enacted in the diagnosis, treatment, and prevention of atherosclerosis is multiple."[43] Together with Law they argue that the diverse practices associated with a particular disease subsequently enact it multiply. As they write, "there are various enactments of hypoglycaemia. To put it provocatively: there are various *hypoglycaemias* – with an –s, however unconventional."[44] Focusing on patients' medical records, Berg and Bowker argue something similar: "different records ... are intertwined with the production of different patients' bodies."[45] I draw on their ideas when I assume that medical articles have a parallel implication.

The multiple nature of individual diseases makes them somewhat unruly, however, giving rise to a compulsion to contain them within classification systems. The impulse to classify is not exclusive to medicine – indeed, we must classify constantly just in order to be able to carry out even the most trivial and mundane tasks. To cook, for example, we need to differentiate the top of the stove from its inside, flour from sugar, a rapid boil from a simmer. When we get dressed we know that socks are in the sock drawer, and pants are hanging in the closet. To be sure, classifications help us get through the day.

But, entangled within power relations, classification can also become quite problematic, as when we differentiate Blacks from Whites, women from men, homosexuals from heterosexuals, the sane from the insane. All of these bifurcations entail the normative creation and exclusion of a constitutive Other and as dichotomous constructions, none are able to account for the space(s) in-between, the people who do not quite fit into either extreme. Interestingly, it turns out that due to the shifting and contingent nature of norms and classifications, this turns out to be everyone.[46] Ludwik Fleck demonstrated as early as 1927 that no two clinical pictures are alike and that no strict boundary between what is healthy and diseased exists. Rather, medical thinking produces ideal types around which phenomena are grouped without complete correspondence.[47] Much more recently, Judith Butler similarly illuminates how the performance or repetition of the norms implied by classifications is never quite the same each time, and why they constantly have to be reasserted.[48] Bowker and Star, through their incisive discussion of the normative *International Classification of Disease*,[49] provide a map for critiquing classification in general and the *Diagnostic and Statistical*

Manual of Mental Disorders in particular, especially alongside works by Kutchins and Kirk who highlight the politics and inconsistencies of the DSM.[50] These authors all help me to show that even what seems like the best classification system cannot manage the non-compliance of disease concepts, or the people they represent.

The non-compliance of disease concepts derives in part from their constructedness. Taken together, the work of such scholars as Fleck, Georges Canguilhem, Allan Young, Ian Hacking and Bruno Latour each convincingly contributes to a picture of disease ideas as humanly invented and agreed upon knowledges that are, therefore, subject to scrutiny. Latour describes the material aspect of fact or disease-building. He shows, for example, how a fact, a solid instance of knowledge, develops through such things as the writing of scientific articles, the recruitment of allies, laboratory work, the accumulation of financial resources, and so forth.[51] His ideas are especially resonant in terms of the most recent history of agoraphobia with its emphasis on research.

The processes into which the fate of a claim is so tightly bound, though, are not exclusively material (in the strict sense). Canguilhem offers an epistemology of health and medicine organised around the central distinction between the normal and the pathological, taking medicine to be a science of norms.[52] And as Fleck writes in his study of syphilis, "The concept of syphilis must be investigated like any other case in the history of ideas, as being a result of the development and confluence of several lines of collective thought."[53] The scientist's phenomena are the product of "technologies, practices, and preconditioned ways of seeing."[54] Medical facts are perceived to be timeless and seamless discoveries, but

supporting them is a "harmony of illusions" that solidifies their transformation from "hazy ideas" to "rigid structures".[55] As Young writes in his analysis of the history of Post-Traumatic Stress Disorder [PTSD]:

> The disorder is not timeless, nor does it possess an intrinsic unity. Rather, it is glued together by the practices, technologies, and narratives with which it is diagnosed, studied, treated, and represented and by the various interests, institutions, and moral arguments that mobilized these efforts and resources.[56]

To argue that facts – diseases – are constructed, is to speak to how we apprehend them. Thus I agree with Hacking who argues in his study of multiple personality disorder that to say that diseases are historically and collectively constituted – constructed – is not to say that they are not real. As he writes:

> Is multiple personality a real disorder as opposed to a product of social circumstances, a culturally permissible way to express distress or unhappiness? That question makes a presupposition that we should reject. It implies that there is an important contrast between being a real disorder and being a product of social circumstances. [...] [We] must allow a place for historically constituted illness.[57]

Returning to Young again, he argues something very similar regarding his study of PTSD:

> If, as I am claiming, PTSD is a historical product, does this mean that it is not real? [...] On the contrary, the reality of PTSD is confirmed empirically by its place in people's lives, by their experiences and convictions, and by the personal and collective investments that have been made into it. My job as an ethnographer of PTSD is not to deny its reality but to explain how it and its traumatic memory have been *made* real, to describe the mechanisms through which these phenomena penetrate people's life worlds, acquire facticity, and shape the self-knowledge of patients, clinicians, and researchers.[58]

To these remarks I add that we must also allow a place for the role played by representation. That is, no disease (or anything, for that matter) can be apprehended outside of its representation which occurs primarily through language, neither

within one's own mind nor on the pages of a psychiatric text. Representation is central to the production of meaning; it is the grid through which we can know *anything* and make sense of *everything*. And when it comes to representing the "mad," as Sander Gilman argues, the images – visual and linguistic – that we construct of the patient are "always a playing out of [the desire to demarcate] between ourselves and the chaos represented in culture by disease."[59] The DSM and the literature it engenders illustrate Gilman's point exceedingly well.

Disease and Embodiment

The study of (a) disease also takes us into literature on the body, since, of course, this is where diseases happen. Although a particularly fashionable area of scholarship lately, the body has arguably been a significant theme within sociology since its early classical days. Anthony Synnott observes, for example, a "working" body in Marx and Engels, a "sacrificed" body in Durkheim, an "ascetic" body in Weber, and a "sentient" body in Simmel.[60] Chris Shilling describes the body in sociology along similar lines as an "absent presence": absent because social theory is disembodied, and present because sociology has always been concerned with the ways in which embodied subjects have externalised, objectified, and internalised social institutions.[61] Williams and Bendelow follow their lead, arguing that "despite ritualistic cries of bodily neglect, [...] [m]uch of the sociological literature ... just needs re-reading in a new, more corporeal, light," that is, against the dualistic grain of the mind-body split that sociology inherited from the legacies of Plato, Aristotle, and Descartes.[62]

This mind-body dualism, arbitrary yet so central in Western thought and especially medicine, is one that I do not accept (or pursue in this thesis).[63] Indeed, agoraphobia is perhaps one of the finest examples of its conceptual inadequacy because, as Shilling so aptly puts it, the mind is inextricable from the body "as a result of the mind's location *within* the body."[64] And in the context of mental disease, the bifurcation of mind and body is not a useful tool for trying to make sense of things. As Andrew Strathern writes:

> The conundrum of mental illness is ... simply an artifact of what we may call the Cartesian compromise between the impulses toward religion and science. Once we recognize that there is a mental component in all bodily states and, conversely, a physical component in all mental states, the boundary between mental and other illnesses disappears.[65]

Moreover, the dualism has also always been an insidious way of legitimising the exclusion of women from many arenas of social life, which is largely why the body has been, especially recently, a burgeoning area of feminist scholarship. Feminists have initiated many challenges against the oppressive and hierarchical equation of women with the body, nature, and reproduction, and the privileged equation of men with the mind, culture, and rationality.

Foucault's work has had an especially important part to play in this scholarship, cutting through the dualism with his studies of how certain social institutions have historically exercised power over human bodies through discursive practices and the deployment of knowledge – what he refers to as "bio-power." Foucault asked how things worked to control "docile bodies": "How does one punish?"; "What truths are at work?"; "How are divisions operated?"[66] He apprehends the body as the surface upon which historically specific discursive forces are played out, and the task of genealogy is "to expose a body totally imprinted by

history and the process of history's destruction of the body."[67] Bodies are thus materialised through "truth regimes" and relations of power/knowledge; the body is both the target and instrument of power, the medium on and through which power functions.

Foucault's ideas have enabled feminists to theorise women's oppression and gendered bodies as socially constructed – as constituted effects rather than naturally given causes. But feminists have also discovered limitations with Foucault's work on the body. He tends to treat the body as monolithic, as if women and men were the same and have the same relationships to the characteristic institutions of modern life.[68] And in emphasising the *effects* of power, he reduces social agents to passive or docile bodies caught in the grip of an inexorable disciplinary power.[69]

I maintain that Foucault is a good place to *begin* a theory of the body. Foucault asks and enables new kinds of questions: his genealogical work and his conceptualisation of the relations between knowledge, power, and subjectivity enable me to conceptualise agoraphobia as a kind of truth deployed in the production and government of bodies. That said, I can also see possibilities beyond Foucault's conception of bodies that is limited to a view of them as the outcome of discursive practices. I put forward a conception of bodies that accounts for the inextricability of the discursive *and* the material. This "epistemontology"[70] of the body includes both the enactments (à la Mol and Law) of agoraphobia in and by medical articles, and the reiteration (à la Butler) of normative categories within these texts.

With the above texts and issues as my backdrop, I seek to answer the following questions in this dissertation: What were the conditions of possibility of agoraphobia and its (re)gendering? How have shifts in psychiatric and cultural terrain been implicated in the history of this disease? How do the processes of psychiatric classification both draw from and reinforce the social fabric? And finally, how might agoraphobia be "read" not only as a disease phenomenon, but also as a social theory? In addressing these concerns I hope to offer a sociocultural history of this disease. I turn now to the methodology of my study.

Notes

[1] See for example Bordo (1993) Brumberg (1988) and Turner (1991) in Featherstone, Hepworth and Turner (esp. Ch. 5 "The Discourse of Diet"). Turner also gestures towards agoraphobia (twice) in his *Regulating Bodies: Essays in Medical Sociology* (1992:32, 216).
[2] Abigail Bray and Claire Colebrook (1998) offer an incisive analysis of the tension between feminists who blame the "social or ideological domain of representation" that produces such disorders as anorexia, and others who are reluctant to "locate women as passive victims in some point of innocence outside representation" (35).
[3] The lacuna becomes even bigger when considered in light of how much feminist sociological research has been done on other domestic phenomena, such as labour and violence. In other words, sociologists have amply demonstrated that the social at home is worth studying, yet they still have not taken up agoraphobia substantively.
[4] de Swaan, 1990:141. (1981 was the original publication date for this article.)
[5] de Swaan, 1990:146.
[6] de Swaan, 1990:149.
[7] de Swaan, 1990:160-1.
[8] de Swaan, 1990:146.
[9] Seidenberg and DeCrow, 1983:5. Notably, Seidenberg was a psychoanalyst and DeCrow a lawyer.
[10] Seidenberg and DeCrow, 1983:6, 31.
[11] Seidenberg and DeCrow, 1983:7.
[12] Seidenberg and DeCrow, 1983:212.
[13] Reeves and Austin, 1986:154.
[14] Reeves and Austin, 1986:153.
[15] Brown, 1986:188.
[16] Brown, 1986:abstract.
[17] Brown, 1986:abstract.
[18] Brown, 1986:376.
[19] Brown, 1986:378.
[20] Since her main source of data is in-depth interviews, the reverse is, of course, also true of her research.
[21] In the same year as Gardner's piece was published, an Australian woman completed a PhD dissertation called "Agoraphobia in Women: Its Social Origins" (Loney, 1994). I was not able to obtain a copy, but the abstract suggests an argument related to the works I have outlined so far: Based on interviews with 20 agoraphobic and 20 non-agoraphobic women, Loney argues that "agoraphobic women ... experience a more oppressive life than other women and believe they are powerless to resist [...] Factors associated with the development of agoraphobia in women, have their social origins in oppression, including gender construct and expectations, and agoraphobic women's belief they are powerless to resist that engendered oppression."
[22] Gardner, 1994:335, 337.
[23] Gardner, 1994:337.
[24] Gardner, 1994:341.
[25] Wilson, 1995:151; see also Hindelang et al., 1978.
[26] McSpurren's thesis came into my possession this past fall, but not wanting to be influenced by her reading of the literature, I opted to wait to read it until I was finished my own thesis. I found many similarities between our projects, owing no doubt to the fact that we read many of the same psychiatry articles, but also gesturing towards the salience of these questions and issues for sociologists.
[27] McSpurren, 1996:1.
[28] McSpurren, 1996:iv.
[29] Capps and Ochs, 1995:10.
[30] Capps and Ochs, 1995:8.
[31] Capps and Ochs, 1995:2.
[32] Capps and Ochs, 1995:11.

[33] Capps and Ochs, 1995:11.
[34] Freud, 1963 [1908].
[35] Benjamin, 1973.
[36] Rose, 1994; Vidler, 1991, 1993, 1994.
[37] Briggs, 2000; Herzig, 2000.
[38] Hansen, 1992; Poovey, 1987.
[39] Barrett, 1999; Hunter, 1991.
[40] Mol, 1998.
[41] Mol and Law, 1999.
[42] Berg and Bowker, 1996.
[43] Mol, 1998:162.
[44] Mol and Law, 1999 (their emphasis).
[45] Berg and Bowker, 1996.
[46] Cf. Butler, 1993.
[47] Fleck, 1927.
[48] Butler, 1993.
[49] Bowker and Star, 1999.
[50] Kirk and Kutchins, 1992; Kutchins and Kirk, 1997.
[51] Latour, 1987.
[52] Canguilhem, 1989.
[53] Fleck, 1979 [1935]:23.
[54] Young, 1995:10.
[55] Fleck, 1979 [1935]:28; Young, 1995:9-10.
[56] Young, 1995:5.
[57] Hacking, 1995:11-2.
[58] Young, 1995:5-6.
[59] Gilman, 1988:4.
[60] Synnott, 1993:147-8, 251-60.
[61] Shilling, 1993. In a later text, he and Philip Mellor use Durkheim especially in their analysis of "re-formations" of the body in relation to religious life, especially the Protestant Reformation and Catholic Counter-Reformation. See Mellor and Shilling, 1997.
[62] Bendelow and Williams, 1998:2.
[63] As Synnott writes, "mind and body are so compartmentalized as to be treated by different disciplines: psychology and psychiatry for the mind, medicine for the body." Fortunately, this state of affairs is improving, especially since the medical recognition of "stress." See Synnott, 1993:35-6.
[64] Shilling, 1993:13 (my emphasis).
[65] Strathern, 1996:3-4.
[66] Foucault, 1991:74.
[67] Foucault, 1977:148.
[68] Bartky, 1990.
[69] McNay, 1992.
[70] Barad, 1998.

Chapter 3
Method and Methodology

In his essay "Genealogy and Social Criticism," Foucault observes an "increasing vulnerability" in recent years to "criticism of things, institutions, practices, discourses." He remarks that the "inhibiting effect of global, *totalitarian theories*" has become evident, as well as a "certain fragility" in "the very bedrock of existence," especially those "aspects of it that are most familiar, most solid and most intimately related to our bodies and to our everyday behaviour."[1] Foucault's own work has contributed greatly to this "insurrection of subjugated knowledges," this emergent interest in "historical contents that have been buried and disguised in a functionalist coherence or formal systematisation." He offers a genealogy of knowledge, a history of the centralised production of theories within privileged regimes of thought.[2]

Though he would not say he had a method per se, I follow Foucault's genealogical approach by assessing critically the totalising role of psychiatric practices and discourses in the production of agoraphobia. My aim is to disrupt those aspects of this disorder that are taken-for-granted, especially the stability and authority of psychiatric knowledge and the "historical contents ... buried and disguised."[3] Specifically, I am interested in the processes by which social categories are naturalised within and by psychiatry, and my objective methodologically is to trace these extant categories genealogically, as historical formations, in order to problematise their apparent self-evidence. As Foucault writes: "It's a matter of shaking this false self-evidence, of demonstrating its precariousness, of making visible not its arbitrariness, but its complex interconnection with a multiplicity of

historical processes."[4] Such a poststructuralist approach can reveal how dominant rationalities – such as psychiatry – are deployed as technologies of power: "how forms of rationality inscribe themselves in practices or systems of practices, and what role they play within them."[5]

It is arguable that several methodologies would have suited a sociological study of agoraphobia, including, for example, qualitative interviewing, surveys, participant-observation, ethnography, and, of course, statistics based on any or all of these. Interviewing would certainly have been the best way to get at sufferers' own accounts of their experiences, allowing for a depth of meaning and interpretation unavailable through other methods. (That said, I equally could have interviewed psychiatrists.) The open-endedness of interviews, however, would have come at the cost of a lack of definition and possibly even codeability of the information collected. Surveys would have ensured strong reliability through standardisation, but they tend to decontextualise the subject matter from social life, imposing a sterile, impersonal and rigid framework that is unsuitable for exploring the social at its most complex. Both participant-observation and ethnography would have allowed a thesis about agoraphobia as a culture, enabling an understanding of the meaning that both sufferers and practitioners assign its various facets. But both methods would have restricted the study to a small sample group, since I could have shadowed only one housebound person or one practitioner at a time. Conversely, I could have attended support groups, for example, which would have permitted the monitoring of several agoraphobic individuals. The drawback here, however, is that the data would only have reflected the meanings and experiences of those who actually make it out of their homes

and of the one facilitator in charge of the group. Further, participant-observation and ethnography (and interviews for that matter) provide an opening for the awkward position of pseudo-therapist. Both of these methods also raise ethical issues stemming from the sensitive nature of mental illness, the possible intrusion on doctor-patient confidentiality and the opportunism inherent in researching the suffering of individuals. Yet, all of the above methods would have permitted the study of agoraphobia from the perspective of patients, an important contribution at the present time, especially when the medical literature is completely devoid of patients' own voice(s).

My interest, however, in agoraphobia is twofold: 1) I am interested in its *historical* context – which none of these methods would have permitted. Following Foucault, I hope to illuminate the conditions of agoraphobia's continued possibility, and this requires tracing its history since it was first named through to the present in its psychiatric and cultural context. And 2) I am interested in its mobilisation in and through medical texts, because these texts have always constituted a central venue for doctors to dialogue with one another about disease. Journal articles are highly valued within the profession, as they are crucial to the implementation of medical work. In addition to being professionally important, journal articles are also "vivid documents of social history,"[6] thus constituting an essential site for exploring the processes that Foucault describes. I take these materials as empirically viable indications of the material and discursive practices and social relations involved in the emergence of agoraphobic patients. Medical articles are indispensable historical artefacts, each with many possible stories to tell and very much a part of this pathology's history.

To this end, I examine psychiatric articles on agoraphobia, taking them as representative of the ideas held about this disorder in terms of its symptoms, treatment, causation, and its classifiability. Like Foucault, I ask not *what*, but *how* cultural categories have been deployed through this history and how they have been "capable of being accepted at a certain moment".[7] I explore the cultural assumptions that inform psychiatric writing, such as dichotomous ideas about gender, and especially the question of what it means, both medically and culturally, to be "normal" and "pathological." Social theories help to contextualise these representations and to expose their scientific – but still deeply social – underpinnings, and they illuminate how the invention and re-invention of agoraphobia has, in Mary Poovey's words, historically "performed critical ideological work."[8] Medical texts are revealed as an important arena where values, meanings, and identities are negotiated,[9] and a space is thereby also created for the political claims of those marginalised by the dominant categories of knowledge contained within them.

The main source of data for this project has been journal articles written about agoraphobia since the article published by Westphal in 1871. I restricted my search to English-language articles only, which has largely meant a focus on British and American psychiatry, though I do include translated articles whenever available. In the last two to three decades especially, the discourse on agoraphobia has become more international, though it is important to note that the discourse continues to be oriented particularly to Western concerns and experiences.

I began collecting article references by manually combing through the *Index Medicus*, a paper index to current published medical literature of the world. Its first volume was published in 1879 but it included the literature that followed Westphal's "Die Agoraphobie" of 1871. I used the *Index* to find literature published between 1871 and 1965, looking under "agoraphobia" and its related terms, including anxiety, fear, panic, phobia, neurosis, phobic disorders, diseases of the nervous system, claustrophobia, cenophobia, kenophobia, topophobia, neurasthenia, neurology, phobic disorders, and so forth. Some additional references were also found within the bibliographies of articles catalogued in the *Index*. I also collected dictionary definitions (the oldest from 1882) in order to compare; they were not especially helpful, though, largely because over time they became extremely short. They did however provide me with synonyms (e.g., cenophobia, kenophobia) for the term agoraphobia that I otherwise would not have discovered. As it turned out, practitioners did not use these synonyms and I found no articles when I searched for them in the *Index*.

All told, I found approximately 130 relevant publications between the years 1871 and 1965.[10] I divided the literature chronologically according to natural breaks in the literature, and wrote several discrete chapters accordingly. This meant that thematically speaking, medical, psychoanalytic, and behaviourist literature appeared all together, in all the chapters. Eventually, however, it was decided that organising these chapters thematically rather than chronologically, despite the overlaps, would make more sense, especially since their peaks came in different periods. Hence, the reader will find what are now Chapters 4 through 7

(medical literature, psychoanalysis, behaviourism, and the history of the DSM, in that order).

For articles published between 1966 and the present, I took a different approach. I stopped using the *Index Medicus* and switched to *Medline*, the online catalogue of medical literature, because it includes articles published since 1966, and because publishing in the last few decades has expanded enormously and computerised searching was expected to save a great deal of time (which it did). A broad search done through the US National Library of Medicine's PubMed website in October of 2000, that is, simply the term "agoraphobia" with no limits other than language of publication, turned up 899 references, nearly all of which were published after 1980, the year that the DSM-III was released.[11] I separated out the references (approximately 40) to articles published between 1966 and 1980 and wrote a chapter based on them alone. (Once the chapters were reorganised thematically, the contents of this chapter were appropriately relocated.)

Given the high number of references remaining between 1980 and the present (that is, 850+), my initial plan was to read only articles published in every fifth year, but it became apparent that this method may have excluded interesting and noteworthy evidence published in "off" years. I decided instead to base my selection on the titles and abstracts of the articles. Thus I first downloaded all of the references and abstracts (whenever available) in order to get a sense of the landscape. I sorted the references thematically and some of the themes that surfaced included:

- physiological and psychological characteristics
- drug therapy
- cognitive-behaviour therapy
- drugs and cognitive-behaviour therapy together
- agoraphobia, depression, and other conditions
- symptoms/diagnosis/aetiology/classification
- marriage and family relations
- heredity
- nursing
- children
- agoraphobia and other conditions

I then went through each "pile", choosing articles according to emergent themes, relevance to my topic, and the law of diminishing returns. (For example, I did not need to read *all* of the articles on the anti-depressant imipramine to know that it has been widely used in the treatment of agoraphobia.) I read a total of 370 articles, but not without some disquiet.

Despite the obvious dominance of some themes (especially drugs, behaviour therapy, physiological and psychological characteristics, and symptoms, diagnosis, aetiology and classification), managing the large amount of literature in this period (1980 to the present) was particularly complicated. Although a relationship between the release of DSM-III in 1980 and the scope, tone, and amount of literature published since then was evident, the task of sorting the articles was counter-intuitive to the strong sense I had already developed by this point that the classification of agoraphobia was extremely problematic. Yet here I found myself with the need to classify (however loosely and inconsistently) the articles written about it in order to proceed with my research. Needless to say, the divisions I assigned to the literature were arbitrary, but knowing of no other way to

manage the huge number of references, I continued sorting and summarising the literature in terms of its emergent themes.

Near the end of this process, I began to realise that pulling all of these themes into a coherent and interesting chapter was going to be as complicated as delineating the themes had been in the first place. I found myself especially at a loss for what to do with articles that seemed purely descriptive rather than concerned to address questions of treatment and causation. This was no small problem considering that articles of this nature comprised one of the biggest themes (next to pharmaceuticals and behaviour therapies).

As the point of so much descriptive research literature continued to elude me, I informally interviewed a cognitive psychologist and a physiologist. (I chose them on the basis of their research interests which seemed in both respects to overlap somewhat with the literature that I was examining.) I specifically asked them to explain the purpose of descriptive research and to account for its abundance. They both said that overall, research of this type is done in order to delineate the phenomenology of disease (their signs and symptoms), the causation of disease, and in order to develop and target appropriate treatments. Although stunningly obvious, this clarified things immensely, and I decided to organise Chapter 8 (which concerns the literature published after 1980) using these three medical concerns as my guide.[12]

Following the extensive review of the medical literature, I turned to the cultural literature in order to situate the medical literature in a more critical and sociological context. This literature also helped bridge the fault-line inevitably created by choosing to approach this study thematically rather than strictly

chronologically. That is to say, on some level I did set out to write a traditional history of agoraphobia from the time it was named until the present. Doing so permitted an overview of agoraphobia in the context of psychiatry as a professional discipline, with shifting emphases and allegiances. But I also wanted to write a more self-conscious history, looking not for the truth of agoraphobia per se, but rather, for answers to sociological questions about its cultural emergence and persistence, and the extent to which social theories and medical theories have historically overlapped and interconnected.

To this end, I attempt to stay as close as possible to the language used by doctors. Since one of the main objectives of this work is to provide a cultural analysis of these texts, attention to the actual words that these writers used is necessary so that the *sociality* of the clinical discourse will become evident. In my effort to stay as close as possible to the language that doctors employ, however, I use a number of terms interchangeably, especially disease, disorder, syndrome, symptom, pathology, as well as agoraphobia and panic, and I do so because the doctors do. This means, for example, that in one passage describing a particular article I may use one particular term, while in the next, if it concerns an article using a different term, I will follow the second usage. (As it turns out, many articles use more than one term *within* them.) While this may be confusing, it helps illustrate, in part, the extent to which agoraphobia has been, despite its relative consistency of symptoms, a remarkably unstable category.

Concerning stylistic decisions, I also attempt to do justice to the various disciplines within psychiatric practice, namely medicine, psychoanalysis, and psychology, by dedicating one chapter to each – at least up until the literature

published after the watershed of 1980. I suspect that academic psychologists would be the most offended by this, but I often use the words "doctor", "psychiatrist", and "medicine" to include psychologists who often are themselves MDs, but sometimes not. In addition, their work is considered medical to the extent that Medline catalogues it. Meaning no professional disrespect to psychologists, I therefore choose not to distinguish between them wherever the point I wish to make allows for such glossing over. Similarly, I sometimes also use "clinician," "physician," "practitioner" and "doctor" when sometimes, technically speaking, I mean "researcher" (the latter being a more relevant term in the most recent literature). With this as well I distinguish among these when it is necessary for the argument; otherwise, I use terms interchangeably simply in order to avoid monotony in the text.

Before concluding, it seems worthwhile to consider briefly how I would undertake this research if I were to redo it, knowing what I do now. I have two points to make. First, as I said above, I wish I had realised sooner that phenomenology, treatment, and causation were the central organising principles of medical discourse. Thus, if I had it to do over again, I would sort the literature primarily according to these themes, and then according to the sub-themes that emerge within them. Overall this would have been a more efficient method of weeding out the extraneous literature. Second, although the idea of tackling a shorter historical period is very tempting, chronologically speaking, I would still approach this research exactly as I have because to do a genealogy of knowledge, a history of the present, necessitates situating present knowledges in the context of their conditions of possibility. Had I focused on a specific period of time, say, 1871 to

World War I, I may not have learned, for example, that agoraphobia's prevalence switched from men to women, or that psychoanalysis was dominant for decades and then ousted, or that the impetus to classify was and would eventually become again the lifeblood of psychiatry. That said, however, I recognise that undertaking a project encompassing such a long period has been at the expense of a deeper understanding of the nuances of this history. What energy and attention I have spent trying to manage this ambitious bibliography is energy and attention taken away from a greater immersion in the texts themselves.

Of course these are not the only weaknesses in my approach. For one thing, I cannot offer the last word on agoraphobia, but, then, nor would I want to. I can only offer *one* interpretation of these medical texts and as Clifford Geertz would argue, it is a matter of "thick description."[13] These texts are interpretations of normative concepts and structures – interpretations of interpretations of interpretations. Indeed, the notion that I *could* get at the truth of agoraphobia is precisely what I take as my problematic here. A second criticism that may be levelled is that I approach this work from the perspective of doctors' written words: like the articles they write, the voices of patients do not emerge in any substantive way in these pages. But I contend that the absence of patients is actually quite telling, that the silence "opens a space in which meanings can proliferate."[14] As we will see in Chapter 8 especially, the exclusion of patients from the literature written ostensibly about them is critically important to the objective façade that scientific writing must project and says much about patients positioning as subject-objects in relation to the practice of psychiatry.

Thus, although this methodology has mirrored the psychiatric literature in excluding patients' voices, it *has* enabled the exploration of three things. First, it has enabled me to explore the ways in which representational practices are indicative of (psychiatric) culture and cultural shifts. Second, it has permitted an understanding of how psychiatric claims become facts through practices of representation, namely medical publication. And third, it has illuminated the ways in which knowledge about agoraphobia has been *made* and not simply *found*.

Notes

[1] Foucault, 1994:40; his emphasis.
[2] Foucault, 1994:41.
[3] Foucault, 1994:41.
[4] Foucault, 1991:75.
[5] Foucault, 1991:79; see also 1982:210.
[6] Hansen, 1992:106.
[7] Foucault, 1991:75.
[8] Poovey, 1988:2.
[9] Poovey, 1987:138.
[10] This number is necessarily approximate because it includes references to Freud's writings on agoraphobia, none of which was the main focus of any journal article, but nonetheless centrally important in this history and in terms of the body of psychoanalytic literature that developed as a result. That said, I do *not* include the *Diagnostic and Statistical Manual of Mental Disorders* and its precursors in this number, though they all pertain, simply to distinguish between it – a manual to "all" mental illnesses – and the journal literature specifically on agoraphobia.
[11] I repeated the search in March, 2001 and the list more than doubled, but by then it was evident that adding to the bibliography would not augment my reading of the literature in a significant way. Lag-time between publication date and indexing, perhaps the addition of new journals to the Medline index, and continual research would help account for this huge jump in numbers.
[12] In retrospect, I regret not having spoken to these scientists (Kate Harkness and Greg Ross) at the beginning of my research because had I done so, the research would have been somewhat less time-consuming and the writing process less difficult. That is, I could have oriented my reading and organising of the literature more efficiently from the outset.
[13] Geertz, 1973. See especially "Thick description: Toward an interpretive theory of culture."
[14] Poovey, 1987:152.

Chapter 4
Getting their Bearings: The Early Literature

Continuing an established tradition of academic brain psychiatry primarily concerned with the scientific understanding of psychiatric disorders through systematic observation, experimentation, and dissection, German physician Carl Otto Westphal published monographs on diseases of the brain and spinal cord.[1] He also published what would become the most famous article on agoraphobia ever. Still cited by practitioners, Westphal's work in this area was arguably pathbreaking in its influence, and far-reaching in its impact insofar as it was his nomenclature that seemed to actually set things in motion.[2] This chapter looks first at this important article, and then at the medical literature it inspired up until the First World War.[3] In the first few years (late 19th century) physicians were mostly concerned to generalise as to who developed agoraphobia (mostly men), and to delineate the phenomenology of agoraphobia in terms of its symptoms and status as a disease, its causation, its difference from or relationship to other conditions, and of course, the best approach(es) to treating it. Soon after the end of the First World War, an important shift in the history of this disease took place, namely, the shift from a prevalence in men to women, as well as the beginning of an increase in diagnoses of agoraphobia overall. Though I shall look at psychoanalysis in more detail in the next chapter, these post-war years also helped set the stage for what would become the dominant psychiatric approach for several decades. But turning now to Westphal's article, I examine how the early years in the his-

tory of agoraphobia were a time for physicians to just get their bearings with this new disease.

"Die Agoraphobie"

"Die Agoraphobie"[4] appeared in two parts; an article and an afterword that appeared in a later issue. In these, Westphal described the symptoms of three male patients: a 32-year-old commercial traveller, a 24-year-old merchant, and a 26-year-old engineer. Complaining of symptoms that still resonate in case reports today, these three patients had much in common: "The similarity and agreement between the three cases can be easily seen, an agreement that goes into the smallest detail such as places of a specific city which are feared to be crossed."[5] All the men resided in the city of Berlin, and their symptoms all turned on the difficulty that they had with walking through open spaces, crossing streets and squares, and with crowds and enclosed spaces. When they found themselves in these situations they felt unsafe and were overcome with fear and even trembling. They thought that they would be unable to cross the ("monstrous") square, believing that something would happen while in this state of fear and confusion. The presence of an "escort," a "vehicle going the same direction," or "seeing an open door in one of the houses located on abandoned streets" seemed to alleviate the anxiety, enabling the men to get where they needed to go.[6] All were fairly embarrassed about their condition and worried about being perceived as insane. All had lived with the condition for a period of time before consulting a physician. None knew the reasons for their fear and noted that it seemed to come on without

warning. Similarly, they could not explain why at times they might make it halfway across a street or square and then feel the need to turn back instead of carrying on to the other side. In addition, all had to some extent developed anticipatory anxiety – a fear of fear – following the first episode. Part of the reason they could no longer walk across open spaces was their memory of the initial incident and experience of anxiety, which they did not care to repeat.

Westphal attempted to understand the disease and determine the cause of these men's suffering by attending closely to anatomical details, including a thorough eye examination and in one case extensive measurement of the patient's physical features. His conclusion was that agoraphobia may have been allied to but *was not* of itself vertigo, as suggested by Benedikt. He returned to this point in his afterword where he wrote: "That such an explanation is weak in view of my observations can be proven through direct comments of patients, who do not speak of dizziness, but of anxiety which overcomes them."[7]

The eye examinations he performed likewise revealed no link to impaired vision:

> There is nothing in the eyes that could lead to conclusions in respect to the questioned affliction. [...] Eye examinations concluded that two of the patients had absolutely no insufficiency of the interni; the third patient suffered of a minor yet often occurring one that became noticeable only close-up. Thus the explanation that the discussed condition is a result of an insufficiency of the interni, which leads to the alteration of the muscle consciousness, is hereby positively excluded..., irrespective of the previous mentioned reasons.[8]

Although his patients had had some experience with epileptic seizures, Westphal also maintained that agoraphobia was not a form of epilepsy because epileptic

symptoms were known to occur throughout mental disorders. As he pointed out in his rather lengthy discussion of this (im)possibility:

> Though it could have been justifiable to identify the depicted conditions as epileptoid, I have refrained from doing so for certain reasons ... [S]eizures ... belong to the most common symptoms of the most diverse psychopathic and neuropathic conditions.[9]

Rather, he emphasised the symptom of anxiety about walking through spaces as being of the most importance in this phenomenon, and contended that the

> occurrence is obviously cerebral (psychological). It has little to do with the analogy of normal psychological occurrences and, as such, cannot be understood as well as other pathological emotional conditions, emotional disturbances, conceptions, and wilful impulses.[10]

Westphal also emphasised that agoraphobia was not necessarily an exclusive condition but could appear as a component of another illness. To support this point, he added a description of a fourth patient, a 39-year-old salesman, at the end of his report. This patient's other problem was "hypochondria" and Westphal distinguished him from the other three patients on the basis of his "'general and lasting psychological anomalies'" and his complaints about "'all kinds of abnormal, changing sensations.'"[11] The man had suffered from a number of different apprehensions ranging from the fear of *his wife* going out of their apartment more than a few steps, to being robbed, to having a stroke. Two years prior to his consulting Westphal, a feeling of fear of walking through the streets alone had plagued the patient. The man was "aware of the foolishness of his fear" and the extent to which it controlled him, but the fear continued and changed trajectory frequently. Westphal maintained that the hypochondria in this patient was "only a part of agoraphobia" and that cases such as this one were "to be separated from the preceding ones, as much as both forms of illness may be related."[12]

Since agoraphobic fears were traceable to circumstances that could be avoided, (such as the street), then the notion of a "chronic psychological disorder" could not, as far as Westphal was concerned, be supported. Rather, agoraphobia was different from any other condition that he had seen. In apparent contradiction he wrote:

> ...Agoraphobia is different from all others [mental diseases] because the appearances of pathological emotional disturbances (fear and anxiety) are tied to external situations and conditions, and, upon their removal, the disturbances disappear. [...] Should someone really want to find and emphasize [sic] something pathological, that this appearance developed only during the process of the sickness – which is difficult to determine – one should recognise in comparison with the actual phenomenon of the sickness, that the influence of certain external conditions do not come into question.[13]

Declaring that agoraphobia differed "fundamentally from psychological diseases in a narrow sense"[14] Westphal defined the condition as neuropathic, despite acknowledging that patients' feared avoidable aspects of their surroundings. Still, as he went on to say, he was "unable to find an analogy to other known conditions, and, of all those peculiar sufferings that I have become familiar with in lunatic asylums, this one is quite different."[15] In trying to determine the conditions' aetiology, Westphal also considered "hereditary disposition to nerve disturbances," bodily as/symmetry, moderate masturbation "to which one of the patients admitted," and the suddenness and location of patients' first attack.[16]

Westphal attempted several treatments, all to no avail. Cultivation of patients' willpower failed, as did the "systematic procedure in which ... the patient was given the task to walk across the dreaded areas daily." The "taking of wine, beer and suchlike to put an end to or alleviate the condition [was] of no therapeutic value." Patients reported feeling some relief from various other remedies

such as "kalium bromate" (potassium bromate), but Westphal preferred not "to attach great importance to these comments." Electrical current applied to the neck, head, and upper cervical vertebra produced equally no effect.[17]

With these observations Carl Westphal's report of four cases of agoraphobia effectively set the stage for a discourse as to the causes and most effective treatment of agoraphobia that has survived more than a century.

After Westphal

A number of general observations can be made about this first phase of publishing on agoraphobia. First, as important sources of medical publishing, British and American practitioners, not surprisingly, wrote all of the reports on agoraphobia published in English. These reports were about evenly divided between them, with ten written by American and eight by British physicians.

The chronological distribution of the articles in this period suggests something of a dialogue between the two nations in that the writers seemed to take turns publishing on the topic. There was no overlap of articles except in 1889 when each country produced one article. In total, including the two German articles by Westphal and Cordes, there were twenty articles, and of these, two were written by the same physician.[18] It is difficult to assess whether this would constitute "a lot" of literature on the subject. Opinions varied among these writers as to whether or not agoraphobia was more common than we might realise,[19] or "rare" and "peculiar"[20] and lacking in literature on the subject.[21]

Leaving aside the distribution of articles in this period, I turn now to their content, which will be examined under the thematics of what agoraphobia is and who was diagnosed with it.

What is agoraphobia?

Generally speaking, agoraphobia has taken a few different forms in the literature of this period but in general terms the pathology was understood as the fear of being alone, that is, without aid, in case something happens, in public spaces. Within this general understanding, the symptoms, theories of causation, and treatment modalities varied and therefore also reflected the different ways in which agoraphobia was conceptualised. In this section I will describe agoraphobia as practitioners described it in terms of these three items (symptoms, causation, treatment),[22] as well as in terms of the main debates, namely whether or not agoraphobia was really just vertigo, and its related status as pathology.[23]

Symptoms

There were several constants in these reports in terms of the description of what agoraphobia *felt* like. Most if not all reports spoke of a "morbid" feeling of "dread" that was often described as "inexpressible in language"[24] and that usually came over the patient when *he* was alone in an open space or court, needing to cross the street, or riding in an omnibus, cab or train car. Some patients described being unable to be in a church or theatre unless they were seated next to a door so they could escape if necessary. As in Westphal's report, the inability to get

more than halfway across a street or open space was also observed.[25] Patients described a fear of insanity[26] and of dropping dead.[27] In most cases these feelings were avoidable if the patient had a companion or even a carriage, a stick, or an umbrella to accompany them through the places that caused them to become anxious, though one patient did say that such accoutrements were not enough.[28] The reports also described patients' tremors,[29] giddiness,[30] nervous apprehension,[31] fear of falling or even death,[32] violent heart palpitations, flushing in the face, weakness in the legs as if they would collapse under the body, itching, coldness, numbness, sweating,[33] "deadly terror,"[34] and other nervous symptoms such as throbbing of the carotid arteries and numbness.[35] Though the word panic was not used until 1887 when Fisher described something "painful to observe [that] once seen [are] not to be forgotten," what these patients were describing were "panic attacks."[36]

Also notable in these reports is the tendency for patients' agoraphobic symptoms to encompass other phobias we now know of, such as acrophobia (heights) and claustrophobia (being locked in),[37] which were the most commonly cited. However fears of rats and mice, accidents, men working on a building or steeple,[38] falling down, stepping over gutters or sticks,[39] and the fear of fear itself in anticipation of further attacks were also described.[40] In some cases there were allusions to obsessive-compulsiveness (though these words are not used), as in Jones who described his patient's problem as a tyranny of imperative ideas – a motor form of obsessions that "escape all attempts at volitional control."[41] "Surgeon" probably captured this best though, when he wrote that his worst symptoms were the agoraphobia and "that perhaps when I have done a thing I may go

back again and again before I can rest assured I have done it right."[42] Some patients also experienced melancholia, such as Van Horn's whose agony pushed her towards suicidal impulses because it "offer[ed] a door of escape."[43] Consistent with this, Headley Neale (1898) believed agoraphobia in women to result in melancholia.

Vertigo

An important debate pertained to the question of whether or not agoraphobia was or was not a form of vertigo and/or giddiness. Recall that as Westphal pointed out in disagreement with Benedikt (or Benedict as Westphal spelled it [see Chapter 1]), agoraphobia was perhaps related to vertigo, but could not be reduced simply to this diagnosis.

Citing the case of a 42-year-old seaman and soldier, American S.G. Webber, who was incidentally among the first to respond to Westphal's report in 1872, also rejected the notion of agoraphobia as vertigo. Another American physician disagreed, however, and offered this explanation for agoraphobia:

> A person attacked with vertigo naturally seizes hold of the nearest object for support; a person subject to such attacks loses confidence in his power to walk alone, and feels unsafe without something at hand to cling to in case of emergency; he has the same feeling in crossing a square that other men do in standing on the edge of a precipice, there is danger of being run over; add to this a state of nervous irritability amounting almost to insanity, and the pathogenesis is clear.[44]

Drawing on his own personal experience with vertigo for the three years prior to this report, and the experiences of others similarly affected, Williams insisted that agoraphobia was "nothing more than vertigo with an element of nervous ap-

prehension."[45] Henry Sutherland from the UK, however, had an entirely different perspective on the matter. Citing a subjective aetiology, he argued that the root of the disease was not vertigo, but a lack of self-confidence and the fear of being unable to walk a certain distance, to resist eating for a certain time, living without fresh air, and making a journey without fainting.[46] Ten years later American Albert Blodgett described agoraphobia as a "vertiginous affection" accompanied by "anxiety" similar to the unsteadiness that would be experienced in seasickness, and related therefore to some "derangement" of the sympathetic nervous system, or to disturbed functions of the inner ear.[47] Two years later another American, H.W. Hermann, asserted that "this form of vertigo" occurred mostly in people with a predisposition to neuropathy.[48] Robert Jones described a case in 1898 of agoraphobia in a man whose vertigo was believed to be the result of irregular stimulation of isolated cortical centres causing impellent ideas. Thus the debate over whether or not agoraphobia were true vertigo persisted.

Symptom vs. Disease

Informing the vertigo debate was the issue of whether or not agoraphobia was a disease in its own right or merely a symptom of something else, out of which came the question of nomenclature, a question that to this day has yet to be resolved. Also implicit in these discussions, then, was the question of how to conceptualise disease in general; throughout the articles there were several words used interchangeably to describe this phenomenon of un-health. These included: "disease", "symptom", "condition", "affection", "malady", and "disorder", even within articles that premised agoraphobia as idiopathic. Related to this was the

use throughout the articles of different terms to refer to the individuals with agoraphobia, and these included "patient", "victim", "sufferer", "subject", and their title/initials, such as "Mr. T.". For now I shall deal only with the first two issues of nomenclature and its status as a disease versus a symptom.

Only two physicians took up the issue of nomenclature. The first was American John D. Jackson, who in 1872 argued that the term agoraphobia was something of a misnomer in that it referred only to a fear of public places. Based on the experiences of his patient, a physician as well, who only experienced the symptoms of agoraphobia when he was alone, Jackson contended that the terms "isolophobia", "eisophobia", or "autophobia" were more appropriate. As his patient said: "...*I* never had one [attack] while in company with a single individual [...] I occasionally suffered it in an unfrequented place, and more especially when at a considerable distance from a house, but never when in close company with two or more persons." He later added: "For six or eight years, I may say that I have never traveled [sic] a quarter of a mile alone, and as silly as it may sound to other ears, I speak the plain truth, when I tell you that to-day, the wealth of all the Indies could not tempt me to do so."[49] Sutherland later put forward the suggestion that "autophobia" was a better name for this pathology as it was centrally a fear of self, or the idea that the "self will be unable to fulfil certain duties...undoubtedly the most prominent feature of this disease."[50]

Although the discussion of an appropriate name for the disease was short-lived, the issue persisted implicitly in the discussions of whether to conceptualise agoraphobia as a symptom or as a disease. Probably the most overtly contradictory position was Webber's who argued that agoraphobia represented a struggle

against ideas derived externally, but then went on to say later that at the core of the anxiety was a corporeal cause occurring in a certain pathological group. He seemed to be saying it was both a symptom as well as a disease in its own right.[51]

Other authors tended towards the notion of agoraphobia as symptom, though Williams thought the term "symptom" was even too distinctive, and insisted that the condition was a form of vertigo combined with nervousness and apprehension, all of them symptoms of the commonest occurrence in a large proportion of cases of nervous disease.[52] Still, another writer (writing about his own agoraphobia) declared that the "worst symptom" of his illness was the agoraphobia.[53] In 1890 British physician C.W. Suckling argued that agoraphobia was simply a symptom of neurasthenia, and it was only one of many morbid fears that manifested in neurasthenic people. As we have already seen, there was some debate as to whether or not agoraphobia was a sign of epilepsy. As one physician wrote in 1898, the "condition" in his patient would come and go and may have been related to epilepsy as the patient sometimes wet the bed.[54] Melancholia was also considered to be the main disease behind agoraphobia; in 1884 R. Prosser White had already insisted that agoraphobia was "essentially a form of mental depression...allied to what is called simple melancholia."[55] In 1898 another physician speculated that agoraphobia in women "runs through the course of deception, introspection, hypochondriasis, [and] on to melancholia."[56] Others asserted that agoraphobia was related to hysteria; as American B.F. Records wrote in 1896, this "pathological condition" could exist in different morbid conditions of the brain and spinal cord, and also in hysteria. Charles Mercier wrote in 1906

that because agoraphobia betrayed a link to hysteria it was therefore amenable to imperative suggestion (as opposed to hypnotic).

Still others debated whether or not agoraphobia was psychopathological or neuropathological, a mental or corporeal disorder. For example, commenting on a paper given by Albert Blodgett in 1887 at the meeting of the Massachusetts Medical Society, physician T.W. Fisher stated that based on the few cases that he had seen, this disease was "purely a mental disorder" while another commented that it fell under the category of "folie du doute."[57] Neville Taylor by implication, agreed with Fisher in arguing in 1895 that agoraphobia was of "that class of mental deviations described under the head of 'imperative [involuntary] ideas' of the French alienists."[58]

Apart from these discussions, many writers were not concerned to differentiate between agoraphobia as a disease or a symptom at all; it was a question that did not need asking as far as they were concerned, and so they used the terms interchangeably.

Causation

For many centuries, disease causation has been the central concern in the discourse of disease, taking many forms and classified according to hard and fast categories. Doctors have viewed causation of illness in one of two main ways that have always been opposed and vying for dominance: 1) as an expression of many distinct bodily afflictions, and 2) as an imbalance of the body's normal functioning.[59] These two views are known respectively as the ontological and physiological theories of disease.[60]

The *ontological* perspective places the origin of disease outside of the body as a specific, objective entity distinct from the affected organism. (Germ theory or tuberculosis come to mind here.) In contrast, the *physiological* perspective locates pathogenesis within the body; disease is seen as a consequence of disturbed functions operating within individual human beings. The pathological process in question is internal rather than external to the affected organism. That is, the conditions of possibility for a given disease already reside within the individual. A moral undercurrent that viewed disease as a punishment also plays a role here.[61]

As categories imposed by historians and philosophers, the ontological and physiological designations have helped 20th century writers *about* medicine to organise conceptual debates that have persisted since their advent in ancient Roman and Greek medicine.[62] As already mentioned, proponents of these views have been in longstanding tension with one another. In this section I focus mainly on how the physiological theory of disease causation informed these reports. Although there are a few gestures towards the ontological theory, as when physicians describe agoraphobia as something that "attacks" their "victims," the physiological theory of disease is much more easily discerned. Ironically, though it is easier to find examples of the physiological theory, in a sense it is the ontological concept of disease that inevitably dominates. This is because diseases thought to be physiological in origin become ontological simply by virtue of being named. Once a health phenomenon thought to originate within the body is defined as a disease, it becomes an entity with its own ontology "out there with power."[63]

This aside, one of the major debates within these early discussions of agoraphobia was indeed over the question of its causation. As noted above, several physicians argued that agoraphobia was simply a "vertiginous affection." They traced the problem to derangement of the sympathetic nervous system and trouble with the inner ear and noted that it was sometimes accompanied by "belching large quantities of gas."[64] The agoraphobia in one man who was "the very opposite of calm" and who so dreaded walking outside that he sometimes travelled "backwards and forwards" by omnibus, was explained as "irregular stimulation of isolated cortical centres."[65]

"Properly adjusted eyeglasses" were thought by another physician to help with this "distressing symptom" in people with a predisposition to neuropathy[66] and hence a faulty constitution. This idea of predisposition or "taint" informed the tendency to note any family history of insanity and qualities of "peculiarity" and "nervous temperament"[67] and was consistent with the popular belief that heredity was the principal cause of mental degeneracy. It conveniently also helped to disguise the "inconsistencies and anomalies of psychiatric knowledge while strengthening physicians' claim to expertise."[68]

Agoraphobia was also, as in one woman's case, believed to have resulted from excessive lactation and frequent childbearing (which gave rise to the neurasthenia alleged to be the disease of which agoraphobia in turn was a symptom). The physician looking after this particular patient was "struck by the marked potency of childbearing as a cause of agoraphobia and allied morbid fears."[69] Along similar lines, another woman's agoraphobia was caused – or at least exacerbated – by a "laceration on the cervix"; her agoraphobic problem was always much

worse in the week prior to her menstrual period. After the physician "made local applications" the patient was still unable to travel without trepidation, however and so she took matters into her own hands:

> A bottle of valerianate of ammonia, and a flask well filled with brandy, were always her constant companions when undertaking a journey by rail ... when she is traveling [sic], she invariably sits with a brandy flask in the right hand, and her Bible in the left; presumably the one counteracting the influence of the other.[70]

Another physician argued that "imperative ideas" (compulsions) were more common in females during or after menstruation or pregnancy (as they were in other less hearty groups such as the young and weak-minded).[71] The assumption that agoraphobia had something to do with the reproductive system was generally reserved for the few cases of agoraphobia in women, a link especially noticeable when compared with those describing agoraphobia in men. Williams (1872) argued for example that Webber's (1872) patient was clearly suffering from delirium tremens or mental confusion due to a chronic lesion of the right half of the brain. Blodgett (1887) cited a derangement of the sympathetic nervous system, or dysfunction of the inner ear, and recall Jones (1898) who emphasised irregular stimulation of isolated cortical centres (1898). Finally Ruttle (1889) believed the agoraphobia in his patient to have been caused by his myopia and a fog that gave rise to "'deadly terror, palpitations, and profuse sweating'", which the patient re-experienced whenever he found himself in any large open space on his own. None of these writers considered their male patients' reproductive systems in their analyses, though one other writer (Headley Neale), having heard medical men "pooh-pooh agoraphobia and vaguely hint at 'male hysteria,' as if some storm

were raging in the sinus pocularis," did remark that agoraphobia in men needed to be taken altogether more seriously.[72]

A different adaptation of the physiological theory of disease can be found in another article in which the cause of agoraphobia was attributed to the "revival of instincts which existed in full force, and had great biological value" when "our ancestors were arboreal in habit," leaping "from bough to bough and from tree to tree."[73] In the arboreal stage of existence, the "ancestors had a very strong aversion to any extended excursion from their place of security and refuge." So when away from trees they felt a well-founded dread. In agoraphobia this state of mind was reproduced, he argued, so the "mental craving" of the "subject of this malady" was not to be near trees necessarily, but near any tall vertical structures. In claustrophobia, the instinct derived similarly from the "old primitive habit of roosting under the open sky" which was disrupted by "the modern innovation of taking shelter from the weather."[74]

A moral sensibility is also evident in several of these reports and, although nobody went so far as to say that sin or personal moral failure caused illness, lifestyle choices were often blamed.[75] In the earliest reports, several writers reduced causation to moral impairment that manifested as debauchery and excess. One physician described a patient who suffered from agoraphobia due to overwork, another who "devoured ... three times as much meat at each meal as is usually taken by a healthy person" and a third whose agoraphobia was precipitated by "the habitual indulgence in sexual excitement ... unaccompanied by natural gratification."[76] The agoraphobia in this patient, an artist, was aggravated by the six glasses of sherry he drank per day and the nude models who regularly passed

through his studio. A fourth patient, a clergyman, found himself afraid to walk in the street three months after marriage while a fifth was "scarcely able to 'crawl' about the town, as he was so much reduced by the unusual calls made upon his *physique* during [the] first few days of married life."[77] A sixth patient indulged in "excessive and promiscuous sexual intercourse," taking leave of his marriage and his home for days at a time and complicating the situation with the consumption of spirits. "After these debauches he was unable, through nervousness, to walk down the stairs of his office without leaning on the arm of a clerk."[78] The physician treating these men concluded that agoraphobia was not a disease but rather a symptom – of self-abuse – that disappeared when the physical cause – sexual indulgence, alcoholic excess, and yielding to groundless fears – was eliminated. Underpinning this writer's theory, however was the idea that these men all had depraved senses of morality.

Masturbation was also noted in some cases though more so in the psychoanalytic literature, which I shall examine in the next chapter. While it was not directly articulated that masturbation *caused* agoraphobia, it was insinuated that masturbation was a crime for which mental illness was its punishment. For example, one physician cited a family history of insanity in his patient, noting that he "practised masturbation till seven years previous to [his] seeing him."[79]

Other physicians encouraged will and "moral determination" as means of avoiding or lessening the severity of symptoms.[80] As we saw earlier, one doctor cited deception as one of the stages of agoraphobia in women, while another physician, drew on the controversial ideas of phrenology developed by Austrian Franz Joseph Gall and J.C. Spurzheim in the 18th century. Phrenology held that

the brain determined character and that personality depended upon its configuration, signalled by the size, shape, and contours of the skull.[81] Degenerationist thought, taken up by Italian psychiatrist and criminologist Cesare Lombroso in the 19th century, was also influential here. He viewed criminals and psychiatric patients as "evolutionary throwbacks often identifiable by physical stigmata."[82] Accordingly, Jones described his agoraphobic patient as a "degenerate" whose head accorded "with those unexpected measurements often found in the insane, being full and well shaped."[83] He classified his patient as neurotic but acknowledged that not all neurotics were immoral types since "their kindred ... are noted for high literary and intellectual attainments."[84]

Treatment

In addition to overt statements such as these, the treatments that physicians use(d) can also tell us something about what they believed the cause of agoraphobia to be.[85] In some cases improvement of general health, sufficient rest, and sometimes sedatives such as bromide of potash were used. As well, suggestion, careful training, and properly adjusted eyeglasses were thought to possibly help with this "distressing symptom."[86] In Sutherland's cases, as we have already seen, the three patients that recovered from their agoraphobia were "cured" when sexual indulgence, alcoholic excess, and yielding to groundless fears ceased (1877). Potter, as we have also already seen, made "local applications" to the cervix of his patient. One physician promoted attention to personal hygiene[87] while in another cause the patient felt better when he was given cod liver oil, put on a good diet, given dark spectacles, cold head baths, and small doses of stimulant.[88] He was

encouraged to lie down and to avoid "such associations as aggravate the disorder". He was also given a dose of bromide[89] of potassium and strychna[90] to enable him to climb a hill or do work that he ordinarily would not have been able to do. Finally, he benefited from nux vomica, iron, and hydrobromic acid.

In another case, the woman was given (without success) various tonics and effervescing bromo-caffein. A substance called celerina, however did help her, as it did in a number of other cases as well. For this woman "[I]mprovement rapidly commenced, and...[after] only one week her husband found that he could leave the house without her instantly following his footprints."[91] Another woman was treated successfully with "reassurance" and small doses of bromide potassium.

A successful outcome was also achieved in a case of a man who was given bromide of potassium and valerianate of zinc and iron.[92] Suckling (1890) used a similar treatment, but did not indicate whether or not it was successful. The patient he described was admitted to his asylum, which would suggest that perhaps in this case it was not. In any event, arguing that treatment of agoraphobia required the "cause of the exhaustion" of the brain to be located and removed, he prescribed nervine tonics such as those already mentioned, and also recommended time at the seaside or in the country, a liberal diet, moderation in stimulants such as coffee, tea, and tobacco, and cheery surroundings. Taylor made similar recommendations in 1895 when he encouraged, among other things, a sea voyage. After a time this patient said he felt more confident of overcoming the attacks, however Taylor was not so optimistic.

Another patient took a very long time to improve using various remedies, and in fact, suffered a number of setbacks, but in the end, after more than half a

year, reported herself cured.[93] In 1898 Headley Neale contended that treatment of this condition was to be "primarily psychological" in that the patient needed to be convinced that there was "nothing in his condition inimical to life or which may not be overcome by strength of will."[94] Like Prosser White Headley Neale was prescribing "moral determination", but alongside these inner methods, he recommended avoidance of mental strain and excess, a careful diet, and digestive aids and tonics that would "ensure the disappearance of this pathological 'spook.'"[95]

The final article written in this period, the one in which Mercier argued that arboreal instinct was at the root of agoraphobia and claustrophobia, easily offered the most unconventional treatment approach (whose effectiveness was discovered by accident, as is usually the case). Describing the case of man with "very definite agoraphobia," "ordinary remedies" brought improvement in the man's overall nervous situation, *except* for his agoraphobia. Discouraged, Mercier told him "that this was a matter for which little could be done" as it was an "enduring malady."[96] Yet after four months the patient returned looking "tranquil, placid" and even triumphant. He told Mercier of the "dreadful shock" he had had when his daughter ran away and married her lover of whom he and his wife did not approve. This shock "completely cured" the man, and Mercier observed that this was "the only case of agoraphobia [he had] ever known to recover completely."[97] He acknowledged the impracticality of prescribing this particular treatment: "there are persons to whom this mode of treatment could not possibly be applied. Some of the sufferers from agoraphobia are old maids."[98] In light of this he suggested that perhaps minor emotional shocks could be effected: "a miti-

gated trouble ... might produce an amelioration of the symptoms even if it did not effect a complete cure."[99] While the case he described did not necessarily "place in our hands any very efficacious curative agent", it did at least demonstrate that "the malady [was] not as deep-seated as its long continuance and recalcitrance to treatment might lead us to infer."[100]

Who got it?

According to Headley Neale, the agoraphobic was easily recognisable. Their identifiability in the street would lie obviously in their suddenly grabbing a railing or a wall, but they could also be distinguished by their never being without a stick or umbrella "which you will notice he will plant at each step at some distance from him, in order to increase his base line of support."[101] In the clinic context, he added, "you will have occasion to ask him but few if any questions, so graphic and pathognomic will be his statement of his symptoms."[102] Aside from these behaviours, we do not generally know what the men who presented looked like, other than Mercier's male patient who was "tall and spare" and Jones' male patient who had a "wild and wandering" look about him. In contrast we tend to know more about the women's physical appearance. Potter's patient was a brunette (1882), Van Horn's was "of large, robust frame" with "[d]ark hair and skin" (1886), and Records' patient was of medium size, fair complexion, and blue eyes (1896).

From a population perspective, middle-class, educated, professional men play the most prominent role in these reports. Beginning with Westphal (1871)

and Cordes (1872) right through to Mercier (1906), agoraphobia is far and away reported most commonly in married "adult men of education."[103] A dictionary entry for agoraphobia published in 1882 even noted that agoraphobics were often intelligent and well educated, of the total of 62 cases reported in this period, over 80% were reports about men and only 15% about women.[104] Approximately 40% of the case reports included social class, education, intelligence, and/or profession in their descriptions of patients, and only in one case was someone described as "not at all educated, nor particularly intelligent."[105] Holding the same overall impression as Van Horn, Headley Neale remarked, in his discussion of the "selection by agoraphobia of its victims,"[106] that the "disorder" was more common in males. As he stated, "In my experience professional men suffer most, clergymen in particular, but I have known merchant princes, commercial travellers, middle-aged spinsters, and even young married women caught in its toils."[107] Nevertheless, he used "the male pronoun for brevity, for be it understood that female agoraphobics exist in plenty, although the disorder is more common in males and is essentially one of adult life only."[108] He also observed the class component, noting that agoraphobia "seldom attack[ed] poor people" though he had had evidence of an exception to this rule in one young married woman who presented herself for admission to the infirmary and eventually ended up in the lunatic asylum.[109]

Thus there was, first of all in these early reports, a prevalence among married, educated men of means, although a few reports documented agoraphobia in married women,[110] single women,[111] and single men.[112] Agoraphobia also occasionally occurred in the uneducated, as in Van Horn's case above, as well as in

educated women with means.[113] Some patients were also parents[114] while others were not. All of the patients were adults, ranging in age from 24 (Westphal) to 56 years of age (Hermann), with the average age about 35.[115] Only one physician mentioned the city specifically (Sutherland) even though crowds and streets, which tend to be urban, were commonly noted as objects of fear. Finally, it was predominantly a clinical phenomenon, but it was also reported in asylum patients, albeit infrequently.[116]

Another significant characteristic of the agoraphobics in these reports has to do with duration. It is apparent that patients waited a long time before going to see a physician about their problem. Patients are described in some cases as having been of generally nervous temperament prior to the initial attacks of agoraphobia, but in other cases patients are described as having endured the agoraphobic symptoms for several years. For instance, Sutherland stated that although his patient was unable to say when she first noticed the symptoms of her disease (which was her inability to ride in a moving train), she had foregone travel by train for years. Prosser White's patient had complained that for the previous five or six years he had suffered from attacks of a nervous light-headedness occurring about twice per week and brought on by the ideas of space, vastness, height, depth, eternity, and other such things.[117] "Surgeon's" problems began nine years prior to his writing with an inability to dispense, that was replaced by religious mania for a few weeks, and then finally the agoraphobia.[118] Van Horn's "farmer's wife" had for three years been unable to be alone.[119] Hermann's two patients had suffered for three and four years respectively,[120] while Records' patient, who had suffered from nerves for eight years, had been having agoraphobic symptoms for

three.[121] The question of why patients waited to seek help finds its answer at least partially in the sense of embarrassment and the fear of insanity that were also documented as symptoms. As Roberts wrote in 1882, during the attacks patients wanted to cry out, *but did not want to be considered insane*. They feared that others knew of their dread and endeavoured to conceal their feelings. They were indeed "aware of the foolishness of their fear" but could not be reasoned out of it.[122]

The Years of Transition

World War I would have had an impact on publishing overall, so not surprisingly, very few articles on agoraphobia were published during these years. Still, as a transitional period, it did mark the beginning of an important trend: women were beginning to be diagnosed with agoraphobia more often. Of a total of 9 cases described, 5 were women, as compared with previous years when only 15% of patients were women.[123]

Irrespective of the shift in population, the medical articles retained many of the qualities that appeared earlier. Physicians continued to be concerned with the question of pathogenesis, and the description of patients' symptoms and experiences was maintained as a means of substantiating theoretical and medical claims. Patients' shame was still indicated by the length of time they waited prior to seeing a physician about their problem and was captured especially poignantly by "Vincent," an author who wrote his "Confessions of an Agoraphobic Victim."[124]

This report exemplified the autopathographical[125] style that several writers had adopted in the previous period, but was the only report of this type in this

group. The author was an educated man (Yale), not a physician, who was self-admittedly unfamiliar with the medical literature but wanted to write of his personal observations of his "condition", sensations and experiences.[126] There were two striking things in this article: First was the link he made to aesthetics and architecture, thereby spatialising agoraphobia in a profoundly new way.[127] As he put it, he'd outgrown his fear of crowds but

> an immense building or a high rocky bluff fills me with dread....the architecture of the building has much to do with the sort of sensation produced. Ugly architecture greatly intensifies the fear. In this connection I would remark that I have come to wonder if there is real art in many of the so-called 'improvements' in some of our cities, for, judging from the effect they produce on me, they constitute bad art.[128]

Until now, only open spaces, enclosed spaces, and vertical spaces had come up.

The second interesting thing about Vincent's confession was the way he described the gravity of the situation, making implicit (possibly explicit) references not only to his shame, but to his masculinity which was at stake. His invoking of the language of a "confession" provides the first indication that there was stigma attached to these experiences and diagnosis:

> No one knows the truth about my condition. It is one of the characteristics of the victim of the disease to conceal it most cunningly. I think I am an honest man in all essential things. My credit is good at the banks. But I have deliberately told lies to avoid embarrassing situations and have even changed my plans to have my lies 'come true'.[129]

At this time, only some men were eligible to obtain credit; his reference to credit provides an important marker of gendered identity at that time. A later reference adds to this:

> ... in my own mind I am a nervous wreck, weak, worthless, and unworthy of the high respect which the community accords me.
>
> In spite of all this I seem to exercise marked power of leadership in my town, and am known as a public speaker of ability. [...] Can I ever take

> my place in the world unhandicapped as other men are, and enjoy a single day undepressed by dark dread? If I could be as other men, it seems to me that my usefulness should be increased a hundredfold.[130]

Aside from this autopathographical piece, the voices of patients were still largely absent from the reports, save for one case history in which the physician quoted at length from a manuscript written by his patient.[131] Other phobias in addition to agoraphobia were present in some cases, as were the fear of fear and the fear of becoming insane that patients often developed following their first episodes of anxiety. Indeed, the symptoms described are generally the same as in the earlier cases. To sum up, the war years were continuous in terms of symptoms, but they were also important years of change, insofar as it was after this period that women started to be diagnosed more. Before concluding this chapter, I have a few brief observations to make, both about the years leading up to 1952 when the first edition of the *Diagnostic and Statistical Manual of Mental Disorders* was released (described in Chapter Seven), and about the literature we have looked at so far.

Between 1939 and 1951, mostly due to the Second World War and its aftermath, very few articles that dealt *specifically* with agoraphobia were published.[132] To be sure, one of the most striking characteristics of those reports that *were* published was their more general scope, represented by the interest in "fear," "phobias," and "anxiety." Yet even when the central focus of the report was agoraphobia the articles had broader titles like "The Significance of Fear,"[133] "Common Phobias,"[134] and the "Phobic Syndrome,"[135]. As one author wrote in his preamble:

> Phobias may be for place, space or time. When a person has evolved a reaction pattern of always evading situations in which these specific fears might arise, he [sic] is phobic. Patients who suffer from the phobic syndrome are afraid to venture into the world alone, and when they do they feel the need of a protective influence. They carefully avoid crowds and all social gatherings, as well as open spaces, such as streets and country roads, where they might be entirely alone...[and] where they may experience] the disagreeable symptoms of faintness, weakness...which have become associated with certain situations or conditions, and so avoid any place in which these unpleasant feelings may occur.[136]

That these writers were beginning to construct phobias as a more general issue while still ultimately focusing on agoraphobia suggests that agoraphobia was quite common.

The extent to which agoraphobia had implications beyond the individual also came under scrutiny. For example, describing it as a "community hazard," Henderson argued emphatically against the notion that fear-based mental illness was inexorable and irresolvable:

> ...many physicians and social reformers, and the public generally, are so appalled by the magnitude of the problem that they feel nothing can be done about it; they show no interest or enthusiasm; they refuse to face the actual facts. Such a method of evations [sic] or defence is dependent, to a great extent, on the fatalistic, hereditarily determined ideas regarding the inevitability of mental illness, and an accompanying therapeutic nihilism. There is no other form of illness which creates in the public mind such a sense of disaster, failure, and defeat, and it is natural enough that the instinct of Fear should become a predominant factor both as cause and symptom.[137]

Reminiscent of Durkheim's study of suicide, Henderson's remarks underscored the sense in which the agoraphobic individual had implications for the social, as much as the social had implications for the agoraphobic. As well, Henderson wrote these words in 1941, and like the years of World War I, publishing on agoraphobia decreased significantly during World War II, and did not gain momentum again until the 1950s when the first DSM came out.[138] (Although heavily in-

fluenced by psychoanalytic concepts and theories, as was its 2nd edition of 1968, with its emphasis on statistically based codification and classification, this short manual would unwittingly prove itself to be the first nail in the psychoanalytic coffin.)

It is also important to take notice of the types of journals in which these articles – especially the earlier ones – were published. Westphal and Cordes were the only practitioners to publish in a formally *psychiatric* journal. The other articles appeared in general medical and surgical publications (and dictionaries), with the exception of Sutherland's article which was published in the *Journal of Psychological Medicine and Mental Pathology*.

In addition, nearly all of these articles were a cross between a case report and a discussion paper, though the titles of the articles often did not reflect what the papers were ultimately about. Writers used their articles as opportunities to describe their patients as well as flesh out theories and ideas about agoraphobia, and descriptions of patients were spun to support whatever medical claim the authors were trying to make.

Another point worth noting about these reports is that the authors often described the symptoms of claustrophobia (the fear of being closed or locked in) under the rubric of agoraphobia.[139] Those patients described as having the need to be near a door or avenue of escape when indoors were, arguably, suffering from claustrophobia in addition to their agoraphobia. It is in this sense that it can be understood that agoraphobia and claustrophobia have historically been subsumed together. As we shall see in the most recent literature described in Chapter

Eight, the question of claustrophobia's status as a separate condition is never resolved.

My final observation is that even though the articles often describe particular cases, the voice of the patients is not usually heard in these reports and then only if a) they wrote the piece themselves, as in "Surgeon's" letter to the Editor of *The Lancet* or if b) what the patient had to say supported the writer's thesis. Direct quotes were marshalled only rarely. Despite this, these reports have an important human quality to them in that *they are about people* as much as they are about an illness, as compared with the literature we will see in Chapter Eight.

Let us turn now to Freud's work and the important influence that he had on both the conceptualisation and treatment of agoraphobia, if not the very trajectory of psychiatry itself.

Notes

[1] Porter, 1997:509.
[2] That said, another article written by his colleague E. Cordes, the director of a hydropathic hospital in Germany, who also suffered from agoraphobia for a time, immediately followed Westphal's piece. Cordes examined 29 patients, only one of whom was a woman, and of these 29, 27 fell into the category of irritable weakness and suffered from a high degree of psychic fear. The last two (including the woman) were individuals who feared large places. Cordes delineated three sub-types of patients: those who experienced fear in a crowd, those when alone, and those who had agoraphobia proper. He felt that three conditions contributed to irritable weakness, namely overexertion at work, gastric problems, and sexual overindulgence. These things could also bring on physical illness but these physical illnesses were different from "Platzangst" as he referred to it because of the presence of tremors. All of Cordes' cases had been treated successfully though a few had to return to him for further treatment which consisted of hydrotherapy, then a widely used procedure. Patients were given luke warm rub downs, then cold rub downs, hot baths, and then wave baths over a course of six weeks. They were also required to follow a nourishing diet (see Knapp and Schumacher, 1988).
[3] The reader will notice some significant gaps in the literature. These are partly due to both World Wars and their respective impact on publishing. But also, much of Freud's writing on agoraphobia (discussed in the next chapter) overlaps chronologically with this material. Behaviourism, to be taken up in Chapter Six, will also round things out a bit.
[4] For a translation of and commentary on "Die Agoraphobie" see Knapp and Schumacher, 1988.
[5] Westphal, 1988 [1871]:73.
[6] Westphal, 1988 [1871]:74.
[7] Westphal, 1988 [1871]:76.
[8] Westphal, 1988 [1871]:78.
[9] Westphal, 1988 [1871]:81.
[10] Westphal, 1988 [1871]:78-9.
[11] Westphal, 1988 [1871]:86. Whether or not agoraphobia is an exclusive condition has been an important debate and continues to be. As we shall see in the literature published between 1976 and 1999, the relationship between agoraphobia and panic is never really resolved.
[12] Westphal, 1988 [1871]:87.
[13] Westphal, 1988 [1871]:79.
[14] Westphal, 1988 [1871]:79.
[15] Westphal, 1988 [1871]:80.
[16] Westphal, 1988 [1871]:84-5.
[17] Westphal, 1988 [1871]:85.
[18] Webber, 1872.
[19] Headley Neale, 1898.
[20] Potter, 1882; Van Horn, 1886; Suckling, 1890.
[21] Records, 1896.
[22] It should be noted here that although these are discussed separately, they were by no means discrete considerations.
[23] The medical dictionaries show that agoraphobia also went by the names "kenophobia" or "cenophobia" however I found no clinical literature under these headings.
[24] See for example Webber, 1872.
[25] Webber, 1872.
[26] Taylor, 1895.
[27] Records, 1896.
[28] "Surgeon," 1885.
[29] Webber, 1872
[30] Blodgett, 1887.
[31] Williams, 1872.
[32] Hermann, 1889.
[33] Roberts, 1882.

[34] Ruttle, 1889.
[35] "Surgeon," 1885.
[36] In Blodgett, 1887:410.
[37] The frequency with which acrophobia and claustrophobia appeared as a related problem says something *very* interesting about the spatiality – both vertical and horizontal – of this *type* of phobia.
[38] Webber, 1872
[39] Hermann, 1889.
[40] Prosser White, 1884.
[41] Jones, 1898:569.
[42] "Surgeon," 1885:93.
[43] Van Horn, 1886:603.
[44] Williams, 1872:353.
[45] Williams, 1872:353.
[46] Sutherland, 1877.
[47] Blodgett, 1887.
[48] Hermann, 1889.
[49] Jackson, 1872:61.
[50] Sutherland, 1877:265.
[51] Webber, 1872.
[52] Williams, 1872:351.
[53] "Surgeon," 1885:93.
[54] Jones, 1898.
[55] White, 1884:1141.
[56] Headley Neale, 1898:1323.
[57] Fisher and Knapp in Blodgett, 1887. "Folie du doute" was the term given to manic psychosis of abnormal doubting regarding ordinary acts and the inability to decide upon definite courses of action (Taber's Medical Dictionary, 17th edition, 1993).
[58] Taylor, 1895:397. "Alienists was the term for "psychiatrist" used at that time. (Interestingly, the word "alien" comes from the Latin "alienus", meaning "of another, of others; alien, strange; unsuited to, different from; hostile...stranger" (Kidd, 1996:17).
[59] Ziporyn, 1992:83.
[60] Theories of causation were not limited to the dichotomy between the ontological and physiological, but extended as well into the presumption of a split between mind and body (see Webber, 1872) and between the subjective and the objective (see Sutherland, 1877).
[61] Punishment as posited first by religious suggestions within medical practice and then later, with the emergence of psychoanalysis, for forbidden desires.
[62] See King (1982) as well as Risse (1978) and Hudson (1987).
[63] I owe this insight to Jacalyn Duffin.
[64] Blodgett, 1887:407.
[65] Jones, 1898.
[66] Hermann, 1899.
[67] Jones, 1898.
[68] Dowbiggin, 1991:5.
[69] Suckling, 1890:478.
[70] Potter, 1882:474. These two reports are especially interesting because when they were published, it was still mostly men who were being diagnosed with this pathology, and this trend persist until after World War I.
[71] Taylor, 1895.
[72] Headley Neale, 1898:1322. The sinus pocularis is the lacuna in the prostatic part of the urethra (Thomas, 1993:1803).
[73] Mercier, 1906:990.
[74] Mercier, 1906:990. The implication of Mercier's argument is that agora-claustrophobics (and homeless people) are therefore unevolved: the "habit" of seeking shelter is a gradual thing, not yet "fully acquired by all our race" since there is evidence that many people would rather "lie out un-

der a hedgeside ... even in the worst weather" (Mercier, 1906:990). Ironically, in the 1980s, there was a debate over the possibility that Darwin himself suffered from panic attacks. See the debate between Adler, 1997; Barlon and Noyes, 1997; Colp, 1997; FitzGibbon, 1997; Gordon, 1997.
[75] See for example Dowbiggin (1991:1) and his discussion of a similar tendency in 19th century French medical literature.
[76] Sutherland, 1877:267).
[77] Sutherland, 1877:268; emphasis in text.
[78] Sutherland, 1877:268.
[79] Webber, 1872:297.
[80] Prosser White, 1884.
[81] Porter, 1997:501.
[82] Porter, 1997:511.
[83] Jones, 1898:568.
[84] Jones, 1898:570.
[85] Physicians did not always write of treatment, however, and many articles were more concerned with conceptualising agoraphobia than with treating it. As we shall see from the plethora of drug and behaviour therapy studies described in Chapter 8, the opposite is true in the most recent literature.
[86] Hermann, 1889:234.
[87] Fisher in Blodgett, 1887.
[88] Prosser White 1884.
[89] Bromide is defined in Taber's medical dictionary as a compound that acts as a central nervous system depressant.
[90] If strychna is related to strychnine, then according to the OED, it is also related to nux vomica, which is a homeopathic remedy used in cases of phobia, among other things (Personal communication, Richard Putnam (ND), 1999).
[91] Van Horn, 1886:604.
[92] Ruttle, 1889.
[93] Records, 1896.
[94] Headley Neale, 1898:1323.
[95] Headley Neale, 1898:1323.
[96] Mercier, 1906:991.
[97] Mercier, 1906:991.
[98] Mercier, 1906:991.
[99] Mercier, 1906:991.
[100] Mercier, 1906:991.
[101] Headley Neale, 1898:1323.
[102] Headley Neale, 1898:1322.
[103] Van Horn, 1886:601.
[104] The remainder do not specify.
[105] Van Horn, 1886. Recall that Van Horn's report was about agoraphobia in a woman, and there would have been socio-cultural reasons for why she would not have been educated.
[106] Headley Neale, 1898:1323.
[107] Headley Neale, 1898:1323.
[108] Headley Neale, 1898:1322.
[109] Headley Neale, 1898:1323.
[110] See Potter, 1882.
[111] See Records, 1896.
[112] See Sutherland, 1877.
[113] See Hermann, 1889.
[114] See Potter, 1882 and Mercier, 1906.
[115] Writers often wrote that the patient was "about..." so many years oid, so this calculation of average age is necessarily approximate.
[116] See Suckling (1890) and Jones (1898).
[117] Prosser White, 1884.

[118] "Surgeon," 1885.
[119] Van Horn, 1886.
[120] Hermann, 1889.
[121] Records, 1896.
[122] Roberts, 1882; see also Jones, 1898.
[123] This shift may be due to three things. First, during the war there would have been fewer men physically present in the urban setting in which these diagnoses were generally made. Additionally, "shell shock" and "war neurosis" had been "invented" by this time and were used quite regularly to describe anxiety in men. The concomitant increase of diagnoses in women may also have had to do with the increasing presence of psychoanalysis on the medical landscape, and its contribution of a new vocabulary with which to describe individual angst. Moreover, given the contested (and ideological) views that were held at that time about hysteria, women's psyches and their mental fitness, we have reason to think that psychotherapy was a service now used disproportionately more by women.
[124] "Vincent," 1919.
[125] I borrow the term "autopathography" from Jacalyn Duffin.
[126] "Vincent,"1919:295.
[127] One of Patrick's (1916) patients (described below) also spatialised the disease in a new way in that her problem was that she could not cross a large room unaccompanied. This was the first time that the inability to cross a large space indoors had been noted.
[128] "Vincent," 1919:297.
[129] "Vincent," 1919:299.
[130] "Vincent," 1919:299.
[131] Williams, 1916.
[132] There was nothing published until 1941, and in total I found only 4 articles for this brief period.
[133] Henderson, 1941:649.
[134] Fenichel, 1944.
[135] Terhune, 1949.
[136] Terhune, 1949:165.
[137] Henderson, 1941.
[138] I found only 5 articles between 1941 and 1951 while, following the first DSM, there were at least two articles published nearly every year.
[139] Even today the DSM does not code claustrophobia separately.

Chapter 5
The Freudian Legacy and the Rise of Psychoanalysis

> ...Freud did not often speak about himself and his intimate life. My impression is that he became more confidential after his seventieth birthday; at least he then told me some things about himself which I could never have guessed. One memory is the most important. I accidentally met him one evening in the Kaertnerstrasse in Vienna and accompanied him home. We talked mostly about analytic cases during the walk. When we crossed a street that had heavy traffic, Freud hesitated as if he did not want to cross. I attributed the hesitancy to the caution of the old man, but to my astonishment he took my arm and said, "You see, there is a survival of my old agoraphobia, which troubled me much in my younger years." We crossed the street and picked up our conversation after his remark, which had been casually made. His confession of a lingering fear of crossing open places...made...a strong impression upon me. [...] [T]he free admission that his neurosis had left this scar on his emotional life would have added to my admiration of his great personality...[1]

Leading up to the First World War

While he may or may not have been motivated to do so by his own personal experiences with agoraphobia, Freud wrote extensively on the subject of anxiety neurosis, whose symptoms included phobias and agoraphobia in particular.[2] His cases, "Little Hans" (1909), a five-year-old boy with a phobia of horses, and "Wolf Man" (1918), named for a dream he had about wolves sitting in a tree outside his window, are perhaps his best known work on the topic of phobias; the only case literature he published on agoraphobia per se was actually relegated to a footnote.[3] Still, although he published no cases, his thoughts on agoraphobia are traceable to pre-Oedipus writing he did as early as 1892, when he (already) suspected that "forgotten" trauma and sexual experiences and impulses played a part in the development of hysterical symptoms. Indeed, his theory of neuroses did not remain consistent throughout his career. He developed what is widely con-

ceptualised as earlier and later views of this phenomenon, the earlier more consistent with a widely accepted biological understanding of mental disease, while his later view, launched by an essay written in 1926, took psychosocial factors more into account. In this section I shall describe Freud's earlier position on phobia and neuroses.

According to Compton,[4] the story of Freud's interest in phobias begins with an 1892 footnote in his translation of Charcot's lectures. Disagreeing with Charcot's assertion that the hysterical attacks, vertigo, and agoraphobia in his patient were caused by heredity, Freud wrote:

> I venture upon a contradiction here. The more frequent cause of agoraphobia as well as of most other phobias lies not in heredity but in abnormalities of sexual life. It is even possible to specify the form of abuse of the sexual function involved. Such disorders can be *acquired* in any degree of intensity; naturally they occur more intensely, with the same aetiology, in individuals with a hereditary disposition.[5] (SE 1, 139)

Seeking to distance himself from the view of hysteria as degeneracy (as opposed to being the result of un-abreacted[6] traumatic experiences), Freud, with his first collaborator the highly respected Viennese internist Josef Breuer, tried to establish hysteria as a form of illness.[7] At this time Freud believed that phobias were, similar to hysteria, the result of traumas but while "psychical factors...may account for the *choice* of...phobias, [they] cannot explain their *persistence*."[8] Their persistence was the result of "aktual" neurosis, or the development of symptoms as a result of disturbances in the sexual economy, that is, obstacles to the gratification of instinctual sexual needs.

Freud and Breuer published a number of case histories together in 1893. In one, "Frau Emmy," Freud wrote that a "*neurotic* factor" – the fact that the pa-

tient had been living for years in a state of sexual abstinence...[is] among the most frequent [cause] of a tendency to anxiety."[9] In a footnote (mentioned above) to another case, which he included to explain his investigative technique, Freud describes a woman of thirty-eight who suffered from "anxiety neurosis (agoraphobia, attacks of fear of death, etc.)."[10] "[L]ike so many such patients," she was reluctant to admit "that she had acquired these troubles in her married life" and told Freud that she was seventeen at the time of her "first attack of dizziness, with anxiety and feelings of faintness, in the street in her small native town." Freud decided to "embark on an analysis" of this first "hysterical" attack and began by having her set the scene. Her first attack, she related, "came over her while she was out shopping" for something to wear to a ball. Freud responded:

> 'Something must have happened to agitate you a few days before, something that made an impression on you.'
>
> 'I can't think of anything. After all, it was twenty-one years ago.'
>
> 'That makes no difference; you will remember all the same. I shall press on your head and when I relax the pressure, you will think of something or see something, and you must tell me what that is.'

Soon, though she was sceptical of any connection, the woman recalled two girls who had died in the town. Then Freud asked,

> 'Now, can you remember what you were thinking about when you felt dizzy in the street?'
>
> 'I wasn't thinking of anything; I only felt dizzy.'
>
> 'That's not possible. States like that never happen without being accompanied by some idea. I shall press once more and the thought you had will come back to you....Well, what has occurred to you?'
>
> 'The idea that I am the third. [...] When I got the attack of dizziness I must have thought: "Now I am dying, like the other two girls."'

With the attack now explained "to some extent," Freud attempted to discern what had precipitated the memory of those girls, and he formed "what happened to be a lucky conjecture.":

> 'Do you remember the exact street you were walking along just then?'
>
> 'Certainly. It was the principal street, with its old houses. I can see them now.'
>
> 'And where was it that your friend lived?'
>
> 'In a house in the same street. I had just passed it, and I had the attack a couple of houses further on.'
>
> 'So when you went by the house it reminded you of your dead friend, and you were once more overcome by the contrast which you did not want to think of.'

Freud was not satisfied with this, however, and sought to uncover what had "aroused or reinforced the hysterical disposition of a girl who had till then been normal." He asked the woman about her menstrual periods:

> 'Do you know at what time in the month your period came on?' [...]
>
> 'Do you expect me to know that, too? I can only tell you that I had them very seldom then and very irregularly. When I was seventeen I only had one once.'

Freud did the calculations and they determined that her only period that year came on just before the ball – her first ball. While the text of this exchange does not especially support the thesis he would develop over the next decades, it does demonstrate the pathogenic link Freud made between neuroses (agoraphobic) and experiences "retained in the patient's memory even when they seem to be forgotten."[11] But primarily, Freud's thesis at this time was recorded in a letter to Wilhelm Fliess that same year, and suggested that such difficulties were rooted in undischarged libido:

> ... Things become more and more complicated as confirmation comes in. Yesterday, for instance, I saw four new cases whose aetiology, as shown by the chronological data, could only be coitus interruptus. It may perhaps amuse you if I give a short account of them. They are far from being uniform.
>
> (1) Woman, aged 41; children, 16, 14, 11 and 7. Nervous trouble for the last 12 years; well during pregnancy; recurrence afterwards; not made worse by the last pregnancy. Attacks of giddiness with feeling of weakness, agoraphobia, *anxious* expectation, no trace of neurasthenia, little hysteria. Aetiology confirmed: simple [anxiety neurosis]...[12]

In 1894 Freud delineated three classes of phobias under the rubric of "defence neuro-psychoses."[13] These three groupings included 1) purely hysterical phobias, 2) typical phobia, and 3) obsessional phobias. Freud does not unpack what he means by "purely hysterical" phobias, but does distinguish between obsessional phobias which comprise the "great majority of phobias" and "typical phobias".[14] The latter, "of which agoraphobia is a model, cannot be traced back to the psychical mechanism" of repression of sexual ideas. Rather, the

> mechanism of agoraphobia differs from obsessions...and the phobias that are reducible to them, in one decisive point. There is no repressed idea from which the anxiety affect might have been separated off. The anxiety of these phobias has another origin.[15]

Freud also distinguished between obsessions and phobias on the basis that in phobias the emotional state associated with them "is always one of 'anxiety', while in true obsessions other emotional states, such as doubt, remorse, or anger, may occur just as well as anxiety."[16] Moreover, while obsessions were varied and individualized, phobias were "uniform and typical"[17] and divisible into two groups: those common phobias that were simply an exaggerated fear of things ordinarily feared by everyone (such as snakes, night, death, illnesses, solitude), and specific contingent phobias – read: typical – phobias of "special circumstances that inspire no fear in the normal man".[18] As an example he cited agora-

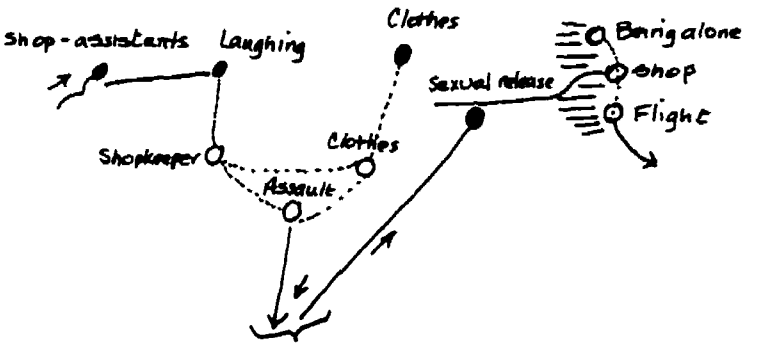
phobia and "other phobias of locomotion" that are based in the *recollection* of a state of anxiety, whereby the "emotional state appears in their instance only under special conditions which the patient carefully avoids."[19] As he put it, "what the patient actually fears is a repetition of such an attack under those special conditions in which he believes he cannot escape it".[20] The "anxiety attack" thus feared is characterised by "disturbance of the heart action" and of "respiration," as well as "sweating," "tremor and shivering," "ravenous hunger," "diarrhoea," vertigo, "congestions," "paraesthesias."[21] Agoraphobia in turn is frequently "based on an attack of vertigo that has preceded it," but not always. In some cases vertigo occurs without anxiety, permitting "locomotion" to continue, but when anxiety occurs with vertigo under certain conditions "such as being alone or in a narrow street ... locomotion breaks down."[22]

For Freud, the phobia was a symptom and psychical manifestation of anxiety neurosis caused by sexual tension "extremely frequent in modern civilized society."[23] In 1895 Freud illustrated the "special constellation in the sexual sphere" with an anecdote about a patient:[24]

> Emma is subject at the present time to a compulsion of not being able to go into shops *alone*. As a reason for this, [she produced] a memory from the time when she was twelve years old (shortly after puberty). She went into a shop to buy something, saw the two shop-assistants (one of whom she can remember) laughing together, and ran away in some kind of *affect of fright*. In connection with this, she was led to recall that the two of them were laughing at her clothes and that one of them had pleased her sexually. [...]
>
> Further investigation now revealed a second memory, which she denies having had in mind at the moment of Scene I. Nor is there anything to prove this. On two occasions when she was a child of eight she had gone into a small shop to buy some sweets, and the shopkeeper had grabbed at her genitals through her clothes. In spite of the first experience she had gone there a second time; after the second time she stopped away [sic]. She now reproached herself for having gone there the second time, as

> though she had wanted in that way to provoke the assault. In fact a state of "oppressive bad conscience" is to be traced back to this experience.[25]

The description is accompanied by a visual representation of Emma's problem with shops:[26]



Consistent with his analysis of Emma, in letters to Fliess written between 1896 and 1899, Freud theorised that phobias or "anxiety symptoms" were derived from fantasies which are an "unconscious combination of things experienced and heard, according to certain tendencies."[27] These tendencies are directed towards "making inaccessible the memory from which symptoms have emerged or might emerge". Unconscious fictions are developed and "if such a fantasy increases to a point at which it would be bound to force its way into consciousness" the fantasy is repressed and a symptom is generated through a [process of] "pushing the fantasy back to its constituent memories". Freud went on in this letter to say that in phobias a "romance of alienation is found regularly ... agoraphobia seems to depend on a romance of prostitution, which itself goes back once more to this family romance. *Thus a woman who will not go out by herself asserts her mother's unfaithfulness*",[28] presumably because her mother cannot be trusted to

be alone at home with her father. This is interesting in light of an earlier letter to Fliess:

> ...I actually confirmed a conjecture I had entertained for some time concerning the mechanism of agoraphobia in women. No doubt you will guess it if you think of 'public' women. It is the repression of the intention to take the first man one meets in the street: envy of prostitution and identification.[29] (17 December 1896)

From this we can see that phobias have a "more complicated structure than purely somatic anxiety attacks" and are "linked to a definite ideational or perceptual content." Still, it is clear that the disruption of sexual instinct is primary. As Freud stated in a reply to his critics (written just prior to his letters to Fliess):

> I see no reason why I should try to hide the gaps and weaknesses in my theory. The main thing about the problem of the phobias seems to me to be that *when the vita sexualis is normal* – when the specific condition, a disturbance of sexual life in the sense of a deflection of the somatic from the psychical is not fulfilled – *phobias do not appear at all.*[30]

Despite this apparent contradiction, the correspondence with Fliess suggests that it was only women who were agoraphobic, a conclusion presumably drawn from his own clinical practice (though not, given his own personal experiences). Taken in the context of the rest of the medical articles for this period, this makes Freud's patient roster anomalous since other physicians reported on agoraphobia in men (though of course it depends on how many agoraphobic patients Freud had in total). His remarks are also interesting because they signify the early germination of Freud's Oedipus theory and the concept of desire to explain agoraphobia, something no one had yet done. Freud would eventually (after 1900) make a link between agoraphobia and "the sexual nature of pleasure in movement",[31] and the idea that the street was the site of forbidden sexual seduction.[32] Agoraphobia was like a "frontier fortification against the anxiety" so generated.[33]

By 1900 Freud had established the psychoanalytic method and "discovered" infantile sexuality, the Oedipus complex, the unconscious, the dynamic nature of mental processes, and the dominance of the pleasure principle (the mechanism for reducing psychic tension arising from the drives). Briefly, his theory was inspired by the classical story of Oedipus, son of Jocasta and Laius, King of Thebes. Laius had left his son on a mountain to die after an oracle told him that he would be killed by his own son. A shepherd saved the baby Oedipus who returned eventually to Thebes and, unaware of who he was, killed his father and married his mother. When the truth was revealed, he gouged out his eyes, and Jocasta committed suicide. From this story Freud derived the notion of an Oedipus complex. This referred to the set of emotions aroused in young boys by their sexual desire for the parent of the opposite sex, emotions that included not only desire, but aggression towards the rival same-sex parent as well and subsequent guilt and fear of repercussion for the illicit emotions.

When it came to the case of Little Hans in 1909, Freud introduced the term "anxiety-hysteria" to represent the psychic processes explicable through the Oedipus story.[34] Yet, despite the new terminology, Freud was talking about the same neurotic phenomena, namely phobias. The story begins when Hans was "seized with an attack of anxiety" one day in the street. He was unable at first to articulate what it was that was causing him his distress but Freud eventually surmised that Hans was afraid of horses falling down.[35] Freud defined Hans' "disorder" as a phobia. "[W]ere it not for the fact that it is a characteristic of [agoraphobia] that the locomotion of which the patient is otherwise always incapable can always be easily performed when he is accompanied by some specially se-

lected person", Freud would have classified Hans' phobia as agoraphobic. Hans' phobia did not meet this criterion of companionship that was so common among agoraphobics, however, and Hans' problem "soon ceased having any relation to the question of locomotion", becoming entirely focused on horses.[36]

At the time of writing this case report, there was no definite position within the classificatory system of the neuroses assigned to phobias.[37] Freud asserted that phobias "should only be regarded as *syndromes* which may form part of various neuroses [so] we need not rank them as an independent pathological process."[38] Thus Freud deemed Hans' phobia and others an "anxiety-hysteria" because it was similar to the psychological structure of hysteria in all ways except one. In anxiety-hysteria "the libido which has been liberated from the pathogenic material by repression is not *converted* (that is diverted from the mental sphere into a somatic innervation), but is set free in the shape of *anxiety*."[39] Little Hans' case was a simple anxiety-hysteria that had no "admixture of conversion."[40]

It was at this point in the analysis that Hans recalled the precipitous event that preceded the "outbreak of the illness" and was clearly its cause. On a walk with his mother he saw a bus-horse fall down and kick. Hans was terrified and henceforth believed that all horses would fall down. His father, who wrote the biographical document about Hans on which Freud's assessment was based, conjectured that when Hans saw the horse fall down, he must have thought of his father and wished he would fall down in the same way and die. The falling horse represented his father who would punish Hans for the "evil wishes he was nourishing against him".[41] On hearing this interpretation, Hans did not disagree and later played a game that consisted of biting his father, thereby showing his ac-

ceptance of his father's theory of identification. Hans' behaviour to his father from then on was unconstrained, fearless, and "a trifle overbearing"[42] and his fear of horses ceased.[43]

Freud described anxiety-hysteria as the most common of all psychoneurotic disorders that tends to develop into a phobia[44] and, he noted, they make their appearance in childhood. This should be noted as an important point among the reports we have seen thus far; some of the patients described had "nervous temperaments" since early on and all of them had lived with their specific agoraphobia for several years before seeking help. Whether or not their anxieties could be traced to childhood was only clear in some reports, but then physicians might not have been looking to do so, as Freud would have been, given his interest in infantile sexuality. He was aware of other perspectives on agoraphobia and noted that "[I]t has not yet been established whether anxiety-hysteria is determined, in contradistinction to conversion-hysteria and other neuroses, solely by constitutional factors or solely by accidental experiences, or what combination of the two."[45] His sense was that "there is no reason to suppose that anxiety-hysteria is an exception to the rule that both predisposition and experience must co-operate in the aetiology of a neurosis."[46] Nonetheless, of all the "neurotic disorders", anxiety-hysteria depended the least upon constitutional predisposition and thus phobias were easily acquired at any time in life.

If phobias were not "converted," and akin to hysteria, then the task incumbent upon Freud was to explain the nature and *process* of a phobia. As Freud stated, anxiety-hysteria developed into a phobia as the consequence of ridding oneself of anxiety. That is, the patient pays a "price of subjecting himself [sic] to

all kinds of inhibition and restrictions....Nothing is left for it [the mind] but to cut off access to every possible occasion that might lead to the development of anxiety, by erecting mental barriers in the nature of precautions, inhibition, or prohibition". These are "defensive structures" that take the form of phobias and are the "essence of the disease".[47] This view of anxiety as a defensive structure deriving from the issues and emotions associated with undischarged (and misdirected) libido was, as Compton observed, relatively consistent with the position Freud had taken until the Hans case.[48] Undischarged libido was at this time (1909) still perceived as the source of anxiety in both aktual neuroses and defense neuroses.

Contra previous methods[49] that were not successful in Freud's estimation, after a certain amount of psychoanalytic work an analyst can succeed in uncovering the "actual content" of a phobia. In these cases of anxiety-hysteria repression has "descended upon the unconscious complexes", and is "continually attacking their derivatives" obscuring the "products of the disease itself."[50] The analyst's role thereby seemed to be to help the disease by "procuring its due of attention". That is, those who misunderstood the nature of psychoanalysis would think that it would cause harm rather than help, but Freud argued, on the contrary, "you must catch your thief before you can hang him" and for this the analyst needs to "get securely hold of the pathological structures at the destruction of which the treatment is aimed."[51]

By 1917 Freud included all phobic syndromes under the rubric of "anxiety hysteria." He distinguished between phobic anxiety and "free floating expectant anxiety"[52] and observed two phases of the neurotic process – repression and the transformation of libido into anxiety, followed by the

> erection of all the precautions and guarantees by means of which any contact can be avoided with this danger, treated as it is like an external thing. [...] A phobia may be compared to an entrenchment against an external danger which now represents the dreaded libido.[53]

Further, with his description of the Wolf Man in 1918, Freud demonstrated that anxiety was not exclusively pathological, but rather a mechanism developed by the ego in response to a perceived danger.[54]

In 1918 Freud distinguished between two classes of agoraphobia, one mild and the other severe, and proposed a slight modification to his analytic method – one that would eventually become the cornerstone of behavioural treatment, namely, the need for exposure. As Freud wrote:

> Our technique grew up in the treatment of hysteria and is still directed principally to the cure of that affection. But the phobias have already made it necessary for us to go beyond our former limits. One can hardly master a phobia if one waits till the patient lets the analysis influence him to give it up. [...] One must proceed differently. Take the example of agoraphobia; there are two classes of it, one mild, the other severe. Patients belonging to the first class suffer from anxiety when they go into the street by themselves, but they have not yet given up going out alone on that account; the others protect themselves from the anxiety by altogether ceasing to go about alone. With these last [sic] one succeeds only when one can induce them by the influence of the analysis to behave like phobic patients of the first class – that is, to go into the street and to struggle with their anxiety while they make the attempt.

Freud continued that it is only once the phobia has been "moderated" that "the associations and memories come into the patient's mind which enable the phobia to be resolved."[55]

Psychoanalysis and The Years of Transition

In the previous chapter we looked briefly at the war years as a transitional period in the early history of agoraphobia in terms of who was being diagnosed (the shift

from men to women). These years were also important however, because at this time a debate emerged over treatment, especially regarding the validity, utility, and scientific merit of Freud's work. A closer look at the articles should provide a clearer picture of the extent of this debate.

Freud's colleague, Karl Abraham wrote the first article of the period in 1913. Picking up on Freud's work and presumably his comments noted earlier regarding the pleasure in movement, Abraham was interested in the question of why some neuroses manifest in *this* particular way, that is, as agoraphobia or what he called "street" or "locomotor anxiety". He asserted that in these individuals there must have been a specific factor present in their sexual constitution that was not present in that of other neurotics. This factor was the failure in these neurotics to repress the pleasure derived from movement when in the company of those people who were the object of their desire in childhood.

To support his argument, Abraham described patients who experienced pleasure when walking. In one case this was demonstrated by the "pollution dreams" of dancing that a male patient had been having, and for whom walking outside with his mother was like dancing and therefore equally gratifying. For this man walking and dancing offered a substitute for sexual gratification, which was otherwise denied him by his neurotic inhibitions. In another patient, the pleasure in movement was derived from walking with her father, which symbolically fulfilled her incest wish and prevented her from being able to walk with anyone else. As Abraham wrote, "Any deviation from this law enforced by her neurosis would have signified unfaithfulness to her father."[56] Thus these individuals only derived "locomotor pleasure" in the company of particular companions, and

in the company of others the pleasure in movement was transformed into a fear of movement and subsequent street anxiety.

Freud's Critics

Not all the practitioners were as receptive to Freudian ideas, however, and the articles that followed Abraham's demonstrate psychoanalysis' contested early relationship with the medical establishment. For example, Roy Porter describes the response of the neurological section of the British Medical Association to one Freudian's presentation of a case of hysteria in 1911: "At the end of his talk, the entire audience, including the chairman, rose and walked out in icy silence."[57] Charles Mercier, whom we looked at in the previous chapter (he ascribed agoraphobia to an arboreal instinct), is said to have bragged in 1916 that

> 'psychoanalysis is past its perihelion, and is rapidly retreating in to the dark and silent depths from which it emerged. It is well that it should be systematically described before it goes to join pounded toads and sour milk in the limbo of discarded remedies.'[58]

American physician Hugh T. Patrick, also in 1916, explicitly rejected the Freudian explanation, writing that with this type of nervous disorder patients did not realise that they had a fear per se. Rather, they were dominated by an idea, and the problems they experienced obtained from temperament. He argued that intellectuality was no guarantee against phobias and the "cultivated [were] quite as susceptible as the stupid and ignorant."[59] The key to overcoming their problem was to recognise the mechanism of the fear by going back to the first appearance of symptoms and the circumstances. Patrick asserted that the patient had usually experienced some sort of trauma.

But he also noted that a number of other factors were involved: food, tobacco, and alcohol poisoning; dizziness or loss of consciousness due to overheated to overcrowded rooms; weakness from typhoid or other acute illness, surgery or confinement; heat stroke; excessive eating; rheumatism, aural vertigo, tinnitus; syphilis; nocturnal emissions; the shock and haemorrhage of initial coitus; cerebral thrombosis; migraine; indigestion; uremic convulsions [urine in the blood]; night numbness or night palsy; and predormal shocks. He stated that the remedies most frequently prescribed were absolutely futile. As he put it:

> How can "tonics" or "sedatives," change of climate, a vacation, tacking up a floating kidney, lifting a prolapsed uterus or rest in bed and massage eradicate fear? Would a winter in Florida, a trip around the world, an operation for haemorrhoids, or strychnin pills make a sinner less afraid of eternal punishment?[60]

Rather, the only solution for treatment was "analysis" and re-education through gradual exposure, but by analysis, he emphasised, he did not mean the Freudian variety. Each patient was an individual and not a machine, not something out of a mold. As he wrote, "We can scarcely be said to treat a psychoneurosis; we are working with the individual who has it."[61] Yet despite his concern to reject the Freudian framework, Patrick nevertheless did argue that the key to discovering the causation of agoraphobic symptoms was to trace the patient's history to a traumatic event that could be redefined through re-education and with this he was effectively drawing on Freud's earliest thesis. Interestingly, in his response to discussants he added that the object of treatment was not to give the patient the true explanation, but to give him [sic] an explanation which would satisfy him, which would appeal to his mentality and harmonise with his viewpoint, his past, his education, and his environment: "...some of the successes of the freudians

have been attained not because they have found the truth, but because they have done something which begot confidence, which presented to the patient what for him was an adequate explanation."[62]

Indeed, the discussion section of the paper demonstrated that the importance of Freud's perspective was greater than Patrick expected or wished, since his passing remark (that he did not mean Freudian analysis) was precisely what his discussants were interested in talking about. The views offered were relatively split; one physician ambiguously offered that Freudian "doctrine" may have some elements of truth, but there was a biological factor to consider, that there was "something which brings about those conditions in addition to ideas."[63] The rest of the remarks were more explicitly for or against, with one writer expressing sarcastically or seriously – it is not clear which – his wish to have a Freudian explain to him his own fear of snakes and lizards.[64] Another stated that Freudian theory was crucial in this question, that it was "the freudian wish on which is involved the essential determining factor of life itself."[65] Opposing views included the stance that there was no place in the practice of medicine and psychiatry for "the freudian intrusion in any serious sense" because with phobias it "does not do to remind the patient too soon that his trouble is psychic."[66] Another discussant stated that Freud's symbolic theories were used as mechanically as a set of chemical analytic tables, and

> this has led not to the careful detailed personalized examination of the individual under consideration, but to a request for symptoms and their automatic pigeon-holing on a basis of preconceived data of purely pontifical character.[67]

Another participant (Williams) insisted that "[t]he only explanatory analysis is not freudian [sic] analysis. People were cured of these troubles long before that doctrine was known."[68]

Despite his hostility towards the Freudian method, this physician's approach bore a startling resemblance to that used by Freud in his analysis of Little Hans in 1909. In the case of Little Hans, Freud's analysis was based on Hans' father's written notes about Hans. By comparison Williams' patient was asked to write an account of the way in which she viewed her own psychology. Moreover, as we shall see next, both Williams and Abraham were operating under the assumption that an object of fear could be turned into an object of pleasure or, at least, something tolerable. Let us examine Williams' case, a woman who suffered from agoraphobia and claustrophobia, in more detail.

Claiming to have removed her "disturbance" in one week, Williams contended that there were two types of phobias. One was the sort that manifested from an "emotional predisposition ... inherent in the constitution of [the] organism" and the other the sort that is "readily removable by present psychotherapeutic methods."[69] The first type was incurable, but the second, whose genesis and mechanism were different, could, as with Pavlov's dogs, be reconditioned. It was his belief that once the mechanism of origin was determined, the patient, "comprehend[ing] the real nature of his [sic] condition", could view his reactions rationally and then "forestall them."[70] The patient could face these situations "with a clear and open mind and by analyzing his own relationship to the situation each time it arises." Thus the situation "rapidly becomes shorn of its emotional aspect, for the patient has learned to view it scientifically."[71] And like Pat-

rick above, Williams was critical of other methods that had been used because they did not focus on the cause of the condition. He argued that the cause of the curable type of phobias was the key to their elimination, because "[t]he *essential cause of phobias* of this type is a *conditioning of the effective reaction* towards a given situation *because of a mistaken notion regarding it.*"[72] Indeed, responses could be "reconditioned" insofar as

> the same signal which at one time provoked fear can be later utilized to provoke pleasure if the dog is reeducated [sic] by accustoming him to associate with this signal a pleasurable experience, whereby there is a gradual disappearance of the painful or fearful association.[73]

Thus, he maintained, re-association and substitution was the way to effect a change in the meaning that the "subjects" attached to the situation. The emotional disturbance was not due to "vaguely envisaged hereditary constitution", nor to a "specifically nervous disposition", but was environmental and due to a "faulty attitude of mind or way of looking at the situation."[74] The removal of such a phobia was a purely intellectual process of re-learning and cognitive adjustment and with this Williams foretold of the cognitive approach that would become more popular much later in the century.

For now, however, it was psychoanalysis that really dominated the clinical landscape. Let us now turn to Freud's later writings and those of other psychoanalysts that followed his framework.

The later writings of Sigmund Freud

There is no evidence to suggest that Freud was necessarily aware of or involved in the debates outlined above, however he did publish more on the subject of neuro-

ses after 1919. Freud's interest was in determining how it is possible for the familiar to become unfamiliar and terrifying, significant for subsequent explanations of ego. In his essay, "The Uncanny" – which would become one of his most famous – he described the uncanny as that class of the frightening which stimulates "dread and horror" and leads back to what is "known of old and long familiar."[75] The term "uncanny", meaning at once homely, familiar, agreeable, intimate, *and* unfamiliar, frightening, kept out of sight, has the double semantic effect of signifying its opposite. The concept refers to the development of meaning in an object towards ambivalence, that is, from that which was familiar and homely to that which is unfamiliar and estranging. Freud conjectures that if his psychoanalytic theory is correct – namely that every affect is transformed into anxiety if it is repressed – then

> among instances of frightening things there must be one class in which the frightening element can be shown to be something repressed which *recurs*. This class of frightening things would then constitute the uncanny; and it must be a matter of indifference whether what is uncanny was itself originally frightening or whether it carried some *other* affect.[76]

This helps to account for ambivalence, for how a parent can be both hated and desired at once, a factor that shows up repeatedly in psychoanalytic case histories. The essay also illuminates the question of how the street and open spaces can become "unfamiliar" for a person by explaining how that which is repressed can come to the surface and manifest itself in these duplicitous and ambivalent terms. Along with his essay on modern nervousness (1908), Freud's concept of the uncanny seems consistent with the ideas of other social critics of the period. These included Georg Simmel, Emile Durkheim, Walter Benjamin, and Charles Baudelaire who shared a collective ambivalence (and in some cases dis-

dain) in response to the sea changes of modernity taking place on the urban socio-cultural landscape. In another essay, published the same year, Freud wrote about war neurosis[77] through which soldiers returning from the front find – both psychically and literally – that which was familiar before they left, to be quite unfamiliar and frightening.[78]

By 1926 Freud had revised his theory of anxiety and phobia formation to include (in addition to sexual impulses) the role of aggression in the aetiology of neurotic disorders. In effect he recanted his earlier theory when he said:

> Anxiety never arises from repressed libido. If I had contented myself earlier with saying that after the occurrence of repression a certain amount of anxiety appeared in place of the manifestation of libido that was to be expected, I should have nothing to retract to-day. [...] I must admit that I thought I was giving more than a mere description. I believed I had put my finger on a metapsychological process of direct transformation of libido into anxiety. I can now no longer maintain this view.[79]

Freud maintained that his theory about disrupted sexual impulses was "still ...good." But he asks "how can we reconcile this conclusion with our other conclusion that the anxiety felt in phobias is an ego anxiety and arises in the ego,[80] and that it does not proceed out of repression but, on the contrary, sets repression in motion?"[81] With this second theory of neurosis he held that where sexual impulses were perceived to lead to danger – that is, when desire for mother ultimately leads to castration by father – an unconscious and self-protective displacement occurs. In conflict with the ego, the id impulses are sublimated and shifted to a substitute activity or object that is considered appropriate and not dangerous. Thus in agoraphobia, the fear of the street masked the fear of sexual temptation.[82] Similarly we may recall that in the case of Little Hans, his instinctual impulses were shifted to the horse:

> He hates his [father],[83] who is more powerful than he is, and he would like to have him out of the way. If "Little Hans', being in love with his mother, had shown fear of his father, we should have no right to say that he had a neurosis or a phobia. His emotional reaction would have been entirely comprehensible. What made it a neurosis was one thing alone: the replacement of his father by a horse. [...] As we see, the conflict due to ambivalence is not dealt with in relation to one and the same person: it is circumvented, as it were, by one of the pair of conflicting impulses being directed to another person as a substitute object.[84]

Thus an ego-derived fear of the substitute object manifests in consciousness, in place of the fantasies of danger and desire. And as long as the neurotic patient avoids the substituted fear-object(s), they avoid the anxiety associated with it:

> Anxiety is a reaction to a situation of danger. It is obviated by the ego's doing something to avoid that situation or to withdraw from it. It might be said that symptoms are created so as to avoid the generating of anxiety. But this does not go deep enough. It would be truer to say that the symptoms are created so as to avoid a *danger-situation* whose presence has been signalled by the generation of anxiety[, such as...] the danger of castration or something traceable back to castration.[85]

Anxiety is no longer the *result* of a defense against ungratified sexual impulses, but now *activates* a defense against the repercussions of acting on those impulses – anxiety is a reaction of the ego to danger. Phobia sets in after a first anxiety attack in "specific circumstances, such as in the street or in a train or in solitude." Whenever the "protective condition" cannot be fulfilled, the phobic mechanism "does good service as a means of defence."[86] Developing the symptom of agoraphobia following an attack of anxiety in the street may then be "described as an act of inhibition, a restriction of the ego's functioning" by which the agoraphobic patient "spares himself anxiety attacks."[87]

By the third decade of the century, the psychoanalytic dominance in psychiatric publishing was well-established. Notwithstanding the shift in Freud's thinking (a shift that ultimately was not that much of a departure from his earlier

sexual framework), he developed an alternative way of conceptualising phobia that departed significantly from his colleagues. Conceiving of phobia as a neurotic symptom deriving from psychosocial and family-relational factors (a view held more so later on in his oeuvre), meant that (agora)phobia was a social process set in motion by personal historical events. Nearly all of the articles written between the years 1922 and 1938 were from a psychoanalytic perspective and it is to these that we now turn. (I choose this periodisation because during World War II publishing slowed down markedly.) Consistent with Freud's position, these display further movement towards conceptualising agoraphobia as a symptom of anxiety neurosis.

1922-1938

During these years, publishing about agoraphobia was relatively steady, with at least one article coming out most years, and peaks of more than five articles in 1922, 1926, and 1929.[88] Not surprisingly, publishing dropped off considerably as the Second World War approached. Geographically speaking, the articles were still divided about evenly in terms of American and European practitioners. Of the European, most were from the United Kingdom, however there were reports from Germany, Austria, and Italy as well.

Of the articles that named the gender of the patient, sixteen were male and 22 were female; of those that did not, the discussion nevertheless took women to be the essential sufferer. It is difficult to say with certainty the total number of articles produced because only a minority of articles had "agoraphobia" as their main focus. Most of the publications were concerned with "anxieties", "fears",

"phobias" and "neuroses" and while they all discussed agoraphobia to varying degrees, only in six out of thirty-five pieces that I reviewed was agoraphobia named in the title and/or was the diagnosis that was made. One writer, in fact, even said that with all phobias having a similar origin, there was little gained by giving the different manifestations of phobia different names.[89] Other writers took up the issue of classification as well, such as this one who said in defence of nomenclatural flexibility:

> The group name being disposed of, we may now consider the chief reaction types that come within the group, remembering that we are not dealing with 'clinical entities' – a conception dear to those who kiss the rod of verbal tyranny – but with patients, whose symptoms will not always fit nicely into the most perfect scheme. Any classification must be loose; but this looseness is necessary and inherent to the subject, and may not be entirely removable by any advance of knowledge.[90]

Another stated that the "classification of the processes by which an irrational fear may arise is necessarily artificial, for several may, and indeed usually do, contribute to a given case..."[91]

Nevertheless, when agoraphobia *was* named in the title and presented as central to the discussion during the second half of the 1930s, it was mostly by psychoanalysts. Indeed, until then most of the articles were general discussions appearing primarily in general medical journals and alluding to particular cases rather than being primarily concerned to outline cases per se. Thus with the increased prevalence of both agoraphobia *and* the psychoanalytic method of treating it, came an increase in the case history style of reporting.

Represented in 21 articles, those with a psychoanalytic orientation offered lengthy and highly detailed descriptions of the patient and the psychoanalytic concepts being used. By comparison, eight articles were behaviourist in orienta-

tion, one was clearly biological, and the rest were not clearly classifiable. Symptoms described were consistent with past reports, but now the question of agoraphobia's status as a disease in its own right versus a symptom of something else was no longer an issue. These reports took fears, phobias, anxieties, and neuroses as their point of departure, and agoraphobia tended to be presented as a symptom or manifestation of these more general pathologies.

Instead, the most significant debate in these articles was over the issue of treatment (and by implication then, causation), with psychoanalysis and behaviourism as the two main contenders. With the predominance of psychoanalytic perspectives among these reports, however, there was really no contest: psychoanalysis clearly had the upper hand throughout the period. In the following pages I shall outline briefly the highlights of the psychoanalytic articles, and in the next we shall look at behaviourism.

Freud's Disciples

At least up until his death in 1939, Freud's intellectual and clinical leadership, as well as his tendency towards professional gatekeeping, largely shaped mainstream psychoanalysis.[92] His influence is evident in the psychoanalytic articles on agoraphobia whose authors built upon his theory of the ego as one of the three fundamental psychic components of the mind (the other two being the id and the superego). Freud postulated that the ego was formed by gradual modification of the id that resulted from the impact that external reality made on instinctual drives. This process led to the gradual replacement of the pleasure principle by the reality principle, signalling the effect of instincts on ego development, and the

potential dangers that could develop. In other words, the ego's job was to represent reality and put up defenses in order to control internal drives in the light of reality and its implications. Freud's theory of phobias, we may recall, was that they developed as a protection from danger:

> The phobic mechanism works very well as a means of defense...[a]nxiety is the reaction to a situation of danger; and it is circumvented by the ego's doing something to avoid the situation or retreat from it...[S]ymptoms are created in order to avoid the danger situation of which anxiety sounds the alarm.[93]

The danger that Freud described stemmed from the fear of castration elicited by instinctual wishes or desires.[94] As he stated: "The majority of phobias, so far as we can see at present, are traceable to such a fear on the ego's part of the demands of the libido."[95] It was the ego's need for protection that gave rise to repression, not the libido.[96] Symptoms developed in order to remove or rescue the ego from danger[97]; "[t]he defensive process is analogous to flight, by means of which the ego avoids a danger threatening from without, and that it represents, indeed, an attempt at flight from an instinctual danger."[98]

What Freud also observed in this discussion was that the street in agoraphobia was the site of temptation, a conclusion toward which he had previously moved in his correspondence with Fliess. This idea of temptation was linked, as he said at that time, to prostitution and exhibition fantasies that were a means of managing desire. As Freud wrote in a letter in 1897:

> ...I dreamed that I was going up a staircase with very few clothes on. I was moving, as the dream explicitly emphasized, with great agility. [...] Suddenly I noticed, however, that a woman was coming after me, and thereupon set in the sensation, so common in dreams, of being glued to the spot, or being paralyzed. The accompanying feeling was not anxiety but erotic excitement. So you see how the sensation of paralysis characteristic of sleep was used for the fulfilment of an exhibitionistic wish. (249)

The question of exhibitionism was taken up by Deutsch, for example, who noted that with one of her patients, anxiety was at first only associated with a certain part of her way from home, a path where she often saw men urinating. Deutsch stated: "My reason for emphasising this is that I have received the impression that exhibitionistic tendencies play an important (though subordinate) part in the determination of street-perils."[99] Katan agreed and asserted as well the importance of exhibitionistic desires in this etiology. Her patient was "very exhibitionistic" and this was traceable to her asking as a child to be put on the toilet by her father when she called him to her bed late at night with her nocturnal anxiety attacks (this served the purpose of disrupting relations between her parents). Indeed, "[t]his exhibition while urinating served the purpose of seducing her father."[100]

Related to this were the fantasies of prostitution that several writers observed. Weiss said that in those female patients who suffered from agoraphobia and had fantasies of prostitution, the fantasies were an "utterance of the destructive instinct, announcing itself through the medium of the super-ego ... an aggressive qualification on its part."[101] In all successful repression, he continued, there was a conflict between libidinal impulse and self-destructive tendency (the unconscious desire for punishment). Identification with their emotional rivals led patients to turn the aggression they felt inward, as with Bergler's patient who wished death for her mother.[102] This patient became engaged to a man with tuberculosis with whom she broke up once he became cured, only to become engaged to yet another man with tuberculosis. Bergler theorised that putting herself

in the position of caregiver in relation to these men was a means to bring to fruition her need for punishment for the libidinous feelings she had for her father.

In another case it was clarified that redirection of repressed desires towards strangers in the street served to protect the ego from the more dangerous oedipal desires.[103] This process was what Katan, following Freud, called "displacement" referring again to the mechanism whereby desires are displaced from the incestuous object onto other new objects. Katan asserted that this was a component of normal adolescent development that normally only occurred once in a person's life, and that it was only when this process failed, that objects became cathected pathologically resulting in agoraphobia. In the "process of normal puberal development...[the result is] successful relinquishment of the old infantile object relationships."[104] Agoraphobic patients, hostile to their drive and to their object, successfully replace the dangerous incestuous object and retain the direction of the displacement, but the instinctual energy has still not been engaged, hence the fantasies of prostitution.

The super-ego acted as the gatekeeper of the desires that informed such fantasies and, in the context of agoraphobia, the super-ego was said by Miller to reside out of doors:

> [T]he external world contain[s] all those persons who can administer censure ... – the world at large. Our external world is built up by intersubjective intercourse and the moral order finds its social expression in the opinion of people outside – in the agora – or market-place. However much we speak of the moral law within us, we are always projecting into the external world the physical manifestation of its force. We speak of the external sanctions which make laws possible. The personal moral law is described as a something not ourselves which make for righteousness. And thus the agoraphobe at the level of sociality sees in the external world the mentor of all offences against the moral law which has gone to make up the super-ego against which it has offended.[105]

This writer's patient had a conflicted relationship with her mother whom she both desired and hated. Her desire was represented by a fascination with mouths (her oral fixation), and her hatred stemmed from the access her mother had to her father whom she herself desired. In this case, relations between mother and child were cold and, to compensate, the patient engaged in secret sexual play with a nephew and other boys. This play also included cunnilingus with a younger girl behind half-closed bathroom doors, giving rise eventually to claustrophobia that was intimately associated with her agoraphobic fear of open spaces. This patient's desire

> for the male organ would have achieved a return to the mother, but this desire for the penis was regarded as an unpardonable offence, and hence what was most desired became what was most to be feared. [...] In enclosed spaces all the offences were committed, and alone in an enclosed space all the evil thoughts had returned to her.[106]

Also signifying a super-ego conflict, another patient had a mother who did not allow her to go out alone when she was younger; when this patient grew up and had her own daughter, she repeated the situation of being watched vis-à-vis her inability as an adult to go out alone. The only person whom she would accept as a companion was her daughter who had to ensure that she did not succumb to instinctual impulses. She thereby assumed the role of the super-ego, "the vigilant faculty, the guardian who forbids and menaces – the role which was formerly filled by the patient's mother."[107]

In another case, a middle-aged woman with three children was unable to go out on the street and experienced a horrible murderous obsession that destroyed her nightly rest: she worried that she might get up in the night and stran-

gle her children in their sleep.[108] To compensate for these death wishes against her children (which were versions of her childhood death wishes against her brother and step-sister), the woman developed a severe super-ego to keep these murderous impulses in check. She adopted an unusually self-sacrificing life to remove her sense of guilt and in her married life was ascetic and dutiful, experiencing no pleasure – sexual or otherwise. Indeed it was her children who stood in the way of pleasure between her and her husband, just as her siblings obstructed relations with her father.

This theme of the ascetic mother appeared in other cases too and Greenschpoon (1936) surmised that this kind of self-sacrifice actually represented the Janus-faced relation of hatred and love. As he put it, his patient claimed to live for her daughter, but "[w]hen we hear such words we must always think of the bipolarity (ambivalence) of feelings."[109] Exaggerated love was, in his view, an overcompensation for repressed hate, and this patient's dreams did indeed reflect the death wishes she had towards her daughter.

A striking thing in these reports is that agoraphobia did not always manifest as an individual who could not go out. In some cases it appeared in individuals who could not bear to have their *object of desire* go out. Deutsch's patient, for example, could not stay home or go out without her mother. She worried, on one hand, that something might happen to her mother if she went out without the patient, and on the other hand, that her mother might "bestow her love on the father" if the patient left the mother alone at home with him.[110] Similarly, a patient of Katan's, a young boy, experienced anxiety whenever his mother left the house without him. He became anxious whenever he knew she was going to use a

means of public transport; he feared that the strong men who directed traffic would harm her and he was convinced that he could protect her. In fact, he was not reassured when his father accompanied his mother into the street; rather it increased his anxiety. Katan concluded that the boy felt compelled to play the masculine aggressive and protective role in order to defend himself against his feminine desires towards his father and against the corresponding death wishes that he harboured against his mother whom he saw as his competitor.[111] At the time of Katan's writing, this patient was not considered an agoraphobic per se, though elements of his case indicated that he was well on his way to becoming one. He avoided going into the street to avoid anxiety, and similarly forbade his mother from going out either.[112]

The notion of penis envy was also raised in several cases. Weiss for example had one patient for whom large open squares was the main anxiety. This patient dreamt that her analyst (Weiss) had to have sex with her, but he had no penis, just an "empty space" where the penis "should have been". The analyst transformed into her mother for whom it was normal not to have "the desired organ", and Weiss concluded that this dream showed "that *open places*, from the dread of which term *agoraphobia* is derived, [signified] *the castrated mother.* Probably some inner urge prompts us to put a statue, an obelisk and, especially, a fountain in the middle of squares."[113] Desire for the male organ was even clearer in Greenschpoon's patient "Frau Gina" who had a "very strong homosexual fixation."[114] And Miller's patient actually articulated her wish to have masculine genitals.[115]

Like some of the earlier cases, masturbation continued to play a central role in that it was a significant source of the guilt that patients felt. One woman, who had been sent to a convent school as a child, lived there in a constant state of fear. The nuns, in an effort to curtail masturbation, said that the devil lived in the washroom. The patient did not recall masturbating as a child but admitted to doing so in puberty and felt "murderously guilty" for it.[116] Another patient understood that anxiety was a punishment for engaging in masturbation. Believing that an admission of symptoms was as good as an admission to masturbation, she waited 27 years before seeking psychiatric help.[117]

Ultimately the goal of all of these psychoanalysts was to achieve transference, or the transferring of emotions previously experienced with important figures such as parents and siblings to the analyst. Patients related their memories to the analyst

> not only in words, but, as though driven by an inner and unconscious power, re-experienced them, re-enacted them while they worked with him. The analyst is made father, mother, brother, sister, lover, benefactor, malefactor, thus becoming the target for the patient's behavior which at first appears nonsensical, unjustified, exaggerated, out of joint, until we discern that in this 'transference' resides an enforced new edition of experiences which had a particularly important bearing on the patient's life long ago.[118]

The patient to whom this writer was referring could not go anywhere without his mother which suggested that "if a patient cannot exist without a certain other person who has the power to allay his anxiety, this very person is the kernel of the neurosis."[119] Transference allowed the analyst to get at the repressed emotions that resided in the unconscious and which "the patient felt in his childhood towards the psychically unmastered people of his environment to whom he was at-

tached – which emotions he now repeats towards the person of the doctor, *whoever this may happen to be.*"[120]

1939-1951

In the decades following War II, psychoanalysis continued to predominate as a treatment approach, and the authors of these articles formulated their discussions according to much of the same major themes and concepts that we have already looked at, namely the Oedipus complex, exhibitionism, masturbation, sadism and prostitution fantasies, repression, displacement, witnessing of the primal scene, and ultimately, a defective superego (and hence questionable morality).

In 1944, for example, Fenichel focused on the street, and emphasised the guilt associated with masturbation. He described agoraphobia as an "equilibrial phobia", a psychologically painful sensation of disequilibrium in space.[121] His patient felt his legs being pulled from under him whenever he went outdoors, and analysis revealed a close connection between learning to walk and prohibitions against masturbation. Fenichel thereby surmised that sensations of equilibrium and position in space were important sources of sexual excitement and extended this observation to include the role that street-width played in agoraphobics' experiences. Specifically, he noted that some agoraphobics feared narrow streets, while others feared wide streets, and still others feared both. Thus, like "Vincent," described in the previous chapter, anxiety could be highly spatialised.[122]

Another example comes from a psychoanalytic report published in 1951. Schmideberg wrote of a young female patient whose agoraphobia derived from

having witnessed her parents' having intercourse when she was a child.[123] "Ruth" had masturbation fantasies and related sadistic fantasies; she believed herself to be a menace, infecting everything she touched or possessed because her hand had been in contact with her genital organs.[124] Suffering from catatonia and voices in her head as well, her agoraphobia was concluded to be a manifestation of obsessional neurosis and schizophrenic substrata.[125] The agoraphobia, though successfully eliminated, was masking the more serious problem of schizophrenic psychosis, which was difficult to treat with psychoanalysis.[126]

Psychoanalysis had a virtual monopoly on neurosis and only one writer, a behaviourist by the name of Terhune, argued that the concept of repression was not a convincing explanation, that phobias were simply the outcome of a "soft" upbringing.[127] Still, although the articles in this period were dominated by psychoanalytic perspectives (and secondarily by the behaviourists), other aetiological theories were evident as well, albeit to a lesser extent. Biological predisposition, for example, like the earlier articles, was taken by some as an important indicator. This ranged from looking at immediate family to looking at human's earliest ancestors as McConnelly did, for example, when he asserted in 1926 that "fear" conflicted with our "herd instinct". Young (1932), in rejecting psychoanalysis on the basis that there were too many cases of claustrophobia to accept the repressed memory theory of agoraphobia, argued that biological inheritance was "inextricably interwoven" with the environmental factor. Heredity was not the only thing that Young observed however; other physiological commonalities between patients led him to note that eleven out of sixteen of his "downright cases of phobia" had "outstanding somatic abnormalities" and showed "marked skele-

tal or endocrinological variations."[128] Two of these cases were of agora-claustrophobics who had hyperpituitarism and gigantism.[129] Another physician stated that from his point of view, the difference between the fearful and the fearless was the relative size of the cortex and medulla. Fearless people had a larger cortex in relation to the medulla, while the timid and meek had a smaller cortex and larger medulla.[130] Thus in contrast to the psychogenic perspectives, biological thinkers believed that mental characteristics were inborn and the psychic mechanism was "but the foam on the surface."[131] Still, these sorts of ideas, while not conspicuous, remained relatively marginal for the next several decades until the 1960s-70s when psychoanalysis declined along with its psychosocial view of mental illness. I turn now to the psychoanalytic articles published after the release of DSM-I.

Psychoanalysis and Agoraphobia after the DSM: 1952-1968

Following the release of the first edition of the *Diagnostic and Statistical Manual of Mental Disorders* (whose history will be outlined in Chapter 7), publishing in English on the topic of agoraphobia remained relatively steady until 1965 with the publication on average of two articles per year. The total number of diagnoses reported within this literature increased overall, especially among women. Of a total of 180 cases reported (mostly psychoanalytic), a solid 158 were of agoraphobia in (mostly married) women. Patients continued for the most part to be educated and from privileged backgrounds (or at least the *reported* patients were privileged. Tucker took issue in 1956 with the overrepresentation of middle-class individuals and actually focused his discussion on clinical outpatients at all eco-

nomic levels).[132] The DSM classification system is discernible in these articles, not surprisingly, given the major influence of psychoanalytic thought on the very structure of the manual itself. Following the release of DSM-I, most of the authors continued to take a psychoanalytic approach, though the behaviourist model was making headway.

Despite the availability of the DSM, however, the classification of agoraphobia continued to be an issue. As one writer put it, "any systematic classification of the phobias is rather difficult" because the "phobic defense is highly individual." The same phobia "can show wide variation" and this suggests that "the phobias might be regarded as a whole series of related illnesses rather than a single disease entity." Many of the names applied to phobias, as one physician observed, "seem more confusing than helpful."[133] A case in point is the frequent conflation of agoraphobia, claustrophobia, and travel phobia.[134] With regard to claustrophobia, for example, it was often noted that patients needed to be near an exit when they found themselves in enclosed spaces. It was observed equally often that agoraphobic patients had a fear of travel; one practitioner stated that many patients were literally confined to their homes because of a morbid fear of being alone on the open street with an accompanying inability to ride on public transit.[135] Symptoms of claustrophobia and travel phobia were frequently described, yet a distinction between them was rarely made.[136] Nor was there a distinction (as yet) between "common" and "specific" phobias.[137] One writer proposed that the term "common phobias" be used to refer to exaggerated fears of those things which all people hate and fear to some extent, such as snakes, spiders, and illnesses, but that reached neurotic proportions. The term "specific

phobias," on the other hand, could be used to describe those things that do not inspire fear in "normal" people, such as cats, escalators, and open fields.[138]

Interestingly, the question of whether or not agoraphobia was a symptom or a disease in its own right, was, however subtly, still contested. According to the DSM (and the psychoanalytic perspectives that informed it), agoraphobia was a symptom of psychoneurosis. Yet the occasional remark suggests that the language on this (at least) was not settled with terms such as "disease", "symptom", "disorder", and "syndrome" used interchangeably. Although not a psychoanalyst, Terhune, for example, declared emphatically that agoraphobia should be considered a disease entity but then later, *within the same article*, observed that phobias were symptoms of an underlying condition.[139] Equally confusing was another article which stated agoraphobia and travel phobia were not fixed diseases but "particular symptom groupings."[140]

Despite these unresolved questions, the psychoanalytic perspective continues to rely on the notion of a failed superego[141] but there is an additional interest in incest and sexual abuse, and the role these play in patients' confused sense of morality. Specifically, these articles point to abusers' and/or parents' failure to instil a properly functioning superego by acting as role models. For example, one analyst wrote about a patient – "Diane" – whose father regularly exhibited himself before his children and was seductive towards her: "Definitely he was not a figure who gave Diane a sense of moral strength. He confused her with respect to what was and was not permissible."[142] Diane's older brother was similarly inappropriate; they had sexual relations until her brother turned his attentions to their younger sister. Hurt by the rejection, Diane competed with him for the

younger girl's attentions, which culminated in a sexual relationship between the two girls for many years. And though not directly related to the issue of sexual abuse, Diane's nurse and mother also contributed to her failed superego by introducing racist sensibilities to the mix. They were cruel towards the "Negro" servants which resulted in Diane's apprehension about meeting Jews and Puerto Ricans – "little black people" – downtown.[143] Whether or not the racism contributed to the phobia, it did provide Diane with an object on which to displace her neurotic agoraphobic fear. Ruddick described a similar scenario in 1961. His patient's agoraphobia was also related to the failure to incorporate a functioning superego in that this woman, a lesbian, had been sexually abused by her brother from the age of five to twelve. Their parents failed along with her brother to act as "acceptable superego figures."[144] The abuse, coupled with unresolved feelings of desire for her father, caused the street to represent dangerous heterosexuality.

While these cases describe situations where parents were effectively guilty of under-parenting, others depict the opposite. One case of over-parenting was described by an analyst whose patient, a 25-year-old, male, orthodox Jew, struggled with deep cultural conflicts (as well as an inability to go against his mother's plans). As his doctor noted, "[t]he patient on the couch who talks of his agoraphobia is a person in whom more than fear of the 'open spaces' is involved."[145] This man battled against the compulsion to masturbate, homosexual desire, religious doubts, and an overbearing mother who wanted him to marry the woman of her choice. Her efforts to sequester him from the world, along with his religious upbringing, led him to fight for the preservation and development of a free ego, but at a cost. He feared that he would exhibit himself, and developed guilty

feelings about any relationship with women, however casual, that manifested as agoraphobia.[146]

This patient was demonstrating, according to his psychiatrist, a kind if immaturity, a difficulty that another practitioner found to be present in 77 other patients. There was almost always a problem of unhealthy dependence on the mother that ranged from complete dependence on a completely dominant mother, to a fear of doing anything of which she might not approve. Unhealthy marital attitudes were frequently inherited from the mother in these cases, and manifested in the rejection of sexual activity, fear of childbirth, a martyr attitude towards the role of wife and mother, resentment towards men. Thus his patients had "difficulty adjusting to the duties and responsibilities of [being a] wife and mother" and needed to change their relationship to their own frequently neurotic, demanding, critical, and overprotective mothers.[147] In one case, for example, the patient was able to modify her attitudes "resulting in a better acceptance of the female role and a better adjustment to her husband and child."[148] Although Tucker (not an analyst) blames mothers for their daughters' mental demise, fathers were not entirely free of blame:

> The personality and influence of the father also contribute to the problem, particularly if he is overprotective or overpunitive, and there may be a problem in the patient's relationship to both parents. However, the father is more frequently a passive individual who plays a relatively minor role of influence on the patient.[149]

But he adds that in this and other respects gendered expectations played an important part in explaining women's agoraphobia.

Psychiatrists revealed an awareness of the historical specificity of mental illnesses (though of course, as psychoanalysts, history mattered on several levels.)

As one analyst wrote, influences on the incidence, types, and variations in emotional illness "tend to bring about what might be called a vogue in symptoms."[150] One such influence was modern society, which "requires a degree of emotional maturity in which many instinctual drives and demands must be controlled or redirected in more socially useful and constructive directions."[151]

By the 1960s and 70s, psychoanalysis gradually started to find itself on the downward slope. Still, there were a few psychoanalytic articles,[152] one of which signified an important trend in psychoanalytic discourse that would develop over the next three decades, namely an interest in the problem of narcissism. In this particular article, the writer argued that there was a specific relationship between heightened narcissistic vulnerability and the development of agoraphobia. Specifically, the analyst described how sexual and non-sexual childhood traumas led to the development of a "narcissistic character structure". His patient's aspiration to marry into wealth, her scoptophilic and exhibitionistic fixations that stemmed from her father, brother, and herself all exposing themselves in the bathroom for many years, and four separate instances of admirers losing interest in her, all contributed to her narcissism. The neurotic outcome of her narcissistic vulnerability, turning on her inadequate sense of self and lack of identity, was the outbreak of the agoraphobic "symptom complex."[153]

Another psychoanalytic article considered "space phobias" in the context of early childhood separation, a theme that would become relatively popular in later years.[154] Following an object-relations framework, these writers argued that just as the child's attitude towards the outside and unknown territory beyond his [sic] mother depended on her ability to tolerate the child's explorations of it, so

too did the agoraphobic person fear the outside due to its inherent uncertainty. Reminiscent of the husband described above who depended upon the maintenance of his wife's pathology, the phobic's partner is usually bound closely to the patient within the safe territory and agoraphobic symptoms ensure that their relatedness is not lost. In other words, agoraphobia acts as a substitute for the dependent relationship of early childhood, symbolising the attachment-autonomy conflict that comes about with separation-individuation.[155] But as a behaviourist even pointed out, "[n]owadays the term [separation] is applied, not so much in relation to the fear of open spaces, as to the fear of being at a distance from familiar and supportive surroundings."[156]

Childhood issues were also considered in light of the question of onset. Specifically, a relationship was being pieced together at this time between agoraphobia and school phobia. Several reports actually made this their focus, presumably in an effort to understand why the onset of agoraphobia was later in life (that is, after marriage, as it turns out). In one study it was concluded that school phobia *may* predispose to later agoraphobia but only in a small number of cases, and that it seemed more likely that both conditions – agoraphobia and school phobia – simply reflected a lasting tendency to neurotic illness.[157] That said, there may have been basis for a distinction to be made – between school phobia and "school refusal" – based on the notion that what was really at issue for these patients was separation. As Frances and Dunn wrote: "Since the agoraphobic often feels most acutely the loss of his companion (often his home), rather than the presence of the dangerous territory, many authors question the applicability of the term phobia."[158] In other words, they distinguished between "school refusal"

and "school phobia" to underscore the fact that leaving home was the basis of the fear, not being in school.

While Frances and Dunn's object-relations approach signified the "branching out" of psychoanalysis, on the whole, psychoanalysis was beginning to have to share its foremost position on the clinical landscape with the behaviourists, to whose ideas we turn next. Although at first there were not as many articles of this orientation as there were psychoanalytic, their ideas are important to consider because in later years the amount of publishing from the behaviourist perspective (discussed in Chapter 8) is extensive. Indeed, behaviourism (along with pharmaceuticals) would eventually overtake the psychoanalytic perspective by leaps and bounds.

Notes

[1] Reik, 1948:15.
[2] Several of the references to Freud that follow could not have been located without benefit of Compton, 1992a and 1992c.
[3] Freud, Lucy, 1955 [1893]: 112-114, fn 2.
[4] Compton, 1992a.
[5] Freud, Footnotes, 1966 [1892-4]:139.
[6] Abreaction refers to the bringing to consciousness of repressed (unconscious) material.
[7] Compton, 1992a:209.
[8] Freud, Emmy, 1955 [1893]:88
[9] Freud, Emmy, 1955 [1893]:88
[10] This description is taken from Freud, Lucy, 1955 [1893]: 112-4, fn 2.
[11] Freud, Lucy, 1955 [1893]:112
[12] Freud, Letter 14, 1966 [1893]:184-5. Freud goes on here to describe 3 other, non-agoraphobic cases, 2 in men and one in a "nice, stupid young woman."
[13] Freud, Defence. , 1924 [1894]
[14] Freud, Neuro-Psychoses, 1962 [1894]:58
[15] Freud, Neuro-Psychoses, 1962 [1894]:57-8, fn 1
[16] Freud, Obsessions, 1962 [1894]:75.
[17] Freud, Obsessions, 1963 [1894]:89-90. (Also 1962 [1894]: 75).
[18] Freud, Obsessions, 1963 [1894]:89-90. (Also 1962 [1894]: 80).
[19] Freud, Obsessions, 1962 [1894]:80
[20] Freud, Obsessions, 1962 [1894]:81
[21] Freud, Grounds, 1962 [1894]:94-5
[22] Freud, Grounds, 1962 [1894]:96.
[23] Freud, Obsessions, 1963 [1894]:90-1; see also Freud, Civilized, 1963 [1908]. In his essay "'Civilized' Sexual Morality and Modern Nervousness," Freud argues against marital monogamy and pre-marital abstinence. He insists that sexual morality promotes chronic modern nervousness due to the opposing forces of a patient's constitution and the demands of civilization.
[24] It should be noted that this anecdote is actually taken from an essay on the psychopathology of hysteria. However it so clearly describes a "classic symptom" throughout the history of agoraphobia – the inability to go into shops alone – it warrants inclusion here.
[25] Freud, Psychopathology, 1866 [1895]: 353-54.
[26] I find it very interesting that Freud chose to map Emma's agoraphobia in the text, because it set him apart from other practitioners, both then and since. Visual representations have always been a crucial source of medical knowledge yet, historically, agoraphobia has been anomalous in this respect.
[27] Freud, Letters, 1985 [1889]: 246.
[28] Freud, 1899:246 (my emphasis).
[29] Freud, Letters, 1985 [1896].
[30] Freud, 1962 [1894]: 134; emphasis in text.
[31] Freud, Infantile, 1953 [1905, 1910]:122. (Original: 1905, footnote added 1910).
[32] See Freud, Hat, 1953 [1911]:479 and Freud, Little One, 1953 [1911]:480-2.
[33] Freud, Dreams, 1953:738.
[34] Freud, Boy, 1955 [1909]:115.
[35] Freud, Boy, 1955 [1909]:124.
[36] Freud, Boy, 1955 [1909]:114.
[37] Freud, Boy, 1955 [1909]:114.
[38] Freud, Boy, 1955 [1909]:114 (my emphasis).
[39] Freud, Boy, 1955 [1909]:114 (emphasis in text).
[40] Freud, Boy, 1955 [1909]:114.
[41] Freud, Boy, 1955 [1909]:126.
[42] Freud, Boy, 1955 [1909]:125.
[43] Freud, Boy, 1955 [1909]:144.

[44] Freud, Boy, 1955 [1909]:116.
[45] Freud, Boy, 2955 [1909]:116.
[46] Freud, Boy, 1955 [1909]: 116 n. 2.
[47] Freud, 1909:116.
[48] Compton 1992a, 218
[49] Freud wrote in this regard: "Experience has shown that it is impossible to effect the cure of a phobia (and even in certain circumstances dangerous to attempt to do so by violent means, that is, by first depriving the patient of his defences and then putting him in a situation in which he cannot escape the liberation of his anxiety". The patient naturally looks for protection wherever he can, and "he is merely regarded with a not very helpful contempt for his 'incomprehensible cowardice'" (1909:117).
[50] Freud, 1909:124.
[51] Freud, 1909:124.
[52] Freud, Anxiety, 1963 [1916-7]:400
[53] Freud, Anxiety, 1963 [1916-7]:410
[54] Compton, 1992a, 219.
[55] Freud, Lines, 1955 [1918]:165-6
[56] Abraham, 1913:237.
[57] Porter, 1997:518.
[58] Porter, 1997:518.
[59] Patrick, 1916:181.
[60] Patrick, 1916:183.
[61] Patrick, 1916:186.
[62] Patrick, 1916:186.
[63] Ball, 1916:185.
[64] Booth, 1916:185.
[65] Parsons, 1916:184.
[66] Rhodes, 1916:185.
[67] Kennedy, 1916:185.
[68] Williams, 1916:184.
[69] Williams, 1919:181.
[70] Williams, 1919:182.
[71] Williams, 1919:182.
[72] Williams, 1919:183; emphasis in text.
[73] Williams, 1919:183.
[74] Williams, 1919:185.
[75] Freud, 1955 [1919]:219-20.
[76] Freud, 1955 [1919]:241; emphasis in text.
[77] Freud, 1955 [1919].
[78] Freud regarded the war neuroses as *traumatic* neuroses enabled by a conflict in the ego between the soldier's formerly peaceful ego that was threatened by the libido, and his new warlike one that was threatened by external violence. He observed that when the war stopped neurotic disturbances brought about by the war had vanished (1955 [1919]:207), yet he went on to add that what is feared in both cases is nevertheless an internal enemy, that is, repression. (Septimus, in Virginia Woolf's *Mrs. Dalloway* comes to mind here.)
[79] Freud, Inhibitions, 1959 [1925]:109
[80] That is, is perceptive of danger
[81] Freud, Inhibitions, 1959 [1925]:110
[82] Freud, Inhibitions, 1959 [1925]:109
[83] The original text actually reads "master" here because Freud is making an analogy to the servant; for the purposes of clarity I have substituted "father" here.
[84] Freud, Inhibitions, 1959 [1925]:103.
[85] Freud, Inhibitions, 1959 [1925]:128-9
[86] Freud, Inhibitions, 1959 [1925]:128.
[87] Freud, Instinctual, 1964 [1932]:83.

[88] There were also many books being published at the time, three of which are included here.
[89] Snowden, 1934:315.
[90] Culpin, 1922:109.
[91] Hampton, 1922:17.
[92] Mitchell and Black, 1995:xvi. Other major figures in the early decades, namely Jung, Adler, Ferenczi, and Rank, were "expelled from the Freudian mainstream as their ideas diverged significantly from established doctrine" (xvi; see also p. 21). As such, they do not come up in the literature on agoraphobia.
[93] Freud, 1926:83-5.
[94] Freud, 1926:86.
[95] Freud, 1926:50.
[96] Later reports did not all agree and the notion that it was libido being repressed was not completely abandoned (see for example Deutsch, 1929).
[97] Freud, 1926:111.
[98] Freud, 1926:114.
[99] Deutsch, 1929:60.
[100] Katan, 1937:49.
[101] Weiss, 1935:80.
[102] Weiss, 1935:401.
[103] Katan, 1937.
[104] Katan, 1937:45.
[105] Miller, 1930:265-6.
[106] Miller, 1930:266-7. There was also a nurse in this particular case who seemed to occupy the role of the uncanny that Freud described a decade before. His patient both depended upon and loathed the nurse who, when she was a child, was violent and abusive towards her. Yet in the absence of a mother (she died, and when she was alive, was very cold and preferred her brothers), the nurse was evidently all the patient had for companionship. Once the claustrophobia in this patient set in she could not be indoors alone and always had to have someone with her; yet the "family had a sense of the uncanny influence of the nurse and tried to induce her to rid herself of her" (Miller, 1930:259).
[107] Deutsch, 1929:59.
[108] Alexander, 1930:60.
[109] Greenschpoon, 1936:390.
[110] Deutsch, 1929:54.
[111] Notice the positing of bisexuality...
[112] Katan, 1937. See also Bergler, 1935:393 fn 1.
[113] Weiss, 1935:67.
[114] Greenschpoon, 1936:391.
[115] Miller, 1930:259.
[116] Bergler, 1935:396.
[117] Katan, 1937:45.
[118] Wittels, 1938:12.
[119] Wittels, 1938:14.
[120] Bergler, 1935:398.
[121] Fenichel, 1944.
[122] Fenichel, 1944:324.
[123] Schmideburg, 1951:347.
[124] Schmideburg, 1951:346.
[125] Schmideburg, 1951:351.
[126] Schmideburg, 1951:343.
[127] Terhune, 1949.
[128] Young, 1932:310.
[129] Young, 1932:311.
[130] Otis, 1926:427.
[131] Leland, 1927:104.

[132] Tucker, 1956.
[133] Laughlin, 1954b:443.
[134] As we shall see in Chapter 8, this problem is really never resolved.
[135] Leland, 1962:83.
[136] That said, Laughlin observed that travel phobia and agoraphobia were similar (thereby implying a distinction), both in terms of the gradual development of the phobic problem, and in terms of their dynamics (1954a:391).
[137] In a later DSM the category of "simple phobias" would be introduced which would include "specific" phobias.
[138] Leland, 1962:83.
[139] Terhune, 1961:231, 234.
[140] Clapham et al., 1956:168.
[141] See Miller, 1953; Laughlin, 1954a, 1954b; Clapham et al., 1956; Ivey, 1959; Wangh, 1959; Ruddick, 1961; Leland, 1962; London, 1963.
[142] Wangh, 1959:680.
[143] Wangh, 1959:681, 684.
[144] Ruddick, 1961:539.
[145] London, 1963:607.
[146] London, 1963.
[147] Tucker, 1956:827.
[148] Tucker, 1956:825.
[149] Tucker, 1956:829.
[150] Laughlin, Part II, 1954:444.Laughlin's remark is interesting considering that in more recent times the fashionable psychoanalytic diagnosis is narcissism (which, I would argue, reflects more of a cultural pathology than an individual one).
[151] Laughlin, Part I, 1954:380.
[152] The psychoanalytic articles I do not discuss were written in French, and this study examines only English-language articles (including translations).
[153] Stamm, 1972:267.
[154] Frances and Dunn, 1975.
[155] Frances and Dunn, 1975.
[156] Williamson, 1974:1840-1.
[157] Marks et al., 1974.
[158] Frances and Dunn, 1975:435.

Chapter 6
'Brief and Economical': Behaviourism and Agoraphobia

The Early Stirrings

The scientific origins of behaviourism may be traced back to the early 20th century or earlier.[1] There was, for example, Ivan Petrovich Pavlov's famous experiment with the conditioning reflex in dogs, wherein he showed how the secretion of saliva can be stimulated by both food and the ringing of a bell, whose sound was associated with the presentation of food. As well, there was the classic 1920 experiment by American psychologist J.B. Watson (who coined the term "behaviourism" in 1913) and R. Raynore on an eleven-month-old infant named Albert. Viewing behaviour as determined by a combination of genetic and environmental factors, their experiment on Albert allowed them to show how a phobia could be created (and resolved) with conditioning and they developed a controversial stimulus-response model based on this work.[2]

Drawing on these sorts of ideas, the handful of early practitioners oriented more towards behaviour psychology took as their first assumption that anxiety could be resolved through rationalisation, re-education, and persuasion. Patrick, for example, argued in 1916 that precipitative traumatic events could be redefined through re-education. The Williams patient from 1919 is another case in point insofar as her "disturbance" was removed through reconditioning inside of a week.[3] For the early behaviourists the cause of agoraphobic anxiety was the conditioning of wrong ways of thinking (giving us a taste of early cognitive psychology), though in one article the writer attributed the primary cause to a depletion of glandular secretions.[4] And as with Pavlov's dogs, "the reflex action itself, like

other reflex actions, is a physiological phenomenon...attended by conscious sensations."[5]

As we saw in Chapter 5, these doctors were highly critical of the psychoanalytic perspectives of their colleagues, and especially the notion that repression or inhibition were necessary factors in the production of fear or anxiety.[6] On the contrary, the cause of phobia was better explained by the notion of "physiological disharmony" with provocative stimuli from the patient's environment. Fear was seen as a conditioned emotional reaction to the complexities of

> our modern business world [where there is a] struggle for existence, especially in large congested monetary centres, [and] contagion now and then breaks out in fright, which imperils the fortune and lives of individuals or a peoples' financial stability; just as a country's cause is sometimes lost through panic striking its armies in battle.[7]

Such fears occurred in "certain individuals who are more impressionable [and] suggestible."[8] One physician argued that anxiety was more likely to occur when the nervous system was already over-excited, as in toxaemia.[9] In these weaker types it was not always worthwhile or necessary to determine the conflicts underlying the neurosis:

> ...it would be impossible to bring every patient suffering with a neurosis characterized by fear to a psychiatrist or to a psychoanalyst who, by virtue of the great time required for analysis, could see but a very limited number of patients. Any physician who is experienced and who has the confidence of life, and the physician as often as the priest has been the repository of confidences which have relieved and cleansed the patient of headaches and troubles.[10]

The removal of the symptom through re-education was much easier and faster than the psychoanalytic method of tackling the patient's character; indeed "the exercise of ordinary homely horse sense and advice frequently suffices."[11] A number of these writers insisted that the

> mind works in the same way in a patient disabled by a psycho-neurosis as it does in the healthy individual, the difference being that in the psycho-neurosis the patient is out of harmony with his environment by some accident of temperament or training, including previous experience.[12]

Knowing that the mental processes were in fact quite normal, the patient could face the phobia with confidence[13] so the key was to get the patient to "adopt a different attitude towards the facts"[14] through explanation because the anxiety was simply a matter of misinterpretation.[15] The other component of treatment – what would later come to be known as "exposure" – was to get the patient to face those situations which were frightening:

> If he is afraid to walk alone, the first day he may be accompanied in one direction for two blocks and instructed to walk back alone. Daily this is increased until finally within a short time he is ordered to walk back alone. Daily this is increased until finally within a short time he is ordered to walk alone, then to ride on street cars, then to enter into all the activities that a normal individual would encounter, despite his feelings.[16]

Yet, despite their overall rejection of Freud, these physicians nonetheless did draw on certain concepts and ideas that sounded a lot like psychoanalytic theory. For example, Thomas (1922) maintained that fear resulted from the inhibition of instinct and Freud's concept of the id was how he accounted for this. Williams was interested in his patient's dreams; this woman had visions as she fell asleep of "a rough, brutal, very large skulking negro under the bedclothes" and he took such dreams as the point of departure for many associations and questions.[17] He referred to psychoanalysis as the "Freudian cult" yet advised this patient that "the satisfaction of her repressed impulse might be secured by the co-operation of her husband."[18] Snowden observed that phobias were produced when the mental picture of an original, terrifying experience was forgotten. Specifically, if recall of a terrifying memory meant the reappearance of the painful

sensation of terror in the body, then gradually all those things associated with the original experience were avoided until it was completely forgotten and surrounded by a barrier or guard of forbidden activities.[19] All terrifying experiences had the potential to become phobias through the process of forgetting, he maintained. Hadfield stated in 1929 that the difference between normal fear and anxiety was in the "damming back" of the normal expression of fear so that it failed to express itself normally and discharged itself in activities connected with the autonomic nervous system. Anxiety remained chronic because of the persistent conflict between sexual or egoistic impulses, and because of the fear associated with the need for protecting the ego. He continued by saying, however, that repressed libido as an explanation was not the only game in town; indeed anything threatening the ego was cause enough for the creation of a protective anxiety. And in 1949 Terhune argued that his patients, twice as many women as men,[20] had simply not experienced enough of life's challenges. These patients were overprivileged and overprotected by neurotic parents on whom they were emotionally dependent and from whom they needed to "divorce" themselves. The solution to their problems would come from "reconditioning" and, in order to prevent this problem from occurring, apprehensive children were to be recognised as "soft" and shown in childhood how to deal with their problems. Adults whose soft upbringing had not been caught in time, needed to be re-educated through psychotherapy and resocialised through graded exposure to anxiety-producing activities.[21]

Behaviourism Gathers Momentum

Behaviourism was still a minor player during these years, however, and it was not until after the 1950s and the emergence of three influential research traditions in behaviourism, that its ideas and methods really began to crystallize. These three traditions derived from the work of Wolpe, Lazarus and Rachman (originating in South Africa and then moving to the US), American B.F. Skinner and his followers, and British practitioners M.B. Shapiro and Isaac Marks, the latter publishing extensively on agoraphobia. Indeed, by the 1960s, behaviour therapy was fully recognized within psychiatry, and an APA task force appointed in 1970 to evaluate its potential gave it favourable reviews.[22]

Though it developed very much in the background of psychoanalysis, the two psychiatries were similar in that they both pertained to feelings and thoughts. They differed epistemologically, however, in that behaviourism was based in the experimental scientific method. Behavioural psychotherapy insisted on the observability of phenomena, as opposed to psychodynamic therapies that were satisfied with *inferences* of psychic processes. Probably the most important – and influential – difference between psychoanalysis and behavourist methods, though, was the clearer orientation of behaviourism toward patients' problems and its concomitant ability to bring faster results than lengthy psychoanalysis. Indeed, because of these differences, behaviourism would come to be seen as the more *economical* treatment option.[23]

There were several examples of behaviourist orientations in the agoraphobia literature after the 1950s. Yet while they may describe the treatment technique differently, essentially they were all variations on a theme. In any behav-

ioural treatment, *exposure* of some form to the anxiety-provoking stimulus was the most crucial ingredient. "Gradual exposure" was used by Malleson in 1959 for example, who had his patient go increasing distances from his front door and stay there until "he has felt all the fear possible there – and cannot feel more, so bored of it has he become."[24] Clark used "reciprocal inhibition" with his patient who experienced spasms in the jaw muscles whenever she had to go out. She was trained in progressive relaxation and exposure: when a spasm would start she was to smile widely in order to inhibit the tension of the jaw muscles.[25] She was also to go increasing distances into the garden and return to the house as soon as she felt any apprehension until eventually she was able to go to the chain stores a motorcycle ride away. Meyer and Gelder had a somewhat different objective in their use of both reciprocal inhibition and graded exposure with their five patients. They sought to determine whether or not behaviour therapy would be effective in all phobic patients and what effect the successful treatment of one symptom or a group of symptoms would have on other untreated symptoms. Their article was among the first "studies" of the effectiveness of behaviourist methods in treating agoraphobia that would eventually become the norm for behaviourist reports on this disorder.[26] Finally, "re-education" and "reconditioning," used by Terhune was aimed at re-programming the habituated response to the underlying problem. His approach was significant for its emphasis on cognition, also something that would develop into a major area of study closely connected with behaviourist approaches. The reader will recall that Terhune sought to "re-educate" his patient and to facilitate "emotional maturation." These patients needed to understand that "neurosis is the income tax of civilization and that reeducation reduces that

tax."[27] His approach, though focused on cognitions, would still involve exposure in that the re-education that he proposed was to occur in a hospital setting where the patient could socialise with other patients and practise walking increasing distances away from it.

In Chapter 5 we looked at cases of agoraphobia believed to have been related to under- and over-parenting. This form of reasoning was not limited to the psychoanalytic reports (though there were technically so many more of them). Recall Terhune's 1949 thesis that phobias were the result of "soft" upbringing. He maintained his argument in 1959 and 1961 that patients needed to move beyond the dependence that they tended to have on one of their parents, who was often neurotic too. He also observed that agoraphobia commonly developed when patients were expected to become more independent.

Also like the psychoanalytic cases, gendered expectations were a contributing factor evident in other practitioners' explanations. This was especially captured in Roberts' report on five female patients, who, following treatment, were found to all be "coping adequately with routine home duties."[28] Bignold, in 1960, described the circumstances of 10 female patients in order to make the case that they were opportunists who used agoraphobia to get their way. As he wrote: "When the symptom served a useful purpose, it was refractory to treatment. The possessive mother features in several histories. Dominant dames have diffident daughters."[29] The success or failure to do gender correctly evidently constituted an important measure of (the lack of) pathology.

Still, that there was a gain to be derived from agoraphobia was not exactly a revelation; phobias protected patients from having to deal with difficult under-

lying emotional issues.[30] This meant that there had to be some guarantee of success in treatment for patients to be willing to give up the protective shield that their neurosis provided. The implication, however, was that patients were often seen as responsible for their illness insofar as strong will and determination were considered key to their recovery, as we saw in Chapter 4. Tucker (1956) even wrote that the effectiveness of treatment was not dependent so much on the number of office visits, as it was on the attitude and resources of the patient.[31]

The late 1960s and 1970s marked another turning point in the history of agoraphobia. Between 1966 and 1975 a total of 38 articles,[32] written by British and American practitioners, were published.[33] Nearly three-quarters were published between 1974 and 1975, only *six* of which were psychoanalytic.[34] The remaining articles were mostly behaviourist, informed no doubt by the widely cited and influential *Fears and Phobias* published in 1969 by leading behaviourist Isaac Marks. Pharmaceuticals were also being tested at this time, but to a lesser extent.[35] Several of the behaviourist reports, written by nurse therapists, were published – one could say segregated – in nursing journals such as *Nursing Times* and *Nursing Mirror*.[36] Articles were also increasingly published in psychology journals such as *Behaviour Research and Therapy* and *Psychological Reports*. Evidently not only psychoanalysis and medicine and psychiatry proper were losing their monopoly on the management of agoraphobia. Still, evidentiary research that included psychological study, was beginning to accumulate, a trend that would become the mainstay of medical publishing for the next thirty years. Meanwhile, in 1968 the DSM-II, the first major revision of the infamous psychiatric manual, was released and its consequences reverberated far beyond the

walls of psychiatric clinics.[37] Only seven articles were published before the publication of DSM-II; after the numbers would increase, and they would do so exponentially.

In terms of content, the behaviourist articles published between 1966 and 1975 were fairly consistent with past articles with regard to patients' average age and the long duration and form of their symptoms. Diagnoses have increased and most of the patients are married women with children. For example, one study used a sample of 29 agoraphobics, including 18 women[38]; another involved 34, 31 of whom were women.[39] Still another used a sample of 786 agoraphobics – *all of whom* were women.[40] Indeed, writers frequently commented on the disproportionality of female incidence[41] and suspected a possible link between agoraphobia, depression, and marital and sexual difficulties. It seems, in other words, that most of the patients described were married, and many unhappily.[42]

Behaviour therapy was by this time endorsed as a fast-acting and cost-effective approach to treating phobic disorders. One patient's previous resistance to other forms of therapy and her "reduced economic circumstances," in her therapist's words, "necessitated selection of a method which held at least some promise of relatively quick results." As two practitioners put it: "[i]f behaviour therapy must be carried out more than three times a week it is no longer a brief and economical treatment."[43] The benefits of behaviour therapy could be maximised even further through group therapy which meant "a considerable time-saving for the therapists."[44] In contrast, psychoanalysis had never been either cheap or quick. As Peter Gay writes,

> From the first day on, while the analysis is getting under way, analyst and analysand have practical, worldly matters to settle [so as not to] to cripple psychoanalytic inquiry from the start. [...] The patient agrees to lease a certain hour of the analyst's time and pays for it whether he avails himself of it or not.[45]

"To ensure continuity and intensity," most of Freud's patients were seen by him as many as six times a week, and this arrangement could go on for years. Behaviour therapy, on the other hand, claimed to produce results in as little as three weeks.[46]

The increase in behaviourism, combined with a "waning asylum era" and a "new social psychiatry" that had by this time begun to see mental illness as "part of normal variability,"[47] signalled a greater likelihood for agoraphobia treatment to take place in a day-hospital setting rather than in an analyst's office.[48] As Roy Porter writes,

> A new social psychiatry was being formulated, whose purview extended over an entire populace. The implied blurring of the polar distinction between sane and insane was to have momentous practical consequences for custody and care. As emphasis tilted from institutional provision *per se* to the clinical needs of the patient, it pointed in the direction of the 'unlocked door', prompting a growth in outpatients' clinics, psychiatric day hospitals and regular visiting, and encouraging treatments which emphasized discharge.[49]

Although agoraphobic patients had never really been confined to asylums, their decline still had implications throughout the field of mental health, including the treatment of agoraphobia.

The ascendance of behaviourism contributed to the late 20th century shift towards the experimental; single-authored case reports decreased while multi-authored reports on the efficacy of various behaviourist methods began to increase, though their real moment would come after the release of DSM-III. Drug

therapies – on their own and in conjunction with behaviour therapies[50] – were also explored to some extent, but like behaviour therapies, even more so after 1980. In one 1966 report even psychosurgery was advocated –as a means of facilitating behavioural therapy – with researchers hypothesising that modified leucotomy (a kind of lobotomy) could be useful in treating severe agoraphobia. After lobotomising twenty-two severe agoraphobics they found that this surgery produced an overall reduction of anxiety, enabling patients to relax enough to relieve specific phobias with behaviour therapy.[51] Evidently this questionable surgery was not popular or especially well-received; psychosurgery would really never be mentioned in the literature again, save for one letter to the editor of the *British Medical Journal* that criticised psychosurgery trials as "crude and inappropriate."[52]

The behaviour therapies described in these reports continued to involve some form of exposure. Methods included "systematic desensitisation," "successive approximation," "flooding" *in vivo* and in the imagination (both alone and in groups), "self-observation," "group therapy," "relaxation," "modelling" through video, "reinforced graded practice," "stress inoculation," and "behavioural counselling." Behaviour therapies assumed that a person's behaviour was a way of adapting to their environment and so specific behaviours were targeted for modification.

Systematic desensitisation was used to reduce anxiety gradually and was a variation on "reciprocal inhibition" therapy discussed above. (Recall Clark's patient who experienced spasms in her jaw whenever she had to go out.)[53] Operating on the principle that if a partial or complete suppression of an anxiety re-

sponse could be made to occur in an anxiety-provoking situation, then the link between stimulus (e.g., the street) and response (e.g., fear) would be weakened. *Relaxation*, for example, was often used in this way, as it was with "Mrs. James", a 45-year-old widow with two children who had been suffering from agoraphobia for 14 years prior to her husband's death. Since his passing, her mobility was completely impaired because until he died, she had been completely dependent upon him for help and companionship. She lived in a quiet suburb of Belfast, Ireland, but was unable to shop in the city, take her children on a holiday, or visit friends for fear of travelling on public transport. Her nurse therapist trained Mrs. James in relaxation, along with a programme of graded (incremental) exposure outside the hospital, which enabled Mrs. James to avoid using medication. Prior to each session, the patient was made aware of exactly what was to happen, an especially important step with "so much of the treatment taking place outside the hospital, where there is always a danger of traffic on top of other problems experienced when trying to carry out domestic activities in Northern Ireland." The therapist continued: "Since Mrs. James had never been in the city for any length of time since the outbreak of violence, she had to be prepared for the security arrangements and what to do during a bomb scare, all of which were new to her."[54]

Another therapist, also Irish, described a similar situation with an agoraphobic-claustrophobic woman. "Cynthia," his patient, decided to pursue treatment even though

> [e]veryday somewhere in Belfast buses were being hi-jacked. Everyday there was the possibility of being injured in bomb blasts. People were being shot. There were security checks to pass through which meant waiting to be searched. And not long ago, a shopping centre, similar to the one she

> [wanted] to go to, had been wrecked in a car bomb which had resulted in three deaths and many injuries.[55]

These two patients had very good socio-cultural reasons to be agoraphobic. Still, Mrs. James' treatment was a success; eventually, she was able to take her family to the zoo, to shop in bigger stores, to ride the bus, and even visit relatives in the country. Cynthia's treatment also had a good outcome, despite a couple of minor relapses. After 62 days, though, she was discharged from the day-hospital where she received her therapy. By then, she was doing all kinds of things in town and even going on trips. Only

> going to church, however still caused her some unease. She could go and sit through the longest of sermons purely as a therapeutic exercise, but she felt she could not believe in the church as an institution, and had previously only attended because she felt she owed it to her parents for the disappointment she had been to them.[56]

In some cases, relaxation training was done in preparation for the use of an "anxiety hierarchy," or the ranking of anxiety-provoking stimuli.[57] A list of situations associated with the agoraphobia was developed and each situation ranked according to how much anxiety it produced in the patient. Then, in a relaxed state, the patient was to imagine the least anxiety-provoking situation and concentrate on remaining relaxed. Gradually, she[58] was to move from imagining one situation to the next until the most anxiety-provoking situation could be imagined without experiencing phobic reactions. The principle of this technique was that if the patient could imagine these situations and relax through them, she would be able to tolerate them in real life without feeling anxious. The effectiveness of this approach was debated in some of these reports but used nonetheless by several practitioners.[59]

In *self-observation* patients were expected to keep track of how long they could spend in the anxiety-provoking situation before beginning to feel tense. With *successive approximation*, therapists did the recording and patients were praised for their accomplishments.[60] The use of praise or reinforcement was itself the subject of study, having been shown to have effects on animal behaviour, human verbal behaviour, schizophrenia, mental retardation, and children's disorders.[61]

But reinforcement was also contentious because it was seen to have the power to hinder as well as encourage progress. Family members, for example, in trying to be supportive, may actually *prolong* illness by reinforcing avoidance behaviours. To this end, one clinician actually instructed his patients' relatives to ignore the complaints because they were just encouraging dependency and fostering ambivalent attitudes towards the results of therapy:

> ...it is presumably impossible to become an agoraphobic without the aid of someone who will submit to the inevitable demands imposed upon them by the sufferer. Theoretically, if a person starts displaying agoraphobic symptoms, but finds no one willing to pander to his insistent orders to "stay and guard me, look after me and protect me," he will not display persistent agoraphobia, whatever other neurotic symptoms he may develop. Agoraphobia, then depends as much upon interpersonal as upon intrapersonal variables both for its origin and its maintenance.[62]

Interestingly, this writer also observed that the impetus to reinforce agoraphobia in loved ones could come from a certain familial need to *maintain* the patient in a state of pathology. One patient's husband went through treatment (assertiveness training, cognitive modification through "thought-stopping," and desensitisation to themes of rejection) in order *to be able* to stop reinforcing his wife's behaviour.[63]

Flooding was used to reduce avoidance behaviour through *prolonged* exposure to the anxiety-producing object or situation and this treatment approach took three forms[64]: One was *in vivo exposure* or exposure to the real situation. For example, one nurse therapist treated his patient's agoraphobia by having the patient practise walking through and crossing streets, first on quiet side roads and then later on busy city streets. The treatment was not completely successful, since the patient remained uncomfortable with busy streets, but eventually she was able to shop without discomfort.[65] Flooding could also take place in the imagination by a live or tape recorded therapist talking about the feared situation. One man who had as many as 50 movement induced epileptic seizures a day feared going out and having his attacks publicly. He had been afraid of leaving home without his wife, crossing roads, and entering crowded shops or cinemas, and had been unemployed for over a year. His psychiatrist had him listen to tape recorded 'flooding themes', a new one for each session, but all describing the patient in intensely phobic situations, having a seizure accompanied by all the feared embarrassment. The patient practiced the "fantasized" situations, and after 10 sessions in three weeks, the patient had no trouble travelling throughout London or entering crowded shops.[66] Thus flooding could also be a combination, both real and imaginal. There was general agreement that exposure in the imagination was inadequate on its own, that patients did need *in vivo* exposure to real anxiety-provoking situations in order to overcome them. That said, however, it was also suggested that actually experiencing the anxiety may not have been necessary in order to treat agoraphobia successfully.[67] In other words exposure could occur only until anxiety *starts* to build and still have the same effect.

Graded practice entailed incremental advancements towards the behaviour goal. With agoraphobics it meant having the patient walk outside a certain distance with a companion, then walking a bit further, and then a bit further and so on until eventually the patient was walking the desired amount without a companion. In one case, for example, the patient had been self-medicating – with alcohol – his fears of heights, trains, crowded places, walking alone, and driving on motorways. Not uncommonly, his family life was in jeopardy and his relationship with his sons in tatters, but graded exposure sessions enabled him to overcome his fears. Unfortunately, the patient subsequently developed a fear of water which was interpreted by his caregivers as a way to prevent the end of treatment. It was decided that he should be slowly "weaned" and monitored by telephone, and he continued to improve.[68]

Another technique used was *stress inoculation* which involved teaching the patient how to relax quickly in a stressful situation and how to think positively so as to avoid initiating or exacerbating panic attacks. Stress inoculation was to occur in stages (preparation, mild anxiety, severe anxiety, self-reinforcement), and relevant positive statements compiled for use in each stage. For example, in the preparation stage, a patient might wonder "what will happen to me if I get a panic attack later[?]" and an example of a positive statement could be "Even if I do become anxious, I will stay calm and cope." Another example, something a patient might say to herself in the mild anxiety stage, may be "Relax! I'm in control. I can handle the situation."[69] This technique could also work well in conjunction with the use of an anxiety hierarchy to allow the patient to imagine stressful situations and practice a relaxation response.[70]

Behaviourist methods were not restricted only to these hands-on sorts of techniques, however. *Behaviour counselling* was, like psychoanalysis, a non-directive approach that encouraged patients to talk about their particular problems and experiences but in the context of psychological principles of conditioning and learning. Indeed there was a certain sense that the best approach to treating agoraphobia was a combination of behaviour and psychotherapy.[71]

With these behaviourist reports, written roughly a century after Carl Westphal's important contribution to the discourse of agoraphobia, we can make the following observations. Agoraphobia was by this time clearly an issue for women more so than men. Psychoanalysis was on the decline and effectively being replaced by behaviourism. Consequently, reports on individual cases were becoming less fashionable, while research reports on large trials and studies were increasing. In many respects these shifts set the stage for what was to come next; in the next two chapters we shall see how the face of psychiatric and psychological treatment has moved from being about individuals with particular problems to being largely concerned with hypothesis testing. I turn now to the development of the DSM and the far-reaching effects it would come to have on psychiatry as both a practice and a profession.

Notes

[1] Birk, 1978:433.
[2] Birk, 1978:433.
[3] See also Williams, 1922; 1930.
[4] Williams, 1922.
[5] Thomas, 1922:129.
[6] Thomas, 1922:129.
[7] Lopez, 1926:424-5.
[8] Pollock, 1928:44-5.
[9] Hadfield, 1929:35.
[10] Pollock, 1928:44-5.
[11] Pollock, 1928:46-7.
[12] Snowden, 1934:315. See also Hadfield (1929) and Lopez (1926).
[13] Snowden, 1934:320.
[14] Williams, 1930:436.
[15] Pollock, 1928:43-4.
[16] Pollock, 1928:46.
[17] Williams, 1930:438.
[18] Williams, 1930:438.
[19] Snowden, 1934:318.
[20] Terhune, 1949:162.
[21] Terhune, 1949:168-71.
[22] Birk, 1978:434, referring to an APA report on the matter released in 1973.
[23] Birk, 1978:434.
[24] Malleson, 1959:226.
[25] Clark, 1963:246.
[26] Meyer and Gelder, 1963.
[27] Terhune, 1959:768.
[28] Roberts, 1964:195.
[29] Bignold, 1960:333.
[30] Laughlin, 1954.
[31] Tucker, 1956:829.
[32] A few additional articles in French and German were also published, bringing the total to 44.
[33] I chose these years because Medline indexes articles beginning in 1966, and the major increase in articles between 1974-5 gestures towards a natural cut-off point.
[34] Seven, if we count an article on hypnotherapy.
[35] Pharmaceuticals and their use in the treatment of agoraphobia is traceable to as early as the late 1950s, but as I describe in Chapter 8, it was not until the 1980s that clinical publishing and pharmaceutical research really intensified (at least with regard to agoraphobia).
[36] As one nurse remarked, "[t]he growing involvement of nurses in a more responsible clinical role than they have played hitherto will mean that psychiatric nurses will be called upon increasingly to give treatment..." (Bradley, 1975).
[37] Kutchins and Kirk, 1997.
[38] Emmelkamp, 1974.
[39] Emmelkamp et al., 1975.
[40] Marks et al., 1974.
[41] See for example Hawkrigg, 1975a:1280; Weekes, 1973:469.
[42] Evans and Liggett (1971) found that agoraphobics showed more concern about loss and bereavement than did other phobics. This may also support a link between agoraphobia and depression.
[43] Marks and Gelder, 1966:318.
[44] Emmelkamp and Emmelkamp-Benner, 1975. Also, there may even have been a psychiatric trend toward group therapy developing at this time, if we consider that it was being used by then for the purposes of weight loss, as in Weight Watchers, and recovery from alcoholism, as in Alco-

holics Anonymous (Hand et al., 1975). Group therapy situations not only would have saved therapists' time, but would also have allowed patients to support one another. The rise of group therapy in the treatment of agoraphobia also suggests that there were quite a number of agoraphobics around, or at least enough to warrant treating them in groups.

[45] Gay, 1998:296-7.

[46] See for example Pinto, 1972.

[47] Porter, 1997:521.

[48] See for example Williamson, 1974.

[49] Porter, 1997:521.

[50] See for example Lipsedge, 1973. Also, there was some evidence of resistance to this shift to evidentiary medicine. See Agras et al., 1968 who, arguing against large clinical trials, made the point that it was better to study a single case through an experimental therapy. As they wrote: "The effect of a single therapeutic variable on neurotic behavior can then be determined by its introduction, removal, and reintroduction in sequence" (423). That said, Agras was still supportive of the scientific method.

[51] Marks et al., 1966.

[52] Shafar, 1975:40.

[53] Clark, 1963.

[54] Bradley, 1975:967.

[55] Williamson, 1974:1843-4.

[56] Williamson, 1974:1845.

[57] See Hawkrigg, 1975b.

[58] I use the pronoun "she" because by now pretty much all the authors do; agoraphobia is firmly established as a female problem.

[59] See for example Friedman, 1974; Williamson, 1974; "Agoraphobia":1974 (author unknown).

[60] See for example, Everaerd et al., 1973.

[61] Agras et al., 1968:423.

[62] Lazarus, 1966:97. (Lazarus was one of the leading figures in the development of behaviourism.)

[63] Lazarus, 1966.

[64] Emmelkamp and Wessels, 1975.

[65] Deakin, 1975.

[66] Pinto, 1971:287.

[67] Everaerd et al., 1973.

[68] McArdle, 1975.

[69] Hawkrigg, 1975b:1338.

[70] Hawkgrigg, 1975b.

[71] Shafar, 1975.

Chapter 7
DSM and the Demise of the Social

I. In the Beginning

The first official effort to classify mental disorders in the US was developed by the federal government for census purposes, which meant that census officials were closely involved in the diagnosis of mental illness. By 1880 there were seven official categories of mental illness, namely mania, melancholia, monomania, paresis, dementia, dipsomania, and epilepsy.[1] After the turn of the century, census officials decided to standardise nosology and asked the American Medico-Psychological Association (later the American Psychiatric Association) to strike a "committee on nomenclature" that would compile data on mental disorders.[2] In 1917 this committee adopted a report of its "Committee on Statistics" whose mandate it was to "provide for a system of uniform statistics in institutions for mental diseases" and "promote the introduction of the system throughout the country." This first *Statistical Manual for the use of Institutions for the Insane* was compiled and published to assist mental institutions in gathering their annual statistics of psychiatric nosology. It was "earnestly hoped...that a national system of statistics of mental diseases [would] become an actuality."[3] To this end, specialised forms for the purpose of preparing statistical reports were provided along with instructions on how to complete and submit the forms.[4]

The statistical manual was a success; as noted by its editor in the preface to the second revised edition published in 1920, the system of classification "met with general approval" and was "adopted by nearly all of the state hospitals" and many other public and private hospitals as well. Indeed, "demand for the manual

[was] so great that the supply of the first edition [was] nearly exhausted."[5] This success was despite the fact that there were absolutely no citations or references, which meant a convenient inability to test its categories for scientific validity – a theme that would become all too redundant over the next 80 years. Ironically, as early as this second edition, the authors of the foreword wrote:

> In order that the statistics of the several hospitals may be compared and combined, much care should be exercised in compiling them, and the suggestions in this manual should be closely followed. In no other way can accurate, nation-wide information concerning mental diseases and the operations of hospitals for their treatment be made available to supervisory boards, managers and superintendents and to other persons interested in hospital management or in the scientific study of mental disorders.[6]

They go on to say:

> This revised edition of the manual is essentially the same as the first but the instructions have been amplified and some new items have been added. Although no fundamental changes have been made in the classification of mental diseases, a few terms have been modified to conform with current usage.[7]

The minor modifications to which these lines refer were most likely relatively innocuous and meant only for the purposes of amplification. In retrospect, however, these changes foreshadowed a series of questionable and highly political revisions that would subsequently mar the DSM throughout its history. Though this will become much clearer later in the chapter, each edition of the DSM makes fact-claims only to replace them in revised editions with "truer" fact-claims based on "current usage." These revisions according to Kutchins and Kirk "can seldom be explained by advances in science but can often be explained by the shifting fortunes of various powerful factions."[8] Although Kutchins and Kirk are referring specifically to revisions of the DSM after 1979, its history of making scientific

claims was established early within this second edition of the *Statistical Manual*, that is – long before the release of the DSM proper.

Between 1918 and 1942, the early manual, used by the US Census to survey mental institutions annually, went through ten editions.[9] By the time the sixth edition had been published,[10] the American Medico-Psychological Association had become the American Psychiatric Association whose role it was, in co-operation with the National Committee for Mental Hygiene, to act in an advisory capacity to the Department of Statistics of the National Committee for Mental Hygiene.[11] True to form, "[s]ignificant changes in the classification of mental disorders were made by the American Psychiatric Association at its annual meeting in New York in 1934. The revised classification together with new definitions and explanatory notes" were contained within the sixth edition. Not only was this classification system being used by the Census Bureau and practically all of the hospitals throughout the country, the United States Public Health Service, the United States Army, and the Veterans' Bureau had also adopted it, a first step in bridging the professional and diagnostic divide.[12] It would largely be this disconnect between military and civilian medical and psychiatric classification that would ultimately set in motion the development of the first DSM so as to standardise the categories for *all* medicine.

In 1928, the New York Academy of Medicine held a conference on the nomenclature of disease in New York and many organisations, including, medical, government, military, and life insurance, were in attendance. An executive committee was struck and a basic plan established that "provided for a dual method of classification, etiological and topographical (anatomical)."[13] Until then, medi-

cal nomenclature had varied in form: hospitals, health organisations, and insurance companies all had to devise their own systems.[14] The American Medical Association was therefore in search of consistency but, in the words of H.B. Logie (Executive Secretary of the NYAM conference) however, "the terminology employed...represented the personal choice of the author" and meant that "the original plan was forsaken in places for purely etiological, functional, epidemiological, or less important considerations."[15] The resultant *Standard Classified Nomenclature of Disease*, published in 1933, aimed to be a "central guiding influence" in the face of a "confusing multiplicity of effort."[16] It was to include "every disease which can be recognised clinically, to avoid repetition and overlapping, to classify the diseases in a logical manner,"[17] and it was also intended as a reference for clinicians, public health officials and clerks.[18] By 1935, with the release of the second edition of the nomenclature, the *Standard* had "found its way" into nearly 500 hospitals in Canada and the United States. By 1942 and the release of the third edition, it had expanded to include surgical operations.

In all its editions, however, the method of classification was based upon two main factors: the location of pathology (topographical classification) and causation (etiological classification). Topographical classification was divided into eleven major categories, one of which was "diseases of the body as a whole," including diseases of the psyche and of the body generally and diseases that did not affect a particular system exclusively.[19] Etiology had 13 major categories, including, for example, "Diseases due to prenatal influence", "Diseases due to a lower plant or animal parasite," "Diseases due to intoxication," and "Diseases of undetermined cause."[20]

The new classification system was intended to meet the needs of government, not patients and doctors. As we have already seen in the medical articles, psychiatric treatment at that time was still quite non-specific. The uselessness of this classification became dramatically apparent during and after World War II. With the increase of psychiatric case loads during the war, military psychiatrists, induction stations psychiatrists and Veterans Administration psychiatrists were forced to work with a nomenclature, that in the words of the APA, was "not designed for 90% of the cases handled." In particular, "[n]o provisions existed for diagnosing psychological reactions to the stress of combat, and terms had to be invented to meet this need. The official system of nomenclature rapidly became untenable."[21]

The APA struck a committee charged with drafting another revision, using the guidelines drawn from the experiences of the Armed Forces and Veterans Administration. In April, 1950, the committee distributed copies of the draft along with a questionnaire to 10% of its members and practitioners from other organisations and, based on their responses, they prepared a revision deemed acceptable to the American Medical Association. The Council of the American Psychiatric Association officially adopted the new nomenclature and the Committee was authorised to prepare the first edition of the *Diagnostic and Statistical Manual of Mental Disorders*, otherwise known as the DSM.[22] The manual was to serve as a "statement of general principles and procedures" to replace the compilations of statistics on mental illness previously prioritised. It offered a "completely new classification in conformity with newer scientific and clinical knowledge, simpler in structure, easier to use and virtually identical with other national

and international nomenclatures."[23] It also provided guidelines for the statistical recording and reporting of psychiatric conditions. Ironically, what it did not provide (like its predecessors) were bibliographic references. Though considered a huge success especially helpful to psychiatrists who wanted a manual specific to their field, ultimately the DSM was, in Kutchins and Kirk's words, a "compendium of constructs,"[24] a collection of abstract concepts – shared ideas – about mental illness.

When it was first published in 1952, Freud's impact on psychiatry was evident, both in the organisation of disorders and the diagnoses included. As we saw in Chapter 5, the psychoanalytic approach had a monopoly on psychiatric practice for several decades, and this newly emergent *Diagnostic and Statistical Manual of Mental Disorders* was a reflection of this. There were three major divisions of the functional (nonorganic) disorders – into psychoses, psychoneuroses, and personality disorders.[25] While agoraphobia was not named, "anxiety reaction" and "phobic reaction" were located with "disorders of psychogenic origin or without clearly defined tangible cause or structural change."[26] The term "*disorder*" was used "generically to designate a group of related psychiatric *syndromes*" and each of these groups was further subdivided "into more specific psychiatric *conditions*" defined as "*reactions*."[27] These Psychoneurotic Disorders were defined by their chief characteristic, anxiety, that was "directly felt and expressed, automatically controlled by such defenses as depression, conversion, dissociation, displacement, phobia formation, or repetitive thoughts and acts."[28]

In contrast with psychoses, psychoneurotic disorders did "not exhibit gross distortion or falsification of external reality (delusions, hallucinations, illu-

sions)" nor "gross disorganization of the personality."[29] Anxiety was explained – notably consistent with Freud's view – as a "danger signal" felt and perceived by the conscious component of the personality:

> It is produced by a threat from within the personality (e.g., by supercharged repressed emotions, including such aggressive impulses as hostility and resentment), with or without stimulation from such external situations as loss of love, loss of prestige, or threat of injury.[30]

Patients were seen to handle anxiety in various ways, with varying reactions. In the "anxiety reaction", which was distinguished from "normal apprehensiveness [sic] or fear,"[31] anxiety is diffuse and unrestricted to specific situations and objects. This is contrasted by "phobic reactions" or "phobias" (which included "anxiety-hysteria") in which the "anxiety of these patients becomes detached from a specific idea, object, or situation in the daily life and is displaced to some symbolic idea or situation in the form of a specific neurotic fear." Common examples of "phobic reactions include fear of syphilis, dirt, closed places, high places, open places, animals, etc." Patients try to control their anxiety by avoiding these phobic objects and situations.[32]

The DSM-II:

The first edition of the DSM was widely popular, having been reprinted twenty times since its release in 1952 and distributed throughout the US and other countries.[33] The Committee on Nomenclature and Statistics developed an expanded successor to the DSM-I in order co-ordinate its nosological categories with those of the World Health Organization's *International Classification of Diseases* [henceforth ICD], a glossary of illness that included mental disorders,

then in its 8th edition. The DSM-II was authored by the Committee on Nomenclature and Statistics, comprised of experts and consultants who felt the time had come for American psychiatrists to collaborate in preparing and using the new ICD-8 and for an integration of psychiatric nomenclature and classifications with the rest of medicine.[34] With "the adoption of the *DSM-II*, American psychiatrists for the first time in history will be using diagnostic categories that are part of an international classification of diseases." It was still recognised, though, that a revised DSM could only be "an important first step...an agreement to use the same sets of categories for classifying disorders."[35]

The revision process commenced in 1965 with the first meeting of the Committee. A key figure in this was Dr. Robert Spitzer who became a major spokesperson for psychiatric diagnosis for two decades and an emphatic defender of the manual.[36] A draft of the manual was circulated to 120 psychiatrists in early 1967 with a request for feedback,[37] yet revising the DSM-II was a "relatively private and simple process, more like changing rules and regulations within one organization than negotiating treaties among many rival factions."[38] By May 1967, the responses from members of this "in-group" had been collated and incorporated into a new draft, which was then submitted to the APA's Executive Committee for approval. In December, 1967, the APA Council authorised publication of the new DSM and the classification system went into effect on 1 July, 1968.[39]

The new DSM was meant to reflect nomenclature in its current usage and psychiatry in its current practice.[40] As with the first edition of the DSM, there were no references or citations perhaps because the manual "made no pretense of being [a] scientific" document.[41] It was, rather, an administrative codebook[42]

that, like the first edition, sought to facilitate the recording of mental disorders and provide a framework for how mental disorders could be talked about.

The DSM-II contained many new categories of disorder and the nomenclature was also organised in a new way. Unlike the first edition, the recording of multiple diagnoses and associated physical conditions was encouraged[43] while qualifying phrases and many definitions were changed.[44] Perhaps the most noticeable change in the revised manual was that whereas in the DSM-I nomenclature was divided into three major groups, the DSM-II had ten. "Functional Disorders" was subdivided into several major categories, including Neuroses (formerly "Psychoneuroses"), and all of the subcategories within this group were changed from "reactions" to various types of "neuroses". For example, in the first edition, phobias were called "phobic reactions", whereas in this edition, they are called "phobic neuroses."[45] Though still consistent with the language of psychoanalysis, this particular shift was considered by the Committee to be "[o]ne of the most striking differences between DSM-I and DSM-II, and perhaps the one that will generate the strongest feelings."[46] Though its members anticipated controversy, it was not the intention of the Committee to present mental disorders as fixed disease entities nor to reconcile disparate views, but rather to designate suitable labels.[47]

Anxiety was still considered to be the chief characteristic of neuroses and was still differentiated from phobias on the grounds that anxieties were diffuse abnormal apprehensions or fears, while phobias, on the other hand, were "characterized by intense fear of an object or situation which the patient consciously recognizes as no real danger to him."[48] Still following psychoanalysis, phobias

were "generally attributed to fears displaced to the phobic object or situation from some other object of which the patient is unaware."[49] But the link to psychoanalysis would not last; as we shall see in the next section, the next DSM would prove to be its death knell.

II. The Beginning of the End

From the perspective of publishing *on the one hand*, the last few decades of the 20th century constitute a period in psychiatric history like no other. During this time publication of articles dealing with agoraphobia virtually explodes; an unrestricted Medline search for "agoraphobia" turns up nearly 2000 references to articles, and these are no longer exclusively written by British and American practitioners and researchers.

From the perspective of epistemology *on the other hand*, this period is also unique in its palpable embrace of "hard science". Although the articles are nearly all in English, over time they become increasingly difficult to understand for the non-specialist with the growing use of the language (and method) of scientific expertise. In this respect, the range of journals both opens up and becomes more specialised than ever before; psychology, psychiatry, pharmacology, and neuroscience journals take their collective place as the most prevalent fora for these discussions, as opposed to general medical or even psychoanalytic publications.[50]

Likely due to a combination of trends in research funding and mental health journals' respective interests and ideologies, in the last two to three decades there has been little room for talk about agoraphobia that does not conform

to this shift. Pharmaceuticals are big business with world-wide sales in 1998 exceeding $420 billion (CD).[51] Although some case reports continue to be published, the days of their exclusivity are long gone. Evidence-based medicine has clearly taken centre stage and the articles – including the psychological ones – reflect this. There is a remarkable predominance of empirical studies and scientific-sounding reports and researchers have taken the place of clinicians as the key players in psychiatry.

In the meantime, and not coincidentally as we shall soon see, the DSM, a stunning example of "science in action"[52] has been revised four times (with the latest version just released in 2000). While the DSM-II of 1968 largely still embodied the psychosocial framework that had been the organising principle of American psychiatry since at least World War II, by the time it was released this approach – represented by followers of Freud – had already begun to fall out of favour. Its main assumptions, namely that the boundary between mental illness and wellness was fluid, that mental illness was a continuum, that a mix of environment and psychic conflict caused mental illness, and that mental illnesses were mediated by psychological mechanisms, gave rise to a widespread and intensely hostile anti-psychiatry movement.[53] If the boundary between normal and abnormal was fluid, then diagnoses must be arbitrary. If pathogenesis of mental illness was psychic, then there could be no basis for calling these things diseases.[54] Thomas Szasz, a leading figure among these critics, claimed that mental illness was a myth (the title of one of his books) and criticised psychiatric labels for being "arbitrary designations that, far from serving the needs of patients, serve[d] professional needs and the needs of the dominant...society."[55] Michel

Foucault argued similarly that psychiatry was a normative disciplinary regime. We shall look at Foucault's texts directly in Chapter 9, but I am compelled to quote Andrew Scull in the meantime:

> Foucault and his followers developed a portrait of a far more thoroughgoing Orwellian nightmare: a system of control and regimentation ... that operated insidiously and all but invisibly, reaching out to encompass the normal, to snare them within an ensemble of 'benevolent' interventions and a discourse of personal fulfillment, and in the process serving to manage and manipulate a universe of ever more 'docile bodies.'[56]

In the 1970s, then, psychiatrists realised that they needed to do something to reassert their profession's scientific and medical status, and "there appeared a concerted effort...to offer a rebuttal to the antipsychiatrists, criticize the psychosocial model (and its untoward consequences), and defend the medical model."[57] Moreover, the US government and private insurance companies were putting pressure on the profession to get its act together. They saw psychiatry as a "voracious consumer of resources and insurance dollars – because its methods of assessment and treatment were too fluid and unstandardized." The heretofore dominant psychosocial model of psychiatry would have to be "significantly altered, if not jettisoned altogether."[58] In the meantime, there was an increasing awareness that psychotropic medications were of some benefit and this held great promise for the development of more effective medications in the treatment of discrete pathologies. Clear diagnostic criteria were going to have to be developed then, so that clinical trials based on homogeneous samples could be conducted. "Medications, in other words, helped to create a need for a more experimentally and empirically based psychiatry; explicit diagnostic inclusion and exclusion criteria were essential elements in this endeavour."[59]

Although not in time for DSM-II's release, psychiatrists sought to establish clear professional boundaries, however contradictory, distinct from other mental health disciplines and especially from psychoanalysis on the grounds that psychoanalysis was unscientific:

> Psychiatry needed to secure professional dominance over the mental health field, given the expansion and rise in importance of both psychology and social work as important mental health disciplines in the last several decades. By securing unity within its own profession, and dominance over allied professions, psychiatry solidifies the claim that it is 'hard' medicine worthy of government support for education and services and for third-party reimbursement.[60]

The DSM released in 1980 reflected the move away from psychodynamic understanding of mental disorders as biopsychosocial reactions, an understanding so predominant in earlier years,[61] toward research-based, descriptive, scientistic psychiatry more compatible with the medical model. The DSM-II notion that psychiatric disorders were "reactions" to biopsychosocial factors was dropped in DSM-III because it implied a theoretical – read: psychoanalytic – viewpoint, and proponents of DSM-III claimed to be presenting an etiologically neutral document, to be presenting the straight objective facts of mental illness. As Cooksey and Brown observe:

> The leaders of the diagnostic project claim that they are being atheoretical. While it is true that they are emphasizing symptom clusters and avoiding traditional arguments, such as those between organic and psychoanalytic perspectives, they cannot be atheoretical. Everything is based on some theory, and the theory in this case is a biopsychiatric one.[...] The claim to be atheoretical is really a technical means to avoid a political question, namely: who should have the power to define and implement psychiatric knowledge and practice?[62]

Thus, psychiatrists were in fact realigning themselves with a particular approach, namely that of biological psychiatry and the DSM-III marked this paradigm shift

(Rogler, 1997), a shift zealously maintained in the name of "good science" in its revised and expanded editions of 1987 (DSM-III-R), 1994 (DSM-IV), and 2000 (DSM-IV-TR). The irony of this positivistic turn is that it may have been the APA Task Force that was, at least metaphorically, a little bit mad. As Peterson and Sicherman argue in their clever and convincing examination of the neurophysiological parallels between schizophrenia and hypostatization: "...'normal' politics – in which people accept, without question, the hypostatizing of certain values, beliefs, narratives, meta-narratives – is crazy. Or put otherwise: when we valorize values, beliefs, ideals, and consider them transcendent, we are behaving, at least metaphorically (if not 'really'), as schizophrenics."[63]

Widely accepted by the general public, government, the judicial system, pharmaceutical companies, and third-party payers, the DSM has served as the very infrastructure of mental health in the recent history of psychiatry – and of agoraphobia.[64] Even extra-psychiatric mental health care practitioners such as psychologists and social workers have had to subscribe to the DSM system in order to gain professional respect, obtain research funding, and to qualify for third-party payment. The DSM has effectively ensured psychiatry's professional dominance, secured through the exclusion of *other* approaches to mental health care that have had no choice but to adopt the very DSM framework that excludes them. In other words, insiders obeyed evidentiary norms and scientific method; outsiders did not.[65]

As the "official map of mental illness and disorder ... the manual [also] establishes, in effect, what it is possible to suffer in the way of problems psychiatrists recognize and treat."[66] As Scott goes on to say:

> Privately, psychiatrists may practice the art of medicine by doing what they think best for their patients. Professionally, however, they must conform to current scientific consensus or run the risk of being labeled 'quacks.' When a formal diagnosis is required, they must use the most recent DSM in order to state officially whether or not someone is sick.[67]

Indeed, the DSM-III was considered by leading psychiatrists to be the most important psychiatric publication to appear between 1970 and 1980.[68] It is not uncommon for the research articles described in the next chapter to contextualise the research by describing the "subjects" (and sometimes just "Ss") as having met DSM criteria. The DSM diagnostic schema clearly influenced the design, implementation, and interpretation of research on agoraphobia (and possibly even its results).[69]

I turn now to the "practical politics" of DSM-III, including the processes of arriving at its standards and categories and of deciding what would and would not be visible within it.[70] Following from Bowker and Star, the indeterminacy of these processes has meant that the enforcement of DSM categories involved negotiation, force, and plenty of conflict; to be sure, "classification systems are often sites of political and social struggles [with] agendas that are often first presented as purely technical and [that are] difficult even to see."[71]

The DSM-III

In light of a "growing recognition of the importance of diagnosis for both clinical practice and research",[72] in 1980 the Task Force on Nomenclature and Statistics of the American Psychiatric Association released its latest incarnation – at nearly 500 pages – of the *Diagnostic and Statistical Manual of Mental Disorders*.[73] As the Task Force's Chair Robert Spitzer argues in his introduction to the new man-

ual, clinicians and investigators needed a "common language with which to communicate about the disorders for which they have professional responsibility."[74] Proper treatment begins with an accurate diagnosis, he contended, and, almost as if to predict the future onslaught of controlled trials that would take over not only the agoraphobic scene but medicine in general, Spitzer stated that the "efficacy of various treatment modalities can be compared only if patient groups are described using diagnostic terms that are clearly defined" (1980:1). Promising to be an advance over DSM-II (a refrain that returns with each subsequent edition),[75] the new and improved DSM-III offered several new features, a multiaxial approach to evaluation, and expanded descriptions and additional diagnostic categories, "some with newly-coined names."[76]

Interestingly, the decision to revise the second DSM from 1968 was made only five years after its release,[77] when the Task Force on Nomenclature and Statistics was called back to service. Spitzer describes how the ninth edition of the *International Classification of Diseases* was scheduled to go into effect in January of 1979, but there was concern that the section on mental disorders would not be appropriate in the United States.[78] The classifications of ICD-9 "did not seem sufficiently detailed for clinical and research use."[79] It contained for example "only one category for 'frigidity and impotence' – despite the substantial work in the area of psychosexual dysfunctions that has identified several specific types with different clinical pictures and treatment implications."[80]

This need to standardize[81] the diagnosis process by clarifying diverse types of mental disorders was consistent with the Task Force's mandate to separate diagnostic labels from debatable etiological theories. This would enable a focus of at-

tention on the development of descriptive criteria for the disorders and on research for alternative theories to psychoanalysis.[82] This "separation standard" meant the separation of symptoms into other disorders: affective, anxiety, somatoform, and dissociative. "Neuroses", so clearly pointing to a psychodynamic orientation, were channelled into the section on anxiety disorders, the prime recipient of this redistribution.[83]

Diagnostic categories thereby expanded with the inclusion of new disorders and the splitting of old ones into "offspring disorders with taxonomic status equal to their parents."[84] Categories also remained stable and decreased in some instances, since some diagnostic categories were moved to other sections of the system, while others were collapsed and incorporated, or sometimes even eliminated. The decrease "can be observed when a disorder's original identity, its proper name so to speak, is obliterated as the disorder is incorporated into another disorder, the parent disorder."[85] Agoraphobia and panic are a case in point, as we shall see below.

Like its precursors, the third DSM was meant to "reflect the most current state of knowledge regarding mental disorders" and to be clinically and administratively helpful. Unlike DSMs I and II, DSM-III was also meant to provide a *basis* for research. Spitzer goes on to outline a number of other objectives of the Task Force:

- clinical usefulness for making treatment and management decisions
- reliability of the categories
- acceptability to clinicians and researchers irrespective of theoretical orientation
- the avoidance of new terminology except when absolutely necessary
- consensus on the meaning of certain diagnostic terms used inconsistently until that time

- consistency with research studies [*that are actually never cited: SZR*] to lend validity to the diagnostic categories
- suitability for describing subjects in research studies, and
- responsiveness to critiques by clinicians and researchers during the development of the DSM-III.[86]

Claiming to rely heavily on relevant research evidence, Spitzer remarks nonetheless that it "should come as no surprise to the reader that... Task Force members often differed in their interpretations of the findings."[87]

This was a bold if not contradictory admission from one of the staunchest defenders of the suitability and internal stability of the previous DSM's categories. With Spitzer positioned at the forefront of DSM-II's complete demise[88] (underwritten in the name of scientific progress), it is rather interesting that in this introduction to DSM-III he does not talk about some of the possible *other* reasons for a third edition of the DSM. For one thing, gay activists staged protests against the inclusion of homosexuality as a mental disorder at annual APA conventions, protests to which the APA had no choice but to finally respond.[89] Indeed it was this and other controversies that demonstrated "the architecture of classification schemes" as "simultaneously a moral and an informatic one."[90]

Second, researchers attacked the theoretical foundations of the manual and the reliability of diagnostic practices also came under internal fire by researchers who considered psychodynamics unscientific.[91] The DSM-III was to aim for theoretical neutrality. An "invisible college" of neo-Kraepelinian psychiatrists was the major force behind a drive to remedicalise psychiatry through this official taxonomy.[92] A contemporary of Freud's, Emil Kraepelin (1856-1926) was a German psychiatrist famous for his psychiatric nosology and systematisation. Using a prognostic approach, he sought to classify definite disease entities, espe-

cially manic depressive psychosis and schizophrenia. His system of psychiatric classification was based on three assumptions: 1) that mental disorders were best conceptualised by analogy to physical diseases; 2) that the classification of mental disorders can only be done through the systematic and careful observation of visible phenomena; and 3) that empirical research would demonstrate that serious mental disorders are organic and biochemical in origin.[93] As Kraepelin wrote:

> ...[N]o one can deny that further research will uncover new facts in so young a science as ours [...] Only scientific research can bring about the realization of such advances. [...] [O]nly a well-planned and comprehensive program of research can bring us closer to the goal which we are striving to attain.[94]

Kraepelin approached his patients as "symptom carriers" and therefore concentrated on the core signs of their disorders,[95] but his emphasis on discrete psychiatric syndromes was not a big hit during the psychosocial heydey. So it was ironic, as Rogler notes, that

> a move toward the future had reverted to the past. The [neo-Kraepelin] credo affirmed that psychiatry, being a branch of medicine, should be scientifically oriented, should focus on biological aspects of mental illness, and should attend explicitly to the codification, reliability, and validity of psychiatric classifications.[96]

To the neo-Kraepelinians, psychodynamic and psychosocial approaches to mental illness demedicalised psychiatry, such that the

> [s]ignificant others in their reference groups were not the couch-oriented psychoanalysts dwelling into the details of unconscious conflicts in the clients' mental processes or the community-oriented social psychiatrists exploring the methods and theories of social psychology, anthropology, and sociology. Their significant others were the modern epidemiological and experimental researchers, who were making notable advances in modern medicine and public health.[97]

A third impetus to revise the DSM, as mentioned above, was the burgeoning drug industry's need for efficacy trials in order to have their drugs approved

for sale by the federal government. Without clearly delineated psychiatric categories, it was difficult to define the situations in which a particular drug might be effective.[98] Even European drug companies required DSM criteria if they wanted their products approved by the Food and Drug Administration. Moreover, foreign studies were (are) more likely to be published in American journals if their definitions and sampling procedures were based on DSM guidelines.[99] Finally, outpatient treatment increased in the 1970s due to an increase in third-party support (i.e., insurance coverage). This meant that reliable and coded diagnostic categories to match insurable treatments were required. In all of these respects the gaps in DSM-II and the need for a new edition became apparent.[100]

Spitzer also does not contextualise the decision to create DSM-III in terms of the unique opportunity that it represented at this juncture in the history of American psychiatry to respond to all these professional and societal changes.[101] The Task Force was not interested in simply *updating* psychiatric nosology – its members wanted a *complete overhaul*[102] whose outcome would be a set of reliable diagnostic concepts and the expansion of a differentiated mental health system in an increasingly medicalised American society[103]: hence, what Rogler (1997) and Cooksey and Brown (1998) describe as the paradigm shift to a DSM rooted in the medical model that precluded socio-cultural and institutional considerations.[104]

Aware of the difficulties in developing a classification system, the Task Force knew they could not reach consensus among mental health professionals as to what the categories should be or even as to what ought to be included in DSM-III. DSM was a way of effecting unity in a disunified profession,[105] but the "devel-

opers knew that it was impossible to organize a classification system that would satisfy multiple constituencies with different views about etiology, prognosis, structure, and treatment".[106] Spitzer fails to mention this arguably major challenge that the task force had faced in reaching its – his? –goals for the new DSM.[107]

The new DSM was to meet the needs not only of diagnosis, but, arguably more importantly, of *billing*: "For DSM-III, the mentally ill were by definition those seen by psychiatrists. DSM-III desired for every client a reimbursable diagnosis, if not quite a chicken for every pot."[108] Thus for the practitioners on the task force, the old adage "when in doubt, do without" was not part of the game plan. They included many new categories not only to reflect the diversity of clinical problems, but also "to capture more fiscal coverage from third-party reimbursements, which had become much more important to the financing of mental health care."[109] It is no surprise, then, that the DSM-III had nearly quintupled in size.

Procedurally, the development of DSM-III was more or less the same as its predecessors, with versions drafted, circulated (among supporters that is), and modified as necessary. Notably, only one psychoanalyst (John Frosch) was added to the task force, but "he quietly resigned 2 years later because he felt that his suggestions for shaping the manual in a more psychodynamic direction had been dismissed out of hand."[110] Kirk and Kutchins offer their assessment of the revision process:

> ...the process of revising each version of the DSM begins with the first official questioning of the current nosology, proceeds to tout the superior status being used for the version being developed, moves to proclaim that

> the brand-new version represents vast improvements over the old, encourages everyone to purchase the new publication with its paraphernalia (casebooks, tapes, instructional aids, etc.), and ends with a new task force questioning the scientific status of the latest version.[111]

There were three significant changes in the process worth mentioning, however. First, a Committee on Women was struck and consulted to review the DSM-III "from their own perspective."[112] Other professional organisations were also consulted, and differences in point of view resolved as much as possible.

Second, a multiaxial system was developed to ensure that information pertaining to treatment and its outcome was recorded on axes separating mental (Axes I and II) from physical disorders (Axis III) and reflecting other things such as severity of stressors (Axis IV) and level of adaptive functioning (Axis V).[113] But as Rogler observes, while it was clear that a single class of information was no longer considered sufficient, it is not clear what the axis structure meant or how the relationship between axes meant to be understood.[114]

Third, the Task Force conducted field trials because prior to this edition of the *DSM*, "new classifications [had] not been extensively subjected to clinical trials before official adoption."[115] Trials took place between 1977 and 1979, with the evaluation of 12,667 patients by approximately 550 practitioners in 212 different facilities, using drafts of DSM-III.[116] Most participants responded favourably to *DSM-III*, but changes were made wherever necessary. In addition, to ensure the reliability of its categories, pairs of clinicians were asked to diagnose independently several hundred patients, the results of which reflect "far greater reliability than had previously been obtained with DSM-II."[117] The reliability of the reliability studies was, however, questionable. In Paula Caplan's words "one could get a

large group of people to agree to call all horses 'unicorns,' so that their inter-rater reliability would be perfect, but that would not mean that any of them ever really saw unicorns."[118] And as Kutchins and Kirk observe, "The illusion that psychiatrists are in agreement when making diagnoses creates the appearance of a united professional consensus" when in fact there was "considerable professional confusion."[119] Indeed, the

> field trials themselves could more accurately be described as uncontrolled, nonrandom surveys in which several hundred self-selected and unsupervised pairs of clinicians throughout the country attempted to diagnose nonrandomly selected patients and, after some sharing of information, made 'independent' assessments of these patients...[120].

In a recalculation of scores it was revealed that for no diagnostic category was reliability consistently high yet the DSM-III Task Force played this issue down, insisting that this issue had been resolved.[121] (Cooksey and Brown, 533-4). But critics, such as Schacht, charged that

> [p]sychiatry seeks to achieve predictive power in a situation where certainty is low. This phenomenon is common to positivist approaches to the social world – uncertainty is viewed as an interloper to be overcome rather than as a basic feature which may provide problems that cannot be surmounted. With the stature of an official document, the DSM makes it appear possible that mental disorders can be classified with certainty.[122]

Critics of the DSM also called into question the validity of the categorisation process. While its validity was constructed on the basis of its widespread acceptance and the high number of copies sold "these sales [were] largely required by the hegemony of the psychiatric leadership."[123] Third-party payment schedules and drug research that works within DSM criteria are cases in point. Tellingly, the manual does not actually cite any of the trials upon which the manual is based; this, however, does not seem to be of concern.[124]

With DSM-III's questionable methods, motives, and results in mind, it would be worthwhile at this point to examine a few (more evidently loaded) passages from DSM-III's official definition of "mental disorders" before turning to its handling of agoraphobia specifically. Spitzer writes: "Although this manual provides a classification of mental disorders, there is no satisfactory definition that specifies precise boundaries for the concept 'mental disorder' (also true for such concepts as physical disorder and mental and physical health)."[125] What he seems to be saying here is that classification is a dodgy process and while we cannot *definitively* sort through the various categories, the *DSM-III* should still be used nonetheless. (Certainly there would *be* no DSM if the problem of classification were actually permitted to stop the DSM project in its tracks.)

Spitzer states later in the section: "In DSM-III there is no assumption that each mental disorder is a discrete entity with sharp boundaries (discontinuity) between it and other mental disorders, as well as between it and No Mental Disorder."[126] In light of Spitzer's remark we could recall the position of that preeminent anti-psychiatry critic, Thomas Szasz who said: "there is no such thing as 'mental illness.' Psychiatrists must...choose between continuing to define their discipline in terms of nonexistent entities or substantives, or redefining it in terms of the actual interventions or processes in which they engage."[127]

Despite Spitzer's admission, he forges ahead with a definition of mental disorders: "In DSM-III each of the mental disorders is conceptualized as a clinically significant behavioral or psychological syndrome or pattern that occurs in an individual and that is typically associated with either a painful symptom (distress) or impairment in one or more important areas of functioning (disabil-

ity)."[128] Yet, if we consider Ziporyn's (and many others') discussion regarding the difficulty of defining the concept of disease – is it a "condition", a "disorder", a "syndrome"? – then what the DSM-III really offers conceptually is *merely* affirmation of the sense that something is wrong. Incongruously, Spitzer goes on to say that

> there is an inference that there is a behavioural, psychological, or biological dysfunction, and that the disturbance is not only in the relationship between the individual and society. (When the disturbance is *limited* to a conflict between an individual and society, this may represent social deviance, which may or may not be commendable, but is not by itself a mental disorder.)[129]

The question of where we ought to draw the line between mental disorder and social deviance is certainly illustrated by the example of agoraphobia; the line between "ordinary female fear" of male aggression and "pathological agoraphobic fear" is difficult to demarcate.[130] Moreover, as Foucault (and Szasz) would no doubt argue, "the disturbance" is very much one between the individual and society. Foucault states:

> In the serene world of mental illness, modern man no longer communicates with the madman: on one hand, the man of reason delegates the physician to madness, thereby authorizing a relation only through the abstract universality of disease; on the other, the man of madness communicates with society only by the intermediary of an equally abstract reason which is order, physical and moral constraint, the anonymous pressure of the group, the requirements of conformity.[...] The language of psychiatry...is a monologue of reason about madness...[131]

And although it is apparent from Spitzer's remarks that the APA has re-thought their inclusion of such things as homosexuality, what his perspective obscures is that even the "purely" *biological* is socially constructed.

The ultimate irony comes when Spitzer states: "A common misconception is that a classification of mental disorders classifies individuals, when actually

what are being classified are disorders that individuals have."[132] Yet the DSM *essentially* represents a dividing-up of individuals according to the fundamental schema of bodies that are sick and those that are not. Though arguably a somewhat more theoretically sophisticated approach to the practice of diagnosis (and third-party billing as it were), the notion that the DSM-III is somehow removed from the trappings of cultural classification is a thin if not ridiculous claim. Even descriptive observations are based on criteria of normality, which are fundamentally value judgements.[133] The several hundred pages that follow Spitzer's introduction are precisely a how-to guide for the practice of sub-classifying the abnormal bodies, the Other(ed) bodies mired in the "vague specifics" of DSM-III and its parameters for differential diagnoses. Surely, the "individual with [*insert diagnosis here*]" means very little outside of her or his occupation of that particular category. Following W.I. Thomas, Bowker and Star capture the problem in the following anecdote:[134]

> ...we told the story of the homicidal maniac who needed the insight of a psychic to understand his murderous urges as such. "Don't you get it, son? You're a homicidal maniac." End of explanation. The story is powerful and funny because it reminds us, ironically, that a classification is not of itself an explanation. All we understand at the end of the scene is that the maniac now has a label that others, and he himself, can apply to his behavior. Although the classification does not provide psychological depth, it does tow the person into an infrastructure – into a set of work practices, beliefs, narratives, and organizational routines around the notion of "serial killer." Classification does indeed have its consequences – perceived as real, it has real effect.[135]

Although Spitzer's acknowledgement may allow for the sense that the individual ought to be defined by more than a diagnosis, it does not follow that it is merely the disease and not the individual that is being classified by DSM and its

users. The two are necessarily co-extensive – mutually engaged and embedded together in a social and moral order.[136]

Now let me turn to DSM-III's presentation of agoraphobia. Agoraphobia's precarious positioning within DSM diagnostic criteria begins with the significant and controversial decision to eliminate the class of Neuroses in DSM-III and the attendant rejection of the psychodynamic conceptual framework that was implicated in this move. Psychoanalysts had never been fans of the DSM project that was serving to cultivate resentment among them for "what was felt to be the wholesale expurgation of psychodynamics from the psychiatric knowledge base." As one analyst wrote:

> 'I do not know...who determined that this small group of people should try to reorganize psychiatric thinking in the United States but I am ... concerned that they have such an arrogant view of their mission and are not willing to incorporate some of the things which we have learned over the past 70 years.'[137]

The concept of neurosis was the "bread and butter" of psychoanalysis[138] and the decision to exclude it from DSM-III was met with acrimonious conflict and opposition on the part of psychoanalysts:

> The contending factions, suspicious of the intentions of their opponents, battled over the word *neurosis*, arguing about whether and how it might be included in the manual.[...]Toward the end it looked as if the battle would escalate out of control, threatening to publicly embarrass American psychiatry and to prevent the final approval of DSM-III after five years of effort. Finally, after all the posturing and silliness, DSM-III was approved, with the symbolic use of the controversial term *neurosis* used in parentheses in several places. [...] After six years of preparation, a substantial financial expenditure, and the promotion of the manual in many APA journals and in the popular press, it would have been hard to reject the new product.[139]

The exclusion of the concept of neurosis, presented by Spitzer as relatively innocuous, had actually stood in the way of DSM-III's approval by the APA Board

of Trustees. In order to get it approved, Spitzer, in a "by-now familiar manner of compromising without giving up anything of real importance," had to agree (as a result of negotiations) to include a statement of clarification of the concept in the manual's introduction.[140]

The statement explained that when Freud coined the term psychoneurosis, he was referring to four subtypes, namely anxiety neurosis, anxiety hysteria (phobia), obsessive compulsive neurosis, and hysteria proper. He used the term psychoneurosis both descriptively, to indicate a painful symptom as well as to indicate etiological process, or the notion of unconscious conflict underpinning anxiety and leading to defense behaviour and symptom formation (see Chapter 5).[141] But because the definition of neurosis was ultimately not agreed upon among clinicians, it was decided to dispense with the concept "neurosis." DSM-III introduced the term "neurotic disorder" on one hand to be used descriptively to reflect a symptom or group of symptoms distressing to the individual. The term "neurotic process" was meant to reflect the etiological process, *supposedly* irrespective of which theoretical framework for understanding the development of neurotic disorders that a given physician chooses to adopt.[142] As a result, Neurotic Disorders were cross-listed to chapters on Affective, Anxiety, Somatoform, Dissociative, and Psychosexual Disorders.[143]

So what becomes of "agoraphobia" in all of this? It resides in the Anxiety Disorders section, under the subcategory "phobic disorders" (or phobic neuroses), but now with its very own designation. (Recall DSM-II, where the subcategory "Phobic neurosis" was all of one paragraph that did not mention agoraphobia specifically.) In DSM-III anxiety is defined sometimes as the predominant

disturbance, and sometimes the result of trying to overcome particular symptoms (such as a phobia). Phobic disorders are defined by a "persistent and irrational fear of a specific object, activity, or situation that results in a compelling desire to avoid the dreaded object, activity, or situation (the phobic stimulus)."[144] The manual acknowledges that many people harbour irrational fears of certain things, like spiders. When such fears and concomitant avoidance behaviour infringe upon their social role and social functioning, however, then a diagnosis of Phobic Disorder is appropriate.[145] Agoraphobia is considered the most severe and common type of Phobic Disorder among those seeking treatment, the others being social and simple phobias (the most common in the general population).[146]

The new manual was, by comparison, a significant expansion on DSM-II's one-paragraph outline of phobic neurosis, offering a total of 1.5 pages dealing specifically with Agoraphobia with and without Panic Attacks.[147] Although Agoraphobia without Panic Attacks is outlined in relatively comprehensive terms, what remains unclear is why it is distinguished from Agoraphobia *with* Panic Attacks, which has no accompanying text. It is noted under Agoraphobia without Panic Attacks that initially agoraphobia often begins with recurrent panic attacks, but we are asked to look under the subsection "Anxiety States (or Anxiety Neuroses)" and sub-sub category "Panic Disorder" a few pages later. There it states that when the individual becomes reluctant to be alone or in public places away from home due to an anticipatory fear of helplessness or loss of control during a panic attack, then the diagnosis of Agoraphobia with Panic Attacks is warranted.[148] The sense here is that Panic Attacks may lead to agoraphobia, that agoraphobia is actually a *complication* of Panic Disorder, the primary condition.

Back in the category of Agoraphobia without Panic Attacks, where agoraphobia is evidently the primary (and only) condition, it is stated that the essential feature of this disorder is a "marked fear of being alone, or being in public places from which escape might be difficult or help not available in case of sudden incapacitation."[149] "[M]ore frequently diagnosed in women",[150] avoidance behaviour of this type gets in the way of normal activities, such as being in crowds, on busy streets, in crowded stores, or being in tunnels, on bridges and elevators, or public transport.[151] As we've seen in many of the clinical articles, agoraphobic individuals often need a companion when they leave home.

At this point the distinction being made between Agoraphobia with Panic Attacks and Panic Disorder with Agoraphobia becomes somewhat difficult to follow. About Agoraphobia without Panic Attacks the DSM-III states:

> Often the initial phase of the disorder consists of recurrent panic attacks.[...] The individual develops anticipatory fear of having such an attack and becomes reluctant or refuses to enter a variety of situations that are associated with these attacks. When there is a history of panic attacks (which may or may not be currently present) associated with avoidance behaviour, the diagnosis of Agoraphobia with Panic Attacks should be made. Where there is no such history (or this information is lacking), the diagnosis of Agoraphobia without Panic Attacks should be made.[152]

The language used here and in the text that follows is decidedly ambiguous. For instance, a history of panic attacks *may or may not be* currently present. Depression, anxiety rituals, compulsions, ruminations are *frequently* present but agoraphobia without panic attacks *is not due to* any of these. Age at onset is the late teens or early 20s, *but it can be much later*. The activities dreaded by the individual *may change from day to day*. The individual *may be housebound*. Avoidance of certain situations *may grossly interfere with functioning*. All of

these ambiguities lead me to wonder why *this* diagnosis and not *another* in any given diagnostic encounter. It also leads me to wonder just how useful for diagnosis the manual really is. If clinicians are instructed to "use the diagnostic criteria as guides in making diagnoses"[153] – in other words, as a checklist of sorts – then just how helpful can a set of hazy "maybes" really be? I can imagine that at some level the categories might be useful. It's important, for example, to know that someone is agoraphobic and not a kleptomaniac. But once the classification scheme starts to get narrower and more specific, delineating certain numbers of criteria that have to be met and so on, it becomes difficult to imagine that the DSM has any merit beyond offering codes for third-party billing and the acquisition of research funds. Finally, while it is true that the proverbial alarm bells would sound if anything more definitive than "may" were used in this veritable inventory of signals to pathology, it is nonetheless still amazing that with all its known ambiguities and contradictions, the manual is so widely utilised. Peddled as an improvement over DSM-II, this expanded catalogue of mental disorders, the DSM-III, like its successors, is big business – a psychiatric "bible" indeed.[154]

The DSM-III-R

Another frame in "'the ongoing process of attempting to better understand mental disorders.'"[155]

DSM-III was extremely successful.[156] It was widely adopted as "the common language of mental health clinicians and researchers"[157] and became a framework for many major psychiatric textbooks. As we shall see in the next chapter, published clinical articles made extensive reference to aspects of DSM-III and it had considerable international influence.[158]. Still, the APA decided to treat DSM-III as

only one step in the scientific process and in so doing they effectively muted the force of criticism and deflected opposition.[159] Spitzer, Chair of the Work Group to Revise DSM-III, wrote in his introduction to DSM-III-R:

> In 1983 the American Psychiatric Association decided, for several reasons, to start work on revising DSM-III. For one, data were emerging from new studies that were inconsistent with some of the diagnostic criteria. In addition, despite extensive field testing of the DSM-III diagnostic criteria before their official adoption, experience with them since their publication had revealed, as expected, many instances in which the criteria were not entirely clear, were inconsistent across categories, or were even contradictory. Therefore, all of the diagnostic criteria, plus the systematic descriptions of the various disorders, needed to be reviewed for consistency, clarity, and conceptual accuracy, and revised when necessary.[160]

What better way to deal with the criticisms of DSM-III than to construct them as the fodder for self-reflection? With the decision to start revisions so soon after DSM-III's 1980 release despite the fact that DSM-IV was already scheduled to be released in 1990, the provisional DSM-III was protected as a "moving target"[161] – that much more difficult for critics to knock down.

The process of revising DSM-III was much the same as for DSM-II. Adopting the goals that had guided the development of DSM-III (outlined above), a Work Group was appointed, its members "selected to ensure a broad representation of clinical and research perspectives."[162] Twenty-six advisory committees were formed, each with expertise in and responsibility for a particular area.[163] Most proposals for revisions came from members of these committees but some came from other professional experts outside the committees.[164] For the most part clinical experience with the DSM-III criteria dictated any fine-tuning that was required. For example,

> the DSM-III criteria for Panic Disorder did not permit giving the diagnosis (as the Anxiety Disorders Advisory Committee agreed they should) to peo-

> ple who had only a single panic attack followed by agoraphobic avoidance.[165]

But some proposals also came from reconsideration of DSM-III decisions, from research studies that had evaluated DSM-III criteria, and from experiences with its structured diagnostic interviews.[166] Empirical data supporting various proposals was given the most emphasis in decisions as to whether or not to make changes. But in the absence of data – indeed, "for most proposals, data from empirical studies were lacking"[167] – other things were taken into consideration instead. These included

> clinical experience, a judgement as to whether the proposal was likely to increase the reliability and validity of the diagnosis under consideration; or, in the case of a new diagnosis under consideration, the extent of the research support for the category as contrasted to its perceived potential for abuse.[168]

Seemingly in response to previous criticisms (and in anticipation of still more), Spitzer makes a weak attempt to try and disengage from the sheer profitability of the DSM categories, if not the DSM itself. Ironically he writes:

> It should be noted that in all of the discussions regarding the revision of the over two hundred DSM-III categories, the possible impact of a proposal on reimbursement for treatment was mentioned only with regard to three of the categories. Furthermore, that issue did not play a major role in the relevant decisions.[169]

Two drafts of DSM-III-R were written and distributed for critical review. Three national field trials were conducted for the development of diagnostic criteria for a number of diagnoses, including Generalised Anxiety Disorder and Agoraphobia without History of Panic Disorder. Spitzer states that an Appendix describing each field trial and a list of participants is included at the back of DSM-III-R,[170] but a look at these pages reveals that the only thing especially informa-

tive about them is the lists of participants. There is merely a sort blurb describing the objective of each field trial and the number of subjects – that is, nothing about results. Indeed, Kutchins and Kirk allege that "[i]n fact, no new reliability studies were conducted, and the reliability appendix symbolically included in DSM-III was dropped when DSM-III-R was published."[171]

Finally, in 1985 an ad hoc committee was appointed to help the Work Group deal with controversies that arose in response to the revision. Spitzer does not specify that it was actually *feminist* psychiatrists who had "expressed concerns" (his words) about the proposed inclusion of three new psychiatric disorders, namely Paraphilic Rapism, Premenstrual Dysphoric Disorder, and Masochistic Personality Disorder.[172] In May, 1987, the revised manual, marginally bigger than DSM-III at nearly 570 pages, was released *with* several new categories, *without* several others, and a new take on the relation between the individual and society.

First, the "individuals" of DSM-III are now termed "people", as in: a "common misconception is that a classification of mental disorders classifies *people*, when actually what are being classified are disorders that people have."[173] In spite of this shift from the impersonal to the personal (likely an effort to stave off further criticism), I maintain that people and the mental disorders with which they are associated are not separable in the way that Spitzer would have us believe. The change in terminology from "individuals" to "people" does nothing to alter that necessary connection.

Second, whereas in DSM-III Spitzer described the disturbances in question as existing beyond the individual's relationship to society, as being indicative

of behavioural, psychological, or biological dysfunction (qtd above), in DSM-III-R, he modifies this section in an important sense with a new definition of Mental Disorder. In DSM-III-R he alters the definition by saying: "Neither deviant behavior, e.g., political, religious, or sexual, nor conflicts that are primarily between the individual and society are mental disorders unless the deviance or conflict is a symptom of a dysfunction in the person..."[174] Yet the new manual does include such things as gender identity disorder, transsexualism, and pedophilia as mental disorders. I contend that all of these instances of the individual and society have more to do with power relations, normalising discourse and oppressive social structures than with mental illness, and as Cooksey and Brown so aptly put it, diagnosis is an important arena of struggle and diagnosis serves as a social gatekeeper.[175]

Moreover, as with the DSM-III, a section is included at the back of the manual called "V Codes for Conditions Not attributable to a Mental Disorder That Are a Focus of Attention or Treatment." There, problems "not attributable to a mental disorder" but still requiring "professional attention or treatment" are listed.[176] These could be academic problems, marital problems, and even bereavement is listed. Despite the section's title and the 4-line explanation for its inclusion contained within the manual's introduction, simply by virtue of naming these not-quite-mental disorders, the normative structure is there and being invoked. This is especially so given that in some instances "the scope of the diagnostic evaluation has not been adequate to determine the presence or absence of a mental disorder."[177] In Cooksey and Brown's words, "It is indeed odd for a manual of psychiatric disorders to include codes for non-psychiatric ones,"[178]

unless its real purpose is help distinguish between "real" mentally ill individuals and malingerers.

As for agoraphobia, its diagnostic parameters, once again, have been modified and several options for classifying agoraphobia are offered in this six-and-a-half page[179] section on "Anxiety Disorders (or Anxiety and Phobic Neuroses)". Panic disorder has now been subdivided into Panic with agoraphobia (300.21)[180] or without agoraphobia (300.01). The previous category Agoraphobia with Panic Attacks (300.21) has been eliminated and Agoraphobia without Panic Attacks modified to become Agoraphobia without History of Panic Disorder (300.22) instead. Whereas in DSM-III agoraphobia was the most common disorder among those seeking treatment,[181] in DSM-III-R it is said to be Panic Disorder. Also, it is noted: "It is unclear whether Agoraphobia without History of Panic Disorder with limited symptom attacks represents a variant of Panic Disorder with Agoraphobia, and whether the same disorder without limited symptom attacks represents a disorder that is unrelated to Panic Disorder."[182] It certainly is unclear, but what is especially unclear is when the two appear together, how and when to decide which is the primary problem – the panic disorder or the agoraphobia?[183] Presumably it is the difference between meeting less than four or more than four criteria.

In the DSM-III-R version of agoraphobia, it is observed that the diagnosis is more commonly made in females than in males, and most commonly begins in the 20s or 30s.[184] That the diagnosis is more common in females raises the question as to what extent the DSM has itself made that inevitable – to what extent is the DSM not only descriptive, but prescriptive? Although after World War I the

prevalence did shift from men to women, it could as easily have shifted back, but didn't. Although referring specifically to DSM-IV, Kupers also questions the gender distribution of mental disorders in DSM, arguing that they reflect gender stereotypes and perhaps "serve to create an upper limit for the very characteristics that are socially encouraged in each gender."[185] Mental illnesses are diagnosed in those who do not conform to prescribed social roles.[186] As Kupers goes on to say:

> It is a little like the college and pro football teams that encourage players to be hyper-aggressive and then have to discipline some of them when they draw negative publicity by raping women after a game. The mental disorders typically assigned to men, like the fines assigned for the overly aggressive football players, serve to keep the lid on the very behaviors that are being encouraged.[...]There is little if any support for creating new, improved forms of masculinity and femininity in [DSM-III].[187]

Moreover, since the release of DSM-III, the number of reported cases of agoraphobia overall has increased significantly and the largest proportion of this literature reflects a prevalence of this diagnosis among women, suggesting that the category has in large part created its object, and not the other way around.

Additionally, that age of onset of agoraphobia in DSM-III-R is most commonly the 20s or 30s, up from late teens and early 20s in DSM-III, apparently reflects the trend towards later age at first marriage increasingly common in the West in the past few decades.[188] It also corroborates Durkheim's observation of more than a century ago, that marriage is not as good for women as it is for men.

Finally, to return to the issue raised above regarding the individual's relationship to society, in the DSM-III-R version of Agoraphobia (without History of Panic Disorder), compared with DSM-III, an important new criterion seems to be the element of embarrassment.[189] Specifically, DSM-III-R states:

> The essential feature of this disorder is Agoraphobia without a history of Panic Disorder. Agoraphobia is the fear of being in places or situations from which escape might be difficult (or embarrassing), or in which help might not be available in the event of suddenly developing a symptom(s) that could be incapacitating or extremely embarrassing. [...] Usually the person is afraid of having a *limited symptom attack*, that is, developing a single or small number of symptoms...[190]

The issue of possible embarrassment is not mentioned in DSM-III, but its inclusion in DSM-III-R suggests a very obvious issue in the relation between the individual and society; there could be no sense of embarrassment without a social order of conduct defining what constitutes normal or embarrassing behaviour. Its inclusion also raises the important question of *why now*? Did women's increasing equality mean that agoraphobia was becoming embarrassing in a way that it would not have been before? The embarrassment component is also very interesting when considered in light of the fact that in DSM-III-R, there is an absence, once again, of empirical evidence. Allan Compton, writing quite recently about the "DSM system," charges that many of its categories "are based on assumptions unsupported by empirical data." In particular, he targets the description of agoraphobia just related for containing "such a complex mixture of ideas that it is difficult to see even how it *might* be evaluated." He goes on to unpack this definition:

> The statement implies something like the following: a particular situation, or the approach to such a situation, activates (1) a belief that a panic attack may occur; (2) a belief that helplessness may occur, apparently on account of the anticipated panic attack; (3) that one type of adaptive behavior, escape, may be prevented by (a) difficulty or (b) embarrassment; and (4) a belief that a second type of adaptive behavior, help-seeking on account of an anticipated helplessness, will be thwarted because help will not be available in the situation.

He concludes that "At least four beliefs, associated with two possible types of possible relief behavior are included in a statement for which no documentation whatever has been supplied." Moreover, the "hypothesis, in addition to being undocumented, appears to be untestable."[191]

The main point I've tried to convey in this discussion of agoraphobia as seen by DSM-III and DSM-III-R is that the manuals' descriptions of this condition really are not all that helpful. In fact, they are utterly confusing, especially when trying to account for the differences between them (differences that Spitzer and the APA try to pass off as scientific advancements). As we shall see in the next chapter, it is no wonder that so many clinical articles were published that deal with and critique the DSM categories themselves. For now, let's turn to the DSM-IV.

DSM-IV

Despite controversy about whether or not a new DSM was needed,[192] the first meeting to discuss the release of DSM-IV was held only months after the release of DSM-III-R. A Task Force was established, now headed by Allen Frances, out of which 13 Work Groups, each responsible for a section of the new manual, was developed. Unlike Spitzer's handling of DSM-III-R, Frances appears to have been less concerned to control the outcome of the Work Groups and did not serve on any of them. In the meantime, the World Health Organization's *International Classification of Diseases and Related Health Problems* (ICD-10) had been published and those working on the two projects tried as much as possible to coordinate their efforts.[193]

By this time medicine was firmly evidence-based, and its sub-field in psychiatry was no exception. To this end, the DSM-IV Task Force established a formal evidentiary process for its Work Groups to follow. This was a three-stage process consisting of an expansive review of existing literature, re-analysis of existing data sets, and extensive (twelve) issue-specific field trials.[194] Unlike its predecessors that made any follow-up impossible due to the absence of citations, a five-volume *DSM-IV Sourcebook* was created, containing condensed versions of the literature reviews, reports of the data re-analyses, reports of the field trials, and a final summary of the rationale for each Work Group's decisions.[195] And, so as to avoid controversy and conflict, Frances stipulated a basic rule not to accept any changes to the DSM without an explicit rationale and sound empirical support.[196]

At first glance this appears to be a step in the right empirical direction, given the flawed empirical foundations upon which DSM-III and III-R were based. Yet the implication of Frances' policy was that in the absence of evidence, the questionable categories of DSM-III- and DSM-III-R were actually institutionalised by default.[197] In any case, against call for renewed empiricism, the 900 page DSM-IV was published in 1994 with hundreds of departures from DSM-III and just as many conformities.

The manual's near doubling in size results not only from the inclusion of new disorders and more information about them, but also from the inclusion of such things as an annotated listing of changes in DSM-IV and an outline of indigenous (culture-bound) syndromes. While DSM-III-R had displayed some cultural sensitivity in its section "Cautions in the Use of DSM-III-R", it had not

elaborated the issue nearly to the same extent as in DSM-IV. Yet despite this increase in cultural sensitivity, it is evident that the DSM-IV still suffered from some cultural myopia. Women have historically been more likely to be diagnosed with depression, phobias, and histrionic personality disorders, and men to be diagnosed with paranoid personality and antisocial disorders. Certain mental illnesses are explained in terms of innate racial differences, and there is a tendency for more middle-class articulate persons – people who are just like their doctors – to be taken on as clients.[198] These culturally-based issues are not examined; it would seem that "people view more seriously the abnormality or rule-breaking of those who are different from them."[199]

One especially noteworthy inclusion was an almost apologetic acknowledgement – bordering on postmodern – to the definition of mental disorder: There it is noted that there is an "unfortunate" distinction between physical and mental disorders, a "reductionistic anachronism of mind/body dualism" that the Task Force has no choice but to retain until an appropriate substitute is found.[200] Taking this disclaimer further, the editors[201] continue:

> ...although this manual provides a classification of mental disorders, it must be admitted that no definition adequately specifies precise boundaries for the concept of 'mental disorder'. The concept of mental disorder, like many other concepts in medicine and science, lacks a consistent operational definition that covers all situations. All medical conditions are defined on various levels of abstraction...[...] Each is a useful indicator for a mental disorder, but none is equivalent to the concept, and different situations call for different definitions.[202]

Nonetheless, they have retained the definition of mental disorder because it is "as useful as any other available definition" and has been helpful with regard to "which conditions on the boundary between normality and pathology" should be

included in DSM-IV.[203] With this, DSM-IV, following from DSM-III and III-R, stands by the claim to be classifying disorders, not their hosts.[204] The following remarks made under the heading "Limitations of the Categorical Approach" supports this:

> ...naming of categories is the traditional method of organizing and transmitting information in everyday life and has been the fundamental approach used in all systems of medical diagnosis. A categorical approach to classification works best when all members of a diagnostic class are homogeneous, when there are clear boundaries between classes, and when the different classes are mutually exclusive.[...] The clinician using DSM-IV should...consider that individuals sharing a diagnosis are likely to be heterogeneous even in regard to the defining features of the diagnosis and that boundary cases will be difficult to diagnose in any but a probabilistic fashion.[205]

Turning now to DSM-IV's section dealing with agoraphobia, the major section, simply "Anxiety Disorders", begins with a brief summary of all the conditions included within it. Notably the term "neurosis", looking for a home in the last revision, has been completely banished from this edition.

Agoraphobia by itself is "not a codable disorder"; it occurs in the context of Panic Disorder With Agoraphobia and Agoraphobia Without History of Panic Disorder.[206] Nevertheless, DSM-IV contains 1.5 pages, including – unlike DSM-III-R – a discussion of its "features" and a summative list of criteria on "Agoraphobia" before embarking upon the various distinctions and its relationship to Panic Disorder. The description of agoraphobia is essentially the same but it is now noted that "[i]ndividuals' avoidance of situations may impair their ability to travel to work or carry out homemaking responsibilities (e.g., grocery shopping, taking children to the doctor)".[207] In contrast, DSM-III notes an "increasing constriction of normal activities"[208] while in DSM-III-R "Panic Disorder with Agora-

phobia, by definition, is associated with varying degrees of constriction in lifestyle." Severity of agoraphobic avoidance ranged in this edition from "mild," denoting the ability a "relatively normal lifestyle" and the ability to travel alone as necessary such as to get to work and to shop, to "severe," or being "nearly or completely housebound or unable to leave the house accompanied."[209]

The uncertain boundary between agoraphobia and simple and social phobias is also acknowledged in DSM-IV: "The differential diagnosis...can be difficult because all of these conditions are characterized by avoidance of specific situations."[210] This difficulty is, however, more or less dismissed with the unqualified assertion that "anxiety or phobic avoidance is not better accounted for by another mental disorder."[211] Only after several pages does the reader receive guidance on distinguishing between them, and even then it is noted that "[s]ome presentations fall between...prototypes and require clinical judgement in the selection of the most appropriate diagnosis."[212]

From there the section moves to Panic Disorder. New inclusions are a much expanded section on "Associated Features and Disorders" (including descriptive features and mental disorders, laboratory findings, and physical examination findings and general medical conditions), "Specific Culture and Gender Features", and "Familial Pattern". Diagnosis with or without agoraphobia is made accordingly, [213] but concerns about a future panic attack or its implications often lead to the development of avoidance behaviour that then qualifies the individual for a diagnosis of Panic Disorder with Agoraphobia.[214] That said, "[s]ome cultural or ethnic groups restrict the participation of women in public life, and this must be distinguished from Agoraphobia."[215] Panic Disorder Without Agoraphobia is

said to be diagnosed twice as often in women than in men, while Panic Disorder With Agoraphobia is diagnosed three times as often. Onset of Panic Disorder is said to be typically between late adolescence and mid-30s, but can sometimes occur earlier or later. Agoraphobia, if it develops, usually occurs within a year of recurrent Panic Attacks.[216] In short, the relationship between agoraphobia and Panic Disorder as it is laid out is vague and difficult to follow:

> The course of agoraphobia and its relationship to the course of Panic Attacks are variable. In some cases, a decrease or remission of Panic Attacks may be followed closely by a corresponding decrease in agoraphobic avoidance and anxiety. In others, Agoraphobia may become chronic regardless of the presence or absence of Panic Attacks.[217]

Unlike previous editions, DSM-IV goes on to talk about prognosis following treatment[218] and the contribution of genetics to the development of Panic Disorder. Following an extensive discussion of differential diagnosis (especially noteworthy is the instruction for how to choose between Panic Disorder, Social Phobia, and Specific Phobia), the diagnostic criteria for Panic Disorder Without Agoraphobia and diagnostic criteria for Panic Disorder With Agoraphobia are conveniently listed in user-friendly bullet lists. Then, we come to Agoraphobia Without History of Panic Disorder.

It remains unclear why there is no category "Agoraphobia with History of Panic Disorder", i.e., why Panic Disorder is primary when the two occur together. In DSM-III, code number 300.21 *was* Agoraphobia with Panic Attacks.[219] That code became Panic Disorder with Agoraphobia in III-R. DSM-IV offers the following confusing distinction between them:

> The essential features of Agoraphobia Without History of Panic Disorder are similar to those of Panic Disorder With Agoraphobia except that the focus of fear is on the occurrence of incapacitating or extremely embar-

> rassing panic-like symptoms or limited-symptom attacks rather than full Panic Attacks. Individuals with this disorder have Agoraphobia (see p. 396) (Criterion A). The 'panic-like' symptoms' include any of the 13 symptoms listed for Panic Attack (see p. 394) or other symptoms that may be incapacitating or embarrassing...[220]

What is especially troubling about this distinction is that it is made on the basis of how many symptom criteria are met in the course of a panic attack, that is whether small or major. The distinction is clear, obviously, if there are no panic symptoms. But what if each panic attack is different? What if someone has several but is just shy of enough symptoms to bump them over the line? The manual would say that clinical judgement is in order, but then the question becomes, what is the point of having a "scientific" classification system then? Can it ever be more than a loose guideline?

Finally, specific Culture and Gender Features are noted, but less specifically than they were with Panic Disorder, as in "[t]his disorder is diagnosed far more often in females than in males."[221] (It makes me wonder if the work group responsible for this section was also having difficulty developing their categories.) Ultimately, "[r]elatively little is known about the course of Agoraphobia Without History of Panic Disorder."[222]

In the name of scientific validity and progress, the DSM has become more, not less, complicated. There is, to be sure, a notable correspondence between the associated features described here and the literature available. In other words, a search of Medline does yield many articles dealing with several of the features observed in the DSM. The question remains, however, as to why the DSM-IV does not include citations for any of this literature, and to what extent the results of studies conducted after the release of DSM-IV may have been skewed by DSM-

IV's arguably prescriptive claims. In other words, what comes first in this literature – the DSM categories or the shape and outcome of these trials? And as Scott observes in his history of the inclusion of Post-Traumatic Stress Disorder [PTSD] in DSM-III, theories "represent competing sets of assumptions that are inseparable from the interpretation of the evidence taken to support those theories and prediction."[223] With the addition of new categories and criteria in each successive DSM it is increasingly difficult to believe that this manual could be helpful in any classification situation. Approximations? Yes. Clear distinctions? Not by a long-shot. As we shall see in the next chapter, I am not the only person who thinks so. For now, let's turn to the most recent revision to DSM, released in the year 2000.

DSM-IV-TR

DSM-IV-TR, roughly the same size as DSM-IV, is described as a "text revision". With DSM-V not expected for another six years, it was decided that this was an interval too long to wait without updating the information in the text to be consistent with current research.[224] The goals of this text revision included:

- correcting any errors in DSM-IV
- ensuring all information therein was up to date
- incorporating information acquired since the literature reviews for DSM-IV were completed in 1992
- enhancing the educational value of DSM-IV
- updating the ICD-9 codes changed since the DSM-IV Coding Update.[225]

Following from the protocol established with DSM-IV, all changes had to be supported with empirical data (which raises the issue again of the reification of problematic criteria by virtue of no evidence being available). "No substantive changes in the criteria sets were considered,"[226] thereby limiting all revisions to

the text sections only. No proposals for new disorders, subtypes, or changes in the appendix categories were entertained.

The process of revising the text of DSM-IV began in 1997 and followed roughly the same pattern as previous versions with the establishment of a Task Force and specialised Work Groups to deal with each section. Comprehensive literature reviews of research published since 1992 were carried out. Each Work Group drafted proposed changes where necessary, accompanied by written justifications for the changes along with relevant references (which, as usual, are not included in the DSM-IV-TR). Following review at various levels final drafts were produced and eventually approved by the American Psychiatric Association's Committee on Psychiatric Diagnosis and Assessment.[227] Most changes, deriving from evidence based on literature reviews, were in the sections Associated Features and Disorders, Culture, Age, Gender, Prevalence, Course, and Familial Patterns. In some cases the Differential Diagnosis section was also expanded. DSM-IV-TR does not present as a new edition of DSM, even though technically, it is not the same as DSM-IV. In other words, in all references to itself, it refers to DSM-IV rather than DSM-IV-TR, making it difficult to clearly distinguish where DSM-IV stops and DSM-IV-TR begins.

In any event, there are some changes to the section on Anxiety Disorders and agoraphobia. The text delineating types of Panic Attacks and their association with specific anxiety disorders is updated. Information about triggers to panic attacks is expanded, as is the list of associated medical conditions, the account of prevalence, familial patterns, and differential diagnoses. Agoraphobia on its own is still "not a codable disorder", and must be coded in relation to the spe-

cific disorder in which it occurs.[228] Agoraphobia Without History of Panic Disorder retains essentially the same features as Panic Disorder with Agoraphobia except that the focus of the fear is on the possibility of developing embarrassing symptoms while outside and not being able to get help.[229] (Indeed, to be diagnosed with Agoraphobia without History of Panic Disorder, the *full* criteria for Panic Disorder must never have been met. Thus the number of panic-like symptoms remains less than four).

Conclusion

It remains to be seen how the criteria for agoraphobia and other disorders play out in DSM-V, expected within the decade. In the meantime, however, with each new edition the DSM has become almost palatable and even trustworthy – which ends up meaning more "scientific." Empirically, conceptually, and politically, however, the DSM is still problematic.

As we have seen, the DSM diverts attention from socio-cultural factors and emphasises a positivistic rather than interpretive approach. This results in a kind of diagnostic determinism as well as a narrowing of the psychiatric gaze to exclude depth of mind (the unconscious), time (the unfolding of a life over time), and reduction in content of clinical concern.[230] Established by insurers, government, mental health agencies, a mental disorder only becomes official when the proper DSM code is assigned. The DSM's ahistorical approach fails to consider disorders within their cultural context.[231] The scientific imperative directs attention towards gathering more data, yet the manual includes no citations, at least none that are readily accessible. A social/historical model would ask how social

interests determine views on psychopathology and scientific progress.[232] As Kupers asks, why do certain things get pathologised and not other things and why, for example, isn't homophobia pathological, rather than homosexuality? I could ask along similar lines, why is agoraphobia pathological, when there are lots of good reasons, such as violence, for women to fear being out? Why is there no such category as "domestophobia", for men who do not come home, or who may as well not come home because they do not contribute to household labour and are emotionally unavailable when they are home? *Why is there no such thing as "fear of home"?* With more women participating in the process, the deletion of homosexuality, the defeat of masochism, and the inclusion of sections on ethnic and racial difference, the newest DSMs *are* improved insofar as they demonstrate some cognisance of cultural conditions at work in a given mental illness situation. But, the manual is undeniably longer, more complex and difficult to understand, and "psychiatry has little or nothing to say about the social ramifications of its pathologizing."[233] Indeed, I agree with Nash and Chrisler who argue that "psychiatric knowledge can be a dangerous thing."[234]

Notes

[1] Kutchins and Kirk, 1997:39.
[2] Kutchins and Kirk, 1997:39.
[3] American Medico-Psychological Association, 1918:3.
[4] In addition to a classification of mental disease, the manual also contained several tables to assist institutions with their classifications. These tables included financial information, nativity, citizenship, and race. The latter was based on a (fascinating) *Dictionary of Races or Peoples* published by the US Immigration Commission in 1911. We shall look at issues of immigration and race in more detail in Chapter 9.
[5] American Medico-Psychological Association, 1920:3.
[6] American Medico-Psychological Association, 1920:4.
[7] American Medico-Psychological Association, 1920:4.
[8] Kutchins and Kirk, 1997:39.
[9] Kutchins and Kirk, 1997:39.
[10] These were the only editions that I could obtain.
[11] The Foreword to each revised edition reflects how the distribution of responsibility shifted over time.
[12] American Psychiatric Association [henceforth APA]: 1934:3.
[13] Logie, 1933:xii.
[14] Logie, 1933:xi.
[15] Logie, 1933:xi.
[16] Logie, 1933:xi.
[17] Logie, 1933:xii. See also Kutchins and Kirk, 1997:39. Kutchins and Kirk cite 1935 as the year of the first edition; in fact this was the second edition.
[18] Logie, 1933:xii. An abridged version was even published, for use in small hospitals and communities, but was subsequently rejected on the grounds that abridgement meant that some diseases had to be omitted and it failed to meet the needs of Public Health Service and Military Medical Departments (Logie, 1933:xiii).
[19] Jordan, 1942:vii.
[20] Jordan, 1942:viii.
[21] APA, 1952:vi-vii.
[22] APA, 1952:ix-x.
[23] APA, 1952:1.
[24] Kutchins and Kirk, 1997:24. See also pp. 37-40, 57, 247.
[25] Kutchins and Kirk, 1997:57.
[26] APA, 1952:6.
[27] APA, 1952:9; my emphasis, meant to underscore that the terms are conflated.
[28] APA, 1952:12.
[29] APA, 1952:31.
[30] APA, 1952:32.
[31] APA, 1952:32.
[32] APA, 1952:33.
[33] APA, 1968:ix.
[34] APA, 1968:v.
[35] APA, 1968:134.
[36] Kutchins and Kirk, 1997:41. See the DSM-II (p. 121) for a "Guide to the New Nomenclature" by Spitzer and Paul T. Wilson, who, in their preamble, state that the "purpose of this article is to facilitate the transition by explaining how the new manual differs from the old one and how in many ways it is improved" (APA, 1968:120). "New and improved" would effectively become the DSM's mantra.
[37] APA, 1968:ix.
[38] Kutchins and Kirk, 1997:40.
[39] Kutchins and Kirk, 1997:41.
[40] Kutchins and Kirk, 1997:41.

[41] Kutchins and Kirk, 1997:247.
[42] In contrast, editions since the DSM-II have been considered "a major repository of knowledge of mental disorders, as a distillation of the major literature reviews and field trials, and as the product of more than a thousand consultants and as many committee meetings, ... promoted by endless journal articles and promotional newsletters" (Kutchins and Kirk, 1997:247). "The essence of *DSM*'s scientific contribution is a method of identifying mental disorders through the use of checklists of specific behaviors, the diagnostic criteria" (Kutchins and Kirk, 1997:247).
[43] APA, 1968:2-3, 122-4; Kutchins and Kirk, 1997:41.
[44] APA, 1968:3-4; Kutchins and Kirk, 1997:41.
[45] APA, 1968:9.
[46] APA, 1968:122.
[47] APA, 1968:123.
[48] APA, 1968:40.
[49] APA, 1968:40.
[50] Primary care publications are also represented to some extent, owing in part to the pressure on family physicians to publish for the purposes of tenure and promotions. See Duffin, 1999:354-5.
[51] This represents an increase of 5% over sales in 1997. In Canada, which represents less than 2% of the world market, total manufacturers' sales increased to approximately $7.8 billion, up 11.4% from 1997 (Patented Medicine Prices Review Board, 1998. The US is the largest market for drugs and accounts for roughly 40 per cent of the total (Industry Canada, 1997.
[52] Latour, 1987. This insight was borrowed from Cooksey and Brown, 1998:535.
[53] Wilson, 1993:400.
[54] Wilson, 1993:402.
[55] Wilson, 1993:402. See Szasz, 1974.
[56] Scull, 1989:15.
[57] Wilson, 1993:402.
[58] Wilson, 1993:403.
[59] Wilson, 1993:404.
[60] Cooksey and Brown, 1998:531.
[61] Spitzer writes that the first DSM was "the first official manual of mental disorders to contain a glossary of descriptions of the diagnostic categories. The use of the term 'reaction' throughout the classification reflected the influence of Adolf Meyer's psychobiological view that mental disorders represented reactions of the personality to psychological, social, and biological factors" (1980:1). The second DSM started to avoid the term "reaction" in order to get away from implying a particular theoretical framework for understanding the nonorganic mental disorders (1980:2). By DSM-III the break from this perspective is much more clear and definite. See also Cooksey and Brown, 1998.
[62] Cooksey and Brown, 1998:531.
[63] Peterson and Sicherman, 1995:34.
[64] See Bowker and Star's analysis of the ICD as an important informational infrastructure (1999).
[65] Rogler, 1997:17. See also Cooksey and Brown, 1998:525-6.
[66] Scott, 1990:294.
[67] Scott goes on to say: Two types of error thus may result in the application of these official diagnoses: well persons may be diagnosed as sick, and diseased ones may be misclassified or considered healthy. See Scott, 1990:308.
[68] Survey cited in Wilson, 1993:399.
[69] Yet, given the later DSMs claims to being research based (at least in terms of revisions), it is also the case that this relationship was mutually influential to some extent.
[70] Bowker and Star, 1999:44.
[71] Bowker and Star, 1999:196.
[72] APA, 1980:1.
[73] *DSM-II* was a mere 134 pages.
[74] APA. 1980:1.
[75] In both the spirit of progress and in seeming concession to the fallibility of the APA, Spitzer's final remark in his introduction reads as follows: "In the several years that it has taken to develop

DSM-III, there have been several instances when major changes in initial drafts were necessary because of new findings. Thus, this final version of DSM-III is only one still frame in the ongoing process of attempting to better understand mental disorders" (12).
[76] APA, 1980:1.
[77] Kutchins and Kirk, 1997:42.
[78] APA, 1980:2.
[79] APA, 1980:2.
[80] APA, 1980:2.
[81] See Bowker and Star's discussion of the relationship between classification and standardisation (1999:10-6).
[82] Rogler, 1997:10-1.
[83] Rogler, 1997:11.
[84] Rogler, 1997:14.
[85] Rogler, 1997:15.
[86] APA. 1980:2-3.
[87] APA, 1980:3.
[88] Kutchins and Kirk, 1997:43.
[89] Kutchins and Kirk, 1997:41-2.
[90] Bowker and Star, 1999:324.
[91] Kutchins and Kirk, 1997:43.
[92] Rogler, 1997:16; see also Cooksey and Brown, 1998.
[93] Young, 1995:95-96.
[94] Kraepelin, 1962 [1918]:151-5.
[95] Porter, 1997:512.
[96] Rogler, 1997:11.
[97] Rogler, 1997:17.
[98] Kutchins and Kirk, 1997:42.
[99] Cooksey and Brown, 1998:535.
[100] Kutchins and Kirk, 1997:42.
[101] Rogler, 1997:18.
[102] Kutchins and Kirk, 1997:42.
[103] Rogler, 1997:5.
[104] Cooksey and Brown, 1998:526.
[105] Cooksey and Brown, 1998:530.
[106] Kutchins and Kirk, 1997: 43.
[107] As I discuss below, Spitzer served on practically every subcommittee.
[108] Kutchins and Kirk, 1997:43.
[109] Kutchins and Kirk, 1997:43.
[110] Interview with W. Frosch by Mitchell Wilson cited in Wilson, 1993:405.
[111] Kirk and Kutchins, 1992.
[112] APA, 1980:4. Arguably tokenist, however, there was a marked "lack of diversity among the people providing input and making the final choices (mostly white male North American psychiatrists)" (Caplan, 1995:197). See also Terry Kupers (1995) who observes that people in power determine what constitutes mental disorder among those over whom they have power. With reference to the debate that took place over the inclusion of "premenstrual syndrome", Kupers goes on to ask: "...is it merely coincidental that just when middle-class women are entering the workplace in record numbers, premenstrual syndrome is declared a form of mental disorder" (1995:69)?
[113] APA, 1980:8.
[114] Rogler, 1997:12. This vagueness would continue with DSM-IV in the sense that diagnostic categories are less exclusive, making it less necessary to rule out one category in order to diagnose in terms of another. As a consequence, the assignment of two or more "comorbid" diagnoses becomes more common (Kupers, 1995:68).
[115] APA, 1980:4.
[116] APA, 1980:4-5.

[117] APA, 1980:5.
[118] Despite skilled public relations, so-called research efforts by Spitzer and his colleagues intended to curtail any notion that DSM-III is unreliable and unscientific have since revealed the "research" as deeply flawed. In a study conducted to see whether pairs of therapists would agree on diagnoses, they only agreed about half the time, and this was based on only a handful of patients. Needless to say, much of the research to which the Task Force refers has never been published and is unavailable for inspection by those with questions about validity (see Caplan, 1995:197-9).
[119] Kutchins and Kirk, 1997:53.
[120] Kirk and Kutchins, 1992 (qtd in Caplan, 1995:201-2).
[121] Cooksey and Brown, 1998:533-4.
[122] Schacht in Cooksey and Brown, 1998:533.
[123] Cooksey and Brown, 1998:535.
[124] Szasz wrote in 1974 that psychiatrists "have...persisted in speaking of mysterious mental maladies and have continued to refrain from disclosing fully and frankly what they do" (1974:1).
[125] APA, 1980:5-6.
[126] APA, 1980:6.
[127] Szasz, 1974:1.
[128] APA, 1980:6.
[129] APA, 1980:6.
[130] See Gardner, 1994.
[131] Foucault, 1988:x-xi.
[132] APA, 1980:5.
[133] Cooksey and Brown, 1998:531.
[134] It is purely coincidence that the protagonist of their anecdote is insane.
[135] Bowker and Star, 1999:319.
[136] See Bowker and Star, 1999:319.
[137] Paul Fink cited in Wilson, 1993:407.
[138] Wilson, 1993:407.
[139] Kutchins and Kirk, 1997:44-5.
[140] Wilson, 1993:407.
[141] APA, 1980:9.
[142] APA, 1980:9-10. I say "supposedly" because the emphasis in DSM is on biology which *is* an etiological perspective.
[143] APA, 1980:10.
[144] APA, 1980:225.
[145] APA, 1980:225.
[146] APA, 1980:225-6.
[147] APA, 1980:226.
[148] APA, 1980:230.
[149] APA, 1980:226.
[150] APA, 1980:227.
[151] APA, 1980:226.
[152] APA, 1980:226.
[153] APA, 1980:11.
[154] Cooksey and Brown, 1998; Kutchins and Kirk, 1997.
[155] APA, 1987:xvii.
[156] APA, 1987:xviii.
[157] APA, 1987:xviii.
[158] APA, 1987:xviii.
[159] Kutchins and Kirk, 1997:46.
[160] APA, 1987:xvii.
[161] Kutchins and Kirk, 1997:46.
[162] APA, 1987:xix. Spitzer writes in his introduction that one of the major tasks of the Work Group was "to serve on advisory committees on subjects in which they had special expertise" (APA, Spit-

zer, 1987, xx). A cursory glance at the list of subcommittees at the front of the revised manual reveals that Spitzer and Janet Williams (his wife?) sat on nearly all of them. Does this mean then, that Spitzer and Williams were experts on nearly everything psychiatric? This, coupled with the fact that the APA actually excluded certain experts such as feminist psychiatrists, raises the question of how exactly the Work Group defined the concept of "representative" (see Franklin, 1987).

[163] APA, 1987:xx.

[164] APA, 1987:xx.

[165] APA, 1987:xx. Over the course of one week in the winter of 1999, I developed a migraine headache so severe that late one night, in desperation, I took myself to the Kingston General Hospital. There, they administered a course of medication by IV that caused my blood pressure to drop rapidly and resulted in a full-blown panic attack. As the nurse explained, "You're having a panic attack because your blood pressure has dropped so much, so suddenly". (Not to be confused with a "limited symptom attack" which only requires fewer than four symptoms.) Once I stopped experiencing the "sudden onset of intense apprehension, fear...terror...impending doom...shortness of breath...smothering sensations...dizziness...unsteady feelings...faintness...accelerated heart rate....trembling...shaking...sweating...abdominal distress ... depersonalisation ... derealization ... flushes ... chills ... fear of dying ... fear of doing something uncontrolled during the attack" (APA, 1987:236), the first thing I thought to myself was, "Unless I am unconscious, I am never setting foot in a hospital again." To be sure, I couldn't get out of that hospital fast enough and I made several attempts to leave that were thwarted by the nurse mentioned above. That took place nearly one year ago, the memory of that awful night still vivid enough for me to remember how it felt for my body to be that completely out of control. Vivid enough for me to still feel very strongly about ever going to a hospital willingly again. According to the new DSM-III-R criterion for Panic Disorder (a single panic attack followed by agoraphobic avoidance), my taking this position on hospitals makes me someone with a classifiable mental disorder. The thing is, I don't feel mentally ill.

[166] APA, 1987:xx.

[167] APA, 1987:xxi.

[168] APA, 1987:xxi.

[169] APA, 1987:xxi.

[170] APA, 1987:xxi-xxii.

[171] Kutchins and Kirk, 1997:47.

[172] Kutchins and Kirk, 1997:47. See also Caplan, 1995 and Franklin, 1987.

[173] APA, 1987:xxiii.

[174] APA, 1987:xxii.

[175] Cooksey and Brown, 1998:545-6.

[176] APA, 1987:xxiii.

[177] APA, 1987:359. To illustrate the implications of this section's inclusion, under the category "malingering" it states: "The essential feature of Malingering is intentional production of false or grossly exaggerated physical or psychological symptoms, motivated by external incentives such as avoiding military conscription or duty, avoiding work, obtaining financial compensation, evading criminal prosecution, obtaining drugs, or securing better living conditions. [...] Under some circumstances Malingering may represent adaptive behavior, for example, feigning illness while a captive of the enemy during wartime" (APA, 1987:360). According to these guidelines, a lot of POWs and draft dodgers were "almost" mentally ill and in need of a more comprehensive diagnostic evaluation, i.e., a sturdier category to slot them into.

[178] Cooksey and Brown, 1998:548.

[179] I include Panic Disorder with and without Agoraphobia in these 6.5 pages.

[180] Like DSM-III, this subcategory still has no accompanying text.

[181] APA, 1987:226.

[182] APA, 1987:240.

[183] Tucked into the description of Agoraphobia without History of Panic Disorder it states in "Panic Disorder with Agoraphobia, the panic attacks may be in full remission while the agoraphobia persists, but a history of Panic Disorder would preclude a current diagnosis of Agoraphobia

without History of Panic Disorder. (Note: Panic Disorder does not preclude a preexisting diagnosis of Agoraphobia without History of Panic Disorder" (APA, 1987:241).
[184] APA, 1987:240.
[185] Kupers, 1995:74.
[186] Kupers observes that emotionality and assertiveness in women, rebellion on the part of minority members, and homosexuality have all been pathologised at one time or another (1995:76).
[187] Kupers, 1995:74.
[188] *Statistical Abstract of the United States* shows: in 1970 the median age at first marriage for women and men was 20.6 and 22.5 respectively; in 1986 (the year prior to DSM-III) the median age was 23.3 and 25.1 respectively; in 1990 it was 24.0 and 25.9 respectively. Similarly, the *United Nations Demographic Yearbook* shows that in the United Kingdom (England and Wales) in 1979, only 54,744 women married between the ages of 25-29, as compared with 1986 when 70,495 women married. Similarly, in 1979, 26,710 women married between the ages of 30-34, while in 1986, 30,055 women were married. (Notably, in 1986, many women also married earlier than in 1979; 149,174 women were married between the ages of 20-24, as compared with 1979 when only 141,568 women married) (United Nations, 1979:483; United Nations, 1986:467).
[189] Yet the manual also states that in severe cases of social phobia, "the person may also avoid the same kinds of situations that are avoided in Agoraphobia with History of Panic Disorder. The motivation, however, is to avoid doing something or acting in a way that would be embarrassing or humiliating rather than to avoid the sudden development of a symptom" (1987:241). In other words, embarrassment in the new definition of agoraphobia is important enough to include where it wasn't included in DSM-III. But the bottom line is the fear of a limited symptom panic attack, i.e., fewer than four symptoms, which would not actually be *considered* a panic attack, hence the name Agoraphobia without History of Panic Disorder. But to return briefly to my own panic experience related above, it is difficult to imagine having fewer than four of those symptoms listed, or even being able to draw a clear enough line between them to be able to count symptoms and know whether it is a "limited symptom attack" or not.
[190] APA, 1987:240.
[191] Compton, 1998:706.
[192] Kutchins and Kirk, 1997:48.
[193] APA, 1994:xx-xxi.
[194] APA, 1994:xviii.
[195] APA, 1994:xx. This was a bibliographic improvement over previous DSMs, however it should be noted that the DSM-IV itself *still* has no citations and the Sourcebook was no doubt an added boost to DSM's profit margin (see Kutchins and Kirk, 1997:49). Anyone wanting regular access to the references had to buy this additional and very expensive APA publication (if the price of the DSM is any indication – $96.25 at Indigo).
[196] APA, 1994:xx.
[197] Kutchins and Kirk, 1997:48.
[198] Cooksey and Brown, 1998:542-5.
[199] Cooksey and Brown, 1998:542.
[200] APA, 1994:xxi.
[201] It's not clear who wrote the introduction; in the other volumes Spitzer signed his name to it, but in this, Frances, the likely writer, does not.
[202] APA, 1994:xxi.
[203] APA, 1994:xxi.
[204] APA, 1994:xxii.
[205] APA, 1994:xxii.
[206] APA, 1994:396.
[207] APA, 1994:396.
[208] APA, 1980:227.
[209] APA, 1987:239.
[210] APA, 1994:396.
[211] APA, 1994:397.
[212] APA, 1994:401.

[213] APA, 1994:397.
[214] APA, 1994:398.
[215] APA, 1994:399.
[216] APA, 1994:399.
[217] APA, 1994:399.
[218] APA, 1994:399.
[219] APA, 1980:226.
[220] APA, 1994:403.
[221] APA, 1994:403.
[222] APA, 1994:404.
[223] Scott, 1990:308.
[224] APA, 2000:xxix.
[225] APA, 2000:xxix.
[226] APA, 2000:xxix.
[227] APA, 2000:xxx.
[228] APA, 2000:433.
[229] APA, 2000:441.
[230] Wilson, 1993:408.
[231] Cooksey and Brown, 1998:548-50.
[232] Kupers, 1995:70.
[233] Kupers, 1995:76.
[234] Knowledge of the official psychiatric diagnosis of "premenstrual dysphoric disorder" ("PMS"), for example, was found by Nash and Chrisler to increase people's tendency to pathologise the premenstrual phase as a problem for women in general. In their study the diagnosis acted as a cultural message that reinforced the stereotype of moody, emotional women (1997:321).

Chapter 8
The DSM Decades: The (Re)Turn to Positivism

> ...a 42-year-old store clerk reported that the further he drove from home the more anxious he became. His driving consisted chiefly of commuting to and from work. He presented for therapy because another psychiatrist to whom he had gone had recently seen agoraphobia described on television, and assumed that the patient suffered from it. This patient...was initially treated with a simply-designed systematic desensitization program, accompanied by the request that he monitor his anxiety during his commuting. Before long, we realized that the pattern was unusual, in that his anxiety mounted the nearer he approached a certain bridge, which it was necessary to cross on the way to work. Further questioning revealed that the core problem was acrophobia, but that the anticipatory anxiety during driving did indeed resemble agoraphobia to some extent. It was interesting how the patient's perception of his problem had been coloured by a belief-system shared by the media, himself, and two psychiatrists.[1]

> ...a 46-year-old housewife, who diagnosed herself after reading about agoraphobia in a local newspaper, presented for therapy. She was treated with relaxation, systematic desensitization and graded home practice in taking short walks in the neighbourhood. After three weeks she reported that the home practice was more productive of boredom than of anxiety. This is most uncommon in agoraphobia. Accordingly she was re-assessed. It was now discovered that when she 'went out' she was referring to the engagement in social situations involving self-expression to a variety of people. She had, in fact, a typical social anxiety. But her initial exposure to the newspaper account had caused her to slant her history in such a way that it was easy to mistake her story for one of agoraphobia.[2]

With the DSM securely established,[3] mental health research has largely been driven by three interconnected concerns, and in this chapter I focus on the first two.[4] The first concern is that of *treatment* in the sense that ultimately, clinicians want to be able to alleviate human suffering. Studies that test the efficacy of various treatments, such as cognitive-behavioural methods or certain drug therapies, seek to determine what treatments do and do not work to relieve certain disease states.

In order to target and test the right treatments, however, there is a more fundamental need to understand the *phenomenology* of disease, meaning its ob-

served and associated symptoms and features based upon which the disease is classified.[5] Studies that describe the various characteristics of agoraphobia seek to establish a set of symptoms and related signs that practitioners can then treat. In other words, clinicians need to understand what a disease looks like – its physiological and psychological markers – in order for the treatment modality to be appropriate.[6] Articles concerned to demarcate the physiological parameters of agoraphobia gaze upon such things as:

- functions of the endocrine system, including the thyroid, the hypothalamus, the pituitary, the adrenals, and related hormones.[7]
- the heart, including heart rates and heart conditions such as mitral valve prolapse.[8]
- the skin, especially skin conductance of electricity.[9]
- the inner ear, especially balance and otoneurological and audiovestibular abnormalities.[10]
- the eyes and the processing of visual stimuli.[11]
- the brain, especially activity level of right versus left side, electroencephalography (measurement of electric signals emitted by the brain), brain blood flow, and brain morphology.[12]
- the respiratory system, and especially the problem of hyperventilation in panic.[13]
- MAO (monoamine oxidase) and serotonin activity and levels are examined (presumably for the purpose of MAOI and SSRI drug development).[14]
- and non-specific physiological markers, such as chronic pain.[15]

The shift in psychiatry towards positivism is not limited to biological investigations, however, as positivist packaging is the normative standard in the cognitive-behavioural reports as well.[16] Concerned primarily with the psychology of agoraphobia, these articles describe such things as:

- agoraphobics' cognitions, including: understanding of their symptoms,[17] irrational beliefs,[18] types of thoughts during panic attacks and scary tasks,[19] catastrophising,[20] cues to and anticipations of panic,[21] information processing,[22] interpretations of the environment[23] and of bodily sensations.[24]
- self-consciousness and embarrassment, interaction with others and willingness to discuss symptoms.[25]
- memory bias, especially in relation to phobic content.[26]

- social roles and interpersonal style.[27]
- and avoidant personality, coping strategies and escape/safety-seeking behaviour.[28]

Epidemiological research also contributes to phenomenology by providing data that measure the incidence, distribution, treatment, and prevention of disease.[29] They relate the distribution of disease to various factors affecting the population, and by "understanding the magnitude of a disorder and the patterns of risk for the occurrence of a disorder (risk factors), clues as to what alterations might lead to prevention of the disorder may be obtained." This type of information "is important for understanding [the] full clinical picture, who is at risk for being ill, and who may need treatment."[30]

The third concern for practitioners thus pertains to a disease's *aetiology* specifically about which there is actually less discussion in the literature and certainly no agreement. Indeed, there is a longstanding rift over causation known in many contexts as the nature versus nurture debate but it is *implicit* in the literature rather than the subject of extensive publication. On one side of the divide is the question of whether the origin or causation of agoraphobia is genetic predisposition or some sort of biological mechanism, as in, for example, the notion that panic is truly spontaneous (as opposed to stimulated by phobic fear and dysfunctional thinking). On the other side are those who presume its origins to be psychosocial and rooted in such things as separation-individuation, trauma, and stressful life changes.[31] These divergent (though not always mutually exclusive) positions underlie all of the treatment methods described, tested, and used in these reports.

That they inform treatment, however, should not be taken as a statement of one-to-one correspondence between treatment modality and aetiology. It is *not* the case that just because a physician uses drugs rather than cognitive-behavioural therapy [CBT], for example, that this means that the cause is biological. Drugs lead to changes in thinking just as CBT leads to changes in the brain, therefore the use of a particular treatment can only be taken as a *sign* of what a practitioner's *theory* of causation is.[32] Indeed, theories of causation are often not developed until *after* a particular treatment does or does not work. Treatments only point to theories – theories rooted in biological versus psycho-social frameworks – and there is plenty "of aetiological confusion."[33] To be sure, though, studies released after the publication of DSM-III tend to favour the biological; there is clearly a prevailing sense in which "biological factors are preeminent" and "outweigh psychosocial factors" in the aetiology of this condition.[34]

Research oriented towards these three main objectives –phenomenology, treatment, and aetiology – helps paint a picture of what agoraphobics are like – how they think and what (their bodies) do.[35] Bearing in mind that they are not mutually exclusive goals of research, but rather function together to give contemporary psychiatry its profoundly biological dimensions, this kind of information facilitates accurate (differential) diagnosis and disease-appropriate treatments, and hopefully, leads to prevention of disease altogether. The opening anecdotes, taken from a letter to the editor of the *Canadian Psychiatric Association Journal*, illustrate the importance of "prompt and accurate diagnosis" in order to "prevent further disability and needless suffering."[36] Thus a significant proportion of the literature published between the years 1976 and 2000 pertains to the

phenomenology and classification of agoraphobia vis-à-vis measures of patients' cognitions and physiology, its symptomatology, nosology and nomenclature, and its epidemiology. To this end, there are over 100 tools used to study agoraphobia and panic,[37] and "[c]onsidering the heavy use made of these inventories and the importance of the scientific and therapeutic decisions now guided by them, it is obviously critical that they measure what they intend."[38]

One way of classifying agoraphobia is through the delineation of what agoraphobia *is not*. For example, Isaac Marks, a leading figure in agoraphobia literature since the 1970s, reported on thirteen people who had been diagnosed with agoraphobia when they should have been diagnosed with "space phobia" or "pseudoagoraphobia". The patients in this report differed from *normal* agoraphobics in several important ways. The disorder developed when they were older (the mean age of onset was 55) and most of them showed signs of neurological and/or cardiovascular disease.[39] These patients responded less well to exposure treatment than "normal" agoraphobics, and they feared falling over in open spaces:

> ...actual physical support was not usually necessary, only *visual* support nearby. As patient five said "I need to be closed in while I'm walking. The fear is the space around me." [...] Patients did not need to touch such support to maintain balance, though they often did cling to it. They commonly crawled on the floor to cross a room, or walked close to walls or hedges in streets. [...] The disorder progressed in several patients until they were confined to a wheelchair even indoors.[40]

Unlike agoraphobia where the "fear of public places is a central feature" and "fear of open space is an inconstant minor characteristic and falls are very rare," Marks argues that "space phobia" is a separate and sometimes mislabelled disorder with "presumably ... overlapping physiological mechanisms."[41]

As several articles illustrate, it is also very common for agoraphobia to be confused with cardiovascular and gastrointestinal problems and even epilepsy.[42] For example, because panic attacks almost always entail "frightening palpitations and tachycardia," patients often go to emergency rooms or to see cardiac specialists, fearful that they are dying of a heart attack.[43] As it turns out, a high percentage of cardiology patients with chest pain having normal coronary angiographic results actually have undiagnosed panic disorder.[44] The tendency to misread gastrointestinal symptoms is the subject of an exchange of letters published following a report describing four patients with bowel obsessions (two of whom had histories of panic disorder with agoraphobia). Jenike et al., the report's original authors, maintained that their patients "did not have irritable bowel syndrome"[45] because "none of them had diarrhea or constipation, [nor] abdominal pain or discomfort." They insisted instead that they had "an obsessive fear of having a bowel movement in public" and some of them "also developed secondary rituals, such as compulsive anal wiping and compulsive searching for a bathroom."[46] The authors go on to say that

> the most important point remains that many of these patients improve markedly with simple pharmacologic trials, and academic discourse should not cause us to lose sight of this observation. Patients are not concerned with how we classify them, they only want to get better.[47]

Despite "growing evidence that...patients [with cardiac and gastrointestinal symptoms] represent an unrecognized but substantial portion of patients in primary care, internal medicine and cardiology,"[48] doctors likely would agree on the importance of recognising the

> fine line between appropriate investigation of somatic complaints, and risking the reinforcement of an organic conceptualization of illness in pa-

> tients, when a psychological explanation may represent the most parsimonious understanding of presenting symptoms.[49]

Yet it may also be the case that the issue is not one of *confusion* of somatic with psychological symptoms so much as oversight: "[j]ust as depression is a frequent concomitant of medical illness, so is anxiety [since] many patients present with 'anxiety' symptoms that cannot be easily separated out from their physical illness."[50] Separating the psychological from the somatic may in fact be counterintuitive.

That said, somatic conditions such as cardiovascular and gastrointestinal problems are not the only red herrings standing in the way of proper diagnosis. Agoraphobia is also considered extensively in relation to psychological conditions and disorders – that is, in terms of mental disorders that agoraphobia *is not*. In 1978, one practitioner argued that agoraphobia should not even be classified as a phobia, that it is rather a variable feature of anxiety neurosis.[51] Pointing out that the things that agoraphobics are afraid of require leaving the house such as shopping, riding in a train, open spaces, crowds, Hallam contended that it was a misnomer to describe this fear as fear of leaving the house per se because "agoraphobics frequently experience panic attacks in the home, especially when they are alone...[and] often have 'good days' when they are free from anxiety in the street."[52] Moreover, cues in public places such as crowds, noisy streets, etc., are "normally physiologically arousing" and can trigger other sources of anxiety and produce panic attacks. Hallam warns that agoraphobia may be better understood as the fear of these specific things so as not to perpetuate the state of disarray and "diagnostic vagueness" in which the classification of neurotic disorders found it-

self. The selection of one symptom – avoidance of leaving the home unaccompanied – to characterise this complex syndrome, was, as far as Hallam was concerned, unwarranted.[53]

Rapp and Thomas make a similar point a few years later (in 1982) when they write that agoraphobia "is not much better understood today than it was a dozen years ago." At that time (1970) Marks described the disorder as a "cluster of fears" about going into public places.[54] Yet Rapp and Thomas take issue with the "housebound" descriptor because other psychological conditions can also render a patient housebound, conditions such as social anxiety, fears of traffic accidents or of being attacked, and obsessive thoughts about misbehaving in public.[55] This point finds support in a more recent study which found that panic patients, with and without agoraphobia, spent about the same amount of time at home: "Agoraphobic patients have often been described as housebound housewives [...] and 'homeliness' is indeed a common characteristic in agoraphobia but [...] [a]goraphobic patients are not more 'housebound' than panic patients without agoraphobia when matched for demographic characteristics."[56]

Rapp and Thomas concluded that agoraphobia was not well-understood, which provoked a devastating response in the form of a letter to the journal's editor. The gist of this scathing critique by a Dr. Bowen, was that Rapp and Thomas did not do a thorough enough review of available literature, a comment that Rapp and Thomas felt was "manifestly unfair," "overkill", and Bowen was just "upset" over comments they made previously about a paper of his.[57]

While Bowen is convincing in that he does indeed cite quite a lot of articles disputing the co-authors' substantive conclusions, Rapp and Thomas' sense of the

incomplete state of knowledge about agoraphobia ought not be dismissed, since, as we shall see shortly, more recent articles *also* debate the validity of DSM categories and criteria. For example, the relationship between agoraphobia and other phobias, especially simple and social phobias, is a steady interest in the 1980s and 1990s[58] and there is evidence on both sides that they *may or may not* be wholly discrete disorders.[59]

There is similarly no consensus on whether or not basic personality traits and disorders[60] play a role in the development of agoraphobia. Studies conducted in the late 1980s found that a "preponderance of dependent, avoidant, and histrionic diagnoses and traits" and "patients who exhibited a greater number of personality traits were also significantly more symptomatic, more neurotic, and...less extraverted."[61] Another study, however, disaffirmed these findings; agoraphobia "was not associated with higher rates of axis II [personality] disorders in PAD [panic disorder agoraphobia] patients" suggesting that the role of personality disorders as "preexisting [sic] or even predisposing factors to anxiety states, should be viewed cautiously".[62] Some personality traits "can be related to behavioral and life-style changes induced by the clinical symptoms during the course of illnesses."[63] A few years later, however, a study based on a sample of panic disorder with agoraphobia patients in remission, determined that "avoidant behavioral and attitudinal patterns may be enduring personality characteristics of panic disorder with agoraphobia patients."[64] Even in periods of stable remission, patients displayed "a greater tendency than normals to see themselves as rather unassertive, indecisive, self-critical, and emotional individuals, who are easily frustrated and often feel rejected when criticized."[65]

Although these findings conflict, they raise a red flag where gender is concerned because the majority of agoraphobics are indisputably women[66] and this is the one thing of which we can be certain in this literature. The prevalence of agoraphobia in women points to a possible link between agoraphobia and sex roles. Research on the marital systems of agoraphobic women found that husbands who saw themselves as more supportive and were more able to accept their wives' disability, tended to have a traditional view of marital relationships. These husbands "regarded dependency, timidity and an exclusively domestic focus as desirable traits in their wives, which agoraphobic symptoms reinforced and consolidated." In contrast, the wives "usually regarded their agoraphobia and associated symptoms as highly distressing obstacles to an extension of their activities beyond the purely domestic."[67] Behaviour therapy enabled the women to take on many new activities outside the home, yet "many husbands clung to the notion that their wives should be devoted exclusively to homemaking activities."[68]In some cases, improvement in the wives was very distressing for husbands. As one researcher found, "the agoraphobic adjustment is often supported or reinforced by a spouse with complementary problems and...an unconscious investment in the continuation of the symptoms."[69] One man even "attempted suicide...because since his wife's recovery he had felt useless and inadequate: she was no longer almost totally dependent on him in the way she had been while agoraphobic."[70]

For one writer, women's agoraphobic adjustment "almost suggests an ironic caricature [of femininity], perhaps a mocking over-compliance with expectations of dependent and passive behaviour."[71] The neurotic male is equally shaped by sex role stereotyping:

> He maintains a position of masculine strength by denial of dependency and vulnerability which he projects into his wife who then becomes the object of his protection; or he may detach from these needs and pursue a more schizoid existence, withdrawing socially, emotionally and sexually, turning to alcohol for support. [...] Women may pursue a phobic and dependent adjustment and still function adequately at home, in fact the housebound housewife may be an asset to some families. Men cannot hide at home but must face the workaday world where a super-independent, hardworking, hard-drinking adjustment may be socially reinforced.[72]

Femininity and masculinity are also problematised by another study published two years later, in which female agoraphobics were hypothesised "to be more stereotypically feminine and less masculine." Finding that women were more depressed and anxious than men, the authors correlated this finding with a lack of masculine characteristics. They argued that fearful behaviour was more acceptable for women because "women are taught and allowed to be fearful and to perceive themselves as incompetent and helpless without male assistance."[73] Not only were women more likely to become agoraphobic, but even among a mixed sample, women were more avoidant, especially when "functioning without the protective shield of men."[74] A much more recent study supported this argument, finding that women agoraphobics required a companion more often than men did, and were much more willing to stay home alone. Women's higher dependence on a companion for support may have been due to cultural and psychological factors.[75] As Chambless and Mason had put it several years earlier, "a society that does not teach women to be instrumental, competent and assertive rather than just nurturant and expressive, is one that breeds phobic women."[76]

This last point, however, was not the final word on the matter. While there is general agreement between studies that agoraphobia is prevalent in women, there is evidence that phobias and other psychiatric disorders are actually the

greatest risk factor for the development of panic disorder and agoraphobia – a risk factor greater even than female gender.[77] A major American epidemiological[78] study done in the late 1980s determined that while women are two to four times more likely than men to develop agoraphobia,[79] the presence of another phobia[80] or psychiatric disorder is far more likely to predispose them than their gender.[81] Of course, this finding begs the question of why more women have predisposing psychiatric disorders (and why that predisposing psychiatric disorder is most likely to be depression).[82] That most agoraphobics are grown women[83] (and urban-dwelling)[84] is certain. But questions of race, class, and culture are more debatable, and before turning to the relationship between agoraphobia and panic, I would like to make a few brief remarks about race and class.

Clinical articles, all published out of the developed West, reflect – through their silence on race – a (normative) predominance of agoraphobia among married, educated, middle-class white women.[85] American epidemiological articles based on random community samples, however, reflect a prevalence among single/divorced, uneducated, low income, Black women.[86] This finding is not entirely surprising; evidently, the outside world is a scary – read: racist –place for poor, Black women.[87] Still, other than the epidemiological study [the "ECA"] upon which these articles are based and the occasional comment in the rest of the literature, race is almost never mentioned but only, again, implied.[88] Indeed, I found only three publications overtly concerned with race, and these articles notwithstanding, in 130 years' worth of clinical writing and research, that race would suddenly emerge as an important demographic suggests two possible explanations.

First, poor, urban, Black women do not present for treatment, which is why they are generally not reflected in clinical articles and why they would only emerge in community studies. This would make especial sense if psychodynamic psychotherapy – which can be costly – is in fact the most common form of treatment, as Goisman et al. asserted in 1994. This, coupled with the fact that African Americans do not receive the same quality of care as do white Americans, suggests that access is an important obstacle to health and has negative implications for health outcomes.[89] But an even more troubling reason that African Americans do not present for treatment is a longstanding legacy of distrust in the medical establishment, marked most famously by the Tuskegee, Alabama Syphilis Study but predated by a long history of racist medical experimentation.[90]

Briefly, the US government funded a 40-year syphilis study (1932-72) designed to document the disease's natural course. The subjects were 399 poor Black men from whom physicians conducting the research deliberately withheld treatment and on whom they conducted other procedures, telling them they were being treated for "bad blood".[91] Unfortunately, despite public disclosure of the experiment and subsequent implementation of a National Research Act in 1974 that was meant to protect human subjects of experimentation, questionable research continued. As late as 1989, the Centers for Disease Control and Prevention were involved in a study to test an experimental measles vaccine. By 1991, most of the approximately 900 infants to whom the drug had been administered, were of African and Latin descent. It was not disclosed until 1996 that the parents had not been told that the vaccine was not yet licensed in the US, or that it had been linked to increased death rates in Africa. In short, medical racism and the contin-

ued exploitation of "minority" communities for the purposes of research ensure a virulent level of scepticism on the part of patients of colour.[92]

Another possible reason for this finding of prevalence among Black women is reflected in the extent to which whiteness has historically been the normative clinical variable, culminating in the "discovery" of race (and gender) in medicine – the idea that the body is not always that of a 70 kg white male. As Vanessa Gamble writes,

> ...in the past, most clinical researchers have used white men as the standard or norm from which to extrapolate data to the rest of the population. Young white men were presumed to be a homogeneous population that had fewer confounding factors. Members of minority groups and women were frequently excluded from clinical studies.[93]

Perhaps whites get written up normatively by clinicians because that is who actually seeks help, but it may also be the case that once race and gender were "invented" as research variables, researchers needed only to look to be able to find them.[94] I deal with the issue of race more explicitly in the next chapter, but for now I must emphasise – in defiance of the DSM – the extent to which the epidemiological evidence must be interpreted (and challenged) on the basis of social, not genetic or biological, explanations.

The ECA study, like many others, also looked at the relation between panic and agoraphobia – an important and recurring debate that appears to have hung on two central problems. The first problem, one that some practitioners actually do recognise, stems from the DSM criteria which subsume certain diagnoses under others, the modification(s) that occurred with the release of DSM-III-R, and the concomitant difficulty in delineating between panic, panic with agoraphobia, and agoraphobia without panic. In the words of one investigator:

> Essentially, panic had been viewed in DSM-III as a frequently comorbid symptom of agoraphobia, whereas, in DSM-III-R, agoraphobia is seen as a severe complication of panic...Furthermore, DSM-III criteria for agoraphobia required an 'increasing constriction of the normal activities until the fear of avoidance behavior dominates the individual's life'...However, in DSM-III-R criteria for PDA [panic disorder and agoraphobia] and AWOPD [agoraphobia without panic disorder], this threshold impairment criterion is eliminated, so that very mild agoraphobic avoidance...would cause a subject to be considered as having PDA, resulting perhaps in a dilution of a PDA sample with subjects phenomenologically more similar to a PD sample... Thus it is difficult to compare the results of studies conducted with DSM-III and DSM-III-R criteria.[95]

A significant proportion of researchers and clinicians take the position that agoraphobia is actually a conditioned response to panic attacks, that agoraphobia *without* panic is really very rare. This view may be particular to American clinicians and researchers.[96] In the UK there is more support for the idea that agoraphobia does occur without panic.[97] However, while the American ECA study (described above) did find agoraphobia to be more commonly associated with panic attacks,[98] it also found a substantial number of agoraphobics who did not meet DSM-III criteria for panic.[99] The research showed a considerable overlap with panic disorder, but it also showed that agoraphobia and panic occur in pure forms, that agoraphobia is a heterogeneous disorder that develops along several different pathways other than panic.[100] Even a clinical report written very recently – that is, post DSM-III-R and DSM-IV – illustrates how this might occur: In four "presentations of agoraphobia without panic," one person was fearful of developing a migraine headache away from home. Another was worried of having spontaneous and uncontrollable bowel movements in situations where he did not have ready access to a restroom. A third avoided flying, most public situations, hospitals, and being away from home at night for fear that she might vomit. And

the fourth patient had frequent episodes of tachycardia [rapid heart beat] and thumping in his chest (but yet never had the requisite four symptoms to qualify officially for a DSM-III-R panic attack).[101]

In other words, agoraphobia can "develop in response to fears of a variety of symptom attacks other than panic."[102] This clinical assertion was corroborated by an epidemiological survey of 3021 respondents classified as having agoraphobia with panic. These investigators found that there were "marked differences in symptomatology, course, and associated impairments between panic disorder and agoraphobia," calling into question the view of agoraphobia as a "secondary complication of spontaneous panic attacks or paniclike experiences."[103] Another study done in Germany published just last year takes a similar point of departure in observing that many panic patients do not develop avoidance behaviour. The investigators interpret this to mean that "[e]vidently there must be other factors than just the existence of panic attacks in general, which either predispose, or, on the other hand, protect individuals from developing avoidance behavior."[104] They conclude that the development of agoraphobic avoidance in panic patients is not coincidental, nor a straightforward process.[105] This divide points to the possibility that epidemiological studies may have actually overestimated the prevalence of agoraphobia without panic disorder. (It also indicates a lack of diagnostic clarity between agoraphobia and simple phobia, especially if we recall, à la Hallam (1978), that agoraphobia may not be about a fear of leaving the house per se, but rather a fear of specific stimuli located outside of the house.)

Yet, when 22 subjects diagnosed with agoraphobia without panic in the original American ECA study were reinterviewed 7-8 years later using a new,

more highly structured interview schedule and clinical interviewers[106] blind to their original diagnoses, only one case of agoraphobia without panic remained, and this case was classified as being only of "probable" certainty.[107] Indeed, 19 out of the 22 were diagnosed with "simple phobia" but not agoraphobia. Moreover, the new interview schedule (the "SADS-LA") used in the assessment of the 22 individuals described above was based on DSM-III-R criteria, unlike that (the "DIS") used in the ECA study in which the 22 subjects originally participated, which was based on DSM-III criteria. For one thing, the DIS was used without benefit of lengthy testing of its clinical reliability; investigators worried that the Reagan administration would not have proceeded with the project. The ECA launched the study too early even though more evidence of the reliability and validity of its diagnostic criteria was desired.[108] For another thing, the new SADS-LA schedule permitted "a diagnosis of simple phobia of crowds, being alone or going out of the house alone, tunnels, bridges, and public transportation" whereas the DIS would diagnose fear and avoidance of one of these situations as agoraphobia,[109] implying a likely overestimate of agoraphobia, and an underestimate of panic disorder.

The second problem contributing to the lack of consensus on the question of panic's relationship to agoraphobia derives from the methodological discrepancy inherent in clinical versus random community (epidemiological) sampling. Clinical populations are a very select group, "subject to a raft of knowable and unknowable epidemiologic biases, which makes scientific inference difficult."[110] Clinical studies may yield fewer agoraphobics without panic than do epidemiological studies.[111] For example, a clinical study of 562 subjects using rigorous ago-

raphobia criteria[112] found that while there were some agoraphobics who did not experience panic (n=30), there were far more who did (n=363).[113] But as Weissman observes, in clinical practice clinicians usually only see agoraphobics who *have* had panic symptoms. An individual who suffers from agoraphobic social withdrawal may never go to the doctor.[114] The ECA survey, designed to "obtain true community prevalence rates,"[115] shows that only 23% of agoraphobics seek treatment.[116] It is arguable that the agoraphobics who go for treatment – the subjects of clinical studies – are those with the most severe symptoms in the most need of help, for which clinical reports would be the most useful. This may explain why so many practitioners subscribe to the idea that agoraphobia is simply a secondary complication of the primary panic disorder – the patients they actually see come for help with their panic because panic disrupts lives. Agoraphobia without panic, on the other hand, is presumably much easier to live with – once one makes the necessary accommodations. It could equally be the case, however, that patients with the *mildest* symptoms are the ones *most able* to seek psychiatric assistance, which would leave the most severe agoraphobics unaccounted for. Either way, psychiatrists cannot treat people who do not seek treatment, nor can reports based on the patients who *do* manage their way in for treatment, be taken as absolutely representative of agoraphobia as it is found in the general population.[117]

These two problems interrelate in that the incongruity between clinical and epidemiological findings exacerbates the tenuous nature of DSM criteria. Epidemiological surveys may offer a more representative picture of disease at the community level, but clinical studies may tell a better story about what goes on in

practitioners' offices, and we cannot ignore the fact that clinical commentary is the predominant source of information about agoraphobia. Moreover, the DSM criteria are both supported and disputed by all this conflicting research. It may be better to think of agoraphobia as two discrete syndromes that commonly co-occur.[118] Perhaps the names should be changed to avoid implying a primary-secondary relationship and "an etiological relationship that has not yet been established, as the current system, overtly or implicitly, seems to do..."[119] Alternatively, the disorders could be viewed on a continuum.[120] As it stands, the classification of agoraphobia has persisted as a site of contestation for the last two decades[121] – a conflict rooted squarely within the DSM framework(s):

> We have had three different sets of official criteria for agoraphobia without a history of panic disorder in 15 years (DSM-III, DSM-III-R, and DSM-IV), clear variance in the application of the criteria even within one version of DSM..., significant discrepancies between clinical and community samples within one set of criteria (DSM-IV...), and at least two equally plausible but contradictory theoretical explanations of these findings...[122]

Indeed, the relation between panic and agoraphobia was not nearly the issue it has become until the release of DSM-III. Roth and Argyle perhaps best captured the dilemma when they wrote:

> An affect such as anxiety must resist unequivocal and precise definition, for the emotions merge insensibly with one another in mental life, and cannot be expected to have sharp boundaries. The boundaries are artificial, created to reduce the task of investigating affective states to manageable proportion.[123]

It is important to observe, however, that they do not shy away from the notion that classification is in fact possible. They maintain that accurate classifications constitute a solid foundation for research and, citing Karl Popper, advocate continued study of the clinical phenomenon, because "precise definitions come only

with closer investigation." Indeed, "premature imposition of strict and unambiguous definitions on difficult concepts" is "counter-productive."[124]

It would seem, judging from the amount of research literature published in this period, that they are not the only practitioners/researchers who endorse this sort of contradictory scientific optimism. The ambiguity of Roth and Argyle's remarks is indicative of the fact that despite all these debates, it seems that for every clinician sceptical of precise classification, there seems to be another investigator waiting in the wings who is quite confident that bounded definitions are possible. Equal in irony to Roth and Argyle, W.G. Wood, critical of the tendency toward confusion between panic and medical problems (that is, cardiac, gastrointestinal, or neurological disorders), and the confusion between agoraphobic anxiety and panic attacks related to panic disorder, said in 1990 that there "is little excuse at this point for this disorder to be ineffectively diagnosed or treated."[125] Much of the research above would suggest, quite contrarily, that there is most definitely an excuse – and it is one that begins and ends with the DSM.

While continued publishing does reflect a greater wealth of knowledge about this illness, it also shows a concomitant lack of unified theory about it. Irrespective of confusion with cardiovascular and gastrointestinal problems and difficulties delineating the lines between psychiatric disorders, it is evident in this period that the symptoms of agoraphobia today are pretty much the same as what they were more than a century ago. Patients complain of basically the same things. In the meantime, publishing and research on agoraphobia has increased exponentially, which might lead one to expect that practitioners would have achieved a great degree of precision by now, that the parameters of agoraphobia

would be crystal clear. The situation could not be less so; the category of agoraphobia shifts, is disparate, and is both indirectly and directly debated throughout this period.

We have seen that these debates are driven by the central question of what, if any, is the relationship between agoraphobia and panic? This is, as we have also seen, as yet unresolved. Efforts vis-à-vis the DSM to systematically clarify nosology have ultimately failed to settle conclusively and reliably issues of classification and operationalisation. (The use of different interview schedules based on different DSMs – the DIS and SADS-LA described above – is a case in point.) The change in diagnostic criteria from DSM to DSM, and the frequent tendency to use them interchangeably results in a kind of *dis-order* whose implications are no doubt obvious: the "labels applied to clinical phenomena have a profound effect on methods applied to their investigation and treatment and agoraphobia is no exception."[126] With the relationship between agoraphobia and panic disorder perpetually unclear and indefinitive,[127] the two terms are conflated constantly– between reports, by Medline,[128] and even within individual articles that often do not distinguish between agoraphobics who panic and those who do not. Compounding this inconsistency is the fact that current research frequently cites old DSM criteria. Indeed, it seems to be common practice for researchers to use whichever edition they happen to have on hand,[129] thereby defeating the central purpose of the DSM, which was, purportedly, to have a unifying effect on psychiatry and psychiatric research.

Finally, although no two patients exhibit the same symptomatology, the range of available agoraphobic symptoms has remained relatively stable over 130 years. As it was put in an editorial for the *British Medical Journal* from 1982,

> Westphal's men had much the same fears that agoraphobic patients tell their doctors about today: they felt anxious not only in the street but also in crowded places indoors; and, like our patients today, they were less anxious when a trusted companion was present. Nowadays our agoraphobics tell us about anxiety in crowded shops and buses, rather than the churches and theatres that Westphal described, but these variations reflect social changes rather than any fundamental difference in the disorder.[130]

Modern accounts emphasise patients' anxious thoughts, whereas Westphal did not, but even this is not especially new. His colleague Cordes (discussed in Chapter 4) referred to patients' cognitions in a paper he published in the same year as Westphal's pathbreaking report.[131]

In other words, except for the shift from men to women following World War I, and subsequent paradigm shifts in mental health care, the big picture of agoraphobia – its symptoms – has been remarkably consistent. What has changed is the packaging and it is when we look more closely at this disease object and try to make categorical divisions based on often vague and inconsistent criteria that we run into problems. That the APA is constantly in the process of releasing new (but not necessarily improved) editions of the DSM makes it reasonable to assume that the next edition may contain within it yet another set of revised criteria. With different studies utilising a different edition of the DSM, and each subsequent edition of the DSM calling into question the status of previous research based on its old criteria,[132] we are faced with a rather convoluted state of clinical affairs. Even if we give the APA's efforts the benefit of the doubt and credit each new edition of the DSM as scientific progress and the accumu-

lating research as having contributed towards the fine-tuning of what is known about agoraphobia, the categories stipulated therein still raise important questions. What about the patients who do not quite fit the DSM schema(s) and is there room in the DSM for heterogeneity among patients?[133] In over twenty years since Hallam complained of "diagnostic vagueness," agoraphobia still has no "underlying unity and coherence."[134]

The Treatment of Agoraphobia

The adequate treatment of agoraphobia is important for a very obvious reason: it is better for everyone involved (except maybe neurotic husbands) when people in distress may have their suffering alleviated. A less obvious justification for treatment may be found in both the personal and social costs of living with this type of condition. Indeed, from the perspective of quality of life, the cost of anxiety is not negligible. People with anxiety disorders sleep less, which, alongside the drugs used by many to manage their disorder, could lead to driving accidents. In addition, the ability to work, to sustain family life, and to enjoy life in general are affected.[135]

From the perspective of social and economic costs, there are both direct and indirect costs. Direct costs might include charges for hospital visits or outpatient appointments, or even unnecessary cardiac related tests.[136] Indirect costs involve economic activities without direct cash charges such as the loss of economic productivity; patients with chronic psychiatric disorders do not maintain continuous employment and agoraphobia may especially contribute to the large economic effect of work incapacity. There is as well a social and psychological

price to pay by spouses, children, and extended families.[137] Finally, we must also consider the impact on the economy overall: if the behaviourist literature is any indication, it would seem that agoraphobics do not shop nearly as much or as effortlessly as "normals" do. As we shall see shortly, the ability to go shopping is widely cited by patients as a goal of their treatment.

Thus, treatment is probably more cost-effective than anxiety left untreated.[138] Of course, it depends on what kind of treatment we are talking about. A recent article set out to disprove the view (initiated by Freud) that the high cost of psychotherapy helps to ensure its success. The thinking here is that because clients pay a fee they may try harder in order to justify the expenditure, and may work harder in order to cope with it.[139] The author, affiliated with the Israeli National Insurance Institute, contends, however, that there is "little scientific evidence supporting the effectiveness of psychotherapy in these conditions."[140] Advocating publicly-funded treatment (for mild disorders) in community clinics or through corporate-financed mental health programmes, he maintains that "while psychotherapy reduces the *risk* of suffering an attack on the way to/from work, the cost of therapy might reduce the *tendency* to take risks, thus acting to undermine treatment." In other words, the high cost of psychotherapy may actually *encourage* work avoidance in less severe cases, thereby aggravating the phobic disorder and adversely affecting the economy.[141]

As an insurer, Yaniv's interest in reducing costs borne by third-party payers is self-evident. But he is not alone in his denigration of psychoanalysis for its lack of scientific status. With the groundwork for its decline laid by the release of DSM-III, psychoanalysis has long been an easy target for scientific rationalists

and in this respect it is no surprise that its published contribution to the discourse of agoraphobia has significantly reduced. What is surprising, however, is that the number of both psychoanalysts and psychoanalytic patients has steadily increased.[142] Still, a cursory look through the indexes of selected psychoanalytic journal publishing between 1976 and 2000 revealed a scattering of references to "anxiety" but almost no references at all to agoraphobia.[143] The publication of psychoanalytic papers on agoraphobia has dwindled despite recent evidence that psychodynamic psychotherapy (which includes psychoanalysis) is the most commonly received form of psychosocial treatment.[144] And, of the handful of psychoanalytic case articles that have come out in the last two decades, only one specifically addresses the profession's outsider status.[145] In this section I shall describe a few of the psychoanalytic cases, followed by further discussion of the increasingly contested position of psychoanalysis within the field of mental health.

Psychoanalysis

Separation anxiety and overparenting, though not fundamentally psychoanalytic concepts per se,[146] emerge as a relatively significant theme in these psychoanalytic reports.[147] In one case described by Donald Coleman, the "life-long pattern of anxiety unless surrounded by the familiar" suffered by his patient "R.", a "sweet" and "somewhat shy, retiring" 40-year-old mother of two is attributed to the *maternal* overprotection she experienced as a child.[148] This woman could only function within a dyad with the other person looking after everything for her, as her mother had done. "[Her] mother supervised every aspect of her life, with the overt premise that she was a weak, sickly child who might at any mo-

ment be carried away by a fatal illness", even though "there were no major illnesses to account for this." Suffering from mild diarrhea and the fear that she would lose sphincter control in unfamiliar situations, R. "lived a life of 'quiet desperation' with no close friends and a husband who, like her mother, had "doll-like expectations of her."[149] Open conflict with both her mother and husband had to be avoided at all costs because any resistance on R's part signalled autonomy that her mother refused to permit her. R. was not allowed as an adolescent to do the "simplest tasks", such as picking up shoes from the repair shop, or any other minor errands "that most parents would encourage or require". In short, she was "not allowed to exercise her judgement."[150] Thus she came to learn that "the outside world was...a terrifying place, full of disasters that the patient could not possibly cope with alone."[151] The "neurotic bargain" R. had with her mother was one later replicated in her marriage. Her husband exacerbated her sense of self-doubt by denying her perceptions of reality, making it difficult to venture out into the world.[152]

Through the denial of her autonomy, R's ego was weak and underdeveloped, and only capable of functioning in the context of a dyad. It was not until her husband died of a sudden illness in the third year of therapy that R became "much more resourceful," with more of an "anxiety-free ego than was apparent at the beginning of...therapy."[153] She could travel long distances without anxiety, displayed good judgement and a sense of humour, and showed an interest in (and anxiety about) sexual matters. By the end of the 4th year of this preparatory pre-psychoanalytic therapy, R came to realise that more formal psychoanalysis needed to begin. As such, she would have to start using the couch, a situation she

had until then managed to avoid for fear she would be "helpless" and "carried away," by her impulses or "by the therapist's intrusiveness to penetrate every aspect of her mind, leaving her empty and without a self."[154]

In response to this report, another analyst (Austin Silber) acknowledged that Coleman had done a "splendid preliminary job"[155] but he expressed concerns for the transference relation implicated in Coleman's plan to conduct the analysis himself:

> Why does he not let someone else conduct the formal analysis that he feels is indicated? It seems that he is placing too heavy a burden on his patient. She has been too severely used by those who have heretofore managed her life. Why not let her gradually understand the clarifications Coleman has made available to her, as she freely analyzes her relationship with him, while she continues her treatment with a new analyst? [...] Even a benevolent environment can be an encumbrance; she needs to develop her sense of herself (individuation) in a different setting and with a different analyst.[156]

Coleman replied that among other reasons, "any suggestion to change therapists might have been responded to as loss of the good mother."[157]

The weak, undeveloped ego at the heart of R.'s neurosis is a theme that also emerges in another report that seeks to demonstrate how "conservation of the psychic status-quo is reflected in specific self-preservative mental activities to which we refer as defenses."[158] "Mary," an adolescent suffered from "street phobia" and a fear of men to the extent that she was unable to leave her home and walk unaccompanied by her mother or a girlfriend. In other words, her companion had to be female. In her prephobic period, Mary "looked neither right nor left when walking alone to school...always sensing around herself a presence of men...men were constantly on her mind without being associated with any conscious mental content."[159]

The essence of Mary's symptom formation seemed to be rooted in two different versions of a secret that Mary told the analyst as well as her mother (who in turn also told the analyst).[160] The mother's version of the secret was that when Mary was about 4 years old, she was in her parents' bed one Sunday morning "fooling around" with her father while her mother was up, dressed, and ready to go out. Her mother reproached her father's behaviour, saying "in a stern voice": "'You do that only with your wife.'"[161] Mary took this phrase to heart. In Mary's version of the secret her mother said "'You do that only with your husband!'"[162] In the version that Mary told her mother, her father was the guilty one, whereas in Mary's version told to the analyst, Mary was guilty. Both versions signified – traumatically – a forbidden sexual relation between Mary and her father.[163] The discrepancy between these two versions of the secret represented "opposing sides of the mental conflict which had become manifest in the phobia" – opposing sides that her ego had failed to synthesise.[164]

Blos, the analyst who reported on Mary's case, advocated a developmental approach to adolescent psychotherapy because it is not always clear "what is a normal disturbance due to the developmental upheaval of the age and what constitutes a truly psychopathological condition."[165] He argued that in a normal individual's lifetime not one, but two processes of individuation take place. The first is when the toddler "internalizes the caretaking person or persons, usually the mother, and thus acquires object representations which possess an internally available object presence." At this time the line between fantasy and reality is drawn "more sharply and also more indelibly."[166] Later on, puberty brings with it a necessary "overhauling of internalizations, identifications, and object rela-

tions." This is in short, a second process of individuation, whereby the adolescent achieves "independence from the internalized objects and their early formative influence on ego and superego."[167] "Malfunction of the adolescent personality" indicates a failure in the second, adolescent individuation process which can only succeed when there is the "capacity to regress in order to rework those infantile tasks which had been too taxing to master at the tender age of early childhood."[168] Mary's case illustrated this view in that once her phobic symptom – the agoraphobia – was resolved, "her demands on her mother became more exacting and frenzied."[169] Although she "had lost her symptom as smoothly and completely as a snake slithers out of its skin[,] [e]motional transformations do not occur in this fashion." Mary and her mother had "passionate love and hate arguments" signalling, paradoxically,

> the fact that during adolescence therapeutic achievement becomes manifest not only by a symptomatic improvement and a more satisfactory performance in life generally, but also by the appearance of a new wave of disturbances...of a developmentally more phase-adequate nature.[170]

The focus of Mary's disturbance had shifted to a "regressive acting out of a typical mother-daughter ambivalence struggle...a reengagement in preoedipal dependency and attachment issues...a normal and transient stage in female adolescence."[171]In other words, Mary's acting like a "normal" bratty teenager was evidence that she was on the road to (psychic) recovery.

Several years prior to the publication of Blos' report, the insights available through adolescent therapy had also been realised by Feigelson, another therapist. Arguing for the reconstruction of the adolescent experiences of adult patients as a route into childhood fantasies, he contended that during adolescence,

"the childhood fantasies are reworked and published in new editions." In the adult analytic experience, in order to resurrect the childhood experience in a way that the patient really knows and feels, one must also acquaint him [sic] with the new edition that appears in adolescence."[172] Adolescence is an intermediate stage and the failure to "uncover" its role, would make it "difficult to show a patient in a meaningful way the connections between the childhood and adult fantasy."[173]

This analyst illustrated his argument by drawing on a case of agoraphobia in his patient "Mrs. Y" who was a "bright, intellectually oriented, married, professional woman" and the youngest of three daughters born to a "successful, intellectual Protestant couple." She sought analysis for symptoms of anxiety, depression, and "difficulty resolving the conflict between the demands of marriage and motherhood and those of professional, intellectual ambitions." It was, however, not until late in the first year of analysis, that with "marked embarrassment and shame" she admitted her "extremely troublesome symptom."[174]

Whenever she was in an open street she was overwhelmed with anxiety; everything seemed to be in motion and continuing analysis revealed that it was in fact sexual excitement that was making itself felt to her in these situations, hence her embarrassment.[175] Everything would seem "dizzying, in movement, and exciting – like she had remembered spinning in her room being dizzying and exciting."[176] Spinning for hours alone in her room to make herself dizzy, was a pleasure she enjoyed very much as a child. Indeed, dizzying circles were a persistent theme in her sessions.

An important point in her analysis was marked by a dream she had about two people skating "round and round in dizzying circles...falling and rising...in rhythmic sequence." She described the feeling she was left with:

> ...I woke with that terribly uncomfortable sensation in me, like there is a space deep inside me that needs to be filled. It is a commanding feeling, a consuming feeling. I began to rub the outside of my vagina. Seems like I should have put my finger inside, but I didn't. It was the same feeling I sometimes have before intercourse, I have to get in exactly the right position during intercourse to have the feeling that the space is filled. It's like there is an emptiness inside of me.[177]

Recalling this dream and her thoughts on waking led Mrs. Y. to think about masturbating as an adolescent, a practice she engaged in every night despite vowing in advance not to. She described being in denial that she masturbated even when in the throes of it:

> I would lie on my bed and would rub my externals...When I would do it, I would look at the ceiling or the light or some part of the room. They would seem to move, like all concentration was on making the room or things in it move. I would rub first one part and then another to make different things in the room seem to move.[178]

Focusing on the movement of things in her room allowed Mrs. Y. (then an adolescent) to remain unaware of her genital sensations.

Meanwhile, growing up, Mrs. Y had a very upsetting and sexually charged relationship with her father. Spinning in her room as a child and the transference repetition of this sensation through masturbation as an adolescent, was her way of keeping her sexual feelings out of consciousness. Further analysis revealed that the overwhelming feelings of dizziness and excitement she had in the street as an adult were also connected to her father:

> The spinning was a dramatization of a sexual fantasy in which the excited things outside her represented her father who would overwhelm her; [...] she had forgotten the genital sensations which accompanied the experi-

> ence, much as in the adolescent masturbation she did not let herself know about the genital sensations.[179]

Her agoraphobic experience of adulthood "was a symptom which represented a dramatization" of a childhood fantasy Mrs. Y had of being overtaken by her excited father. Her adolescent masturbation facilitated the link to childhood spinning which was a dramatization of that masturbatory fantasy in childhood. In other words:

> One might say that the adult symptom, the adolescent experience, and the childhood spinning represent a repetition of exciting erotic experiences with her father and different renditions of a masturbatory act, an act which simultaneously dramatized fantasies that derived from and led back to these childhood and adolescent experiences.[180]

An understanding of the infantile origins of an adult patient's agoraphobic "symptom" was thus facilitated through the reconstruction of her adolescence.

Although the emphasis in this report was more on methodology, it is difficult to ignore the extensive discussion of masturbation and its role in Mrs. Y's neurosis. Another much more recent case also emphasises masturbation (though not as graphically).[181] The patient – Gennaro –was a young university student who began analysis at the age of 18. He was "very intelligent and knew more literature and philosophy than the average of people of his age."[182] Gennaro suffered from agoraphobia and had difficulty concentrating on his school work. It did not take long to resolve his agoraphobia, which actually drove Gennaro to despair. His parents, who were struggling financially, assumed he no longer needed therapy and wanted him to stop in order to reduce their expenses. The sessions continued, however, albeit under the constant threat of termination. As this re-

port continues, it becomes clear that Gennaro's biggest problem, bigger than the agoraphobia, was that he masturbated compulsively.

The analyst describes Gennaro's history as beginning with his conception out of wedlock. Within a few months of his birth, his mother became pregnant again. After the birth of his younger brother, he'd been sent to live with his grandparents, when his mother, who did not breast-feed him,[183] "realized that she was not able to cope with two young children."[184] He was happy living with his grandparents, however when he was 8 or 9 years old, they moved and no longer had room for him in their home. He was "given back" to his parents. He lost his family a third time when he moved to Genova to attend university, and during the course of the analysis, lost family a fourth time when the relatives he was living with while in school divorced, leaving him to find yet another place to live.

Presumably all of these losses of family were at the root of his tendency to "defend against any affects." Lying underneath was a "world of confusion between sex and violence, and between homosexuality and heterosexuality."[185] Gennaro worried, for example, that en route from the analyst's door to the couch, he would be attacked by his doctor homosexually. This confusion was also manifest in Gennaro's tendency towards habitual masturbation, a tendency that developed early on:

> ...when he was about 12 years old, he was surprised by his mother while using her make-up. [...] [S]ometimes, masturbating, he tried to imagine what a woman could feel during sexual intercourse, and felt some strange sensations under his testicles. He was worried and wondered what his parents would think if he became openly homosexual and transvestite.[186]

What persists in the images of masturbation is Gennaro's affect-less detachment: "...he talked about a strip-tease programme he had watched the previous night on television. He masturbated without sexual excitement, as if it were something mechanical." Morra (the analyst) interpreted that "the kind of cold and compulsive masturbation [Gennaro] described seemed an expression of [the] isolation" from Morra that he was feeling.[187]

Further analysis revealed Gennaro's feeling of rejection by the maternal body which to him was anything but a shelter, as it is usually imagined. To him the maternal body contained "monsters and witches." Eventually this patient reported that he'd stopped the masturbation, and his associations in analysis indicated that he had begun to experience the analysis as a kind of addiction that replaced the masturbation.[188] The moratorium on masturbation did not last, however. Feeling conflicted between continuing with the analysis, as his analyst thought he should do, and stopping, as his family was pressuring him to do, Gennaro (in the first-person voice of Morra, the analyst)

> tried to imagine his future, and complained that I did not want to tell him to which kind of cure I wanted to bring him. I interpreted that he was frightened by the possibility that I could have in my mind a preconception of normality and righteousness for him, and this could sound narrow-minded and unoriginal to him. Gennaro seemed stuck, and said that maybe it was him who had such a preconception, because it gave him a feeling of security.[189]

The quote demonstrates the analyst's power both to define reality for the patient and to define normalcy and decide when the patient is better and no longer a deviant.

Following this revelation, Gennaro declared in another session that he no longer wanted to attend therapy, and did not want to accept the analyst's rules

because that would mean having to give up masturbation, which he preferred more than "having" a woman. "Masturbation had the advantage that he could do it when he wanted, [and] that he did not have to convince a woman to agree."[190] To be sure, some sessions later he described being unable to detach himself from the television the previous night:

> ...he could only change programme. When he found a suitable programme, he masturbated. He went to bed at almost 3 a.m. and read until 4 a.m. He stayed in bed until 1 p.m. and masturbated again. [...] His comment was that he was attached to the television by a kind of passion.[191]

The analyst concluded that Gennaro's defences against affect were mainly obsessional. It was over the course of analysis that his withdrawal of affects became more dramatic and pathological as he felt a sense of persecution that derived from within him, hence his cold isolation and compulsive masturbation which approached "something similar to children's autism."[192]

Like the previous report, this one began with agoraphobia but quickly turned its attention to masturbation as a defence against emotions. These two articles also had in common the aim of making certain points pertaining to theory and technique,[193] something that other reports in this group try to do as well.

Another message that emerges from these articles is that psychoanalytic principles (without its method) can be a helpful complement to non-analytic psychotherapy. Indeed, with the proliferation of other forms of psychotherapy and psychiatric medication in the decades since Freud's death and the tendency towards DSM-based mental health care, psychoanalysis proper, as we have seen, has lost its near monopoly. Yet, in a way psychoanalysis has also expanded its influence, in that most of the non-psychoanalytic psychotherapies available employ

classical and contemporary psychoanalytic concepts with striking regularity. Cognitive and behavioural psychotherapy has been especially influenced by object relations and self-psychology theories.[194]

For example, one article (published in a non-psychoanalytic journal) illustrated the advantages of drawing on object-relations theory when implementing exposure treatment to deal with agoraphobia stemming from the problem of separation anxiety. The author attempted to transcend the "unnecessary dichotomy" between analysis and behaviour therapy "based upon mutual suspicions of methodology and basic assumptions as well as ignorance of recent developments."[195]

Friedman, the author of this article, observed that although it has been a longstanding theme in the history of psychotherapy, integrating psychotherapeutic approaches has not always been well-received.[196] He maintains, however, that while the cognitive-behaviourist model offered many useful clinical strategies, it did not address the predisposition to the disorder. Nor did it provide a framework for conceptualizing the patient-therapist relationship, the nature of which may have implications for treatment outcome.[197] This lacuna, he insisted, illuminated the need to consider object-relations interpretations of agoraphobia.

Rather than focusing on the symbolic dangers of proscribed territory as Freud emphasised, Friedman emphasised the home and companion of the patient, permitting a connection back to early failures in the separation-individuation phase, as seen in cases above. As Friedman states, "The sequence of the toddler darting away from the mother, experiencing anxiety, and returning to closely 'shadow' mother, so closely parallels the phenomenology of agoraphobia

as to suggest an underlying identity and similarity of conflict." The separation, when not "normal", can either be too harsh or too insufficient, sending the message independence is not desirable or even safe. The child's attitude toward outside and unknown territory is contingent upon the mother's ability to allow the child to separate,[198] as we saw with R's mother (above) who was unable to let her daughter go.

In terms of theoretical assumptions, this piece is not so different from others we have seen in this period. Where Friedman departs, however, is in his application of these principles to the role of the therapist. In any separation-individuation phase, the mother's emotional availability is crucial. Similarly, in implementing exposure therapy, the therapist must avoid being like the "good" or "bad" parent so as not to reproduce the separation anxiety that the patient experienced as a toddler:

> The actions of the behavior therapist may be seen as mimicking the actions of the 'good enough mother' of the toddler, who similarly experiences separation anxiety in the face of spatial separation. [...] The 'good enough' mother (therapist) will encourage separation, while still being emotionally available as the child (patient) explores the outer world. The therapist attempts to find a middle ground between being 'overcontrolling' or infantilizing. In in-vivo exposure, the therapist firmly insists that the patient attempt to involve himself in anxiety-producing situations, being careful not to assign tasks that are too difficult, the therapist is also available to support and provide encouragement.[199]

He draws on a case to illustrate this last point. "M.G.", a "29-year-old, white woman" was, as a child, overprotected by her mother. She developed a fear of travelling alone when she became engaged to marry, but initially was not diagnosed as "an agoraphobe" because she would often travel long distances alone. She had a pattern of staying home for several days and then becoming furious,

"and in a frenzy of activity [she would] go outside in spite of her panic attacks."[200] Her "activity level would heighten, until she would become exhausted and collapse and return to her housebound state."[201] In her in-vivo exposure, the therapist trainee made use of object-relations theory by resisting M.G.'s efforts at premature independence through attempts to take on bigger assignments. M.G. would be told that "at appropriate times she would be encouraged to try harder assignments." At other times, when M.G. felt "'sick and unable to go on,'" the therapist would offer encouragement and empathy.[202]

The process of therapy, like the parent-child relation, does not always go so well, however. As Friedman notes, therapists often either try too hard to cure the patient, or alternatively, give up when they do not get the desired results, both of which, again, replicate a failed separation: "The therapist, like the family, can then be seen as either a safety-producing companion or a spokesman 'pushing' for a traumatic degree of separation."[203] For example, a 31-year-old agoraphobic man came to the clinic for treatment of his phobia of riding in elevators so that he could comfortably visit his parents and girlfriend.[204] The therapist trainee developed a gradual programme of in-vivo exposure, but it was several weeks before the patient would get on an elevator and the therapist was becoming frustrated. When the man finally did want to get on the elevator, they ended up agreeing to try going up just one flight. The therapist accidentally on purpose hit the number seven, which, not surprisingly, greatly alarmed the patient. Evidently, the therapist

> was caught between having polarized responses to the patient's severe avoidance and phobic behavior. At first, the therapist 'infantilized' the patient by not firmly insisting upon at least visiting an elevator. Then, once

> the patient and therapist agreed upon the therapeutic task, the patient asked for 'more'. The therapist at this point, instead of slowing the patient down, agreed to get on the elevator. [...] The 'mistake' of pushing number seven on the elevator could be seen as an 'attempt' to punish the patient and push him to improve in one session.[205]

The influence of psychoanalysis on other forms of insight therapy was not limited to the principles of object relations. Self-psychology, a variation on psychoanalysis (à la Heinz Kohut) that takes narcissistic personality disorders as its point of departure, also makes an appearance. Examining the "syndrome" of panic attacks, hypochondriasis and agoraphobia (described throughout the article as occurring fundamentally together), the author seeks to develop a comprehensive theory that can account for the "dynamics of onset," the "association of these symptoms as a clinical syndrome," and the "premorbid personality structure which underlies their development."[206] Central to such a theory would be the concept of the self-object which can be defined as "an object which is experienced psychologically as part of the self rather than being perceived as separate or independent."[207] When the self-object functions properly, the child develops a "firm and cohesive self-structure...capable of neutralizing anxiety." Functioning *improperly*, the capacity to regulate anxiety fails, predisposing the patient in later life to "self-fragmentation" whereby "under particular stresses, the structures which compensate for [self-fragmentation] and defend against it are undermined."[208]

Panic is the experience of self-fragmentation, while hypochondriasis and agoraphobia elaborate upon and defend against further self-fragmentation.[209] In panic, the "sense that something is seriously wrong with the body indicates that the somatic representation of the self is undergoing fragmentation." There is a

sense that the "psychic structures cannot be trusted to contain panic" and parallel to this is "the fear that the body cannot be relied upon to carry out life-sustaining physiological functions."[210]

Hypochondriasis is defensive, an "attempt to concretize, rationalize and demarcate the broader process of self-fragmentation." The central fear in hypochondriasis is "massive collapse resulting in disability, helplessness or death." The unconscious themes of feared dependency and loss are recurrent and embedded in the hypochondriacal expansion on the self-fragmentation that is occuring.[211]

Agoraphobia, on the other hand, represents the patient's desperate need in childhood for "attachment to a secure, calming self-object." In the absence of a secure self-object, the crucial need for it is deeply repressed and isolated by the defensive structure.[212] The common need among agoraphobics for a companion is suggestive of this long-repressed need "burst[ing] forth with disturbing force."[213] Psychotherapy and the exploration of defences against affects leads to a reversal of the pathogenic process of self-fragmentation at the root of this neurosis. Self-cohesiveness is increased and the "psychic and somatic components of self-representation, ...dissociated under the threat of self-fragmentation, are reformed."[214]

The above articles reflect how methodological and theoretical frameworks may guide clinical practice and psychotherapeutic interpretation. There is another methodological consideration that surfaces in these reports, however, and it has deeper disciplinary and professional implications. Specifically, it concerns the lack of scientific rigour in psychoanalysis and its jeopardised professional

standing within the field of mental health care (for which the lack of psychoanalytic literature on agoraphobia may be a strong indicator).

A subtle reference to this is made in an article lauding the elaboration of the unconscious through mathematical concepts of symmetrical and asymmetrical thinking, as outlined by Matte Blanco, an Italian psychoanalyst.[215] Briefly, according to Matte Blanco's theory of the unconscious and the "logical laws" by which it is governed, the unconscious treats all relations as symmetrical and without a difference between the part and the whole, and without recourse to the existence of space and time. In other words, "traumatic events of the past are not only seen in the unconscious as ever present and permanently happening but also about to happen, hence the need or compulsion [à la Freud] to repeat the defensive behaviour."[216] The self and object cannot be differentiated, both occupying the same places and the whole and its parts are interchangeable.[217] This means that conscious thoughts are asymmetrical, and the purpose of analysis is to enable the patient to understand the transference that occurs with a move from symmetry to asymmetry.[218] Two cases illustrate this thinking.

The first, "Peter," was a 32-year-old dentist of German descent, married and father of three children. He had developed his agoraphobic symptoms following the Second World War when he was young, but when his family emigrated to Britain and he was faced with learning a new language, a new school, and a new environment, his symptoms disappeared. Following an emergency surgery at the age of 15, however, the symptoms reappeared and Peter was unable to go anywhere alone. He saw a psychoanalyst and then a psychiatrist, both to no avail. When he went to university he found another psychoanalyst whom he saw for five

years until the analyst left the country. He switched to a new analyst, with whom he also remained in therapy for five years, until this analyst also moved away. Peter made no advancements in these 10+ years.

Eventually Peter switched to Fink – the author of this article – frequently missing sessions and dragging out the therapy. Only when Fink imposed a termination date and declared that he would not tolerate any more absences, did Peter begin to make real progress.[219] Setting a deadline and a boundary on missed sessions

> made time appear in the analysis; it stopped it being a timeless affair and caused some part of it to shift from the unconscious to the conscious level of his mind...[which made] possible the introduction of other asymmetrical factors into his thinking.[220]

Peter used timelessness to deceive himself about the non-passing of time, resulting in endless, unsuccessful analysis.[221]

In addition to setting these limits, Fink also called Peter on not letting go of his agoraphobia, on using it as an identity: "as if on his visiting card he had put his name and underneath 'Agoraphobic' instead of 'Dentist.'" With this Fink introduced the problem of space into Peter's analysis:

> When Peter realized his space factor symptoms, his agoraphobia, could not function any further as a symptom or as I put it previously, as a cathected object-symptom, that is, as an identity, the acceptance of it on a conscious level in terms of asymmetry allowed him to decathect it, to give it up.[222]

With this Peter "gained access to a large portion of his ego that had finally emerged from the chaos of symmetric thinking...into the conscious world of asymmetric thinking."[223] Evidently, it is not only outside public space that is im-

plicated in agoraphobia; unfortunately this point remains unexamined in the literature .

Conversely, the other case in the report, "Caroline," was not able to make the transition from symmetrical to asymmetrical thinking. She was born prematurely – "a colossal deviation from normality"[224] – and remained in an incubator for several months where she was subjected to all sorts of "medical tortures."[225] "She was in a confined space with transparent walls permanently lit up, observed at all times by the hospital staff, connected to tubes, handled only with great care by doctors and nurses wearing sterile gloves, and so on."[226] Like Peter, she too suffered from agoraphobia, which was becoming a significant problem in terms of her employment. She was also "sexually naïve" and could not tolerate the idea of intercourse, though the thought of being slapped on her bare bottom was quite exciting to her. Unfortunately, unlike Peter, analysis did not help her at all. As Fink described it:

> Nothing she or I said would make any difference to her state of feelings, she felt a prisoner of her symptoms and felt desperate because time was passing and she was getting nowhere, feeling more and more inadequate. [...] Caroline's basic problems never changed. She continued for two and a half years to attend her sessions [...] [but] nothing ever touched her inner self. After five and a half years of analysis we fixed an ending date a few months ahead...[227]

Of course the question becomes, why didn't setting a deadline have the same positive effect for Caroline as it did for Peter? The answer is because she "never acquired a normal capacity for asymmetric thinking; ...her ego remained incomplete."[228] Her concept of space was defective, owing to the early post-natal trauma of being confined to an incubator when she should have still been a foetus. Moreover, having to undergo endless medical interventions and penetrations

(needles) symbolically left her with a resistance to sexual intercourse.[229] Unlike Peter, for whom the concept of time was the main obstacle, Caroline's issues were with space:

> space being denied outside herself was also concretely denied inside herself, hence neither could her partner penetrate her with his real penis nor could I penetrate her with my interpretations. In Caroline there was and there is no space to be penetrated... [...] I think Caroline never really left the incubator, she is still inside it. Her fear of leaving it constitutes, to a large extent, her agoraphobia.[230]

Unfortunately for Caroline, traditional psychoanalysis is ill equipped to deal with early post-natal trauma, leading Fink to propose developing "wider concepts" that could "explain more phenomena in a unitary way." Fink credits Matte Blanco with attempting to address this problem through making a theory of the unconscious "into an exact science by using the most exact of sciences, mathematics." Fink urges colleagues to consider that only

> when we gain new scientific knowledge will we be able to introduce new methods and only if the new facts warrant it. I believe psychoanalysis has been, is and always will be in a state of development which is the only way in which a science remains young, potent and alive.[231]

This sentiment is one strongly endorsed in a recent paper by Allan Compton, an American psychiatrist.[232] A vocal proponent of making psychoanalysis more scientific if it is to survive its veritable exile from mainstream psychiatry, Compton has recently published several articles in which he argues for an overhaul of DSM-IV's nosology to re-incorporate psychodynamic considerations. The development of sound treatment outcome studies – something psychoanalysts have historically resisted – is, in Compton's estimation, the most effective means to such an end.[233]

Compton's endeavour began with an effort to revive the psychoanalytic view of phobias and anxiety through a four-part series on the subject.[234] He observes, as I have, that in "recent years almost innumerable papers on phobic conditions have appeared in the psychiatric literature, while none have come from psychoanalysis."[235] As he puts it, this is "certainly not a sign of avid psychoanalytic interest in this most common clinical condition."[236] There is extensive literature on treatment results coming out of pharmaceutical and behavioural-cognitive methods, but no treatment outcome studies have ever been published by psychoanalysts. For this reason it is fair to say that "psychoanalysis has lost its clinical moorings"[237] and if psychoanalysis is to regain its credibility, treatment results need to be presented in a scientific manner.[238] Compton acknowledges that case studies, the traditional psychoanalytic forum for reporting on results, have a certain value, but psychoanalysts need to delineate clear boundaries around the conditions being treated in descriptive, not theoretical terms.[239]

In other words, what Compton seems to be arguing is that if psychoanalysts are to reclaim their rightful place in the world of mainstream psychiatry, they need to play more by the DSM's rules. He sees the DSM as a "route to legitimacy" and a "guideline to what is 'real' in the realm of psychopathology," and something that analysts have "backed away from."[240] Without a clearer system of classification in psychoanalysis, "results cannot be aggregated in a meaningful fashion [and the] validation of psychoanalytic hypotheses, or choices among competing hypotheses, depends largely upon the comparison of therapeutic results."[241] To this end, he asserts that the terminology needs to change, at least with regard to agoraphobia. Since agoraphobia tends to include fears of a number

of things (such as elevators, travel, closed spaces, intercourse, and so on), it would be more appropriate that its nomenclature reflect this:

> Before we can decide whether the dynamics of any syndrome show consistent features, we must have a clinical picture with reasonably well-defined boundaries; that is, we must know what the syndrome is that we are trying to investigate. The most natural boundaries, descriptively, here seem to me to include all of the above kinds of fears, since they tend to occur together in any event, even though not all may be present in any given instance. The name 'agoraphobic syndrome,' rather than 'agoraphobia,' then seems more appropriate [to denote this] agoraphobic cluster...[242]

In the final instalment of the four-part series Compton continues this point by saying that the criteria for what counts and does not count as a phobia are "to most analysts...arbitrary, artificial and unduly restrictive in clinical practice...[but] necessary for research."[243] It seems that psychoanalysts are in a position to offer improvement on this state of affairs, but they have as yet failed to develop a coherent theory of phobias out of a refusal to use demographic data and statistical methods. Of course, implicit in this statement is the assumption that other psychiatric disciplines have done better by using demographic data and statistical methods. But I would argue, as we have already seen, that there is *still* no coherent theory. To be sure, practitioners today cannot even agree on whether panic and agoraphobia are separate or synonymous disorders.[244]

It is in a more recent article (1998) that Compton takes up his own challenge, and begins the task of constructing the research he called for in the earlier series. He offers a rationale and design for a preliminary research project intended to challenge the "hegemonic knowledge claims of the DSM system" by offering a "reliable, psychoanalytically influenced nosology"[245] as a first step towards enabling reliable outcome studies of psychoanalytic treatment for agora-

phobia.[246] Once the validity and reliability of its criteria are tested and refined by the inclusion of psychodynamic concepts, then the outcome studies so desperately needed by the profession will be possible. He laments that psychoanalysis is under considerable duress.[247] With its tendency to disparage diagnosis, treatment, and science, it comes as no surprise that the discipline is "criticized as unscientific and...of little treatment value by those who are not psychoanalysts."[248] The failure to produce convincing generalizations based on traditional rational and empirical methods has not helped to shore up the status of psychoanalysis:

> ...those steps which in other sciences are reasonably designated as 'advances in knowledge' have not been taken in psychoanalysis. We have not met our obligation to be part of science as a cumulative endeavor [...] evaluating the feasibility of generalization as mere 'number crunching.'[249]

If psychoanalysis is to participate in the advance of knowledge, Compton insists, then analysts need to take the same steps as in any other clinical science:

> [the] careful design of studies; parsimonious hypotheses; replicable data; empirical methodology in data analysis, not just in data collection, assemblage of outcome results; and comparative evaluation of treatment efficacy.[250]

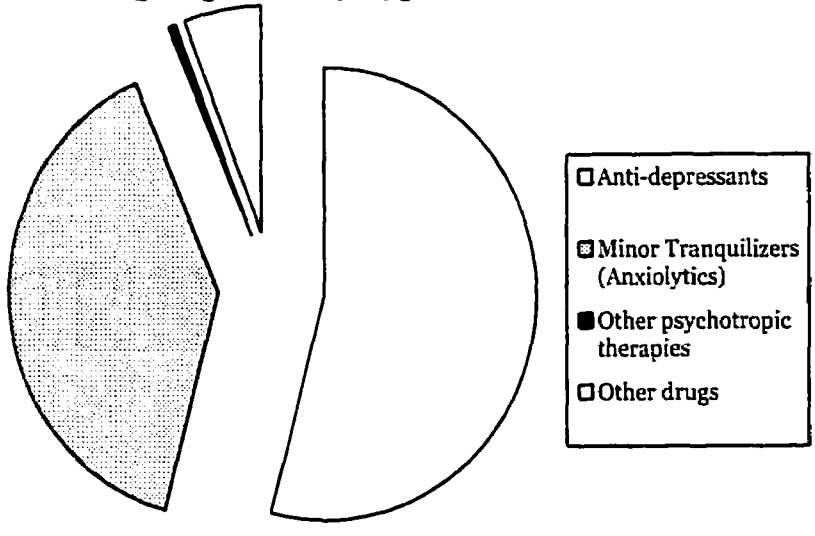
It remains to be seen whether or not Compton's remedy for professional exile will come to fruition. In the meantime, as we shall see next, pharmaceuticals have held significantly more sway.

Psychotropic drugs:
The prevalence of anti-depressants and minor tranquillisers:

Although its history as a major component of medical practice begins as early as the nineteenth century,[251] without question the pharmaceutical *industry* has had a significant and lucrative involvement in the treatment – and arguably the bio-

psychiatric (re)construction – of agoraphobia in the last 30 years.[252] It is important to consider this involvement in two important respects. The first point concerns the particular classes of drugs predominantly in use and the issue of who prescribes and who uses them. As the diagram below demonstrates,[253] the main types of drugs used and researched in the treatment of panic/agoraphobia are anti-depressants and minor tranquillisers.[254]

Use of and Research on Drug Therapies for Agoraphobia by Type, 1976-2000



Second is the issue of how the profit motive and pharmaceutical research interconnect. As I noted previously, there has been a shift of emphasis within clinical publications to representations of evidence-based medicine (a shift that is related to the controversial data compiled for and as a result of the DSM). In light of this shift, the relationship between controlled trials, drug prescription, drug marketing, and (a necessity for) the construction/invention of relevant disorders becomes apparent. In this section I will deal with these two points in turn.

Anti-depressants fall into four major sub-categories, namely Tricyclics, Monoamine Oxidase Inhibitors (MAOIs), Heterocyclics, and Selective Serotonin Reuptake Inhibitors (SSRIs).[255] The use of anti-depressants to treat agoraphobia is interesting in light of the longstanding debate in psychiatry over the question of whether or not depression and anxiety are in fact related conditions.[256] For those clinicians who see them as linked and who opt for a biological treatment of agoraphobia, however, far and away the most popular anti-depressant has been the tricyclic imipramine,[257] valued for its effect of fear reduction and its ability to block panic before it happens.[258] Physicians have long preferred imipramine, despite early evidence that the MAOI phenelzine is equally or more effective.[259] Presumably imipramine, "the most extensively studied pharmacologic treatment of panic disorder,"[260] has been more popular than phenelzine because it does not require the dietary restrictions characteristic of MAOIs, nor does imipramine have the unwanted side effect of weight gain, for which phenelzine is known.[261] There is also recent evidence supporting a greater efficacy of the more recently developed (and heavily marketed) SSRIs (such as Prozac), but it remains to be seen whether or not this class of drugs will entirely replace imipramine and other tricyclics in the treatment of agoraphobia.[262]

The other class of drugs – the anxiolytics or minor tranquillisers – are valued for their efficacy in blocking anticipatory anxiety or the fear of the physical symptoms of panic so often described by sufferers. Anxiolytics can also be subdivided into two main categories, namely high potency benzodiazepines and azaspirodecanediones (such as buspirone).[263] Clearly the benzodiazepines – known in some circles as "housewives' pills[264] – have been the more popular of the two.

The study and use of alprazolam (Xanax) has been especially widespread although other benzodiazepines have also been used to treat agoraphobia and panic to a lesser extent.[265]

With tricyclics and benzodiazepines both compared and combined throughout these articles,[266] it is evident that the matter of which drug is the better choice of treatments has been the subject of longstanding debate (and a source of contradiction).[267] It may simply come down to which drug company is more forthcoming with research funding.[268] But what is clear from these reports is that the best approach to treating agoraphobia and panic is believed to be pharmacotherapy – either or both anti-depressants and benzodiazapines – used *in conjunction with* behaviour and/or cognitive therapy.[269] As we have seen, by the end of the 1970s psychodynamic therapy, "once the mainstay of treatment, [had] largely become an adjunctive procedure".[270]

Given that it is anti-depressants and tranquillisers that have predominantly being been used in the pharmacotherapeutic approach to treatment, the fact that this pathology is firmly associated with women should ring an alarm bell. In other words, we have to wonder if "the problem with no name" identified by Betty Friedan as early as 1962 has actually gone by a few names (depression, agoraphobia, panic, etc.). We also have to ask, is it a coincidence that both the prevalence of agoraphobia and the concomitant consumption by women of these particular drugs increased at a time in history when women's participation in the paid labour force increased as well? Moreover, as Waldron argued in her study of the use of Valium in the US, the rapid growth in the use of minor tranquillisers in

the 1970s coincided with a rise in social problems, including suicides, homicides, and alcoholism.[271] As she stated:

> ...use of Valium and Librium...would appear to have significant social consequences. Perhaps most significantly, it focuses attention on individual malfunction and the alleviation of symptoms of distress, rather than on seeking to understand and deal with the problems and their causes. As a consequence, social and economic problems are dealt with in the framework of a medical model of relief of individual distress rather than in a social and political context of cooperative efforts for societal change. It is tempting to speculate that the 'medicalization' of these problems reduces pressures for social change and that this outcome is advantageous from the point of view of those who profit from the existing economic and political order.[272]

The important social changes of the last thirty years would no doubt have introduced certain new stressors for women, but what Waldron's allegation suggests is that their medicalisation vis-à-vis anxiolytics may have proved to be a very effective means of (gendered) social control. Related to this issue is the alarming evidence showing that benzodiazepines – alprazolam and others – are addictive.[273] Benzodiazepines are the most widely prescribed anxiolytic,[274] if not one of the most widely prescribed medications overall,[275] and there is much evidence to show that stopping alprazolam (and imipramine) too soon or too abruptly can lead to a relapse of symptoms – a quality that is indeed very good for the pharmaceutical business.[276]

This might help to explain why some individuals, such as "Anna" (described in one case report from 1979), was – for *10 years* – only able to "carry out normal daily activities" with "out-patient support supplemented by diazepam (Valium) and Chlordiazepoxide (Librium)".[277] Yet the issue for "Anna" has implications on a much larger scale; it is undeniable that these drugs help reduce the number of patients in mental hospitals[278] and that they have had positive effects

for some patients in enabling them to function "normally" in their day-to-day lives. But these positive effects *must* be contextualised; these drugs serve not only as a tool in the management of agoraphobia and panic experiences, but may also be seen to constitute a kind of social system as well.[279] In other words, analysis of the role of pharmaceuticals in the history of agoraphobia entails looking beyond the reinforcing (addictive) properties of the drugs themselves to questions of pharmacoepidemiology[280] (patterns of drug use) and the relationship between "pills, profits and politics".[281]

If we take into consideration the number of people diagnosed with agoraphobia – prevalence figures have been cited as high as 5 per cent of the American population[282] – we are looking at a potentially very lucrative site for benzodiazepine (and imipramine) sales. Allow me to put this in clearer and more compelling terms: 5% of the US population is roughly 12,500,000 people – the strong majority of whom are women. That is, in other words, up to 12,500,000 may have already experienced or may still have yet to experience either or both of these drugs. Meanwhile, it is well-known that women are the heaviest users of mood-modifiers.[283]

To be sure, one article published in 1991 reported on studies in the US, which showed that 15% of the general population reported using psychotropic medications, with one-third of these users reporting a dependence on minor tranquillisers. The same article reported that in the US 50% of all prescriptions were for anti-anxiety medications, and minor tranquillisers accounted for the largest share of prescriptions.[284] The Pharmacia & Upjohn company, for example, one of the producers of alprazolam and considered one of the "big boys"[285] of

drug manufacturing, shows $321 million USD in sales of alprazolam in 1998, up from $279 million USD and $279 million USD in 1997 and 1996 respectively.[286] The Patented Medicine Prices Review Board of Canada reports that patented drugs used to treat conditions of the nervous system, the category under which imipramine and alprazolam fall, accounted for $655.9 million in 1998 and 15.1% of all pharmaceutical sales that year. Moreover, these Canadian figures represent a growth of 39.6% or $186 million dollars from the year before. In total the Canadian industry earned $4346.8 million in 1998.[287] It has been observed even more recently that the global antidepressant market is expected to increase from its current value of $11.1 billion USD to $13 billion USD by 2005.[288]

It is probably self-evident that the marketing and promotion of pharmaceuticals has had a big role to play in these huge earnings. These activities can include everything from what to name a drug,[289] to what to emphasise in promotional materials,[290] to sponsoring physicians' trips to conferences and paying for fridges for their offices, to paying for textbooks for medical students, to keeping clinics in good supply of free drug samples,[291] to research and development (R&D).[292] Spending an estimated $1 billion dollars this year on marketing alone, all of this is financed of course by a given company's profitable sales of already-marketed pharmaceuticals.[293] Marketing considerations "have a significant effect in determining how pharmaceutical research and development funds [henceforth R & D] are allocated" so that demand – not disease – dictates.[294]

In other words marketing may play a role in deciding how R&D funds are allocated and also which indications or claims for a new drug will be researched. Marketing research can be used *prior* to drug development as a means of "de-

signing clinical trials that address market needs" and "providing guidance to new business development/product management to ensure that the product is positioned to showcase the clinical properties that R&D has created based on prior assessments of market need."[295] And, when faced with increasing competition, pharmaceutical companies can choose to market old drugs for new indications.[296] Research and development " may also be influenced by marketing's need for clinical evidence to promote a specific competitive advantage for a product" and the needs of shareholders and medical needs therefore often conflict.[297] In some cases, researchers themselves may benefit when they own the very company that stands to gain from the research, an increasing occurrence in Canada which, although it has caused some consternation, is perhaps inevitable in a "'resource-based economy slowly going down the tubes'".[298]

One implication of all this is that in the last few decades the academic and corporate worlds have become disturbingly close bedfellows, a relationship that is all too often concealed – if not a source of conflict – in pharmaceutical trials. (Witness the nasty response to University of Toronto's Nancy Olivieri whose findings were "contra-indicated" to what was expected and desired by the drug company that funded her work.) In Canada, between 16 and 30% of all research at big medical schools (McGill, Queen's, Toronto, and British Columbia) is funded by pharmaceutical and biotech companies, raising questions as to the possibility that "links with drug companies change the way scientists work".[299] Another implication is that R&D funds may be used to develop profitable pharmaceuticals that satisfy consumer needs but actually contribute little or nothing to health care.[300] Jackie Orr, in her postmodern autopathography, observes that

> [t]he story of panic disorder, as told by a medical/corporate model of biological illness, recirculates women's panic within the transnational economy of (re)productive relations: reproducing women-bodies as a secure, because we're panicked, site for pharmaceutical profits. The effect of women's panic when experienced within this discourse is to speed up the theoretical and technological machinery of transnational corporate capital.[301]

This adds critical perspective to the extensive research in the last 30 years on agoraphobia, imipramine and alprazolam – used primarily by women and suggests that perhaps all this research has not been medicine so much as market-driven. Irrespective of the force(s) behind it, it is undeniable that biological and positivist research has dominated the discourse on agoraphobia. And, even among the behaviourists, the (re)turn to positivism and the rise of neo-Kraepelinian biopsychiatry that I described in my earlier discussion of the DSM is evident. It is to the cognitive-behaviourists that I turn next.

Behavioural and Cognitive Therapies

The case report, though useful for conveying newsworthy accounts of illness, is nowadays regarded with scientific skepticism as to its generalizability. "As a variety of the personal essay, the case report struggles with the problems of subjectivity and contingency, and these problems have earned it the suspicion of clinical scientists."[302] Thus although there are some case reports, as we shall see shortly, writers using behavioural methods have for the most part published controlled and uncontrolled, often multi-authored, studies.[303] Moreover, the disaffected language of the scientific method overshadows any sense of individuality or agency on the part of the agoraphobics participating in the studies. [304]

The success of behavioural-cognitive treatment is usually measured not only by the status of the patient's symptoms immediately following treatment, but also according to whether or not the patient remains free of symptoms after months and even years have passed.[305] Still, the reports disagree as to whether patients have a very good,[306] very poor,[307] or mediocre[308] chance of recovery.

A review of these publications shows interest in a number of behavioural methods, including relaxation,[309] breathing retraining,[310] and even hypnosis.[311] The most prevalent form of behavioural treatment is exposure[312] and it is widely believed by clinicians of this persuasion that some form of exposure *must* take place to ensure recovery for agoraphobic patients[313] whether or not drugs are also used.[314] Despite the widely shared view of exposure as a necessary ingredient for recovery, in addition to exposure methods (described in chapter 6), cognitive therapy,[315] including assertiveness training,[316] self-statement training, guided mastery and paradoxical intention (all derivatives of cognitive therapy), also have their proponents.

Cognitive therapy seeks to effect recovery by focussing on patients' understandings of their circumstances and the meanings and labels attached to their feelings and the stimuli. Seeking to "modify the internal dialogue,"[317] cognitive therapy can also be a means of improving patients' sense of self-efficacy, or the idea patients' often have that they cannot cope effectively with their phobia. For example, "self-statement training" takes negative thoughts such as "I'll never be able to handle shopping in malls, or I'll certainly make a fool of myself if I go shopping in a mall and faint" and replaces them with alternatives such as

> 'I'll be able to cope with the situation even though I may not feel perfectly relaxed, it won't be impossible to handle; or, even though I may experience some anxiety, it certainly is no worse than the discomfort I experience in other situations, and I am able to handle those situations alright...'

Thus self-statement training seeks to address "preparing", "confronting", "coping", and "reinforcing".[318]

Related to both cognitive and exposure therapies, the method of "paradoxical intention" works from the assumption that avoidance is the most salient aspect of agoraphobia. Incorporating elements of exposure therapy, the most effective way to overcome phobic anxiety therefore, is to enter situations that increase anxiety. The objective with paradoxical intention is to become as panicky as possible, to accept the anxiety, to feel it and to ride it out until it subsides, rather than trying to control and avoid it which only serves to fuel further anxiety. A report on the successful use of this method to treat the avoidance behaviour associated with agoraphobia describes a 16-year-old girl who was instructed to

> approach each phobic situation and to focus her attention on the experience of any fears or thoughts of death, the pounding and tightness in her chest, the weakness in her legs, and her breathing difficulty. She was also requested to notice and accentuate any diminution in subjective anxiety during exposure...and not to withdraw from any situation due to discomfort, but rather, only momentarily to cease carrying out the paradoxical instruction while still maintaining her exposure.[319]

Paradoxical intention thus directly opposes methods that seek to manage anxiety by limiting or avoiding altogether any panicky feelings, as is the case, for example, in the technique of graded exposure which has the patient stopping at the threshold of panicky feelings.[320]

In "guided mastery" the focus is on "people's success in enacting progressively more challenging tasks and their sense of accomplishment and mastery

from doing so" rather than simply placing passive patients into a phobic situation in order to deal with stimuli. The therapist has a major role to play in guiding, supporting, and assisting patients toward success, unlike exposure, which discourages the therapist as helper. The goal of guided mastery is increased self-efficacy, even if it means a reduction in stimulus exposure. [321]

Writers debate various issues pertaining to cognitive and behavioural therapies, such as the merits of cognitive therapies versus exposure methods[322] as well as the efficacy of imaginal versus *in vivo* (real life) exposure[323] and exposure. Prolonged exposure *in vivo* tends to be preferred over strictly cognitive methods but not entirely; one group of authors rationalises with the following statement their finding that cognitive restructuring does not work as well as some other studies:

> ...it seems probable that the level of intelligence of our (mostly lower-class or middle-class) clients will on the average have been lower than that of the subjects in the [other] studies, who were students in almost all cases. Cognitive restructuring might well be more effective with intelligent students used to thinking rationally than with a clinical population.[324]

Frequently, cognitive and behavioural methods are used together.[325]

The relationship to the therapist is also examined in these articles, both in terms of who should carry out therapy, with how many patients, and in terms of how important the presence of a therapist actually is. I shall deal with these in reverse order. One recent study, for example, found telephone therapy to be beneficial, especially to rural patients who would not otherwise have access to specialised treatment centres.[326] Nevertheless, when telephone therapy was compared with exposure therapy, the latter was demonstrably superior.[327] This suggests that "while self-directed or telephone-guided treatments may be of some

value to persons who are unable to travel to treatment centres, this sample of severe agoraphobics is probably the one least likely to benefit from such procedures."[328] It also supports the wide agreement among these writers that exposure of some form is a necessary component of successful treatment. The degree of exposure assumed missing from telephone treatment points to other related considerations, namely the spacing of exposure sessions, the level of exposure (intense versus graduated), and whether or not endurance (versus controlled escape) is necessary to attain the desired outcome.[329] Spacing exposure sessions close together in order to block opportunities for avoidance behaviour is also shown to be effective,[330] as are intensive "mega-doses" of behaviour therapy, especially for people who do not respond to therapy.[331]

Group therapy and its implications for savings on therapists' time and cost-effectiveness, as well as the benefits of a supportive group dynamic are also discussed.[332] A program of cognitive-behavioural group psychotherapy aimed at confronting the "fear-of-fear" at the root of this "disability" is described by Belfer et al who state:

> Agoraphobia is a highly demoralizing condition. The support and sense of commonality...offered by members of the group to each other are invaluable in reducing demoralization and maintaining motivation to engage in anxiety-provoking treatment. Group members share strategies to cope with both everyday challenges, that otherwise lead to avoidance and withdrawal, as well as to cope with anxiety engendered by exposure treatment. The nature of the agoraphobic panic attack, its overwhelming nature and attendant sense of doom, often fosters social isolation. The empathy expressed by members for each other's experiences has a "ring of truth" that therapists are rarely able to match.[333]

The question of who should carry out therapy is addressed in studies that examine the strengths and limitations of family members acting as co-

therapists.[334] It is in the nursing literature, however, that we find the most compelling alternative to the traditional doctor-patient arrangement. Although they do touch on many of the same themes represented in the other types of reports, this set of roughly 25 articles written mainly by nurses (but published exclusively in nursing journals) represents a marginal yet convincing avenue into understanding this pathology. Peaking in the early 1980s and again in the early 1990s, nearly all written by British male and female nurse therapists, and nearly all taking a behaviourist approach, these reports tend to be single-authored publications that come across more as magazine articles than as scholarly academic pieces.[335] Written in the first-person and in a popular and accessible style, they include descriptive graphics and photos, advertisements, and sidebars. Mixing fiction with non-fiction, nurses have *stories* to tell – narratives about patients, about patient care, about the nature and causation of the pathology, and about the role and contribution of nursing itself. For example, observing that agoraphobia is occasionally known as the calamity syndrome because distressing incidents so often precipitate the disorder, one "clinical parable" begins:

> A harvest moon hovered fleetingly behind banks of wispy clouds as Mary wended her way cheerfully from the local dance hall. Her mind was racing with recollections of the past few hours – minor flirtation and the prospect of still more pleasant liaisons. [...] Her stiletto heels rattled along the lonely country lane. Suddenly...she missed her footing and slid into the roadside ditch. [...] All at once Mary found herself sinking into a slimy morass...she was quite convinced that there would be no escape from total submersion and suffocation in a God-forsaken bog.[...] Ruefully she clawed her way back to the road and surveyed the damage; nothing worse than a pair of laddered tights and a soggy skirt. Or so it seemed. But the greater harm was still to show.[336]

Another begins with a quote from an agoraphobic patient:

> I gripped the pram as tightly as I could, thankful that I had it to hold on to. My breathing was becoming laboured, surely my heart was going to burst, right here on the street in front of everybody. I must try to hang on, we're almost at the school, I mustn't run, it would only draw attention to myself, frighten the kids. Suddenly my scalp had pins and needles all over it, tears welled in my eyes. I began to get a funny sensation in my ears, a sensation of enormous pressure. I told myself I was having a brain haemorrhage.[337]

Along these same lines, the articles are also often given imaginative titles such as "Agoraphobia: far from the madding crowd"[338]; "Agoraphobia: another brick in the wall"[339]; "Behind closed doors"[340]; "Imprisoned by fear"[341]; "Learning to enjoy the great outdoors"[342]; and "Dependency in agoraphobia. A woman in need."[343] Rather than formulaic expressions of empiricist studies, the titles are creative and they capture what it *means* and how it *feels* to suffer with this "baffling syndrome."[344]

There is also in these articles a certain sense of nurses' politicisation – a sort of claim to professional space –that comes through in subtle ways. Specifically, the psychiatrists and psychologists may design the behavioural treatment programme, but nurses are the ones delegated the important responsibility of actually carrying it out. As one nurse wrote at the end of a report:

> This care study shows contributions which the nurse can make within the team, but functioning as an individual therapist; the nurse played an important part in the caring and treatment of the patient. It indicates how in many areas the role of the psychiatric nurse is changing, to involve a more actively therapeutic one.[345]

Another nurse was even more blunt: "It is interesting to note that the only intervention which kept [this patient] relatively symptom free for the longest period in the last seven years, was that of the nurse therapist."[346] In the spirit of solidarity, some of the writers also offer testimonials and networking information, as one nurse did in an autopathography about her own anxiety: "I am a nurse who

knows all about agoraphobia...because I have suffered from it. [...] [B]elieve you *can* do it. The cure is within yourself. [...] Have courage. Agoraphobia *can* be cured."[347] Her words of inspiration are followed by contact information for The Phobic Society in Manchester and references for self-help books.

These reports offer extensive detail about the sorts of interventions that the nurses make. They outline not only the steps in treatment and patients' progressions from visit to visit and week to week, but they also illustrate quite vividly the settings in which these encounters between patient and therapist take place:

> Mr Prince lived in a prestigious part of Hackney. In sharp contrast to the rest of the borough, the area was exceptionally clean, with well cared for houses and gardens.
>
> The door was opened to my knock by a short slim man who stood behind the door. He appeared subdued as I introduced myself. I was reluctant to go in because a huge fierce-looking black dog stood in the corridor barking ferociously.
>
> "Are you sure it is all right? Does your dog bite?" I asked. "Come in, it's all right. He won't bite you," said Mr Prince. I cautiously edged myself into the house.[348]

In addition to this kind of setting description, space and place become an issue in these reports in ways uncharacteristic of the other positivist studies. Specifically, because so many of these narratives describe a graduated exposure approach, certain sites cause anxiety and we are given a clear sense of the extent to which overcoming agoraphobia is so profoundly about negotiating one's relationship with space. For example, one nurse therapist offers guidelines and principles for "significant others" to follow in supporting their spouse through treatment. She writes that if a patient experiences a panic attack in a certain situation, the patient should be pushed to stay in that situation until the fear subsides. But if the patient cannot manage to stay there, then it is possible to overcome the

problem circumstance by returning to the same site until they come to terms with that fearful place.[349] Another paper tells how "Mrs. A" had, for the last three years, not ventured beyond a three-block radius of her home, and increasingly avoided certain situations and places which she identified as anxiety-producing, including shopping malls, movie theatres, banks, hairdressers, and dentists.[350]

For some patients the challenge was not in being in particular places, but in moving *through* space – walking certain distances and riding in public transport.[351] For this reason, several of the nurse therapists carried out their treatment programmes way from the patients' homes, gradually working toward clinic visits.[352] For some patients this was not a challenge that could be overcome. One in-patient, "John", after making enough progress to be permitted a weekend at home, was too afraid to return to the clinic on the following Monday; "the idea of a taxi journey was sufficiently frightening to make him stay indoors."[353] John was discharged from treatment as a result.

Mr. Prince (described above), on the other hand, was "encouraged to go on short walks by himself and to increase the distances gradually."[354] By the end of the third week of his treatment he was made to come on his own for an appointment at the clinic: "To my great surprise, Mr Prince turned up at the hospital and knocked on the door of my office at the appointed time. I was delighted that he had made the effort."[355] From this the patient graduated to public transportation:

> His next step would be to retrace his steps and take the bus to the city where he worked. I went with him on the bus during the first trip, and as far as the bus stop on the next. I let him board the bus alone. He was to get off in the city and find his way to his bank [where he worked], and return home when he felt like it. This exercise was completed at the beginning of the fourth week.[356]

Making it to back work on his own was a major accomplishment for Mr. Prince. With his career at a large international bank lying in the balance, he was determined to return to his job after five months away. Following successful treatment he did manage to resume working and "was very pleased with himself ... grateful...that we had helped him retain his work and with it his dignity and self-respect...[I]f he had lost his job he would have been utterly demoralised."[357]

The extent to which Mr. Prince's "dignity and self-respect" – his identity really – were bound up with his (in)ability to go out to work stands in stark contrast with many of the other reports, mostly about women, for whom the central goal of their treatment was to overcome their inability to shop.[358] (One clinical trial of imipramine even located the "test walk" component of the study in a shopping mall.[359]) Some patients found local shops to be the absolute limit of their excursions, as with "Mrs Griffiths" for whom it "seemed that that the furthest she could venture alone was to the two shops about 50 yards from her house."[360] Although resentful for having been "tied to the house for 14 years" and forced into "the role of wife and mother,"[361] she was almost completely dependent upon her husband "who had to carry out for or with her many of the normal day to day tasks of a housewife."[362] She did, however, manage eventually to achieve her goal of paying a visit alone to the local shops. This step of the programme was scheduled for the day that she normally bought meat "so that she had a good incentive to succeed or the family would be hungry!"[363] Other examples of the tenuous relationship these women had with shopping abound. For "Holly", a "pleasant, tubby 46-year-old woman," problems arose on the first day of her programme when she started to walk with her nurse to the shops.[364] On the way she

began to get very anxious, sweaty, and faint, but with encouragement from her nurse they were able to walk a bit further until the shops were in sight, at which point they returned to the hospital. The next day Holly was more successful and made it *all the way* to the shops. Similarly, "Mrs. A" wanted

> to be able to go into a dress shop in a mall near her home. She was familiar with the store and was able to imagine herself going through the process of getting to the store, entering it, looking at dresses, going into the changing rooms, standing at a sales counter, paying for her selection, leaving the store and going home.[365]

"Mrs. Manton", an "extremely obese woman" who was unable to use public transport or visit friends and relatives, was unable to shop.[366] Even a more recent article describes how shopping and other domestic errands had to be fulfilled by "Brenda's" teenage daughter who frequently missed school in order to get everything done.[367] Also suffering from an inability to shop for groceries, part of "Helen's" treatment was to visit the supermarket two times per week including a Saturday morning, and remain there for at least an hour.[368]

Unlike these other patients for whom shopping was a *goal* of treatment from the outset, "Joseph" actually developed his desire to consume as a *result* of treatment. His nurse therapist would bring records over to the house, seeking to cultivate in Joseph an interest in music so that eventually they could take a walk to the local library to borrow records.[369] Joseph did indeed develop a taste for country music and after nine months of treatment took his first walk in two years. This trip to the library was followed by many other excursions – to records shops, to hi-fi stores, and to supermarkets.

Save for Joseph, there is a certain sense in which shopping for the women, (as opposed to returning to paid work for Mr. Prince), points to a link between

consumption and gender identity. But gender identity issues manifest in other ways as well. For example, "Anna's" life "was greatly influenced by the fact that her father very much wanted his second child to be a boy." Her eldest sister had been encouraged to behave and dress femininely, while Anna "became a tomboy figure, enjoying sports rather than the academic studies which her sister was channelled into pursuing." As a result, when Anna was a child she believed that "she had little to attract her parents' love and esteem."[370] When she was seventeen years old, she went away to train as a nurse but "having no confidence as a girl among other girls" she had difficulty and returned home. Eventually she married a Royal Air Force pilot with whom she had two children, a boy and a girl. After he died of cancer, she spent much time at her father's home, cleaning it and making meals even though he beat her when he was drunk. Looking after others – which she tried to do in almost becoming a nurse – served the function of substituting for her own need to be looked after herself, a need that went unfulfilled by virtue of being born the wrong sex.

In additional to carrying out directed exposure programs, nurses can also play a role in setting up support groups for patients. Indeed, "traditional" methods of treatment are not the only possibilities for agoraphobic individuals seeking help for their problem. As expected by the common need for a companion, the limitation on movement that agoraphobics experience can limit their social support network, which in turn can have negative implications for the development and course of agoraphobic illness and for marital relations.[371] One organisation – the 'Outside World' Society – came about through the efforts of "one young mother-to-be" as a result of a home visit from her nurse/health visitor. Upon

hearing about two other young mothers suffering from agoraphobia, she wrote to local papers and radio stations asking to hear from others who experienced similar problems.[372] A group soon developed whose members would obtain support from each other through talking on the telephone and fortnightly meetings. The 'Outside World' Society was successful in its mission; some members were eventually even able to speak to groups of social workers and ladies clubs.[373]

We can see, then, that setting up a support group can be immensely helpful to sufferers of agoraphobic fear. A survey of members of the "Out and About" self-help association in Dublin supported this, finding that its members were "overwhelmingly enthusiastic" about the group and that it was a highly effective source of support to them.[374] Some psychiatrists' express concern that, like family members are wont to do, such a group may enable an avoidance response "by labelling [agoraphobia] as an 'illness' in a socially acceptable way, and by providing a crutch which promotes exaggerated dependency needs."[375] Such a concern was not entirely without basis, as the authors of the survey report. In its first few months the association's "newsletter was full of hints from agoraphobics on the use of such crutches as dark glasses, a newspaper under one's arm, or a shopping basket on wheels for alleviating anxiety."[376] Moreover, members made demands of the staff, phoning "for trivial reasons, hang[ing] on to the telephone for hours, and ... demand[ing] to be collected by car to the meetings."[377] Even so, the association was successful in its goals of creating awareness of the condition and of giving help to its members. A later study confirmed that the formation of neighbourhood support groups is a good thing; members can encourage each other by "attending a meeting at the home of another group member or by meeting an-

other subject at an agreed half-way point."[378] Though this may not conform with the sort of programme that clinicians would develop (and that nurses frequently carry out), it does suggest an opportunity to practice the exposure that is so widely seen as the crucial component of treatment.[379]

Conclusion

After what many think of as the huge psychoanalytic sideshow,[380] psychiatry has fully (re)turned to positivism, not only in terms of pharmaceuticals, but cognitive-behaviourism as well. It is difficult to imagine Compton's "call to science" ever being taken up psychoanalysts; they do not seem to be as willing as the cognitive-behaviourists to conform to the normative empirical standards of mainstream psychiatry.

In the next chapter, I turn to the cultural literature. By calling into question the authority of scientific knowledge, I hope to demonstrate that the boundary between medicine and culture is artificial, and that embedded within the history of agoraphobia is a normative theory of social order.

Notes

[1] Rapp and Thomas, 1978:275.
[2] Rapp and Thomas, 1978:275.
[3] As we saw in the previous chapter, by 1980 the DSM was firmly in place as the organising framework for psychiatric diagnosis. My choice to outline the history and limitations of the DSM should not obscure what I believe is frequently a *mutual* engagement between the manual's criteria and the research and publishing that has accumulated since the release of DSM-III. Research has both informed and been shaped by the DSM.
[4] This discussion of three concerns is informed by an interview with cognitive psychologist Kate Harkness, 24 January 2001. It should be noted that these three concerns are not new to medicine/psychiatry, but simply take what I see as a hyper-empirical form at this point in medical history.
[5] For example, a symptom of agoraphobia would be avoidance, while associated features would be, for example, disrupted levels of a particular chemical in the blood, or thoughts of danger.
[6] More obvious but no less important, patients who are considered undiagnosable by clinicians probably do not receive treatment. Helzer and Robins in Edlund, 1990:17.
[7] Note that the adrenals are connected with the body's fight-or-flight response. For papers on this and other glands listed see for example Edlund, Swann and Davis, 1987; Brown et al., 1988; Munjack and Palmer, 1988; Uhde et al., 1988; Rapoport et al., 1989; Kopp et al., 1989; Kathol et al., 1989; Anton et al., 1989; Cameron et al., 1990; Tancer et al., 1990; Garvey et al., 1990; Eriksson et al., 1991; Gurguis, Mefford and Uhde, 1991; Maddock et al., 1993; Maddock, Gietzen and Goodman, 1993; Abelson, Nesse and Vinik, 1994; Braune et al., 1994. Pathology of the thyroid is also examined. In one case of agoraphobia in a 28-year-old woman, for example, it was revealed through biochemical analysis that she had an excess of thyroid activity (Weller, 1984:553). Treatment of the agoraphobia with behaviour therapy, psychotherapy, and anti-depressant medication decreased her psychological symptoms (553). Writing in response to the letter about this case another physician describes two patients, one a housewife and the other a bank clerk, both of whom were diagnosed with thyrotoxicosis and both of whom responded well to behaviour and drug therapies (Turner, 1984). In contrast to the previous case, however, both of these patients developed agoraphobia after their diagnosis as thyrotoxic. In any case, the basis for investigation of a relationship between agoraphobia and the thyroid was there.
[8] Mitral valve prolapse is when the cusp or cusps of the mitral valve is displaced into the heart's left atrium. The link to agoraphobia, however, is not agreed upon. See Kantor, Zitrin, and Zeldis, 1980; Grunhaus et al., 1982; Mavissakalian et al., 1983; Gorman et al., 1986; Yeragani et al., 1987; Ben-Noun, 1989; Thayer et al., 2000.
[9] See for example Roth et al., 1986; Roth et al., 1990; Birket-Smith, Hasle and Jensen, 1993.
[10] See for example Jacob et al., 1985; Gordon, 1986; Sklare et al., 1990; Yardley et al., 1995; Jacob et al., 1996; Jacob et al., 1997.
[11] See for example Watts and Wilins, 1989; Dupont, Mollard and Cottraux, 2000.
[12] See for example Uhde and Kellner, 1987; Kallai et al., 1996; Knott et al., 1996; Lucey et al., 1997; Wurthmann et al., 1999.
[13] See for example Ley, 1985; Pollard, 1986; Kartsounis and Turpin, 1987; Holt and Andrews, 1989; Bass, Lelliott and Marks, 1989; Ben-Amnon et al., 1995. One study found agoraphobia and panic disorder to be more prevalent among asthmatics than in the general population (Shavitt, Gentil and Mandetta, 1992). Another study considered the problem of confusing the symptom of hyperventilation with the hypoglycaemia that sometimes occurs in diabetics (Steel et al., 1989). Allergic reactions were also found to be highly prevalent among panic disorder patients with and without agoraphobia (Schmidt-Traub and Bamler, 1997).
[14] See for example Yu et al., 1983a, 1983b; Evans et al., 1985; Khan et al., 1986; Norman et al., 1986; Balon et al., 1987; Norman et al., 1988; Flaskos, Theophilopoulos and George, 1989; Norman et al., 1989a, 1989b; Norman, Judd and McIntyre, 1990; Norman et al., 1990.
[15] The authors of a letter to the editor suggest that immobility in a patient that is disproportional to the degree of physical impairment may in fact signify agoraphobia (Leak et al., 1989). These authors describe a 39-year-old former secretary who was "never well enough to go out" (554) and

whose chronic pain persisted despite a variety of treatment modalities. It turned out she had a history of panic disorder and avoided going out whenever possible, using the more "acceptable" diagnosis of chronic spinal pain to avoid situations where she tended to panic. Her "continued pain served an important function, being a more socially and emotionally acceptable explanation for her disability than anxiety or agoraphobia" (555). This link to chronic pain was contested several years later by a study that showed that agoraphobia was minimal and did not differ significantly between chronic pain patients and patient controls (Asmundson, Norton and Jacobson, 1996).

[16] Sodium lactate and carbon dioxide are often used to induce panic attacks in susceptible patients, allowing investigators to measure further physiological and psychological reactions. See for example Gorman et al., 1981; Ehlers et al., 1986; Rapee, 1986; Cowley et al., 1987; Koenigsberg et al., 1987; Levin, et al., 1987; Cowley and Dunner, 1988; Pain et al., 1988; Aronson et al., 1989; Dager et al., 1989; Lynch et al., 1992; Goetz, Klein and Gorman, 1994; Perna et al., 1995. There is also some evidence of investigation into the use CO_2 inhalation as a treatment method, however, introduced in 1945, it is rarely used this way anymore. See Griez and van den Hout, 1986.

[17] Liddell and Acton, 1988.

[18] Warren, Zgourides and Jones, 1989.

[19] Zucker et al., 1989; Williams et al., 1997.

[20] See for example Ahmad, Wardle and Hayward, 1992; Khawaja and Oei, 1998.

[21] Street, Craske and Barlow, 1989; Andrews, Freed and Teesson, 1994; Cox, Endler and Swinson, 1995.

[22] Hayward, Ahmad and Wardle, 1994.

[23] Jones, Humphris and Lewis, 1996.

[24] Kamieniecki, Wade and Tsourtos, 1997; Chambless et al., 2000.

[25] Katerndahl, 1991; Whittal and Goetsch, 1997; Amering et al., 1997; Saboonchi, Lundh and Ost, 1999.

[26] Nunn, Stevenson and Whalan, 1984; Pickles and van den Broek, 1988; Lundh, Czyzykow and Ost, 1997; Lundh et al., 1998; Neidhardt and Florin, 1999; and Lundh et al., 1999.

[27] Shean and Uchenwa (1990) studied the presumed link between "traditional feminine sex role attitudes" and "agoraphobic anxiety". The research found significant positive correlation between anxiety scores and a range of interpersonal styles, including submissive/deferent, self-effacing/obedient, mistrusting/cold, submissive, inhibited, and unassured. Another study (Clair, Oei and Evans, 1992) found that agoraphobics were less extroverted, more neurotic, more hostile and intropunitive, and less likely to include others in their activities than were "normals".

[28] See Mavissakalian, 1990; Cox et al., 1991; Saviotti et al., 1991; Fava et al., 1992; Hoffart and Martinsen, 1992, Perugi et al., 1999; Hoffart and Martinsen, 1993; Hughes, Budd and Greenaway, 1999; Salkovskis et al., 1999. In addition to its examination in relation to personality disorders agoraphobia is also studied in connection with such things as schizophrenia (Argyle, 1990) and hypochondriasis (Noyes et al., 1986 [see also 1987 for erratum]; Fava, Kellner et al., 1988).

[29] Barber, 1998:469; Campbell, 1996:249.

[30] Weissman, 1990:3.

[31] See for example Faravelli et al., 1985; Michelson et al., 1998; David et al., 1995; Moisan and Engels, 1995. Also, that most agoraphobics are women, coupled with this link to sexual abuse, adds another, more volatile and political dimension to the gender component of this pathology.

[32] It also signifies that the two aetiological frameworks may not be mutually exclusive.

[33] Lancet, 1990:1314 (no author).

[34] Sheehan et al., 1981. This study lists major life changes such as losses, illness, and surgery and the authors conclude that "there are no specific psychosocial stresses that precipitate this disorder" (545). Notably absent in their list of major life events is first marriage, even though the mean age of onset of their participants was 24 years (Sheehan et al., 1981), many of whom – at that historical and cultural juncture – were most likely recently married. Could it be a coincidence that another study conducted nearly a decade later found a link between age and high levels of neuroticism (Kenardy et al., 1990)?

[35] It is important to note that not all research of this nature is done purely for the sake of understanding the underlying basic mechanism of a given disease, which points to some additional mo-

tives for this kind of research. In fact, a larger proportion of research is applied, done for commercial purposes, such as the development of drugs (whose effectiveness for particular diseases is more often than not found by [rational] accident). Viagra, originally developed as an antihypertensive, is a case in point. Moreover, not all of this type of research originates with an interest in the given disease per se, but may actually be based upon only some aspect or phenomenon that happens to relate to it. For example, a researcher may really only be interested in how dopamine (an amino acid derivative) works in the body. In order to ensure their work is well received by their research community, however, they will actually locate their investigations in the problem of schizophrenia (apparently linked to supersensitivity of dopamine receptors). Similarly, someone really interested in mitral valve prolapse might actually end up situating their research on this within the context of agoraphobia, since it is frequently found among agoraphobics. Generating enthusiasm towards one's work is a crucial component of research if it is to continue. Thus the viability of research depends on being able to justify a given investigation's contribution to curing disease (as opposed to decontextualised knowledge that has no positive application) (Interview with Gregory Ross, 24 January 2001). Research justified in this way is ensured continued funding (a great measure of peer enthusiasm), as well as promotion and tenure for its investigators (Duffin, 1999:354).

[36] Vittone and Uhde, 1985:330. That said, however, a "successful therapist must...be willing to use various modalities of treatment and not be bound by any one traditional conceptualization of agoraphobia" (Goldney, 1980:278).

[37] Compton, 1998.

[38] Kinney and Williams, 1988:513.

[39] Marks, 1981:387, 390.

[40] Marks, 1981:387.

[41] Marks, 1981:391.

[42] The link to epilepsy is by no means widely discussed, however agoraphobia is reported in a letter to the editor to be "invariably accompanied by paroxysmal cerebral dysrhythmia", or in other words, by epilepsy (Lutz et al., 1987:388). This condition "could be considered the pathophysiological basis for extremes in behavioral, emotive, and ideational intensity and particularly for agoraphobia" (388). Toni, Cassano, Perugi et al. (1996) cite a "greater than chance association between PDA and a history of seizures" (125). "Complex partial epilepsy" is frequently misdiagnosed for and treated as a neurotic disorder. Also, while it is generally believed that epileptic seizures are never purely psychogenic, Freud did write in 1928 ("Dostoevsky and Parricide") that epilepsy was an organic mechanism that could be activated by a number of different precipitants, including fear, excitement, or other strong emotions (Campbell, 1996:250). Also, several of the features of a "complex partial seizure" overlap with those of panic attacks, such as churning in the stomach, dizziness, flushing, tachycardia, changes in breathing, as well as affecting perception, cognition, and mood (Campbell, 1996:251).

[43] Ballenger, 1987:39J.

[44] Ballenger, 1987:41J-2J.

[45] See Jenike, et al., "Bowel obsessions responsive to tricyclic antidepressants in four patients." *American Journal of Psychiatry*. 1987, 144: 1347-1348. See also Lydiard et al., 1988.

[46] Jenike et al., 1988:1324.

[47] Jenike et al., 1988:1325.

[48] Ballenger, 1987:45J. See also Fleet et al., 1997 for their description of a detection model developed to improve the probability of recognising panic disorder in patients who come to the emergency department complaining of chest pain.

[49] Goldney, 1980:274.

[50] Edlund, 1990:19.

[51] Thereby still hanging onto the psychodynamically influenced framework of the DSM-II. See Hallam, 1978:314.

[52] Hallam, 1978:317.

[53] Hallam, 1978:316-7.

[54] Rapp and Thomas, 1982a:419; Marks in Rapp and Thomas, 1982a:419.

[55] Rapp and Thomas, 1982a:419. See also a later article by Rapp in which he makes the same point and observes that agoraphobia can also be confused with depression, panic disorder, personality disorder, alcoholism and drug abuse, schizophrenia, paranoia, physical illness and disability, or simply a preference for being at home: "...I saw a young woman who was able to travel to work and home comfortably and had no other problems but was urged to consult a psychiatrist because she went nowhere else. Apart from her trips to work she remained housebound. She stated she did not want therapy and had merely chosen to live this lifestyle. ('That's just the way I like to live, Doctor.')" (Rapp, 1984:1044).

[56] Dijkman-Caes, et al., 1993:1291

[57] Bowen, 1982:699-700; Rapp and Thomas, 1982b:700.

[58] Photophobia or light sensitivity (literally fear of light), for example, developed in a minority of patients and was influenced by cognitive behavioural therapy (Davey et al., 1997).

[59] See Roth and Argyle, 1988:37; and Boyd et al., 1990.

[60] Personality disorders are defined by the *Oxford Dictionary of Psychiatry* as maladaptive "patterns of relating to the environment that are so rigid, fixed, and immutable as to limit severely the likelihood of effective functioning or satisfying interpersonal relations." The DSM-IV lists paranoid, schizoid, schizotypal, histrionic, narcissistic, antisocial, borderline, avoidant, dependent, compulsive, passive-aggressive, cyclothymic, explosive, asthenic, and inadequate personality disorders. Of course two things to note here are that "often the label is more a social diagnosis of nonconformity than a designation of disease process in the usual sense," and DSM nomenclature varies considerably with each edition (Campbell, 1996:529-30).

[61] Mavissakalian and Hamann, 1988:542. See also Mavissakalian and Hamann, 1986, 1987.

[62] Sciuto et al., 1991:450.

[63] Sciuto et al., 1991:450.

[64] Mavissakalian and Hamann, 1992:305.

[65] Mavissakalian and Hamann, 1992:308. Another study (using DSM-III-R criteria, however) conducted in 1994 also found a "clinically important relationship" between personality pathology and various anxiety disorders (Reich et al., 1994).

[66] Although the proportion of men with agoraphobia is relatively small, a handful of articles reflect a concern to discern differences between women and men in their experiences of agoraphobia. See for example Hafner, 1981, 1983; Mavissakalian, 1985.

[67] Hafner, 1984:223.

[68] Hafner, 1984: 223.

[69] Quadrio, 1974:169.

[70] Hafner, 1977b:293. I would like to think that this particular type of dynamic is less common in agoraphobic marriages today...

[71] Quadrio, 1984:168.

[72] Quadrio, 1984:169-70. This point, of course, must be read in consideration of Rapp and Thomas' critique of the concept of housebound-ed-ness above. Also, the tendency for men to self-medicate their agoraphobia is corroborated, for example, by Cox et al., 1993. No doubt some women use alcohol as well and needless to say, agoraphobia presents a distinct problem for both and women when it is mixed with alcoholism in that patients will have difficulty attending Alcoholics Anonymous meetings. See Cudrin, 1991.

[73] Chambless and Mason, 1986:231. Their study may have been corroborated by another done in 1990 which observed a correlation between "patterns of interpersonal behavior associated with the female sex role stereotype (e.g., submissive, deferent, unassured, and submissive behavior) and "agoraphobic-like anxiety experiences among a normal college student population" (Shean and Uchenwa, 1990:406-7).

[74] Chambless and Mason, 1986:234. Also, there is a surprising paucity of animal modelling research in this area. One of the few articles, however, is especially worthy of note in that its author proposed a comparison of the extent to which female and male rats engage in safety-seeking behaviour to determine if the sex difference in agoraphobia is biologically based. See Baum, 1986.

[75] Starcevic et al., 1998.

[76] Chambless and Mason, 234.

[77] See Boyd et al., 1990. Bradley (1990) also observes that panic disorder occurs with other psychiatric disorders such as anorexia nervosa, as in her three female patients who "had panic disorder that, when treated, led to the alleviation of intense nausea, the part of the panic attack that produced the avoidance of eating" (445).

[78] Epidemiologic Catchment Area survey begun in 1980 and based on a random sample of 15,000 adults in 5 American cities: New Haven, CT; St. Louis, MO, Los Angeles, CA; Piedmon, NC; and Baltimore, MD.

[79] Weissman, 1990:6.

[80] Joyce et al., 1989:311.

[81] Boyd et al., 1990. This study also found that agoraphobia was far more common in the general American population than previously suspected: lifetime rates of agoraphobia without panic ranged from 1.4 to 6.6 cases per 100 people; agoraphobia with panic ranged from 1.7 to 2.6 cases per 100. Other epidemiological factors include the higher prevalence of agoraphobia among Black, urban dwelling, single/divorced, uneducated, poor women with mean age of onset between 13 and 18 years old and an average duration of 21 to 31 years and the presence of agoraphobia most commonly in women between 18 and 44.

[82] Studies compare patients suffering from depression and patients with panic-agoraphobia on numerous measures. Patients who suffer from both panic and mood disorders have more severe symptoms of anxiety and respond less well to anti-depressant drugs (Bowen, South and Hawkes, 1994). Agoraphobia may precede depression (Thompson, Bland and Orn, 1989), but it may not be the depression per se that makes the panic-agoraphobia symptoms more severe, so much as the fact that the person has two disorders (Maddock et al., 1993). The extent of the depression can affect the outcome of treatment for agoraphobia (Bowen, et al., 1994) but the opposite is also true in that a history of panic/agoraphobia also predicts a poor response to treatment for depression (Frank et al., 2000). See also Bowen and Kohout, 1979; Curtis, Cameron and Nesse, 1982; Coryell, Noyes, and Clancy, 1983; Breier, Charney and Heninger, 1984; Peterson et al., 1985; Stewart and Lawlor, 1985; Koehler, Vartzopoulos and Ebel, 1986; Kathol et al., 1988; Cassano et al., 1989; Maier et al., 1989; Beitman et al., 1990; Wetzler et al., 1990; Hoffart and Martinsen, 1991a and 1991b; Maddock and Blacker, 1991; Carter, Maddock and Magliozzi, 1992; Warshaw et al., 1995.

[83] That said, a recent study maintains that panic disorder with agoraphobia *does* occur in childhood, that there is in fact continuity between juvenile and adult panic disorder and agoraphobia. See Biederman et al., 1997.

[84] George et al., 1986.

[85] Several studies in the 1970s and 1980s examined the marriages of agoraphobics. They looked at such things as the effects of agoraphobia on husbands and the extent to which husbands resisted improvement in their agoraphobic wives (Hafner, 1977a, 1979). It was evident from these studies that husbands frequently harboured their own pathologies that discouraged wives from "relinquishing" the symptoms that allowed them to manage their troubled relationships (Hafner, 1977b). An especially troubling manifestation of this was evident in a woman described as married to a man who was allegedly so jealous that, when they were out together, she felt she had to keep looking at the floor. If she glanced up at a man, her husband might accuse her of infidelity, and would often physically attack her during the ensuing argument.[...] [I]t subsequently became clear that she needed to remain agoraphobic in order to protect herself from the violent arguments about her fidelity... (1979:101)

[86] Weissman, 1986, 1990; Boyd, 1990. (Both report on the same ECA study.)

[87] Blurring the line again between the normal and pathological, we "discover" another good reason that one might become agoraphobic.

[88] One article, published in 1981, describes a case of agoraphobia in an Alaskan "Eskimo" and argued that this was the only known case of agoraphobia in non-Europeans. This 31-year-old married male living in an Eskimo village in Western Alaska could not carry out his male responsibilities due to his feelings of nervousness exacerbated by going out alone: "The men of his village were responsible for hunting, fishing, and carrying water or ice to the house, these activities being done with snowmobiles or dog teams. As he became increasingly anxious over the preceding several years, he became housebound and unable to perform these necessary activities, having to rely on other villagers, relatives, and public assistance" (Hudson, 1981:224). Emphasising that it is

implausible to think that agoraphobia is culture-bound, that it is strictly a "by-product of western European civilization and its ever-increasing cultural complexity and stresses" the author goes on to say: "It is far more likely that agoraphobia occurs in the planet's many and diverse cultures, but just has been overlooked or misdiagnosed, as it has been in American psychiatry until recent years. It would be interesting to know what form agoraphobia takes in nomadic groups or among the Chinese" (Hudson, 1981:224). Speculating on the severe and widespread problem of alcoholism among some native American groups, Hudson contends that perhaps many native Americans suffer from severe phobias such as agoraphobia and they treat themselves through alcohol consumption or through their own culturally-specific treatment methods (Hudson, 1981:225). Two much more recent studies comparing European and African American patients were published as well, both out of the same American psychiatric department. The earlier study observed similar symptoms between both groups except that African Americans tended to go to the medical emergency room more often and had more unnecessary psychiatric hospitalisations. (There were some other differences as well. See Friedman et al., 1994.) The later study observed in African Americans a higher rate of comorbid posttraumatic stress disorder, a later age of onset of agoraphobia, more intense tingling in extremities, less satisfaction with social and financial support, less self-blame, and higher tendency to use religion as a coping strategy (Smith, 1999).

[89] Geiger, 1997:1766.

[90] Gamble, "Shadow," 1997.

[91] Gamble, "Women's Health," 1997:195. See also Lederer, 1995:120-1.

[92] Gamble, "Shadow," 1997:1776-7.

[93] Gamble, 1993:37. Unless of course the disease being explored (e.g., agoraphobia) was being constructed as a women's disease, in which case the problem was the exclusion of men.

[94] I owe this insight to Jackie Duffin.

[95] Goisman et al., 1994:72-3.

[96] Horwath, 1993:1496. That said, a random survey of 1498 urban adults in New Zealand (acknowledged to be overrepresented by women) also found that "when there is moderate agoraphobic avoidance, it seldom, if ever, exists in the absence of panic or other psychopathology" (Joyce et al., 1989:311).

[97] Horwath et al., 1496.

[98] Pollard, 1987.

[99] Weissman, 1986:789.

[100] Weissman, 1986:789; Weissman, 1990:11. Weissman observes that if agoraphobia does occur in pure form then there is controversy about the best way to treat it (drug versus psychological therapies). See also Wittchen, Reed and Kessler, 1998:1023-4. See also Reed and Wittchen (1998) who argue (based on the same sample) that panic attacks are "highly indicative for more severe psychopathology and not only for panic disorder and agoraphobia" (335).

[101] Pollard et al., 1996.

[102] Pollard et al., 1996:61-2.

[103] Wittchen, Reed and Kessler, 1998:1017.

[104] Langs et al., 2000:44.

[105] Langs et al., 2000:47-8.

[106] That is, Master's level social workers and psychologists, as opposed to lay interviewers as were used in the original ECA study.

[107] Horwath, et al., 1993.

[108] Edlund, 1990:17. See this paper for a critical analysis of the ECA studies.

[109] Horwath et al., 1993:1498. Of course, it is important to note that this study was funded in part by the Upjohn company, a major producer of Xanax, a minor tranquiliser widely used in the management of panic.

[110] Sackett in Edlund, 1990:15.

[111] The report by Pollard et al on 4 cases notwithstanding...

[112] That is, agoraphobia without panic disorder was only diagnosed when no panic criteria were met.

[113] Goisman et al., 1994. These researchers also found that compared with panic disorder and panic/agoraphobia subjects, agoraphobics without panic were the most dysfunctional, meaning

its duration was the longest, they were less educated and more likely to also suffer from major depression and the most likely to be receiving financial assistance (social security and disability). They also found that nearly everyone had taken drug therapy, most commonly benzodiazepines, and that psychodynamic psychotherapy was the most commonly administered psychosocial , and behaviour therapy the least. This is particularly interesting considering that this is by no means reflected in the amount of literature, which is weighted heavily in the opposite direction. It is "significant in that psychodynamic psychotherapy remains of unproven efficacy for panic disorder...whereas behavioral methods are widely cited for their efficacy for these indications" (Goisman et al., 1994:77).

[114] Weissman, 1986:787.

[115] Edlund, 1990:15.

[116] Boyd, 1990:317.

[117] A 1987 study comparing the baseline characteristics and treatment outcomes of two panic disorder/agoraphobia populations who differed in their method of referral (indirectly solicited versus self-referred) found that indirectly solicited patients were more chronic and symptomatically severe, and more likely to accept treatment and remain in treatment than self-referred patients (Aronson, 1987). This finding suggests that treatment outcome studies may be affected by sample selection biases not dissimilar to that which precludes absolute comparisons between community and clinical findings.

[118] Goisman et al., 1994:77.

[119] Goisman et al., 1994:77; my emphasis.

[120] Goisman, Warshaw, et al., 1995:1438. In the end, this is not a debate particular to the 1990s (i.e., it germinated prior to the release of DSM-III-R). See also Hallam, 1978; Shafar, 1975; Gelder, 1982.

[121] And of course throughout its (pre-DSM) history, albeit packaged differently.

[122] Goisman, Warshaw, et al., 1995:1439.

[123] Roth and Argyle, 1988:34.

[124] Roth and Argyle, 1988:34. "Faithful and accurate description and a valid classification provide the most solid foundation for clinical practice and scientific investigation of the morbid states of anxiety. The operational definitions of the different anxiety syndromes within DSM-III (1980) have performed a valuable service to contemporary psychiatry by promoting more consistent and reliable clinical and scientific practices. There is, however, an inevitable element of arbitrariness in the framing of operational definitions on the basis of a consensus of cooperating [sic] psychiatrists (Roth and Argyle, 1988:36).

[125] Wood, 1990:197. Or recall, for example, that one of the symptoms commonly cited in agoraphobia reports is the fear of being confined without possibility of escape, hence, for example, the fear of riding in trains. A letter to the editor (unrelated to Wood's piece) from a group of Italian forensic psychiatrists published that same year also illuminates the problem of precise definition: "... we frequently see patients in the correction field. [...] In clinical practice we often see prisoners who have panic attacks with claustrophobia. [...] Would it not be feasible to redesignate the category as 'panic disorder with agoraphobia or claustrophobia' and to modify the criteria accordingly?" (See Ferracuti, Giusti, and Ferracuti, 1990:1573-4).

[126] Hallam, 1978:314.

[127] Perhaps this is why Roth (1996) refers to the disorder as "panic-agoraphobia syndrome".

[128] Specifically, my search for literature for this review was restricted to the term "agoraphobia"– I did not use any MeSH terms, yet Medline still turned up articles on "panic disorder".

[129] See for example (one of many) Shioiri et al., 1996. (Publishing this study in 1996, they were in a position to use DSM-IV criteria, but instead used DSM-III-R from 1987.)

[130] Gelder, 1982:72.

[131] Gelder, 1982:72.

[132] It is also not uncommon for studies to invoke old DSM criteria even when new ones are available at the time that the research takes place. In some instances this may be due to the possibility that the research begins prior to the release of the newest DSM, but the practice still raises the issue of validity of research results once new criteria have been adopted.

[133] Hafner and Ross wrote of the "heterogeneous nature of agoraphobia" in 1983. In 1990 Lelliott and Bass found that patients with panic disorder and agoraphobic avoidance were "heterogeneous with respect to the system to which panic symptoms refer (cardiovascular/respiratory, gastrointestinal, or neurological] and it "would be difficult to support the suggestion that PD [panic disorder] is a uniform illness (as indicated by DSM-III-R)" (Lelliott and Bass, 1990:596).
[134] Hallam, 1978:317.
[135] Edlund, 1990:19-20.
[136] Edlund, 1990:21.
[137] Edlund, 1990:21-2.
[138] Edlund and Swann, 1987.
[139] Yaniv, 1998.
[140] Yaniv, 1998:238.
[141] Yaniv, 1998:240.
[142] Mitchell and Black, 1995:xviii.
[143] The journals examined include *International Journal of Psycho-Analysis*, *Psychoanalytic Review*, *Psychoanalytic Quarterly*, and *American Journal of Psychotherapy*.
[144] Goisman et al., 1994:77. They also found that behavioural methods were the least common, which is especially interesting considering the extensive publishing in this area. Conversely, the findings of an Australian survey conducted by Hall et al. (1982) showed that "it is clear that Australian psychiatrists approve of intensive [verbal] psychotherapy and prefer to treat most of their patients in this way. Data on actual practice, however, show that they do not do so" (1982:230). The authors continue: "...although long-term psychotherapy [including but not limited to psychoanalysis] may be the *zeitgeist* of Australian psychiatry it is by no means the reality" (1982:230). It would be interesting to know if this was still the case at the time of Goisman et al.'s report.
[145] Rather than reporting on cases, there appears to be more interest in such things as the aims of psychoanalysis, its theory, technique and methodology, the history of psychoanalysis, psychoanalytic concepts such as repression, conditions such as narcissism and hysteria, and issues in social theory. The role of separation anxiety and overprotection in agoraphobia makes a few appearances, but the overarching sentiment pertaining to psychoanalysis in this period seems to be more about psychoanalysis as a profession, discipline, and clinical practice, than about the actual reporting on agoraphobia cases.
[146] Compton, 1998. Thus it is important to note that the question of parental over- and underprotectiveness is examined by practitioners of other persuasions as well. See for example Solyom, Silberfield and Solyom, 1976; Parker, 1979; Arrindell et al., 1989; also Silove, 1986; Faravelli et al., 1991; Wiborg and Dahl, 1997; Shear, 1996.
[147] I say relatively because there are so few reports to speak of. There is more extensive discussion of under- and overparenting in other reports not overtly psychoanalytic in orientation. I shall review these in the final section of the chapter on aetiology.
[148] Coleman, 1982:539.
[149] Coleman, 1982:539-40.
[150] Coleman, 1982:540.
[151] Coleman, 1982:540.
[152] Coleman, 1982:542-3.
[153] Coleman, 1982:547.
[154] Coleman, 1982:549.
[155] Silber, 1982-3:554.
[156] Silber, 1982-3:554.
[157] Coleman, 1982-3:559.
[158] Blos, 1983:578.
[159] Blos, 1983:585.
[160] This story is confusing in that if her mother was present in this conflict scene, then how could it have been a secret Mary told her?
[161] Blos, 1983:585.
[162] Blos, 1983:586.
[163] Blos, 1983:586.

[164] Blos, 1983:587-8.
[165] Blos, 1983:579.
[166] Blos, 1983:581.
[167] Blos, 1983:581.
[168] Blos, 1983:582.
[169] Blos, 1983:588. Also, it is worth noting that Blos chooses to apply psychoanalytic principles but not to use psychoanalysis proper due to his "conviction that a psychoanalytically grounded comprehension of a case influences more decisively and favorably the conduct and outcome of therapy than does the frequency of weekly sessions. The intensiveness of therapy is by no means proportionate to the frequency of therapeutic contacts (1983:583). He goes on to say that the choice of treatment modalities is contingent upon the disorder to be treated, but "in clinical practice extraneous factors affect the decision, such as the ability to pay, the patient's psychological accessibility, or the therapist's geographical accessibility" (1983:583).
[170] Blos, 1983:591.
[171] Blos, 1983:592.
[172] Feigelson, 1976:225.
[173] Feigelson, 1976:226.
[174] Feigelson, 1976:226.
[175] Feigelson, 1976:227.
[176] Feigelson, 1976:228.
[177] Feigelson, 1976:228.
[178] Feigelson, 1976:228.
[179] Feigelson, 1976:232.
[180] Feigelson, 1976:235.
[181] Morra, 1991.
[182] Morra, 1991:488.
[183] Morra, 1991:488. This is an issue that comes up later in a dream (495).
[184] Morra, 1991:487.
[185] Morra, 1991:488.
[186] Morra, 1991:490.
[187] Morra, 1991:491.
[188] Morra, 1991:493.
[189] Mora, 1991:495.
[190] Morra, 1991:495.
[191] Morra, 1991:496.
[192] Morra, 1991:498.
[193] Arguably, this is an endeavour implicit in all psychoanalytic reports, in the sense that psychoanalysis is both a theory and a clinical practice.
[194] Mitchell and Black, 1995:xviii.
[195] Friedman, 1985:525. See also Milrod and Shear, 1991.
[196] Friedman, 1985:525.
[197] Friedman, 1985:527.
[198] Friedman, 1985:529.
[199] Friedman, 1985:533.
[200] Friedman, 1985:529, 533.
[201] Friedman, 1985:534.
[202] Friedman, 1985:534.
[203] Friedman, 1985:535.
[204] Friedman, 1985:535-6.
[205] Friedman, 1985:536-7. Note that the patient had a fear of elevators, i.e., claustrophobia. Claustrophobia comes up a lot throughout the reports and it is not clear that it is in fact a separate disorder. It is also interesting in a spatial sense and suggests that perhaps the question is not fear of open spaces or closed spaces, but fear of space period.
[206] Diamond, 1987:79.
[207] Diamond, 1987:79.

[208] Diamond, 1987:80.
[209] Diamond, 1987:80.
[210] Diamong, 1987:81.
[211] Diamond, 1987:81.
[212] Diamond, 1987:83.
[213] Diamond, 1987:83.
[214] Diamond, 1987:82.
[215] Fink, 1989. See also Blanco, 1989.
[216] Fink, 1989:482-3.
[217] Fink, 1989:483.
[218] Fink, 1989:483.
[219] There was another incident that also played an important part in Peter's turnaround, namely, overhearing Fink on the phone telling someone off in German, which reminded Peter of his "very energetic" father, a village leader who "handled the occupation forces in a clever way protecting his family and the village from excessive demands and arbitrariness" (1989:484).
[220] Fink, 1989:485.
[221] Matte Blanco, 1989:496.
[222] Fink, 1989:485-6.
[223] Fink, 1989:486.
[224] Matte Blanco, 1989:497.
[225] Matte Blanco, 1989:497.
[226] Fink, 1989:486.
[227] Fink, 1989:486-7.
[228] Fink, 1989:487.
[229] Fink, 1989:487; Matte Blanco, 1989:497, 499.
[230] Fink, 1989:487.
[231] Fink, 1989:488.
[232] For a critique of psychoanalysis as being unscientific, see Grünbaum, 1993.
[233] See also Fonagy and Moran, 1993; Wallerstein, 1993; for further discussion pertaining to psychoanalysis, research, and the DSM system.
[234] Compton, 1992a; 1992b; 1992c; 1992d.
[235] Compton, 1992a:206.
[236] Compton, 1992b:230.
[237] Compton, 1992a:207.
[238] Compton, 1992a:223.
[239] Compton, 1992a:223-4.
[240] Compton, 1998:692.
[241] Compton, 1992a:224.
[242] Compton, 1992c:414.
[243] Compton, 1992d:435. Compton also argues in this part that there is no specific or clear psychoanalytic theory of phobias. I would agree that there are many versions, however, as I put forth in my article for publication, there are clearly some commonalties that tie the various frameworks together, namely guilt, family relations, and a moralistic sensibility.
[244] Based on the strong overall impression I get having reviewed the clinical articles and the revisions in the DSM entry on agoraphobia and panic, I have tried to convey the inconsistency throughout the chapter so far. I say with certainty that *there is no certainty* about the relationship between panic and agoraphobia. As I stated earlier, it fundamentally depends on which edition of the DSM is being used to guide the research being reported. Even in a panel discussion chaired by Compton in 1995 it is evident that this issue is not resolved. As one pharmaceutically oriented participant asserted, "panic disorder alone and panic with agoraphobia *may* represent two distinct syndromes" (Busch et al., 1995:212, my emphasis). Within this report panelists variously referred to the illness as "agoraphobia and panic states," "agoraphobia/panic," "panic disorder and agoraphobia," "panic disorder without agoraphobia," "anxiety disorders," "neurosis," "panic," and simply, "agoraphobia."
[245] Compton, 1998:700. See his article for a detailed outline of his proposed research.

[246] Compton, 1998:715.
[247] Compton, 1998:691.
[248] Compton, 1998:692.
[249] Compton, 1998:693.
[250] Compton, 1998:694.
[251] Forms of pharmaceuticals had been used since much earlier, of course. See Silverman and Lee, 1974:2-3. See also Liebenau, 1987 for a history of the evolution of the American pharmaceutical industry between 1890 and 1930, and an analysis of the relationship between science and pharmaceuticals.
[252] For discussion of mid-century chemotherapy see Puhl, Berchou and Rainey, 1982; Rohs and Noyes, 1978; Telch, Tearnan and Taylor, 1983.
[253] This chart is based on literature derived from the first Medline search that I did (which yielded 899 articles), and approximately 150 references to drug therapies. (This number is approximate because in classifying the articles I frequently had to make decisions about articles that did not clearly fit into one pile or another on the basis of what I considered to be the main point of the article. This chart includes only articles whose central concern was pharmaceuticals.
[254] There is also some (very limited) evidence of the use of other types of drugs such as propranolol, a beta-blocker (anti-hypertensive) used to treat the tachycardia (rapid heartbeat) often reported by people who panic (Rosenbaum et al., 1995:A14). The diagram shows the use of and research on drug therapies for agoraphobia by type in roughly the last thirty years, where propranolol appears under the category of "other drugs".
[255] Canadian Pharmaceutical Association. 1996:4. Also tricylcic anti-depressants include clomipramine (also used to treat obsessive-compulsiveness), desipramine, doxepin, lofrepramine, nortriptyline, trimipramine. SSRIs that appear in this literature include mostly fluoxetine (Prozac) and fluvoxamine while references to MAOIs are largely to phenelzine. There were no references to heterocyclics.
[256] See studies cited in the section on depression. Also, if so many doctors are prescribing antidepressants, then presumably they are assuming some kind of link. See for example Pohl, Berchou and Rainey, 1982.
[257] See for example The Medical Letter, 1974; Mattick et al., 1990; Mavissakalian et al., 1998. See also Friedman, Sunderland and Rosenblum, 1988. These researchers (all affiliated with the American Psychiatric Association, so presumably involved with the DSM field trials) report on their imipramine trial conducted on monkeys. This article is quite anomalous in its use of animal subjects; given the dramatic increase in research on panic and agoraphobia, perhaps there are so few studies of animals because there are more than enough willing and desperate human subjects.
[258] Schwartz and Val, 1984:40; Laybourne and Redding, 1985:112; Mavissakalian, 1993:188.
[259] See Mountjoy et al., 1977; Rohs and Noyes, 1978; Sheehan, Ballenger and Jacobsen, 1980 (cited in Harnett below); Ravaris, 1981; Lydiard and Ballenger, 1987:156; Harnett, 1990:213. For a contrasting view see Mattick et al., 1990. [Note: Sheehan was a past director of Upjohn Co.-sponsored research into panic disorder in Boston, research that was part of a transnational clinical study which sought to "establish the worldwide existence of a disorder that had not yet, Upjohn believed, been adequately defined and treated". Findings from the study were to be used to support Upjohn's application to the FDA for approval of Xanax in the treatment of panic disorder (Orr, 1990:476-7).]
[260] Mavissakalian et al., 1998:848.
[261] See Pohl, Berchou and Rainey, 1982; Solyom, Solyom and Ledwidge, 1991.
[262] See Mavissakalian and Ryan, 1998:193.
[263] Canadian Pharmaceutical Association. 1996:7. Also, Laybourne and Redding note that benzodiazepines are effective against anticipatory anxiety (1985:112), but they are sometimes also used for acute situational anxiety (Flint, 1999:2677).
[264] Harding, 1986:52.
[265] References to anxiolytics (minor tranquillisers or benzodiazepines) are largely to alprazolam but also include other compunds such as adinazolam, clonazepam, diazepam (Valium), and lorazepam (see for example Sheehan, 1987). See also Lynn, 1991 and also Lexchin, 1984 for ac-

counts of the rise and fall of Hoffmann-La Roche's Valium (and Librium). I contend that (Upjohn's) Xanax may have filled the gap in the market left by Valium's collapse into disrepute.

[266] See Liebowitz et al., 1986; Ballenger et al., 1989; Harnett, 1990:212-13; Ballenger, 1990; Mattick, 1990; Michelson and Marchione, 1991; Cox et al., 1992; Clum and Surls, 1993; Rosenbaum et al., 1995:A15.

[267] In support of the use of imipramine rather than benzodiazepines, the key position taken by Klein in 1964 (cited in Rosenbaum et al., 1995) (also Klein, 1980 ctd in Ballenger, 1990 and Harnett, 1990) that panic attacks were the core problem leading to the later development of anticipatory anxiety was dominant for quite some time. Yet a *Lancet* editorial from 1979, for example, describes benzodiazepines as "counterproductive", while a retrospective study published out of Germany as recently as 1995 states that benzodiazepines comprise 48% of drug treatments for panic disorder and agoraphobia (compared with tricyclic anti-depressants which are rated at 42%) (Bandelow et al., 1995). As the above figure shows, a Medline search actually turns up more references to imipramine suggesting that *it* is the more widely studied drug (as Michelson and Marchione, 1991 also observe), but in any event, the efficacy of one over the other continues to be the subject of debate. See also Ballenger, 1990; Mavissakalian et al., 1998; Flint, 1999.

[268] For example, Hoffmann-La Roche funded a three year stress study at Cornell Medical School (to the tune of $4 million USD), a study that lent great support to Valium. See Lynn, 1991:54 (Merck and Glaxo).

[269] See for example Telch et al., 1983; Pecknold, 1987; Harnett, 1990 (who also advocates a revival of psychoanalysis); Sakai and Takeichi, 1996; Bakker et al., 1998. I elaborate on behavioural therapies below.

[270] Rohs and Noyes, 1978:701. A recent study found that among psychological therapies, patients were more satisfied with behavioural/cognitive therapy than with psychodynamic therapies (Bandelow et al., 1995:170). I will deal further with "the demise" of psychoanalysis in agoraphobia treatment below.

[271] We've already seen evidence that alcoholism in agoraphobic men is higher than in women. As Craske and Rodriguez put it in their review of behavoiur therapies for panic and agoraphobia, "agoraphobic avoidance is viewed as one style of coping with the apprehension of panic. Of note is the finding that another style of coping, which may be more common for make panickers, is confronting anticipated situations with the aid of alcohol or drugs" (Barlow, 1988 in Craske and Rodriguez, 1994:5).

[272] Waldron cited in Lexchin, 1984:24.

[273] The Medical Letter, 1981, 1982; Pecknold and Swinson, 1986, The Medical Letter, 1988; Salzman, 1993; Hallfors and Saxe, 1993.

[274] As opposed to barbiturates, meprobomate, and alcohol. See Botts, 1997. There is also evidence that benzodiazepines are overprescribed. See Swinson, Cox, and Woszczyna, 1992.

[275] Salzman, 1993. See also, for example, a study of Australian patient records (81 women and 30 men) which showed that benzodiazepines were "the most frequently prescribed drug by both general practitioners and psychiatrists in the treatment of patients with agoraphobia and panic attacks referred to the Anxiety Disorder and Agoraphobia clinics in Brisbane" (Evans, Oei and Hoey, 1988:76). These authors also found however that general practitioners were less likely overall to prescribe psychotropic drugs, as compared with psychiatrists. A more recent (American) marketing study of the factors that influence general and family physicians' drug product selections in the treatment of panic disorder showed that two-thirds of the physicians used benzodiazepines for panic disorder (often in combination with antidepressants) "regardless of the presence or absence of phobic avoidance" (Freeman et al., 1993).

[276] National Institute of Health, 1993. (NIH Consensus Statement) The Institute of Contemporary Pharmacy Research (US) published a Treatment Guide advocated the following tactic: "When considering benzodiazepines for the treatment of anxiety, use them – then lose them fast!" (cited in Portyansky, 1997.

[277] King, 1981. See also Stantworth, 1982.

[278] Silverman and Lee, 1974:12.

[279] I adapted this insight from Annette Burfoot and her analysis of reproductive technologies. Pers comm., 7 December 2000.

[280] Uhlenhuth, Balter and Mellinger, 1993. Unfortunately, the critical social analysis to which these authors gesture in the opening paragraphs of this report does not come to fruition in the remainder of their paper. They rightly observe in their introduction that a "conceptually enriched pharmacoepidemiological research approach reveals an array of additional factors that control patterns of use, including sex and age...cultural milieu...specific attitudes...and general medical condition" (90), yet they fail to pursue any of these things. They focus instead on symptomatology and conclude, not at all surprisingly, that "[g]reater prevalence of use of anxiolytics and antidepressants was associated with higher levels of symptomatic distress" and "[m]ore prolonged use of anxiolytics and antidepressants was associated with higher levels of symptomatic distress and chronicity" (94). The "users" they describe have no gender and interestingly, the acknowledgements show that The Upjohn Company – a major US producer of alprazolam – provided the funding for preparation of their report (95).

[281] Taken from the title of Silverman and Lee, 1974 (noted above).

[282] See Rosenbaum et al., 1995:A4.

[283] See Lexchin, 1984:232; Harding, 1986.

[284] Michelson and Marchione, 1991:100. See also www.rxlist.com/top200.htm which shows Alprazolam as one among the top 200 prescriptions for 1999 by number of US prescriptions dispensed.

[285] Wyke, 1987:4, written prior to the 1995 merger between Upjohn and Pharmacia, when Upjohn was just Upjohn.

[286] Pharmacia & Upjohn. 1998:35. The report also shows that in 1998 $1.199 billion dollars were spent on research and development, though it unfortunately does not break these figure down by product (p. 62). These figures are especially remarkable when compared with those of 1982 when Upjohn Co. reported earnings of (only!) $12 million USD (Orr, 1990:466).

[287] Patented Medicine Prices Review Board, 1998.

[288] Jarvis, 2000. Much of these profits have been earned in the US, as Foote observes that antidepressant sales there have grown from $2 billion USD in 1993 to over $7 billion USD in 1998 (Foote, 2000). The increase is attributed to improvements in existing technology, namely the development of SSRIs.

[289] In a two-part series on the "art of drug marketing", J. Paul Caldwell (1999 medical post online) explains how pharmaceuticals are given their chemical, generic, and trade names. While chemical names (e.g., alprazolam, imipramine hydrochloride) reflect a very "specific, scientific documentation of the chemical compound," generic names reflect the "entire class or genus" to which the drug belongs (e.g., benzodiazepines, tricyclics) and are named according to strict World Health Oranization international standards. Trade names (e.g., Xanax, Tofranil) however, have to "be short, catchy, easily remembered, 'nice' to say, and most importantly, must interrupt the speech flow. Pharmaceutical manufacturers just want you to remember it, and prescribe it regularly" (part 2 of the series). They want "the patient to be able to ask for the new drug by name", such as "Xanax (alprazolam), an elegant pharmaceutical trade name that sounds a little like anxiety, but has a positive tone of elimination" (part 2).

[290] For example, a recent study of the factors influencing prescription choices in the treatment of panic disorder showed that for general practitioners, side effects and drug efficacy were the most important influences while cost was next. The authors of this study concluded therefore that drug companies needed to incorporate physicians' personal experiences with particular drug products and in the case of panic disorder treatments, that promotional materials should emphasise safety and efficacy (Freeman et al., 1993).

[291] Foss, 2001:A1 and A6. Freebies are not limited only to these things. Other things Foss lists are salsa lessons, ballet tickets, golf games, pens, mugs, dinners, prestige through ghostwritten research publications, and cash payments just for *attending* conferences where new therapies are being discussed (A6). As André Picard writes in the fourth piece in this series, however, drug companies may also offer desparately needed funding unavailable from government coffres. He describes the failed efforts of Montreal lawyer and health activist Barry Stein to secure government funding for colorectal cancer projects – hospital equipment, colorectal cancer society, support groups, drop-in centre, conference – all of which are primarily funded by pharmaceutical companies (Picard, 2001: A8).

[292] See Evans, Oei and Hoey, 1988 (noted above); Bartone, 1992, Myers, 1992, and Freeman, 1993 (noted above).
[293] The funding relationship between industry and academe began in the period between the two World Wars (in the US), before which time physicians were disdainful of ties with the "pill peddlers" (Swann, 1990:78). Yet the influence of industry on academe is not limited to the research funds it provides; a quick glance through medical journals and even the *CPS: Compendium of Pharmaceuticals and Specialties* reveals another crucial connection – advertising revenue.
[294] Myers, 1992:229.
[295] Bartone, 1992:296.
[296] Jarvis, 2000.
[297] Myers, 1992:222.
[298] UBC's university-industry liaison Angus Livingstone, quoted in McIlroy, 2001:A6.
[299] McIlroy, 2001: A1 and A5.
[300] Especially when we consider diseases unique to developing countries. See Myers, 1992:229-30.
[301] Orr, 1990:483.
[302] Hunter, 1991:94.
[303] Yet even the case studies read like scientific reports. See for example Kolko, 1984. See also Jackson and Elton (1985) who remark that "tightly-controlled empirical investigations into the efficacy of *in vivo* exposure...do not respond to individual needs" nor accommodate the "varying degrees of complexity of this disorder." These authors accordingly advocate a multimodal approach to the treatment of agoraphobia. See also for example Biran (1987) and her presentation of a two-stage approach to the treatment of agoraphobia in her patient, "Mrs. X": *in vivo* exposure and cognitive restructuring followed by deep exploration of cognitive structures through dynamic psychotherapy.
[304] Nevertheless, coupled with the smattering of actual case reports, several authors of the more empiricist behavioural investigations do refer to their patients as "clients" rather than simply research "subjects", suggesting that their patients are not completely devoid of personhood. See for example Emmelkamp, Kuipers and Eggeraat, 1978; Foa et al., 1980; Ascher, 1981.
[305] See for example Emmelkamp and Kuipers, 1979; McPherson, Brougham and McLaren, 1980; Munby and Johnston, 1980; Jansson, Jerremalm and Ost, 1986; Evans, Holt and Oei, 1991; Rijken et al., 1992; Fava et al., 1995.
[306] Ferentz, 1990:186.
[307] Linder, 1981:226.
[308] Rachman, 1983:567.
[309] For example, relaxation is part of the program used by Linder, 1981.
[310] Craske and Rodriguez, 1994:6.
[311] See for example Tilton, 1983 which describes a patient who successfully underwent hypnosis combined with desensitisation and other therapies. Similarly, Harris (1991) reports on a 34 year old female "victim" "seeking surcease from the malady within" whose panic and agoraphobia was eliminated through progressive relaxation, systematic desensitisation and hypnosis. Sakai and Takeichi (1996) describe their successful use of autogenic training (a form of self-hypnosis and deep relaxation) and *in vivo* exposure. See also Van Dyck and Spinhoven (1997) who find that hypnosis has no additional effect when used with exposure.
[312] James, 1985.
[313] See Cobb, 1983 for a review of exposure *in vivo* and Ferentz, 1983 for a general overview of therapies including exposure. See also Saran, 1984 for an integrated approach to therapy that includes psychoanalysis and cognitive/behaviour therapies and Norton et al., 1983 for a study showing that patients and non-patients alike consider exposure to be the most effective form of treatment. Also important to note under the category of exposure is the safety-signal approach to exposure therapy in which patients are made to move *towards* safety rather than away from it. For example, this could mean making home the target destination rather than the point of departure, or having the patient meet her husband at the store downtown rather than being left by the husband at the store, or being made to take the bus to a safe area instead of away from it. See Rachman's discussion of this (1983). Williams, 1990 (esp. pp. 91-2) offers a critique of exposure and guided mastery as an alternative.

[314] Sakai and Takeichi, 1996. Especially notable about this report is that between the two cases the authors describe this "chronic disease" very differently. The first case was "a 33 year old woman living with her husband and three children, who were aged between 2 and 12 years" and who came to the authors' clinic in 1986 complaining of panic attacks after the birth of her third child; "[n]o other stress was evident" (335). The woman satisfied DSM-III-R criteria for panic disorder with agoraphobic avoidance and following successful use of "autogenic training" and exposure without medication (she was unwilling to take any due to negative past experiences with tranquilisers), her treatment was terminated after four sessions. At 9 years telephone follow-up she had maintained the treatment gains. The first curious point about this report is that the woman is classified according to a set of DSM criteria that did not yet exist when she presented to the writers. The other point of curiosity is one of contrast; the second patient they describe was a "23 year old single male patient [who] was referred to [the] clinic in...1991". He "worked for the sales department of a company in a technologically advanced industry for 1 year following his graduation from college. He worked hard but reported that his working conditions were stressful" (335). His agoraphobic avoidance began after suffering a panic attack while out on business with the company car. Notice that his education and his paid work define his identity in the report, while the woman's identity is defined by her status as wife and mother (even though she may very well have had postsecondary training and paid work as well that we do not get to know about). It is also striking that what she does as a wife and mother of three young children is not considered by the authors to be either "work" or "stressful".

[315] See for example Last, Barlow and O'Brien, 1984; Mavissakalian et al., 1983 (cited below); Filewich, 1988; Williams, 1990. See Thyer (1986) who, working from the premise that panic attacks have a biological rather than psychological etiology, considers the possibility that avoidance and escape behaviour may follow superstitious conditioning that occurs as a result of panic attacks. See also Oltmanns and Mineka, 1992 and their tribute to the work of Morton Prince, a leading early psychopathologist and neurologist known for his work on dissociative disorders. Critical of the emphasis in psychological literature on either psychoanalytic or behaviourist approaches, they observe that Prince's work on anxiety disorders has largely been ignored. They argue that in his rejection of psychoanalysis and behaviourism, Prince actually may have anticipated cognitive therapy and the safety-signal perspective with his assumption that agoraphobia was more about the fear of having a panic attack than about agoraphobic situations per se (609).

[316] See for example Emmelkamp, van der Hout and de Vries, 1983, These authors found that when assertiveness training and exposure *in vivo* were used separately and in combination, exposure had the largest effect in terms of phobic targets while assertiveness training had the largest effect in terms of assertive behaviour. Their findings suggest that both methods may have something to offer unassertive agoraphobics (67).

[317] Biran, 1987:127.

[318] Mavissakalian, Michelson and Greenwald, 1983:78. Examining cognitive approaches, they compared paradoxical intention and self-statement training and found that at 6-month follow-up, self-statement training proved to be equally as effective as paradoxical intention.

[319] Kolko, 1984:53.

[320] See Ascher, 1981; Michelson and Ascher, 1984.

[321] Williams, 1990:93-94. Highly critical of exposure therapies, Williams (1990) describes guided mastery as "a fresh approach to performance-based treatment [that] is long overdue" (92; see also Williams and Zane, 1989). An article by Rachman, 1983 is comparable in its dissatisfaction with exposure and concomitant emphasis on methods that promote self-efficacy.

[322] See Emmelkamp, Kuipers and Eggeraat, 1978; Norton, Allen and Hilton, 1983; Last, Barlow and O'Brien, 1984; van der Hout, Arntz and Hoekstra, 1994; Bouchard et al., 1996; Burke, Drummond and Johnston, 1997.

[323] See for example Mathews et al., 1976; James, Hampton and Larsen, 1983; James, 1985. Following from B.F. Skinner, Linder (1981) advocates the use of operant conditioning (rewarding target behaviours) with desensitisation. See also Tyrer, Horn and Lee (1978), Lee and Tyrer (1980), and Lee, Tyrer and Horn (1983) for their work on the effects of subliminal and supraliminal exposure to phobic films.

[324] Emmelkamp, Kuipers and Eggeraat, 1978:39.

[325] See for example Biran, 1987; Belfer et al., 1995.
[326] Swinson et al., 1995. This study is especially interesting for its rare emphasis on rural patients; the literature on agoraphobia tends to paint a rather urban picture of this disorder.
[327] Craske and Rodriguez, 1994: 11.
[328] Craske and Rodriguez, 1994:11. Related to this is the possible relationship between therapists' conduct and treatment outcome. See preliminary study by Gustavson et al., 1985.
[329] Craske and Rodriguez, 1994: 9-12.
[330] Foa, at al., 1980.
[331] Rapp, Thomas and Reyes, 1983.
[332] Teasdale et al., 1977; Linder, 1981; Belfer et al., 1995. See also Telch et al., 1993 which combines (effectively) cognitive and behavioural methods.
[333] Belfer et al., 1995.
[334] Efforts to be supportive could actually reinforce avoidance behaviour. See see Hafner (1981) regarding spouses as co-therapists and Barlow and Seidner (1983) for their study of the feasibility of extending the "couples treatment" paradigm to adolescent agoraphobics. In their study of three agoraphobic teenagers – a talkative, overweight 15-year-old male, a fairly attractive (but previously obese) 16-year-old female, and an attractive 17-year-old female – they found a correlation between improvement in phobias and improvement in parent/child relationships. They also found, however, that adolescents were much less tolerant than adults of the unpleasant and anxious sensations associated with the practice sessions.
[335] Only a few nursing articles were of the same style as the others, i.e., reports of trials/studies. Also, one article (Gaze, 1992) was even written as a news release, reminiscent of the health bulletins so often found in women's fashion magazines. What was especially interesting about this article, however, was that it revived a theory of causation offered nearly a century earlier, namely that agoraphobia was related to problems with the eyes, balance and co-ordination. Recall (from Chapter 4) Jones' patient's "impellent ideas" that were similarly believed to have been caused by "irregular stimulation" of "isolated cortical centres", which led to motor instability, vertigo, disturbed sensations and emotions (Jones, 1898). Recall also that Westphal did a thorough eye examination.
[336] Martin, 1979:2170. Similar to the woman who endured travel by train so long as she had her brandy and her Bible (Potter 1882:474, see Chapter 4), Mary also had to "brace herself with a bottle of sherry" as "[L]eaving the house became more and more of a threat" (Martin, 1979:2170). Mary's was not the only case of alcoholism mentioned however. Another, "John", on programmed walks alone away from the Clinic, "was visiting a public house for a couple of pints to help him relax after the day" (Allen, 1981:269).
[337] In Hodgkinson, 1981:37.
[338] Hodgkinson, 1981.
[339] Wondrak, 1980.
[340] Lim, 1982.
[341] Lim, 1985.
[342] Hodgkinson, 1981.
[343] King, 1981.
[344] Martin, 1979:2170.
[345] Wondrak, 1980:44.
[346] Brooker, 1980:367.
[347] Anderson, 1979:42.
[348] Lim, 1985:18.
[349] Nicholson, 1985.
[350] She was actually also afraid of all public transportation. See Pyke and Longdon, 1985.
[351] Like Mrs. A, "Mr. S" had been similarly unable to go further than a ½ mile from his home for the past six years. See Pyke and Longdon, 1985.
[352] See also a study by Gournay (1991) which shows that there is no real difference between outcome of treatment delivered from the patient's home and the out-patient clinic, but for patients who are unable to attend the out-patient clinic home-based treatment works well. Some patients in this set of reports were admitted to hospital and treated as in-patients. See for example

Brooker, 1980; Allen, 1981; King, 1981. Waddell and Demi (1993) did a study of the effectiveness of partial hospitalisation for treatment and found that on all measures participants had improved.
353 Allen, 1981:269.
354 Lim, 1985:19.
355 Lim, 1985:19.
356 Lim, 1985:19.
357 Lim, 1985:19.
358 Though not exclusively about women. As the following quote from Allen's report suggests, "John's" desire to be able to shop without anxiety is related to a discomfort in (urban) crowds, as the "great success of the day was walking through the Eldon Square shopping centre. This is the largest indoor shopping precinct in Europe and it was very busy; the wide enclosed walkways between the stores being crowded with Christmas shoppers" (Allen, 1981:270).
359 Roth et al., 1988.
360 Stantworth, 1982:400.
361 Stantworth, 1982:403.
362 Stantworth, 1982:400.
363 Stantworth, 1982:402.
364 Wondrak, 1980:43.
365 Pyke and Longdon, 1985:21. This is interesting in light of the findings of a recent survey investigating the question of whether agoraphobics interpret the environment in large shops and supermarkets differently from "general" shoppers. It was found that in fact layout features, stairways, and diminished access did provoke more anxiety in agoraphobics. See Jones, Humphris and Lewis, 1996.
366 Brooker, 1980.
367 Liffiton, 1992:33.
368 Garland, 1992:26.
369 Lim, 1982:51.
370 King, 1981:35.
371 Pyke and Roberts, 1987.
372 Maskens, 1981:205.
373 Maskens, 1981:205. Evidently, it was predominantly a women's organisation, since as the nurse writes: "If any health visitor knows of a young agoraphobic mother living within reasonable distance of Romford, please tell her about the 'Outside World' Society" (1981:205). There were no "male sufferers" at the first meeting of this group due to feelings of "deep shame", though one or two joined later.
374 McGennis, Hartman and Nolan, 1977.
375 McGennis, Hartman and Nolan, 1977:12-3.
376 McGennis, Hartman and Nolan, 1977:13.
377 McGennis, Hartman and Nolan, 1977:13.
378 Sinnott et al., 1981.
379 Needless to say, the advent of the internet has greatly facilitated a different sort of networking but a sort that does not entail leaving the house. One has only to type "support" and "agoraphobia" into www.google.com – this search turned up 11,200 hits. Interestingly, there is no literature on the impact of the internet on agoraphobia. Like Sigourney Weaver's character in the movie "Copycat,", I expected to find research documenting agoraphobics' use of their computers, something that is evident from a browse through agoraphobia web pages. The following example from < http://www.geocities.com/raymondblackmoore/asa.htm> illustrates (accessed 14 February 2001): "I felt alone and lost. In desperation one night I decided I would do a search on the newsgroups to see what I could find [...] I couldn't believe it, the people on [alt.support.agoraphobia] were the same as me [...] I felt less alone [...] I was dazzled by the replies ... and ... e-mails I received [...] there is always a little family there every day of regulars from all round the world."

Although there has been no research on this type of thing, what does appear, however, is some evidence that computers can be used successfully in treatment. One study shows that small handheld computers can be useful for recording self-report data (Taylor, et al., 1990). Not only can computers be useful for keeping a detailed record of behaviour, they can also be used to ad-

minister vicarious exposure treatments (Harcourt et al., 1998; Kirkby et al., 1999). They can even be used as a substitute for human intervention as a form of self-help by providing ideas on how to do self-exposure therapy and helping patients set weekly exposure goals (Shaw et al., 1999).
[380] Porter, 1997:524.

Chapter 9
Psychopathology, Social Order and the Psychiatric Narrative

> Medicine, for a historian of the present, must be analysed as constitutively social. To say that medicine is constitutively social does not mean that medicine has to be understood in a 'social context', that it has been subject to 'social influences', or that its activities have been 'socially determined'. Rather medicine has been bound up with the ways in which, since the end of the eighteenth century, the very idea of *society* has been brought into existence and acquired a density and a form [...] Society, as it is historically invented, is immediately accorded an organic form and thought in medical terms. As a *social body*, it is liable to sickness, that is to say, it is problematized in the vocabulary of medicine. As a social body it needs to be restored to health ...[1]

Introduction

In the previous chapter I described in detail a segment of the behaviourist case literature that was written primarily by nurses. I remarked in particular upon the style of these reports and how they seemed to tell a story about individual patients whom the reader could actually get to know. The patients were, in effect, protagonists – characters vividly portrayed as sufferers who overcome agoraphobia through dedication, hard work, and the right amount of support and direction from compassionate and tolerant caregivers. The narrativity of these accounts was easy for us to discern: they read very much like stories in the usual sense. Yet they were unusual in tone and form as compared with the rest of the literature published alongside it. Their anomalous-ness underscores one of the arguments I wish to make in this chapter.

The authority of psychiatric knowledge is largely derived from an objectivist scientistic tone that departs considerably from what we commonly think of

as "narrative," and this is especially the case in recent decades. Following Michèle Barrett, I will demonstrate that the sharp line traditionally drawn between "objective" psychiatric and "subjective" cultural discourse has always been a vexed distinction, that despite the medical-scientific packaging, the "clearly narrative" (fiction) and the "clearly theoretical" (medicine) have never been demarcated.[2] In other words, medical discourse is narrative as fiction is, and as Kathryn Montgomery Hunter writes, "That physicians are scientifically educated and technologically trained alters not one bit the narrative structure of their practical knowledge."[3]

In this chapter, I examine agoraphobia in the context of its historical conditions of possibility in order to illustrate the overarching assumption I have held throughout this work, namely that agoraphobia represents a kind of narrative, and that the *moral* of the (his)story pertains to the health, that is to say, the order, of society. Indeed, I argue that from the outset a normative theory of social order has been embedded in the discourse of this disease, crucial shifts in cultural and medical-scientific terrain notwithstanding. By juxtaposing cultural and psychiatric texts, my objective is to illuminate the "writerliness"[4] of both, and to destabilise the privilege that the "grid of [scientific] knowledge"[5] holds in our culture.

In the first section I examine the ways in which anxiety about social change informed 19th century ideas about agoraphobia. At this time, social theorists such as Marx, Durkheim, Weber, Tönnies, Simmel and later Benjamin, as well as physicians, architects, and urban planners were all concerned in one way or another about the intensity and social estrangement of modern urban life. The

subtext to their arguments reflected a deep concern for the well being of society, thrown into disarray with the sea changes of modernity. Implicated in the spectre of individual pathology and entrenched in the unrelenting psychiatric question of what it meant to be "normal" was the overarching question of what it meant to have social order. This question, as it turned out, had gender, race, and class implications. In the second section I examine the feminisation of agoraphobia as well as its origins as a disease of class privilege. We will look at gender ideology and separate spheres as they pertained to the gendering of disease, the issue of consumption, and the impact of World War I. This discussion will be followed in section three by an examination of the implied whiteness of agoraphobia. Drawing on other medical historical examples elaborated by Rebecca Herzig and Laura Briggs, I explore how a discourse of agoraphobia that almost never mentions race is in fact profoundly racialised. Psychoanalytic ideas were no exception to this rule, and in section four I examine some of the criticisms of psychoanalysis, namely its indifference to difference, and its power-ful effects as a normalising episteme. Finally, in the last section I examine the recent return of psychiatry to biological and positivist explanations for mental illness and the related "disappearance" of the social. In order to demonstrate a sense of science as practice and culture, I turn to arguments developed primarily within the field of Science Studies. I look at the question of social order as it has played out since the DSM took the helm, as well as its central assumption that diseases – people – *can* be classified, orderly, and, ultimately, managed and controlled through the objectivity of science.

What I seek to show overall in this chapter is that all of these processes contributed to a narrative of social order embedded within the discourse and experience of agoraphobia.

The City, Social Change and Mental Life

In the 19th century medical professionals found themselves in an excellent position to aspire to higher status.[6] This was "the age of improvement"[7] and as self-employed, petty bourgeois professionals working within a potentially lucrative – albeit competitive and insecure—market, doctors had an unprecedented degree of social authority to facilitate this.[8] A trend towards specialisation and division of labour in an "overstocked medical market" led doctors increasingly to psychological medicine,[9] and the ascendancy of professional psychotherapy provided a "vocabulary of troubles ... shaping lay definitions of everyday difficulties [and] moulding the presentation of individual complaints [into] problems suitable for professional treatment."[10] Psychiatry was becoming the gatekeeper whose societal task was to "persuade their fellow citizens to behave in accordance with certain norms"[11] and to police the boundaries between the sane and the insane, the normal and the pathological.[12] The citizenry, including those who presented themselves for treatment, supported this new kind of moral work because medical discourse gave people a language and a framework for speaking about themselves, their experiences, and their problems. Thus patients collaborated in the construction of both the *condition* agoraphobia (as opposed to a set of behaviours) and the *type* of person (agoraphobic) who did not conform to "normal" behavioural parameters.

During these same decades, with the rise of industrial capitalism, urban existence was taking on a new – and allegedly unhealthy – character. As one physician wrote in a paper called "Do Our Present Ways of Living Tend to the Increase of Certain Forms of Nervous and Mental Disorder?", "our rapid and over strenuous life", unaccompanied by sufficient rest, is the cause of the "increase in nervous and mental derangement." Mental strain is

> consequent on the increased demands upon us, the increased number of sensory impressions and variety of ideas forced upon by our increasing interests. There is scarcely time for the reception of impressions and no time at all for their proper assimilation. [...] The emotions are intensified by our present rapid methods of living, and drawn upon continually.[13]

These "rapid methods of living" were particular to the modern urban context, and this physician's remarks reflected an "emerging and generalized fear of [the] metropolis" that was manifest in physicians' writings.[14] Dr. Sutherland (Chapter 4) expressed a similar concern in 1877, we might recall, when he observed that some patients only experienced agoraphobic feelings in cities, as demonstrated by their ability "to bear the sight of a wide green plain." And while he departed from the tenets of mainstream psychiatry, even Freud expressed such concerns, arguing that "modern nervousness" was spreading rapidly. The tension between individual constitution in the nervous patient and the demands of civilisation, between "living in simple, healthy, country conditions" as the "forefathers" did, and living in "the great cities", was causing "'increasing nervousness' of the present day and modern civilized life."[15] Subsequent psychoanalytic understandings of agoraphobia expressed a similar concern through their preoccupation with urban streets as threatening and seductive.

While doctors had strong opinions about the perils of modern urban living, various social theorists shared their critical sentiments about social change. They argued that the decline of small-scale craft production and consumption, and its replacement with modern mass production and a new division of labour, produced impersonal relations and a loss of individuality, even as the *ideology* of individualism continued to develop.

For example, Marx's (1818-1883) historical materialism, concerned as it was with the transformation of society from feudal to capitalist relations of production, turned on the concept of alienation and the idea that in capitalist society "*[p]olitical economy conceals the estrangement inherent in the nature of labor by not considering the direct relationship between the worker (labor) and production*", and between the worker and the "objects of his production."[16] Estrangement manifested "not only in the result but in the *act of production*, within the *producing activity*, itself." Marx goes on to ask: "How could the worker come to face the product of his activity as a stranger, were it not that in the very act of production he was estranging himself from himself?"[17] Human beings were estranged not only from their work, its products, and themselves, however. They were also estranged from their fellow human beings. As Marx also writes, "An immediate consequence of the fact that man is estranged from the product of his labor, from his life activity, from his species being is the *estrangement of man* from *man*."[18]

Durkheim (1858-1936) described the new social order as a shift from (premodern) mechanical to (modern) organic solidarity. In traditional societies, people integrated through the values and symbols of tradition and homogeneity and

"what we call society is a more or less organized totality of beliefs and sentiments common to all the members of the group."[19] In modern urban societies, however, it was "quite otherwise" due to "the solidarity which the division of labor produces." Organic solidarity is possible "only if each [individual] has a sphere of action which is peculiar to him." Durkheim offered the following analogy:

> This solidarity resembles that which we observe among the higher animals. Each organ, in effect, has its special physiognomy, its autonomy. And, moreover, the unity of the organism is as great as the individuation of the parts is more marked.[20]

Weber (1864-1920) described the changes in terms of the increasing bureaucratisation of modern industrial society, and the concomitant destruction of human creativity, and as he wrote, the "most important opponent with which the spirit of capitalism ... has had to struggle, was ... traditionalism."[21] The "cage" of "rational conduct" was "one of the fundamental elements" of both "modern capitalism" and "of all modern culture."[22] Finally, Tönnies (1858-1936) used the terms "gemeinschaft" and "gesellschaft" to describe the change from social relations based in "community" to relations based in "associations," or the individualistic, impersonal, competitive, calculative, and contractual dealings endemic in the modern industrial context. As he wrote:

> [H]uman Gesellschaft is conceived as mere coexistence of people independent of each other. [...] [A]ll praise of rural life has pointed out that the Gemeinschaft among people is stronger there and more alive; it is the lasting and genuine form of living together. In contrast to Gemeinschaft, Gesellschaft is transitory and superficial.[23]

But it was Simmel (1858-1918) in particular, and later his (occasional) student Walter Benjamin,[24] who drew attention to the metropolis – "the seat of the money economy"[25] – where exchange value and consumption were the basis

for social relations. The city (especially the capital city because it was there that bourgeois culture tended to dominate) was a "key [site] for the changing modes of experiencing modernity"[26] with its transformations in work, housing, and ultimately, in social relations.[27] As physicians were also suggesting, these social transformations were ideal conditions for the development of mental problems. The "psychological conditions which the metropolis create[d]" were constituted, in Simmel's words, by

> the rapid crowding of changing images, the sharp discontinuity in the grasp of a single glance, and the unexpectedness of onrushing impressions. [...] [The city sets up a deep contrast with small town and rural life with reference to the sensory foundations of psychic life. The metropolis exacts from man as a discriminating creature a different amount of consciousness than does rural life.[28]

In the metropolis, "an asphalt and stone wilderness, the opposite of nature,"[29] life was phantasmagoric and fragmented, giving rise to a new way of perceiving and experiencing the social that rendered time and space highly discontinuous.[30] All this "nervous stimulation"[31] produced a particular personality type with a "blasé attitude" that was "unconditionally reserved to the metropolis." This blasé attitude was the result of

> rapidly changing and closely compressed contrasting stimulations of the nerves. [...] A life in boundless pursuit of pleasure makes one blasé because it agitates the nerves to their strongest reactivity for such a long time that they finally cease to react at all. In the same way, through the rapidity and contradictoriness of their changes, more harmless impressions force such violent responses, tearing the nerves so brutally hither and thither that their last reserves of strength are spent; and if one remains in the same milieu they have no time to gather new strength. An incapacity thus emerges to react to new sensations with the appropriate energy.[32]

Thus the individual was driven to take social distance by developing "an inner barrier" that was

> indispensable for the modern form of life. For the jostling crowdedness and the motley disorder of metropolitan communication would simply be unbearable without such psychological distance. Since contemporary urban culture, with its commercial, professional and social intercourse, forces us to be physically close to an enormous number of people, sensitive and nervous modern people would sink completely into despair if the objectification of social relationships did not bring with it an inner boundary and reserve.[33]

As Simmel's remarks demonstrate, people were alienated and estranged psychologically and spatially – from one another, from themselves, and from their work. Emotional withdrawal and retreat into the self was a way of coping with progress and the exigencies of modern existence.[34] But the condition that best captured this "emotional trait" of anxious reserve at its most acute, this "pathological deformation," was, as Simmel wrote, "the so-called 'agoraphobia': the fear of coming into too close a contact with objects, a consequence of hyperaesthesia, for which every direct and energetic disturbance causes pain."[35] For Simmel, then, psychological conditions were solutions for living in too close proximity to too many others. But even isolation – an implication of agoraphobic behaviour – was considered by Simmel to be essentially social, contra physicians who conceptualised it as strictly anti-social and therefore pathological (such as Dr. Sutherland who wrote that his patient "scarcely ever leaves the house, [and] never goes into society").[36] As Simmel explained: the "mere fact that an individual does not interact with others ... does [not] express the whole idea of isolation. For, isolation ... refers by no means to the absence of society." Moreover, the feeling of isolation is never as intense as when one is a stranger among many physically close, as in a crowded city street.[37] Isolation is *determined* by a*ssociation*; it "attains its unequivocal, positive significance only as society's effect at a

distance – whether as lingering on of past relations, as anticipation of future contacts, as nostalgia, or as an intentional turning away from society."[38] Isolation represents a very specific relation *to* society and "a given quantity and quality of social life creates a certain number of temporarily or chronically lonely existences."[39]

This remark, coupled with his discussion of the blasé attitude and its extreme manifestation in agoraphobia, reflects the idea that psychological conditions were an inevitable consequence of modern urban life. Even modernist architects – "doctors of space"[40] – argued that "urban phobias were precisely the product of urban environments"[41] and through their building designs, sought to cleanse the city not only of physical disease, but of its mental disturbances as well.[42] We might recall "Vincent" (Chapter 4) for example, and his description of how "[u]gly architecture greatly intensifie[d] the fear."[43] Agoraphobia in particular was taken as proof that the city was essentially bad for health. As Camillo Sitte, a city planner who was well known for his opposition to the development of a public square (the Ringstrasse) in Vienna, wrote in 1889:

> Recently a unique nervous disorder has been diagnosed – 'agoraphobia.' Numerous people are said to suffer from it, always experiencing a certain anxiety or discomfort, whenever they have to walk across a vast empty place. [...] Agoraphobia is a very new and modern ailment. One naturally feels very cozy in small, old plazas. [...] On our modern gigantic plazas, with their yawning emptiness and oppressive ennui, the inhabitants of snug old towns suffer attacks of this fashionable agoraphobia.[44]

Mental problems were not the only health risks of urban living, however, and psychological distance and aesthetically pleasing architecture not the only strategies for achieving "health." The evidence was clear, for example, that cities without sanitation bore directly upon public health (witness cholera): the "mias-

mic conception of epidemics [believed to inhere] in the relation between social space and human character lent itself to a medicine of social spaces." As such, medicine played a crucial role in the very organisation of social space, insofar as its practices were bound up with the regulation of urban life, problematised as it was in the language of disease. Rose observes that

> ... diseases were produced in certain types of social space, circulated around social space, alighted upon those predisposed by character or habits to succumb and ran its course in them. [...] Disease could be seen to coincide with physical squalor and moral degradation.[45]

Subjected to the "purifying gaze of civilization", a variety of schemes for improvement was developed to facilitate hygiene and civility. These "spatial technologies of health" included zoning, which established "absolute lines of demarcation between work and residential areas, and between cultural and commercial activities."[46] City planning, also out of concern for the "health of the social body," sought to reconstruct public space "in order to penetrate the dark and fetid locales where disease bred untouched by the purifying effects of light, air and civility."[47] In both city plans and the architectural

> design of buildings – prisons, asylums, schools, homes, bathrooms, kitchens – one sees the desire to make space healthy. Architects and planners seek to enact a medical vocation by organizing ... relations ...in order to minimize all that would encourage disease and to maximize all that would promote [...] the dream of the healthy body ...[48]

It is no coincidence, then, that the private sphere was constructed by middle-class ideologues as a purified and aerated refuge from the filth and immorality that the lower classes produced in urban streets.[49] Indeed, it was this separation of space that was of such strong interest to Walter Benjamin. Whereas Simmel was concerned to theorise the *inner* barrier that urban individuals developed, thereby

laying the groundwork for an understanding of the direct psychical consequences of modern urban life, Benjamin was more interested in the *outer* barriers, that is, the retreat of the bourgeoisie into the privacy of their homes.

Benjamin simultaneously loathed and praised the city – it was the site of bourgeois domination on the one hand, and the space of intoxication and intrigue, of excitement and distraction, on the other. Fascinated with public space and all its stimuli, the display of commodities in the shopping arcades, the changing "structure of experience," and the different types of people moving through the crowds, Benjamin saw the city as a source of pleasure and danger, shocks and nervous pressure. Like Simmel, he described how people developed a defensive urban consciousness as a protective barrier against too much stimulation. Although more willing than Simmel to celebrate city life, Benjamin also observed that the city was alienating and necessitated self-preservation:

> The greater the share of the shock factor in particular impressions, the more constantly consciousness has to be alert as a screen against stimuli; the more efficiently it is so, the less do these impressions enter experience ... tending to remain in the sphere of a certain hour in one's life."[50]

The shocks and stimuli of the urban environment were "unassimilable by the consciousness of the individual, and ... parried or deflected into the realm of the unconscious where they remain[ed] embedded."[51] Finding a parallel in both Freud's theory of the unconscious and Simmel's observation that modern individuals' only psychological recourse was to retreat into themselves, Benjamin focused on the bourgeois interiorisation of private life so peculiar to the period. City planning in the name of health offered the bourgeoisie a way of separating themselves from the unpleasantness and danger of the lower classes. A physical

boundary– a "psychoanalysis of space"[52] – was developed and the bourgeois home became a sanctuary:

> For the private person, living space becomes, for the first time, antithetical to the place of work. [...] The private person who squares his accounts with reality in his office demands that the interior be maintained in his illusions. [...] From this springs the phantasmagorias of the interior. For the private individual the private environment represents the universe. [...] His drawing room is a box in the world theatre.[53]

Despite the best efforts to separate spaces of work and home, however, it was apparent that the home could not be a constant haven. As Henri Lefebvre argues, and as demonstrated by some patients unable to be alone even *at home*,[54] the apparent "solidity" of the interior was an illusion. The house was "permeated from every direction by streams of energy which run in and out of it by every imaginable route."[55] Thus, the bourgeoisie sought to "compensate...for the inconsequential nature of private life in the big city [...] within...four walls" by accumulating a "host of objects." Although the "bourgeoisie is unable to give his earthly being permanence, it seems to be a matter of honour with him to preserve the traces of his articles and requisites of daily use in perpetuity."[56] In other words, commodity consumption enhanced the retreat into the private home, offering an additional method for coping with the pressures of modern life.

As an important signifier of social status,[57] one might even argue that consumption was an equally important (if not paradoxical) signifier of normal bourgeois behaviour.[58] By implication, then, the "refusal" to participate in consumption – an inevitable implication of agoraphobia (at least until the advent of internet and catalogue shopping) – has long been an implicit criterion of pathology. Even as recently as the last few decades, patients being treated within a cognitive-

behaviourist framework who did *not* set shopping alone as a goal of their treatment were few and far between (Chapter 8).[59]

In sum, we can see how physicians, social theorists, architects and planners helped give social estrangement "all the dimensions of a psychological complex" constructed from a range of new mental diseases, which seemed to be tied to the urban context. Agoraphobia (and claustrophobia) was at once diagnosis and metaphor: the pathology described symptoms of anxiety at the same time as it captured the alienation that individuals felt and experienced in modern society.[60] More importantly, the diagnosis gave agoraphobic individuals a medical framework through which to make sense of their experiences in the city, and of themselves as different from others.[61]

The Gender of Agoraphobia

Of course, while the cultural significance of agoraphobia – that is, the perils of social change – had, in a sense, surpassed the significance of its medical etiology[62] – that is, over-stimulation in fast paced cities – the individual characters of patients were also considered fair game. Mental disorders were equated with moral depravity and personal weakness and as one American neurologist wrote: "mental disorder, in neurotic individuals, [could bring] about a moral epidemic or even [threaten] to change the structure of society and unity of the household."[63] Turning again to Dr. Sutherland, for example, he concluded that the agoraphobia in his patients was the result of excess and debauchery. His theory was consistent with a popular notion among doctors of that time that diseases "followed in the wake of excesses of all kinds,"[64] and were caused by

> excesses or deficiencies in the way a patient lived. The conjunction of natural equilibrium and health fitted easily within a moral context, for unbalancing immoderation could follow not only from improper behavior regarding heat, fresh air, exercise, and food, but also from drinking, piety, and venery.[65]

While excess and debauchery was a popular explanation for illness, also central to this "moral epidemic," not surprisingly, were strong ideas about gender and class. For example, where women were concerned, 19th century messages about consumption were highly contradictory. As Wilson writes, "Just as nineteenth-century society was trying to deepen and secure the boundary between public and private, industrial capitalism was erasing it."[66] Alongside a desire to control women's movement in urban space, there was also a tendency to encourage it, for women's social status hung in the balance. This tension was evident in an increasing market consumerism and the seductions it provided. These included new forms of employment for working and lower middle-class women, as well as exhibitions, department stores, refreshment rooms, rest rooms, and reading rooms – all places where bourgeois women could go unchaperoned.

Sanctions on women's movement may explain in part why most of the early patients diagnosed with agoraphobia were men, since staying home for a woman was a sign of normality, not pathology. Yet, following Vidler, even though most of the earliest patients were men, "from the outset," these mental problems "were assigned a definite place in the gendering of metropolitan psychopathology [...] and thought of as fundamentally 'female' in character."[67] Vidler does not do a thorough analysis of how this came to pass but considered in the light of a paper by Nancy Theriot, we begin to get a clearer picture. Theriot observes that, in the 19th century, women's nervous systems were thought to be more honed than

men's, indeed, nerves themselves feminine. Medical illustrations depicted the nervous system as female (as opposed to the muscular system normally represented as male), rendering women "inherently prone to nervousness and to manic, depressive, or hysterical responses to life's difficulties."[68]

Thus when men were diagnosed with agoraphobia, nerves were frequently cited as the culprit, and agoraphobia was thereby feminised. (Ironically, when *women* were diagnosed with agoraphobia, their reproductive organs were blamed as the central cause. Evidently blaming their nerves would have been redundant.[69]) As Dr. White wrote in 1884, for example, agoraphobia represented a "curious phase of nervous phenomenon." He then went on to describe the symptoms in a 30-year-old professional gentleman with no family history of nervous disorders but who "suffered from a nervous kind of light-headedness [...] brought on by the ideas of space."[70] Dr. Webber, whose patient was a 42-year-old man, wrote that at "the foundation of these sensations of anxiety lies one common ... corporeal cause" occurring "in a certain pathological group, including what may be expressed by the name nervous irritability, crethism, irritable weakness." In these cases the "entire nervous system ... may be thrown into extreme commotion."[71] Nerves were not the only offender, however; the femininity of agoraphobia was also underscored by Freud when he described it in a letter to Fliess as the "repression of the intention to take the first man one meets in the street."[72]

But there was arguably more going on than both a theory of repression and a gendered "ideology of nerves." To be sure, a patriarchal ideal of femininity (and masculinity), inextricable from a contradictory imperative of social and spatial order, also had an important part to play. More specifically, the ideology of sepa-

rate spheres, evident in the deportment literature of the 19th century, declared women's role to be, primarily, that of wife and mother. Prescriptive guides to True Womanhood bore titles such as *The Young Lady's Book: A Manual of Elegant Recreations, Exercises, and Pursuits* and *Woman As She Was, Is, and Should Be.*[73] These books were premised on the middle-class notion that a True Woman's place was in the home and their directives sought to maintain a clear and definite boundary between these women of refinement and the lower classes. Alongside a general unease about the city and women's sexual and intellectual independence, women in the streets unaccompanied were seen as a moral problem.[74]

The early historiography on separate spheres, of which Welter's work was representative, assumed a congruence existed between such prescriptive literature and women's real experiences. Though there were restrictions on women's presence in the streets alone, more recent historiography questions the extent to which women *strictly* occupied a separate sphere.[75] Historiographical debates suggest that the separate spheres metaphor oversimplified the "real" situation of women in the latter half of the 19th century, that the *rhetoric* departed somewhat from the *reality*. Indeed, there *was* something to the metaphor, but women's lives were more complex than straightforward confinement in the home, varying by class, region, degree and type of industrialisation, and numerous other factors.[76] Still, it is undeniable that the ideology of gender roles that informed the rhetoric had a remarkable consistency with the symptoms of agoraphobia.

In fact, the resonance between gender ideology and agoraphobic symptomatology suggests an explanation for why earlier agoraphobic patients were men.

Most likely, as I noted earlier, this kind of behaviour was considered quite appropriate for women: the symptoms of this disease mapped so well onto what was expected of them. I would also argue that agoraphobia diagnosed in men, however, suggests a resistance on their part to an imperative of masculinity imposed upon them that they could not fulfil, a resistance that was subsequently pathologised.

World War I may also have reinforced the gendered division of this disease and especially the shift in prevalence from men to women, so that what was normal (feminine domesticity) became pathological (agoraphobia). During the war women achieved some measure of independence from men, but with enhanced independence came more duties and responsibilities, an adaptation that not all women could (or would) make. For those women for whom emancipation was not a priority, that is, women who had no feminist quarrel with the status quo, agoraphobia may have been a way for them to avoid the issues of gender politics legitimately. And since separate spheres was more rhetoric than reality, the invention of a pathology that could equally effect the kind of social control that was the driving force of gender ideology may have been just what the doctor ordered. With all the social authority that medicine had secured for itself, re-inventing True Womanhood in the language of disease and femininity provided a way for doctors (with the collaboration of their patients) to stem the tide of equality.[77] The re-gendering of agoraphobia, then, is a story not only about individual experiences of panic, but about social and moral panic as well, deriving from a perceived loss of control over women's bodies and sexualities.

A third reason may also help to explain why agoraphobia, once it had shifted to women, remained their provenance. War neurosis (masculine because war-related) had been "discovered" by then and was a common framework for understanding men's post-war anxieties, while agoraphobia (by comparison, emasculating because home-related) was really only beginning to be diagnosed substantially in women. With this in mind, we might compare the following passages: The first, by Pat Barker, is a fictionalised account of (real) psychiatrist William Rivers' efforts to treat soldiers with shell shock. He observed that

> in leading his patients to understand that breakdown was nothing to be ashamed of, that horror and fear were inevitable responses to the trauma of war and were better acknowledged than suppressed, that feelings of tenderness for other men were natural and right, that tears were an acceptable and helpful part of grieving, he was setting himself against the whole tenor of their upbringing. They'd been trained to identify emotional repression, as the essence of manliness. Men who broke down, or cried, or admitted to feeling fear, were sissies, weaklings, failures. Not *men*.[78]

The second passage is one we looked at in Chapter 4, taken from the "confession" in 1919 by "Vincent" who lamented his inability to "take up [his] duties on account of indisposition." As he asked in his autopathography: "Can I ever take my place in the world unhandicapped as other men are, and enjoy a single day undepressed by dark dread? If I could be as other men, it seems to me that my usefulness should be increased a hundredfold."[79] A similar sentiment was expressed by a physician suffering from this "affection". The "spells"

> grew upon me, until I was afraid to go a hundred yards by myself, even out in my own premises. [...] Engaged at the time in the practice of medicine and farming, of course my business had to suffer and I grew melancholy, feeling that all my prospects in life were blighted. I however tried manfully to brave off the spells, though at each time I permitted myself to be alone, I suffered terrible agony...[80]

The point I wish to make in juxtaposing these three excerpts is that physicians were debating not only clinical issues but also questions about what people were supposed to be like, what they were supposed to be doing, and where they were supposed to be. In other words, the literature conveyed implicit (and sometimes explicit) messages about a gendered social order and the role of psychiatry in its negotiation.

Nonetheless, following the First World War and the gendered shift in prevalence, questions started to emerge regarding the possibility of a link between women's social inequality and the state of their mental health. As one physician remarked in 1925, perhaps their mental troubles were due to the fact that "[w]omen through their early education and home environment up to the present age have been denied that knowledge of sex to which they are rightly entitled and have been taught to suppress all thought of such matters as immodest."[81] A similar, if ambiguous, thesis was suggested by American neurologist Abraham Myerson who, in his 1929 book *The Nervous Housewife*, argued that the "psychasthenia" of the housewife (which included fears of open and closed places, leaving home and being alone) was the result of a malcontent made apparent by feminism.[82] As he wrote:

> A woman may be hyperaesthetic in one sphere of her tastes and as thick-skinned as a rhinoceros in others. She may squirm with horror if her husband snores in his sleep, but be willing to live in an ugly modern apartment house with a poodle dog for her chief associate. Or the overconscientious woman may expend her energies in chasing the last bit of dirt out of her house but be willing to poison her family with three delicatessen meals a day. The overemotional housewife may flood the household with her tears over trifles but be a very Spartan in the grave emergencies of life. And the neurotic woman, a chronic invalid for housework, may do a dragon's work for Woman Suffrage.[83]

Whether he was critical of women for having feminist inclinations or simply remarking on the benefit that accrues to them when they work in their own interests is not clear. Other remarks he made pertaining to race were quite clear, however, and it is to this issue (and his remarks) that I turn next. This discussion of race will include discussion of both 19th century and contemporary medicine and psychiatry.

The Race of Agoraphobia

Though Myerson insisted that the forces of social life were mainly responsible for mental problems, he maintained that women were ultimately predisposed due to their over-emotionality, especially Jewish women because the "Jewish home reverberates with emotionality and largely through this the attitude of the Jewish housewife."[84] The notion that Jews were especially prone to nervous disease seems to have been quite popular and longstanding. As Sander Gilman writes: "The face of the Jew was as much a sign of the pathological as was the face of the hysteric" and the notion that Eastern European Jewish men were most at risk for hysteria was a "truism of medical science" for decades.[85] An American physician named C.E. Atwood wrote in 1903, for example, that 80 per cent of the cases of neurasthenia that he saw at one clinic in 1902 were foreign born, and mostly Russian Jews.[86]

But the pathological psyches of Jews was not strictly about their Jewishness. In America at least, this sensibility was inextricable from a widespread discourse of anti-immigration. As Atwood wrote in the same article, most at risk for nervous disease was the immigrant, especially in large cities, and this was

> partly owing to some inherent racial peculiarities, partly to neurotic heredity, or tendencies, partly to deprivation, partly to competition, and partly to the fact that the sordid processes of evolution are before him. [...] It is chiefly in this imported foreign population that we find types of degeneracy, physical stigmata, perversions, mental enfeeblement, neurasthenia, insanity and criminals. The immigrant in this case has been thrown on his own resources and has entered the strife as an inferior, and he becomes an easy prey to his physical and vital environment.[87]

Atwood argued in conclusion that the "subject of immigration is of exceeding importance" in the prevention of nervous disease. He goes on to say:

> The fact that eight tenths of cases of neurasthenia at the Vanderbilt Clinic, and two thirds of the insane of the State of New York, are either foreign born or of foreign parentage, points to possibilities of prevention by restricting immigration. But it is my province merely to point out some of the dangers and not suggest a cure for them.[88]

Atwood's remarks are revealing, however it should be noted that his concern was with neurasthenia in particular. This kind of flagrant anti-immigration racism was decidedly *not* evident in the literature on agoraphobia. Indeed, save for the racial inference in Myerson and a handful of more direct references, in 130 years' worth of writing about agoraphobia what has remained remarkably consistent is the almost complete absence of any mention of race. This is despite the fact, as we have seen and shall see again shortly, that it was common for diseases – both physical and mental – to be racialised.[89] As Gerald Grob writes, psychiatry was not "immune from the racial and ethnic divisions of the larger society. Many believed that susceptibility toward mental illness was in part determined by race."[90]

To be sure, the invisibility of race in agoraphobia literature suggests that the typical patient suffering from this disorder has historically not only been female (since World War I), married and middle-class, but also white. The silence is especially offset by the few occasions when race *is* mentioned, that is, in cases

of "racial deviance." Two patients described in Chapter 5 provide good examples: In one case, the patient ("Diane") was afraid of running into "little black people" (Jews and Puerto Ricans) downtown, while in the other, the patient himself was an orthodox Polish Jewish immigrant.[91] A third patient, described in Chapter 8, was a 28-year-old West Indian woman with excessive thyroid activity and agoraphobia.[92] In contrast, I found no articles describing patients as Protestant and white. As such, it was especially surprising when the American epidemiological evidence from the 1980s that we looked at in Chapter 8 revealed that the majority of agoraphobics are poor, single or divorced, Black women.

In the earlier discussion I suggested two possible explanations for this unexpected evidence. The first is a lack of economic access to therapy (which leads to overrepresentation of whites within clinic populations and agoraphobia research based on these populations).[93] This is borne out by US National Health Survey data that show a substantial difference between white and Black family income levels,[94] corresponding disparities in private health insurance coverage[95] and State and county mental hospital admissions.[96] Recent census data (1998) also reveal significantly fewer visits by Blacks to physicians' offices,[97] reflecting a longstanding, complex, deeply entrenched – and well-justified – distrust of medical professionals by African Americans. The distrust derives from a long history in the US of (ab)using African Americans for the purposes of medical experimentation. I already outlined the Tuskegee Syphilis Study in Chapter 8, but will now focus briefly on earlier studies, as they add further historical perspective to the absence of Blacks in agoraphobia literature.

First, antebellum gynecologist J. Marion Sims used three Alabama slave women that he purchased expressly for the purpose of practising a technique for repairing post-partum vaginal tears.[98] These tears ("fistulas") caused urine and feces to leak through the vaginal opening, causing great discomfort and distress. Sims was said to have arranged with one slaveowner as follows:

> 'If you will give me Anarcha and Betsey for experiment, I agree to perform no operation on either of them to endanger their lives, and will not charge a cent for keeping them, but you must pay their taxes and clothe them. I will keep them at my own expense.'[99]

These were the days before anaesthesia and Sims performed dozens of operations on the women. And even though he was spending a lot of money "'to support a half-dozen niggers,'" Sims continued to try and perfect a cure. It took 30 operations on Anarcha before Sims found success through the use of silver sutures.[100]

Another example from around the same time was when a Georgia physician, wanting to test remedies for heat-stroke, had a slave (provided to him as repayment for a debt) sit naked on a stool placed on a platform in a pit that had been heated to a high temperature. This poor soul was given various medications while the experiment was conducted over a period of two to three weeks. The experimenter's overall purpose of this experiment was to make it possible for slaves to work longer hours on the hottest days. Obviously, among other abuses of their human rights, these "research" subjects, unlike their white counterparts, were not paid for their participation.[101]

The cultural effects of these damaging research practices were compounded by the prospect of urban "night doctors" taking African Americans away dead or alive for use in medical research.[102] Coinciding with the great migration

of Blacks to industrial urban centres between 1880 and the end of the First World War, the entrenched notion that city people were in danger of being kidnapped and murdered was possibly the most effective rumour deliberately circulated by Southern labour-conscious whites seeking to prevent Blacks from migrating to the North.[103] As one statement in an 1896 issue of the *Journal of American Folklore* read:

> On dark nights negroes in cities consider it dangerous to walk alone on the streets because the "night-doctor" is abroad. He does not hesitate to choke colored people to death in order to obtain their bodies for dissection. The genesis of this belief from the well-known practice of grave-robbing for medical colleges, several of which are located in Southern cities, is sufficiently evident.[104]

Though no evidence has been found that these "night riders" really existed,[105] the substantial folklore about it, following W.I. Thomas, served to define the situation as real, rendering the idea real in its consequences.[106] In fact, the leap from this to agoraphobic fear does not require much imagination, especially in light of the following *Boston Herald* article from 1889:

> The negroes of Clarendon, Williamsburg and Sumter counties have for several weeks past been in a state of fear and trembling. They claim that there is a white man, a doctor, who at will can make himself invisible, and who then approaches some unsuspecting darkey, and having rendered him or her insensible with chloroform, proceeds to fill up a bucket with the victim's blood, for the purpose of making medicine. After having drained the last drop of blood from the victim, the body is dumped into some secret place where it is impossible for any person to find it. *The colored women are so worked up over this phantom that they will not venture out at night, or in the daytime in any sequestered place.*[107]

The thought of being bled and dismembered terrified African Americans so much, that until the 1930s at least, many stayed away from the vicinity of hospitals during the daytime, and avoided night travel and even certain cities altogether.[108]

The more contemporary example found in the Tuskegee Syphilis study conducted between 1932 and 1972 (described in Chapter 8) is commonly cited as *the* defining event in this racist medical history. Distressingly, however, racist experimentation did not stop once that study was exposed. As recently as 1996, the Centres for Disease Control finally disclosed a trial for a measles vaccine in progress since 1989. Most of the 900 babies who were inoculated in this study were Black and Latino, and the infants' parents had not been informed that the vaccine was not licensed in the United States and had been associated with increased death rates in Africa.[109] Remarkably, this occurred despite the National Research Act that had been implemented in 1974 following the syphilis study disclosure. The act was "established to protect subjects in human experimentation, [and] mandates institutional review board approval of all federally funded projects with human subjects."[110]

These examples go a long way to illustrate why African Americans would be resistant to medical interventions. It also helps explain why, in recent history, they have declined for the most part to participate in clinical trials and organ donation, and why many believe the AIDS virus to be synthetic, and a deliberate attempt at genocide against them.[111] But the most compelling illustration comes from the "night doctors" example, which demonstrates most revealingly that similar to affluent white women's "passing" as True Women rather than agoraphobic, African Americans' anxieties about being out in white-dominated racist and dangerous public space may have also "passed" unnoticed – that is, as something other than agoraphobia. Hence, the surprising contemporary epidemiological evidence.

Indeed, public health statistics such as these have also contributed their fair share to the narrative of racial difference. To return again to the epidemiological study, the interviews conducted for that were based on a schedule (the "DIS") defined by the criteria of DSM-III. If the revised DSM-III-R schedule (the "SCID") is any indication, it is likely that the DIS was also based on normative white experiences and did not address issues of racism.[112] This is very suggestive: the single, poor Black women who comprised the strong majority of agoraphobics may have "qualified" as *decontextualised* agoraphobics simply because the interview(er) did not ask the "right" questions, that is, questions that might have illustrated the possibility that racism, not phobic fear per se, discourages Blacks from public places.[113] This tacit normalisation of whiteness in the discourse of agoraphobia has given whiteness the position of silent but privileged signifier throughout the history of its representation. I turn now to two recent studies of other diseases that help to illustrate this point.

First, Rebecca Herzig, in her work on the diagnosis of hypertrichosis (excessive and unwanted hair) before 1930, argues that the very category of 'sex" was often at stake in medical diagnosis and treatment. Central to negotiations over the definition of hypertrichosis were debates over the nature of sexual difference to the extent that the question of how much hair was "natural" and "unnatural" was an important dilemma for medical practitioners. This question was inseparable from ideas about race to the extent that within the discourse of this disease, body hair was invested with the weight of evolutionary progress (or rather, its lack) that directly signified racial difference. Herzig contends that

> even when acknowledging cultural variation in perceptions of beauty and normalcy, physicians were quick to mark some bodies as fundamentally 'deficient' or 'excessive' in secondary hair growth. [...] At stake in the diagnosis of hypertrichosis, then, was the very meaning of racialized manliness and womanliness themselves..."[114]

Even more fundamentally, as Herzig states later in her paper, the desire to appear feminine, that is, not excessively and unnaturally hairy,

> made sense only against the backdrop of an already-presumed distinction between normal [read: white] and abnormal [read: non-white] bodies, since *only the normal body could become ill* with hypertrichosis. Other bodies were presumed to be [merely] expressing their characteristic racial difference.[115]

Thus Caucasian bodies could be the only candidates for this pathology because they were the only bodies qualified to be considered "normal." "Mongolian" and "Negro" bodies were excluded both from the normal and the pathological. They simply constituted "deficiency" – a separate category altogether. In other words, their hairiness (or hair-less-ness) was simply an expression of their race. In fact, whiteness, for all intents and purposes, though superior, was not really even a race in the sense that these and other groups were considered to be. The term "coloured" captures this negative relation well, the assumption being that white was and is not a colour at all.[116]

This assumption is evident in the *Statistical Manual for the Use of Institutions for the Insane*, discussed in Chapter 7. As a precursor to the DSM, this publication, in addition to disease classifications, included various instructions on how to classify the "race of first admissions" to hospital. The categories outlined in these pages were derived from a publication that the United States Immigration Service released in 1911 called the *Dictionary of Races or Peoples*. There, under the category called "Negro, Negroid, African, Black, Ethiopian, or

Austafrican,"[117] it is stated that this "grand division of mankind" is "distinguished by its black color and, generally speaking, by its woolly hair." "Negroes" are "alike in inhabiting hot countries and in belonging to the lowest division of mankind from an evolutionary standpoint."[118] In contrast, the "English" are described as "the principal race," but of course, when they use the term "race" here they do not *really* mean race the way it is meant when used to refer to brown-skinned people reduced to sub-humans on some level. Rather, what is meant by race here is that white is the normative standard against which all the other so-called races shall be measured. The elevated evolutionary status of whites is simply assumed and in fact, as the Dictionary states: "Of course there is no necessity in this dictionary for discussion of a subject so well understood by all as the character, social institutions, and other qualities of the English as an immigrant people."[119]

To the extent that the classification of races and peoples was based on ideas about evolutionary progress, I want to argue, following Laura Briggs, that the normalisation of whiteness was also intrinsically linked to ideas about civilisation and modernity, and related assumptions about the frailty of affluent women's bodies. In her article on the history of race and hysteria (including neurasthenia), Briggs argues that hysteria was about race as much as it was about class and gender, insofar as nervousness was characterised as a problem of "over-civilization". As Atwood wrote in that rich 1903 piece, for example: "General paresis[120] has been called a product of civilisation and syphilization. It was first described in 1820, and probably did not exist to a pronounced extent before that time. It has gradually increased in frequency, especially in cities."[121] Early scholarship on women and hysteria, as has been noted, viewed this diagnosis as a

"dismissal of women as competent participants in public life, a social role uncomfortably inhabited by suffering women, and a warning about the dangerous consequences for women of engaging in 'unfeminine' behavior."[122] This early argument was a convincing one, but like its cousin in the discourse of separate spheres, it fell short of addressing race in any meaningful way, presuming the category "woman" to be monolithic and unencumbered by any other social contingencies.

Briggs argues, in contrast, that as "a disease of 'overcivilization,' hysterical illness was the provenance almost exclusively of Anglo-Americans, native-born whites, specifically, white women of a certain class."[123] These women were understood to be frail and nervous, a conception popularised by famous physicians such as S. Weir Mitchell and George M. Beard, and suffering from a nervous weakness "produced by the frantic pressures of advanced civilization."[124] As Beard wrote, for example,

> Nervous disease ... scarcely exists among savages or barbarians, or semi-barbarians or partially civilized people. Likewise in the lower orders in our great cities, and among the peasantry in the rural districts, muscle-workers, as distinguished from brain-workers – those who represent the habits and mode of life and disease of our ancestors – functional nervous diseases, except those of a malarial or syphilitic character, are about as rare as they were among all classes during the last century. These people frequently need more violent and severe purging, more blood-letting, more frequent blistering than the higher orders would endure. [125]

As Beard also argued in his treatise on nervousness: "functional nervous disease" resulted only when "civilization prepare[s] the way." As he went on to say, "Civilization is ... the one constant factor, the foundation of all these neuroses, wherever they exist."[126]

For the purposes of our understanding of agoraphobia, what is especially interesting about this notion that only civilised (white affluent) people could become hysterical, neurasthenic, and as I am arguing, agoraphobic, is that all of the social theorists mentioned earlier – Marx, Durkheim, Weber, Tönnies, Simmel, and Benjamin too, to some extent –were also pre-occupied with evolution and the dangers of civilisation. And as Briggs points out,

> [c]ultural evolutionism and other sciences of racial difference encoded many diverse relations in the notions of '(over)civilized' and savage ... [including] the differences between country and city ...the edenic, innocent pastoral as against the vexations of industrialization, the nostalgic against the modern.[127]

These theorists were (implicitly) differentiating between the civilised and the uncivilised vis-à-vis their eschewal of modern times and their concerns about the impact of social progress. As one physician put it (albeit in 1959), "neurosis [was] the income tax of civilisation."[128] The social progress that these theorists bemoaned implied a normative standard of evolution against which the dominant class (and race) could measure their own progression. Of course, the social theorists, the physicians, and Laura Briggs all demonstrate that civilisation and its concomitant privilege came at a cost; evidently the affluent, by virtue of being the "right" – read: "normal" – race, also had the prerogative of socially sanctioned disease. The affluent were less hardy and more prone to illness than their uncivilised counterparts, but with their evolutionary status at stake, that was to be expected.

With these ideas in mind, what I want to convey is that the racialisation of agoraphobia occurred by insinuation. White middle and upper-class people were the privileged subject of medicine – and social theory – because as civilised sub-

jects only they had the prerogative of being normal.[129] The normative white subject has persisted throughout the 20th century discourse of agoraphobia, making the epidemiological findings discussed earlier especially interesting. Yet while I have outlined some of the historical conditions of possibility for the normative nature of whiteness, this still does not address adequately the implications of this new evidence of a prevalence of agoraphobia among poor Black women. In other words, we must account for how this kind of evidence could come to light *now*.

To explore this, the meaning of this "new" finding, we must problematise the concept of race as it is used in contemporary epidemiological research. An extensive body of literature demonstrates the inviability of a biological concept of race. A social and historical construct, the purpose of the biological concept has been to give meaning to human variation based on the notion that different packages of genes exist between human groups. This notion has failed to deliver, however, because the boundaries between racialised groups are indistinct, and because, even though individuals within groups may share certain external features such as skin colour, they are heterogeneous in other genetic respects. [130] But the primacy given to such visible characteristics is ultimately arbitrary, and a single trait is inadequate grounds on which to characterise human diversity.[131] Rather, as Sandra Harding states, "'Race is not a thing, [...] but a relationship between groups'" and racialising is "a consequence of the symbolic meanings and structural relations of races, not the reverse."[132] Consistent with this kind of thinking, in 1967 UNESCO released a revised Statement on the Biological Aspects of Race, (originally penned in 1951), declaring that the concept of race as applied to humans was no longer acceptable and had no place in biological science.[133]

Yet, despite all the evidence and arguments against it, and despite the fact that there is still no international agreement on racial classification, the concept is still routinely used, not least in epidemiological research. References to race have steadily increased in recent decades, as one group of researchers found by examining papers published in two epidemiology journals between 1921 and 1990, where 79% of 124 US studies contained references to race. They also found an increasing trend towards the explicit exclusion of 'nonwhite' subjects, despite the National Institute of Health's requirement that all groups be included in studies *unless there is some compelling scientific evidence justifying exclusion.*[134]

This kind of research must be called into question methodologically due to three important limitations: First, there is a lack of continuity between data collection agencies as to how to count/classify/categorise race and ethnicity. Miscounting and misclassification by race occurs frequently. Second, individual subjects' self-reporting of race and ethnic identity varies depending on different indicators, surveys, or times, and, I would add, differing and subjectively understood criteria. And third, the race concept itself is simply untenable. Statistics generated on the basis of an inherently unsustainable concept of race may not be accurate or meaningful.[135] Although such information is necessary in order to redress excess morbidity and mortality among "minority" populations, what is arguably more important is exploring how race relations and discrimination have health consequences, rather than how race *explains* racial differences in health.[136]

In sum, reports on the Epidemiological Catchment Area project noted that the subjects of the study came from the community rather than from private clinics (as is usually the case in agoraphobia literature) and that this had implica-

tions for the study's findings. But the question of *why* poor Black women supposedly suffer with agoraphobia so much more than whites was not considered. Cooper's analysis of the prevalence of heart disease among Blacks in the US may help to answer this:

> ... black people in this society are imprisoned by institutional racism; this is the attribute of blackness which at bottom determines their health status. [...] The epidemiology of [coronary heart disease] among [them] has ... been determined by ... social conditions. Greater cigarette use, relative exclusion from preventive campaigns, bad nutrition, excess hypertension, and obesity are all important attributes of the contemporary experience of black Americans. Higher rates of [coronary heart disease] are to be anticipated.[137]

Similarly, the possibility that racism might prevent African Americans from leaving their house and from seeking treatment from medical professionals they do not trust is equally plausible. Their sudden appearance on the epidemiological radar screen, standing in stark contrast to an entire discourse of agoraphobia that suggests this group of people did not even exist, is at once counterintuitive and entirely predictable. I have tried to show that non-whites have also had to cope with the frenetic pace of modern life – but in this case the experience is different, thoroughly infused by the degradation of racialised identities.

Let us turn now to the cultural politics of psychoanalysis, which include the issue of race, among other things.

Psychoanalysis and the (Conceptual) Politics of Normal

Freud's initial foray into the depths of the unconscious led to the development of several major – though not mutually exclusive – schools of psychoanalytic thought, all of which offered, in one form or another, sexualised conceptions of

social order. People not only have desire, but their psyche and their lives are structured around and in deference to that desire. We have certainly seen this among the cases in my study, which generally follow the Freudian and object-relations frameworks.

While psychoanalysis offered a refreshing departure from strictly biological explanations of mental illness, the basic premises and concepts of psychoanalysis have come under intense and important criticism. To clarify, as compared with what came before and after it (that is, positivism), psychoanalysis was for all intents and purposes *social* – but only in a very qualified sense to the extent that Freud's ideas were specific to his milieu. It can be no coincidence, however, that in seeking to offer a (moralistic) account of how social values are reproduced and internalised, the mind as he described it, divided as it was into private and public, mirrored the ideology of separate spheres itself.[138] Feminists have also taken particular issue with his asocial account of subjectivity, as though subjectivity simply develops out of inherent and invariable desires. They have contested the universalistic claims of psychoanalysis, arguing for further pluralism in at least two respects.

First, to the extent that dominant values are encoded in its framework, psychoanalysis presumes a homogeneous society. There is a tendency towards normative heterosexuality as well as an exclusive emphasis on the unfolding of the family drama as the key moment in the origin and development of the psyche. The Oedipus complex, that crucial trans-historical foundation of Freudian theory, presumes the family – a certain kind of family – to be fundamental to the devel-

opment of subjectivity. Yet non-familial events could equally be cast in that developmental role. As Michèle Barrett writes:

> [It is not] that psychoanalysis overtly preaches 'familialism' as a good thing (although it may do on occasion) but that its entire frame of reference is locked into the assumption that all interpretation proceeds from the centrality of 'original' family experiences and thus its operation is deeply 'familialist' in the sense that it cannot imagine anything else.[139]

Through its insistence that the self can only be understood in terms of the psyche, it offers only a partial concept of the social: psychoanalysis forecloses on the relevance of social processes that are not explicitly familialist even as it offers an account of their internalisation.

Second, this foreclosure informs feminist critiques of psychoanalysis that target its failure to explain how we become raced and classed. Elizabeth Abel writes that the "traditional indifference of psychoanalysis to racial, class, and cultural differences, and the tendency of psychoanalysis to insulate subjectivity from social practices and discourses all run contrary to a feminism increasingly attuned to the power of social exigencies and differences in the constitution of subjectivity." If psychoanalysis is to be useful for contemporary feminism, she argues, it "needs some infusion of the social – whether the 'social' is construed as the technologies that regulate desire or ... as the roles of race and class in a diversified construction of subjectivity."[140]

Abel's remark is somewhat ironic, given that it was the perceived *oversociality* of psychoanalysis that gave rise to its eventual exclusion from mainstream psychiatry since DSM-III. Still, she has a point: Informed by a bourgeois sensibility, psychoanalysis reflects class ideals (crystallised by the requirement that patients pay a fee for this service as a condition of treatment). But I would

not characterise its silence on race and class, as Abel puts it, as (merely) a sign of "indifference." The impact of "indifference," as I have already tried to show in the section on African Americans above, is that a silent or absent discourse still "speaks a thousand words."

Similarly, given the powerful associations between race and disease that were commonplace when Freud was writing (and – disturbingly – still today), it is arguable that he, as both a medical scientist and a Jew, *needed* to construct psychoanalysis as racially neutral in order to eclipse the racial 'truth' of medicine and psychiatry.[141] Emil Kraepelin[142] for example, as a leading 19th century German psychiatrist and a major influence on the biopsychiatric turn following DSM-III, "spoke with authority about the 'domestication' of the Jews, their isolation from nature and their exposure to the stresses of modern life." In this respect, Jews were the modern medical subject par excellence, and Sander Gilman writes that even "Jewish physicians themselves accepted the premise of their own potential mental collapse because of the stress of the 'modern life' into which they entered simply by becoming part of the medical establishment."[143] And since most early analysts were Jews, "the lure of psychoanalysis for them may well have been its claims for a universalization of human experience and an active exclusion of the importance of race from its theoretical framework" and, I add, from its conception of social order.[144]

In spite of its subversive potential *within* the realm of medicine, as a central force in the larger transformation of the West into a "therapeutic culture",[145] psychoanalysis has nonetheless been criticised as a normalising episteme. Foucault, of course, is the most well-known exponent of this particular line of think-

ing, and has characterised psychoanalysis as a regime of truth through which individuals become subjects of (its) knowledge and through which social cohesion could be maintained. He argued throughout his work against psychiatry as a non-autonomous human science involved with power, and in particular against psychoanalysis as a discourse (and practice) of normalisation. As he wrote in *The History of Sexuality v. 1*:

> ...the least glimmer of truth is conditioned by politics. Hence, one cannot hope to obtain the desired results simply from a medical practice, nor from a theoretical discourse, however rigorously pursued. Thus, one denounces Freud's conformism, the normalizing functions of psychoanalysis [...] and all the effects of integration ensured by the 'science' of sex and the barely equivocal practices of sexology.[146]

Even though psychoanalysis challenged dominant biogenic notions of mental illness – "it assumes an adversary position with respect to the theory of degenerescence"[147] – Foucault contended that the personality should be understood as a style of behaviour and not as an objective theory of a totality of functional components.[148] As he wrote in *The Order of Things*, "nothing is more alien to psychoanalysis than anything resembling a general theory of man."[149]

In later work, Foucault focused on the social effects of the human sciences, locating the conditions of possibility for pathology within the social world (and even sociology). As he wrote: "The analyses of our psychologists and sociologists, which turn the patient into a deviant and which seek the origin of the morbid in the abnormal are ... above all a projection of cultural themes."[150] Thus psychoanalysis was not liberating but represented, rather, the zenith of a "normalizing confessional technology" developed by early Christians.[151] Foucault was interested in "truth-effects" and argued that the individual with desires – the focus of

psychoanalytic theory – was produced first by Catholic confessional practices that imposed "meticulous rules of self-examination" and

> attributed more and more importance in penance ... to all the insinuations of the flesh: thoughts, desires, voluptuous imaginings, delectations, combined movements of the body and the soul; henceforth all this had to enter, in detail, into the process of confession and guidance. According to the new pastoral, sex must not be named imprudently, but its aspects, its correlations, and its effects must be pursued down to their slenderest ramifications ... everything had to be told.[152]

Desire (forbidden) was an "evil that afflicted the whole man," and one had to always be suspicious, and always work to understand the true motivations behind it. Foucault quotes from a confession manual to show the remarkable resonance with Freud's psychoanalytic method:

> 'Examine diligently, therefore, all the faculties of your soul: memory, understanding, and will. Examine with precision all your senses as well ... Examine, moreover, all your thoughts, every word you speak, and all your actions. Examine even unto your dreams, to know if, once awakened, you did not give them your consent. And finally, do not think that in so sensitive and perilous a matter as this, there is anything trivial or insignificant.'[153]

Contra what Foucault calls "the repressive hypothesis," sex was

> driven out of hiding and constrained to lead a discursive existence. [...] It may well be that we talk about sex more than anything else; we set our minds to the task; we convince ourselves that we have never said enough on the subject [...] It is possible that where sex is concerned, the most long-winded, the most impatient of societies is our own.[154]

Like confessional practices, psychoanalysis was a technique for the deployment of sexuality , having "the task of alleviating the effects of repression (for those who were in a position to resort to psychoanalysis) that this prohibition [on incest] was capable of causing" and allowing "individuals to express their incestuous desire in discourse."[155] The danger in this, however, was that psychoanalysts were thus the arbiters of lifestyle and the self-inspection of psychoanalysis/confession

had become a way of life, seeping out past the limits of a period of therapy and the examination of a specific problem, and manifesting as norms based on an alleged science of human nature,[156] the "philosophical status of man."[157] Bio-power and normative social control, effected through the production of psychoanalytic truth, permeated every aspect of people's lives, turning everyone into self-normalising subjects, with each person striving to ensure that all their actions and thoughts conform to what science had shown to be normal, healthy and productive.[158] As Dreyfus writes:

> The ultimate form of alienation in our society is not repression but the constitution of the isolated individual subject to which all psychiatries contribute. Just as an individual ... comes to have a one-dimensional, normalizing understanding of reality, which every anomaly must finally be made to yield to its truth and confirm his systematic interpretation, so our culture, in its pursuit of objective truth and the total ordering of all beings for the sake of efficiency, health, and productivity, focused in the paradigms of the panopticon and the confessional couch, has reached a stage in which human beings can only show up as sexual individuals, each striving to be a normal subject so as to maximize his [sic] human potential.[159]

Moreover, the threat of sexuality, produced as dangerous by psychoanalysis, was accessible only in the context of "the calm violence"[160] of the analyst-patient relationship, that is, with the guidance of an authority – the analyst – whose expert knowledge provided the necessary remedy for the psychical danger circling (from) within.[161] In other words, empirical knowledge of the individual was made possible by "the regulated organization of persons under the gaze of authority."[162]

Of all the psychiatries Foucault was most critical of psychoanalysis, but by comparison, it was much more explicitly social than the positivistic work of late. Indeed, the recent (re)turn to positivism *epitomises* the authoritative gaze Fou-

cault describes – the privilege and power of the DSM to "regulate" and "organise" the "normal" and the "mentally ill" is a testament to this.

The (Re)turn to Positivism Part II: The Death of the Social Revisitted

Evidence-based medicine as we have seen it in the most recent literature is not new to this period. Parisian P.C.A. Louis, considered to be the founder of "numerical medicine", analysed two thousand cases of tuberculosis in 1825, long before the concept of probability and the field of statistics had been fully developed.[163] Subsequently, the transition from "natural" to "normal", traceable to statistical medicine of the 1850s, manifested most obviously in the ways that physicians recorded their thoughts about patients' *disorders* and how they represented them quantitatively and graphically.[164] But insofar as

> words reflect and mold thinking, this alteration in clinical language marked an important change in cognition. The shift in the way physicians thought about disease – from a disruption of natural balance to a deviation from fixed norms – had fundamental implications for medical theory [and] epistemology ...[165]

The shift from "natural" to "normal" had important implications for how physicians conceptualised treatment and its objectives, that is, the restoration of patients to a "normal" state of health.

As for statistics on the mentally ill, by the 19th century, the confinement of individuals in asylums provided a "mountain of information" (that the pre-DSMs sought to organise) based on observations of patient behaviour. This information could be used in support of new models and classifications of mental diseases, which in turn enabled diagnosticians to develop categories of psychiatric diseases capable of being recognised on the basis of their symptoms.[166] Thus while statisti-

cal medicine is not new, what *is* new is the *obsession* with empirical research. With the decline of psychoanalysis and especially since the release of DSM-III, the embrace of positivism has wholly transformed psychiatry. And although it had a relatively slow start, recent cognitive-behaviourism has benefited greatly from this transformation insofar as it has been willing to play by the rules, bundling its own normative take on agoraphobia (and social order) in a scientific format acceptable within the mainstream.

Psychiatry's (re)turn to positivism and biopsychiatric explanation, along with shifting cultural terrain, have added to the existing canvas a notably functionalist hue. Medical ideas about agoraphobia, inasmuch as they are based on patients' functionality, reflect a certain vision of society that overlaps considerably with a functionalist view of social order. To be sure, as much as the DSM was intended to guide psychiatrists in the practice of diagnosis (however successful it has or has not been in this endeavour), it has served historically – like functionalism – as a kind of moral and ideological prescription for how people *should* live if society is to operate smoothly. Consider, for example, this passage from Parsons, written nearly 50 years ago:

> [T]he marriage bond is, in our society, the main structural keystone of the kinship system [...] Very definite expectations in the definition of role, combined with a complex system of interrelated sanctions, both positive and negative, go far to guarantee stability and maintenance of standards of performance. [...]
>
> To be the main "breadwinner" of his family is a primary role of the normal adult male in our society. The corollary of this role is his far smaller participation than that of his wife in the internal affairs of the household. Consequently, "housekeeping" and the care of children is still the primary functional content of the adult feminine role in the "utilitarian" division of labor.[167]

Now let us compare this with a passage from the DSM: "Individuals' avoidance of situations may impair their ability to travel to work or carry out homemaking responsibilities (e.g., grocery shopping, taking children to the doctor)."[168] (Amazingly, the "homemaking" criterion was a new addition to the DSM published in 1994.)[169]

Given this criterion, agoraphobia has the potential to cause a real disruption to the normal order of things.[170] Apart from the obviously gendered definition of disease that the DSM-IV deploys and through which it draws from and reinforces a Parsonian conception of society, the notion that health can be measured by the ability to work is interesting to think about insofar as productivity and pathology are being articulated together. Granted, homemaking has had a longstanding history of *not* being valued as much as paid work per se, but the point I wish to make here is that in the DSM, the agoraphobic person is defined (at least in part) through their decreased productivity and consumption. We might recall from Chapter 8 the papers that examined the economic and social costs of having this disease. Agoraphobia is bad for the economy, and while on one hand not working (for pay) may still pass today as consistent with ideal gender behaviour, the resistance to shopping, on the other hand, might just be a sign that a woman is crazy. This has been demonstrated time and again in the behaviourist literature insofar as shopping alone was set frequently as a desirable goal of behavioural treatment. When doctors sanction this as a goal by incorporating it into treatment programmes (that nurses subsequently carry out more often than not), they are transmitting – reproducing, supporting – an ideological cultural imperative to their patients. This imperative reflects dominant ideals of feminin-

ity and consumption (and as in the case of "Mr. Prince," masculinity and work) as they *should* be occurring *normally*.[171]

Signifying a collective denial of science's cultural basis, and in striking concert with Parsons' assertion that "our occupational system" requires "rationality...universalistic norms, and ... functional specificity,"[172] the DSM has always conceived of society as systematic, classifiable, and orderly. (Of course, it has had to assume this because operating on this principle has served to guarantee legitimacy to its claims to medical truth.) By deeming pathological those people who do not conform to its prescribed limits of "normal" (working, homemaking), the DSM and the literature it has generated has constructed as transgressive the possibility of living outside the assumed boundaries of modern society. Thus functionalist (economic) assumptions are woven into the DSM and the medical literature it has generated, shaping the lens through which individual psychiatrists' gaze at their patients.

But make no mistake: I am not suggesting that the transmission is simply one-way. Medical notions both draw from and reinforce the social fabric and in so doing, reflect an ethical agenda alongside its social/moral prescriptions. Each standard and category in the DSM "valorizes some point of view and silences another," seamlessly obscuring the politics and contestations surrounding its assembly. Yet we rarely see such "artifacts [as] embodying moral ... choices that in turn craft people's identities, aspirations, and dignity." [173] It is in this respect that the DSM, an information artifact fraught with normative dimensions, converges with the social world.[174]

To be sure, the kind of social order that the DSM espouses informs the vast empiricist literature that has been generated since the 1980s. Whereas the early physicians and theorists assumed that at bottom social disorder and agoraphobia came from the changes of modern society,[175] I argue that lately the assumption has been – as reflected in the medical literature – that social disorder comes from the refusal of rationalism and the scientific method.[176] A rejection of society is implied by the very symptoms of agoraphobia and the colonisation of its presumed irrationality by the agoraphobia industry provides an avenue to reclaiming these individuals to the modern world, thereby restoring social order through reason and science.[177] But the rationality being so vociferously defended through psychiatric scientific practice is a *masculine* rationality that *appears* to be gender and race-neutral (if it names a subject at all), even though most of the representations are of women. At once celebrating and repudiating as pathological the still so-called private sphere, the *scientification* of agoraphobia "negates what is truly 'social' in social life."[178] As the imperative of standardised evidence collection has become the central feature of contemporary psychiatry, the laboratory – not the street – has become the "real" context for agoraphobia, thereby naturalising the social and effectively severing the patient from ownership of her own condition.[179] Amounting to a hyper-rational "science of social order," the collectively constructed theory of society implicit in recent psychiatric literature assumes an "objective" understanding of bodies and disease and claims to be unproblematically extracted from *social* life. Patients are reified by science as "Ss" – as nonpersonal, medicalised, identities to be experimented upon.[180]

Science has thus become an exercise that presumes to exclude the social, that is legitimated by research and reporting in which the social is nowhere to be found – indeed, such extraction from the social is integral to the scientific stance. In contrast, this is essentially what has been perceived by mainstream psychiatrists to be wrong with psychoanalysis – it is intensely personal, disdainful of the DSM classification system, and therefore deeply unscientific.[181] Written (ironically) in a passive and profoundly disinterested voice, as if to suggest that the alleged absence of researchers somehow makes the work they do more objective, the "new" literature constitutes a discourse that *seems* "to rise above uncertainty, power struggles, and the impermanence of the compromises."[182] It is a narrative informed by a DSM that "enforces a certain understanding of context, place, and time ... [and] makes a certain set of discoveries (which validate its own framework) much more likely than an alternative set outside of the framework." To clarify, the issue is not that the definitions contained within the DSM are good or bad, so much as they are dangerous and "arbitrary ways of cutting up the world" that is "always slightly out of reach."[183]

These dangerous divisions are heavy with social, ethical, and political meaning and "do not describe the world as it is in any simple sense [but rather] model it."[184] Insofar as classifications of all kinds are ubiquitous and invisible in society, and given that "we stand for the most part in formal ignorance of the social and moral order created by these invisible potent entities,"[185] it is arguable that this search for knowledge about agoraphobia is not "undirected." Evelyn Fox Keller asks "how the very framing of the questions" that scientists ask might "already commit us to the possibility" of certain social initiatives. She focuses in

particular on eugenics[186] but her argument can be applied equally here since she goes on later to say that

> ...our confidence in the purity of scientific knowledge – even, or especially, at that historic moment which finds science at its most impure – works ... to foreclose the questions we would otherwise ask about the aims of science, about the ways in which both the form and content of scientific knowledge have been shaped by the motivations driving it (either from below, in the consciousness or unconscious of individual scientists, or from above, in the programs of the sponsoring agencies). Most crucially, such confidence prevents us from thinking about the possibility of redirecting science, of doing it differently.[187]

Keller's insights are quite compelling when read against the following excerpts from a 1988 article by Robert Spitzer and Janet Williams, long-time Chair and member respectively of the APA Work Group to revise DSM-III. Briefly, the article argued for a new structured diagnostic interview schedule (the "SCID") that could be used to make DSM-III-R Anxiety Disorders diagnoses in adults. As they write:

> We believe that the inclusion of revised diagnostic criteria and the fact that it is modelled on the clinical diagnostic interview will make this instrument a valuable tool for diagnosing patients with Anxiety Disorders for psychopharmacologic research. This instrument is already being used for patient selection in a multinational study of the efficacy of alprazolam in the treatment of Panic Disorder and Agoraphobia, sponsored by the Upjohn Company.[188]

In this case, Upjohn's research agenda literally *preceded* – indeed, created the need for – a new interview schedule that could better differentiate between anxiety disorders and that would allow investigators to maximise the homogeneity of their patient samples.[189] Most important, though, is the fundamental assumption embedded in the act of revising the interview schedule, namely that people *can* be sorted out, that they *can* be ordered – and more accurately at that.

This kind of thinking is what gives rise to the "standardized form," one type of "boundary object" described by Susan Leigh Star and James R. Griesemer. Whereas Bruno Latour argued in 1987 that the collective construction of scientific knowledge, that is, the production and stabilisation of scientific facts, derives from networks of alliances between interested individuals, Star and Griesemer seek to go beyond this. Their concept of the "boundary object" denotes objects of scientific inquiry that inhabit multiple and intersecting social worlds. They "are produced when sponsors, theorists, and amateurs collaborate to produce representations of nature" with "different worlds" sharing the goal "of making an orderly array out of natural variety."[190]

The DSM can be seen as a boundary object since it inhabits "several communities of practice" (such as the insurance industry, the courts, the world of social work, government and judicial bodies, research funding agencies, pharmaceutical companies, and of course psychiatry) and is able to "satisfy the information requirements of each of them."[191] "Standardized forms" of boundary objects remain stable across social boundaries allowing for "common communication" and eliminating "local uncertainties."[192]

Joan Fujimara takes things one step further because she is doubtful that the boundary object is a concept strong enough to handle the collective work across social worlds necessary for fact stabilisation to occur. She proposes something she calls "standardized packages," which includes both "a scientific theory and a standardized set of technologies adopted by many members of multiple social worlds to construct a new and at least temporarily stable definition of [agoraphobia] as well as a thriving line of ... research."[193] In other words, the collective

action of science has to be managed across social worlds in order to achieve enough agreement to get work done and to produce relatively stable facts. "Standardized packages and other such crafted tools" also enable scientists "to define their areas of expertise and power."[194] Star and Griesemer's concept of the "boundary object", in its elasticity and adaptability in different contexts, allows for the management of collective scientific work across social worlds. But it also may, according to Fujimara, actually hinder the "fact stabilisation" necessary if scientific knowledge is going to fly. As she writes:

> ... although boundary objects promote collective action and coherence of information from different sites because they are more easily reconstructed (re-represented) in different local situations to fit local needs, they are equally disadvantageous for establishing the kind of 'stabilization' of allies behind 'facts' [...] That is, while boundary objects can promote translation for the purpose of winning allies, they can also allow others to resist translation and to construct other facts.[195]

Thus Fujimara proposes a model that includes both Star and Griesemer's concept of "boundary objects" that, through their local adaptability facilitate collective work by members of different social worlds, *and* Latour's interest in fact stabilisation. But what does this all mean for agoraphobia?

The combined effect of a "standardised package" – consisting in the case of agoraphobia of biopsychiatric theory and a standardised set of technologies including the DSM, the various fear and phobia inventories, pharmaceuticals, journal discourse, as well as empirical evidence and so forth – is "what builds bandwagons."[196] This notion of bandwagons is certainly one we could use to describe the activities of mainstream psychiatry and all other social groups having a *vested* interest in subscribing to the DSM framework since the release of its 3rd edition in 1980. We have seen, for example, that cognitive-behavioural psychologists

have been reluctant to subscribe wholesale to the biological approach to mental illness so prevalent in contemporary psychiatry. It is evident that they recognise that if they are to have any hope of staying in the research game, they must adopt psychiatry's "conventionalized ways."[197] In fateful contrast, by refusing to climb aboard, psychoanalysts have demonstrated equally clearly through their excommunication the important need to conform.

Indeed, the DSM and the literature it has generated have been very successful in "enrolling many members of multiple social worlds in constructing a new and at least temporarily stable definition" of agoraphobia.[198] Participants in many different social worlds work with agoraphobia and all assume a certain conception of social order. And, through their work, they see to it that social order will happen. The very goal of all the various forms of treatment – restoring a patient to a "normal" state – flags this assumption as a central organising principle of medicine. Thus the science of psychiatry as we know it – motivated by this desire for social order(ing) – can only work with the standardised DSM classification system in place, bolstered and reinforced as it is by research designed very much in its own image. Moreover, the construction of agoraphobia as a monolithic entity is necessary for different social worlds to be able to talk about the disorder among themselves. We may recall that the Work Groups responsible for the DSM, even in its earliest incarnations, stated openly that standardisation across military and mainstream psychiatry was their central objective in creating (and subsequently revising) the DSM.

Yet the sensibility of order that we have been discussing turns on another assumption, that is, besides the notion that people and diseases can be classified

and ordered. What I am referring to now is the fundamental – and problematic – assumption that diseases and their causation can be apprehended with certainty. Working from the premise that diseases can be *defined* amounts in effect to what Bruno Latour calls a "black box," or something used to represent the established, the taken for granted, the certain-but-too-complex-to-unpack scientific knowledge that is unnecessary-to-unpack.[199] Notions of disease qua black boxes ensure the efficacy of medicine as a form of organised knowledge about the world and enable it to proceed as a form of collective action. As a corollary to scientific practice, to paraphrase Simon, diseases as black boxes can even be seen as the basis of social order in medicine, and their closure as the goal of medical activity. Their opening can only spell disorder and controversy.[200] Thus, as the very basis of all medical transactions, diseases are of central importance in the doctor-patient relationship; it is imperative, then, that everyone concerned, especially the doctors, know what they are dealing with. But the fact is, as several attempts to define disease demonstrate, they do not. I turn to some of these discussions now, focussing on the problems of defining disease and their causation, and the importance of cultural context. I begin with Talcott Parsons.

Parsons predictably approached the concept of disease from the perspective of social roles and social action. He emphasised illness rather than disease, defining it as an impairment of the individual's "teleonomic" capacities, that is the individual's capacity to maintain equilibrium of his organic and action level subsystems and "to undertake successful goal-oriented courses of functioning, especially behavior."[201] Both the DSM and all the literature it has generated are

consistent with this view; as the DSM-III stated, for example, one sign of agoraphobia was the "increasing constriction of normal activities."[202]

Illness for Parsons was dysfunction, and something that gave rise to what he called the "sick role". This included both the status and the treatment of individuals whose normally expected levels of health were impaired.[203] Parsons' definition is notable for its having gone beyond the internal anatomical-physiological components to present sickness as a socially sanctioned form of deviance, subject to medicine as an agent of social control.[204] Parsons illuminates the sociality of illness, but as we began to see earlier, his ideas are not only prescriptive (and ideological), they are circular as well. He fails to explain the interdependence of the various parts of the body/society but only asserts it; what is health is simply not disease and what is disease is simply not health. This begs the question of when exactly someone is "sick". Parsons also equates the individual body's subsystems with those of the larger society but it is difficult to discern with certainty what each needs to be considered "healthy." Moreover, if the system (corporeal or social) is self-correcting (as the concepts of teleonomy and equilibrium suggest), then is somebody ever *really* sick in this model? The chicken pox, for example, may not in fact qualify as disease according to Parsons' logic. While it does set the individual back in all the ways we think of as "being sick," it also represents the body's internal mechanisms for enhancing health – by virtue of *having* the chicken pox, the body immunizes itself. This suggests that the individual is actually *even healthier* with the disease than without it. Finally, Parsons takes for granted the stability of social norms from which diseases deviate. As we shall see in the next chapter, the norms of disease are not so stable, for, as Hunter writes:

> each patient is potentially abnormal, an anomalous instance of disease. 'Normal' science in medicine is like 'normal rhythm' in Shakespeare's blank verse: the meter, we know, is iambic pentameter, but we are often hard pressed to find a classic invariant line.[205]

Outside of sociology, the question of disease causation, as we have already seen in Chapter 4, has been understood mainly in terms of two theories: the ontological and the physiological. To review briefly, the ontological theory of disease locates pathology outside the body, as an invader, such as tuberculosis. The physiological theory attributes causation to the disturbance of functions already operating within the individual, such as genetic or auto-immune diseases.

These theories help to illuminate the ways in which medical knowledges are constructed simply by virtue of the fact that they often appear simultaneously in one disease picture. Thus trying to demarcate the two theories of causation may be a red herring insofar as diseases usually do not fit within any one category. As Lester King has argued, disease causation must be understood not as a singular phenomenon, but as the outcome of interactions between several causal factors.[206] I would depart from this somewhat and argue (as I have tried to thus far) that diseases are better understood as "effects" enabled by social and physical conditions of possibility. Still, King's point serves us well inasmuch as it *is* difficult if not impossible to pin a disease down to any *one* cause.

A theory of causation aside, the notion of disease also largely depends on what is considered "normal" culturally. For example, epidemiological research that looks at the "why" and the "when" of diseases depends on the range of normal within the given population. In other words, if in a particular group *everyone* is afraid to go outside, it may not be considered a problem per se. As Rose states,

"What is common is all right, we presume."[207] Certainly the fear many women have of going out (alone at night) would not be considered pathological – agoraphobic – but, rather, prudent.[208] Thus diagnosis is not value-free, nor is it immune to cultural constraint. What passes for "normal" has political implications, and it matters very much who is doing the looking.[209]

In light of these issues, I contend that disease concepts are historically and culturally contextual shifting forms of knowledge, better understood as social processes -- as scientific and popular *representations* of illness, of causation theories, and of cultural imperatives. Rosenberg argues that a disease can be said not to exist until it is agreed that it does by naming it and responding to its symptoms that are identified, categorised, and linked.[210] Indeed, we have seen that disease classifications are not naturally given and the collation of symptoms into discrete categories comes with a risk of overemphasising some symptoms at the expense of others.[211] Thus what may be viewed as worthy of mention at one time and place, may not be in another, so that the same phenomenon may be considered pathological in the first instance, and normal in the second, as was the case with homosexuality (eventually eliminated from DSM-III-R).[212]

The especially intriguing thing about disease concepts and their indefiniteness, is that we (doctors especially) proceed as though we *really* know what is meant by the concept of disease, when what we are really doing is operating on the basis of *ideas* of disease and causation. Garfinkel's ethnomethodology brings this type of conventionalised behaviour into sharp relief. As he wrote in 1967: "For the purposes of *conducting their everyday affairs* persons refuse to permit each to understand 'what they are really talking about' in this way." The "antici-

pation that persons *will* understand" is a sanctioned property of discourse.[213] Thus the concept of disease presumes a "'seen but unnoticed' background of common understandings."[214]

But arguably, every single entry in the DSM is merely a *hypothesis* about how the individual is expected to – should – act when s/he is mentally ill. Moreover, since absolute precision regarding the concept of disease is not possible, it seems especially significant that mental/emotional symptoms have proved particularly difficult to name. As we have seen throughout this dissertation, "panic" and "agoraphobia" are conflated regularly, while words like "syndrome," "disorder," "illness," and "symptom" are used interchangeably even though they all technically refer to different aspects of un-health, and despite the fact that causation cannot technically be known.[215] If the symptoms of agoraphobia have not really changed over the years, but yet we do not know what the concept of disease *really* means – or whether the panic component of agoraphobia is primary or secondary – then where does the *idea* of agoraphobia get its stability from?

To borrow from Latour again, as long as all the elements of a (disease) black box "act as one", the only thing that seems to matter is its "input and output."[216] Failing to provide us with a definitive framework by which to define disease both generally and particularly, theories of disease are at best *tools* that force us to make sense of the ways that these ideas known as diseases – these knowledges – are socially constructed.

But the black boxiness of disease and its causation is also suggestive of the possibility that medical actors unwittingly – through their professed objectivity – subvert the boundary between fiction and non-fiction. If we accept this point,

then it becomes possible to destabilise the conventions within which medical and social theoretical texts are differentiated and read.[217]

Conclusion

In this chapter we have seen that underpinning the disease concept of agoraphobia has been a normative conception of social order evident in both socio-cultural and psychiatric discourses. I have called into question the gendering and re-gendering of agoraphobia, as well as its racialisation. I have also looked at how recent psychiatric discourse, despite its pretensions to objectivity, has in some respects been *more* social than ever before. By reading the psychiatric and cultural texts together, I have tried to demonstrate that they have never been far apart. What remains to be examined is how, despite a powerful classification system, a multiplicity of agoraphobias persists. In the next and final chapter I explore the problem of agoraphobic embodiment and attempt to account for the uncontainable plurality of this disease.

[1] Rose, 1994:54.
[2] Barrett, 1999, esp. Ch. 1 (pp. 1-17).
[3] Hunter, 1991:xviii-xx.
[4] Barrett, 1999:203.
[5] Barrett, 1999:2.
[6] Porter, 1997:348.
[7] Cf. Hansen, 1992:119. See also Porter, 1997:305.
[8] Hansen, 1992.
[9] Porter, 1997:498.
[10] de Swaan, 1990:139.
[11] Grob, 1985:267.
[12] Porter 1997:513.
[13] Atwood, 1903:1070-2.
[14] Sutherland, 1877:266. But this fear was not limited to the turn of the century. In 1961 Terhune described a patient who "hated the huge city, the impersonal way of life, an environment in which she felt she was a nobody after having been an important somebody all her life." He went on to say: "It may be that there is actually an increase in incidence because of the increasing complexities of modern life. To a much greater extent than even a generation ago, people are called upon to make quick adjustments of all kinds. Everything is speeded up – the pace of travel, of communication, the advances of science, the growth and pressures of population, and so on. As a result, individuals with personalities that tend to make them phobics are more challenged by life than in former times" (1961:233). He maintained that his patients, twice as many women as men, had not experienced enough of life's challenges. These patients were over-privileged and overprotected by neurotic parents on whom they were emotionally dependent and from whom they needed to "divorce" themselves. The solution to their problems would come from "reconditioning" and, in order to prevent this problem from occurring, apprehensive children were to be recognised as "soft" and shown in childhood how to deal with their problems. Adults whose soft upbringing had not been caught in time, needed to be re-educated through psychotherapy and resocialised through graded exposure to anxiety-producing activities (1949:168-71).
[15] Freud, 1963 [1908]:21. Freud pursued these ideas in *Civilization and its Discontents* as well, arguing that the demands of instinct and the moral restrictions of civilization were in constant conflict (because there was a "tendency on the part of civilization to restrict sexual life") (Freud, 1963:41). Thus, as we saw in Chapter 5, Freud did not attribute modern psychical problems solely to the pressures of modern urban living. He cited several expert opinions on the topic and asserted that while they were not wrong, they failed to consider as well the "undue suppression of the sexual life in civilized peoples (or classes) as a result of the 'civilized' sexual morality which prevails among them (1963 [1908]:24).
[16] Marx, 1964 [1884]:109-10 (his emphasis).
[17] Marx, 1964:110 (his emphasis).
[18] Marx, 1964:114 (his emphasis).
[19] Durkheim, 1933:129.
[20] Durkheim, 1966 [1933]:131.
[21] Weber, 1958:59.
[22] Weber, 1958:180-3.
[23] Tönnies, 1957:34-5.
[24] Benjamin was a contemporary of Simmel's son and attended some of Simmel's lectures.
[25] Simmel, 1950:411.
[26] Frisby, 1986:5.
[27] Frisby, 1986:70; Wolff, 1989:143.
[28] Simmel, 1950:410.
[29] Vidler, 1993:34.
[30] See Frisby, 1986:4.
[31] Simmel, 1950:410.

[32] Simmel, 1950:413-4.
[33] Simmel, qtd in Frisby, 1986:73.
[34] Simmel, 1978:475.
[35] Simmel, 1978 [1907]:474-5. (Hyperaesthesia refers to excessive physical sensibility, esp. of the skin.)
[36] Sutherland, 1877:267-8.
[37] Simmel, 1950:118-9.
[38] Simmel, 1950:119.
[39] Simmel, 1950:119.
[40] Lefebvre, 1991:99.
[41] Cf. Vidler, 1993:36.
[42] Cf. Vidler, 1993:36.
[43] As he also went on to say: As he went on to say: "I have come to wonder if there is real art in many of the so-called 'improvements' in some of our cities, for, judging from the effect they produce on me, they constitute bad art" ("Vincent," 1919:297). This insight was first conceived by Vidler, 1994.
[44] Sitte, 1965 [1889]:45. Credit for the discovery of Sitte's text goes to Vidler (1991:35).
[45] Rose, 1994:55-6.
[46] Burgin, 1993:37.
[47] Rabinow in Rose, 1994:64.
[48] Rose, 1994:65.
[49] Wilson, 1995:149 and Rose (citing Foucault), 1994:65.
[50] Benjamin, 1973 [1955 and 1969]:117.
[51] Gilloch, 1996:143.
[52] Lefebvre, 1991:99.
[53] Benjamin, 1978:154.
[54] Recall Deutsch's patient (1929), for example, who could not go out alone without her mother and also could not remain home as long as *her mother* went out alone.
[55] Lefebvre cites as examples "water, gas, electricity, telephone lines, radio and television signals, and so on. (1991:93). Although these are all material intrusions, they do serve to demonstrate the porosity of this split between private and public (Burgin, 1993) which in turn destabilises the illusion so important to agoraphobes who feel safer in their homes believing that the home is hermetically sealed.
[56] Benjamin, 1973:46. Interestingly, William Thorsell expressed a remarkably similar sentiment in the Globe and Mail as recently as 9 March, 2001. He writes: "People are edgy and rushed. They are working too hard and too long, and most of them will choose to keep it that way. [...] We do not consume because we are rich; we are rich because we consume – a pressing social obligation that drives us to irrational labours. [...] Capitalism depends on the willingness of consumers to keep spending – not beyond their means, but beyond their needs, and ultimately, beyond their capacity to handle stress. [...] Too much supply meets too much demand – a perfectly modern conundrum. [...] In truth, we like the machine. It's who we've become" (A15).
[57] Wolff, 1989:153.
[58] Agoraphobia is commonly defined as "fear of the market" (though it should be noted that the Greek "agora" encompassed more than the marketplace, referring as well to public meeting space).
[59] Pathology and consumption have also been articulated together by pharmaceuticals. Exemplifying Benjamin's ambivalence brilliantly, anti-depressants and minor tranquillisers, largely driving the "agoraphobia industry" through their intense profitability, have been at once a source of relief to their consumers and a fetishistic distortion of the capitalist social relations informing their production. (By consumers I mean both these individuals as patients, and pills as the object of projected desire.)
[60] Vidler, 1994:12.
[61] Cf. Hansen, 1992:123.
[62] Vidler, 1994:18-9.
[63] Atwood, 1903:1072.

[64] Agar, 1886:3. These ideas were very popular but hardly restricted to that time. Witness AIDS and the moral panic associated with its conceptualisation as a "gay disease."
[65] Warner, 1986:86.
[66] Wilson, 1995:149.
[67] Vidler, 1993:35. Citing a text by Proust, Vidler reads an association between agoraphobia and homosexuality as well and suggests that perhaps the link was the result of Westphal's work in the area of "contrary sexual feelings" (35). I did not really see that link in the clinical literature, except for maybe a little bit in the psychoanalytic literature, and then not really the early material.
[68] Theriot, 1997:165.
[69] See for example Potter (1882), Suckling (1890), and Van Horn (1886).
[70] White, 1884:1140.
[71] Webber, 1872b:446.
[72] See Chapter 5.
[73] In Welter, 1966:152, fn 6 and 7.
[74] Wilson, 1992:5-6. See also Strange, 1995.
[75] See for example Kelly, 1979; Davidoff and Hall, 1987; Kerber, 1988; August, 1994; Vickery, 1993.
[76] Wolff, 1989:153.
[77] It could equally have been the only way for some women to secure it. We might recall the article by Bignold in 1961 describing several patients attending an Australian out-patient mental hospital and for whom "the symptom was personally useful to the patients" as a way of avoiding scrubbing the kitchen floor, controlling family outings, and "bring[ing] pressure to bear on [a] husband" who refused to capitulate to his wife's wish to move to Holland.
[78] Barker, 1991:48. If Rivers' were alive he no doubt would have felt vindicated by a recent article in *The Globe and Mail* detailing the recent discovery by some of Canada's military that it is in fact alright and even desirable for male soldiers to cry. The writer describes how "a major with decades of experience in the Canadian military's toughest, most battle-hardened regiments, found himself in a circle with 30 of his military comrades, crying, confessing and searching for his inner soldier." The sensitivity training seminar where this outpouring of emotion took place has opened "emotional channels that had been blocked by years in the military, where the expression of feelings has long been discouraged." Advocates of institutionalised sensitivity training were "laughed out of a lot of offices", because, in the words of the major described above, "'You were taught to hide your feelings. To show your feelings was to show weakness. [...] Boys don't cry. They fight.'" This was underscored by the comments of Sergeant Patricia Callahan at the end of the article: "'I never saw this before [....] Men are in there crying. I think it's long overdue." Indeed. See Cheney, 2001:A3.
[79] "Vincent," 1919:299.
[80] Jackson, 1872:61. The indefinite boundaries between masculinity and femininity, war neurosis and agoraphobia are suggested even more evocatively by the words of a military psychiatrist who wrote in 1981 that "agoraphobia does not respect...military rank" (Hudson, 1981:511-2). Although neither of the two patients he describes in this report had actually served in any war (one was a newly inducted officer and the other an electronics technician), the writer does make a point of saying that agoraphobia "has an important bearing on military psychiatry because it is a common disorder" and occurs in "physicians, college professors and officers, as well as enlisted men" (511-2). In other words, it could easily be missed in military *men* who *have* experienced combat, suggesting that on a certain level, war neurosis and agoraphobia actually may have overlapped.
[81] Tracy, 1925:343.
[82] Myerson, 1929:13.
[83] Myerson, 1929:71-2. Atwood agreed, finding in 1902 that 80% of cases of neurasthenia at the Vanderbilt Clinic in New York "belonged to our foreign population, Russian Jews predominating!" (1903:1072).
[84] Myerson, 1929:59-60.
[85] Gilman, 1991:63.
[86] Atwood, 1903:1072.
[87] Atwood, 1903:1702.

[88] Atwood, 1903:1073.
[89] Tay-Sachs comes to mind here because its discourse has historically included references to race as a matter of course.
[90] Grob, 1985:269.
[91] This physician described the patient's education in quite a bit of detail, supporting implicitly the stereotype of the Jew as intellectual and creative but degenerate, the line between his religiosity and his madness difficult to discern (see Gilman, 1991:129). The patient's mother did not escape the doctor's brush untarnished. Her attributes were stereotypically that of the "Jewish mother": overbearing, irrational, and unreasonably demanding.
[92] Weller, 1984:553.
[93] Jones, LaVeist, and Lillie-Blanton, 1991:1079.
[94] In 1984 (the approximate time of the ECA study), median family income for whites was $27,686 (USD) while for Blacks it was only $15,432 (USD). See U.S. Department of Health and Human Services, 1986:14.
[95] National Health Survey Series, 1987:14.
[96] Whites had the lowest admission rates than other races, especially for persons aged 25-44 (National Health Survey Series, 1987:74).
[97] In 1998 Blacks paid a total of 89.8 million visits to physicians in their offices, as compared with whites who saw physicians in their offices 702.2 million times (U.S. Census Bureau, 2000:125). This translates to 259 visits per 100 Blacks, and 317 visits per 100 whites.
[98] See Briggs, 2000:262; Gamble, 1997:1774; Lederer, 1995:115.
[99] Qtd in Lederer, 1995:115-6.
[100] Lederer, 1995:116.
[101] Lederer, 1995:115.
[102] Gamble, 1997:1774.
[103] Fry, 1975:171-3. See also p. 210.
[104] Cited in Fry, 1975:173.
[105] Fry, 1975:210.
[106] Thomas, 1958 [1919]. While there may not have been any actual evidence of "night-doctors", there *was* evidence of a graverobbing ring in Philadelphia (exposed in 1882) that was responsible for stealing from graves in Black cemeteries (Gamble, 1997).
[107] Cited in Fry, 1975:201. The italics are mine.
[108] Fry, 1975:210-1.
[109] Gamble, 1997:1776-7.
[110] Gamble, 1993:36. One cannot help but wonder who/what oversees research that is funded by corporations, as so much of it is today.
[111] Gamble, 1997:1773-5. Sickle cell screening and birth control programs have also incited allegations of genocide (see Gamble, 1997:1773), the former making me wonder about Tay-Sachs screening and other similarly racialised diseases.
[112] The SCID asks *no* questions about race or anything else social for that matter.
[113] For that matter, nor do they ask questions that get at the possibility that fear of violence might discourage women from going out. As I noted in Chapter 2, none of the psychiatric literature reflects this reality, yet as Carol Brooks Gardner (1994) found in her study, agoraphobic and non-agoraphobic women engage in remarkably similar behaviours.
[114] Herzig, 2000:np.
[115] Herzig, 2000:np; my emphasis.
[116] An anecdote may serve to clarify further: A colleague recently told me a story about a young man in her class – a "big Black guy." As it turned out, his Blackness had absolutely nothing to do with the story she then proceeded to tell about him. In an ethnomethodological sense, her inclusion of the man's racial particulars exemplified just how common it is to hear people qualify race when they are describing people who are not white. It is "normal" to talk about white people as *just* people (as opposed to Black or whatever people) and it is "normal" to *assume* and *imagine* the people who are *just* people as being white.
[117] A bitter irony is the Dictionary's use of the term "immigrants" here but evidently, this euphemistic characterisation was not exclusive to the dictionary. Atwood (above), well into his anti-

immigration rant, states in the same paragraph cited earlier regarding the degeneracy chiefly found among "imported foreign population" that "[m]ental derangement in the negro is increasing – especially degenerative types, imbecility, idiocy and the dementias" (1903:1072).
[118] Dillingham, 1911:100. I could not resist looking at what the Dictionary had to say about "Hebrews": "Physically the Hebrew is a mixed race, like all our immigrant races of peoples, although to a less degree than most. [...] In every country they are found to approach in type the people among whom they have long resided." This, yet: The 'Jewish nose,' and to a less degree other facial characteristics, are found well-nigh everywhere throughout the race, although the form of the head seems to have become quite the reverse of the Semitic type. The social solidarity of the Jews is chiefly a product of religion and tradition. Taking all factors into account, and especially their type of civilization, the Jews of to-day are more truly European than Asiatic or Semitic." Emigration from Europe has been "reinforced by...the millions of wealth...which Baron de Hirsch and other Jewish financiers have devoted..." (Dillingham, 1911:74).
[119] Dillingham, 1911:54. Equally interesting, "American" is not a race category but used rather to indicate "imported Caucasian stock" (Dillingham, 1911:77).
[120] Paresis is defined in Taber's medical dictionary (17th edition) as "An organic mental disease with somatic, irritative, and paralytic focal symptoms and signs running a slow, chronic, progressive course," simulating "any psychoneurosis or psychosis" (Thomas, 1993:1438).
[121] Atwood, 1903:1073. Remember the reference he made in a passage cited above that the immigrant was especially vulnerable because he still had the "sordid processes of evolution ... before him."
[122] Briggs 2000:247.
[123] Briggs, 2000:246.
[124] Porter, 1997:511.
[125] Beard, 1881:92-93.
[126] Beard, 1881:171.
[127] Briggs, 2000:249.
[128] Terhune, 1959:768.
[129] The irony, though, is that racialised bodies (and mice) have historically been considered different enough to be racialised and too different to be normal, yet the "same enough" to be reliably experimented upon with the results safely applicable to whites.
[130] Cooper, 1984:716.
[131] Cooper, 1984:716.
[132] Harding made this statement as a member of a medical panel on race (as reported on by Freeman, 1998:221).
[133] Freeman, 1998:222.
[134] Jones, LaVeist and Lillie-Blanton, 1991. In addition to African American's distrust of medicine, their finding may shed further light on why the normative subject of agoraphobic discourse has been white – African American's do not participate due both to their exclusion and their own reluctance.
[135] Freeman, 1998:223.
[136] Freeman, 1998:223-4.
[137] Cooper, 1984:722.
[138] Subsequent psychoanalytic literature did the same by virtue of adopting his framework (despite modifications and developments in theory).
[139] Barrett and MacIntosh in Barrett, 1991:117.
[140] Abel, 1990:184.
[141] For a forceful examination of the effect of racial science on identity as a Jew and medical scientist, see Gilman, 1993.
[142] Recall Kraepelin from Chapter 7. He was a central influence in the paradigm shift in psychiatry that developed with the release of DSM-III in 1980.
[143] Gilman, 1993:93.
[144] Gilman, 1993:6.
[145] Barrett, 1991:115.
[146] Foucault, 1978:5.

[147] He calls this the "perversion-heredity-degenerescence system" (1978:119).
[148] Dreyfus, 1987:312.
[149] Foucault, 1970:376.
[150] Foucault, 1987:63.
[151] Dreyfus, 1987:318.
[152] Foucault, 1978:19.
[153] Foucault, 1978:20.
[154] Foucault, 1978:33.
[155] Foucault, 1978:129.
[156] Cf. Dreyfus, 1987:320.
[157] Foucault, 1973:198.
[158] Dreyfus, 1987:319. Dreyfus notes that Foucault only addressed the Lacanian revision of Freud and speculates that object-relations theory, which emphasises pre-Oedipal factors, shows the limitations of a purely Oedipal account and therefore approached Foucault's understanding of the self somewhat more favourably. Still, both the Lacanian and object-relationist theories make causal claims that justify the normal/pathological structure, of which Foucault was deeply critical. See Dreyfus, 1987:332 fn 5.
[159] Dreyfus, 1987:330.
[160] Foucault, 1970:377.
[161] See Flax, 1990:205-9.
[162] Rose, 1994:61.
[163] Duffin, 1999:77.
[164] Warner, 1986:87-90.
[165] Warner, 1986:91.
[166] Porter, 1997:505-6.
[167] Parsons, 1954:187-91.
[168] APA, 1994:396.
[169] With regard to homemaking, I am reminded of the logic problems that my Introductory Philosophy professor would ask us to do. A rough approximation: Premise 1: The DSM-IV notes that women are diagnosed with agoraphobia three times more often than men. Premise 2: Failure to carry out homemaking responsibilities may be a sign of agoraphobia. Premise 3: Studies show that women are responsible for homemaking (men "help"). Premise 4: Therefore women who do not do their housework are pathological.
[170] And like Parsons' famous and deeply problematic AGIL model, the DSM also provides "boxes" in which all individuals are supposed to fit one way or another. Interestingly, however, the DSM contains no code for "normal," unlike Parsons who outlines normal behaviour very clearly, at least in terms of gender roles.
[171] See Waitzken, 1989.
[172] Parsons, 1954:191.
[173] Bowker and Star, 1999:4-5.
[174] Bowker and Star, 1999:82.
[175] An intervening period of predominantly psychoanalytic discourse was equally imbued with ideas about culture.
[176] In her essay "The Rationality of Mania" (2000), Emily Martin locates the notion that "rational thought would produce order, knowledge, and scientific truth" and that "rational arrangements of time, space and bodies would yield efficient and productive societies" in the early part of the 20th century. Judging from the amount and kind of research done in recent decades, I contend, however, that at no time in history (at least, medical history) have these assumptions been more true than in the last 30-50 years.
[177] Cf. Martin, 2000.
[178] Benjamin, 1988:184-5.
[179] See Bowker, 1998:275.
[180] Cf. Hunter, 1991:134.

[181] Yet, to paraphrase Kathryn Montgomery Hunter, impersonality is not the equivalent of inattention; even impersonality comes with the guarantee of acceptance and care no matter what (1991:133).
[182] Bowker, 1998:259. Bowker's discussion is concerned with the *International Classification of Disease*, a statistical manual very similar in form and agenda to the DSM but pertaining to diseases in general. The reader may recall that the DSM-III was intended to go beyond the ICD (9th edition) which did not address mental illnesses adequately.
[183] Bowker, 1998:273. See also Bowker and Star, 1999:5.
[184] Bowker, 1998:286-91.
[185] Bowker and Star, 1999:3.
[186] Keller, 1992:77. Keller's argument brings to mind a recent front page article run by the *Globe and Mail* describing a study seeking to explain why Asians are (supposedly) better at math. The researcher offers a social explanation, suggesting that Asians "have memorized more basic math and relied less on calculators in elementary and high school" (McIlroy, "Asians," 2001:A1). It is a relief that some kind of Phillipe Rushton-esque explanation is not being marshalled here, but it is still deeply troubling, à la Keller, that the research question is even being asked.
[187] Keller, 1992:83.
[188] Spitzer and Williams, 1988:56.
[189] A cursory look at the proposed interview schedule shows that responses were to be scored according to the extent to which the criteria for SCID disorders were met. In other words, interviewees were either normal or pathological, but in varying degrees. It turns out that even the pathological has normative limits.
[190] Star and Griesemer, 1999:517.
[191] Bowker and Star, 1999:16.
[192] Star and Griesemer, 1999:519.
[193] Fujimara, 1992:169.
[194] Fujimara, 1992:168, 205.
[195] Fujimara, 1992:175.
[196] Fujimara, 1992: 176.
[197] Fujimara, 1992:178.
[198] Cf. Fujimara, 1992:176-7.
[199] The concept of the black box was made famous by Bruno Latour, but was "invented" by Richard Whitley in a 1972 paper called "Black Boxism and the Sociology of Science" (from Simon, 1997).
[200] Simon, 1997.
[201] Parsons, 1978:591.
[202] APA, 1980:227.
[203] Parsons, 1978:595.
[204] Parsons, 1978:596.
[205] Hunter, 1991:18.
[206] King, 1982:203.
[207] Rose, 1985:32.
[208] Cf. Gardner, 1994.
[209] For discussion of the ideology and politics of the concept of disease, see Engelhardt, Jr. 1976; 1978 and Margolis, 1978; 1986.
[210] Rosenberg, 1992:xiii.
[211] Engel, 1960:463.
[212] Ziporyn, 1992:51. See also Miner, 1953.
[213] Garfinkel, 1967:41.
[214] Garfinkel, 1967:44.
[215] Some diseases have no symptoms; some symptoms can themselves have symptoms (witness agoraphobia that has been at different times a symptom of neurosis or anxiety disorder with its own symptoms). Sometimes symptoms are mistaken for diseases, as are syndromes, a term often used to describe "nameless diseases" (see Ziporyn, 1992:99-128). Diseases and disorders are often confused, though psychiatrists still distinguish between them, working from the premise that

"diseases represent a disturbed anatomical structure, while disorders represent a disturbed physiological function" (Ziporyn, 1992:214 n. 16).

[216] Latour, 1987:3 and 131.

[217] Adapted from Barrett, 1999:16-7.

Chapter 10
Conclusion: Doing Agoraphobia(s)

In *The Birth of the Clinic*, Foucault posits an epistemic shift in how diseases "were given to be seen,"[1] contending that with the advent of modern medicine, the diseased body was radically and conceptually transformed into a discursive site.[2] With the development of the "Clinic," diseases changed from being conceptualised as *dwellers in* to *conditions of* the human body, which thereby became both subject and object.[3] The body was – is – the object of positive medical knowledge, the "clinic", the medical gaze,[4] and it was – is – also the living body, embodied humanness, the "fleshy condition for, or, better, the fleshy situatedness of, our modes of living."[5] As Foucault wrote:

> The gaze is no longer reductive, it is, rather, that which establishes the individual in his irreducible quality. And thus it becomes possible to organize a rational language around it. The *object* of discourse may equally well be a *subject*, without the figures of objectivity being in any way altered. It is this *formal* reorganization, *in depth*, rather than the abandonment of theories and old systems, that made *clinical experience* possible...[6]

Foucault's "archaeology of medical perception" demonstrates that patients have historically been both subjects of disease theories and objects of the clinical gaze deployed according to a standard of "normal" functioning – according to the binary of health and morbidity, the normal and the pathological.[7]

In the literature on agoraphobia we have seen repeatedly at least two forms of this dualistic ontology. The construction (and reification) of individuals who are ill as "cases" and "Ss" to repair and to write about has rendered agoraphobic bodies as subject-objects of psychiatric discourse and its gaze. As well, the attention of physicians historically has been directed not to the (whole) patient,

but to the signs that differentiate one disease from another – that is, their classification (engendered most explicitly in the DSM) – again, enabled by the clinical gaze. Indeed, the gaze, productive as Foucault describes it, has been central to the carrying out of psychiatry, be it treatment or research.

Although productive, the gaze is nonetheless a limiting concept. Specifically, it posits bodies as docile and monolithic subject-objects of the psychiatric and cultural order. Perhaps the best example of this view of bodies is found in Susan Bordo's work on anorexia. She locates the aetiology of eating disorders in the distorted body images contained within popular representations of women.[8] What troubles me about Bordo's thesis is that it presumes that women (in particular) are cultural dupes, that they are profoundly victimised by merciless media. It also presumes that all anorexic women respond to these images in the same way and for the same reasons, and fails to account for those women who do not become anorexic in response to what they see. While the gaze is immensely useful for understanding the power relations of medicine and psychiatry (and in Bordo's case culture as well), it cannot explain the diverse agoraphobic bodies that emerge in seeming defiance of the norms intended or assumed to constrain them. Thus a persistent question that emerges from my research is how to account for the multiplicity of agoraphobic bodies (and by implication non-agoraphobic bodies) encountered in the clinical articles.

At this point, I see two related theoretical responses. First, the body is never simply a body, but is rather, an *enacted* body whose meaning – in this case agoraphobia – is always shifting. And a theory of the body as meaningfully enacted destabilises not only the apparent uniformity of agoraphobia, but also the

presumed distinction between the discursive and the material. This involves a challenge to the divide between "words and things" that has, especially within recent feminist literature, caused so much "perplexity and irritation."[9] Specifically, the privileging by feminists of materialist explanations for women's oppression has been seriously challenged by more contemporary feminist arguments that the "importance of meaning" has been ignored.[10] Materialist feminists have been resistant to this turn to culture and discourse, seeing it as "an ideologically suspect attempt to deny material reality."[11] But, to borrow from Hortense Spillers' work on slavery, "We might concede, at the very least, that sticks and bricks *might* break our bones, but words will most certainly *kill* us."[12] I turn now to what this might mean for a theory of agoraphobic bodies.

In their work, Annemarie Mol and John Law replace the dualistic question of what it means to *have* or *be* a body with the question of what it means to *do* a body. They propose a theory of the body as *enacted* by the various practices associated with it. The notion that diseased bodies – in their case hypoglycaemic and in my case agoraphobic – are enacted may be illuminated, for example, by the case literature. There we see patients who do things like panic, avoid crowds, stay at home, lie about their problem, walk with a companion, take medication, attend clinics, and so forth. One early physician remarked that agoraphobics were easily recognisable for they often suddenly grabbed railings or walls, and could often be seen carrying a stick or umbrella to increase their base line of support as they walked.[13] Following from this we could similarly argue that the DSM is effectively a compendium of actions identifiable with mental pathologies, offering us a list of things that patients with various disorders can be expected to *do*. So to follow

Mol and Law, the actions that patients engage in *enact* their agoraphobic embodiment. Bodies are "enacted" and my focus here is what they might describe as "doing agoraphobia."

Having identified that agoraphobic patients engage in certain practices that can be characterised as "doing agoraphobia," I hasten to point out that certainly patients do not do agoraphobia on their own, indeed, patients *and* doctors do agoraphobia *together*. For example, doctors examine, measure, test, and listen to their patients talk about their experiences – and they represent agoraphobia by writing the disease in the form of articles (and DSMs). I would expand Mol and Law's concept of enactment a bit further to include, then, the writing and publishing that psychiatrists do. As Berg and Bowker write, "knowing *in the practice of medicine* is ... dependent on writing" and medical literature "mediates the relations that it organizes [and] the bodies that are configured through it."[14] Like the medical records that interest Berg and Bowker, clinical literature is fundamental to the production of modern diseased bodies. Indeed, "the patient's body becomes its representation."[15]

Given this dissertation's focus on published representations of agoraphobia, and since agoraphobia is so fundamentally connected with the body, it seems important (if obvious) to acknowledge the connection between representations of agoraphobia and the agoraphobic bodies they help to enact. We could see, then, "convergences" between the body and its representation(s), insofar as representations inscribe themselves in the bodies they represent.[16] To summarise, agoraphobic bodies are enacted by the practices engaged in by both patients and doctors. These practices include doctors' writing and publishing about agoraphobia.

Over the 130 years of this writing and publishing there has certainly been compelling continuity in the symptoms of agoraphobia that patients present, and an unmistakable effort (à la the DSM) to contain *the* agoraphobic body within "a single time and space."[17] This singularity, however, is belied by much difference insofar as each patient has been fundamentally inimitable (even if we usually do not have access to that inimitability). To paraphrase Mol, agoraphobia is "*performed* in a variety of ways, or better ... the name ["agoraphobia"] is used for different objects – which also have names of their own."[18]

As we have seen throughout the dissertation, agoraphobia has indeed been many things: a disease of men, a disease of women, as well as panic, panic disorder, agoraphobia with/without panic, space phobia, claustrophobia, neurosis, anxiety, symptom, syndrome, disease, and so forth. Agoraphobia's multiple ontologies are, through a lot of effort, mobilised as aspects of some monolithic entity and projected as a virtual object ("agoraphobia") behind the variety of agoraphobias that are performed.[19] In reality, however, every examination, conversation, designation – every publication – constitutes a different "enactment" of *this kind* of body. As Mol writes: "The material manipulated, the concerns addressed, the reality performed, all vary from one place to another. The ontology incorporated ... in the diagnosis, treatment, and prevention of [agoraphobia] is multiple."[20] So not only do doctors *and* patients enact agoraphobia, they enact *many* agoraphobias through a range of necessarily unique practices.

But something is still missing from this formulation because the multiple enactments of agoraphobia cannot be understood as a matter of decontextualised ontology. Representations of agoraphobia become meaningful through the grid of

culture. Bodies may be something that we *do*, but the *doing* is rendered intelligible and relevant through normative categories, in this case, the category (and subcategories) of disease. When doctors make claims about agoraphobics, they invoke certain knowledges formulated in the language of disease, including as we saw in Chapter 9, ideas about gender, race and class as well as aetiology. These knowledges constitute the normative conceptual structure *through which* agoraphobic bodies are enacted, and bodies can be said, in Judith Butler's words, to "only appear, only endure, only live within the productive constraints of certain ... regulatory schemas."[21] A body is never *just* a body, but a body with normative meaning.

Ian Hacking captures this in his discussion of the causation of multiple personality disorder:

> Psychiatry did not discover that early and repeated child abuse causes multiple personality. It forged that connection, in the way that a blacksmith turns formless molten metal into tempered steel. [...] I am pursuing a ... profound concern, namely, the way in which the very idea of the cause was forged. Once we have that idea, we have a very powerful tool for making up people, or indeed, for making up ourselves.[22]

Hacking's remarks illuminate the ontological *and* epistemological process of how these particular material subjectivities – agoraphobic bodies – are apprehended through normative structures called up in the symptoms, diagnosis, treatment, and representation of this disease. "A seemingly innocent theory on causation ... becomes formative and regulatory."[23] This means, as Bowker and Star write, that "classifications and standards are *material*, as well as symbolic. [...] [T]hey have material force in the world."[24] To recapitulate, doctors and patients together enact multiple agoraphobic bodies, and these enactments derive their meaningful-

ness from cultural ideas and categories. Enactments are both material and discursive. That is, enactments are inextricable from meaning structures.

In Chapter 9, the cultural categories to which I attended were those of disease, gender, race, and class, and Judith Butler shows how such (particular) kinds of bodies are the outcomes of power relations. Focusing on the sexing of bodies, Butler contends that the performance of gender is a performance to the extent that gender is a repetition of conventions and norms, and power relations so "cited" and concealed. The "reiteration" of norms is a process that creates, excludes and maintains abjected Others – bodies that fall outside the shifting boundaries of normalcy – bodies that "don't matter." Social norms make the material constitution and cultural intelligibility of *certain* bodies – those that do matter – possible. In other words, bodies that don't matter provide a constitutive outside for those that do. Thus abnormal bodies – in her case homosexual and in my case diseased – are the materialisation of norms – an ongoing structure of exclusion which, in their reiteration, create and recreate relations of power.

Yet, although it may appear to be, the process of reiteration that Butler describes is not closed or stable. The lines of inclusion and exclusion upon which normative classifications depend are always shifting because people interpret and reiterate the norms in particular contexts. Norms are not solid or unwavering, and, as we have seen repeatedly in the medical literature, agoraphobia has not successfully mobilised as a single complete identity. In other words, each reiteration of agoraphobic norms (the DSM criteria imply that these exist) reflects a different disease. Here we might revisit something that Mol and Law said (quoted above): Agoraphobia is "*performed* in a variety of ways, or better ... the name

["agoraphobia"] is used for different objects – which also have names of their own."[25] Thus, while enactments necessarily reiterate cultural meaning structures, which, when "cited," affirm relations of power, "*different* [medical articles and] *different* practices of reading and writing are intertwined with the production of *different* patient's [sic] bodies, different bodies politic, and different bodies of knowledge."[26]

Indeed, the concept of reiteration illuminates an understanding of agoraphobic bodies as multiple in three respects. First, the materiality of agoraphobic bodies is constituted *in* and *through* disease categories that are normative and regulative. This has implications in and for the bodies so produced because bodies are unintelligible outside of these meaning structures. Certainly, agoraphobic bodies could not be understood *as such* outside the essential conceptual framework of medicine –the bifurcation of normal and pathological. But the concept of reiteration demonstrates that it is *in and through* this conceptual framework that multiple agoraphobic bodies have historically materialised. In this respect, social discourses such as that of medicine – through the positioning of pathology as the constitutive outsider to health – have shaped the social world through the normative frameworks that they create and deploy vis-à-vis the social and intellectual authority of (medical) science.

Second, reiterations are necessarily open and this is confirmed by the variable images of agoraphobia that manifest in the literature, including the various editions of the DSM. To be sure, the DSM presents agoraphobia as a "done deal" – again, an agoraphobic norm is suggested – but agoraphobia has always been emergent, open-ended and on-going. Each reiteration of agoraphobia has been

different and particular – in terms of socio-historical context, the patient presenting, the doctor diagnosing, the method of apprehension and treatment, the DSM in vogue, the theory of causation, and so forth. That several theories of causation and classifications of this disease have been in circulation over time and often at the same time – that the discourse of agoraphobia has been *fragmented* in this respect – destabilises the notion of *an* agoraphobic body, as well as the notion that agoraphobia has been a unified production. This sense of friction and plurality calls into question the popular and clinical notions of what agoraphobia is and also has implications for how other pathologies are understood. The process of classification, as it relates to ontologically variable phenomena, is disrupted and the problem of social order that is imposed by the categorisation of "symptoms that matter" is exasperated.[27] Psychiatric and cultural categories taken up in particular clinical reports are called up in particular bodies in ways that actually reveal both the power of the categories *and* their vulnerability as each embodied agoraphobic person takes them up – reiterates them – differently.

Third, the concept of reiteration also helps to situate the sorts of practices that are implied by the concept of "enactment" within their linguistic, symbolic, and normative contexts. Practical actions – enactments – can only be understood in terms of the normative categories of knowledge that are called up in their execution. We could say that agoraphobic bodies have been the outcome of *knowledgeable* practices in that they represent the enactment of knowledge categories. To be sure, medical classifications guarantee these symptomatic beings a recognisable and enduring social existence[28] by imposing stability on their variable and unstable bodies. These discursive categories have been necessary for mean-

ingful material existence and at the centre of this process has been the social differentiation of these bodies through the process of abjection. Agoraphobic bodies enacted by clinical articles are given intelligibility through the regulative and normative meaning structures of medical discourse.

Thus the embodied mobilisation of agoraphobia is a material-discursive mobilisation in that theories, ideologies, and structures of cultural-medical categories are reiterated and enacted by physicians who treat and publish literature about their agoraphobic patients and necessarily call up these categories in the process. In fact, borrowing from Karen Barad's "epistemontology," we could say that doing agoraphobias reflects an "intra-action" of enactments and reiterations. Enactments and reiterations are similarly pluralistic, but still indistinguishable to the extent that enactments of agoraphobia can make no sense outside of a normative conceptual order that designates which aspects of agoraphobia shall be "given to be seen."[29]

To sum up, Butler emphasises the exclusionary reiterative and normative power of discourses. Abjection is central to the Othering that is the basis of classifications. This was especially reflected in cases where, for example, causation was traced to reproductive organs in women, or DSM-IV, where the failure to complete homemaking responsibilities is taken as a marker of pathology (and thereby Othering women not only on the basis of their mental health but their gender too). A theory of the body as normative reiteration elucidates these examples as constitutive exclusions. By the same token, Mol and Law's theory of the body as enacted gives an account of the *practical* and active material component of embodiment. We could theorise practices associated with agoraphobia, not the

least of which has been the publication of clinical literature, as central elements of its enactment. But, as I have tried to show, actions are necessarily attached to meaning structures established through the matrix of history and the symbolic order – through the politics of culture embedded within medical literature. It is in this respect that agoraphobias are at once reiterated and enacted. In other words, the body is not simply where a disease happens, but is, also, the material-discursive instantiation of deeply social contestations. We could even say that the enactment of bodies through particular practices involves as well the enactment of certain exclusions of bodies, and of diseases not enacted. Indeed, this is the essence of classification. In this dissertation I have tried to show that agoraphobic bodies are mobilised – *inter alia* – in and by medical literature. The theories of disease and the ideas about culture and the social that are invoked in writing about agoraphobia amount to the deployment of discursive structures of abjection that regulate the material intelligibility of this disease. Clinical literature is a productive and performative material-discursive apparatus that *knowledgeably enables* a range of embodied agoraphobic subjectivities.

Still, practitioners' scrutinise agoraphobia – and every other disease for that matter – in a very particular way that is the driving force, the essential ideology, of psychiatric practice. This way of knowing the body marks a crucial difference between the "person presenting symptoms" of agoraphobia and "*The* agoraphobe", or the sense in which any corporeal pathological condition *essentially* defines an individual's very identity. The most recent articles especially – and most certainly the DSM – intensify this sensibility by compromising the subjectivity of the unique person who presents with her/his unique and highly per-

sonal(ized) set of agoraphobic symptoms. At the nexus of contradictory normative demands is a particular individual, yet the psychiatric gaze, unfazed by the range of ways to "do agoraphobia(s)," is directed to *The* pathology that is named.

A material-discursive account of agoraphobia enhances our understanding of the multiplicity of agoraphobic bodies, but it is important not to lose sight of psychiatry as a set of power relations that incorporate notions of gender, race, and class. I maintain that these relations are central in the history of psychiatry in general and agoraphobia in particular. Practitioners, as active proponents of the normal/pathological dualism have yet to demonstrate an interest in adopting a more critical and socio-cultural epistemology in its stead. Were it so, the discursive practices of agoraphobia might come to matter in altogether new ways...

Notes

[1] Rajchman, 1991.
[2] The chronological innacuracies and generalisations of Foucault's medical historical work have been the subject of much criticism and debate. Still, the point he makes is useful to consider in light of the psychiatric literature we have been looking at throughout this dissertation because "the gaze" he describes has become a dominant point of departure for critiques of medicine.
[3] From Mol and Law, 1999.
[4] Foucault, 1973:197.
[5] Mol and Law, 1999. See also Foucault, 1973:196.
[6] Foucault, 1973:xiv
[7] Foucault, 1973:35; see also Canguilhem, 1991.
[8] Bordo, 1993.
[9] Barrett, 1999:18.
[10] Barrett, 1999:19.
[11] Barrett, 1999:25.
[12] Spillers, 1987:68.
[13] Headley Neale, 1898:1323.
[14] Berg and Bowker, 1996.
[15] Berg and Bowker, 1996.
[16] Star and Bowker, (1994) cited in Berg and Bowker, 1996.
[17] Berg and Bowker, 1996.
[18] Mol, 1998:161.
[19] Cf. Mol, 1998:150.
[20] Mol, 1998:161-2.
[21] Butler, 1993:xi.
[22] Hacking, 1995:94-5.
[23] Hacking, 1995:95.
[24] Bowker and Star, 1999:39.
[25] Mol, 1998:161.
[26] Berg and Bowker, 1996.
[27] I owe this insight to Bart Simon.
[28] See Butler, 1997:20.
[29] Rajchman, 1991. (See note 1).

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