SELF/DISCIPLINING/BODY: A GENEALOGY OF OSESSEIVE-COMPULSIVE DISORDER

by

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Abstract: In this thesis, I posit and elucidate a relationship between processes of cultural knowledge production and the so-called psychiatric syndrome, obsessive-compulsive disorder (OCD). Using a primarily Foucauldian-derived framework, I draw from the work of major writers in the sociology of the body to produce a reading of Western culture through the embodiment of the disorder. I argue that many of the symptoms and characteristic experiences of OCD can be reconceptualized as expressions of, and engagements with, positively valued cultural beliefs, discourses and practices. In particular, my analysis centres upon discourses and processes of the self, body dualism and risk, and the way in which these are manifested in social bodies and spaces. In so doing, I call attention to the arbitrary distinctions between 'normal' and 'abnormal' psychology and behaviour, and between mentally 'ordered' and 'disordered' persons.
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Introduction

Using his own vocabulary, Boutroux said that even the most general laws of psychology are relative to a "phase of mankind". For a long time now, one fact has become the commonplace of sociology and mental pathology: mental illness has its reality and its value qua illness only within a culture that recognizes it as such. Janet's patient who had visions and presented stigmata would, in another country, have been a visionary mystic and a worker of miracles. The obsessional who moves in the contagious world of sympathies seems, in his propitiatory gestures, to revive the practices of the primitive magician: the rituals by which he circumvents the object of his obsession assume, for us, a morbid meaning in that belief in taboo with whose equivocal power the primitive wishes, normally, to be reconciled and of whose dangerously favourable complicity he wishes to be assured (Foucault, 1986 [1954], pp. 60-61).

There is an interesting history behind Michel Foucault's *Mental Illness and Psychology*, the text from which this opening passage is taken. Originally published as *Maladie Mentale et Personnalité* (Mental Illness and Personality) in 1954, the book was divided into two parts: an account and description of known mental pathologies and predominant psychiatric theories (particularly Freud's work) and a brief attempt to situate mental health conditions within sociohistorical
contexts. Foucault chose to revise the second part of the book in 1982, shortly after the first French publication of his far better known *Histoire de la Folie* (Madness and Civilization), and the changes he made illustrate key shifts in the development of his critique of Western history's deployment of power and knowledge. As the change in titles indicates, the revised edition sought to implicate disciplinary knowledge, rather than individual pathology, in the appearance of mental disorder. Thus, while the majority of Part 1 of *Mental Illness and Psychology* remains largely intact (and somewhat unrecognizable for those of us who were introduced to Foucault's later work first), the second half of the book has been dramatically altered. In Part 2, Foucault presents a clear and deliberate critique of Freud and traditional psychology and a history of its ultimate commitment to the idea of mental illness as a morbid physical reality rather than social and cultural construction.

There are a number of reasons behind my decision to begin this thesis by recounting this story. Most obviously, it is a convenient introduction to both the question I am dealing with-the relationship between obsessive-compulsive disorder (OCD) and culture- and the critical spirit in which I undertake this project. My main concern is to suggest and explore a few entry points from which to begin an examination of the conditions of cultural life in Western societies that situate OCD and make it intelligible. The most basic question behind the thesis is therefore, 'In relation to what, exactly, is OCD disorderly?' What this means to me is emphatically *not* that I will, in the proceeding arguments, reveal the unknown 'truth' about obsessive-compulsive disorder, although I do hope to present some
insights that will enable thinking about the condition in novel ways. Rather, I understand my work as most directly expository of the patterns in cultural beliefs, priorities and processes that make OCD visible, perceived and experienced as it is. Thus, while this is in many ways a 'reading' of OCD, it is more importantly a translation of culture voiced through the heuristic language of the disorder.

Genealogy of the Thesis

There are two parallel themes that comprise my fundamental argument. First, I contend that in the symptoms and characteristic experiences of OCD can be seen extensions of otherwise 'normal' cultural beliefs and values, which blur the distinction between states of mental illness and wellness. Second, I argue that these same beliefs and values also organize Western culture's appreciation of psychological order and disorder, and so yield the potential for these symptoms to be understood as indicating a discrete category of pathological mental difference. Thus, cultural knowledge production is the central issue in my thinking. This approach to writing social theory is indebted to Foucault, and may be characterized as an examination of the 'conditions of possibility' by which particular social realities and developments are enabled (Rose, 1998). This brings me to my second reason for beginning with Foucault; the method, as well as the content, constitute important conditions of possibility, as it were, for my own work. So, while there are aspects of each that I hope not to reproduce (such as his characterization of 'primitive' people' or what many have criticized as an inattentiveness to human sensuousness and the immediacy of experience), I
want to acknowledge that this work could not exist without these influential ideas and the long line of theorists to have taken them up. Many of these writers' own work appears in these arguments.

Third, and more personally, the change that occurred in Foucault's understanding of mental health and illness gives me a chance to say something about the development of my own thinking about OCD and mental disorder. Through random circumstances, I have been intimately involved with people with obsessive-compulsive disorder for the last twelve years, close to half of my life. My initial response to this twist of fate was not remarkable. The nature of the relationships it affected was such that my first understanding of OCD was, at my most generous, that the disorder was an objective and painfully distressing condition that caused unthinkable disruptions in the lives of people I care for. At my worst, I felt that OCD was an irrational weakness unfairly imposed upon me by others as a condition of our relationship, and that accommodating it was a massive interference in my life.

I will not try to describe the tension this caused, except to say that it became productive, in a strange way. These people were sufficiently considerate and trustful of me to describe what anxieties they felt about the world, why they responded to these as they did, how they felt about themselves both individually and in relationships as a result and ways I could be of support or hindrance. Many of the ideas and insights I present here are not originally or exclusively my own, but rather reflect what I have been told about what it is like to experience, interpret and try to function with OCD. Through long conversations, I began to
see the tension as a product of conflicting sensibilities about the world and how to operate within it, and that this conflict existed within these people I care for, as well as between us.

This exposure had a number of important effects. It became clear to me that when such views conflicted, a certain set of ideas was always and automatically privileged, while another (the 'disorderly' one) was always marginalized. I began to examine (ironically, first as a way of substantiating my side of arguments!) the bases of many of my foundational assumptions about what constituted normalcy and 'order'. I realized that the world is accommodating towards some kinds of difference, and illnesses, and harsh to others, and that OCD lands squarely within the latter category. As well, I started to become aware that while the anxieties I was hearing about and living with were obviously amplified they were not per se very different from concerns and feelings voiced by 'normal' people in 'normal' contexts, myself included. In light of this contradiction, I felt angry at the fact that in addition to the gut-wrenching material difficulties OCD brings, there existed virtually no acknowledgement of these cultural aspects, particularly by mental health professionals. This might at least have reduced some of the indignity and shame of being coached to see oneself as fundamentally different from, and lesser than, others.

This amounted to a fairly inarticulate, but nonetheless passionate, conviction that the notion of disorder is ambiguous, a matter of degree and highly contradictory, as I shall explain in the body of the thesis. For much of the time that I was 'growing up' around OCD I was, by coincidence, taking an
undergraduate degree in sociology as well. This introduced me to questions of social power and knowledge, and the notion that things commonly taken as objective, like race, gender, sexuality and disability could be understood as constructed through cultural processes and in support of particular interests and interpretations of the world. I believe that over time, a more sophisticated understanding of these processes and the issues in theory and practice that surround them has sharpened my ability to articulate problems of OCD and culture. We shall see.

OCD as Cultural Metaphor

In this thesis, I suggest that OCD can be understood as reflecting both deep collective anxieties about acceptable or unacceptable social behaviour and social relations of power that produce that judgment. I also wish to explore, as a preliminary project, the profoundly cultural nature of OCD, and to outline some aspects of Western cultural life which serve to produce and regulate the disorder. In so doing, I wish to move beyond the understanding of OCD as a purely biological anomaly and suggest that as a 'disorder', it is grounded in and governed by multiple and intersecting cultural and social ideas, which are expressed both normatively and symbolically, in social, cultural and political life.

In order to provide a reference point throughout the thesis, a working understanding of what is understood to constitute obsessive-compulsive disorder, within dominant perspectives, is useful. The American Psychiatric Association’s (1994, pp. 417-423) Diagnostic and Statistical Manual of Mental
Disorders (DSM) is widely considered to be the final authority on delineating mental difference, and requires the following criteria for diagnosing OCD.

A. Either obsessions or compulsions:

**Obsessions as defined by (1), (2), (3), and (4):**

(1) recurrent and persistent thoughts, impulses, or images that are experienced, at some time during the disturbance, as inappropriate and that cause marked anxiety or distress

(2) the thoughts, impulses or images are not simply excessive worries about real-life problems

(3) the person attempts to ignore or suppress such thoughts, impulses, or images, or to neutralize them with some other thought or action

(4) the person recognizes that the thoughts, impulses, or images are a product of his or her own mind (not imposed from without as in thought insertion)

**Compulsions as defined by (1) and (2):**

(1) repetitive behaviours (e.g., hand washing, ordering, checking) or mental acts (e.g., praying, counting, repeating words silently) that the person feels driven to perform in response to an obsession, or according to rules that must be applied rigidly

(2) the behaviors or mental acts are aimed at preventing or reducing distress or preventing some dreaded event or situation; however, these behaviors or mental acts either are not connected in a realistic way with what they are designed to neutralize or prevent or are clearly excessive

B. At some point during the course of the disorder, the person has recognized that the obsessions or compulsions are excessive or unreasonable. Note: This does not apply to children.

C. The obsessions or compulsions cause marked distress, are time consuming (take more than 1 hour a day), or significantly interfere with the person's normal routine, occupational (or academic) functioning, or usual social activities or relationships...

The disorder is equally common in men and women, and is estimated to have a lifetime prevalence of 2.5% of the general population, or 1.5%-2.1% in any given year (p. 420). The most common obsessions focus on contamination and germs, repeated thoughts of doubt (over, for example, causing harm to others), a need to have things in a particular order, aggressive impulses and sexual imagery.

Compulsions tend to be driven by obsessions, and the most common compulsions include washing and cleaning, counting, checking, requesting or
demanding assurances, repeating actions and putting things in order. Although it is not entirely clear to me that different manifestations of the disorder constitute distinct subtypes, I would like to clarify that for the most part, I will be dealing with obsessions and compulsions that are chiefly concerned with contamination, cleanliness and washing.

Whereas this seems a fairly straightforward outline of a disorderly state, I suggest that matters may not be so clear at all. Some ambiguity is even admitted by the APA:

Culturally prescribed ritual behavior is not in itself indicative of Obsessive-Compulsive Disorder unless it exceeds cultural norms, occurs at times and places judged inappropriate by others of the same culture, and interferes with social role functioning (p. 420).

Moreover, it appears that a great number of other conditions share so many of obsessive-compulsive disorder's symptoms that even trained professionals are likely to misdiagnose them as OCD. This list includes: Generalized Anxiety Disorder Due to a General Medical Condition; Substance-Induced Anxiety Disorder; Body Dysmorphic Disorder; Specific or Social Phobia; Trichotillomania (hair pulling); Major Depressive Episode; Generalized Anxiety Disorder; Hypochondriasis; Delusional Disorder; Schizophrenia; Tic Disorder; Stereotypic Movement Disorder; Eating Disorders; Paraphilias; Pathological Gambling; Alcohol Dependency or Abuse; Delusional Disorder; Obsessive-Compulsive Personality Disorder; superstitions; repetitive checking behaviors; and the rather cryptic Psychotic Disorder Not Otherwise Specified (pp. 421-422).

We can see pathologized in this list a vast range of feelings, urges and behaviours that, depending upon their intensity, apparently indicate psychoses.
More importantly, while the fact that many of these could potentially be mistaken for OCD seems to indicate a certain formlessness, or at least flexibility, to the criteria of that disorder, its ambiguity extends far beyond the simple presentation of unusual symptoms. The vagaries of the category call attention to central concerns about the 'cultural' nature of OCD and mental illness more generally. Accordingly, my argument is that much of what is taken to indicate OCD can be reconceptualized as literal or metaphorical expressions of popular cultural beliefs, discourses and practices. For example, I will argue that a collective preoccupation with health and disease is individually embodied in OCD, much the same way as it has been argued that anorexia/bulimia nervosa can be seen as a metaphor for the social subordination of women and rejection of particular kinds of female bodies. Thus, through a close analysis of the role of cultural processes in the experience and perception of the disorder, I hope to problematize the rarely-questioned conceptual separation of normal and abnormal psychology, as well as the corollary validity of categories of mentally orderly and disorderly persons.

This is not to suggest that the experiences of people with OCD are anything less than 'real', nor that these individuals are in any way either discursive puppets or personally accountable for their difficulties. A tendency to investigate questions of medical truth, cause and individual agency in terms so simplistically interrelated is, in fact, an important component of the way OCD's meaning in relation to culture is fixed, one of its conditions of possibility. Rather, I have assumed and emphasized that it is possible for OCD to be seen
simultaneously as a construct of knowledge and a material phenomenon of staggering proportions. Thus I argue throughout my discussion that many aspects of the form and experience of OCD can actually be seen as sensible, self-directed actions and viable expressions of reflexive agency. My concern is not what causes OCD, but what is articulated by it.

This question is imported from Susan Bordo's (1993) analysis of anorexia nervosa, as is the methodology of the thesis. For Bordo, anorexia is an exaggeration of discernable patterns in the modal and historical logic of the present cultural moment. These patterns, whose intersection appears as anorexia, she terms 'axes of continuity', insofar as their extrapolations can be observed in far less obvious norms and behaviours. The three such axes that organize her discussion are the dualist axis, the control axis and the gender/power axis. Individually and/or collectively, suggests Bordo, these convergent streams can be understood as revealing contemporary and historical affinities between anorexia and culture, and so between anorectic and healthy women. Thus Bordo's axes, and her argument more generally, take the body as their central object of concern, both as it appears in the grip of discursive practice and power, and as it is lived phenomenologically through/with anorexia.

This is an interesting approach to theorizing mental disorder, if for no other reason than that it encourages critical thought about the everyday division of experience, including illness, into the distinct realms of the mental and the physical. A particular focus upon the body and issues of embodiment is one feature of Bordo's model that I retain in my treatment of obsessive-compulsive
disorder. As well, I have organized my discussion into separate dimensions of
cultural thought and practice, which are instructive for thinking about OCD.
Loosely, these deal with 1) a relationship between selfhood and disorder; 2)
body-mind dualism; 3) cultural constructions of risk and security; and 4)
manifestations of the first three in spatial relations and culture. The nature of
these dimensions is such that in practice they overlap and seep rather
 uncontrollably into one another’s domain; it is rather naive, for example, to
suggest that questions of ‘the self’ and ‘body dualism’ can ever be fully isolated
from one another. Of course, such distinctions are far easier in theory, and are
heuristically necessary. The chapters correspond to this arrangement.

Chapter Overview

Chapter One takes up theories of how cultural production and
reproduction is accomplished through individual subjectivities, or processes of
identity and self-formation, and of the relevance of the body in shaping
perspectives upon the self. I argue that while these processes apply to both
orderly and disorderly cultural embodiments, a more sophisticated understanding
of subjectivity is required to negotiate the pitfalls of essentializing the self,
reducing disorder to biology or undermining the personally meaningful character
of individual social action, or agency. Nikolas Rose’s explication of the
‘genealogy of subjeckification’ is used to suggest that contemporary notions and
practices of the self can be understood as both regulated cultural objects and the
material projects of recognizable individuals. Rose’s work implicates the
emergence of 'psy' (-chology, -chiatry, -choanalysis) disciplines in the installation of a paradoxical regime of 'obligatory freedom', and the creation of categories of mental health and illness, and links this to liberal politics of ever-increasing progress through world mastery. My argument is that with agency and mental health thus conflated and normalized, any form of mental difference that appears to display a lack of autonomy, as in OCD, is automatically selected for marginal status. In contradiction to that status, I present some possibilities for how individual mental disorders could be framed as positive attributes or skills.

Chapter 2 focuses more explicitly upon the body and its role in the cultural production and embodiment of the mental as positively or negatively valued states of personhood. Western thought's historical reading of the body is situated within a larger tradition of mind-body dualism, in which the physical is always the lesser valued. I argue that a residual disdain for the body is manifest as a contemporary ethic of body-mastery and that this frames the perception and experience of OCD. At the level of formal knowledge systems, this is discernable in both psychological and physiological medicine's appraisal of the body as an indicator of mental and physical health. For individuals with OCD, the body can be understood as both a problem, constituted as a vulnerability and source of anxiety to be quelled through creative mental labour and, paradoxically, as the mechanism through which mental strategies for relieving anxiety are realized. Thus reading through OCD both accommodates and resists cultural constructions of mind and body, and their distinction, blurring the coherent boundaries of mental agency and bodily deficiency. I conclude by suggesting that
a notion of compulsory health be considered alongside, or as a component of, Nikolas Rose's notion of 'obligatory freedom'.

This theme is carried through to Chapter 3, which is concerned with the real and perceived dangers associated with failing to be healthy, and the way these circulate and develop over time and space. I argue that the nature of an individual understanding of, and accordant response to, these dangers is an important difference between people with and without obsessive-compulsive disorder. This chapter charts political, technical and epistemological developments that have precipitated important changes in the ways risks are created, understood and managed, collectively and individually, in Western societies. Risk discourses proliferate in number and complexity, and many centre upon the vulnerability of bodily health, which is increasingly treated as an individual burden to manage in one's life as a condition of citizenship. Ironically, in this risk-obsessed culture people with OCD, who frequently appear the most cautious about health, are conceptualized as diminished, rather than ideal citizens. I discuss further relations of OCD and risk in the context of individual sense-making, lifestyle and problems of identity, attachment and self in the late/post modern era.

The fourth and final chapter tries to elucidate the position that questions around self, body and risk, as viewed through OCD, relate to and within ideas and practices of cultural space. I consider space and separation as important concepts behind how mental difference is perceived and marked as 'Other', as well as ways in which the spaces of body and world are taken up through models
of boundaries, penetration and regulation in the presentation of the disorder. From this, I glean a number of principles by which people with OCD operationalize a response to body contamination, and argue that these rules are closely reproduced in everyday sociospatial relations that seek to exclude persons, practices or other matter defined as undesirable or polluting. Thus, the disorder can be seen as somaticizing in various 'obsessive-compulsive spaces'. My concluding comments follow.
Disciplining Difference: Obligation, Compulsion and Disorderly Subjectivity

The broadest aim of this thesis is to lay a conceptual foundation for what might be referred to as a reading of culture in the psychological condition obsessive-compulsive disorder (OCD). The most immediate 'topic' of the thesis, therefore, is not OCD per se, but rather culture, and the ways in which it produces and perceives difference between people. By this, I mean to critically examine the role played by culture in the constitution of the disorder and to argue that many of the symptoms that indicate OCD can be reconceptualized as performances of popular cultural beliefs, discourses and practices. In so doing, I hope to trouble what I believe to be a too-often taken for granted distinction between normal and abnormal psychology and behaviour and, by extension, the corresponding distinction between mentally ordered and disordered persons.
This approach to OCD echoes recent\(^1\) or groundbreaking theorizing of other mental disorders, such as depression in women (Stoppard, 1998), paranoia (Harper, 1996) and particularly Susan Bordo's (1993) treatment of anorexia nervosa, insofar as it uses a discursive framework to describe the body of a sufferer as something like a storehouse of and/or site for the expression of collective assumptions, values or anxieties; a repository of cultural definitions. Contested ideas pertaining to women, the body and social power, Bordo argues, are reflected and reproduced in anorectic embodiment, and are evident in anorectic women's narratives of their experience. Cultural problems and contradictions are thus 'voiced' as pathology; figuratively, the body 'speaks'. Similar conclusions are made by Bryan S. Turner (1992, see also 1996 for more of Turner's sophisticated treatment of anorexia), who combines his own work with that of Hilde Bruch in describing anorexia nervosa as a 'talking disease'.

There are a number of strengths to these approaches. One is that by exploring the relationship between normal and abnormal bodies, psychology and behaviour, they effectively reveal the paradox inherent to the cultural practice of stigmatizing behaviours and feelings, which are often unproblematic or even valorized, when they appear exaggerated or in greater concentrations. To continue with the example of anorexia, being too concerned with body size and eating is one kind of disorderly state, but being insufficiently concerned with it is another. By implicating culture in this way, it is possible for social theory to argue

\(^{1}\) Bordo's influential chapter, 'Anorexia Nervosa: Psychopathology as the Crystallization of Culture', was originally published in 1985, and her work on anorexia dates back to 1983.
against the stigma of mental illness without resorting to biologic and/or causal 'explanations'.

Also, these authors do not imbue the monolith 'culture' with any undue sense of agency. Rather than suggest that certain floating discourses are preying upon hapless individuals, they emphasize ways in which 'a variety of cultural currents or streams converge [and] find their perfect, precise expression' in particular syndromes (Bordo, 1993, pp. 141-142, parentheses added). Thus, I will argue in later chapters that there is an important continuity between a person with OCD who cannot escape the urge to wash their hands and, for example, the warning voiced in television commercials for many sanitizing products that dangerous germs proliferate unseen all around us, and that the best way to protect ourselves and our families from this serious health risk is through the use of this or that household bleach or soap.

This model does, however, make a difficult assumption about the relationship of the general -culture- to the particular, the individual. It is not adequate to simply suggest that because there are similarities between obsessive-compulsive and normal anxieties, that the disorder is entirely and exclusively a social construct. Not only would this be entirely disrespectful of those people for whom the reality of OCD is painfully immediate, it also overlooks an opportunity to take up a central problem for social theory. To put it plainly, how is it that cultural values and other notions that circulate about sources of anxiety and the 'abnormal' individual are actually taken up by people and become part of their understanding of the world, themselves and their daily lives?
The question does not pertain exclusively to theorizing mental disorders, but indicates a need to elaborate on the mechanism(s) by which real people come to embody discourses to the extent that they become visible, in practices understood as mundane or as pathological. It is therefore a question of the place of identity and subjectivity in such cultural contexts, and needs to be considered in relation to how and why people become invested and locate themselves within this or that system of historically and locally specific ideas, values, epistemologies or other explanatory frameworks. For brevity's sake, I will simply call these 'systems, and their content, cultural knowledge'.

This chapter is intended to present some possibilities for thinking towards a partial resolution of this problem. It is a central component of the arguments I will present here that in particular, the body is key to Western culture's appreciation of both subjectivity and OCD, and I will elaborate upon this below. The immediate issue is a question about how any cultural knowledge, not simply that which reveals obsessive-compulsive or otherwise disorderly tendencies, is negotiated and manifested by individuals as they develop a coherent sense of their world and a position from which to act and be recognized in it. In the past, I have tended to answer this question by reference to the production of self and identity (Paul, 2001).

Object Relations

It remains something of a truism in social psychology that the self results from considering and addressing oneself from the standpoint of attitudes and
beliefs of others, which are learned in the course of social experience. George Herbert Mead, who is frequently credited with the introduction of the self to sociological study, refers to the internalized totality of these as the 'generalized other', and suggests that 'the self reaches its full development by...thus becoming an individual reflection of the general systematic pattern of social or group behavior in which it and all others are involved' (1934, p. 158). In Mead's reasoning, the unique feature of human subjectivity is that 'the self has the characteristic that it is object to itself' (p. 136). Social persons can and must reflect upon themselves, and respond as an individual to their interpretive organization of the attitudes and knowledge of others. The variability of social experiences and interactions, however, means that no two individuals develop 'self' in precisely the same way. The affiliations and differences that are produced in this way can be understood as 'identity', or one's understanding of oneself in relation to others, and of one's coherent location within the social order. This assumption forms a crucial basis for Mead's symbolic interactionism and more generally for those perspectives collectively called 'object relations' theories, which seek to articulate the ways in which individual identity is connected to the context in which it emerges (Sibley, 1995).

It is possible to approach OCD as something like an identity that is thus 'learned' through interaction and object relations. Such a treatment might go like this: in the normal and necessary process of assuming and reconstructing self and identity, people inevitably come in contact with culturally-specific ideas about germs, contamination, disease and so forth. The way this information is
interpreted, however, depends very heavily on individual social experience\(^2\), meaning that people's responses (both in psyche and in behaviour) range broadly. For some people, the concerns expressed will resonate much more severely than for others, provoking a response so extreme that it is defined as a kind of illness. However, I could argue, most people respond to discourses about the dangers of germs in one way or another, and many of these differ from those designated 'obsessive-compulsive' in degree more than in form. The implication of this argument would be that since OCD is in some ways continuous with normal thought, its difference is largely a social construction and the stigma associated with it is unjustified.

This is a very rough restatement of a general argument I've made before and, indeed, aspects of this reasoning reappear throughout this thesis. But its usefulness expires at a point, and while this position previously been helpful for organizing my thinking, it does not fully resolve the problem I introduced above. In fact, if it successfully destabilizes the notion of disorder in this way, it has done so only by galvanizing the irreducibility of the notion of self. If the arbitrariness of the disorder is to be explained by reference to the work of an essential self, I need first to address how the self has come to be understood as so immovable in social life and social theory. Only when that is done can I move credibly into more elaborate discussion of the relationship of OCD to notions and processes of the self and social location.

\(^2\) The notion of unique experience could incorporate the differences in brain chemistry and functioning that many researchers (outside of social theory) argue cause OCD (Rapoport, 1989).
This is not, I want to qualify, to suggest that object relations theories invariably interpret the self's irreducibility as inertia. In fact, the perspectives I draw upon later in this chapter are heavily influenced by object relations, and are unified and selected by virtue of their tendency to emphasize the dynamic nature of learning and subjectivity and, therefore, of identity. As Mead (1934, p. 178), asserts,

The self is not so much a substance as a process in which the conversation of gestures has been internalized within an organic form. This process does not exist for itself, but is simply a phase of the whole social organization of which the individual is a part.

The suggestion here is not only that the self emerges in social experience, but also that this process reciprocates by capacitating social life. There is a first hint here as to why the self is accorded the status that it is; Meadian analysis privileges the ever-present communication of the thinking individual and the imagined collective as the basic unit of society, and needs a thus-operationalized concept of the self to do so. This is so fundamental to such analysis, and also so intricate, that 'we do inevitably tend at a certain level of sophistication to organize all experience into that of a self' (p. 135, emphasis added). From this perspective the self is not exactly 'natural', but is nonetheless so intertwined with other considerations that trying to distinguish it from these is rather like trying to unscramble an egg: possible conceptually, but not in practice. My argument is that while this is helpful to a point, a more agnostic approach to the self yields more productive possibilities for engaging with questions of social learning, subjectivity and the notion of an 'abnormal' psyche. With that in mind, I want to consider how, as socially and culturally governed categories of being, Western
notions of self and identity can be related to the production and regulation of metal disorder and OCD.

The Psy Complex: Disciplines of the Self

My chief objection to Meadian symbolic interactionism is that on its own, it fails to address the compelling power relations inherent to a logic of the self that has so pervasive a grasp over the way we frame experience. As such it is difficult, from this perspective, to critique those exercises in cultural knowledge and discipline that produce and stigmatize OCD as a distinct and undesirable category. It is worthwhile to try to understand how it has come to be that the self appears so unproblematic in our understanding of subjectivity. This requires centralizing power relations in analyses of both the self and mental difference.

These issues have been productively taken up by Foucauldian scholarship. Indeed, Foucault (1982) characterizes the latter two-thirds of his own work as studies of the ways by which persons are made distinct from one another and questions of how a human being turns him- or herself into a subject. In Inventing Our Selves: Psychology, Power and Personhood, Nikolas Rose (1998) builds on this project in the interests of articulating a critical history of the concept of self, which he calls a 'genealogy of subjectification' (p. 23). His primary concern here is to specify the disciplines and practices that have co-operated in constructing the current state of affairs, in which as human beings, we understand and address ourselves in reference to an individuated mental interiority we call 'self'. He presents an intricate and multifocal argument to that
end, from which I will extract a number of points that are of particular relevance to my own project. The first of these is the suggestion that the modern sense of self is intimately linked to the emergence of the 'psy' disciplines, those professionals and perspectives that claim formal and special competence in understanding 'the inner determinants of human conduct [and] ability to provide the appropriate underpinning, in knowledge, judgement and technique for the powers of experts of conduct, wherever they are to be exercised' (p. 13). In staking that claim, they are aligned, at least in origin, with other specializations of knowledge such as medicine, criminology and indeed, early sociology, which have sought to impose or expose conceptual structures upon and within the world of social beings. Such ordering can be understood as a rationalization project, and has been accomplished to a great extent through the creation of categories of person, and the organization of actual persons according to those categories. As Rose argues,

One fruitful way of thinking about the mode of functioning of the psychological sciences...might therefore be to understand them as techniques for the disciplining of human difference: individualizing humans through classifying them, calibrating their capacities and conducts, inscribing and recording their attributes and deficiencies, managing and utilizing their individuality and variability (p. 105, emphasis original).

In this way, psy has worked to normalize a notion of rationally individuated subjectivity through a systematization of the abnormal individual, simultaneously creating that domain and affirming its authority within and over it. Finally, Rose suggests that the popularization of this mode of encountering people is intrinsically related to the development of political ideology and power in liberal democracies, to both government and
governments. This is partly illustrated in the sciences of difference noted above, a major purpose of whose deployment is to inform and direct social policy and other authoritative action. Rose calls particular attention, however, to the importance of the notion of freedom in liberal ideology. The construction of the political subject of such a regime emphasizes the qualities of liberty, autonomy and choice, but the governance of these citizens means '…ruling them through their freedoms, their choices and their solidarities rather than despite these' (p. 117). In other words, liberal democracy requires its subjects to act as self-governing allies of its rule. Rose positions psy as the complex of sciences in support of this priority. This is accomplished via its notion of the normal individual as an agent making choices according to the character of his/her own unique interiority, but aware that as an individual these choices also constitute the personality presented to and assessed by others. In the case of OCD, it is easy to see how compulsory freedom of normalcy inevitably diagnoses disorder in obsessive thoughts and compulsive actions, which are by definition not directed by the person who experiences them. More generally, psy presents itself as knowledge and techniques for organizing the actions of people according to this regime of ethical self-fulfillment, advising on the forms of personal, professional and political governance likely to be most rewarding (pp. 156-159). At least in the instance of the personal, the kinds of interaction and attachment that result are '…profoundly subjectifying because they appear to emanate from our individual desires to fulfill ourselves in our everyday lives, to craft our personalities, to discover who we really are' (p.17).
So, Rose's genealogy is able to expose a complex of ideological developments and practices that can be seen as a background to notions of self like those of Mead, which are somewhat allegiant towards human individuality. At the same time, it allows self-directed action, the governance and shaping of self, to be understood as utterly material to the people engaged in such projects. These can therefore also play an important role in theory's address of individuated subjectivity.

**Embodiment, Subjectivity and Abjection**

I would like to argue for the centrality of the body to most any discussions or questions of subjectivity, and for the analysis of obsessive-compulsive disorder. Equally individuated, the body is both the metaphor and the locus for processes of the self. It is popularly accepted that every body is allocated one self, and in psychological discourse, occasions in which one body appears to contain more than its proper allowance are met with a diagnosis of dissociative identity or multiple personality disorder (Sass, Whiting and Parnass, 2000). Additionally, it is through the body that the dialoguing between any individual self and society is expressed and become visible -or perhaps audible is better- as part of the 'other' to be generalized by other selves. Accordingly, there is a growing number of theorists who suggest that to know the relationship between individual and collective, we ought to learn how to decipher the signs of cultural inscription on the body (e.g. Falk, 1994; Shilling; Synnott, 1993; Turner, 1996). Many of these explicitly take the position that much of the work of the self can be
understood as serial and concurrent body-projects. In other words, the ongoing construction of the self is accomplished through a variety of body-centred practices such as sex, fitness or fashion. Prevailing and competing cultural discourses around these are thus embodied, and combine with more apparently 'natural' bodily characteristics, such as race, gender or sexuality to produce coherent trends, affiliations and differences.

Our own and other people's bodies are discursively loaded with cultural practices and attitudes, even in the most mundane of instances, which in turn regulate the ways we perceive and act towards ourselves (Foucault, 1980). The subjectivity constructed in this process is material, an embodied self and an identifying body. Some of these encoded meanings of the body are more problematic than others, and I would suggest that a relationship can be drawn between many aspects of obsessive-compulsive disorder and the ways in which these tensions are encountered and negotiated through the work of embodying culture and producing the self.

Julia Kristeva's (1982) notion of abjection offers rich possibilities for discussing the subject's embodiment of culture, and one that is particularly well-suited to addressing obsessive-compulsive disorder. Kristeva argues that a coherent and singular self requires the exclusion of anything understood as opposed, harmful or obfuscating to that identity. Abjection is the name given to this simultaneous process of definition and repulsion. The precise definitions, however, are mediated by the cultural discourses discussed above. At least in Western cultures, these have tended towards disdain or even revulsion towards
the body, compared to the 'purity' of the soul, mind or self (Synnott, 1993). I believe this problem of dualism to be of central importance to the reading of OCD, and I will elaborate upon it in chapter two. For immediate purposes, it suffices to say that the body itself, bodily fluids and wastes more specifically, as well as food, disease, germs and dirt acquire abject status because they expose vulnerabilities of corporeal existence. As such, they '...stand for the danger to identity that comes from without: the ego threatened by the non-ego, society threatened by its outside, life by death' (Kristeva, 1982, p. 71).

The process Kristeva outlines is eerily like the obsessive-compulsive concern over maintaining cleanliness and order through the avoidance or cleansing of that which is perceived as polluted or polluting to the individual. The residues, wastes, fluids, diseases and openings of the body are sources of heightened real concern for people with OCD, just as they are symbolically loaded indices of the abject. In both cases, the centre (be it the body or the self) is defended against the margin, and both depend upon cultural representations to create these categories. However, as David Sibley (1995) points out, the abject is never actually and finally excluded; rather it is always there at the ontological border of the self. This cannot be reconciled with the absolute imperative of sustained identity, placing the subject of abjection in a state of permanent anxiety over the care of the self (p. 8). Similarly, anxiety over the possibility of bodily contamination pervades OCD and painstaking efforts are made to patrol and maintain the integrity of this border through washing and cleansing. And this anxiety can be similarly enduring. Stress may be relieved
temporarity, but always returns, becoming a long term consideration in the way that people with OCD carry out their lives. The 'compulsive' responses to this anxiety can be equally interminable; in the case of washing, many people wash for hours upon hours consecutively, continuing well beyond the point at which skin blisters, chaps, cracks and bleeds, taking on an obvious rough texture and redness. If abjection refers to the tension of a selfhood under permanent threat of disintegration, the obsessive-compulsive body can thus be seen as a physical expression of a characteristic discontent of the individuated, embodied self.

From the Body-as-Text to the Textures of Self and Agency: Some Objections and Directions

Thinking through abjection reveals one way in which problems of cultural discourse, in this case concerning subjectivity and difference, are absorbed and reflected through processes of the self and become visible in the disorder. I believe this advances my reading of OCD, but it raises another problem. In emphasizing the discursive means by which the body comes to be a source of revulsion, I risk overlooking the obvious fact that this revulsion registers within the person who is that body. In many ways, this treats persons as mere textual displays, things to be read, disavowing the tendency of people to create as well as to interpret and understand the meanings generated between oneself and others. One immediate problem such a perspective raises is that it tends to reproduce the objectifying gaze characteristic of disciplinary knowledge systems, and of which I am critical in this and other chapters. In short, I would risk remaking people with OCD as exotic bodies to be consumed for the validation of
an authoritative discourse, (sociology or social theory), and my own place within that system. While I do wish to retain the objectification of oneself or one's body as an important element of my analysis, reducing self, body or conditions (like OCD) to effects or constructions of language and culture grossly underestimates the intensity of the commitments, investments and immediacy of feeling those experiences. As Arthur Frank (1991, p. 79) suggests, in actual practice, an essential quality of the body '...is that it is a body in process of creating itself'. Body and self need to be understood as sites for the production of meaning as well as for their inscription.

This is perhaps nowhere more important than in approaching states of disorder and suffering, either physical or mental. In the case of women's depression, for example, Stoppard (1998, p. 83) asserts that analyses should '...start from (but not remain with) women's experiences, experiences that are at the same time, and always, both subjective and embodied'. Bodily changes that characterize depression, such as loss of sleep, appetite and energy and recurring aches and pains, she argues, can only be understood in this way. The same can be said of OCD, in which changes in activity and life satisfaction are experienced first and foremost as distressing to the self, without consideration of whether they might be biological or constructed in origin. That this dimension of the condition is neglected by traditional, clinical psychology's emphasis upon biochemical constituents is fairly straightforward. Stoppard's point is that another error is committed by overzealous discursive efforts, whose interest in refuting these claims may ironically ignore the overwhelming impact the disorder can
have on social life. The utter materiality of embodiment and selfhood is easily
discounted if either or both the disorder and the biological entity in which it is
located are approached as simple texts to be read.

Innovative theorizing of the body and self may be the key to avoiding both
cultural and biological reductionism. The most productive and respectful of these
would properly embrace both materialist and sociolinguistic perspectives not only
on health and illness but also on social life and social individuals more generally
(Yardley, 1996). For example, it may be possible to agree that subjectivity is
constituted in discourse but that it nonetheless occupies so fundamental, widely
enacted and agreed upon a position in our apprehension of the world that it may
be more practically understood as a sort of necessary and shared illusion. As
well, the personal and individualized character of different people's embodiment
or production of their own 'self', in this formulation, speaks against the tendency
for discursively derived theories to render persons as automatons or overly
determined cultural dupes. Thus there might be room in discourse for agency,
conflict and immediacy of experience (Rose, 1998). Similarly, it can be agreed
that the body is also a cultural artifact, inseparable from the attitudes and
corresponding practices in which it is constituted. However, the internalizing and
representation of the social world of the individual is accomplished through
everyday uses of the body in the vested interests of persons (Radley, 1998).
Through the body and the senses we are able to act in, survive and make sense
of the world we inhabit. The body not only expresses individual experience, it
also allows individuals to be inserted into that world and its endless
reconstruction. Understanding the simultaneity of material and discursive aspects of personhood is key in approaching questions of body, self and states of health.

Hermans and Kempen's (1995) discussion of the dialogical structure of social action is on point here. They argue that meaning and action are construed through interaction between oneself, others and the cultural order, and that the capacity for individuals to position themselves as acting through the body in space both real and imagined is essential to this process. So obvious as to be largely taken for granted is the fact that doing - acting, in and on the social world- necessarily implies the use of the body, not only because of what is done to it but also because of what is done with it.

This opens some interesting avenues for an address of psychological disorders to allow for the possibility of seeing expressions of meaningful self-work in the embodiment of their symptoms. Disorderly action can be recast as creative and individualized engagements of the self with the social through the body, by which affiliations and dissent are negotiated and expressed. Women's narratives of anorexia, for instance, often reveal satisfaction, dissatisfaction and confusion with various aspects of femininity, rather than direct reproductions of simple messages communicated through mass media or other cultural forums (Bordo, 1993).

Some writers have gone further, suggesting that aspects of some disorders could actually be seen as uniquely developed skills or skill sets in correspondence with particular tasks that respond to widely approved cultural knowledge and practice. Anorectics might be seen as displaying a particular
'talent' for embodying the cultural distaste for both fatness and femininity (Baerveldt and Voestermans, 1998), and sometimes do experience a sense of accomplishment and enhanced self-esteem with the reduction in their body size (Bordo, 1993). Emily Martin (1997) suggests that the increased sensitivity to stimuli and short attention span that characterize attention deficit disorder also describe a nearly ideal-typical subject for the 'multitasking' workplace: flexible and capable of quickly changing strategies to manage 'complex systems in a constantly changing environment' (p. 224). Following these arguments, I would suggest that the obsessive rumination over detailed hypothetical outcomes and scenarios in OCD would be of value to impact- or risk-assessment in many professional fields. The point is that in acknowledging the creative and dynamic quality of self-work and identity production, it becomes clear that it is patently inaccurate and professionally inadequate to assume that the symptoms of mental illness indicate true dislocations from psychological 'normalcy', or simple irrationality. Rather, they can be seen as different interpretive configurations of the social world and how to act within it, which are at odds with the sensibilities of the majority of others.

Are these examples somewhat tangential to a theory of the self as it relates to the body and OCD? I think they are more than an interesting distraction. Subjects of disorder are subjects of approved discourses at the same time, and that all of these are performed and adapted in the embodied engagement with the social. Over the next two chapters, I will try to support this from the other side of the same coin by showing how elements of the disorderly
in general and OCD specifically are grounded in 'normal' beliefs and practice. More immediately, there is the question of how to characterize a 'self' that is engaged in this way, as both materiality and construct, and interdependent with both body and collective.

The dialogical approach noted above is a strong step in this direction, because it explicitly suggests the inclusion of the body and spaces, actual and imagined, as constituents of the field of object relations, and hence, of the self as well. This is of particular value to me, as I will discuss body and space in the context of OCD in chapter four, but I prefer the allusions of thinking the self as an ecological phenomenon (Sibley 1995). Admittedly, this is possibly little more than an aesthetic preference on my part, but to me this term captures not only the notion of the total environment in assembling the subject, but also the infinitude, simultaneity and contingency of the parts of that environment, and the sense that the 'self', as such, is committed to its own continuity within that environment. Complex and conflicting systems are managed in the interests of maintaining stability and coherency. Metaphorically, the work of self is closer to overhearing the chatter in a high school hallway than to proper dialogue: the body proliferates and is everywhere in flux, and the conversations may be multiple, partial and fraught with dubious interests and fabrications. The range of formative experiences cultivated in such an environment includes both normalcy and pathology. From this perspective, it is possible to argue that distinguishing those aspects of subjectivity that are natural or real from the way these are experienced or constructed is, for some purposes, less important than
acknowledging the relevance of each. Thus the social is prioritized as the irreducible, and order, disorder and OCD can appear concurrently as material phenomena and effects of discourse and power, in society and social relations.
Body, Dualism and Obsessive-Compulsive Disorder

In the previous chapter I sought to examine the role played by the self in the ontology of mental disorder. Perhaps it would be more appropriate to say roles here; certainly the notion of 'self' describes and operates on a broad range of dimensions in social life. I have tried to indicate some minimal boundaries of such operations. These include its relevance, first, as both a personal story of invested subjectivity and as a historical cultural artifact, and second, in the embodied experience and ontological framing of mental illness and obsessive-compulsive disorder.

Additionally, I drew from the work of Nikolas Rose to introduce an argument elucidating the relationship between the popularization of a particular understanding of selfhood and the development of liberal democracy in Western society. This understanding, bolstered by the authoritative voices of mental health and personal development experts, is expressed as a regime of 'obligatory freedom', and is intrinsically embedded in the conceptual separation of mental
disorder as different and pathological. The category 'obsessive-compulsive' is therefore also a political distinction related to the mutual constitution and reconstitution of personal and social order.

Body and Self: Correspondence as Citizenship

I have also suggested that as both a representation and a location for the self, the body plays a critical role in both individual and collective understandings of subjectivity, and so ought to be equally central to analyses of mental health. As well, in terms of the fit between the individual and the social order it is, more precisely, the amiable co-location of a body and a self that forms the criteria predicting the mentally 'healthy', and therefore rational, subject. When instances of embodiment (people, that is!) appear to unsettle an agreed-upon pairing of body and self, they are normally judged to belong to a separate, reduced or problematic category of social being or citizen. By way of illustrating this point, think of the example I presented in chapter one, that a single body displaying more than one apparent 'self is often assigned the distinction of 'multiple personality disorder' (Sass, Whiting and Parnass, 2000). When I gave this example in a thesis group workshop, another participant immediately carried the principle along, suggesting that in another context, the occupation of a body by the 'wrong' self has frequently been understood as 'possession', in the spiritual sense. Similarly, the term 'sociopath' is reserved to describe a person whose

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1 This may be somewhat outside the scope of the present argument, but it is worth considering how this works in less obviously political contexts as well. The cultural fascination with identical twins, for example, could potentially be read as incited by the imagination that two distinct persons have somehow not been issued entirely distinct bodies. Conversely, presences
actions, especially crimes, are deemed so reprehensible as to seem to indicate the total lack of a moral conscience. If it is not too great a stretch (and I do not think that it is) to include the actions of moral persons under the heading of 'self', then it is possible to see the figurative absence of a self in the trope of the sociopath, as yet another kind of social psychopathology.

These examples call attention to the way in which different conceptual schemes—in this case, psychological, religious and legal—create categories of person in order to understand (and evaluate) the health (or appropriateness) of individuals. They suggest that the way the body and the self are expected to fit with one another is critically important to notions of order and disorder within a given knowledge framework. Like the self, an orderly body is of great importance to the assemblage of the social person. This assertion forms the point of departure for this chapter of the thesis, in which I shift the focus somewhat away from the self, and more directly towards the body, in the context of social theory, cultural production and obsessive compulsive disorder. To begin this, I will consider a series of related questions that seek to understand the role of the physical in the cultural and particularly in the production and embodiment of the mental as positively or negatively valued states of personhood. The first two questions outline some key problems in thinking disorder and psychology through body and self, or mind, and should provide a foundation for the third, which considers OCD specifically in the light of that context.

described as ghosts, spirits, or gods are distinguished, set aside, by virtue of their absent bodies, and often assume temporary and/or inanimate material forms
Thus far I have used the terms, 'body' and 'self' relatively easily, as components of a cultural vocabulary for commenting upon and categorizing individuals through what are frequently understood as natural dimensions of their existence. However, I have suggested that the perceived relationship of these aspects in a given person is of great concern in theorizing mental illness and OCD. This point raises an issue as to what possibilities exist for interpreting that relationship, and how cultural assumptions about each figure in diagnostic taxonomies. The first question I want to consider is therefore 'What is the quality of the relationship between the ontological figures of the body and the self?'

Dualism and the Treacherous Body

In Western culture, this conceptual distinction of body vs. mind has a long and complex genealogy. This can be situated within a larger tradition of articulating human existence and the world in which it is played out as bifurcated between the distinct and opposed realms of the natural, on the one hand, and the cultural, on the other (Kirby, 1997). This fundamental distinction has spawned an elaborate series of corresponding dichotomies, extending to material/spiritual, animal/civil, emotion/reason, female/male, private/public and so on. Their history in cultural thought and treatment, however, is far from balanced. While preferences for either of these poles have existed and continue to exist in particular moments in social thought, normally, the first partner in each of these conceptual couplets is accorded lesser status than, or worse, taken as an abomination and threat to the first. The dominant (and enduring) tendency has
been towards considerable disdain for physical vulnerabilities, products, processes and needs, as well as for those bodies (for example, of women) understood as more susceptible to, or governed by, these contingencies (Synnott, 1993). At least as early as Plato, and continuing through Augustine to Descartes and the modern period, spiritual and intellectual pursuits have tended to enjoy relatively great prestige whereas the body has often been treated as spoiler, the source of much constraint and distraction. In contrast, the self, conceptualized as that which is most irreducibly human, is identified with the spiritual, casting bodily imperatives, vulnerabilities and pleasures as the enemy, the anti-self. As Susan Bordo (1993, p.5) suggests, despite sophisticated oscillations in terms of western body-thought,

what remains the constant element throughout historical variation is the construction of the body as something apart from the true self (whether conceived of as soul, spirit, will, creativity, freedom...) and as undermining the best efforts of that self. That which is not-body is the highest, the best, the noblest, the closest to God; that which is body is the albatross, the heavy drag on self-realization (emphasis original).

The question of the fit between body and mind must therefore be understood in the context of the world thus-operationalized, in which the two figures are assumed to be real and antagonistic and mind is always and already privileged. The resulting dynamic has been a reification of the notion that the body, for social beings, is a site for the subordination of irrationality and desire to reason and willpower (Turner, 1996). Moreover, this dynamic has played a fundamental role in the way projects of citizenship and proper embodiment have been conceptualized and carried out in modern and contemporary Western history. These tensions and projects, I will argue presently, have come to occupy a
position of central importance in ontologies of both physical and mental health and illness, and in the embodiment of OCD. This development too, however, has its own historical specificity, which I want to consider for contextual purposes.

There are numerous schools of thought and practice that have illustrated animosity towards the body’s supposed irrationality, but Christianity, and the Protestant Reformation in particular, have been especially influential upon its present status. Certainly, body asceticism was well developed in early Christian theology, which frequently adopted a view of the body as needy, wanton flesh, requiring much maintenance and easily tempted, and therefore imprisoning and betraying the cherished soul. Mastery of the body became an organizing feature of monastic orders, whose practices have included relatively moderate denial such as poverty, celibacy and diet regimentation, as well entirely more hostile acts such as public flagellation and ritual mortification. Synnott (1993, p.20) provides some specific illustrations of the lengths taken in order to overcome the body:

Mary-Margaret Alacoque (1647-90) filled her mouth with the diarrhoea of a sick man, and she cleaned up the vomit of another with her tongue; Angela of Fuligno described how she drank the dirty water with which she had just been washing the hands and feet of lepers... ‘Never had I drunk with such pleasure. In my throat was lodged a piece of scaly skin from the lepers’ sores. Instead of getting rid of it, I made a great effort to swallow it and I succeeded. I shall never be able to express the delight that inundated me.

Notably however, these rituals were largely confined to, and performed by, the religious elite - nuns, monks, priests- ostensibly, at least, in pursuit of the salvation of the masses. With the Reformation, however, came a breakdown of the distinction between the sacred and secular worlds, and a corresponding
broadening of regimentation. Thus, asceticism expanded from behind the walls of
the monastery and into the general population (Turner, 1996; Weber, 1930),
although thankfully somewhat less fervently than Angela of Fuligno might have
suggested!

This development was associated with many major changes in social and
political life, but it is especially important for this argument to note that these
included the equation of health with morality and an increased focus upon
personal responsibility for both. As Bryan Turner (1996, p. 209) puts it,

This management of the individual body had a close relationship to the
government of the social body; both required discipline, order, and morality. In
the final analysis, health depended upon morality, since improper life-styles were
the root of personal illness, and individual immorality was the product of social
disorder.

The medicalization of the social and individual body can be taken up instructively
in the context of mental disorder and OCD from at least two different points of
entry: from the top down and the level of medical disciplines, or from the bottom
up, the level of the individual. I will consider them in that order.

Mind-ing and Mining the Body

Turner, in agreement with Rose and with Foucault, suggests that the
transfer from sacred to secular accountability for health, as well as the corollary
coding of bodily states as moral states, is linked to the proliferation of rational
human and natural sciences. Medicine and psychology, which produce and
sustain categories of illness, be it mental or physical, have been profoundly
impacted by the legacy of dualism, and arguably had their impetus within it
nature and culture (for example, in biology vs. anthropology), as well as mind and body (psychology vs. physiology) as distinct fields of knowledge and objects of study. As Robert Kugelmann (1998, p. 185) clarifies in the context of professional approaches to the care of patients with pain, 'Above all else pain signalled: it represented danger in the external world or damage to the body. Each region of this divisible space had its caretakers. Physicians anatomized the body, psychiatrists the soul, and physicists the fire.'

The 'space' Kugelmann imagines is not, however, evenly divided. I have suggested that the body has been taken up as a, and perhaps even the, foundational source of disorder, and a threat to personal health. I should point out that an analytic focus upon the relevance of dualism to questions of health in social and cultural contexts is far from a new approach in sociology. And, although OCD remains a relative newcomer in this regard, various authors have brought this issue of body binarism to the forefront contributions in relation to other psychological differences. mental disorder and illness (e.g. Bordo, 1993; Harper, 1996; Stoppard, 1998).

Still, the idea of the unruly, vulnerable body may at first glance seem rather more straightforward in the case of physiological diseases of the body than in the case of mental disorder and illness. Clearly if I am inattentive to the vulnerabilities that are part of my existence, I put myself at risk for contracting diseases and for physical degradation generally. It is more difficult to extend this biologic model of contagion and exposure to the concept of mind, which lacks
the tangibility of the body in a Cartesian framework (Sampson, 1998). It can be and certainly has been done; it is possible to speak of 'exposures' to stressors which trigger mental episodes, or of 'organic' problems in the brain biochemistry of individuals (APA, 1994). I am not advocating that these approaches be dismissed outright; they are of value in devising pharmaceutical and behavioural therapies, which in many cases provide very important relief to sufferers. They offer far less, however, in the way of examining the ontological bases of the categories by which that suffering is described or processes of cultural knowledge production. Reflexive, critical inquiry is forgone in the interests of clarity, objectivity and treatment.

The second question to be explored in this chapter is, I hope, considerably more productive: how is the body understood in psychology and how does this relate to its project of defining mental states of wellness? My contention is that uneven dualism leads psychology to particular assumptions about the body as well, which in turn impact upon assessments of mental health and the address and experience of those assessed. Presently, I will connect these to OCD. I would like to explore the relevance of these assumptions now.

With one of the most recognizable quotations in western philosophy, 'Cogito, ergo sum' (I think, therefore I am), Descartes provides a convenient introduction to one such assumption. Human existence is here defined by thought and the reflexive self; conspicuously absent is the body (Kirby, 1997). This sentiment is reproduced in one major tradition in psychology, which understands the body as simply the housing of the mind, or at best the fleshy
vehicle through which praxis and agency are executed in the material world; a necessary but otherwise dumb 'collection of sophisticated drips and squirts' (Stam, 1998, p. 4). In this reasoning the thinking, or cognitive self is cast as the captain of the vessel, and the statistical norm, leaving psychology to set about the work of detailing the processes and content of normal cognition (Wilson, 1998). The field is thus constituted as a reproduction of culture/nature binary, here elaborated as order/disorder, and much of its work serves to sustain Cartesian thought by systematically ordering individuals according to its categories, and declaring this to be proof of their validity (Ussher, 1989).

When it subordinates the concept of body to that of mind in this way, psychology circumvents questions of phenomenology and the immediacy of psychological states of distress. Similarly, it ignores the possibility that particular disorders might be reactive to problems of embodiment, how a person feels about their 'drips and squirts', as I argue is the case in obsessive-compulsive disorder. Moreover, it fails to acknowledge how the symptomatic actions and feelings associated with psychological states might be understood as sensible ways of engaging with the world as it is experienced (Baerveldt and Voestermanns, 1998). As a result, any opportunity to challenge the content or labels of disorder, or even to look reflexively at the practices and discourses by which these are produced, is forgone.

However, to argue that the body was undervalued in foundational psychology is not equal to suggesting that it was, or has remained, nonexistent. Medicine, both physical and mental, went hand-in-hand with the Enlightenment
project's secularization of society and the shift towards what we now unproblematically call liberal democratic societies in the industrial west (Turner, 1996). This change was in part predicated upon the installation of ideological norms and practices of freedom and rational individualism as proper citizenship. The delineation, validation and popularization of these norms and practices was, and remains, largely the work of the sciences, particularly as they seek to rationalize social life by creating highly differentiated categories of normal and pathological individuals and 'corrective' responses (ranging from self-help to capital punishment) for the latter of these (Rose, 1998). For Foucault, quantifying populations in this way amounts to the creation of knowledge as an exercise of disciplinary power, based upon social relations of looking (Synnott, 1993). The objective medical gaze was equated with revelation and the exposure of truth about the objects upon which it fell. In the case of anatomy, the secrets of the body could only be truly discovered through the practice of the autopsy, which opened to plain sight what was hidden in life:

That which hides and envelops, the curtain of night over truth, is, paradoxically, life; and death, on the contrary, opens up to the light of day the black coffer of the body...Nineteenth-century medicine was haunted by that absolute eye that cadaverizes life and rediscovers in the corpse the frail, broken nervure of life (Foucault, 1994, p.166).

Psychology's domain can be understood correspondingly, as an opening of the secrets of the psyche. What could be gleaned in this way was instrumental to the organization, regulation and eventual self-regulation of populations. One difficulty inhering in a science of persons predicated upon the primacy of the thinking self, however, is that cognition, as a process, simply cannot be seen; it
needs to be inferred from another signification system. This presents a major problem for the psy disciplines, and calls attention to another way in which the body figures in their understanding of mental disorders. While the body is disavowed in favour of the mind as a crucial element of personhood by mainstream psychology, it is precisely the body that is observed for indicators, in the form of behaviours and symptoms, of mental anomaly. As Henderikus Stam (1998, p. 2) points out,

_ Bodies were no longer the source of consciousness and feeling so much as the casement for its expression. Indeed the body was given in a pre-fabricated fashion. Consciousness and feeling however were the province of a science that sought out the range of its possibilities in its quantifications._

Dualism thus permits the body to serve as something of a receding framework in psychology, an external surface whose qualities are understood as indicative of the character of the interior. So, the stable fit of body and mind is in fact assessed by means of observing the interactive embodiment of regulated individuals as members of a collective in everyday life. And, just as deviances of the mind are inferred from deviances of the body, the correction of deviant minds is undertaken as a disciplining of appraised bodies (Foucault, 1979). This too occurs in both formal/institutional (the prison, the hospital, the school, the asylum) expressions of discipline and informally in the metaphorical panopticon. By this, I mean the literal and figurative engagement with social others I discussed in the first chapter, by which we shape and perform our personal social location, called self or identity. In everyday life, the social practice of the
collective representationality of our bodies means that we are not simply regulated, but 'co-regulated'\(^2\) (Baerveldt and Voestermanns, 1998).

This is quite a sophisticated idea, and has obvious purchase well beyond the strict boundaries of psychology. We quite regularly relate to one another, and invite others to recognize us, upon the agreement that certain aspects of who we are and what we are like are expressed in our bodily presentations. Other scholarly disciplines have picked it up as well; indeed, sociology and social theory have certainly adopted the notion that bodily surfaces can be decoded for the purposes of learning about the social history, experience and character of individuals. This is the essence of the 'discursive' body so widely and sometimes very strictly espoused in postmodern and poststructural perspectives, and it represents an important and productive turn away from the biological reductionism that characterized earlier approaches to thinking about embodiment. Indeed, the production of such a reading of what I will awkwardly term the 'obsessive compulsive body' is a significant part of what I am hoping to accomplish in this thesis.

Yet, even such terminology, with its reference to 'the' body of any sort reeks of the type of rationalistic and abstract categoricalism, of which I have been (I hope!) openly critical (Radley, 1995). There is no single obsessive compulsive body that is not first and foremost a text, or a source of meaning, to and for itself, the person. Henderikus Stam (1998, p. 5) expresses the implications of failing to recognize the lived quality of body and/as subjectivity eloquently:

\(^2\) This is their term, and it is not as punitive as it sounds. Baerveldt and Voestermanns propose to view bodily intercommunication as a continuous flow of interaction (p. 161). This interaction is co-
We are in danger here of construing the body as a new Cartesian entity, taking the place of the discarded dualism of mind with equally opaque categories that would psychologize the body into a language of discourse, desire, style, performativity and the like while jettisoning its sociality and materiality.

I have said very little to this point in the chapter specifically about OCD. This has been a conscious choice in the interests of explicating a handful of rather involved ideas and tendencies in Western culture and knowledge, which, I think, bear heavily upon the disorder. With Stam's caution in mind I will turn now to considering the relationship between these 'axes of cultural thought' (Bordo, 1993) and ways in which they are accommodated and resisted in the experience of OCD. I am also concerned with the ways in which OCD can help us to understand the lived dimensions of cultural discourses about body, mind and disorder. The third question I have posed to myself as a way of organizing this discussion is therefore, 'How does the body matter at the level of the individual instance and experience of the condition?'

Thinking Dualism Through OCD

Perhaps the most straightforward indication of the influence of dualist subjectivity upon the quartering off of OCD as a discrete syndrome can be found in the title of the disorder itself. It is quite ambiguous as to the content of the symptoms but clearly reproduces the binaristic tendency in its specification of both obsessive (cognitive; mental) and compulsive (behavioural; embodied) aspects. The label would thus seem to indicate a comprehensive disruption in regulated in the sense that one's bodily communication responds to and affects that of others.
subjectivity, insofar as both of its constituent parts are disturbed. Whereas traditional psychology tends to view this as an individual pathology, I would like to suggest that this represents a tension between ontology and the lived world, a problem that becomes visible when people try to accommodate and reproduce the logic of body and self. In other words, people with OCD only appear on the list of disordered 'others' because they appear to experience body and self in the world in a way that is markedly different from, and therefore disordered in comparison to, the majority. However, the indications of this difference only become visible as a direct result of the actions taken by those people in an effort to restore the feelings of order in themselves that we all require to feel secure.

The assumption I am making here is that people with OCD live in the social world according to the categories and consequent tensions of body and self to the same variable extent that other individuals do. Residual asceticism proliferates as an individual preoccupation in contemporary western culture. In everyday life, many people struggle to subject the body to the will of the mind, and experience a sense of regimentation, of systematically conquering one's own physical resistance, as accomplishment, pleasurable and self-affirming. One of the most precise expressions of this tendency can be found in habits and attitudes towards exercise and eating. Each of these can be understood as 'body techniques' (Mauss, 1979), insofar as while they derive from more-or-less objective, physiological 'facts' of the body, their practice by, and meaning to, people is strictly regulated by cultural knowledge. As a result, exercise and eating frequently articulate a dialectic of self-mastery through the submission of aspects
understood as bodily weaknesses (hunger, pain, fatigue) to regimens of willpower (effort, denial). The pathology of this preoccupation is made explicit in anorectics' narratives, which sometimes reveal a paradoxical pleasure in the suppression of sexuality and fertility and in imagining oneself as having the power to move beyond the body and hunger by literally and figuratively encouraging its disappearance through starvation (Bordo, 1993).3

Habitual and compulsive exercise can be related to anorexia in that people engaged in both of these tend to derive feelings of motivation, accomplishment and euphoria from the successful shaping and control over their bodies. While it would be neither sensitive nor accurate to make the identical claim about people with OCD without an elaborate qualification of what broader meanings could be imputed onto the terms 'motivation' and 'accomplishment', this condition does display a similar struggle for control between body and self.

The feelings of contamination and consequent rituals that characterize obsessive-compulsive cleaning express this struggle in a number of ways. They are often accompanied by, or manifest as, embodied sensations (panic, for example), or may become focused on socially relevant parts, uses or differences of the body. The World Health Organization (1992) reports that handwashing rituals are more common in women, whereas generalized indecisiveness and slowness is more frequent in men. It may be relevant that more men experience the disorder as an interruption in personal efficiency and more women as a

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3 In Bordo's discussion, the 'body' in question is particularly a female one. Thus it is a female sexuality which is to be suppressed through the cessation of menstruation and fertility. Similarly, 'hunger' both takes its literal meaning and stands in as a metaphor for femaleness as needy and
problem of body-management. This seems to suggest, at least at the symbolic level, a manifestation of the oppositions of body/mind, woman/man/ private/public which, not at all incidentally, also extends to tainted/pure (Synnott, 1993).

For both men and women with OCD, the feeling that the hands are contaminated is among the most common of symptoms, and carries particular symbolic value. In Schilling's (1993, p. 102) terms,

> The hand allows humans to complete their own and each other's bodies by feeding and caring for their young, and by providing for their sustenance and shelter. In working on their environment with their hands, humans also develop particular orientations to their bodies. The hand also allows humans to create their world.

Hands are laden with meanings, prime literal and metaphorical instruments of human praxis and effective action in the natural and the social worlds. They are also symbolic of agency, and our capacity to translate self-directed, reflexive thought into the shaping of identity and secure the recognition of others. Anxiety over the hands is therefore fundamentally anxiety over access to social participation with others and the ability to operate according to the structure of social life. It is understandable that one would take action if these functions were threatened.

The sense that these important capacities have been disabled by contamination can be quite clearly read as a problem of/on the body, to which the mind must respond. This reproduces the uneven dialectic of body and self in which the body is understood as irrational and unreliable, an obstacle or even a threat to the self and the fulfillment of personhood. Similarly, mind is irrational. It is thus a distinctly female hunger being transcended in the extinguishing of those
reconstructed as agency and discipline, the source of rational praxis, which is empowered and enlisted in this framing to secure the right to meaningful and rewarding social participation.

A second translation configures many of the same terms in a slightly different way. When OCD produces feelings of emotional discomfort, sufferers engage in rituals enacted through the body to restore mental order. On one hand, this could be interpreted as a resistance to traditional regimes of dualism, insofar as here, the relationship is reversed and the body appears as the solution to a psychic crisis. At the same time, however, these rituals are performed repeatedly, even while the individual recognizes their severity and futility, as though agency, or the willpower to stop, is absent. What I wish to suggest here is that in one sense, the way this feels from the 'inside' as well as the way it is observed from exterior perspectives is framed and regulated by binary sensibilities that are hostile towards the corporeal. Within the logic of the Cartesian matrix, OCD can be viewed and experienced as an 'unruly' embodiment, a body left unchecked. Many wash past the point of chapped and bleeding skin; reports of washing for twelve uninterrupted hours are not unusual (Tallis, 1996). This may represent the closest link between OCD and other mental disorders in this context: perception of a danger or stigma (fatness; persecution; contamination) means that the self is subjected to a tyranny, enacted through the body and experienced as externally imposed. Of course, the great contradiction is that while an extreme disciplining of each of these perceived 'tyrannies' is treated as random and disorderly, extreme manifestations traits that mark the woman as an unruly body.
of them are understood as equally pathological.

**Dual-ing with 'Axes': Some Convergences of Accommodation and Resistance**

This affirms one of the very general arguments that I am working from (and towards) in this chapter, that medical 'disorder' is always fixed in relation to a culturally produced political economy of meanings, including an understanding of order. This can be seen as a rationalization of social life, and materializes as a pathologizing of difference enacted through and upon the distinction between nature and culture, and body and mind. In particular, the body, encountered as something of a pre-fabricated problem, appears as requiring extensive personal maintenance.

What I am suggesting in this section, however, is that the ways in which these categorical oppositions are individually interpreted and acted from must be understood as troubling the distinction between discursivity and materiality as they are applied to the social 'meaning' of illness and OCD. The values that comprise cultural order(s) may govern us, but they also situate us and provide us with reference points from which to act and to make sense of our actions in the social world. Thus, interpretive reproductions of discourse can also be seen as self-invested and self-directed engagements with cultural knowledge, existing, ultimately, to locate ourselves socially. The body's need for rationalization is as much a personal, as a collective, priority. The subordination of the body may be a regulated construction of discourse, but it is one that is experienced and reproduced most fundamentally as practices of the self.
Of course, rationalization manifests in positive values for other categories and traits which, while not immediately associated with body dualism, are nonetheless equated with order as well. One of the most valorized of these is efficiency. In liberal democracy, we place a great deal of emphasis upon efficiency, which I will define here as 'being able to identify and respond quickly, creatively and effectively' to problems. Like dualism, this priority has a lengthy social history, and one which is amplified in late capitalism, as social reproduction is increasingly understood in neo-liberal discourse as more of an individual problem and less of an institutional responsibility (Turner, 1996).

Something quite similar to this is expressed in the inflated sense of responsibility and guilt over everyday tasks and events that is frequently associated with obsessive-compulsive disorder (Tallis, 1994). I would argue that the compulsive aspect of OCD be seen as stress management and creative problem solving, as a response to the intense anxiety of the obsessive aspect. Problems are identified or anticipated, and a solution to them is devised, implemented and adjusted according to circumstances. For example, suppose I have OCD and I feel that my hands have become contaminated. If I am at home, it might go like this: I know that if I use a bar of soap to wash my hands, I will likely feel that whatever was on my hands has spread to that soap, making it more of a problem than a solution, and be discouraged from using it again. This is unacceptable because I also know that there is every likelihood that I will need to wash my hands again. One solution to this might be to simply throw the used soap out, but could raise several problems for me, depending upon my individual
sensibility. First, I may have to accomplish this without actually touching the soap, which I can do by using a paper towel or other tool to pick it up and dispose of it, and then throw the paper towel out as well. This may mean I will at some point in the future need to devise a way to throw out the garbage without concerning myself about the status and communicability of its contents, which I already feel are contaminated. More importantly, if I do go this route, I will be replacing a lot of soap, which is expensive and time-consuming and requires that I expend energy monitoring the level of my soap reserves. As a second option, I could buy a liquid soap dispenser and large quantities of liquid soap from which to refill it. The advantage of this approach is that I can wash the dispenser as needed without contacting the important soap itself, which is inside it. However, I still have to deal with the dispenser itself; I can do this by having a sterilizing agent of some sort on hand which I use, only after I have washed my hands the first time, to clean the pumping apparatus of the soap dispenser. Complicated as this may seem, it is actually rather an oversimplification of some of the problems negotiated by people with OCD in the interest of feeling secure. If I am away from my home for example, I have as well to deal with having considerably less control over the environment and my privacy within it. Similarly the level of my anxiety is not constant, but fluctuates in accordance with a range of factors such as my feelings about the source of the contamination (perhaps I am more concerned about walking by dog feces than a person with a cold, or perhaps the reverse is true) and my general mood.

Importantly, this anxiety derives from a sense that body or environment
has fallen into a state which would prevent them from functioning properly in other roles (Radley, 1991). Thus, it is understandable that someone might feel compelled to sterilize the family car tonight, if not doing so would prevent them from feeling secure using it to drive their children to school tomorrow. As well, the ritualistic response to anxiety occurs, by definition, during moments of stress, and can be taxing upon the individual performing it. Experiencing and performing obsessions and compulsions constitutes rigorous work in and of itself, and a strong argument can be made that performing a ritual can be a more efficient decision (i.e., take less time) than resisting the urge to perform it (Tallis, 1996). Unfortunately, such rituals likely ease anxiety in the short term only, and lose their effectiveness if they become normalized. If people respond with more extensive rituals, the standard keeps getting higher. The reward for industriousness, in this instance, is further stress and distance from ‘normalcy’.

The point, however, is not to suggest that OCD is necessarily an effective strategy, or misguided personal choice for dealing with dualism. Rather, I am arguing here that the disorder makes sense within certain problematics and processes of western culture and thought, and that examining the embodiment of OCD can help to make these explicit. One such problematic, I have suggested here, is Cartesian dualism, particularly its manifestation in medical sciences, and their impact upon ways of framing and interpreting embodied experience. While physiology and psychology appear at first glance to deal with distinct spheres of life, a closer look reveals these spheres to be artifacts of cultural knowledge. Both operate as mutually confirming cultural rationalization projects, and as
sciences of personhood they systematically work to expose, isolate, describe and classify the minutiae of human social experience and difference. I will close this chapter by suggesting that a degree of parity can be drawn between Rose's (1998) discussion of 'obligatory freedom' of the psyche that characterizes western society and a comparable notion of 'obligatory health' and a citizenship of interpretive rational embodiment. In this way a massive cultural rationalization project is executed through dissemination to the level of the person, and the individual rationalization and sense-making of intimate embodied experience using the conceptual tools of cultural knowledge and practice in the world. In the next chapter I will connect this project more explicitly to obsessive-compulsive disorder via a discussion of the real and perceived consequences of failure in this obligation in relation to collective and individual constructions of risk.
Embodiment and Citizenship in the Risk Society

Chapter 2 concluded with the suggestion that citizenship and belonging in industrial Western societies are characterized by a paradoxical obligation to health and freedom, which amounts to a rationalization of governance by demanding and rewarding the self-regulation of individuals and populations. I have attempted to show a relationship of this project to, on the one hand, subjectivity and the possibility of the mental category 'obsessive-compulsive disorder' and, on the other hand to ways in which the body and mind are taken up in both the disciplinary and the personal understandings and practices of embodiment that together indicate the syndrome.

Supporting a notion of collective obligations would seem to suggest that there must be a collective anxiety around meeting these duties. This is, in a general sense, the argument that I make in this chapter, but I want to acknowledge that this is also a particularly problematic point to establish in the theory at work here. After all, it is quite true that the discourses, beliefs and
practices I am implicating in my understanding of the relationship between
Western culture and OCD clearly circulate among a much greater number of
gexperts that eventually develop the condition. Following this thinking, it might be
possible to argue that if my reasoning were sound, the current state of affairs
would be inverted, and a majority of people would exhibit the symptoms of
clinical OCD while a minority of persons without these symptoms would appear
at least statistically, if not conceptually, disordered.

While this is not precisely my point, I have argued and will continue to
argue in this chapter and this thesis that much of what constitutes OCD is far
more widely distributed than is commonly understood. And, this does raise a
legitimate question as to what sorts of critical things or causes might move a
person towards or away from the trajectories of clinical OCD. I would prefer to
deal with this concern by restating the scope of this work. I have not attempted,
and will not try, to argue that culture 'causes' the appearance of disorder in
particular people in the same sense that salmonella bacteria cause the
appearance of food poisoning and its symptoms. Rather, I am suggesting that in
OCD can be seen some of the problems, priorities and contradictions of
contemporary Western culture and its history. I cannot, therefore, adequately
explain why in a more or less shared cultural context, one person has OCD while
another doesn't. What is most clear to me about this question is that different
people have different levels of sensitivity to these cultural discourses, and so
take them up in different ways and to different degrees. So, I argue in this
chapter that the currency of that sensitivity, the language by which it circulates
and articulates in practices, is a language of risk. I am concerned here with changes in the ways that risk has been understood both socially and sociologically, with the ways in which risk is differently assessed and responded to by individuals and collectivities and with drawing a relationship between those responses understood as normal and those understood as obsessive-compulsive. Before making this argument there are a number of points I would like to make for contextual purposes.

**Risk in Society and the Sociology of Risk: Some Background**

Deborah Lupton (1999) begins her recent book (aptly titled for this chapter^1^) *Risk* by citing Robert Muchembled’s depiction of the dangers of everyday life in medieval France. Lupton writes:

> During this era, death was ‘on display everywhere’ (Muchembled, 1985, p.31). The most extreme of these threats and dangers were hunger, cold, epidemic disease and war. Food supply at the end of the Middle Ages in Europe was very tenuous. Grain provided the basis of the diet, and production was vulnerable to the vicissitudes of the seasons. Infant mortality was very high and lifespans short (reaching the age of 40 being considered a fair lifespan). Epidemics of such diseases as smallpox, whooping cough, typhoid, syphilis, dysentery and the plague frequently struck villages and towns, decimating their populations. People living in rural areas faced other dangers, such as wolves, who were known to attack children and sometimes adults in the fields and near their cottages. Wild dogs presented the threat of rabies should they bite and wild pigs were known to attack and eat small children. Bands of brigands roamed the forests and high roads, regularly attacking and robbing peasants... Insecurity was rife and permanent, and 'fears, real and imaginary, abounded' (Muchembled, 1985, p.22)... Bodies of hanged men dangled from gallows, slowly rotting for several days or weeks in public places, executions took place in public and the dead victims of brigands and soldiers were to be found on roads, as were the bodies of

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^1^ Lupton’s work is more than just well titled for my purposes. With *Risk*, Lupton has neatly presented the key ideas of the most important writers on risk, including Anthony Giddens, Ulrich Beck and Mary Douglas, as well as Foucauldian approaches to governmentality as a response to the possibility of danger. This is very much one of those fortunate occasions in theorizing in which an established writer has compiled a substantial analysis, which lends its support to a variety of uses and conclusions. I draw heavily from her work and am very much in her debt for the preparation of this chapter.
beggars and vagabonds who had perished from starvation or disease. Villagers and townspeople closed themselves in their dwellings at night, not daring to go out once darkness had fallen, because night was considered the domain of all dangers: the kingdom of the Devil, of demons, of witches and werewolves and monstrous beasts (Lupton, 1999, pp.1-2).

Risks are, of course, not new. Because human societies are contingent upon maintaining the health and well being of their individuals and institutions, some understanding of risks and some notions of risk-management have always been organizing features of social life. Accordingly, 'risk' is not a new concept in social theory, and has figured in the theoretical work of many classical and modern writers. More recently however, explicit efforts have been made to examine risk in its own right as a structuring component of social organization. In addition to Lupton (1995, 1999), Mary Douglas (1966, 1992), Ulrich Beck (1992a, 1992b, 1995, 1999 and with Elisabeth Beck-Gernsheim, 1995), Niklas Luhmann (1993) and Anthony Giddens (1990, 1991, 1992) are among the growing number of writers with full studies published exploring the possibilities of a dedicated sociology of risk and the 'risk society'.

One interesting development that has emerged from this growing body of work has been the observation that what is signified by the concept 'risk' has undergone important changes over the course of Western social development. Early uses of the term appear to have been associated with dangers to humans and their efforts, and which originated in the natural and supernatural forces of the world. Catastrophic events of weather, disease and the like were generally understood as resulting from super-human forces, and were therefore also believed to be far beyond the reach of human responsibility and intervention.
As I have argued previously, the epistemological changes associated with Enlightenment thought and the period known as 'modernity' brought about new ontological possibilities for ordering and understanding categories of persons and their relationships to each other and the social world. It is generally agreed that one of the central elements of this shift was the emergent assumption that the constituents of the world, whether natural or social, events or objects, behaved in consistent ways according to calculable rules. It was believed that through study, these normative rules could be learned and the behaviour of events and objects could be predicted and manipulated in human interests (Giddens, 1991).

The resulting taxonomic urge directed itself not only to the psychic and bodily states of persons and populations, but also to the dangers these might encounter, and the ways such encounters could be accounted for, minimized or averted (Beck, 1992a). Risk therefore became understood in a new way, as the statistical probability of a particular outcome given this or that action. This new emphasis upon relative likelihoods and human action amounted to 'the understanding that unanticipated results may be the consequence of our own activities or decisions, rather than expressing hidden meanings of nature or ineffable intentions of the Deity' or another power of cosmic scale (Giddens, 1990, pp.30-31). 'Risk' was thus fixed as the field of the calculable, in opposition to the inestimable or unknown (Lupton, 1999). Societal progress can also be seen in these terms, to the extent that the proliferation of liberal politics, economy and society depended heavily upon the increase of the former field at the
expense of the latter, and upon the enlistment of expert disciplines, populations and individuals in this effort² (Rose, 1998; see also chapter 1).

From Probability to Ambiguity

As the scientization of the world and its dangers has continued, however, the association of risk with the more neutral notion of probability has eroded considerably. This erosion is not to be understood as a decline in the number or volume of discourses around risk; rather the term has tended more and more to be used synonymously with 'danger' or 'hazard' (Douglas, 1992). And, risk discourse proliferates in Western media and society. Lupton (1999) suggests that at least six categories of risk can be identified, around which these concerns are articulated. These are:

'environmental risks', or those caused by pollution, radiation, chemicals, floods, fires, dangerous road conditions and so on; 'lifestyle risks', those believed to be related to the consumption of such commodities as food and drugs, engagement in sexual activities, driving practices, stress, leisure and so on; 'medical risks', those related to experiencing medical care or treatment (for example, drug therapy, surgery, childbirth, reproductive technologies, diagnostic tests); 'interpersonal risks', related to intimate relationships, social interactions, love, sexuality, gender roles, friendship, marriage and parenting; 'economic risks' implicated in unemployment or underemployment, borrowing money, investment, bankruptcy, destruction of property, failure of a business and so on; and 'criminal risks', those emerging from being a participant in or potential victim of illegal activities (pp. 13-14).

Quite frequently, events are understood as representing more than one of these types of risks at one time. As I am writing this for example, one of the most heavily covered local media stories concerns an outbreak of E. Coli bacteria in Walkerton, Ontario, a small town not far from Toronto. In the spring of 2000,

² I have also referred to this in earlier chapters as the 'rationalization project' or 'rationalization'.
heavy rains washed cow manure from a farmer's fields into the water supply through a broken seal over a public water well. The resulting contamination left seven people dead and over 2300 people sick. That this qualifies as an 'environmental' and 'medical' risk is straightforward; it also has implications for 'lifestyle' (the water manager's lackadaisical approach to his work and ethics has been a point of major contention and taking the safety of tap water for granted is problematic); 'interpersonal' (home and family lives were disrupted; people were forced into new patterns of care); 'economic' (productivity as well as personal losses; tourism badly affected;) and legal dimensions (lawsuits have been filed).

Interestingly, these dimensions more or less correspond to particular disciplines or knowledge bases as well, (community systems and public health, medicine, psychology, economy and industry, law). One of my central contentions in this chapter is that both material and socially constructed aspects of obsessive-compulsive disorder need to be understood in direct relationship to the characteristic ways in which we create, talk about and respond to notions and sources of risk, in Western societies. By extension, I suggest that it is also the case that through OCD we can learn much about our relationship to risk in society. This relationship is heavily mediated by expert knowledge systems, which are generally understood as responsible for learning and disseminating information about unique kinds of risks, in the public interest. Moreover, in contemporary liberal societies, individuals are construed as consumers of this information, and are encouraged to demand and apply these disciplinary advisories in their personal interests. As Rose (1998) puts it,
Consumers are constituted as actors seeking to maximize their 'quality of life' by assembling a 'life-style' through acts of choice in a world of goods... The sphere of consumption, and the mechanisms of its promotion and molding, can be extended to incorporate problems that were previously governed in other ways. Health stands as an exemplar of this transformation. Healthy bodies and hygienic homes may still be a public value and a political objective. But we no longer need state bureaucracies to enjoin healthy habits of eating, of personal hygiene, of tooth care and the like... In the new domain of consumption, individuals will want to be healthy, experts will instruct them on how to be so, and entrepreneurs will exploit and enhance this market for health (p. 162, emphasis original).

Here we see an artful conflation of personal choice and interest with political governance, with a central notion of 'citizenship' presupposing a dialogue between providers and interpreters of expert advice. Citizens are here conceived of as rational, self-governing consumers of information they use to make choices in the interests and defense of their own health and lifestyle. This becomes obviously problematic when the information supplied fails to notice emerging risks, and so insufficiently prepares systems or individuals against them. The paradox of this situation is that the same epistemological shift that may be credited for an optimistic approach to (as well as remarkable, practical success in) rationalizing the world's dangers through an extensive effort to organize, predict and minimize them has also in a sense created more risks by bringing them directly to the collective attention and obligation.

It is possible to extend this line of reasoning one step further. Arguably, the sciences and processes of modernity and modernization have not only created and disseminated expansive vocabularies of risk, but also have actually brought about 'new' and more insidious types of hazards (Beck, 1992a, 1992b). Ulrich Beck suggests that one cumulative effect of twentieth century science, industry and globalization has been the introduction of an unprecedented number
and magnitude of risks to human society. Mass centralized production, population explosion and concentration, wealth polarization, resource depletion, reliance upon dangerous substances, rapid global circulation of goods and people and other regular features of advanced economies have brought about new and increasing possibilities for catastrophic pollution, contamination, contagion and relative poverty and dependency. While these possibilities come to light in the context of the generalized emphasis upon evaluating and anticipating risk that I discussed earlier, it is not the case that our collective strategies for dealing effectively with the risks we perceive have grown at the same rate as our talent for producing and describing them. Rather,

The magnitude and global nature of risks is such that risks are becoming more and more difficult to quantify, prevent and avoid. Contemporary hazards are now often open-ended events, rather than events that have a foreseeable end [with] higher and higher levels becoming the norm' (Lupton, 1999, pp. 62-63).

Despite increasing attention to risks, in both popular discourse and risk-oriented specializations such as public health, epidemiology, insurance, policing and industrial standards (Peterson and Lupton, 1996), practices known to be risky are maintained, accidents continue to occur and hazardousness continues as a motif for describing the world. Similarly, the residual emphasis upon attributing cause to unwanted events is met with the reality that contemporary risks are rooted in processes that are difficult to imagine as the direct results of particular or individual actions, or which cannot be changed without causing massive disruptions to interdependent systems. Modern Western societies are therefore in the contradictory position of simultaneously producing new risks, new risk awarenesses, an obligation to attend to these and the sense that this may not
always be possible. An important question is, 'Given this ambiguity, what constitutes and differentiates between orderly and disorderly, or rational and irrational, responses to risk?'

**Deafening Discourses of Health and Illness: OCD and Anxious Embodiment**

One of the more consistently repeated themes in this jumbled approach to risk is the vulnerability of the body. Risk, I am hoping to suggest, is closely related to the Enlightenment idea of autonomous mastery of the world's uncertainties. It is thus grounded in normative social practice, and the minimization of risk is derived and deployed in the interests of the rationalization of unfavourable outcomes, both at the level of the individual and collectively. As I argued in the previous chapter, modernity's appraisal of the body has frequently found it to be the poorer half of human existence and an object directly opposed to these aims. Thus, risk and embodiment are intrinsically linked, as the body appears in modernity as an *a priori* risk object. As I also argued previously, anxiety about maintaining the acceptable state of the body characterizes many people's experience of OCD, which can be understood in one sense as expressing a desire to manage bodily liabilities. I now want to consider these discourses of corporeal anxiety more specifically, and the ways they are taken up in both everyday and obsessive-compulsive embodiment. I also want to be clear at this point that for the moment I am restricting my comments to those symptoms and instances of OCD that are concerned with issues and anxieties around contamination and cleanliness. The risk knowledges that are most clearly
centralized in these symptoms are ideas about health and medicine.

Health-talk proliferates in contemporary Western culture, issuing from and disseminating via numerous formal and informal social institutions, agencies, practices and other forms of relation. Public policy, health education, media alerts, popular literature, information from doctors, anecdotal discussions and so on are distinguished by the way they appear to both claim 'objective' knowledge about healthy and dangerous objects, lifestyles and practices, and to be genuinely concerned with providing societies and individuals with the most up-to-date (and therefore reliable) information available. People are assumed to use this information to make rational decisions about a panoply of choices, ranging from what things to eat and how much sleep to get, to what city to live in and what people to associate with. In one obvious sense, by investing people with this information, these discourses play an essential role in enriching health and quality of life. However, this does not mean that they are entirely benign. In fact, while sophisticated detailing of the causes, processes and cures of 'being sick' is arguably responsible for the success of Western medicine, it is in some ways also quite problematic, leading especially to new possibilities for anxiety. As Alan Peterson points out, the intensifying discussion of health risks 'signals a broadening of the focus of health promotion...everything potentially is a source of 'risk' and everyone can be seen to be 'at risk" for a wide range of illnesses if they fail to take the recommended precautions (1997, p. 195).

3 While I would prefer not to engage in a debate about the degree or possibility of objectivity in medicine, suffice it to say that this is widely disputed by most writers on the sociology of health and illness. The fact, for example, that the information provided is subject to change and 'updating' indicates its contingency.
Consider discourses of contagious illness. An elaborate understanding of bio-pathology, which has been essential to the effectiveness and proliferation of Western medical science, has also introduced into the Western imagination a deadly and invisible world of germs, toxins, microbes, cells, bacteria, parasites and viruses, waging a never-ending battle within and against the topography of our bodies. Within this realm, the dangers are many and frequently mortal, certainly serious enough to warrant our undivided attention. They cannot be seen, heard or otherwise detected by the normal sensorium, and by the time evidence of their presence is recognizable as such, the moment for preventative measures has passed. As well, we are aware that in many instances, even the very slightest exposure can transfer these infiltrators to our bodies. Breathing is a risk behaviour. And, should the borders of the body be compromised in this way, restoring its health may involve submitting to medical therapies and procedures that are similarly difficult to conceptualize, often cause tremendous physical and emotional discomfort, and which may not even succeed. The body as constructed in medical discourse is therefore one that is both difficult to protect and difficult to regenerate.

It is thus perhaps not surprising that the vernacular this discourse takes is frequently and increasingly one of prevention and avoidance (Peterson and Lupton, 1996). Entire nations, for example, may shut their borders to travelers or goods from other areas where outbreaks have occurred. Individual responses to this flood of information problematize the strict division between rational

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4 The possibility of a single, 'Western' imagination is, I realize, somewhat problematic given the diversity of persons residing in the West. As I argue later, this is a broad trend, taken up in
(ordered) and irrational (disordered) thinking. Dangers that cannot normally be detected could, by definition, be anywhere. They have behind them the weight of personal investments in lives, relationships, work and joy; they must be acknowledged. Given this, how is it possible to definitively decide that some responses are so severe as to constitute irrationality, particularly when failure to take health information seriously is also believed to be marginal, perhaps even disorderly, behaviour? The way of responding to the possibility of danger that indicates obsessive-compulsive handwashing (anxiety, ritualistic, repetitive) in fact presents a clearly logical response to this knowledge. It is logical to view the world as a series of potential hazards and to be overwhelmed by a resulting sense of concern with micro-contaminants. It makes sense that something touched before washing one's hands could be considered tainted by whatever inspired the handwashing, and is thus logical not to touch it again. And it is reasonable, if you never saw the polluting element in the first place, to have trouble feeling certain about when the danger has passed, and to act with extra caution. The fact that more people don't actually become sick in this way contradicts, but does not refute, this logic. I would prefer, therefore, to understand that what is most outstanding about OCD is that it seems to indicate an inability to ignore the possibility of medical misfortune, and to suggest that by extension, 'normal' subjectivity must to some extent depend upon such ignorance.
The Trouble with Normal

Of course, this raises an important question as to whether and how the apparently 'non-disordered' are managing to escape that sensitivity or, if you like, maintain that ignorance. Product marketers appear to have determined that fears about disease and contamination resonate with at least sufficiently wide an audience as to make a profit selling goods that promise to reduce the risk of becoming ill. 'Hand sanitizers', which we are encouraged to use after 'risky' activities like using a public pay phone, bank machine or door handle, a laundry detergent that sterilizes your clothing, antibacterial dish soaps, disinfecting aerosols and liquids, tapwater filters for home use and numerous similar products have been successfully marketed in recent years. Their advertisements tend to depict a world in which microscopic terrorists lurk at every turn, eager to prey upon the innocent and unsuspecting victims, threatening the sanctity of the home, the family and the body. One marketing campaign I find particularly interesting in this regard is for a product called 'Fit', a chemical solution with which to wash fruits and vegetables before serving, to ensure they are rid of all impurities. In one of its television commercials, a maternal older woman moves at a leisurely pace through her expansive garden harvesting all manner of tempting fruits and greens, as the voice-over speaks about the health benefits and

5 The trend is not restricted to concerns about cleanliness; an endless array of home security devices, personal insurance plans, psychic readings, credit cards, cellular communications devices and investment funds are just a few of the products whose value is often predicated upon the possibility of misfortune, and which promise 'peace of mind' about an unsure future. I have chosen to leave these out of the main argument only in the interests of presenting a somewhat consistent line of reasoning.

6 Such depictions correspond to a more generalized binary opposition between relative states of security and anxiety in the form of the local vs. the foreign, which I explore in more detail in Chapter 4.
pleasure of eating wholesome fresh produce, and hearkening back to the simpler, safer times when her own mother needed only to rinse nature's bounty in plain water. The imagery of the ad is quite direct drawing from notions of purity, health and vigor, and playing off the tranquility of the rural garden and nostalgia for past simplicity against the clutter and anxiety of contemporary urbanity. The ironic implication, of course, is that modernization has both revealed and created a new order of risks (pesticides and other pollutants), for which only a non-traditional solution is appropriate. Interestingly, no 'objective' information is provided as to the specific nature or severity of the risk these contaminants pose, and there is no mention of how advanced the 'epidemic' of illness resulting from eating produce washed in water alone has become, or even that it exists. Symbolic manipulation is sufficient to convey the simple message that even the purest things are now suspicious and in need of ritual attention: 'it is better to be safe than sorry'.

This places us squarely within the realm of anxious, ritual responses to symbolic problems, and therefore upon a continuum of obsessive-compulsive reasoning. Of course, there is a world of difference stretching out between opposite ends of this range, with substantive concerns and difficulties at one extreme that are plainly not an issue at the other. I do, however, mean to suggest that a greater concentration of 'obsessive-compulsiveness' is distributed more widely in society than is typically acknowledged by the sharply differentiated language of diagnoses. My argument is not that advertisements of this sort directly cause anxiety in any simple or direct way, but rather that for them to
make sense to people, they must be engaging with a more broad concern over
germs and so on than is explicitly recognized as 'normal'. Even clinical
psychology seems to acknowledge the existence of a certain amount ambiguity
as to who does and doesn't have OCD; the very interesting diagnosis of
obsessive-compulsive personality disorder (OCPD) has more recently been
made available to practitioners who encounter such cases (APA, 1994). The
criteria for this diagnosis include such damning and irrational behaviours as
being scrupulous about moral and ethical matters, being rigid and stubborn,
excessive adherence to social conventions, and a preoccupation with details.
This would certainly seem to open the field to quite a wide range of people, who
might otherwise have foolishly thought they were merely 'anal', 'uptight' or 'picky'!
The population can apparently be divided into three, rather than two categories of
person; in addition to the two poles of 'ordered' and 'disordered', there is the
additional (and probably very large) third denomination of people who are, by
logical extension, 'partially disordered'. This median group, 'other', nicely blurs
the taken-for-granted conceptual clarity of diagnostics, and the suggestion I want
to make here is that what constitutes full-blown clinical definitions of OCD is
largely a question of the degree of disruption of normal activities, rather than the
per se fact of such disruption. I also wish call attention to the problematic notion
of a category of 'normal' daily activities in relation to obsessive-compulsive
disorder, in the, and explore how both might be understood as regulated by the
substantive social forms and elements of 'risk society'.
'Responsible Citizenship': Risk as Pedagogy of Self-Governance

To recognize that application of the label 'disorder' has much to do with relative states, differentials and degrees of impediment in one's ordinary practice is to open the conversation to new possibilities for thinking about disorder and difference in and between people. By bringing normal activities into this discussion, my intention is to argue that there is an anxiety at work behind rigorous attention to cleanliness and contamination in addition to wariness towards health. Health worries, and the products and discourses around illness and contagion which sit behind them, suggest that it is more than simply smart behaviour to be cautious, that it is in fact part of our mutual responsibility as citizens, a part of how we assure our belonging within the collective and its social rewards. By incorporating and equating notions of rational behaviour with notions of responsible behaviour under the mantle of 'good sense', risk discourse intertwines with notions of obligatory freedom, rationalized populations and good, responsible citizenship (Rose, 1998). Understanding health risks therefore requires at least a minimal discussion of precisely what is taken to be at stake.

As I've noted at a number of points, the contemporary ethic of compulsory health and autonomy operates as 'a moral technology...to discipline the future' (Ewald, 1991 c.f. Lupton, 1999, p. 87), and is closely aligned with the liberal (and now, neo-liberal) goals of productivity, progress and world mastery. The concept of liberal citizenship, as both a presumption and an outcome of these aims, is predicated upon the intellectual 'transformation of human conduct into...the actions of psychological subjects engaged in making sense of their experience,
driven by wishes, hopes and fears, bound into dynamic relations with other persons and their social world', in order that populations could become self-governing 'in ways consonant with the ideals of liberty, equality and legitimate power' (Rose, 1998, p. 118 emphasis original). Risk, in this context, can be understood as a technique for measuring the likelihood that persons or phenomena will hinder these objectives, and categories of personhood can be seen as organizing individuals according to the severity or type of such risk they pose.

This is clear in the case of both OCD and OCPD, whose diagnostic criteria share a good deal of ambiguous and qualified language, such as 'excessive' scrupulosity, 'inappropriate' thoughts or 'marked' anxiety (APA, 1994, pp. 422-423). It is particularly interesting that in fact, none of the telltale symptoms of OCD receive any attention unless they are severe enough to constitute a significant interruption in daily life, routines or social relationships. According to the American Psychiatric Association, 'significant' means anything over one hour per day. This seems an odd infusion of rather vague criteria with objective, precise authority. Its peculiarity becomes especially clear when held against the number and range of personally rewarding and socially reproductive activities that are forsaken by most people for the minimal eight hours out of each day for formal employment. And yet, whereas the deep investments people often make in their work, the strong identification of self-image with productivity and occupation, and particularly the anxiety and depression that they sometimes experience when unemployed by the formal labour market is acknowledged by
psychologists and psychiatrists, it is not normally done within the specifications of abnormal behaviour, and is certainly not discussed within the context of OCD. Thus, it is not the fact of disruption that speaks of irrationality, but rather the risk such disruption poses to existing conditions.

I do not mean by this to advocate a radical inversion of socioeconomic relations in order to make the category of OCD non-existent in any material way. Rather, I am interested in calling attention to a collective obsession with economic productivity to suggest that the fact that such an inversion can be done conceptually highlights how some processes are protected, while others are reviled, by notions of order and disorder. This, I am contending, explicitly links constructions of risk and OCD to the social construction of citizenship as the embodiment of the ultimate rational, public actor making informed, self-interested choices about how to conduct (him)self in liberal, democratic society. Status as a citizen depends upon the extent to which individuals cooperate by managing the risks that inhere in their lives. As Peterson (1997, p. 198) puts it, 'individuals whose conduct is deemed contrary to a risk-free existence are likely to be seen, and to see themselves, as lacking self-control, and as therefore not fulfilling their duties as fully autonomous, responsible citizens'. Thus citizenship, in this context, is represented as a kind of productivity rate, and individual status has much to do with one's personal accountability, credits and debits on the balance sheet of collective progress in the accumulation of wealth, economic and political sovereignty and pleasure. Furthermore, as the market-based logic of corporatism and competition continue to encroach upon, or arguably to dominate, public
institutions, civic processes and perspectives on the governance of populations, this rendering becomes all the more entrenched and popular (Osborne, 1997).

The monetary contributions made by citizens as 'taxpayers' are frequently invoked to substantiate claims to individual rights of self-determination and access to participation in policy-related activities. Similarly, a tremendous emphasis is placed upon the orchestration of one's personal life and risks in such a way as to avoid becoming a burden to others and to society.

This focus can be seen with particular clarity in the context of discourses around health risks and health promotion, in which the notions of autonomy and the vulnerable body collaborate to normalize personal responsibility for wellness, and whose broad pedagogy is disseminated in the interests of encouraging an entrepreneurial, 'value-added' citizenship. The intensifying mobilization against cigarette smoking in North America nicely illustrates some of the dynamics and anxieties that such a notion implies. The expense associated with tobacco-related illness, both the direct costs of medical care for the ill and the productivity losses incurred due to time smokers or their families spend away from work to provide or receive medical care and shortened life spans, is seen as representing a formidable and unnecessary encumbrance to fatigued health care structures. Smokers are constructed as persons who made a poor, but voluntary, decision to take up the habit, and who thus must make a similarly rational choice to give it up. The difficulty in quitting posed by nicotine addiction is given far less attention, meaning that the fact that smokers are expected to submit themselves with rigorous discipline to physical discomforts not experienced by non-smokers in
order to be recognized as similarly responsible. More importantly, their failure to do so is taken up as presenting a major health risk imposed by a 'guilty' group who choose to expose themselves to the countless toxins in cigarette smoke upon an 'innocent' majority who have made no such choice. The ensuing resentment and outright hostility towards people who smoke therefore has to do with the right to self-determination in addition to what might be called 'intrinsic' health issues. It speaks of an underlying anxiety that the contagion of secondhand smoke can undermine health autonomy and, by extension, the extent to which one can be considered a full person, a non-encumbrance to civil society and significant others.

To show how this case of anxiety is related to obsessive-compulsive disorder I want to briefly consider some aspects of the response to the problem of cigarette smoke. First, through expert knowledge, it is identified as a risk. That established, further calculations are employed to determine how to minimize the burden imposed by smoking, and it is decided that best practices are to be found in prevention rather than treatment. Next, multifaceted efforts are launched, including things like educational and media campaigns, the designation of annual days in recognition of the effort (at least in Canada), the banning of smoking in public areas and the emergence of a deafening popular discursive space for discussion of the problems around cigarettes and smokers. What I want to highlight from this is that a rational perspective notices the risk, sounds the alarm, and is proposed and deployed in the response, which penetrates both deeply and broadly into ways of seeing and understanding the world. This is
reproduced quite closely in OCD. Risks understood in relation to a disciplinary way of viewing the world are subjected to strategies that also emphasize rationalization in themselves, such as developing a plan, setting aside the necessary time to execute it, breaking it into smaller tasks and keeping meticulous records as to what has been done, and how often. These strategies, while they may at first appear unusual, are above all anticipatory; imported from one situation to the next, in part or in full, they in fact can be understood as minimizing the disruption caused by an uncontrollable anxiety. The irony of course is that what is thus essentially a pinnacle of rationality, a 'systematic predetection' (Lupton, 1999, p. 93) is taken up as disorder.

Reflexivity, Risk, Agency, Creativity, Difference: OCD as Self-Work

I also believe, however, that the relationship of OCD to risk is quite a bit more sophisticated than simple faith in medical knowledge or a literal enactment of its barrage of advisories. On the contrary, I have sought to argue for seeing some elements of OCD as expressions of agency and resistance to authoritative narratives about the world, and to adopt a 'reproduction of expert discourse' thesis unproblematically would seem to directly contradict that position. Instead, let me reiterate that people with and without OCD take similar approaches to

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7 A more detailed (but hypothetical) account of how a person with OCD might go about this is given in the previous chapter, but the 'record keeping' aspect I've mentioned here needs some elaboration. In the case of compulsive washing a person might decide upon a particular number of washings for each of a number of different body parts and coordinate these with a sequence of other activities that are necessary for him or her to relieve anxiety. The numbers can get quite high, and the procedures quite complex, which entails a need for some method for keeping things straight and for knowing how much progress has been made. Some people count out loud, for example. My inclination is to suggest of this that in such a procedure, the numbers and counting
understanding and responding to risk and anxiety, and that these contain elements of both accommodation and resistance. To explain this, I want to briefly revisit the argument I made above concerning the dubious status of expert knowledge in contemporary societies.

The ambiguity that characterizes a modern understanding of risk has been described by Anthony Giddens as indicative of a greater tendency towards ontological reflexivity, or 'the susceptibility of most aspects of social activity, and material relations with nature to chronic revision in the light of new information or knowledge' (1991, p. 20). Under such circumstances,

even the most reliable authorities can be trusted only 'until further notice'; and the abstract systems that penetrate so much of day-to-day life normally offer multiple possibilities rather than fixed guidelines or recipes for action. Experts can always be turned to, but experts themselves frequently disagree (p. 84).

So, it is not actually possible to reproduce expert discourse, in any simple sense, because expert discourse is somewhat contradictory. Giddens further contends that in light of this, people have become more and more skeptical towards the absolute reliability of expert knowledge (c.f. Lupton, 1999, p. 75). This entails a kind of paralysis, posing a difficult problem for individuals, whose validation in society is inexorably tied to their ability to act rationally on the basis of information inputs, as well as for the societies constituted by those individuals. It presents a similar problem for the game of theorizing the relationship between the two, particularly when confronted by the evidence that people do in fact act, and address themselves to the social every day despite what might be described as

cannot be separated from the 'objective' technologies of measurement and precision that they represent, nor from the security these promise.
as a basic ontological insecurity. What can be said about this?

This question goes to a far deeper tension in social theory, to long-standing tensions and debates around structure vs. agency, and the possibility (or impossibility!) of articulating an elusive 'human condition'. While I certainly do not propose to solve this dilemma here, I do believe that some productive steps have been taken in sophisticated discussions of the self in contemporary Western life, and that these are useful in accounting for different understandings of, and reactions to, risk, obsessive-compulsive or otherwise.

For Giddens, modernity's reflexivity is a characteristic not only of expert knowledge but of individual sense-making as well. As traditional sources of truth and identity are increasingly called into question by the continuous, self-conscious revision of most bodies of knowledge, the production and location of self becomes a more tenuous affair. More and competing claims about the world position the self in something of an existential angst, yet they do not alleviate the responsibility of people for making choices; rather, this duty is more heavily emphasized. In terms of confronting the world's dangers, Giddens argues that 'living in a "risk society" means living with a calculative attitude to the open possibilities of action, positive and negative, with which, as individuals and globally, we are confronted in a continuous way in our social existence' (1991, p. 28). The potential anxiety of such an existence is unthinkably vast and demands that individuals develop a highly personalized risk 'calculus', a perpetual re-amalgamation of received information with personal experience, from which risk judgements and self-directed action may be taken (c.f. Lupton, 1999). Thus,
modernity's self is reflexive and vacillating, and risk knowledges are creative and contingent.

Giddens eschews terms like 'postmodernity' and 'poststructuralism' as descriptors of the present Western moment, in favour of the somewhat more cautious 'high modernity' or 'post-traditional' society, viewing much of what is considered to be evidence of a distinct social period as inevitable 'consequences of modernity' itself (1991). The phenomena described in either case, however, are largely similar, at least if Lupton's assessment is accurate:

Most theorists agree that post or late modernity is characterized by a growing sense of the failed promises of early or 'simple' modernity and a tendency to challenge the key assumptions of this period...uncertainty related to constant change and flux, cultural fragmentation and the breakdown of norms and traditions (1999, p.11).

As a proponent of a decidedly more 'postmodern' analysis, Nikolas Rose actually comes to some observations concerning contemporary selfhood that are quite similar to Giddens', but does so with a greater emphasis upon the power relations that make the auto-assemblage of a self possible. Rose directly implicates the 'psy' disciplines in the enabling of reflexivity, the prerogative of the psyche to be an object of its own consideration. He argues that psychology has become transformatively saturated within ways in which we construe and conduct our relationships with others...Each mode of encounter has been reconfigured in terms of personal feelings, desires, personalities, strivings and fears. Psychological techniques have come to infuse, dominate or displace theological, moral, bodily, dietary and other regimens for bringing the self to virtue or happiness, and also those deployed for reconciling the self to tragedy or disappointment (1998, p.95).

Happiness, health and personal fulfillment in all the spheres of one's life are the
stakes in question. These are thus linked to one's ability, *not* to simply place blind faith in the discursive advisories of professional discourses are, but rather to become enterprising and 'responsibilized', to develop what Rose calls a 'reflexive hermeneutics which will afford self-knowledge and self-mastery' (p. 157, emphasis added). In other words, it is the *interpretation* of discursive advisories that constitute one's sense of, and guide one's response to, the risks of the world. Knowing thyself includes knowing thy risks, and including this knowledge in the forging of the lifestyle judged most rewarding in terms of quality of life and emotional gratification and security. This 'lifestyle' is produced through 'informed choices' as a consumer not only of market goods and services, but also of relationships, commitments, anxieties and the gamut of passionate and emotional aspects that constitute who we understand ourselves to be. Thus, Rose's reading of governmentality incorporates the phenomenological and creative dimensions of personhood, although he is admittedly more concerned with the conditions of their possibility.

Giddens' theorizing also emphasizes the importance of personal relationships, affinities and lifestyle activities in understanding the contemporary self. My reason for comparing them in this way is to argue that individual risk knowledges, while clearly inseparable from risk discourses, are nonetheless also related to differences in life experience, personal interpretation and creative constitution of identity. Giddens' risk 'calculus' is, I am suggesting, roughly comparable to Rose's notion of a 'reflexive hermeneutics' of risk and self. Modern individualization and notions of autonomy demand that people approach their
lives as ongoing projects of self and identity, to be conducted reflexively in the context of intimacies and experiences, in pursuit of our 'unique personalities' against a cacophonous backdrop of information. Risk, it would seem, is both a partial cause for, and a generative component of, these projects and their importance. Hence differential understandings of risk despite a generally shared social experience are not only possible, they are quite presumed in a cultural milieu that places a high value on individuality and difference.

And indeed, different people come to remarkably different positions towards the level of hazard represented by varying risks, and two individuals can feel markedly different levels of comfort in identical circumstances. Thus, travelling by airplane is for many a terrifying prospect, which they take great lengths to avoid, while for others it does not warrant a second thought. The anxieties that result from this dialogue between experience and discourse are extremely complex and deep-rooted, and people often enlist the services of psychoanalysts or other therapeutic professionals to help unpack their internal genealogies, when they become obstacles to personal development. Similarly the anxiety of obsessive-compulsive individuals is manifest in particular ways, and the concerns felt by one person may be entirely beyond the normal comprehension of another (Rapoport, 1989), as may the practices they evolve to cope with these concerns. For example, a person so overwhelmed with the possibility of coming in contact with trace fecal matter that they take large and regular doses of anti-diarrhoea medication and avoid public washrooms at all costs may be entirely mystified as to the logic that leads another to shun any
restaurant where beef is served, for fear of contracting Creutzfeldt-Jacob's disease. And, to continue with the comparison, some therapeutic encounters, and some people's attempts to come to terms with their OCD, involve seeking out the 'root' of the obsession, or simply wondering, 'Why or how have I become this way?'

'Size Matters'

Risk and obsessive-compulsive disorder are thus related not only to one another, but also to the project of interpreting and acting in the world. This implies constriction, but also the possibility of feeling secure through the active construction of a personal knowledge that allows us to organize risks in such a way that we can continue to act, and to understand ourselves as whole persons. Emily Martin's (1997) study of lay people's construction of their own immune systems argues, for example, that for many people, vivid imaginings of how the body's internal processes work to fend off disease allow for continued operation in a world that is understood as never completely free of external threats (pp. 67-68). Although the outcomes clearly differ, the similarities between this conceptualizing work and that typified in OCD are strikingly similar. That their depictions may be scientifically 'inaccurate' or run counter to media imagery of immunology is, in this context, beside the point. All responses, I am arguing, are intended to maintain or restore order and a sense of personal control. Thus, I

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8 I would be remiss if I did not qualify this by saying that the more popular (and more successful) approaches to treating OCD tend not to seek out 'root causes', preferring to deal with the immediacy of the problems experienced through chemical or behavioural therapies, or a
also propose that even when people’s OCD translates into constructions of risk and contagion that are so cautious as to cause their withdrawal from meaningful activities in the social world, it is not appropriate to describe this exclusively as an inability to cope. While the severity and shock of the experience of having those thoughts and feeling those sensations that motivate such a withdrawal cannot be underestimated, it is also the case that this can be understood as a reorganization of one’s life into a smaller, more controllable area, given the imposition of a highly restrictive set of rules of risky conduct. So paradoxically, the capitulation to discourses of limitless possibilities in this case also signifies a claiming of some spaces in which a kind of autonomy is asserted, forms of identification with others are undertaken, and rational personhood is defended.

OCD, I am suggesting, is fundamentally ‘about’ the utter impossibility of saying, finally and with absolute certainty, that something could not or will not happen. It is about what one can do with the limitless range of possibilities in the world, and how to make sense of them in such a way as to enable forms of action in and on that world. And, it is about the claiming of a space within which to conduct this self-production. I will suggest in Chapter four that the regulation of actual, social spaces has much in common, in terms of both form and content, with obsessive-compulsive notions of risk to the body and the amplification of dangerous possibilities. For the moment however, I wish to delay this discussion of space and comment briefly upon the viability of seeing a special relation of OCD to the body in terms of a particular time, or era.

combination of the two (Rapoport, 1989). When psychotherapies are included, it is often in the interests of helping people to cope with the social experience of being disordered or different.
Many theorists argue that the contemporary period, late or post modernity, is characterized by a high acknowledgement of subjectivity and ambiguity. Many of these also suggest that this has meant that the projects of the self and its representation in the social world, which Giddens and Rose emphasized so heavily, are accomplished as ongoing projects of the body (e.g. Shilling, 1993, 1997; Synnott, 1993, Turner, 1996). Put simply, as the plane of possibilities broadens, the prominence of choice and agency intensifies, concentrating to the scale of the person and the prone but pliant body. The body is all at once more individualized, more visible, more susceptible to risk, more malleable to change and more important and stable as the expressive and representational medium of the self. It thus becomes the focus of consumptive choices in terms of relationships, lifestyle, identity and the general mode-of-being, in the social world (Falk, 1994).

OCD is also a way of being in the world, one which I am tempted to describe as a metaphor for a more general postmodern ontological disorder. I want to be cautious about this, however; while there is certainly something very 'timely' about OCD, I do not mean to suggest that the metaphorical relationship is also causal. As well, it is likely that similar processes at other historical moments have been apprehended in entirely different ways. To illustrate what I mean, and to conclude this discussion, I want to return briefly to the lengthy example I borrowed from Deborah Lupton at the beginning of the chapter. It describes how in Medieval France, a generalized anxiety about nightfall and the constituents and ontological status of darkness provoked the behavioural response of
retreating indoors. I have argued here that in obsessive-compulsive disorder, particular notions of responsible personhood, agency and the body have combined with an overwhelming and alarmist body of data concerning the hazardous character of everyday life and a collective learning process that repeatedly proves itself inadequate to sufficiently prepare us for these, to produce a similar state of anxiety and uncertainty. What is done with this anxiety is, however, critical. What must be emphasized about this is not that it is simply an irrational response to an equally irrational, false concern. Rather, given the knowledge possessed about the world at a particular historical moment, sensible, positive action was taken as a way to reduce that anxiety and gain a sense of control over the world.

In the current context, OCD might be viewed as a rather practical, 'commonsense' response to what Beck and Giddens have called the 'risk society'. Of course, the unfortunate outcome of such a response is not only the harsh reality of the disorder, but also that this very effort at sense-making is socially pre-constructed as unproductive social deviance, and is not recognized as deserving of any social status. Thus, the material difficulties faced by people with OCD are pathologized in a social vacuum, reinforcing the medical notion of biological disorder and the medicalized vision of the 'disorderly citizen'. The question as to under what conditions such a marginal citizen is possible are thereby circumvented. In this chapter, I have hoped to point to the disciplinary politics of regulatory power, the prerogative of managing risk as an ongoing project and the way these are embodied in the navigational work of the self.
Cartographies of Anxiety and Abjection: OCD and Spatial Culture

The three preceding chapters have followed a generally similar structure, which is itself borrowed from Susan Bordo's (1993) explication of particular streams of cultural thought that converge in the disorder anorexia, but also highlight important continuities between anorectic embodiment and everyday life. With Bordo's work as a guide, I have focused upon ideas about the self, the dually-conceived body, and risk, and have tried to sustain discussions of various ways that aspects of each of these can be seen to be relevant to obsessive-compulsive disorder. This can be tentatively characterized as describing culture through its representation in OCD and embodiment.

This chapter represents, to my mind at least, something of a departure from those that have come before it. Once again, I take a cultural theme - social space- and examine its relationship to OCD. The difference is that while I do consider spatial questions in OCD, I am also concerned here with the inverse, that is, reproductions of OCD in social space. This latter point is, of course, a
figurative comparison. It is impossible to characterize the spatial practices I will address below as truly 'disorderly' in any clinical sense; because they actually constitute 'normal' relations, they cannot be at odds with them. To put it another way, they cannot both be, and be against, the grain. As I have argued previously, true 'disorder' in the sense of its clinical mobilization, demarcates only those instances, bodies and persons for which/whom this convenience is no longer possible. The point, again, is to call attention to this contradiction.

This chapter makes use of a number of additional continuities from the previous chapters. Risk and subjectivity are recurring themes, and I aim to maintain focus upon the role played by the body as it relates to both OCD and social space. There is just 'something about' space and the body in social theory; as discrete points of analysis and when approached together, they share a similarly ephemeral quality and often figure prominently in theoretical excursions that approach the metaphysical in scope. Further, it is widely suggested that both body and space are inscribed by cultural practices, and can be instructively decoded by those who wish to learn about and describe these. Minimally, I would suggest that an intrinsic relationship can be drawn between the two figures simply because, on the one hand, each seems imperceptible without the other, and on the other hand, each is arguably both a source and an effect of cultural knowledge production. In this chapter, I explore this relationship in the context of risk, body and OCD.

As well, I want to bring a spatial perspective to issues of power and knowledge. The organizing assumption of this thesis has been that OCD can be
conceptualized as part of a continuum, such that certain 'normal' cultural priorities can be discerned in the seemingly irrational presentation of the disorder. Disciplinary cultural knowledge production systems (particularly medicine, psychology, and pharmacology) exist which simultaneously introduce and reproduce OCD as a discrete syndrome, actively disavowing its continuous character, fixing the separation of 'normal' and 'abnormal' psychic life and patrolling this boundary.

Terms like 'separation' and 'boundary' might easily be used here without a second thought towards the spatial metaphor they construct. And yet, there is also 'something about' this scientific concern over a pure category of normalcy which I think bears some comparison to other cultural expressions that often go unexamined. Specifically, I want to suggest a relationship between two prevalent anxieties that circulate in everyday cultural discourse, over, on the one hand, the threat of bodily contamination, and on the other, the corruption of physical space by persons or practices defined socially as undesirable. It is this relationship that will be outlined and explored below.

The positing of this relationship permits asking fundamental questions about the production and perception of disordered bodies and spaces: In what ways, if both body and space are indeed culturally inscribed, can symptoms of OCD be revealed in taken-for-granted space? Or, conversely, how might space, both figurative and physical, configure the experience and/or the understanding of mental disorder and OCD specifically? This is therefore about the configurations and reconfigurations of boundaries and transgressions of a
particular kind in social relations. It is a series of probes into a complex problematic, which emerges from the conceptual and practical interworkings of body and mind, self and other in space, of culture and the individual, the central and the marginal, the pure and the tainted, the normal and the pathological, of borders, fluidity and risk.

**Somatic Society**

Something of a context for this investigation has come from the work of Bryan S. Turner. Turner (1996) suggests that societies can be conceptualized as 'somatic', insofar as the major individual and collective social problems of a given era are animated in and through the body. Although it appears in a more complete form in Turner's later work, the somatic thesis is developed in *The Body and Society*, which posits a sophisticated, if somewhat overarching, model for thinking about the relation of body to society. His argument is that, in order to solve the Hobbesian question of social order (i.e., 'what capacitates society?') all societies must reproduce and regulate their populations over time and space by applying techniques of internal and external restraint and representation at the level of the individual body (p. 108). While these tasks are universal, the particular characteristics of a given society depend upon its unique historical (and, presumably, ideological) development, and define as ill or disordered those conditions which contradict or impede its' address of these priorities. Thus, 'all

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1 Although the term 'somatic society' is associated with Turner's (1992) *Regulating Bodies: Essays in Medical Sociology*, the arguments presented there organize much of his better known study, *The Body and Society*, which was first published in 1984. I am working from the second edition, published in 1996.
illness is social illness', insofar as symptoms can be understood as reflections of deep cultural preoccupations (p. 124).

Turner argues that in the industrial West, where liberal notions of individualism are heavily emphasized, actual individuals experience a 'representational crises of self-management' (p. 125). The effects of this crisis are more severely felt by women in patriarchal society, and the illness that is most precisely symbolic of the current tensions and ambiguities of being female is anorexia. Certainly, there is a cultural pathology articulated in the anorectic body. I would suggest, however, that anorexia can be seen as a form of obsessive compulsiveness over the meanings culturally ascribed to body size through regimes of knowledge such as gender and self-control (Bordo, 1993). Ironically, there is support for this interpretation among traditional psychological/psychiatric thought and practice, as well. Of anorexia, the current Diagnostic and Statistical Manual of Mental Disorders states:

> Obsessive-compulsive features, both related and unrelated to food, are often prominent. Most individuals with Anorexia Nervosa are preoccupied with thoughts of food. Some collect recipes or hoard food. Observations of behaviors [sic] associated with other forms of starvation suggest that obsessions and compulsions related to food may be caused or exacerbated by undernutrition. When individuals with Anorexia nervosa exhibit obsessions and compulsions that are not related to food, body shape or weight, an additional diagnosis of Obsessive-Compulsive Disorder may be warranted (1994, p. 541).

Men and women are diagnosed with OCD at a comparable rate (p. 420), which suggests that the cultural 'crises' it expresses, to continue with Turner's language, are unrestricted by gender, reflecting a more broad base of concerns. As a larger category of disorder, OCD is fundamentally about an individual's level of sensitivity and response to a cultural program.
Despite Turner's inclusion of 'space' in his matrix of body/society/illness, his attention never leaves the presentation/inscription of symptoms in the particular bodies of individuals. The simple question as to what disorderly space is, and actually looks like, remains implied but unanswered. In the case of anorexia, a strong case could surely be made for viewing public spaces of exercise as cultural shrines erected in homage to weight loss, body mastery and the modification of physical nature. There is also, and perhaps even more clearly, a spatial somaticization of OCD, a wide range of cultural practices of space, which closely correspond to its symptoms.

What's Space Got to do With it? Thinking Spatially about Disorder and Difference

OCD is situated within an authoritative medical discourse concerned with the mental health of individual, abnormal cases. Returning briefly to the diagnostic criteria outlined in the introduction to this thesis, consider the way that OCD is indicated as a separate territory whose population and limits are defined by the intersection of a group of strange characteristics. This amounts to a demography, a conceptual and heuristic distance for discerning categories and distributions of persons. Note as well that the spatial logic used in marking this difference between individuals is also employed to describe the evidence of that difference. Symptoms are provided with a place of origin ('within the sufferer'), which gently confirms the uniqueness of their appearance and disavows the possibility of a cultural component. Additionally, they move from this point of issue, unwanted, into another territory, the mind. So, 'mind' in general is here
also conceived of as space, a finite region with discernable limits. A healthy mind is that which remains inviolate, while the disordered mind is understood as having been penetrated and corrupted. The diagnostic work of psychiatry might thus be recast as a mapping of sorts, in which the concept of rationality is used to organize difference both between and within subjects.

There is however, within this diagnostic mapping, at least one peculiar ambiguity to which I want to call attention for a moment. The World Health Organization’s International Classification of Diseases quite clearly identifies that while the anxieties of OCD originate within the individual, these 'ideas, images or impulses enter the individual's mind again and again' (p.1). This would seem to raise a serious question as to the primary, precise source of this distress. Could it be the body? After all, having bracketed off both mind and collective, what else remains? Now, while this vagueness is almost certainly not intentional (on face value, the suggestion appears ridiculous) it may not be entirely coincidental. There is a powerful symmetry taking shape here, which can be instructively explored. Recalling the tendency, discussed earlier, to view the flesh as weak, it is perhaps more than a poetic slip that the body is somehow implicated by elimination, in compromising the sanctity (sanity?) of the discrete, rational mind.

A critical reappraisal of this Cartesian legacy, including the triumph of mind over body, reason over passion and the reign of the autorationalizing, individuated subject, is what I argue must form the context for a new and skeptical approach to the social relations which constitute the categories, 'mental illness' and, specifically, 'obsessive-compulsive disorder'. As a system of
power/knowledge in correspondence with this legacy, notes Foucault, psychiatry has from its inception been, ironically, quite 'obsessed' with identifying madness and fixing its ontological opposition to reason (c.f. Sheridan, 1980). Moreover, Foucault illustrates how this opposition is not merely conceptual, but enacted physically and spatially as well. The history of psychiatry is not only a history of defining the bodies of the mentally ill; it is also a history of excluding those bodies. A useful distinction may be drawn here between modes of exclusion, however, between expulsion and confinement. To the contemporary observer, confinement is likely the more familiar response to madness, as the mental hospitals and group homes of today are fairly direct descendants of the asylums of past eras. Expulsion is compellingly illustrated in the 'Ship of Fools', quite literally a vessel loaded with the mad, who were '... expelled from the city itself, but allowed to wander freely over the countryside. To prevent their return, they were often entrusted to groups of merchants or pilgrims, who then deposited them at a safe distance from their point of origin' (p. 17). There is a wealth of symbolism present in the figures of water and travel in the 'Ship of Fools' as a cultural response to difference, which seeks a restoration of order through both spatial and conceptual segregation. Key properties of this practice suggest an almost allegorical mode of signification; the metaphor of 'the voyage' for personal transformation, the sea as a wall and its representation of the limits of known

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2 As a partial aside, it is interesting that Alan Sheridan points out that Foucault's investigation into the historical treatment of madness yielded, as the unifying characteristic which transcends different periods' definition of the condition, '... an unproductive idleness, outside human achievement [and] the great work of history (p. 15, parentheses added). This may be usefully compared to the inclusion of 'significant interruption of daily activities' as a criterion for diagnosing OCD.
space and the cultural imagination of the unknown. Foucault's comment on this is typically obscure, but eloquent:

But water adds this to the dark mass of its own values; it carries off, but it does more: it purifies. Navigation delivers man to the uncertainty of fate; on water, each of us is in the hands of his own destiny; every embarkation is, potentially, the last. It is for the other world that the madman sets sail in his fools' boat; it is from the other world that he comes when he disembarks...He has his truth and his homeland only in that fruitless expanse between two countries that cannot belong to him...One thing at least is certain: water and madness have long been linked in the dreams of European man (pp. 17-18).

This deep-seated link Foucault speaks of may go some way to explaining the water's more familiar relevance to ritual purification and more literal forms of cleansing. Consider the Christian baptism, as an illustration of the principle at work here: in its natural state, the newborn human infant has an ambiguous, and therefore irrational, status. The baptism, including the recitation of sacred words and the application of holy water to the head of the baby, serves to correct this by way of an explicit initiation into the church, and therefore into organized human society and culture as well3. With distinct membership in society thus confirmed, anxieties over the liminal infant body, and by extension, over the reproduction or re-embodiment of the population, are assuaged. The point is that water is understood as useful for the treatment of anxiety and the exclusion of disorder; it is literally and figuratively restorative. Not surprisingly, it figures prominently in obsessive-compulsive washing, as a strategy for removing the perceived threat of disorder from the space of the body itself.

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3 Another example can be seen in the Mikveh practices of Orthodox Judaism. Here, menstruating women (whose bodies are doubly disorderly) participate in bathing for ritual purification. Interestingly, the Mikveh site is physically removed from everyday life, and is forbidden to men. It should be noted, however, that this has also permitted the Mikveh to be conceptualized, and to...
Spatial Systems in OCD

Leaving aside momentarily the deep signification of water, I want to narrow my focus to the actual, individual bodies of people with obsessive-compulsive disorder. One feature shared by those two responses to madness discussed above, expulsion and confinement, is a great metaphorical and actual concern to establish and act upon a system of internality/externality, margin and centre, self and other. Parallels can be drawn between this logic and that employed by people with OCD to develop a system for determining what is clean or contaminated, and how to respond to feelings of anxiety, as they are experienced under this system. In both instances an opposition is set up between a local (centre, self) and an extralocal (margin, other) with the latter perceived as a danger to the former. Both demonstrate great concern over the boundary between these two, and in each case tremendous anxiety may result from acts or threats of transgression. Accordingly, a great deal of effort is made to patrol this border and to maintain its integrity.

My argument is that in OCD, the body represents this border precisely, and that this is illustrated in the predominance of ritual body washing and cleansing in OCD. In the first chapter, I drew upon Julia Kristeva's (1982) notion of abjection to explore the relationship of obligatory freedom and the formulation of self-identity to mental disorder and OCD. It is an equally useful device for discussing similarities between the borders of bodies and spaces as well. The abject, again, is that Other which challenges or threatens the uniformity or serve, as a somewhat insurgent site for the cultivation of women's political solidarity and personal relationships sheltered from the male gaze.
coherent identity of a local or Self, and so must be continuously and vigorously expelled. Thus madness, or in more contemporary language, mental disorder, which was once physically removed from civil society, is now conceptually set apart from psychological normalcy.

In bodily terms, the abject is associated with things perceived as pollutants: bodily fluids and wastes, food, disease, germs, dirt and death. The items on this list all pass through the borders of the body, exposing its contingencies. Not coincidentally, they also figure prominently as foci for obsessions and compulsions, as do the regions of the body through which they pass. This implies a spatial ordering, an obsessive-compulsive mapping of the body, or those bodily regions perceived as vulnerable. In addition to the hands, discussed above, the mouth and nose, perhaps the ears and eyes, and certainly the genitals and anus are frequently centralized as spaces of concern upon the body. Feet are also problematic: as a condition of public life, feet come in contact with what may be imagined as an uncontrollable quantity and diversity of germs. For some people with OCD this may pose a problem in passing from the public to the private simply because it is quite impossible to wash the feet without subsequently putting them back on the ground.

If there were few surprises in this (by no means complete) mapping of bodily danger zones, it is perhaps because of the very great amount of ritual hygiene, fetishization and general mythology which already directs itself to these centres in acknowledged culture and 'normal' practice. Moreover, the knowledge systems that produce this way of comprehending embodiment generally
stigmatize those people whose bodies are perceived as non-compliant, unruly, or otherwise too far outside the obvious grasp of accepted cultural norms (Synnott, 1993). This point is made to call into question the separation of ordered and disordered individuals. If, as abjection suggests, cultural processes demand disgust towards certain constituents of social life as criteria for securing both individuality and group approval, isn't revulsion and the urge to clean a reasonable, even desirable, response to feelings of contamination? I would argue that it is indeed, and that we ought therefore to understand OCD as a continuum of culturally sanctioned traits, widely displayed to degrees of greater or lesser intensity by most people.

A second lesson from abjection: each unit in the pairings of the self and the abject, or the centre and margin, is only ever intelligible in relation to its Other. By extension, neither is ever entirely discrete; each is always implied by and so contained within the ontological limits of that which is positioned as its opposite. There is correspondence between this and the anxiety in OCD over the arbitrariness of the surface of the body, as sufficient defense of the interior against its environment. Karen Berman's (1998) theorization of the Amsterdam attic that hid Anne Frank and her family from the Nazis during the Second World War articulates a similar theme via an architectural and spatial poetic of the problem of secrecy and exposure, and of slippage between borders.

A building is a collection of opacities and transparencies, a theater of appearance and disappearance in which we mask our presence or make it known. Every

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4 This is also a key feature in Susan Bordo's (1993) explication of anorexia nervosa. Bordo notes that in anorectic individuals (still overwhelmingly female), cultural undercurrents concerned with gender, body dualism and self-control interact to produce a sense of oneself as 'too much body'. She casts anorexia, in turn, as a response to this perceived stigma.
existing wall contradicts itself with openings, places where the obduracy of matter yields to the necessity of passage... These gaps present us with opportunities to be seen and heard. Yet the exchange across the buildings porous envelope makes us vulnerable... We are revealed through these traces, the things that architecture cannot keep, the separation it cannot provide, its secretions, the excess that leaks through like light (p. 169).

Indeed, many different 'architectures' can be seen in operation here, each struggling with the impossibility of its own finitude and that of those that surround it. Anne's mind pours from her person to her diary, which also disguises a rich and deep tapestry of her reflection within its inauspicious shape. Anne's body in relation to the bodies of her cohabitants; the group in relation to the attic; the attic to the house; the house to the city... the model repeats over and over again, the interfaces innumerable in a single snapshot, or moment. Each instance of relation implies both merging and differentiation, and both the exhilaration of being discernable to others and the immense problem of exposure.

Bermann's insight suggests that any space of greater intimacy may come to represent an exo-skeletal self, relative to its environment. The implication of this, taken here to refer to the particular 'meaning' or quality of the relation between a centre and its margins, is not given objectively. On the contrary, it derives dialogically in the former's self-identification, made possible only through its imagination of the latter. The centre, in order to exist, '...must fix or better still objectify the Other in time and space' (Holloway and Kneale, 2000, p.75).

However, while these acts of imagination reconstruct a social order, they are also structured by their cultural context, such that any action of the self reflects its engagement with the collective. In Bermann's instance, the Nazi's objectification of Jews as Others meant that the Franks were subject to unimaginable
restrictions of body, geography and identity, and relations of persecution and power also heavily configured their possibilities for self-other-work, despite the hidden context in which it occurred.

The simultaneity of individual and collective voices contradicts any antimony of individual and society. Instead, the individual is a micro-society, and society functions as an extended self... The self is not simply in the body, but rather distributed between positions located in real or imaginary space, with the possibility of moving to and fro between the several positions (Hermans and Kempen, 1995, p. 111).

Other spaces, in which the self is imagined, stand in for the body. This is particularly true of those most familiar and secure locations with which we most closely identify ourselves. Those we inhabit like a second skin, occupied, marked and shaped in our image by everyday acts of intimacy; the inauspicious 'doing' of self. Think of the adolescent bedroom or school locker, for their testimonial displays of the ongoing process of individuation. Seeing your car in a parking lot, like finding your face in a photo of a crowd. Spaces that wink at you; your old house that you walk by more slowly, even years after moving out.

In reproducing familiarity and security, however, there is also the generation of marginality, insecurity and risk. The contrast between these spaces above, whose 'meaning' blooms, and those which collapse into the category of 'other' is expressed by Michel de Certeau (1985, p. 136) in the opposed figures of 'synecdoche' and 'asyndeton'.

These two perambulatory figures are mutually reflective. One enlarges one element of space in order to make it play the role of a 'more' (of a totality) and substitute itself for that (the motorbike or the furniture for sale in a shop window stands for the entire street or neighborhood); the other, through elision, creates a 'less' and makes gaps in the spatial continuum, retaining only relics or selections from it... Thus handled and shaped by practices, space forms itself into enlarged anomalies and separate islets. Through such swellings, diminutions and fragmentation, a spatial sentencing is created... (p. 137).
This 'totality', the 'spatial sentencing' to which de Certeau refers is, I will suggest, the re/production of culture and the social through the dialogical reconstitution of self and other. While by no means would I argue that such work only occurs spatially, or in speaking/walking de Certeau's 'perambulatory rhetoric', something instructive is offered in this model for the theorization of OCD. The coherence of the self that is created by this mode depends upon the capacity to construct the other as dangerous and exotic. This suggests that ignorance of the particularities of the external represent a coping mechanism for the integrity of the internal. An individual's inability to perform this ignorance would seem to result in a self spread too thinly in its constitution, a weakness of its boundary; disorder. Again, this is precisely the metaphorical, and in some ways the actual, circumstance of obsessive-compulsive disorder: an apparent amplified sensitivity to logical possibilities (i.e., contamination) which others seem to ignore unproblematically, and a consequently greater concern with the status and upkeep of bodily borders.

**Obsessive-Compulsive Spaces**

In the foregoing discussion, I have tried to develop a theoretical framework with which to call attention to ways in which abjection, centre, margin and amplified sensitivity to the risk of penetration constitute organizing principles not only for obsessive-compulsive bodies, but within everyday socio-spatial relations as well. I hope that I have done this sufficiently to now move to considering
examples of what ordinary cultural practices might thus be considered as constructing obsessive-compulsive spaces.

I have suggested that both the home and the body can be understood as physical representations of the self. It follows that if the body can be mapped according to its regional associations with the abject, so too can dwellings. Certain zones are designated for certain kinds of practices in correspondence with cultural orientations to body and space. Perhaps, for example, the argument I made above concerning the dubious status of feet may be extended to the 'mud room', that peculiar hybrid zone which mediates the inside and the outside in some homes. This operates as something of a buffer, a holding area for boots and other outdoor paraphernalia considered out of place in the interior, but nonetheless not to be left on the porch.

More obviously (and maybe more convincingly!) other bodily considerations are reproduced in kitchens and bathrooms, where the vulnerable parts of the body are most likely to be exposed or in use. Because of their proximity to eating, excretion, cleansing, and other bio-processes, these locations become the focus of much ritual activity, with a particular focus upon minimizing risk (or its perception) through cleaning. They are often decorated in whites or light colours, brightly lit and with smooth hard surfaces like tile, emphasizing sterility, purity and easier cleaning. Additionally, these zones typically contain water access; water, it is suggested above, being closely linked to the history of ritual purification. Not only do the architectural conventions of water location effectively regulate where engaging the abject may occur; they
also suggest mastery over nature (water and its wild flows) by culture and civilization (the permanent home, directing water through pipes), an extensive disciplining of space. Sinks, bathtubs and, to a lesser extent, toilets often have more than a simply functional aesthetic; they are stylized and chosen like shrines. The unruly abject body is thus relegated to spaces arranged to contain and transform it, symbolically and literally. In this sense bathrooms and kitchens can almost be taken as genres, standardized communicative forms that articulate highly rational and objective spaces, anticipating the perceived irrational and contingent qualities of the body and nature.

Moving beyond the boundary of the home (tellingly, a security code may be required to open this door), the abject body is reproduced as points and objects of relegation in public space. The collective anatomy is subject to much the same hierarchical ordering as that of the individual. A plain illustration of this can be found in the discursive distinction between rural and urban spaces, which is frequently a differentiation of the virginal and homogeneous countryside from the swarms of the city, despoiled and ambiguous. Indeed, industrialization and urbanization have, from their outset, provoked a tremendous degree of anxious and regulatory imagination in philosophy, literature, medicine, policy and other forms of social commentary (Donald, 1999). And within the city, places, or types of places, whose character is identified with the irrational abject body are frequently the subject of similar attention. It has been my experience, for example, that it takes only a few pointed questions before ordinary individuals will
intimate a great distrust for public bathrooms and describe techniques they have adapted for visiting them securely. A more sophisticated, if also more generalized, anxiety is particularly the case where the public sphere 'shows its privates'; where the sexual parts of the city are found. Strip clubs, brothels and, especially, the red-light zones of prostitution are constituted through discourses of immorality, dirt and desire as breeding grounds for the degradation of 'proper' communities.⁶

As well, the ensuing anxiety and hostility form the impetus for a kind of medicalization of such places. As the subjects of much and varied 'panoptic' attention (Foucault, 1979; Rose, 1998), their constituents are pathologized through enumeration and categorization of deviances, and in forums such as income, crime and public health data. This 'biopsy' acts to produce only one possible reading of these spaces, and they are taken up as social problems. Collective systems are devised to excise or, more often, contain the problem. The stronger police presence in areas known for prostitution, or otherwise criminalized, might be seen as a patrolling of both literal and figurative boundaries that are drawn between kinds of bodies/citizens and kinds of spaces, in accordance with policies designed to assess and manage risk.

Thus we have a) the cultural constitution of a risk of border transgression; b) an anxious response that seeks to conceptualize this problem in an orderly way; and c) the implementation of a strategy corresponding to this

⁶ Recent conflicts over the shipping of Toronto's garbage and processed solid waste sludge to outlying rural communities for disposal offer an exceptionally strong example of body abjection as a process that is both discursive and spatial.
conceptualization, which hopes to ease the anxiety. This is, I will suggest, precisely how OCD works. It is therefore also the key for locating the symptoms of the disorder's spatial somaticization. A virtual catalogue of these exists in David Sibley's (1995) Geographies of Exclusion: Society and Difference in the West, from which the current chapter's title takes its cue. Echoing Paul Rabinow, Sibley's project is to 'anthropologize the West' through an interrogation of largely unexamined spatial practices that produce and respond to subordinate groups as social undesirables (p. ix). The regime of rationality/non-ambiguity figures heavily in this analysis, which suggests that public space has come to be defined as rational and fit for capitalist relations of production and consumption. This operates as a master discourse in Western societies, articulating an ideal citizen as the bourgeois, healthy, adult, white male, earning and spending money. The less one is able to embody this ideal type, the more one, and the space that one occupies, are understood as polluted and posing a risk of defilement.

Admittedly, these distinctions are rarely so precise in practice; different bodies display the corporeal indicators of rational citizenship with more or less success. Nonetheless, the cultural order imagines a list of high-risk others, including the mentally and physically disabled, the homeless and poor, prostitutes, queer sexualities, some ethnic others, political dissidents, disenfranchised youths, convicts and other defiled persons, locating them 'on the

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Gender is part of the equation here. That these spaces tend to overtly display female sexuality means a double offense is done to the notion of public, which defines itself in association with masculine reason and rejects feminine passion.

7 Here Sibley distinguishes himself as one of the remarkably few social scientists to refer to OCD, even in passing. He notes the repressive nature of cultural regimes of personal hygiene, so widely encouraged for medical and social reasons that '...washing and deodorizing the body has assumed a ritual quality and in some people can become obsessive and compulsive' (p. 4).
margins or in residual spaces and social categories' (p. 67). Fear of mixing entails a set of segregated and segregating spatial arrangements that exclude these people from rational space and work feverishly to prevent and punish transgressions. Psychiatric and residential hospitals, prisons, boot camps; urban renewals, social housing, gated communities, bath houses and downtown alleys; laws, policing, all manner of rehabilitation, immigration procedures and private security forces, with and without remote cameras and other techniques or apparatus of surveillance, in public space. The amalgam is what Sibley refers to by a 'geography of exclusion': a corroborating spatial reproduction of the cultural logic of power and difference.

As an organizing assumption of this paper, I have suggested that via a critical interrogation of this cultural logic, and the representation of its symbolic order, it is possible and necessary to draw a line of continuity between psychologically 'normal' individuals and those with OCD. One cornerstone of that argument was that, given the high levels of ambiguity and subjectivity that typify the contemporary period, uncertainty in assessing risks to the individual body are understandable. For the present argument, I hope to have extended this consideration to the collective, by suggesting a degree of parity between 'real' bodies and other relatively local spaces, as representations of the self. Thus, this ambiguous epistemological moment means a retreat not only to projects of the body, but also to a concentration upon these representative locals of scale. In homes, communities and other intimate places, as is arguably the case of the body, the crucial work of 'selfing' -development and protection- is done largely
through the consumption of goods, services and policies (Falk, 1994; Shilling, 1993, 1997).

The relationship of consumption, citizenship and the commodified body in the spatial instance clarify the importance of power relations in defining and regulating difference and abjection; simply put, more social resources means a greater capacity to manipulate these processes in the interests of the powerful. It also suggests that capitalist social relations represent an 'absent totality', a fundamental signifier or base from whose logic everyday spatial objects and practices issue, and acquire their meaning (Jameson, 1997). I think that there is a great deal to be learned from this line of thinking. It has much in common with the argument I drew from Nikolas Rose's work earlier in the thesis; roughly that (if I may be permitted to mix paradigmatic vocabularies) the drive for world rationalization and ever-increasing progress have spawned 'superstructural' notions of liberal freedom and delineated particular possibilities and obligations for understanding subjectivity, mental health and good citizenship. However, as compelling as these arguments are, I would suggest that behind world mastery, behind rational capitalism, and behind economic and political systems in general, there lies the body, and the absolute imperative for societies to reproduce it in time and in space.

This brings me back full circle to Bryan Turner's 'somatic society', his treatment of the Hobbesian problem of order and the impact of cultural problems upon individual bodies, in the form of characteristic illnesses. Like the body, space is marked by the symptoms of disorder; in the case of OCD, this marking
occurs in problems of abjection, boundaries, containment, contamination and risk. It is interesting that Hobbes himself described society as a 'body politic', a collective body fabricated for the security of actual bodies. If these actual bodies can be taken as the basic physical representation of selves, or individuals, I will suggest that space, similarly, must be understood as the physicality of the body politic.

It should therefore come as no great surprise that the two should share the same stripes. Bodies and spaces each mediate individuals and collectives, creating, communicating and displaying messages about themselves and one another. Social space implies both curriculum and pedagogy; both things to learn and ways to learn it. Given the cultural order's encyclopedic fascination over risk and pollution, it is difficult to imagine how its bodies and spatial relations could be anything other than at least slightly obsessive and compulsive.
Concluding Remarks

I said in the introduction that my interest in a sociology of obsessive-compulsive disorder began as an undergraduate student. In the roughly four and a half years since then, I have searched sociological social-psychological and related literature on mental health and illness and, despite finding the necessary components to approach such a project, I have located the words 'obsessive-compulsive disorder' exactly twice. Neither of these took up OCD, rather they mentioned it in passing and in comparison. Thus, while I am not completely certain of this, I say with reasonable confidence that sociology and social theory have utterly ignored OCD.

This remains a mystery to me. Some of the most fashionable areas of theoretical investigation (body, self, risk and space) intersect with and in OCD. Similarly, many the recurrent themes and tensions surrounding OCD and cutting across these substantive interests are the stuff of metatheories of human society: marginalization, power and knowledge, gender and sexuality, cultural process,
subjectivity, materiality, difference, psyche, rationalization, biology vs. culture, structure vs. agency and so on. As well, OCD and its metaphors and problems cut across numerous disciplines; not simply in social theory, but also in fields like epidemiology, urban planning, medicine, criminology, and even economy and marketing. There is no question as to its relevance to social theory, and place in sociology of the body. If nothing else, I hope to have presented a viable group of arguments to that effect.

There is also no question as to its ambiguity as a diagnosis of objective difference. The anxieties of OCD are fixed in relation to notions of proper selfhood, embodiment and citizenship, themselves not entirely distinguishable from their framing in power and knowledge. Moreover, these anxieties are distributed amongst supposedly normal people, and practiced without question as a matter of everyday life in the spaces of the body and body politic.

As I've said, it is tempting to suggest, with so much of OCD framed in language and discursive practices, and for its expression of ontological ambiguity in the wake of the erosion of many modern sources of identity and security, that here we have the true 'postmodern condition'. This is an engaging idea, but tantalizing as it is, it may not be entirely appropriate. For one, whether we, and then of course, precisely which of us, are in fact post-rather than late-modern people, can be disputed. Additionally, in the excitement over the possibility of making a grand proclamation of theory, it is easy to overlook the fact that for most people with obsessive-compulsive disorder, only some aspects of thought and behaviour are subject to obsessions and compulsions. That is, it is not
necessarily the case that the whole or even the majority of their identity fits the characteristic ambiguity of postmodernity. In harvesting only those aspects that prove the postulated idea, 'Other' bodies are once again treated as the mute objects of a theoretical gaze. For the moment, I can offer only this insight: while OCD may be constituted and governed in discourse, it would be futile to argue that acknowledging these arbitrary aspects of the disorder-in-concept somehow diminishes the difficulty it poses for real people. First and foremost, the condition is salient as it is encountered and negotiated phenomenologically through the sensuous, lived body.

This brings me to my final comment on OCD, or rather on cultural process as it is revealed through the disorder. This is not an entirely original point, but rather an old argument about disease made new again in the instance of OCD. Obsessive-compulsive disorder calls attention to the characteristic ambiguities and tensions in the cultural moment, exposing and interrogating the deep structure of normalcy through the eruption of difference. In so doing, it confirms the simultaneously and irreducibly material and discursive ontological status of bodies and embodiment as the fundamental units and symbols of society and cultural production. Thus, the everyday structures of dependency, creativity, discipline and difference are brought to bear, literally and metaphorically, in the politics of disorder in society.

A critical analysis of the cultural genealogy of OCD can therefore highlight the nexus of a number of fundamental dimensions of social organization and relations. By way of a conclusion, I want to suggest some questions or
observations this work raises which might usefully serve in further directions for studying the embodiment of the 'official' marks of OCD, and writing social and political theory more generally. First, as disorder and OCD acquire their particular and marginal meaning in relation to broad trends in society, the cultural analysis of OCD serves as a platform for the study of social and cultural change. As social orders evolve and transform, so too does the notion and embodiment of disorder. This leads towards another potential deployment of this work, insofar as it may be used to open a dialogue about the ways in which social organization are reflected in and affected by cultural forms such as the body, or social space. Multitudes of such forms exist, and materialize in social arrangements that include, but range well beyond, the embodiment of illness or disorder.

Additionally, issues of embodiment immediately call attention to issues of selfhood and subjectivity. The arguments I have presented raise philosophical questions as to the very nature of subjectivity and its evolution in contemporary Western society. In many ways, this is organized around notions of purity of body and of identity, and the ways in which these are configured within cultural constructions of risk to the self, the secure and the familiar. When these deeply invested identities combine with discourses of obligatory liberal freedom and autonomous, self-responsible citizenship, the stage is set for particular kinds and expressions of identity politics in Western societies. In terms of social and political theory, this may be helpful in thinking through what some of the strengths and limitations of identity struggles framed under these circumstances might be, historically, presently and for future communities.
Finally, by bringing some mechanisms of cultural knowledge production to light in the context of embodiment, OCD and the politics of social and personal order and disorder, we are left with a related series of broad but poignant and urgent questions: Whose 'obsessions' are we ultimately burdened with? How do we bear or embody these? How has this happened? Who does this marginalize? What sorts of effects does this marginalization have on people? And, perhaps most the most important issue at hand: What should we do about it?
References


