(Re)Gendering Panic: Towards a Critical Sociology of Agoraphobia

Shelley Z. Reuter
Concordia University

KEYWORDS: AGORAPHOBIA, GENDER, PSYCHIATRY, SOCIAL ORDER

Since 1871, when the first psychiatric article on agoraphobia was published, this disease—known variously as panic, panic disorder, agoraphobia with or without panic, and so forth—has had a curious trajectory: beginning with a marked prevalence in men that lasted roughly five decades, the disease was ‘re-gendered’ after the First World War and has persisted as a predominantly female problem ever since. Using the method of discourse analysis and working from the premise that psychiatry is shaped by factors beyond medicine, this paper examines psychiatric reports of agoraphobia since the late nineteenth century to argue that the history of this disease represents more than simply that of an individual psychological/biological disease phenomenon. Rather, it is important to understand agoraphobia in the context of the complex normative social and historical process of its re-gendering.

In the industrialised West, a surprisingly high proportion of the population suffers from agoraphobia, the fear of public or open spaces. Mostly urban dwelling (George, Hughes & Blazer, 1986), some agoraphobics are too fearful of public spaces even to step just a few feet beyond their front door to collect their mail or newspaper. With prevalence rates estimated as high as 5% (Rosenbaum et al., 1995) or over 12 million sufferers in the United States, agoraphobia has emerged as a significant social problem. To date the vast majority of people who are reported to suffer from agoraphobia are women. In fact, women are between two to four times more likely than men to develop agoraphobia/panic disorder (Sheikh, Leskin & Klein, 2002; Weissman, 1990; also Joyce et al., 1989). Moreover, being female increases the likelihood of developing one of a number of anxiety disorders by as much as 85% (Cloitre et al., 2004). But these rates are particularly striking when considered in historical context: prior to the First World War over 80% of reported agoraphobia sufferers were men (Reuter, 2001, p. 73).

Using the method of discourse analysis and working from the premise that psychiatry is shaped by factors beyond medicine, this paper will interrogate the gendering, and subsequent re-gendering, of this disorder following the war. Following Arthur Kleinman who argues that ‘[p]sychiatric concepts, research methodologies, and even data are embedded in, ’ and further, that ‘psychiatric diagnostic categories are constrained by history and culture as much as by biology’ (1988, pp. 3-4),

---

1 For inquiries, Shelley Reuter can be reached at Department of Sociology & Anthropology, Concordia University, 1455 de Maisonneuve Blvd. West, Montreal, Canada, H3G 1M8 (sreuter@alcor.concordia.ca)
the paper aims to demonstrate that from the outset of its recorded history, the discourse of agoraphobia has been more than simply descriptive of an individual biological or psychological disease phenomenon. Rather, it is important to understand the (re)gendering of agoraphobia as a complex normative social and historical process—one that is distinct from other medicalised conditions over-ascribed to women. For example, previous feminist studies of hysteria, another ‘female disease’ with origins in the nineteenth century, have forcefully illustrated the politics and subordinating implications of medicalising femininity (see Reuter, 2006 for an overview of this literature). However the present discussion goes beyond these accounts of hysteria—written mainly by historians and literary theorists—to offer a distinctly sociological perspective.

First, on the face of it, agoraphobia seems to be a problem for individuals and more suited to psychological study, which may account for why only a few social scientists have taken interest in this apparently anti-social, disorder (see Brown, 1986; de Swaan, 1990; Seidenberg & DeCrow, 1983; Reeves & Austin, 1986). Yet even the isolation typical of agoraphobic behaviour could be seen as essentially social. Durkheim certainly demonstrated the sociality of individual behaviour when he argued that suicide—an act that seems to encapsulate individual distress par excellence—is in fact a social phenomenon (Durkheim, 1951 [1897]). Furthermore, as Simmel has argued: the ‘mere fact that an individual does not interact with others… does [not] express the whole idea of isolation. For, isolation… refers by no means to the absence of society.’ Isolation represents a very specific relation to society and ‘a given quantity and quality of social life creates a certain number of temporarily or chronically lonely existences’ (1950 [1903], pp. 118-9).

Second, central to the psychiatric accounts of agoraphobia is the fundamental and normative question of what it means to have social order, which, as we shall see, includes ideologies of gender, culture and political economy. As such, psychiatric discourse emerges as an important site for sociological analysis since, as Rose has argued, the psychosciences are profoundly social (1998, p. 67).

Third, existing critical accounts of this disease accept rather uncritically the disease category of agoraphobia as uniform and stable, yet a close reading of the psychiatric literature reveals that in fact, practitioners and researchers deploy this disease concept quite inconsistently, suggesting that agoraphobia has been a disease with many ontologies. Not only has agoraphobia been a disease prevalent in men and in women, but it has also been referred to by several different names and descriptions, including panic, panic disorder, agoraphobia with or without panic, space phobia, claustrophobia, neurosis, anxiety, a symptom, a syndrome, a disease, a disorder and so forth. This variability has persisted despite the American Psychiatric Association’s efforts to
contain it within their ‘scientific’ system of classification, the Diagnostic & Statistical Manual of Mental Disorders.

Fourth, the study of apparently individual problems such as agoraphobia in sociological terms is critical to the sociological imagination itself. As C. Wright Mills famously stated, an accumulation of ‘personal troubles… must be understood as public issues.’ Sociologists must explore ‘the human meaning of public issues’ and relate them ‘to personal troubles—and to the problems of the individual life’ (1959, p. 226).

And finally, the current reductionist feminising of agoraphobia must be understood in terms of its substantive and distinct early history as a disease prevalent in men. As demonstrated elsewhere, psychiatric representations of agoraphobia have served as a key conduit to its production as a meaningful and powerful psychiatric category because within these representations is contained what may be referred to as the ‘psychiatric narrative’ (Reuter, 2006). Specifically, while the disease embodies very real physiological and emotional experiences of suffering, implicit in this medical narrative is a normative and gendered (and ‘raced’ and classed) socio-cultural account of patriarchal capitalist social order. That is, the disease must be understood in terms of the intersection of gender, class, race and culture. Thus building on Foucault’s genealogical work, this paper seeks to understand the role of psychiatric discourse in producing gendered agoraphobic subjects in this context. As Foucault argues (in a discussion of genealogical method): ‘It’s a matter of shaking this false self-evidence, of demonstrating its precariousness, of making visible not its arbitrariness, but its complex interconnection with a multiplicity of historical processes’ (1991, p. 75).

The paper begins by outlining its methodology, to be followed by a brief discussion of agoraphobia’s modern urban origins in order to provide a context for understanding the early prevalence of agoraphobia in men, and its subsequent re-gendering after the First World War.

**METHODOLOGY**

In assessing critically the role of psychiatric discursive practices in the production of agoraphobia as first a male and then later a female disorder, the present discussion takes a genealogical approach. It emphasizes the processes by which social-psychiatric categories are naturalised and aims to trace and problematise these extant categories as historical formations. Such an approach can reveal how dominant rationalities—such as psychiatry—are deployed as technologies of power: ‘how forms of rationality inscribe themselves in practices or systems of practices and what role they play within them’ (Foucault, 1991, pp. 79; see also 1982, p. 210).

As part of a larger historical-sociological study of agoraphobia, psychiatry and psychoanalysis (see Reuter, 2001; 2002; 2006), the main
source of data for this paper is primary-source psychiatric reports of agoraphobia since the first cases were documented in 1871. The mobilisation of this disease category in and through these medical texts is of particular interest because these texts are a key means for doctors to discuss with one another such things as causation and treatment. Therefore, they constitute an essential site for exploring the discursive processes that Foucault observes. Reading these materials enables us to explore the cultural assumptions that inform psychiatric writing and in the case of this paper, dichotomous (that is, bifurcated, ideological) ideas about gender. These materials especially enable us to see how these ideas intersect with and are inextricable from the question of what it means, both medically and culturally, to be ‘normal’ and ‘pathological.’ In other words, how do these texts perform critical ideological work (Poovey, 1988, p. 2)? A close reading of these texts reveals not only the gendering and re-gendering of panic but also a gendered and medicalised response to first men and then women who step(ped) outside the prevailing social order.

The materials to be examined here are primarily comprised of individual psychiatric case reports by individual physicians because this style of medical reporting of agoraphobia has, until relatively recently, been most common. Over time the discourse has also come to include larger multi-authored scientific studies and entries in the Diagnostic and Statistical Manual of Mental Disorders (American Psychiatric Association, 1952; 1968; 1980; 1987; 1994; 2000). In collecting these data, the search was restricted to English-language reports only, which has largely meant a focus on British and American psychiatry. However, whenever possible, translated materials are also included. In the last two to three decades especially, the discourse of agoraphobia has become more international, yet the influence of the American Psychiatric Association and its DSM categories is evident. The discourse of agoraphobia continues to be oriented particularly to American concerns and experiences; moreover, most of the literature published today is in English.

The reports published between 1871 and 1965 were compiled using the Index Medicus, a paper index to current published medical literature of the world. Approximately 130 relevant reports between the years 1871 and 1965 were found, with twenty written prior to the First World War, an electronic index to medical literature, was used to locate reports published between 1966 and the present. A broad search, i.e., simply using the term ‘agoraphobia’ with no limits other than language, turned up over 2400 reports with most having publications dates after 1980 (i.e., the release of DSM-III). Given the high volume, these reports were sorted

---

2 Berrios & Link (1995) offer an account of the history of anxiety disorders from the perspective of French and German physicians that is largely consistent with the present account.

3 The diagnosis of agoraphobia/panic disorder remains most common in North America and Western Europe.
according to emergent themes (see Reuter, 2006), relevance and the law of diminishing returns. Reports informing the present discussion were selected on the basis of explicit or implicit references to gender.

**URBAN INDUSTRIAL MODERNITY & AGORAPHOBIA**

In the late nineteenth century amid growing secularism, medicine moved into a position of great social importance. Physicians’ abilities were considered to be both ‘powerful and seductive,’ and sickness was increasingly seen as best left in ‘credentialed hands’ (Rosenberg, 1992, pp. 267-268). Combined with an increasing propensity among the laity to seek self-improvement, doctors working within such a potentially lucrative medical market developed an unprecedented degree of authority (Hansen, 1992, p. 119; also Porter, 1997, p. 305).

As the role of medicine in society expanded, so too did the division of medical labour. As a result, many doctors tended towards specialisation in psychological medicine, for which demand was on the rise. Indeed, professional psychotherapy provided a ‘vocabulary of troubles… shaping lay definitions of everyday difficulties [and] moulding the presentation of individual complaints [into] problems suitable for professional treatment’ (de Swaan, 1990, p. 139). In other words, psychiatry gave lay individuals a language and a framework for speaking about themselves, their everyday experiences and, most importantly, their problems.

Among the problems that individuals were experiencing was that of the agoraphobic—a ‘new’ category to label people who were fearful of public or open spaces. This new social type emerged at least partly as a result of the professionalisation of psychological medicine (Clark, 1995, p. 567) and the medical publications that emerged following doctors’ encounters with agoraphobic patients (Reuter, 2002). But as Clark has demonstrated, the delineation of anxiety and panic disorders ‘required more than just the existence of an organized medical profession and psychiatric specialty and the presence of free-floating symptomatologies waiting to be appropriated and classified.’ What was also required was enough of a change in society so that ‘anxiety and panic no longer appeared as more or less continuous or recurrent features of common life, but rather as exceptional and to some extent avoidable disturbances to individual mental health and well-being’ (Clark, 1995, p. 567).

Dr. Charles Atwood of New York, for example, wrote a paper on ‘our present ways of living,’ that in the city ‘our rapid and over strenuous life,’ unaccompanied by sufficient rest, is the cause of the ‘increase in nervous and mental derangement.’ He saw mental strain as the result of the ‘increased demands upon us, the increased number of sensory impressions and variety of ideas forced upon by our increasing interests.’ Atwood argued that ‘[t]he emotions are intensified by our present rapid methods of living and drawn upon continually’ (1903, pp. 1070-1072).
The ‘rapid methods of living’ that Dr. Atwood describes were particular to the modern urban context (of that time), where abnormal anxiety was on the rise and acquiring a higher profile among neurologists, psychiatrists and surgeons throughout the industrialised world. Therefore it can be argued that agoraphobia emerged also partly in response to the changes in society due to the growth of industrial capitalism and the associated challenges of urban existence. Building on Clark’s arguments and combined with those of Atwood, it was only with the changes brought about by urban industrial modernity that the anxiety and stress that Atwood describes could be perceived as extraordinary: whereas it was ‘normal’ in pre-modern and modern times to be anxious about things such as crop failure and famine, epidemic diseases, personal security, war and so forth, only with ‘the rise of urban industrial capitalism,’ as well as modern medicine and psychiatry, did anxiety and panic become ‘more exceptional’ and ‘individualised’ (see Clark, 1995, p. 568).

Atwood’s remarks also reflect an emerging and expanding fear of the modern city evident in many physicians’ reports of agoraphobia. Dr. Henry Sutherland, for example, maintained that some patients only experienced agoraphobic feelings in cities, as demonstrated by their ability ‘to bear the sight of a wide green plain’ (1877, p. 266). Though he wrote very little on agoraphobia per se, the psychoanalyst Sigmund Freud also expressed some concerns about city living, arguing that ‘modern nervousness’ was spreading rapidly. The tension between individual constitution in the nervous patient and the demands of modern civilisation—between ‘living in simple, healthy, country conditions’ as the ‘forefathers’ did, and living in ‘the great cities’—was causing “increasing nervousness” of the present day and modern civilized life’ (1963 [1908], p. 21).^4

As discussed elsewhere (Reuter, 2001; 2006), these concerns about the city were also echoed by architects and urban planners (see for example Sitte, 1965 [1889], p. 45), for whom agoraphobia was ‘not simply… an affliction of the modern city dweller’ but ‘proof that contemporary cities were in their very form bad for health’ (Vidler, 1991, p. 35). A parallel discourse emerged among social theorists such as Karl Marx (1964 [1884]), Emile Durkheim (1933 [1893]), Max Weber (1958 [1904-5]), Ferdinand Tönnies (1957 [1887]) and Georg Simmel (1950 [1903]; 1978 [1900]), all of whom perceived a growth in social problems and turmoil brought about by the changes of modernity. Among their concerns were the rise of mass production, the increasing division of labour and the growing estrangement and the progressively more impersonal nature of social relationships. Indeed, by century’s end, anxiety came to be seen as reflective and symptomatic of problems in society at large (Clark, 1995, p. 564).

Simmel especially focused on mental life and the metropolis or ‘the

^4 Freud also blamed the ‘undue suppression of the sexual life in civilized peoples (or classes) as a result of the ‘civilized’ sexual morality which prevails among them’ (1963 [1908], p. 24).
seat of the money economy’ where exchange value and consumption were the basis for impersonal social relations. Like others, Simmel perceived that modernity had brought with it a host of social problems. He observed that life in the modern city, with all its ‘nervous stimulation’—the crowds, the intensity and the rampant individualism—produced the ideal conditions for the development of mental and emotional difficulties. The ‘psychological conditions which the metropolis create[d]’ were constituted, in Simmel’s words, by the ‘rapid crowding of changing images, the sharp discontinuity in the grasp of a single glance, and the unexpectedness of onrushing impressions.’ Simmel argued that, ‘[t]he metropolis exacts from man [sic] as a discriminating creature a different amount of consciousness than does rural life’ (Simmel, 1950 [1903], pp. 410). Life was so fragmented in this ‘asphalt and stone wilderness’ (Vidler, 1993, p. 34) that people had to create an ‘inner barrier’ in order to protect their fragile psyches—a ‘blasé attitude’ as Simmel put it. This blasé attitude was a response to the ‘rapidly changing and closely compressed contrasting stimulations of the nerves.’ In the modern urban context, one’s nerves were agitated ‘to their strongest reactivity for such a long time that they finally cease to react at all.’ Moreover, ‘harmless impressions force such violent responses, tearing the nerves so brutally hither and thither that their last reserves of strength are spent.’ Eventually, one would become unable to ‘react to new sensations with the appropriate energy’ (Simmel, 1950[1903], pp. 413-414), driving one to take social distance by developing ‘an inner barrier.’ This inner barrier was ‘indispensable for the modern form of life.’ Without such psychological distance, the metropolis, with all its ‘jostling crowdedness,’ would ‘simply be unbearable’ for the ‘sensitive and modern individual’ (in Frisby, 1986, p. 73).

Thus, as Simmel’s remarks demonstrate, a self-preserving response of emotional withdrawal was a way of coping with progress and the exigencies of modern existence. As he wrote, ‘Since contemporary urban culture, with its commercial, professional and social intercourse, forces us to be physically close to an enormous number of people, sensitive and nervous modern people would sink completely into despair if the objectification of social relationships did not bring with it an inner boundary and reserve’ (in Frisby, 1986, p. 73). And the condition that best captured this ‘emotional trait’ of anxious reserve was, as Simmel wrote, ‘the so-called ‘agoraphobia’: the fear of coming into too close a contact with objects, a consequence of hyperaesthesia, for which every direct and energetic disturbance causes pain’ (1978 [1900], pp. 474).

In sum, physicians, architects, planners and even social theorists helped give social estrangement ‘all the dimensions of a psychological complex’ constructed from a range of new mental diseases, which seemed tied to the urban context. Agoraphobia was thus at once both diagnosis and metaphor: the pathology described symptoms of urban anxiety at the
same time as it captured the alienation that individuals felt and experienced in modern society (Vidler, 1994, p. 12). More importantly, the diagnosis gave agoraphobic individuals a medical framework through which to make sense of their experiences in the city and of themselves as different from ‘normal’ others (Hansen, 1992). It was in this context that physicians diagnosed the first patients—all men—and it is to them that we turn next.

Gendered Panic

First among the early reports of agoraphobia was that of the German physician, Carl Otto Westphal (1833-1890), whose ‘Die Agoraphobie’ appeared in the *Archiv für Psychiatrie und Nervenkrankheiten* in 1871 just as the discourse of urban anxiety was beginning to escalate. Already well known for his monographs on diseases of the brain and spinal cord and for publishing the first-ever case report of ‘sexual inversion’ (1869), Westphal would also become known for having given the fear of public or open spaces its permanent name (his colleague M. Benedikt previously described the problem as *platzschwindel* in 1870.)

In addition to being the first case report to deal with this disease, also noteworthy about ‘Die Agoraphobie’ was that all of the patients Westphal described were men. They included a 32-year-old commercial traveller, a 24-year-old merchant and a 26-year-old engineer (as well as a fourth man, a hypochondriac, who suffered only occasional bouts of agoraphobia), all of whom resided in the city (Berlin) and complained of symptoms such as difficulty walking through open areas, crossing streets and squares, and being in crowds and enclosed spaces. When the men found themselves in these situations they felt unsafe and were overcome with overwhelming fear, confusion and even trembling. But the presence of an ‘escort,’ a ‘vehicle going [in] the same direction,’ or ‘seeing an open door in one of the houses located on abandoned streets’ seemed to alleviate the anxiety, enabling the men to go where they needed (1988 [1871], p. 74).

Westphal was not unusual in his reporting only on men. The evidence, gleaned from the psychiatric reports of the period between ‘Die Agoraphobie’ and the First World War, suggests that affluent ‘adult men of education’ (Van Horn, 1886, p. 601) were generally the most prone to developing agoraphobia (though it must be acknowledged that as individuals of means, these men may have been the most likely to seek medical help). Dr. J. Headley noted that agoraphobia ‘seldom attack[ed] poor people,’ and in his ‘experience professional men suffer most, clergymen in particular.’ Headley Neale noted that he had known ‘merchant princes, commercial travellers, middle-aged spinsters, and even young married women caught in its toils,’ but opted to use ‘the male pronoun for brevity’ since ‘the disorder [was] more common in males’ (1898, pp. 1322-3). However this was only true until the war, after which time the (reported) incidence of agoraphobia in males dropped, while the
incidence in women increased significantly.

So the question becomes why? Why did the gendered prevalence of agoraphobia shift to women? How did this shift come to pass? If the thesis put forth by Simmel, physicians and architects and urban planners was correct that the anxiety people experienced in the city led some individuals to develop agoraphobia, then why were men apparently—yet only initially—more vulnerable to urban stress? The next section will explore possible explanations.

(Re)Gendering Panic

Together with the view that agoraphobia was connected with the perils of modern social change and over-stimulation in cities, the individual characters of patients figured prominently in the perceived etiology of agoraphobia. Mental disorders were often equated with moral depravity and personal weakness and were seen as threatening to bring about a ‘moral epidemic or even… change the structure of society and unity of the household’ (Atwood, 1903, p. 1072). We might recall, for example, Dr. Sutherland; he was certain that the agoraphobia in his patients (all male) was the result of their excess and debauchery (1877). His theory was consistent with a widespread belief among doctors of that period that diseases ‘followed in the wake of excesses of all kinds’ (Agar, 1886, p. 3) and ‘deficiencies in the way a patient lived’ (Warner, 1986, p. 86). As one physician, F.W. van Dyke (from Oregon) observed, ‘with the majority of men who begin [drinking alcohol] in moderation, the immoderate use becomes the rule, and with this a decline of mental and physical power’ (1908, p. 178).

But these moralistic interpretations of agoraphobia’s etiology cannot be fully understood in isolation from some very strong turn-of-the-century bourgeois ideas about gender roles (i.e., how proper women and men should behave) that were in force at that time. In particular, we might consider the restrictions on women’s movement in public space (still occurring in some contexts) aimed at excluding them from public life—albeit restrictions that were bound up with highly contradictory messages. As Wilson writes, ‘[j]ust as nineteenth-century society was trying to deepen and secure the boundary between public and private, industrial capitalism was erasing it’ (Wilson, 1995, p. 149). This was because women’s social status hinged in part on her and her husband’s material possessions and ability to consume (Wolff, 1989), resulting in an increasing and seductive market consumerism that included exhibitions, department stores, refreshment rooms, rest rooms and reading rooms—all places where bourgeois women could go unchaperoned. But of course alongside this tendency to encourage (bourgeois) women to consume and move about in public space, was a perhaps stronger desire to control them.

This desire—the ideology of ‘separate spheres’—was evident in
ladies’ nineteenth century deportment manuals, for example, where women’s role was declared to be primarily that of wife and mother. As Barbara Welter has shown, prescriptive guides to True Womanhood (such as the aptly titled The Young Lady’s Book: A Manual of Elegant Recreations, Exercises & Pursuits & Woman as She Was, Is & Should Be (Welter, 1966, p. 152), promoted a clear and definite boundary (still evident today) between women of refinement and those of the lower classes. Premised on the middle-class notion that a ‘lady’s’ place was in the home and consistent with reformers’ unease about women’s sexual and intellectual independence, women unaccompanied in city streets were seen as a moral problem (see Wilson, 1992; also Strange, 1995). Thus in this context, staying home for a bourgeois woman—agoraphobic or not—may well have signified normality in so far as it consisted with what was deemed proper and moral middle-class feminine behaviour.

However, the early historiography on separate spheres, which included Welter’s work, was based on two contested assumptions that must also be taken into account. The first was that nervous diseases such as this were ‘a kind of pathological by-product of middle-class Victorian and Wilhelminian society’ (Micale, 1995, p. 156). Yet historians have established convincingly that these problems have manifested in lower-class populations since well before the nineteenth century. That such problems were evident among the lower classes suggests not that they were rare, but rather, that they were ‘simply unrecognized, untreated, and unreported.’ Citing Charles Rosenberg, Micale observes that in the latter decades of the nineteenth century health care services administering to and increasingly used by the working classes were created. But until the early twentieth century the bourgeoisie and aristocracy were much more able and likely than people of the lower classes to go to doctors and to be treated and studied by the professionals doing the sort of medical writing under examination here (Micale, 1995; Rosenberg, 1974).

This early historiography also assumed congruence between the prescriptions of deportment literature and bourgeois women’s real experiences. Although there were restrictions on women’s presence in the streets alone, scholars have questioned the extent to which women occupied a truly separate sphere (Davidoff & Hall, 1987; Kerber, 1988; Vickery, 1993). Evidence suggests that the metaphor of separate spheres oversimplified the ‘real’ situation of women in the latter half of the nineteenth century, that the rhetoric—the ideology—was a departure from the reality. While there was something to the metaphor, women’s lives were more complex than straightforward confinement in the home. Indeed, their experiences varied by class, region, degree and type of industrialisation and numerous other factors (Wolff, 1989), including the imperative of consumption as well as the greater participation of men in domestic life than the notion of separate spheres would suggest (Davidoff & Hall, 1987). Certainly working-class women would have been more
concerned about subsistence than the ideological requirement of domesticity; as August (1994) has demonstrated in his study of lower-class and poor women’s employment in the late nineteenth-century (London), contrary to the middle-class notion that married women only worked when the household was in financial crisis, in fact it was common for single, married and widowed poor women to work hard throughout their lives.

While clearly the symptoms of agoraphobia mapped directly onto what was expected of bourgeois women, then, it can be argued that prior to the shift in prevalence after the First World War, their staying home had gone unrecognised as pathological. Perhaps this ‘passed’ as appropriate feminine behaviour rather than making women candidates for psychiatric diagnosis like their male counterparts, precisely because the symptoms of agoraphobia corresponded with the ideological criteria for ‘normal’ and class-based femininity. However what was previously considered normal bourgeois feminine behaviour—domesticity—did eventually become seen as pathological—as agoraphobic—and there are several possible explanations for this change in perception.

First, affluent (white) women’s experiences of public space were changing, pointing to a possible relationship between the increasing tendency to diagnose women with agoraphobia after World War I and their increasing participation in the public sphere. During the war and in the absence of their male relatives, women achieved some measure of independence but this independence came with increased public responsibilities that some but not all women necessarily wanted to assume. As Kohler Riessman has demonstrated in her study of the medicalisation of childbirth and reproductive control, ‘women have simultaneously gained and lost with the medicalization of their life problems.’ In fact, women have ‘actively participated in the construction of the new medical definitions…. Women were not simply passive victims of medical ascendancy [and to] cast them solely in a passive role is to perpetuate the very kinds of assumptions about women that feminists have been trying to challenge’ (Riessman, 1998, p. 47). Extrapolating from this, it is conceivable that with modern urban life apparently so difficult for many people, not all women could face their own emancipation and/or were deterred from doing so by other social forces and relationships. Therefore, in some instances, post-war agoraphobia may have provided a legitimate means to avoid gender politics. In other words, following Rosenberg’s (1972) influential argument that hysteria served as ‘an alternate role option for particular women incapable of accepting their life situation’ (p. 655), the agoraphobic ‘sick role’ may have similarly provided a means for some women to circumvent the gap between the ideal and the reality of wartime and post-war independence.

Second, and conversely, although the doctrine of separate spheres was on some level rhetorical, the ‘invention’ of agoraphobia provided the
added advantage of social control. With the social authority medicine had secured for itself by this time, perhaps reinforcing the imperative of ‘True Womanhood’ in the language of disease was a way of thwarting the expansion of (bourgeois) women’s rights. As the American psychiatrist Abraham Myerson put it (in 1929) in one of the several essays he wrote on the tyranny of domesticity, ‘the neurotic woman, a chronic invalid for housework, may do a dragon’s work for Woman Suffrage’ (pp. 71-72). Myerson’s support of feminism was exceptional for its social-historical time, though, and despite a substantial number of women practitioners, early twentieth-century psychiatry, in its ‘aggressive masculinism’ was unmistakably a man’s field (Lunbeck, 1994, pp. 35-36). Accordingly, it was predominantly men who wrote the scholarship on agoraphobia and by the war’s end little space was left for the possibility of this disease being anything other than a peculiarly feminine problem whose subtext was a narrative about proper (normal) gender and class-specific behaviour. As Lunbeck observes, in the early twentieth-century American psychiatry shifted its focus from insanity to the normal; that is, to the ‘realm of everyday concerns—sex, marriage, womanhood and manhood’ and so forth, thereby ‘weaving a psychiatric point of view into its many aspects’ (1994, p. 47). The shift in prevalence of agoraphobia from men to women may well reflect psychiatry’s overall shift to an emphasis on normative gender roles.

Third, ‘war neurosis’ or shell shock had also emerged on the psychiatric landscape by this time (and notably, here too the labels were classed and gendered). Allan Young documents that in total the Royal Army Medical Corps, for example, had treated 80,000 cases of the disorder and 30,000 troops diagnosed with nervous trauma had been evacuated to British hospitals (1995, p. 42). In fact, this diagnosis—rather than the diagnosis of agoraphobia—was frequently invoked in doctors’ reports of men’s anxieties—whether or not they had been anywhere near an exploding shell (Shephard, 2001). With 200,000 ex-servicemen in receipt of pensions for nervous disorders (Stone, 1988, p. 249), the war produced ‘large numbers of men who acted like women,’ that is, ‘strangely hysterical.’ Psychiatrists had no choice but to reconceptualise hysteria as a strictly female problem (Lunbeck, 1994, p. 252). Because the conceptual separation of hysteria and agoraphobia did not ‘take’ until Freud’s ideas did, (that is not until well into the 1920s), arguably agoraphobia was included in (American & British) psychiatrists’ rethinking what they meant exactly by hysteria, especially in relation to men, before and after the war.

Fourth, given its resonance with the ideals of True Womanhood and the perceived essential femininity of nervous disease, a diagnosis of agoraphobia would have called into question male patients’ masculinity, unlike the comparatively more heroic war neurosis. Of course, diagnosing men with shell shock would not necessarily have saved them from stigma
or disgrace, but the point is that agoraphobia served the important purpose of demarcating feminine gender identity. As one agoraphobic writer (Vincent, 1919) lamented ‘Can I ever take my place in the world unhandicapped as other men are, and enjoy a single day undepressed by dark dread? If I could be as other men, it seems to me that my usefulness should be increased a hundredfold’ (p. 299). The following passage taken from Regeneration, Pat Barker’s fictionalised account of the (real) British medical psychologist William Rivers’ efforts to treat soldiers with shell shock, vividly captures the pressure to be masculine that ‘Vincent’ describes. Rivers observes:

> in leading his patients to understand that breakdown was nothing to be ashamed of, that horror and fear were inevitable responses to the trauma of war and were better acknowledged than suppressed, that feelings of tenderness for other men were natural and right, that tears were an acceptable and helpful part of grieving, he was setting himself against the whole tenor of their upbringing. They’d been trained to identify emotional repression, as the essence of manliness. Men who broke down, or cried, or admitted to feeling fear, were sissies, weaklings, failures. Not men.

(Barker, 1991, p. 48)

Rivers’ words echo those of one male pre-war agoraphobic who told his physician, Dr. John D. Jackson of Kentucky, that he ‘tried manfully to brave off the spells’, but as he said, ‘at each time I permitted myself to be alone, I suffered terrible agony’ (Jackson, 1872, p. 61).

These passages are juxtaposed in order to demonstrate that men measured themselves against a historically located (and class-based) cultural ideal of manliness; the man ‘who did not measure up as a man’ was thus perceived as mentally unhinged (Lunbeck, 1994, p. 238). Agoraphobia diagnosed in men, who especially during and after the war were expected as to keep a ‘stiff upper lip,’ may even suggest resistance on their part to an imperative of masculinity imposed upon them that they could not fulfil—resistance that was subsequently pathologised (as it may have been for women diagnosed with hysteria and its accompanying signs and symptoms; see Rosenberg, 1972). This could be difficult to prove, however the real point here is that physicians’ concerns were not strictly ‘medical’ insofar as they both reinforced were clearly embedded in ideas about class, gender and gender roles.

---

5 These words resonate with an article on the military that recently appeared in The Globe & Mail. The writer describes how a ‘major with decades of experience in the... toughest, most battle-hardened regiments, found himself in a circle with 30 of his military comrades, crying, confessing and searching for his inner soldier.’ This outpouring opened ‘emotional channels that had been blocked by years in the military, where the expression of feelings has long been discouraged.’ In his words, ‘[y]ou were taught to hide your feelings. To show your feelings was to show weakness.... Boys don’t cry. They fight.’ (Cheney, 2001, p. A3).
And finally, we must also consider the possibility that regardless of who was being diagnosed with the disease, it was, essentially, seen as a feminine disorder (allowing heterosexism and homophobia to also play out in the process). Even when it was primarily men being diagnosed with the disease, agoraphobia was ‘assigned a definite place in the gendering of metropolitan psychopathology… and thought of as fundamentally “female” in character’ (Vidler, 1993, p. 35). Consider that on the few occasions prior to World War I that a diagnosis of agoraphobia in women did occur, the origin of the disease was attributed to the woman’s reproductive system. In one case, for example, agoraphobia was thought to have resulted from excessive lactation and frequent childbearing. With symptoms that were suggestive of post-partum depression, this woman’s physician, Dr. C.W. Suckling (of the Queen’s Hospital in Birmingham), was actually ‘struck by the marked potency of childbearing as a cause of agoraphobia and allied morbid fears’ (Suckling, 1890, p. 478). Along similar lines, another woman’s agoraphobia was thought to be the result of—or at least exacerbated by—a ‘laceration on the cervix’ since her fear was always much worse in the week prior to her menstrual period. After Dr. L.T. Potter ‘made local applications,’ this Chicago patient was still unable to travel without trepidation, however, and so she took matters into her own hands. As the doctor observed, a ‘bottle of valerianate of ammonia, and a flask well filled with brandy, were always her constant companions when undertaking a journey by rail.’ Whenever this patient travelled, ‘invariably’ she sat ‘with a brandy flask in the right hand and her Bible in the left; presumably the one counteracting the influence of the other’ (Potter, 1882, p. 474).

In contrast, diagnoses of agoraphobia in men were usually made in the context of problems with their nervous systems. As Dr. White wrote in 1884, for example, agoraphobia represented a ‘curious phase of nervous phenomenon.’ He then went on to describe the symptoms in a 30-year-old professional gentleman with no family history of nervous disorders but who ‘suffered from a nervous kind of light-headedness… brought on by the ideas of space’ (1884, p.1140). Dr. Webber wrote that at ‘the foundation of these sensations of anxiety lies one common… corporeal cause’ occurring ‘in a certain pathological group, including what may be expressed by the name nervous irritability, crethism, irritable weakness.’ He maintained that in this ‘pathological group the entire nervous system… may be thrown into extreme commotion.’ Yet, as Nancy Theriot observes, in the nineteenth century ‘nerves’ were themselves perceived as feminine. Medical illustrations depicted the nervous system as female (as opposed to the muscular system normally represented as male) and rendered women ‘inherently prone to nervousness and to manic, depressive, or hysterical responses to life’s difficulties’ (1997, p. 165). The diagnosis of agoraphobia in men thus failed to mitigate against its being seen as
a feminine disorder given that all things nervous were seen as feminine by definition.

_Gendered Expectations_

The focus of the discussion thus far has been agoraphobia in the late nineteenth and early twentieth centuries. However, the tendency towards gendered (and re-gendered) psychiatric thinking was not limited to these early cases. For example, gendered expectations informed a 1964 report on five female patients who, as Dr. Roberts reports, were all ‘coping adequately with routine home duties’ (1964, p. 195). Dr. B.C. Bignold described ten women he saw at the Mental Hospital of Claremont in Western Australia as opportunists for whom ‘the symptom was personally useful’ as a way of avoiding scrubbing the kitchen floor, controlling family outings, and in one of these cases, ‘bring[ing] pressure to bear on [a] husband’ (who refused to capitulate to his wife’s wish to move to Holland). ‘When the symptom served a useful purpose, it was refractory to treatment. The possessive mother features in several histories. Dominant dames have diffident daughters’ (1960, p. 333). The description of two patients in another report published as recently as 1996 is also provocative: the first patient was a ‘33 year old woman living with her husband and three children, who were aged between 2 and 12 years’ and who came to the authors’ clinic in 1986 complaining of panic attacks after the birth of her third child; ‘[n]o other stress was evident.’ The second patient was a 23-year-old single male who ‘worked for the sales department of a company in a technologically advanced industry for 1 year following his graduation from college. He worked hard but reported that his working conditions were stressful.’ His agoraphobic avoidance began after a panic attack while out on business with the company car (Sakai & Takeichi, 1996, p. 335). Interestingly, this male patient is defined by his education and paid work, while the female patient is defined by her role as wife and mother—problematic because neither aspect of her life is perceived by these writers as a source of stress, nor for that matter as work.

These contrasting descriptions reflect the seemingly benign criteria listed in the American Psychological Association’s (APA, DSM-IV, 1994), when it was already clear that most diagnosed agoraphobics were women. As listed there: ‘Individuals’ avoidance of situations may impair their ability to travel to work or carry out homemaking responsibilities (e.g., grocery shopping, taking children to the doctor)’ (APA, 1994, p. 396; emphasis added). Jarring for its having been added to the 1994 edition, this wording is reminiscent of sociologist Talcott Parsons’ assertion that a wife’s ‘primary function’ was housekeeping and the care of children (1954). But as an extension of gender ideology more generally, the APA’s message to women is double-edged: Being in the stereotypic feminine role—staying at home, being anxious and (apparently) non-functional,
depending on a significant other—is an increasingly unacceptable way for modern women to behave. Yet, family responsibilities must remain their priority or they risk being pathologised. Women ‘are expected to be “out there” in the world and still put their families first’ (Fodor, 1992, p. 201).

Behaviourist therapy programmes which flow out of DSM criteria and have been increasingly common in the treatment of agoraphobia since the 1970s (Reuter, 2006), also tend to build upon this very important-because-gendered conception of agoraphobia. Specifically, in the few case reports of agoraphobic men, there is a tendency in their treatment to gear the programme towards getting them back to paid work. In contrast, women’s treatment tends to emphasise getting them back into stores, the implication being that not shopping (and by extension not being good, feminine homemakers) is abnormal. This observation is by no means intended to disparage homemaking, nor should it be taken to suggest that agoraphobia is not really a disabling condition because, clearly it is. But it is meaningful that, for example, one clinical drug trial included a ‘test walk’ through a shopping mall (Roth et al., 1988), while another study examined whether agoraphobics interpret the environment in large shops and supermarkets differently from ‘general’ (read: ‘normal’) shoppers (Jones, Humphris & Lewis, 1996). As Kupers observes, since ‘the explosive growth of consumerism in the 1920s, newer, milder, diagnoses are needed for those who are capable of working, who buy into the promise of advertising campaigns that the purchase of one commodity after another will lead to happiness, and yet are unable to attain the kind of happiness portrayed in advertisements and films.’ They must be ‘neurotic; perhaps they need psychoanalysis, psychotherapy, a tranquilizer or an antidepressant’ (1995, p. 70).

Following Kupers, what could be more problematic than a disease that prevents some individuals from even entering stores? For example, for a ‘Mrs Griffiths’ the ‘furthest she could venture alone was to the two shops about 50 yards from her house’ (Stantworth, 1982, p. 400). Although resentful for having been ‘tied to the house for 14 years’ and forced into ‘the role of wife and mother’ (p. 403), she depended almost completely on her husband ‘who had to carry out for or with her many of the normal day to day tasks of a housewife’ (p. 400). She did, however, manage eventually to achieve her goal of entering the local shops on her own, a challenge Mrs. Griffith’s therapist planned for the day that she normally bought meat ‘so that she had a good incentive to succeed or the family would be hungry’ (p. 402). For ‘Holly,’ a ‘pleasant, tubby 46-year-old woman,’ problems arose on the first day of her programme when she started to walk with her nurse therapist to the shops (Wondrak, 1980, p. 43). On the way she became very anxious, sweaty and faint, but with encouragement, she was able to walk a bit further until the shops were in sight, at which point she and her therapist returned to the hospital. The
next day Holly’s success was even greater—Holly made it all the way to the shops this time. A ‘Mrs. A’ similarly wanted to make it to a dress shop in the mall near her house. She ‘was able to imagine herself going through the process of getting to the store, entering it, looking at dresses, going into the changing rooms, standing at a sales counter, paying for her selection, leaving the store and going home (Pyke & Longdon, 1985, p. 21). But ‘Mrs. A’ had not ventured beyond a three-block radius of her home in years, and increasingly avoided certain anxiety-producing situations and places, including shopping malls, movie theatres, banks, hairdressers, and dentists. Another woman (described as ‘extremely obese’), ‘Mrs. Manton’, also had difficulty shopping and was unable to use public transport or visit friends and relatives (Brooker, 1980). For another patient, shopping and other domestic errands had to be fulfilled by her teenage daughter who frequently missed school in order to accomplish everything her mother wanted done (Liffiton, 1992, p. 33). Also suffering from an inability to shop for groceries, one therapist’s treatment of a patient named ‘Helen’ had her visiting the supermarket two times per week, including busy Saturday mornings and remaining there for at least one hour (Garland, 1992, p. 26).

In contrast is a patient named ‘Mr. Prince’ who had difficulty walking certain distances and riding on the bus, making it impossible for him to get to his work place. As part of his therapy, Mr. Prince was ‘encouraged to go on short walks by himself and to increase the distances gradually.’ By the end of the third week of his treatment from home, he was to come on his own for an appointment at the clinic and to the nurse therapist’s great surprise and delight Mr. Prince was successful. From this the patient graduated to public transportation: ‘His next step would be to... take the bus to the city where he worked... and find his way to his [place of employment].’ With his career at a large international bank on the line, Mr. Prince was determined to return to his job after five months away and achieving this goal was a major accomplishment. He was ‘very pleased with himself [and] grateful ... that we had helped him retain his work and with it his dignity and self-respect... [If] he had lost his job he would have been utterly demoralised’ (Lim, 1985, p. 19).

The extent to which Mr. Prince’s ‘dignity and self-respect’—his identity—were tied to his (in)ability to get to his place of employment contrasts sharply with the other reports about women for whom the central goal of their treatment was to overcome their inability to shop. While it is possible that the gendered nature of these behaviourist treatment programmes may simply reflect a gendering in the types of agoraphobic situations reported by the male and female patients (that is, a gendered social reality), and while it is also true that in cities one must shop for (as opposed to grow) one’s food, it is meaningful that in these reports this particular activity—shopping—is associated only with women and unpaid work. Again, Mr. Prince’s anxiety was associated
with going to paid work yet surely he also required groceries and the occasional item of new clothing? Moreover, production and consumption are being cited by these reports (and eventually the DSM-IV) as criteria for ‘normal’ behaviour. That is, when doctors incorporate shopping into treatment, they transmit an ideological cultural imperative to their patients, one that reflects a dominant ideal linking normal femininity with consumption and unpaid work while in Mr. Prince’s case, defining normal masculinity by his employment. Edlund (1990) has demonstrated convincingly that agoraphobia is bad for the economy, so while some may consider not working (for pay) ideal feminine behaviour, the implication is that political economic assumptions colour the lens through which psychiatrists gaze at their patients (as do class issues if we consider who can and cannot afford to shop). The possibility of living outside the framework of patriarchal capitalism is thereby pathologised.

Gendered economic questions also extend into the role of pharmaceuticals in treating agoraphobia. In the last two to three decades, the pharmacological approach to treating this disorder has involved mainly anti-depressants and benzodiazepines (minor tranquillisers), making the disproportionate diagnosis of agoraphobia in women alarming. Among the most widely prescribed and possibly overprescribed anti-anxiety medications (Botts, 1997; Swinson, Cox & Woszczyna, 1992), if not among the most widely prescribed of medications (Salzman, 1993; Evans, Oei & Hoey, 1988; Freeman et al., 1993), certain benzodiazepines (alprazolam and others) are known to be addictive and stopping them too soon or abruptly can lead to a relapse of symptoms (Hallfors & Saxe, 1993; Medical Letter, 1981, 1982, 1988; Pecknold & Swinson, 1986; Salzman, 1993; and Verster & Volkerts, 2004). These addictive properties may help explain why one patient named ‘Anna’ (as described in a case report from 1979), for example, was – for 10 years – only able to ‘carry out normal daily activities’ with ‘out-patient support supplemented by diazepam (Valium) and Chlordiazepoxide (Librium)’ (King, 1981; also Stantworth, 1982).

It is undeniable that pharmaceuticals have, among other social and political forces, helped reduce the number of patients in psychiatric hospitals (Silverman & Lee, 1974, p. 12). It is also true that they have had positive effects for some patients in enabling them to carry out their ‘normal’ responsibilities in their day-to-day lives. But given their addictiveness – an attractive feature from a drug manufacturer’s point of view – we must question the gendered pharmacoepidemiology of agoraphobia/panic. These drugs have served not only as a tool in the management of agoraphobia and panic experiences, but arguably also in the management (through their medicalisation) of women themselves. For example, as Kupers has pointedly remarked in a discussion of gender bias and the psychiatric diagnosis of PMS, ‘is it merely coincidental that
just when middle-class women are entering the workplace in record numbers, premenstrual syndrome is declared a form of mental disorder’ (1995, p. 69)? Similarly, is it merely a coincidence that both the prevalence of agoraphobia and the prescription of these particular drugs to agoraphobics who were mostly women increased at a time in history when their participation in the paid labour force increased as well?

The Normative ‘Whiteness’ of Agoraphobia

Before concluding, it is important to note that racialism also is, albeit implicitly, an important factor in this story insofar as the ‘white’ medical subject has persisted as normative throughout the discourse of agoraphobia, a tendency that is evident even in the earliest literature on the disease when medical racialism and a discourse of ‘race’ (and immigration) were already in motion (Reuter, nd). Yet the fact is that although racialism was a dominant theme in other medical contexts, the agoraphobic patients in these reports are rarely described in ‘racial’ terms at all, even though historically many mental diseases have been racialised and the use of racial categories by psychiatrists has not been uncommon (Grob, 1985, p. 269; Lunbeck, 1994, p. 125). That the discourse of agoraphobia has been ‘race-less’ suggests that the typical agoraphobic patient has historically been ‘white’, since in Western discourse—medical and otherwise—whiteness tends not to require qualification or even articulation. Whiteness is taken for granted and tacitly normalised in its position as the privileged signifier (Dyer, 2002; also McIntosh 2003).

The findings of two American epidemiological studies on agoraphobia (Boyd et al., 1990; Weissman, 1990) are especially striking. In this community study of five major US cities, the researchers discovered that the prevalence of agoraphobia (and other phobias) was higher among African American women with the lowest socioeconomic status (Boyd et al., 1990). That this finding was new can be explained in part by the fact that most of the psychiatric literature on agoraphobia is based on clinical populations comprised of the most severely disabled phobics (as opposed to community populations comprised of individuals who tend not to seek treatment). For historical and economic (class-based) reasons these clinical populations are over-represented by middle-class ‘whites’. Historical reasons for the overrepresentation of middle-class ‘whites’ in the agoraphobia literature include a longstanding legacy of distrust among African Americans that prevents them from going to see doctors with their problems (see Gamble, 1993; 1997). Economic reasons point in large part to gross economic disparity; in 1984 (approximately when the epidemiological data was collected), median annual family income for

---

6 Orr observes, the ‘story of panic disorder’ is one ‘told by a medical/corporate model of biological illness’ that reproduces ‘women-bodies as a secure, because we’re panicked, site for pharmaceutical profits’ (1990, p. 483).
‘whites’ was significantly higher at $27,686 (US) as compared with that of African Americans, which averaged only $15,432 (US). This inequality corresponds with inequality in health insurance coverage and state and county mental hospital admissions (see U.S. Department of Health & Human Services, 1986, pp. 14 and 74.) as well as a greater opportunity to avail themselves of private therapy by ‘whites’ (US Census Bureau, 2000; US Department of Health & Human Services, 1986; 1987), which means they appear more often in the clinical literature on agoraphobia. It is also well established that not only do African Americans visit physicians less frequently than Whites, but they also do not receive the same quality of care (U.S. Census Bureau 1999; 2000; U.S. Department of Health & Human Services, 1986; 1987; Geiger, 1997, p. 1766).8 In light of these data, it is not especially surprising that poor, urban, African American women do not present for treatment, which is why they are generally not reflected in clinical articles (reinforcing the perception of agoraphobia as a white middle-class disease) and why they would only emerge in a community study.

However the findings of this epidemiological study also reflect the possibility that agoraphobia may have gone undetected in poor, African American women because the official criteria for this diagnosis—derived from the DSM-III—are based on a normative, white, middle-class urban experience that excludes racism as a possible (and legitimate) reason for not going out into public spaces. The interviews conducted for the epidemiological study were based on a schedule (the ‘DIS’) defined by the criteria of DSM-III. If the questions included in the revised DSM-III-R schedule (the ‘SCID’) are any indication, it is likely that the DIS was also based on normative white experiences and did not address issues of racism. Indeed, as Knowles has insightfully demonstrated, ‘[p]sychiatry contains a series of powerful, racialized narratives which dictate the terms on which certain lives will be lived and judged’ (1996, p. 56).

Moreover, though not explicitly about ‘race,’ two cases reported from the volatile social-political context of Northern Ireland (during the latter part of the twentieth century) are instructive here: As the therapist of one patient, Mrs. James, described, she ‘had never been in the city for any length of time since the outbreak of violence, [so] she had to be prepared for the security arrangements and what to do during a bomb scare, all of which were new to her’ (Bradley, 1975, p. 967). Another therapist, also Irish, described a similar situation with an agoraphobic-claustrophobic woman patient. ‘Cynthia,’ decided to pursue treatment even though ‘[e]veryday somewhere in Belfast buses were being hi-jacked. Everyday there was the possibility of being injured in bomb blasts. People were

---

7 1.28 for African Americans versus 1.00 for ‘whites’, with p< 0.01; 1.00 for highest quartile of SES versus 1.80 for lowest quartile, with p<0.001 (Boyd et al., 1990, p. 318).
8 US Census data reveal that in 1998 African Americans made 89.8 million office visits to physicians (259 visits per 100 patients); ‘whites’ made 702.2 million visits (317 visits per 100).
being shot. There were security checks to pass through which meant waiting to be searched. And not long ago, a shopping centre, similar to the one she [wanted] to go to, had been wrecked in a car bomb which had resulted in three deaths and many injuries’ (Williamson, 1974, pp. 1843-1844). As noted with reference to C. Wright Mills in the introduction to this paper, these passages illustrate how the social historical context can be a factor in what has primarily been an individualised phenomenon.

Poor, African American women living in inner city America would have their own parallel concerns. In fact, contrary to the usual way in which agoraphobia is characterised in the literature, these examples underscore the possibility that agoraphobic fear could be a completely rational response to the pressures of public urban space. This does not mean that African American women do not really experience the distress of agoraphobia, but rather, this may account in part for why their agoraphobia had gone previously unnoticed. Thus, similar to affluent white women’s ‘passing’ as ‘True Women’ rather than agoraphobic at the turn of the nineteenth century, contemporary African American women’s legitimate anxieties about being out in possibly racist and dangerous public spaces may have also ‘passed’ as something other than agoraphobic. In other words, the epidemiological findings point to the possibility that conditions of ‘racial’ inequality shapes the fear these women have of going out into public urban spaces. Moreover, racism in psychiatric narratives has important psychological (and political) consequences and can feature in both its silences and explicit statements. This is very significant: the African American women ‘discovered’ through community (as opposed to clinical) research may have ‘qualified’ as agoraphobics simply because researchers did not avail themselves of a theoretical framework drawing attention to interacting social factors and thus did not ask the right questions—that is, questions that might have illustrated the possibility that racism and fear of crime and violence, rather than irrational fear, discouraged these women from public places.

CONCLUSION

This paper has argued that psychiatric categories are socially shaped. The discussion has attempted to show how the discourse of agoraphobia both informs and is informed by our culture and social relations. More than an individual disease phenomenon, contained within the discourse of this disease is an exclusionary and normative imperative of social order. Reading the psychiatric literature on agoraphobia with this in mind enables us to see this and other psychiatric narratives in terms of cultural processes and assumptions—assumptions that include, but are not limited to, ideological notions of gender and especially the deep sociality inherent in the question of what it means, both medically and culturally, to be ‘normal’ and ‘pathological’. In so far as psychiatric categories bear a
certain amount of social content, then, it has been argued that psychiatric thought would be strengthened by a more critical and sociologically informed understanding not only of the pathologies with which it is concerned, but also of the social-historical context in which these pathologies exist.
REFERENCES


