Social & Cultural Geography, Vol. 5, No. 4, December 2004

Routledge
Taylor & Francis Group

Disturbing geography: obsessive-compulsive disorder as spatial practice

Jeremy Segrott[1] & Marcus A. Doel[2]
[1]School of Health Science; [2]Department of Geography, Swansea University, UK

This paper explores the spatial practices of obsessive-compulsive disorder (OCD). It begins by introducing the key elements of the disorder: obsessions and compulsions. It then concentrates on obsessions and compulsions relating to fears of bodily contamination. Such fears necessitate the formation of psycho-social boundaries in ways that are similar to agoraphobia and other mental-health problems. Avoiding bodily contamination also involves complex spatial orderings to prevent the illicit movement of contaminants. The vital importance, yet fragile nature, of these spatial formations means that negotiating social space and interactions can be immensely fearful, and the OCD sufferer may retreat to the relative safety of home. However, the domestic is a space of ambivalent safety. Everyday objects become saturated with fear, transforming the experience of 'home'. Boundaries and spatial orderings are transgressed in the movement of people and objects. Thus, the OCD sufferer is driven *to (re)order space constantly, and in doing so often uses everyday materials in inventive ways. We critique the depiction of OCD as irrational and excessive, and set the creative practices of OCD in relation to the 'slippage' of Michel de Certeau's distinction between spatial strategies of domination and the art of tactical living.*

Key words: obsessive-compulsive disorder, mental-health, spatial practice, domestic space, consumption.

Introduction

A different world ... slips into ... place. (de Certeau 1984: xxi)

This paper explores the quotidian world of obsessive-compulsive disorder (OCD), a more or less debilitating anxiety disorder with a disturbing geography. Our interest in OCD stems from the personal experience of living in close proximity to someone with the condition, and a more general interest in the often fraught relationship between subjectivity and space, and the pathological nature of modernity and postmodernity as socio-spatial formations (Clarke and Doel 1997; Doel 2001; Doel and Clarke 1999; Doel and Segrott 2003a, 2003b). However, it is not the intention of the present paper to read the ambient fear and diffuse dis-ease that haunts modernity and post-modernity into the experience of OCD. As tempting as such a reduction might be, 'The drawback, though, is that this approach seems to attribute to ... sufferers an insight they don't have' notes Carter (2002: 209). 'It risks discounting the suffering, the actual, chronically debilitating unease'. Consequently, the paper

ISSN 1464-9365 print/ISSN 1470-1197 online/04/040597–18 © 2004 Taylor & Francis Ltd
DOI: 10.1080/1464936042000317721

offers an original perspective on OCD by focusing precisely on the embodied practices that living with the disorder requires.

Given our commitment to the experience of OCD, our concern here is not with how the disorder is caused, treated or overcome. We focus instead on what people 'do' with their obsessions and compulsions, and the ways in which such forms of action take place in and through particular spatial formations (Freeston and Ladouceur 1997). We begin by introducing OCD and outlining the two key elements of the disorder: obsessions and compulsions. Our discussion then concentrates on a particularly common and highly geographical form of the disorder: obsessions and compulsions regarding bodily contamination, with particular reference to domestic space. Three key geographical themes are developed throughout the paper: firstly, the formation of psycho-social boundaries for the maintenance of self-identity; secondly, the organization of space for the circulation of things; and, thirdly, OCD as a creative form of practice. Our concern with how particular spaces are experienced and used, and the role that they play in the construction of self-identities, engages with the growing corpus of work on the geographies of mental health. At the same time, in exploring OCD as a form of spatial practice we disturb a number of academic boundaries and make connections between areas of human geographical inquiry that often remain 'curiously isolated', to use a term employed by Wolch and Philo (2000). Thus, our consideration of OCD explores the painful emotions of fragile pyschosocial boundaries with reference to what are normally considered mundane, everyday practices such as grocery consumption. Equally, our concern with the phenomenology and experience of OCD acknowledges the capacity and agency of non-humans that can disrupt or enhance human spatial orderings. OCD raises important questions for a range of geographers, including those interested in the connections between health and place, the experience of domestic space (Domosh 1998; Dyck 1995; Moss 1997; Rose 2003), emotional geographies (Anderson and Smith 2001), consumer society (Clarke, Doel and Housiaux 2003) and material practices more generally. By way of conclusion, we critique the frequent depiction of OCD as irrational and excessive, and set the creative practices of those suffering from OCD against the 'slippage' of de Certeau's (1984) distinction between spatial strategies of domination and the art of tactical living.

Obsessive-compulsive disorder as spatial practice

As its name implies, there are two distinct elements to OCD: obsessions and compulsions (Toates, 1992). While both elements are normally co-present and linked, obsessions and compulsions sometimes exist independently of each other. According to de Silva and Rachman (1998: 3), 'an obsession is an unwanted, intrusive, recurrent, and persistent thought, image or impulse. Obsessions are not voluntarily produced, but are experienced as events that invade the person's consciousness ... An obsession is a passive experience: it *happens* to the person'. Indeed, the word 'obsession' derives from the Latin *obsidere*, to besiege. However, a person with OCD typically realizes that the obsessions are internally derived: the obsessional thoughts, images and impulses belong to them, and are not implanted from an external source. Although individuals may know that their obsessions are excessive or even irrational, repressing them often produces extreme discomfort, and overt resistance frequently wanes with time. In extreme cases, obsessional thoughts, images and impulses can

become virtually all-consuming and thoroughly debilitating. In the context of OCD, then, obsessions have nothing whatsoever to do with the colloquial usage of the term to denote an absorbing passion into which the subject enters freely (although see Baudrillard 1996, on the pathology of collecting).

Obsessions relate primarily to the prevention of danger, especially the fear of harming oneself or others, and they generally produce feelings of anxiety, guilt and even panic. Their content commonly includes contamination, illness, violence, death, destruction, disorder, asymmetry, immorality and blasphemy. Most obsessions have an external or internal 'trigger', thus differentiating OCD from more generalized 'over anxiety'. For example, obsessions with death could be triggered by seeing a kitchen knife or a 'mental event', such as remembering a deceased relative (de Silva and Rachman 1998).

Compulsions are forms of behaviour—such as washing, cleaning, checking, counting, touching, hoarding, arranging and ruminating—that a person is *driven* to perform, often in direct response to obsessional thoughts, images and impulses.[1] Where compulsions accompany obsessions, they tend to have two primary goals: to *neutralize* the anxiety or discomfort produced by an obsessional thought, image or impulse; and to *prevent* the outcome or disaster that the obsession portends. Little wonder, then, that compulsions, like obsessions, are never pleasant, and frequently acquire a repetitive and ritualistic nature which can itself be endlessly prolonged and refined.

Most compulsions are overt bodily actions that are visible or audible (e.g. touching and washing), and which are highly geographical in that they involve using space in particular ways (e.g. arranging and hoarding). Other compulsions are covert or purely mental acts (e.g. counting and ruminating). Tallis (1992: 10) suggests that 'sometimes, [compulsive] behaviour is completely irrational, and resembles a superstitious ritual. Other kinds of compulsions are related more logically to the obsession, but are clearly excessive'. However, while compulsions can often be rationalized and naturalized in relation to obsessions (e.g. washing to cleanse or checking for safety), it is crucial to appreciate that the person does not choose to behave in this way. Compulsions *must* be performed. So, while certain forms of OCD may appear to demonstrate little more than an *excess* of action (e.g. too much washing and too much checking), which is often counterproductive and frequently ineffective (because the action is itself deleterious or simply misguided), it is important to recognize that compulsions are not in and of themselves functional. One is *compelled* to act—irrespective of whether or not one wants to act; and irrespective of whether or not the circumstances 'objectively' necessitate such action. This is why the connection between obsessions and compulsions is neither causal nor functional, but arbitrary and contingent; why one can experience 'pure' obsessions and 'pure' compulsions; and why OCD is so resistant to a rational discourse of moderation and efficacy. So, while the difference between housework and compulsive cleaning may appear to be a difference of *degree*, there is also a difference in *kind* in play: the difference between efficacy and excess is over-determined by the difference between choice and necessity.

Although the content of OCD has changed temporally, with fears regarding asbestos during the 1970s giving way to concern about HIV and AIDS by the 1990s, OCD appears to be a global dis-ease, present in many parts of the world (de Silva and Rachman 1998; Rapoport 1989).While the 'classic' *form* of OCD is quite stable (obsessions and/or compulsions are always present), the *content* of the obsessions

and compulsions may relate to almost any facet of existence, and Lemelson (2003) suggests that the 'symptomatic expression' of OCD may be shaped by cultural factors. There is also some evidence to suggest that the impact of OCD on quality of life and social functioning is context-dependent (Bobes et al. 2001). Despite the semblance of a coherent 'illness' with a stable set of symptoms, OCD is in reality uniquely constituted through each experience of the disorder. Moreover, while most people with OCD tend to have one type of obsession, it is not uncommon for them to experience multiple obsessions, for their primary obsession to shift over time, and for the disorder to be associated with other mental and personality disorders (Rapoport 1989). The disorder affects both men and women in fairly equal numbers, although there is conflicting evidence regarding the proportion of men and women experiencing particular kinds of compulsive behaviour (Franzblau, Kanadanian and Rettig 1995). Adolescence and early adulthood are the key periods during which OCD is most likely to develop (de Silva and Rachman 1998), and its onset is especially associated with traumatic stress (de Silva and Marks 1999); although OCD can present itself at different times in the life-cycle, such as during pregnancy and childbirth (Baer and Jenike 1990). However, Franzblau, Kanadanian and Rettig (1995: 100) suggest that OCD is in many ways an 'enigmatic' illness, with 'little information that allows a valid determination of the racial or social class makeup of persons with OCD'.

Despite the fact that OCD involves complex experiences and practices, studies of the disorder by geographers and other social scientists are virtually non-existent. The extensive clinical literature on OCD often draws upon individual case studies, but, as Parr (1999) rightly notes in relation to other mental-health problems, this is primarily to assist in the isolation of the disorder, the identification of its etiology and the determination of effective therapeutic interventions. The tendency to describe typical sets of obsessions and compulsions risks overlooking the highly individualized nature of OCD (but see Rapoport 1989, which blends clinical and experiential material). Consequently, Franzblau, Kanadanian and Rettig (1995) critique the dominance of reductionist models based primarily on the overproduction of the neurotransmitter serotonin to explain OCD (cf. Castle and Groves 2000).[2] They argue that

> [B]eyond issues of etiology ... a model which emphasizes [the] meaning and value of these behaviours would enable us to understand why these behaviours are so *resistant* to treatment ... [They] have meaning and value in the context of a person's attempt to adapt their response to a particular environment as s/he perceives it. (Franzblau, Kanadanian and Rettig 1995: 104)

Compulsions should therefore be seen as meaningful practices designed to regain a sense of being in control of one's external environment when this has been lost. The interaction between self and environment, and the suggestion that OCD is often context-specific, clearly underline the complex geography that is in play. The frequent recourse to schemas of typical obsessions and compulsions within many accounts of OCD also risks presenting the disorder as an abstract set of symptoms, rather than thoughts or practices that take place and unfold within the context of everyday life and which interact with the other aspects of people's lives and identities. Franzblau, Kanadanian and Rettig (1995: 100) suggest that 'In patients whose OCD was classified as episodic, rather than continuous or deteriorative, these behaviours were in many cases viewed by

patients as adaptive and integrated into their lives' (see also Seedat and Stein 2002).

Having introduced OCD, in the rest of the paper we explore some of the spatial practices that constitute obsessions and compulsions regarding bodily contamination. We base our account on a range of sources, including material provided by self-help groups, the clinical and self-help literatures on the disorder, and the personal experience of an OCD sufferer. Indeed, our initial interest in OCD emerged as a result of living in close proximity to Jane, a woman in her late twenties who has suffered from the disorder for approximately ten years (a pseudonym is used to maintain her anonymity). Our discussion of Jane's experience is based primarily upon one of the authors' personal reflections. We have also discussed the specific concerns and argument of the paper with Jane, including the way in which she has been presented and her experience of OCD interpreted.

Geographies of germs: OCD, bodies and boundaries

Like many others who suffer from OCD, the main theme of Jane's obsessive thoughts is that she will contract a fatal illness (or cause others to do so) by coming into contact with germs or bacteria. Such contamination can be direct (e.g. a drop of polluted rainwater falling on to someone) or indirect (e.g. someone touches a door-handle that has been contaminated by polluted rainwater). The slightest physical contact can cause cross-contamination, and only the smallest amount of contaminated material needs to be involved (e.g. a single particle of dust or a molecule of mercury). For some OCD sufferers with this manifestation of the disorder, contamination takes place through proximity as well as physical contact. For others, the mere sight or even knowledge of a contaminant is enough for contamination to take place (e.g. looking at dustbins or thinking about them). Whilst some OCD sufferers may be able to explain the process by which contamination takes place, this is not always so, as Stanley, a teenager suffering from the disorder, makes clear. 'Don't ask me why or how something got to be impure; I don't know why, it just felt that way' (Rapoport 1989: 131).

However contamination comes about, an object will remain contaminated until properly disinfected, a process which is often as much symbolic (and ritualized) as material. Thus Jane's compulsions are either preventative or undertaken to disinfect an object (or the self) when contagion occurs, thereby rectifying the situation. These compulsions involve washing, cleaning, ordering and maintaining barriers between herself and sources of contamination by using rubber gloves and kitchen roll. In the absence of adequate containment and decontamination, an endless process of indirect cross-contamination is set in motion through which germs and danger proliferate rapidly until there are literally 'germs everywhere' (Thomsen 1999). This proliferation is both spatially extensive (from object to object) and psychologically intensive (a heightening of anxiety, fear and discomfort). Jane's OCD waxes and wanes, and although it intrudes permanently upon *certain* activities (e.g. handling raw meat), for much of the time daily life can be faced with relative ease. Nevertheless, there have been periods when her OCD has become more debilitating: the frequency and intrusiveness of obsessive thoughts have increased, and they have spread to more and more activities. Everyday life sometimes becomes almost impossible, and a great deal of Jane's time is devoted to ensuring that she does not become contaminated. At such times of heightened anxiety, Jane has been unable to

leave home except for the most urgent of tasks and only feels truly safe in bed.

A point often made in the clinical literature on OCD is that it involves an exaggerated sense of self-responsibility, the origin of which is specific to each individual (de Silva and Rachman 1998; Wilson and Chambless 1999). Whilst the responsibility for the initial creation of contamination and its subsequent proliferation through space and time may lay in the hands of a range of actors, to blame others serves no useful function in the context of OCD. The individual must defend his or her own bodily boundaries, and avoid acting as a conduit for the onward spread of contamination that might harm other people. Compulsions are therefore creative in the sense that they compel the self to take some form of overt, covert or mental action to re-order the chaotic circulation of contaminants initiated by others.

Insofar as this form of OCD revolves around the contracting of an illness through physical contact, a key aspect of contamination compulsions involves erecting and defending boundaries: around the self, but also around a range of objects, people and spaces experienced as contaminated.[3] Work by Davidson (in relation to agoraphobia) and Parr (on delusional experiences) has highlighted the way in which mental-health problems disrupt both bodily and psychic boundaries. Davidson (2000a: 641) suggests that agoraphobia may involve the dissolution of the boundary between 'inner self' and 'outer world', and the inability of the individual to project their presence into the social space that they (and especially others) inhabit. In one account, a respondent describes experiencing confusion

> in the boundaries of her phenomenal body, an *intolerable* and unsustainable confusion of internal and external space. She clearly loses the ability to project a protective boundary around herself, and as a result, is both assaulted by external space, *crumbling* inwardly under its pressure, and unable to prevent internal space from *exploding* outwards. (Davidson 2000a: 650)

Similarly, in discussing the psychic spatialities of delusional experiences, Parr (1999: 679) suggests that 'disrupted identities, as related by participants ... were very much tied to the lack of a sense of psycho-social borders and boundaries'. An individual may experience their inner self as unbounded and immense, even while their physical body may be placed within the confined space of a hospital ward or a prison cell. In both cases, the authors suggest that regaining one's boundaries may help restore feelings of ontological security. Despite the fact that obsessions often invade or besiege consciousness, OCD does not typically involve the disruption of psycho-social boundaries. The self remains bounded and coherent, and its interface with the natural and social environment is not significantly altered. In other ways, however, there are strong similarities with the accounts discussed by Davidson and Parr. The boundaries of the self are under perpetual threat from outside forces and must be constantly monitored and maintained. Jane was intensely distressed by being forced into physical contact with other bodies, coats, bags and exhalations whilst travelling on a crowded bus, and was immensely worried that she would contract some form of illness. On leaving the bus she became convinced that she had stepped in dog excrement on the pavement, and was overpowered by a sense of invasion and contamination. Reaching the safety of home, she stopped in the hallway, scared of entering the rooms of her house for fear of contaminating everything she touched. Taking a pair of rubber gloves from her shopping bag she cautiously removed her shoes and clothes, placed them in a bin bag, and wept uncontrollably.

Unable to cook the food that she had bought from the supermarket because it had been contaminated, she retreated to bed.

One way of protecting the self from contamination is to avoid spaces experienced or perceived as dangerous (Tallis 1992). Given the highly individualized composition of obsessions, the kinds of spaces and places experienced as dangerous or contaminated vary widely. For instance, de Silva and Rachman (1998) describe a young woman's fear of excrement which led her to avoid public toilets and sewer covers. This strategy of spatial avoidance accords with the cases recounted by Davidson and Parr. For example, agoraphobics may avoid being in public spaces where they feel unable to maintain their psycho-social boundaries or the specific locations where they have previously experienced panic attacks.

Within the context of OCD, all places are dirty to a greater or lesser extent, and even the most hygienic of spaces contain significant amounts of polluting material. Although some places are experienced as dirty in an *absolute* sense, the fear of dirt may be linked as much to the way in which it is managed, as to its presence. In those spaces that are well ordered, objects are arranged so that contamination cannot be put into circulation. People's interactions with such objects are also ordered in such a way that cross-contamination does not occur, especially through practices such as hand-washing and the adoption of a strict sequencing of household activities. Thus, when 'correctly' ordered and confined, dirt does not become contamination. Dirty objects (such as shoes) can be tolerated as long as they are located in 'proper' relation to other objects, and people handle them in a 'safe' way. Douglas (1966: 36) argues that the notion of 'dirt as matter out of place ... implies ... a set of ordered relations and a contravention of that order. Dirt ... is never a unique, isolated event. Where there is dirt there is a system. Dirt is the by-product of a systematic ordering and classification of matter'. For Douglas (1966: 2), therefore, 'dirt is essentially disorder'. In well-ordered environments the self may interact relatively freely with the social and physical world whilst maintaining effective boundaries against germs and bacteria because the prospect of proliferous contamination is brought under control. Although such a disciplining of space is invariably idiosyncratic, not least because it reflects a specific combination of obsessions, compulsions and triggers, it nonetheless accords with the more familiar subject-centred dis-enchantment and rationalization of the world that has been the hallmark of modernity. Our objects were meant to be '*de-spiritualized*, de-animated: denied the capacity of a *subject*' (Bauman 1992: x). The most frightening of spaces are therefore those that are disordered (and thereby re-enchanted and re-animated), not necessarily those places that we commonly think of as inherently dirty. For Jane, the local public library became a space of anxiety because books were in constant circulation and in contact with people, shopping, animals and other household objects. She perceived the proliferation of dirt and germs as being so rapid and immense to the point where it was impossible to comprehend—let alone control—the presence of danger. Public spaces more generally are often very traumatic for people with OCD. It may be impossible to maintain a protective zone or barrier between the self and other bodies and objects. People disrupt the 'proper' spatial order. They break down and invade the bounded, protected self, and precipitate an illicit circulation of materials. 'Dirty' objects come into contact with 'clean' ones, and contaminants consequently proliferate everywhere. In this sense, OCD may be seen as constituting a heightened sensitivity to the ways in which other people make use of, and

project themselves into, space. Franzblau, Kanadanian and Rettig (1995: 101) suggest that 'obsessive ritualizers may be more sensitive than others to their environment ... overly sensitive to stressful events ... needing to establish a certain environment'. Again, the similarities with agoraphobia are striking.

> [W]hen the agoraphobic leaves home, space ceases to be subjective. Sufferers are too highly *sensitized* to the ways in which space is charged by others; it thus becomes corrosive or, we might say, abject, a term Julia Kristeva uses to denote that which we must 'radically exclude' from ourselves, but which is always present, threatening to invade us and causing anxiety. (Davidson 2000b: 34)

Such a magnified state of sensitivity makes it very difficult to habituate social relations and spatial practices. Those who suffer from OCD need to be eternally vigilant against the ambivalence and duplicity of people and things. They are burdened with a responsibility that can become absolutely overwhelming, not least because it is extremely difficult to delegate such intense vigilance, even to the most 'trusted' of others (people, sensors, machines, routines, etc.). This can devastate social relationships, which invariably require reciprocal acts of entrustment in order to endure. Indeed, OCD can be so acutely distressing precisely because those who suffer from obsessions and compulsions can trust neither the world, nor others, nor even themselves. Little wonder, then, that so many of those who endure OCD come to rely on a kind of self-conscious acting out of automatism which is all too liable to crash: the programmatic execution of exacting and exhaustive routines which have very little to do with instrumental rationality and functional efficacy. For example, consider a 'number ritual', based on the figure 4: 'I pull my chair in at the table four times, recite in my head four different prayers four times, use the pepper four times, putting it on four different places on my plate, put my knife and fork down four times during the meal, chew the food four times or in multiples of four' (personal account in de Silva and Rachman 1998: 40).

Kirby (1996: 99) suggests that '[T]he problem with space isn't just space; it is the fact that there are other people in it—other people who are creating it, determining it, composing it ... [I]s it surprising then, that space could seem a bit hostile?' To which Davidson (2000b: 33) responds: 'Her statement implies that space is somehow charged, populated with the constructions of others. Most of the time, most individuals are quite literally *impervious* to these unwholesome attributes of space'. Like agoraphobics, then, OCD sufferers are also acutely sensitive to the spatial practices of others, which perpetually risk conflicting with their need for a 'proper' organization of things. However, we would concur with Carter (2002) that this spatiality concerns more than *boundary* disputes (between inside and outside, private and public, self and others, clean and dirty, etc.). Anxiety disorders are profoundly concerned with the *circulation* of things: '[A] little step always potentially slipping away' (Carter 2002: 92). Accordingly, in the remainder of the paper we will consider the spatiality of OCD in terms of both boundary disputes and the circulation of things.

Domestic geographies

In the personal accounts of agoraphobia and delusional experiences discussed by Davidson and Parr, the avoidance of fearful, mostly public, spaces is frequently accompanied by a retreat into the relative safety of the home. Domestic space offers protection from other people's presence, judgements and disorderli-

ness, and allows the self to re-establish its boundaries and coherence. In the case of OCD, domestic space may also offer the possibility of maintaining the protective barriers of the self: of creating a 'protective zone' against the sources of dirt that might invade it (Lupton and Miller 1992). However, this is not to say that the 'retreat' into domestic space involves a disengagement from the world and a descent into passivity. For whilst certain facets of the home may offer feelings of safety (the ability to shut the world out), in other ways the domestic is no less dangerous in terms of the presence of dirt than public places. Boundaries and spatial orderings have to be achieved and worked at (Law 2000), and the home, far from offering these things as a matter of course, merely provides an environment in which such spatial practices might be more successful and its spatial formations might endure. OCD involves creative practices and complex interactions with people and objects. This is underlined by Parr's (1999) account of delusional experiences which connects 'psychic geographies' (the spaces of the inner self) with social space and the material world.

> '[D]elusional geographies' are disruptive spatialities produced by, and experienced within, the mind-body (crudely speaking, 'internal' spaces). They are also, however, experiences which are physically located in material spaces and comprise particular sorts of relationships with existing objects, people, and institutions (crudely speaking, 'external' spaces). (Parr 1999: 676)

For those people who obsess about contamination, the domestic arena is one of the few contexts where effective boundaries can be held in place, and where space itself can be ordered without the disruptive intrusion of others. Dirt and other sources of contamination can be kept out through reinforcing the external boundaries of the house, thus making the domestic a safe space. de Silva and Rachman (1998) and Thomsen (1999) cite several examples of people who rigidly policed who and what could enter the domestic sphere. Certain visitors were barred from entering the home because they were deemed to carry germs. Items such as school books and outdoor clothing had to be deposited in the garage upon returning home. Inside the house, strong boundaries were maintained between rooms, thus regulating both what kinds of activities may take place in different parts of the home, as well as the movement of people and objects between them. Thomsen describes the case of a 17-year-old man who

> would shower for at least half an hour in order to leave his home to go to school and go to bed at night. If for some reason he was interrupted in his shower ritual, he would not permit himself to sleep in his own bed, but would sleep in a sleeping-bag in the hall. This was to ensure that germs were not transmitted to the rest of the house. More often than not he would, during the course of the day, only permit himself the use of the hall, kitchen and his own room. If, for example, he were to enter the lounge, he would spread germs there. (1999: 18)

In short, an order of sorts can be established and maintained within the home. Objects, and people's interactions with them, can be arranged in such a way that contamination does not spread, and those household items with which the self comes into intimate contact can be kept clean. For instance, the mother of an OCD sufferer describes how 'Jenny would get very upset if her things were touched by any of us ... Her towel is kept well away from the other towels in the bathroom, her soap is kept in a paper bag, separate, and her toilet paper is kept in a bag, separate ... Jenny's chair at the dining table is kept covered with a sheet and

her plate, mug, and cutlery are kept separate in a drawer' (cited in de Silva and Rachman 1998: 52). Jane described how her compulsive cleaning in the home is driven exclusively by the need to protect the self, and not by a positive desire for spatial cleanliness *per se*; a kind of specificity also discussed by Rapoport (1989).[4] At one time Jane could only operate light switches when holding a piece of kitchen paper so as to prevent contaminating her hands. Once used in this way, however, Jane was unable to put the contaminated paper into the rubbish bin because such an operation would involve excessive bodily contact with contaminated material. Consequently, contaminated papers were simply thrown away from the body, which resulted in them accumulating on the floor. Whilst this practice may be viewed as unclean from the perspective of household maintenance, from the point of view of the obsessive-compulsive body it effectively put contaminated material in its place.

Broken boundaries and the disordered domestic

At best, home is a place of relative safety compared with the disordered, intrusive public world because bodily and spatial boundaries can be more effectively maintained, and space can be ordered to minimize the risk of contamination. However, the domestic may also be experienced in more negative ways. Whilst certain inherent facets of domestic space offer feelings of safety (e.g. being bounded by its walls), other aspects of the 'ontological security' experienced at home only exist as a result of effort (e.g. keeping doors, windows and lids closed).

The disorder has the potential to transform radically the nature of everyday 'domestic routines and spaces' (Parr 1999: 682). Seemingly mundane objects and activities become riddled with fear, and they demand enormous amounts of time and energy over and above that which is 'normally' expended on them. Indeed, it is important to recognize that our objects and possessions demand a significant amount of our labour. Whether one likes it or not, one must attend to the world around us. 'Enormous as is the labour we expend to produce all these objects, it is probably exceeded many times by the sheer drudgery of organizing them, maintaining them, cleaning them, storing them, disposing of them', notes Levin (1996: 33). For Jane, home became a place of considerable fear, a place where she was forced to touch raw meat and vegetables, outdoor shoes, carrier bags and incoming mail. So, whilst the home may be a place of relative safety and security, it can also be the locus for a range of other emotions, including anxiety, fear and panic. The disruption of commonly held understandings of everyday spaces and practices is vividly described in Valentine's (1998: 321) personal account of harassment.

> [I]t is into this meaningful space [the home]—which I considered a more or less impermeable bounded, safe environment, of which I was in total control—that hate mail, calls, and nighttime disturbances have intruded. The letters and calls have disrupted the taken-for-grantedness of my domestic life ... Simple objects (the envelope), everyday sounds (the phone ringing), have taken on new meanings, meanings laden with threat, potent with menace.

Another reason why the home may become a space of fear is because, as Law (2000: 135) notes, '[I]t takes some effort ... to build boundaries and to keep them in place'. Intransitivity is the rule, rather than the exception. Maintaining a bounded, protected self requires an intricate set of spatial practices concerning

precisely *which* objects the body may touch and exactly *how* such contact is to be managed. Yet these systems rarely work in practice because the rules are absolute, and everyday life could not continue without some deviation from them. Shoes have to be handled. Dirty clothes have to be touched. Even the act of decontamination may involve spreading germs, through the cross-contamination of soaps, taps and towels. Since no irrelative position can ever exist, the self is always in and of the world, and it is therefore impossible to withdraw to a place of ultimate safety. Our very being in the world involves physical and psychological contact with the objects, people and spaces around us. For Jane, certain zones of the body were never considered to be completely clean because of their endless physical contacts with the external world, thus indicating the intricate, multiple and often unachievable rules of OCD. During a particularly traumatic period, Jane felt that she must not touch any item of food with her hands that she then went on to place in her mouth (e.g. crisps, biscuits and sweets).

Despite vigorous attempts, the domestic is rarely—if ever—turned into a sealed-off space. The physical boundary of the house fails to provide a total barrier against the intrusion of contaminants, with its holes, pipes and cracks through which disease-carrying rodents, insects and dust motes can enter. The house is also quite legitimately a place of circulation for mail, shopping, rubbish, public utilities and, perhaps most importantly, people (Christensen, Allison and Jenks 2000). Other people may bring contamination into the domestic sphere on their own bodies, and through the articles that accompany them, but also by disrupting space, by misusing it in various ways and by misplacing objects around the home. Where OCD sufferers share domestic space with others (such as family members), particular conflicts may arise. Faced with the spatial disruptions set in train by others, the OCD sufferer is faced with two equally challenging strategies to pursue. They may abandon the attempt to keep the domestic safe, and retreat into an even smaller parcel of space (typically a bedroom or even a bed).[5] Alternatively, people with OCD may seek to continue with the attempt to order domestic space by asking cohabitants either to comply with particular systems and compulsions or to participate actively in them (Cooper 1996; Waters and Barrett 2000).

As we have seen, the relative safety of the home depends in large part on the ability to impose a certain kind of order on the material world, and the way in which people engage with it. Objects need to conform to a particular spatial system of arrangements, relations, separations and boundaries that is meant to keep the fabric of the world in its place. These spatial systems must contend with a world of objects that increasingly possesses a life and an affective potential of its own (Rose and Thrift 2000; Thrift 2002; Thrift and French 2002). Despite the best efforts of modernity to disenchant, objectify and rationalize the world around us, our objects no longer seem willing to play dead. For example, as alienated commodities, many household items are intensely *ambiguous*, offering few clues to their trajectory through space and whether they are indeed safe or contaminated (Baudrillard 1996). Once inside the home, the attempt to order objects—to make them passive and well behaved—may be subverted or transgressed (Cresswell 1996; Sibley 1995). The vacuum cleaner is an excellent example, an object which to most people symbolizes containment and cleansing, but for Jane it is a fearful object because it disperses dirty air and dust throughout the spaces it is used in.

Faced with permeable boundaries, the disruptive spatial practices of others and the

transgressive capacity of the material world, one is left with a stark choice—to abandon oneself to risk and fate or else to renew continually order and boundaries, taking endless, personal responsibility for the prevention of contamination. A range of normally mundane objects can be utilized to re-establish control, to negotiate the dangerous world of contaminated objects and to bring comfort, reassurance and relief from anxiety. It is here that we may need to be especially open to the range of emotions beyond anxiety and fear that permeate OCD, though whether compulsive behaviour can ever produce feelings of satisfaction or pleasure is a moot point. Although such practices may be saturated with fear and anxiety (the latter because one is never sure where contamination may be), these uses of materials are also arguably creative, a fact which puts the compulsive body into proximity with that of the consumer. Objects that are commonly thought of as mundane (and with a single use) can nevertheless be used in many different ways, often to the consternation of manufacturers and those with a vested interest in promulgating a 'correct' and 'good' use for things. For instance, 'A fourteen year old boy ... [who] feared breathing "other people's air", which he thought would be full of infectious germs ... was compelled to wear a crash helmet, complete with visor, to protect himself from the breath of other people' (Thomsen 1999: 18–19). For de Certeau, consumption is creative, productive and full of possibilities. Users (i.e. consumers) always have a margin of freedom to act otherwise. Invariably, they prefer not to use things in the way that producers expected. They *make* use of things. They appropriate what appears alienable, and in so doing they turn the world to their advantage (*détournement*).

So, whilst contamination-based compulsions may appear entirely goal-directed and highly unpleasant, they also harness everyday materials in inventive and creative ways. Perhaps one of the most important uses of materials in this respect is to maintain spatial boundaries when the self is forced to handle contaminated objects. Kitchen roll is an immensely useful material that can be employed to form a protective barrier around the self when opening doors, picking up the mail or using the telephone. Whilst kitchen roll is commonly considered to be a household item that absorbs moisture, here it possesses the power to bring feelings of relief, comfort and security. The use of materials to maintain order also extends to the wider space in which one lives, thus re-ordering space, clamping down on the proliferation of germs and allowing the self to re-engage more easily with its surroundings. Jane made sure that cracks and holes in the walls of her flat were covered with parcel tape to prevent creatures from invading or at the very least to indicate that they had done so. Similarly, she used empty spring-water bottles (perceived as safe) to store her toothbrush and to guard against infection from rats. In the move to pacify objects (and deny them their own will), the material world is simultaneously personified. The world consists of alienable and estranged objects of fear (to be repressed, controlled and cleansed), and simultaneously an array of materials that are clean, safe, useful and productive. Products that are sterile and sealed are especially helpful items since they can be used with the minimum of bodily contact and then immediately thrown away. If Buck-Morss (1994) is right to suggest that fashion has become our collective tempo of history, such that built-in obsolescence has supplanted natural decay in virtually every domain, then one might suggest that waste disposal is the tempo of OCD. In both cases, '[O]bjects are discarded before they decay. Material things fall away from the present with a speed faster

than their natural decline' (Buck-Morss 1994: 14).

Conclusion

In this paper we have sought to foreground the everyday practice of living with OCD. For whilst the disorder produces intense emotions of anxiety, fear and discomfort, it also frequently engenders creative forms of action. As well as a general openness to the 'livedness' of OCD, geographers are well placed to examine the relations between the embodied self and an affective environment that are a fundamental aspect of the disorder, and its often situation-specific manifestation. A geographical analysis is also fruitful because of the way in which obsessions and compulsions are embedded within the spaces and practices of everyday life and have the potential to transform them radically. As we have seen, boundaries and regimentation are difficult to sustain and must be continually worked upon. Just as obsessions can transform 'harmless' artifacts into sources of deadly contamination (telephones, toothbrushes, mail, dust motes, etc.), compulsions can find creative uses for materials such as parcel tape and kitchen roll to restore order and bring about relief. Home may become a space of complex and intense emotions, ranging from feelings of safety and comfort to those of pain, fear and entrapment. The multiple worlds of OCD point to the fact that supposedly mundane spaces and practices can be saturated with emotions and feeling (Anderson and Smith 2001). Our argument is that many of the spatial practices that constitute OCD (as with other kinds of material practice) are neither purely functional nor especially symbolic: they are first and foremost affective, rather than instrumental or meaningful (Doel and Segrott 2003b; Thrift 2002; Thrift and French 2002). The spatial practices of OCD demonstrate all-too-vividly that the non-human world should not be regarded as a passive collection of objects which human subjects control and draw upon to sustain a sense of an embodied identity. In the world of OCD, as in the realm of spatial practices more widely, a body is defined through its relations (Doel 1995). Following Spinoza, Deleuze (1992: 625) argues that first and foremost, a body 'is composed of an infinite number of particles; it is the relations of motion and rest, of speeds and slowness between particles that define a body, the individuality of a body. Second, a body affects other bodies, or is affected by other bodies'. Living with OCD is a profound illustration of such a conception of the body as an articulation of affective relations. One's being-in-the-world is forcefully felt.

As we noted at the outset of this paper, many accounts of OCD highlight its supposedly abnormal, irrational and seemingly excessive nature (e.g. Thomsen 1999). Yet these same accounts also point to the fact that the obsessions and compulsions present in OCD are 'normal' in that they are experienced to a lesser degree by most, if not all of us. For Rapoport (1989: 178), it is difficult to determine 'where the obsessionality of everyday life leaves off and OCD begins'. In most clinical accounts, 'normal' obsessions and compulsions 'become OCD' when they begin to hamper significantly a person's ability to conduct his or her everyday life (de Silva and Rachman 1998). Thus, OCD is defined not by the irrationality or uncontrolled nature of its obsessions and compulsions, but by the way in which they cross certain quantitative and qualitative thresholds of intensity and intrusiveness. Parr (1999) argues that we need to challenge dualisms such as normal/abnormal and consider instead mental health in terms of a complex continuum of states of being. Echoing such comments, David-

son suggests that because agoraphobia is an example of quotidian fears in an extremely heightened form, it provides us with a window on to aspects of life that we tend to take for granted.

> [T]hose 'boundary' problems experienced by [agoraphobic] sufferers are neither so unique, nor so bizarre if we choose to understand them in terms of a pathology of everyday life and existence. We are not Cartesian subjects. There are no fixed and immutable boundaries between the self and world. The self is a project that needs to be constantly renegotiated. (Davidson 2000a: 655)

The intricate hand-washing and decontamination rituals employed by some people with OCD might well be seen as excessive, irrational and counter-productive. Yet, viewed as forms of practice designed to take responsibility for the minimization of risk, they may find an echo in what are commonly viewed as rational discourses. For instance, the UK's Food Standards Agency informs caterers that '[I]f hands aren't clean they can spread food poisoning bacteria all around the kitchen. But a quick rinse won't make sure they're really clean. So it's important for you and all your staff to know how to wash your hands properly'.[6] Faced with the problem of profusion—the problem of consumer culture *par excellence*—obsessions and compulsions are aligned with necessity rather than choice. Like kleptomania in the nineteenth century (Camhi 1993), OCD takes possession of the subject. By exploring its practices more closely geographers may be able to make an original contribution to the understanding and appreciation of the disorder. In addition, by holding on to the specificity of OCD we can also say something much broader about the often taken-for-granted ways in which we inhabit our bodies, construct boundaries and make creative use of the world around us.

By focusing on the creative dimension of living with OCD we have sought to distance ourselves from the view that people with OCD are deprived of their ability to resist the overwhelming power of obsessions and compulsions. For although they may be compelled to act, the *specificity* of their actions could always have been *otherwise*. Indeed, we are struck by the contingency of obsessions and compulsions, and their mutability over space and time. Rather than speak of power and resistance, we find it preferable to draw on de Certeau's (1984) more subtle distinction between two ways of being in the world: 'strategies' and 'tactics'. Strategies represent a desire for power and mastery, which is expressed in the passion for arranging, ordering, controlling and dictating. Taken together, these strategies constitute a 'calculus of force-relationships which becomes possible when a subject of will and power ... can be isolated from an "environment." A strategy assumes a place that can be circumscribed as *proper*', and a subject that can be circumscribed as *proprietor* (de Certeau 1984: xix). de Certeau derives several consequences from this desire to inflict such strategies on social space. First, space is made functional and instrumental. It becomes an adjunct (property) of the controlling power, which distributes itself throughout such a space. Second, these strategies tend to enforce a mastery of space through sight, thereby instituting a passion for surveillance and surveying. Finally, these spatial strategies transform uncertain time into readable space. They still life and inaugurate a dead geography exemplified by the empty structures of pure geometry. As the strategic forces of rationalization, dis-enchantment and de-animation bear down on the world as never before, it is not surprising to hear de Certeau (1984: xiv) insist that

> [I]t is all the more urgent to discover how an entire society resists being reduced to it, what popular procedures (also 'miniscule' and quotidian) manipulate the mechanisms of discipline and conform to them only in order to evade them ... deflecting their functioning by means of a multitude of 'tactics' articulated in the details of everyday life.

In stark contrast to strategies of domination, tactics constitute 'a calculus which cannot count on a "proper" (a spatial or institutional localization) [nor "proprietor"], nor thus on a borderline distinguishing the other as a visible totality' (de Certeau 1984: xix). These tactics of impropriety—of deviation, displacement and transformation; of *bricolage*, *détournement* and seduction—allow one to live again in the world. To borrow a fine phrase from Bourdieu, tactics are the 'ground of habitude'. Let us close this paper, then, by simply noting that the ambivalence of those who endure OCD should caution us against the current vogue for too readily denouncing the desire for strategic control and for too hastily affirming the art of tactical living. de Certeau (1984), Carter (2002) and countless others are right to insist on the fact that life slips by. The problem that faces those who endure OCD, however, is that sometimes life does not slip *into* place, but that it slips *out* of place.

Acknowledgements

We are especially grateful to Jane for her participation in this study. Thanks are due to Gavin Andrews, Wil Gesler, Jeanette Hewitt, Robin Kearns, Hester Parr and to the participants at the Emotional Geographies conference held at Lancaster University for their helpful comments and suggestions on an earlier version of this paper.

Notes

1 See Obsessive Action untitled information leaflet (2000). Available from Obsessive Action, Aberdeen Centre, 22–24 Highbury Grove, London.

2 Of course, this is not to deny that individuals who have OCD frequently engage with health-care professionals, scientists, allopathic drugs, and complementary and alternative medicine, each of which has an affective and performative specificity all of its own.

3 In a very different context, Wilton (1998: 173) explores connections between individual identities and socio-spatial orderings, and argues that 'because people internalize social norms as a condition for subjective becoming, their own sense of identity is to some extent dependent upon the maintenance of surrounding social and spatial order'. These issues are drawn out through the example of local residents' reactions to the siting of an AIDS hospice in Los Angeles. For Wilton (1998: 181), negative attitudes that encompased fears of proximity and contamination 'implied a challenge to the existing socio-spatial order, felt concomitantly at the level of individual identity'.

4 Although Jane believes that her identity as a woman helps shape her experience of living with OCD, it is important to avoid drawing a causal connection between compulsive cleaning and the domestic roles traditionally performed by women in many Western societies. Jane's cleaning compulsions are driven by an obsession concerning the protection of the self and others. Furthermore, contamination-related cleaning is a feature of OCD in many men who suffer from the disorder.

5 Even this strategy is not always practical. Rapoport (1989) recounts the experience of a man who felt unable to keep his apartment sufficiently clean, and therefore resorted to sleeping in local parks and streets. Not only does this highlight the spatial specificity of OCD, but it also underlines the ambivalent nature of the comfort that home provides. '[A]lmost every cleaner or washer tells me that being outside or in some public room is almost always easier because those places are "*already* dirty" ' (Rapoport 1989: 137). However, for Jane at least, home is a space of safety when compared with public places.

6 See http://cleanup.food.gov.uk/data/handwashing.htm (accessed 23 November 2004).

References

Anderson, K. and Smith, S. (2001) Editorial: Emotional geographies, *Transactions of the Institute of British Geographers* 26: 7–10.

Baer, L. and Jenike, M. (1990) Introduction, in Jenike, M., Baer, L. and Minichiello, W. (eds) *Obsessive-Compulsive Disorders: Theory and Management* (second edition). London: Year Book Medical Publishers, pp. 3–9.

Baudrillard, J (1996) *The System of Objects*, trans. Benedict, J. London: Routledge.

Bauman, Z. (1992) *Intimations of Postmodernity*. London: Routledge.

Bobes, J., González, M., Bascarán, M., Arango, C., Sáiz, P. and Bousõno, M (2001) Quality of life and disability in patients with obsessive-compulsive disorder, *European Psychiatry* 16: 239–245.

Buck-Morss, S. (1994) Fashion in ruins: history after the cold war, *Radical Philosophy* 68: 10–17.

Camhi, L. (1993) Stealing femininity: department store kleptomania as sexual disorder, *Differences* 5: 26–50.

Carter, P. (2002) *Repressed Spaces: The Poetics of Agoraphobia*. London: Reaktion.

Castle, D. and Groves, A. (2000) The internal and external boundaries of obsessive-compulsive disorder, *Australian and New Zealand Journal of Psychiatry* 34: 249–255.

Christensen, P., Allison, J. and Jenks, C. (2000) Home and movement: children constructing 'family time', in Holloway, S. and Valentine, G. (eds) *Children's Geographies: Playing, Living, Learning*. London: Routledge, pp. 139–155.

Clarke, D. and Doel, M. (1997) Transpolitical urbanism: suburban anomaly and ambient fear, *Space and Culture* 1: 13–36.

Clarke, D., Doel, M. and Housiaux, K. (eds) (2003) *The Consumption Reader*. London: Routledge.

Cooper, M. (1996) Obsessive compulsive disorder: effects on family members, *American Journal of Orthopyschiatry* 66: 296–304.

Cresswell, T. (1996) *In Place/Out of Place: Geography, Ideology, and Transgression*. London: University of Minnesota Press.

Davidson, J. (2000a) A phenomenology of fear: Merleau-Ponty and agoraphobic life-worlds, *Sociology of Health and Illness* 22: 640–660.

Davidson, J. (2000b) '...the world was getting smaller': women, agoraphobia and bodily boundaries, *Area* 32: 31–40.

de Certeau, M. (1984) *The Practice of Everyday Life*, trans. Rendall, S. Berkeley: University of California.

de Silva, P. and Marks, I. (1999) The role of traumatic experiences in the genesis of obsessive-compulsive disorder, *Behaviour Therapy and Research* 37: 941–951.

de Silva, P. and Rachman, S. (1998) *Obsessive-Compulsive Disorder: The Facts*. Oxford: Oxford University Press.

Deleuze, G. (1992) Ethology: Spinoza and us, in Crary, J. and Kwinter, S. (eds) *Zone 6: Incorporations*. New York: Zone, pp. 625–633.

Doel, M. (1995) A hundred thousand lines of flight: a machinic introduction to the nomad thought and scrumpled geography of Gilles Deleuze and Félix Guattari, *Environment and Planning D: Society and Space* 14: 421–439.

Doel, M. (2001) 1a Qualified quantitative geography, *Environment and Planning D: Society and Space* 19: 555–572.

Doel, M. and Clarke, D. (1999) Dark panopticon. Or, attack of the killer tomatoes, *Environment and Planning D: Society and Space* 17: 427–450.

Doel, M. and Segrott, J. (2003a) Self, health, and gender: complementary and alternative medicine in the British mass media, *Gender, Place and Culture* 10: 131–144.

Doel, M. and Segrott, J. (2003b) Beyond belief? Complementary medicine, lifestyle magazines, and the dis-ease of everyday life, *Environment and Planning D: Society and Space* 21: 739–759.

Domosh, M. (1998) Geography and gender: home again, *Progress in Human Geography* 22: 276–282.

Douglas, M. (1966) *Purity and Danger: An Analysis of Concepts of Pollution and Taboo*. London: Routledge.

Dyck, I. (1995) Hidden geographies: the changing lifeworlds of women with multiple sclerosis, *Social Science and Medicine* 40: 307–320.

Franzblau, S., Kanadanian, M. and Rettig, E. (1995) Critique of reductionist models of obsessive-compulsive disorder: toward a new explanatory paradigm, *Social Science and Medicine* 41: 99–112.

Freeston, M. and Ladouceur, R. (1997) What do patients do with their obsessive thoughts?, *Behaviour Research and Therapy* 35: 335–348.

Kirby, K. (1996) *Indifferent Boundaries: Spatial Concepts of Human Subjectivity*. New York: Guildford Press.

Law, J. (2000) Transitivities, *Environment and Planning D: Society and Space* 18: 133–148. Q2

Lemelson, R. (2003) Obsessive-Compulsive Disorder in Bali: the cultural shaping of a neuropsychiatric disorder, *Transcultural Pyschiatry* 40: 377–408.

Levin, C. (1996) *Jean Baudrillard: A Study in Cultural Metaphysics*. Hemel Hempstead: Prentice Hall.

Lupton, E. and Miller, J. (1992) *The Bathroom, the Kitchen and the Aesthetics of Waste—A Process of Elimination*. New York: Kiosk.

Moss, P. (1997) Negotiating spaces in home environments: older women living with arthritis, *Social Science and Medicine* 45: 23–33.

Parr, H. (1999) Delusional geographies: the experiential worlds of people during madness/illness, *Environment and Planning D: Society and Space* 17: 673–690.

Rapoport, L. (1989) *The Boy Who Couldn't Stop Washing*. New York: E. P. Dutton.

Rose, G. (2003) Family photographs and domestic space: a case study, *Transactions of the Institute of British Geographers* 28: 5–18.

Rose, G. and Thrift, N. (eds) (2000) Special issue: spaces of performance, part 1, *Environment and Planning D: Society and Space* 18(4).

Seedat, S. and Stein, D. (2002) Hoarding in obsessive-compulsive disorder and related disorders: a preliminary report of 15 cases, *Psychiatry and Clinical Neurosciences* 56: 17–23.

Sibley, D. (1995) *Geographies of Exclusion: Society and Difference in the West*. London: Routledge.

Tallis, F. (1992) *Understanding Obsessions and Compulsions: A Self-help Manual*. London: Sheldon Press.

Thomsen, P. (1999) *From Thoughts to Obsessions: Obsessive Compulsive Disorder in Children and Adolescents*. London: Jessica Kingsley.

Thrift, N. (2002) Closer to the machine? Intelligent environments, new forms of possession and the rise of the supertoy, *Cultural Geographies* 10: 389–407.

Thrift, N. and French, S. (2002) The automatic production of space, *Transactions of the Institute of British Geographers* 27: 309–335.

Toates, F. (1992) *Obsessive Compulsive Disorder: What It Is—How to Deal with It*. Wellingborough: Thomsons.

Valentine, G. (1998) Public/private voices—'sticks and stones may break my bones': a personal geography of harassment, *Antipode* 30: 305–332.

Waters, T. and Barrett, P. (2000) The role of the family in childhood obsessive-compulsive disorder, *Clinical Child and Family Psychology Review* 3: 173–184.

Wilson, K. and Chambless, D. (1999) Inflated perceptions of responsibility and obsessive-compulsive symptoms, *Behaviour Research and Therapy* 37: 325–335.

Wilton, D. (1998) The constitution of difference: space and psyche in landscapes of exclusion, *Geoforum* 29: 173–185.

Wolch, J. and Philo, C. (2000) From distributions of deviance to definitions of difference: past and future mental health geographies, *Health and Place* 6: 137–157.

Abstract translations

La géographie perturbante: le trouble obsessionnel compulsif comme pratique spatiale

Cet article étudie les pratiques spatiales du trouble obsessionnel compulsif (TOC). Il débute par un survol des principaux aspects du trouble en termes d'obsessions et de compulsions. Par la suite, il met l'accent sur les obsessions et les compulsions relatives aux craintes liées à la contamination corporelle. Ces craintes exigent que des frontières psychosociales se forment selon un mode qui rappelle l'agoraphobie et les autres problèmes de santé mentale. Les moyens d'évitement de la contamination corporelle s'accompagnent aussi d'agencements complexes de l'espace pour prévenir le mouvement illicite de contaminants. La fragilité de ces formations spatiales d'une importance vitale implique que l'engagement dans l'espace social et les interactions peuvent être des expériences très angoissantes. Ceux qui souffrent du TOC chercheront donc à se réfugier dans leur domicile qui est relativement plus sécurisant. Toutefois, l'espace domestique offre une sécurité qui est ambivalente. Les objets de tous les jours sont empreints de sentiments de peur qui bouleversent l'expérience du «chez soi». Les frontières et les agencements spatiaux sont enfreints par le mouvement des gens et des objets. Par conséquent, ceux qui souffrent du TOC sont poussés à (ré)ordonner continuellement l'espace et, ce faisant, ils se servent d'objets de tous les jours avec beaucoup de créativité. Nous critiquons la représentation du TOC comme étant irrationnelle et excessive, et situons les pratiques créatives associées au TOC en rapport avec l'idée de «glissement»; dans la distinction que propose Michel de Certeau entre les stratégies spatiales de la domination et l'art de la vie tactique.

Mots-clefs: trouble obsessionnel compulsif, santé mentale, pratique spatiale, espace domestique, consommation.

Geografía perturbadora: trastorno obsesivo-compulsivo como práctica espacial

Este papel explora las prácticas espaciales del trastorno obsesivo-compulsivo. Empieza por introducir los elementos principales del trastorno: obsesiones y compulsiones. Luego se centra en las obsesiones y compulsiones en relación con el miedo a la contaminación del cuerpo. Este tipo de miedo exige la formación de fronteras psicosociales parecidas a las de agorafobia y otros problemas de la salud mental. Evitar la contaminación del cuerpo supone un orden espacial complejo así para impedir que los contaminantes se muevan ilícitamente. La importancia, y sin embargo la naturaleza frágil, de estas formaciones espaciales hacen que la negociación de espacios sociales e interacciones sean aterradoras, y la persona que padece del trastorno muchas veces se retira a la seguridad relativa de la casa. Sin embargo, el espacio doméstico es de seguridad ambivalente. Objectos cotidianos llegan a ser saturados en el miedo y, de este modo, transforman la experiencia de 'casa'. Con el movimiento de personas y objetos las fronteras y el orden espacial están transgredidos. Esto empuja a la persona que padece del trastorno a poner el espacio en orden constantamente, y al hacerlo muchas veces utiliza materias cotidianas con inventiva. Hacemos una crítica de la representación del trastorno como irracional y excesivo y analizamos las prácticas creativas del trastorno en relación con el 'bajón' de la distinción que hace Michel de Certeau entre las estrategias espaciales de dominación y el arte de una vida táctica.

Palabras claves: trastorno obsesivo-compulsivo, salud mental, práctica espacial, espacio doméstico, el consumo.