JOURNEYS AND BATTLES:

SPATIAL AND GENDERED DISCOURSES OF OBSESSIVE-COMPULSIVE DISORDER

by

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ABSTRACT

Obsessive-compulsive disorder (OCD) is a (mental) health condition that, despite its highly spatial characteristics and high prevalence, has been largely overlooked by human geographers. This thesis seeks to help rectify this oversight by examining the ways in which OCD is gendered, especially in relation to the metaphors used to describe the condition. A conceptual model for a "radical body politics" provides the theoretical framework for this research. Semi-structured interviews, critical reading of stories published by and about people with OCD, and autobiography are used in order to investigate the ways in which men and women utilise discourse in order to represent and make sense of their experiences with OCD.

I argue that the ways in which men and women choose to represent through discourse their experiences of OCD have profound implications for their sense of self. Two over-arching discourses are discussed: that of the journey and that of the battle. The more feminised discourse of a journey suggests that the experience of women with OCD is a cathartic pathway of self-realisation with the end-goal of recovery. The more masculinised discourse of battle positions OCD as being both Other to the self and a struggle within the self. Both discourses invoke spatial imagery and have profound implications for how individuals with OCD experience and manage the condition. I also suggest some possible avenues for further geographic research into OCD.

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CHAPTER ONE

INTRODUCING OBSESSIVE-COMPULSIVE DISORDER

This thesis is an examination of the relationship between gender, materiality, and discourse for people with obsessive-compulsive disorder (commonly referred to as OCD by psychologists/psychiatrists, individuals with the condition, and the general public). It investigates the implications of such relationships on an individual's sense of self. In doing so, it seeks to destabilise the long-established dualisms of mind/body, self/Other, and discourse/materiality. In previous research, inspired by my own experiences of OCD, I looked at the ways in which the condition manifests spatially (Campbell, 2010). Several themes emerged from this research: firstly, the compulsions and obsessions experienced by a person with OCD can engender feelings of guilt, disgust, and self-loathing that can have profound implications for an individual's sense of self; secondly, OCD can result in the self-regulation of behaviours in public spaces in order to avoid the censorious or judging gaze of others; and thirdly, many individuals with OCD feel safer in their workplace than in their home, challenging traditional conceptions of workplaces as stressful environments and homes as sites of relaxation and leisure. While this research illustrated how space and OCD are inextricably linked, it did not address issues of gender. It is the intention of this thesis to add further to the work that I have already done on OCD and spatiality.

It is generally acknowledged by mental health professionals that OCD affects men and women equally in terms of its prevalence or incidence (Camarena, Rinetti,

Cruz, Gómez, de la Fuente & Nicolini, 2001). One could therefore assume that the condition remains unaffected by issues of gender. However, because OCD is embodied and because men and women are different in many material and discursive ways, it seems likely that gender differences do, indeed, exist in relation to OCD. The aim of this thesis is to investigate what some of these differences are. It focuses upon how these differences affect men's and women's sense of self in relation to OCD; feelings and emotions associated with their experiences of OCD; experience of space as an individual with OCD; and ability to cope and means of coping with OCD. Keeping the above in mind, my specific research question is *'How do men and women with OCD understand and conceive of their condition thus (re)constructing their sense of self and space?'*

1.1   What is OCD?

OCD is an anxiety 'disorder', as classified by the DSM-IV – the Fourth Edition of the Diagnostic and Statistical Manual of Mental Disorders (American Psychiatric Association, 1994).[1] Anxiety 'disorders' are one of the most common types of mental health conditions: It is estimated that one in ten people will be affected by an anxiety 'disorder' sometime in their lives (Canadian Mental Health Association, 2011). Anxiety 'disorders' affect many different facets of life, including behaviour, thoughts, emotions, and physical health. Age and ethnicity appear to have little bearing on the prevalence of anxiety 'disorders'. However, they are generally more prevalent in women. Indeed, women are twice as likely as men to experience an anxiety 'disorder' in their lifetime and they develop earlier in

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[1] This is the American Psychiatric Association's current manual of standard criteria for the classification and diagnosis of (mental) health conditions.

women than in men (Anxiety Disorders Association of America, 2011a). For example, women are twice as likely to have panic 'disorder' or social phobia as compared to men, and three times as likely to have agoraphobia (Nauert, 2006). Factors that may explain the greater prevalence of anxiety 'disorders' in women than in men include "cultural pressures [on women] to meet everyone else's needs except their own, and fewer self-restrictions on reporting anxiety to doctors" (A.D.A.M. Inc., 2009, para. 2). Whether this is the case or not for OCD in particular is something that is yet to be confirmed.

While the origins of anxiety 'disorders' remain unknown, a combination of biological factors and an individual's personal circumstances or background is believed to be a likely cause. Anxiety 'disorders' often occur concurrently, and it is common for a person to experience more than one at any given time. Other (mental) health conditions such as depression, eating 'disorders' and substance abuse are also highly likely to exist alongside anxiety 'disorders'. Because they rarely manifest in isolation, they are often influenced by the fears and concerns associated with these other conditions in a cycle in which each condition can exacerbate and perpetuate the other. Indeed, it can become difficult to ascertain where one ends and another begins.

OCD is characterised by two main symptoms through which the condition is known: obsessions and compulsions. Obsessions are thoughts and/or images that are recurrent, intrusive, and often disturbing. Such thoughts and images are acknowledged by the individual experiencing them to be excessive and/or ridiculous but, despite this knowledge, they cannot be dislodged (Goodman, 2006).

As a result, these thoughts and images are perceived by the individual to be "senseless or repugnant" (De Silva, 2001, p. 21). Those with OCD recognise that their obsessions are products of their own making and embodiment – that is, they recognise that their obsessions are not 'implanted' by someone or something else (as is sometimes believed by those with some other conditions, such as schizophrenia). However, it is important to note that obsessions are formed against one's will and can be extremely distressing to the person experiencing them. Obsessions can include concerns with contamination, safety and/or harm, unwanted impulses, unwanted acts of aggression/violence, the need for symmetry or exactness, and having unacceptable sexual or religious thoughts.

Compulsions are the results of a person's need to lessen the anxiety caused by his or her distressing and disturbing obsessions (Segrott & Doel, 2004). Compulsions often, but not always, manifest in the form of elaborate rituals. People with OCD feel *driven* to perform their rituals and gain no pleasure or gratification from them aside from a short-lived feeling of relief from the temporary alleviation of their distress. Like obsessions, these behaviours are acknowledged by the person with OCD as senseless (De Silva, 2001) for they do not always have a 'rational' connection to the obsessions that they address. Such rituals are often highly spatial and include ordering and arranging (e.g. arranging objects in their 'right' places), repeating routine activities (e.g. going in and out of a doorway numerous times before entering or exiting a space), and moving in specific, prescribed ways (e.g. having to stand on every white tile in a hallway while walking down it) (Goodman, 2006)

OCD thus has the potential to be extremely spatial in nature. It is widely acknowledged by geographers that space is an integral aspect of everyday life and how we interact with and negotiate space (at all the scales at which space exists) affects our realities in profound and numerous ways. Having OCD can alter the ways in which individuals engage with and perceive spaces (Segrott & Doel, 2004). Therefore, people with OCD, who generally experience space in markedly different ways from those who do not have the condition, potentially have very different realities and lives compared with 'normal' individuals.

1.2 'Sufferers' and 'Disorders': The Problematic Terminology of (Mental) Health Discourse

Throughout the process of completing this thesis, I encountered the epistemological dilemma of how to refer to people with OCD without framing them using the inherently negative language associated with discourses of health and illness. The language used in these discourses has a tendency to portray those who have (mental) health conditions in a profoundly negative way. People with such conditions are often positioned as passive victims and the conditions themselves to be painful afflictions. Certainly, there are many individuals who do suffer and who do experience pain and unhappiness as a result of having a (mental) health condition. It is not my intention to dismiss their experiences. However, attached to words like 'sufferer', 'afflicted', and 'victim' (these are just a few of the terms used in health discourses to describe a person with a (mental) health condition) are negative connotations that shape the ways in which we think of health and illness.

Such terminology is problematic as it fails to acknowledge the full and multi-faceted reality of living with a (mental) health condition. Not all experiences of ill-health are innately negative. For example, Peter, one of the participants of this study, stated that having OCD could sometimes be a positive experience. He felt that it improved his workplace performance because he was more methodical and meticulous than he might otherwise have been. In another example, many individuals with Autism and Asperger's syndrome (AS) are "proud of their differences and committed to the value of the uniqueness and nuances of their experiences of AS" (Clarke & van Ameron, 2007, p. 771-772). It is thus clear that, for certain individuals and in certain situations, framing a (mental) health condition in a way that implies that it is wholly 'bad' dismisses the myriad and complex nuances of experiencing it. Feelings of hope, pride, and for some, accomplishment, are all also a part of living with a (mental) health condition.

Throughout this thesis, I aim to avoid the negative terminology inherent in discourses of health and illness. One of my intentions in writing this thesis is to give a voice to a group of individuals who often go unheard in academic scholarship (Davidson, 2003). As will be discussed in Chapters Three, Four, and Five, many people with OCD are participating in interviews with academics, documentaries about the condition, and contributing to stories in newspapers and magazines. They are writing blogs and contributing to online forums. This is a clear indication of how the long-established discourses of health and illness, which position those with (mental) health conditions, such as OCD, as having no or little agency and as powerless, are misleading and misrepresentative. Utilising words such as 'sufferer' and 'disorder' can undermine their efforts to be active

participants in the very discourses that frame them as such. However, while it might be easy to criticise these discourses and the language inherent within them, finding an alternative is a difficult task. There appear to be limited linguistic or discursive frameworks through which individuals with (mental) health conditions are represented positively. It is clear, then, that existing (mental) health discourse is extremely pervasive.

Two words that I found particularly problematic and which are used very commonly in academia, the medical profession, and general society, are 'sufferer' and 'disorder'. The term 'sufferer' is used, often without conscious thought, to refer to a person who has a (mental) health condition. It implies passivity, victimisation and perhaps, to some extent, the idea of the Other. It also assumes that those with (mental) health conditions such as OCD are weak, unhappy, emotional and in constant pain. This is not necessarily the case, as I illustrate in Chapters Four and Five. In order to reflect this idea, I have chosen to refer to people with OCD as exactly that: people with OCD. I have done so for several reasons. Firstly, the term avoids representing people with OCD as being passive, powerless victims of circumstance. Secondly, it implies that OCD is not necessarily the whole identity of those who have it, nor the most important or largest part of their identity. Thirdly, it acknowledges the individual as a person with complex emotions, feelings, and material realities rather than as the somewhat abstract and disembodied notion of the 'sufferer' or the 'afflicted'.

I have also chosen to refer to OCD itself as a 'condition' rather than as a 'disorder' (as it is commonly thought of amongst psychologists, psychiatrists, some people

with OCD, and many people who do not have OCD). I have done so because the term 'disorder' suggests that there must first be 'order'. The idea of order denotes ideas of control and belonging. In referring to OCD as a 'disorder', those who have the condition are positioned as being *out of order* and thus also out of control and out of place. The term therefore perpetuates the problematic Cartesian dualisms of control/lack of control, order/disorder, and self/Other.

1.3   Historical Context

For many centuries, the symptoms of OCD (obsessions and compulsions) were thought to be signs of 'melancholy' which, as Hippocrates characterised it, was "all fears and despondencies, if they last a long time" (Allison, 2010, para. 4). In seventeenth century Europe, OCD was considered to exist exclusively in the religious domain. It was believed to be caused by either 'religious melancholy' (a fear of saying something indecent or blasphemous at a sermon or other similar silent auditory (Koran, 1999)) or possession by the devil (Krochmalik & Menzies, 2001). It wasn't until the late nineteenth and twentieth centuries that the modern understanding of OCD began to develop and not until the late twentieth century that OCD became known by wider society through its increased presence in the media through such channels as news programming, current affairs programming, television, film, and the internet. The condition, originally thought to be very rare (Beitman & Klerman, 1991) has seen an increase in diagnoses and is now considered to be a fairly common (mental) health condition (Pallanti, 2008). It is considered by the World Health Organisation to be the tenth most debilitating medical condition (including physical ailments) in the developed world (Medical

News Today, 2008). However, regardless of the growth of public interest in OCD and the increase in its prevalence, the condition has remained something largely unstudied by geographers despite its highly spatial characteristics.

1.4   Academic Context: Three Waves of Mental Health Geographies

There have been, as discussed by Philo and Wolch (2001), three 'waves' of inquiry in mental health geographies. In the opening years (the 1970's-1980's) of mental health geography scholarship the focus was centred upon the spatial-distributional aspects of mental health. This is considered to be mental health geography's 'first wave' of research. One main concern of this first wave was to examine the shifts of people with (mental) health conditions, people historically thought to be somehow 'deviant', from asylums/hospitals back into the wider community (Philo & Wolch, 2001). The first wave thus achieved what the limited previous geographic research that had gone before it had not: It "examined numerous phenomena never previously examined by geographers, highlighting dimensions of human pain, concern, and struggle never previously acknowledged by the discipline" (Philo & Wolch, 2001, p. 231). Studies were largely influenced by the 'quantitative revolution' that took place in the discipline in the 1960s and 1970s and it can perhaps be argued that their 'human subjects' – people with (mental) health conditions – were somewhat absent from the research.

The 'second wave' of mental health geography, which developed in the 1980s rectified, at least to some degree, the oversight mentioned above. Rather than

concentrating on large-scale spatial distribution, the second wave paid particular

attention to

> smaller scales of analysis where it is easier to make sense
> of individual human perceptions, psyches, hopes, and fears.
> At the same time, this work shift[ed] attention from the
> analysis of space, forsaking an overview of distributional
> patterns, to more interpretative engagements with
> disability, identity, and place. (Philo & Wolch, 2001, p.
> 231)

The second wave was focussed on geographies of difference, rather than deviance,

in order to examine how 'identity' is shaped and understood by those with a

(mental) health condition. Several diverse theoretical frameworks informed the

second wave of mental health geography, including feminism, post-colonialism,

and psychoanalysis. It is in the second wave that a connection was formed with

geographies of disability, the primary concern of which is physical disability. This

was a particularly important development as it introduced the idea of "the role of

bodily difference in the fragmentation of identity seemingly endemic to the

contemporary human condition" (Philo & Wolch, 2001, p. 234). Another chief

concern of the second wave was with the role that particular places play in an

individual's identity and sense of self, as they are related to experiences of having

a (mental) health condition.

Philo and Wolch (2001, p. 237), however, claim that there is a danger of second

wave research being "disengaged from real-life politics or the policy-making

process". They argue that geographers should therefore look to the creation of a

'third wave' of mental health geographies in which the micro-scale research that

characterises much second wave inquiry should be applied to macro-scale

research into policy and economics.

While this thesis may be considered to 'fit into' the second wave of mental health geographies, it certainly does have implications for the third. In order for policy to be effective and to make real and positive changes to the lives of those with (mental) health conditions, there must be an understanding of their lived reality, including their emotions, feelings, and actions. The implications of this research have the potential to inform policy of the embodied and everyday realities of people with OCD.

1.5 Chapter Outline

In this chapter I have explained my reasons for embarking on research on this topic, followed by a discussion of my research focus and research question. I have critiqued the terminology of the health and illness discourses and shown how this thesis will move away from such terminology in order to avoid framing (mental) health conditions, and the people who have them, in ways that are at least partially negative. I have then provided the historical context of how OCD has been perceived and portrayed before discussing the three waves of mental health geographies and how this research fits into this academic context.

Chapter Two provides the theoretical framework which guided and shaped my research. It begins with a discussion of the long-established Western tradition of dualistic thinking and challenges its usefulness in conceptualising (mental) health conditions. In particular, I look at the dualisms of male/female, self/Other, and mind/body. I then go on to examine the problematic nature of the social and

medical models of disability which have dominated scholarship on geographies of disability. These models frame the corporeal, material body as a separate phenomenon to discourse. I propose that the notion of a "radical body politics" (Moss & Dyck, 2003) is more suitable to a study of OCD as it positions discourse and materiality as being mutually constitutive and thus inextricably linked to one another. In order to have a nuanced and full understanding of OCD, it is important to realise that materiality and discourse are not isolated from each other but are interwoven to the point that they may even be considered 'meshed' together. I lastly discuss the role of metaphor, and thus also discourse, in issues of health and illness.

In Chapter Three I turn my attention to the methodology used in order to investigate OCD, gender, and space. I first look at the usefulness of qualitative data collection methods and explain why I have chosen to use such methods in this research. I then contemplate my own positionality as a researcher with OCD and how this positionality influenced the findings before focussing on issues of ethical research behaviour, a particularly important consideration given the sensitive and very personal nature of the subject material. I discuss the implementation of several methods of collecting qualitative data, including that of semi-structured interviews, autobiography, and a critical reading of texts (blogs, films, and forum postings) produced by and about individuals with OCD. Discourse analysis is addressed as a means of data analysis.

In Chapter Four, I examine the ways in which OCD is often conceptualised by women in very spatial terms. The condition is represented by women as a journey,

comprising a starting point, a path comprising obstacles and landmarks, and a destination or end-goal. Using a journey metaphor or discourse suggests that women are likely to conceptualise their experiences of OCD as a 'pathway' to recovery and a journey of self-discovery and long-term commitment. I discuss how women utilising this discourse use movement-oriented language in order to describe their setbacks, or obstacles, and triumphs, or landmarks. How the journey is evidenced in film is addressed. I then look at how child-birth and child-rearing can be considered as both landmarks and obstacles in a woman's pathway to recovery. The importance of sharing the journey with others is also discussed.

Chapter Five addresses the battle, or struggle, trope evident in a lot of men's discourse of OCD. In particular, I examine the implications of such representations upon a person's sense of self and Other in relation to their OCD. I first discuss the overarching battle discourse, how it is constructed as masculine, and how it implies that OCD can be seen as Other to the self. I then focus on the idea of OCD as monster before looking at the condition as an internal struggle between the self and Other. Implications of this discourse for recovery are then addressed.

I conclude my arguments in Chapter Six. I summarise my findings and highlight some of the implications of this research upon how geographers conceptualise individuals with OCD. I suggest that there is a need to look beyond historical representations of individuals with (mental) health conditions as lacking in agency. I also argue that there are still a great many avenues for future geographical inquiry into OCD, including looking at OCD over the lifecourse, the role of

religion in OCD (a condition traditionally and historically associated with the Christian church), and the ways in which the internet shapes the experiences of individuals with OCD.

CHAPTER TWO

THEORETICAL FRAMEWORKS AND LITERATURE REVIEW

2.1   Introduction

In this chapter, I discuss the theoretical framework and the various literatures which have shaped and guided this thesis. In particular, I look at geographical work in the health and disabilities field, with a specific focus on the dualisms that have long-permeated scholarship within the discipline. I pay attention to the work of Kearns (1997), Parr and Butler (1999), Davidson (2003), and Moss and Dyck (2003). Specifically, I look at the male/female, self/Other, mind/body, and material/discourse dualisms which have shaped how geographers have traditionally conceptualised (mental) health conditions.

I propose that there is a need to look beyond such dualisms as the experiences of people with a (mental) health condition such as OCD often demonstrate a blurring of boundaries between the self and Other, mind and body, materiality and discourse. I look primarily to Moss and Dyck's (2003) conceptual model for a "radical body politics" as a theoretical framework in which the concepts of self/Other, mind/body and (particularly) material/discourse are acknowledged as being inextricably linked rather than diametrically opposed. This model is highly applicable to my investigation of the gendered dimensions of OCD because a person's experience of the condition is greatly impacted by both the material reality and discursive frameworks within which that reality is represented and understood.

In the following section, I first examine traditional Cartesian dualisms and how these dualisms have influenced the ways in which reality is perceived, represented, and understood. I then look at the dominant social and medical models of disability, and how these models position the material and the discursive, the self and the Other, and the mind and the body, as distinct concepts that are disparate and disconnected. I argue that there is a need for a change in how geographers represent and conceptualise disability through an examination of Moss and Dyck's (2003) conceptual model for a "radical body politics". I posit that, in acknowledging the mutually constitutive nature of materiality and discourse, Moss and Dyck's model has the potential to broaden our understanding of OCD. Lastly, I touch briefly on the role of metaphor in discourses of health and illness in order to understand the ways in which discourse can affect how people with a (mental) health condition frame, perceive, and ultimately comprehend their experiential realities.

2.2   Traditional Dualistic Thinking

There is, as Elbow (2006) states, an 'ancient tradition' of dualistic thinking that has influenced how individuals conceptualise reality. It has been argued that the Western philosophical tradition of dualistic thinking shapes the ways in which we conceptualise people and places (Grosz, 1993). It is so deeply ingrained that, for many individuals, it seems to come 'naturally' (Bing & Bergvall, 1996). As a result, dualisms are rarely questioned or examined outside of academic study.

Dualistic thinking frames an issue or phenomenon as it exists in relation to its 'opposite' (Elbow, 2006) and places it in a definitive discursive category.

However, there are several issues with this conceptual framework. Firstly, the idea of absolute opposites almost always lends itself to one category being dominant over the other category. One 'side' is privileged over another, resulting in the formation of a hierarchy. As a result, it can be argued that dualistic thinking facilitates the continued Othering of those who do not 'belong' to the dominant (or 'right') dualistic category or who fall outside of either dualistic category. Dualistic thinking is thus all too evident in the issues surrounding OCD. Indeed, those with any type of (mental) health condition are often Othered because they do not fit into the 'able-bodied' or 'sane' categories of the norm.

Secondly, dualisms reinforce and perpetuate traditional and patriarchal discursive relations and ways of being (Rodino, 1997). Feminist geographers claim that they serve to reinforce gender stereotypes (Aitchison, 2003) by naturalising, or normalising, the differences between men and women (Plumwood, 1993). Rose (1993, p. 82) claims that "[d]ualisms maintain order by offering only two positions, both of which are constituted around a single term – the masculine Same".

The male/female dualism is perhaps the most pervasive in Western thinking. Many other dichotomies, such as mind/body, reason/passion and self/Other, are rooted in that of the male/female (Elbow, 2006). This dualism reinforces the 'symbolic opposition' between the masculine and the feminine in which the

former is dominant over the latter. As mentioned above, the male, or masculine, is associated with the mind, reason, culture and objectivity; the female is associated with the body, emotion, nature, and subjectivity (Bondi, 2005). It might be argued that "the hierarchical relations between reason and its opposites – or between higher and lower forms of reason – have undoubtedly contributed to the devaluing of things associated with the feminine" (Lloyd, 1993, p. xii), Thus the result of women being positioned as 'out of control', 'emotional' and 'irrational' is the privilege of the masculine over the feminine. Through this discourse women are positioned as being subject to, or victims of, their 'passions', which are conceptualised as "alien intruders from the realm of the body" (Lloyd, 1993, p. xv). Women are, therefore, constructed by the male/female dualism as passive, weak and powerless.

The self/Other dualism is one that is apparent in (mental) health discourses. Traditional Western philosophy views the individual, or the self, as an independent, self-contained and autonomous entity that is detached from context (Markus & Kitayama, 1991). Thus the Other is outside of, or not realised by, the self. As such, the self and Other are often (re)constructed as being two distinct and separate entities. This is particularly relevant to notions of health – or rather, of 'ill' health. There is a long standing tradition of positioning illness, both physical and psychological, as an alien invader of the body/mind (Sontag, 1999). In breaching the boundary that demarcates the individual, illness is shown to be a 'threatening Other'. As a result, the conventional self/Other dualisms in (mental) health discourse position that which is Other as deviant, undesirable, and dangerous.

Philo and Wolch (2001) point out that the identities of those who are 'normal' (also positioned as 'us', 'the same' and 'self') on the body-mind continuum are always constructed in terms of their perceptions and conceptions of those who are 'abnormal' (also positioned as 'them', 'the Other' and 'not-self') on that same continuum. Philo and Wolch (2001, p. 230) go on to state that "such difference becomes crucial to both the establishment of identities and the pursuit of practices, often hateful and prejudicial ones, which 'the same' then enacts toward 'the Other'". We can thus see how the dualism of self/Other in issues of (mental) health establishes one discursive category – that of the self – as dominant over its opposing counterpart – that of the Other.

There is, however, an argument that the self is viewed as "*inter*dependent with the surrounding context and it is the 'Other' or the 'self-in-relation-to-Other' that is focal in individual experience" (Markus & Kitayama, 1991, p. 225, italics in original). This view positions the self and Other not as opposite, conflicting, and separate phenomena but as somehow connected and overlapping. Both of these ways of thinking about the self and Other could potentially provide useful lenses through which (mental) health conditions such as OCD could be examined.

It has also been argued that the social sciences, including geography, have been largely centred on the mind/body dualism (Johnston, 1994). Contemporary debates on the problematic nature of mind/body dualism began in the late 1950s and 1960s (Kim, 2000). Traditionally, the mind and body have been treated by academics across a wide range or disciplines as two separate entities that, while

acting upon each other, are not directly linked or connected. Descartes (1968), after whom the concept of 'Cartesian binaries' is named, made the distinction between the 'res cogitans' and the 'res extensa'. The 'res cogitans' was understood to be the soul, or mind, that was characterised as "a thing that thinks" (Bracken & Thomas, 2002, p. 1433). The 'res extensa' referred to the body's material 'stuff'.

This dualism positions the body and mind as two opposing phenomena. It aligns the mind with reason, rationality and masculinity and the body with passion, irrationality and femininity. It is a pervasive dualism in which "the activity of the mind is valued over and against the life of the body" (Kirmayer, 1992, p. 323) leading to "a hyper-rationalism that ignores the significance of bodily felt meaning and minimises the way in which emotions compel thought, choice and action" (p. 324). The Latin statement "cogito ergo sum", or, "I think, therefore I am" suggests that the foundation of our existence lies in the functions of the mind and overlooks the importance of the body to our experience of being. It privileges the mind at the expense of the body. Thus it can be argued that the mind/body dualism privileges men and the masculine (conceptualised as the mind) over women and the feminine (conceptualised as the body). In affording primacy to the mind, this dualism reinforces patriarchal systems of power.

The conceptualisation of 'mental health' as something entirely different from 'physical health' is in itself an illustration of how the mind and body are perceived as being ontologically separate. However, such a conceptualisation fails to acknowledge the holistic nature of 'health'. Many (mental) health conditions have

physiological origins (such as an imbalance of serotonin in the brain, as is likely to be the case in OCD) and/or consequences (such as psychosomatic pain) and many physical health conditions have psychological origins and/or consequences. It is important to remember that the body is a vehicle through which processes of the mind (such as thought and emotion) are experienced (Kirmayer, 1992). Essentially, the mind is situated in a biological organ – the brain. It is the body that forms thought, and thought that moves the body. To identify any definite boundary between the mind and body would be to dismiss the inter-connectedness of the two insofar as health is concerned (Parr & Butler, 1999).

The mind/body dualism has been challenged by academics across a wide range of disciplines. It is argued that to think of the body and mind as disparate limits our understanding of human reality and, in the study of health and 'illness' in particular, our ability to fully comprehend a person's experience of suffering and pain (Kirmayer, 1992). The mind understands the world through bodily feeling and activity (McWhinney 1997). Therefore, it is impossible to separate thinking (traditionally conceived of as a function of the mind) and emotion (traditionally conceived of as a function of the body). Parr (1999) suggests that the body and mind should be conceived of as being part of a continuum without boundaries, rather than as a dualism positioning the two as opposing and separate entities. In conceptualising the two in such a way, we are better able to fully comprehend the complex relationships between the body and mind.

2.3   The Medical and Social Models of Disability

Geographic – and indeed wider academic – research on disability and impairment (including both the physical and the psychological, as in the case of OCD) has long been dominated by two models of thought: the medical model of disability and the social model of disability (see Shakespeare, 2004; Parr & Butler, 1999). These models, while providing interesting and important insights into the discursive or material aspects of disability, do not tend to address both nor do they examine the ways in which the discursive and material are connected.

The medical model of disability, which predates the social model of disability and appears to be especially prominent in Western cultures (Parr & Butler, 1999), positions impairments as 'individual medical tragedies' (Shakespeare, 1993) in which the body/mind simply does not meet the expectations of the norm (Parr & Butler, 1999). It is the individual body that is at fault: the disability or impairment is a 'problem' that needs to be 'fixed' by science and technology. The medical model thus focuses upon the *material* (the biological/scientific/essential) reality of the body and in doing so overlooks the role of society and the discursive in the lives of those who have a (mental) health condition. This isn't to say that the medical model of disability does not have its place. It is useful in the understanding and development of technologies that can help ease the difficulties faced by individuals with disabilities in everyday life.

While the medical model of disability looks to the individual by addressing the essential body it fails to acknowledge a person as exactly that: a person. The lived

and embodied reality of people with (mental) health conditions – the emotions and

feelings inherent within them – is largely absent. The model tends to emphasise

> clinical diagnosis, the very nature of which is destined to
> lead to a partial and inhibiting view of the disabled
> individual. In order to understand disability as an
> experience, as a lived thing, we need more than the
> medical 'facts'... The problem comes when they determine
> not only the form of treatment (if treatment is appropriate),
> but also the form of life for the person who happens to be
> disabled. (Brisenden, 1986, p. 173)

Furthermore, the model is a

> mechanism by which people with mind and body
> differences have been categorised and responded to by a
> Western society which increasingly pathologises certain
> peoples ... [and] has rarely extended to a full questioning
> of the social categorisation of 'disability' or the
> complexity of disabled people's lives. (Parr & Butler,
> 1999, p. 3)

It can therefore be argued that the medical model of disability, so deeply

entrenched in the material and essential, itself undertakes discursive practice in

categorising individuals with (mental) health conditions. Brisenden (1986, p. 173)

argues that in doing so, the model positions those with disabilities or health issues

as "inadequate" and classes them in a "category of rejects, as people flawed in

some aspect of their humanity". He goes on to claim that the medical model

perpetuates the 'myth' that "disabled people are seen as weak, pathetic and in

need of sympathy" (p. 174) and that "what we have to get to, instead of this, is the

real person inside the image of disability" (p. 174). While Brisenden clearly

outlines the discursive power that a model such as the medical model of disability

wields, it must be remembered that the model itself focuses upon the material, and

supposedly essential nature of the body.

The social model of disability, which is often discussed in relation to its medical counterpart, is very different and addresses the discursive concerns related to issues of disability and impairment. This model argues that it is society that does not accommodate impairment – that is, it is society and not necessarily the body itself that limits and restricts the body with disability or other health concern. Disability and 'ill' (mental) health are thus social constructs. Chouinard, Hall and Wilton (2009, p. 7) further lend credence to the idea that the model is focussed on the discursive and state that, in the social model of disability,

> experiences of impairment can be seen as social in terms of meanings ascribed to impaired bodies and minds (e.g., as 'lacking') and in that the social conditions of life, such as poverty, malnutrition and war, cause and exacerbate physical and mental impairment.

In particular, the model emphasises the influence of broad economic structures upon our conceptualisation and understanding of disability, as those with disabilities often cannot wholly "conform to the time-space work regimes of capitalist society" (Parr & Butler, 1999, p. 4).

While the model succeeds in outlining the part that discourse plays in impairment and disability, it does have some shortcomings. Parr and Butler (1999) argue that the social model of disability can be seen as a rejection of reductionist explanations for inequality based on physiological and psychological difference. They claim that, like the medical model of disability, the social model of disability fails to recognise "the 'true' pain and inconvenience" (p. 4) that impairment can cause. The embodied reality is lost. Thus it is clear that, like its medical counterpart, the social model of disability does not acknowledge the mutually constitutive nature of discourse and materiality.

The terms 'impairment' and 'disability' (around which, it may be argued, these

models are focussed) further reinforce the idea that discourse and materiality are

two separate entities with little connection to one another. It is therefore

important in the context of this thesis, to have an understanding of what these two

terms mean and to acknowledge that they are not interchangeable. The World

Health Organisation, as cited by Crow (1996, p. 207) defines impairment and

disability thus:

> Impairment: Any loss or abnormality of psychological,
> physiological, or anatomical structure or function.

> Disability: Any restriction or lack (resulting from
> impairment) of ability to perform an activity in the manner
> or within the range considered normal for a human being.

Chouinard, Hall and Wilton (2009, p. 9) claim that the social model makes the

problematic distinction between "impairment as a pre-social biological state and

disability as a social process". Impairment, then, is aligned with the material and

essentialism; disability with the social and discursive. There appears to be no term

used by either model which is 'neutral'. The very terminology employed to frame

the phenomena (disability/impairment) upon which the medical and social models

of disability focus positions them as being *either* materially *or* discursively

produced.

I posit that there is a need for geographers to reconsider how disability and

impairment (both physiological and psychological) are framed in literature and to

acknowledge that the material and the discursive are not diametrically opposed.

One cannot exist without the other. Crow (1996) echoes this concern, stating that,

rather than focusing on impairment and disability separately, academics should be

focusing on them as mutually constitutive and complementary ideas. She points

out that

> Impairment is about bodies' ways of working and any
> implications these hold for our lives. Disability is about
> the reaction and impact of the outside world on our
> particular bodies. One cannot be wholly understood
> without the other, because whilst they can exist
> independently of each other there are also circumstances
> where they interact. (Crow, 1996, p. 218)

Remembering that disability is connected with the social/discursive and

impairment with the material/essential, it appears that Crow is arguing for a

reconceptualization of the medical/social models of disability that acknowledges

the mutually constitutive nature of materiality and discourse.

While the social and medical models of disability are useful, each tends to deal

with only one side of the material/discursive dualism. The material and the

discursive seldom touch, meld or mesh. They tend to be treated as two distinctly

separate ideas. The same may also be said of Joyce Davidson's treatment of the

two concepts in her book *Phobic Geographies: the Phenomenology and Spatiality*

of Identity (2003), which addresses the phenomenological and material concerns

of the anxious body but largely overlooks the part that discourse plays in the

(re)construction of such bodies. However, Davidson (2003, p. 18) does identify

that the feminist phenomenological approach she uses

> should not be interpreted as positing a pre-discursive
> body, a body uninfluenced by and beyond the reach of
> language's circumlocutions. [It] does not deny the role and
> import of the linguistic mediation of, or contribution to,
> our experiences.

 Nevertheless, Davidson generally overlooks the fact that the material and the

discursive are mutually constitutive, that one cannot exist without the other.

Davidson's (2003) focus upon the material perhaps at the cost of the discursive may be the result of a need to be critical of what she sees as the phallogocentric nature of discourse. She claims that "the power of the word (logos) [is used] to order and apportion meaning to women's experiences in a patriarchal society" (Davidson, 2003, p. 18). Language and discourse, then, can be seen to be tools used by patriarchal society to subjugate and oppress women. Women's embodied experiences are often difficult, if not impossible, to express in the dominant (patriarchal) symbolic order. One of the explicitly stated aims of Davidson's research is to allow women a space in which their often overlooked voices can be heard and where they can articulate their embodied and material experiences as women with agoraphobia. Discourse is rarely addressed.

2.4   A Conceptual Model for a Radical Body Politics

While the above models and works offer important and valuable insights into the nature of the discursive and the material as they individually exist, they fail to address how these two concepts are connected. However, a theoretical framework that does take into consideration both the discursive and the material, as well as their relationship with one another, and is particularly useful for this study of OCD space and gender is Pamela Moss and Isabel Dyck's (2003) framework for a "radical body politics". Any geographical research of the (ill) body needs to address these two phenomena that interact with and build upon each other in the process of (re)constructing the body as we know it. There are, as outlined by Scheper-Hughes and Lock (1987) three distinct realms of the body: the

"individual body-self of lived experience, approached by phenomenology . . . the social body of representation, and the body-politic of power, domination and control" (Kirmayer, 1992, p. 324). Moss and Dyck's (2003) conceptual model for a "radical body politics' acknowledges that these three distinct bodies are, in fact, intertwined and inextricably connected in a single system (see Figure 2.1). In doing so, the model provides an understanding of the "processes that mediate the relationships between the body, self and society" (Kirmayer, 1992, p. 324).
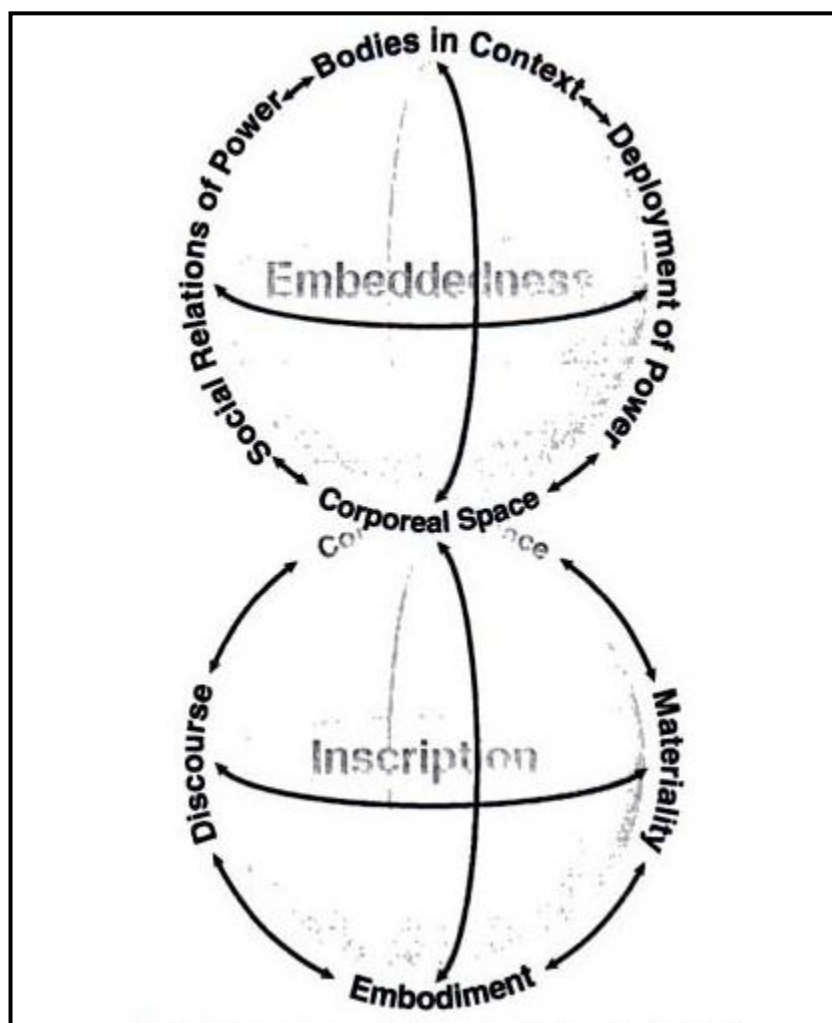
Figure 2.1: A Basis for Conceptual Framework for a Radical Body Politics
(Source: Moss & Dyck, 2003, p. 53)

This is one of only a few theoretical frameworks that seek to challenge the traditional models, and ways, of thinking about disability and (ill) health. The long-established conceptions of disability (particularly the medical and social models of disability) suggest that there is an insurmountable divide between discourse and materiality. As I have pointed out, such (re)imagining of disability, impairment, and illness is problematic. As Imrie (1997, p. 263) argues, "for the understanding of the determinants of disability to progress, a closer correspondence between the medical and social models of disability has to be developed". While this appears not to have yet happened, Moss and Dyck's conceptual model does introduce the idea of connectivity between the material and the discursive. This perspective provides a refreshing view of geographies of disability and health, one that I believe is sorely needed given how discourse and material reality both play vital roles in a person's experience of a (mental) health condition. Moss and Dyck's model therefore has great potential usefulness for this thesis. The ideas within the model are very much applicable to issues of disability and (ill) health and thus also for any study of OCD.

Moss and Dyck's (2003) conceptual model for a "radical body politics" challenges the idea of dualistic thinking by proposing that the material and the discursive are not binary opposites but are, in fact, connected and overlapping: indeed, the model illustrates that neither can exist independently from the other. Thus a separation between the two cannot and should not be readily defined. The model addresses the material/discourse dualism that has long separated the fleshy reality of the ill body from the discursive practises that surround it. The body, ill or healthy, is the nexus through which women (and men) experience both

discourse and materiality. Therefore, the body is crucial to our experience of both, a point that is particularly relevant to this thesis as it seeks to understand how OCD bodies negotiate and experience the material and the discursive. A "radical body politics" challenges the material/discourse dualism in order to expose, explain and understand the ways in which power is disseminated and enacted in society.

The idea underpinning the notion of a "radical body politics" is that the individual, material body does not exist within a vacuum. The (ill) body is not a lone entity, separate from all else. Rather, it is an entity that is 'already in context' insofar as it is both socially constructed and materially present. Moss and Dyck therefore rename the body as 'the body in context'. The 'body in context' exists as "part of a collective, imbued with power and a political being" (Moss & Dyck, 2003, p. 52). It is constituted through its (discursive) relations to other bodies and objects. Without such relations the body cannot truly materially exist. It is discourse, Moss and Dyck argue, that gives meaning to and allows us to fully conceptualise and understand our material reality.

Moss and Dyck's (2003) conceptual model for a "radical body politics" consists of two essential components: embeddedness and inscription (see Figure 2.1). These two concepts form the base around which other components comprising processes of power converge, mesh and interact. These additional components include: discourse, embodiment, materiality, corporeal space, social relations of power, bodies in context, and deployment of power. It is corporeal space which

provides the link between embeddedness (which can be read as materiality) and inscription (which can be read as discourse).

Moss and Dyck (2003, p. 53) explain that the 'body in context' is "embedded in social relations of power, organised around ability, age, citizenship, class, ethnicity, gender, health status, nationality, race, sex, sexuality and other sets of relations we have yet to name". Moss and Dyck posit that this notion of embeddedness is crucial for an understanding of how 'bodies in context' are connected to structures of power in society. Specifically, embeddeness is concerned with how these 'bodies in context' are positioned in relation to one another. Such positioning shapes power deployment and dissemination in society through such processes as colonisation, domination, and marginalisation, to name but a few. Many of these processes are yet to be named.

However, Moss and Dyck's (2003) model is not without its limitations. In offering a diagrammatic representation that breaks down a "radical body politics" into its separate components (embededness, bodies in context, inscription, etc.) and creating certain categories and sub-categories that comprise the whole, Moss and Dyck are in danger of subscribing to the very categorical thinking processes they seek to subvert. Furthermore, the discursive and the material are shown in the model to merely touch – they are thus positioned as separate components that are in some way connected to each other rather than as fully mutually constitutive components that are so tightly interwoven and meshed together that separation is impossible, as Moss and Dyck suggest in their description. The model, however, is an excellent starting point from which we can begin to examine how these

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supposedly opposite phenomena are interrelated and it does offer a great deal as a framework that has helped to shape and guide my research.

Within Moss and Dyck's (2003) model it is corporeal space, or the space of the body, that is the site in which the discursive and the material both exist. The body is the nexus at which the discursive and the material are linked, interwoven and meshed together. In order to understand how the two operate and are interdependent upon each other, it is important to understand the nature of the body and, particularly for geographers, the ways in which bodily experience reflects and influences a person's relationship with physical and social environments (Longhurst, 1997). That is, the relationship between the material and the discursive can only be understood through a person's embodied experiences. It is the body that "is the centre around which the body is given a correlate of its activities" (O'Neill, 1970, p. 13) and is "the vehicle of [our] perception and movement in the world" (O'Neill, 1970, p. 15).

2.5   Health, Illness, and Metaphor

Metaphor plays an integral part in the ways in which we "think about and experience ourselves . . . [and has] a widespread influence upon the creation of ourselves and our world" (Pritzker, 2003, p. 11). It has been argued that the embodied self is central in the conceptualisation of many common metaphors. Rohrer (1995, p. 2) states that "human beings systematically characterise abstract ideas – thoughts religious beliefs, political and ethical situations – in terms of bodily movements and bodily functions". The journey metaphor (discussed in

Chapter Four), for example, can be, as articulated by Pritzker (2003, p. 12) "traced

back to the embodied experience of motion, and the notion that we are moving

through life as if moving through space". Because the linguistic framework

through which we understand the body as it concretely exists is limited, it follows

that for us to interpret our bodily experiences we must look to conceptual

structures outside of the body itself. Pritzker (2003, p. 12) points out that

> in our quest to interpret the processes of the body
> (including emotions) we consistently turn to other natural
> and created systems in our environment to fashion the
> metaphors we use. Such systems include nature,
> technology, science, and religion.

As such, nature often influences the metaphors that we use to refer to the body

and thus also the self. Pritzker (2003, p. 12) goes on to state that

> while embodiment is hypothesized to create our
> impressions of external models, nature and human
> constructs are also hypothesized to influence our
> understanding of body. Language and thought and what
> they describe are thus engaged in a cyclical, interactive
> process. Our interpretations of ourselves create the world
> outside us, and the world outside us in turn influences the
> way we understand ourselves.

We can therefore see just how vital a role metaphor plays in the (re)construction

of bodies and environments, allowing us to concretely grasp what might otherwise

be too abstract to fully understand.

It has been argued that metaphors are used by people in times of social and

economic instability in order to forge a connection between the familiar and the

unfamiliar, thus making sense of their changing lives (Kearns, 1997). Kearns

(1997, p. 271), states that the use of metaphors "represents a discursive coping

strategy deployed by interpretative communities to construct understandings of

their changing places and changing place-in-the-world". Those who have a

(mental) health condition such as OCD and their friends and families are often faced with extenuating circumstances and difficult situations. It is therefore unsurprising that metaphor is very much present in (mental) health discourses. As Kearns (1997, p. 273) points out, language plays a pivotal role in the "construction of health and healing contexts". Thus discourse –institutionalised systems of language and meaning that condition not only what we say and how we say it but also what we do not say –is central to issues of health and healing. The ways in which we understand and conceive of the world impinges on language and consequently also how we (re)construct the contexts of health, illness, and healing (Kearns, 1997).

Sontag's examination of illness as a metaphor (1999) clearly demonstrates the power of metaphor in framing the ways in which people conceptualise and experience health concerns. Cancer has long been conceived of in profoundly negative ways. It has been described as the "killer disease" or "Big C" against which a "crusade" or "fight" is waged (Sontag, 1999). As such, the illness is framed as a 'culprit' and it is this conceptualisation that is invoked when the cancer metaphor is used to represent other phenomena. Sontag (1999) argues that illnesses such as cancer, whose cause cannot be readily defined and treatment for which is often ineffectual, are associated with that which is most dreaded: decay, corruption, death, and weakness. The disease itself becomes a metaphor. To call something 'disease-like' is to imply that it is ugly, disgusting, and threatening. Illness is positioned as profoundly negative and as a result those who have such illnesses are positioned as Other.

Reisfield and Wilson's (2004) work on metaphor and cancer provides some telling insights into the ways in which the use of metaphor by individuals with the illness can have profound effects upon the ways in which they experience it. Reisfield and Wilson (2004, para. 4) argue that

> For patients, metaphors can impose order on a suddenly disordered world, helping them to understand, communicate, and thus symbolically control their illness. And for the therapeutic relationship, the language of metaphor can serve as the basis for the shared understanding of clinical reality.

While Reisfield and Wilson treat the individual as a 'patient' who needs to be 'cured', they do suggest that conceptualising illness using metaphors affords people who are 'unwell' some sense of agency in a situation in which they may otherwise feel they have very little. Thus we can see the power of metaphor in shaping the experience of illness.

2.6 Conclusion

This chapter has examined a range of geographical literature on health and disabilities, especially in the disciplinary field of mental health geographies. Firstly, I discussed the traditional social and medical models of disability and their limitations insofar as their treatment of the material and discursive as two disparate notions. I touched briefly on Davidson's (2003) phobic geographies and the ways in which it reflects the social and medical models' tendencies to treat the material and discursive as separate entities. Secondly, I argued that, in order for a greater understanding of OCD (and, potentially, other (mental) health conditions) to be reached, the material and the discursive must be addressed as co-dependent concepts that are intertwined and inseparable. A conceptual model for a "radical

body politics" (Moss & Dyck, 2003) is particularly suitable to a gender-focussed study of OCD as it considers that the condition is as much rooted in discourse as it is in the material, and that one cannot exist without the other. Thirdly, and finally, I discussed the importance of understanding metaphor in health and disabilities discourse and the role that it plays in shaping people's experience of illness.

CHAPTER THREE

METHODOLOGY

3.1　Introduction

This chapter examines my use of a range of various qualitative data collection methods in order to address the research question 'How do men and women with OCD understand and conceive of their condition thus (re)constructing their sense of self and space?' This chapter has three objectives: the first is to discuss the usefulness of qualitative data in a project such as this; the second is to analyse my own position within the research and to address issues of ethical conduct, a concern of particular relevance given the sensitive, and somewhat controversial, nature of the topic of inquiry; and the third is to describe and discuss each method I have chosen and the overall research process undertaken. The key methods I employed for collecting data include semi-structured interviews, critical reading of texts produced by and about individuals with OCD, and autobiography. I also look at discourse analysis as a means of analysing the information that I have gathered. Throughout the chapter, I will refer to a range of texts on qualitative methodologies, including some key geographical works by Crang (2002, 2005) and Rose (1997).

3.2　Methods of Qualitative Data Collection

Qualitative methods of obtaining data have long been used by cultural geographers (Crang, 2002) as they enable researchers to catch glimpses of the

lives of different groups and individuals in society; they allow us insights into

how reality is seen, understood, and conceived of by others (Robinson, 1998). It

can be said that qualitative research is "based on a phenomenological position"

(Maykut & Morehouse, 1994, p. 3). That is, qualitative research focuses upon

understanding the meaning that events have for the individuals being studied,

rather than on "measurable variables and provable propositions" (Maykut &

Morehouse, 1994, p. 3) that are the focus of quantitative research methods. As this

research seeks to explore the feelings and emotions of women and men with OCD

– that is, what having OCD *means* to them – qualitative methods of collecting

information seem more appropriate than their quantitative counterparts.

For the purposes of this research I used multiple methods and triangulated the

information obtained by each. I have thus ensured that my research is as rigorous

as possible (Baxter & Eyles, 1997). By selecting a range of methods, rather than

relying on just one, I have maximised my understanding of the research question

(Longhurst, 2003) and in doing so have broadened my own perspective and

brought forward new ideas and insights into my research. My use of multiple

methods has allowed me to gain insights from a wide range of sources and

therefore also from a wide range of perspectives.

The methods chosen for this research project were semi-structured interviews with

individuals who identify themselves as having OCD and an interview with a key

informant; textual analysis of materials (including film, blog posts, forum postings

and books) produced by or about individuals who have the condition; and

autobiographical recollections of my own experiences as a person with OCD.

3.3 Situating Myself in the Research Process

As a researcher, it was important for me to realise that my presence in the research process did impact upon the findings in some way. Self-reflexivity and positioning oneself in the research makes it possible for us to recognise and make visible the complex operations of power that exist in any research method (Crang, 2005). It is not possible for a researcher to be completely subjective or impartial while researching – he or she is a 'positioned subject' and as such must be aware of what and where he or she is and how he or she does things (Baxter & Eyles, 1997). In being self-reflexive, the researcher is better able to consciously deliberate over what has been done, how data has been interpreted, and the relationship with research participants. Such awareness allows for a more comprehensive analysis of any information obtained from the field (Robinson, 1998).

I believe that my own embodiment has had a profound effect upon the research undertaken. I am a 24 year old Pākehā/Asian woman who has been formally diagnosed with OCD. I have experienced many of the same emotions, thoughts and experiences as the participants in this research. Accordingly, I can consider myself to be an insider of this particular group in society. I was able to empathise with interviewees in ways that those unfamiliar with the realities of living with OCD may not. My embodied identity as a young woman with OCD did, I believe, make possible the relaxed and conversational nature of the interviews. This was preferable to a question and answer session because free-flowing dialogue was encouraged: interviews were conversations. There was a sharing of stories that, while different, were in many ways similar. The fact that I was an insider of the

group I interviewed – a group that traditionally keeps to itself (Healthyplace.com,

2010) – enabled me to forge a rapport of commonality with those I interviewed.

This rapport would have been absent had I been an outsider. One participant

brought this to my attention, saying:

> It's actually nice to talk about it because, to be honest, I
> didn't even tell my therapist half of the things I do that I
> just told you … because you go through it as well … I
> thought it would be nice, if you have OCD that it would be
> much nicer talking to you … you can empathise.

Had I been an individual without personal experience or knowledge of the

condition, it is likely that much of the information I gleaned from participants

would not have been revealed to me or I possibly would not have recognised it if

it had been.

It was also important that I was aware that my position was multi-faceted and

fluid (Rose, 1997). I was not just an insider but also an outsider because I am both

a person with OCD and a researcher. These two aspects of my identity cannot be

separated and are in many ways intertwined. By being self-aware of my own

position in the research, I was able to recognize the power relations that existed

within the interview (Crang, 2005). I was aware of my personal role and how I

performed that role, as well as the relationship and rapport forged between me and

the participants in my research (Sultana, 2007): this has allowed me to better

understand the nature of my findings.

3.4   Engaging in Ethical Research Practice

In any academic research, issues of ethical conduct are an extremely important consideration. This is especially true of any research which involves interacting with others. Behaving ethically is crucially important as it

> protects the rights of individuals, communities, and
> environments involved in, or affected by, our research. As
> social and physical scientists interested in helping to
> 'make the world a better place' we should avoid (or at
> least minimise) doing harm. (Hay, 2003, p. 39)

Any research on (mental) health conditions deals with sensitive subject matter. Lee (1993, p. 4) defines sensitive research as that which "potentially poses a substantial threat to those who are or have been involved in it". It is research in which there are "potential consequences or implications, either directly for the participants in the research or for the class of individuals represented by the research" (Sieber & Stanley, 1988, in Dickson-Swift, James & Llamputtong, 2008, p. 1). Given that an individual's experiences of OCD are very personal and private, it was vitally important that I was empathetic and sensitive not only during interviews, but during the research process as a whole. This research had the potential to be psychologically damaging to those who participated in it if I, as the researcher, behaved in a manner that did not respect participants and their contribution. Thus it was imperative that my research and my behaviour were ethically sound.

3.5   Semi-Structured Interviews

As part of my empirical data collection I conducted four semi-structured interviews. The aim of these interviews was not to be representative but rather to

understand how individuals "experience and make sense of their own lives" (Valentine, 2005, p. 121). In order to realise this objective, I used the interviews to investigate how people with OCD attribute meaning to their lives and the myriad and changing processes that operate in a range of societal contexts.

Semi-structured interviews seemed particularly appropriate given the subject matter as they can be described as dialogue and conversation rather than as interrogation. Accordingly, semi-structured interviews tend to be more sensitive and people-oriented than their structured counterparts (Valentine, 2005). A semi-structured interview is not merely about talking, but also, as Krueger and Casey (2000, p. xi) articulate, is

> about listening. It is about paying attention. It is about
> being open to hear what people have to say. It is about
> being nonjudgemental. It is about creating a comfortable
> environment for people to share. It is about being careful
> and systematic with the things people tell you.

Semi-structured interviews, therefore, were particularly well-suited to a study of this kind, where I was interacting with individuals relating very private and personal feelings about living with a (mental) health condition (which is often considered to be a somewhat taboo subject). Furthermore, there has been a long-standing argument made by feminist researchers that interacting and sharing with participants is, in most cases, better research practice than regarding – and treating – them merely as "subordinates from whom you are extracting information" (Valentine, 2005, p. 121).

Given the focus of this research upon the gendered dimensions of OCD, I aimed to interview both men and women with the condition. In addition to these

interviews, I also interviewed a psychologist, who specialises in treating anxiety 'disorders', for a clinical expert's perspective on OCD's gendered nature.

In order to recruit participants I published a short article on my research in a local community newspaper, *Hamilton News* (see Appendix A for the full article). In addition, the psychologist I interviewed (someone I already knew) offered to put up a small advertisement in the reception area of her offices and to circulate it via email to her colleagues. Finally, I made arrangements for an advertisement to be placed in a newsletter (distributed every three months) produced by the Christchurch-based OCD Support Group – the only support group specifically for individuals with the condition in New Zealand – but the February 22 Christchurch earthquake early in the week of the newsletter's publication resulted in my forgoing that particular recruitment opportunity.

Two individuals (both women, aged between twenty and fifty) responded via email to the story run by *Hamilton News* about my research and two individuals who I already knew (both men, aged between thirty and sixty) offered to participate when I told them of my research topic. All participants were Pākehā/European from Hamilton, New Zealand and self-identified as having the condition. Once initial contact was established, information letters (see Appendix B) detailing the research focus, participant rights, implications of giving full consent, and expectations of both parties during the interview process were sent as attachments via email. At the onset of interviews, issues of informed consent, anonymity, and confidentiality were further discussed before consent forms (see Appendix C) were signed both by the participants and myself.

Three participants had been formally diagnosed as having OCD. I did not see lack of formal diagnoses to be problematic as the experiences of the undiagnosed have just as much significance as the experiences of the diagnosed. I have used pseudonyms to protect the identities of all participants. While the number of participants may seem small, it should be remembered that coming forward and speaking to a stranger about experiences that are extremely personal and private can be very difficult. It has been suggested that those with OCD are inclined to feel somewhat ashamed of and embarrassed about having the condition (Healthyplace.com, 2010) and thus are likely to be uncomfortable volunteering to participate. As interview transcripts are only one of several information sources being drawn upon in this research, I do not believe that the low number of respondents has impacted greatly upon my findings.

All participants experience OCD 'episodes' of varying intensity. Levels of OCD vary from mild (rare bouts of OCD which, when experienced, are not greatly debilitating) to severe (frequent/unceasing bouts of OCD which are greatly debilitating and inhibit nearly all facets of life). As two of the four participants interviewed had undertaken some form of cognitive behavioural therapy and/or were on a course of prescription medication to manage the condition, many of the accounts were reflective of past experiences rather than those currently endured.

Interviews were conducted in the homes of the participants and at the University of Waikato campus. These were the participants' choices of location. In giving them this choice, I ensured that we would be communicating in a space in which

they were comfortable. Each interview was between one hour and one-and-a-half

hours long. Permission to digitally record the audio from these interviews was

granted at their onset. Interviewees were asked questions about how their

obsessions and rituals impact upon their experiential realities and how they shape

their life-worlds (see Appendix D for the full interview schedule). Questions I

asked include: "how does having OCD affect your perception of and behaviour in

different places?"; "can you tell me what sorts of compulsions and/or rituals you

perform?"; and "how does having OCD affect your relationships with others?"

My interview with the key informant – a psychologist who specialises in treating

anxiety 'disorders' – was about the clinical aspects of OCD and some of her own

observations of how the condition manifests in women and in men. Initial contact

was made via email as was all subsequent communication. As in the interviews

involving individuals with OCD, issues of informed consent were discussed at the

onset of the interview. The interview took place at the interviewee's place of work

and lasted approximately one hour. The interview audio was digitally recorded

with her permission. Questions asked include: "what are the feelings that people

with OCD typically experience?"; "how does having OCD impact on how men

and women fulfil typical gender roles such as mother, father, wife and husband?";

and "what are the different treatment options for OCD?"

I listened to each interview recording and transcribed it verbatim. Transcribing is

a lengthy process, and it was not always possible for me to complete transcribing

one interview before the next was undertaken as several interviews happened in

rapid succession. It is important to note that transcription is inherently interpretive

(Kvale, 1996). A transcript is not raw data – it is in fact a representation of it: Transcripts are, as Lapadat and Lindsay (1999, p. 74) state, "interpretive constructions arrived at through choices made by the researcher". It was therefore important for me to recognise that the process of transcription as well as the transcripts themselves were shaped in some ways by me and the decisions that I made.

3.6   Critical Reading of OCD Stories

Alongside semi-structured interviews I also gathered some 'life stories' of individuals who have OCD. Such stories were found on internet blogs, forums and video clips, in films, and in autobiographical books. They are accounts of, and insights into, the embodied spatial experiences of people with OCD in their daily lives. I examined these texts in order to investigate the emotional geographies of those who produced and/or were the focus of them. In doing so, I aimed to gain an understanding of how these emotional geographies contribute to the condition's gendered dimensions. I paid particular attention to the narrators' feelings and thoughts as they undertook spatially-oriented rituals and to any differences I could discern between the experiences of men and the experiences of women.

Many of the online blogs and forums I used in this research were found before I ever contemplated doing a thesis on this subject. I first encountered these websites not as a researcher but as a person with OCD wanting to learn more about the condition. My initial goal in seeking out these websites was to better understand my own position as an individual with OCD to make sense of my shifting identity

after first being diagnosed as such, and to reassure myself that I was not alone and that others had experienced some of the same issues and worries that I was facing.

Online forums are websites or areas of websites specifically designed to enable discussion. Within an online forum, members can post messages and read and/or reply to the messages of others in conversations referred to as 'threads'. Many threads can exist within one forum. Online forums are not 'real-time' conversations as in online chat-rooms. Rather, messages can be posted, read and replied to at any time by members of the forum and, in some cases, the public. Examples of online forums specifically for individuals with OCD include the OCD-UK Discussion Forums, the StuckInADoorway forums, and the OCD sections of the SocialPhobiaWorld forums. These are by no means the only OCD online forums in existence.

At its most basic, an online blog is a frequently (or infrequently, as the case may be) updated, reverse-chronological series of entries posted on a single webpage (Blood, 2004). Bloggers are "driven to document their lives, provide commentary and opinions, express deeply felt emotions, articulate ideas through writing, and form and maintain community forums" (Nardi, Schiano, Gumbrecht & Swartz, 2004, p. 41). I felt, therefore, that blogs would provide rich insights into emotions and experiences of individuals with OCD, as well as into the (online) OCD community.

The blogs and forums I chose to examine were selected because they appeared at, or near to, the top of the Google.com search results list for the keywords "OCD

blog" and "OCD forum". The decision to use the Google search result ranking system (known as the PageRank system) may not seem to be the most academically rigorous option for selecting appropriate blogs and forums for analysis. However, an understanding of how the ranking system functions shows that it is a tool by which we may discern how popular a website may be. Google's PageRank system sorts search results and displays them in order from websites with the most number of links from other webpages those with the least (Malseed & Vise, 2005). It can therefore be expected that those websites appearing near to or at the top of a list of Google search results for "OCD forums" are, being the most linked to, likely to experience the largest volume of traffic and facilitate the largest online OCD communities.

I decided not to investigate real-time virtual chat-rooms. Had I chosen to do so, I would have been required to sign up to the website in question and participate in online conversation with its members. I would have been interacting directly with those inside of the chat-rooms, which would have raised ethical issues and difficulties in obtaining fully informed consent. Obtaining fully informed consent in chat-rooms is particularly problematic due to the transient nature (Frankel & Siang, 1999) and doubtful legitimacy (i.e. whether they – or I as the researcher – are who we claim to be) of its participants (Donath, 1999).

I examined three online forums and twelve blogs. The forums, and the threads within them, were numerous. Many threads had titles like 'Having a bad day' or 'OCD taking over my life' which gave little indication as to what the thread was specifically about. It fell to my own judgement to decide which were appropriate

for investigation and which were not. The blogs were easier to filter as there were

far fewer. I chose to examine blogs produced by individuals rather than by

organisations, such as clinics and mental health information websites, as the latter

tended to focus more on medical information and on means of obtaining help

rather than on emotion and experience. Information gathered from forums and

blogs had been 'published' in public webpages that were accessible by me without

any sort of membership.

In online forums and on blogs it is very common for participants/writers to

present themselves using a pseudonym, or username, to ensure some level of

anonymity. I have chosen not to identify individuals by these usernames and have

instead referred to them by pseudonyms of my own choosing. Traditionally,

researchers have tended to dismiss the idea that pseudonyms and usernames can

be as true and important as 'real' identities (Frankel & Siang, 1999), directly

quoting from individuals under their 'real' pseudonym. Doing so disregards the

investment that individuals make in their online personas which can, for many, be

as large and significant an investment as in their 'real-world' identities within a

physical community. I have also chosen not to refer to any specific forums or

blogs by name to ensure that as much anonymity as possible is afforded to

participants on these websites, and that such websites remain safe spaces for

individuals to express their emotions and feelings.

Additionally, I examined three film texts about individuals with OCD. These were

The Aviator (2004), directed by Martin Scorsese; *As Good As It Gets* (1997),

directed by James L. Brooks; and *Matchstick Men* (2003), directed by Ridley

Scott. Films focussing on the personal struggles of an individual with OCD were surprisingly hard to find. Several threads in online OCD forums did discuss films about people with OCD, and it was apparent that those in the community were eager to find narrative accounts of other individuals' experiences of the condition. *The Aviator, As Good As It Gets,* and *Matchstick Men* were the only movies that were consistently mentioned in these threads. In each of these films it is the central character, not merely a supporting or peripheral character, who exhibits OCD traits. Interestingly, these characters are all male, aged thirty or older, and Pākehā.

The Aviator (Scorsese, 2004) is the story of film director and aviator Howard Hughes and his struggles with OCD. The narrative encompasses his early years, from the production of the 1930 film *Hell's Angels* (directed by Hughes himself) through to his test-piloting run of a 'flying boat'. As the film progesses Hughes' OCD begins to spiral 'out of control'. At the end of the film, Hughes is depicted hiding from the media alone in a bathroom and in the midst of an obsessive-compulsive breakdown, suggesting that he never really gets his OCD 'under control'. Hughes is portrayed in this film as having had the particular OCD traits of excessive cleanliness and perfectionism, as well as the repeating of routine behaviours and 'chanting' of particular words and/or phrases. Interestingly, Leonardo DiCaprio, who plays the part of Hughes, has OCD himself and is compelled to take particular routes while travelling and to step on all cracks or spots of gum on sidewalks (Fisher, 2009).

As Good As It Gets (Brooks, 1997) tells the story of an obsessive-compulsive and misanthropic bigot, Melvin Udall (played by Jack Nicholson), as he becomes increasingly involved in the lives of a single mother and a homosexual neighbour. Udall's everyday routine is disrupted when two events occur: the first is his gay artist neighbour's hospitalisation; the second is the resignation from work of the only waitress who tolerates him so that she can care for her ill son, rendering it impossible for Udall to have breakfast. *As Good As It Gets* follows Udall's experiences as his life becomes increasingly intertwined with that of the neighbour and the waitress while he struggles to manage his OCD.

The third film, *Matchstick Men* (Scott, 2003), is the story of a criminal con man with OCD, Roy Waller (played by Nicholas Cage), who discovers that he has a daughter. This discovery is made through therapy he undertakes as a response to his condition becoming increasingly difficult to manage. At first, his daughter's appearance in his life disrupts his obsessively regimented routine but, as their relationship develops, his obsessions and compulsions lose their power and he is able to function without the aid of the anti-depressant pills his psychologist has prescribed for him. Roy's OCD behaviours include repeating actions in groups of three, excessive cleanliness and a preoccupation with symmetry.

Each film was viewed two or three times. Notes were taken during viewing on the obsessive and ritualistic behaviours that the characters engaged in, how these behaviours affected their relationships with others, and how these behaviours affected and were affected by a range of different spaces.

3.7 Autobiography

The feelings, thoughts, and experiences of people with OCD are infinitely varied. They are shaped by individual circumstance and personal background. An individual's age, socio-economic position, gender and sexuality – just to name a very few variables – can have profound effects upon how they perceive and cope with having the condition (Wellness.com, 2011). As such, no two people's experiences of OCD are entirely the same. I found that revisiting my own experiences as a person with OCD gave a richer, more nuanced understanding of the condition's gendered dimensions. In utilising my own experiences of OCD I acknowledge that my identity as a researcher and my identity as a person with OCD are intertwined and connected so closely as to be inseparable (Longhurst, forthcoming).

Autobiographical data is that which contains information about the self (Tenni, Smyth & Bourcher, 2003). Purcell (2009) defines autobiography as a qualitative method of obtaining data whereby the researcher narrates or reveals his or her own life, or parts of his or her own life. Autobiography thus has the aim of providing a rich and nuanced account of personal human experience. This method of information gathering is used mainly by geographers as "critical mini-autobiographies that accompany reflexive examinations of a researcher's subject position" (Purcell, 2009, para. 1). It therefore must be understood that the process of autobiography is not necessarily 'scientific' or objective. Rather, it is a subjective process of representation and accordingly has the potential to comprise "complex relations between representer and represented" (Purcell, 2009, para. 2).

As autobiography is the narration of an individual's experience it might be expected, then, that autobiography is concerned with the self, insider, and individual at perhaps the expense of the Other, outsider, and group/society. However, an individual person is embedded within society. Therefore, the individual is (re)constructed by society and vice versa (Purcell, 2009). In autobiography, the representation of the individual is also the representation of the group or of wider society. As no self exists in isolation, the purpose of autobiography is not to elucidate *only* the self. Thus the practice of autobiography blurs the boundaries separating self from Other, insider from outsider, and individual from group/society. Autobiography, in this instance, can reveal the ways in which my experiences and identity are both products and reflections of processes in wider society.

In geography, autobiography exists in a somewhat liminal space. It can be argued that "autobiographical approaches are not widely accepted as a standard method for geographic research" (Moss, 2001, pg. 190) perhaps because of a "lingering positivism that devalues autobiography because it does not produce 'objective' data that can be counted" (Purcell, 2009, para. 4). However, despite a growing body of research based on qualitative methods in the geography discipline, autobiography has remained largely overlooked. Purcell (2009) notes that *The Dictionary of Human Geography* does not include an entry for autobiography. This oversight is despite entries for ethnography and autoethnography, the qualitative methods that are acknowledged to perhaps be autobiography's closest cognates. However, as Daniels and Nash (2004) claim, there does appear to be

something of an 'autobiographical turn' in geography, with an increase in use of the method in disciplinary research (see Longhurst, forthcoming).

Purcell (2009) outlines several different forms of autobiography. Those that I feel are relevant to my research are 'autobiography of phenomenology' and 'autobiography of reflexivity'. The idea of autobiography as pertaining to phenomenology values everyday experience and thus the 'ordinary' individual is prized above the extraordinary individual. It is concerned with feelings and emotion. The aim of phenomenological autobiography is "to sift through the artifacts [sic] of everyday experience to better understand the emotion, mind, and spirit of one life" (Purcell, 2009, para. 7). As this project aims to gain a better understanding of the emotions and feelings experienced by individuals with OCD, I feel that autobiography of phenomenology is particularly relevant.

Autobiography of reflexivity has strong connections to post-structuralism (Purcell, 2009). This method of autobiography requires that the researcher critically examines his or her subject position. Knowledge is taken to be actively created by the researcher him- or herself. In this type of autobiography, the researcher tends to use 'mini' autobiographies in order to investigate his or her own positionality. These mini autobiographies are "designed primarily to examine reflexively the production of academic knowledge" (Purcell, 2009, para. 8). Therefore, autobiography is taken to be a part of, but not the main focus, of the research. Though this thesis encompasses a wide range of different data collection methods, I question my own positionality and how this positionality has affected the ways

in which I have (re)presented the information gathered throughout the research process.

While autobiography can be problematic insofar as it is at once fact and fiction, private and communal, lessons and lies (Tenni, Smyth & Boucher, 2003), it can also provide rich and full narratives that "include the messy stuff – the self-doubts, the mistakes, the embarrassments, the inconsistencies, the projections and that which may be distasteful. It is about writing all of it" (Tenni, Smyth & Boucher, 2003, para. 10). I have chosen autobiography because my own life and experiences are those that I know most intimately and can consequently draw the richest detail from. Thus autobiography can provide a great wealth of issues for analysis.

Because my OCD has improved markedly since I was first diagnosed to the point where I consider myself to be in a 'remission-type' phase where obsessions and compulsions have a much smaller presence in my life than they once did, I must rely on my memories of times in which my OCD was much more intense and much more persistent. I have no records of what I was feeling, thinking, or experiencing during the periods of time in which my OCD at was at the forefront of my life. The pieces of my own experience that I share are those with significant meaning to me and that have had on-going and long-term influence upon my life as a person with OCD. They are memories that, for the most part, come from my late teens and early twenties (about three or four years ago).

3.8 Analysis of Data

All data collected (including interview transcripts and published stories) were analysed using critical discourse analysis. Critical discourse analysis, rather than merely describing discourse structures, seeks to understand and explain them in terms of social interaction (van Dijk, 1998). Specifically, critical discourse analysis is concerned with "the ways discourse structures enact, confirm, legitimate, reproduce or challenge relations of *power* and *dominance* in society" (van Dijk, 2003, p. 353, italics in original) and this can particularly be seen in how interview participants, blog authors, and forum users with OCD describe their feeling of helplessness and relative 'abnormality'. Critical discourse analysis focuses upon the examination of language and how it (re)constructs systems and hierarchies of power through the formation of discourses. It also incorporates the process of listening to what people say and identifying themes therein: I therefore looked for shared concerns, experiences, and feelings that were common to most, if not all, of the OCD accounts that were examined in this research. Once themes were identified, I analysed the ways in which they were communicated by interviewees and authors, paying particular attention to words and phrases used, and what these words and phrases revealed about power relations in society as experienced by men and women with OCD. Some of the more notable themes that have appeared across the data were the notions of journeys, battles, and struggles.

3.9 Conclusion

In this chapter I have addressed several issues of methodological practice and epistemology as they pertain to my investigation of the gendered nature of OCD. I

have illustrated the usefulness of methods of qualitative data collection to obtain information about the meanings that individuals attribute to certain events and phenomena. I then examined my own positionality within the research process and the implications of that positionality before discussing issues of ethical research practice, a concern that is particularly relevant to a study such as this, which deals with sensitive and possibly controversial subject matter. I explained the process of undertaking semi-structured interviews, critical reading of published stories, and autobiography. I also briefly addressed how I analysed data using discourse analysis.

CHAPTER FOUR

JOURNEYS, OBSTACLES, TRIUMPHS AND DESTINATIONS

4.1   Introduction

In this chapter, I investigate how OCD is represented as a journey by some with the condition. Interestingly, such positioning appears to be used most commonly by women with OCD. I refer to blog postings, films, books, interviews, and autobiographical experience to investigate how the condition is frequently represented as a journey towards recovery. In particular, I will address the idea of a 'journey metaphor', how it is gendered, and how it applies to OCD. I argue that, in using the journey metaphor, women with OCD position the condition as being a part of the self.

In the following section I first offer an explanation as to what the journey metaphor is and outline its composite parts. I then go on to examine how authors of OCD blogs invoke the journey metaphor in order to frame and articulate their experiences with the condition. Following this, I look at the ways in which this metaphor is apparent in OCD films and the resultant gender implications. I then turn my attention to how child-birth and child-rearing can present both obstacles and triumphs for mothers in their metaphorical OCD journey before discussing the importance of sharing the journey with others to an individual's sense of identity and sense of self.

4.2   The Internet, Blogs, and Gender

It is clear that the number of OCD blogs – that is, blogs produced by people with OCD about OCD – is highly gendered. Of the twelve blogs examined, ten were written by women and two were written by individuals whose gender was indeterminable. Thus the female presence in OCD blogging seems to be overwhelmingly dominant over that of males. Nine of the blogs were hosted by Blogger.com, which contains the 'profile' feature in which gender is one of a variety of demographic details that users have the option of disclosing to their readers. Four of the blog authors indicated that they were female. Six other individuals wrote under pseudonyms, or their real names, that were clearly indicative of their gender.

That so many women, in comparison to men, with OCD appear to be using blogs as a means of chronicling and discussing their OCD experiences comes as no great surprise, considering first that women are thought to be more open, and more inclined to self-disclosure on the internet in comparison to men (Van Doorn & Van Zoonen, 2009) and second that the blog, as a diary or journal, is dependent upon self-disclosure and discussion of the personal. The fact that a proportionately higher number of women compared to men have chosen to use blogs as spaces in which to write of their experiences of OCD suggests that women tend to be more willing to openly discuss having the condition. This correlates with the perception that women are more in touch with their emotions and thus are more comfortable or more able to talk about them with others (Ashley, 2010). OCD is a very personal and emotional condition – it is perhaps unsurprising, therefore, that it is mostly women, traditionally positioned as emotional (see Plumwood. 1993), who

choose to articulate their experiences of the condition on online blogs and thus also to those who would read them.

Blogs are extremely personal. They are their author's creation. Blogger.com, the eleventh most visited internet domain as ranked by 'unique' visitors (that is, subsequent visits by the same individual are not counted) and the highest ranked blog hosting service (Meattle, 2007), states that "your blog is whatever you want it to be" (Blogger.com, 2011, para. 2). This claim suggests that authors have control over almost all aspects of their blogs and that, as a result, blogs are unique, individual and personalised. The blogger decides how often he or she updates, what content is included in each update, the aesthetic features of the blog, and what other blogs (or websites) are referred or linked to. The blog is a product almost entirely of the blogger's imagining and this implies that high levels of personal commitment and involvement are commonly invested. This can perhaps explain why blogs appear to be cathartic outlets and sites of creativity and self-expression. Each blog I examined had a different design (see Figure 4.1 and Figure 4.2 (blog titles and personal photographs have been obscured to ensure anonymity of authors)). Some were colourful and whimsical, while others were dark and artistic – to reflect the author's personality or their outlook on their lives and/or OCD. The majority of postings were personal anecdotes from the authors' lives. Some blog authors used visual images to communicate what they perhaps couldn't articulate in words; some used humour as a means of communicating ideas that were upsetting. All blogs featured posts in which the authors reflected on past OCD experiences, wrote of their struggles and challenges, and chronicled
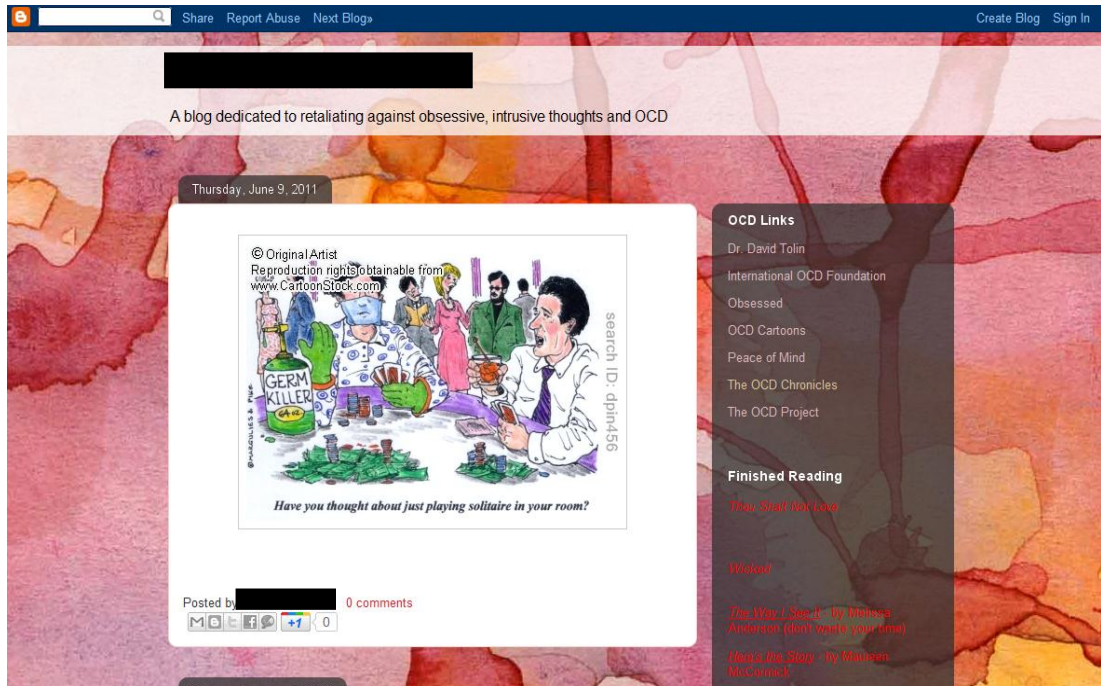
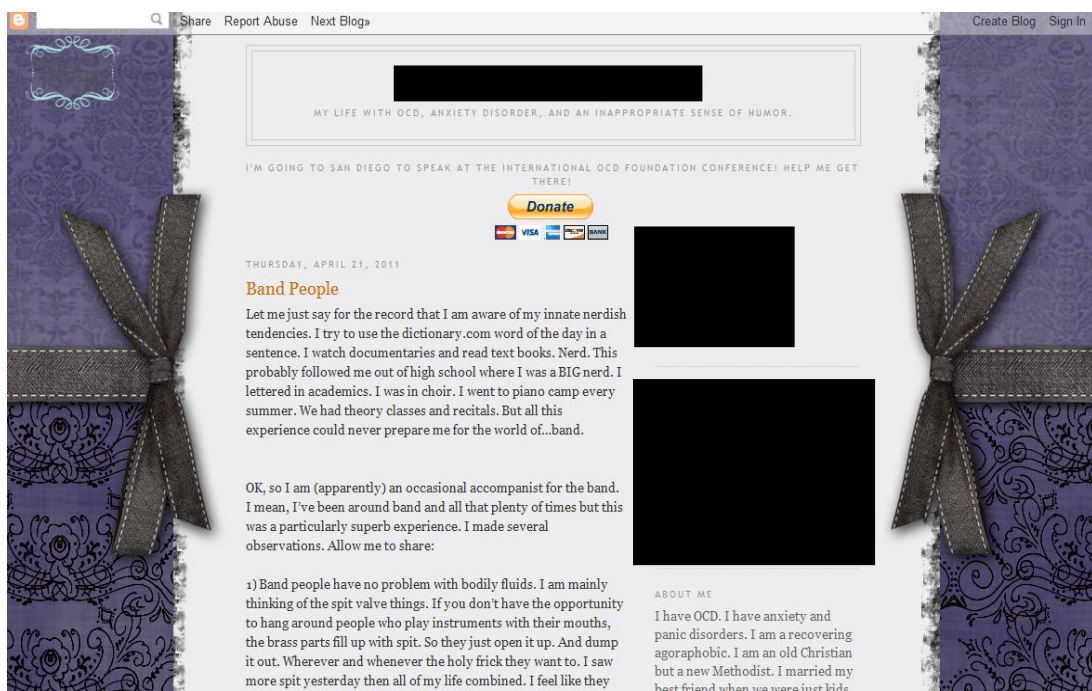Figure 4.1: Screenshot of an OCD Blog (Source: http://aroundandaround-
b.blogspot.com/)

Figure 4.2: Screenshot of an OCD Blog (Source: http://angelaandluke.
blogspot.com/)

their triumphs while acknowledging the lessons they have learned from their experiences.

4.3 The Journey Metaphor in OCD Blogs

The journey metaphor is one of the most visible and most frequently used metaphors to appear on on-line blogs on OCD. The metaphor of a 'journey' or 'pathway' is referred to frequently by many of the blog authors. One author, upon being invited to speak at the International OCD Foundation (IOCDF) annual convention, writes that she will be "speaking about my journey on the path with OCD"; a second mentions that her blog will be about her efforts to 'beat' her OCD and will "chronicle that journey"; a third states that some of the issues she discusses are fascinating while "other aspects of my journey are mundane"; a fourth claims that her blog is a means of chronicling her "journey to sanity". These are but a small number of instances in which OCD bloggers – mostly female – refer to their experiences of OCD and their life with the condition as a metaphorical 'journey' or as being on a 'path' that may or may not lead to recovery. The metaphor of OCD as a journey seems appropriate to the medium given the creative, cathartic nature of blogs as sites of self-expression and self-disclosure. The idea of 'emotional journeys' is one that appears often in the contemporary lexicon so it is perhaps not surprising that the idea of a journey as it pertains to OCD is common in blogs, which are inherently emotional spaces.

The journey metaphor has been analysed in many different disciplines. It has been discussed, for example, in relation to education (Turner, 1998), religion

(Abdulmoneim, 2006), and medicine (Reisfield & Wilson, 2004). The journey metaphor is so pervasive that it is often unconsciously 'mapped' onto the process of life, starting from birth and ending at death (Turner, 1998). It is "so universal, and its referents so engrained in the most cognitive lexicons" (Reisfield & Wilson, 2004, p. 4026) and yet it has remained largely unexamined by geographic researchers, despite its highly spatial characteristics. Indeed, the idea of a journey in and of itself is very much a spatial one: it implies ideas of forward motion (or progress), speed of motion, and distance travelled (Abdulmoneim, 2006). It is interesting that individuals with OCD often use the journey metaphor – and thus the idea of space – so frequently while discussing or communicating their experiences of the condition.

Like a 'real' journey, the journey *metaphor* is comprised of three distinct parts. These three parts are a starting point (or source) from which movement begins, a path traversed, and a destination (or goal) to be reached (Abdulmoneim, 2006). Lakoff (1987) terms this as the 'source path goal' image schema. Image schemas are "preconceptual structurings emerging from pervasive everyday experience" (Turner, 1998. p. 29). That is, they are ways of thinking that are derived from everyday lived experience. In the case of the journey metaphor, every movement we take in our day to day lives – it could perhaps also be argued that every *action* we take – involves a place from which we start, a place at which we end, and a direction (Turner, 1998).

The 'starting point' in the journey metaphor is the source from which movement stems. It can be argued that, for the individual who has OCD, such a point can be

difficult to define. There are several possibilities, but these are deeply subjective as each person's experience of, and attitude towards, OCD is different. Is the starting point when the individual starts treatment? Is it when formal diagnosis is made? Or is it when the first OCD behaviours begin to manifest or are first realised? I personally identify the beginning of my OCD journey as being when I first found out (from a relative who also has OCD) that my 'strange' behaviours and fears were caused by the condition. Becoming aware of having OCD is, I perceive, the beginning of my journey to overcome it. However, that is not to say that this is the same for everybody. It could perhaps be argued that there is no definitive starting point, or source, from which the OCD journey begins. The starting point is almost never explicitly stated by blog authors so the exact point of their journey that constitutes its beginning is something that is often not communicated. It may be the case that many individuals with OCD are not consciously aware of the 'start' of their journey. It was only until I applied myself to thinking about my own starting point that I came to any conclusion as to where – or when – my journey began.

The path component of the journey metaphor, however, was clearly evident in many of the online blogs, films, and interviews. Paths inspire ideas of forward motion. Thus the journey is not static or fixed: instead it is temporal and moves along a singular path or series of paths. That the blog authors utilise this metaphor of a path suggests that having OCD, and living with OCD, is but a temporary stage in their life journey and that they do not necessarily perceive having the condition as permanent.

Abdulmoneim (2006, p. 101) states that the path in any journey

> consists of spatial 'points' in linear succession, which may include salient 'landmarks'. The path may also feature 'crossroads' or 'forks'. The traveller may be faced with 'obstacles' that he [sic] has to go around.

These constitutive components of the journey are alluded to frequently in blogs. The triumphs that the OCD blog authors write about are often expressed as being important points or landmarks in their journey to recovery, and are often referred to as 'steps' towards their end-goal. For example, 'Sally' usually avoids outings, particularly visits to her family as she fears that somebody will be sick and that she herself will catch the illness. When she goes to a family gathering without taking a shower prior (something she does in order to alleviate her intense anxiety) she describes this as being "a HUGE step forward" in her treatment. In the OCD blogs, it is clear that the women authors took pride in their accomplishments, though they were often framed as being small 'steps' towards a much more encompassing end-goal. In my own experiences of cognitive behavioural therapy for my OCD, I thought of my own personal achievements as being steps, or stepping stones, on a long path towards being able to manage the condition. The weekly goals set by my psychologist were difficult to achieve, but doing so always seemed like a triumph and sometimes like a turning point in my journey.

It is not only the metaphorical landmarks that are discussed by the OCD blog authors but also the numerous obstacles that they face. Much of the blogs' content is concerned with the challenges and the difficulties faced by their authors as they struggle to manage their OCD. Such postings are commonly concerned with events that have waylaid progress in treatment or with 'bad days' in which no one

thing, but a combination of many, have left the author feeling depressed and discouraged. 'princessofOCD' states that on such days, she feels as though she is "spiralling downward and there is no way [to] come back again" and 'OCDsufferer', when feeling particularly upset, writes: "I feel like I'm losing something . . . I could assume the worst and take my changing behavior as proof that I no longer have any interest in my disorder and am back to square one". 'OCDsufferer's comment clearly illustrates how feelings of depression or failure can result in people feeling as though they've regressed in their journey and that they have returned to 'square one'. The feeling of forward motion and momentum is lost. This is a sentiment shared by many women authors of OCD blogs, who commonly use phrases such as "two steps backward" and "back at the beginning" during periods of particularly high stress.

A path cannot go on forever and must have some end or destination: in using a journey metaphor, it can be argued that many of the authors of OCD blogs are, whether consciously or not, trying to reach a particular goal or end result. It is not difficult to discern from blog postings what this goal might be: 'Sally', for example, states that it is 'beating' or overcoming OCD that drives her journey. This idea is echoed in many of the other blog postings, with many other authors writing of the various treatments and medications undertaken in their journey to recovery. Indeed, most of the blogs contain many postings on activities undertaken to reach this goal and the challenges authors have faced in doing so. 'OCDsufferer' writes that her blog is about her "ups and downs in the process of recovery" after finding appropriate treatment. 'ellowoman' states that she is "sharing what has worked for me, as well as my current challenges with Exposure

and Response Prevention Therapy." The end-goal of the metaphorical journey for both these authors is recovery and a life in which OCD can be, if not eradicated, at least managed. Accordingly, the OCD journey is a cathartic pathway to recovery central to which is self-growth and self-realisation. It can therefore be seen that the journey positions OCD as a part of the self, rather than as distinctly Other. In overcoming obstacles and marking landmarks/triumphs in the OCD journey, an individual experiences changes that occur within the self. The idea of OCD as a journey thus further illustrates that the mind and body are indeed inseparable, given that traditional Western thinking positions the mind as self and the body as Other.

4.4   The Journey Metaphor in Film

While the journey metaphor appears to be particularly visible in online blogs written by and about people with OCD, it is also apparent in films about the condition. OCD films follow a narrative structure that is in many ways a mirror of the journey metaphor favoured by many women in online blogs. Such films most commonly have as their main protagonist the person with OCD who is a male character. This is certainly the case in the three films studied for this research. The journey metaphor's 'source path goal' schema has been applied to men's experiences of having the condition. This is particularly interesting given the metaphor's more feminine characteristics of self-growth, gradual processes of recovery, and sharing of stories. This isn't, however, to assume that, in general, men do feel comfortable articulating their experiences in this way. Indeed, these films are not the reflections, feelings, or thoughts of a person with OCD but are

produced by large-scale production teams comprising individuals who are likely to have little personal experience of the condition.

The narrative (or plot) structure of most films share much in common with the structure of the journey metaphor. The three-act story structure, the most widely utilised model of dramatic structure (Lights Film School, 2011), comprises act one (the 'beginning', including a set-up of the scene and an 'inciting' incident from which action occurs) which may be seen as the 'starting point' or source; act two (the 'middle' in which many obstacles are faced and overcome) which may be seen as the 'path'; and act three (the 'end', including a climax and resolution) which may be seen as the 'end-point' or goal.

As Good As It Gets (Brooks, 1997) clearly follows the three-act story structure and thus also the 'source path goal' schema of the journey metaphor. At the beginning of the film, or at its 'starting point' (act one) we see Melvin Udall as a dysfunctional, unkind misogynist whose OCD is all-pervasive. This is the point from which the 'path'(act two) begins. Along the path, Udall encounters many obstacles to his peace of mind, including when Carol Connelly, the only waitress he tolerates at his local diner (and also his romantic interest in the story) leaves the diner's employ and he is no longer able to have breakfast there, an integral aspect of his routine. The 'end-point'(act three) sees Udall become a 'better man' whose OCD behaviours and rigid attitudes are somewhat softened. We can see how Udall's 'journey' of self-realisation and managing his OCD follows the 'source path goal' schema of the journey metaphor. It is important to note, however, that, for Udall, his journey is fraught with conflict, a masculine

construct. Udall is continually engaged in a battle against his OCD, himself, and the people he encounters in his everyday life.

Matchstick Men (Scott, 2003) also unfolds as a journey. At the beginning (or starting point, in the language of the journey metaphor) of the film Roy Waller is portrayed as a man suffering deeply with his OCD. His OCD is so inhibiting to his life that he is unable to 'pull off' an important job (he is a conman) because of his panic attacks. We can see that, as in many of the blogs, his starting point on his OCD journey is one of pain and suffering. The path he embarks on in act two, after finding out from his therapist that he has a long-lost daughter, encounters many different obstacles that he must overcome, such as when his newly found daughter, Angela, leaves him. This results in his many phobias and OCD behaviours resurfacing. At the end-point of the journey, we see Waller enjoying peace with his new wife – his OCD compulsions and rituals at a relative end. It can be argued that the purpose, or destination, of his metaphorical and emotional journey is to be recovered from his condition so that he may live a 'normal' life. The entrance into Waller's life of his long unknown daughter provides the catalyst for his journey to recovery. In his initial masculine characterisation as a criminal conman, Waller's OCD experiences are extremely distressing: it isn't until he engages in activities that are 'non-masculine' – Waller's transition from conman to caregiver of his daughter, a role traditionally allocated to women – that the audience sees him begin to change as he embarks on his cathartic OCD journey.

The Aviator (Scorsese, 2004), like *As Good As It Gets* (Brooks, 1997) and *Matchstick Men* (Scott, 2003), follows the typical three-act story structure.

However, the journey that unfolds is different in that the end-goal is never reached. Hughes does not recover nor does his ability to manage his OCD improve. In the last scenes of the movie, we see Hughes becoming increasingly agitated as he becomes embroiled in his compulsion to repeat the phrase "the way of the future" over and over again. The very final scene depicts Hughes in a shadowed bathroom, cloistered away from all others, repeating that same phrase even as he reflects on his childhood dreams.

4.5   The Journey Metaphor and Child-Rearing

It is apparent in the blogs, interviews, and films, that children are a consideration that can have a significant impact upon the OCD journey. As discussed above, the introduction of Angela in *Matchstick Men* (Scott, 2003) to Waller's carefully regimented and routine life is a positive influence that encourages him to strive for the end-goal of recovery. The birth of children and their presence in the life of a person with OCD may be considered positive landmarks on the pathway to recovery. For Claudia, an interview participant, this is certainly the case. Claudia's obsessions are primarily connected to hygiene and germs, though these are by no means the only types that she has experienced. At times, her OCD can result in her becoming physically ill and incapacitated. Claudia found that having children gave her "more confidence" and that she now feels "less worried about harming them than about harming someone else's kids". Claudia infers that her children have prompted positive changes in her OCD experiences. They are markers of success on her OCD journey.

However, it is clear that this is not the case for all women with OCD. Rather than providing a positive influence on a parent's OCD, children can exacerbate or trigger OCD obsessions and compulsions that were either mild or non-existent beforehand. Thus having children often can make the obstacles present in the OCD journey larger and feel more insurmountable, or create new ones entirely. This appears to be particularly the case for women with OCD. Psychologist Jo Clarkson pointed out that "with a new born baby, a woman might be more likely to develop OCD".

Osborn (1998, p. 152) speaks of a female patient (given the moniker Tina in his book *Tormenting Thoughts and Secret Rituals*) he once treated, stating that Tina's "major [OCD] difficulties began . . . right after the birth of their first child." He goes on to say that "Tina's severe OCD symptoms had been triggered by the unique stresses of being a new mother" (p. 154). It is clear, then, that for Tina many of the obstacles she encountered in her OCD journey were the result of the 'stress' of the wholly new situation of being a mother. The presentation of more obstacles for her to overcome would have made her journey more difficult to navigate. Tina's most pervasive obsessions revolved around her fear of contaminating her child and she feared changing his diaper incorrectly, cleaning his crib insufficiently, and having unclean baby bottle nipples.

Interestingly, Tina was a stay at home wife and mother who was "worrying all day long, doing 'next to nothing'" (Osborn, 1998, p. 152). 'OCDblogstar' experienced something similar when cut off from work. While at work she was able to shrug off her compulsions and rituals as she had other responsibilities to

distract her. However, while at home she found herself engaging in rituals and obsessing much more. A conversation thread entitled 'Stay at home mom/boredom OCD' in an online OCD forum discusses how being at work and keeping busy can alleviate OCD symptoms. 'OCDbrit' writes:

> when the mind has time after an intense period of stress and anxiety it can become absorbed in thoughts that you would otherwise dismiss as nonsense. This process creates images and fears that perpetuate the anxiety. My experiences is [sic] that OCD fills you [sic] mind with crap that you fear, when you are bored there is just less to distract you and more space to fill.

In the same thread, 'Glow' says that "my OCD got worse when I had my son, going to work and being busy has definitely helped me as it gives me something to concentrate on". This suggests that it is the absence of activity that can create obstacles in the OCD journey. It is therefore apparent that traditional gender roles assigning women to the home as mothers or house-wives can encourage the exacerbation of OCD symptoms. In the case of Tina, it was her fulfilment of these traditional gender roles in addition to the unfamiliar and stressful experience of having a new child that caused her condition to worsen. Thus it can be argued that having children can serve as a barrier, or obstacle, to successful treatment and on the 'journey to recovery'.

4.6   Sharing the Journey

It is clear from blog accounts that the journey is not meant to be something traversed alone. 'Mary', a blog author, explains that she sees her blog as a means of "connecting with others who have OCD, sharing my struggle with the [sic] those who don't understand, refusing to suffer alone in society". 'ellowoman' wishes to "share what works for me" and states that her blog "hopefully will be

useful" to her readers. Forging connections with other people who have OCD is therefore an important facet of the journey. Davidson (2003), in her research on agoraphobia, highlights the importance of creating links or friendships with others who have similar experiences of a (mental) health condition. Davidson used self-help groups as focus groups in her research. She found that being a member of a group of people with shared experiences was an "important factor in mediating the respondents' sense of self and group identity . . .[it] can offer its members a collective identity based on the mutual recognition of shared experiences and a shared 'form of life'" (Davidson, 2003, p. 34). I argue that this is the same for those with OCD, and particularly women who write OCD blogs and engage in the journey discourse. Authors provide hyperlinks to each other's blogs on their own webpages and comment on each other's postings.

Many women who use the journey metaphor do so with a view to helping others with OCD by sharing their stories. Blog author 'Sascha' illustrates this desire, saying "I hope that by sharing my journey, I can help bring compassionate awareness to Obsessive Compulsive Disorder, bring hope to those bound by this secret struggle, and inspire everyone to fight for their own free spirit". 'OCDsufferer' writes: "These are my reflections on how OCD has impacted my life, both in the past and the present, as well as a chance for me to share my ups and downs in the process of recovery. I hope that my thoughts and experiences resonate with other sufferers as theirs have resonated with and inspired me!" 'ocdblogger' tells her audience that "I hope that my thoughts and experiences will be uplifting for those who suffer with me". All three bloggers clearly show that an important component of the journey for women with OCD is being able to

somehow 'help' others to overcome obstacles in their own journeys. This is perhaps reflective of traditional conceptualisations of gender in which women are positioned as nurturers (Laws, 1997) because of their role as primary care-givers to children.

4.7   Conclusion

This chapter has examined the ways in which the journey metaphor is evident in the experiences of people with OCD. Firstly, I discussed what the nature of the journey metaphor is. Secondly, I looked at how blog authors have referred to the idea of the journey, and how their postings have shown use of language framing their experiences of OCD in this way. That the majority of blog authors are female suggests that the journey metaphor is gendered. Thirdly, I discussed the different components – known as the 'source path goal' schema – inherent in a journey, metaphorical or otherwise, and how such components may be evidenced in blogs, films, and interviews. In doing so, I examined the gender implications of the journey metaphor as it pertains to OCD. Fourthly, I investigated how child-birth and child-rearing can prompt positive change but also can present obstacles in the path to recovery for women, particularly stay at home mothers and house wives. Lastly, I investigated the importance of sharing the journey for women with OCD on their pathway to recovery.

CHAPTER FIVE

STRUGGLES, BATTLES, MONSTERS, AND SOLUTIONS

5.1   Introduction

As discussed in Chapter Two, many mental health geographers tend to address discourse and material reality as two disparate entities with little connection to one another. It is my intention in this research to illustrate how such a conceptualisation of the discourse/materiality dualism is problematic and cannot be applied to OCD, a condition in which discourse and materiality are inextricably and inescapably linked. In this chapter, I examine how OCD is often represented as a battle employing the traditionally masculine discourses of war and violence. In doing so, I illustrate how such discourses about OCD are mutually constitutive with the lived and embodied reality of those who have the condition. In particular, I look at how discourses and representations of OCD by those who have the condition position the self and Other, and how such positioning is grounded in the body/mind. I also illustrate how the ideas of the self and Other are conceptualised through discourse on OCD.

In the following, I first discuss how men's portrayals of OCD ascribe to discourses of war and battle and how such discourses reinforce typical gender stereotypes. I then turn my attention to the notion of the 'OCD monster'. Specifically, I investigate how use of this term suggests that OCD is Other to the self; that OCD is perceived to be so daunting and overwhelming a force that it can position some people with OCD as somewhat passive victims; and that OCD is

seen as something repugnant, freakish, and unnatural. Following the idea of an OCD monster, I look at how men describe having the condition as an internal struggle and how this representation implies that much of the distress associated with OCD consists of the inability to separate the individual self from the OCD Other. Though I argued in Chapter Two that the self and Other cannot and should not be separated, it is apparent that the breaching of the boundaries between the two results in much stress and anxiety. Lastly, I examine the implications of the battle/war discourse for recovery from, or better management of, OCD. Throughout this chapter, I refer to blogs, interviews, newspaper articles, autobiographical experience, books, and online forum postings.

5.2   OCD as Battle or Struggle

The military metaphor (the positioning of illness as a battle or struggle) is one that is particularly visible in the medical profession and has been for quite some time. It is perhaps the dominant metaphor in health, or medical, discourse (Reisfield & Wilson, 2004). Bacteria, for example, are often represented as 'agents of disease' (Sontag, 1999, p. 139) that 'infiltrate' or 'invade' the body. This metaphor sets up clear body boundaries that, when breached, are positioned as being 'under attack'. Thus the attacker – the illness, whether psychological or physical – is framed as a threat to the body/mind and also the 'natural order'. It is Other. Sontag (1999) claims that it is not just the clinical manifestation of a health condition and its subsequent medical treatment that are positioned in such a way: The disease itself is thought of as the enemy against which society wages war. We can therefore see just how pervasive this metaphor, or trope, is. It is particularly powerful because it

has an exceptionally strong focusing quality, and its images of power and aggression serve as strong counterpoints to the powerlessness and passivity often associated with serious illness. (Reisfield & Wilson, 2004, para. 6)

It is perhaps easy, then, to see why those who have a (mental) health condition, or who are family or friends of a person with a (mental) health condition, might choose to engage with this metaphor and discourse.

While the battle metaphor certainly does resound with many individuals with serious illnesses it does have some limitations, as outlined by Reisfield and Wilson (2004). Firstly, it is "inherently masculine, power-based, paternalistic and violent" (para. 12). Aggression and conflict are not necessarily always a person's preferred method of coping with an illness or other health concern. Secondly, it suggests that 'winning the war', or overcoming the condition, simply comes down to fighting hard enough. The blame is placed on the individual if the 'war' is 'lost': It is the person who fails treatment or therapy, not the treatment or therapy that fails the person. Thirdly, it centres upon the biological and essential at the expense of other aspects such as the social, psychological and the existential as all 'resources' are focused upon the fight, or war. There is an intense focus upon 'beating' the condition which can create a barrier to understanding the aspects of an individual's life that fall outside of the immediate 'battle'.

As I have illustrated in Chapter Four, women tend to refer to their experiences of OCD as being composed of obstacles and/or landmarks on a pathway to rehabilitation. Such representations suggest that women perceive OCD to be a cathartic journey of self-realisation in which the individual grows with each

experience. It can thus be argued that women's articulation of OCD as journey-based positions the condition as being connected to, and perhaps even part of, the self. Men's tendency to refer to their lives with OCD as comprised of a series of struggles or battles often implies the opposite and situates the self as being in opposition to an external threat – an Other.

The ways in which men represent their experiences of OCD as being battles or struggles position the condition (which is perceived to be rooted in the mind) as being something that is apart from themselves. In online forum postings, interviews, and films, OCD is most often referred to by men as being a fight that has to be won. When Michael, an interview participant, talks of some of the more distressing OCD obsessions and compulsions he has, he says "yeah, it's like a battle", one that 'threadtoclingto', a member of an online forum for those who have OCD, writes is "impossible to beat".

In the film *As Good as it Gets* (Brooks, 1997), the main character Melvin Udall is depicted as 'waging war' against the world and his existence within it as a person with OCD. He uses violent language and behaviour in order to cope with his having the condition. Indeed, it might be argued that his combative, antagonistic personality is, in some part, a result of the distress he experiences as a result of his obsessions and compulsions. The scene in which Udall learns that his favourite waitress, Carol Connelly, has resigned from the diner where he eats breakfast every morning clearly shows his aggressive response to a change in his routine. Such a change disrupts his sense of peace and triggers an OCD reaction. Udall becomes enraged slamming his fist against the table and shouting at the new

waitress. Throughout this event, Udall becomes increasingly agitated as he struggles to remove plastic cutlery from the plastic bags in which he has sealed them. Udall's behaviour is an example of how, for some men, the disruption of their carefully ordered lives is met with anger and aggression.

It is not only individuals who themselves live with OCD who portray the condition using a discourse of battle and struggle but also some psychologists and help/support centres. The OCD Resource Centre of Florida describes their suggested strategies to manage obsessions and compulsions as "weapons in your arsenal in this battle against OCD" (2011, para. 2). While it is difficult to ascertain whether this statement was written by a male or female, it should be remembered that the psychological profession as a whole is historically male-dominated (Standley & Soule, 1974). Gender of the author aside, the words 'weapons', 'arsenal', and 'battle' all invoke the idea of aggression, violence and conquest and are commonly associated with discourses of war. Such discourses, it can be argued, are masculinised. It is clear that there seems to be an idea amongst men particularly that having OCD is akin to being at war. This is perhaps unsurprising, given that traditionally men have been identified as being active aggressors imbued with inherent physical strength (Saunders, 1992). That men often implicitly or explicitly refer to themselves as fighting OCD could potentially afford them a sense of agency where perhaps they would otherwise feel powerless or weak. Furthermore, portraying OCD as being a fight implies that there must be an opponent to beat or vanquish. Thus the condition is often framed by men as being some sort of external enemy threatening to encroach upon the individual, or

self. We can therefore see how OCD is represented and thought of by many men with the condition as being Other.

It is important here to have an understanding of what the notion of the self, and by extension the Other, is (as discussed in Chapter Two). Valentine (1999, p. 50) describes it as "about both being and having a body". Accordingly, we can see that the self is firmly entrenched in the material. It is important, therefore, to note that how individuals with OCD articulate and thus understand the material reality of the self is through discourse. Discourse and materiality are mutually constitutive and difficult, if not impossible, to separate (Moss & Dyck, 2003). Valentine also points out that Merleau-Ponty (1962) identifies the body as being the "original subject that constitutes space – that there would be no space without the body" (Valentine, 1999, p. 49). It can then be argued that the material self is the closest of spatial scales. However, it is not just the body that constitutes this idea of the self. It must be remembered that the body and the mind are not two unrelated phenomena (Parr & Butler, 1999) and that, accordingly, the mind too is an integral and inseparable part of the individual and also of the self.

5.3   OCD as the Monster

As mentioned above, it is clear that the battle and war discourses as they are applied to OCD situate the condition as being Other to the self. So too does the 'monster' trope that is a part of this wider discourse. The monster trope, like its battle/war counterpart, is inherently masculine. It positions OCD as a somewhat tangible enemy against which the individual must wage war and win. The

International OCD Foundation organised a conference that took place on the 26 July 2010. The conference's promotional Facebook advertisement used the catchphrase "I can beat the OCD monster!" This is but one example of how the monster trope sets OCD up to be an opponent over which the individual must triumph. David H., who has contributed his own story to the Anxiety Disorders Association of America describes his experiences with the condition as "fighting the monster of OCD" (Anxiety Disorders Association of America, 2011b, para. 1). It is interesting to note that, despite the fact that the idea of the monster is innately non-feminine, it appears that many women also engage with this discursive framework and often use the term 'monster' to describe OCD.

Portraying OCD as a 'monster' suggests several things. Firstly, it positions OCD as Other to the self. Secondly, it implies that OCD is something so terrible, frightening and overwhelming that it appears to incapacitate the individual so that he or she is unable to do anything about it, thus positioning him or her as being somewhat of a passive victim. Thirdly, it suggests that OCD is something unnatural and freakish.

Like the battle/war discourse, the OCD monster reinforces the Cartesian dualism of self and Other by positioning the condition as something that exists outside of the individual. This idea is echoed by the following sentiment voiced by 'Oddish' on his (or her) blog: "It's not me, it's my OCD". This mantra is one that some psychologists suggest their clients use as a tool of cognitive behavioural therapy in order to "reattribute the intensity of the thought or urge to its real cause, to recognize that the feeling and the discomfort are due to a biochemical imbalance

in the brain" (Westwood Institute for Anxiety Disorders, 2011, para. 16). This suggests, then, that by visualising a boundary between self and Other, an individual can find some relief from OCD obsessions and compulsions. It also suggests that there is a separation between the biological and material processes of the body and the self, and the discourse(s) that surround them.

Lauren, interviewed for a story about OCD in a magazine supplement, *Tempo*, from the newspaper *Waikato Times,* refers to her OCD as a monster that she has to "get rid of" (Cronin, 2010, p. 4). This suggests that her OCD is something separate to her body/mind and something that can be removed without negative consequence to herself. Furthermore, she goes on to describe OCD as being "an intrusion, an external thing" (Cronin, 2010, p. 4). 'Gillian', a blog author, also portrays her OCD as something Other to her self and calls it "the monster that lives in my head". This interpretation of OCD suggests that it is something external to the self that has invaded and taken up residence in a part of herself. She goes on to say that "It's because of the monster, I told my friends. You can't stay the night at my flat because of the monster". In saying this, she distances herself from the problem and implies that it is not her, but her OCD, that has caused the difficulty. In rejecting OCD as being part of themselves, those with the condition clearly position it as being Other.
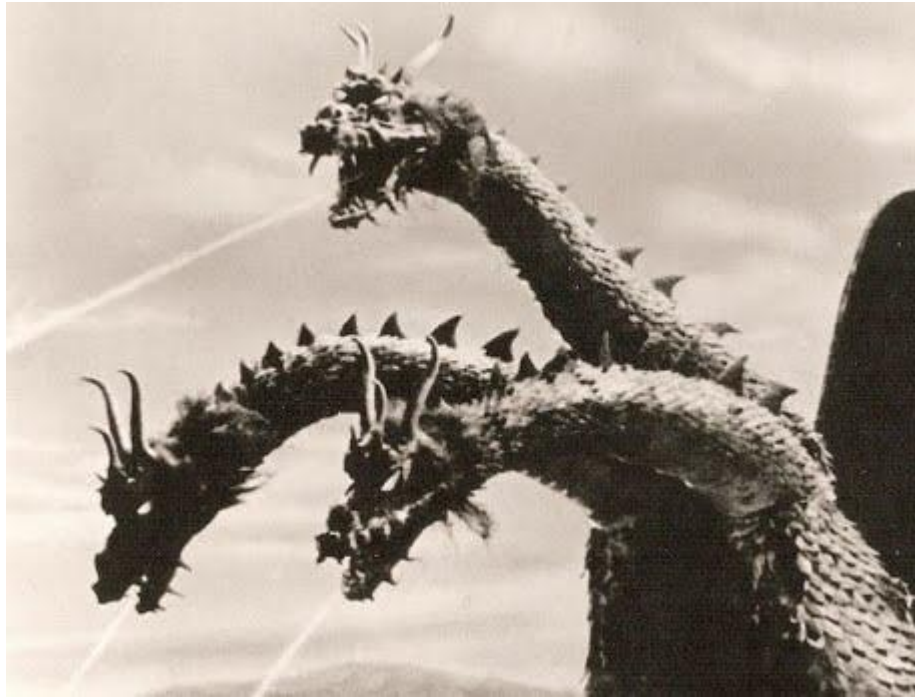
Figure 5.1: 'Chantel's Pictorial Representation of the OCD Monster

(Source: http://momswithocd.blogspot.com/2010/05/ocd-monster-with-multiple-personalities.html)

Furthermore, the term 'OCD monster' suggests that the condition is something frightening and terrible. One of the meanings of the term monster is something "of great size and ferocious appearance" (Oxford English Dictionary, 2011, para.1). In her blog, 'Chantel' entitles one post "OCD – the monster with multiple personalities" and illustrates this idea with a picture of a three headed dragon shooting flames from its mouths (see Figure 5.1). The creature is depicted as being aggressive and dangerous. OCD can thus be seen to be an insurmountable and intimidating condition. Some remarks made by those with OCD suggest that OCD is so overwhelming and all-encompassing that it can emotionally incapacitate those who have it. Indeed, blog author 'princessofOCD' indicates that having the condition makes her feel weak and helpless. Such feelings are illustrated in her blog postings, one of which states: "some days I feel like giving up. The OCD monster is sucking the life out of me." This statement suggests that,

at this point in time at least, 'princessofOCD' feels like something of a passive victim rather than the active fighter that much of the aggressive and battle-oriented discourse implies men to be. This excerpt from an online poem entitled "OCD Monster" further illustrates this idea:

> I cannot describe this feeling
> Unbearable loneliness . . . emptiness:
> Like an unwelcome memory . . . I want to Scream!!
> I'm drowning . . . I can't breathe. (Foster, 2003)

There is a clear connection between the title of the poem – OCD Monster – and the feelings of helplessness and powerlessness expressed in the text itself. However, it should be noted that, in order for victory to be meaningful and for the individual to become the 'hero' or the 'winner', the opponent (OCD) must be frightening, terrible and powerful.

The idea of OCD as monster also suggests that the condition is something unnatural, perhaps even somewhat abject. A monster is commonly considered to be "an imaginary creature that is large, ugly, and frightening" (Oxford English Dictionary, 2011, para. 1). Traditionally, monsters have been depicted as grotesque creatures and a sign that the natural order has been upset. Thus they are positioned as being freakish – as being out of place, out of order, and out of control. In using this metaphor to understand or describe OCD, it is implied that the condition is also out of place, out of order, and out of control. It is further positioned as being Other to the self because it is portrayed as something that doesn't 'belong' or have a place in 'normality'. In representing OCD as a monster, it could be argued that some individuals with OCD see the condition, and perhaps also themselves, in this light.

5.4   OCD as Internal Struggle

Unlike the idea of the OCD monster and the overarching discourses of battle and struggle, which suggest that OCD is an external force outside of an individual's control, the idea of an internal battle clearly positions the condition as something that occurs within the self. 'threadtoclingto', posting in an online forum, writes that "every day I fight myself" and asks "is anybody else tired of fighting there [sic] self [sic]". 'nope425', a guest on the same forum (although in a different discussion thread) says this of one particular OCD impulse he experiences: "One half of me says I want to do it and the other fights it and so there is a major internal conflict". It is apparent, from 'threadtoclingto' and 'nope425's comments, that the boundaries separating the self from the Other, the rational from the irrational, and the internal from the external become blurred. It can therefore be argued that the Cartesian dualisms that so often frame our ways of thinking about such things as (mental) health and gender are not always applicable to (men's) experiences of OCD.

Interview participant, Michael, reinforces this idea of OCD as an internal battle, saying:

> In a sense you try to survive, but I guess the battle was between me saying this is ridiculous and then the obsessive thought coming back again and thinking as if, well, maybe it is, maybe I am a terrible person.

The following discussion further illustrates the idea of a struggle with the self:

> Michael: It's an internal battle.
> Me: Of your own mind.
> Michael: Yeah. And thinking I'm going mad.

Michael's comment that his internal battle with OCD results in his "thinking I'm going mad" is particularly interesting. It suggests that it is not the condition itself that makes him feel as though he is losing his rationality. Instead, it is implied that it is the struggle within himself between two facets of his identity that is so distressing to him. The first of these two facets is the part of him that obsesses and believes that certain OCD behaviours must be carried out in order to lessen the distress caused by such obsessions. The second facet is the part of him that believes his behaviours and obsessions are irrational and illogical. This internal battle, or struggle, appears to have resulted in Michael's perceived loss of control over his own mind and body, thus throwing the relation he has with his sense of self into profound question.

My own experiences of OCD are similar. At the peak of my distress and when I still was unaware that I had OCD, I believed that I was 'losing my mind' because I felt some kind of 'tug-of-war' between my rational self and my irrational obsessions. It was this feeling of going 'insane' that was hardest to manage and accept. Reconciling such an emotion with my own sense of self and my own identity as a logical individual was particularly difficult and it was my apparent failure to do so that engendered much of my distress. It is this idea of something 'gone wrong' – in my case it appeared to me to be my own mind and my ability to think logically – that brings the body/mind to the centre of attention, as "we are no longer 'at one with' our bodies [and minds], and our relationship with [them] is no longer unconscious or unproblematic" (Davidson, 2003, p.16).

This internal struggle, and the loss of control that comes with it, clearly challenges traditional conceptions of masculinity which, as discussed in Chapter Two, frame men as being rational and logic-oriented (Bondi, 2005). The loss of control Michael feels is directly related to what he perceives to be a loss of rationality. Irrationality, Kirmayer (1992) posits, is in the medical profession conceptualised as 'pathological' and in the social sciences as 'deviant' or 'exotic'. Irrationality is Other and thus exists in opposition, and as a threat, to the self. Peter, an interview participant, points out that the illogical nature of many of his obsessions and compulsions make them seem "stupid", and that, as a result, his sense of self as a logical, rational individual is questioned. He suggests that, although he is aware that his behaviours are "stupid" he cannot stop doing them. Thus control over his own actions is lost. This is illustrated by his saying that

> most of what you do is probably not possible, or the
> thoughts are not possible but that doesn't stop them . . .
> When you think about it logically it's a stupid thing . . .
> you gotta control your own mind, don't let your mind
> control you . . .you fight it [OCD] with rationality.

'Kbf', an OCD forum member, reiterates how important it is for control to be maintained, and says to a fellow author that he "sounds like your [sic] in control but get help to make sure it doesn't [sic] get out of control." This idea of control is further articulated by Michael in the following:

> Michael: In the office I feel reasonably in control.
> Rebecca: And at home, not so much?
> Michael: Not so much.

He goes on to state that at work he "enact[s] a performance" over which he has control and feels comfortable with. The Other (OCD) does not have a role within this performance: It is the self that takes centre stage. Michael suggests that work is a safe space because it is one in which he can maintain control over his own

body/mind. His comments highlight how important a feeling of control is for many men who have OCD.

This loss of control as a result of the struggle between one part of the self and the rest of the self can contribute to the feelings of guilt, shame and disgust that many individuals with OCD experience (Anxiety Care, 2011). The two male interview participants, Peter and Michael, point out that the irrationality of their obsessions and compulsions (engendered by the internal struggle within the self and leading to a feeling of loss of control) resulted in them feeling one or more of the following: 'stupid', 'silly', 'embarrassed', 'ashamed', 'guilty', and 'disgusted'.

When speaking about an obsession in which he fears contracting HIV from a public toilet, Michael illustrates how a perceived loss of rationality can lead to feelings of guilt, anger, and fear:

> Panicking when using a public toilet and I might catch
> HIV . . . which is just, I knew it was stupid and it sort of
> pissed me off because it turns, you know, it was making
> me being [sic] afraid of people who I had no reason of
> being afraid [of] and I felt really bad. I felt guilty as, you
> know, and that just makes it worse.

This particular comment reveals several things. Firstly, it shows that the irrationality of obsessions and their resulting compulsions can seem "stupid" to the individual experiencing them. This mirrors Peter's earlier articulation of his OCD compulsions as being "stupid things" that are not logical. Michael goes on to say that he has "obsessions about, oh, all sorts of weird things", implying that he feels that his OCD is not normal, that it is out of place and Other. Secondly, it illustrates how irrational obsessions can lead to feelings of fear. In Michael's case, he feels afraid of "people who I had no reason of being afraid [of]". This suggests

that the loss of control of his thoughts and behaviours resulting in "stupid" or "weird" obsessions and compulsions is something that causes fear. Thirdly, it reveals that the response to the fear engendered by irrational obsessions or compulsions can be anger. Michael's reaction to feeling afraid is to be "pissed off". This reaction can be argued to be masculine in nature, and ascribing to the wider trope of OCD as a battle in which confrontation and aggression are commonplace. Fourthly, it shows how the blurring of the boundaries between the rational and irrational leads him to experience extreme guilt because of his illogical fear of those he feels do not deserve it.

Guilt seems to be a recurring theme for those with OCD and it appears that it is often the result of behaviours or thoughts that are deemed by the person experiencing them to be 'irrational', 'illogical', or 'stupid'. 'OCDblogstar' explains that

> in addition to obsessions and compulsions, many people with OCD struggle with doubting themselves, their actions, etc. This can lead to all sorts of frustration and false guilt. OCD can make you feel bad about things that aren't wrong at all. Tiny things I'd do – if I'd look at someone wrong, etc – made me feel guilty.

'OCDblogstar's explanation of guilt as it is experienced by those with OCD suggests that it is the struggle with the actions of and thoughts created by the self that results in "false guilt" for that which they are aware "aren't wrong at all". Guilt, which in itself can become an obsessive thought if persistent enough (Hartwell-Walker, 2007) is suggested by 'OCDblogstar' to come from an individual's contested sense of self as logical and confident in their thoughts and behaviours.

The film *The Aviator* (Scorsese, 2004) suggests that the loss of control as a result of the struggle between the rational self and the OCD Other is something that needs to be hidden from the gaze of others. In the final scenes the main character, iconic aviator and film producer Howard Hughes, gives in to his compulsion to repeat the phrase "the way of the future" over and over again while at a party celebrating the successful test run of his 'flying boat'. He is unable to regulate or hide his behaviours himself because he is so consumed by his compulsions. His friend and fellow aviator, Glenn Oderick, and the Chief Executive of Hughes' Tool Company, Noah Dietrich, do so for him. Oderick and Dietrich lead Hughes into a secluded space – a bathroom – where he is able to engage in his ritual away from the scrutiny of others. Dietrich tells Oderick that "no one sees him [Hughes] like this". This implies that there is an expectation that others will look upon Hughes' OCD behaviours and condemn them as 'abnormal'. It also implies that Dietrich himself, who does not have OCD, may also consider them in the same way. It could perhaps be argued that Hughes' behaviours might be seen as a weakness as he is clearly no longer in control of his own body/mind.

5.5   Recovery

The battle and struggle discourses suggest that men see OCD as an opponent to be beaten. Rather than an on-going, gradual process of recovery, OCD is represented as something that, once triumphed over, will be 'out of the picture'. The person with OCD becomes the victor and OCD the vanquished. Unlike women, who predominantly use internet spaces, such as blogs, in order to chronicle their journeys and share their experiences with others as a means to help themselves on

their pathways to 'recovery', men predominantly use internet spaces – particularly OCD forums – for a very different purpose. Rather than sharing their experiences in a cathartic process of self-disclosure, men appear to visit forums in order to get advice and to seek solutions to their problems so that they can 'vanquish' their OCD.

Unlike blogs, which require a long-term commitment from the author, who has sole responsibility for updates, forums have a much more transient membership. Individuals can enter the forums for short periods of time. This means that an emotional connection to the forum may not necessarily develop and perhaps it is this that makes it a more comfortable place for men, largely acknowledged to be wary of seeking medical help and advice (Tudiver & Talbot, 1999), to ask others for 'solutions' to their OCD 'problems' rather than other (real or digital) spaces.

In one thread, the author asks "Are all these common OCD symptoms? I am about to go see a counsellor, should I do this? Can anyone relalte [sic] with these messed up sexual and religious feelings? What are some suggestions for handling some of these thoughts?" From these questions, we can see that the author has entered the forum with the express intention of finding answers to his anxieties surrounding his OCD. This could perhaps be interpreted as his wanting to find a strategy with which he can 'win' against, or 'beat' the condition. His last question, in particular, indicates that he wants to find immediate workable 'solutions' to having OCD. This is in direct contrast with women's tendency to want to take small, gradual steps towards recovery.

A forum thread, entitled "OCD taking its toll . . . need some advice" clearly illustrates how many men use the forums as a means of acquiring 'solutions' to their OCD related 'problems'. The thread's author, 'Bballfan', writes, "I guess my question for you all is: have any of you lessened the severity of your symptoms on your own? . . . I know I should seek professional help . . . but I'm also sort of looking for a quick-fix." 'Bballfan's goal in starting this thread is clearly to find out how to 'solve', or 'fix', his having OCD. 'Bballfan' goes on to say, while discussing how OCD has posed a problem in his relationship with his partner, that "my compulsions are starting to get in the way of both of us living an ordinary life." This suggests that it was only when OCD started to have a visible and perhaps threatening impact on his life that he sought aid from others. Sharing information about OCD experiences and revealing the need for help in a public space such as a forum thus seems to be a reactive rather than proactive means of coping with OCD. Blog postings, as are more commonly used by women, tend to be ongoing and not only made in times of distress.

Indeed, it seems that threads such as 'Bballfan's are often somewhat of a last resort for those who make them. Such threads can be considered pleas for help and are often posted at a time when the author perceives himself to have no other option but to seek advice and solutions from others who have shared similar experiences. 'ocdh8er', in a thread entitled "I need closure or some serious help" that he started in an online forum, asks "am i just ****ing crazy? I need closure please people! This OCD bullspit [sic] needs to go can't live like this anymore". 'GermyGuy', another forum member feels that he's

> Not really sure what to do. I feel like I'm dead again and
> have nothing to live for . . . I don't know who to talk to

and I need to talk to some people really badly. If anyone
went through something like this, I would really
appreciate some advice.

These comments clearly illustrate how many men with OCD choose to ask for

help only when they are feeling a sense of hopelessness or despair.

5.6   Conclusion

This chapter has examined the ways in which OCD is depicted by men with the

condition as being a battle or struggle. First, I discussed how discourses of war

and battle are predominantly used by men with OCD and how such discourses

reinforce traditional conceptualisations of masculinity which position men as

active and as aggressors. Second, I looked at the idea of the 'OCD monster' as it

is typically used by men and women, and how the term indicates three things: that

the self and Other are seen by some to be separate entities; that OCD is viewed by

some to be daunting and insurmountable, thus positioning them as passive victims;

and that OCD is portrayed as being repugnant, unnatural and freakish. Third, I

examined how men with OCD represent their experiences as an internal battle and

how this portrayal suggests that men view OCD as the struggle between the self

and Other, inextricably linked within the individual. Lastly, I investigated how

men with OCD tend to use online forums to get advice from others with the

condition in order to 'fix' their OCD 'problems'.

CHAPTER SIX

CONCLUSIONS

In examining the journey and battle discourses that women and men (respectively) use to frame their experiences of OCD, I have illustrated how the condition is gendered. There is a common perception that there are few, if any, gender differences in OCD because its incidence rate is the same for both genders, as are the obsessions and compulsions. Despite this perception, it is clear that the ways in which OCD is discursively framed by men and women are vastly different. Because the discursive and material are inextricably linked, it should be expected that men and women's experiential realities and embodied experiences of the condition are also likely to differ.

In this chapter I reflect upon my initial research question: 'How do men and women with OCD understand and conceive of their condition thus (re)constructing their sense of self and space?' I summarise the arguments that I have made and discuss the possible implications of my research upon the current understanding of OCD as gender-neutral. In particular, I address these implications as they pertain to the 'solutions' undertaken by people with OCD in the treatment and recovery process. I then identify some possible avenues for further research into mental health geographies and how such research has the potential to lead to a greater understanding of the relationship between the material and discursive in conditions such as OCD.

In Chapter One, I outlined the focus of my research and identified the research question that I address throughout this thesis. It was important that the nature of OCD be explained because many of the issues discussed in the thesis are specific to the condition. I also provided the some of the historical context of OCD and the academic context of geographical research of mental health in general and OCD in particular. I discussed the 'three waves' of mental health geographies and highlighted the importance of a study such as this given that there is a need for geographers to understand the experiences, emotions, and thoughts of individuals with (mental) health conditions in order to create informed policy that can prompt positive changes in a person's life. I then went on to discuss the problematic nature of some of the terminology associated with health discourses such as the words 'sufferer', 'disorder', and 'afflicted'. These words are often used by mental health geographers despite the fact that they can position individuals with (mental) health conditions as passive, Other and victims.

In Chapter Two I outlined the theoretical framework which informed and shaped my research. I also critically reviewed relevant literature in the field of mental health geographies and geographies of disability. I argued that there is a need to look beyond the Cartesian dualisms that have underpinned much of the health and disabilities literature. The long-established medical and social models of disability, in particular, are problematic as they fail to acknowledge the mutually constitutive nature of discourse and materiality. In positioning (mental) health conditions as being either discursive or material, these models do not reflect the full reality faced and experienced by individuals with disabilities and other health issues. It is therefore important to conceptualise the material and discursive as being

inextricably connected if we are to gain a full and nuanced understanding of how (mental) health conditions affect those who live with them. Moss and Dyck's (2003) conceptual model for a "radical body politics", unlike the medical and social models of disability, is a theoretical approach that recognises this connectivity. Moss and Dyck's model is particularly relevant to my research as it provides a more holistic perspective on (mental) health issues than many of its more 'traditional' counterparts. I also discussed the important role that metaphor and discourse play in a person's understanding of a (mental) health condition. Using metaphor to refer to a person's experiences of an illness can engender a sense of agency in a situation in which feelings of powerlessness, weakness, and loss of control are all too common.

In Chapter Three, I turned my attention to methodological practice. I chose to use several methods of qualitative data collection including semi-structured interviews, a critical reading of blog and forum postings, a close reading of film texts, and autobiography. I discussed my own fluid positionality and how it affected the research process. I was both insider and outsider as I was at once a person with OCD and a researcher. My positionality allowed for relaxed and conversational interviews with other individuals with OCD. I then addressed issues of ethical research practice. This was particularly important given that having OCD is very personal and private and, as with any (mental) health condition, has the potential to be a taboo subject. The utilisation of several methods and the triangulation of the results obtained by each provided a wealth of issues for analysis and a range of valuable perspectives. I then proceeded to outline the process of analysing data through critical discourse analysis.

Chapter Four focused upon the gendered dimensions of the journey metaphor and how it melds discourse and materiality. In particular, I looked at how women with OCD represent their experiences of the condition as a journey and how this journey is evidenced in OCD blogs and films. On the surface, it may appear that the journey metaphor has little to do with the material reality faced by people with OCD in their everyday lives. However, as I have illustrated, an articulation of the condition as being a journey is reflective of embodied experiences. Indeed, I have argued that such articulation gives people a framework within which the embodied reality can be understood.

Like any real journey, the metaphorical OCD journey has a starting point, a pathway characterised by landmarks and obstacles, and an end-goal or destination. I showed how blog entries written by women with OCD reflect this metaphor and the implications of this reflection. In using the journey discourse, women position their experiences with OCD as a gradual and long-term process of healing, undertaken in stages. The notion of a journey suggests ideas of forward motion, catharsis, and self-expression. These three ideas not only characterise journeys, but also are associated with blogs. It is thus unsurprising that OCD blogs (predominantly produced by women) are sites in which the journey is communicated. By sharing the journey through this medium, women aim to help themselves and in doing so help others overcome their own OCD. That the journey metaphor, here associated with emotions and feelings, is most often invoked by women on OCD blogs reinforces gender stereotypes in which women are perceived to be both emotional and nurturers. The OCD journey is marked

with obstacles and landmarks and it is apparent that these in themselves are gendered. Child-birthing and child-rearing can be enabling but can also be significant obstacles faced by women in their journeys. They seem to be the obstacles that are most likely to halt progress, or even stimulate backward movement.

Chapter Five examined how men with OCD tend to position their experiences with the condition as being a 'war' or a 'battle' that has to be won. I argue that this 'battle discourse' comprises three different tropes: OCD as a battle or conflict, OCD as the monster, and OCD as an internal struggle. It is clear that by portraying OCD as a battle, men position the condition as being something outside of themselves. OCD is seen to be Other to the self and an external threat that needs to be beaten or nullified. Violent and militaristic imagery invoked by this discourse reinforces traditional categorical thinking that positions men as aggressive, active, autonomous fighters with inherent physical strength and psychological resilience. As a result, many men seek 'solutions' to their OCD 'problems' in online forums.

I then discussed how OCD is sometimes represented as a monster, which suggests three things: first, it suggests that OCD is Other to the self; second, it implies that the individual is something of a passive victim as OCD is portrayed as being terrible, frightening and overwhelming; third, it suggests that OCD is unnatural, freakish, and abject. Interestingly, despite the fact that the monster trope is innately masculine, some women ascribe to this representation of OCD. OCD is positioned by this metaphor to be an external and alien phenomenon which has

taken up residence in the body and must be somehow expelled. This perspective suggests that OCD is a temporary aberration that, once 'fixed' will no longer have any impact upon the individual.

In the final section of the chapter, I examined the idea of OCD as an internal struggle. This representation portrays the condition as a battle in which it is the individual's own mind, behaviours and attitudes that are the enemy. As such, the internal struggle occurs within the self rather than without, as suggested by the OCD as battle and the OCD as monster analogies. It is implied that, rather than the condition itself being the source of distress, it is the tension between two distinct facets of an individual's psyche (the part of him/her that is 'irrational' and driven by his OCD, and the part of him/her that is 'rational' and driven by logic) that throws a person's identity and sense of self into profound question. The internal struggle experienced by many men with OCD results in a perceived loss of control over their own mind/body and it is this loss that appears to be one of the most distressing aspects of having the condition.

6.1   Implications

My examination of the journey and battle discourses commonly used by women and men respectively to frame their lives with OCD has demonstrated that neither gender is positioned as passive or powerless. I have shown how both men and women are portrayed and choose to portray themselves as having some sense of agency and autonomy in how they cope with and manage the condition. While it is important to note that many people's experiences with OCD are painful,

debilitating, and distressing and thus likely to cause feelings of impotence and powerlessness, both the journey and battle tropes offer agency in some form. The journey metaphor, employed predominantly by women with OCD, suggests that women are making conscious choices on their pathways to recovery. They are implied to be actively moving forward, overcoming obstacles, and celebrating achievements. They are not merely standing still, but actively making progress. The masculine battle discourse suggests that men 'fight back' and 'rage against' OCD in aggressive, perhaps sometimes even violent, encounters. Men are thus positioned as fighters actively strategising a war against their OCD. As Sontag (1999) and Reisfield and Wilson (2004) point out, metaphor in health and illness discourse is an important part of being able to cope with having a (mental) health condition and does, for many people with such conditions, provide a sense of agency and power.

Acknowledging that these discourses represent men and women with OCD as active and with agency is particularly important given society's (and to an extent, academia's) tendency to (re)construct individuals with (mental) health conditions as passive, powerless, vulnerable, and somewhat incapable victims. They are often perceived as Other and somehow less than and different from 'normal' individuals. That we frame OCD as a 'disorder', 'affliction' or 'illness' and those who have it as 'sufferers' is a clear indicator of how OCD (and indeed other (mental) health conditions) is perceived. This thesis has shown that this is not always the case for many people with OCD. There is a need to acknowledge the active and independent role that these individuals embody in their fight against or journey through having OCD. Rather than characterising (mental) health

conditions as being only negative, depressing and full of 'doom and gloom' we need to recognise that many people with such conditions are making positive steps towards living full and fulfilling lives and that there is hope. The very act of writing a blog, for example, and becoming involved in an online community (as discussed in Chapter Four) is just one instance in which it is evident that many people with OCD do have agency. The triumphs encountered in their OCD journeys and the victories won in their OCD battles clearly illustrate that, while many experiences of OCD are painful and distressing, there are also instances of positive emotion. Portraying (mental) health conditions as being profoundly negative potentially can exacerbate feelings of helplessness and powerlessness.

This research has implications for the 'solutions' undertaken by people with OCD in an effort to make their OCD more manageable. For women, the journey trope suggests that 'solutions' are on-going in nature, reached in gradual stages over a long period of time and commitment rather than a short-term fix. It is about healing the self and sharing this journey with others in a cathartic process of self-expression. The purpose of doing so is to help others with OCD cope with having the condition. Women can perhaps then be seen, somewhat stereotypically, as nurturers, as providers of encouragement and of possible 'solutions' for others. The battle trope positions having OCD as a battle in which one opponent must defeat the other and suggests that 'solutions' to the OCD 'problem' must be immediate and non-reversable. It is apparent that men tend to look for 'quick fixes' and do so by asking for advice in online forums where anonymity is all but guaranteed and membership is transient. It is about 'solving', or 'getting rid' of the 'problem'. Many threads started by men in OCD forums have the specific

purpose of gaining advice, or 'solutions' to 'problems', from other members on the forum. That many men appear to ask for advice only when their situation becomes untenable suggests that the traditional gender stereotypes positioning men as inherently strong and rational opposed to the feminine weak and emotional is a barrier in men's ability to seek help. Rather than embarking upon a long-term journey of steady and measured improvement, it appears that men wish to find a fast 'solution' that is immediate, rather that gradual. This raises questions as to whether men might 'relapse' more than women and whether their way of 'solving' the 'problem' is less effective in the long run than women's. While the scope of this research has not enabled me to fully address these questions, they are concerns that could be addressed in future research.

6.2   Suggestions for Further Research

This research has made a theoretical and empirical contribution towards mental health and health geographies. It has opened a door into investigating the ways in which (mental) health conditions such as the anxiety 'disorder' known as OCD destabilise the Cartesian dualisms of mind/body, discourse/materiality, and self/Other. It has also offered insights into how gendered discourses about OCD reflect and reconstitute people's embodied and lived realities. However, much is still unknown about the condition and, more specifically, its spatial characteristics. While I have addressed gender within the space of this project, I have not discussed issues of age, ethnicity or religion. Such axes of difference could potentially have vast implications for the ways in which individuals with OCD experience, perceive, communicate, and cope with having the condition.

Take age, for example. Children with OCD could potentially have very different experiences from their adult counterparts. Unlike adults, who must be aware that their thoughts are 'irrational' in order to be diagnosed as having OCD, children do not yet have the cognitive ability to recognise that their obsessions and behaviours are illogical (Koran, 1999). The lived and embodied reality of being a child is greatly different from that of being an adult: the expectations, responsibilities and levels of autonomy and power are not the same. Thus it cannot be expected that their experiences of OCD would be identical to that of older individuals. Because geographic research on (mental) health conditions has a tendency to focus upon 'middle-aged' individuals, an examination of OCD over the lifecourse would allow for a better understanding of how those who are age 'minorities' (the elderly and children, for example) experience the condition.

Another possible avenue of further inquiry would be into the role that religion occupies in OCD. As mentioned in Chapter One, the condition has been historically conceived of as existing almost exclusively in the (Christian) religious domain. While current definitions of OCD stipulate that it occurs in many different situations, there is a 'subset' of obsessions that revolve around the Christian church and scripture. Sexual obsessions about acts or feelings that are deemed to be 'un-Christian' by those who have them are relatively common in OCD and can have vast, and often quite damaging, implications for an individual's sense of self. The ways in which space is experienced by those who endure such obsessions is as yet unstudied and warrants investigation.

Finally, with the growing presence of the internet in our daily lives and the increase in geographic and wider academic study into online spaces, further investigation into the role the internet plays in issues of (mental) health would be useful. This thesis has used many online blogs and forum postings as data for examination and throughout the research process I have found that there exists a vibrant and growing online community for people with OCD. Examining the ways in which online experiences, sharing, and community informs and shapes the everyday realities of people with (mental) health conditions would be greatly beneficial to a more nuanced understanding of the ways in which people live with, understand, and (re)construct their OCD experiences.

In summary, these possible directions for future study will help broaden our understanding of how those with (mental) health conditions such as OCD negotiate their lifeworlds and experiential realities. Given the almost complete absence of work on OCD in geography, any further inquiry into the condition will be vastly beneficial in filling a void in disciplinary knowledge.

Student researches Obsessive Compulsive Disorder

Rebecca Campbell, a postgraduate student at the University of Waikato, is researching obsessive-compulsive disorder (OCD).

Rebecca is currently looking for people with OCD to participate in her research. People interested in taking part in this research can choose to either participate in a one-on-one interview or in a focus group with up to four other individuals.

Participants will be asked to share their experiences, feelings and emotions as individuals with the disorder.

The research will be used for the completion of her Master's degree in Social Science. It is inspired by previous research that Rebecca conducted last year, which revealed that people with OCD find it difficult to carry out rituals in public places because they tend to feel judged by others. The current project focuses on if and how OCD affects men and women differently. She is interested in men's and women's experiences of places such as homes, shopping malls, workplaces and cafes.

In particular, Rebecca wants to find out more about how people with OCD feel about various aspects of their private and public lives.

■ If you would like to participate in the research, or if you have any questions regarding this research, contact Rebecca at rsc10@students.waikato.ac.nz, or call (07) 856 2935 or 027 339 5443 (mobile).

(Source: Hamilton News, 2010)

APPENDIX B: INTERVIEW INFORMATION LETTER

Interview Information Letter

For the Research Project

Gendered Dimensions of Obsessive-Compulsive Disorder

23/11/2010

Dear _____,

My name is Rebecca Campbell and I am a graduate student in the Geography Programme at the University of Waikato.

My own experiences have led to me undertake a Master's thesis on how men and women with obsessive-compulsive disorder negotiate and experience a range of places such homes, shopping malls, workplaces, cafes, and so on. I am particularly interested in any gender differences that might exist in relation to OCD.

As a participant in this research, you will be asked to participate in a one-on-one, face-to-face interview with me. The interview will be carried out in a location and at a time that suits us both. The interview will last for approximately forty minutes and will be tape recorded (if you are agreeable to this). We will be talking about your feelings and experiences as an individual with OCD.

If you choose to take part in this research, you will have the right to decline participation at any stage of the interview without reason; you can also decline from answering any questions if you so choose during the interview process. You can also choose to withdraw from the research up to three weeks after the interview. Your identity will only be known to myself and a pseudonym will protect your identity in any material produced. I will enforce to the best of my ability the private and confidential nature of all discussions we will share and will be the only person with access to the obtained data, to be used only for academic purposes, including a Master's thesis (a completed copy of which will, in addition to being published in a hard copy format, be made available online) and journal articles. The data will be destroyed after five years in storage.

This research project has been approved by the Human Research Ethics Committee of the Faculty of Arts and Social Sciences. Any questions about the ethical conduct of this research may be sent to the Secretary of the Committee.

Email fass-ethics@waikato.ac.nz
Faculty of Arts and Social Sciences, Te Kura Kete Aronui,
University of Waikato, Te Whare Wananga o Waikato,
Private Bag 3105,
Hamilton 3240,
Aotearoa, New Zealand

Please text or call 027 339 5443, or email me at rsc10@waikato.ac.nz so that we can organise a time and place to meet if you wish to participate or if you have any further questions. If you wish to contact my supervisor, Dr. Robyn Longhurst, regarding this research, please call (07) 838 4466 ext. 8306 or email robynl@waikato.ac.nz .

I look forward to hearing from you.

Rebecca Campbell

APPENDIX C: CONSENT FORM

Consent Form (Interview)

For the Research Project

Gendered Dimensions of Obsessive-Compulsive Disorder

Description of Research: The research aims to examine the ways in which men and women with obsessive-compulsive disorder experience a range of places. Particular attention will be paid to gender issues.

I [your name].. agree to participate in the research project 'Gendered dimensions of obsessive-compulsive disorder' which is being carried out by Rebecca Campbell under the supervision of Dr. Robyn Longhurst of the Department of Geography, Tourism and Environmental Planning at the University of Waikato.

I understand that:

• All information collected will remain at all times **secure** under lock in the office of the researcher or in a computer accessible only by password known exclusively by the researcher.

• My identity will remain **confidential** and **anonymous** unless I specifically request otherwise and grant permission.

• I have the right to **withdraw** from the project up until 3 weeks after the interview and understand that any information obtained from me will not be used if I choose to do so.

• I have the right to **decline** answering any questions asked.

• Information obtained will be used for a completed Masters thesis (which will be made available online in addition to a hardcopy), seminar and conference presentations, and any resulting publications.

• After five years all collected data will be destroyed.

This research project has been approved by the Human Research Ethics Committee of the Faculty of Arts and Social Sciences. Any questions about the ethical conduct of this research may be sent to the Secretary of the Committee.

Email fass-ethics@waikato.ac.nz
Faculty of Arts and Social Sciences, Te Kura Kete Aronui,
University of Waikato,Te Whare Wananga o Waikato,
Private Bag 3105,
Hamilton 3240,
Aotearoa, New Zealand

Feel free to contact me at any time. My contact details are as follows:

Home phone number: (07) 856 2935
Cellphone number: 027 339 5443
Email address: rsc10@waikato.ac.nz

If you wish to contact the supervisor, Dr. Robyn Longhurst, regarding this research, please call (07) 838 4466 ext. 8306 or email robynl@waikato.ac.nz.

Thank you for your participation,
Rebecca Campbell

'I wish to have a copy of the interview recording and transcript'
YES/NO (Please circle)

'I wish to have complete anonymity of my personal identity'
YES/NO

'I wish to have a copy of a summary of the completed research project'
YES/NO

'I consent to being interviewed under the above conditions'

_____*To be signed and dated by participant*

 'I agree to abide by the above conditions'

_____*To be signed and dated by Rebecca*
                                                            Campbell

APPENDIX D: INTERVIEW SCHEDULE

Gendered Dimensions of Obsessive-Compulsive Disorder

Interview Schedule:

1.   Can you tell me a little bit about yourself and your life as a person with obsessive-compulsive disorder?

2.   Can you tell me what sorts of obsessions you have?

3.   What do you *feel* as you obsess?

4.   Can you tell me what sorts of compulsions and/or rituals you perform?

5.   What are your thoughts and feelings as you perform compulsions and/or rituals?

6.   What are your thoughts and feelings as you resist/are unable to complete these compulsions and/or rituals? What do you believe will happen if you fail to complete compulsions and/or rituals? What does happen if you fail to complete compulsions and/or rituals?
(*Prompt:* Thoughts, feelings, physical response)

7.   How does having OCD affect your perception of and interaction with different places?
 (*Prompt:* Do you find yourself avoiding certain places? Have you altered spaces in order to accommodate your rituals or to avoid getting in situations where you have to perform your rituals?)

8.   How do these rituals affect your relationships with others?
(*Prompt:* Family members? Strangers? Workmates? Do relationships become more strained?)

9.   What do you think are some of the enabling factors/barriers to seeking and getting medical or professional help for OCD?

10.   Do you think these enabling factors/barriers are different for men and women?

11.   What do you think are some of the (other) differences between men and women who have OCD?

(*Prompt:* Differences in obsessions and compulsions experienced differences in how men and women cope with having OCD, differences in how men and women seek professional help. To answer this question it might also help to think about your roles as a father, mother, partner, brother, sister or about gendered activities in which you might engage such as sport, dance, music, or gendered work you do such as trades, clerical, professional and so on

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