Doing agoraphobia(s): a material-discursive understanding of diseased bodies

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Abstract
This paper draws on a reading of selected English-language case reports of agoraphobia that are representative of the medical literature written between 1871 and 1930. This reading demonstrates how agoraphobic bodies were materialised through a mutual engagement between practices associated with diagnosing agoraphobia, specifically the writing and publishing of case histories, and the reiteration of normative cultural categories implicit within them. Locating the discussion in the specific case of agoraphobia, the paper analyses the concept of disease, not only in terms of its social construction, but also in terms of its materialisation, thereby illuminating the socio-cultural process of embodiment as one that unfolds in and through (disease) categories. Seeking to transcend current theoretical debates that demand a choice either between a material or a discursive explanation of medical phenomena, the body is thereby conceptualised beyond Foucault’s subject-object as an intra-action between the material and the discursive, whilst retaining his key insights into the power relations inherent in the clinical gaze.

Keywords: agoraphobia, embodiment, disease causation, medical publishing, material-discursive

Introduction
The earliest descriptions of ‘men who feared “that which need not be feared” ’ were written by Hippocratic physicians who classified the symptoms of phobia under the category of melancholia (black bile), one of the three major types of insanity delineated at that time. Phobic symptoms continued to be associated with melancholia well into the 18th century, when treatment of the insane was not yet a specialised branch of medicine, but when great emphasis was placed nonetheless on the classification of phobic symptoms. The surgeon Le Camus (1722–72) sought to classify phobias according to...
the sense most affected, while Sauvages (1706–67), a botanist, classified his observations by symptomatology, identifying vertigo as the most striking characteristic of phobias. 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 (see Errera 1962: 328–31).

The remarks of Beauchêne (1783), Brück (1832), and Benedikt (1870), however, are especially pertinent because they spoke most directly to what would ultimately become the diagnostic category known as ‘agoraphobia’. First, Beauchêne observed that for his patients the presence of a companion often relieved phobic symptoms (in Errera 1962: 331); this would remain a common characteristic reported throughout the case literature. Second, Brück characterised symptoms he observed as ‘schwindel angst’ (in Van Horn 1886), while Benedikt, considered by some to be the first to chronicle agoraphobic symptoms proper, used the term platzschwindel (dizziness of places) to describe a patient he had seen who was ‘unable to cross wide streets or open spaces’ (in Knapp and Schumacher 1988: 25).

It was, however, German (Prussian) neurologist Carl Otto Westphal’s (1833–90) pathbreaking article ‘Die Agoraphobie’ (1871) published in the journal Archiv für Psychiatrie und Nervenkrankheiten, which has, since its publication, been widely regarded as the starting point of the history of agoraphobia and possibly even the modern literature on phobias (transl. in Knapp and Schumacher 1988: 25). Westphal’s report, in which he disagreed with Benedikt’s vertigo thesis and gave this pathology its permanent name, led to the relatively immediate publication of a number of responses written by American practitioners. From this point on, the clinical discourse of agoraphobia developed a life of its own and has continued to expand ever since, with the increasing publication of case literature, trials and studies, discussion papers, letters to the editors of journals, and entries in the American Psychiatric Association’s Diagnostic and Statistical Manual of Mental Disorders (1952, 1968, 1980, 1987, 1994, 2000). All these publications have served as a forum for physicians to theorise about the phenomenology, causation, and treatment of agoraphobia, and many cite Westphal’s report even today.

In the discussion that follows, the role of early clinical publications in the history of this pathology is examined. I will argue that the mutual engagement between the writing and publishing of case histories and the reiteration of normative cultural categories implicit within them has been a significant vehicle for the materialisation of agoraphobic bodies. The paper analyses disease categories, not only in terms of their social construction but also in terms of their materialisation, thereby illuminating the socio-cultural process of embodiment as one that unfolds in and through (disease) categories. Seeking to transcend current theoretical debates that demand a choice either between a material or a discursive explanation of medical phenomena, the body is thereby conceptualised beyond Foucault’s subject-object as an
intra-action between the material and the discursive, whilst retaining his key insights into the power relations inherent in the clinical gaze.

I begin the paper by providing an overview of the clinical discourse of agoraphobia between 1871 and 1930 to show how ‘the agoraphobe’ was described and produced as a dualistic Foucauldian subject-object (1973). I then explore the possibility of conceptualising the body in terms of an ‘intra-action’ or mutual engagement between the material and the discursive (see Barad 1998). The practices performed by a body define it as a particular body – bodies are something that we do, that we enact (see Mol and Law 1999) so I take the representation of disease through the reporting of case histories in medical journals as one type of practice that connects in powerful ways with its material outcome, namely (diseased) bodies. Yet, the idea that bodies are enacted also demands a discursive analysis in the sense that they may also be understood as the reiteration of normative cultural categories (see Butler 1993). Practices related to agoraphobic bodies are only rendered intelligible and relevant through the expression of this disease category in language. I seek to show, then, that the material and the discursive are inextricable and at once responsible for the production of agoraphobic bodies. Although I seek to conceptualise the body beyond Foucault’s subject-object, I will however retain his concept in the final section of the paper because, while it is useful to reach beyond the dualism that it implies, the subject-object nevertheless remains an important constituent of embodied agoraphobic subjectivities.

Theorising agoraphobia(s): the clinical discourse

In The Birth of the Clinic (1973), Foucault posits an epistemic shift in medical practice, contending that with the advent of modern medicine, the diseased body was radically and conceptually transformed into a discursive site. With the development of the ‘clinic’, diseases changed from being conceptualised as dwellers in to conditions of the human body (from Mol and Law 1999). The body was – is – both the object of medical knowledge, the clinic, the medical gaze and its tools, and it was – is – also the living body, embodied humanness, the ‘fleshy condition for, or, better, the fleshy situatedness of, our modes of living’ (Mol and Law 1999). This epistemic shift made possible a rational, positive science of ‘man’ whereby the individual could be both ‘subject and object of his [sic] own knowledge’, constituting himself ‘in his own eyes as an object of science’. 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; it lifted the old Aristotelian prohibition: one could at last hold a scientifically structured discourse about an individual (Foucault 1973: xiv, original emphasis).

To the extent that it was concerned with ‘“man’s’ being as object of positive knowledge’ – that is, with “the philosophical status of man”’ (Foucault 1973: 197–8) – medicine thus came to have an importance that was not only methodological, but also ontological.

This dualistic subject-object ontology manifests in clinical writing about agoraphobia and is reflected in physicians’ tendency to direct their attention not to the (whole) patient, but to the signs that differentiated one disease from another, a tendency illustrative of what Foucault describes as ‘a new “carving up” of things’ (1973: xviii). Doctors did not ask, ‘What is the matter with you?’, a question characteristic of eighteenth-century doctor-patient encounters, but replaced it rather with ‘that other question: “Where does it hurt?”’ (Foucault 1973: xviii). Carl Westphal’s patient ‘Mr. C.’, for example, a 32-year-old commercial traveller, complained of a ‘feeling of fear’ that would overtake him whenever he attempted to walk through open spaces: ‘After questioning’ Mr. C. indicated ‘that the feeling is located more in the head than in the area of the heart, although the heart palpitates’ (Westphal 1871 [1988]: 60). A second patient, ‘Mr. N.’, was a 24-year-old merchant who could not cross open spaces nor go for long walks or rides in taxis, buses, carriages, and the train. He equally could not spend time in theatres, concert halls, or larger rooms where large crowds assembled, and in all of these situations, ‘the response [was] an immediate breakout of intense anxiety, which is introduced by an ascending feeling of warmth from the abdomen to the head along with strong palpitations of the heart’ (Westphal 1871 [1988]: 66). With these and his other patients, Westphal paid protracted attention to anatomical details, including a thorough eye examination and in one case, extensive measurement of the patient’s physical features.

As far as Westphal was concerned, agoraphobia was not a form of vertigo, and to suggest that it was, as his colleague Benedikt did, was indicative of ‘insufficient examinations’ of the patient (Westphal 1988 [1871]: 77). Rather, the eye examinations Westphal’s patients underwent revealed no link to impaired vision (which Benedikt thought was related to dizziness):

There is nothing in the eyes that could lead to conclusions in respect to the questioned affliction. [. . .] 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 . . . (Westphal 1988 [1871]: 78).

Westphal also concluded that agoraphobia was not a type of epilepsy but indicative rather of neuropathy. As he remarked, ‘Though it could have been
justifiable to identify the depicted conditions as epileptoid, I have refrained from doing so for certain reasons... seizures... belong to the most common symptoms of the most diverse psychopathic and neuropathic conditions (1988 [1871]: 81).

As Foucault put it, we may recognise in these examples of Westphal’s practice ‘the operation of the clinic and the principle of its entire discourse’ (1973: xviii) whereby, through practices of objectification, patients – human beings – are transformed into subjects of medicine – that is, into patients. These transformative practices include the ‘modes of inquiry which try to give themselves the status of sciences’, the ‘dividing practices’ that differentiate between, for example, the mad and the sane, the sick and the healthy, or as we might say, the vertiginous epileptoid and the neuropathic, and finally the way in which humans turn themselves into subjects, through recognition of themselves as subjects of, for example, sexuality (Foucault 1982: 208, 1978), surveillance (Foucault 1979), or as I am arguing, of disease. Foucault’s exegesis on modern 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 (Foucault 1973: 35, see also Canguilhem 1991). Indeed, Foucault’s dualistic characterisation of modern medical work and the clinical gaze is a very useful starting point for thinking about disease and particularly these late-19th century medical images of agoraphobia. Yet, while the concept of the gaze is immensely useful for understanding how modern medicine functions, it is nonetheless limited because in this view bodies are posited as docile and monolithic subject-objects of the psychiatric order, thereby failing to account for the diverse agoraphobic bodies that emerge in apparent defiance of the diagnostic norms intended or assumed to constrain them.

On the one hand, a plurality of agoraphobic bodies was mobilised by virtue of the differing characterisations offered in each article (as well as by the symptoms described and experienced, the effects agoraphobia had on daily living, gendered differences and varied clinical approaches). On the other hand, this plurality of bodies also melded together to form a singular discourse of agoraphobia generated by the physicians who wrote and published the case reports. Two related theoretical responses are possible here: first, the body is never simply a body, but is, rather, an enacted body whose meaning – in this case agoraphobia – is always shifting. Second, 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 scholarship, caused so much ‘perplexity and irritation’ for the privileging of materialist explanations for women’s oppression at the expense of meaning (Barrett 1999: 18–9). Materialist feminists have been resistant to this turn to culture and
discourse, seeing it as an ‘ideologically suspect attempt to deny material reality’ (Barrett 1999: 25). But, to borrow from Hortense Spillers’ (1987) 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’ (1987: 68, original emphasis).

This tension is evident in doctors’ use of disease theories in their accounts, and the cultural assumptions that are implicit within them. In order to give readers a sense of how agoraphobic bodies were meaningfully enacted through this discourse, I shall explain the theories of disease invoked by the case histories, and then turn in the section that follows to what I mean by ‘the material-discursive’.

The concept of disease
The discourse of disease has turned for many centuries on two main (and competing) theories of causation (see Ziporyn 1992: 83 and Risse 1978). The first, known as the ontological theory, views disease as an expression of various distinct bodily afflictions. This perspective locates the origin of disease outside the body as a specific, objective entity external to the affected organism. (Germ theory and tuberculosis come to mind here.) The second, known as the physiological theory of disease, views disease as an impairment of the individual body’s normal functioning, thereby locating pathogenesis within the body. Disease is theorised as a consequence of disturbed functions operating internally. In the physiological theory, the conditions of possibility for a given disease already reside within the individual. A moral undercurrent that framed disease as punishment, first for sin (as posited by religious suggestions within medical practice) and then as the effect of taboo interpersonal relations (as recognised in an emergent psychoanalytic tradition that emphasised biological drives and desires), is often evident within this view.

As categories imposed by historians and philosophers, the ontological and physiological designations have helped 20th century writers about medicine to organise conceptually debates that have persisted since their introduction in ancient Roman and Greek medicine (see King 1982, Hudson 1987, Risse 1978). The physiological theory of disease tends to be more easily discernible in the agoraphobia literature, but there are a few gestures towards the ontological theory, such as when physicians describe the disorder as something that ‘attacks’ their ‘victims’. In what follows, I focus mainly on how the physiological theory of disease causation manifested in the case literature and thereby played an important constitutive role in the materialisation of agoraphobic bodies. Still, although it is easier to find examples of the physiological theory of causation, in a sense it is the ontological concept of disease that invariably dominates in medical ideas. 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’.

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The physiological theory of disease

One of the major debates within the early discourse of agoraphobia was indeed over its causation and phenomenology (signs and symptoms). We have already seen physicians argue that agoraphobia was simply a ‘vertiginous affection’. American physician Albert Blodgett (1887), for example, traced the symptoms to derangement of the sympathetic nervous system and trouble with the inner ear, and noted that in his patient, a 40-year-old male ‘of fine sensibilities and . . . acute understanding’, the agoraphobia was sometimes accompanied by ‘belching large quantities of gas’ (1887: 407). The agoraphobia experienced by another patient, a 39-year-old male who was ‘the very opposite of calm’ and who so dreaded walking outside that he sometimes travelled ‘backwards and forwards’ by omnibus, was explained by his British physician Robert Jones (1898) as evidence of ‘irregular stimulation of isolated cortical centres causing impellent ideas’ (1898: 568–70).

‘Properly adjusted eyeglasses’ in the case of visually impaired patients were thought by American physician H.W. Hermann (1889) to help with this ‘distressing symptom’ in people with a predisposition to neuropathy and 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’ (Jones 1898), and was consistent with the popular belief that heredity was the principal cause of mental degeneracy.

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 from which she suffered, and of which her agoraphobia was symptomatic). The British physician C.W. Suckling who looked after this particular patient was ‘struck by the marked potency of childbearing as a cause of agoraphobia and allied morbid fears’ (1890: 478). Along similar lines, another woman’s agoraphobia was caused – or at least exacerbated – by ‘a laceration on the cervix’. After the American physician L.T. Potter (1882) ‘made local applications’ the patient was, however, still unable to travel without trepidation, and 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 (1882: 474).

These two female patients are particularly interesting to consider because mostly men were diagnosed with agoraphobia at the time these reports were written. This continued to be the case until well into the post-war (WWI) years, after which agoraphobia became ‘re-gendered’ with an increase in reported diagnoses of agoraphobia overall from then on, but among women especially.
The early assumption that agoraphobia had something to do with the reproductive system was generally reserved for the few cases of agoraphobia in women, however, and the gendered contrast is especially noticeable when we compare these articles with the ones describing agoraphobia in men. One American physician, Edward T. Williams (1872) argued, for example, that a patient of his American colleague S.G. Webber (1872) was clearly suffering from delirium tremens or mental confusion due to a chronic lesion on the right half of his brain. Another physician, 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. Finally, British physician Robert Ruttle (1889) believed the agoraphobia in his patient, a 38-year-old insurance agent, was 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, a British physician named J. Headley Neale (1898), 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 (1898: 1322). 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’ (Mercier 1906: 990). This British doctor, Charles Mercier, argued that in the arboreal stage of existence, the ‘ancestors had a very strong aversion to any extended excursion from their place of security and refuge’. When away from trees the patients felt an understandable sense of dread and in agoraphobia this arboreal state of mind was reproduced, such that the ‘mental craving’ of the ‘subject of this malady’ was not the instinctive need to be near trees necessarily, but near any tall vertical structures.

These are just a few examples of how doctors invoked the physiological theory of disease by locating the origins of agoraphobia within their patients’ bodies, be it in a defective nervous system, notions of heredity and instinct, and even biological sex. In the next section, I outline how a moral discourse also materialised in these reports and was transformed from religious allusions to an emphasis on sexuality that was established through the introduction of psychoanalysis to the discourse. Although the psychoanalytic case histories became more prevalent in later years (through to the 1960s), I concentrate on only a few of the earliest contributions to the discourse of agoraphobia.

**Morality and pathology**
A moral imperative is evident in several of these articles and, although nobody went so far as to say that sin or personal shortcomings caused
illness, lifestyle choices were often blamed and there was an assumption that the patients in question all had depraved senses of morality. In the earliest literature, for example, several writers attributed the aetiology of agoraphobia to moral impairment that manifested as debauchery, excess, and even the practice of masturbation (see Webber 1872: 297). One UK physician, Henry Sutherland (1877), described a patient – a government official – who suffered from agoraphobia due to overwork, another – a ‘literary man’ – 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’ (albeit ‘unaccompanied by natural gratification’) (1877: 267). 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 came and went through his studio. A fourth patient, a clergyman, found that three months after marriage he was afraid to walk in the street, while a fifth, a cavalry officer, similarly found that he 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’ (Sutherland 1877: 268, original emphasis). A sixth patient, a merchant, 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. As Dr. Sutherland put it: ‘After these debauches’, this patient was ‘unable, through nervousness, to walk down the stairs of his office without leaning on the arm of a clerk’ (268). Based on these cases, Sutherland concluded that agoraphobia was not a disease but rather a symptom that disappeared when the physical cause – sexual indulgence, excessive consumption of alcohol and meat, and yielding to groundless fears – was eliminated.

Other physicians encouraged will and ‘moral determination’ as means of avoiding or lessening the severity of symptoms (Prosser White 1884). One doctor (Headley Neale 1898) cited deception as one of the stages of agoraphobia in women. Another physician, drawing on the ideas of phrenology, described his patient as a ‘degenerate’ whose head accorded ‘with those unexpected measurements often found in the insane, being full and well shaped’ (Jones 1898: 568). 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’ (1898: 570).

In the psychoanalytic cases, social relations – especially those considered taboo – were invoked more explicitly. Even though Freud published no cases on agoraphobia per se, he wrote extensively on the subject of ‘anxiety neurosis’, whose symptoms included phobias and agoraphobia in particular. Still, though he published no cases, Freud’s 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 (1966 [1892–4]: 139). In a footnote to one case (‘Lucy’) among those that he published with
his colleague Josef Breuer in 1893, for example, Freud demonstrated a pathogenic link between neurosis (agoraphobic) and experiences ‘retained in the patient’s memory even when they seem to be forgotten’ (Freud 1955 [1893]:112, fn 2). But primarily, Freud’s thesis on agoraphobia at this time was recorded in a letter to Wilhelm Fliess, in which he suggested that the difficulties were rooted in undischarged libido (1966 [1893]: 184–5). In another letter to Fliess written in 1894, he described agoraphobia as a symptom of the ‘defence psychoneuroses’:

. . . 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 (1985 [1887–1904; 17 December 1896]).

For Freud phobias were symptomatic of anxiety neurosis caused by sexual tension ‘extremely frequent in modern civilized society’ (1963 [1894]: 90–1; see also Freud 1908). Phobias derived from fantasies – an ‘unconscious combination of things experienced and heard, according to certain tendencies’ (1985 [1897–1904; 1897]: 246) that sought to make ‘inaccessible the memory from which symptoms have emerged or might emerge’ (1985 [1897–1904; 1899]: 246). Unconscious fictions 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’ (1985 [1897–1904; 1899]: 246).

Freud revised his theory of neurosis over the years, and eventually (after 1926) added to it the impulse of aggression, arguing that while neuroses were still traceable to disturbances of the sexual economy, they largely derived from the repression of illicit – read: immoral – desires. Where sexual impulses were perceived to lead to danger – that is, when desire ultimately leads to castration by the father – an unconscious and self-protective displacement occurs. In conflict with the ego, id impulses are shifted to a substitute activity or object considered more appropriate and not dangerous (Freud 1959 [1925]). His famous analysis of ‘Little Hans’ (1955 [1909]) with his fear of horses was (in retrospect) a case in point: for agoraphobics, who experienced a fear of the street, the real feared object was the sexual temptation represented by the street (and in Hans’ case, horses). Developing the symptom of agoraphobia following an attack of anxiety in the street could be described ‘as an act of inhibition, a restriction of the ego’s functioning’ by which the agoraphobic patient ‘spares himself [sic] anxiety attacks’ (Freud 1964 [1932]: 83) and manages his/her unacceptable incestuous – immoral – impulses.

With these ideas, Freud explained agoraphobia in terms of both personal history and desire, something that no other physician had yet done. The influence of Freud’s intellectual and clinical leadership was evident in other
psychoanalytic articles whose authors built upon his concept of the ego and the theory that it put up (phobic) defences in order to control internal drives. One psychoanalyst, Karl Abraham, was concerned in 1913 to know why some neuroses manifest in this particular way in some people, that is, as ‘locomotor’ or ‘street anxiety’. He asserted that in these individuals there must have been a specific factor in their sexual constitution not present in other neurotics, namely a failure to repress the pleasure they derived from ‘locomotion’ when in the company of those people who were the object of their childhood desire. Abraham described patients who experienced pleasure when walking, as in one patient who had ‘pollution dreams’ about dancing and for whom walking outside with his mother offered sexual gratification otherwise denied by his inhibitions. In another patient, a woman, the pleasure in movement 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’ (1913: 237). These individuals only derived ‘locomotor pleasure’ in the company of particular companions, without which the pleasure in movement was transformed into a fear of movement and subsequent street anxiety.

In 1929 another analyst, Helene Deutsch, concluded that for her patient the street was the site of temptation, and her mother’s companionship served two purposes. First, she protected the patient from the dangers she imagined existing in the street. Second, the patient identified with the mother through her desire for her father, and the agoraphobia represented the displacement of aggression from her mother to the street and the outside world – aggression that stemmed from this rivalry between the two women. As long as the mother remained in the patient’s presence, the patient was able to protect her from danger.

In 1930, Emmanuel Miller reached a similar conclusion about a patient of his who suffered from an oral fixation. Like the others, this patient had conflicting feelings towards her mother who on the one hand nursed her but was also, on the other hand, an obstacle to the fulfilment of her desire for her father. Miller focused on the link between the superego – that which administered censure over immoral desires – and the world outside the patient’s safety zone of the house. As he wrote:

Our external world is built up by inter-subjective intercourse and the moral order finds its social expression in the opinion of people outside – in the agora – or market-place [...] 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 (Miller 1930: 266).

He theorized that his patient feared the out of doors because that was where her illicit desires would be subject to moral judgement.
In summary, the examination of symptoms, the theorisation of causation, the attempts at treatment, and most fundamentally the construction of these individuals as something to repair and to write about, rendered these agoraphobic bodies Foucauldian subject-objects of medical (and psychoanalytic) discourse and its gaze. As I have already suggested, however, an archaeological analysis of the case histories limits us to an understanding of bodies as docile and monolithic. In the next section I seek to demonstrate how practices and discourses of agoraphobia functioned together in the production of embodied agoraphobic subjectivities – how the material and the discursive intra-acted.

**Doing agoraphobia(s): enacted reiterations**

In their study of hypoglycaemia, Annemarie Mol and John Law (1999) 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, and 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 details in 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 remedies, attend clinics, and so forth. One physician even remarked that agoraphobics were easily recognisable for they often suddenly grabbed railings or walls, and could often be seen carrying a stick or umbrella as they walked to increase their base line of support (Headley Neale 1898: 1323). Although we as readers of this case literature have no ‘real’ access to what patients did (leaving us only the option of reading their actions through the lens of doctors’ writings), it stands to reason that, like Mol and Law’s hypoglycaemic patients, the actions that patients engaged in enacted their agoraphobic embodiment. In other words the body is ‘enacted’ through patients’ practices – what we might describe as ‘doing agoraphobia’.

How patients deport themselves and move through open spaces, however indirectly we may apprehend this as readers of medical literature, represents only part of a range of actions through which agoraphobia ‘gets done’. By examining, measuring, testing, and listening to their patients talk about their experiences, doctors also enact agoraphobia. But they also do so through writing the disease in the form of articles, so I expand upon Mol and Law’s concept of enactment to include, then, the writing and publishing that doctors do. As Berg and Bowker (1997) observe in their study of medical records and bodies, ‘knowing in the practice of medicine is . . . dependent on writing’ and, like medical records, medical literature ‘mediates the relations that it organizes [and] the bodies that are configured through it’ (1997: 514). I contend that the case literature helps ‘perform the medical body’, that, in other words, there is a convergence here: representations inscribe themselves
in the bodies they represent, such that the patient’s body becomes its representation (1997: 519).

It is important to note that this convergence does not happen uniformly. As we have seen, agoraphobia has been many things: vertigo, epilepsy, neuropathy, a symptom, a disease, a disease of men, a disease of women, the result of debauchery, punishment for masturbation, a neurotic defence, and so forth. Yet agoraphobia’s variable ontologies were mobilised as aspects of some monolithic entity and projected as a virtual object (‘Agoraphobia’) behind the variety of agoraphobias that were performed (c.f. Mol 1998: 161). In reality, however, every examination, conversation, designation – every publication – constituted a different ‘enactment’ of this kind of body. As Mol writes in her analysis of atherosclerosis: ‘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’ (1998: 161–2). So not only did doctors and patients enact agoraphobia, they enacted many agoraphobias through a range of practices. Not least of these were the telling and writing of the disease. But here I must also draw the reader’s attention to the constitutive epistemology of these practices, for agoraphobia cannot be understood outside the grid of culture. Judith Butler’s study of the sexing of bodies illuminates this point.

Butler (1993) contends that the performance of gender is a performance insofar as gender is a repetition of conventions and norms, and power relations so ‘cited’ and concealed. The reiteration of norms is a process that is dependent for meaning upon the creation, exclusion, and maintenance of an abjected Other – bodies that fall outside the shifting boundaries of normalcy and are, by implication, defined as abnormal – as bodies that don’t matter. As part of a productive process that unfolds within a regulative structure, 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. Abnormal bodies – in Butler’s case homosexual and in my case diseased (agoraphobic) – are thus the materialisation of norms – an ongoing structure of exclusion which, in their reiteration, create and recreate relations of power. An individual’s identity and experiences are produced, mediated, and constrained by the workings of this order.

The point is that bodies may be something that we do or enact, but the doing is (only) rendered intelligible and relevant through normative knowledge categories, as in this context with the category (and subcategories) of disease. When doctors made certain claims about agoraphobics and, for example, their excessive behaviours, they invoked certain assumptions – categories of morality – couched in the language of disease causation. There is a sense in which theories and categories mediated the practices involved in enacting agoraphobia – in which they constituted the normative conceptual structure through which agoraphobic bodies were enacted. Bodies can thus
be said, in Butler’s words, to ‘only appear, only endure, only live within the productive constraints of certain . . . regulatory schemas’ (1993: xi). In other words, a body is never just a body, but a body with normative meaning – the outcome of power relations. Ian Hacking’s discussion of multiple personality disorder further underscores this link between bodies, reiteration, and theories of disease causation:

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 (1995: 94–5).

Hacking’s remarks underscore the ontological and epistemological process of how these particular material subjectivities – agoraphobic bodies – were made intelligible through normative structures that were called up in the representation of this disease. As Hacking also writes: ‘A seemingly innocent theory on causation . . . becomes formative and regulatory’ (1995: 95).

Doctors and patients together enacted agoraphobic bodies, and these enactments derived their meaningfulness from cultural disease ideas and categories. Enactments are thus both material and discursive to the extent that enactments are inextricable from meaning structures. Given our earlier discussion of the variability of agoraphobic bodies, it is also worth noting, however, that the process of reiteration Butler describes is neither closed nor 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, so that as we have seen in the case literature, agoraphobia has not successfully mobilised as a single or complete identity. In other words, each reiteration of agoraphobic norms (the impetus to theorise and classify the disease indicates that these exist) reflects a different disease. Here, we might revisit 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’ (1998: 161). 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 patients’ bodies, different bodies politic, and different bodies of knowledge’ (Berg and Bowker 1997: 514).

Thus, the concept of reiteration illuminates an understanding of agoraphobic bodies as (multiple) enacted reiterations in three respects. First, as we have seen, 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 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 agoraphobic bodies have historically materialised. In this respect, 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 authority accorded to (medical) science.

Second, reiterations are necessarily open-ended and this is confirmed by the variable images of agoraphobia that manifest in the case histories. Each reiteration of agoraphobia was different and particular – in terms of socio-historical context, the patient presenting, the doctor diagnosing, the method of apprehension and treatment, theory of causation, and so forth. The range of agoraphobic patients that presented themselves to physicians combined to generate a single discourse – a discourse of agoraphobia – but this study reveals that a plurality of different ideas about agoraphobia helped to enact a plurality of agoraphobic bodies. That several theories of causation and classifications of the disease were in circulation over time and often at the same time – that the discourse of agoraphobia was fragmented in this respect – destabilises the notion of an agoraphobic body, as well as the notion that agoraphobia was a unified production. This sense of friction and plurality calls into question contemporary lay and medical notions of what agoraphobia is, and has implications for how other pathologies are understood. The social process of classification, as it both relates to and produces ontologically variable phenomena, is disrupted and the problem of order that is imposed by the categorisation of ‘symptoms that matter’ is exasperated. 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 place the practices 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 also say that agoraphobic bodies were the outcome of knowledgeable practices in that they represented the enactment of knowledge categories. In attempting to impose stability on their patients’ bodies, medical theories guaranteed these symptomatic beings a recognisable and enduring social existence (c.f. Butler 1997: 20), even while exacerbating their instability through the open-endedness of norms. Discursive categories were necessary for meaningful material existence, and at the centre of this process was the social differentiation of these bodies through the process of abjection, the constitutive distinction made between the normal and the
pathological. In sum, agoraphobic bodies enacted by the writing of clinical articles (and other practices engaged in by both doctors and patients) derived their intelligibility through the regulative and normative meaning structures of medical discourse.

The subject-object: a return to Foucault

The embodiment of agoraphobia is thus a material-discursive mobilisation in that the theories, ideologies, and structures of cultural-medical categories are reiterated and enacted by physicians who treat and publish case reports about their agoraphobic patients, necessarily calling up these categories in the process. In fact, borrowing from Barad (1998) we could say that doing agoraphobias reflects an ‘intra-action’ of enactments and reiterations. Enactments and reiterations are equally pluralistic, but also indistinguishable to the extent that enactments of agoraphobia can make no sense outside a normative conceptual order that designates which aspects of agoraphobia shall be ‘given to be seen’ (Rajchman 1991). Mol and Law’s (1999) theory of the body as enacted gives an account of the practical and active component of embodiment, enabling us to theorise practices associated with agoraphobia, not the least of which has been the publication of clinical literature, as central elements to its enactment. As I have tried to demonstrate, however, actions are necessarily attached to meaning structures and it is in this respect that agoraphobias were at once reiterated and enacted. In other words, the body is not merely where a disease happens, but is, also, the material-discursive instantiation of a deeply social contestation: the theories of disease and the ideas about culture and the social that are invoked in writings about agoraphobia amount to the deployment of discursive structures of abjection that regulate the material intelligibility of this disease. Pushing this further, the enactment of bodies through particular practices involved as well the enactment of certain exclusions of bodies, and of diseases not enacted.

As we saw at the beginning of the discussion, Foucault’s ideas illuminate the extent to which patients were the subject-objects of modern disease discourse, of the Clinic and its gaze. But Foucault’s subject-object may not permit us to transcend the dilemma of conceiving the body in either material or discursive terms. He demonstrates that phenomena are the effects of power-knowledge systems and boundary-drawing projects that make some identities or attributes intelligible to the exclusion of others, but the identities or attributes that are measured as part of such boundary projects do not represent inherent properties of subjects or objects. Indeed, subjectivity and objectivity are constituted through and within particular practices – they do not pre-exist (see Barad 1998: 106). I contend that it is necessary to extend Foucault’s concept of the subject-object, and I have attempted to do so by considering the role of the material-discursive in agoraphobia. I have tried
to show that diseased bodies are intra-acted in and by published case histories (along with other things).

Yet, almost in spite of this critical reformulation, the ‘old’, dualistic genre of medical knowing is still evident in the case histories that I have reviewed. Practitioners scrutinise disease in a very particular way that is the driving force, the essential ideology of medical 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 pathology essentially defines an individual’s very identity. The agoraphobe is a subject-object in relation to the discipline of medicine and its gaze. The articles intensify this by compromising the subjectivity of the unique person who presents with her/his unique and highly personal(ised) set of agoraphobic symptoms. At the nexus of contradictory normative demands and shifting material-discursive apparatuses, is a particular individual, yet the 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 and materialisation of agoraphobic bodies, but it is important to preserve Foucault’s insight into psychiatry as a set of power relations, relations that are central in the history of psychiatry in general and agoraphobia in particular. I am not quite ready to let go of Foucault’s subject-object, then, for without it there would be no pathological Other(ing) by/for the Clinic to take as problematic. I maintain that agoraphobic bodies occupy a theoretically vital position in relation to the Clinic, and the process of their subjectification-objectification has been an implicit concern here alongside my endeavour to provide a material-discursive account.

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Notes

1 And still are today, vis-à-vis the category ‘depression’.
2 This discussion is based upon 19 selected English-language reports of agoraphobia (plus a number of references to the disorder from Freud’s writings) that are largely representative of the literature on agoraphobia between 1871 and
1930. British and American practitioners wrote most of these texts, but translated pieces (psychoanalytic) have also been included.

3 Copyright note from Mol and Law: This online paper may be cited in line with the usual academic conventions. You may also download it for your own personal use. This paper must not be published elsewhere (e.g. mailing lists, bulletin boards, etc.) without the author’s explicit permission. But please note that it is a draft for discussion only. Many of the sources derive from presentations at recent seminars for which I have not cleared authors’ permissions to make formal attributions. Please therefore do not quote from this paper. If you cite, copy or quote this paper you must include this copyright note, this paper must not be used for commercial purposes or gain in any way; note you should observe the conventions of academic citation in a version of the following form: Annemarie Mol and John Law, ‘Situated Bodies and Distributed Selves: Enacting Hypoglycaemia’ (draft) published by the Department of Sociology, Lancaster University at: http://www.lancaster.ac.uk/sociology/stslaw5.html

4 The chronological inaccuracies 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 because the ‘gaze’ he describes has become a common point of departure for critiques of medicine.

5 Perhaps the best example of this view of bodies is found in Susan Bordo’s work on anorexia (1993). She locates the aetiology of eating disorders in the distorted body images contained within popular representations of women, thereby constructing girls and women as dupes of the media. This view also presumes that all anorexic women respond to these images in the same way and for the same reasons, failing to account for male anorexics as well as women who do not become anorexic in response to what they see.

6 I owe this insight to Jacalyn Duffin.

7 The sinus pocularis is the lacuna in the prostatic part of the urethra (Thomas 1993: 1803).

8 See for example Dowbiggin (1991: 1) and his discussion of a similar tendency in 19th century French medical literature.

9 His cases, ‘Little Hans’ (1955 [1909]), a five-year-old boy with a phobia of horses, and ‘Wolf Man’ (1955 [1914]), named for a dream this man 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 Freud published on agoraphobia per se was actually relegated to a footnote (see Freud 1955 [1893]: 112–4 fn 2).

10 This jump from diseased minds to diseased bodies may strike the reader as problematic. I would however argue that agoraphobia represents the conceptual inadequacy of this particular dualism par excellence. As Shilling astutely observes, the mind is inextricable from the body ‘as a result of the mind’s location within the body’ (1993: 13; my emphasis).

11 I owe this insight to Bart Simon.

References


