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THE SOCIAL AND ANTICIPATORY GEOGRAPHIES OF SOCIAL ANXIETY

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Abstract

Social anxiety is deeply entangled with an individual's social and interpersonal environments, provoking distress for those who experience social interactions and spaces as threatening. Social anxieties rupture the fabrics, places and spaces of everyday life and are fundamentally geographical, bound up in an intimate social geography of experience where anxiety, fear, embarrassment and shame occur across a range of social settings. This thesis examines the everyday lived geographies of people experiencing often debilitating and distressing social anxieties.

The research landscape of social anxiety is one dominated by the disorder/illness model, one that prioritises the presence of an organic or cognitive abnormality as the cause of disorder. Against these individualising biomedical understandings, I develop a novel conceptualisation of social anxiety as a social and spatial phenomenon. I examine the relationship between social anxieties and the temporalities and spatialities of everyday life by prioritising everyday routines, practices, interactions, situations, sites and settings through and in which social anxieties are embodied, enacted, sustained and managed. Social anxieties shape, and are shaped by, our social and spatial surroundings: first, where anxieties shape the perception or experience a person has of/in a particular place or space and second, where an interaction, site or setting shapes the intensities or contours of anxious experiences.

Drawing on lived accounts of experience that were gathered through qualitative research methods, including an online questionnaire and semi-structured, online and telephone interviews, I contribute to research on the relationship between health and place by engaging experience-centred knowledges that takes seriously the lived reality of living, experiencing and managing social anxiety. The methodological approach also contributes to debates concerning how 'we' (as researchers) research experiences of health and place, highlighting the need for flexibility in the research process and designing research that fosters participation while enabling people to define the nature and limits of their participation.

Through the conceptual underpinnings of psychoanalytic, anticipatory, habitual and emotional and affective geographies mapped against a background of critical approaches in health geographies, findings account for the importance of social and spatial factors in producing, sustaining and experiencing social anxieties. This thesis engages with lived accounts of mental health and illness that disrupt, challenge and nuance the medicalisation of mental health experiences, towards a social and spatial understanding of social anxiety.

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Definitions/Abbreviations

CBT – Cognitive Behavioural Therapy
CMHT – Community Mental Health Team
DTC – Direct to Consumer
GP – General Practitioner
LOL – Laugh Out Loud
NHS – National Health Service
NICE – National Institute for Health and Care Excellence
SAD – Social Anxiety Disorder
IR – Interview Response
QR – Questionnaire Response
[...] – Indicates Text Removed
[] – Indicates Text Added

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Author's Declaration

I hereby declare that, except where explicit reference is made to the contributions of others, this dissertation is the result of my own work and has not been submitted for any other degree at the University of Glasgow or any other institution.

Signed: Louise Elizabeth Boyle

CHAPTER 1

INTRODUCTION

LIFE WITH SOCIAL ANXIETY¹

[Anxiety] is a state that comes over me all too often. It is familiar and anticipated but, even so, I dread it. It tortures and suffocates me with a profound feeling of shame in the pit of my stomach. I feel so intensely out of place and utterly powerless to control it. My social anxieties gnaw at the very core of me, telling me [that]:

- *I am undeserving of close friendships and relationships.*
- *I am a burden to those who, for whatever reason, have remained relatively close to me.*
- *I am a failure in most aspects of life, including relationships, education [and] career, and I haven't succeeded in reaching any of life's 'milestones'² and so, will never amount to anything.*

It has tortured me for as long as I can remember. These crippling fears of other people and the judgements they impart have restricted my life in every way imaginable. The blush of embarrassment when attention is focused on me, the wave of panic as I'm put on the spot or the intense weight of anxiety that comes with trying to move through life, it's all unbearable. I feel completely useless in my ability to gain any sort of momentum for life. This fear has driven me away from the world and even alienated me from myself.

I stand on the side lines of social life, immobilised by a fear of interacting with or being around other people. I am terrified of what they must think about me. It feels like a fear of living because people are everywhere and it is impossible to do anything, [such as] answer the door, walk down the street, buy something from a shop, order food in a restaurant, go to university, get a job, travel on the bus, go to the gym or visit a museum without encountering other people. All of those situations and more are intensely uncomfortable to the point of being

¹ This opening section is a creative rendition of five participants' questionnaire and interview responses gathered as part of this research project. Each participant uniquely captured a particular element of the phenomenon that is social anxiety. This rendition, weaving together these diverse elements, aims to represent both the individual and collective experiences of social anxiety as communicated by all who participated in this research project. Included here are responses from Sarah, Amelia, Dawn, Karen and John. Pseudonyms are used throughout this thesis (Chapter 4: 'Researching Social Anxiety').

² For several participants, 'milestones' include life events such as attending and/or completing university, going on a first holiday with a group of friends, attending 'prom' and/or graduation ceremonies, moving away from home, meeting a partner and getting a job.

unbearable for me. There are very few places for me to anchor to because of how my anxieties affect me. I feel such intense shame about not being able to do things that are probably second nature to most [people]. Every activity in this world that people take for granted is incredibly hard for someone like me. Because of this, I experience a real feeling of disconnection from the world around me and a feeling of disconnection from myself. I feel I am looking at myself from the outside sometimes and that's terrifying – to feel so disconnected [from] everything.

Unsurprisingly, I do not have a good relationship with myself. Every conversation I have, opportunity that is presented [to me] or place I go [to], anxiety is there. Waiting. Waiting to tell me that I will embarrass myself, be laughed at, be humiliated, be ignored and then rejected. It makes me doubt everything about myself, tells me I'm worthless, useless, pathetic and weak. I'm so ashamed of not being able to control this. I'm waking up every day and worrying about what will happen, who I will have to talk to and where I will have to go. Will the door go? Will the phone ring? [Then], at the end of the day I go over in my head every last detail of what I did, what I said, how I said it, what my face looked like, did I make enough eye contact and how were people reacting to me? I'm constantly questioning myself, doubting myself, criticising myself [and] then it starts all over again. This anxiety builds and builds over a matter of days or weeks [...] I just can't control my thoughts, or see [situations] clearly, everything is foggy and gets increasingly intense and my body doesn't contain anything. I sweat, and blush, shake, stutter and it's as if my anxiety is just oozing out for everyone to see. It's awful.

Yet, social interaction or, at the very least, one moment of connection without this crippling weight of anxiety is something I want. I endure most social things, try to pacify myself with alcohol and always have an exit plan. I spend days, weeks or months planning and preparing to enter upcoming social situations or even simply making an appointment to see my doctor or get a haircut. For me, these things are genuine accomplishments rather than something I do in the course of my daily life. I go through painstaking and meticulous levels of planning, running through every possible scenario in my head about what could go wrong or the potential for me to embarrass myself. I am stuck in this never-ending cycle of 'what-ifs'. It is relentless and exhausting.

In the beginning, my anxiety kept me safe from harsh social realities; now, I am trapped by it.

In order to capture the complexity of life as it is lived with social anxiety, it feels appropriate to begin this thesis with the words of those who have participated in this research. Their experiences have not only nurtured my own understanding of social anxiety; they have also inspired and shaped the direction of this research immeasurably.

From its very beginnings, this project has been a profoundly personal one³. Therefore, there is also a certain personal ‘politics’ exercised in the process of acknowledging and ‘giving voice’⁴ to the experiential knowledges of those people who are enduring mental and emotional distress; one that underlines the overriding motivation for, and justification of, this research and its primary objectives.

The experience commonly understood today as ‘Social Anxiety Disorder’ (SAD) is embedded in a diagnostic system that constitutes a multitude of physiological symptoms and psychological constructs⁵. SAD has been considered the most ‘neglected’ of the ‘anxiety disorders’ (Liebowitz et al., 1985; Sheeran and Zimmerman, 2002) and the majority of literature and research on the topic to date remains largely ignorant about the complexities of SAD as a lived set of experiences. Ultimately, what is neglected in the simplified descriptions of this complex psychic and social phenomena are the subjective and experiential accounts of those living *with* social anxiety. Where subjective accounts are represented, the salient memories of painful social situations, moments of self-conscious criticism, vivid social humiliation and shame, and the embodied and messy realities of navigating daily life are masked, manipulated and misconstrued by statistical analysis in clinical trials. Therefore, it is important that the words of research participants are encountered first, in order that the most salient and resounding aspects of social anxiety are allowed to breathe, unconfined by clinical definitions or conceptual frameworks. As such, a central concern of this thesis is the dominance of biomedical, cognitive and behavioural perspectives, chiming too with recognising the lack of critical attention paid to wider social and cultural conditions and neoliberal and disciplinary regimes that serve to create and sustain social anxiety (Hickinbottom-Brawn, 2013; Scott, 2006). The following section maps the histories and controversies surrounding the classification of social anxiety as a pathological and psychiatric ‘disorder’.

³ This project is also a continuation of my Masters of Research project (Boyle, 2012) and related outputs (Boyle, 2013).

⁴ The wider research and ethical implications involved in the process and practice of ‘giving voice’ are discussed in far more depth in Chapter 4.

⁵ I attend fully to the history and diagnostic criteria in the remainder of this chapter and to the existing research landscape in Chapter 2: ‘Situating Social Anxiety’.

SOCIAL ANXIETY, FROM DIS-EASE TO DISEASE⁶

The phenomena that manifest in the lived experience of social anxiety are not new, but what has changed significantly is the focus and emphasis on particular signs and symptoms of anxiety, the various permutations and combinations with which a person may present with anxiety and, most significantly, their social meanings. This section tracks the emergence of social anxiety alongside the globalisation of psychiatric practice and classification systems. To begin, I trace social anxiety's gradual shift in status from a normal, albeit distressing, part of the human condition to one of the most prevalent⁷ mental health problems of the 21st Century. I examine the conceptual antecedents of social anxiety that are present in medical and philosophical texts throughout history. Then, I explore the 120-year history of social anxiety as a 'disorder' by examining the conditions through which social unease became controversially pathologised and categorised through psychiatric classification. It is often said that anxiety has become modern society's prevailing condition – a cultural epidemic – one that is associated with the ever increasing pace and demands of life. In the face of capitalism, economic collapse, threats of war and terrorism, climate catastrophe, natural disaster and biological hazards, which not only threaten the social order but humanity's very survivability, a 'general malaise has descended over us' (Dunant and Porter, 1997, p. n.p.). Outlining the 'contours of modernity', Giddens (1991) argues that the social, political and economic climates surrounding late-capitalism generate anxieties and insecurities in our everyday social and spatial worlds. The interaction of these factors in conjunction with 'self-reflexive'⁸ projects fuels a preoccupation with monitoring the boundaries between self and others. Bauman writes extensively about the increasing frailty of human bonds (2013) and the 'liquidity' of modern life (2012), arguing that, despite living in a hyper-connected world, we humans are now increasingly disconnected from each other and ourselves. Definitions of anxiety abound; it is often difficult to ground its complexity in a concrete definition, but, as Rachman (2004, p. 3) outlines, it is unmistakably *felt* as 'the tense, unsettling anticipation of a threatening but vague event', is often 'shapeless' and grafts 'at a lower level of

⁶ Combrinck-Graham's (2014, p. 699) offer a critical discussion on the implications of human suffering ('dis-ease') being classified as mental illness ('disease'), arguing it could 'impos[e] another layer of suffering' on patients and wider society.

⁷ Prevalence refers to the 'proportion of a population who have a specific characteristic in a given time period' (National Institute for Mental Health, 2017).

⁸ As late-modernity is conceptualised by increasing uncertainty and instability, Giddens' (1991) concept of the 'reflexive self' outlines how, in an attempt to obtain and maintain some sense of (self) security, people continually (re)construct the self in order to adjust to the rapidly changing and continuously shifting parameters of social, spatial and economic life. The dynamics of (self)-reflexivity and their relationship to social anxiety will be explored later in this thesis (see also: Boyle, 2018).

intensity' and is 'unpleasant, unsettling, persistent, pervasive, and draining, [...] prolonged [...] disabling and even destructive', yet also seems an unavoidable and necessary component of the human condition.

Contemporary interpretations of early forms of 'individual' anxieties are often discussed alongside states of melancholy, timidity, stage fright and shyness that have long been associated with religion, ethics and morality. Our understanding of anxiety and phobias is more or less unchanged from the understandings of ancient Greece. The demands of social life and the public presentation of the self have been considered a source of unease and cause of avoidance throughout history and furnished contemporary accounts on the practice and performance of social life (Goffman, 1956). In the 17th century, Burton (1847, p. 164), in his text *Anatomy of Melancholy*, refers to Hippocratic texts from c. 400 BC, to describe a condition that is often thought to anticipate contemporary accounts of social anxiety:

Many lamentable effects this fear causeth in men, as to be red, pale, tremble, sweat, it makes sudden cold and heat to come over all the body, palpitation of the heart, syncope, [etc.]. It amazeth many men that are to speak, or show themselves in public assemblies, or before some great personages, as Tully confessed of himself, that he trembled still at the beginning of his speech [...]. It confounds voice and memory, as Lucian wittily brings in Jupiter Tragoedus, so much afraid of his auditory, when he was to make a speech to the rest of the Gods, that he could not utter a ready word, but was compelled to use Mercury's help in prompting. Many men are so amazed and astonished with fear, they know not where they are, what they say, what they do, and that which is worst, it tortures them many days before with continual affrights and suspicion. It hinders most honourable attempts, and makes their hearts ache, sad and heavy. They that live in fear are never free, resolute, secure, never merry, but in continual pain.

Here, Burton breaks down the all-consuming nature of social anxiety highlighting the signs and sensations that make anxiety visible and exacerbate distress; the sites (with a focus on performance situations) that trigger anxieties and hinder social life; the anticipatory dynamics that build and 'torture'; and the overall implications on a person's mental health and wellbeing. Burton (1847, p. 253) continues, detailing the case of a man who 'dare not come in company for fear he should be misused, disgraced, overshoot himself in gesture or

speech or be sick; he thinks every man observes him⁹.

Themes of social and existential anxieties are also heavily present throughout 19th and 20th century philosophy and literature. Kierkegaard¹⁰ (2014, p. 188) captures the all-consuming nature of anxiety, writing that:

[N]o Grand Inquisitor has in readiness such terrible tortures as has anxiety, and no spy knows how to attack more artfully the man he suspects, choosing the instant when he is weakest, nor knows how to lay traps where he will be caught and ensnared, as anxiety knows how, and no sharp-witted judge knows how to interrogate, to examine the accused as anxiety does, which never lets him escape, neither by diversion nor by noise, neither at work nor at play, neither by day nor at night.

A tension arises, inescapably for some individuals, against the inherently social nature of being human and social life as a primary focus and cause of distress¹¹. Psychoanalytic conceptualisations of anxiety argue that anxiety is an ‘essentially human condition’ and that, despite its often distressing and ‘paralysing effects’, it is also ‘the very condition through which people relate to the world’ (Salecl, 2004, p. 9). Anxiety presents as a negative affective state whereby other people, simply through their own being, have the capacity to inflict great psychological suffering on the individual.

Sartre’s (1956) construct of ‘*being-for-others*’¹² encapsulates the existential problems present in, and the relational context of, our own being, positioning others as inherently anxiety provoking: one is never *just* (socially) anxious, rather always anxious before another person in a specific set of circumstances. *Being-for-others* is a central component to the structure of self-hood and to our own vulnerability in that our own sense of being is constituted in the perceived consciousness of Others and centred on the objectifying ‘*look*’ (Davidson, 2003). Ultimately, we are a projection of what others think of us. *Being-for-others* describes the awareness of being perceived by others and the anticipation of

⁹ During the time of these early writings, women would have been less socially active but doubtless remained attuned to social pressures to conform to certain ideals regarding femininity (Manion, 2003). Men’s anxieties would have been concerned with masculinity and concealing emotions. Embarrassment and blushing, considered a sign of femininity and therefore weakness, were to be avoided in order to preserve a man’s social status and morality.

¹⁰ Davidson (2001), in her geographical engagements with agoraphobia, invokes Kierkegaard’s existentialism to examine experiential accounts of anxiety and fear in consumption spaces and practices. Similar dynamics are examined in Chapter 8.

¹¹ Davidson’s (2000a, 2003) work also draws on the existential-phenomenological philosophy of Sartre and Merleau-Ponty.

¹² The first and second constructs are being-in-itself (unconscious being) and being-for-itself (conscious, yet incomplete, being) (Sartre, 1956). Being-for-others is Sartre’s third concept of Being.

negative evaluation that comes from being the actual, potential or imagined object of someone else's gaze¹³. It is through the 'look', which also instructs a painful self-consciousness, that social and moral assessments are made regarding how *I* appear in the eyes of the Other or what am *I* to an 'other'¹⁴. There are inherent risks involved in the self's undesirable attributes becoming known to others. Yet, the desire for positive social evaluation, as much as the experience of negative evaluation, often leads to self-destructive behaviours, including avoidance, self-harm and even suicide (Bering and Shackelford, 2004).

The construction of social anxiety as a disease category has been subject to a particular set of historical conditions and social-cultural influences. The 120-year history of social anxiety as disease category has been the subject of intense debate and conflict between members of the psy-disciplines¹⁵ and has intensified significantly over the last four decades, beginning with the disorder's inauguration into the American Psychological Association's diagnostic system, the Diagnostic and Statistical Manual of Mental Disorders (DSM-3, 1980) and the use of direct-to-consumer (DTC) pharmaceutical drug advertisement in the promotion of Social Anxiety Disorder (Good and Huhmann, 2018).

In 1903, the French psychiatrist Janet¹⁶ coined the term 'Social Phobia' ('*la phobia sociale*'). Social Phobia was one of four disorders classified under 'situational phobias', and the others were related to physical situations: agoraphobia (open spaces), acrophobia (fear of heights), and claustrophobia (confined spaces). Social phobia denoted a fear of society as well as of performing or participating in social situations (Lloyd, 2006a, p. 143). Another French psychiatrist, Hartenberg¹⁷ and his 1901 text on shyness and timidity ('Les

¹³ The look does not require the physical presence of another person.

¹⁴'Other', in Sartre's writings, has similar (although not identical) connotations to the psychoanalytic (specifically Lacanian) notion of the 'big Other' ('L'Autre'), which is discussed in-depth in Chapter 3: 'Conceptualising Social Anxiety'. Briefly, other here refers to another person and/or object; Other is hence the sum of the experiential phenomena (of others) in the social world (see Hook, 2015).

¹⁵ The disciplines of psychology, psychiatry, psychotherapy and psychoanalysis.

¹⁶ Pierre Janet (1859-1974) was a French psychologist and neurologist. He is widely thought to be one of the founding fathers of psychology.

¹⁷ Paul Hartenberg (1871-1949) was a French psychiatrist who completed his medical and psychiatric training at the Nancy School (a hypnotherapy-focused faculty of psychotherapy in France) under Hippolyte Bernheim (who influenced Freud and subsequently his psychoanalytic theory) and established a facility in Paris dedicated to the study of mental illness.

Timides et *la timidité*)¹⁸ heavily influenced Janet's work on social phobia. According to Berrios (1999, p. 91), Hartenberg (1901) described timidity as a result of 'a combination of fear, shame and excessive embarrassment engendered by social situations', believing the best course or treatment to be 're-assurance' and 'self-administered behavioural therapies'. His early observations considered situational anxiety that ranged in severity from excessive to pathological and, consistent with contemporary perspectives (discussed in Chapter 2), outlined a phenomenology of social phobia prioritising the physiological and psychological symptoms of disorder, laying the foundations of our understandings of the disorder today (Fairbrother, 2002). This phenomenology also imbues the 'social phobic' with a particular set of personality characteristics and traits, including emotional sensitivity, tendency towards isolation, perceptiveness, self-awareness and self-criticism. Furthermore, he noted that people experiencing phobia have two aims: to mask the visible signs of anxiety and to avoid interactions and situations that provoke the signs and symptoms of anxiety (Fairbrother, 2002).

Next to nothing was written about social phobia and its associated phenomena after Hartenberg and Janet's preliminary work – their work is rarely cited in psychiatric literature¹⁹ – and social phobia did not gain much traction in the psy-disciplines until over 60 years later when Marks and Gelder's²⁰ (1966) seminal paper, and later Marks' text on *Fears and Phobias* (1969), carved the foundations of the 'disorder' into the psychiatric and clinical landscape²¹. This work culminated in the creation of 'Social Phobia' as a clinical entity in the third edition of the DSM (1980)²². This earlier definition had a much

¹⁸ Early work by French psychiatrists, including Janet and Hartenberg, is widely omitted from North America accounts of social anxiety/social phobia. Lloyd (2006a) examines the emergence of social phobia in France and how current practice blends psychoanalytic and psychotherapeutic (namely, cognitive-behavioural) models to create an understanding of mental and emotional life as it is communicated by patients in therapeutic settings.

¹⁹ It should be noted that the French psychiatry does not adhere to the globalised model of mental illness and their psychiatric system remains one of the last dominated by psychoanalysis (Argentina being another). Social phobia or social anxiety disorder is not recognised as a 'disorder' in France as per DSM classification – Lloyd (2006b) provides an interesting assessment of this 'clinical clash'.

²⁰ Isaac Marks is a psychiatrist who trained at Bethlem-Maudsley Hospital. His research focuses on the treatment of anxiety (including social and obsessive-compulsive) and sexual disorders and computer-aided psychotherapies. He is a founding member of the Royal College of Psychiatrists and of the British Association for Behavioural and Cognitive Psychotherapies. Michael Gelder (1929-2018) was founder of the Department of Psychiatry at the University of Oxford (1969). His work combined behavioural and cognitive strategies, and the use of gradual exposure, in the treatment of anxiety and panic disorders.

²¹ Marks (2005 cited in Lane, 2007, p. 13) later notes that 'psychiatrists have eroded crucial distinctions between normal and acute anxiety to hype their own research'.

²² The 5th and current version of the DSM was the subject of severe controversy and criticism on several counts including: its tendency to medicalise everyday patterns of behaviour that would not be considered 'extreme', the medicalisation of emotional states such as grief, and the heavy influence of the pharmaceutical industry in the categorisation of 'disorders' and their proposed treatment (Callard, 2014).

narrowing focus, outlining the phobia as a fear of, or extreme discomfort in, performance situations. Even by the mid-1980s the psy-disciplines still had not taken advantage of this ‘fertile area for psychobiological and clinical investigation’, causing social anxiety to be viewed as the ‘neglected disorder’ (Liebowitz et al., 1985). As more people presented with social phobia, the focus of the phobia was found to be more ‘generalised’, Social Phobia was re-labelled in the DSM-4 (1994) as ‘Social Anxiety Disorder’, a change which aimed ‘to connote a more pervasive and interfering condition’ (Kerns et al., 2013, p. 710).

This formal, medically-sanctioned classification of social anxiety as a disorder was not inconsequential. The definition of disorder, and the classification of social anxiety as such, has been a source of severe conflict within the psy-community. The DSM-5 (2013, p. 20) outlines the definition of a ‘mental disorder’ as follows:

A mental disorder is a syndrome²³ characterized by clinically significant disturbance in an individual’s cognition, emotion regulation or behaviour that reflects a dysfunction in the psychological, biological, or developmental processes underlying mental functioning. Mental disorders are usually associated with significant distress in social, occupational, or other important activities. An expectable or culturally approved response to a common stressor or loss, such as the death of a loved one, is not a mental disorder. Socially deviant behaviour (e.g., political, religious, or sexual) and conflicts that are primarily between the individual and society are not mental disorders unless the deviance or conflict results from a dysfunction in the individual, as described above.

The dominant models of, and existing research on, social anxiety present various definitions and measurements of individual pathology (see Chapter 2). The diagnostic system is controversial on many counts, not least insofar as the focus on disease nosology²⁴ has failed to elucidate a clear biological ‘marker’ of mental illness or had a marked impact on improving treatment decisions and outcomes (Chapter 2). A ‘disorder’ is a socially constructed label describing a set of concurrent symptoms that are not necessarily attributed or related to a specific aetiology²⁵ or pathogenesis²⁶.

Those opposed to the diagnostic classification of mental illness argue that such diagnoses impede treatment decisions and outcomes and increases societal stigma (Callard et al., 2013; Timimi, 2014). While the above definition appears to acknowledge and advise

²³ A syndrome is a set of concurrent symptoms but may not be specific to one disease category.

²⁴ The branch of medical science dealing with the classification of disease.

²⁵ Aetiology is the cause of disease or condition.

²⁶ Pathogenesis refers to the development of disease.

against the over-pathologising specific life events and behaviours, the DSM-5 was recently the subject of intense criticism for medicalising experiences of grief²⁷ and there are numerous situations where diagnoses are deployed as a political device²⁸.

DSM-5 Diagnostic Criteria of Social Anxiety Disorder
<ol style="list-style-type: none"> 1. Significant anxiety occurs in interaction or performance-based situations when one fears being judged negatively by others because of their behaviour (eg, saying something “foolish”), or because they may appear nervous or anxious 2. These types of situations often cause the person to feel anxious, and this anxiety should persist for >6 months 3. The anxiety is excessive compared with what would be expected given the situation or cultural context 4. The feared social situations often are avoided or, if unavoidable, are endured with a high degree of distress 5. The person experiences several negative consequences because of anxiety or avoidance (eg, inability to perform in important social, educational, or occupational roles), or is highly distressed because of his (her) anxiety 6. The anxiety is not due to substances, medical conditions, or symptoms of other mental disorders

Table 1: DSM-5: Diagnostic Criteria: Social Anxiety Disorder summarised by Dalrymple and Zimmerman (2013, p. 23)

The current clinical definition and criteria (Table 1) of SAD are the most definitive to date, outlining that the individual is:

Fearful or anxious about, or avoidant of, social interactions and situations that involve the possibility of being scrutinized. These include social interactions such as meeting unfamiliar people, situations in which the individual may be observed eating or drinking, and situations in which the individual performs in front of others. The cognitive ideation is of being negatively evaluated by others, by being embarrassed, humiliated, or rejected, or offending others. (DSM-5, 2013, p. 190)

What is known about SAD is that it is one of the most ‘persistent anxiety disorders’ (National Institute for Health and Care Excellent [NICE], 2013) and the third

²⁷ In previous editions of the DSM, there was a ‘Bereavement Exclusion’ associated with the diagnostic criteria of major depression (MD). The exclusion dictated that a diagnosis of MD could not be given in the two months following death of a loved one. The BE was removed from the DSM-5 (2013) enabling a person experiencing grief to be diagnosed with major depression after a period of two weeks (Bandini, 2015), which has major implications regarding opportunities for pharmaceuticalisation. Bandini (2015) discusses in detail the micro and macro level consequences of medicalising such aspects of the human condition.

²⁸ Moncrieff (2010, p. 370) highlights that psychiatric diagnoses have been used to shape how people perceive themselves and their everyday social worlds, employed to ‘legitimate activities that might otherwise be contested’ and mobilised as a form of social control to deal with “unruly” populations through institutionalisation and medication.

most common ‘mental illness’ after alcoholism and depression, with a lifetime prevalence, according to US studies, of 12% (Kessler et al., 2005). While no statistics exist for the adult population in the UK, one study on the mental health of young people looked after by local authorities in Scotland showed that 1.8% of the youth population had social anxiety (cf. 0.4% in England and 0.6% Wales) (Office of National Statistics, 2004); while social anxiety is reported to affect approximately 15 million Americans (Anxiety and Depression Association of America (ADAA), n.d.), 3 million Canadians (Dowbiggin, 2009), one in ten Australians (approx. 2.4 million people) (Australian Bureau of Statistics, 2008), and one in eight Irish (approx. 600,000 people) (Social Anxiety Ireland, 2013)²⁹. Women more commonly experience it than men, while women report greater clinical severity (Asher et al., 2017). The age of onset typically occurs in late-childhood or early adolescence and the average age of onset is 13 years old (NICE, 2013). People formally diagnosed with SAD³⁰ experience high levels of ‘co-morbidity’³¹ with other mental health conditions, notably depression, and the condition may also resemble and/or overlap with personality disorders; for example, Avoidant Personality Disorder (AvPD) (Table 2). Although a greater pattern of avoidance of given situations is often observed in AvPD, similar ‘patterns of social inhibition, feelings of inadequacy, and hypersensitivity to negative evaluation’ (DSM-5, 2013, p. 645) are observed in both SAD and AvPD. Despite the intense levels of distress and impairment experienced, NICE (2013) report that only half of those experiencing SAD will ever seek treatment and those who do will wait between 15 and 20 years before approaching primary care. This delay is further hindered by lack of professional understanding of SAD in primary care where poor recognition, inadequate assessment and limited awareness, or lacking availability, of suitable treatments impact treatment (NICE 2013).

SAD is hence widely framed as an individual pathology, and there is only a small body of research that attempts to relate it to wider social and cultural contexts (Hickinbottom-Brown, 2013; Scott, 2004) (also Chapter 2). This work does not intend to diminish the painful and disruptive experience of living with social anxiety, but alternatively recognises the limits and dangers of (over) medicalising this dimension of the human condition. It is only within the last century that anxiety has increasingly been constructed as the ‘ultimate obstacle to the subject’s wellbeing’ (Salecl, 2004, p. 84) as an entity that should be

²⁹ There is no specific publication for the Irish statistics. Social Anxiety Ireland is an online resource founded by Clinical Psychologist Dr. Odrhan McCarthy (Mater Hospital, Dublin).

³⁰ This is not to be confused with Seasonal Affective Disorder, which is also acronymised to SAD.

³¹ The presence of one or more diseases.

diagnosed, controlled and, ultimately, eradicated. Hacking (1998) argues that ‘transient illnesses’ are circumscribed by an ‘ecological niche’, that is a particular set of social, cultural, institutional and economic conditions that create and sustain various categories of illness. Such a niche is a product of four interactive vectors (i.e. forces): medical, observable, cultural and release. Hickinbottom-Brawn (2013) explores in-depth the four vectors that led to social anxiety’s psychiatric classification (an explanation of each vector and its role in the context of social anxiety is outlined in Table 3).

DSM-4 Diagnostic Criteria: Avoidant Personality Disorder
<p>The essential features of a personality disorder are impairments in personality (self and interpersonal) functioning and the presence of pathological personality traits. To diagnose avoidant personality disorder, the following criteria must be met:</p> <ul style="list-style-type: none"> 1.Avoids occupational activities that involve significant interpersonal contact, because of fears of criticism, disapproval, or rejection. 2.Is unwilling to get involved with people unless certain of being liked. 3.Show restraint within intimate relationships because of the fear of being shamed or ridiculed. 4.Is preoccupied with being criticized or rejected in social situations. 5.Is inhibited in new interpersonal situations because of feelings of inadequacy. 6.Views self as socially inept, personally unappealing, or inferior to others. 7.Is unusually reluctant to take personal risks or to engage in any new activities because they may prove embarrassing

Table 2: DSM-4 Diagnostic Criteria: Avoidant Personality Disorder (DSM-4, 1994, p. np)

These conditions comprise the very act of ‘making up people’, which Hacking (2007) argues refers ‘to the ways in which new scientific classification may bring into being a new kind of person, conceived of and experienced as a way to be a person’.

Classifications thereby engender a ‘looping effect’, which aims to account for how systems of classification interact with classified people. Psychiatric discourses have a causal impact on the disorder with which a person is diagnosed. The history and creation of social anxiety as a clinical condition is a particularly intriguing, if not harrowing, example of how a small group of leading psychiatrists and drug company executives have re-shaped the clinical landscape. Lane (2007, p. 10) in his assessment of how shyness became an illness, brings to light how in the late-1990s a task-force of psychiatrists, pharmaceutical giants, public relations experts and marketing consultants embarked on a multi-million dollar campaign and ‘successfully turned shyness, self-consciousness and even introspection into

major psychiatric disorders'. The resulting anxiety epidemic was greatly aided by the DSM-3, which had 'dramatically expanded the pharmaceutical market for anxiety disorders' (Lane, 2007, p. 120). Barry Brand (cited in Lane, 2007, p. 105) the product designer for Paxil, the first DTC³² medication for SAD, states unabashedly that 'every marketer's dream is to find an unidentified or unknown market and develop it. That's what we were able to do with social anxiety disorder.'

Vector	Forces enabling SAD to thrive
Medical taxonomy – requires medical legitimacy to be established through classification:	Social fears, uncertainty, introversion and shyness are pathologised through diagnostic classifications.
Cultural polarity – phenomenon's position in the public consciousness:	SAD is situated between the socio-cultural narratives of 'introvert' or 'social misfit' and 'dangerous loner' causing people to be wary, suspicious and avoid them.
Observability – requires an increase in public visibility and surveillance of phenomenon	A substantial system of awareness raising, marketing and advertising campaigns are put in place to increase public awareness of social anxiety 'disorder' and individuals (particularly young professionals) are targeted through DTC pharmaceutical advertising.
Release – phenomenon may provide certain freedoms despite suffering:	Diagnostic categories provide justification for 'abnormal' social behaviours as well as legitimising distress

Table 3: Summary of Hickinbottom-Brawn's (2013) four Vectors of Social Anxiety Disorder

Targeted marketing campaigns by pharmaceutical giant GlaxoSmithKline and public relations company Cohn and Wolfe were strategically and nationally advertised with the tag-lines 'Imagine Being Allergic to People' (Figure 1), and 'Should Have, Would Have, Could Have' (Figure 2). The focus of the Cohn and Wolfe marketing campaign set out to bring awareness of SAD into the public consciousness by focusing on the physical symptoms of the condition and drawing a comparison between SAD symptoms and allergies, intimating that symptomatic relief could be found in a pill.

Pharmaceutical drug campaigns targeting adverse life events and workplace and social performance also now offer consumers the potential for empowerment by re-gaining control over their 'disordered' or 'failing' lives. DTC campaigns signal 'failure' as a

³² DTC is direct-to-consumer advertising of pharmaceuticals is the advertisement of pharmaceutical drugs, usually via visual media and print, to the general public. It is a deeply contested terrain with regards to the impact on patient-doctor relations, biased information and advertisements and the effective communication of side effects (Grow et al., 2006).

symptom of SAD and, on the other, demonstrate the potential to increase productivity and performance in careers and success in relationships via pharmaceutical means. Despite messages of empowerment (Figure 3), DTC campaigns therefore reinforce the medicalisation of failure, emotions and bodily processes, placing the responsibility for recovery and success firmly on the individual consumer (Chapter 6).

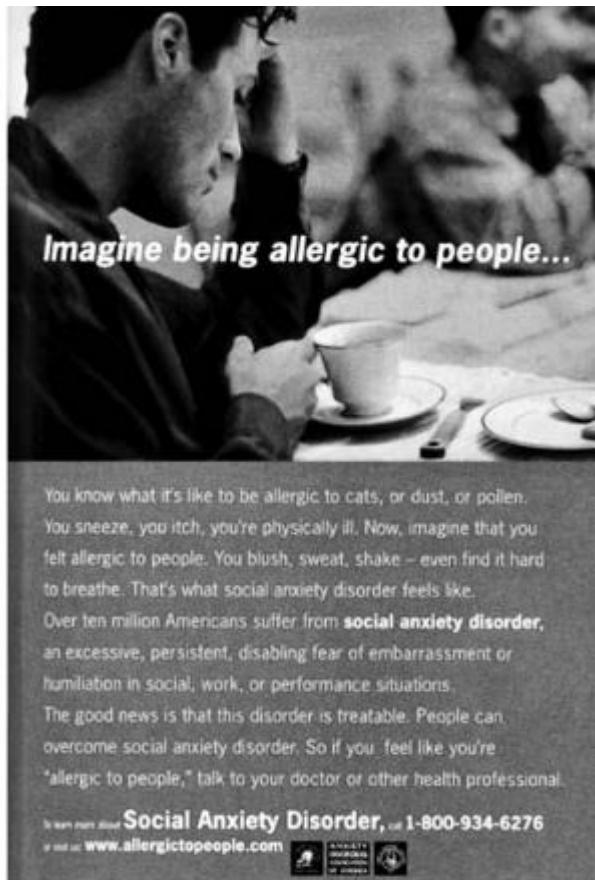


Figure 1: Paxil Advertisement: Imagine Being Allergic to People (Lane, 2007, p. 63)

Subsequent revisions of the DSM diagnostic criteria have signalled an increasing trend in diagnostic elasticity, where the terms ‘phobia’ and ‘anxiety’ get used interchangeably and entail the incorporation of ever more situations where precaution or wariness may be advisable, e.g. meeting strangers (Hickinbottom-Brawn, 2013). Thus, the ‘medical taxonomy’ of social anxiety was put in place via the DSM and its increasing ‘observability’ was ensured through DTC advertising and marketing campaigns. Both Hickinbottom-Brawn (2013) and Scott (2004) note that people with social anxiety have, in the process, become subject to particular constructions of ‘deviance’ where displays of shyness, embarrassment and anxiety in social interactions and settings pose a threat to the rules of interaction (Goffman, 1956).

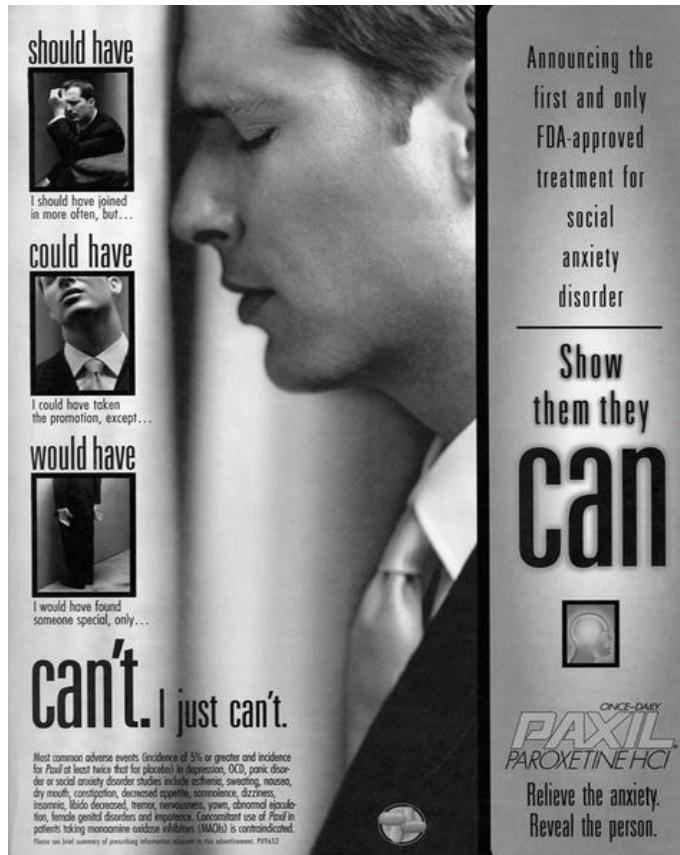


Figure 2: Paxil Advertisement: Should Have, Could Have, Would Have (Lane, 2007, p.65)

The medicalisation of ‘social deviance’ is here enabled by the expansion of medical power and knowledge into everyday life (Conrad, 1992). Consequently, social anxiety has fallen victim to darker narratives, particularly in media and film (Hickinbottom-Brown, 2013, p. 734). The ‘social misfit narrative’ whereby a person’s ‘awkwardness creates awkward situations for us [coupled with] their inability to follow convention makes them unpredictable, further compounding [social] tension[s]’.

As a result, an individual is likely to withdraw further from social and spatial life, but these narratives can take on a much more troubling nature, as in the ‘dangerous loner’ narrative, which constructs a deviant and even psychopathic individual ‘stewing over social disappointments and humiliations’ (Hickinbottom-Brown, 2013, p. 743). Scott (2004, p. 134) contends that the medicalisation of shyness as a sub-clinical condition operates as ‘an extension of this pervasive social attitude of disapproval towards those who fail to conform

to certain values of contemporary Western culture.³³

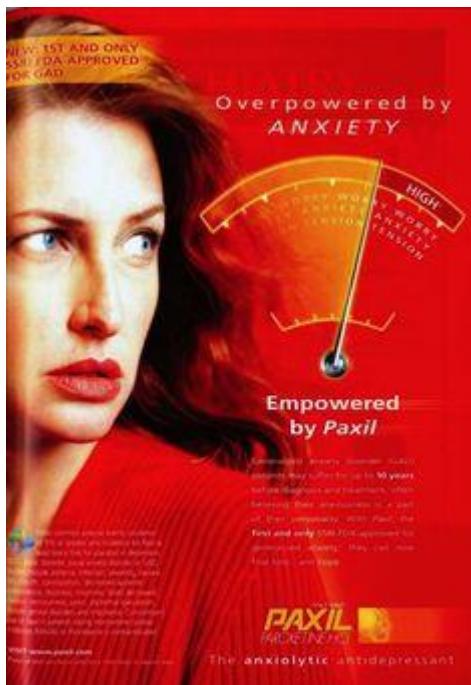


Figure 3: Paxil Advertisement: Empowered by Paxil (Lane, 2007, p. 67)

TERMINOLOGY

Throughout this thesis, I use the term ‘social anxiety’ rather than ‘Social Anxiety Disorder’ when referring explicitly to lived and experiential accounts. My reasons for doing so follow from the critical perspective sketched in outline above. First, ‘Social Anxiety disorder’ is used to designate the formal clinical category of disorder as outlined by the DSM, whereas the use of ‘social anxiety’ (with no reference to disorder) seeks to distance lived experience from dominant biomedical and/or clinical constructions of social anxiety disorder. In terms of advancing a social and spatial understanding of social anxiety, one that views social anxiety as more than an innate problem within the individual and seeks to account for the wider social and cultural conditions that enable social anxiety to thrive, it is important to step back from diagnostic categories that define social anxiety through a cluster of clinical symptoms outlined by the DSM void of personal, social and/or cultural considerations.

³³ The increase in diagnosis mimics a cultural specificity of mental illnesses that has been witnessed throughout history, e.g. hysteria as the ‘female malady’ (Showalter, 1987) the emergence of mania and depression (‘bipolar disorder’) in the 20th and 21st century and its affinity with American culture (Martin, 2009), the ‘diagnostic legacy’ of Post-Traumatic Stress Disorder (PTSD) (Summerfield, 2001) and in psychological formulations of psychosis (Johnstone, 2000).

Second, Stravynski (2007, 2014) employs the term ‘social phobia’ in his interpersonal model (considered in Chapter 2) as an explicit rejection of the DSM-5’s construction of social anxiety as a disease entity. In many ways ‘social phobia’ is a more encompassing term that extends beyond the narrow focus on the state of anxiousness. That said, ‘social anxiety’ is the terminology used most often by participants and online support groups in this study: it is the term or concept that they research online and maybe elsewhere, about which they communicate with others and through which they understand their fears and anxieties about social situations³⁴. Social phobia will hence only be used to refer to early clinical definitions of disorder and where participants have explicitly employed the term.

Third, ‘social anxiety’ reflects the dynamics of lived experience, acknowledging that not everyone (including not all of the participants in my own project) has sought or received an ‘official’ diagnosis of ‘social anxiety disorder’ from a healthcare professional. Participants - whether or not they have received the diagnostic label – tend to drop the ‘disorder’ label when considering or relating to their own lived experience.

RESEARCH OBJECTIVES

I proceed with four broad research objectives in both my theoretical and my empirical work in order to examine the everyday and longer-term social and anticipatory geographies of people living with social anxiety:

- To explore how social anxiety shapes everyday lives with particular reference to the experience of living and coping with social interactions, situations and spaces.
- To explore the emotional and affective dimensions of anxious experiences.
- To examine how health-seeking is a practice negotiated through a) formal agencies and ‘biomedical’ authorities and b) online communities and health resources.

These objectives are explored in detail in the following Chapters. I now provide an outline of the content of each chapter that follows below.

THESIS MAP

CHAPTER 2: SITUATING SOCIAL ANXIETY: Dominated by biomedical and

³⁴ With the exception of one participant who was diagnosed in the early-1980s before the terminology was revised in subsequent editions of the DSM.

cognitive-behavioural accounts, the social and spatial landscape of social anxiety is scarcely mapped in the academic literature outside of these fields. In Chapter 2, strengths and gaps in existing research across a diversity of disciplinary fields are examined to lay the groundwork for advancing a social model of social anxiety. This chapter also draws on engagements in critical health geographies, and I attend to existing literature from the sub-fields of mental health, chronic illness and disability geographies.

CHAPTER 3: CONCEPTUALISING SOCIAL ANXIETY: I attend to the conceptual underpinnings of the research, particularly as informed by my engagements with the subfields of psychoanalytic, anticipatory, habitual and emotional-affective geographies. This chapter builds on the health geographies literature outlined in Chapter 2 one that builds into its heart alertness to questions about space and time. The key operatives of anticipation and habit are emboldened by a wider engagement with psychoanalytic and emotional-affective literatures. However, these underpinnings operate as a flexible framework for, rather than rigid imposition upon, the empirical materials that are the heart of the empirical chapters at the centre of the thesis.

CHAPTER 4: RESEARCHING SOCIAL ANXIETY: I outline the methodological foundations of the thesis, attending to the methods of data collection and analysis employed in the research project. Given the difficulties faced by people with social anxiety in social interactions, I discuss the design and implementation of a mixed-method approach that includes online questionnaires and online and telephone interviewing, as well as addressing the analytical approach adopted for interpreting the data. I discuss how carefully considered online approaches can be implemented to enrich geographical inquiry. I take account of the wider politics and goals of the research through an engagement with feminist and psychoanalytic approaches to reflexive practice. I provide an assessment of the research process, practice and my own positionality. This discussion is situated within the wider development of qualitative approaches in human and specifically health geography.

CHAPTER 5: INTENSITIES OF SOCIAL ANXIETY: I explore the emotional and affective ‘intensities’ of social anxiety in order to examine the various ways in which social anxiety is embodied and enacted as people orientate their social and spatial worlds. Through the intensities of participants’ experience, I consider the force and form of social anxiety and how, materially and discursively, these manifestations texture participants’ everyday lives.

CHAPTER 6: GOVERNMENTALITIES OF SOCIAL ANXIETY: I explore how dominant discourses and medical authority over mental health and illness contribute to societal and personal understandings of social anxiety, and how this governmentality feeds into the spatialities, temporalities and embodied habits through which everyday life is lived by people experiencing social anxiety. I examine the role played by various medical and ‘therapeutic’ spaces, asking about their influence on how social anxiety is understood and managed. I explore how individuals obtain and make use of their diagnosis within, alongside or outwith medical/clinical treatment pathways. I pay attention to how medical practice and spaces not only shape the experience of diagnosis, but also lay the groundwork for the course of treatment, care and ‘recovery’.

CHAPTER 7: SPATIALITIES OF ANXIOUS EXPERIENCES I: I attend to the spatial contingencies of living with social anxiety in order to map both the everyday spaces that are disrupted and the disruptive geographies of anxious experience. I pay attention to the formative spaces of home, education and work, taking into consideration the complexity of physical, material and socio-spatial factors that comprise both these everyday spaces and the practices that emerge through them, seeking to unpack their significance for a geography of social anxiety.

CHAPTER 8: SPATIALITIES OF ANXIOUS EXPERIENCES II: This chapter deepens the accounts from Chapter 7 by focusing on the relational and embodied encounters and reactions, and the micro-textures of these encounters that comprise anxious experiences, by exploring longer-term impacts on familial and interpersonal relationships and social life. Addressing participants’ social worlds uncovers the complexity in, and limitations placed on, everyday social life and the broader impact over a life-course as opportunities for encounter, both passing and sustained, become increasingly diminished.

CHAPTER 9: CONCLUSION: I offer a summary of the key findings from the previous chapters, including critical reflections on what I have accomplished and suggestions for future research. I clarify the contribution of this work to the wider academic literatures and to the ‘real world’ understandings of social anxiety. Furthermore, some reflections are offered on the implications this work may have for policy and professional practice regarding social anxiety.

CHAPTER 2

SITUATING SOCIAL ANXIETY: LITERATURE, DISCIPLINES, PERSPECTIVES

INTRODUCTION

Beginning with biomedical and psychological science perspectives, I draw attention to the various ways in which social anxiety has been constructed either as an organic abnormality or physiological malfunction, one that can maybe be cured or prevented, or as a cognitive abnormality in need of correction through psychological therapies. Following this opening, I attend to cultural and social perspectives examining both ‘cultural and anthropological’ and ‘social and counselling’ frameworks. The cultural perspectives addressed here are more or less situated in the discipline of trans-cultural psychiatry and are broadly reflective of cognitive-behavioural perspectives; and, as such, they do not offer much in the way of critique of the biological and psychological sciences, but rather offer interesting insight into culturally different and culturally bound manifestations of social anxiety across populations and cultural groups. Anthropological perspectives start to unpick the biological/psychological foundations of social anxiety, however, highlighting the material and political constraints on, and disordering of, contemporary life.

Social and counselling perspectives take seriously the realm of subjective and experiential dynamics, while starting to unpack the wider social and cultural conditions that enable social anxiety to flourish. Counselling perspectives, also embedded in wider psychological theories, offer a practice-based understanding of social anxiety focusing on experiences of therapy and recovery. Finally, moving into the psychoanalytic and interpersonal perspectives, the focus shifts to the conscious and unconscious facets of the relational self, signalling the need to take seriously the constitution of self-other and self-world relations. Throughout this chapter, I am introducing themes – some more conceptually-directed, others more empirically-facing – that are picked up on throughout later chapters in the thesis, and on occasion such links forward to later chapters are explicitly signposted. Then, various strands from social, counselling, psychoanalytic and interpersonal perspectives are further enriched with insights derived from different corners of my own disciplinary background of human geography and, in particular, critical geographies of health and

illness in order to furnish a social and spatial model of social anxiety. This model will be gradually developed here in Chapter 2 and throughout Chapter 3.

BIOLOGICAL AND PSYCHOLOGICAL SCIENCE PERSPECTIVES

BIOMEDICAL PERSPECTIVES

The aetiology of social anxiety is ‘yet to be established’ (Bandelow et al., 2004, p. 397; Coupland, 2001) and biological correlates ‘remain elusive’ (Dewar and Stravynski, 2001, p. 244)³⁵. Despite these admissions, the widely received view is that mental ‘illness’ is based on the principle that cognitive and physiological ‘deviances’, like those experienced in social anxiety, are the product of ‘biologically-based brain diseases’ (Deacon, 2013, p. 846). Through a biomedical lens, social anxiety is hence construed as a ‘chronic neurodevelopmental illness’ (Mathew et al., 2001). People living with social anxiety experience a vast range of bodily symptoms in anticipation of, while participating in, or reflecting upon troubling social interactions and situations (e.g. blushing, sweating, shaking, palpitations and nausea). Such physiological responses to innocuous social situations are viewed – arguably too easily – as symptomatic of structural abnormalities in the brain (Talati et al., 2013) or maladaptive functioning in physiology. Therefore, mental ‘disorders’ such as ‘social anxiety disorder’ are indeed cast as brain diseases in that they are a product of the various excesses, deficits, losses, lacks, transmissions, patterns of wiring and misfiring of the brain’s processing structures (e.g. hyper reactivity in the amygdala³⁶) that can increase the risk of psychopathology (Martin et al., 2009). To summarise crudely: ‘[p]eople who suffer from mental illness suffer from a *sick or broken brain*’ (Andreasen, 1985, p. 8, *emphasis in original*) rather than the bodily states simply being secondary manifestations of an underlying psychosocial condition,

The biomedical interpretation of social anxiety as a disease entity is largely centred on three related principles. First, the structural and functional pathology of social anxiety lies

³⁵ There is an extensive body of work identifying various biological, psychological and environmental risk factors associated with the aetiology and maintenance of social anxiety (for a review see: Wong and Rapee, 2016), but no widely accepted aetiology exists of social anxiety as a ‘disease’.

³⁶ Stravynski (2014) notes that the activation of specific regions of the brain is present in all ‘fear responses’, as well as being present in other anxiety disorders to varying degrees. Other ‘brain areas’ that control fear responses are brain stem (controls heart rate, breathing), limbic systems – generally considered the ‘emotional seat’ of the brain – (i.e. amygdala, hypothalamus, etc. effects mood and anxiety), prefrontal cortex (helps assess risk and danger) and motor cortex (muscle response and control). None of these areas can be identified as the *cause* of social anxiety, only that they activate during fear responses.

in neurobiological abnormalities and ‘faulty’ neurotransmitters, which lead to chemical/hormonal imbalances in the brain (Fink et al., 2009)³⁷. Events in particular areas of the brain are ‘associated with quantitative changes in particular neurobiological or biochemical substances’ (Stravynski, 2014, p. 112). Second, that these ‘abnormalities’ are aligned with genetic and hereditary risk factors (Gelernter and Stein, 2008). While social anxiety is ‘highly hereditary’ (Torvik et al., 2016, p. 114), there is no specific, identifiable ‘genetic architecture’, or marker, of social anxiety (Stein and Gelernter, 2014, p. 61). Therefore, any emphasis on the genetic *aetiology* of social anxiety seems short-sighted. In their paper regarding the genetic and environmental risk of social anxiety (and avoidant personality disorder), Torvik *et al.* (2016, p. 114) state that ‘environment is most important in determining whether the disorders manifest’, such as changes in career, family situation and social environment. The biological and genetic basis (‘cause’) of social anxiety is hence ‘unfounded’ (Stravynski, 2014, p. 154). Lastly, from the biomedical perspective, social anxiety is a disease to be diagnosed, treated and cured using pharmaceutical (i.e. psychotropic) and therapeutic interventions (primarily, Cognitive Behavioural Therapy [CBT]) or both. However, treatment-seeking itself is not precluded from the evident fear of interaction, avoidance and distress (Chapter 6).

Psychotropic interventions dominate the mental health landscape (Deacon, 2013) and aim to reduce the physical symptoms and functional limitations (Muzina and El-Sayegh, 2001) experienced in social anxiety. Popular anxiolytic³⁸ prescriptions for social anxiety are selective serotonin re-uptake inhibitors (SSRIs), monoamine oxidase inhibitors (MAOIs) and benzodiazepines. Beta-blockers are generally prescribed for performance-related social anxieties to lessen the physiological symptoms and sensations before an event (e.g. before a presentation) (Muzina and El-Sayegh, 2001). Psychotherapeutic interventions like CBT aim to induce cognitive reframing by drawing awareness to negative thought cycles, self-talk and mental images that fuel and intensity patterns of anxiety while learning to cultivate new patterns of thought and belief systems³⁹.

Given the weight and influence of the ‘disease model’ in the construction of social anxiety and the thrust of pharmaceutical psychotropic interventions in the targeting of presumed

³⁷ The primary neurotransmitters associated with social anxiety are norepinephrine, serotonin, dopamine and gamma-aminobutyric acid (GABA).

³⁸ Anxiolytics are ‘anti-anxiety’ medications.

³⁹ This is similar to Mindfulness Based Stress Reduction (MBSR) techniques. CBT tends to be conducted in a therapeutic environment either via one-on-one with a therapist or in a structured and facilitated group therapy setting. MBSR are *self-help* techniques.

organic ‘abnormalities’, the distinct *lack* of such a model – in the sense that a model is specific, observable and measurable – is alarming. Of this, Stravynski (2014, p. 141) says:

The bulk of research surveyed is consistent with the fact that on any measure, socially phobic individuals are far more like their ‘normal’ counterparts than different from them. Startlingly, this state of affairs neither has thrown into doubt the view of social phobia as a neurological disease of sorts, nor diminished its influence. Rather, it seems acceptable, in this field of inquiry, to be following the inferential logic that if hypotheses have not been conclusively refuted, there is no pressing need to question them.

He then adds:

[T]he inference of malfunctioning neurobiological processes, allegedly implicated in social phobia from pharmacological treatments, is unwarranted. The unspoken presumption that the pharmacological agent directly affects a putative biological substrate of social phobia is speculative at best [...]. On current evidence, it is probable that the impact of pharmacological treatments is wide and diffuse rather than narrow and specific. All result in functional improvement, by dampening the activity of the systems involved in emotional regulation and therefore without actually influencing any putative underlying neurobiological defect. This is quite likely to be the case in social phobia since pharmacological agents with very different pharmacological profiles have been shown to be equipotent in reducing anxious distress. (Stravynski, 2014, p. 141)

On this accounting, the aetiology of social anxiety is still unspecified, yet, drawing on a general biomedical outlook of mental illness, it remains categorised as a distinct disease entity. Stravynski (2014, p. 129) concludes that research is ‘inconclusive at best’ and that ‘no major structural or functional brain abnormalities are inherent in social phobia’.

COGNITIVE-BEHAVIOURAL PERSPECTIVES⁴⁰

Three of the most widely cited and applied models of social anxiety are based on cognitive and cognitive-behavioural frameworks of social anxiety (Clark, 2001; Clark and Wells, 1995; Rapee and Heimberg, 1997). Figure 4 shows Clark and Wells (1995) cognitive model of social anxiety. The cornerstone of the cognitive-behavioural framework asserts that *abnormal* cognitive processes are the primary cause of psychopathology, an approach that has played a significant role in how social anxiety is now conceived and understood. There are subtle theoretical and methodological differences between cognitive-behavioural

⁴⁰ ‘Cognitive’ and ‘behavioural’ approaches represent two separate approaches, the former emerging largely in response to the latter. Behaviourism reduces human (and animal) experience to a series of ‘stimuli-response’ mechanisms, largely omitting thoughts, feelings and emotions. ‘Cognitive behavioural’ (as in CBT) is usually reserved for therapeutic practice and there are distinct differences in methodological approach. Clark and Wells’ (1995) model is, first and foremost, a cognitive model, although the ‘behavioural’ dynamics are a key factor.

science and therapeutic practice. Cognitive-behavioural perspectives suppose that a distortion and bias in the processing of social and evaluative information results in certain types of behavioural responses or ‘safety behaviours’ that, while practised to avoid anxiety, actually serve in maintaining anxiety. Cognitive-Behavioural Therapy (CBT) is the most prescribed therapeutic treatment for social anxiety and aims to direct a change in behaviour through ‘self-monitoring’ and gradual exposure to feared situations, which, in turn, aims to direct cognitive change in assumed psychological vulnerabilities (Beidel and Turner, 1986; cf. Rapee and Heimberg, 1997).

Here, I address the role of cognitive science in shaping a particular understanding of social anxiety. According to this framework, the interaction of several ‘cognitive and behavioural’ processes generates and maintains social anxiety⁴¹. An individual will experience distress in anticipation of, or participating in, everyday social situations; for fear that they will be negatively perceived and evaluated by others (Stopa and Clark, 1993). Social situations activate a series of negative beliefs about the self as a social object, causing them to perceive social interactions as threatening. Patterns of ‘dysfunctional’ thought and overarching belief systems, viewed as a direct result of distortions in an individual’s cognitive processes, result in psychological and emotional distress, evoking a ‘behavioural’ response in the individual (Figure 4). The behavioural consequences of distress serve to reinforce negative beliefs and, in turn, maintain social anxiety. Individuals will then engage in ‘post-event’ processing and make predictions about future performance (Clark and Wells, 1995; Rapee and Heimberg, 1997). For the most part, the two key models offered by Clark and Wells (1995) and Rapee and Heimberg (1997) respectively share many commonalities, but there is one subtle distinction about the focus of the individual’s attention (Wong et al., 2014). In the Clark and Wells (1995) model, negative attention is focused towards the self and projected outwards:

Instead of observing other people more closely in order to gain clues about what they think about him or her, the social phobic appears to turn attention inwards, notice how he or she feels, and then automatically assume that this information is relevant to others’ evaluation. (Clark and Wells, 1995, p. 71)

⁴¹While the proponents of the cognitive model assert that the model ‘does not postulate a sequential, unidirectional relationship in which cognition precedes emotion’ (Clark and Steer, 1996, p.76 cited in Stravynski, 2014, p. 144), Stravynski notes that this is ‘precisely [the] sort of causal relationship’ that the model presumes, drawing on Stopa and Clark’s cognitive model of social anxiety to address his point: ‘social phobics become anxious when anticipating or participating in social situations *because* they hold beliefs (dysfunctional assumptions) which lead them to [become anxious]’ (Stopa & Clark, 1993, p.255; cited in Stravynski, 2014, p.145).

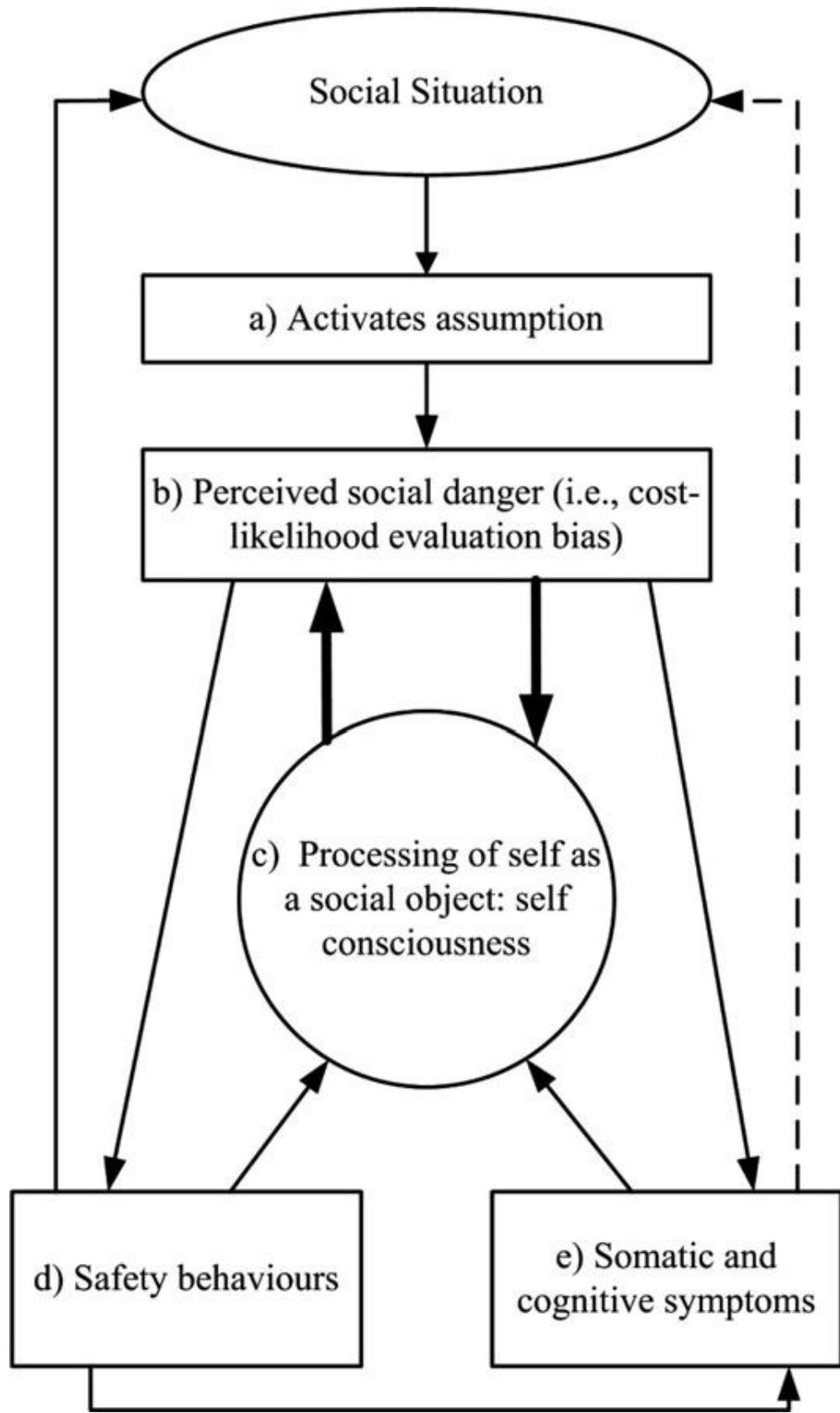


Figure 4: The Cognitive Model of Social Anxiety Disorder (Clark and Wells, 1995)

Rapee and Heimberg (1997, p. 746) conversely, suggest that information is taken from the external environment:

[S]ocial threat takes the form of potential negative evaluation from others. Thus, individuals with social phobia will scan the environment for any signs of impending negative evaluation, will detect such signs rapidly, and will have difficulty disengaging attention from them.

Despite the authority held by cognitive approaches, the underlying nuances have proven problematic. The premise that dysfunctional thinking can cause psychological abnormalities that lead to mental illness is conceptually ‘inadequate’ (Power and Champion, 1986) and fails to account for the human *being* as a(n) emotional, bodily, dynamical, social and/or worldly ‘system’. Stravynski (2014, p.144) argues instead that the cognitive ‘outlook is in sharp contrast to considering the person as a whole being – involved in dynamic relationships with a human and physical environment’. Westcott (1987) argues that the structural maps of cognitive approaches tell us ‘almost nothing’ about the processes that *underlie* ‘cognition’ or ‘behaviour’ in general.

In similar critiques questioning the cognitive formulation of social anxiety, Stravynski (2014) argues that cognitive models and research operate under one significant and ‘crippling handicap’: the key term, *cognitive*, is ill defined, referring, on the one hand, to a ‘hypothetical information processing system’, and, on the other, to the ‘products of such a process’. Westcott (1987) argues that cognitive approaches tell us ‘almost nothing’ about processes that underlie ‘cognition’ or ‘behaviour’ as they only isolate a ‘fragment’ of the whole human condition. Both authors therefore reject the cognitive model’s reliance on the conception of the human mind as an ‘information-processing system’ (Stravynski, 2014; Westcott, 1987).

Cognitive models assert that cognitive ‘abnormalities’, because of errors or bias in an individual’s thinking and information-processing patterns, give rise to social anxiety. In a thorough review of cognitive literature on social anxiety, Stravynski (2014, p.144) argues that there are indeed significant problems with the cognitive model, concluding that the cognitive causation of social anxiety is ‘unfounded’. He is sceptical of the claims from cognitive experiments that claim people with social anxiety have different cognitive processes to ‘normal’ individuals⁴²:

[I]n some experiments socially phobic subjects showed responses that differed – to some degree – from those of other subjects. The source of this difference remains obscure. There is no evidence, however, to support the claim that it

⁴² Stravynski compares Amin et al. (1998) Hackmann et al. (1998) cognitive model of social anxiety, arguing that the same ‘cognitive processes’ were found in both anxious and non-anxious subjects.

reflects an inherently socially phobic ‘cognitive bias’. Crucially, in absolute terms, no ‘cognitive’ activity – objectively measured – inherently and exclusively typifies social phobia [...]. What they highlight of alleged cognitive processes remain uncertain at best. In most studies under review, socially phobic subjects’ responses to experimental tasks were indeed somewhat different from those of contrast subjects. However, since all subjects in those studies seem to be exhibiting the hypothetical cognitive quality to some extent, these results cannot be regarded as compelling proof of specific socially phobic cognitive processes. (Stravynski, (2014, pp.151-152)

He is equally resistant to the idea that cognitions *maintain* social anxiety:

Notwithstanding these insistent claims, no cognitive processes (or their configurations) uniquely characterising socially phobic individuals have been identified. For this reason, socially phobic individuals cannot be characterised or identified in terms of these processes. (Stravynski, 2014, p.152)

Cognitive models assert that cognitive ‘abnormalities’, as a result of errors or bias in an individual’s thinking and information-processing patterns, give rise to social anxiety, but, to summarise, there is no conclusive evidence for the existence of such ‘abnormalities’, certainly not in the strict behavioural, stimulus-response logics of the cognitive-behavioural model and related theories.

CULTURAL AND SOCIAL PERSPECTIVES

CULTURAL AND ANTHROPOLOGICAL PERSPECTIVES

Cultural considerations of social anxiety have received increasing attention in recent years as psychologists recognise the ‘intricate interplay between culture and psychopathology’ (Heinrichs et al., 2006, p. 1187). Recent cross-national epidemiology studies (Stein *et al.*, 2017) have found that instances of social anxiety are lowest in lower to middle-income countries in Africa and East Mediterranean and highest in high-income areas in the Americas and Pacific regions. Cultural perspectives portray the various ways in which social anxiety is ‘culturally moulded [...] [by] social roles embedded in social structures [that are] organised into a way of life’ (Stravynski, 2014, p.104). Cultural approaches have centred around three distinct areas of study: cross-cultural notions of individualism/collectivism (Hofmann *et al.*, 2010); cross-cultural studies related to difference, adjustment and treatment seeking in immigrant and student populations (Hasenson-Atzmon *et al.*, 2016); and culturally-bound manifestations of social anxiety (Greenberg *et al.*, 2004; Kleinknecht *et al.*, 1997).

CROSS-CULTURAL STUDIES

Cross-cultural studies examine the relationship between social anxiety and cultural conditions. Studies have focused on the influence of culture on the experience and expression of social anxiety, primarily between individualistic and collectivist countries (Stein and Matsunaga, 2001). Of significance in this area is the role played by ‘self-construal’, meaning how a person defines themselves in relation to specific others and in groups, as well as in relation to actual and perceived cultural differences (Cross, 2011). This self-view determines that people define themselves independently of others, relationally with others, and/or interdependently with others. The degree to which an individual subscribes to a particular ‘model’ of self-other relations is largely shaped by culture and cultural attitudes. The impact of cultural differences is most evident in the divergent self-views held by collectivistic and individualistic countries: for example, people in North America (individualistic) would be more likely to prioritise a self-view that is independent of others and characterised by separateness, individuality and autonomy; compared with Japan (collectivist), where people are more likely to recognise one’s self as part of a larger social ‘unit’ (Markus and Kitayama, 1991).⁴³

CULTURAL DIFFERENCE STUDIES

Others have conducted cross-cultural studies examining the relations between social anxiety and cultural differences, perceived cultural norms (Heinrichs et al., 2006) and cultural attitudes and adjustments between immigrant populations versus native populations (Hasenson-Atzmon et al., 2016) and student populations (Hsu and Alden, 2008). Comparative studies between Saudi Arabia and Scotland (Al-Khodair and Freeman, 1997) compare cultural factors affecting experience and treatment-seeking in people with social anxiety. The authors note that certain differences may be shaped by societal and cultural differences, including age at treatment-seeking, duration of illness and comorbidity of other mental illnesses, including agoraphobia, alcoholism and depression. The Scottish sample had significantly higher instances of anticipatory fears (i.e. fears about *entering* future social situations compared with being *in* a social situation) than the Saudi samples, while age of treatment-seeking was more prominently influenced by external factors such as social isolation and alcohol intake/dependence. The structure of Saudi society (‘collectivist’) and the significant role of familial support in the Saudi sample cause

⁴³ The relational model takes account of the role of close, personal and dyadic relations in the construction of self. The prioritising of individual-individual relationships would allegedly be more typical in Western cultures (Cross, 2011).

people to present for treatment at an earlier age, although the authors note that this early presentation is to ensure later conformity with strictly enforced communication rules in Saudi society (Al-Khodair and Freeman, 1997, p. 132).⁴⁴

CULTURE-BOUND STUDIES

Studies on culture-bound manifestations of social anxiety have focused on *taijin kyōfushō* in Japanese cultures and *aymat zibur* in ultra-orthodox Jewish communities. *Taijin kyōfushō* (*TKS*) (literally: a fear of interpersonal relations [Tarumi *et al.*, 2004]) has been documented since the 1930s and is a seemingly distinct form of social anxiety endemic to Japan. An individual experiencing *TKS* is primarily concerned that their appearance, in terms of body and/or behaviour, including blushing, eye contact and body odour, will offend or embarrass other people (Kleinknecht *et al.*, 1997). *TKS* has been linked to the use of shame as an ‘external social sanction’ in Japanese history and culture. Cole (2013, p.65) explores the relationship between shame and *TKS*, arguing that ‘shame serves to regulate an individual’s behaviour in the context of the greater collective.’ *Taijin kyōfushō* has also been referred to as ‘an obsession of *shame* and anxiety’ (Maeda and Nathan, 1999, p. 526), as the individual will avoid or withdraw from social situations for fear of offending other people and bringing shame on themselves and their family.⁴⁵

Jewish-specific manifestations of social anxiety, known as *aymat zibur* (literally: fear of the congregation), are closely tied to social relations in Jewish law. Greenberg *et al.* (2004) explore manifestations of social anxiety in young men in ultra-orthodox Jewish communities. Their findings relate social difficulties to performance-related religious situations (e.g. performing a sermon), culturally significant feelings of shame, and an individual’s status and authority within the Jewish community. These aspects are inter-related in many ways: for example, opportunities for public speaking through teaching and prayer are important within the Jewish community and therefore associated with high social standing and recognition. Greenberg *et al.* also note, that social and religious status

⁴⁴ There are significant problems with cross-cultural studies that have been addressed in the discipline of (transcultural) psychiatry and anthropology. Bains (2005, p. 145) (drawing on Kleinmann, 1977) argues that ‘Western psychiatry dispenses with local illness categories, designating them the status of cultural phenomena, but then imposes Western categories as if they were not also culturally derived. [Kleinmann] encouraged psychiatry to ‘learn from anthropology that culture does considerably more than shape illness as an experience; it shapes the very way we conceive illness’ and that ‘a true comparative cross-cultural science of illness must begin with this powerful anthropological insight’.

⁴⁵ Despite Japan’s high suicide rate, suicide and suicide attempts amongst those with *taijin kyōfushō* and *hikikomori* (an associated disorder characterised by isolation, literally “*to retreat inwards*”) are low (Sarchione *et al.*, 2015).

within the community will govern the particular ‘psychopathology’ of a person, dictating whether the extent that their social anxieties interfere with religious duties is sufficient to be deemed problematic⁴⁶.

SOCIOLOGY AND COUNSELLING PERSPECTIVES

Sociological and counselling perspectives are closely related as they both take account of the wider social and cultural conditions that enable social anxiety to flourish. The relatively limited cohort of qualitative accounts of social anxiety that can be identified, ones not inflected anthropologically, is based within these fields. The field of counselling psychology draws upon and speaks to both cognitive behavioural and interpersonal (see also below) approaches to understanding and treating social anxiety, while also highlighting particular social and spatial concerns regarding recovery.

McCarthy’s (2014) doctoral dissertation explores social anxiety recovery journeys through narrative methods (c.f. Anderson et al., 2008). Having both lived experience of social anxiety and experience of treating people in therapeutic environments, McCarthy (2014, p.24) argues that the medicalisation of the human condition is ‘frustrating’ and so, ‘in practice, we are trying to strike a balance between the biomedical, positivist paradigm in which psychology largely operates and the humanistic tradition in counselling psychology which values the narratives people bring to therapy’. McCarthy employs a recovery-oriented narrative approach in order to understand how people make sense of their experiences and what factors promote and/or hinder recovery, uncovering in particular how personal and collective strategies are prioritised, particularly against the medical vision of recovery in which the goal is seemingly to return to a ‘pre-illness’ state. In terms of collective strategies, recovery group membership and narratives are shown to legitimate individual experience, shape understandings of recovery and recovery journeys. What is most problematic for McCarthy’s participants is the dominant recovery model and, indeed, the term ‘recovery’ itself, which are predominantly centred around the medical model’s focus on alleviating symptoms (primarily through pharmaceutical interventions) at the expense of taking seriously the personal, social and situational attributes that sustain

⁴⁶ They compare the Jewish case with a study on Muslim women’s experiences of fear/agoraphobia, quoting El-Islam’s (1994) explanation of why so few Qatari Muslim women present at the clinic with agoraphobia: ‘Being bound to the home, which is a sign of severe agoraphobia in the West, is a sign of virtue in a Muslim housewife; the Koraan addresses women in the verse ‘stay in your homes and do not misbehave like the early pagans’ (El-Islam, 1994, p.139; cited in Greenberg et al. 2004).

anxieties⁴⁷.

Nielsen and Cairns (2009), meanwhile, employ an open-ended qualitative questionnaire to explore social anxiety and close relationships. Questionnaire responses were analysed using a hermeneutic phenomenology approach to reveal what it means to be in a close relationship for people with social anxiety. Participants shared a range of social and interpersonal difficulties, including struggling to develop close relationships, feeling like a burden and lapsing into over-dependence in relationships, and self-criticism of interpersonal skills. There were also positive relational dynamics emerging from the data, including close relationships with a high degree of intimacy and trust, and feelings of security and safety when in close proximity to participants' friendship circles.

Clinical studies show that women are consistently more likely to experience social anxiety and carry a greater burden of illness than men (McLean et al., 2011). Social anxieties in women are also likely to lead to an increase in substance (ab)use. As the onset of social anxiety is frequently associated with, and observed in, late-childhood and early-adolescence, feminist perspectives argue that social anxiety 'may stem from adolescent girls' attempts to define their social identities and navigate a new social system of peers, friends and parental relations' (Briggs and Pepperell, 2009, p. 65). Pipher (2005) notes that broader forms of culture have a significant impact on young adolescents, particularly young women, and on their views of self and identity wherein social evaluations are often based on appearance and defined by specific socio-cultural roles. In terms of social roles, Bunker (2012, p. 28) highlights that women moving into public spaces in Mexico and demanding control and use of space by protesting smoking in public places has led to 'a growing social anxiety [in men] over the female's lack of enclosure and perceived threats to patriarchal privileges' – albeit this is a more *societal* social anxiety than an immediate mental health concern, is still highlighting the anxieties produced through social and spatial uncertainty.

Further factors considered in sociological perspectives are social position, rank and hierarchies, and, as highlighted by Pipher (2005), the role of broader consumer and enterprise culture. Stravynski's (2007, pp. 354-355) interpersonal model is instructive for elaborating a socio-spatial model of social anxiety, in that it is embedded within social,

⁴⁷ This narrative of recovery resonates with many of the participants involved in this research, but there are also a significant number of people who advocate for 'recovery' in terms of returning to a 'pre-illness' state or their 'old self' (although not necessarily via a medical model), highlighting the importance of both individual and collective approaches to recovery (Chapter 6).

cultural and spatial considerations:

Social environment in the abstract denotes a variety of ways of life characterising various communities. It provides values (e.g. what is good, beautiful, [and] true). It determines worthwhile things to do, who is admirable and who is important. It inculcates approved practices (e.g. showing respect [or] reaching an agreement). It assigns social roles and designates social units. It structures important human activities (e.g. relations between parents and children, women and men, [and] neighbours). Communities, however, are often stratified, with quite different patterns of life [...] characterising each stratum. Concrete people enacting the various practices of their community woven into the fabric of social institutions and informal structures provide the context – the danger – evoking socially anxious [...] reactions. This is determined by the power embedded in their social role (defined by institutions), their place in the ruling hierarchy of the fact that they possess desirable characteristics, much admired in the community. Who is powerful, and why one needs to take them into account, is culturally constituted. Their powers to grant or deny what one wishes for (e.g. a position, a loan, but also love) or mock one's impudence make them important and dangerous.

Social rank is related to an individual's self-perceived agreeableness and desirability in the social sphere and is associated with factors such as IQ, friendliness, attractiveness, being well liked and/or rewarding to be with (Gilbert, 2000). Featuring heavily in sociological understandings of human relations and interactions are the operatives of power and status and dominance and submission (Kemper, 2006). These power dynamics are present in everyday workplace cultures and education environments, as well as in psychotherapeutic treatments advocating compliance rather than collaboration (Hickinbottom-Brawn, 2013). Stravynski (2007, pp. 35–36) argues that these relational dimensions between individuals and across groups play a significant role in social anxiety viewed from the interpersonal perspective. Social anxiety correlates with submissive behaviour and feelings of inferiority in relation to social rank (Gilbert, 2000), manifesting in feelings of shame, fear of conflict, humiliation, criticism and embarrassment. Social rejection and marginalisation serve to reinforce negative self-beliefs. Social comparisons made between the anxious self and other people often find the self to be inferior in some way: for example, through a lack of confidence and an inability to recognise or utilise one's personal skills or resources, a person may engage in socially cautious or withdrawn (submissive) behaviours, including averted gaze and avoidance. These dimensions are significant for considering anxieties about social interactions, relations and spaces where power, status and dominant-submissive dynamics may all play a key role, notably, for example, in work-places and education spaces (Chapter 7 and 8). Drawing on Goffman, Scott (2004, p. 134) argues that shyness can be understood as response to the 'dramaturgical dilemmas of interaction [...] that is often perceived as deviant behaviour'.

Furthermore, specific environments are associated with increasing social anxieties: for example, the just-mentioned domains of workplace culture and education environments ‘not only make social anxiety more *observable*’ – that is, the observable and felt behaviours associated with the ‘disorder’ are recognised as unacceptable in, and un-conducive to, particular socio-cultural environments – but also serve to maintain and exacerbate it. Hickinbottom-Brown (2013, p.739) states that these environments, may be imbued with current neoliberal enterprise culture, often shape ideal conceptions of self as ‘confident, bold and striving in interactions’, but such dynamics will likely instil in the socially anxious individual a pervasive practice of self-surveillance whereby they are constantly monitoring the self ‘for signs of failing to meet this ideal’. In addition, consumer-driven culture configures, and relies upon, certain forms of subjectivity and identities, provoking high levels of anxiety and moral panic in those who fall short of these forms. Cultural and consumer spaces are saturated with shame-based advertising for products and services that aim to improve the socially unacceptable aspects of self (Hickinbottom-Brown, 2013). People with social anxiety already often feel out of place, or that they do not belong, in consumer and/or public spaces, and these crucial dynamics are discussed further in Chapter 7.

PSYCHOANALYTIC PERSPECTIVES

Lloyd (2006a, p. 162) notes that the definition of social anxiety outlined in the DSM-5 is ‘of little interest to psychoanalysts’ because it works at the level of the symptom or syndrome (a set of symptoms)⁴⁸ that tell us very little about any ‘underlying conflict or adaptation’ to the emergent pattern of social anxiety⁴⁹. Psychoanalysis is more concerned with psychic structures, of which there are three: neurosis, psychosis and perversion. In Lacanian terms, these three structures operate in every individual to varying degrees; there is no ‘normal’ structure that is set against the three ‘deviant’ ones⁵⁰.

⁴⁸ The use of medications in psychoanalysis is also considered problematic due to the ways in which psychotropic medicines may interact with a person’s subjectivity. As noted above, psychoanalysis is relatively uninterested in the specific symptoms, but, as discussed by Lakoff (2003) masking the symptom does not address the root cause. However, there are examples of Lacanian psychoanalytic practice working alongside psychotropic medications, and Lakoff (*ibid.*) explores the benefits and tensions between physician-analyst identities in a psychiatric setting in Buenos Aires.

⁴⁹ This is one of the major sticking points that psychoanalysis has with behavioural therapies which aim to treat the symptoms of ‘disorder’. Psychoanalysis contends that, while you can unlearn current patterns of behaviour, the symptom will continue to relocate unless you address the underlying psychic structures. I unpack these dynamics further in Chapter 3.

⁵⁰ Freud’s thinking is slightly different in that he proposed that there was a more or less ‘normal’ position from which neurosis, psychosis and perversion would deviate.

Lloyd (2006, p.174) conducts an in-depth exploration into the emergence and categorisation of social anxiety/social phobia in France, isolating a common theme emerging in the interviews with both patients and psychoanalytically-oriented clinicians: namely, that attention and treatment must centre on a person's social relations and wider environment, rather than being reduced to the symptoms of the 'disorder'. Psychoanalytic models point to a broader set of relational problems rather than the 'circumscribed problems in either one or more situations' as outlined by diagnostic criteria. Echoing Lloyd (2006), McEvoy et al. (2016) approach the DSM definition with caution, stating that the diagnostic label and associated criteria 'suggests the presence of something in particular and set apart, which in actuality may relate to a simple variant or set of points within a normal process of relating to others'. Both Lloyd and McEvoy *et al.*'s comments communicate a concern for the clinical framework in that it does not acknowledge how, for example, an acute fear of scrutiny is embedded 'in a socially complex and demanding society' (McEvoy et al. 2016, p.544).

There is, however, no singular or accepted psychoanalytic 'model' of social anxiety. Despite the centrality of the concept of anxiety in psychoanalytic writings, psychoanalytically-informed research specifically on the topic of social anxiety is virtually non-existent with the exception of two studies: one practice-focused paper outlining a psychodynamic model of therapeutic treatment with 'a specific focus on shame and on unrealistic demands' (Leichsenring et al., 2007); and another qualitative study by McEvoy, et al. (2016), who employ Winnicottian object relations theory to examine the underlying interpersonal 'dynamics in the origin and maintenance of social anxiety'. The latter highlight the unconscious role of 'seeing and being seen' as a great source of distress, embarrassment and shame. The internalisation of the gaze plays a central function in identify formation and, in particular, for the infant establishing a relation between their inner world ('*Innenwelt*') and the outer world ('*Umwelt*') (Lacan, 1977). The link established between subjectivity and gaze is therefore crucial in that 'we are beings who are looked at; the gaze circumscribes us, and which in the first instance makes us beings who are looked at' (Lacan, 1977, p.72). In the context of social anxiety, visibility (increased by embodied and visible anxious symptoms such as blushing, sweating, shaking), alongside making and maintaining eye contact, being seen and seeing the reactions of others, is overwhelming in that through this 'unbearable gaze [...] an inner space has opened up' (Steiner, 2015, p. 1590). It also re-directs attention towards the failing and incompetent social self. Consequently, a person may withdraw or 'avert their own gaze, turning it to the floor and inwardly, so that they no longer need to observe their

objects. They can avoid both *seeing* and *being seen*' (Steiner, 2015, p.1590). These dynamics can be related to interpersonal dynamics of power and status, but they arguably begin to sit closer to what people with social anxiety palpably experience, feel and understand on a daily basis.

Debilitating self-consciousness and self-criticism may, according to some psychoanalytic formulations, be embedded in a narcissistic and saturated sense of self. Narcissism, not to be confused with a grandiose, egotistical or selfish self, relates here to vulnerability in self-esteem, self-representation and possibly a distorted sense of self as inadequate in dealing with a complex, demanding and engulfing social world. This conceptualisation of narcissism is more akin to the 'vulnerable narcissism' discussed by psychoanalysts Bernardi and Eidlin (2018). From a clinical perspective, they note that vulnerable clients, for whom 'closeness to others' is particularly problematic, find it difficult to face or revisit past events and traumatic experiences. Consequently, they 'seek to withdraw from social situations when their own unfavourable evaluations of themselves with respect to others provoke intense feelings of shame, pain' and self-directed aggression. Drawing on Britton (2004) these authors argue that this vulnerability lends itself to a 'hyper subjective' subject. Therefore, in the clinical setting, the intersubjective 'third position' of the analyst's evaluation and interpretation is unbearable.⁵¹

McEvoy et al. (2016) describe a common experience of 'hiding behind a mask' as individuals attempt to negotiate how to *be* in social situations (and, interestingly, in the research interview environment). Similar protective strategies are explored in relation to social anxiety in Boyle (2018) and agoraphobia in Davidson (2003) in terms of shielding the self from others and 'putting on a face', and feature later in this thesis (especially Chapters 6, 7 and 8). In order to advance a psychoanalytically-attuned social geography of social anxiety, the bald outlines of which may already be apparent from the last few paragraphs, in Chapter 3, I map out the contours of a predominantly Lacanian (but also Freudian) psychoanalysis that have most profoundly influenced this research.

INTERPERSONAL PERSPECTIVES

An interpersonal approach to social anxiety (Alden and Taylor, 2004; Stravynski, 2007,

⁵¹ This analysis is very much situated within the Object Relations Theory school of thought, which prioritises childhood development and, in particular, 'the triangular relationship between mother, father and child' (McEvoy et al. 2016, p.562).

2014) implicates, in its conceptual framework, the inherently social nature of human beings embedded in social interactions and relationships, anchored in a variety of social and cultural systems (e.g. social roles, rules and hierarchies) and situated in the wider social-spatial environment. Crucially, these dynamics (i.e. interactions, systems, environments) do not operate as a backdrop to everyday life, but instead actively produce, and are produced by, the individual. Situated in an interpersonal framework, social anxiety can be identified as ‘an extended pattern of self-protection, enacted purposefully, against the threats embodied by other individuals in the social environment’ (Stravynski 2014, pp. xii-xiii). Crucially, in seeking to shift the narrative of social anxiety from one that is concerned with dysfunctions and abnormalities in organic and cognitive systems, Stravynski asserts that social anxiety is something that is ‘enacted, not something one has’. He argues that a state of ‘anxiousness’ cannot be discerned as a sealed in, *a priori*⁵² ‘inner’ state, but rather as ‘a dynamic process, reflecting the variations in the manoeuvring of the individual in the face of ceaselessly evolving threatening circumstances’ (Stravynski, 2014, p.25). This conceptualisation of social anxiety as a ‘social practice’ (Jackson and Everts, 2010) aims to take account of the whole person as situated within a wider network of social and spatial relations. Attention must hence be paid to the context in which socially anxious ‘patterns’ unfold, for attempting to account for such patterns void of social, spatial or even circumstantial events is to render them indiscernible and unintelligible:

Fearsome circumstances and fearful activity are intertwined and form a dynamic system; socially phobic conduct arises in response to (or is evoked by the prospect of) definite activities set in social or interpersonal contexts. Both fearful activities and the fearsome settings in which they occur become meaningful only as embedded in a culture or way of life; otherwise they remain a denatured abstraction. (Stravynski, 2014, p.90)

The interpersonal approach proposes that an individual’s social and interpersonal relationships provide important contexts for the ways in which social anxiety manifests in people’s everyday lives.

Particular versions of the interpersonal model nonetheless still draw heavily from cognitive approaches, where problematic social functioning is viewed as an integral feature of psychopathology (Sullivan, 1953), positioned as a consequence of abnormal biological and/or cognitive vulnerabilities within the individual (1999). Much of the research in an interpersonal vein has followed this trajectory, exploring frequency, quantity and quality of interpersonal relationships and the detrimental interpersonal effects of social anxiety. For

⁵² Existing before experience.

example, Beidel et al. (1999) highlight that children with social anxiety have fewer friendships and less extra-curricular involvement. Anderson et al. (2008) conduct a linguistic analysis of autobiographical narratives, meanwhile, to understand the role played by negative or painful social memories in causing and sustaining social anxiety. The study analyses grammatical, psychological (e.g. emotional, perceptual) and personal (e.g. occupational, education) content but does not make explicit reference to experiential accounts of participants. However, the accounts are linked to anticipatory processes that influence present and future-oriented thinking, emotional and management strategies. Other interpersonal difficulties reported are: fewer friendships and less peer-support in close friendships (La Greca and Lopez, 1998); fewer romantic relationships (Starr and Devila, 2015); poor quality of romantic relationships (Cuming and Rapee, 2010); and less intimacy in long-term relationships (Montesi et al., 2013). The interpersonal difficulties highlighted by the aforementioned studies are overwhelmingly regarded as the consequences of abnormal processes and, therefore, become indicative of a pathological anxious state (Stravynski, 2014), which reinforces the reductive logics of the cognitive model previously discussed.

Stravynski's (2014) model diverts from such a 'consequential' perspective, though, and views social anxiety as an on-going relational pattern that builds gradually and intensifies throughout the life course, as opposed to being predetermined by particular and abnormal mental or bodily processes. Interactional and interpersonal difficulties interact reciprocally to develop and to maintain social anxiety, usually associated with defensive strategies aimed at self-protection: for example, avoidance, withdrawal and passive participation. Stravynski (2014) addresses in detail various environmental and development factors that may contribute to (but not 'cause') the emergence of social anxiety: for example, parental and family influence, early social environment, peer environment, experiences of victimisation (e.g. bullying and ridicule) and adverse life events. Developmental aspects are often conceptualised within the broader relations of human attachment, specifically insecure attachment (Ainsworth and Bowlby, 1991), and linked with temperament and behavioural inhibitions (Rosenbaum et al., 1991). Similarly, Alden et al. (2014) address the relational processes in social anxiety and argue that childhood developmental experiences play a key role, although Stravynski and others (Shamir-Essakow et al., 2005) determine that specific effects of attachment, temperament and inhibitions could not be ascertained. Even so, that finding does not dilute the potential of a perspective alert to how iterative developmental and environmental factors *contribute* to the overarching relational patterns of social anxiety.

Social anxiety is thought to develop through processes of social learning where individuals are repeatedly mistreated in, diminished by and excluded from social and interpersonal relationships. Significant links have been found between childhood victimisation and social anxiety (McCabe et al., 2003) and childhood experiences of violence (Binelli et al., 2012). Stravynski (2014) nonetheless maintains that no one specific traumatic event or experience leads to social anxiety. In fact, a fearful, repetitive and historic pattern of rejection, exclusion, social diminishment and unabashed ridicule ‘consolidates when an individual systematically and repeatedly fails to engage various aspects of social life of his or her community in a participatory and assertive manner and instead responds both fearfully and defensively (Stravynski, 2014 p. 286).

In conclusion, Stravynski (2014, p.196) asserts that ‘[t]he fully formed socially phobic pattern is forged by adult demands made on the individual, by the way of life of his or her community. These crystallise in late adolescence or early adulthood; so does the onset of social phobia’. The relational tactics employed, whether avoidance, withdrawal, patterns of submissiveness, hyper-vigilance or through prescribed medication or self-medicating with drugs and alcohol, are done so defensively as a mode of self-protection against being ignored, maligned or negatively evaluated. Social anxiety is thus ‘highly idiosyncratic’ and ‘historically contingent’ (Stravynski, 2014), always tied to specific life experiences and circumstances. Patterns of social anxiety are unavoidably embedded and implicated in a person’s social and spatial environments.

REFLECTIONS ON PERSPECTIVES

Before this chapter moves to map the contours of what I have termed a ‘social geography of social anxiety’, it is useful to tease the threads of the aforementioned perspectives, which, in conjunction with a critical approach to geographies of health and illness, lays the foundation for the conceptual and empirical materials that follow in the remainder of this thesis. I outline these briefly in three broad strokes and they are discussed in more depth later in this chapter and in Chapter 3.

First and foremost, this research takes seriously the subjective and experiential dynamics of social anxiety in order to acknowledge real, living, maybe suffering and distressed, human beings and, as much as possible, give voice to that experience. This lends a certain priority to matters of meaning and understanding, and cultivating an awareness to space and place at a range of scales. In particular thinking of how the spaces occupied by people

are not just abstract surfaces but deeply textured ‘places’ of being, practice and encounter. There is of course an imbalance in the current literature as these aspects are missing from the dominant biological and psychological narratives and peppered throughout the others.

Secondly, the interpersonal, habitual patterning of social anxiety outlined by Stravynski (2014) is a novel perspective, which not only values the socially and culturally constituted practices, roles, communities and environments that form the fabric of social life and play a significant role in social anxiety, but also, how these dynamics are governed by, and embedded in, wider institutions and structures⁵³. While Stravynski’s model attempts to account for the ‘whole being’, by neglecting what he terms the ‘intrapersonal’ dynamics – the cognitions and bodily processes, signs and symptoms – he ignores the personal and social consequences of such emotional, embodied and affective events.. Arguably, Stravynski’s omission of these elements appeals to his rejection of biomedical and cognitive models of social anxiety that view ‘abnormal’ cognitions and bodily processes as the ‘whole problem’ and I sympathise greatly with this account. However, I argue that these signs, symptoms and sensations are significant elements when considering how bodies are socially and spatially implicated in anxious experiences. So, while Stravynski omits them as ‘intrapersonal’ dynamics grounded in, and reinforcing, the fundamental notion of a ‘mind-body’ split; they can, in fact, be viewed *inter-* and *trans-*personally/subjectively as they embody symbolic meaning – defined socially and culturally – for the individual experiencing them. A useful comparison to draw upon here is the work of Bissell (2009, pp. 918 and 923, 2010a) who examines chronic and transient pain, typically localised *in* bodies (‘neurologically’) or between bodies and minds (‘psychosomatically’), as an affective and relation force which can augment and diminish quality of life and an intensity that is ‘folded through memory and past experience’. A similar perspective is fashioned here, one that views social anxiety as an affective intensity. Affective and emotional geographies are discussed in-depth in Chapter 3, and advanced further in Chapter 5 on ‘Intensities’.

Thirdly, I am concerned with the self-other-world relations that emerge in the social, psychoanalytic and interpersonal accounts. Crucially, the theme of the ‘disorder’ is that individuals are anxious-in-relation-to-others, bringing to light the various ways ‘space’ and ‘place’ may become much more complicated, diminished and isolating because of anxious experience. Similarly, they attend to issues of how the self is situated in such spaces and

⁵³ These dynamics also speak to the psychoanalytically-orientated concerns, for example, the Lacanian concept of ‘the big Other’, discussed in Chapter 3.

places as ‘other’, ‘abnormal’ and ‘out of place’ (Chapter 7 and 8).

This chapter now moves to situate these loosely outlined concerns within a geographical framework by considering critical approaches in geographies of health and illness.

ADVANCING A SOCIAL GEOGRAPHY OF SOCIAL ANXIETY

Kearns (1993) argues that medical geography, with its primary focus on the spatial epidemiology of disease and inequalities of health and care provision⁵⁴, is ‘incomplete’ without considering the wider links between health and place. His calls to engage with the situated and experiential, rather than biomedical⁵⁵, accounts of health and illness are intended to ‘release’ medical geography ‘from the shadow of medicine’, so as to produce a distinct vein of research centred around the ‘geographies of health and healing’ (Kearns and Gesler, 1998, p. 3). Kearns (1995, 1996, 1997) avows that, conceptually, geographers should be more concerned with the roles played by social and cultural differences, and by experiences of ‘otherness’, and suggests the need, methodologically, to consider narrative methods for ‘storying’ experiences of health and illness. At the time, critical work addressing such themes – often through a lens alert to people ‘storying’ their own socio-spatial worlds – has already emerged and become a fixture within social and cultural geography: for example, reconvening experiences of chronic illness, care and management at the intersections of gender, race and ethnicity (Dyck, 1995a, 1995b) or young men with HIV/AIDS internalising stigmatising perceptions of ‘otherness’ and ‘difference’ (Wilton, 1998). Crucially, though, this work has not been ‘released’ from the medical as such, but instead has sought to re-engage critically with it by addressing socially and culturally constructed meanings of illness.

In three ‘progress reports’ assessing the sub-disciplinary landscape, Parr highlights health geographers’ critical engagement with medical practice, science and discourse through

⁵⁴ Medical geography became a recognised subfield in geography in the 1950s (May, 1958) concerned with either the spatial patterning of disease or the provision of medical care and access to facilities (Mayer, 1984). In a critical response to Kearns’s (1993) calls for a reformed medical geography, May and Meade (1994, p. 103) argue that medical geography is anything but void of concerns about the links between health and place. Using the tradition of disease ecology (omitted from Kearns’s discussion), they claim that ‘[d]isease ecology considers the numerous social, economic, behavioural, cultural, environmental, and biological factors which create disease in specific places at specific times’. They comment further that social geography should be an ‘element’ of medical geography but should not define the field.

⁵⁵ The biomedical model prioritises a curative model of a set of precipitating disease symptoms but is less concerned with, for example, health-related experiences and access to healthcare (Kearns, 1993).

work on the geographies of the body (Parr, 2002) the spaces of care provision (Parr, 2003) and the application of social theory in geographical research and practice (Parr, 2004). Parr promotes the connective tissue between health and medical geographies, encouraging and ‘urging [...] geographers to think outside, and beyond, usual boundaries of medical beliefs, treatments, bodies and authority’ (Parr, 2004, p. 253)⁵⁶. Yet, while asserting that we must think about all manner of ways in which health and well-being must be conceived outwith the ‘biomedical’ tradition, Parr argues that we must acknowledge that medical institutions, practices and spaces continue to structure – so powerfully – the worlds of illness and healing. Philo (2007, p. 84) furthers Parr’s arguments, stating that those working with all matters and issues of disease, health, illness and wellbeing should fundamentally remain as ‘medical geographers’ – precisely in this critical guise – encouraging an engagement with ‘medical ideas, practices and spaces. Arguably, geographers working broadly in the context of health and illness are engaged in this kind of critical work, approaching illness experiences as ones grounded in material practices and – albeit accepted, negotiated and resisted in various ways – embedded in wider (neoliberal, biomedical and/or social) discourses (Moss and Dyck, 1999) (the nuances of these critiques are discussed in the remaining sections of this chapter). Elsewhere, Parr (2002, p. 86) notes how the dispersion of medical knowledge, previously restricted to medical professionals and communities (e.g. how to spot malignant melanomas or how to conduct breast examinations), across online spheres has, on the one hand, usefully disrupted the hierarchies of the doctor-patient relationship⁵⁷ by empowering and educating individuals about their health and, on the other, has opened them up to ‘new and more specialised medical discourses and technologies which serve as resources for self-maintenance, discipline, and control.’ She also highlights the ‘emancipatory’ potential of sharing, discussing and contesting conventional (medical) and alternative knowledge in the context of online chatrooms for those with Multiple Sclerosis (MS), spaces enabling individuals to re-write a lived experience of illness.

⁵⁶ In an earlier review of the sub-disciplinary field of mental health geographies, Dear echoes these sentiments, stating that, not only would it be a “mistake for mental health geographers to lose sight of the traditions of ‘medical’ geography”, but also for ‘medical geographers to overlook mental health’ (Dear, 2000, p.258).

⁵⁷ Stevenson et al. (2007) examine the benefits and limitations of Internet knowledge in the context of the doctor-patient relationship. Although some tensions were reported -- for example, reliability and interpretation of online health information – patients in this study viewed online information as an ‘additional resource’ rather than an outright challenge to medical authority and practice.

Thus, health geography arguably is ‘post-medical’⁵⁸ in the sense that it is still operating, as it were, in the shadows of the biomedical in an attempt to critically engage with, understand and re-frame discourses and narratives around health and illness. The significance of these critiques and arguments to this research is, as highlighted in Chapter 1 and the prior sections here in Chapter 2, there are particular social, cultural and spatial conditions and discourses that shape the lens through which social anxiety is viewed and experienced. So, while this project is situated outwith the biomedical paradigm that has dominated the landscape of social anxiety research, it absolutely acknowledges that daily life with social anxiety is deeply embedded *in*, for example biomedical perspectives, language and discourses through the search for diagnosis and in the pursuit of normality through ‘cure’ that concerns to many individuals (Chapter 6). This also means, contra to Stravynski’s interpersonal framing of social anxiety, taking seriously the *intrapsychic*⁵⁹ dynamics (i.e. signs, symptoms, sensations and ruminations), not simply as pathological or symptomatic consequences but embodied and situated phenomena (Chapter 5).

SUBJECTIVITY AND SPACE

Situating the following discussion in the sub-disciplinary fields of mental health, chronic illness and disability geographies, I will now outline the three facets of health geography that have influenced my own research on the geographies of social anxiety under the broad heading of subjectivity and space. The spacing and placing of subjectivity aims to account for the various positions, practices, processes and politics through which subjects and subjectivities are made, mediated, ‘performed, resisted and disciplined [...] in and through space’ (Brown and Knopp, 2003, p. 322 cited in Longhurst, 2003, p. 344). The ‘subject’ and their ‘subjectivities’ are often entangled with notions of the body, self, person and identity, as deeply embedded in and constituted by everyday social and spatial life. It is through these points that we are able to map ‘the subject’ into the social landscape and speak to experiences, expressions and composition of subjectivities (Pile and Thrift, 1995, p. 2; Simpson, 2017). Rather than an abstraction, the subject is thoroughly embodied and emplaced in relation to various subject positions⁶⁰, discourses and social systems and contexts (Simpson, 2017).

⁵⁸ As noted by Kearns (1995, p. 253) – and Philo (2007) – ‘post’ in this sense alludes to a sensitivity towards post-modern and post-structuralist concerns with difference, nuance and contingency

⁵⁹ To reiterate, ‘intra’ is the term used by Stravynski to refer to the symptomatic dimensions of anxious experiences, ones that he aligns with biomedical and/or cognitively paradigms. I choose to view these aspects more inter-/trans-personally, by drawing on emotional and affective geographies in Chapter 3.

⁶⁰ For example, gender, class, race, sexuality and disability.

With this focus on ‘relatedness’, subjectivities are never singular or static; rather, they are contingent, unstable, incoherent, unfixed and incomplete (Pile, 2008). In order to advance these ideas, geographers have engaged with psychoanalytic accounts of subjectivity to widen the lens through which the subject is viewed, one that: on the one hand, delves beyond and beneath any autonomous and transformative potential (popularised in structure-agency debates) to account as well for repetitive, fragmented and ‘unyielding features’ of subjectivity (Pile, 2008, p. 214)⁶¹; and, on the other hand, does not presume a transparent and accessible subject (Pile, 1996). Probyn (2003, p. 298) argues that:

We need to think of subjectivity as an unwieldy, continually contestable and affirmable basis for living in the world. Subjectivities are then simply a changing ensemble of openings and closings, points of contact and points [that] repel contact. In space, we orient ourselves and are oriented. That is the spatial imperative of subjectivities.

The necessary ‘openings and closings’ for mapping the subjectivities of social anxiety are discussed hereafter through notions of outside in/inside out/in-between; (in)visibility and (un)certainty; and normality/abnormality.

OUTSIDE IN / INSIDE OUT / IN-BETWEEN

The ‘fraught relationship between subjectivity and space’ (Segrott and Doel, 2004, p. 597) is intensely encountered in episodic and enduring experiences of illness and/or impairment. Davidson’s (2000a, 2000b, 2001, 2003) work on the geographies of agoraphobia is instructive for considering troubling ‘bodily events’ that fundamentally interfere with an individual’s capacities for leading a fulfilling social and spatial life. Davidson (2000a, p. 641) details not only the ‘difficulties [faced] in traversing social space’, but also the ‘complete breakdown of the boundaries between ‘inner’ self and ‘outer’ world. Similarly. Parr (1999, p. 675) examines the ‘disruptive senses of borders, boundaries, and borderlessness’ experienced with/in the self and one’s social and spatial surroundings through, for example, voice-hearing. Through this work Parr highlights that unconscious processes are actively bound up with issues of time and space and thus require our (geographical) attention (Chapter 3). Segrott and Doel (2004) examine ritualistic and repetitious behaviours enacted by those living with Obsessive Compulsive Disorder (OCD) as often futile and exhausting attempts to regain, and if possible to maintain, a sense of control over ‘inner’ intrusive obsessions through compulsive spatial practice. This work highlights how subjectivities and corporealities are inextricably intertwined through

⁶¹ This matter is discussed in further detail in Chapter 3.

spatialised accounts of panic, delusion and compulsion, highlighting their relevance for mapping anxious subjectivities that repeatedly wreak havoc on normally taken-for-granted, mundane, habituated relations between self, space and others.

There are similar repetitions and intensities experienced in social anxiety and there is indeed a sense that the relationship with the self is ‘thrown off’ by the perceived lack of control the individual has over the ‘self’. Visceral and intrusive thoughts and memories as well as uncontrollable bodily symptoms (e.g. palpitations, hyperventilating, sweating and blushing) are continually problematic. This, in addition to external intrusions and tensions that mark social space unpredictable, feeds cyclically and uncontrollably into a habitual and inescapable anxious patterning that radically changes and disrupts a person’s self-other-world relations.

(UN)CERTAINTY / (UN)PREDICTABILITY

Brashers et al. (2003, p. 497) note that uncertainty is fundamental in the experience of ill-health. Echoing this assertion, work in the geographies of chronic illness and mental health has productively disrupted notions of illness as a static phenomenon with a linear progression towards recovery, rather illness experience is marked by uncertainty, ambiguity and unpredictability. The onset and progression of illness can often leave the individual in ‘unknown territory’ (MacKian, 2012) as bodily, social and spatial dimensions become ‘routinely unpredictable’ (Crooks, 2010). Uncertainty presents in various guises: there is, on the one hand, immediate unpredictability experienced with changing bodily states and fluctuating symptoms, for example during panic attacks, hypo/hyper-glycaemia and seizure (Davidson, 2000b; Lucherini, 2015; Smith, 2012) and ambiguities in everyday practices, routines and spaces, particularly home (Crooks, 2010) and workplaces (Moss and Dyck, 1996) and, on the other, longer-term concerns about diagnosis and recovery, including whether diagnosis is obtainable and recovery is achievable and sustainable (Moss and Dyck, 1999). There are also further concerns about changing social roles and identities as illness progresses or is disclosed (Dyck and Jongbloed, 2000; Crooks and Chouinard, 2006). Crooks (2010) also argues that social and spatial worlds are ‘unpredictably routine’, as illness can, to a certain extent, structure daily life by diminishing mobility and restricting interactions. Thus curbs spontaneity as bodies and symptoms are continuously monitored, checked and controlled, which in turn affects mobility and social activities. Lucherini (2015) examines the regimented lives of people living with diabetes and the daily considerations required for management. He argues that,

‘spontaneous geographies involved the ability to do things and go places at a moment’s notice without significant pre-planning [...] spontaneity [is] missing for [people with diabetes]’ as bodies need to conform, be controlled and contained.

NORMALITY / ABNORMALITY

At the crux of the shift from medical to health geography is the opportunity ‘to rescue [...] the living, experiencing, thinking, feeling, often anxious, perhaps suffering, maybe dying human being’ (Philo, 2007, p. 83) from the objectifying and reductive gaze of scientific medicine. The classic medical model has been criticised extensively for pathologising mental illness and disability, thereby designating abnormal disease categories or limitations in functioning that are seemingly in need of treatment and correction⁶². Geographers working within the scope of mental health and disability have been particularly attentive to how conceptualisations of normal/abnormal are historically, socially and culturally entangled with/in space. These debates are of critical importance to this research, which seeks not only to understand the ‘disordered’ geographies of anxious experiences, but also to question the extent to which ‘disorder’-centred constructions of self and perceptions of social norms are influenced, even encouraged, by diagnostic and classification systems.

There is a deep history of social and spatial segregation of people with mental illness and disabilities in society (Parr, 2008; Philo, 1997), of which I will give a brief overview⁶³. A significant body of research attending to institutionalised settings of ‘asylum spaces’ – arising as a significant feature of the Western world from at least the 18th century onwards – explores the historical accounts of asylums as spaces of containment, isolation and separation (Parr et al., 2003), as therapeutic environments (Philo, 2014) and as sites of experimental practice (McGeachan, 2013). These sites, often removed and isolated, were successful in hiding ‘the unacceptable from contemporary societies’, a shutting away which, in turn, ‘fostered a lack of knowledge and negative perceptions about mental health among the protected public’ (Moon, 2000, p. 241). Institutional policies and practices of social exclusion, fuelled by stigmatising attitudes towards those with mental illness and

⁶² Compare with the field of narrative medicine, which aims to: utilise narrative accounts of illness in clinical practice to understand journeys through illness; place emphasis on the relations between physician-patient-practice; and encourage practitioner reflection in/of medical encounters. Narrative approaches encourage a model of medical practice that is empathy- and patient-centred (Charon, 2008).

⁶³ Early work in the geographies of mental health was primarily concerned with either the spatial epidemiology of mental illness, most notably Giggs’s (1973) landmark paper on the spatial patterning of schizophrenia in Nottingham, and the mapping of mental health care facilities (Davey and Giles, 1979).

disabilities, have duly ‘woven [fear] into the fabric of society’ (Livingstone, 2013, p. 9)⁶⁴. As a result, more recent (post-mid-20th century) processes of de-institutionalisation – that is, the decentralisation of psychiatric services and relocation of institutionalised populations back into the community – have often been met with strong community opposition (Dear and Taylor, 1982; DeVerteuil, 2013). The sub-disciplinary field of mental health geography has paid sustained attention to this changing landscape of mental health care and to the emerging social consequences for ‘post-asylum’ populations. This body of work has explored how societal attitudes towards people experiencing mental health problems oscillate between tolerance, stigma and exclusion (Parr and Philo, 2003) and how such oscillations seep into vital spaces of care and support (Parr, 2000; Parr et al., 2004).

Negative community attitudes towards the siting of community-based mental health facilities, notions of difference, practices of ‘othering’ and societal attitudes more broadly, often underpin discourses that frame people with mental health problems as deviant, violent, unpredictable and/or strange social misfits⁶⁵, and these attitudes can often lead wider communities to question the moral status and character of such shunned people⁶⁶. Processes of ‘othering’ signal a perceived deviation from socially and culturally constructed norms and are deeply embedded in societal attitudes towards mental health. Diagnosis, labelling and stigmatising⁶⁷ attitudes, in particular and often framed by the medical model, erect social and structural barriers that situate people experiencing mental health problems as ‘beyond or outside of society’ (Imrie, 1996, p. 398).

Rose (1998, 1999) argues that collectively the psy-disciplines operate as an instrument of social governance, an ‘individualising technology’ that makes ‘visible and intelligible certain features of persons, their conducts, and their relations with one another’ (Rose, 1999, p.11). A central concern of Rose’s work is how the psy-disciplines shape and govern

⁶⁴ Wahl and Aroesty-Cohen (2010, p. 249) note that, while there has been an overall increase in positive attitudes towards mental health problems, negative attitudes still prevail regarding ‘social acceptance and expectations of *people* with mental health problems.’

⁶⁵ Crucially, Moon (2000) notes that high profile cases of vulnerable and violent individuals with severe mental illness who have harmed themselves and/or others are marked, in the UK, by significant ‘inter-agency’ failures between the National Health Services (NHS) and social care services. He draws on six cases of murder and five cases of suicide and self-harm, each demonstrating a ‘lack of comprehensive care planning’.

⁶⁶ Similar themes have also emerged in research concerning the ‘moral economy of poverty’. Hansen, Bourgois and Drucker (2014) explore how austerity and welfare sanctions in the US are redefining welfare eligibility, leading to a ‘pathologising of poverty’ whereby ‘permanent medical or psychiatric diagnosis is required to qualify’ for public support and people need repeatedly to prove their ‘disabled’ status.

⁶⁷ Stigmatising attitudes are found to be one of the key deterrents to people accessing mental health treatment and care (Clement et al., 2015).

the self in modern society. There is an increasing diffusion of psy-knowledges into the governance of social and spatial life (Foucault, 1997; Rose, 1999) that is evident in the medicalisation and pharmaceuticalisation of mental and emotional distress (Hickinbottom-Brown, 2013; Summerfield, 2001) and it operates through the psychologising of everyday life, workplaces, educational and criminal justice institutions (De Vos, 2016; Gagen, 2013; Jones et al., 2011).

The practice and construction of ‘normalcy’ can therefore be considered as ‘less a condition of human nature than it is a feature of a certain kind of society’ (Davis, 1995, p. 3). Social life is established, ordered and given meaning through routinised social and discursive practices (Simonsen, 2010), which perpetuate the social norms to which society conforms. Social anxieties are driven by, on the one hand, comparisons between ‘normal’ and ‘abnormal’ others or ‘correct’ and ‘incorrect’ behaviour and, on the other hand, criticism of a ‘socially awkward’ or ‘inept’, ‘weird’ and ‘incapable’ self. At the individual level, such anxieties may, in turn, encourage the pursuit of a supposedly ‘normal’ life – that is, stable, functioning and productive self – through, for example, pharmaceutical and psychological means. This thesis is attentive to the extent to which social norms and societal expectations feature, or are indeed internalised, in the lived geographies of social anxiety: for example, Chapter 6 explores the discursive and material realities of diagnosis, treatment and recovery, alongside the consequences of falling short of social ideals; and Chapters 7 and 8 explore how social geographies unfold against a backdrop of (perceived) ‘normalcy’ and the failure to attain it through ‘normal’ signs of achievement such as success in relationships, education, career and life’s ‘milestones’ (as highlighted in the narrative at the beginning of Chapter 1).

CONCLUSION

In this chapter, I have outlined the existing disciplinary landscape of social anxiety research. By drawing on literatures and perspectives from biological and psychological sciences, cultural and social studies, and psychoanalytic and interpersonal theories, I have provided an extensive – although not exhaustive – understanding of how social anxiety is understood within these particular frameworks. I have attempted to map an understanding of social anxiety that is socially and spatially embedded in the practices, roles and relations that comprise everyday life – dynamics that will be examined in detail in Chapters 5 through 8. Significant conceptual threads from social, counselling, psychoanalytic and

interpersonal perspectives were then taken forward and discussed in the context of critical approaches to the geographies of health and illness, namely work in the sub-disciplinary fields of mental health, chronic illness and disability geographies. The underlying themes will furnish the conceptual underpinnings of the research discussed in Chapter 3 and nourish the empirical heart of the thesis that follows.

CHAPTER 3

CONCEPTUALISING SOCIAL ANXIETY: PSYCHOANALYSIS AND HUMAN GEOGRAPHY

INTRODUCTION

In order to deepen the social, cultural and ‘psychical’ accounts outlined in the previous chapters, this chapter maps the conceptual resources that inform a geographical sensibility of social anxiety. I begin by discussing the psychoanalytic concepts and geographies that have informed this research. The meeting points between social theory, human geography and psychoanalysis are instructive here for approaching an understanding of the unconscious as more than an internal, closed off kernel, but rather a ‘structure’⁶⁸ that is socially and spatially constituted, not only by our earliest experiences, but shaped continuously by events and encounters throughout our lives. Drawing on particular strands of psychoanalytic thought/geographies, I demonstrate how the unconscious operates as the ‘connective sinews’ (McGeachan 2014, p. 99) between our inner and outer worlds. I then move to discuss the anticipatory geographies that open up a temporal dynamic to lived experiences of social anxiety. Following this, I move on to the emotional and affective geographies, drawing some conceptual similarities between them and psychoanalytic geographies. Finally, I disrupt ‘normative’ accounts of habitual practice and embed these discussions, which echo the ‘uncertain’ and ‘unpredictable’ geographies outlined in Chapter 2, in a brief discussion of ‘home’ and ‘mobility’. Each of the four ‘geographies’ mapped here, and their respective times and spaces, are not neatly configured to the four empirical chapters that follow. They should therefore be regarded as conceptual pinpoints and resources, which feed into and inform, in varying moves, degrees and intensities, the empirical heart of this thesis.

PSYCHOANALYTIC CONCEPTS AND GEOGRAPHIES

If the unconscious – as something innate and inherently *within* us, hidden from view, unknown even to ourselves – is only decipherable in analysis by a trained analyst, what then, are the challenges and implications of psychoanalysis for constructing a social geography concerned with questions of subjectivity and space? A decade ago, Kingsbury

⁶⁸ This is in a sense a social ‘structure’ or ‘grid’, not one that is in any way organic.

(2009, p. 481) wrote that ‘psychoanalysis has been frequently viewed by a significant number of geographers with a cautiousness that borders on suspicion that even borders on paranoia’. Despite a concentrated body of research drawing on a range of psychoanalytic schools, frameworks and concepts – including: Freud’s ‘uncanny’ (Hook, 2005; Wilton, 1998), Lacan’s ‘extimacy’, ‘jouissance’, ‘desire’ and ‘Other’ (Kingsbury, 2007, 2008, 2015, 2017; Proudfoot, 2017), Kristeva’s ‘abject’ (Sibley, 1995), Winnicott’s ‘transitional space’ (Aitken and Herman, 1997); as well as a Special Issue in *Social and Cultural Geography* (edited by Philo and Parr, 2003) and an edited collection (Kingsbury and Pile, 2014) dealing with issues of history and practice (McGeachan, 2014), space and scale (Naraghi, 2014), technology (Thien, 2014), and social life and its discontents (Nast, 2014) – there still exists a feeling of unease, even scepticism, about psychoanalysis in geography and the wider social sciences (Kingsbury, 2007; Philo and Parr, 2003).

This caution pivots on the widely received view that psychoanalytic theory is ‘ahistorical’ and ‘acultural’⁶⁹, imposing a universal, singular and unchanging model of humanity’s common psychic structuring, an orientation set in stark contrast to academic geography’s wider paradigmatic trajectories. Conversely, and despite its own insistence on taking ‘difference’ seriously, another – almost diametrically opposite – criticism of psychoanalysis targets its determined focus on the personal histories and inner worlds of the individual, for some locking it away in the extreme particularity of individual experience. Psychoanalysis then faces criticism⁷⁰ for being both ‘backward looking’, for example Sartre’s critique that ‘the dimension of the future does not exist for psychoanalysis’ (Sartre, 1956, p. 563), and ‘inward gazing’, for example Foucault’s (1978) argument that the gaze of interiority, in conjunction with the authority of the analyst, serves to silence experiences and expressions of ‘madness’ (see also Whitebook, 2005). Even within the psychoanalytic community, there are admissions that ‘psychoanalysis is reluctant to attend, both in theory and in practice, to the social forces that structure our very being and underwrite our lives’ (Rozmarin, 2017, p. 458). Pile (1993) nonetheless replies that psychoanalysis is uniquely situated to disrupt existing conceptual frameworks,

⁶⁹ This guiding principle strongly associated with ego psychology (a post-Freudian school of psychoanalytic thought), in which socio-cultural contexts are deemed relatively unimportant in the processes of human development. Ego psychology (the ‘American school’) was closely associated with behaviourism, an association that enabled ego-psychologists to situate themselves under the banner of objectivist science. This was particularly well received in the US as it aligned itself at the time (and today) with the wider socio-political landscape and the persistence of individualism in the US (McClure, 2010, pp. 144–147).

⁷⁰ Another resounding criticism of psychoanalysis is that Freud’s work, in particular, flourished on the idea of the ‘normal’ sexuality and function and contrasting them ideas of the abnormal and pathological (Davis 1995). Crucially, I think Lacan’s work moves away from this binary distinction and offers a more nuanced approach that acknowledges the diversity in/of psychic life.

particularly the ‘structure-agency’ debate and the ‘new models’ of self emerging in geography in the late-1980s and early-1990s, models predicated on a knowing/knowable subject and favouring the autonomy and transformative potential of the individual in their social, cultural and political worlds.

Callard (2003, pp. 299–300) offers a critique of human geographers’ apparent ‘taming’ of psychoanalytic concepts, arguing that they have been diluted and ‘too quickly co-opted [...] into the service of a particular model’ of human geography concerned with difference, power, resistance and progressive transformation. Outside of geography, Copjec (1989) levels similar critiques at film theorists, accusing them of a fundamental misrepresentation of the Lacanian gaze through its conflation with the Foucauldian ‘panopticon’. While Callard would not go as far as to say psychoanalysis has been misrepresented, she does make note of, on the one hand, the limited engagement with the vast body of Freud’s work and, on the other, the over-reliance on specific texts, namely *The Uncanny* (Freud, 1919) and *Civilisation and its Discontents* (Freud, 2010). Kingsbury, responding to Callard’s claims, argues that the ‘taming’ of psychoanalysis in academic geography is more to do with geography’s uncertainty *about* psychoanalysis, and that ‘un-taming [...] is neither possible nor even desirable’ until there is an in-depth engagement with the substantial body of psychoanalytic theory. In agreement with Callard, he argues that this ‘taming’ is not simply ‘lame dismissals of wild concepts’ or an ‘overestimation’ of social-cultural-political transformation, but rather amounts to ‘a simplification – an over-rapid spatialisation – of the psychoanalytic subject and the social’ (Kingsbury, 2007, p. 240). A geographical engagement with psychoanalysis is, however, well positioned to engage in a ‘de-clinicalised’ re-reading of psychoanalysis that fosters the plurality of meanings inherent to the texts that have the potential to enrich current conceptualisations of subjectivity and space.

Elliot (2004) argues that psychoanalytic theory has provided a conceptual vocabulary to dismantle the binaries between individual/society, public/private, structure/agency and inner/outer. In its most fundamental form, psychoanalysis enables us to account for the idea that one cannot exist without the other and that both ‘sides’ of these dichotomies continually constitute one another. Furthermore, of particular interest to the subject of social anxiety, which has remained firmly in the grasp of biomedical and clinical accounts over the last 60 years (as covered in Chapter 2), Whitebrook (2005) suggests that psychoanalysis can offer a much needed ‘de-psychologising’ of the subject and their experience. There is no intention to replicate clinical-analytic practice, that is, to

psychoanalyse research participants, endeavouring to locate some deep-rooted trauma or ‘kernel’ as the cause of their social anxiety. Rather, a reading of social anxiety influenced, in part, by psychoanalytic theories and geographies aims to shift the focus beyond clinical and/or medical accounts by descriptively enhancing our understanding of social anxiety as lived in the everyday world (and alert to how individuals with social anxiety may face particular and peculiar challenges in the conduct of everyday socio-spatial life).

Rather than offer a re-reading of Freud’s and Lacan’s vast theoretical works⁷¹ in the following sections I address certain key psychoanalytic concepts, together with a discussion of the wider ‘psychoanalytic’ and ‘geographical’ frameworks that can support their use in relation to an analysis of experiencing social anxiety. Other psychoanalytic concepts are also discussed further in relation to ‘anticipatory’, ‘emotional’, ‘affective’ and ‘habitual’ geographies, both later in this chapter and then woven through the empirical chapters that ensue.

ANXIETY

The concept of anxiety itself is located at the very core of psychoanalysis. The following outlines a rudimentary account, highlighting the significance of anxiety to the structure of psychoanalytic thought and the key facets and differences inherent in both Freud’s and Lacan’s theorisation of anxiety. I draw primarily on Freud’s *Inhibitions, Symptoms and Anxiety* (1926), as his most ‘developed’ understanding of anxiety, and Lacan’s *Anxiety: Book X*, a collection of seminars that he delivered on the subject between 1962 and 1963, as well as from secondary literature by Hook (2005, 2013) Kingsbury (2009, 2017) and Salecl (2004), in order to situate these concepts within a geographical frame for the analysis of social anxiety.

FREUD’S ANXIETY

Anxiety has been positioned as the foundation on which the entire architecture of Freud’s psychoanalytic theories are built, with Freud himself asserting that ‘there is no question that the problem of anxiety is a nodal point at which the most various and important questions converge, a riddle whose solution would be bound to throw a flood of light on our whole mental existence’ (Freud, 2001, p. 393). The way in which anxiety is structured

⁷¹ The vast and expansive psychoanalytic oeuvres of Freud and Lacan alone span from 1891-1939 and 1952-1981, respectively, and were subject to continual revisions and iterations and the occasional monumental shifts. I have thus chosen quite specific concepts that speak to the subject of social anxiety.

is presented as lying at the root of all psychoanalytic explorations of the human condition. Freud developed his understandings of anxiety throughout his lifetime's work. From 1895-1925, he asserted that 'neurotic anxiety', which he distinguished from 'realistic anxiety'⁷², was the transformation and manifestation of repressed sexual energies: 'anxiety is the transformation of accumulated tension' (Freud, 1894, p. n.p.). This theory, while preserved, then underwent several subsequent modifications, particularly as Freud developed his theory on repression⁷³. In his final iterations, presented in *Inhibitions, Symptoms and Anxiety* (1926), he outlined a dual structure of anxiety. Here, on the one hand, he re-positions anxiety as a something that is 'felt', an 'affective state' operating primarily as the 'precipitate of traumatic experiences' (Freud, 1926, p. 12). On the other, he outlines anxiety as a mode of distressing anticipation, one of 'anxious expectation', as a future-oriented signal related to the dread of a future event. This temporal structure of anxiety, as a mode of repetition and anticipation, elevates the status of anxiety beyond a symptom and a consequence of trauma, reconfiguring it instead as the 'precipitant of other mental processes' and defences (Wong, 1999, p. 819).

LACAN'S ANXIETY

For Lacan, too, the question of anxiety was particularly urgent. Lacan's psychoanalytic project is positioned as a 'return to Freud'⁷⁴. Book X: Anxiety is one of Lacan's most

⁷²'Realistic anxiety' is considered to be rational and intelligible; an expedient reaction to danger, in which there is an expectation of harm and/or injury and combines 'a mixture of the affect of anxiety and defensive action' (Freud 1973 [1917], p.442) in the form of the fight or flight reaction. Freud (1917) dissected the 'situation of anxiety' further, determining preparedness for anxiety as an expedient behaviour and the generation of anxiety as an inexpedient behaviour. In the face of an external threat or danger, where anxiety is generated to an excessively high level, resulting in the paralysis of all action, including flight or defence, and interfering with instinctual self-preservation, it is considered to be an inexpedient behaviour. However, the generation of anxiety is also presented as a requirement for preparedness, a state of increased sensory attention and motor tension, considered to be an advantageous element in the face of external danger; as long as generation is confined to a mere signal, 'preparedness for anxiety [will] transform itself without disturbance into action' (Freud, 1973 [1917], p.443).

⁷³The concept of repression is one of the most fundamental in psychoanalytic theory, denoting the 'process through which thoughts and memories are expelled from consciousness and confined to the unconscious' (Evans, 2002, p. 168).

⁷⁴ Lacan heavily criticised the American ('ego-psychology') and British ('object relations') schools for straying too far from the fundamentals of Freud's theory, particularly in the field of language and the function of speech. Thus, Lacanian approaches are 'diametrically opposed' to these schools (Lacan, 1953, p.204). There are fundamental differences between Lacanian and ego psychology and object relations theories (ORT), particularly in relation to ego psychology's biological structuring of the unconscious and the dual subject-object focus of object relations. In terms of the former, Lacan argues that the biological/anatomical foundation of the unconscious ignores the dimensions of nature and culture. In terms of the latter, Lacan argues that the focus on the reciprocal subject-object (child-mother) relation in ORT is misplaced, although there are those who have attempted to think through the 'spaces in between' theoretical and clinical fragments in Lacanian and, for example, Winnicottian object relations (Luepnitz, 2009).

fundamental texts, in which he outlines several distinct turning points in the development of his psychoanalytic thought and aims to ‘shape a true orography⁷⁵ of anxiety’ (Lacan, 2016, p. 7). It is by re-mapping the affective terrain of anxiety, in its various forms and reliefs, that he makes this critical diversion. A thorough explanation of anxiety in the Lacanian vein requires a mapping, not only of anxiety, but also of the wider co-ordinates of his theory – of which anxiety is a fundamental component – namely, the ‘big Other’, ‘desire’ and the ‘objet a’. I will address these three with reference to Lacan’s specific ‘moves’ in his theorisation of anxiety, notably as he shifts the focus of anxiety from an ‘intrasubjective’ to an ‘intersubjective’ force by reconfiguring it in terms of the subject’s relationships with the (transsubjective) Other (Hook, 2015).

BIG OTHER

The ‘big Other’, as a symbolic dimension of the unconscious, is a concept invoked by Lacan that has a structuring and regulating function. While Freud engages a more familiar understanding of the term ‘other’ to refer to an ‘other’ person or ‘otherness’, for Lacan, there is a fundamental distinction between the little other (*‘l’autre’*) and the big Other (*‘l’Autre’*). This big, capital-O, Other⁷⁶ stands for ‘a non-existent locus or point of reference that tacitly anchors, mediates, and gives consistency to symbolic rules, conventions, and mandates’ (Kingsbury, 2017, p. 2). The Other here operates as a symbolic network that is irreducible to one point, but for which – or in relation to which – the individual has to maintain an appearance with respect to the field of social rules. In short, interpersonal relations are mediated by social norms, gestures, hierarchies, expectations, representations, and so on. Evans⁷⁷ (2002, p. 136) explains that:

The big Other designates a radical alterity, an other-ness which transcends the illusory otherness of the imaginary because it cannot be assimilated through identification. Lacan equates this radical alterity with language and the law, and hence the big Other is inscribed in the order of the symbolic. Indeed, the big Other is the symbolic insofar as it is particularised for each subject. The Other is thus both another subject, in his [*sic*] radical alterity and unassimilable uniqueness, and the symbolic order [that] mediates the relationship with that

⁷⁵ Orography is the branch of physical geography studying and mapping the formation and feature of mountains. It is interesting that Lacan should deploy this fundamentally geographical notion of the physical landscape to advance his reasoning here.

⁷⁶ It is the mother who first occupies the position of the other for the child. Mother is often stylised by Lacan as ‘(m)other’ to signify the mother is often the first other that the infant encounters (Luepnitz, 2009)

⁷⁷ Lacan also contends that it is in the place of the Other that the psychoanalyst must situate themselves in the therapeutic encounter (Evans 2002). This is a stand in position, whereby the analysand can impact onto the analyst their unconscious desires, a process known as transference.

other subject.

Crucially, Evans also notes that the Other as another subject ‘is strictly secondary’ to the Other as a symbolic order:

It is thus only possible to speak of the Other as a subject in a secondary sense, in the sense that a subject [i.e. parent, teacher or analyst] may occupy this position and thereby ‘embody’ the Other for another subject. (Evans, 2002, p.136)

The Other is therefore conceived of as a structural necessity that occupies a symbolic ‘third dimension’, not another human being per se but ‘a subject that stands above the interaction of real human interaction’ (Žižek, 2011a, p. 41).

Hook (2015, p.10) neatly conceptualises the differences between ‘inter-subjectivity’ and ‘trans-subjectivity’ in way that is useful for considering social anxiety in terms of mapping the ‘co-ordinates of how [an individual is] understood in the perspective of this other’. He writes that the degree of anxiety experienced in social situations is ‘often proportionate to the number of people’ present and ‘the difficulty one has in reading their prospective intentions’. Indeed, the subject’s position(s) (i.e. from where ‘I’ see myself in the eyes of the o/Other) is peppered with negative (self) evaluations, perceptions, guesswork, and the fear of negative evaluation, rejection, and isolation and so on. What becomes increasingly hard to manage and therefore more anxiety-provoking is ‘how an unfamiliar group as a whole sees one’ (Hooks, 2015, p.10 *original emphasis*). This is the level of the ‘trans-subjective’. What emerges is not an ‘aggregate of intersubjective views’: although, arguably, ‘each single member of a group does have a view of you, and this combined force can be significant [, it is but] one vector in the overall trans-subjective consensus’ (Hooks, 2015, p.11). Therefore, as Kingsbury (2009, p. 488) highlights, ‘the unconscious is the accumulation of other people’s spoken words, that is, the subtle din and babble of people’s desires, demands, compliments, scolds, as well as cultural codes, more generally’, echoing Lacan’s (2006, p. 16) famous aphorism: ‘the unconscious is the discourse of the Other’. Our unconscious is, in this sense at least, the Other.

The Other (as the social world of language, the law, and social conventions) is hence the fundamental principle that underlies and structures the symbolic order and, by extension,

our interactions with and within our socio-spatial worlds⁷⁸. Anxiety emerges in this unassimilable ‘gap’ between the subject and the Other, that is ‘between the subject and what they take their symbolic and socio-historical location to signify and, importantly, *to desire*’ (Hook, 2015, p.115 *original emphasis*).

DESIRE

Desire emerges in the unconscious field of the Other and relates to the subject’s desire for social recognition, love and belonging (Evans, 2002), a concept that led to one of Lacan’s most repeated phrases: ‘Desire is the desire of the Other’. The desiring Other prompts the question from the subject, ‘what do you want from me?’ and, in turn, constitutes ‘our own recurring and idiosyncratic patterns of desire’ (Lapping, 2017, p. 911) our own quest to be made ‘whole’. We desire to be desired (i.e. recognised, loved and to belong). Crucially, desire is situated in the Lacanian oeuvre as a ‘social product’ not an inner process: ‘it is always constituted in a dialectical relationship with the perceived desire of other subjects’ (Evans, 2002, p.39). What provokes anxiety is that ‘the desire of the Other does not recognise me, and even if I have the impression that the Other does recognise me, it will not recognise me sufficiently. The Other always puts me into question, interrogates me at the very root of my being’ (Salecl, 2004, p.15). The insufficiency of the Other bothers the subject: it is because the Other is fragmented and incoherent that we cannot say ‘what the Other’s desire is or how one appears in the desire of the Other’ (Salecl 2004, p.14). This uncertainty and unknowability hence lies at the heart of anxiety.

Echoing Pile (1991) in his assessment of what psychoanalytic geography can offer to an understanding of self and subjectivity, is the notion that the subject is, in a sense, ultimately unknowable both to themselves and to others beyond the experiences, knowledges, relationships and environments through which they construct meaning, identity and sense of self. Hook (2015, p. 116) argues that ‘the prospect of being stripped of the symbolic⁷⁹ co-ordinates underlying one’s most basic identifications thus provides us with perspective on what engenders anxiety’. When viewed through the lens of social anxiety, we see an individual whose basic sense of self is destabilised, when (they

⁷⁸ Not any specific legislation *per se*, but rather the principles that make social relations possible and govern, for example, social exchanges and gift-giving. Kingsbury (2017) explores how these dynamics contribute to an ‘uneasiness in culture’.

⁷⁹ The symbolic is one of the three Lacanian ‘orders’ (the others being the ‘imaginary’ and the ‘real’). The symbolic attends to the ‘a-subjective social grid’ in which individuals ‘assume a position, a role [or] a place’.

perceive) their performance and place in the social world as the subject of (the) o/Other's scrutiny – a scrutiny whose well-springs and expectations remain forever obscure, fractured and unpredictable – and are therefore convinced of their own (self-perceived) failure judged against the (perceived but not fully known) demands of the o/Other.

Anxieties manifest across a spectrum of social and interpersonal spaces, for example, in the workplace and spaces of education (Chapter 7) and across an array of public settings (Chapter 8). Taking the example of the university, these environments constitute, in part, a desiring other in the form of lecturers, peers, academic expectations (from the self, family and/or degree courses) and/or the ‘institution’ in its entirety. These spaces, and consequently the interactions and relations that are produced through them, are exemplary of how the individual is confronted with the symbolic order, whereby all manner of institutional boundaries, pedagogical encounters, social conventions, rules and hierarchies – tantamount to the Other – are inscribed. Therefore, how the subjects encountering these spaces orient themselves in relation to this order is a considerable source of anxiety, potentially overwhelming for some. Lapping (2017) explores the shifting dimensions of desire and o/Other within academic research and practice, addressing the ‘overwhelming sense of institutional pressure’ that can indeed invoke a disturbing ‘otherness’. The Other here may become an ‘unknowable constituent of the self’ (Lapping 2017, p.376). In the context of academic practice, Lapping highlights how lack and otherness are constituted in the interview process between the (disciplinary) identities of herself (education) and her research subject (literary studies):

[I]n so far as literary studies constitutes a specific other from which my subjectivity is constituted, and in so far as there are opaque aspects of literary studies that cannot be articulated within this subjectivity, it might be said that my interview with F evoked a disturbing otherness. This experience of otherness confronted me with my incompleteness, the gap in my ability to perform as researcher, and a certain, inevitable limit to my ability to concentrate on or attend to my participant – Because I don't understand F, because I am in a sense overwhelmed by her otherness, I attribute my lack to her: *she* reduced me to a dull social science interviewer, *she* was being defensive (when in fact it is the unconscious relations between signifiers that constitute these interpretations). (Lapping, 2017, p.377)

What is crucial to Lapping’s assessment (particularly relating to social anxiety) is the sense of opaqueness and uncertainty that the Other embodies, ultimately signifying to the subject that something is inherently lacking *in them* (i.e. I am not good enough, I am not capable). There is an inherent geography here, in that specific spaces engender different meanings, different articulations of desire and, as a result, variations in the intensity and focus of

anxiety.

UNCANNY LITTLE OBJECT

Freud (1926, p.100) famously claimed that anxiety is ‘about something. It has a quality of indefiniteness and lack of object’. This lack of object is also significant in phenomenological approaches to the problem of anxiety (Heidegger, 1953; Kierkegaard, 2014; Sartre, 1956). In both accounts, fear is often used as a point of contrast when attempting to determine precisely what anxiety is and where it is located. Whereas fear encompasses a sense-perception of a present and a definite object or danger, anxiety is construed as ‘free-floating’ with an unknown or indeterminate object⁸⁰. Lacan’s (1990, p. 82 *original emphasis*) second objective was to extend Freudian and phenomenological conceptualisations by establishing that anxiety is ‘*not without an object*’. In this sense, anxiety may well lack the definitive and material object that induces fear inherent in, for example, biophobias⁸¹ (Davidson and Smith, 2003; Smith and Davidson, 2006) or a fear of needles (Andrews, 2011), but, as Lacan points out, this lack is not the same as ‘not having’ an object.

The interactions, sites and settings of social anxiety are ‘not without’ significance in that they induce the most destabilising and distressing experiences of anxiety. The significance of the particular *quality* of the interactions and spaces, which may shift in location and intensity, can be exemplified by the person who can give a presentation to their team members but crumbles in anticipation of a one-to-one review of her performance with her manager⁸². There is hence a subliminal *something*⁸³ at the root of anxiety, something that

⁸⁰ Despite this distinction, in the empirical heart of this thesis I still use fear and anxiety interchangeably, as do participants, as social environments are experienced as inherently fearful and anxiety-provoking. The difference between the two is often difficult to determine.

⁸¹ Smith and Davidson (2006) explore, through Kristeva’s notions of the ‘abject’, the subjective feelings of disgust that emerge in phobias of nature. The ‘abject’ sustains the notion that the production and maintenance of identity is closely implicated in, and to an extent facilitated by, the expulsion of subjects and/or objects defined as ‘other’, in this case the threatening and uncontrollable presence of animals and nature, e.g. rats, cockroaches, snakes, etc.

⁸² In this example, the former situation may enable more control as an individual can prepare, rehearse and have notes; whereas the anxieties present in the latter situation may revolve around issues of evaluation, performance, authority (of the manager), direct face-to-face or eye contact, or where the meeting will take place, e.g. in her manager’s office (another layer of authority/power).

⁸³ Lacan (2013, p. 140) notes that the processes of ‘sublimation’ are responsible for transforming everyday objects, interactions and spaces into the ‘place of the Thing’. The ‘Thing’ is something familiar or ‘ordinary’ that is simultaneously profoundly terrifying (Kingsbury, 2011)

escapes signification, which Lacan refers to as the *objet petit a*⁸⁴. Kirshner (2005, p. 85) argues that we should not attempt to explain the meaning of human relationships through abstract concepts like the *objet petit a*, in the sense of offering a concrete answer to their complexity. Rather, the claim is that these concepts operate as ‘metaphysical constructs’ aiming to ‘bridge a gap’ between our biological existence and subjective experience.

At the heart of the *objet a* lies a paradox. The *objet a* ‘fills the gap constituted by the inaugural division of the self’ (Lacan, 1964, p.270). This division accounts for Lacan’s theorisation of subjectivity, in that for him the subject can never be anything but split or alienated from a part of them⁸⁵. The *objet a* stands for the object’s cause of desire insofar as the object of desire (discussed above) is unattainable. In this sense, desire has a relation to ‘lack’, in that we cannot assimilate the self with the desire of the Other. In other words, because the question ‘what do you want from me?’ cannot be answered, we experience an inherent ‘lack of being’ (Lacan, 2006, p.251) and perpetual uncertainty. Despite this, Lee (2017, p. 146) states that the subject ‘hauls itself onto a path for finding out what the Other might want or what might satisfy the Other’s desire.’ Hook (2015) notes that there are many indications in the social world (e.g. in culture, advertising and social media) that inform the subject on what is of value *in them*, how they can become *more* valuable (to others and their self) and what they should aspire to be. These ambitions for becoming more valuable are always unachievable, and thus arises the continual drive to *do* more and *be* more than what we currently are: in the end, of course, these ambitions are unfulfilling and unfillable. Kingsbury (2011, p.659) summarises this unattainable object of desire, stating that when a ‘person desires, they do not aim to satiate an appetite but rather aim at something more, something bigger, something better, something worthier, something somewhere else’. Desire can never be satisfied⁸⁶, it only desires, manifesting in the continual ‘*desire for something else*’ (Lacan, 2006, p. 431)). This relation between lack and desire is doubly-framed through the inherent constitutive lack of the subject as well as the lack in the Other. It is at this deadlock that the subject encounters anxiety. Therefore, the *object petit a* is ‘what falls from the subject in anxiety’ (Lacan, 1990, p. 82): it is the object that is encountered ‘where the world fails’ (Žižek, 1994, p.178 cited in Kingsbury, 2010, p. 544).

⁸⁴ Lacan requested that ‘*objet a*’ remain untranslated so as to determine its separateness from the little ‘other’ (*l’autre*) and also to maintain the position ‘a’ in his algebraic matheme as, if translated, it would translate in English to ‘o’ for ‘other’.

⁸⁵ In his algebraic matheme, the subject is depicted by \$ (barred S), demonstrating the split subject.

⁸⁶ This differentiates desire from, for example, hunger or thirst.

Anxiety is particularly hard to locate or concretely define as there is something fundamentally paradoxical about anxiety, either as an absence occurring in the presence of a particular set of interactions or situations, or a lack that manifests through the intensities of experience (Chapter 5). The Freudian concept of *unheimlich*, the ‘uncanny’, plays a particularly important role in Lacanian theorisations of anxiety. Freud (1919, p.370 *emphases added*) defines the uncanny as follows:

The German word *unheimlich* is obviously the opposite of *heimlich*, *heimisch*, meaning ‘familiar’, ‘native’, ‘belonging to the home’; and we are tempted to conclude that what is ‘uncanny’ is frightening precisely because it is *not* known and familiar. Naturally, not everything that is new and unfamiliar is frightening; however, the relation cannot be inverted. We can only say that what is novel can easily become frightening and uncanny; some new things are frightening but not by any means at all. *Something has to be added to what is novel and unfamiliar to make it uncanny.*

The uncanny, as simultaneously and paradoxically unfamiliar and disturbingly familiar, entails a repetition of sorts (Chapter 5). The ‘uncanny’ as concept has been employed in geography (and the wider social sciences) to capture the ‘strangely familiar’: in the emotional geographies of migration (Marinelli and Ricatti, 2013); in the breakdown of self-identities and bodily boundaries in experiences of chronic pain (Honkasalo, 2001); by problematising the boundaries of home/not-home in experiences of homelessness (McCarthy, 2018); and situating the proximity of difference as a perceived threat to social order in experiences of HIV/AIDS (Wilton, 1995). Hook (2005) demonstrates the ‘polemics’ of the uncanny through monumental structures and architecture that embody a felt sense of presence in the viewer, arguing that:

[T]here are two basic ‘poles’ of the uncanny: anxieties concerning variants of *embodied absence* on the one hand, and *disembodied presence*, on the other. At basis, these are ontological anxieties about the status of the object, and more particularly, anxieties about its *status as human*. Put differently, these are anxieties about the soul, which becomes problematic by virtue of either its absence (where it should be present) or its presence (where it should be absent). (Hooks, 2005, p. 697 *original emphases*)

Robertson’s (2015, p.20) account of the uncanny is also particularly useful for considering the uncanny dimensions of social anxiety:

It is always marked by the horrible feeling of being out of place and of everyone else seeing it written on your face, as if in bold, uppercase script. When I am asked to give a toast at a party or a wedding celebration, for instance, my mind suddenly goes blank and I find myself squirming and wringing my hands while everyone’s eyes fix me to the spot. All of a sudden, I

have the mildly psychotic experience in which the faces of my family and friends somehow seem to shed their sense of recognisability and familiarity. In the place of the familiar face or the recognizable friend, all that I see is the space of those horrible, gaping eyes opening up like uncanny black holes in the surfaces of everyone's face.

In relation to social anxiety, the manifestations of this paradox are indeed numerous, as the following empirical chapters will demonstrate, but, as an example, these dynamics could refer to the feelings of isolation and loneliness that emerge even when a person is surrounded by others, the seeming insufficiency of their not being 'good enough' in this situation becoming emotionally and affectively overwhelming and destabilising to their sense of self. It is precisely in these situations that even known and familiar people, for example friends and family, come to occupy a radical alterity or 'Otherness'. Equally, the person experiencing social anxiety may also feel that their private, inner worlds have been radically exposed in the face of 'agonising and paralysing embarrassment' (Robertson, 2015, p. 21). In reviewing Lacan's theoretical move, Hook (2015, p. 119) concludes that:

Anxiety then is less about an object *per se*, than about a crushing experience of 'out of placeness'. Given the conditions of anxiety, [...] an object of sorts will invariably be there, intruding upon the experience of the subject. Crucially however its disconcerting quality has less to do with any of its inherent properties, than with *where it occurs*, with how it disturbs the subject's 'fantasmatic schematization of the world'^{87c}. It is this phenomenon of the object out of place that so directly links Lacan's notion of anxiety to Freud's conceptualisation of the uncanny.

Anxiety, and its affects (e.g. shame, guilt and embarrassment) represent 'our sense of an inalienable and yet un-integratable surplus of self' (Copjec, 2006, p. 23) that has the dual effect of distancing us from our self but also making us increasingly aware of our self, bodies and surroundings. Thus, psychoanalytic theory is useful to understand the fundamentally topological nature of social anxiety, in terms of how it is shaped personally, socially and culturally through traumatic circumstances, social norms and cultural codes and conventions. It also accommodates concerns about how everyday social interactions, situations and spaces occupy an inherent sense of uneasiness and uncertainty, at best, and an excruciating sense of loneliness and isolation, at worst.

ANTICIPATORY CONCEPTS AND GEOGRAPHIES

The anticipatory dynamics of the subject-matter for this project are centred on three

⁸⁷c Literally, how the world is understood, constructed, experienced and made sense of.

intertwining trajectories: the embodied temporalities and spatialities of anticipation; the role of anticipation in the constitution of (anxious) subjectivities; and the role of anticipation in the (un)habitual patterning of social anxiety. There is a burgeoning interest in human geography with the ‘topology of the future’ (Brown and Michael, 2003, p. 4). Research in this area is broadly concerned with the assemblages of anticipatory knowledges, for example ‘pre-emptive’, ‘precautionary’ and ‘preparatory’ logics, as well as anticipatory practice. This concern encompasses the various ways in which the future is ‘mobilised’ and made present (Anderson, 2010) and its impact on the materialities and vitalities of everyday social and spatial life. Logics are defined as a ‘coherent way in which intervention in the here and now, on the basis of the future, is legitimised, guided and enacted’⁸⁸ (Anderson, 2010, p. 778) adds that, if pre-emptive and precautionary actions aim to ‘prevent the occurrence of a future’, then preparedness ‘prepares for the aftermath’ of what does end up occurring.

Anticipatory processes are orchestrated within particular technologies and regimes of (self) governance and (self) securitisation (Adey and Anderson, 2011; Anderson, 2010; Evans, 2010). Forms of anticipatory governance are considered geographically through scientific and technological ‘modulation’ of molecular processes (Anderson, 2007), natural hazards and disasters (Adey and Anderson, 2011) and threats to biosecurity (Hinchliffe *et al.*, 2012). They have also been influential in health-related studies concerning the management of ‘risky’ bodies through policy interventions geared towards obesity prevention (Evans, 2010), and also with respect to the biomedical management of pregnant bodies (Parker and Pausé, 2018) and epilepsy (Smith, 2013)⁸⁹. Outside of geography, others examine ‘anticipatory discussions’ in health and social care settings, demonstrating their formative role in the end-of-life care, by enabling patients, in collaboration with General Practitioners and their families, to account for potential events and interventions in the course of their treatment (Oude Engberink *et al.*, 2017).

Much of this scholarship is operationalised on a macro-scale, but there are small pockets of work where the focus has shifted to assess the logics of practice and performance in everyday life. Tucker (2013) considers the spatial anticipation of the future through mental health service users’ practices of ‘home-making’. Drawing on the experience of two men

⁸⁸ The anticipatory experiences in social anxiety are not often ‘coherent’ and do not always appear to make sense: these ‘logics’ are contextualised and examined in Chapter 5.

⁸⁹ These aspects are embedded in the ‘responsible’ of health care, processes that are evident in the ‘governing’ of social anxiety (Chapter 6).

(‘Chris’ and ‘Roy’), whose social and spatial geographies are mostly limited to home and a mental health day-centre in the community, Tucker argues that home becomes the quintessential anticipatory space for people living with mental and emotional distress (Chapter 7). Present states of wellbeing are enacted through anticipatory ‘home-making’ aimed at reducing (future) uncertainty and instability – and this argument is particularly interesting given that both men have relatively precarious living situations in terms of geography and tenancy agreements. First, Tucker (2013) illustrates how Chris’s practices of stock-piling dried and canned foods can be viewed as a form of anticipatory action in the present. For Chris, regular ‘stockpiling’ produces consistency in his routine habits and future stability by increasing resiliency should he fall upon future hardship. Second, he discusses Roy, who had recently taken over tenancy of his late mother’s house, illustrating here how Roy’s sense of ownership is anchored in the materiality of the home by sorting, de-cluttering and re-organising his (and his mother’s) belongings. Anticipatory practices of home-making not only stabilise the present but aid in generating hopeful and positive futures. A central theme that progresses through these iterations of anticipation is the conceptualisation of anticipatory knowledge, practice and governance as a stabilising, regulating and enabling force in the face of unknown and uncertain futures. Tucker is less concerned, however, with the *lived* experience of anticipation as a temporally and spatially disruptive force (cf. Boyle, 2018; Smith, 2013).

Anticipatory processes are not just about management of bodies, they are embodied, dis-embodied and re-embodied in the everyday experiences of health and illness. Locock *et al.* (2016) identify temporal and spatial cues that cause women to anticipate a formal diagnosis of breast cancer and how various medical sites, sounds, settings and procedures invoke an accompanying affective uneasiness. Smith’s anticipatory analysis of experiences of epilepsy is particularly instructive for this research. While addressing the wider biopolitical governance of epileptic bodies, he also considers in-depth how the anticipatory dynamics of the epileptic body manifest and shape everyday social and spatial worlds. He highlights this point through the event of seizure, outlining how the ‘event’ in and of itself is not and cannot be known by the individual having a seizure due to loss of consciousness and subsequent memory blanking. It is only before the event, through anticipation and ‘aura’⁹⁰, and after the event when a person regains awareness – which, even then, is marked by a ‘lower state of consciousness’ – that events become known. Botterill *et al.* (2017, p. 9) examine practices of self-securitisation by ethnic and religious minority youth

⁹⁰ Smith (2013, p. 4) describes an aura as an ‘embodied sensation’ akin to a warning sign that an epileptic seizure is immanent for example, a feeling or a smell.

in Scotland, arguing that they are fundamental to preserving a person's sense of 'ontological security'. They state that:

In anticipating certain futures, individuals calculate risk, taking into account a series of imagined futures. Their subsequent actions are justified through the preservation of ontological security. We conceptualise 'pre-emptive strategies' of young people as acts that are based on an emergent and indeterminate threat.

Anderson's anticipatory 'logics', by definition, assume 'coherence'. Yet, in social anxiety, the vision of the future and the experience of the present is often incoherent, destabilising and wrought with uncertainty. Useful parallels can be drawn between lived anticipation and 'anticipatory grief', which in part is characterised by feelings of suspense, being overwhelmed, a disconnection from social and spatial life, not being able to think through or construct 'futures' beyond the anticipated event, and contradictory and conflicting feelings and desires (Duke, 1998). In this sense, anticipation as a 'forewarning' can be viewed as 'rehearsal' for the actual event of death (Fulton et al., 1996). Anticipatory anxiety can lead the individual to construct similar bodily, social and spatial mechanisms in preparation of an impending and/or imagined future event (Boyle, 2018). The reality of anticipation is felt as a pervasive threat, where time and space and their relational dynamics are written, unwritten and rewritten as people orientate their everyday social and spatial worlds. Social and spatial environments, comprised of relational patterns and interactions, are, by their very nature anticipatory. As an affective condition, anticipation is a dynamic movement that therefore takes place between a person and their social spatial surroundings, and these felt dynamics or 'intensities' (Chapter 5) find 'corporeal expression in bodily feelings' (Anderson, 2006, p. 736).

Important aspects of anticipatory processes have thus far been neglected in geographical research, namely those concerned with a relational unfolding of anticipatory experiences. Future-orientations are not stable, they are continuously written, unwritten and rewritten in the face of increasing social and spatial demands, and therefore attention must be paid to how anticipations are temporally and spatially (mis)placed. The anticipatory sensibility put forward in this thesis aims to make sense of the anticipation that emanates from the (un)knowns, (un)certainties and (in)securities of everyday social and spatial life as it relates to experiences of social anxiety. Anticipation is integral to the constitution of the (anxious) subject, to the shaping and re-shaping of anxious experiences and to the 'full-blown' pattern of social anxiety that gradually comes into being. Anticipated social threats are made present through the visceral 'reoccurrence' of past events. These events are re-

experienced in the emotional and affective dimensions of anticipation and embodied in the symptoms and sensations indicative of social anxiety (Chapter 6). Anticipation, in this sense, serves to destabilise, disorganise and disable the individual. An anticipatory geography of social anxiety is concerned with what happens *before* and *after* an anticipated event and the various ways that anticipations are socially and spatially constituted and embodied in the present. Moreover, the cyclical iterations of past events, social rebukes and criticisms, projected forward and coloured by various intensities, further bolster the habitual pattern of social anxiety.

EMOTIONAL AND AFFECTIVE GEOGRAPHIES

Bondi et al. (2007) note that the crux of emotional work is most apparent at the intersections of two streams of geographic thought: critical geographies of health and embodiment, on the one hand, and geographies of identities and social relations, on the other. The ‘emotional turn’ continues to enrich and enhance geography’s previously ‘emotionally barren’ (Bondi et al. 2007, p.1) disciplinary landscape. Davidson and Milligan (2004, p. 542) conceptualise emotions ‘as a form of connective tissue that links experiential geographies of the human psyche and physique with(in) broader social geographies of place’, highlighting the interconnections between mind-body-world. By unearthing and placing emphasis, in the context of health, illness and care, on: the emotional dynamics of situated doctor-patient and workplace relations (MacKian et al., 2004; Rowland, 2014); narratives of help and treatment-seeking (Kingsbury et al., 2012); physical and emotional labour in the context of care-giving (Giesbrecht et al., 2016; Parish and Montsion, 2018); biographical disruption in experiences of health and illness (Bell et al. 2016; Lucherini, 2015); and the embodied experiences of health and illness (Davidson, 2001; Longhurst, 1994; Smith, 2012): in all of these ways emotional geographies research has captured how emotions are thoroughly embodied and embedded in everyday aspects of health, illness and wellbeing⁹¹.

Emotional geographies have been influenced by three wider disciplinary trajectories: humanistic, feminist and non-representational (Bondi, 2005). Early humanistic approaches privileged a knowing and knowable subject, replete with consciousness and agency in

⁹¹ The integration of emotions into geography as a ‘field of study’ required geographers to turn the emotional lens on themselves, and consequently various authors have highlighted the emotional dimensions of academic life, for example, research(er) anxieties (Laurier and Parr, 2000; Proudfoot, 2015) (and the emotional labour of fieldwork (McGarrol, 2017) (Chapter 4).

interaction with their surrounding environments⁹². Bondi (2005, p.435) argues that, while humanistic approaches paved the way for the discipline's engagement with emotion, this body of work, concerned with the 'wholeness' of the subject, did not challenge or attempt to rework the distinctions between self, other and environment or see emotion as located anywhere else but in the 'interior lives' of the individual⁹³. Feminist approaches aim to disrupt the gendered politics of emotion that situate 'feminine' notions of emotion and the subjective in opposition to masculine rationality and the objective (Anderson & Smith, 2002). For example, Valentine (1989) and others (Brownlow, 2005; Wilson and Little, 2008), through their work on the geographies of fear, demonstrate how feelings of fear, doubt and vulnerability manifest relationally through culture, the media and attitudes of family and friends, impacting how both men and women perceive, use and navigate both built (Koskela and Pain, 2000) and natural (Burgess, 1998; Madge, 1997) environments. These approaches also aim to disrupt the coherent narratives of the self as advanced by humanistic approaches by taking account of the fluidity of emotions and permeability of bodily boundaries – aspects that are particularly evident in phobic (Davidson, 2000; 2001; 2003) and delusional (Parr, 1999) geographies.

Despite these disruptive attempts, inquiries alert to emotional geographies are often accused of still being too concerned with the cognitive and 'interior' lives of the individual (McCormack, 2006; Pile, 2009a). Psychotherapeutic ideas and methods have taken account of how emotions are relationally and inter-subjectively (mis)understood (Bondi, 2009), embodied, practised and produced in and through space (Bennett, 2009; Bondi, 2009; Simonsen, 2007). More importantly, they have furnished an understanding of emotions as not explicitly cognitive, and therefore unavailable for individuals to 'know', to 'represent' and to wilfully act upon – and hence the turn to affect, in order to engage with the more collectively felt, dimly apprehended, hard-to-recognise or articulate dimensions of life. Geographers have worked in various creative ways to gain an understanding of people's emotional and creative lives, by employing methods that extend beyond simply asking, 'how do you feel about that?'⁹⁴, examples being Bingley's (2003) tactile 'sand play' and

⁹² Early humanistic approaches were also largely subjectivist in that place was understood as a cognitive representation inside the human being and ontologically separate from the objective environment outside (Seamon & Lundberg, 2017, p.9).

⁹³ Similarly, Rose (1993) notes that humanistic approaches are too individualistic and do not pay significant attention to broader social and power relations.

⁹⁴ McCormack (2006, p.331), discussing his affective (rather than emotional) approach to Dance Movement Therapy experience, says that he was 'never once asked how [he] felt, nor was anyone else', reflecting a conceptualisation that emotions are cognitive and discursive, that is, the opposite of affects. This issue is discussed in more detail below.

McGeachan's (2017) encounters with 'Art Extraordinary'⁹⁵, which capture the liminal tensions between people's 'inner' and 'outer' worlds. Davidson and Milligan (2004, p. 524) state, that:

[E]motions can clearly alter the way the world is for us, affecting our sense of time as well as space. Our sense of who and what we are is continually (re)shaped by how we feel. Similarly, the imagined or projected substance of our future experience will alter in relation to our current emotional state. As studies of phobic and delusional geographies show, for some, the feeling that space is populated with the complex and often contradictory emotional projections of others results in experiences of unbearable intensity and distress that challenge the very boundaries of the self.

Emotions are woven into the fabric of a person's experience of health and illness and are therefore fluid and complex, reflecting the ebb and flow of experiences over time and across space. During illness, everyday life tends to be marked by uncertainty, as seen in chronic illness (Moss and Dyck, 2003). This intensity of emotional experience can also be positively and/or negatively impacted by external events, for example by the presence or absence of support systems and employment issues (Dyck and Jongbloed, 2000) or by the ability to find enjoyment and fulfilment in leisure activities (McQuoid, 2017). While certain experiences of health/illness may cause a person to be overwhelmed with emotion, other experiences can leave an individual feeling numb, empty, detached and *emotionless* (yet still *feeling*) (Chapter 7).

Parr et al. (2005) demonstrate the thoroughly emplaced dynamics of emotions through a study of mental ill-health in the Scottish Highlands. By working (if loosely) with the Freudian notion of repression, they disrupt the problematic splitting of emotion and affect (as a split between the cognitive and the non-cognitive). They discuss how social and cultural norms inherent in community life render emotions 'unspeakable' and consider the social and emotional consequences of this individual and collective repressive practice: '[t]he consequences of transgressing cultural norms surrounding emotional expression can include community rejection, devastating in its social impact on small rural places' (Parr et al., 2005, pp.93-94). Consequently, for people with mental health problems there:

is a huge sense of social pressure not to disclose or discuss their problematic emotional and psychological states [and] to battle constantly with the experience of emotional and psychological disruption, not only in terms of searching for recovery from illness, but in respect of the need to conceal what

⁹⁵ 'Art Extraordinary' refers to a unique collection of Scottish 'outsider art' from asylum spaces in early-20th century Scotland.

they have learned [as] inappropriate behaviour.

Parr et al. (2005, p.90) also draw attention to the fact that emotion and processes of repression ‘are not anchored solely in the individual, but rather in a more collective, shared, socially, culturally and even environmentally⁹⁶ situated play of exchanges’. The conceptualisations of emotion by Parr et al. (2005) and Davidson and Milligan (2004) share similar conceptual ground to affect, and Pile (2009) notes that the shared relational ontologies in play here could be a productive middle-ground.

Conceptualisations of affect in academic geography (and the wider social sciences) have been effectively grounded in the work of neuroscientist Damasio and developmental psychologist Stern (Papoulias and Callard, 2010). Geographies of affect are often situated *contra* the emotional, the discursive and the cognitive (Wetherell, 2013), and certain conceptualisations of affect, certainly those dominant in non-representational modes of geographic thought, are often impelled to seek meaning and ‘reality’ beyond words, speech, symbols, thoughts and ideas (Thrift, 2004). This polarising of emotion versus affect, representational versus non-representational, bodies versus talk and practice versus discourse, arising it seems in work on affective geographies, has been the subject of criticism from both within and outwith the discipline (Thien, 2005; Wetherell, 2015, 2013).

Thien’s (2005) criticism centres on the dichotomy of affect and emotion. As the former becomes positioned on a more mechanistic and ‘theoretically sophisticated register’, the latter, she complains, is reduced to a more ‘touchy-feely’ feminised sphere. She is critical of how affect is operationalised in geographic thought, specifically objecting to the fashion in which the language employed to describe how affect is ‘engineered’ becomes ‘something more akin to the networks of pipes and cables’ that ‘provid[es] the basic mechanics [...] to urban life’ (Thrift, 2004, p.58; cited in Thien, 2005, p.452). Thien (2005, p. 450) contends that:

This model of affect discourages an engagement with everyday emotional subjectivities, falling into a familiar pattern of distancing emotion from ‘reasonable’ scholarship and simultaneously implying that the emotion of the individual, that is, the realm of ‘personal’ feelings, is distinct from wider (public) agendas and desirably so.

For Thien (2005), there is an implicit feminisation of emotion occurring here when

⁹⁶ Recent work in an ‘environmental’ vein has sought to engage emotional geographies with climate change action studies in order to orchestrate transformative change (Ryan, 2016).

positioned opposite more masculinised conceptualisations of affect.

There is hence an impasse of sorts between affective geographies and any interest in representation⁹⁷. Affect is strongly associated with a non-representational ontology (Thrift, 2008) that is centred around practice and performativity⁹⁸. Non-representational orientations prioritise the pre-discursive and visceral forces that are ‘irreducibly bodily and automatic’ (Massumi, 2002, p. 28) and therefore apparently resist or escape representation and signification. The body is taken to have ‘a grammar of its own that cannot be fully captured in language’ (Shouse, 2005, p. np). Affective geographies are centred around notions of the excessive, sensorial, intensive, atmospheric, proprioceptive and kinaesthetic dimensions of everyday social, cultural and political life (Anderson, 2009; Bissell, 2009; Thrift, 2004). Bissell (2010a, p. 81) highlights the affective registers of the chronically pained body:

First, there is the affective force of the physical painfulness of the pain itself impressing through the body: the sheer bite of pain through the body itself. Then there is the affective power of the materiality of the hospital that is significantly enhanced by the presence of the pain, demanding a bodily response through choosing to sit on a particular side of the bus [...] But then there is the affect of the hospital that intensifies the embodied sensation of physical pain, the clenched fists, the thumping of the heart, through its proximity. Furthermore, there is also the affective power of the condition of uncertainty itself.

Bissell, relaying how these various registers come together to disrupt and to overwhelm, articulately represents the complexities of affect. However, of these affective relations between body and world, he rather pessimistically says that ‘affect always exceeds understanding and conceptualisation [...] it precedes signification and the formation of meaning’ (Bissell, 2010, p. 82). Yet, the intensity of his experience provokes an attempt to make sense of it, to harness the ‘bite’ of pain and the body’s responses to it, by representing it, in detail, through written word.

Wetherell is critical of geography’s orientation towards affect, not least because it positions affect within a non-discursive framework that she argues is ‘unhelpful’ and unsustainable. Wetherell (2014, p. np) states that:

⁹⁷ An impasse that many have argued creates a ‘strait jacket’ for empirical work (Wetherell, 2013, p. 357; see also: Laurier and Philo, 2006).

⁹⁸ Practice broadly defined here as the ‘the ongoing mix of human activities that make up the richness of everyday social life’(Painter, 2002, p. 2002).

It is so obvious that semiosis and affect are inextricably intertwined, not just in the production of ‘atmospheres’, spaces and relations but in their effects and in subsequent patterns of engagement. It has been seriously unhelpful to posit a generic category of autonomous affect (applied to relations between all bodies human and non-human). Human affect and emotion are distinctive because of their immediate entanglement with very particular human capacities for making meaning. These entanglements organize the moment of embodied change and are crucial to the ways in which affect articulates and travels. They need to be centre stage in any social theory of affect and emotion.

Similarly, Pile (2009a, p. 16) argues that the construction of affect as a non-representational object split from thought and language renders affect ungraspable and unintelligible. As a result, ‘the means through which affect might make itself known, via feelings or emotions or representations, are thereby rendered opaque’ (Pile, 2009, p.17 *emphasis added*), although Pile fails to note that others had already broached this middle ground, most notably Lea’s (2006) exploration of massage and wellness. Lea’s ‘alternative’ non-representational framing is instructive for this research, as she examines how affective experiences/practices and discourse come together to shape our understandings of self and world (Chapter 7)⁹⁹.

This assessment of emotional and affective geographies does not intend to dismiss their relevance, but rather to address what is lacking in current conceptualisations, chiefly with respect to my own particular project. After all, anxiety is understood to have a particular affective architecture (Chapter 6) and manifests as a social, emotional and affective practice (Jackson and Everts, 2010; Wetherell, 2015). Therefore, an engagement with emotional and affective registers is crucial, and, following Pile (2010), I suggest that psychoanalytic theory can be a useful tool to re-orient our engagement with emotion-affect, one that acknowledges the simultaneity and entanglement of representational and discursive practice.

Indeed, language often fails to capture the richness and complexity of experience and we are left, in the Lacanian sense, with the presence of absence, that is, an embodied lack – a lack that is affectively and emotionally embodied in experiences of social anxiety. Crucially for Lacan, and something that could potentially expand non-representational accounts¹⁰⁰ of emotion-affect, while there is ‘no such thing as a pre-discursive reality, [as] every reality is founded and defined by a discourse’ (Lacan, 2016, p. 32) language is

⁹⁹ Such affects, as products of a wider biomedical and/or political discourse, are discussed in Chapter 7.

¹⁰⁰ Anderson (2018) recently addressed the ‘force of representations’, stating that cultural geography was ‘once again’ concerned with representational analyses and practices.

exercised neither as whole or complete. Lacan argues that affects are inextricably tied up with Freudian ‘ideational representations’ or Lacanian ‘signifiers’, as thoughts, ideas, memories, words, etcetera¹⁰¹. He (1991, p. 57) writes:

The affective is not like a special density which would escape an intellectual¹⁰² accounting. It is not to be found in a mythical beyond of the production of the symbol, which would precede the discursive formulation. Only this can allow us from the start, I won’t say to locate, but to apprehend what the full realisation of speech consists of.

Representation relates to how people understand themselves, their social and spatial worlds, how they (attempt to) make sense of their experiences and the resulting impact on their overall health and wellbeing. Such representations are both conscious and unconscious, depending on ‘traces of previous experiences and on the presenting elements of the situation which at that moment is being experienced’ (Timary et al., 2011). The individual and the social cannot be easily separated and so ‘affect is not something external, added to the symbolic, but an internal component of it’ (Laclau; cited in Glynnos and Stavrakakis, 2010, p.225). However, representations are not conceived as solely interpretative of a person’s individual inner world, but rather reflect what Timary et al. (2011) call a ‘community of content’. Context, past and current practice, and complex acts of meaning-making and representation are involved in the spreading of affect, no matter how ‘contagious’ affectivity may appear to circulate¹⁰³. Reflecting back on Parr et al.’s (2005) work on mental ill-health in the Scottish Highlands, we see the various ways in which representations of emotional-affective life are indelibly bound to context and to individual and collective social/cultural norms and practices.

(UN)HABITUAL GEOGRAPHIES

The habitual practice of daily life is understood to encompass ‘a series of repetitive and mechanistic routines, practices and interactions [...] that establish a sense of familiarity and stability’ (Boyle, 2018, p.2). Habit is an important conceptual hook for geographers concerned with the rhythmic and syncopated embodiments of daily life (Edensor, 2010a).

¹⁰¹ Similarly, Neill (2011, p. 23) notes that: ‘The subject, in a sense is nothing but language, while at the same time, the subject is nothing because of language. It is only through being represented that the subject can be said to exist at all and yet, at the same time, in being so represented, the subject is strictly not there. The signifier is there.’

¹⁰² By ‘intellectual’, Lacan is referring to conscious thought or cognition.

¹⁰³ The viral model of affect is posited by Thrift (2008, p. 235) to highlight how affect ‘spreads’ between bodies and is contagious, seemingly operating like a virus, organically, without the need for human signification or representation.

These approaches have been theoretically guided by Bourdieu's (Bourdieu, 1990) notion of 'habitus' and Merleau-Ponty's (2012) 'lived body', striving to understand the everyday practices through which people 'unthinkingly' shape and navigate their social and spatial worlds. While there is no 'single, authoritative [or] consistent definition' (2013, p.137) of 'habitus' in the work of Bourdieu, he does make the following distinction: '[o]ne of the reasons for the use of the term habitus is the wish to set aside the common conception of habit as a mechanical assembly or pre-formed programme' (Bourdieu, 1977, p. 218 [note 47] cited in Crossley, 2001, p. 139).

The implication of this distinction is that 'habitus' is not conceived of as a 'mechanical' practice, but rather it entails a learned, skilled and acquired adeptness. Merleau-Ponty's conceptualisation of the 'habitual body', as a pre-personal and pre-reflexive body, is rooted in his wider analysis of embodiment and perception¹⁰⁴. Both concepts have been particularly instructive for the non-representational analysis of the sequences, repetitions and practices that structure daily life and become ingrained in habitual and unreflexive routines: for example, everyday mobilities of walking (Edensor, 2010b; Middleton, 2011) and commuting (Binnie et al., 2007) or leisurely mobilities such as cycling (Cook and Edensor, 2017) and dancing (McCormack, 2008).

The mobilities and embodiments that constitute this substantive area of research, whether they are engaging with mundane and repetitive, instinctive and unreflexive routines or with co-ordinated and choreographed practices, often call forth an understanding of habit that elevates its 'unifying' and 'integrative' capacity (Alexander, 1987, p. 147) Edensor's (2010a, p. 8) discussion of everyday routines and 'synchronicities' is particularly indicative:

Familiar places are the unquestioned settings for daily tasks, pleasures and rhythmically apprehended routines, with regular patterns of walking, driving, shopping and other routinised practices as part of a familiar spatio-temporal experience. These patterns are marked by regular paths and points of spatial and temporal intersection that routinise action in space [...] Shops, bars, cafes, garages and so forth are meeting points at which individual paths congregate, providing geographies of communality and continuity within which social activities are co-coordinated and synchronised. This ongoing mapping of space

¹⁰⁴ While Bourdieu was certainly influenced by Merleau-Ponty's *Phenomenology of Perception* (1962), there is a distinct difference between the concepts of "habitus" and the "lived body". Merleau-Ponty was concerned with how the body comprehends movement, acquires habits and, reflecting post-phenomenological concerns, the various ways in which technologies operate as an extension of the body: for example, in driving a car. He refers to this extension of/incorporation into the body image as 'a bodily auxiliary' (Merleau-Ponty, 2012).

through repetitive, collective choreographies of congregation, interaction, rest and relaxation produces what Seamon (1980) calls ‘place ballets’.

Much of the work in the subfield of habitual geographies fails to address those who do not or cannot encounter social and spatial worlds unproblematically, for whom daily life is habitually (un)predictable, where the routine spaces that constitute everyday life are continuously disrupted and habitual practices are routinely ‘written, unwritten and rewritten’ in the face of a patchwork of emotional, affective, relational, social and spatial (un)certainties (Boyle, 2018, p.4). Geographies of health and illness demonstrate that the habitual nature and practice of daily life is arguably *not* as seamless and ‘unthinking’ as normative frameworks of habit suggest. Engman and Cranford (2016, p. 36), for instance, provide an instructive reconfiguration of habit through the lens of physical disabilities, arguing that:

If we consider habits only in the context of normative embodiments, it is easy to mistake the homology between body and world that is developed during habit formation as resulting unilaterally from the body’s ability to mould itself to the environments it encounters.

The role of environment in both the conceptualisation of habit and the development of habits is key. Engman and Cranford note that environmental consistency is crucial to the development and maintenance of habits such that, if one’s surrounding environment is disrupted, ingrained habits can become ‘non-functional’. This perspective, however, fails to account for the ways in which ‘the environment is preconfigured *prior to the development of any particular habit by any particular individual* for action by particular kinds of bodies’ (Engman and Cranford, 2016, p.31 *original emphasis*). Equally, habit that extends a cohesive view of self fails to account for the habitual sense of precarity experienced by people with enduring mental health problems, for whom securing some sense of a stable self from which habits can proceed – which can become habituated – may be supremely difficult.

Few geographers have engaged explicitly with habit/habitual practice in the context of health. Notable exceptions are Lea et al. (2015) and Rowles (2000), who examine the habituation of new habits as a mode of intervention from two different perspectives. Rowles (2000) argues that there is a need to understand ‘the complexity of habitual aspects of being in place’ for older people in the community. He highlights how their time-space routines are part of a larger social and spatial ‘homeostatic’ system that has evolved over decades in, and ingrained through, community life. Consequently, even minor disruptions

(e.g. running late for an appointment) destabilise the rest of the day's routines. Rowles engages habituation as an occupational therapy intervention, highlighting how gradual but repeated environmental adjustments that enrich older people's sense of place, particularly in the event of illness or reduced mobility, can enable them to respond and adapt to change. Lea et al. (2015) explore the capacity to cultivate new habits, routines and positive behavioural changes through Mindfulness Based Stress Reduction (MBSR) techniques. MBSR requires people to engage in a self-reflexive dialogue with the self by directing one's awareness towards habitual patterns of mind-body activity that often escape conscious awareness. In this context, MBSR techniques are implemented to intervene in the daily routines and habits that potentially trap the individual in a negative or unproductive cycle, thereby aiding in alleviating stress and anxieties.

Crucially, what both of these pieces of work highlight is that habituating new habits is often a gradual and time-consuming process, demanding of attention, thought, and reflection – what might be termed the thoroughly *unhabitual* making of the habitual. Habit/habitual practices are hence not always a seamless intertwining of self-body-world, passing through bodies without necessarily much mindful involvement, but neither are they 'easily accessible and readily mutable' (Lea et al. 2015, p.61). Lea et al.'s notion of habitual self-reflexive practice also speaks specifically to people experiencing social anxiety, as daily life is often interrupted by self-conscious and self-critical reflexive practices regarding performance and perceived failures in social interactions and spaces. The pervasive presence of anxiety here acquires a destabilising quality that 'habitually unmakes the assumed structure of daily life' (Boyle, 2018, p.4). Not only does this anxiety operate to prevent change, holding the person captive within repetitive and fluctuating anxious cycles (Chapter 6), but it also serves to destabilise the capacity to orchestrate and ingrain new, potentially supportive habits, thus, stalling any productive transformative potential of habit¹⁰⁵.

With the exception of the aforementioned research, explicit engagement with the notions of habit, the habitual and habituation is largely missing in health geography. This absence is surprising given that work on the geographies of mental health, chronic illness and disability is particularly instructive for viewing habit differently, by considering the ways in which the 'habitual nature' of everyday life is not as seamless and 'unthinking' as

¹⁰⁵ MBSR and Cognitive Behaviour Therapy (CBT) techniques are the primary therapeutic interventions prescribed for social anxiety, but these self-practiced and self-managed techniques carry with them the responsibilisation of treatment, problematic when they fail (Chapter 6; also parts of the literature review work in Chapter 2).

habitual geographies appear to convey. In what follows, I pay attention to the routine disruptions and habitual precarity experienced by those with mental health problems, chronic illness and disability by considering the disruption of time-space routines through two dimensions that underpin daily life: home and (im)mobilities.

HOME

Geographical engagements with home-spaces typically attend to the symbolic and material dimensions of the home (Blunt and Dowling, 2006). Traditionally, home is often constructed as a place of intimate and bounded safety, a place saturated with emotions and nostalgia, and deeply invested in our personal and shared identities where traditions and values instil a sense of belonging and connection. Since the 1990s, geographers have engaged in a more critical assessment of home as a contested space marked by, on occasion, its problematic gendering, uncertainty, precarity, discomfort, loss and/or confinement. Sibley (1995, p.93), for example, notes that the notion of 'home as haven' is not unproblematic, family units/home spaces are replete with often-problematic power relationships and boundary disputes. Thus, home is better conceived of as a space that 'disappoints, aggravates, neglects, confines and contradicts as much as it inspires and comforts us' (Moore, 2000, p. 213). The taken-for-granted meanings of home may also be acutely contested, disrupted and changed with the onset of illness or disability where senses of bodily-social-spatial stability and security become frayed (Dyck, 1995b; Moss, 1997).

When people withdraw from wider social networks and spatial life, the home, despite being the place to which people may alternatively come to anchor, can itself often come to symbolise the *loss* of independence and social identity. For those who retreat to the home with the onset of physical impairment, home can become a form of entrapment and confinement that is socially and psychologically harmful (Imrie, 2004). In experiences of agoraphobia, the boundaries of the home represent a 'reinforcement and extension of the psycho-corporeal boundaries of the self' (Davidson, 2010, p. 380) but this shift can often render people more or less housebound. Establishing personal territories and territorial practices within the home-space often aids in regaining a sense of control over the uncontrollable (e.g. other people, germs or injury), but communal areas shared by family members, visitors or housemates can be inherently distressing, and therefore the space of safety can often be reduced to a single bedroom (Chapter 7). The materiality of home, for example telephones, doorbells and windows, embodies an intimate exteriority, whereby the

‘outside’ is felt as present and ever-encroaching. Drawing on experiential accounts of epilepsy, Smith (2013) highlights that, although the home ‘conceals’ the ‘epileptic body’ in the event of a seizure, the ‘surfaces, textures and spacings’ of the home may become threatening to someone during seizure and hence needing to be strategically altered to avoid injury. The quality and stability of domestic life is further entangled with a wider set of social processes including employment, home ownership, housing tenure, social division (Blunt & Dowling, 2006), aspects that are likely to be more precarious for those with mental health problems, chronic illnesses and disabilities.

Home also speaks to the various other spaces people live in or have lived. Presenting a more nuanced account of what, or where, can be considered home, Parr et al. (2003) highlight how an old ‘lunatic asylum’ (or mental hospital) became a contested, yet home-like space for people with mental illness who had been socially and spatially removed from their own Highland and Island communities across Scotland. Asylum spaces simultaneously represented isolation and community, exclusion and friendship, and containment and care for institutionalised communities, even when ‘discharged’ home or to other living arrangements. McCarthy (2018) also disrupts conventional understandings of home, arguing that, for those living through homelessness, the traditional domesticated sphere of home can be an uncertain and uncanny space and homes are re-made throughout the city in multi-story car parks and hostels.

(IM)MOBILITIES

Binnie *et al.* (2007, p. 165) argue that we are always ‘caught up in banal or mundane mobilities [...] enmeshed with[in] the familiar worlds that we inhabit, constituting part of the unreflexive, habitual practice of everyday life’. Arguably, for many, this claim is true, with daily journeys sinking into the background of daily life, playing out relatively unnoticed. The ‘new mobilities paradigm’ advocates, in part, to consider ‘local’ concerns about everyday transportation, material cultures, and spatial relations of mobility and immobility (Sheller and Urry, 2016). Yet, studies here often neglect to recognise or incorporate those whose mobility, including social mobility, as a result of their (in)visible disabilities, chronic illnesses and/or mental health problems, are, at best, severely restricted and, at worst, marginalised and excluded, as they negotiate everyday life with physical, social and/or functional impairments. For people with social anxiety, these everyday mobilities do not always embed seamlessly into the automatic, unthinkingly routine, but rather continually feature in conscious, repeatedly made and re-made decisions about how

to navigate social and spatial life (Chapter 8).

Imrie (2000) identifies the ways in which urban design and planning incapacitates individuals whose bodies and abilities deviate from the ‘norm’, leaving people with physical and mental impairments socially isolated and spatially marginalised by the ‘design and maintenance of public transport’ (Kitchin, 1998a, p. 348). The individual’s movements across public space are rarely experienced in isolation from other people, but there has been less consideration given to the kinds of personal and socio-spatial barriers that can be presented – to certain groups in society – by social interactions¹⁰⁶ around public transportation and mobility in public space¹⁰⁷. Murray (2018, p. 19), examining the ‘why, where and when’ of mobility for people with learning disabilities, argues that:

Getting from point ‘A’ to point ‘B’ is not necessarily a leisurely or enjoyable mobility from one place to the other, but rather it becomes a ‘put-up-with’ necessity in order to enjoy and experience site ‘A’ or ‘B’. This occurrence leaves behind distinct ‘pods’ of safety and comfort, rather than a network of flows between and within spaces and places.

CONCLUSION

Throughout Chapters 2 and 3, I have outlined the social and spatial configurations for approaching an understanding of the lived experiences of social anxiety. In the following empirical chapters, these conceptual markers are not straightforwardly mapped, rather the various dimensions unearthed in the preceding chapters (Chapters 2 and 3) will be discussed both implicitly and explicitly, in such a way that I hope enables the words of my participants’ to breath unencumbered. Chapter 5 will speak to the entanglements between inner-outer worlds and time-spaces by unearthing the habitual and anticipatory nature of anxious experiences and revealing the emotional and affective intensities which persist for the individual. In Chapter 6, the scale shifts towards the ‘governance’ of social anxiety in order to consider how social anxiety is understood and managed. Here, the appeals and pursuit of perceived ‘normality’ are highlighted and discussed. In the final chapters these ‘intensities’ and ‘governances’ are re-situated back within the context of participants everyday lives. Chapters 7 and 8 are written as a couplet and explore in-depth the everyday

¹⁰⁶ Bissell (2010, p. 273) is a notable exception here, considering the impact of affective atmospheres on (the absence of) sociality in rail passenger journeys, arguing that they “modify passengers” possible field of actions, changing their capacity to feel and act.”

¹⁰⁷ From a policy perspective, in May 2016 Stagecoach, a UK coach company, in partnership with the Mental Health Action Group (MHAG) and Anxiety UK, launched a new initiative as part of the UK Government’s Accessibility Action Plan to increase support for, and improve the experiences of, people with hidden disabilities and mental health problems on their transport network.

sites, settings, spaces and social interactions that affect and are affected by social anxiety.

Now, this thesis breaks from the conceptual groundwork outlined in Chapters 1 through 3, to attend to the methodological specifics of conducting research with people experiencing social anxiety.

CHAPTER 4

RESEARCHING SOCIAL ANXIETY: METHODOLOGY, REFLEXIVITY, METHODS

INTRODUCTION

Over the last two decades, qualitative approaches have changed the focus of both subject and method in research in the geographies of health and wellbeing. Kearns's (1993) call to anchor research in 'post-medical'/health geographies to the central concept of 'place' marked a fragmentation in the sub-disciplinary field of medical geography, shifting focus from a concern with the spatial ecology and epidemiology of disease towards social models of health, illness and care. This shift mirrored trajectories in the wider discipline and social sciences influenced by cultural and humanistic approaches (Ley, 1985) which, in turn, fuelled qualitative and interpretative methodologies in order to explore the social construction of health, illness and wellbeing *in place*. Implementing qualitative methodologies in research involves the systematic collection, organisation and analysis of textual, visual and audio materials gathered from, for example, interviewing or ethnography. Qualitative approaches to health research are grounded in interpretive perspectives that prioritise developing a nuanced understanding of the personal meanings of health and wellbeing, and responses to illness that are ground in people's everyday experiences. Furthermore, through a growing use of qualitative methods there are myriad possibilities to re-conceptualise the field of inquiry by challenging the dominant biomedical discourses and social processes through which experience is constructed (Dorn and Laws, 1994).

The voices and experiences of people with mental health problems have historically been excluded from research about them especially in dominant biomedical and clinical accounts (Davies, 2001). Individuals with experiences of mental health are often positioned by their 'psychopathology'¹⁰⁸ as a passive victim (Laing, 1967) within these

¹⁰⁸•Psychopathology' refers to the origin, development and treatment of mental disorders.

systems. Over and above rendering experience and experiential knowledge invisible¹⁰⁹, the dominant paradigm governing quantitative clinical and biomedical research (and informing related discourses) also erases the reality that this knowledge attempts to represent. Parr (2008) calls for work on the geographies of mental health to ‘correct a methodological imbalance’ by designing inclusive research processes that not only acknowledge the voices of people with sustained experiences of mental (ill) health, but also build ethical research agendas and relationships with participants. Qualitative approaches in mental health geographies unearth corporeal and spatial experiences of madness/illness that are typically understood only by their psychiatric classifications (Parr, 1999a, 1999b). Furthermore, we must consider closely what methods we employ to access these knowledges and how they shape and influence the kinds of data produced. Parr (1998, p. 343) asks researchers, particularly those working in the geographies of mental health, to consider ‘contextual methodologies’ in order to ‘recognise the research subject as embodied, as thinking, as feeling, as acting and as more than just a container for information about geographical patterns and relationships’. Thus, the ethical and methodological implications of conducting research with marginalised and potentially vulnerable groups require careful consideration. In this sense, the research process is (small ‘p’) political in terms of the methodological approaches and tools implemented to access and represent the ‘politics’ of individual experiences: that is, the subjective experience of ill-health and how this experience is assigned meaning and mapped onto symbolic, social and physical space.

Diverse species of qualitative methodologies are used to uncover the diversity and dimensions of mental health experience in place, and exploring illness through lived and experiential accounts is a common way to humanise mental health/illness. This kind of research includes: interviews woven with archival materials to uncover patient narratives of institutional spaces in rural Scotland (Parr et al., 2003); field observations and in-depth interviews to explore staff and ‘service user’ perspectives on mental health facilities and care (Pinfold, 2000); ethnographic interpretations of ‘semi-institutional spaces’ (Parr, 2000); collaborative film-making to understand the impact of the arts on mental health (Parr, 2007); and photo-voice to provide context-rich accounts of mental health stigma and recovery (Han and Oliffe, 2016). Other research prioritises unearthing particular

¹⁰⁹ Despite this, there are prolonged discussions in medical fields concerned with the value of qualitative research to clinical practice and health policy (Poses and Isen, 1998). In this vein, the sub-field of narrative medicine has sought to uncover ‘how physicians can reach and join their patients in illness, recognise their own personal journeys through medicine, acknowledge kinship with and duties toward other health care professionals, and inaugurate consequential discourse with the public about health care’ (Charon, 2001, p. 1897).

‘pathographies’ (Hawkins, 1999) or narratives of illness experience (Frank, 2013), employing interviews and focus groups to explore women’s experiences of agoraphobia (Davidson, 2000b, 2000a) and specific phobias (Smith and Davidson, 2006); personal testimonies of schizophrenia (Woods, 2012) autobiographical accounts of bipolar disorder (Chouinard, 2012); and in-depth interviews (supplemented with ethnographic material) to explore ‘personal-psychic’ dimensions of delusional experiences (as opposed to broader ‘medico-legal’ understandings) (Parr, 1999b, p. 678). Finally, there are pockets of research in both health and mental health geographies engaging with the Internet as a topic of research, field of research and/or a tool for research (Crooks, 2006; Parr, 2002; Parr and Davidson, 2008). As this project engages with all three aspects of Internet inquiry, if to varying degrees, I provide an in-depth discussion of online research and working with ‘vulnerable’ populations on these platforms further below. Briefly to anticipate, though, as a research tool, geographers have approached the Internet in two ways: conducting a ‘passive’¹¹⁰ analysis of already-posted ‘live’ and ‘archived’ online content related to particular health experiences (Campbell and Longhurst, 2013; Parr, 2002); or directly recruiting and engaging with participants online via online surveys and synchronous online interviews (Boyle, 2018; O’Connor and Madge, 2001).

In what follows I outline and provide justification for the methodological approach taken and the methods of data collection and analysis employed in the research project. Firstly, this analysis is embedded in the wider politics and goals of research in the geographies of mental health and, by engaging with feminist and psychoanalytic approaches to reflexive practice, I provide an assessment of the research process, practice and my own positionality. Secondly, the over-arching aim of this research design and methodological approach has been to be inclusive and accessible to individuals who often find face-to-face interactions distressing, and thereby I have sought to reduce the potential for harm as much as possible. While not without its challenges, I explore how carefully considered online approaches can be implemented to enrich geographical inquiry. Throughout, I consider the inherent benefits of, and challenges presented by, online research and offer an assessment of the practical and ethical considerations of conducting research with ‘hidden’ groups who, due to their mental ill-health experiences, may be stigmatised, vulnerable and/or isolated. Finally, I detail my use of, and justification for, the specific methods employed to collect the data, as well as addressing the analytical approach adopted for interpreting the

¹¹⁰ By ‘passive’, I mean that the researcher is not actively engaging with individuals on particular platforms (e.g. conducting interviews via e-mail or in chat rooms) but rather analysing the content of their posts and conversations.

data.

RELATIONAL AND REFLEXIVE APPROACHES

The reflexive turn in qualitative research has endeavoured to address a relational problematic by acknowledging and analysing the positions held, and power relations inherent in, the research process. Feminist and, more recently, psychoanalytic critiques have been central for developing a reflexive and inclusive approach to methodologies and epistemologies in geographic research as a means to achieve ethical practice (Brown, 2006; England, 1994; Pile, 1991; Proudfoot, 2015). This call to reflexivity in scholarly practice aims to unsettle and to question the interpretative authority of the researcher (Borland, 2006) and is characterised by a heightened awareness of the positions that ‘we’ (as researchers) occupy in relation to those who participate in research. This ethico-political shift is geared towards a recognition that the construction of knowledge is situated, partial and diverse (Haraway, 1988; Rose, 1997). Yow (2006, p. 55) calls for an increasing awareness ‘to the ways that [researchers] are affected by their [fieldwork] and how the [researcher], in turn, affected the [fieldwork] relationship, the data it generated and the interpretive processes and product’. This call imposes, on the part of the researcher, an awareness of the relational dynamic between researchers and researched, including the content of fieldwork exchanges and what anxieties, difficulties and/or pleasures arise, as well as a responsibility to acknowledge and to analyse ‘our’ shifting positions in the research process.

Many have offered critical reflections on reflexive analysis as a ‘methodological act’ (Lynch, 2000, p. 149; see also: Cushion, 2018). Indeed, expressing concern for the future of politically engaged and policy relevant research in the geographies of mental health, Wolch and Philo (2000, p. 149) state that, with the shift towards representation and position, there is ‘a risk that some researchers become paralytically self-reflexive’. Lynch (2000, p. 47) argues that ‘confessional modes of self-reflection’ only serve as attempts to re-route us back to the very objectivism we intend to critique and/or avoid; whereas Cushion (2018), drawing on Foucault (1996), critiques reflexivity as a technology of power, arguing that instead of fostering critical thinking, reflection risks becoming a disciplinary practice that objectifies, enforces self-surveillance and, by extension, risks creating systems of docility. Similarly, Lynch (2000, p. 36) comments that reflexive practice does not ‘come naturally; it requires a tutorial under the guidance of a particular programme.’ Arguably, one of the challenges of reflexive practice is to what extent, in the

quest for greater transparency in research process and practices, do we ‘enhance objectivity’ or ‘undermine objectivism’ (Lynch, 2000; see also Kerr, 2003)¹¹¹. However, reflexive practice can also be a tool to challenge the dualism of subjective/objective, so as ‘to allow and create a more conceptual and lived space in which we can be more open to the more blurred genre of our experiences’ (Etherington, 2004, p. 36). As an on-going process and not something that only happens after ‘we’ have left the field (as Lynch’s critique alludes), a continual reflexive awareness of our positions and our ‘self’ serves to enhance the credibility of research design, approach, interpretations and findings.

As I reflect on my own ‘position’, I acknowledge that personally and emotionally engaged research is inherently messy. My own anxieties and vulnerabilities as a researcher *of* experiences of social anxiety and also as a person *with* experience of social anxiety are integral parts of my attempts to (un)situate myself throughout the research process. I thereby take the perspective of ‘insider-outsider’ in relation to the participants of this study. This acknowledgment seeks to address how personal and professional worlds intertwine in simultaneously beneficial and uncomfortable ways, compelling sustained attention to reflexive practice (Bondi and Fewell, 2017; Lucherini, 2017; Moss, 1995; Valentine, 1998). Furthermore, reflexivity is contextual and necessitates a continual reflection upon a project’s methodological and ethical practice (Naidu and Sliep, 2011). As highlighted above, people with experiences of mental ill-health have been historically subject to everyday abuses of power and, in the process, systematically marginalised, devalued, stigmatised and discriminated against. Thus, exploring the lived experiences of social anxiety carries with it some responsibilities to design research that fosters participation, but that also enables people to define the nature and limits of their participation. A contextually reflexive practice ensures accountability and transparency in the research process, as well as an extended duty of care towards research participants, to ensure that past wrongs are not repeated or sustained¹¹². What follows highlights the personal, relational and contextual dimensions of reflexive practice. I explore the unavoidable entanglements between researcher, researched and research context that are especially present when personal and professional worlds intertwine. I also pay attention to how, in my own research, the intimacies of closeness/distance, sameness/difference and insider/outsider status were negotiated and reflected upon throughout.

¹¹¹ Kerr (2003, p.30), in developing a collaborative analysis of homelessness, argues, somewhat controversially, that a more inclusive and reflexive practice ‘produces more objective and effective research’.

¹¹² Similar issues have been discussed in relation to ‘decolonising’ research methodologies (Smith, 2012).

The objects of reflexive practice in feminist and psychoanalytic approaches are fundamentally different (Proudfoot, 2015). Feminist scholarship offers a sustained focus on the knowable power relations present in the research relationship and on the interpretation and production of knowledge. England (1994, p. 82 *original emphasis*) defines reflexive practice as the ‘self-critical sympathetic introspection’ and the ‘self-conscious analytical scrutiny of the self as researcher’. Feminist reflexive practices calls for a greater awareness of how multiple and intersecting identities arise and entangle in the research relationship (for example, age, gender, race, nationality, social and/or economic status), influence the researcher’s position and shape the collection, interpretation and production of knowledge (Madge, 1993). Rose (1997) argues that the ultimately ‘unknowable’ (because to an extent they are unconsciously held) positions of the researcher/researched and the uncertainty of fieldwork obstruct any attempts at providing a fully transparent reflexive practice. These dimensions hence only tell a partial story and exclude important intimate, affective and emotional experiences intrinsic to the research process and wider experiences of social anxiety. Psychoanalytic perspectives¹¹³ are ‘profoundly intersubjective’ (Pile, 1991) and seek to expand on, or to problematise, feminist approaches by acknowledging the inherently ‘unknowable’ through the dynamics of the unconscious. Reflexive practice is conceptualised and fostered in psychoanalytic approaches as an interpretative openness to the ‘methodological significance’ of affectivity and language in the research process, so as to take account of the researcher’s interactions and interpretations (Lapping, 2016). Crucially, this step is not about ‘rendering the unconscious conscious’ (Bondi, 2015, p. 73), but rather is about enabling the researcher to disentangle their own issues from those presented by participants¹¹⁴.

Valentine (1998, p. 308) notes that ‘personal geographies are taken for granted until they are transgressed’. In my own experience, geography¹¹⁵ and mental health (my own experiences included) have formed a reciprocal relationship of sorts, with each pushing the boundaries of my understanding of the other in different ways. Geographies of mental and emotional health – as in inclusive studies and their geographies – have been a creative and conceptual outlet that has helped me to make sense of my own experience. I noticed a

¹¹³ Psychoanalytic perspectives, akin to psychoanalytic traditions, are numerous and draw on various strands of psychoanalytic theory and practice, including Lacanian (Proudfoot, 2015) and Object Relations (Bondi, 2015) conceptual moments.

¹¹⁴ Others question whether we can engage in a truly psychoanalytic reflexive practice without the guidance of the analyst (Brown, 2006; see also Proudfoot, 2015).

¹¹⁵ I am referring here to both “worldly” geography (in relation to my own experience) and ‘academic’ geography, as the two appear to be in perpetual dialogue with one another.

particular ‘geography’ to my experiences in my undergraduate years whereby particular social interactions, sites and settings became increasingly unmanageable (for example, social gatherings, one-on-one conversations, large groups, and university lectures and tutorial classes). Developing a social and spatial understanding of social anxiety has helped me to view my and others’ mental health experiences through a different lens, one that diverts attention away from the dominant conceptualisations present in biomedical and clinical literature. I was excited about the possibility of channelling my experiences of social anxiety into something more positive, and hence I formulated projects (at both Masters and PhD level) with social anxiety quite deliberately chosen as the core focus.

Despite this positivity, it has continued to be difficult for me to *live* and *work* with social anxiety. My initial plan was to situate my own personal reflections of living with social anxiety alongside others’ stories. Chatham-Carpenter (2010) discusses similar implications of auto-ethnographic research on anorexia recovery, highlighting how the desire to get ‘good’ material can exacerbate the researcher’s own on-going physical, mental and emotional health problems. The process of reading, talking, writing and re-visiting my and others’ experiences of social anxiety day in, day out, while trying (and sometimes failing) to manage my own anxieties, was all encompassing and overwhelming. Realising that an auto-ethnographic approach may have been doing me more harm than good, I decided to work solely with the stories of others¹¹⁶. At times, the research affected or depleted my own sense of wellbeing, and the more that I immersed myself in others’ stories (detailing personal histories and trauma, the sites, settings and situations of anxiety and ‘(un)healthy’ coping practices), the more I felt the heavy presence of anxiety. On many occasions, I tried to remove myself, not in an attempt to occupy a detached and objective position, but to distance myself in an act of self-protection from the sites and spaces that social anxiety occupied. I also attempted to mitigate the effects of this immersion: for example, the decision to implement online methods was as much about allaying my own anxieties about the immediacy of face-to-face interactions, as it was about providing a safe environment for participants. Despite the considerations given to participants, I have often considered my chosen methods as an act of avoidance, which also led me to question whether or not I was conducting ‘real’ fieldwork when ‘hiding’ behind my computer screen and whether my data would be missing crucial emotional and relational dimensions.

¹¹⁶ The mode of self-reflection required in auto-ethnographic writing can often be quite painful and distressing when scrutinised through the self-critical lens of social anxiety.

The (un)conscious¹¹⁷ attempts made to ‘un-situate’ myself in the research process can indeed be interpreted as an avoidance, since they served as a means to distance me from the messy realities of social anxiety: ‘I’m trying desperately to keep [participants’ experiences] at a distance because it feels too familiar’ (*Research notes, August 2015*). Identifying with various social, spatial and emotional dimensions of participants’ experiences made them difficult to work with and to keep separate from my own experiences: ‘I can’t work with other people’s anxieties right now. I feel like pouring over these experiences is making me more anxious and making me think of new things to be anxious about that have never occurred to me before.’ (*Research notes, January 2016*). Despite reproducing here two statements presented as research diary entries, I should admit that I did not keep a regular research diary. I often scribbled down thoughts, reflections and anxieties in an application on my phone, but for the most part they simply documented my attempts to maintain a safe distance from any encroaching research and/or social anxieties, as in the two entries quoted here. These materials are incoherent and messy, and I questioned whether they were valuable reflections until I read Tamas’s (2009, p. 18) article on ‘troubling the ethnographic voice’ where she argues that ‘clean and reasonable scholarship about messy, unreasonable experiences is an exercise in alienation’.

Drawing on psychoanalytic perspectives provides a useful conceptual framing for understanding such relational ‘owning’ and ‘disowning’ during fieldwork. Bondi (2015, p. 68) states that identification occurs when the subject ‘absorbs and incorporates aspects or attributes of others, metabolising this material to generate his or her own identity’. This process also involves an unconscious ‘projection of unwanted psychic material’ (Bondi, 2015, p.69) onto other people and objects.

In order to access participants’ personal and emotional experiences, it was necessary to establish a sense of rapport and to build trust in the research relationship. This fostering of trust often demands long-term and on-going interactions that may have been difficult to negotiate with people experiencing social anxiety, but my chosen methodological approach – with its principally online character – greatly aided the overcoming of these temporal and spatial barriers. Equally, disclosing my own experiences with social anxiety and acknowledging the inherent challenges of social interactions positioned me as able to acknowledge, understand and interpret their experiences with empathy and understanding,

¹¹⁷ ‘Unconscious’ in the sense I could not precisely pinpoint – nor name – my own feelings of uneasiness and anxiety, while also recognising the psychical processes of which I am not consciously aware, but may ultimately feel the affects.

thus highlighting the value of the ‘insider’ perspective.

Yet, working with the words of participants meaningfully and ethically has still been a continuous source of tension (Tamas, 2009). I feel a great sense of responsibility about re-telling others’ stories and doing them justice, one that is compounded by feelings of guilt that I will ultimately be the only one to benefit from their re-telling. Bondi and Fewell (2017, p. 115) note that ‘research is a way of bearing witness and contributing to conversations about the world within which we are embedded’. While I am deeply embedded in a world where social anxiety is a live presence, my role as researcher, situated alongside my personal experience, positions me as neither completely ‘inside’ or ‘outside’ of conversations about social anxiety. Furthermore, in the absence of more auto-ethnographic details, I worry that my ‘outsider’ status re-positions me as an academic voyeur, with it becoming in effect the responsibility of participants to tell their stories and for me to select the ‘good’ material. Tamas (2009, pp.16-18) expresses similar concerns about ‘intellectualising’ experiences of trauma and loss for academic audiences, questioning how can we (as researchers) present personal and ‘emotional experiences as knowable and meaningful events’.

I had a pre-existing relationship with the two web-forums on which I placed the research call. I had used both to varying degrees as vital sources of informational and emotional support as I attempted to understand and manage my own experiences of social anxiety (although my engagement with one of these sites was under a personal alias). As mentioned previously, I was conscious of becoming the invasive researcher and disrupting group dynamics, but I was also concerned about changing the nature of my own relationship with these communities. In a sense, my own personal relationship with the online communities *has* happened and it would feel ‘strange’ now shifting my identity back to being a member of the community now that I am beyond the ‘active’ researcher phase.

Engaging with the reflexive psychoanalytic practice advocated by Bondi (2015) helped to unravel and reflect on some of the difficulties that I have faced in negotiating the boundaries between personal and professional worlds. Reflexive practice unearths the difficulties in maintaining a balance between identification (‘closeness’) and detachment (‘distance’). My position throughout this research process has hence been one simultaneously ‘within’ and ‘outwith’, one of oscillation between closeness/distance, sameness/difference and insider/outsider wherein moments of

closeness/sameness/insideness have been repeatedly mediated by moments of distance/difference/outsidedness.

ONLINE RESEARCH

The Internet is a vast repository of written, audio and visual material representing peoples' thoughts, opinions and experiences, and a particularly rich – if complex and tricky – resource for uncovering how people understand, negotiate and express their socio-spatial worlds. The proliferation of Web 2.0¹¹⁸ technologies has revolutionised not only how we generate, consume and share information, but also how we communicate, organise and socialise with each other. The Internet provides infinite opportunities for digital communities to coalesce around particular interests. In particular, virtual communities are instructive platforms demonstrating how individuals separated by time and/or space form around common interests or experiences. This element has been particularly instructive in the shaping of online health-seeking behaviours and communities (Bowker and Tuffin, 2004; Crooks, 2006; Madge and O'Connor, 2004; Parr, 2002) (Chapter 6). As a research tool, the Internet is a less expensive and time-consuming method compared to traditional methods of data collection, eroding boundaries of time and distance and providing improved access to hidden or hard-to-reach populations (Im and Chee, 2006; Madge and O'Connor, 2004; Wright, 2005). The Internet is often conceived as an 'untapped' resource for social researchers (Laurier, 2016). Despite these benefits, we (as researchers) must pay attention to the numerous new considerations that arise from conducting research through computer-mediated communications and with individuals in virtual communities, including those concerning informed consent, privacy, anonymity, confidentiality and autonomy (Wright, 2005). With this in mind, researchers engaging with/in this platform, as both research tool and research field, should do so with a heightened awareness and sensitivity, recognising that it provides crucial spaces of refuge and support that are often limited in the outside world – ones where great care should duly be shown to avoid colonising or damaging them for the people who really need what they offer.

RESEARCH DESIGN AND IMPLEMENTATION

This project employed a multiple-method approach comprised of online questionnaires, online semi-structured interviews and telephone interviews with people diagnosed, or self-

¹¹⁸ Web 2.0 denotes the 'second stage' of the Internet, characterised by the shift from static web pages to a model that 'facilitate[s] interactive information sharing, user-centred design and collaboration' (Bernhardt et al., 2011).

diagnosing, with social anxiety. The online design and implementation of the research encouraged participation by enabling people to define the limits of their personal involvement while still encouraging respondents to write extensively about their experiences of social anxiety – I discuss these issues throughout the remainder of this chapter. The research was also informed by a variety of social anxiety resources and personal experiences documented in blog posts, vlogs¹¹⁹ and forum threads. With permission from website moderators, I administered the research through the two online user-led communities Social Anxiety Scotland (SAS) and Social Anxiety UK (SAUK) and advertised it further via a website and social media listing on Anxiety UK (AUK)¹²⁰, a mental health charity that provides support and services to individuals with anxiety-related health problems. The fee for the website listing was £50 and the listing remained in place for six months, while the fee for the social media listing was £30, which also included a listing in AUK’s magazine issued to their membership every quarter. AUK provided a ‘Letter of Support’ for the research to be distributed via their channels for the purposes of my ethics application (Appendix 1). Despite the ‘wide-reach’ of AUK communication channels¹²¹, recruitment via SAUK was the most productive. A potential reason for this disparity is that AUK supports people from across the anxiety spectrum, whereas SAUK is made up of a specifically social anxiety-focused community. Furthermore, the vast difference in membership numbers between SAUK and SAS, as well as Scotland-based participants’ use of both forums, is also reflected in the difference in recruitment numbers here. It is possible that the community aspect drove participation up as members demonstrated their interest in the project on the forum. Participants’ biographical information (where provided), alongside their assigned pseudonyms, is reproduced in Appendix 2 and provided in graph form in Appendix 12. There was a total of 132 participants, 126 people participated in the online questionnaire, 21 participated in a follow-up interview (20 online, 1 telephone) and 2 participated via telephone interviews only (to be discussed later)¹²². Table 4 highlights participant recruitment numbers and their respective contribution to the questionnaire responses and interviews from SAS, SAUK and AUK.

¹¹⁹ Video blog.

¹²⁰ URLs for each site are as follows: SAS - www.sascotland.co.uk; SAUK – www.social-anxiety-community.org; AUK – www.anxietyuk.org.uk.

¹²¹ 150,000 monthly website visits (although not necessarily to their specific ‘research page’), >100,000 social media followers and 1,500 subscribers to their quarterly magazine ([Anxiety UK](#), n.d.).

¹²² Two participant’s did not complete the online questionnaire and contacted me directly after seeing the call for participants on AnxietyUK’s website to schedule an interview. I discuss the implications of this later.

	Social Anxiety Scotland	Social Anxiety UK	Anxiety UK
Questionnaire:	11	117	0
Interview:	2	17	2

Table 4: Participant Recruitment Numbers for Websites

SAS and SAUK are volunteer-led organisations. As well as providing informational resources on their websites, SAS and SAUK provide moderated web-forums¹²³ to a membership of 400 and 25,000 people, respectively¹²⁴. The structure of the web-forums is ‘hierarchical’, devised as a main forum made up of sub-forums (or ‘categories’). Each sub-forum is made up of numerous topics of conversation known as ‘threads’ composed and contributed to by members of the community. Figure 5¹²⁵ depicts the main forum interface on SAUK, showing examples of sub-forums: e.g. ‘Welcome and Introductions’ and ‘The Social Anxiety Room’. As of July 2016, SAS is no longer active, and I discuss the implications of this curtailed activity in Chapter 6.

SAS and SAUK provided me with a platform to access a socially ‘remote’ population who would otherwise have been difficult to reach due to a lack of offline services available for people with social anxiety¹²⁶. Accessing the groups for research purposes required gaining consent from the web-forum moderators (an example e-mail to SAUK is included in Appendix 3). I advised potential participants that their participation was voluntary regardless of their membership of any of the above platforms, as well as stressing that participation could be withdrawn at any time. Recruiting participants and conducting research online responded to the fact that individuals with social anxiety often find face-to-face interactions challenging and/or distressing and may feel stigmatised offline (Wright, 2005).

¹²³ Electronic discussion boards.

¹²⁴ Despite extensive membership numbers, particularly on SAUK, it is not known how many of these members have active memberships or regularly use the sites. The site provides numbers for members ‘active in the last 24 hours’ and there are about 150-200 active members per day.

¹²⁵ I have removed any identifiable characteristics, including user names.

¹²⁶ In the early stages of the project, there was only offline support group that I could identify, Social Anxiety Self-Help (SASH), located in London, UK. I was aware that this group had already been the focus of McCarthy’s (2014) PhD thesis and made a conscious decision not to approach them for research purposes. This group has since stopped their regular support meetings.

Forum	Last Post	Threads	Posts
Welcome & Introductions Room Gentle area to say hello and be welcomed to the board	Hello fellow SAers. 19/01/2023	5,489	56,092
The Social Anxiety Room This is the main area for Social Anxiety topics and help	Wondering to set up a SA... Today 22:38	23,179	262,564
Other Mental Health Issues This is an area for discussing mental health issues other than SA, and any other health-related topics	Anyone else find it hard to... Today 10:42	590	5,012
Room with a View A place for all our positivity and for sharing our successes.	What are you looking forward... Today 20:28	2,496	34,744

Forum	Last Post	Threads	Posts
The Lounge For off-topic, non-Social Anxiety related discussion and topics of a milder nature	TV programs you're watching? Today 23:05	14,135	585,788
Games Room Forum for games like word association, song titles, quizzes and such	Word Association! (2) Today 13:31	670	273,237

Figure 5: Screenshot of Main Forum of Social Anxiety UK

One of the main research objectives, moreover, was precisely to explore how and why people engage in online communities and Internet technologies, and to enquire about the implications of these platforms for overall mental health and wellbeing. A secondary focus here was to understand the relations between online and offline life. It therefore made sense to record participants' experiences *in-situ*, in a 'space' – virtual, rather than physical – that is contextually relevant to the research project and has the added benefit of facilitating a safe and (if properly managed) anonymous research environment.

Research and events¹²⁷, particularly in/around the geographies of health and wellbeing, have drawn attention to the importance of such *in-situ* research methods as a dynamic form of qualitative inquiry that can be used in order to explore in-depth various time and space-specific responses to wellbeing (Bell et al., 2015; Bell, 2017). Research has typically focused on methods that assume no limitations to social and/or physical mobility, notably in walking, swimming and run-along interviews (Evans and Jones, 2011). The use of online and Internet technologies is instructive here, opening up a more nuanced approach to exploring the relationships between self and place while conducting *in-situ* research that overcomes conventional understandings of spatially and temporally-fixed environments (Dubé et al., 2014). However, it is important to note that participants were still located 'somewhere'. While many were 'online' in the relative safety of home, others were at work or in different public spaces: for example, in the local library or at a coffee shop. In several interviews, there were momentary interruptions as family, colleagues and strangers came

¹²⁷ For example, Geographies of Health and Wellbeing Research Group (GHWRG) 'Hack Day: In-situ and mobile methodologies in health and wellbeing', RGS-IBG, London.

into the participant's personal space. Equally, conducting the interviews from my office at the University, I often experienced interruptions, as it was not immediately obvious to others I was in 'research mode'. Furthermore, I was aware that the decision to recruit participants and conduct research in an online environment might exclude those who do not have access to the Internet, are not technologically 'mobile', are not aware of these supportive platforms, and/or choose to manage their social anxiety in off-line environments. While age is often a concern when it comes to Internet use, there is a thriving sub-community on SAUK specifically for 'those a little older' (aged 30-81) and arguably 'ageing' populations are more technologically connected than ever before.

There are further concerns about implementing the Internet as research field and research tool, mainly relating to how it has shaped social contexts, lives, and practices. The Internet has blurred the boundaries between public and private that, in turn, have changed the nature of communication, including what and how we share information through online platforms; this has certain implications in a research context. Kitchin (1998b, p. 386) comments that the Internet and online technologies 'are creating new social spaces that lack the formal qualities of geographic spaces'. Online, the traditional social plane of face-to-face communications is collapsed, fostering a 'pseudo-sociality' as interactions and participation, removed in space and time, are 'abstract', 'feigned' or 'synthetic' (Thurlow, 2013, p. 244). Despite creating a seemingly more interconnected world, many authors have critically assessed the impact of computer-mediated communication¹²⁸ (CMC) on the development and maintenance of interpersonal relationships (Walther and Burgoon, 1992). Studies conclude that there are significant drawbacks to CMC when compared with face-to-face modes of communication, and assert that, due to a lack of visible social cues, CMC is necessarily inferior (Kock, 2004)¹²⁹, particularly where the communication of emotion is concerned (Byron, 2008). Dynel (2017) argues, notwithstanding the complex participatory frameworks that transcend traditional models of communication, CMC should not be regarded as 'pseudo' as, at the most basic level, they quite directly replicate ordinary 'real-world' conversations even if at a spatial and temporal distance (e.g. asynchronous communication). In the context of online exchanges on social media or web-forums, there

¹²⁸ CMC are 'tentatively' defined by Spitzberg (2006, pp. 630–631) as 'any human symbolic text-based interaction conducted or facilitated through digitally based technologies [...] that requires actual people engaged in a process of message interchange in which the medium of exchange at some point is computerized'.

¹²⁹ Kock's (2004) critique of CMC is based on a psychobiological model drawing from Darwinian evolutionary theory arguing that interpersonal skills have evolved to be used in face-to-face communication. Consequently, CMC falls outside of this degree of 'naturalness', and is therefore insufficient for interpersonal needs and inferior as a mode of communication.

is still a ‘producer’ and ‘receiver’ in the same sense that offline there will likely be a ‘speaker’ and ‘hearer’, although online exchanges may be complicated by Internet discourses with the inclusion of acronyms, images, videos and memes¹³⁰. In the absence of non-verbal cues, individuals imbue their messages with meaning through the use of online language (‘LOL’, meaning ‘laugh out loud’), emoticons/emojis (😊) and punctuation (‘!!’; ‘...’), all of which, Brody and Caldwell (2017, p. 2) argue, ‘increases the emotional intensity’ of, and ‘reduces the ambiguity’ in, text-based exchanges. Equally important here is how the Internet has shifted and blurred the idealised distinction between public and private, and personal and social worlds. Baym and Boyd (2012, p. 320) state that the Internet:

[B]lur[s] boundaries between presence and absence, time and space, control and freedom, personal and mass communication, private and public, and virtual and real, affecting how old patterns should be understood and raising new challenges and opportunities for people engaging others through new technologies.

The implications of these shifting boundaries concerning social life as a whole are equally relevant to those researching social phenomena in and/or through Internet platforms.

THE ETHICS OF DOING ONLINE RESEARCH WITH ‘VULNERABLE’ POPULATIONS

Geographers have contributed to debates regarding online research, acknowledging that many of the traditional considerations and challenges, both ethical and practical, negotiated in conventional approaches remain present and require sensitive assessment in the virtual sphere (Madge and O’Connor, 2002). The following section addresses these concerns alongside offering discussion about the concept of ‘vulnerability’ and its application in social science research.

DEFINING ‘VULNERABILITY’ – LABELS OR LAYERS?

The concept of ‘vulnerability’ is contentious in research ethics¹³¹. Recently, a special issue of *Social and Cultural Geography* (2017)¹³² examined the methodological and ethical

¹³⁰ ‘An image, video, piece of text, etc., typically humorous in nature, that is copied and spread rapidly by Internet users, often with slight variations’ (Oxford Dictionary, n.d.).

¹³¹ Research ethics refers to ‘the moral principles guiding research from its inception through to completion and publication of results and beyond’ (ESRC, 2015, p.43).

¹³² Volume 18, Issue 7.

processes and research responsibilities involved in geographical research with ‘vulnerable’ groups. Elsewhere, a growing body of literature has sought to address how vulnerability is conceptualised and employed in research ethics and practice (Bracken-Roche et al., 2017; Luna and Vanderpoel, 2009). While there is criticism that the concept of vulnerability in research guidelines is ‘too vague’ or ‘too broad’ (Schroeder and Gefenas, 2009), others argue that the vulnerability can only be *meaningfully* defined in the context of the specific research project and should be considered as ‘a spectrum’ (Bracken-Roche et al., 2017). Indeed, von Benzon and van Blerk (2017, p. 897), exploring vulnerability in research in social and cultural geography, argue that vulnerability is ‘socially constructed and dependent on the *way* in which power relations are created’ and negotiated between researcher and researcher. Following Luna and Vanderpoel (2009), it is hence appropriate to look at ‘layers’, rather than ‘labels’, of vulnerability.

This research is interested in a population that may be deemed ‘vulnerable’ due to their experiences with social anxiety. Participants are deemed potentially ‘vulnerable’ in a legal rather than, say, ‘sociological’ sense when a vulnerable group is considered incapable of giving, for example, informed consent, which almost certainly not the case for people with social anxiety (particularly if able to access and utilise online media) People with social anxiety may nonetheless be vulnerable due to numerous, overlapping emotional, social and structural barriers, including but not limited to: significant obstacles in accessing education and employment (Chapter 7); being subjected to discrimination and stigma in workplace and social relations (Chapter 8); and being emotionally and/or psychologically ‘at risk’ due to negative impacts on ‘self-esteem, personal confidence and ontological security’ (Thomas, 2007, p. 72). Participants in my study reflect on their own personal feelings of vulnerability, acknowledging that their social anxieties often leave them feeling socially vulnerable (‘feeling vulnerable especially when surrounded by other people’ [Jo QR41]) or emotionally vulnerable (‘[I] feel very down and vulnerable’ [Ben, QR32])¹³³. Perceived vulnerability not only influenced the initial stages of research design, therefore, but also required an on-going and open-ended process of consent to be established (von Benzon and van Blerk, 2017)¹³⁴ to cover the legal base just mentioned

¹³³ Structural vulnerability manifests in various social contexts and wider institutional settings within society. This vulnerability relates to (a lack of) income and/or job security and discrimination in employment (Chapter 7) and healthcare settings (Chapter 6). Another participant highlights that she is trying to allow herself to be ‘more vulnerable’ (Jess, QR88) by exposing herself to new or often distressing social situations.

¹³⁴ This on-going and informed process of consent is discussed further in relation to specific methods.

The interpersonal perspective covered in Chapter 2 suggests that relations of power, specifically ones of dominance and submission, mediate interactions and exchanges between people with social anxiety and others. Stravynski (2007, p.351) describes how such power relations are ‘choreographed’ whereby ‘a fixed stare is met with lowered eyes and averted gaze’. Issues of social power and rank have been found to influence socially anxious behaviour and to shape an individual’s interpretation of verbal and non-verbal social cues, including eye contact, body language, posture, facial expressions and tone of voice (Gilboa-Schechtman and Shachar-Lavie, 2013). Face-to-face interactions can thereby present serious challenges to people with social anxiety in everyday life, and so the research encounter, if conducted face-to-face, holds the potential to exacerbate existing and unequal power relations. Therefore, adapting my research design and methods to facilitate participation as free as possible from such stressful dynamics was fundamental to developing an accessible and inclusive research process suitable for the population under study. Equally, this approach maybe helped to address inherent power relations in the research relationship by removing normative assumptions made about ‘non-normative’ bodies, given that a person’s ‘body’ (inclusive of the social cues mentioned above) is not necessarily visible online (Fox et al., 2007). Online environments served to remove elements of social evaluation and the inherent risk of scrutiny and judgement that are normally present in face-to-face interactions (Bowker and Tuffin, 2004). While there are limitations of online methods (discussed later), the perception of online anonymity meant that respondents, already particularly accustomed to expressing themselves in written and online forms, were more open to writing about difficult and sensitive aspects of their mental health experiences.

However, even with these ‘protective’ measures in place, online encounters still presented many challenges and anxieties – with one participant in particular. Recently, geographers have discussed at length anxiety-inducing encounters in the field (Proudfoot, 2015) while Lucherini (2017) discusses a problematic online and asynchronous encounter in his research with people with diabetes. One participant e-mailed me after completing the online questionnaire to request participation in an interview. They were particularly enthusiastic about the project, suggesting local mental health groups with which they were involved that may be beneficial to participant recruitment. They specified their preference for a telephone interview that we scheduled for the following week. The weekend following our e-mail exchange, I received five consecutive late night e-mails asking various questions about the project and one request to withdraw from the study. Following the protocols from the ethics application, which outlined that anyone who withdrew

consent could do so with no questions asked, I promptly replied, thanking them for their participation to this point and stated that the information that they had provided in the questionnaire would be deleted. I received a final e-mail that said: ‘You don’t give a fuck about me!’ and a further e-mail was subsequently sent to one of my supervisors. At this point, I ceased all communication and forwarded the e-mails to my supervisors for advice on how to approach this situation. This confrontation was extremely anxiety-provoking and, given the reasons for conducting the research and the steps taken to design a sensitive and inclusive approach, I questioned my integrity as a researcher – what had I done to provoke this reaction?

The next morning, I received another e-mail, stating that, after all, they wanted to participate in the study again. This led me to revisit the ethical considerations and, crucially, the process of informed consent. Informed consent is defined as:

[T]he process through which a researcher *obtains*, as well as *maintains*, the permission of a person or a person’s authorized representative to participate in a research study. Informed consent is achieved when a subject of your study receives full disclosure of the research plan and its intent, understands all of the information that is disclosed to him or her, voluntarily consents to participate in the study and is competent to do so, and understand they may withdraw from the study at any time. (Labaree, 2009, p. np *emphasis added*)

After consideration and discussion with my supervisors, I decided to decline the request to participate; this was mainly due to the intensity and content of the e-mails in the preceding 24 hours. In refusing consent, I was not questioning their capacity to give informed and meaningful consent, but rather acknowledging that they may have felt vulnerable about their participation in the research at that time. I felt that the appropriate steps to take were to acknowledge this uncertainty – while not excusing the communications, which I felt were unnecessary, aggressive and excessive – and to refuse participation due to a concern for the participant’s (and my own) wellbeing. I also felt personally and professionally vulnerable and did not want to put myself in the uncertain position of conducting a telephone interview. Equally, I was also concerned about the capacity to maintain consent questioning what would happen if, for example, this situation were to happen again?¹³⁵

As highlighted earlier, the initial role of online forums in the research was twofold: as an object of study (i.e. context analysis of threads) and as a resource (i.e. recruitment and distribution of questionnaires). Many of the ethical debates surrounding research with/in

¹³⁵ There was no further communication.

online communities rest on whether online communities and their content are ‘public’ or ‘private’ (Eysenbach and Till, 2001; King, 1996) and I was indeed conflicted about the use of thread materials. Taking direction from the Association of Internet Research (AoIR, 2012) I negotiated the tensions between the types of data and the specific contexts in which data is produced. The guidelines appropriate to this research are shown in Figure 6.

The online platforms with which I engaged in this research fall under the category of ‘special interest forums’ and, as highlighted in Figure 6, consideration must be given to the level of privacy expected on these platforms and whether researchers can maintain this privacy. Members usually take steps to conceal their offline identities by employing usernames and avatars¹³⁶ to maintain their privacy and anonymity.

Types of Data collected	Types of Venues/Contexts	Commonly asked questions about ethical practice
Interactions, behaviors, transactions <ul style="list-style-type: none"> • Hyperlinks • Comments or Recommendations • File or Information Sharing (file or snippet) • Forwarding /Replying • Interpersonal Interactions, conversations • Networks (e.g., maps visualizing communication flow or strength of relations between persons) 	Direct communication (formal or informal interviews via real-time or asynchronous text, audio, or visual)	How is protection of autonomy of participant/author achieved through informed consent or protection of vulnerable persons? How can researcher ensure that author/participant understands and agrees that content or interaction may be used for research purposes? Is the communication archived or easily searchable and retrievable? Is the data subject to open data laws or regulations? How long does the third party provider or ISP preserve the data and where? Could privacy be achieved through anonymization of email content and/or header information?
	Special Interest Forums (email- or web-based conversations and archives, e.g., threaded discussion forums, chatrooms)	How do terms of service (TOS) articulate privacy of content and/or how it is shared with 3rd parties? Regardless of TOS, what are community or individual norms and/or expectations for privacy? Does the author/subject consider personal network of connections sensitive information? Is the data easily searchable and retrievable? If the content of a subject’s communication were to become known beyond the confines of the venue being studied – would harm likely result? Is the conversation thread or forum perceived as public or private by the author(s)/subject(s)? How is profile, location, or other personally identifying information used or stored by researcher? Is the data easily searchable and retrievable? How is informed consent or protection of privacy achieved? How are vulnerable persons identified and protected? If non-active archives are used, how is vulnerability or harm defined and how are potential or actual subjects protected?

Figure 6: Ethical Decision Making and Internet Research Ethics – Considerations for Direct Communication and ‘Special Interest Forums’ (AoIR, 2012)

Arguably, there are expectations and perceptions of privacy in online communities, particularly when access is only permitted once an individual has completed registration with the website. This was the case with SAS, but is not currently the case with SAUK: SAS’s access was restricted to membership only, whereas all sections of the SAUK forum are open and accessible to anyone without prior registration (with the exception of SAUK – Support Groups’ that are ‘private’: see, Figure 6). The ‘open’ nature of SAUK, while seemingly answering the ‘private/public’ dispute, presents further problems in that search engines index¹³⁷ SAUK forum posts, which means that direct quotations are traceable back to the original source via an Internet search and the individual author identified (even if only by their ‘online persona’). As the boundaries between personal and public

¹³⁶An image used to represent a user in the virtual world that is usually not a portrait of the user.

¹³⁷‘Indexing’ here is the process of adding webpages to Internet search engine results.

communication on these platforms are blurry and, while the Internet is changing the nature of communication, I could not assume users' perceptions of privacy. Ultimately, due to the ease for which this sensitive information can be searched in online search engines, potentially compromising participant anonymity and user privacy, I made a conscious decision not to replicate this material in the thesis. Furthermore, Bowker and Tuffin (2004, p.231) attest that 'public access does not guarantee public disclosure'. Individuals engage with online communities as a means of support and rarely do so with the expectation of becoming research subjects. Research into the interpersonal dynamics of online communities is still an emerging field, but we (as researchers) should strive to ensure that we do not disrupt group dynamics or invade the privacy of groups of interest. The following quotation from an online community member (reproduced in King, 1996, p.122)¹³⁸ highlights the potential for harm involved in conducting research in online communities and reflects my hesitation to 'invade' further into these crucial spaces of support:

I am not going to say any more about myself other than that my name is [deleted], as you can already see from my address. The reason I will not say any more about myself is that since I have become a member of this list, I have been seeing more and more postings from students doing research papers or working on their advanced degrees or journalists looking for interviews for articles. When I joined this, I thought it would be a *support* group, not a fishbowl for a bunch of guinea pigs. I certainly don't feel at this point that it is a *safe* environment, as a support group is supposed to be, and I will not open myself up to be dissected by students or scientists.

As I was conscious that people with social anxiety are often crucially aware of being the focus of attention from 'others', I was especially cautious about reproducing the 'fishbowl' effect highlighted by this participant in King (1996), and thereby disrupting individual interactions or supportive community dynamics on the forum.

Online communities are situated somewhere 'in-between', disrupting the taken-for-granted assumptions about public and private spheres. Researchers negotiating 'private' worlds in the 'public' realm must consider the overall social benefits of encroaching on these spaces versus the potential harm to a given community and its members, while also being aware of the latter's expectations of privacy and safety. Furthermore, gaining informed consent from every member who contributes to a thread conversation of interest would have been difficult and time-consuming, particularly when membership is constantly fluctuating. Considering these issues, I sought to find a balance between using the Internet to engage

¹³⁸ King (1996) reproduced this forum post with permission.

with participants while respecting the supportive functioning of online spaces and communities.

Finally, in terms of ethics applications, I submitted two applications to the University of Glasgow Ethics Committee. My previous Masters of Research dissertation project (Boyle, 2012) proved to be a useful pilot here, insofar as I had gained experience of negotiating the nuances of online research, as well as having previously established research links with the online communities in question. The Economic and Social Research Council's Framework for Research Ethics (ESRC, 2015) guidelines for conducting online research are limited. Instead, I consulted in-depth the Association of Internet Researchers guidelines on Ethical Decision-Making and Internet Research (AoIR 2012) to help with negotiating often blurry and overlapping research boundaries. In order to support the application further and to reduce ethical concerns over participant distress, I completed the Scottish Mental Health First Aid (SMHFA) course in July 2015. This two-day course provided training to help to respond to distress and to prevent a mental health crisis developing into a more serious state. It provided practical steps on how to recognise distress and to provide first aid to people experiencing anxiety, depression and psychosis. The first ethics application was approved in November 2015 (application number: 300140175). The second application requested an amendment to include the participation of 16+ year olds, following a specific request from a younger forum user to be a participant in the project, to which end I applied for PVG¹³⁹ membership that includes an enhanced disclosure to work with young adults. The second application was approved in February 2016 (application number: 300150067).

METHODS

ONLINE QUESTIONNAIRES

The first stage of the research process involved designing and implementing a mixed-method online questionnaire to obtain descriptive-statistical and in-depth experiential data about people's experiences with social anxiety. The online nature helped to facilitate recruitment by allowing participation at a distance, in the sense that there was no direct interaction with myself at any point unless individuals contacted me for more information or opted to participate in a follow-up interview (see below). The use of questionnaires is a path well-trodden in social science research and a staple component of the human

¹³⁹ Protection of Vulnerable Groups (PVG) scheme membership requires a criminal record and background check carried out by Disclosure Scotland.

geographer's toolkit for gathering information about past and present behaviours, attitudes, social characteristics and awareness of specific issues (Clove *et al.*, 2004; Flowerdew and Martin, 2005; McGuirk and O'Neill, 2005; Parfitt, 1997). Web-based surveys have been employed in recent years as an alternative to traditional telephone and mail-based methods (Fleming and Bowden, 2009; Madge and O'Connor, 2004). There are numerous benefits of web-based surveys to the research process, including the relatively minimal time and cost of conducting them and enabling access to geographically remote and/or socially isolated populations. One of the primary concerns of web-based surveys (particularly from a quantitative perspective) is the inability to ensure a representative sample, as there is usually no central database from which to establish the extent to which a sample represents the 'population' (Madge and O'Connor, 2004)¹⁴⁰. It is important to note that mine has been an 'availability' survey dependent on who is online, views the relevant threads and is willing to opt-in or complete the questionnaire, all aspects over which, of course, I could have no control. Therefore, I am not in a position to ensure representativeness in the classic social science mode (Kitchin and Tate, 2013), meaning that extracts which follow must be taken simply as illustrative of diverse experiences of social anxiety, not as anything akin to data from a 'clinical trial'. That said, in analysing the questionnaire returns alongside the interview transcripts, I have sought to 'triangulate' findings wherever possible, in the sense of looking for claims, points, stories and the like that are shared between participants or which clearly disclose certain patterns or regularities of experience, understanding and hopes or fears.

The online questionnaire was created using the software programme Lime Service, an online open source¹⁴¹ survey tool. I chose Lime Service as it met with ethical considerations related to anonymity, privacy and confidentiality, and it is also a service that requires no registration on behalf of participants. The record of their responses did not contain any identifiable information about them, with the exception of questions explicitly asked by the researcher: for example, contact details for interview participation. Participants were able to access the research information page, questionnaire, support information and provide electronic consent via a stand-alone website (Appendices 4-7). The first page of the questionnaire served as the research information page and participants could download this directly from the webpage and retain a copy for their records. I

¹⁴⁰ Fleming and Bowden (2009) distributed surveys via two modes: online and mail, and found that the socio-demographic make-ups from both modes were not statistically different. Other comparison studies also found no significant difference in sampling between web-based and other distribution modes (including telephone, mail, and face-to-face) (Cobanoglu *et al.*, 2001; Lindhjem and Navrud, 2011).

¹⁴¹ Open source denotes programmes and computer software that is freely available to anyone online.

advised participants that their contribution was voluntary and that their anonymity would be maintained at all times. Participants were also made aware that, by submitting the questionnaire, they were consenting to their responses being used in the thesis and related outputs.

The use of the questionnaire method is often criticised for the limited ‘depth’ and ‘extent’ of qualitative data that can be produced (McGuirk and O’Neill, 2005), and de Vaus (2013) argues that questionnaires do not allow for the complexities and contradictions of experience to be adequately portrayed. In this context, however, the questionnaire approach appears to have been an inherent positive of the research design, strengthening rather than hindering the quality of the resulting data. On the one hand, the online and anonymous mode helped to facilitate participation and, on the other, the open-ended and asynchronous nature provided an environment where participants had the time, space and privacy to consider and process their response. This was an extremely important aspect given that many individuals with social anxiety find the proximity and immediacy of in-person communications distressing. This research environment hence enabled the subtleties and nuances of their experience to be expressed in written form, a more comfortable medium of communication precisely for these respondents removed from the potential embarrassment or distress of the encounter.

Crucially, moreover, the design of my online questionnaire did not confine experience to a series of ‘tick box’ responses. The common principles of questionnaire design advocate shortness and simplicity to encourage completion and to avoid ‘fatigue-bias’ (Parfitt, 1997), but for my study, and in order to elicit detailed narrative outcomes, participants were encouraged to give detailed responses inclusive of their thoughts, feelings and socio-spatial surroundings. I purposefully designed a questionnaire comprised of 5 sections and 34 ‘open’ and ‘close-ended’ questions. Closed questions included multiple choice and Likert¹⁴² scale questions intended to elicit descriptive statistics that represented particular attributes of anxious experience (Appendix 6). McGuirk and O’Neill (2005, p.149) argue that ‘closed questions rest on the assumptions that words, categories and concepts carry the same meaning for all respondents and this may not be the case’. Open-ended questions then made it possible to pose more complex questions to generate more detailed and nuanced narrative accounts, but they were equally susceptible to respondents’

¹⁴² A Likert scale provides a range of responses from one extreme to the other, e.g. very unlikely to very likely, usually given a quantitative range (i.e. 5 = very unlikely; 1 = very likely) so as to allow the generation of simple descriptive statistics.

interpretations of the question and the relevance of the question to their own experiences (Appendix 7). The questionnaire design followed a logical and coherent sequence, with questions addressing various aspects of socially anxious experience grouped together under specific headings (Table 5). Given the length of the questionnaire, the design was fundamental to sustaining a participant's engagement: each section featured an introductory statement followed by several closed-ended questions – intended to encourage participants to start thinking about the sites and settings of their anxiety – building up to open-ended questions enabling participants to reflect in-depth and with detail about their experiences.

Questionnaire Outline
Introductory questions: Personal, social and biographic information including age and gender.
Everyday life: Everyday interactions, situations, and spaces that affect/are affected by social anxiety. Closed questions relating to 'feelings of safety' (from very unsafe to very safe) and 'likelihood of anxiety' (from very unlikely to very likely).
Symptoms: How social anxiety manifests, what symptoms are experienced, impact of these symptoms?
Community, management and support networks: Management of social anxiety, sources of support and information.
Final Questions: Opportunity to note anything important that was not covered, additional information, feedback and note interest for further participation.

Table 5: Outline of Questionnaire Sections

The anonymity and unlimited nature of open-ended, text-box answers encouraged participants to write extensively about their experiences, and I found that many participants were indeed prepared to do exactly this – perhaps in part because the very nature of the recruitment process, via web-forums, meant that participants were accustomed to writing at some length online about their social anxiety concerns when blogging/posting. Alternatively, the lengths at which some participants wrote also signalled that the topic was one they may not have had the opportunity previously to discuss at length, a possibility highlighted by many of the positive comments added at the end of the questionnaire and by the sheer amount of data collected via this method (approximately 70,000 words of qualitative text). Two iterations of the questionnaire were produced before the final version was uploaded and made available to participants, and these versions were piloted with four people (two from SAS and two from SAUK) and one moderator of SAUK.

While the questionnaire was the most appropriate method to engage participants in the research process due to how it was implemented, i.e. anonymously and online, I was

unable to seek clarification or expansion on individual responses unless participants self-selected to participate in a follow-up interview. Conversely, the questionnaire itself was a productive method for researching sensitive topics relating to mental health experiences that are still taboo and stigmatising. The online nature assured anonymity and a medium of interaction with which people were comfortable (i.e. non face-to-face and allowing written responses). These conditions ensured the seemingly open and honest accounts of experience evident in the extremely detailed accounts shared through the questionnaire. Participants may not have been so forthcoming in their responses through other, more corporeally invasive methods. Through the questionnaire data, I devised an iterative framework for semi-structured interviews, in order to engage in an on-going process of developing meaning and sparking new lines of inquiry leading to a refined focus and understanding (Srivastava and Hopwood, 2009).

ONLINE SEMI-STRUCTURED INTERVIEWS

The trend towards creative and visual praxis is fuelled by a sustained hostility towards the importance placed on verbal, written and discursive representations of life that still characterises a lot of research in contemporary human geography (Dowling et al., 2017). Despite this hostility, the interview method is probably the most common mode of data collection in the history of qualitative research in health geography as a way of understanding participants' experiences through their own words and perspectives. A focus section of *The Professional Geographer* (1999) outlined the early methodological issues, challenges and implications of 'qualitative approaches in health geography'. The collection alone highlights the prominence of in-depth interviewing in the sub-discipline for exploring various aspects of health, including: relationships with physicians (Marshall and Phillips, 1999); meanings of health-related risk (Baxter and Eyles, 1999); lived experience of HIV/AIDS (Wilton, 1999); and approaches to heart health promotion (Robinson and Elliott, 1999). In the same issue, Garvin and Wilson (1999) combine interviews with images to develop picture-elicited narratives about women's tanning behaviours. While there is a vast array of literature concerned with the interview process and techniques, there is a small and relatively stagnant body of research discussing Internet-mediated methods, including asynchronous (Ward, 1999), synchronous (Boyle, 2018; O'Connor and Madge, 2001) and Skype-based (Iacono et al., 2016) online interviews and online focus groups (Fox et al., 2007). Arguably, a significant problem with the lack of utilisation of online research methods is that the technology evolves faster than the discussion: for example, the technology implemented by Madge and O'Connor's studies (2001; 2004) is no longer

operational.

The second stage of my research process hence involved conducting semi-structured interviews. I used synchronous online interviews to elucidate further the material gathered from the questionnaires with self-selecting respondents, rather than using an asynchronous method that entails a ‘temporal displacement’ (hours, day or weeks) between the sending of questions and the receipt of responses (Bampton and Cowton, 2002). Respondents who had completed the questionnaire were given the option, at the close of the questionnaire, to self-select to participate in an online interview. Interview schedules were comprised of an iterative framework of general themes emerging from the questionnaire responses and pre-established questions that helped to establish a ‘loose sense of format or structure for the interview’ (Cloke et al., 2004, p.152). In addition to this ‘overarching framework’, interview schedules were also tailored to individual participants to prompt personal lines of questioning, enabling me to expand on details from the questionnaire response – a snapshot section of the generic interview schedule is attached (Appendix 8). Each interview schedule was tailored to the participant’s questionnaire responses in order to focus on and prioritise aspects of experience that were significant to the respondent. I contacted self-selecting participants within two weeks of questionnaire completion with more information about the interview process, including a copy of the research information sheet (Appendix 11). I aimed to schedule interviews within one to two weeks of my initial contact.

The ‘placing’ of interviews was of particular concern given that face-to-face interviews would have been impractical for many participants, not least for the various reasons explained above with reference to my target cohort (people with social anxiety). I aimed to make the research design as flexible, inclusive and accessible as possible, offering online text-based interviews in the first instance and negotiating terms on an individual basis¹⁴³. This approach proved to be beneficial as many participants demonstrated concerns about face-to-face interactions in their remarks at the end of their questionnaire. Several participants stated explicitly that they would only participate further via online methods:

I’d much prefer online, as I struggle to answer phone calls but I would be happy to take part in a follow up interview online. (Olivia, QR187)

I’m willing to do it online, not in person or via Skype. (Molly, QR42)

¹⁴³ People may have been less responsive to participate had the telephone interview been offered in the first instance and online interviews negotiated on an individual basis.

For one participant, despite the anonymity offered by the online environment, the immediacy of synchronous exchange was potentially as distressing as face-to-face interactions: ‘Even the thought of an interview online terrifies me. I may not be of any further use to you but I will give you my e-mail address, I can always decline can’t I?’ (Tina, QR123). I sent a follow up e-mail to Tina one week after she completed the questionnaire, acknowledging her concerns and providing more information about the interview process. Unfortunately, I did not receive a response, but the detail with which she initially recorded her experience in her questionnaire is extremely valuable.

I conducted the interviews using a web-based chat room called ‘Chat Step’ (accessed via www.chatstep.com). As our conversations were not stored or archived on Chat Step’s database, the disposable nature of the platform provided a solution for any concerns over anonymity, privacy and data security. Using Chat Step, I was able to create a password-protected chat room and share the information with participants to log in at a pre-arranged date and time. Initially, I sought to obtain consent via this platform, but this proved too time-consuming, and so instead I negotiated consent electronically in the e-mail communication prior to the interview (Appendix 9). I also provided participants with a set of guidelines to help facilitate the interview process (Table 6). Participants did not have to register to use the services or download the programme on to their computers. At the end of the interview, a transcript of our conversation was available to download immediately and participants could retain a copy of the transcript for their own reference¹⁴⁴. There were no requests to amend transcripts. A screenshot of an interview conducted via Chatstep is attached in Appendix 10.

In my e-mail exchanges with participants, and again in the interview guidelines, I highlighted the importance of their personal experiences; particularly after one respondent worried that she was ‘no expert’ and that her lack of ‘medical knowledge or technical terms’ (Kirsty, QR87) would make her an unsuitable participant. Making participants aware that there were no ‘wrong answers’, and that their own lived experience was the ‘expert knowledge’ and focus of this research project, helped to reduce inhibitions and appeared to encourage an in-depth and detailed range of responses.

¹⁴⁴ One participant noted she had found the discussion so illuminating that she was going to take a copy of the transcript to her next counselling session to unpack the text further.

ChatStep Guidelines for Participants

Thank you for taking the time to chat with me today.

- I would like to chat to you about your questionnaire responses in more detail and have an informal chat about your experiences with social anxiety.
- The interview should last no longer than 1.5 hours.
- Responses on the ChatStep platform are restricted to 200 characters. Please send responses 2-3 lines at a time to avoid any technical problems.
- Please give as much detail as you are comfortable with.
- Finally, if you feel uncomfortable with any of the questions or would like to step the interview, you can do so at any time ☺

Do you have any questions before we get started?

Table 6: Guidelines for participants provided at the beginning of the interview process

One of the limitations of Chat Step is that messages have a 200-character limit. At times, I was unsure whether periods of silences meant that a participant was thinking, did not understand the question or, as happened on several occasions, they had experienced technical difficulties that did not register on my end of the chat-room and been ejected from the room. When participants were responding, a pulsing icon appeared next to their name, providing reassurance that they were still active in the chat room. Madge and O'Connor (O'Connor and Madge, 2001) report similar difficulties with online interviews, noting that, in the absence of visual cues, an attentive but direct line of questioning often replaced the more subtle gestures and probing present in face-to-face interactions. From the perspective of the researcher, online interviews can therefore present some difficulty because the embodied details and social cues inherent in face-to-face interactions are concealed, making it difficult to sense the appropriateness of particular lines of questioning through participants' non-textual responses. Further concerns about the absence of visual and verbal cues relate to those cues that would indicate participant's distress, uncertainty and ambiguity in the research process. From an ethical standpoint, I was concerned that I would not be able to respond sympathetically or appropriately in these instances. Participants often gave indications of their emotions, feelings and frustrations, using symbols and acronyms popularised by CMC, but, even so, their overall words were usually far more insightful in this regard. Significant in this research is that prioritising textual representations removed the element of social evaluation and, by extension, participants' perceived scrutiny and therefore any triggering of their own self-critical perspectives

(Bowker and Tuffin, 2004). Gies (2008) argues that online interviews and CMC in general are ‘impoverished’ by a lack of body language and social cues, viewing textual representations of conversations as merely a process of ‘making do’. From psychoanalytic perspectives¹⁴⁵, the digitalisation¹⁴⁶ of language can only partially capture or represent experience:

[W]riting can only depict some of the melodic patterning of face-to-face speech through the digital means of meter, rhyme, punctuation, etc. When writing is then used to recreate screen-to-screen interface through the Internet (e.g., Facebook), the missing analogical elements, such as emotions, must be added through the digital means of emoticons [(:)], acronyms (LOL, OMG), typeface, and so forth. Most important for analytic work, the nuances of emotions, which are analogical, become increasingly displaced at each digital step in ways that challenge one to re-examine concepts such as disavowal and dissociation. (Litowitz, 2012, p.508).

Litowitz (2012) duly questions how analysts can do the kinds of analytic work required of them in/through online platforms given that the emotional responses, body language, ‘ums’, omissions, silences and so on cannot be adequately represented or interpreted. Certainly, many aspects that may have given a ‘fuller’ representation of social anxiety *in-situ* were missing with this approach. However, it would have been unnecessary, not to mention ethically unsound, to place participants in a social interaction that could have triggered or exacerbated their anxieties in order to capture these dimensions. While not a perfect tool, the Internet allowed access to a marginalised population and enabled their participation in the research on their own terms. It required, in certain instances, more probing to unearth many of the nuances of experience that may have been detectable through body language, facial expressions and emotional responses, but I am confident in the quality and indeed robustness of the data that my online interviewing method afforded

How my participants wrote about their experiences in the ‘virtual’ world was often very emotional, incredibly detailed and no less salient or powerful in the absence of the ‘real’, fleshy person. Textual representations here did not hinder or ‘impoverish’ the research

¹⁴⁵ The primary modality of psychoanalytic practice and theory is rooted in face-to-face encounter and treatment. Litowitz (2012) notes that, despite clients bringing aspects of the Internet into treatment (e.g. social networks), psychoanalysis has been slow to conceptualise or respond to these activities (e.g. are clients avoiding reality or playing with reality?) and what the implications might be (Chapter 6). The principles of psychoanalysis do not map easily on to a culture saturated by the evolving nature of the Internet.

¹⁴⁶ In this sense, all language written or in print ‘digitalises’ experience, although the Internet adds another dimension to this process of ‘digitalisation’ as experience here is expressed through written and online languages (Litowitz, 2012). Interestingly, online language (e.g. LOL [laugh out loud], TMI [too much information]) is now used in everyday face-to-face communication, a reverse move from online to offline.

process, but rather enriched it by providing an anonymous platform through which participants reflected in detail on their experiences. To put this into context, the questionnaire and interview responses together generated over 120,000 words of qualitative data (approximately 70,000 and 50,000 respectively), clearly demonstrating participants' willingness to share in detail and at length their experiences of social anxiety.

TELEPHONE INTERVIEWS

Telephone interviews are regarded as a principal method of data collection in quantitative research (Novick, 2008), particularly in health-related fields (Aday, 1996). Methodological literature concerning the design and implementation of telephone interviews tends to align the method with the questionnaire survey mode of inquiry, describing the approach as a compromise between face-to-face and postal questionnaire surveys (Parfitt, 1997). McLafferty¹⁴⁷ (2010, p. 83) states that telephone interviews are 'generally limited to short questionnaires with fixed-response questions', and it is added that the time limit for telephone surveys should not exceed 30 minutes (de Vaus, 2013). Consequently, in human geography few qualitative studies employ in-depth telephone interviews and little methodological discussion or critical debate about the telephone as a mode of qualitative inquiry beyond survey-based methods. The field of nursing research has engaged with telephone interviews as a qualitative mode of inquiry (Novick, 2008) and conducted comparative studies with face-to-face interviews (Sturges and Hanrahan, 2004). Similar concerns arise with telephone interviewing as with online interviewing regarding the mode's compatibility with an interpretive research approach (Sweet, 2002) and the loss of non-verbal and contextual data (Opdenakker, 2006).

In this project, semi-structured in-depth telephone interviews were implemented to expand on participants' completed questionnaire responses and not used to carry out a telephone-based questionnaire survey. As with the online questionnaire design and online interview method, general research principles relating to type of question or length of interview did not apply in this context. Telephone interviews were equally as in-depth as online interviews and lasted approximately 1.5-2 hours, with no signs of participant fatigue. The three participants (Karen, Moira and Nina) who participated via telephone interviews did so for a variety of reasons, including preference and Internet access issues. They also expressed no overwhelming anxieties about voice communication and/or interactions and

¹⁴⁷ In the same text, Longhurst (2010) discusses semi-structured interviews, but does not mention or discuss telephone interviewing.

felt comfortable participating in this capacity. Similar to the online methods, telephone interviews enabled participation by individuals who were socially and geographically remote¹⁴⁸. Furthermore, Karen had no home Internet connection or access to a laptop, finding the project while browsing the Anxiety UK website on her mobile phone, further cementing the value of maintaining an open and flexible approach that responded to the needs of participants.

Prior to the telephone interviews, I communicated with participants via e-mail and sent an information sheet and consent form (Appendix 9 and 11) that covered the interview process and issues of consent, confidentiality, and anonymity and data collection. This was primarily a repetition of the information sheet that was sent to participants previously, but, as approximately two weeks had passed between arranging and conducting the interview, I wanted to ensure that participants fully understood the research and interview process. This also ensured that all participants were receiving consistent information (Burke and Miller, 2001). I obtained verbal permission from all three participants to record the interviews: telephone interviews were played through the loudspeaker on my mobile phone and recorded using a Dictaphone. As the conversations had to be played on loudspeaker, I had to consider carefully when and where to conduct the interviews so interviewees could not be overheard. Two were conducted in rooms that I had booked in the University of Glasgow and one was conducted at home. Telephone interviews were then uploaded to my PC at the University and transcribed using qualitative analysis software NVivo® (v.11) (see also below), and the Dictaphone was subsequently wiped of all data and recordings.

Opdenakker (2006, p.4) raises concerns over the lack contextual and non-verbal information available to the researcher when conducting telephone interviews when there is ‘a synchronous communication of time but asynchronous communication of place’. Similar issues have been discussed above relating to online interviews. Of those interviewed via telephone, Karen and Nina were at home and Moira was at work; while not visible to me, where these participants were located became extremely important to what they would and could discuss during their interviews. Karen is relatively housebound and discussed her experiences of anxiety in the context of home and relationships with family; Moira focused on the workplace and workplace tasks and relations, raising concerns about an upcoming conference; and Nina, who had returned home from her volunteering role, focused initially on the impact of a supportive workplace for her social anxieties. Much of

¹⁴⁸ The telephone interviewees were located in North East Scotland, South West England and Northern Ireland.

the contextual data was communicated through participants' own words rather than being interpreted through the eyes of the researcher.

While both Karen and Moira were extremely forthcoming in their responses, I found interviewing Nina to be a little more challenging as she seemed hesitant to discuss the emotional dimensions of her experience in-depth. Nina was the only interview participant (online and telephone) who did not complete the online questionnaire¹⁴⁹. She contacted me directly from the post on AUK requesting to participate in an interview. I tried to be as flexible as possible in order to accommodate Nina's request and schedule, but her non-completion of the questionnaire made it more difficult to strike up rapport with her as I was entering the interview with no information about Nina's experiences¹⁵⁰, and she had no previous engagement with the research as other participants did. Therefore, it was difficult to judge the appropriateness of questions and I could sense her becoming quiet or withdrawn when I pressed for more emotional dimensions of her experience. She responded on several occasions with 'I've never actually thought about it' or, if I attempted to re-word a question, 'I don't know'. There was a sense that Nina was hesitant or uncertain and these responses could be interpreted as a way of shutting down discussions that touched upon more uncomfortable or personal dynamics¹⁵¹.

DATA ORGANISATION AND ANALYSIS

Of the 178 people who engaged¹⁵² with the questionnaire, 128 people submitted their responses¹⁵³ (a 72% completion rate¹⁵⁴); while 38 participants self-selected to participate in a follow-up interview, although I was only able to establish contact with 19 interview

¹⁴⁹ I did provide her with the link and requested that she complete the questionnaire prior to the interview so that I could conduct a preliminary analysis of her responses and tailor the interview schedule to her experiences, but she did not have the time. Also, due to her work commitments we had to reschedule the interview on one occasion.

¹⁵⁰ I worked iteratively between questionnaire responses and interviews by reading through the online questionnaire responses made by individuals who I went onto interview (online or over the telephone), so that I already possessed quite a detailed picture of how they lived with their own social anxiety – and of other aspects of their everyday life-worlds.

¹⁵¹ Equally, there was the sense that Nina experienced quite a lot of shame and (self)-stigma regarding her mental health. She highlighted that she was previously a counsellor and was 'angry' that she had found herself 'in this position and not recognised it sooner'.

¹⁵² By engagement, I mean participants who proceeded beyond the research information sheet and either partially completed or fully completed the questionnaire, but did not necessarily submit their responses. Participants were required to submit their responses at the end of the questionnaire in order to provide full consent.

¹⁵³ This does not include Sam's withdrawn response (discussed earlier).

¹⁵⁴ As I advertised the research online via multiple platforms, the potential population size is unknown; therefore, it is not possible to gain information on the response rate.

participants¹⁵⁵. Two participants participated in interviews only. The total number of participants was 130. Using NVivo® I created a ‘case file’¹⁵⁶ and assigned ‘case attributes’ (i.e. characteristics of a person, including age, gender, living situation, sexuality) for each participant, whether or not they proceeded to the interview stage. I filed individual questionnaire and interview transcripts, as well as data collection and analysis memos, for each participant in their assigned ‘case’ files. I assigned participants a case file number, a reference number corresponding to their questionnaire response ID (e.g. QR01). I assigned pseudonyms to participants whose responses were used in the thesis write-up and related outputs.

An advantage of conducting online research was that all of the data generated through this route was written and therefore in effect already ‘transcribed’, and I was able to download the questionnaire and interview transcripts from the Lime Survey and Chat Step platforms. During the process of transcribing the three telephone interviews, I omitted transcribing ‘filler’ words such as ‘um...’, ‘ah...’ and ‘like’, although I noted when participants laughed or sounded frustrated and/or exasperated¹⁵⁷. The textual records are in plain English although some Glaswegian and Scottish vernacular, particularly between me and other Scottish participants, emerged. Similarly, the women who participated in the telephone interviews were from Scotland, Northern Ireland and England, each with very distinct local vernacular and turns of phrase. I have omitted this information as, for the most part, it is also ‘missing’ in the textual representations unless it serves to contextualise specific socio-spatial dimensions of experiences. All identifiable characteristics have been removed and quotations are reproduced in the following chapters with omitted text (signified by ‘[...]’), minimal grammatical and formatting ‘corrections’ for ease of reading.

I implemented an inductive¹⁵⁸ and iterative approach to analysing and interpreting both the questionnaire and interview data by drawing loosely on a constructivist (as opposed to objectivist) ‘grounded theory’. This approach is well established in social science and

¹⁵⁵ Participants may have decided to ignore invitations to participate in the interviews, but this disparity between those opting to participate and those who responded highlights another issue presented by online research. It is possible that my university e-mail address was not ‘recognised’ by the receiver’s e-mail account and was therefore not delivered.

¹⁵⁶ ‘Case’ here is not intended to mimic clinical language, but is simply the language used by NVivo to designate a “unit of observation” in a research study (e.g. participant, organisation).

¹⁵⁷ Two out of the three telephone interview participants became frustrated or exasperated when discussing the lack of understanding that family, friends, workplaces and/or health professionals display about social anxiety.

¹⁵⁸ Obtained from the data.

health disciplines and is defined by Charmaz (2006, p. 2) as a set of ‘systematic, yet flexible guidelines for collecting and analysing qualitative data’. Unlike the objectivist stance, this approach enables a process of theory-building that is rooted in the data collected and, crucially, requires the researcher to acknowledge the wider social context from which data and knowledge are produced¹⁵⁹. This approach, in turn, ‘fosters researchers’ reflexivity’ (Charmaz, 2006, p.131) as we scrutinise our conduct and challenge pre-existing experiences and assumptions that may impact relations with, and representations of, research participants as well as interpretations of the data. Employing an approach that was ‘content-driven’ proved critical to shaping a project that aimed to acknowledge the words and experiences of others. This meant that ‘the patterns, themes and categories of analysis come from the data; they emerge out of the data rather than being imposed on them prior to data collection and analysis’ (Patton, 2002, p. 306). Chapman et al. (2015, p. 202) note that such an approach requires ‘pre-existing knowledge about the topic [to be] deliberately withheld [...] in order to prevent it from influencing the research findings’. Following Braun and Clarke (2006, p. 7), I found this ‘requirement’ difficult as it ‘denies the active role of the researcher’. The subjective and theoretical perspectives that informed my own position, including my own ‘insider’ status as discussed previously, inevitably influenced the collection, analysis and interpretation of the data. I could not wholly remove my own experience with, and understanding of, social anxiety from my interpretation of the experiences of others. Rather, I see this ‘insider’ knowledge as a positive feature, enhancing what I have been able to deduce from ‘complex layers of meaning that can attach to what are often apparently simple [or in the case of social anxiety, often invisible] social behaviours’ (Cloke et al., 2004, pp. 308–309).

Following a tactile period of data immersion, which involved an initial reading and examining of hard copies of the questionnaire and interview transcripts in detail, followed by a second analysis where I started to make notes of emerging themes, I established an initial coding framework. Rather than a linear process of empirical materials → identify/code categories → identify relationships → theme-building, my data analysis here was an iterative process involving numerous rounds of revisiting the data and refining the approach as new themes were unearthed (Cope, 2010; Crang and Cook, 2007). I had intended to maintain a tactile approach to analysis throughout by working with hard copies of the data, but the immense paper trail of detailed questionnaires and interview transcripts made it difficult to catalogue and manage. As a result, I conducted computer-assisted

¹⁵⁹ An objectivist stance assumes that data is ‘discovered’ by the researcher rather than ‘co-produced’ by researcher and researched (Charmaz, 2006, p.131).

qualitative data analysis using NVivo®, which is compatible with ‘grounded theory’ approaches and enabled in-depth descriptive and thematic coding of the data (van Hoven, 2010). The questionnaire and interview transcripts were coded using ‘etic’ and ‘emic’ categories¹⁶⁰, and codes were then organised and collated towards the production of overarching themes (Figure 7 shows preliminary ‘Nodes’ (i.e. codes) on NVivo Platform). I also conducted a descriptive statistical analysis of responses to closed questions from the questionnaire, which provides a summary of, for example, how safe/unsafe participations feel in a given list of researcher-selected spaces and the likelihood of a participant experiencing anxiety in a researcher-selected list of situations; this evidence is situated alongside the illustrative qualitative material in the empirical chapters that follow.

Nodes					
Name	Sources	References	Created On	Created By	
a vicious circle.	2	2	12/12/2017 16:0	LB	
Ability	1	1	12/12/2017 16:0	LB	
abnormal	2	2	12/12/2017 16:0	LB	
Access to services	1	4	12/12/2017 16:0	LB	
Adapt	2	2	12/12/2017 16:0	LB	
Ambiguous	1	1	12/12/2017 16:0	LB	
Anonymity	2	2	12/12/2017 16:0	LB	
answering questions in a class	1	1	12/12/2017 16:0	LB	
Answering the door	1	1	12/12/2017 16:0	LB	
Anticipatory	8	13	12/12/2017 16:0	LB	
as an excuse	2	2	12/12/2017 16:0	LB	
Atmosphere	1	1	12/12/2017 16:0	LB	
Availability	1	1	12/12/2017 16:0	LB	
avoid	4	5	12/12/2017 16:0	LB	
avoidance	5	7	12/12/2017 16:0	LB	
awkward.	1	1	12/12/2017 16:0	LB	
Barrier	1	1	12/12/2017 16:0	LB	
Bedroom	1	1	12/12/2017 16:0	LB	
Being criticized~	1	1	12/12/2017 16:0	LB	
Belonging	1	1	12/12/2017 16:0	LB	
biological fact	1	1	12/12/2017 16:0	LB	
Blame	1	1	12/12/2017 16:0	LB	
Bodily boundaries	1	1	12/12/2017 16:0	LB	

Figure 7: Preliminary Coding Exercise in NVivo.

Once I had completed the final analysis, I spent a substantial amount of time exploring the codes and attempting to re-organise them in a meaningful way through ‘axial’ coding (Cloke et al., 2004). During this period of refinement, it was difficult to ‘box’ experiences

¹⁶⁰ ‘Emic’ categories refer to the words and phrases that appear in the data (i.e. how people describe their experiences) and are used in the identification and naming of codes, while ‘etic’ categories require further interpretation on the part of the researcher and are related to the wider conceptual framework of the project (Cloke et al., 2004).

(in the form of codes and sub-codes) under broader themes, as experiences are dynamic, overlapping and messy. I did not want to reduce the complexity of experiential data through an overly systematic analysis simply in order to make things ‘fit’ into neat boxes. That said, the iterative approach did progressively if slowly lead to a refined focus of the themes, representing the complexity of individual and collective experiences. Four overarching themes were finally identified that form the foundations of the empirical chapters to follow: Chapter 5: Intensities; Chapter 6: Governmentalities; Chapter 7: Spatialities I; and Chapter 8: Spatialities II. Crucially, each chapter serves to build on the last as the emotional, affective, embodied, social and spatial dimensions of anxious experience weave through narrative accounts, demonstrating the complex social and anticipatory geographies of social anxiety¹⁶¹.

¹⁶¹ This can also account for the minor repetition that may exist between chapters.

CHAPTER 5

INTENSITIES

INTRODUCTION

In this chapter I explore the emotional and affective ‘intensities’ of social anxiety in order to examine the various ways that it is embodied and enacted as people orientate their social and spatial worlds. Through the intensities of participants’ experience, I consider the force and form of social anxiety and how, materially and discursively, these manifestations texture participants’ everyday lives. In order to understand the social and spatial implications of social anxiety explored in the substantive heart of this thesis, particularly in Chapters 7 and 8, it is necessary to lay the emotional and affective groundwork, and thereby to contextualise how social anxiety is variously embodied and experienced. The spatial structure of social anxiety is one that is intimately and inextricably interwoven between body and environment. Intensities understanding how social and interpersonal worlds shape, and is shaped by, emotional and affective resonances. Drawing on psychoanalytic geographies, as a conceptual meeting point between emotional and affective worlds¹⁶² (Chapter 3 [Pile, 2009]), I outline the temporalities and spatialities that shape the continuous interplay of ‘embodied affectivity’ (Fuchs and Koch, 2014), an interplay firmly rooted in an emotional and sensorial continuum.

Such *felt* dynamics emerge through states of anticipation, guilt, shame, humiliation, embarrassment and self-consciousness; and arise in/through the bodily signs and symptoms of anxiety, such as blushing, shaking, palpitations, sweating and stuttering. These states continuously punctuate experiential accounts; in situating a discussion with ‘intensities’ at the beginning of this empirical narrative, their persistence should become apparent and not require explicit highlighting in the discussions that follow.

In her psychoanalytic writings, Horney argues that such feelings and symptoms operate

¹⁶² While I draw on affective/non-representational geographies, many geographers in this domain would argue that the methodological approach implemented in this project has already rendered affect lost. This is where I feel a purely non-representational approach falls short, as to attempt to understand the nuances of social anxiety removed from the ‘speaking subject’ (Wetherell, 2013), would restrict our understanding of how people *feel* and *embody* social anxiety, whether this be through the aforementioned intensities that cause feelings of precarity and insecurity to ensue or through internalising ‘pathologies’ or societal norms and stigma (ideas advanced in Chapter 6).

either as the ‘expression of anxiety or of a defense against it’ (Horney, 1937, p. 235). These intensities have the effect of signalling, exacerbating and sustaining anxiety and are key components to understanding how social anxiety moulds and stifles social and spatial worlds. Furthermore, I aim to address Callard’s (2003, p. 295) concerns about how to mediate the ‘palatable’ version of psychoanalysis tends to be employed by human geographers, and present a psychoanalytically-informed geography of social anxiety that necessitates paying attention to the individual prone ‘as much to inertia and repetition as to progressive transformation’. The reality of social anxiety is all-consuming and one that is not entirely ‘progressive’ or ‘transformative’, often rendering the individual liable to ‘repeat that [which] makes them suffer’ (Van de Vijver et al., 2017, p. 1). By attending to the emotional and affective dimensions, I unearth the qualitative character of that experience, one that invariably, to use participants’ words, ‘gets right under [their] skin’, ‘weighs heavily’, ‘paralyses’, ‘builds’, ‘creeps’, ‘seizes’, ‘suffocates’ and ‘invades’¹⁶³ their psychical and corporeal worlds. Crucially, this is not about locating a ‘root cause’ of social anxiety in participants’ personal histories, but rather about developing an understanding of the ways in which anxiety manifests, endlessly and relentlessly, in the everyday social and spatial lives of the individual.

ANTICIPATORY GEOGRAPHIES OF SOCIAL ANXIETY

Traditionally, little has been written about the concept of the future in psychoanalysis, and its determined focus on the personal histories in composing the interior worlds of the individual continues to be a central criticism of both its practice and its theory¹⁶⁴ (highlighted in Chapter 3). Yet, psychoanalysis is fundamentally concerned with the coming into being of the subject, a process that is fraught with anxiety. For Lacan, in particular, anticipation plays an important role in ‘identification’¹⁶⁵ in terms of how our psyches are organised, how we orient ourselves in the world and how we distinguish between our inner and outer worlds. These processes do not start and end with identification¹⁶⁶. As human beings, we are seemingly driven to find our place in the world

¹⁶³ From the following Questionnaire and Interview Responses: QR9, QR111, QR150, QR220, QR41 (Jo), QR182 (Moira) and IR187 (Olivia).

¹⁶⁴ Zizek (1991, p. 202) states that ‘psychoanalysis is not concerned with the past “as such”, in its factual purity, but in the way past events are included in the present, synchronous field of meaning’.

¹⁶⁵ Identification refers to the constitution of the subject in relation to the symbolic order (See Chapter 3).

¹⁶⁶ While many psychoanalysts look to childhood experiences to locate and unearth unconscious traumatic events, Horney (1937) argues that as we continue to change and develop throughout our lives, it is imperative to look beyond exclusive childhood experiences and for ‘patients’ to identify the sources of their anxieties.

by carrying out certain routines, practices and movements in order to find and then to maintain stability (Van de Vijver, 2000, p. 166; see also: Boyle, 2018; Lucherini, 2016; Davidson, 2003). Lacan stresses that the anticipatory processes of the subject are ‘constructed in two suspended motions’ (Van de Vijver 2000) – one of time and one of space¹⁶⁷. A psychoanalytic approach to anticipatory processes prioritises the ever-evolving relationship between the self-body-world, as one that inexorably unfolds in relation to the subject’s previous experiences and (anticipated) futures. I attend to these dynamics through notions of ‘retroaction’ and ‘anticipation’. Therefore, this approach opposes the linear notion of subjective time and space, aiming to trace a conceptual path that tolerates and values the uncertainties and ambiguities that emerge in the ordinary complexities of social and spatial life.

RETROACTION: STUCK IN THE AFTERMATH

In order to understand the complexities of anticipatory processes, I start retroactively, in the *aftermath* of the event. The reason for starting *afterwards*¹⁶⁸ is perhaps not immediately obvious, particularly when anticipation lends itself *towards* an event; however, it serves an important and logical purpose here. Verhaeghe (2012, p. 110) argues that, ‘what is “previous” comes into existence retroactively starting from the “next”’. This retroactive practice encompasses not only how past experiences are projected towards the future, thus influencing experience in the ‘present’, but also how ‘present’ experiences influence the perception and interpretation of past events¹⁶⁹. Psychoanalytic interpretations enable this experience of being ‘drawn back’ to be conceptualised as a return to, or repetition of, an earlier event. As such, experiences, whether or not they actually happened in the manner in which they are consciously/unconsciously catalogued, are often problematically and devastatingly re-experienced in the present.

Lacan’s psychoanalytic theory structures the unconscious like a language, a notion upon

¹⁶⁷ There is an interesting body of research, primarily in sociology, critical philosophy and communications studies, that draws on Freudian and Lacanian psychoanalysis to explore ‘social systems’ as constituted through the recursive relationship between the ‘subject’ and ‘anticipatory’ processes. Based on the subject’s innate capacity to construct futures through a re-construction of the past, ‘being human means being anticipatory’ (Blomme and Hoens, 2000, p. 122).

¹⁶⁸ The Freudian concept of ‘Nachträglichkeit’ (Lacan’s ‘apres coup’) is central to his theories on hysteria and trauma. The term translates to *afterwardness* and concerns how an event ‘retroactively alters the subjective interpretation of the past’ (Bistoen et al., 2014, p. 672). It is crucial for understanding not the reality of the events that unfolded but how ‘the subject responded or reacted to this experience that determined the effects of the so-called traumatic encounter.’

¹⁶⁹ By ‘event’ I mean a happening, memory and/or trauma significant to the individual.

which I draw on briefly to make sense of these anticipatory entanglements (Lacan, 1988, p. 48) (Chapter 3). Lacan argues that a word is only given sense and meaning by the word(s) that precede it; a similar process can be attributed here to the event: *event 1* influences ('anticipates') the experience of *event 2*; while *event 2* retroactively *reshapes* the meaning and experience of *event 1*; *event 3* is influenced by the *reshaping* of *event 1* and the experience of *event 2* and then retroactively works to *reshape e1 and e2*; and so on and so forth. Therefore, an event is re-interpreted and re-defined by/through the previous sequence of events. There are multiple external intrusions significant to experiences of social anxiety, ones that impose on the individual and have a lasting impact on the psyche. First, there are those that are a result of continuous and repeated exposure to interpersonal hostility and aggression (e.g. bullying or physical and/or emotional abuse); then, there are 'micro-events', a series of separate events of a similar quality (e.g. isolated experiences of embarrassment or social exclusion); and finally, there are those that may be considered 'less severe stressors', ones that are not immediately recognisable as traumatic, but can cause long-term mental and emotional distress (e.g. sudden changes in environment or ongoing experiences of stress) (Bistoen et al., 2014). Such events, whether of instantaneous trauma or a regular feature in one's everyday life, serve as a form of 'socio-symbolic violence' that operate as 'brutal interruptions that destroy the symbolic texture of [a] subject's identity' (Žižek, 2011b, p. 292)¹⁷⁰.

Psychoanalysis contends that event-encounters are internalised and inscribed and catalogued at a psychical level through processes of repression¹⁷¹; the 'memories' of which are very much anchored in/to the body¹⁷² (Pile, 2009b) and re-emerge in situations – in specific times and spaces – that are similar, in one form or another, to the 'original' event. Bodily memory can manifest and be activated in different forms: situational, metaphorical, habitual and traumatic (Casey, 2000; Fuchs, 2012). Crucially, memory does not function as a repository where experiences are stored, accessible and retrieved, but rather, like an archive, it is fragmented, pieced together and re-interpreted at a temporal and spatial

¹⁷⁰ A question posed to psychoanalysis is why the psychical consequences of, for example, two people with similar 'traumatic' experiences, play out in completely different ways. Arguably, this rests on a host of internal and external factors and ultimately, it is how these events are processed in relation to these factors that account for how traumatic experiences re-emerge in the individual (or not).

¹⁷¹ Repression is one of the most fundamental principles of psychoanalysis and 'denotes the process by which certain thoughts or memories are expelled from consciousness and confined to the unconscious' (Evans, 2002, p. 168).

¹⁷² Freud uses the term 'aufheben', which translates loosely 'to suppress'. Zizek uses the term 'sublate' meaning 'to assimilate (a smaller entity) into a larger one' (Oxford English Dictionary, n.d.). The latter attends to a 'layering' of traumatic events that build, shift and manifest in other ways and the events each have a qualitatively similar affect.

disconnect. A complex process is at work in the recollection of memories, where recalled memories are comprised of precipitates and traces that are not necessarily representative of the original experience or event¹⁷³. Memories are distorted and distorting, but no less significant and signifying. Memory fragments are re-lived and re-embodied through practices of rumination and their forcible return into conscious thought, one where symptoms speak of a repression, absence and abundance (Hodder, 2017). Therefore, I attend to individual and private memories as social and spatial ‘remains’ (Jones, 2011) and ‘reversions’¹⁷⁴ (Philo, 2006). Crucially, psychoanalysis is less concerned with the real sequence of an individual’s past; rather, it is only concerned with ‘the past insofar as it is historicised in the present – historicised in the present because it was lived in the past’ (Lacan, 1991, p. 12). Thus, the retroactive processes involved are symbolically related to being ‘stuck in the aftermath’ of an event, one where past events (and their associated memories and bodily resonances) always return with an uncanny and uncertain familiarity¹⁷⁵.

In the questionnaire responses, participants often referred to feelings such as being ‘stuck’ (Jane, QR90) or ‘trapped’ (Kim, QR40) by their anxiety¹⁷⁶. One of the most common expressions participants use to describe what it was like to live with social anxiety is ‘a vicious cycle [or] circle’. Such descriptions account for repetitions, not as unproblematically formative practices that ensure continuity and instil belonging (Edensor, 2006), but as embodied events that do in fact burden, disturb, distress and isolate. Freud (1914) asserts that the most basic model of mental life entails, against all therapeutic efforts and interventions, the unconscious compulsion to repeat. It is through repetition that we come to understand past events and experiences of trauma (Blum and Secor, 2011) . Such circuitous loops are not only compulsive, but also counterproductive, representing ‘the perpetual recurrence of the same thing’¹⁷⁷ (Freud, 1920, p. 22) and marking a(n un)conscious return to a qualitatively similar set of experiences. For example, Jane, who

¹⁷³ Laplanche (1999, p. 91) considers ‘the unconscious element or trace *not as a stored memory or representation, but as a sort of waste-product of certain processes of memorisation*’.

¹⁷⁴ A local or temporary return to a previous state or practice (cf. ‘Regression’, a long-term return to an earlier, usually childhood, state) (Bever, 2017).

¹⁷⁵ Freud (1919, p. 245) states that, ‘the uncanny is something which is *secretly familiar*, which has undergone repression and then returned from it’.

¹⁷⁶ Interestingly, while many feel ‘stuck’ and ‘trapped’ by their social anxieties one of the biggest sources of anxiety about navigating everyday environments is a fear of not being able to escape. This is evident when participants discuss being in various social and public spaces and, in particular, on public transport (Chapter 6 and 7) and this lack of progressive movement is arguably also in play here.

¹⁷⁷ This material is the ultimate focus of psychoanalytic therapy.

grew up in an ‘authoritarian’ household, describes how numerous events actively ‘condition’ (in the present) her intense and vivid response to external ‘triggers’, continuously serving to ‘send [her] back to [her] childhood’:

Imagine living with a military commander [her stepfather] who watches your every move, criticises everything and over reacts to everything. Plus, the constant threats of violence and [a] disgusting sexual taint to everything. Although no physical violence or otherwise happened to me, the shouting, attacking furniture and having my bedroom ripped to shreds; the threat of everything melted my brain. [...] I find myself reacting overly fearfully to people [who] raise their voices because of the way my stepfather used to shout, especially with people who are authority figures – which is pretty much everyone because I feel lesser than everyone – I sort of sink into myself and withdraw.

Significant in Jane’s discussion of her early memories are notions of being visible, of being watched, scrutinised and receiving a negative response from her stepfather, aspects that continue to have a pervasive impact on her daily life and form the very foundation of her experience with social anxiety. Through an internalising of authoritative, aggressive and threatening conditions that were a habitual feature in her early/formative years, Jane repeatedly re-experiences the feelings of uncertainty, anxiety and hostility in her current interpersonal and social relations. She also discusses how these traumatic memories are deeply tied to and embedded in places that command repetition¹⁷⁸:

Previous places where I’ve had bad times are a trigger too, for example if I walk by my secondary school that can taint my social interactions for the rest of the day because I keep remembering negative stuff.

The intrusive and uncontrollable repetition of ‘traumatic’ experiences is often inescapable and prevents the individual from moving past them.

The surfacing of anxieties in particular interactions and situations that are symbolically reminiscent of the original event(s) demonstrates the (un)boundedness of the psyche (Parr, 1999b) and its materialisation in the present. Kim describes three situations throughout her life that resurface when she encounters similar situations in the present:

I find myself remembering and kind of reliving all the times I messed up in important or significant situations and looked/felt like an idiot. Things that happened recently to things that happened 10 or 20 years ago [Louise: What

¹⁷⁸ ‘The very mode of this determining is overdetermined by the present synchronous symbolic network. If the trace of an old encounter all of a sudden begins to exert an impact, it is because the present symbolic universe of the subject is structured in a way that is susceptible to it’ (Žižek, 1991, p. 202).

interactions/situations do you remember?] I was bullied by co-workers and feel to some extent I let it happen/deserved it. It was easy for me to become the butt of their jokes/taunts. In school, messing up presentations, awkward exchanges with classmates [and] being singled out and absolutely humiliated by a teacher for getting something wrong. [Then,] the time my mum tried to take me to dancing lessons and I *freaked* out. I was 5 or 6 at that time but I remember all these details so vividly, I remember feeling so overwhelmed that it was painful and that's the same feeling I get time and time again like I'm stuck in my 5 or 15 or 20 year old brain and body and I can't escape. (Kim, IR)

These memories resurface as fragments but their most salient points remain. Kim, now aged 25, tracks back from the most recent event, through her teenage years to the overwhelmingly ‘painful’ childhood memory where she was faced with the threat of performance. Kim’s testimony, although brief, illuminates how various elements of her past (and present) experience are representative of what went before, organised around themes of performance, humiliation, authority and confrontation, and situated in formative social environments. I query Kim’s reasoning for feeling that she deserved to be bullied or taunted. She replies saying, ‘Tbh¹⁷⁹, my self-worth is so low that it was easier to take it than complain plus, how was I going to bring that to my boss and then HR¹⁸⁰ and still have to face them every day? I couldn’t go through that scrutiny.’ Eventually, she quit her job in an effort to escape the hostile work environment, but it is a situation to which she is effectively forced to return to time and time again. Similar to Jane, Kim alludes to fears of authority figures. Throughout Kim and Jane’s testimonies, and the testimonies of other participants, a relationship between social anxiety and the ‘situated’ self emerges. The (past) sites and settings of traumatic and anxious events are highly subjective but shed light on the manner in which they have been reiterated throughout Kim’s (and others’) life-course, affecting her sense of self and self-other-world relations.

RUMINATIONS

The most banal daily interactions can inflict cumulative psychical and emotional harm on the individual. The minutiae of these interactions are often the focus of self-conscious and self-critical practices of rumination that the individual conducts. in the aftermath of an event¹⁸¹. Rumination manifests through habitually and ‘highly negative views of self and a painful and repetitive self-scrutiny [that are] characterised by harsh internal dialogues about social performance or perceived failures’ (Boyle, 2018, p. 2). This critical

¹⁷⁹ Short-hand for ‘to be honest’.

¹⁸⁰ Human Resources.

¹⁸¹ In cognitive-behavioural approaches, this is referred to as ‘post-mortem thinking’.

examination of the self in relation to others compromises a person's self-other-world relations and, leading them to question their own social value and place in the world. In the aftermath, participants report feeling 'worthless', 'useless' 'drained' or 'dead inside'¹⁸², wherein each repeated attempt to 'be normal, live normally, have normal relationships with others and myself – just *live*' (Daniel, QR115 *emphasis added*) reinforces a sense of failure that produces a 'less-than-human' (Philo, 2017) subject.

Daniel writes that he 'spend[s] too much time analysing every interaction or situation' for social mistakes, faults or failings that, from his perspective, cause 'other people to think negatively of [him]' (Daniel QR115). In a follow-up interview, he describes the aftermath of a social event:

Social things are stressful, I feel tense and nervous most of the time and I feel very self-conscious, so they are pretty awful to deal with. When I am alone, I have all this time to sit with myself and run through everything I did or said [and I] worry about what other people think about me. I play it over and over and over again in my head. I really start to hate myself and how awkward and incapable I am of being normal in social situations. It spirals out of control and I can't stop thinking about it.

L: What sort of things do you think about?

D: I go over and over everything I said and did: Why I did it? How I did it? Why I did it that way? How I said something? (e.g. tone of voice, volume, projection, wording); How my body language or general demeanour makes me look anxious and weird and completely unapproachable – I feel people avoid me anyway because of this. I really beat myself up over being so unapproachable.

L: When you have those conversations with yourself, how do you feel?

D: Worthless. Beyond worthless. I've done nothing with my life and I feel so pitiful and empty. I've heard those thought patterns called 'analysis paralysis' and 'post-mortem' thinking, or something like that, but I feel like I'm already socially paralysed by them, I just exist; a lifeless existence. (Daniel, IR115)

Similar to the aforementioned 'retroactive' events, practices of rumination have the capacity to 'paralyse' the individual, regimenting them in past interactions, sites and spaces. Daniel's 'lifeless existence' can be compared to the notion of 'social death'. Králová (2015) situates 'social death' in direct opposition to 'wellbeing' and notes that it is concerned with three interrelated socio-spatial conditions: loss of social identity, the loss of

¹⁸² QR214, QR143 (Lisa), QR118, QR187 (Olivia), QR149 and QR137.

connection and social relations, and the disintegration of the body¹⁸³, which culminate in the individual's disconnection from social and spatial life¹⁸⁴. Amber (QR27) describes her social anxiety as 'crippling':

It leaves me with a constant feeling of dread and unable to relax for any sustained period. My mind constantly recalls bad memories at the most random [times] which invokes hours/days more of self-criticism and feelings of wasted worthlessness. The majority of the time I feel like I just want to escape from everything and everyone and just exist alone.

Callum recalls that feeling like a 'misfit' throughout his school years was shaped by others' perceptions of his character, which hindered his ability to maintain social connections and relationships:

I've never really fit in anywhere. I've always been a bit of a loner and a loser. I didn't fit in at school [and] any "friends"¹⁸⁵ I did have drifted or moved away. I often think about how painful those experiences were, all the times people gave me funny looks [when I was] trying to strike up a conversation with [them] – I was never really teased or anything, they just ignored me – [and] how dismissive teachers were of me. I feel society is equally dismissive now. They see me as this lonely weirdo. (Callum, IR189)

Rumination, therefore, involves a conscious yet uncontrollable undoing of the (past) self in the present. Natalie's ruminative practices have chipped away and hollowed out her sense of self:

I feel like the 'social' world drains the life out of me to be honest. It's so physically and mentally exhausting to try and stay tuned in to situations that are unbearable. I dwell on them endlessly, replaying the embarrassing interactions or awkward exchanges in my head. They are so intrusive and chip away at me. I feel like I've just become this shell of a person, you know?

This undoing of self often entails drawing comparisons to the self *before* it was gripped by social anxiety. Other participants reflected on their 'past' selves with a feeling of sadness and loss for who 'I used to be' (Karen, IR). *Becoming* socially anxious is often a slow and gradual process (Chapter 8), and Sarah comments that it 'slowly infected' different areas of her social life and career, and 'before [she] had really got a hold on what was happening, it had completely wiped them out' (Sarah, QR18S). The practices of rumination raise

¹⁸³ Kravola (2015) notes the terms initiation into the social science literature through Sudnow's (1967) understanding of the 'social value' of patients in healthcare settings and how this impacted care and treatment.

¹⁸⁴ I explore themes of loneliness and social isolation in Chapter 8.

¹⁸⁵ Callum says he writes "friends", as any friends he did have were a product of the environment i.e. 'kids forced together at school or my mum's friend's kids.'

questions about what constitutes continuity and coherence in/with the self, and signals the difficulties in trying to reconcile a (new) sense of self while living with social anxiety. Loss of self and difficulties with identity were strongly related to perceptions of normality and the living with ‘ill/well’ selves.

Jess’s testimony is difficult to situate under a specific heading of ‘retroactive’, ‘rumination’ and ‘anticipation’ as she tracks back and forth through various times and spaces in an effort to ‘locate’ her anxieties. I make no attempts here to restructure Jess’ testimony into a more coherent narrative that follows a logical progression of ‘past-present-future’. Rather, I prioritise the ‘bits and pieces, snapshots, grabs and glimpses of respondent lived experiences’ (Vickers 2012), but situate it here as a reflexive act through which various memories, times and spaces unfold:

I can never quite put my finger on what it is that causes me to experience such crippling anxiety. I wasn’t always like this. Is it that I might be laughed at? Is it that I might come across the wrong way? Is it that I’ll show signs of anxiety or nervousness? All I know is that a whole host of innocuous situations, from going to the shops to making a telephone call to ordering a coffee, cause me to zero in on myself and analyse every aspect of the situation and myself in that situation, replaying how I think I appear to [others] in that moment. Weird, no doubt! [...] I actually just had to phone the doctor (tell me if this is useless info btw¹⁸⁶) and it took me all morning and afternoon but I knew I had to do it before this [interview]. I could kick myself for the STATE I get myself into over making a fucking phone call ... [I’m thinking the receptionist at the doctors] will think: ‘Oh, her again’, ‘what now?’ and I got all flustered trying to make an appointment. Anyway. Sorry, I don’t know how I got here, to this point in my life. (Jess, IR)

In the first instance, Jess is unable to place what came *before* her anxiety but proceeds to project herself forward, anticipating the consequences of an imagined future; although one that is not out-with the realms of her experience. She connects her distressing anticipations with several everyday situations (i.e. shops, telephone and coffee) assuming that there will be an immediate and glaring ‘fault’ or ‘failing’ she ‘zero[s] in’, selecting herself as target. Followed by a short account of making a telephone call several hours before our interview took place, she checks whether her experiential accounts are ‘useless’, before she reflects on the morning’s anticipations before reflexively ‘kicking herself’ for being so overwhelmed by the seemingly simple task of making a doctor’s appointment. She proceeds to ruminate over the receptionist’s perceptions of her before cycling back round

¹⁸⁶ Shorthand for ‘by the way’. Side notes like this one appeared regularly in the questionnaire responses and in conversations with participants, who were unconvinced of the ‘value’ or ‘usefulness’ of their stories. This, in itself, portrays a certain situational anxiety and highlights a self-conscious awareness in the interview

to her initial query: How did I get here? Or, from where did I get here and why does what happened then continue to disrupt what happens in the here and now?

ANTICIPATION: ENCOUNTERING TIME AND SPACE

Leading on from the complex temporal projections back and forth in Jess' case, I turn now to the 'future-oriented' dimensions of anticipation, as an encounter with the times and spaces *before* the event. Anticipation is fundamental to the shaping and sustaining of social anxieties, but this role is ambiguous and paradoxical. On the one hand, anticipation plays an important role as a structuring function in the coming-into-being of the subject (Van de Vijver, 1998). First, in terms of the 'situatedness' of self in relation to others and the social world; and second, as a necessary function for taking 'abstract' ideas and previous experiences and projecting them on to future beings and doings. On the other hand, the emotional and affective dimensions of anticipatory anxieties mark the 'emergence of unpredictability' (Grosz, 2013, p. 225). Reliving the intensities of past and traumatic experiences not only seizes the individual, but initiates the anxiety-drenched anticipations of a future that is continually encroaching on the present. The subject's forward projections and the impending nature of future threats inevitably meet, situating the subject in a space of annihilation. Overwhelming and intolerable levels of anxiety cause significant mental and emotional distress for the individual who is engulfed by memories of negatively perceived past experiences, and hence the threat of those experiences repeating:

It's not just before, the anticipation. And it's not just during, the anxiety during the event. It's the after too. Social interactions from months ago I still haven't let go of. How I was perceived. Whether I wanted to be perceived that way (most the time no). It pulls me down because all social interactions make me feel bad about myself. Not Good Enough. Stupid. Selfish. Pathetic. Wrong. All of those negative judgements that I think of myself, and I perceive others are thinking of me, stick with me for a long time, if not forever. (Sarah, QR18S)

Sarah captures the overwhelming and distressing dynamics of anticipatory processes that are experienced before, during and after the social 'event'. Before ('future-oriented'), individuals experience an accumulation of worry and uncertainty about a potential but unknown future. Crucially, while avoidant behaviours are common, many people endure social situations despite the intense levels of distress experienced. During such situations, she experiences a visceral feeling of vulnerability, causing intense awareness of the self and socio-spatial surroundings. After ('past-oriented'), the individual engages in a repetitive focus on issues of relating to social performance and self-worth. The vision of the future and the experience of the present is often incoherent, destabilising and wrought

with uncertainty. The complexity of the anticipatory processes involved are as such in that they are always contingent upon on the overlapping and intertwining of corporeal, relational, temporal and spatial dynamics.

In this vein of anticipatory action, I have explored elsewhere (Boyle, 2018) the complex relationship between anticipation and the coping strategies that people implement in their everyday ‘routines’. Through various time-space ‘routines’, ‘routes’ and ‘screens’, I discuss those participants who incorporate socio-spatial cues and bodily ‘warning signs’ into a ‘habitually unhabituated’ management of self and space. Much of the work in geography concerned with routine/habit/repetition is concerned with the stabilising capacity of reliable (bodily) rhythms and routines that instil a sense of predictability and certainty to the practice of everyday life (Binnie et al., 2007, 2007; Middleton, 2011). This work, in a predominantly non-representational vein, concerns embodiment through the ‘taken-for-granted’ practices that ‘unburden us from the necessity to constantly find our bearings again’ (Fuchs, 2012, p. 13). While others (Lea et al., 2015) have sought to disrupt this reproductive nature to account for an awareness of how habits are unlearned and re-learned through mindful practice, I argue that current conceptualisation of habit ‘assume[s] the capacity of people to mould into normative temporalities and spatialities’ (Boyle, 2018, p. 2), for there are those whose habits indeed do become habituated and sunk into the taken-for-granted practice of everyday life. For people with social anxiety, however, there can be no such easy habituation as everything is marked by gripping uncertainty with the potential to become the subject of rumination and anticipation. Habit, in this sense, so often becomes a pattern of habitually and disruptively picking apart the minutiae of how to manage the routines, movements and encounters of everyday life as evidenced by Sarah and Jess’s testimonies. There are other temporal and spatial dynamics at play here, including the strategic management of time and space, that are explored later in this thesis.

Amelia’s account of how her anxiety manifests exemplifies a sense of anticipations as continuous and cumulative:

It builds and builds over a matter of days or weeks [...] I just can’t control my thoughts, or see clearly, everything is foggy and gets increasingly intense and my body doesn’t contain anything. I sweat, and blush, shake, stutter and it’s like my anxiety is just oozing out for everyone to see. It’s awful. I’m so ashamed of not being able to control this. I’m waking up every day and worrying about what will happen, who I will have to talk to and where I will have to go. Will the door go? Will the phone ring? At the end of the day I go over in my head every last detail of what I did, what I said, how I said it, what my face looked like, did I make enough eye contact and how were people

reacting to me? I'm constantly questioning myself, doubting myself, criticising myself then it starts all over again.¹⁸⁷ (Amelia, IR)

The intimate entwinement of the time-space interactions and everyday materialities¹⁸⁸ that constitute anticipatory processes are cruelly apparent in Amelia's testimony. Her account describes a 'cumulative effect' that 'builds and builds' over extended periods of time; the repetitive questioning of 'what if...' and the list of bodily symptoms reinforce a sense of uncertainty and accumulation. The affective and emotional manifestations of anticipation signify the impending loss of control and are 'sensorially overwhelming, emotionally uncomfortable, socially stigmatising and so, disabling' (Davidson and Parr, 2010, p. 63). Similarly, terms like 'constantly' and 'starts all over again' and point to a symbolically structured and continuous cycle of anticipatory anxiety, one that cannot but initiate a 'new' cycle of repetition.

Catastrophic thinking entails the imagining of worst case scenarios, magnifying immediate and eventual consequences of internal processes and external conditions that are perceived as threatening to consume the bounded self (Gellatly and Beck, 2016). Anderson (2010, p. 779) states that it is through the act of imagining that 'futures are made present in affects, epistemic objects and materialities.' On the one hand, individuals draw on external cues magnifying the perceived threat from others; and, on the other, they shift attention to internal cues and warning signs (e.g. sensations, thoughts and emotions) that are interpreted as imminent signs of personal and social catastrophe. The perceived lack of control over the self and socio-spatial surroundings reinforces the belief that they cannot 'do any of the normal social things required to be a functioning human being' (John, QR54):

Visually seeing a worst-case scenario in your head. So when my anxiety is at its worst I will actually imagine myself being around other people and having a full-blown panic attack and ending up in the hospital with [doctors] saying 'yes you're going crazy.' These things make my anxiety even worse and those thoughts just spiral out of control. (John, QR54)

Participants frequently reference living with persistent feelings of 'dread' (QR226, QR180) and in a state of 'tension' (Lisa QR143, Callum QR189). Tension is most frequently associated with bodily sensations, including: 'stomach churning, needing [the] toilet, sweating [and] headaches', (QR117); others report, 'palpitations, leg tremor, facial

¹⁸⁷ This material is also included in Boyle (2018).

¹⁸⁸ In the remainder of this thesis (Chapter 6, 7 and 8) I highlight how the materialities of various mundane objects and spaces (e.g. telephones, doorbells, waiting rooms and corridors) are anticipatory.

twitching, sweating, blushing, sweaty palms, headaches, bodily/muscle tension, jaw clenching, disturbed sleep (waking up early in the night and unable to get back to sleep) [and] mental/physical fatigue.' Jane writes that because she 'exists' in a constant state of anticipation, 'it is rare I feel truly relaxed or happy. I can't really enjoy things, they just don't attract me and I feel so little from them because I'm always so worried [...] [and] socialising is so draining and difficult. Not being able to relax properly makes my tension worse as I can't unwind and the fear has me constantly winding tighter and tighter.'

CONCLUSION

This chapter lays the emotional and affective groundwork of anxious experiences that will be discussed at length in the following chapters. I explored the emotional and affective 'intensities' of social anxiety in order to examine the various ways that it is embodied and enacted as people orientate their social and spatial worlds. I have sought to engage an understanding of how social anxiety is continuously structured and situated through the entwining temporalities, spatialities and potentialities of anticipatory processes. Through these intensities, experienced as repetitions, ruminations, and projections, I consider the force and form of social anxiety and how materially and discursively these manifestations texture participants' everyday (and longer-term) geographies. Despite the cyclical and pervasive repetition of anxious experiences, they are never seamlessly habituated rather they continue to habitually rupture the fabric of everyday life and spaces. It is evident that the affective and emotional dimensions of social anxiety cannot be so readily separated from the sites and settings in which they are encountered or from the past memories, experiences and 'traumas' in which they are entangled. The present, presents the individual with repeating scenarios of a humiliated and shamed self, one that is always faltering and failing at the point of human connection or, simply, being human. The remnants of previous encounters and events relived, draws our attention to the inescapable situatedness of social life in a way that highlights what it means to be 'unbearably human' (Philo, 2017). The minutiae of daily life provide infinite fodder for critical, self-reflexive ruminations. The intensities of experience depicted here, point to processes and experiences that exhaust and confine, rather than enliven and liberate the individual and demonstrate the capacity of social anxiety to disturb distress and disrupt the self-body and self-other-world relations.

Chapter 6 moves these arguments forward by employing a wider lens to the experiential accounts of social anxiety, exploring the spaces and authorities of health-seeking practices.

This, in itself, is embedded with its own anticipations and expectations: of recovery, clarity and legitimisation but equally, uncertainty, rejection and failure.

CHAPTER 6

GOVERNMENTALITIES

INTRODUCTION

The conceptualisation of health and wellbeing, and the associated management of illness, are often characterised in geography with reference to Foucault's notions of governmentality, biopolitics and technologies of self (Keane, 2000; Lucherini, 2016). The concept of 'governmentality' is broadly understood as the 'techniques and procedures for directing human behaviour' (Foucault, 1997, p. 82). Governance at a societal level shapes practices of 'self-governance' in that such processes 'seek to act on the actions of others to bring about particular comportments, behaviours and subjectivities' which, in turn, encourages 'subjects [to] act on themselves to produce particular bodily habits and attitudes to the self' (Huxley, 2008, p. 1635). This chapter seeks to explore the concept of governance by examining two spaces of help and/treatment-seeking: primary health care (including, GP and psychological therapies) and the Internet¹⁸⁹.

The relationship between neoliberal principles of individualisation and the self-management of mental health and illness has not gone unnoticed (Brijnath and Antoniades, 2016; Madsen and Brinkmann, 2010; Teghtsoonian, 2009). Healthcare strategies and policies influenced by these principles promise to deliver 'an empowered patient participating in shared decision-making and self-managing her disease' (Brijnath and Antoniades, 2016, p. 1). Principles that prioritise individual responsibility, self-sufficiency and self-regulation over collective responsibility have contributed to a shifting geography of care that promotes the role of the individual, while state, local authorities and healthcare professionals proceed to 'govern at a distance' (Rose and Miller, 1992; see also: Milligan, 2000)¹⁹⁰. This shift between taking care of people who are ill towards teaching people how to manage their own illness is described by Rose (1999, p. 74) as a technology of 'responsibilisation'.

¹⁸⁹ Of course, recovery and self-management is an inherently personal practice that is often strategically negotiated by participants in different ways, across different times and spaces, in response to fluctuating states of mental health. Participant's report practicing yoga, mindfulness, meditation, regular exercise, getting outside, etc. as means to promote positive mental health and wellbeing. There is not the time or space to do justice to these dynamics in this thesis. This could be a fruitful area of future study.

¹⁹⁰ This is mirrored by wider cuts in health and social care spending.

Emerging mental health policy advocates that those who are capable must become active agents of their own wellbeing, following closely the discourses of resilience, responsibility and self-care evident in state programmes designed for the self-management of chronic illness (Kendall and Rogers, 2007). Criticism of various self-management programmes emerging out of the mental health ‘recovery movement’, including Wellness Recovery Action Plan (WRAP) and Mindful Based Interventions (MBI)¹⁹¹, argue that such programmes ‘construct a prudent, responsible subject who plans ahead, maintains control, is constantly engaged in self-surveillance and works incessantly to sustain a healthy lifestyle’ (Scott and Wilson, 2011). Rose provides a productive framework for thinking through the relations between health-illness, governmentalities and the ‘self’ towards an understanding of how processes of subjectification – that is, how individuals ‘think about themselves, act for themselves and transform themselves’ within certain regimes of knowledge (Harvey and Rail, 1995, p. 167) – take shape. However, such programmes may very well play a key role in exacerbating the conditions that enable ‘ontological precarity’ to ensue(Fisher, 2009)¹⁹² as people who self-manage cannot always assure continuity in levels of self-care. This responsibility to be ‘well’ acts to verify ‘the moral aptitude of individuals’ (Greco, 1993, p. 357).

MacKian et al. (2004) note that health-seeking practices and behaviours are a ‘somewhat over-utilised’ and yet ‘under-theorised tool’; and with this caution in mind, this chapter addresses not only the medical and/or therapeutic spaces people engage *with* but also how these spaces shape their understanding of mental health and wellbeing (see also: Popay et al., 2007). Drawing on relevant geographical and psychoanalytic literatures, I explore the agencies, bodies and sources with which people engage in order to acquire information and potential guidance about their social anxiety. What becomes clear is how health, illness

¹⁹¹ There are various strands of mindful practice under the MBI umbrella including, Mindful Based Cognitive Therapy (MBCT), Mindful Based Stress Reduction (MBSR), Dialectical Behaviour Therapy (DBT) and Acceptance and Commitment Therapy (ACT). A recent UK Government report from Mindfulness All-Party Parliamentary Group (2015) advocates mindfulness as a low-cost intervention in many aspects of everyday life including, health, education, workplace and criminal justice settings, with advice mindful parenting, mindfulness and unemployment and its role in character and resilience-building in education.

¹⁹² Notably, the critique of mindful practice centres around its implementation in Western culture and the subsequent ‘neoliberal corporatisation’ of Eastern mindful practice and Buddhist philosophy. Eisen (2014, p. ii) argues that mindful practice, ‘crystallized around an apparently heart-felt need to get back in touch with the present moment’, amounts to a ‘technology of self’ that initiates a ‘reconditioning’ of the subject in line with neoliberal principles of self-management and self-responsibility. Conversely, Walsh (2018), in recognising the critiques directed at mindful practice and dealing with the mechanics of biopower, argues that a ‘queering’ of mindful practice could ‘resist neoliberal governmentality’ while ‘affirm[ing] the lives that it subjugates.’

and ‘recovery’¹⁹³ are predominantly moulded by medical, psychological and therapeutic technologies, but that these models are adopted and resisted in various ways. First, I examine the role played by various medical and ‘therapeutic’ spaces and their influence on how social anxiety is understood. I explore how individuals obtain and make use of their diagnosis within, alongside or out-with medical and/or clinical treatment pathways. I pay attention to how medical practice and spaces not only shape the experience of diagnosis, but also lay the groundwork for the course of treatment, care and ‘recovery’ and shape particular ‘ill’ identities. Second, I pay attention to the role played by online communities and technologies in everyday management and sense making. I address practices of self-diagnosis to unpack their significance for the individual and the implications on the traditional boundaries of the ‘doctor-patient’ relationship. I unpack how interactions and practices in online spaces translate back into lives lived offline and how this connection supports or negates wider ‘recovery’. Overall, I aim to consider how dominant discourses and medical authority over mental health and illness contribute to societal and personal understandings of social anxiety, feeding into the spatialities, temporalities and embodied habits through which everyday life is lived and social anxiety is managed (Chapters 7 and 8).

MEDICAL SPACES

The first point of contact for people experiencing physical and mental health problems in the UK is usually their GP¹⁹⁴. From an initial consultation, a person reporting mental health problems may follow several pathways for treatment, including devising a treatment plan that may include medical and social prescriptions¹⁹⁵; alternatively, they may be referred for further assessment to a mental health care team in their local community (e.g. community psychiatrist) and/or referred to a counsellor or therapist. A person seeking mental health

¹⁹³ For many, the severity and intensity of social anxiety ‘developed’ over time, as opposed to something that is innate to the individual. Recent mental health studies describe a practice of recovery that is ‘always unfinished’ rather than a return to a pre-illness state (Duff 2015). While this resonates with many of the people participating in this project there are those whose focus of recovery is to return to their ‘old’ and ‘non anxious’ self (QR12). The conception of ‘normality’ is significant in this context. Therefore, the application of recovery does not straightforwardly refer to a state *after* illness, but rather acknowledges that ‘recovery’ goals and journeys are unique to the individual and refers to managing to live with social anxiety as much as achieving ‘health’ beyond and/or after social anxiety.

¹⁹⁴ General Practitioner. A GP tends to be located in the person’s local community and may also be a family doctor and ideally familiar with personal and/or family health history.

¹⁹⁵ Social prescribing is a holistic approach to physical and mental health and wellbeing that aims to connect people to sources of non-clinical support within their local community including, community garden projects, art classes, volunteering and befriending (Kings Fund 2017).

care may also be given information about self-management programmes¹⁹⁶ (e.g. Wellness Recovery Action Plan [WRAP]) and self-referral therapeutic services (e.g. Living Life¹⁹⁷).

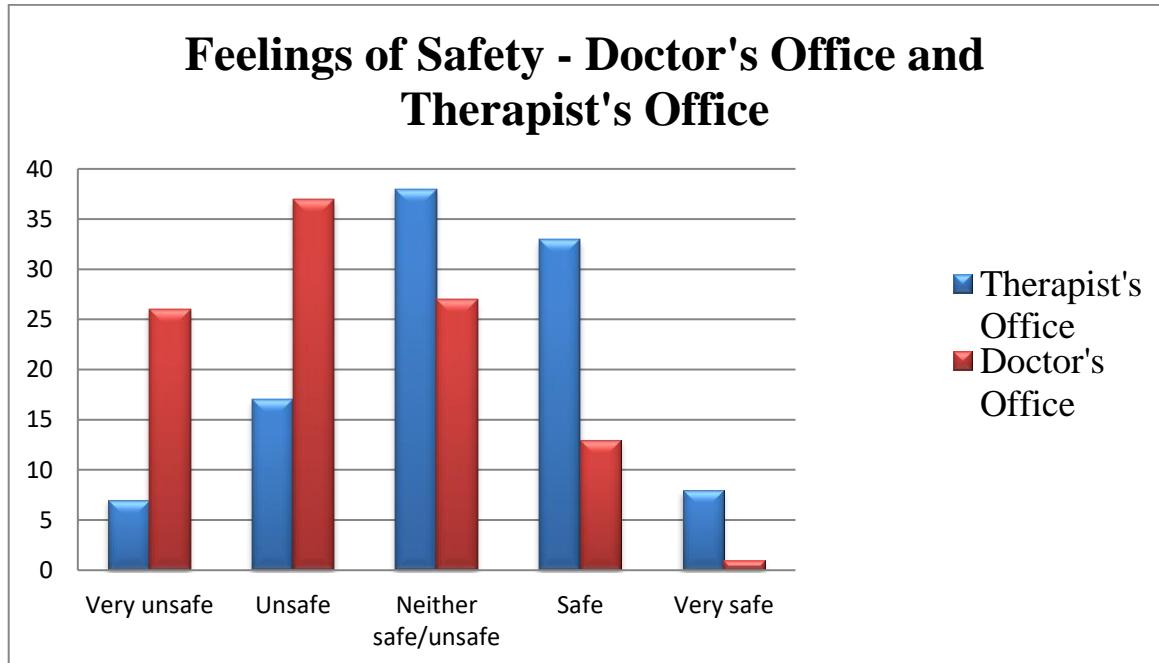


Figure 8: Comparison: Feelings of Safety in Doctor's Office and Therapist's Office

The majority of people experiencing mental health problems will be seen solely by their GP or other primary healthcare professionals¹⁹⁸ (Dehghan et al., 2017) with only a small percentage being referred to secondary ('specialist') care services, such as Community Mental Health Teams (CMHT). Therefore, GP surgeries and therapeutic services are crucial spaces of care and treatment for people experiencing social anxiety.

Ruga (2008) argues that the GP Surgery or primary care environment is comprised of three distinct environments: physical, social and generative. Physical space comprises aspects of the natural and built environment and the sites and spaces therein, including waiting rooms and doctor's offices. Social space is actively produced through interactions with others in these spaces and with the space itself. The primary care environment is also conceived of as a 'generative space', space that 'encourages, supports, and reinforces improvements to health and wellbeing' and is, by extension, 'life-enhancing' (Ruga, 2008, p. 465). This concept advances earlier concepts of 'healing environment' and 'evidence based design' concerned towards a more holistic understanding of how the physical environment and

¹⁹⁶ Participants made reference to these programmes throughout the research process but an in-depth engagement with them is outwith the current scope of this research.

¹⁹⁷ A telephone-based Cognitive Behavioural Therapy service run by NHS Scotland.

¹⁹⁸ Counsellor or therapist

social space interact and condition one another. The physical and social dimensions of the surgery can also influence the doctor-patient consultation, the decision-making process within it, diagnostic effectiveness and response to treatment (Rapport et al., 2007). The effects of the physical environment on healing and wellbeing have proven to be significant to the experience and management of physical, chronic and mental illness. Previous research in the geographies of health and illness have shown that people with epilepsy (Smith 2013) and diabetes (Lucherini 2016) overwhelmingly feel safe in their GP surgery due, in part, to the proximity of trained and knowledgeable healthcare staff in the event of an epileptic or diabetic episode, but the same cannot be said for people experiencing social anxiety, since many of my participants report feeling ‘unsafe’ and ‘very unsafe’ in their GP surgery (Figure 8).

Figure 8 shows, for some participants these spaces had little impact on their feelings of safety. However, a larger proportion of participants felt less safe in their GP surgeries and consulting rooms than the sites of therapeutic practice¹⁹⁹. This is problematic, as GPs are often the first point of contact for mental health care and treatment but only after years of enduring and suffering with social anxiety. As I explore later, people often avoid making an appointment for fear they will not be taken seriously or because previous encounters have had a negative impact on their mental health. Furthermore, the ‘general practice’ for therapeutic treatment is self-referral, which left some participants like Mia feeling dismissed or that their anxieties were not taken seriously – compounding their initial anxieties for avoiding their GP in the first place:

Mia: I was 4 years [living with social anxiety] before I made an appointment at the doctors. It was only when my mum said [the surgery] had an online appointment system that I made the appointment.

L: What happened next?

M: I agonised over it for weeks. When I finally went I was in and out in less than 5 minutes.

L: What did the doctor tell you?

M: I had to self-refer for CBT and medication was an option if I wanted it.

L: How did that make you feel?

¹⁹⁹ It should be noted that ‘therapy rooms’ is a broad descriptor as these rooms may be located across numerous sites and settings through, for example, CMHT or University Counselling Services.

M: It didn't help. It just felt like I was dismissed and then passed from pillar to post, 'come back if you feel even shittier'-type of thing. (Mia, IR).

Self-referral, that is, the action of making an appointment with a medical specialist oneself, rather than being referred by their doctor, can be problematic for people with social anxiety. In Mia's case, like many others, it takes a long time to build up the strength to make²⁰⁰, never mind attend, a doctor's appointment. Self-referral systems often take the form of 'responsibilisation' rather than that of a self-directed and empowered individual. It also assumes an individual 'sufficiently activated' (NHS England, 2016, p. 12).

Routine appointments are often characterised by feelings of vulnerability, uncertainty, anxiety and fear, with the material and social environment often exacerbating these feelings. For instance, Nicole (QR63) explains:

I'm so scared to make and keep an appointment to see my doctor. I don't even know where to start I am so terrified to pick up the phone and even the thought of walking into the surgery makes my skin crawl. [...] [The surgery] is an overwhelming space, all the small interactions that are involved are just a nightmare [...] [such as] going to the reception, going to waiting room, finding a seat, waiting and waiting and waiting, then if the doctor's *running* late which is usually all the time I start thinking I've done something wrong, I'm too late, I didn't hear her call me in, I missed my appointment, I'm too early, am I in *the* right waiting room? If I go check, what if she comes? Then I visibly start to panic and people start to notice. That's the case in pretty much every situation in life! Haha, it's an absolute nightmare but there is *something* about [going to] the doctors that is so overwhelming.

The emotional geographies of these spaces have a significant impact on an individual's therapeutic experience, an experience shaped and disrupted by numerous spatial, social and time-related aspects.

Physical locations can embody therapeutic qualities that harbour restorative, renewing and healing properties (Williams, 2017), but spaces intended to direct and assist in the treatment and care of people with mental health problems are not always experienced in this way and can become sources of stress and anxiety (Curtis, 2016). Georgia discusses how the physical design and organisation of her newly refurbished surgery affects her experience in the space:

The surgery got renovated recently and the building itself makes me really

²⁰⁰ Verbal conversations via the telephone can be as problematic as face-to-face encounters (see also, Chapter 7).

anxious; it's fucking *awful*. I went recently and had to go outside to calm down. By the time I came back in I'd missed my appointment and the doctor couldn't see me. [...] [The building] is a big square block. Inside the ceilings are low and corridors are long. The waiting rooms are these narrow off-shoots off the main corridors with two rows of chairs that face each other, so you're face-to-face with a stranger while you wait [and] there's absolutely no airflow, it's always sweltering! [...] Even the colours make it sterile and clinic-y. [Before] it was kind of welcoming, a nice wee sandstone building that had some character about it. They did install this wee computer to check-in for your appointment, so you don't need to speak to anyone. You just put your name and date of birth in and it tells you what doctor you're seeing and what floor and waiting room to go to. That's quite good but the rest is pretty dire. (Georgia, IR)

Despite new technology that helps Georgia to navigate the surgery space and avoid anxiety-provoking interactions with reception staff, the overall design and organisation of the building causes an unbearable sense of unease and discomfort. Recognising the difficulties that individuals experience in simply making and attending GP appointments, Georgia's existing anxieties are further heightened by entering into a known yet unfamiliar space. The organisation of the space, with its sterile conditions and narrow spaces prompts a negative reaction, resulting in an uncanny sense of uncertainty that leaves Georgia feeling simultaneously exposed and confined. While relations to space can shift over time as illness progresses or mobility decreases (Crooks, 2010; Dyck, 1995b) the jarring transformation of a once reassuring space impacts negatively on Georgia's overall experience. Albrecht et al. (2007) coined the term 'solastalgia' to explore the implications of negatively perceived or experienced changes in the environment on health and wellbeing. Although originally applied in the context of psychological impacts of environmental change, the term has been adopted by geographers to explore the emotional reactions to changes in psychiatric hospital spaces (Wood *et al.*, 2015), demonstrating that what may be an efficient use of space for one can cause distress for another. Georgia reflects with some nostalgia on the warmth and 'character' of the original surgery, set in stark contrast to the sterile reality and modern design of the new facility. Familiarity with and attachment to place helps to establish a strong feeling of security that operates as a foundation from which a person can manage emotional experiences. The shift in meaning attached to the space not only destabilises Georgia's sense of attachment, but has consequences for her overall health and wellbeing to the extent that she even missed a crucial appointment with her doctor.

Lisa (IR143) describes a similar experience between her first and most recent encounter with her University's Counselling and Psychological Services:

They renovated the building and designed this awful ‘functional and efficient’ space. It had a very white, minimal and clinical design. The offices you go to for your assessment are horrible white cubes all lined up next to each other. The walls aren’t solid walls but a grey-white frosted panel. I could sort of see faint shadows from the rooms on either side and hear lots of noise and footsteps. It felt like there was no privacy.

Comparing the design and layout of the room where she had previously received her therapy sessions, she says:

[Before] it was nothing fancy. There was an old fireplace in the room, two mismatched armchairs and a small coffee table with some tissues on it and this little frog ornament LOL! But it felt cosy, sort of like my gran’s house! (Lisa, IR, 143)

Similar to Georgia’s experience, the original furnishing and organisation of the therapy space are nostalgic for Lisa as she recalls a homely environment. Lisa also faces similar difficulties with the spaces of university and campus life (discussed in Chapter 7), which highlights the value in being able to locate crucial sources of practical support and spaces of refuge on campus. The consequences for Lisa are that she ‘never went back [for the CBT sessions and] continued to struggle through the rest of the year before I built myself up to go see my doctor.’ Rapport et al. (2007) examine GP’ workspaces as both a place of work and medical treatment. GPs are aware of the aesthetics of the care environment and attempted to strike a balance between a space that appears lived-in and homely, and a space that is functional for diagnosis (i.e. access to technologies and instruments). The design of the physical, social and symbolic dimensions of therapeutic spaces can promote ‘clinical efficiency’ and ‘wellbeing’ (Gesler et al., 2004). While the changes to Lisa’s University’s Counselling spaces may have been an efficient use of space in order to accommodate growing numbers of students seeking mental health care and support, succeeding in portraying ‘clinical efficiency’ through a ‘hygienic’ and minimal design, it failed to convey an overall sense of safety, security or means to promote Lisa’s wellbeing.

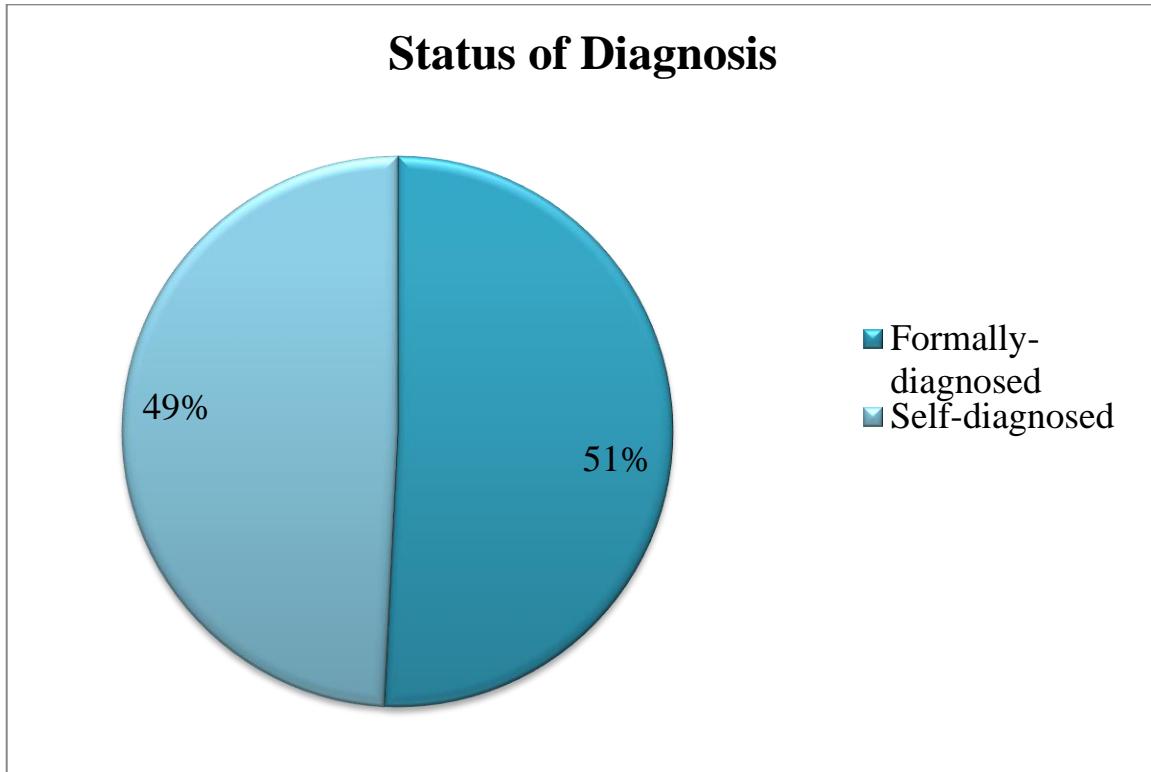


Figure 9: Participants' Status of Diagnosis

Of the 130 participants who completed this section of the online questionnaire, 49% ($n = 62$) report self-diagnosing with social anxiety and 51% ($n=64$) report having obtained a diagnosis from a healthcare professional (e.g. GP, psychiatrist or psychologist) (Figure 9). I asked participants about the process of their diagnosis, i.e., what was their experience of obtaining a diagnosis and what were the implications for their overall mental health and wellbeing. The majority of participant's report that obtaining a diagnosis was arduous. Even those who were happy to receive a diagnosis note that diagnosis was not straightforward and often caused further upset and distress. There was frequent mention of 'being passed from pillar to post' (John, QR54) and 'going round in circles' (Marta, QR33) regarding obtaining a diagnosis. Many participants who were diagnosed by a healthcare professional also report researching their experiences online and/or self-diagnosing online before going to a healthcare professional for a 'formal' diagnosis.

I was interested in the process of diagnosing someone with social anxiety and had the opportunity to discuss this with one Glasgow-based GP. Here, he advises on the conditions that influence his own practice in diagnosing SAD:

Generally speaking if someone came to see a health care professional with a

free flowing anxiety, maybe social phobia but didn't have classical depressive symptoms (tearfulness, early morning wakening, loss of appetite, loss of interest in things (anhedonia), [and] loss of libido. I'd consider a [diagnosis of] social anxiety disorder. Psychological therapies seem to be in vogue at present (particularly CBT and Mindfulness) and generally I'd refer onto other agencies or self-help groups. I don't think there is much evidence for drugs (antidepressants or benzodiazepams) [but] occasionally beta-blockers can help²⁰¹. (Robert²⁰², Personal communication).

This extract is from a very brief discussion about the nature of my research and the focus on help seeking in particular however, it does appear representative of General Practice in that it follows the NICE (2013) guidelines outlined for social anxiety treatment and echoes with what participants have communicated about their diagnostic encounter. Robert's approach is centred around diagnostic symptoms, but given the centrality of anti-anxiety medications as treatment for said criteria (or rather the absence of 'depressive criteria'), it was interesting that his treatment approach was very much situated within psychotherapies and 'outside agencies', i.e. in the community. He does note that CBT and Mindfulness approaches are very much 'in vogue', but that there are concerns over their 'real world effectiveness', which speaks to Stravynski's (2014) criticism of biomedical and cognitive-behavioural models discussed in Chapter 2 (see also: Parker, 2014).

Those who received a formal diagnosis of social anxiety from a healthcare professional often report mixed and complex feelings about the diagnostic encounter, and the impact of diagnosis on their wider understandings of self and 'ill-being'. The overwhelming consensus appears that receiving a diagnosis of social anxiety is a 'double-edged sword' (QR45S), one that has the potential to restrict an individual as much as they hope it will enable them. On the one hand, having subjective experiences recognised and validated within a diagnostic framework helps to facilitate (self) understanding by naming and defining ("labelling") experiences of distress, providing relief and justification, as well as hope for treatment and recovery. On the other hand, locating experiences within a biomedical framework often means that participants view their anxieties as a personal fault and failing, rooted in their own "defective" mind-body, reinforcing negative views of self

²⁰¹ This is consistent with findings of a systematic review where psychological therapies were found to be the most efficacious treatment when compared with pharmacological treatments (Mayo-Wilson et al. 2014). While acknowledging pharmacological interventions are important particularly for those who cannot access or do not want psychological therapies, Mayo-Wilson et al. (*ibid.*) state that the side-effects of medications can reinforce distress and worry, exacerbating existing anxieties. This research has helped to shape NICE guidelines for the treatment of social anxiety in the UK that suggests CBT should be the frontline treatment, although this somewhat controversial in some areas, e.g., psychoanalytic and interpersonal fields.

²⁰² Pseudonym.

and consequently hindering recovery (Pasman, 2011).

As social anxiety is not readily visible to others, receiving a diagnosis can help to validate experiences as well as provide the necessary paperwork for workplace and education accommodations (Chapter 8). Many are relieved to have their social difficulties acknowledged and the authority of a medical diagnosis legitimates anxious states as ‘illness’. For example, Jo (QR41) writes that her diagnosis provides her with, ‘affirmation that I’m not just “shy” or “pathetic” or “weak”. It’s affirmation that it’s an actual illness that I’m not alone in suffering. When the psychiatrist diagnosed me (without me even telling him what I’d self-diagnosed myself with), it was a relief to have my struggles heard and recognised.’ Similarly, for Rachel (QR07) a diagnosis ‘helps me to understand why I feel anxious all the time. It’s not just me being pathetic, I have an illness.’

Diagnosis not only helps people to understand their thoughts, feelings and behaviours, but it provides context for, and also a language to communicate, what they are experiencing:

I am relieved that the problem has been recognised officially. It is important to me that I was diagnosed by the NHS which makes it seem more real and that I am not ‘imagining’ or ‘exaggerating’ it. I received some treatment (CBT via IAPT) before being officially diagnosed but found this strange and did not know how to phrase it to people. Some people do not understand social anxiety and think it is the same as being a bit shy and that you just need to get over it. I find it difficult to tell people about SA so the official diagnosis helps me recognise it is a genuine problem and gives me confidence to refer to it if necessary. (Cara, QR78)

For Cara, it is important to have her social anxiety officially recognised from a societal perspective as well as an employment perspective. It legitimates her experiences as a ‘genuine illness’ and demonstrates to others that, by seeking a diagnosis, she is indeed playing an active role in her own treatment and ‘recovery’.

It shows that you are at least taking some small step in both trying to identify the issues and then can address what actions can be taken to alleviate them. From an employment and societal perspective it helps because you need to prove that you are suffering from a genuine illness, and if you do need any kind of support or become unemployed and need to undergo disability assessment that you have evidence backing your claims.

It is also vital for triggering the administrative process necessary for proving disability,

obtaining work place accommodations or applying for benefits²⁰³:

Routine²⁰⁴ consultations with a GP can have a significant impact on a person's mental health and wellbeing: in the short-term, by providing a safe environment where they feel their subjective experiences have been validated and understood; and, in the long-term, as an instrumental part of their mental health support network and recovery (Buszewicz *et al.*, 2006). The doctor-patient relationship is fundamental and is built on effective communication, establishing rapport and empathy (Kornhaber *et al.*, 2016). Research in the treatment of social anxiety has shown the significance of the therapeutic relationship and 'alliance building' (Valle, 2014) to successful treatment. Yet, the interpersonal dimensions of any therapeutic relationship serves to hinder help-seeking for social anxiety, given a common set of fears about authoritative figures, discussing symptoms and experiences, being perceived negatively and being negatively evaluated by a healthcare professional (Valle, 2014). Amelia received a diagnosis from her family doctor who she felt 'comfortable discussing [her] deepest inner thoughts', but when she moved to a new area she had to register with another practice and was not assigned a new family doctor:

It's so important to find the right doctor. My family doctor has known me since I was a baby and seen me through all my mental health struggles. I haven't found a new doctor yet. When I registered at the new place they basically assigned me on a locum²⁰⁵ list. [L: What does that mean?] Whenever I make an appointment, if there's a locum that's who I see or they put me with any doctor that's got a space. [L: How do you feel about that?] It's not ideal, having to repeat my story to a new person every time I need a sick-line or to discuss meds. It's like justifying my self over and over again.

Continuity of care is therefore seen as a crucial aspect of community mental health care that enables a patient to build a therapeutic relationship with their doctor. It is fundamental to building trust, negotiating treatment and directing individuals to and through increasingly complex health and social care systems, as well as navigating social and structural barriers (Freeman and Hughes, 2010):

Oh my psychiatrist! I just adore him! And my CPN²⁰⁶! I see them two days a week, every week. My GP surgery are so fucking useless – sorry, but they

²⁰³ As highlighted in Chapter 6, workplace accommodations for social anxiety are inadequate at best and, at worst, non-existent.

²⁰⁴ 'Routine' in the sense that a GP may become a regular point of contact for a person experiencing mental health problems and also in the sense of non-emergency care/treatment.

²⁰⁵ A 'locum' is a doctor who temporarily fills a doctor's position in their absence.

²⁰⁶ Community Psychiatric Nurse.

make me so angry – in the past I go to them and I get there and it's too much for me to cope with and they send me up to bloody A&E for a panic attack – they just don't want to deal with me. But my psychiatrist, he worked at [in-patient unit] and left them to come into the community [...] So I don't go to my GP anymore because they make everything worse, they don't take me seriously. (Karen, IR)

Karen found her GP surgery difficult to deal with and as a result her psychiatrist and CPN became her primary care team. However, this transition had consequences for Karen's benefits application. She continues:

[The GP] had sent off a report and [Department of Work and Pensions (DWP)] sent my application back saying I was getting £21.80 a week [based on the GP's report]. I sent my mum up to them 'cause I couldn't deal with them and [they said] 'Karen doesn't really come to see us anymore'. So [DWP] used it against me that I wasn't going to the bloody GP even though I'm seeing my psychiatrist and CPN twice a week [exasperated]. Well, my psychiatrist wrote off a report to them, an A4 page double-sided [letter] writing of my illness and how it affects me and how, at this stage, he sees me every week. He wrote down he was seeing me every week and all the rest. (Karen, IR)

ILLNESS IDENTITY AND VALIDATION OF EXPERIENCE

While many value the authority of a professional in acknowledging and validating their experiences, the presence of authoritative figures can also aggravate anxieties (Stravynski 2014) and can be one of the most significant barriers in accessing support and treatment. Eilidh (QR91) explains:

[Social anxiety] is stopping me from getting going to my doctor. I want to get help but I'm also scared of being defined by my anxiety.

There are many ways that people with social anxiety attempt to navigate this complex relationship of power and the anxieties that ensue. Health information and communities online are valuable sources of information and support for people with social anxiety (discussed later) and while the volume and quality of information available on the Internet is often conceived of as the 'site of a new struggle over expertise in health' (Hardey, 1999, p. 820), it also plays an instructive role in encouraging individuals to seek help offline as well as preparing them for the interactions that take place in medical settings. John (QR54) and Jane (QR90) explain how their online practices helped them to communicate their experiences with their GPs:

I was really struggling and people [on SAUK forum] kept saying 'maybe you should speak to someone', 'go to your doctor', you know, like, you don't suffer

this in silence kind of thing. It was months before I made the appointment [...] I was so scared. I asked loads of questions [about] how to even approach this with a doctor and got great advice. [...] A few people told me to write a letter to my doctor and give it to them in the appointment in case I froze up and couldn't talk, but really it was good to read what people had done themselves and [to] know what to expect. (John, QR54)

[I went to the doctors] when I hit rock bottom. I was done. I'd spent so much time being terrified of the doctor but I couldn't take it anymore. I printed off some things from the NHS website [about social anxiety] and took it with me [to the appointment] to be like, 'this is what I'm going through!' It had taken me so long to get to that point I didn't want them to ignore me or think I was being stupid. I didn't want to come away without some hope. I went prepared. (Jane QR90)

Kathryn (QR96) values a formal, medical diagnosis but writes at length about her struggle to obtain one:

It took a long time for me to be diagnosed by a professional. This was mainly because they didn't want to give the wrong diagnosis and therefore refrained from giving one at all. This was very unhelpful because it made me feel like there was something wrong with me but it wasn't serious enough to be classified. However, my anxiety was significantly impacting my life and I didn't feel like that was being taken seriously. It was important to get a diagnosis because I didn't know which thoughts belonged to me and which were my anxious thoughts. Because I hadn't been through any trauma I was ashamed of my anxiety because I felt like it wasn't justified but the diagnosis made me feel better because it was my brain chemistry that wasn't quite right, rather than me as a person.

Kathryn's social anxiety had become all-consuming, exacerbated by the uncertainty of being 'diagnosable' and the length of time she waited for a diagnosis. She communicates experiencing a sense of relief in being able to locate her 'problems' firmly in her 'brain chemistry', since she felt that her anxieties were unjustified because she had not experienced any 'real' trauma in her life. By 'localising' the problem in this way Kathryn is able to justify, and separate her from, her anxieties. Diagnosis seemingly makes her mental health problems more acceptable and manageable, and provides hope and direction towards recovery:

I was so desperate by the time that I got the diagnosis that it meant that I could be put on medication that specifically addressed how I was feeling. It changed my life because I was able to view myself as a separate entity from my anxiety. This meant that I could accept how I was feeling because my mind became a bit clearer. There was an explanation and I was no longer alone. It was recognised by a professional that I had an issue and so I felt like all of the stigma from people regarding the embellishment and fabrication of mental illness meant nothing to me anymore. I understood my symptoms and kept

them to myself largely before. I was ashamed to show them. Since the diagnosis I have been able to share my story because, to me, it is no different than raising awareness of a physical illness. (Kathryn, QR96)

Kathryn's diagnosis provides her with 'boundaries' and anchors her experiences in a particular set of classifications that separates the distressing and abnormal anxious experiences from her sense of self. The 'authority' of a formal diagnosis can therefore validate experiences of illness, so much so that:

I think that my disorder has got better. 1) because my medication has helped to ease some of my symptoms so I could think clearer and 2) because I was able to accept that I had a disorder that wasn't my fault, it was just a glitch with my brain chemistry. I no longer blamed myself for my issue, rather saw it for the illness it was. Sometimes it feels like it gets worse due to stigma. This is because people tend to scoff at mental health labels and think that we are fabricating our illnesses and so sometimes it is easier to hide our issues and keep them within. I think that people don't understand how bad things get before one can officially be diagnosed with a disorder or how low you need to feel before reaching out (Kathryn, QR96)

Receiving a diagnosis can, as shown, be experienced as a form of release, a process that absolves the self of blame for perceived and embodied interpersonal failings.

In *What You Must Think of Me*, an autobiographical account of living with social anxiety written by Emily Ford (with psychiatrist Michael R. Liebowitz²⁰⁷), Ford documents how her life was adversely impacted by social anxiety and her 'eventual triumph' over the disorder. In a section titled 'At Last, a Diagnosis', Ford recounts the feeling of relief that she experienced in having her personal difficulties with social interactions defined and validated by her psychiatrist. She writes:

When I walked into the psychiatrist's office, I was a blank slate. Dr. A. didn't know me through my parents or my classmates. He didn't know where I had grown up, how well I did in school, or what kinds of incidents from my past had caused me deep embarrassment. He simply listened, and while I didn't speak with flowing ease, I had a feeling that my halting speech was fine with him.

I told Dr. A. that I thought I might be depressed, although I didn't explain why in detail or bring up the anxiety at all. He asked me a series of questions, and I recognized them as similar to those in the book on anxiety that I had read during my first year in college. "Emily," he said, "the score that indicates you might have social anxiety disorder is a 19. You scored a 47. (Ford et al., 2007,

²⁰⁷ Liebowitz is a leading figure in social anxiety research in the psy-disciplines

Ford's autobiographical account of social anxiety is the only source used outside of my own data. I utilise it here as her account of the diagnostic encounter is interesting in that the social and interpersonal aspects of her daily experience are stripped away and her social anxiety is measured and quantified in order for 'Dr. A.' to arrive at a sound classification and diagnosis of her distress. This form of psychiatric assessment that employs rating scales and symptoms checklists rather than paying attention to a person's individual and unique experience, is impersonal at best and dehumanising at worst. Speaking to a medical-clinical gaze, in which bodily phenomena, constitutive of interactive parts and systems, become measurable and controllable (Zwart, 1998). The body, increasingly objectified and monitored by medical science, is deemed to be unaffected by sociocultural and historical influence (Martin, 2007).

NEGATIVE ENCOUNTERS

While some participants found validation and a sense of empowerment in their formal diagnosis, others do not feel they have or want to be labelled with a mental health problem in order to seek help and support. Others, rejecting the medicalisation of their experiences, feel that they are equipped to handle their anxiety without medical intervention or do not want to take medication (Olfson et al., 2000). Sean and Anya also write of having negative diagnostic experiences:

I went to the doctor's and tried to describe what I was feeling but I was so nervous I could only focus on how ridiculous I sounded. I felt like I wasn't being taken seriously. The doctor was really dismissive. After a few minutes he interrupted me and said, 'sounds like mild social anxiety, take these' and handed me a prescription for anti-depressants and that was it. (Sean, QR15)

[When I went to the doctor] I was struggling to function as a person and very unhappy to the point of feeling suicidal most of the time and desperately wanted help. I have seen four doctors since I was diagnosed [6 years ago]. Each [doctor] has upped/changed my medication but not given me any real solutions or help. [...] I feel like a biological fact, that my brain is laid out this way and I can't be helped. I know it's not 'normal' to be this afraid of people. (Anya, IR)

Hall (1996) argues that the diagnostic process for people with mental health problems under the medical model serves to undermine the individual. For some, the process of their diagnosis consisted of them 'filling out a few forms' (QR24). It is unknown what the

²⁰⁸ There is no indication of what the scale is here.

specific forms were as those participants did not participate in follow-up interviews, but it is likely that they were patient health questionnaires implemented as screening tools for anxiety and depression. Participants are often required to self-report the frequency of anxiety and/or depression and the likelihood of avoidant behaviour over a two-week period. While this is arguably time and cost-efficient, since on average it takes 8.4 minutes to diagnose the most common ‘mental disorders’ in primary care (Jackson et al., 2001), it focuses narrowly on problems defined by clinical and biomedical frameworks, resulting in ‘a contrived and sanctioned dehumanisation of the individual’ (Hall 1996, p. 17). The reductive and mechanistic approach in the diagnostic encounter can often have a negative impact on the individual leaving them feeling dismissed or reduced to the ‘category’ of their ‘disease’ – as highlighted in Mia’s testimony earlier in this chapter. These factors influenced Sara’s experience of formal diagnosis following many years of self-diagnosing:

S: I was in and out in 5 minutes. I’d filled out a form in the waiting room, the doctor took one look at it, put it to one side and wrote me a prescription for citalopram²⁰⁹ and beta-blockers.

L: How did that make you feel?

S: I was kind of in shock because, even though it confirmed what I already knew, I was looking for help [and] information. Maybe even support?! I wanted someone to help me and she didn’t really engage me once, didn’t ask me any personal questions or nothing. I’ve had more in-depth appointments over a throat infection to be honest. (Sara, IR)

The focus on, and treatment of, physiological symptoms follow the principal diagnostic framework of the ‘disease model’ (Hall 1996; Stravynski 2007). The lack of time and care spent on the individual’s personal, familial and interpersonal history or the daily implications of their experiences during the diagnosis of social anxiety (and mental health problems more generally) is emblematic of this approach. Furthermore, Sara’s expectations of her GP as a source of knowledge about her mental health and a ‘facilitator’ to mental health services are not met as trusted routes for treatment-seeking pathways appear ‘inaccessible’ (Popay et al., 2007).

Many participants note that the process of obtaining a formal diagnosis is ‘fraught [and] tedious’ (QR09) and ‘an absolute nightmare’ (Lucie, QR28). Crucially, the very experiences that they wish to resolve are the ones acting as a significant barrier to help-seeking and treatment: for example, feelings of shame and embarrassment about

²⁰⁹ A brand of anti-depressants.

symptoms, significant difficulty attending face-to-face appointments with a GP, as well as uncertainty over what to say and how others will react (Olfson et al. 2000). Inconsistency in the therapeutic relationship or in the diagnostic process can cause considerable harm to an individual's health and wellbeing, the repercussions of which may short-circuit attempts towards recovery²¹⁰. Josh's experience also highlights these issues:

I saw a GP before [starting therapy] but did not discuss problems in any detail. After that [there] was a phone assessment. But that was the first time I was encouraged to talk one to one in detail about problems. [The] frustrating thing for me is I had seen a GP over 5 years ago and mentioned some of the symptoms but was not referred any further or probed in detail. It would have been better for me to address the problem then. But the onus was on me to share but obviously, with social anxiety that is not something people find easy. (Josh, IR).

Several participants have hence avoided seeking a formal diagnosis in anticipation that their GP would not 'believe me' or 'take me seriously', or because they would think 'I'm just attention seeking' or 'I'm overreacting' (QR14, QR19, QR48, QR88). Another participant highlighted that a therapist became 'frustrated because I couldn't say *exactly* what it was I was anxious about' and 'didn't seem to understand anything about social anxiety at all' (QR65). People with mental health problems often report feeling dismissed and dehumanised by healthcare professionals and diagnostic processes. Stigmatising behaviours are the key deterrent preventing people from seeking help and delaying treatment, the impact of which is often perceived to exacerbate their mental health (Barney et al., 2009). Sophie (QR37) recalls struggling to 'find answers' and her experience of feeling dismissed by numerous healthcare professionals²¹¹. She writes:

I knew I had something since I was very young, I knew something was wrong. I would cry my eyes out at night wondering why I couldn't do certain things and why I was so weird around people [and] anxious doing normal things. It led to me having a LOT of problems. I tried to go to the doctors and told them I constantly felt panicky around other people but they didn't really take me seriously [...] The response I got [from the doctor] was, word for word, "everyone feels like this but you have to deal with it yourself". I felt severely angry that I wasn't getting the respect and recognition I knew I needed, like

²¹⁰ Pinfold et al. (2005) report that service users feel most discriminated against by mental health care staff.

²¹¹ Social anxiety is associated with significant barriers to treatment, one of which is a lack of awareness from healthcare professionals about the severity of impairment or 'clinical significance' of the disorder (Olfson et al. 2000). The NICE (2015) guidelines for social anxiety also report that it is misunderstood and misdiagnosed in clinical settings. Yet there is no research exploring how it is experienced in healthcare settings or the longer-term implications on a person's mental health (although similar work exists for Borderline Personality Disorder (BPD), Obsessive Compulsive Disorder (OCD) and depression (Barney et al., 2009) and in wider mental health care settings (Hamilton et al., 2016)).

they didn't respect me AT ALL.[I was] just another attention seeking kid. When I went to the GP the second time at I felt like I had no respect and she basically laughed and made me do a quiz. But then she assigned me on Citalopram [an antidepressant] that did next to nothing, so after about 2 weeks of taking them I stopped and began to recognise my anxiety in different situations and used that knowledge to help instead of the meds (Sophie, IR37)

Sophie is highly critical of how numerous healthcare professionals and services failed to acknowledge her social anxiety in a way that legitimated her experiences. Failure to respond effectively to experiences of emotional distress creates serious barriers to accessibility and quality of care:

They judge, they categorise and then they ignore [you]. Oh look another attention-seeker stick her on meds and send her off. I got a number for talking therapies, which were shrinks²¹² that would call you and then you'd talk and that's it. I did one appointment, and then they said they'd refer me further, [but] did they call me back? Did they bollocks! (Sophie, IR37)

This lack of follow-up can have life-threatening consequences for individuals who have no other means of social, emotional or therapeutic support, as Sophie (IR37) continues:

It got so bad and I was so desperate, I tried to kill myself twice. This is why recognition is needed, along with respect and dignity too, without being belittled and made to believe you're being foolish.

The accessibility of information online is vital in practices of self-diagnosis. As shown in Figure 9, more than half of those who participated in this research self-diagnosed with social anxiety after consulting health-information and anxiety communities online. For instance, Dawn (QR01) and Emma (QR18) dispute the diagnosis (or lack of diagnosis) given by their psychiatrists:

[My] psychiatrist only diagnosed generalised anxiety and said it falls under the same umbrella, but lots of Internet research has led me to discover that it by itself warrants its own separate diagnosis, [of social anxiety] and the symptoms listed all match my own. (Dawn, QR01)

My psychiatrist actually doesn't believe I have social anxiety because I'm not crippled by things like giving presentations; he says it's not social anxiety but a lack of social skills. I perform well in work, have a decent job and aced university, but anything outwith those 'comfort zones', I'm a mess. I hate *social* interactions and will go to ANY length to avoid them. (Emma, QR18)

The negative experiences reported by participants here, and discussed widely in other research studies relating to mental health and illness, are indicative of a more systemic

²¹²Clinical psychologist, psychiatrist or psychotherapist.

issue where social anxiety is under-recognised, misunderstood and mis-diagnosed (Knaak et al., 2017). The proliferation of medical information available online, given rapid developments in mobile technologies and applications, has led to a digitisation of diagnosis. Indeed, there are over 100,000 mobile phone applications designed for the purpose of disseminating health and medical information (Jutel and Lupton, 2015). Through such technologies, we are arguably bearing witness to ‘digitally-engaged patients’ (Lupton, 2013) and subsequently changing the nature of lay-professional relations (Lupton and Jutel, 2015).

ONLINE SPACES

There are two aspects of online space: the Internet as an information resource and as a social space. The growth of the Internet has made vast amounts of health and medical information readily accessible to the public. Health information-seeking and sharing online have significantly increased mental health literacy²¹³ (Christensen and Griffiths, 2003) and enables people to participate meaningfully in their own care and to accommodate different perspectives on health and healthcare (Ryan and Wilson, 2008). Equally, the rise of online technologies and virtual communities have become vital sources of information, connection and support for people experiencing mental health problems (Campbell and Longhurst, 2013; Davidson and Parr, 2010; Parr, 2002). The proliferation of health information on the Internet has led to the ‘democratisation’ (Parr, 2002) of medical knowledge, yet there are concerns among healthcare professionals over accuracy, quality, clarity and volume of information that is available to people online (Christensen and Griffiths 2003). The overwhelming amount of information available can cause confusion and uncertainty for users.

Parr (2002) demonstrates an evident shift in Western medical discourse and practice from a practice of ‘collective care’ to a person-centred care fostered by online technologies and health consumerism. Since this analysis, I would argue a further shift is materialising, one that is re-positioning the ‘patient’ as the sole director of their care and treatment. This shift has been branded as a way to create ‘more person-centred service systems’ (Croft et al., 2016) that views people as active agents in the therapeutic/treatment relationship, acutely aware of what supports or impedes their own recovery. In reality, it has fostered (as mentioned earlier) the ‘responsibilisation’ of the subject (Rose, 2000) and the

²¹³ Mental health literacy is defined as the ‘knowledge and beliefs about mental disorders, which aid their recognition, management or prevention’ (Jorm et al., 1997).

‘operationalisation’ of self-management (Brijnath and Antoniades, 2016). In addition to this, as mental health policy strives to deliver an empowered and responsible citizen, a series of social and systemic issues compromise the quality and accessibility of effective treatment options for those with mental health problems and for social anxiety in particular.

While the Internet has undoubtedly played a role in facilitating the task of ‘responsibilisation’ by enabling a more informed citizen in control of their own health and care, the ‘responsibilisation’ of the subject to govern their mental health is a paradox of recovery policy and practice. Not only are ‘citizens urged to turn the medical gaze upon themselves, and engage in such technologies of the self as monitoring their own bodies and health states and taking preventative action in accordance with medical and public health directives’ (Lupton, 2003, p. 57) they are further stigmatised by family members, medical practitioners and society if they then struggle and fail to ‘get well’. In addition, there is a fundamental lack of therapeutic services and community support groups for people with social anxiety. Healthcare systems delivering ‘one size fits all’ care fail to significantly address the specific issues faced by people with social anxiety and treatment approaches that place the onus of management and recovery on the individual inevitably do more to exacerbate social anxiety than heal it. Thus, the Internet has also been instrumental as a response to, what Parr (2008, p. 203) terms a ‘*crisis* of real-space community and its caring capacities.’ The Internet has therefore emerged as a vital space in which individuals can re-position themselves collectively through engagement with online mental health communities.

Overwhelmingly, the Internet is conceived of as an enabling space with online communities providing vital sources of informational and emotional support. Online spaces enable people to socialise, engage with others, relax, enjoy, learn and even resist, without the associated costs and risks involved in ‘real-world’ situations. People have access to ‘the thing’ – connection, community and an engagement with the world – ‘without actually having it’ (Contu, 2008, p. 374). Online spaces are operative spaces of desire for the satisfaction of social need. Social Anxiety Scotland (SAS) and Social Anxiety UK (SAUK) are the two forums that feature in this study and the primary avenues for recruiting participants (see Chapter 4). In mid-2016, SAS was taken offline by the site administrator and is no longer accessible to its members, the implications of which will be discussed later. Both web-forums are user-led and receive no external funding, being supported solely through donations and advertising, although SAS was primarily funded by

the site administrator and was run from their home in Scotland. SAS and SAUK are comprised of three parts: a ‘main site’ (the website, featuring information about social anxiety and links to further information and resources), a chat room (a synchronous platform for communication) and a web-forum (an asynchronous discussion board)²¹⁴. The desire is to create a safe online environment for people to find information about and connect with others experiencing social anxiety. This desire to orchestrate safety is facilitated by a certain organisational structure and community ethos. The websites and forums have similar organisational structures and are run by a group of volunteer staff made up of administrators and moderators. Administrators, known as ‘admins’, are usually the owners of the web-forum or website responsible for day-to-day operations and site management. Moderators, known as ‘mods’, are users granted ‘administrative privileges’ for managing discussions and content and ensuring all users are following community rules. A ‘mod’ would be responsible for moderating user threads (e.g. ensuring they are in the appropriate section on the forum) and suspending and/or banning users who engage in behaviour that breaks community rules (e.g. bullying or harassment). In this sense, they are highly moderated and managed social spaces. SAUK outline the purpose and goals of their online community:

[T]o provide a **starting point** for people just finding out about SA and related issues, to enable them to access further information through this site and through external links; to act as a central hub for the **community** of those with social anxiety problems in the UK; and to attempt to **raise the profile** of SA problems and campaign for change, so that in future, people afflicted by them don’t have to suffer in silence as so many of us have done in the past. (SAUK website: *emphasis in original*)

As feelings of social isolation and loneliness – whether through experiences of marginalisation or the practice of avoidance – maintain a pervasive presence in the daily lifeworlds of people with social anxiety (Chapter 8), SAUK and SAS play a fundamental role in opening up people’s social worlds once again. For instance, Kathryn (QR96) writes about the positive impact that the Internet (and SAUK in particular) has had on her life:

My life in general has been opened up to more possibilities through the Internet. I have forms of support I never had before so if I’m feeling particularly down or harmful or if I’ve had a weird interaction and I’m going into meltdown, I can come home and sort of ‘go back out again’ through the Internet. It’s definitely a way of expelling all the bad shit and connecting with

²¹⁴ Other than the synchronous and asynchronous aspects of chat rooms and web-forums, they differ in that message ‘threads’ (conversation exchange under a particular topic) are usually archived and can be accessed indefinitely from the main forum website. Synchronous chat conversations are not usually available or accessible once someone exits a chat.

people who understand and can give you a reasonable advice or even just the acknowledgement of what you're going through is real.

Social contact and connection through online communities are not only ‘invaluable’ (Cara, Q78), but operate as a ‘life-line’ (John, QR54; QR23) for many who find comfort in the notion that ‘we are not alone in our suffering’ (John, QR54). Being online provides people with a sense of belonging as ‘finding others who experience the same things helps you to feel part of something, part of a community’ (Marcie, QR57). Similarly Hannah (QR77) writes:

It’s my only way to socialise and communicate. The forums have chat rooms so they can be quite busy at weekends. It’s a nice environment and it’s safe as there are mods²¹⁵ so it feels managed. Everyone understands each other and even though our anxieties aren’t all the same, our levels of anxiety vary, everyone understands that we face individual difficulties and really try and reach out to support you if you put yourself out there and ask a question.

Sharing the personal minutiae of daily life as well as the intimacies of mental health experiences is usually reserved for the interpersonal spheres of life. Through online technologies social connections are formed and sustained across geographical distances. The co-presence of people with social anxiety in a dedicated and delineated (online) space helps to foster relational intimacies with other users.

Operating as the primary connective medium as well as a vital source of information, support and everyday functioning, people overwhelmingly experience the Internet as an empowering and enabling space. Yet, despite the benefits of web-forums such as SAS and SAUK and their capacity for social connectivity there are also a number of shortcomings of computer-mediated communications. There are those who feel that engaging in online communities is only beneficial in the short-term and has very little impact in the long-term with respect to providing the necessary structure for building trusting and supportive interpersonal relationships. Cameron writes, ‘relating to each other is surface level stuff’. Others feel that the Internet ‘hasn’t had any long-term positive impact on my life’ (Emily, QR25) and is, ultimately, more of a ‘crutch’ (Ben, QR32), making some ‘even more anxious’ (Molly, QR42) as many are unable to ‘separate my physical self from what I do online’ (Marta, QR33).

²¹⁵ Shorthand for ‘moderator’.

LURKING

‘Lurking’ or ‘lurkers’ is a pejorative term used to describe those who inhabit the margins and peripheries of online communities. Crawford (2009) argues that much of the research on online communities has focused on participation, interaction and ‘having a voice’, but that very little attention has been paid to those who rarely, if ever, contribute to online communities and discussion threads. Lurkers constitute the overwhelming majority of online community users, with up to 90% engaging in only light online activity²¹⁶. There is a surprising amount of antagonism directed at those who do not demonstrate fully engaged and active participation in these communities. Kollock and Smith (1996) deem lurking behaviours ‘selfish’ as users consume information shared by others but do not contribute to the reciprocal nature of online communications. Drawing on Ostrom (1992), they use the term ‘free-rider’ and state that such users are ‘problematic’. Others argue that lurking behaviours are ‘detrimental’ to the purpose and use of collective online technologies (Butler et al. 2002). These claims parallel the neoliberal demand of active citizenship whilst trivialising the value of *inactive* participation.

Nonnecke and Preece (2003, p. 110) call for researchers and online communities alike to acknowledge and ‘rethink’ the practice of lurking, recognising that online communities are unique spaces for enabling access to group conversations, community and information ‘without being visible or forced into public participation.’ For those who ‘lurk’, the practice is not necessarily about ‘scavenging information’ (Harquil, 2010), but rather a hesitation about entering into an unfamiliar social space and exposing themselves to unknown others. For some, online communities encompass various aspects of ‘real’ social space, provoking an intense anxiety and fear that they will be negatively judged, scrutinised and rejected by others, even those who are in a prime position to support and understand their struggles:

I want to contribute to conversations on SAUK and Reddit²¹⁷ etc. but just the fact that there are a group of people talking to each other makes me feel like I’m in group social situation and my anxiety flares up. I can’t bring myself to post a topic or contribute. Anytime I start [to contribute] I agonise over every word, [thinking] Is this relevant? Does this make sense? I sound ridiculous! No one cares! And I’ll delete it. (Lucie, QR28)

²¹⁶ The ‘rule of thumb’ is that Internet culture is made up of 90% lurkers, 9% contributors and 1% creators (Neilsen, 2006).

²¹⁷ Reddit is a news and discussion website. Similar to a web-forum, posts are organised by topic into user-created ‘subreddits’ (i.e. threads) and cover a wide variety of topics, including news, science, politics and health. There is a dedicated social anxiety sub-reddit that, as of July 2018, has 108,000 subscribers.

I'm just overcome with a fear of getting negative feedback or sounding stupid or I post something and it gets completely ignored so I don't [post anything] but I still find SAUK really valuable (Kim, QR40)

Levordashka and Utz (2016) state that, while there is no physical presence in online worlds, there is social presence, one that amounts to an affective quality of 'being there', and so, for many who opt for 'silent' over 'active' participation, this is a particular strength of online forums. Negatively characterising those who opt to 'read only' is inappropriate and could further deter a person's active participation in online spaces. It also fails to acknowledge those for whom regular 'checking in' (QR21) and 'browsing' (QR43) is enough or those who may be learning through the experiences reported by others on the forums. For example Emma (QR18), who is a 'self-confessed lurker', writes, 'I learn from others how to survive social interactions and it gives me a certain strength knowing there are others like me. I don't feel confident enough to share [my own experiences] yet.'

Negative perceptions of lurkers also exist in online communities where many become frustrated about the lack of engagement from other members, how 'quiet' community forums are at certain times or the lack of detailed discussion. However, there are some benefits to 'lurking', allowing members to 'build up' to entering discussions in a similar way to entering 'real world' social situations. Emily (QR25) writes that 'reading some experiences can make the quieter people know they're not alone and maybe they're taking steps to build up to posting,' Similarly Marcie (QR57) writes:

I've just joined SAUK and haven't been particularly active. I have been using it on a daily basis and it seems like a good place but I'm just getting used to it and sort of sussing it out. But I do feel like the advice and support you can get on such a site could potentially be very important.

SAUK clearly has had a significant impact on 30's experience without her having to be active or to show engaged participation on the forums. Crawford (2009) argues that lurking amounts to 'witnessing the comments of others', a virtual 'tuning in' akin to listening to the radio, reflecting a process of engagement with the community that, in turn, forms 'part of the texture of the everyday.' Whereas QR16 'joined only to observe at first, but gradually started to post as well once I gained some confidence.' Nonnecke and Preece (2003, p. 118) argue that those who lurk use the practice to evaluate the group, 'reducing the risk of making a faux pas or being rejected'. These issues are significant in the offline lives of people with social anxiety, while online communities afford those who lurk a sense of belonging and community through shared experiences, mutual understanding and collectively without the pressure of active participation and interactions. Another forum

user responds that 47% of users on Social Anxiety Support had never posted, concluding ‘Lurkers, you are not alone :)’.

Contributing regularly to a web-forum is time-consuming and tiring work, particularly if users feel a personal responsibility to maintain activity on the site. Lurking appears to be less of an issue on the larger SAUK forum where lurking members float under the radar. However, it was mentioned as a particular problem on the much smaller SAS forum. Several participants comment on the lack of activity on the forum, with Claire (QR16) saying:

I wish more members made use of the forum and there was less dependence on a few regulars to keep the discussions going.

The size of the SAS community arguably affects how some members perceive the group and their place within it, which may contribute to people engaging in lurking practices:

I've just been reading a lot of the threads since I joined [2 months ago]. I feel a bit fear²¹⁸ to join in the discussions because it seems to be the same group of people [that contribute]. I know it's not cliquey so I don't mean that in a negative way but it's like a new person joining a group of friends that have known each other forever, does that make sense? I don't want to be the obvious newbie trying to fit in and people being like 'oh who's this?'(QR49)

Arguably, everyone ‘lurks’ in online communities at some point by reading forum posts and choosing whether they wish to engage or not.

CONCLUSION

This chapter has considered the formal agencies and ‘biomedical authorities’, which can legitimise and provide support for social anxiety through diagnosis, and more informal online environments. Focusing on what people with social anxiety do in the context of negotiating ‘ill-being’ and ‘wellbeing’, it details the minutiae of how people negotiate these agencies and spaces, demonstrating the distinctive dimensions, and personal barriers faced by individuals in accessing effective care and treatment, as well as the social and structural conditions that shape and/or restrict access to efficient and supportive care. The Internet has played a key role in the democratisation of health for people with social anxiety enabling them to negotiate their own diagnostic categories and ‘recovery’ journeys. However, as McCarthy (2014) found in her research with a London-based social anxiety

²¹⁸ Scottish word meaning ‘frightened’ or ‘afraid’.

self-help group, certain groups, programmes and platforms adhere to and reinforce biomedical models of recovery and the neoliberal principles of ‘responsible

lisation’ and resiliency that without fundamental support, ultimately sustains the conditions that enable anxiety to flourish.

CHAPTER 7

SPATIALITIES OF ANXIOUS EXPERIENCE I

INTRODUCTION

Chapters 7 and 8 are written as a couplet in order to explore the social and spatial contingencies of living with social anxiety. The chapters are designed to complement one another, moving away from the broader configurations of governance and management discussed in Chapter 6 and turning instead to focus on the more intimate lived geographies of anxious experience. Where this chapter (outlined further below) addresses the formative spaces of home, education and work, Chapter 8 builds a more expansive geography of everyday sites and settings that constitute anxious experiences while simultaneously digging deeper into the relational and embodied encounters in and with such sites and settings, addressing how various social relationships are implicated in anxious encounters with space.

This chapter addresses the spatial contingencies of living with social anxiety in order to map the disrupted and the disruptive geographies of anxious experience. Here I pay attention to the formative spaces of home, education and work, taking into consideration the complexity of physical, material and socio-spatial factors that comprise these everyday spaces and the practices that emerge through them. In doing so, I seek to unpack their significance for a geography of social anxiety.

Following calls (outlined in Chapter 3) to tackle the more ‘unhomely’ aspects of home, I wanted to examine how home is experienced by people with social anxiety. In the online questionnaires, participants acknowledged home as one of the safest spaces (alongside spaces within the home, for example a bedroom). This was perhaps an automatic assumption of what the home *should* be, as further discussions often unsettle initial ‘rankings’ of home as a space of near-complete safety. A core focus of this chapter is to highlight the ways in which home can be seen as a fragmented space, one where meanings can be contested, disrupted, changed and lost as a sense of stability and security becomes frayed during social anxiety.

This chapter also focuses on the socio-spatial challenges associated with educational

spaces and the workplaces. I explore how employment and educational spheres of life have been disrupted over the life-course of individuals who manage (and struggle) to gain and maintain education and employment opportunities. There is a focus on the everyday management and negotiation of these spaces that pays attention to interactions and performances that fuel social anxieties – for example, giving presentations or speaking to people in authority – that make them increasingly fearful and disabling aspects of everyday life. Attention is also paid to the tensions and stigma that arise in relation to working with a (known) mental health problem²¹⁹ at this juncture between (reli)ability and recovery. Participants share detailed accounts of the ways in which their education and careers have been disrupted by pervasive anxieties and fears; often reflecting on personal and structural barriers and the psychological and physiological consequences of trying to (re)gain and maintain meaningful participation in educational, vocational and work-related activities. This also fuelled further discussions in interviews about the temporal, spatial and emotional work involved in managing and negotiating everyday life with their mental health problems (Laws, 2013).

HOME

SHIFTING, FRACTURING AND FRAGMENTING HOME-SPACES

Home is generally regarded as a safe space with set routines and where ‘known’ social relationships with family can be maintained (Blunt and Dowling, 2006), but social anxiety often disrupts this space of safety and the spaces available to (re)gain control are often severely reduced. In this sense, safety within the home is ‘always conditional and contingent’ (Brickell, 2012, p. 232). What emerges in the following section is not only an understanding of the spatial practice in/of home and the therapeutic benefits in the making of home spaces, but a consideration of how homes become psychologically inhabited, disrupted and re-written. As anxieties and experiences are tied to and deeply embedded in their socio-spatial surroundings, it is important to consider the consequences of how invasive and pervasive mental health experiences enfold with the intimate micro-spaces of home.

²¹⁹‘Known’ in the sense that it has been disclosed to management and/or colleagues.

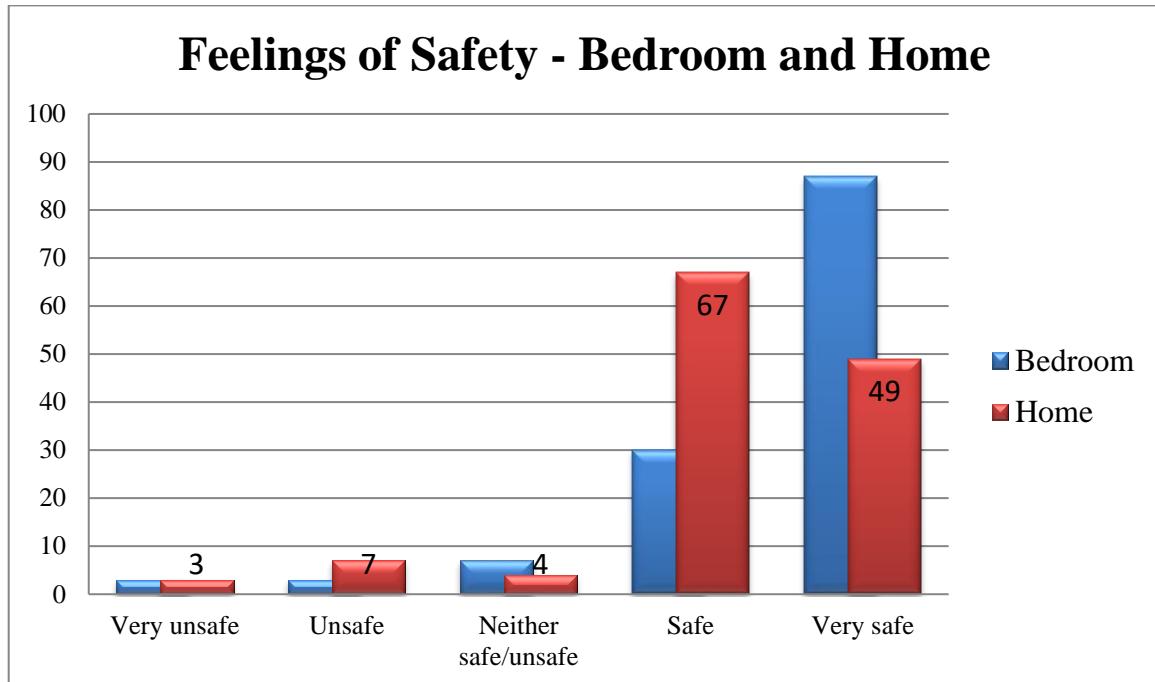


Figure 10: Comparison - Feelings of Safety Bedroom and Home

It is perhaps unsurprising that participants overwhelmingly consider their home to be a ‘safe’ or ‘very safe’ space (Figure 10). For instance, Mia responds saying:

I feel safer here [at home] because it’s my space, you know? My own little part of the world that is solely my own. I live alone and have complete control over this space – who comes to visit, who I answer the door to or who I speak to. I know when I close the front door I feel safe and there’s a feeling of relief that comes with that expectation disappearing. I get home and these four walls are like armour. (Mia, IR119)

For Mia, home marks a clear boundary between the feelings of uncertainty associated with external social space and the feelings of safety and security engendered by being at home. Similarly Lauren (QR179) writes that she felt ‘safe in my home and far too exposed and panicky when outside’. The home is a place where both Mia and Lauren are able to seal themselves against potential exposure to other people. Mallet (2004, p. 71) argues that ‘[d]ifferent performative expectations exist for people’ outside of the home, where ‘different rules of engagement with people, places and things’ apply. The private realm of home is one ‘where tensions built up from the constant surveillance built up in others settings of daily life can be relieved’ (Dupuis and Thorns, 1998, p. 27). Furthermore, the home is a space where Mia feels she has complete control and around which she can place limitations on social interactions and unexpected encounters.

The (imagined) boundaries of home offer idealised separation between inside/outside and

public/private, which may encourage individuals to become housebound for extended periods of time. For example, Dawn (QR01) writes, ‘I wish I didn’t have to ever leave the house. It’s not that I get any actual enjoyment out of staying home a lot [...] I find it harder to go outside when I don’t go out for extended periods of time’. Karen, a single mother of three young children, discusses similar periods where she has been relatively housebound:

I’m comfortable and safe here; it’s just my own surroundings. I did go out with my sister. That was only the other week and I hadn’t been out the house in like six weeks just out in the garden and stuff ... that’s my safe place and I don’t want to leave ... (Karen, IR)

Ultimately, then, Karen discloses here acts of safekeeping (Davidson, 2010) in the face of experiences of social anxiety, which she states have a ‘horrendous’ impact on her day-to-day life. She experiences intense anxiety about being outside the confines of her home and being approached by people within her very close-knit community who may notice her absence from community life, ask questions and spread gossip. She has frequent and recurring panic attacks and can experience up to four panic attacks ‘on a good day’, even within the relative security of her home space. Her home is a known and predictable environment offering privacy to manage routinely (un)predictable bodily experiences, where she has access to medication to control intense periods of anxiety and where she practices established domestic and daily routines:

I just keep myself busy in the house [...] I try to keep busy doing housework and just doing things, you know, like hanging out the washing and maybe sitting out the back [garden]. I’ll sit out there and take my medication. I’m okay in the house [...] I can help cook their [her children’s] dinner, help them do their homework; help them get dressed or ready for bed. My son, I bath him in the morning. Homework and stuff is not a problem. I just cannot take them over that front door. (Karen, IR)

Throughout the interview Karen spoke about wanting ‘to be a good mother’ and how she felt ‘guilty’, and worried about the impact her health has on her children and her relationship with them. It is important to her to provide a caring and facilitative role within the home as she is unable to go beyond it without feelings of intense anxiety and panic.

Home life is punctuated by being able to do ‘little things’ that aid in the everyday management of social anxiety or as a component part of longer-term mental health

recovery²²⁰. Karen places particular importance on roles and rituals practised within the home. It is through these habitual practices that she establishes and maintains a positive sense of home and, by remaining active through her cyclical bouts of panic, her role as a ‘good mother’. Within the home she has a stronger and more stable identity compared to outside, where she loses all sense of herself and the control she has re-built over her socio-spatial and bodily boundaries. Feminist geographers argue that such domestic practices ‘reinforce the stereotypical gendered nature of the home or domestic sphere’ by ‘repeating patterns of oppression within the history of gendered spaces’ (Bankey, 1999, p. 169). Confined within the home, individuals ‘re-inscribe those places and their family relationships through domesticated ideals that immobilise them’ (Bankey, 1999, p. 169) further.

However, for others, experiences of home are not so concrete. Kirsty (QR87) recognises that while at home she is ‘isolated and alone, which is good for the anxiety’, being home it is not necessarily conducive to her overall health and wellbeing. The intensity of social space may prompt long periods of isolation to recover from its multiple and often competing demands²²¹ (Moss, 1997). Far from being an idealised space, the home can often become a space of confinement whereby one’s social geography is restricted to one of homebound isolation. Harriet (QR204) writes:

I’ve been at home for a long time and the suffering becomes just as bad as if I were outside everyday around other people. It’s totally driven me away from the world. It gets to a point where you begin to feel like a prisoner in your own home.

The shrinking of Harriet’s social and spatial worlds has a marked impact on her health and wellbeing. Not only has she lost the freedoms to travel beyond the confines of home, her experience is further complicated by feelings of socio-spatial isolation that have been inscribed into the everyday experiences of home. Individuals living with social anxiety can

²²⁰ Karen has also spent periods of time as an inpatient in a Mental Health Unit where daily routines were set and enforced by staff. Returning home was important for her in being able to (re)establish her own rules and routines. She is mostly housebound except for bi-weekly visits with her psychiatrist. She has no home-based interventions in an act of separating of mental health care from home favouring community based treatments, despite the intense levels of anxiety experienced when accessing them.

²²¹ It should be noted that the experiences documented here and throughout this thesis are not uncommon aspects of everyday life. While presenting at conferences I receive comments and questions where individuals recognise their own social behaviours, thoughts and practices in those I am discussing. However, while I acknowledge that everyone can relate to feelings of anxiety, I do not wish to draw associations between distressing social anxiety and a lethargy of social and spatial life experiences, particularly given the pervasive nature of these anxieties and the disruption caused to social life, health and wellbeing.

often become ‘social captives’ (Charmaz, 1995, p. 668) as social worlds diminish and everyday mobilities become reduced. While the home is typically considered conducive to wellbeing, Anya’s (QR212) experiences of being housebound are extremely tense and palpable, causing her to feel ‘like I’m being crushed’. Similar to Harriet, Anya’s ‘world was getting smaller’ (Davidson, 2000b) to the extent that ‘I was so terrified by the thought of contact with others [...] I wouldn’t hang out the washing in case I met the neighbours; at one point, all the curtains in my house were drawn for four years. I was restricted in every possible way’. The socio-spatial restrictions placed on the self and the boundaries of home, where objects, like curtains, as well as other avoidance strategies, are implemented to limit the dilution of internal personal space by external social forces.

In the wake of deteriorating mental health, tensions manifest in the relationships between the self and socio-spatial surroundings causing experiences of place and the meanings attached to them to shift and fragment. In the following interview excerpt with Jess (QR88), the capacity for mental health experiences to cause disruption becomes apparent:

Jess: As my mental health got worse I became very disconnected from everything and everyone around me. My anxiety was affecting work, friendships, relationships, family; I spent a lot of time at home because I didn’t want to go outside or face anyone not because I wanted to be there I just couldn’t really be anywhere else. Before, I really loved my place. It was mine, with all my things, I would have people round and it was open but then I couldn’t, I shut down ... it began to not feel like home, it was nothing.

Louise: Can you explain why that happened?

J: I guess what was happening was all those horrible feelings – the anxiety, the panic, feeling ashamed and judged by others – those feelings were all coming home with me. They didn’t get left at the door. There was no weight off my shoulders when I stepped over the threshold. My down time is at home and that’s when I’ve really got time to play everything over in my head and think everything through [...]

L: Has that changed now, does it feel like home again?

J: At the moment I’d say it’s the safest place I’ve got but there’s still so much that I can’t control. [L: Like?] Like, people turning up unannounced. That’s probably the worst one. I can’t prepare for anything. I think because my place was so busy before, always people coming and going, there’s the expectation of people coming by so I can’t ever really relax. Plus, I spend most of my time behind these four walls – well, I’m back at work now so it’s better – but my worst days were spent here so I have some pretty bad memories. (Jess, IR)

As Jess’ mental health deteriorated, and the impact of her social anxiety took hold of the important and formative parts of everyday life, there was gradual shift in the meanings she

attached to home. Once a place she ‘loved’, framed by a sense of belonging that reflected her sense of self and wellbeing, her home began to mirror her shifting frame of mind as she slowly retreated and disconnected from those around her. Rather than being a place where she could find relief from the emotional intensity of her anxious experiences, her home played a crucial part in strengthening her anxieties. Home became a place of negative reflection on the day’s events, ones that to those not experiencing crippling social anxieties are likely to appear inconsequential but, for Jess completely disrupt the habitual nature of her everyday life. There is no respite for Jess in this state as the collection of (perceived) negative evaluations that she repeatedly revisits manifest in growing feelings of shame.

Furthermore, her home fosters the anticipatory anxieties that rupture any sense of stability, safety or belonging. Despite an improvement in her overall mental health, signalled by her ability to return to work²²², Jess’ understandings of, and relations to, home become re-written, imbued with a new set of meanings, emotions and histories. These new associations reveal a disconnection between Jess and this once ‘homely’ space. Douglas (1991, p. 289) states that ‘home starts by bringing some space under control’, but Jess ends up struggling to reconnect with a home that, on the one hand, is now riddled with tension and uncertainty of what might happen next and, on the other, is tainted by ‘bad memories’ of when she was at her ‘worst’. Exploring attempts made by people experiencing mental distress to stabilise the home, Tucker (2010, p. 533) proposes that it is through ‘habit and memory that we come to *perceive* patterns of stability and sameness in our lives’. In contrast, I would argue that in experiences such as those discussed by Jess, the repetitive re-playing (habit) of negatively perceived past encounters (memories) is a key disruptive and destabilising force. With reference to agoraphobia-related panic attacks, Davidson (2000b, pp. 652–652 *emphasis in original*) explores how ‘home often seems to be the only imaginable space in which to rebuild your defences, away from the prying eyes and presence of others’, but, because the home is never fully sealed or secure, Jess can never truly feel *at home*. Jess remains highly attune to the potential for external interferences and, exacerbated by her homebound isolation, overwhelmingly expectant of them. For Jess, the role of habit is anything but therapeutic. Home has become the meeting point between a habitual confrontation with negative past experiences and equally habitual anticipation of other people encroaching on the boundaries she has attempted to create and maintain. This overlay of anticipatory processes and events are ‘acts or experiences of severance’ (Brickell, 2012, p. 233) whereby tensions are created between the sense of belonging and

²²² Evans and Wilton (2016) have noted the importance of gaining meaningful employment as a key milestone towards recovery.

connection to place and the negative associations that, in this case, are born out of experiences of ill-health.

The geographies of home are overlapping and conflicting, constituted by ‘multiple material and imagined spaces in which different social relations are enacted and expressed’ (McLean, 2008a, p. 564). The idea of home is negotiated and made sense of through a number of physical spaces (living room, bedroom), social relations (family, friends, visitors, neighbours) and objects within the home (telephones, windows, doors, doorbells), all imbued with different meanings and anticipations. These ‘affective’ or ‘anticipatory’ objects, spaces and encounters of/in the home are unbearable, representative of the individual’s perceived inability to encounter social life ‘normally’ and also the inescapable presence of ‘the social’. Anticipatory objects in geographical research are generally considered in the context of Anderson’s (2010) ‘pre-emptive’ action, to manage or adapt to (un)known futures²²³. In this context, every day, unremarkable objects embody an ‘uncertain immanence’ (Leyshon and Geoghegan, 2012) that encroaches and persists as the (un)certainty of the social world is forced upon the individual.

The encroachment of the outer world into the ‘bounded’ spaces of home was repeated time and time again in the questionnaire and interview responses. There is often a significant effort involved, over and above that, which would ‘normally’ be expended in the process of ‘securing’ the home against unwanted and unwelcome social interactions. As a result, it became evident that the ideal of home does indeed not always correspond with its ‘experienced’ and ‘material realities’ (Brun, 2008, p. 566) as home is still encountered as an intensely social space in which people become even more minutely imprisoned:

People say, ‘home is my safe space’ or whatever, not for me. My house is constantly open to other people, I live in a constant state of tension that the phone will ring, the bell will go, family will visit, brothers – their friends are always around – or someone will come to the door. So, I stay in my room and that’s my space. It doesn’t take my anxiety away but that is the place where I’m safest and I can escape to there when the rest of the house gets busy or unbearable. (Rachel, QR07)

The idea and practice of home is not static. Intense social anxieties, such as those experienced by Rachel, are deeply entangled with the construction of home as a place of ‘movement, communication [and] social relations’ (Massey, 1994, p. 171). The experience of there being too much of the ‘outside’ inside the home is one all too familiar for people

²²³ For example, nanotechnologies or cattle grids (Anderson, 2007; Leyshon and Geoghegan, 2012).

experiencing chronic social anxiety, in which there is often a persistent encroachment of everything ‘out there’ in the public realm into the private spaces of the home. Unable to maintain separations and boundaries within the home environment, particularly with family members, participants often retreat into a smaller space within the home, typically a bedroom. However, perceptions of safety are shifting and relational, inherently responsive to the particularities and levels of social anxiety experienced. The hidden social (micro) geographies of social anxiety are played out across fluctuating, spatial scales (Dyck, 1995b; Parr, 2000). Anna, although relatively housebound, discusses how her safe zone shifts in response to her mental health (simultaneously highlighting the fluctuating nature of anxious experiences):

Everything outside of my safe bubble [is unsafe]. Sometimes, on good days/months that’s anything from my doorstep outwards. Any of it. [On] bad days/months, that’s anything from my bedroom outwards. (Anna, QR157)

In the questionnaire responses (Figure 11), 62% of participants marked bedrooms as ‘very safe’, compared to 40% who marked home as ‘very safe’, highlighting the distinction between the home and a space of safety within the home. Maggie speaks about a ‘hierarchy of safe places’ within her home:

Even in the house, at home, there’s a spare bedroom upstairs, which is now my craft room, that’s very much my space. There are certain rooms in the house that are more mine. So they’d be higher up in the hierarchy of safe places.

Anna demonstrates the difficulty in trying to cope with the uncertainty of home while establishing a personal territory in the search for security:

I have to work very hard to find a safe place anywhere. My bedroom is ‘very safe’ because where I live I have strict rules about who can go in there. I have a partner but we have separate bedrooms. He isn’t allowed in my bedroom/on my bed unless I say so. My bedroom is a safe place I guess because there are no expectations there from anyone else. Obviously outside of my bedroom my partner roams around, people can knock on the front door and I expect to have contact with someone... outside of my bedroom isn’t really completely mine, and so isn’t completely safe.

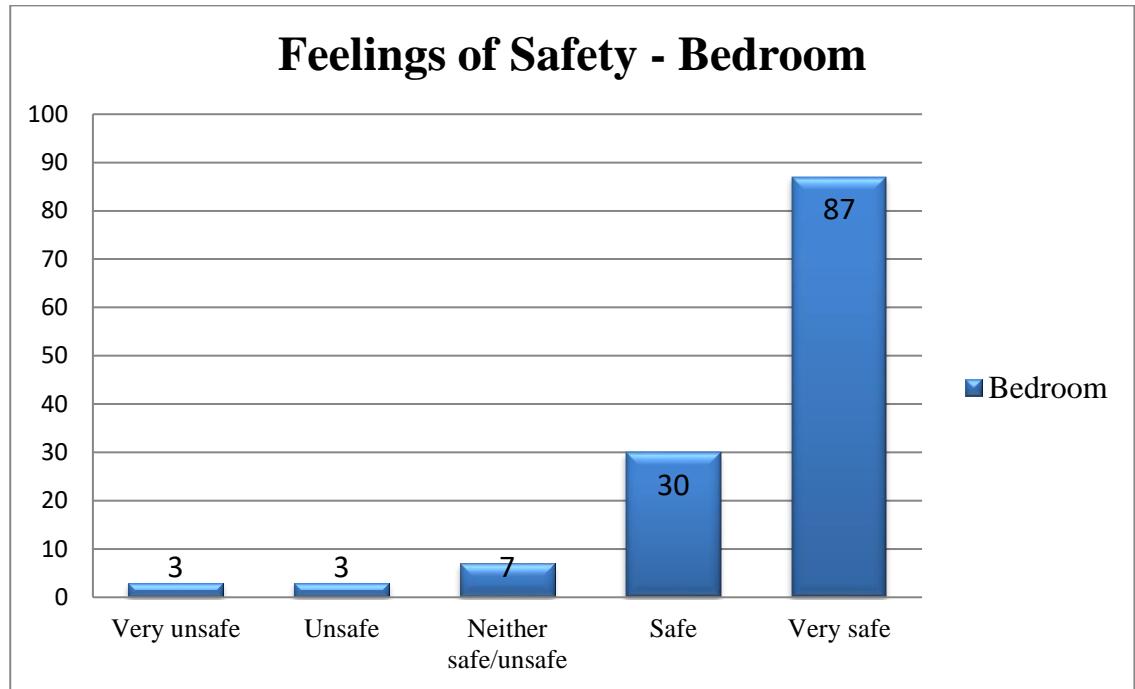


Figure 11: Feeling of Safety in Bedroom

Anna's strict management of her bedroom-space is a coping strategy that affords her near-complete control over a defined space in her home, but also serves to isolate her further. It also demonstrates the struggle to maintain the boundaries outside of the confines of her room where space becomes more unstable and unpredictable. This air of anticipation and perceived lack of control of social interactions and encounters, no matter how familiar or seemingly insignificant, marks anything beyond these boundaries as less safe.

This 'territorialising' of home – drawing on Wise (2000, p. 298) who contends that the notion of 'territory' is both a 'space' and an 'act' – is a twofold process: on the one hand, it involves the creation of a space that marks a distance between the self and an 'other'; and on the other, it addresses how this space is shaped through a variety of socio-spatial 'markers and milieus'. In relation to experiences of social anxiety, this 'other' may be signalled by the intrusion of another person, the unwelcome bodily signs and symptoms that operate as markers of anxieties or the recurring feelings of shame born out of perceived judgement and scrutiny from other people. Socio-spatial 'markers and milieus' relates to those objects and practices that may help to create a cohesive sense of place or may signal a fragmentation of those boundaries. These aspects, emerging across various platforms of social-spatial life, are particularly disruptive in a place pregnant with a sense of security, belonging and identity, such as the home. Unfolding throughout the discussions with participants about their homes, and how it becomes compromised, were the many ways in which various 'markers' – objects, habits and social encounters –

obtrude into the forefront of everyday life to the extent that they may become ‘unbearable’:

When the doorbell rings, I’m scared to death. I almost go into a panic attack; I have shortness of breath and my heartbeat races and have tons of fear about who is on the other side of the door. Most of the time I can’t even bring myself to move to answer [the door]. I get so terrified that they’ll hear me and will know I’m home hiding from them. I sit there rigid, panicking, until they go away. It really knocks me off [pauses then laughs]. Sunday is the only day I know I’ll get complete peace! (Eva, IR)

Valentine (1998, p. 321) discusses how ‘simple objects’ and ‘everyday sounds’ can radically disrupt the everyday ‘taken-for-grantedness’ of home environments. For Eva, the doorbell is a signal that threatens her physical and psychological boundaries, generating intense anxieties associated with face-to-face interactions. Eva’s experience, like Rachel’s, demonstrates how seemingly inconsequential components of the home such as doorbells or windows (see Olivia, below) invoke a series of bodily affects that further destabilise feelings of safety and security.

For similar reasons, telephones become a source of anxiety enabling the potential for instantaneous and unexpected interruptions in the home. Clara states that ‘when the phone rings my anxiety spikes’. Rosie, in response to similar anxious experiences, ‘unplug[s] the phone unless I know I’m expecting a call … like my mum phones on a Saturday so I’ll plug it back in on a Saturday morning’. Furthermore, attention is drawn to the temporality of home, highlighting how it may be disrupted in a single moment, throughout the course of a day or through shifting expectations between the week and the weekend (McLean, 2008a)²²⁴. Despite the fleeting nature of these disruptions, these objects and the anxieties they produce resonate through and saturate the surrounding space:

My house is a safe place, yes, but I do have the blinds closed and I never answer the door. [...] [W]hen the blinds are open, I feel like people can see in, see me and make judgements. I don’t know, it just makes me feel very uncomfortable knowing that people can possibly see in and see me. (Olivia QR187)

Although her home is experienced as ‘safe’, windows are markers of a ‘gap’ in the protective boundaries of home. They are a particular source of intense discomfort that speak to wider social anxieties about being visible to other people, leaving Olivia open to

²²⁴ McLean (2008b, p. 397) suggests greater attention must be paid to ‘temporal dimension[s] more closely connected to the everyday lived enactments, experiences, and expressions of home’ to uncover the meanings of home, not only, ‘across a life-course’ but, also, the shifts that occur day-to-day and between weekdays and weekends that could further challenge ‘the normative and static notions of home.’

potential judgement and scrutiny. As such, the seemingly private spaces of home can be understood more as a ‘turbulent sea of constant negotiation rather than simply some haven for the self’ (Miller, 2001, p. 4).

EDUCATION SPACES

There is now growing evidence that a significant proportion of the student body are experiencing mental and emotional health problems (Eisenberg et al., 2007). The following section considers the everyday reality of secondary, college and university educational spaces as experienced by people with social anxiety, uncovering how in such spaces people are presented with considerable barriers affecting access, attendance, grades, participation and attainment.

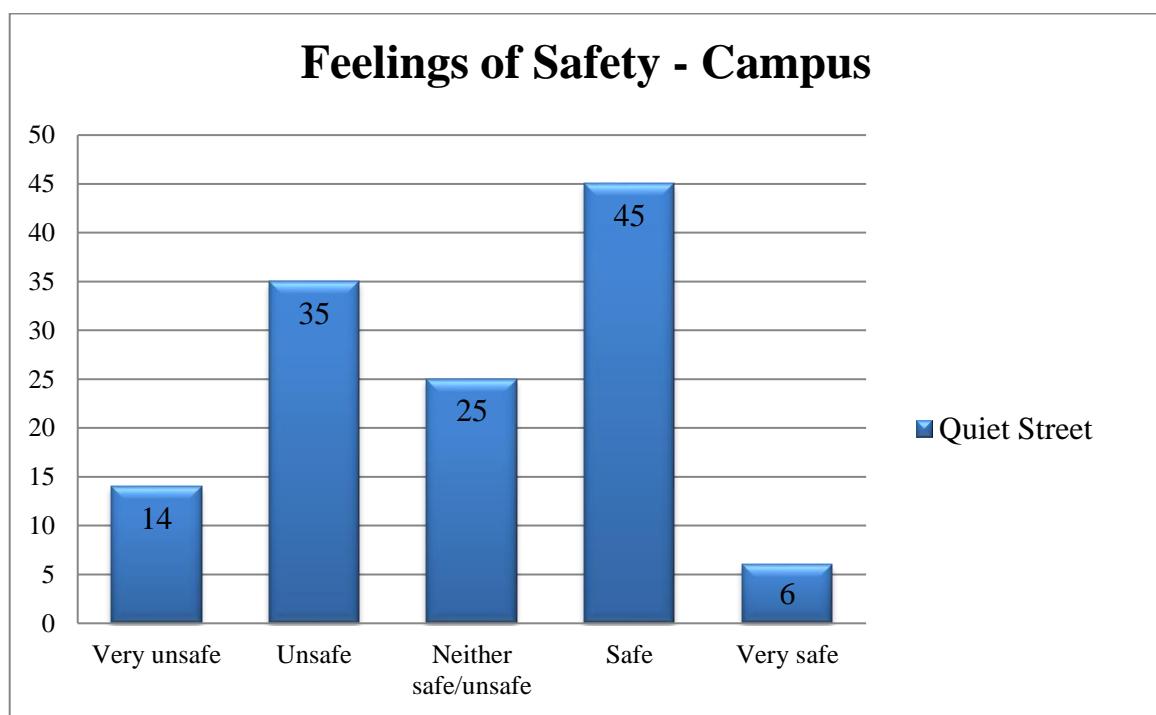


Figure 12: Feelings of Safety on Campus

I focus on general feelings of safety on campus²²⁵ before considering education spaces as platforms where particular anxieties manifest through, for example, interacting with those in a position of authority, answering out in class or the impact of particular pedagogical practices and learning environments, for example, group work, seminars and lecture theatres, through which educational experiences are explored. Appendix 12 shows the

²²⁵ Campus refers broadly to the various spaces where learning or education takes place including, high school, college and/or university and the spaces that ‘make up’ these environments including, classrooms, lecture theatres, libraries, corridors and wider campus grounds.

‘likelihood of anxiety’ experienced in particular situations associated with education spaces, for example, sitting exams, speaking out loud and giving a presentation. The barriers in access to, and learning in, post-secondary education have been addressed elsewhere in relation to those with mobility impairments (Fuller et al., 2004; Norman, 2002), and learning disabilities (Mortimore and Crozier, 2006). The social consequences for students with diabetes has also been addressed concerning alcohol consumption and self-care practices (Balfe, 2009). Attention has also been paid to help-seeking behaviours in relation to mental health problems among the student body across college and university settings. In geography, Hansen (2005, p. 33) explores ‘individual incapacity’ and community/societal perceptions and attitudes in the educational spaces for women with disabilities. Valentine and Skelton (2003) identify social isolation as a key factor in dropout rates among D/deaf students. While Conradson (2016) assesses how to foster student wellbeing from pedagogical practice within the discipline and takes note of the neoliberal shifts and changes in academic culture that may contribute to increasing reports of mental and emotional distress among the student body. He argues that the ‘competitive ethos and performance orientation in some courses of study can induce or exacerbate anxiety, for example, which in turn may negatively impact upon academic performance’. Here he is advocating that pedagogical practices inherent to the discipline, notably group work, residential fieldwork and reflective assignments, can help to foster student wellbeing (2016, p. 240). His argument speaks to that of Hickinbottom-Brawn (2013, p. 732) who criticises the biomedical model of social anxiety and its emergence specifically ‘against the backdrop of neoliberal enterprise culture’. Nevertheless, there is a significant gap addressing the accounts of people with enduring mental health problems in access to, and experiences of, educational settings.

Perceptions of safety on campus (Figure 12) among participants are linked to the micro-social interactions as well as the wider academic and social expectations that play out across various educational environments. Individuals with social anxiety may face difficulties integrating into social and academic life across, and when transitioning between, secondary and post-secondary educational spaces²²⁶. These transitional time-spaces have been explored in relation to the transitions between childhood and adulthood (Valentine, 2010); youths with intellectual disabilities into paid employment (Butcher and Wilton, 2008), and training and learning opportunities for people with mental health problems (Philo et al., 2005).

²²⁶ Equally these difficulties must be considered and negotiated concerning the transition between education and paid employment and between employment opportunities for people with mental health problems.

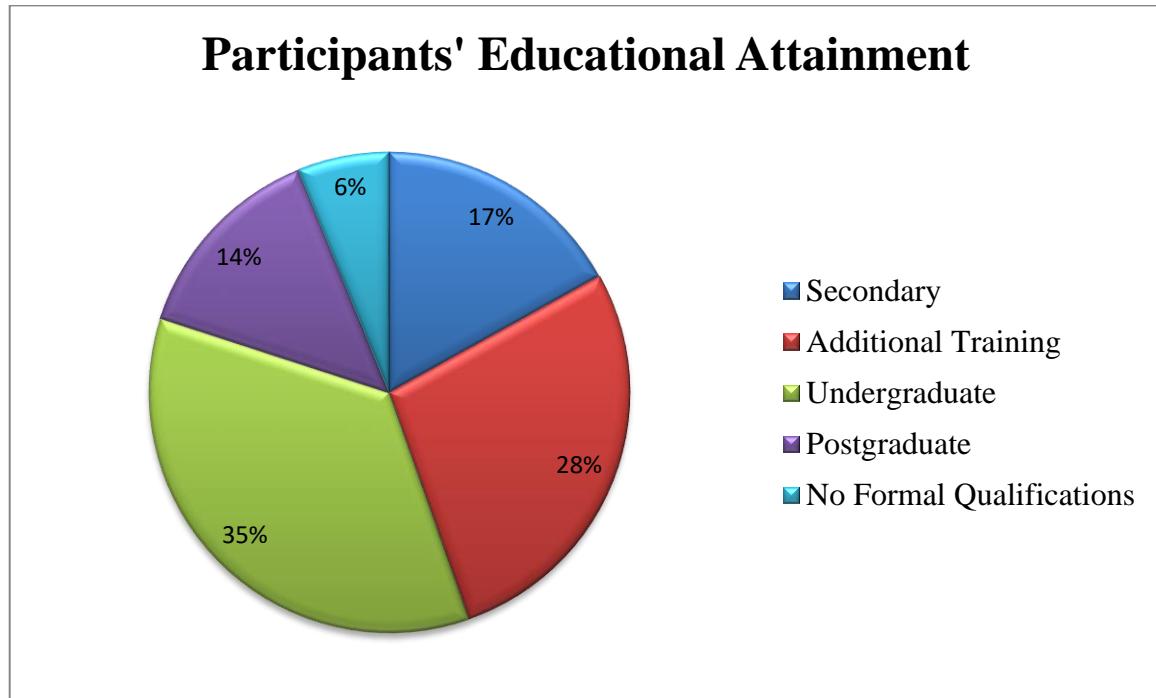


Figure 13: Participant's Level of Education

Although a substantial number (Figure 13) of participants are currently in, or have completed, post-secondary education, further restrictions are placed on the individual who feels that they lack the necessary skills for academic and social success. The learning environment itself can be a considerable source of tension where lecture theatres or classrooms ‘full of people’ (Isla QR12) are experienced as deeply unsettling and unpredictable social environments, often disruptive to learning and leading to socio-spatial isolation and exclusion:

I went to university but I didn’t interact with anyone, join any clubs, socialise or make any long lasting friendships. I went in for lectures, did what I had to do and went home again. (Eve, QR12)

As well as learning environments, spaces of education are innately social environments that should encourage social participation and opportunities to expand social networks. Madge et al. (2009, p. 141), exploring the significance of social media for social integration into university life, advocate that ‘more general social networking practices and face-to-face interrelationships and interactions remain important’²²⁷. This social aspect of education highlights a challenge for people with social anxiety who, like Isla, experience significant levels of anxiety in face-to-face interactions with severe consequences for

²²⁷ Social networking sites like Facebook emerged as a key tool in planning social events and making social links with others while at university. However, face-to-face interactions are still vital for initiating contact with peers (Madge et al. 2009).

interpersonal communications and relations.

A further dynamic of university life that may cause disruption is living arrangements. Attending university often involves living away from home during term-time, predominantly in student residences or shared accommodation. Thomas (2002), assessing student retention, highlights the benefits of shared accommodation for encouraging social interaction and expanding social networks, while still preserving quiet spaces to work and rest. Communal living may add additional stress and disruption to the daily lives of students with social anxiety and, as Claire (QR16) explains, may contribute to withdrawal from Higher Education:

I'm living in shared accommodation [...] my parents thought it would help me socialise but it's nothing but torture. I spend almost all of my time in my room that really feel draws the life out of me sometimes but I don't want to step on people's toes or get in the way. It's having an impact on uni and I'm seriously considering withdrawing and going home.

This approach taken by Claire's parents is arguably indicative of a lack of public awareness and understanding of the impact their social anxiety has on the lives of those experiencing it. Attributing her experiences to shyness or lack of sociability, they believe that altering the settings for sociability will improve her situation, when in fact it is precisely this opening of her accommodation spaces to such sociability that is exacerbating her already heightened anxieties, with detrimental effects on her studies, attendance and overall wellbeing. As shown, both Isla and Claire actively limit the opportunities for social interactions in educational spaces as a protective measure.

Olivia writes at great length about the social anxiety that affected her formative years through school, and it became evident that her experiences and mechanisms for coping were cyclically reproduced, significantly impacting her journey through secondary and post-secondary education. The pervasive and habitual nature is present in her detailed narrative highlighting transitions through different education spaces entailing a sustained and on-going negotiation with the self and in her relationships with others that is responsive to, and contingent upon, the various situations, settings and spatialities encountered. Bourdieu (Bourdieu, 1977, p. 87) states, 'the habitus acquired in the family underlies the structuring of school experiences [...] and the habitus transformed by schooling, itself diversified [...] in turn underlies the structuring of all subsequent experiences, and so on, from restructuring to restructuring'. Reay et al (Reay et al., 2001, para. 1:2) argue that '[h]abitus produces action, but because it confines possibilities to

those feasible for the social groups the individual belongs to, much of the time those actions tend to be reproductive rather than transformative'. Olivia's early experiences of educational spaces are marked by a lack of social integration and support that exacerbates her anxieties about failure and not understanding the curriculum, fears of being reprimanded for this failure and the risk of embarrassment that it entails. It is evident in the following narrative how the perceived and experienced intensities of her early learning environments are consistently re-produced, with serious consequences for the (social) geographies intrinsic to education and learning:

School was always hard; I hated it with a passion. I used to fake illnesses a lot to get time off school- especially on days when I had a lesson I really hated due to the people there or the teacher, or the fact I just didn't get it and not being able to approach anyone about it. At school break times I would always hang around in the hallways or go to the library if I could just to be in a less crowded place. (Olivia, QR187)

This is particularly instructive of Olivia's experience of educational spaces in that practices such as 'faking illness' and avoiding spaces and people are consistently re-produced through her secondary and post-secondary years. Illustrated throughout this narrative are themes of continuity and change – component parts of Bourdieu's notion of 'habitus' – whereby pervasive anxieties produced by, and deeply embedded in, these educational spaces are managed through her capacity to navigate the surrounding socio-spatial environment, routinely seeking refuge in hallways or the library in an attempt to limit internal and external disruptions. She continues:

[At] university, the first day I had a bad panic attack and had to call my boyfriend to come and get me. He persuaded me to stay but he had to stay with me (this was during welcome week and the tutor was very understanding). My boyfriend accompanied me all week for my first week, and then he had to go back to work so I had to cope on my own. I would drag out the break times in the toilets, or wandering around corridors I knew would be quiet, go places I knew no one really stayed. I made every attempt to avoid people as much as possible, avoided the restaurant area, as it was always busy.

Completely overwhelmed by the uncertain and unfamiliar environment on her first day at university, Olivia felt vulnerable to unwelcome interactions with others. Her boyfriend operated as a safety net between her and any external interference: space can be rendered less threatening, temporarily at least, by the presence of known others. Ultimately, his continued presence was not a practical option but it afforded Olivia the time and space to settle into her new environment:

[A]s the year went on I felt worse and worse, regressed in confidence and my coping strategies no longer worked for me, so I ended up missing a lot of days [and] making up excuses for not going in. [M]y motivation really lacked towards the end of the year, and I have now decided to withdraw from the course and do an online/distance learning course with the Open University instead.

The decision to withdraw from university is usually a complex process influenced by a number of interacting factors that occur over time (Thomas 2002). Olivia's deteriorating mental health, potentially exacerbated by her experiences of university and increasing social isolation – factoring in the disintegration of her long-term coping strategies – have clearly played a significant role in her decision to withdraw from university.

Similarly to Olivia, several participants expressed an interest in online and distance learning, in particular the Open University (OU)²²⁸, as an alternative pathway to education when conventional pathways are perceived to be unsuitable for their levels of social impairment and learning needs. Although beneficial in enabling people with social anxiety to complete a degree programme, the key requirements of the courses may still require group work tutorial and/or seminar attendance that could be beneficial to the student:

I'm currently doing an Open University degree, they have been very helpful, but I can't attend tutorials or do any of the video conferencing tutorials [that] would benefit me. (Kim, QR40)

The length of time taken to complete university education can also have a significant impact on people's lives. Tina (QR123) writes:

I was far too terrified to think of going to university after my A-levels Around [age] 36 I did an Open University Science degree. I was getting very good marks but dropped out in my final year because I was too scared to go away for a mandatory 1 or 2 week course full of people I had never met. A few years later I started a different BSc but when a similar scenario presented itself I had a sort of 'nervous breakdown'. [Two] years later I returned to the course and 3 years later graduated with a 1st class honours. A lot of those [three] years felt like having to walk through fire.

Data from the Higher Education Statistics Agency (HESA) reported that withdrawal rates from UK universities due to mental health problems trebled from 2014 to 2015 (Marsh,

²²⁸ The Open University course is a distance and open learning institution that offers flexible and part-time study for undergraduate and postgraduate courses and qualifications. (Open University, n.d.). The OU is an option for further education explored by some participants that may provide a supportive, distance learning environment by removing the difficulties that individuals experience intensive face-to-face environments. The capacity for this option to lead to further socio-spatial, however, isolation should also be acknowledged and considered.

2017). Conradson (2016) notes the importance of various pedagogical practices, including residential field trips, for ‘fostering wellbeing’ in the student body, but intense periods away from home with unknown others, particularly if previous barriers to social integration and support have been identified can be fraught and problematic. Mandatory course requirements such as residential trips²²⁹ can instead present significant barriers to an individual in pursuit of a degree, impacting attendance and grades while causing considerable distress and, in extreme cases, may result in the student’s withdrawal from university altogether.

WORKSPACES

There are commonplace assumptions made about people who experience ‘enduring mental health problems, that they are unable to work unless, or until, they have recovered’, where questions of willingness, reliability, ability and productivity arise (Grove et al., 2005). Employment is also viewed as significant step in the process of recovery (Evans and Repper, 2000; Evans and Wilton, 2016)²³⁰. Beynon and Tucker (2006, p. 78) argue that ‘while people with ill health and disability have positive attitudes to work, their capacity to work is limited by multiple and often mutually reinforcing barriers’²³¹.

Previous research in the area consistently demonstrates that ‘social anxiety has negative impacts on occupational functioning’ (Himle et al., 2014, p. 924). Individuals are likely to experience downward social mobility associated with unemployment or underemployment and a devaluation of workplace knowledges, skills and experiences over time that can have a significant impact on future employment prospects and overall health and wellbeing. Figure 14 shows the breakdown of participant’s employment status. While the highest number of participant’s note that they are in full-time employment, nearly 70% of participant’s are otherwise employed, in further education, on long-terms sickness and

²²⁹ These may be particularly problematic for people with mental health problems on OU courses where there have been limited opportunities for social integration and they are therefore entering a completely new and unfamiliar social/learning environment.

²³⁰ A tension exists between the recognition of gaining and maintaining meaningful employment as a vital step in the recovery process and the realities of disclosing a mental health status to your employer (as either justification for long-term unemployment or order to gain workplace adjustments). Wilton and Evans (2016, 236) explore the potential role of social enterprises in providing opportunities for (re)integration and inclusion in that they can simultaneously ‘accommodate and support’ people with enduring mental health problems while ‘unsettl[ing] prevailing assumptions about mental health’ in the workplace.

²³¹ There are a host of online threads entitled: ‘How do I get a job with severe social anxiety?’ (or similar) so there appears to be a lack of support services, programmes or advice for people with social anxiety in terms of seeking/gaining employment.

disability, or unemployed showing a staggering level of precarity in (un)employment. While this was not a significant focus of this research, it could be a vital area of future research.

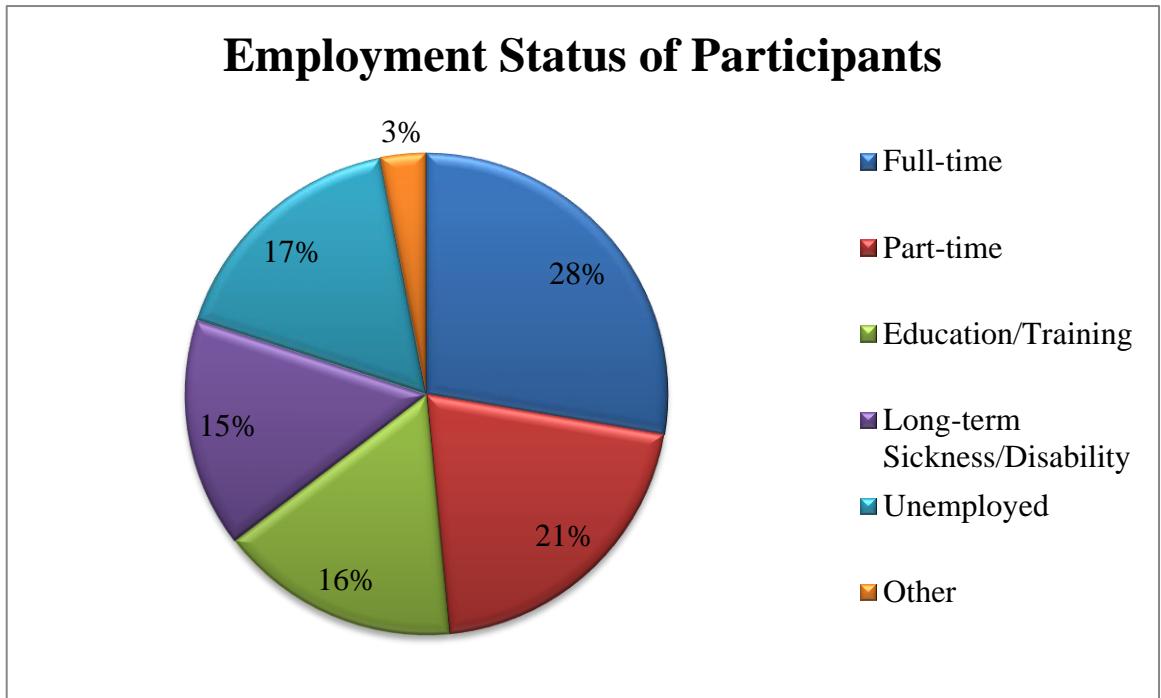


Figure 14: Employment Status of Participants

Questionnaire respondents highlight numerous personal and structural barriers in their attempts to gain and maintain employment – ‘I have never been, or would ever be, able to go for an interview’ (Kim, QR40) – as to advance within/beyond their current role by ‘flatly reject[ing] any possibility of promotion²³²’ (Tina, QR123). Callum (QR189) captures the impact that social anxiety has had on these inter-related spheres of his life, initially on his academic attainment and then the subsequent effect on his employment opportunities:

I managed to graduate from university but feel that I could have achieved a better degree (I got a 2:2) if I had been able to attend lectures, seminars, tutorials²³³ etc. I have had no career, just a succession of menial jobs, because I fall apart in an interview situation. When I did work, I was unable to remain in any job for more than two years, as I would be ostracised by colleagues or become depressed because of the isolation. As time progressed, finding work became harder and harder, because my work record was so poor and because I

²³² Kirsty notes that her manager often encourages her to apply for jobs in order to progress within her role/company but she faces many personal barriers.

²³³ In the UK, graduate schemes and postgraduate programmes minimum entry requirements are generally a ‘2:1’ degree or higher. This rendered Callum’s opportunities coming out of university extremely limited.

have never had a promotion, with the result that I have not had a permanent job since 2004 and not worked at all since 2010. (Callum, QR189)

Callum's experience relays the implications of these anxieties on aspects of attendance and engagement in higher education and how spaces of education are impacted/negotiated are explored throughout this chapter. Many of the wider societal impacts of social anxiety are crystallised in Callum's experience. Singley (2003, p. 25) notes that people with mental health problems are often plagued by various forms of psychological distress, including low self-esteem, and restricted by a lack of 'job skills (basic and specific)[...], work experience [...] and low education levels'. This is particularly pertinent for people experiencing social anxiety where distress is centred around, and exacerbated by, a perceived inability to 'perform' adequately across many social situations, including interview situations. Despite being in full-time employment, Sol's social anxiety has had a marked impact on his ability to progress in or beyond his current position: '[social anxiety] has definitely affected my career progression as I am too nervous to attend interviews/give presentations' (Sol, QR14) While hampering those already in employment, the anxiety and fear can be disabling for those who are actively looking for work. As Jo writes:

I have been looking for work for four years but I freak out whenever I get a job reply so [I] often chicken out as I can't manage the anxiety that goes with an interview. I've cancelled and rescheduled so many interviews because the anxiety is unbearable. (Jo, QR41)

Jo's anxieties, in a similar way to Callum's, greatly hamper her ability to gain employment and further experience within the workplace, reinforcing her pervasive feelings of failure and self-doubt. Moreover, long periods of unemployment are also a significant barrier to securing future employment (Grove et al. 2005). Callum's education and work history are symptomatic of the conditions that create a vicious cycle of social exclusion and un(der)employment in people's lives.

Geographers exploring 'non-accommodating' and difficult to negotiate workplaces for people with disabilities (Wilton and Schuer, 2006; Wilton, 2004), chronic illness (Dyck, 1999; Dyck and Jongbloed, 2000) and mental health problems (Wilton and Evans 2016) all highlight the barriers and tensions in accessing, maintaining and (re)negotiating workplaces and employment opportunities with, or after the onset of, ill-health and/or disability. Similar to those experiencing chronic illness, social anxiety can be inherently disabling despite its relative invisibility in comparison with, say, physical impairment. Despite being able to 'pass as normal' (Davidson and Henderson, 2010), even if they feel

painfully out of place, people experiencing social anxiety face difficulties accessing and negotiating the workplace through a subtle set of mechanisms present in the immediate social and material environment. The following section will map these barriers, tensions and negotiations.

As highlighted above by Jo, the hiring process is a significant barrier to gaining employment for people with social anxiety. The interview is an intensely anticipated event during which the individual's performance is assessed and scrutinised. This encounter can be extremely distressing:

I've had so many bad experiences and failed attempts that I can't even think about trying to look for a job at this point. The last job I applied for was over a year ago and from the moment [the interview] was scheduled it consumed my every waking thought; I couldn't sleep for worrying about it. Every day for weeks I had this feeling in the pit of my stomach that something was going to happen. Constantly playing over all the things in my head that could/would go wrong [L: Like?] Oh, like, not being able to answer questions, failing miserably, being visibly anxious, like, shaking and blushing, having a panic attack, being judged, them thinking I'm stupid or incompetent and having them staring at me, face-to-face situations are crippling and the fear of failing. All of it. It's just terrifying. (Sophie, IR)

Lara's anxieties concerning the interview situation have, based on previous experiences and perceived negative interactions, intensified over time. The enormity of anticipated interaction highlights how every action is perceived to be highly symbolic of her 'incompetence' and inability to perform 'correctly' in social space leaving her vulnerable to – certainly in her own estimation - negative judgement and scrutiny by others. She continues:

By the time the interview came round I was in such a state. I was in the waiting room with all the other candidates and I wanted to burst into tears. I knew I'd failed already. It was so horrible I took a panic attack. My symptoms are visible too, physically trembling, sweating and I had a heavy tightness in my chest, blurry vision and so I felt like everyone could see me freaking out. [L: What happened next?] I left. I felt like I didn't belong there. I couldn't sit in the interview in that state; I was a total wreck²³⁴.

For Lara, the interview process is an emotionally charged, complex situation. The visceral experience of sweaty, trembling and tight bodies give rise to a heightened sense of bodily

²³⁴ I asked Lara how she felt about conducting an online interview. She responded saying, 'It's okay. I have a little time to think through my answers. I was still apprehensive but nothing like before. You can't see me and I can't see you so, there's less pressure I think, and you can obviously relate which helps.' The perception of understanding and empathy was missing from Lara's job interview experiences.

self-awareness, as well as the space the body is occupying, further amplifying experiences of distress. This loss of bodily control and ‘inability’ to self-regulate spiralling emotional experiences, particularly in the professional and formal setting of the interview/workplace, are deemed contextually ‘inappropriate’. Sibley (1995, p. 3) argues, ‘who is felt to belong and not to belong contributes in an important way to the shaping of social space’; and, as such, Lara’s experience renders her intensely ‘out of place’ (Cresswell, 1996).

Gwen works full-time in a job that provides her routine and financial stability. Although her social anxieties do not completely restrict her ability to work, she recognises that they have had a detrimental impact on her occupational functioning and long-term career aspirations. Currently, she feels she is unable to progress further within her current role:

I’m not living life to the full and have got to the point where I’ve lost the confidence to try new things. I also feel that because of my SA I wouldn’t cope with a job that required regular contact with other people e.g. working in a team or dealing with the public. Jobs that say ‘must have an outgoing personality and be a team player!’ ... They’re not for me. This job allows me to avoid talking to people when I’m feeling particularly anxious.

The workplace, like educational spaces, can be an intensely social environment and workplace culture may be further disabling. Wilson-Cortijo (2016, p. np) argues, ‘in the past I imagine it would have been quite easy for a socially anxious individual to make a life for themselves doing some form of manual labour that wouldn’t require the cultivation of ‘people skills’. But in today’s neoliberal world, where selling one’s personal (communicative and performative) attributes are of the utmost importance, such skills are an absolute necessity. Whether it is in a corporate environment (meetings, group presentations, conferences, the importance of “leadership”) or an ordinary retail job, there is a clear correlation between success and one’s ability to produce confident spiel.’ Gwen notes that the culture of her workplace, including expectations from colleagues to be sociable, is a significant factor in triggering her social anxieties:

I find it difficult to socialise with colleagues. I work on an open plan floor and I find this very stressful at times especially when it’s busy and I feel more anxious. Comments have been made about how quiet I am and it has become an issue for me at times. There is an expectation for people to be outgoing and although management are aware of my SA they don’t always seem to understand situations that can affect my anxiety.

Over time Gwen has negotiated the workplace, employing certain strategies to overcome or to replace anxious thoughts and feelings. Communal workspaces encourage

uncontrolled social interactions and create an environment where individuals are under constant observation. Gwen deliberately blocks out her surrounding environment by wearing headphones, restricting external interferences and placing a barrier between her and any potential interactions enabling focus on external objects and tasks:

I've found coping mechanisms to deal with my anxiety but some days are better than others. I wear headphones all day to limit social contact with people and am able to focus on my work. I have my lunch on my own at a quiet time at the same time every day because[,] even though it's monotonous, it's familiar and makes me feel calmer [...] I sometimes go outside work for a walk at lunchtime during the summer months. I also go to the toilet and take a few minutes to do visualisation. If anything disrupts my routine e.g. a meeting [that] runs over my normal lunchtime[,] my anxiety increases greatly and I start to shake, my throat feels tight and I feel a need to escape.

Within her working environment Gwen is able to manage her anxieties and limit her social interactions, but doing so is contingent upon numerous internal and external factors, including the fluctuating nature of her social anxiety and disruptions to her daily routine, that are not always within her control. Maggie expressed similar feelings about her job role and workplace culture that help to create and maintain a stable working environment:

It's a quiet working floor ... people need quiet to think a bit more, whereas other floors are more chatty and busier. If you go up a level it's much noisier, much chattier, that's managers, data co-ordinators, they're not doing an analysis on that floor. There's a lot more analysis on this floor. It's half-empty at the moment. It helps, you get a bit of familiarity [and] folk don't sneak up behind you. It helps.

Kirsty is in full-time employment, and, in attempting to negotiate her social anxiety in the workplace particular accommodations have been made that enable her to maintain employment but cause tensions to arise between colleagues:

Kirsty: On a particularly bad day [at work] I might need to take a few 'time-outs' over and above my breaks to sort of compose myself and gather my thoughts, usually when I'm on the brink of freaking out and I'm getting flustered. I'll take a break. I try to put it off for as long as possible so people don't think I'm skiving²³⁵ [...] They probably think I'm taking the piss but sometimes I just need five minutes to reset, that's all.

Louise: Does that make it worse, that they might think that of you?

K: Without a doubt.

However, despite disclosing her social anxiety to her manager, who is 'pretty

²³⁵ Taking an undeserved break or avoidance of work duties.

understanding', enabling workplace accommodations to be made, Kirsty still feels that she is under surveillance by her colleagues, increasing the social intensity of her job. Her experience highlights that employers making adjustments within the workplace does not necessarily create a culture of accommodation among colleagues²³⁶. In this light, workplace accommodations may be perceived as special treatment and delegitimised due to the relative invisibility of social anxiety (Richardson, 2005). Kirsty's work colleagues are aware that specific accommodations have been made, but are unsure of the exact circumstances under which they have been granted. Dunstan and Maceachen (2014) explore the issue of 'external validity', through which certain accommodations may be resented, when there is a disjuncture between the visibility of the accommodation (i.e. 'time outs') and the relative invisibility of the condition, such as, Kirsty's social anxiety.

Disclosure is a necessary step before requesting workplace accommodations but the decision to disclose/conceal their 'hidden' health condition may have a marked impact on their social relations or levels of functioning. Dyck and Jongbloed (2000) examining the workplace experiences of women with Multiple Sclerosis (MS), note that concealment of health conditions is easier if individuals are relatively free of supervision. For some, there is diminishing access to and status in the workplace in relation to disability (Imrie, 2001), chronic illness and returning to work after an injury (Crooks and Chouinard 2006). Carol (QR216) shifted from full-time employment to unemployment for a period of time and subsequently began re-gaining part-time employment:

I was fired from a job [...] because of social anxiety and stress²³⁷. Some co-workers tended not to respect my work abilities. Soon after that, I applied for and started to receive disability [benefits]. Now, I work just a few hours a week because interacting for several hours with the intensity of doing my job and being with others is just too difficult. I am more successful when I work fewer hours and have some ability to make decisions about how much to work.

Facey and Eakin (2010) discuss the contingent nature of work for people experiencing ill health. Contingent work here refers to part-time, casual, contract, temporary and self-

²³⁶ Colella (2001, p. 104) in an extensive assessment of co-worker attitudes towards workplace accommodations argues that 'whether or not co-workers judge the distributive fairness of an accommodation depends on the salience and relevance of the accommodation' to them. Accommodations made for disabilities that are 'self-caused', socially undesirable and/or psychological, like mental health problems, and therefore 'unstable', are more likely to be received negatively (see also: Richardson (2005, p. 38) for an account of sufferers of chronic pain who continuously need to legitimate their 'invisible' illness and defend themselves against allegations of 'malingering').

²³⁷ Carol entered therapy after cancer treatment where she was diagnosed with Post Traumatic Stress Disorder (as a result of her cancer diagnosis and childhood experiences of illness) and social anxiety. Through therapy, she stated, the extent to which PTSD was impacting her life had 'lessened' but she still faces anxiety in many social situations causing extensive disruption to her everyday life.

employment forms of work that are often unstable and inconsistent. Wilton (2004) notes similar issues for people with disabilities where there may be ‘flexibility’ within the workplace but often no ‘accommodation’.

CONCLUSION

This chapter has highlighted the spatial contingencies of social anxiety. By engaging with spaces of home, work and education, I have shown how uncertainty and ambivalence emerge and the multiple ways these spaces may be renegotiated. The home is often considered a space to anchor, offering seemingly impenetrable protection from the outside world. The questionnaire responses met with these basic, potentially ‘un-thought’ assumptions of home as a safe space. What emerged in my subsequent conversations with participants is a more nuanced, ambivalent and often disruptive tale (Crooks, 2010). In the first instance, home operates as a space through which personal and material boundaries can be established, controlled and defended, yet seemingly unremarkable and everyday objects are symbolic of the ‘outside’ social world encroaching into one’s personal and physical space, as well as a failure of the home to maintain these boundaries between inside and outside. ‘Home-making’ often entails a continual practice of re-establishing bodily and home boundaries through routine and habitual practice – doing the ‘little things’ as Karen (IR) puts it. Crucially, it is often a space-within-the-home, usually a bedroom, that offers the individual the strongest sense of safety and security alluding to an ever-shrinking set of geographies (Chapter 8).

I then discuss the everyday reality of secondary, college and university education spaces, uncovering how people with social anxiety are affected with considerable barriers affecting access, attendance, grades, participation, attainment and overall student experience. General feelings of safety on campus are explored before considering education spaces as a crucial setting in which particular anxieties manifest, for example, interacting with those in a position of authority, answering out in class or the impact of particular pedagogical practices and learning environments, for example, group work, seminars and lecture theatres. Topham and Russell (2012, p. np) highlight that the ‘largely utilitarian model’ of university education has ‘contributed to an education culture where the ability to present oneself and one’s work for critical evaluation is regarded as necessary for academic and occupational success.’ This, arguably, warrants further investigation and would be a fruitful venture of critical study. Finally, building on the difficulties faced in academic/educational settings I examine how the workplace often becomes a key site of

contention: on the one hand; recognised for its role in process of recovery in providing routine and structure²³⁸ and promoting health and wellbeing; on the other, a place fraught with social interactions, performances and the potential for failure and embarrassment. Thus, considerations are often given to the hiring process, mobility, workplace culture, the timing, spacing and pacing of the work environment (Hansen and Philo, 2007), and colleague attitudes (particularly in relation to issues of disclosure)

This chapter has laid the foundations for considering the next ‘layer’ of this geography of social anxiety. Therefore, Chapter 8 seeks to delve deeper into these contingencies, embedding them within a wider network of interpersonal, social and spatial relations.

²³⁸ While acknowledging the role of significant events like gaining meaningful employment in the process of ‘becoming well’, Duff (2016, p. 72) argues that it is the collection of everyday routines and interactions behind the scenes that ‘enable’ these larger milestones towards recovery to ‘transpire’.

CHAPTER 8

SPATIALITIES OF ANXIOUS EXPERIENCE II

Social anxiety has made my world so much smaller (Anna, QR157)

INTRODUCTION

The aim in this chapter is to deepen the accounts from ‘Spatialities I’ focusing on the relational and embodied encounters and reactions, and the micro-textures of these encounters that comprise anxious experiences. Participant’s social worlds uncover the complexity in, and limitations placed on, everyday social life. They also highlight the broader impact over a life-course as opportunities for encounter, both passing and sustained, become increasingly diminished. Significantly, participants expressed difficulty with numerous aspects of social life and relationships, inclusive of the proximal social interactions, bonds and support with family and friends as well as more distal interactions and encounters that comprise everyday life and spaces. Despite the importance of social encounters to psychosocial wellbeing and quality of life, few studies have examined how social anxieties shape social worlds²³⁹. I close this chapter by examining how individuals navigate (between) spaces (including those discussed in Chapter 7). I address (im)mobilities associated with public transport and walking. Of key consideration is how individual’s social geographies are disabled or become diminished to ‘predictable, purposeful trips, origins and destinations’ in the face of mobilities experienced as ‘a messy, unpredictable, diverse and changeable reality’ (Huxley, 1997, p. 2 cited in Imrie, 2000, p. 1644).

FRIENDSHIPS AND FAMILY RELATIONSHIPS

Friendships and family relations are significant social relationships that form the structure of our daily lives (Pahl, 2000). The strong interpersonal bonds integral to these relations

²³⁹ Notable exceptions to this are studies in clinical fields. The research demonstrates the significant difficulty faced by individuals in various interpersonal spheres of life. For example, people are: more likely to have impaired interactions with significant others and strangers (Alden and Taylor 2004); less likely to engage in social interactions (Beidel et al. 1999); more likely to experience negative consequences in their closest relationships (Davila and Beck 2002); less likely to have intimate relationships (Dodge et al. 1987); less likely to have romantic relationships or marry (Hart et al. 1999); and have fewer close friendships or acquaintances (Whisman et al., 2000).

are crucial for managing and maintaining physical and mental health by providing fundamental sources of emotional, instrumental and informational support (Andrews et al., 2014; Kearns and Andrews, 2009; Tough et al., 2017). The vast majority of respondents note a substantial decline in the quality of interpersonal relations with both family and friends. Participants note that the disintegration of social relations occurs ‘over time’, ‘gradually’ and ‘to the point where I faded away [from social life]’ (QR06, Claire [QR16], QR87). Four interrelated themes were identified that capture the processes involved in participants diminishing or changing social relationships: difficulty and uncertainty, opportunities available for social contact and the emotional work involved in sustaining relationships.

DIFFICULTY AND UNCERTAINTY

The progression of social anxiety is associated with increased socio-spatial isolation as patterns of social interaction change and use of public space is encountered with great difficulty or avoided completely (Dyck 1995). Smart et al. (2012, p. 99) explore some of the difficult dimensions of negotiating friendships, arguing that while they may provide a sense of ontological security through mutually supportive and beneficial interactions and a strengthening of self and collective identity, they can also be ‘ontologically unsettling’:

Relationships with family and friends have taken a big hit over the last few years. I’ve slowly withdrawn as social things became increasingly difficult. I have no friends, I slowly pushed them away [by] rearranging [plans] and not turning up – I didn’t want to burden them with my problems. I was constantly making excuses. The longer I didn’t see them the more anxious I was. I was afraid of losing them. I felt incredibly guilty and undeserving, I wasn’t being a good or a true friend, that I was avoiding them, but I was even more afraid of being judged by them and of going outside and being surrounded by people I didn’t know. (Leanne, QR144)

Social relations are deeply entangled with the ‘self’ thus, the physical and emotional need to distance oneself from the objects of anxiety that completely undermine any sense of self is complex. Leanne’s (QR144) gradual disengagement from social life is implemented as a self-protective strategy. Crucially, this is also entangled with her ‘moral worth and ethical standing’ (Smart et al., 2012, p. 107), one in which she believes she is ‘undeserving’ of her friendships. Smart et al. (2012) view friendship as the mirror through which we face ourselves but, for those highly sensitive to such interpersonal dynamics, the difficulties inherent in social relations are that they provide a painfully close channel for unearthing the precariousness of the self.

FEWER OPPORTUNITIES

Due to the difficulties and uncertainties faced by participants in their relationships with family and friends, there are fewer opportunities for social contact. This contributes greatly to participant's experiences of loneliness and isolation:

As my social anxiety got worse, I started to get more insular. The more intense it got over a longer period of time I started to feel very lonely and isolated. Before, I would avoid going to the shops or getting the bus during rush hour because there was too many people but the longer it went on the more it started to affect work and close relationships and friendships [...] so my social life has, well, I don't really have one (Anna, QR157).

This gradual retreat is enacted as a self-protective strategy to mitigate anxiety and distress. Horney notes (1937, p. 138) '[a]ny protective device may have, in addition to its reassuring quality, the quality of creating new anxiety [...] The formation of vicious circles, with all their implications, is the main reason why severe neuroses²⁴⁰ are bound to become worse, even though there is no change in external conditions'.

Gillian is frustrated that she is missing opportunities for bonding and social activities with close friends and, as a result, feels isolated. However, she also recognises the locations and frequency of social contact are unmanageable for her:

I'm fortunate enough to have a few close friends who I now see occasionally but I often feel left out. They are a much closer group and have been on holiday and go out regularly together, go for lunch and things like that, all things I feel I've really missed out on. Even though I'd love to go out with them I can't bring myself to meet up with them 2-3 times a week like they do. It's far too much for me. It's really overwhelming to be in a bar or a cafe, there's so many things involved and too much to consider going to places like that ... or just going out, really.' (Gillian, QR215)

Gillian's experience is emblematic of the gradual restrictions placed on socio-spatial life as certain interactions and spaces become out of bounds. Her experience of missing out leave her feeling excluded and detached from the main group, creating, in turn, fewer opportunities for social interaction.

EMOTIONAL WORK

Participants describe the emotional cost of social interaction, as 'exhausting and a constant

²⁴⁰Note on language used needed.

battle' (QR59), 'debilitating' (QR191, QR194) and 'overwhelming' (QR194). Several respondents commented that not only was there a societal stigma surrounding mental health but people close to them were frequently questioning why they could not 'snap out of it' for the sake of children or their job. A person's struggle to 'get well' (Karen, IR) led to further questions about how much someone wants to get well, particularly when they engage in destructive behaviours, miss or avoid doctor's appointments or relapse. While crucial sources of emotional aid, developing new and maintaining existing social relationships requires considerable amounts of emotional work (Bilecen, 2014). However, simply interacting with other people can have a negative impact on an individual's wellbeing. Marta (QR33) explains:

I'm constantly on edge whenever I leave my home. [...] Every time I interact with someone. I'm constantly conscious of how I look, where my hands are, whether I'm making enough/too much eye contact, what they're thinking of me, if my voice is shaking, if they can tell I'm nervous, if I'm going to make a fool of myself and how I'm supposed to pluck up the courage to ask or say what I need to [say]. It is completely and utterly draining.

These transient and seemingly insignificant micro-interactions result in a state akin to an interpersonal 'burnout'. Burnout, most commonly associated with occupational stress, is characterised by emotional, mental or physical exhaustion that 'originates from emotionally demanding interpersonal relationships' with others (Maslach, 1993):

Since [school], I've had no friends at all. I've never attempted to make any, because I simply don't know how to, and even if I did, I don't know what it's like to have a friend, like how to behave. I feel the pressures of having a friend [would be that] I would have to go out regularly and interact with [them]. It is not worth the effort. (Marta QR33)

Marta highlights her deep-set belief that she is incapable of making friends and lacks the necessary social skills to interact with other people. Equally, she attributes the absence of interpersonal relationships with negative aspects of the self. She expresses a deep sense of shame²⁴¹ and perceives the lack of close social bonds to be a personal failure:

I thought my inability to function properly in social situations was just because I was broken somehow or plain pathetic and I had no friends or social life because I was a horrible person. (Marta QR33)

²⁴¹ When asked to consider how her social anxiety affects her day-to-day life, QR138 states she spends most of her time 'avoiding people, even friends, [and] alienating myself [from them] as I feel such toxic shame' (QR138). The paralysing capacity of shame is entrenched in an inherent sense of self-worthlessness. The emotional and affective states provoked by 'toxic shame' have a significant impact on health, illness and health-related behaviours (Dolezal and Lyons 2017) (Chapter 7).

Rokach (2004) highlights how feelings of social inadequacy and self-criticism in pregnancy and motherhood are not only distressing but profoundly isolating. Similar reflections are discussed in relation to first-time mothers who, because of inadequate social support, coupled with reduced social interactions and exacerbated by feelings of vulnerability, experience motherhood as deeply isolating and lonely (Lee et al. 2017).

LONELINESS AND SOCIAL ISOLATION

It is unsurprising given the nature of social anxiety that the themes of *loneliness* and *isolation* emerged with such prominence. What is striking is the pervasive and enduring nature that ‘feel[ing] lonely’ or ‘being alone’ (QR38) has on the social and emotional lives of people with social anxiety. The majority of conceptual and theoretical work around loneliness has been conducted in nursing studies (Donaldson and Watson, 1996; Kileen, 1998; Rosedale, 2007; Victor et al., 2000) focusing primarily on the elderly. Physical and mental health can cause loneliness but can also be exacerbated by it. Chronic and long-term loneliness is associated with increased mortality rates (Holt-Lunstad et al., 2015), and has similar consequences on health as smoking, obesity and sedentary lifestyles (House et al., 1988).

Yet, loneliness has become something of an academic ‘blind spot’ in human geography where the impact of loneliness on mental health and wellbeing is an often over-looked component. Franklin (2009, p. 343) suggests society is experiencing ‘a disturbing epidemic of loneliness’ making the relative absence of research on loneliness over a life course even more striking. Weiss (1973) developed two distinct forms of loneliness: emotional loneliness and social loneliness. The former describes the lack or loss of intimate social relations with family, friends or a partner. The latter is associated with the absence of a wider social network or system of support. The following addresses a relational perspective, taking into consideration the interplay of emotional and social forces that create and sustain experiences of loneliness.

The pervasive nature of loneliness and social isolation is evident through the questionnaire and interview responses. In the questionnaires, there are 21 references to being *alone*, feeling *lonely* and *loneliness* and 46 references to feeling *isolated*, *isolating* and *isolation*. In some cases, these are single-word responses to questions; for example, *Can you describe what it is like to live with Social Anxiety Disorder?* ‘Isolating’ (QR49) and ‘Lonely.’ (QR90). Responses, such as these, while not detailed often capture the emotional

consequences endured by a feeling of disconnection and detachment from social life²⁴². QR197 expands on her feelings of loneliness:

I am extremely lonely all of the time. Being too afraid to leave the house resulted in me losing all of my friends at one point in time as [I] often face problems when going out and trying to get in contact [with them] I become extremely agitated and nervous. This can lead to me avoiding contact altogether for long periods of time and becoming even more isolated.

The social dimensions of loneliness and isolation are associated with a lack of meaningful social connections and wider networks of support. However, a number of structural barriers can exacerbate these conditions (Olfson et al., 2000) including, stigmatising attitudes to mental health and low professional and public recognition (NICE 2013). Social anxiety is dramatically mis-recognised, under-recognised and under treated in healthcare settings leading many individuals to turn to self-diagnosis (Katzelnick and Greist, 2001) (Chapter 6). Simon (QR211) recounts his experience with the healthcare system:

From my earliest days at school, I was seen as ‘different’ and isolated, despite the school’s insistence that I see a number of child psychologists, none were able to offer anything by way of help [...] I was denied access to the NHS completely [and] I remained isolated for most of my life. After the death of [my parents], I moved to the Midlands, where I became even more isolated than in the past. I joined a [support] group. It took many years to change my experience with social anxiety [...] but at times it seems that I hadn’t made enough changes to be accepted and despite everyone knowing why I was ‘weird’, I was told that I wasn’t welcome at the meet-ups²⁴³. I thought about taking my life several times, I felt alone, isolated, hopeless—I saw no point in my existence.

Loneliness is one of the most frequently reported challenges of major life events such as bereavement (Utz et al., 2014) or moving to a new city (Sawir et al., 2008). Frie (2017, p. n.p) suggests experiences of ‘loneliness may reflect the emotional dynamic of a person’s inner life or be a response to the loss of relatedness and a hostile social environment’. Simon’s painful emotional and social loneliness is compounded by structural barriers that exclude him further from social and civic life including: significant failures by healthcare

²⁴² Single word responses are powerful, however, they highlight a significant weakness in the questionnaire method (Chapter 4). Due to the way the questionnaire was implemented, i.e. anonymously and online, I was unable to seek clarification or expansion on answers unless participants self-selected to participate in follow up interviews. Conversely, the questionnaire was a lucrative method for researching sensitive topics relating to individual’s mental health that are still taboo and stigmatising. The online nature assured anonymity and a medium of interaction that people were more comfortable with (i.e. non face-to-face and written responses). These conditions ensured more, seemingly open and honest, accounts of experience evident in the extremely detailed accounts shared through the questionnaire.

²⁴³An informal meeting or gathering around a collective cause.

professionals to provide information or a diagnosis, a stringent lack of mental health support services and stigmatising attitudes within the community. Despite finding local user-led support groups, Eric was too ‘weird’ and too ‘different’ to participate in straddling the contested boundary between ‘normal’ behaviour and social ‘deviance’ (Busfield, 1996). This experience echoes Parr’s (2000) assessment of mental health drop-in centres, in which more or less acceptable ways of being are ‘constructed and maintained’ through the licensing of ‘certain behaviours and emotions’.

I never had any gay friends growing up, I was far too anxious to socialise and meet people in those circles (or anyone). I don’t really have anyone to reach out to that could help me. I don’t want to be lonely, I don’t want to be single but I feel so uncomfortable and like I don’t belong in LGBT communities or spaces. And now that I’m at a point in my life where I would like to try and improve, I can’t (David, QR08)

David was only one of two participants who spoke explicitly about their sexuality²⁴⁴.

THIRD PLACES

Throughout the questionnaires and interviews, participants reflect on their feelings of safety in specified sites and settings across public space particularly those that support daily routines and wider social and civic life (Figure 15). Participants also expand on their experiences with specific reference to other sites of socialising and enjoyment including, but not limited to, cinemas, theatres, cafes, lunch halls, libraries, gyms, social groups and museums. Informal gatherings and shared spaces, which Jeffres et al. (2009, p. 334) refer to as ‘third places’ operate as ‘unique public spaces of social interaction providing context for sociability, spontaneity, community building and emotional expressiveness’ beyond the home (the first place) and work (the second place) (Oldenburg, 1998).

²⁴⁴ Despite 22% of participants ($n = 27$) identifying as LGBTQ+ on the online questionnaire, only David and Olivia made specific reference to LGBTQ+ identities and only Olivia, who identifies as bisexual, opted to participate in a follow up interview. Olivia only mentioned her sexuality in the context of her romantic relationships but made no explicit reference between her sexuality and mental health. The LGBTQ+ community experience higher levels of anxiety and depression overall but it was not a focus of this research to explore LGBTQ+ mental health and wellbeing issues, which arguably requires sensitive and focused attention. One participant who identified as transgender started, but did not complete, the online questionnaire.

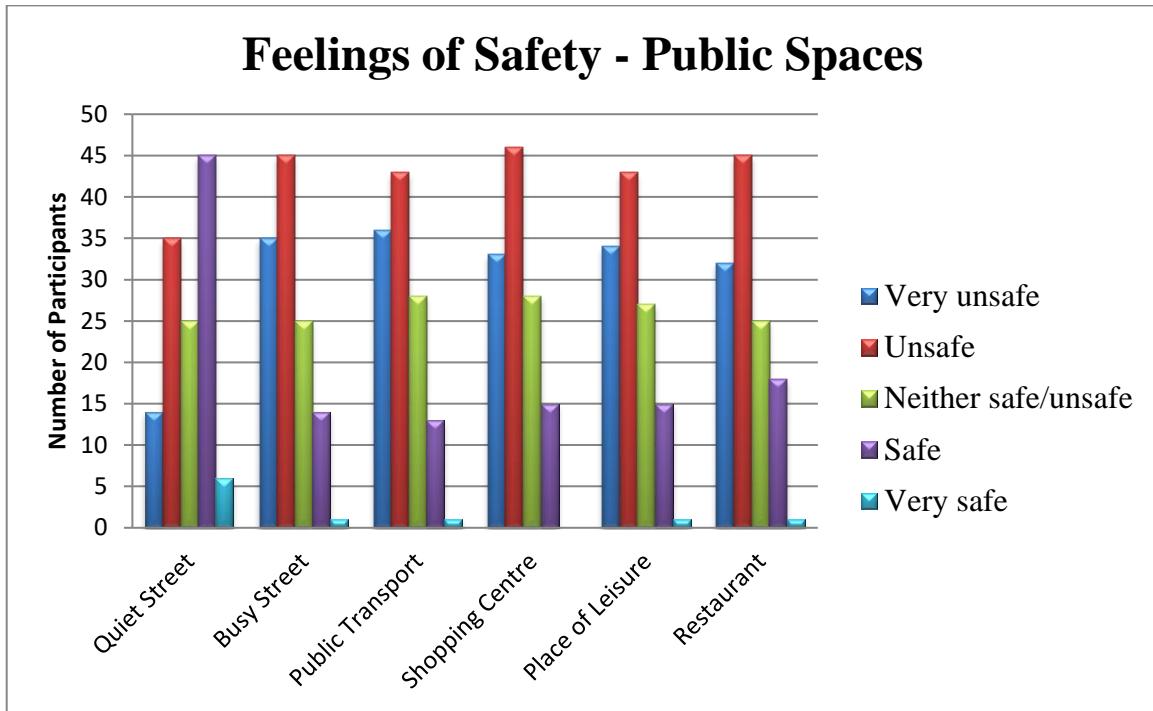


Figure 15: Comparison: Feelings of Safety in Public Spaces

There has been a sustained focus on the significance of third places in promoting and maintaining health and wellbeing in geographical (Butterfield and Martin, 2016) and public health research (Baum and Palmer, 2002) as spaces that help to foster interpersonal relationships and promote a sense of self, community and connection. The therapeutic qualities of third places facilitate health, healing and restoration as places that ‘remedy or prevent emotional loneliness, not just through companionship, but more importantly through personal and emotional support’ (Glover and Parry, 2009, p. 104). Furthermore, these places, situated on peoples’ everyday maps offer a temporary escape from the stressors of everyday life that can provide a sense of emotional relief and regulation. Overwhelmingly, participants express difficulty in developing and maintaining social bonds and interpersonal relationships with friends and family. The following reflects, not only, the magnitude of social and public spaces that people with social anxiety deem ‘out of bounds’, but the specificities of individual experience that render certain interactions and performances associated with these spaces as inherently distressing.

Practices of shopping, purchasing items, engaging with supermarket workers and shopping centre/supermarket spaces all presented as considerable sources of anxiety for participants (Figure 16). Feminist geographers have paid considerable attention to the associations between women’s fear and experiences of panic in the context of consumer spaces (Bankey, 1999; Bondi and Davidson, 2003; Davidson, 2001, 2000b) to uncover how

spaces with no discernible danger present a considerable loss of control to bodily and spatial boundaries (Davidson 2000).

CONSUMER SPACES

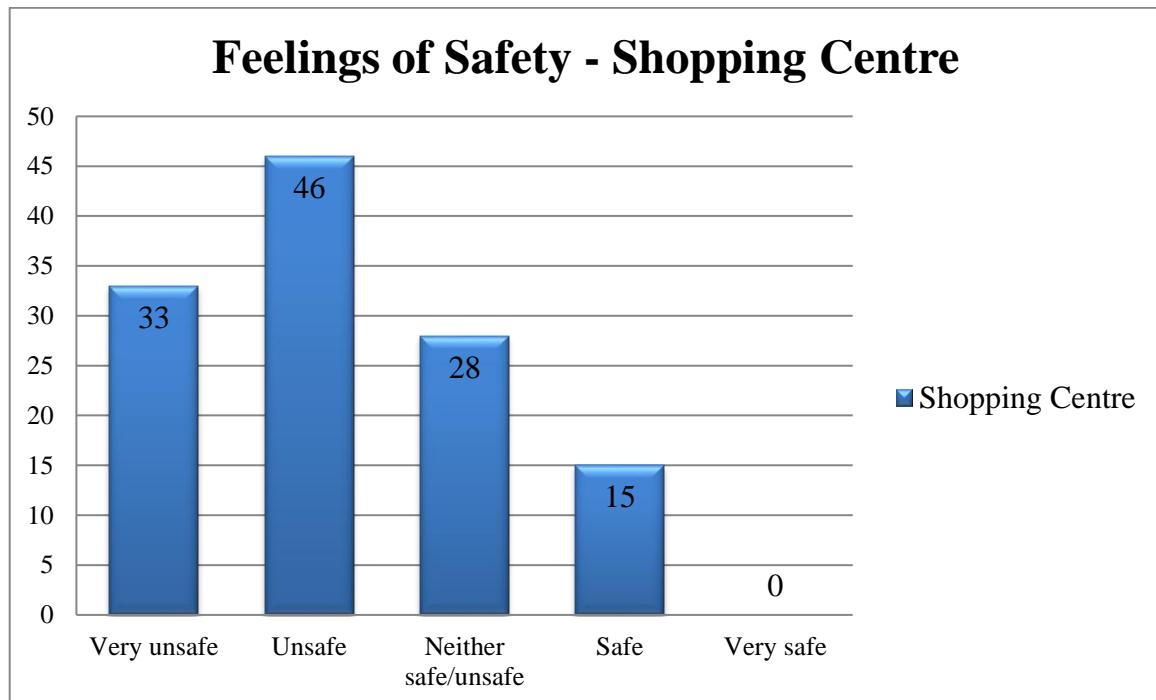


Figure 16: Feelings of Safety in Shopping Centre

They have continued to highlight how consumer spaces are very much part of women's spatial experience as women identify themselves with particular products and patterns of consumption. Davidson (2001, p. np) argues that consumer spaces present 'grave dangers' for agoraphobic women as they enter a 'feminised' space, which constructs 'feminised' identities, or more accurately 'ideals', which they are expected to assume through consumption. Yet, similar to accounts of social anxiety, women became intimately aware of 'our-selves', critically so. Consumer spaces, whether shopping malls or supermarkets, are inherently contradictory as 'marketing strategies often make extensive use of ideas about gender, simultaneously addressing women as consumers and objectifying women's bodies' (Bondi and Davidson 2008).

Hickinbottom-Brown (2013, p. 737) suggests that consumer culture and the psy-disciplines have enabled social phobias and anxieties to flourish by 'shap[ing] self-understandings and promot[ing] regulative ideals for living.' Hickinbottom-Brown (2013) uncovers a much wider socio-cultural progression of social anxiety in the era of 'neoliberal enterprise culture' where personal value is shaped and defined by patterns of consumption. Arguing

that, ‘shame-based advertising, aimed to heighten awareness of offensive aspects of self’ (2013, p. 727) guides consumers towards consumption that leaves no room for unhappiness or psychological and emotional distress. In a similar vein, Jackson and Everts (2010) approach social anxiety as a ‘social condition’ as opposed to an individual experience, exploring how everyday practices of consumption are disrupted in the context of food-related anxieties. Crucially, they highlight how anxiety manifests through practice, in decisions to consume (or not consume) for example, particular food products. The central concern raised by Jackson and Everts (2010, p. 2802) is that ‘some of the very practices that constitute our everyday lives [are the ones] whose disruption further entrenches those anxieties.’

Bondi and Davidson (2008, p. 22) report similar experiences by women living with agoraphobia where intensely gendered consumer spaces, conveying messages of self-improvement, ‘stir up troubling emotions and associations for many women’. This gendering of space is also evident in experiences of social anxiety as consumer spaces, including supermarkets, shopping centres and retail stores, which are strongly associated with negative judgements, and episodes of panic and are spaces in which respondents are ‘overwhelmed by choice, [a feeling of] not being able to escape’ (Anna, QR157) and a ‘pressure to buy things’ (QR10). Supermarkets can be extremely overwhelming and disorientating, with Davidson (2000, p. 31) highlighting the ‘disturbing architecture’ of mall spaces. She states that ‘[t]hey are assemblages of numerous and overlaid attempts at sensory stimulation which can render the atmosphere excruciatingly intense’:

[My] anxiety peaks in the supermarket (or at the thought of going to the shops). It takes weeks for me to build up the courage to go and I’m forced when I’m basically running out of food. High ceilings and horrible lighting, I feel claustrophobic and get a kind of tunnel vision all at the same time, it’s so disorientating. (Claire, QR16)

I cannot stand being in the supermarket, I cannot stand people being near me and find it really hard to cope when it’s busy. I’ll never shop at the weekends and will sometimes go out to do a shop at 11 or 12 at night to avoid the crowds. (Kerrie, QR22)

While neither male nor female respondents report feeling ‘very safe’ in shopping centres, as a percentage of total respondents only 2.4% of female respondents report feeling ‘safe’ compared to 20.5% of male respondents. Equally, participants who discussed anxieties in consumer spaces in the online questionnaire and interviews were predominantly female.

Karen's experience is particularly salient in demonstrating how her perceptions of, and relationship with, shopping and consumer spaces have changed as her social anxiety progressed:

Before this [anxiety] I was just a normal person who did my own shopping every week, took my kids out, paid my own bills, I socialised – I was really sociable – with friends, we'd go to town once a month, shop, have lunch. Now, the thought of doing any of those things terrifies me ... having a panic attack in the middle of the shopping centre with people staring at me when I'm freaking out and screaming get me out of here! If [the children] need anything – pants, socks, new trainers – their Nanny²⁴⁵ takes them 'cause I can't do any of that anymore (Karen, IR)

Habit and routines embedded in everyday life help to foster and sustain social relations with family and friends as well as shaping identity. Davidson (2000, p. 36) notes the difficulty faced by women with agoraphobia entering these 'feminised sphere[s]' of life highlighting they 'can neither 'do' the shopping (for necessities) or 'go' shopping (for pleasure, or contact with friends)'. Karen's routines of shopping and her perceptions of herself as 'normal' and 'sociable' are mutually reinforcing. Later in the interview, she expresses a deep sense of failure about not being able to provide adequately for her children and her dependence on her mother, who is now her career. She reflects fondly on 'the old me' and, although she 'cannot understand how [she] got to this point', her anxieties have had a life-altering effect. The panic that Karen experiences in the shopping centre now is far removed from the enjoyable, sociable or even mundane associations that existed prior to the onset of her social anxiety. The annihilation of this once active sphere of life demonstrates not only how anxiety 'disrupts the flow' of social and spatial life (Jackson and Everts, 2010, p. 2802) but has a significant impact on how she views herself as a parent, friend and daughter.

Winnicott (1971) argues that experience is shaped in 'potential space', akin to a 'third space', where the inner psychical and emotional realities of the individual and their external worlds intertwine. Zimmerman (1999), drawing on Winnicottian psychoanalysis, views public and civic space as a 'potential space'. Highly organised and privatised consumer spaces, carefully curated as public spaces, provide a platform for entertainment and socialising that enable the individual to 'grow in value and self-regard' allowing 'the (false) self to blossom as consumer' (Zimmerman, 1999, p. 570). Echoing Hickinbottom-Brawn (2013), consumer culture is largely concerned with the building or expanding of

²⁴⁵Grandmother.

identities enabling the creation and presentation of a new and improved ‘self’ to the world. Yet, for both Emma (QR18) and Priya (QR142), these spaces, where self and social identities must blend seamlessly with socially accepted norms and expectations, embody a sense of uncertainty, insecurity and anticipation:

Supermarkets, shops [and] shopping centres, more than any other place[s], bring out the worst of my anxiety. I get embarrassed about what I buy and anxious that I’ll be judged for my food choices. I won’t buy something if I think it makes me look unhealthy or greedy. [It is] all made worse by waiting in line to pay and [the] attempts at small talk by the person at the checkout [...] (Emma, QR18)

I will not go to places where there will be lots of people—e.g. I avoid going into a shop I previously wanted to go in if I see there is a long queue or it is busy. I rarely buy things I want in front of friends or parents and have to arrange either to get them alone or order them off the internet so I don’t have to experience the fear of them watching me and possibly negatively judging me. I won’t wear new clothes or t-shirts with words on them for fear of embarrassment. (Priya, QR142)

What is clear is that respondents perceive consumer spaces to have the potential for negative attention. Indeed, these encounters make individuals feel noticed and ‘marked’ fuelling feelings of self-consciousness and fear of judgment from other people. This is evident in anxieties that others will view her as ‘unhealthy’ or ‘greedy’ through her shopping habits and Jo’s fear that her personal choices will invite possible scrutiny from strangers as well as family and/or friends. Southgate (2016, p. 246) argues that the ability to negotiate potential space ‘requires the capacity to tolerate its inherent ambiguity’. Yet, it is precisely at this meeting point, between our inner and outer worlds, where anxieties emanate from, a place where social expectations, interactions and daily processes collide with an intense awareness of ‘I’ and a questioning of self.

ANXIOUS (IM)MOBILITIES

By exploring anxious ‘(im)mobilities’ through use of public transport systems and walking, I do not intend to reinforce the binary that equates mobility with activity and immobility with passivity (Adey 2017). Instead, by focussing on the relational contingencies between mobility and immobility I aim demonstrate how travelling between destinations is often fraught with difficulty and tension for those who experience social space as extremely invasive and complex. In order to contextualise this complexity, it is crucial to recognise the personal difficulties that these people face in negotiating transit spaces in their everyday routines by unpacking the affective, embodied and relational

dimensions of ‘journeying’, while also highlighting the steps taken to mitigate anxieties and routine disruption. There are multiple factors that shape and influence the journey, including crowded conditions, unfamiliar routes, transfer requirements and uncertain interactions, as well as the cognitive and physical aspects of people’s social anxieties. Therefore, it is important to consider how the everyday experiences of travelling by public transport with proximate others unfolds and the wider implications for an individual’s daily and longer-term social geographies.

PUBLIC TRANSPORT

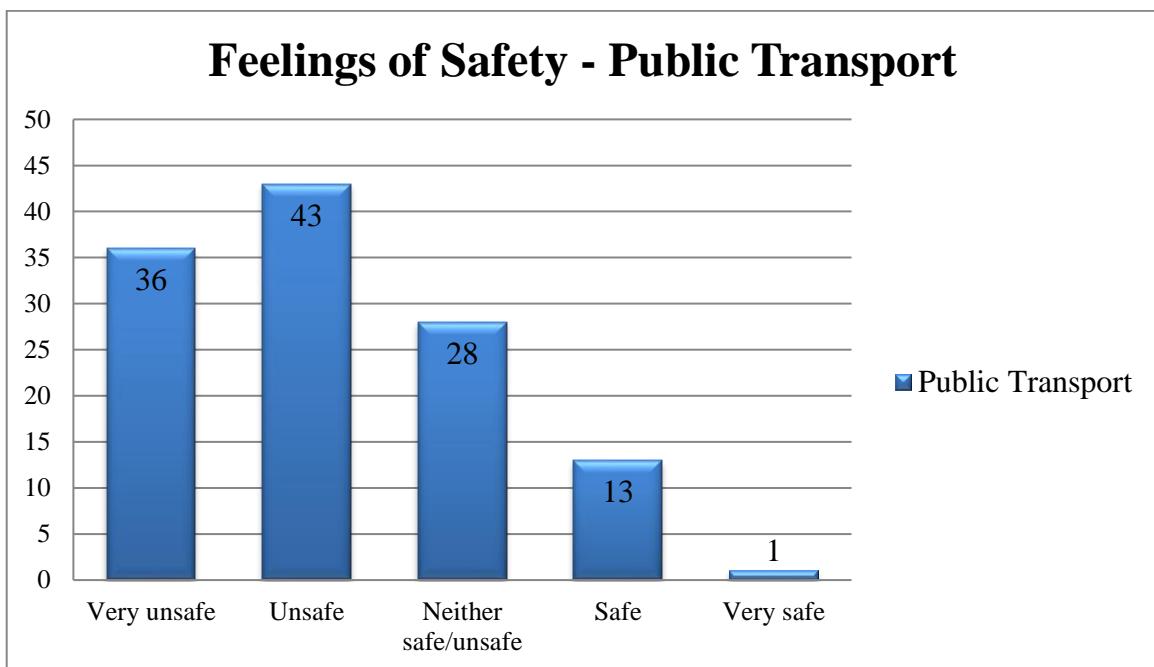


Figure 17: Feelings of Safety on Public Transport

Travelling by public transport is highlighted in the online questionnaire as a situation provoking intense social anxieties for participants. Bissell (2010b, p. 277) notes ‘that [the] experience of being with others in spaces of public transport’ is particularly ‘uncongenial’, as passengers are gripped by a sense of ‘unease’ and ‘foreboding’. Indeed, in an increasingly urbanised and busy world, the daily commute is rarely enjoyable for most people, as everyday frustrations, irritations and anxieties erupt. While these spaces are felt by some respondents to be so unsafe that they ‘avoid public transport almost completely’ (Anna, QR157), for others it is an unavoidable yet deeply disruptive component of everyday life. The spatial confines of transport spaces arguably mark a near-unique space in the public realm, one where people are often confined in an enclosed space in close

proximity to unknown others for considerable periods of time²⁴⁶. As Kim (IR40) explains, ‘I feel very claustrophobic and panicky being in a small space with a lot of people, so the idea of being stuck on a crowded bus or train gives me the absolute fear.’ While being ‘stuck’ is a temporary state between stops, locating spaces of safety is inherently difficult while ‘in transit’, resulting in an urgent need to escape which, for practical and safety reasons, is impossible. Cara (QR78) writes, ‘there’s times where I’ve asked the driver to stop the bus to let me off [between stops] but they can’t, so I just try to get a grip of myself and calm down.’ Others, recognising this temporary confinement, state, ‘once I’m on, I know I need to ride it out … so to speak’ (Ben, IR32).

de Certeau (1984, p. 111) describes the conditions of public transportation as a ‘travelling incarceration [...] A bubble of panoptic and classifying power, a module of imprisonment’, in which the movements of passengers are simultaneously mobilised and confined. Merriman (2016, p. 250) notes that the ‘freedoms, choices and comforts’ of the average passenger are ‘far removed from the experiences of those whose mobilities are enforced or severely constrained’, such as transported prisoners and trafficked migrants. Yet he goes on to argue that there are interesting ‘parallels between the ordinary and everyday incarcerations experienced by passengers on public transport systems and the discourses surrounding the ordering and incarceration of dangerous, deviant and vulnerable bodies.’ Travel by public transport is indeed a deceptively difficult task for those who perceive and experience social space as invasive and threatening. A ‘panoptic bubble’ is created in the confines of the bus, one in which individuals perceive themselves to be more visible, thus more susceptible to potential judgement and scrutiny by others. Where de Certeau’s (1984, pp. 111–113) mobile panopticon refers to how passengers are ‘pigeonholed, numbered and regulated [...] by the grid-work of technocratic discipline’, in this moment, socially anxious passengers may be simultaneously fearful of standing out from the crowd and being consumed by it.

Mia (QR119) provides an account of the internal conflicts and external tensions that arise while travelling by public transport, demonstrating how space and its associated mobilities, often perceived as ‘banal’ (Binnie et al., 2007), quickly become intolerably distressing:

I hate having to buy a ticket [...] counting out the fare and my brain scrambles

²⁴⁶ Other confined spaces of significance are elevators. Ben writes, ‘I can’t go into lifts. Being with other people in such a confined space is my worst nightmare, ‘all eyes on me’ type of thing, they could probably feel me shaking if it was cramped enough, I’d sweat profusely, my face would be beetroot, palpitations, the lot.’

because there's a huge queue behind me and the bus driver is waiting [and] everyone is watching as I get on. Then, if someone [is] sitting next to me or it's packed, it gets too hot, I feel trapped to the point I can't even say 'excuse me' to get off and then [I] miss my stop. I have a bad reaction to small, closed in, packed spaces. I start to sweat [and] panic and then I feel sick and I don't travel well anyway, so I'd usually start feeling really sick [...] Not knowing where to get off, having to stand up while the bus is moving, what if I fall? Am I going to panic with all these people are watching me? It's not even worth the hassle.

Beyond a 'mere transition zone' (Hulme and Truch, 2006, p. 47) between origin and destination the bus journey is a loaded time-space environment. There are a series of overlapping social, spatial and affective dimensions that result in Mia's reluctance to travel by bus, starting with the face-to-face interaction and social performance involved in the strikingly ordinary task of purchasing a ticket. There is an implicit pressure to board quickly and efficiently, prompting her sense of becoming the focus of others' attention. Bissell (2007, p. 285) argues that 'there is a tendency to be quite unaware of one's body' while journeying 'where the body remains passive and acquiescent'²⁴⁷, but said 'passivity' is arguably far removed from Mia's experience of journeying, which not only mobilises very particular anxieties about being in close proximity to other people but, also entails distressing corporeal awareness of the resulting bodily manifestations of those anxieties. Furthermore, the very conditions of travel indicate the ways in which bodies are open and responsive to our immediate socio-spatial surrounding. Take the shrinking of available space: this particularly salient component produces an atmospheric shift that 'registers *in* and *through* sensing bodies' (McCormack 2003, p. 413). This shrinking, coupled with a felt increase in temperature, presses *upon* the body, giving rise to bodily sensations of sweat or panic through which a heightened sense of bodily awareness and the self-in-space emerges. In addition, fleeting interactions, in the form of a mumbled 'excuse me', are rife with anxieties that are further exacerbated by the anticipation of 'embarrassing' events – a stumble, a flush of panic – that will mark her presence in public space all the more visible. Mia finds herself incapacitated by anxieties that register viscerally, rendering her body and its meeting with the surrounding environment completely out-with her control. She subsequently states that she will often 'walk for 40 minutes instead of taking a 10 minute bus ride', highlighting the exhausting and time-consuming measures that are put into practice in order to mitigate the effects of such anxieties.

²⁴⁷ Overall, Bissell's (2007, p. 282) aim is to draw attention to the complexity of mobilities by challenging the assumed passivity of journeying and/through the event of 'waiting', not as a period of inert inactivity but as an intensely corporeal experience, one that presses upon the self, instilling a 'sense of anticipatory preparedness' (see also: Anderson 2010).

Transport spaces become a contained microcosm of wider public space, serving to heighten already existing anxieties. People feel ‘out of place’ and attune to their anticipated and perceived transgressions from socially and culturally constructed ‘norms’. Social codes and rituals serve to increase people’s anxieties about ‘disturbing’ others, anxieties that are somewhat magnified in enclosed spaces. Callum (IR189), who marked public transport as ‘very unsafe’ in the online questionnaire, refers to the public transport ‘code of conduct’ and how this further complicates journeys:

In general, it’s just a painful experience. There’s so many rules about what you should or shouldn’t do; the ‘code of conduct’ of the bus or whatever. I constantly think about whether I’m invading someone’s personal space like, if there’s no spare seats and [I] need to sit next to someone, I’m on the edge of my seat²⁴⁸ so I’m not touching them or too close [to them]. Also, I don’t want the person sitting next to me feeling offended by [me] (probably blatantly) distancing myself from them.

Maintaining a relative distance from the people around him is important for Callum to ensure that *he* is not encroaching into other people’s personal space (as opposed to other people violating his personal space). Goffman ascribes the term ‘civil inattention’ to the socially constructed rituals of social space that encapsulate how individuals maintain a veneer of privacy by actively disengaging from one another. This ritual addresses the transient and fleeting nature of encounters with others as people acknowledge each other’s presence through a glance or a faint smile, but then retreat. While Goffman’s focus in these types of encounter is specular, Callum’s concern is also one of proximity and whether he is seen to create *too much* distance between him and his co-commuters at the risk of appearing rude or causing offence. This distance, what Goffman terms ‘aversion’, is a violation of civil inattention, where the individual is considered to be undeserving of even the most minimal acknowledgement. Arguably, Callum and others avoid such minimal acknowledgements as an act of self-preservation in the face of a debilitating sense of self-consciousness, rather than as an outright rejection of the other person. Goffman conceives the regulation of social encounters as a routine social norm ingrained into the practice of everyday life; but Giddens (1987, p. 123) argues that the practice ‘demands a chronic attention to detail’ – an understanding that resonates more clearly with the experiences of people with social anxiety. In fact, the experience of commuting for most participants is only habitual in the sense that it occurs regularly, and most experience journeys with great

²⁴⁸ Grant clarifies his use of ‘on the edge of my seat’ as both literal and metaphorical: ‘Haha! Yes! Literally sitting as far away from the person next to me as I possibly can. Metaphorically, skin crawling, wanting to run away. Ready to crack!’

trepidation and unease. As a result, people engage in significant amounts of planning, and Mia (IR119) explains the mind-set of being able to ‘ride out’ her journeys (mentioned above) by referring to the laborious planning engaged in beforehand:

It takes a lot for me to get on in the first place, hours of planning and thinking things through, running through all the scenarios in my head, checking the route, how many stops before I get off and just knowing that it’s going to be a really uncomfortable and stressful thing. It’s a pure nightmare, I find the whole thing really overwhelming and stressful, but I got myself there.

Up until relatively recently²⁴⁹, Nina (IR) did not use public transport at all and would take the more expensive option of travelling by taxi. Now she uses the bus, however, like Sam, she goes to great lengths to limit any uncertainty associated with her journey:

[I]f I have to travel, because my job involves having to visit people, I plan the routes really, really carefully and make sure I’ve got access to maps and Google and I know where the bus goes from and where it stops and all that, and how long it’s going to take me to get there [...]. If, which happens quite frequently, if public transports doesn’t turn up or is late [after] the extent I go to plan as rigorously as I do [...] It happened the other week; it’s just a nightmare.

Spaces of public transport are frequently described as non-social environments, although they, like other public spaces of encounter, are primed for ‘potentially integrative events’ (Laurier and Philo, 2006, p. 199). Conversational interactions appear to be uncommon, as participants rarely mentioned explicit instances where they encountered a problematic conversation with other passengers. With the exception of necessary social interactions with a driver or the pleasantries involved in negotiating crowded spaces, which are by no means insignificant (as is evident in Mia’s narrative above), the interactions on public transport are relatively ‘uneventful’.

As Bissell (2010b, p. 271) notes that, a tension ‘exists between the isolation of travelling unaccompanied [...] within a collective of other passengers.’ This collective dwelling disrupts expectations of rights to privacy in public (Laurier and Philo 2006) and the ‘proxemic’ rules that dictate how people perceive and organise their social and personal space. In an act of self-preservation, passengers attempt to extend the boundaries of

²⁴⁹ Nina previous role as a substitute teacher was temporary and sporadic leading to a lot of job and income insecurity. She said that these working conditions, as well as voluntary work on a rape-crisis phone line, had a marked impact on her mental health. She quit both when her social anxiety was ‘critical’ leaving her relatively housebound. She has recently gained part-time employment as a ‘Befriender’ for a local charity where she feels both secure and supported in her role.

personal space, creating what Goffman (1971) terms ‘territories of the self’. Where creating physical distance is difficult, individuals seek socially and emotionally to disconnect from people around them:

I use Google Maps and sort of follow my journey ‘live’ so I tune out and concentrate on my phone. It helps with a fear of getting lost or being stranded somewhere [...] I always wear headphones, people aren’t likely to start any small talk with [me when I’ve got] headphones on and [I’m] zoned out, minding my own business type of thing. [The headphones] help to block everything out so I can just focus on my phone.

Passengers habitually fatigued and frustrated by the daily commute strive to be socially inaccessible, actively choosing seats in an empty row and using mobile technologies to disconnect from their surrounding environments. When there is such a pervasive feeling of uncertainty about journeying as described by Craig (and Nina, above), the use of ‘real-time’ technology such as ‘Google Maps’ enables him to monitor the progress of the journey and to pinpoint his exact location on the map, particularly in unfamiliar territory. Sound (and the ‘awkward silences’) on public transport are implicit here in producing a heightened awareness that permeates individual experience, and so many participants often use headphones to dull the sensory experience of public space, creating a protective boundary as well as ‘marking’ the body as out of bounds (but not ‘out of place’). (Davidson, 2003, p. 120) has compared such tools to Goffman’s (1971) ‘shields’ and ‘stalls’, employed as a normal yet ‘deliberate defence against social engagement’.

Although planning is an exhausting and time-consuming practice, part of this preparation is about being able to mitigate the effects of unexpected interactions and events. Equally, people remain responsive to their surrounding environments and make last minute changes in order ‘to sit on a quiet bus, rather than change tubes and battle through busy stations’ or when the conditions for travel ‘just don’t feel right’ (Dina, QR151). When considerable amounts of time are spent preparing for (even the most habitual of) journeys, there is spontaneity in being able to re-direct its course in response to often uncertain and changing conditions of travel (Chapter 7). That said, the consequences of altering daily routines means that it takes significantly longer to complete everyday tasks. Beth often wakes up ‘two hours early so my dad can take me to college on his way to work’. Similarly, Greg (QR125) writes, ‘I can only get the bus to uni and it’s really problematic²⁵⁰. I tend to avoid

250 Others highlighted issues of accessibility and reliability in relation to service provision, particularly in rural areas: ‘I live out in the sticks and public transport is pretty infrequent. I know if something happens I couldn’t get home immediately, I’d need to wait for the next bus [and] that could take hours. [...] I tend to not go very far because of that and stay closer to home’ (Amanda, IR)

rush hour but if I finish uni later, the buses are always packed. I usually wait a few hours and travel home later or get the night bus that's quieter.' Dyck (1995, p. 310) notes that the use of 'transportation, particularly in crowded, rush-hour conditions,' is problematic for women living with chronic illness as they negotiate the social and physical environment between home and work. Lisa experiences similar disruptions to her day:

I take the bus to university mostly every day and I hate it. I find myself jumping off and taking the next bus if it gets too busy or claustrophobic, but that usually makes me late for class and that makes me panic too. I can't win!

While seemingly ingrained into the habitual rhythm of social life, pervasive anxieties constitute and unsettle spaces of mobility, disrupting understandings of the daily commute as 'the routine and repetitive transition from place to place' (Bissell et al., 2016, p. 12). Consequently, people spend substantial amounts of energy simply getting to and from significant 'dots' on their everyday maps.

Similar to chronic illness, experiences of social anxiety are invariably contingent on individual circumstances, environments and situations that cause experiences to rupture and flare (Chapter 5), but are, for the most part, invisible (Charmaz, 1995; Moss and Dyck, 1996). Samuels (2003, p. 248) argues that the focus on visibility by disability theorists 'continues to render non visible disabilities invisible while reinforcing the exact cultural reliance on visibility that oppresses all of us'. Davis argues that 'disability is a specular moment' in which the gaze has operative power 'to control, limit and patrol' the disabled body (Davis, 1995, p. 12). Samuels (2003) critiques the politics of visibility and the focus on physical markers of difference prevalent in theories of disability (Chapter 7). The focus on the specular not only leads her to 'question' whether she, living with a chronic, life-altering and invisible condition, 'qualifies' as disabled, but it also limits our understanding of what disability is and further marginalises those whose social identities are un(der)recognised, called into question or disputed outright. In order to contextualise the 'complexity and multiplicity of social restrictions' (Mulvany, 2000, p. 585) encountered by people experiencing mental and/or emotional distress, it is crucial to draw connections between the vaguely visible or invisible presentation of their experiences and their everyday use of space. Gail's narrative is particularly instructive here:

I found a website, 'Disabled Travel Advice', when I was searching for information to help me get about with less anxiety. I don't know what I was expecting but it wasn't all that helpful. It said something like, ['Don't be shy

about taking a seat at the front of the bus.' (DTA 2017)]²⁵¹ I could never, ever. I'm 33, I am physically able, you know? What a way to draw attention to myself! [...] Sitting on the bus isn't somewhere I want to start talking to someone at all, never mind about my mental health! (Gail, IR95)

While sitting in 'priority seating' would provide her with a little more personal space and could help to alleviate some of Gail's anxieties, she is firmly attuned to the fact that she possesses no outward sign of impairment²⁵². Being young and 'physically able', the socially and culturally accepted 'markers' of disability are missing²⁵³. The 'solution' to the problem appears to present more problems than it solves, as sitting in priority seating areas is a perceived transgression of the social rules of public transport use. Furthermore, such a scenario could incite possible confrontation with others: Gail does not want put herself in a position where she has to justify her use of the space and, by extension, her mental health. Arguably, the issue of (in)visibility presents further problems in terms justification when 'fraudulent' claims to space or 'undeserving' accommodations are made (Lingsom, 2008; Samuels, 2003) (also evident in the workplace).

Gail's (IR95) anticipated fears are realised in Anna's (IR157) experience: '[I] sat in the disabled seats because the bus was really busy and I wanted to be able to get off if I needed to, you know? And an older woman called me out on it [...] She said I had no right to sit there [...] I got right off the bus [...] It really stuck with me. [Travelling is] difficult enough without being called out [on it].' Anna is one of few participants to discuss face-to-face confrontations in public spaces, it is particularly poignant as she was challenged and publicly reprimanded for occupying 'disabled spaces'. Unfortunately, the experience has stayed with her, invariably influencing her perceptions and use of the public transport system as well as her 'place' within it. Gail and Anna's experiences resonate with Thomas' (2007) concept of 'psycho-emotional dimensions of disability' that concerns the harmful words or actions of non-disabled people towards people with (non)visible impairments. Thomas (2007, p. 72) argues that 'the damage inflicted works alongside psychological and emotional pathways, impacting negatively on self-esteem, personal confidence and ontological security', aspects that, for people with social anxiety, are already particularly

²⁵¹ This is the particular section, quoted from the DTA website, to which Gail is referring to.

²⁵² Public campaigns to recognise invisible impairments and disabilities, particularly on public transport, have been increasing in recent years. In 2016, Transport for London (TfL) launched the 'Please Offer Me a Seat' pin badge designed to assist people with hidden disabilities, health conditions and injuries by alerting fellow passengers to their need for a seat. A similar 'Baby on Board' scheme exists for pregnant women.

²⁵³ Arguably, visible markers of illness and/or difference are not socially or culturally 'accepted' either and serve to mark the body as deviant, abnormal or 'other' (Garland-Thomson, 2005) See also: (Hall 1999, 2010; Imrie 2001)

low and vulnerable.

Several respondents clarified their sense of not feeling safe on public transport spaces as overwhelmingly ontological. Sarah (QR18S) no longer travels by public transport as she frequently experiences panic attacks when in close proximity to other people. Commenting on the response of others to her episodes of panic, she writes: ‘people had no idea what to do, they would just stare like I was nuts or blatantly avoid getting involved’. Cresswell (1996, p. 22) argues that the ‘occurrence of out of place phenomena leads people to question behaviour and define what is and is not appropriate for a particular setting.’ Here Goffman’s ‘aversion’ takes on a different meaning, insofar as Sarah is the subject who is deemed ‘unworthy’ of acknowledgment as her behaviour does not ‘fit’ with the space. As such, she is rendered ‘out of place’ and altogether ignored by her fellow commuters. Others also discussed perceived safety in terms of vulnerability and risk of becoming the target of harassment. Amanda states that ‘travelling home from work on the night bus with groups of drunk people in case they say something or try to get my attention’ causes her incredible discomfort. Equally, Paul feels that he is an ‘easy target for young people to mock, looking and feeling so awkward that it draws their attention like I’ve got a big sign over me’, NS leading him to avoid travel. Feminist geographers have argued that it is women’s fear of crime, violence and harassment in the public sphere that overwhelmingly contributes to their decisions to avoid public transport (Law, 1999; Valentine, 1989). However, Day et al. (2003) further problematises gendered accounts of fear in public space, arguing that men’s perceived vulnerability increases when they are placed in situations that are uncertain or unfamiliar, particularly where there is the potential for confrontation, as experienced by Paul, heightening his sense of negative expectation and further disrupting his relationship with the surrounding space.

Whether these journeys are endured, altered or abandoned; new social routines, practices and negotiations unfold between home, work and social spheres of life in bring about a sense of stability and to regain control over the self- and body-in-space. While the impact of their use is considerable, those who avoid public transport often walk considerable distances, rely heavily on family members or remain within the confines of the home (Chapter 7).

CONCLUSION

This chapter has demonstrated how sustained experiences of social anxiety play a

significance role in regulating, restricting and, as suggested in the opening quotation, a shrinking social and spatial worlds (Davidson, 2000b; Driedger et al., 2004; Dyck, 1995b). Throughout, this chapter has focused on the relation and embodied encounters between self-other-world highlighting the ways in which the ‘fine-grained’ micro-textures of social space trigger and sustain anxious experiences. Precarious and uncertain social and interpersonal worlds are compounded by an overwhelming fear of humiliation, embarrassment and rejection that has the potential to lead to an avoidance of social life and sustained experiences of isolation and loneliness. People’s perceptions of social interactions and situations impact how they construct meaning from them, often exacerbating existing anxieties and fuelling new ones that shape their self-image, identity and ability to participate in, and contribute to, social worlds. A deeper examination of participant’s social worlds uncovers the complexity in, and limitations placed on, everyday social life. While highlighting the broader impact over a life-course as opportunities for encounter, both passing and sustained, become increasingly diminished. Next, I examined consumer spaces and other public and civic spaces used for social and leisure activities. Here, it became apparent that the availability of spaces deemed ‘safe’ for social contact, or to simply navigate through, become increasingly limited leading to further erosion of already restricted social and geographical worlds. Finally, I attend to the various ways everyday mobilities are disrupted and re-negotiated in response to the temporally and spatially contingent nature of anxiety. Individuals encumbered by uncertainty, perceived visibility, the potential for social interactions with others, and the levels of social performance involved in, for example, buying a ticket or crossing the street, public space, for many participants, is full of intolerable disruptions to their daily geographies. Consequently, social, spatial and temporal adjustments are made to the practice of everyday life that sees routes disrupted, journeys (re)negotiated and bodies (re)mobilised in creative but time-consuming ways. The disrupted and disruptive geographies explored throughout this thesis have unearthed a dialectic in the relation between self and space.

CHAPTER 9

CONCLUSION

INTRODUCTION

This thesis has sought to examine the social and anticipatory geographies of social anxiety by placing under geographical scrutiny the sites, settings and encounters in and through which everyday experiences are lived. By exploring the day-to-day realities and consequences of living with social anxiety, this thesis offers a uniquely geographical approach to the disciplinary landscape of social anxiety research and complements existing research on experiences of mental and emotional distress (Butler and Parr, 1999; Chouinard, 2012; Davidson, 2000a; Segrott and Doel, 2004) and chronic illness and impairment (Crooks, 2007; Dyck, 1995a; Lucherini, 2016; Smith, 2012). Interrogating lived experience specifically through geographical and psychoanalytic lenses has aided in unearthing the social meaning and something of the underlying psychic structure of participants' anxious experiences. Psychoanalytic geographies, in particular, offer to enrich our understanding of participants' subjectivities as intimately bound up with their self-other-world relations. In ending this thesis, I provide a summary of each chapter before reflecting upon the wider theoretical and empirical threads mapped over the course of this thesis, before finally offering suggestions about both the practical application of the findings and possible strands of future research.

Chapter 1 set the overall tone of the thesis by foregrounding the 'voices' of research participants, before charting the histories of and controversies surrounding the classification of social anxiety as a mental 'disorder'. The latter move – with a clear critical edge – did not intend to reduce or to negate the accounts of individual distress and suffering in the chapters that follow, particularly from those who subscribe to such classifications, but rather to disrupt existing diagnostic and classification systems and thereby to widen the lens through which social anxiety is viewed. **Chapter 2** mapped the existing disciplinary landscape of social anxiety, highlighting the extent to which it remains dominated by biomedical, cognitive and behavioural models, but also encountering smaller pockets of inquiry into social anxiety where cultural, social, psychoanalytic and interpersonal matters of concern do arise, sometimes anticipating the more geographical considerations central to this thesis. Then, situated within the context of

critical approaches to geographies of health and illness and guided by the just-mentioned social, interpersonal and psychoanalytic perspectives, I advanced towards a social model of social anxiety. **Chapter 3** developed this model – or a term like ‘sensitising framework’ might be more appropriate – and in so doing laid the conceptual groundwork for working with a situated and psychoanalytic account of social anxiety. In particular, threads were drawn out here from four subfields of theoretical concern from the wider orbit of human geography: psychoanalysis/psychoanalytic geographies, anticipatory geographies, embodied and affective geographies and, finally, what has very recently been called habitual geographies.

In **Chapter 4**, I offered an in-depth reflection on the politics, process and practice of researching the lived experience of social anxiety and carefully considered how online approaches can be implemented to enrich such geographical inquiry. Methodologically, I sought to design an inclusive research process that, not only, acknowledged the ‘voices’ of people with sustained experiences of mental (ill) health, but also sought to build ethical research agendas and relationships with my participants. Throughout this discussion, I considered layers, rather than labels, of vulnerability so as to identify the various ways in which people with social anxiety may (or may not) be considered vulnerable in the research encounter. This chapter marked the close of the ‘set up’ for my project – its literature, conceptual and methodological coordinates – and comprised the bridge across into the substantive heart of the thesis, the four empirically-facing chapters where the ‘voices’ of experience from my in-depth primary research came to take centre-stage, albeit always with a variety of routes explicitly traced back into the literature and concepts (and on occasion with new reference and ideas being introduced that relate to the specific contents of each chapter).

In **Chapter 5**, unravelling the anticipatory geographies of social anxiety, revealed the complex temporalities, spatialities and potentialities that manifest relentlessly – with what often seem unbearable ‘intensities’ – in the everyday social and spatial lives of the individual. This chapter laid the emotional and affective platform for the remaining empirical chapters by highlighting the intense, cyclical and persistent nature of social anxiety. It dug deeply into the socio-psychic dynamics undergirding how, through anticipatory processes, themselves often triggered by particular spaces and places, past memories and experiences are continually being projected forward onto future events with present and persistent consequences.

Chapter 6 then cast a critical eye over the formal agencies, ‘biomedical’ authorities and informal spaces that legitimise and provide crucial sources of support – or, occasionally, non-support – for people with enduring mental health problems. It highlights considerable tensions for many between the social understanding and experience of distress and the biomedical understanding. It also demonstrates how medical encounters and spaces speak an exacerbation of distress through the struggles and uncertainties involved in obtaining a diagnosis and the on-going management of mental health and illness. Engaging with online spaces highlighted the various ways in which the Internet is utilised in the management of health-illness, examining social and health-seeking behaviours online, the consumption of health information online and critical sources/spaces of online support in the form of online forums. This chapter uncovered not only how and why people obtain a diagnosis – formal, or otherwise – but how they ‘live through, with, against and beyond’ (Callard, 2014, p. 530) a diagnosis of social anxiety.

Collectively, **Chapters 7** and **8** illuminated a fine-grained set of routines, knowledges and practices fostered in response to the unpredictable nature of social and spatial life for people with social anxiety, and also explored the intricacies of various interactions, situations, movements and encounters habitually experienced as distressing. **Chapter 7** addressed the spatial contingencies of living with social anxiety and its impact on the formative spaces of home, work and education, disclosing a simultaneously disrupted and disruptive set of geographies. I argued here that conceptualisations of home as an inherently safe and bounded space are deeply contested in this context, with the boundaries of home for people with social anxiety in a constant state of flux as everyday interactions, objects and practices in/of home create uncertainty. I also argued that education and workplace environments are anxiety-provoking due to cultures of competition, pedagogical practice, performance expectations, and power relations/dynamics between peers, colleagues and superiors. **Chapter 8** delved deeper into precarious and uncertain social and interpersonal worlds of people with social anxiety that are perpetually marked by feelings of inadequacy and self-criticism, vulnerability, social isolation and loneliness, the aim being to understand better the various sites and settings in which social anxiety manifests.

ENHANCING AWARENESS AND SUGGESTIONS FOR FUTURE RESEARCH

Throughout the thesis I have sought to work with the complex layering of socially anxious

experiences in order to capture the spatialities and temporalities of social life as they are lived and, at times, endured by participants. The next section discusses the impact of experiential knowledge on the inter-related domains of mental health research, practice and education, the limitations of this research and directions for future research.

Current research into social anxiety, normally configured here as a ‘social anxiety disorder’ (SAD), is indeed dominated by biological, psychological and cognitive-behavioural frameworks, which, with rare exceptions, omit the finer details of a person’s social and spatial life while focusing on the symptoms of ‘disorder’ as the pathological basis of illness. In order to avoid reproducing the reductive tendencies of these frameworks, social anxiety is understood in this project and thesis to be a common, meaningful and interpretable response to emotional, interpersonal and social-environmental circumstances, experienced in varying degrees and intensities; not an innately pathological entity, but rather reflective of broader social and cultural conditions and part of the rich diversity of the human condition. The disciplinary landscape of social anxiety is dominated by research that focuses on causative factors and treatment approaches/outcomes, with very little attention paid to lived accounts and the everyday contexts in/through which anxieties are experienced, understood, negotiated and/or managed²⁵⁴. In reaction, this research has communicated an embodied, relational and situated understanding of social anxiety; one that is habitually recurring, anchored in various social sites and settings (e.g. home, workplaces, and shopping centres) and structured by social practices, norms and relationships. Prioritising personal experience as an important source of evidence and knowledge aims to provide meaning, context and perspective to the lived experiences of social anxiety. My framing sensibility here has offered a biographic and socio-spatial context of illness experience as well as an understanding of strategies of negotiating, coping and managing ill-health and wellbeing.

Prior research on social anxiety has not reached out to or utilised user-led online communities specifically set up to help individuals understand, discuss and manage their mental health. This research, on the contrary, employed an innovative approach to the study of social anxiety using online methods, enabling access to an existing, active and flourishing knowledge base within online communities of people with social anxiety. The use of Internet technologies allows the unfolding of a whole new set of research possibilities with such communities through chat rooms, blogs and web-forums. The thesis

²⁵⁴ McCarthy (2014) is an exception, here although she focuses on participants’ recovery journeys rather than living day-to-day life with social anxiety.

also highlights the importance of practising inclusive research, in that face-to-face and verbal interactions may present insurmountable hurdles to those experiencing social anxiety and so, ‘traditional’ research methods are unsuitable or must be strategically negotiated. People with social anxiety do not want their experiences to be masked and neglected; they have a voice and a story to share. This research engages with these voices in order to create greater awareness and understanding of what it is like to live with social anxiety by prioritising the events, encounters and experiences that are inherent to everyday life.

Given the general lack of professional and public understanding of social anxiety, the findings of this research, and stories therein, could prove to be a valuable resource for General and Mental Health Practitioners for considering the personal meanings of, the daily activities that are disrupted by, and the social difficulties that have contributed to, the mental and emotional distress in-built to social anxiety:

I don't think SA is particularly well known, so I think it's important to try and let people know what it is and how they can help/support people they know who might have it. (Nicole, QR63)

The public aren't really aware of social anxiety the same way they are with other mental health problems and doctors aren't equipped to deal with it, I don't think they are really aware either. (Kerrie, QR22)

In order to map the foundations and contours of the social and anticipatory geographies of social anxiety, this research has sought to work with a wide scope of social interactions, sites and settings that were experienced by participants as (un)conducive to their mental health and wellbeing. As such, future research could build on these foundations and narrow the focus of investigation to the social-spatial dynamics of particular spheres of life as experienced by people with social anxiety; for example, employment, education, online and interpersonal spheres.

In terms of policy, the few suggestions I have fall mainly within the realm of healthcare services and how people with social anxiety can be supported in health-care pathways. People experiencing social anxiety demonstrate a resilience in their health-seeking practices and self-management practices but this often increases anxieties and isolation: One significant suggestion I have in this area is the development of policy and practice guidelines aimed at contextualising mental health experiences and treatment plans that

would see GPs working in conjunction with and supporting patients with social anxiety in seeking further treatment if required.

IMPACT AND KNOWLEDGE EXCHANGE

Throughout the course of this research, I have engaged in knowledge exchange and public engagement activities in order to increase the impact of this research. The Economic and Social Research Council (ESRC, 2018, p. n.p.) define the link between knowledge exchange and impact as the ‘two way exchange between researchers and research users [i.e. industry, policy, practice and the public] to share ideas, research evidence, experiences and skills’. In October 2016, I was invited to take part in a live radio interview about my research with Roundhouse Community Radio in Vancouver, British Columbia, and the interviewer was with the cultural geographer Minelle Mahtani (University of British Columbia, Vancouver). This interview provided an opportunity to talk about my research to a public and international audience. In 2018, I was invited write a piece for the Wellcome Trust’s ‘Living with Buildings’ exhibition, which examined how the environment affects our physical and mental health. In the first week, the article, which was published as part of their online collection, received over 2,000 views with people spending on average 12 minutes on the webpage, which hopefully demonstrates significant engagement with the article²⁵⁵.

Alongside these activities, it is important to consider the impact of the research on those who participated. Research participants were incredibly supportive of, and enthusiastic about, a research project that was solely about their, largely neglected, lived experiences, one that worked with their anxieties both practically, in terms of non-face-to-face methods, and conceptually, by viewing social anxiety through a more personal lens. The opportunity to discuss personal mental health experiences – and to have someone listen attentively with genuine care and interest – may be empowering and cathartic, allowing a certain repossession of experiences that are so often dismissed, ignored or marginalised. In addition to being ‘listened to’, these participants are also motivated by the prospect that sharing their experiences will help others living with social anxiety, and their family members, friends and colleagues, understand the often uncertain and distressing aspects of social life. Thus, the kind of ‘therapeutic work’ afforded by attention and representation should not be considered ancillary to treatment and/or recovery, but rather serve as a

²⁵⁵ Figures communicated by the Wellcome Trust’s online editorial team one week after online publication.

central strategy to understanding how social and spatial life is lived, endured and managed at various times and in various places by people living with social anxiety. Acknowledging, on the one hand, the often diminished social worlds of those living with social anxiety and, on the other, the tendency of people to internalise and ruminate over negative social interactions as well as to criticise and socially isolate themselves, mental health experiences ‘externalised’ and ‘made object’ through written word can be an effective way of reconvening and then dealing with mental and emotional suffering (Rian and Hammer, 2013, p.678). At the end of the questionnaires and during the interviews, participants often told me that they had enjoyed participating in the research, and indeed were grateful that someone was interested in, listening to and working with their ‘voices’ of experience:

[The questionnaire] made me ask myself a lot of questions I wouldn’t normally ask myself because of my lack of positive self dialogue. (Jane, QR90)

I appreciate the questionnaire’s inclusion of anecdotal information. It has been useful to reflect. It has helped me to identify what is a problem that I had identified before as belonging to other areas of my life, so thank you. (Hannah, QR77)

It’s been really nice talking to you knowing you understand and aren’t judging me. Thank you for doing this work. It’s so important! (Lucie, IR28)

It’s been really helpful for me. It’s actually given me a fresh perspective on my anxiety, I’m going to take a copy of this interview to my therapist next week and talk it through with her. (Jo, IR41)

These impacts may seem small but, for me, they are the most significant for highlighting the importance of this research and the need to uncover the causes and consequences of our ‘disordered’ lives. If not for participant’s willingness to discuss often difficult-to-articulate, deeply personal and emotional aspects of their mental health, my efforts to humanise and capture the intensity and uncertainty of socially anxious worlds would not have been possible. I hope in some small way, therefore, that this research does justice to the stories so readily shared with me.

FINAL THOUGHTS

Disclosing intimate details and personal narratives of mental health and illness is often an onerous task. Living with social anxiety further complicates this act of ‘opening up’ as anxieties are about interacting with others and deeply tied to everyday social and physical environments. The uncertainty of social encounters is extremely distressing, physical

spaces are imbued with certain ideals, norms and expectations that an anxious person ‘fails’ to meet, and face-to-face interactions are risky, exposing a person to potential judgement, scrutiny, embarrassment, ridicule and shame. There is also a subtle but compelling power dynamic at play concerning perceptions of authority and feelings of inferiority in relation to others. The research encounter is a social encounter, which embodies all of these complexities, and this required careful navigation through a critically reflexive and relational research practice (Chapter 4).

Lived knowledge provides social insight and a deeper level of understanding to the minutiae of anxious subjectivities, my own experiences of which helped shape the research design and methodological approach. The level of distress caused by social anxieties is often dismissed. Therefore, it was a priority to design a project that, not only, fostered participation but also enabled people to define the nature and limits of their participation. In this context, it meant employing multiple methods void, as far as possible, from the stressful dynamics of social encounters mentioned previously. This research – with its principally online character – encouraged faceless, voiceless, bodiless and anonymous research encounters through an online questionnaire and online semi-structured interviews. By removing elements linked to social evaluation, participants accustomed to expressing themselves in written form in online environments.

The findings and, most importantly, the words of those who participated in this research all reinforce the need to re-examine and re-frame the narratives about social anxiety and to create a broader story that looks beyond the symptoms of ‘disorder’ towards more messy, complex and situated realities. The human sciences have provided a discourse of normal versus abnormal to understand our inner worlds. Crucially, Lacanian psychoanalysis offers the conceptual and theoretical underpinnings through which to reframe normal/abnormal in relation to mental health and associated distress²⁵⁶. As highlighted in Chapter 3, his works critically assesses the perceived (and, he would argue, unobtainable) stability of the self. We are subjects who lack. The emergence of social anxiety as a ‘disorder’ is a prominent example of how the nuances of human suffering and distress, as a response to an increasingly interconnected and neo-liberal world, are pathologised and medicalised. Going forward, there is a need to continue to challenge the dominant biomedical model, which is seen to play a powerful role in structuring attitudes towards, and often

²⁵⁶ Unfortunately, within the scope of this thesis, a complete, psychoanalytically-informed re-mapping of social anxiety (or madness and distress, more generally) is not possible. It certainly opens up exciting potential for future work.

perpetuating the stigma associated with, mental health, illness and distress.

By centring experienced-centred knowledges this thesis contributes to existing bodies of research that disrupt, challenge and nuance the dominant biomedical model of mental health and illness. In unearthing experiential accounts that speak to the intensities of our most inner geographies, that of (un)conscious psyches and bodies, but also simultaneously speak about the external geographies of social and spatial governance, I address not only how social anxiety is experienced but also how it is understood, constructed, managed and negotiated. Living with and through social anxiety is often full of contradictions as simultaneous feelings of isolation and exposure are compounded by overwhelming (un)certainty and (un)predictability about bodily reactions, self and social expectations, social spaces and other people. Social anxieties rupture the fabrics, places and spaces of everyday life and are fundamentally geographical, bound up in an intimate social geography of experience where anxiety, fear, embarrassment and shame occur across a range of social settings. Over the course of this thesis, such ‘intensities’ and modes of ‘governance’ are re-situated back into the sites and settings of daily life, bringing to light a little-known social geography of social anxiety, a geography otherwise anxiously hidden to the detriment of many.

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APPENDICES

Appendix 1



2nd July 2015

Letter of Support for Research Project: 'The social geographies of Social Anxiety Disorder (SAnD) in on- and off-line worlds'

To whom it may concern,

I am writing to confirm that Anxiety UK has been contacted by Louise Boyle regarding the above research project.

Anxiety UK's policy is to assist research projects where the work involved aims to raise the profile of anxiety disorders and increase understanding and treatment. I have assessed the research proposal and find that the aims of the research and the methodological approach are in line with the guidelines and regulations outlined by Anxiety UK for researchers. As such, Anxiety UK is happy to advertise the research project to our member database via our social media sites and related media outputs. Advertisement is subject to fee; Louise has been informed of the advertising rates.

Anxiety UK will not be affiliated with the research project in any capacity however, Louise can make participants aware of our extended networks of support and we are happy to review the research and publish the findings if appropriate, once complete.

Kind regards,

Alex Farrington

Communications Officer



Patrons: Dr Sam Cartwright-Hatton • Prof Robert Edelmann • Prof David Nutt • Dr David Baldwin • Prof Sir Cary Cooper • Prof Adrian Wells
Prof Paul Salkovskis • Prof David Clark • Dr Fred Penzel • Prof Karina Lovell • Dr Chris Williams • Prof Ursula James •
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Registered Charity No: 1113403
Company Registration No: 5551121
Established 1970

Appendix 2

	Case number and Pseudonym	Gender	Age	Self-diagnosed (SD) or Formally- diagnosed (FD)	Interview (I), Questionnaire (Q), Questionnaire- Interview (Q-I) respondent	Notes
1	Karen	Female	29	FD	I	No questionnaire recruitment via AnxietyUK. Telephone interview.
2	Nina	Female	53	FD	I	No questionnaire recruitment via AnxietyUK. Telephone interview.
3	#01 Dawn	Female	29	SD	Q	
4	#02	Female	16	SD	Q	
5	#03	Male	29	SD	Q	
6	#04	Female	24	SD	Q	
7	#05	Female	29	FD	Q	
8	#06	Female	28	FD	Q	
9	#07 Rachel	Female	19	SD	Q	
10	#08 David	Male	39	SD	Q	
11	#09	Female	37	FD	Q	
12	#10	Female	18	SD	Q	
13	#14 Sol	Male	29	SD	Q	

14	#15 Sean	Male	36	FD	Q	
15	#16 Claire	Female	33	SD	Q	
16	#18 Emma	Female	22	SD	Q	
17	#19	Female	38	SD	Q	
18	#21	Male	23	SD	Q	
19	#22 Kerrie	Female	23	SD	Q-I	Online interview.
20	#23	Female	47	SD	Q	
21	#24 Eve	Female	25	FD	Q	
22	#25 Emily	Female	21	FD	Q	
23	#27 Amber	Female	20	FD	Q	
24	#28 Lucie	Female	29	SD	Q-I	Online interview.
25	#32 Ben	Male	25	SD	Q	
26	#33 Marta	Female	28	FD	Q	
27	#37 Sophie	Female	20	FD	Q-I	Online interview.
28	#38	Male	36	SD	Q	
29	#40 Kim	Female	34	SD	Q-I	Online interview.
30	#41 Jo	Female	28	FD	Q	
31	#42 Molly	Female	44	FD	Q	
32	#43	Female	31	SD	Q	

33	#48	Female	48	SD	Q	
34	#54 John	Male	26	FD	Q	
35	#57 Marcie	Female	25	FD	Q	
36	#58	Male	43	SD	Q	
37	#59	Female	52	FD	Q	
38	#60	Female	16	FD	Q	
39	#62	Male	27	SD	Q	
40	#63 Nicole	Female	32	FD	Q	
41	#67	Male	44	FD	Q	
42	#77 Hannah	Male	55	SD	Q	
43	#78 Cara	Female	23	FD	Q	
44	#79	Female	31	FD	Q	
45	#81	Female	68	FD	Q	
46	#82	Female	16	FD	Q	
47	#85	Female	17	FD	Q	
48	#87 Kirsty	Female	16	FD	Q-I	Online interview. Kirsty is the youngest participant.
49	#88 Jess	Female	19	FD	Q-I	Online interview.
50	#90 Jane	Female	21	SD	Q-I	Online interview.
51	#91 Eilidh	Female	47	SD	Q	

52	#92	Female	34	SD	Q	
53	#95 Gail	Female	24	SD	Q-I	Online interview.
54	#96 Kathryn	Female	19	FD	Q	
55	#100	Female	21	FD	Q	
56	#103 Amelia	Female	17	FD	Q	
57	#107	Female	37	FD	Q	
58	#111	Female	29	SD	Q	
59	#112	Female	20	SD	Q	
60	#114	Female	28	FD	Q	
61	#115 Daniel	Male	24	SD	Q-I	Online interview.
62	#116	Female	20	SD	Q	
63	#117	Female	51	FD	Q	
64						
65	#119 Mia	Female	24	SD	Q-I	Online interview.
66	#120	Male	26	FD	Q	
67	#122	Female	18	FD		
68	#123 Tina	Female	48	SD	Q	
69	#125 Greg	Male	48	FD	Q	
70	#136	Male	48	FD	Q	

71	#137	Male	29	FD	Q	
72	#138	Female	45	FD	Q	
73	#142 Priya	Female	16	SD	Q	
74	#143 Lisa	Female	25	FD	Q	Online interview.
75	#144 Leanne	Female	26	FD	Q	
76	#147 Josh	Male	35	FD	Q-I	Online interview.
77	#148	N/A	20	SD	Q	
78	#149	Female	19	SD	Q	
79	#150	Female	18	FD	Q	
80	#151 Dina	Female	29	FD	Q	
81	#153	Female	16	SD	Q	
82	#155	Female	37	FD	Q	
83	#157 Anna	Female	29	SD	Q-I	Online interview.
84	#159	Female	44	SD	Q	
85	#160	Female	43	SD	Q	
86	#166	Female	41	FD	Q-I	2 x onlline interviews
87	#168	Male	33	SD	Q	
88	#169	Male	39	FD	Q	
89	#171	Male	42	SD	Q	

90	#177	Male	38	SD	Q	
91	#179 Lauren	Female	18	FD	Q	
92	#180	Male	30	SD	Q	
93	#182 Moira	Female	48	SD	Q-I	Telephone interview.
94	#183	Female	20	FD	Q	
95	#187 Olivia	Female	24	FD	Q	Online interview.
96	#189 Callum	Male	32	FD	Q-I	Online interview.
97	#191	Female	47	FD	Q	
98	#194	Female	47	FD	Q	
99	#196	Female	27	SD	Q	
100	#197	Female	18	FD	Q	
101	#199	Female	24	SD	Q	
102	#202	Male	36	SD	Q	
103						
104	#204 Harriet	Female	25	SD	Q	
105	#211 Simon	Male	55	FD	Q	
106	#212 Anya	Female	37	FD	Q-I	Online Interview.
107	#214	Female	27	FD	Q	

108	#215 Gillian	Female	31	SD	Q	
109	#216 Carol	Female	65	FD	Q	Carol is the oldest participant.
110	#217	Male	44	FD	Q	
111	#218	N/A	47	SD	Q	
112	#219	Female	37	SD	Q	
113	#220	Female	18	FD	Q	
114	#221	Male	38	FD	Q	
115	#222	Female	20	FD	Q	
116	#223	Female	27	SD	Q	
117	#224	Female	24	SD	Q	
118	#225	Female	34	SD	Q	
119	#226	Female	27	SD	Q	
120	#14S	Male	45	FD	Q-I	Online interview. SA Scotland participant.
121	#18S Sarah	Female	32	FD	Q	SA Scotland participant.
122	#26S	Male	38	SD	Q	SA Scotland participant.
123	#21S	Female	21	SD	Q	SA Scotland participant.
124	#39S	Female	21	SD	Q	SA Scotland participant.
125	#41S	Male	50	SD	Q-I	Online interview. SA Scotland participant.
126	#45S	Male	25	FD	Q	SA Scotland participant.

127	#49S	Female	36	SD	Q	SA Scotland participant.
128	#51S	Female	39	SD	Q	SA Scotland participant.
129	#54S	Female	45	FD	Q	SA Scotland participant.
130	#57S	Male	33	FD	Q	SA Scotland participant.

Appendix 3

Louise Boyle (student)

From: Louise Boyle
Sent: 18 June 2015 15:05
To: 'info@anxietyuk.org.uk'
Subject: Research query
Attachments: Research Information Sheet.docx

Hello,

I'm not sure if I've directed this to the correct team, hopefully you can help.

My name is Louise Boyle and I am an ESRC-funded PhD candidate at the University of Glasgow. My PhD is interested in exploring lived experience with Social Anxiety Disorder with a particular focus on everyday environments and how people use the Internet as space for communicating, socialising and sharing/gathering information about Social Anxiety Disorder. I have attached an example research information sheet. I am also a member of Anxiety UK in a personal capacity.

I see from your website you support post-graduate research which increases understanding/treatment and raises the profile of anxiety disorders - something I hope my research will help facilitate. I would be interested in advertising the project to recruit participants through Anxiety UK. I understand you are unable to take responsibility for participant's experience of the research process. The University has a very stringent ethics process for mental health-related research that I am about to go through so I'm trying to gather as much information as possible about the platforms I can advertise with.

1. I'm wondering if you have a copy of Anxiety UK's policy for research and if you can clarify the relationship (if any) you maintain with researchers i.e. do you ever work alongside/collaborate with researchers at PhD level?
2. Do you have any research protocols/regulations for researchers?
3. Could I reference/make participants aware of Anxiety UK services/resources as I understand it can be difficult to talk about their experiences.
4. Would it be possible for me to draft some form of letter that states Anxiety UK are happy for me to publicise the research / recruit participants via your platforms (subject to payment of advertising rates/filling out the submission form) that Anxiety UK could edit as necessary and 'sign off' - it would not mean you are affiliated with the project in any way only that I have gained consent to advertise/recruit through Anxiety UK.

Many thanks for your time.

I look forward to hearing from you and answering any questions.

Kind regards,

Louise Boyle

PhD Candidate
School of Geographical and Earth Sciences University of Glasgow, G12 8QQ
Email: l.boyle.1@research.gla.ac.uk

Appendix 4

Thank you for showing an interest in this research project. Please read the following information carefully.

Invitation I would like to invite you to take part in a research project about living with Social Anxiety Disorder entitled 'The social geographies of Social Anxiety Disorder in on- and off-line worlds'. Before you decide to participate, it is important for you to read the research information sheet on the following page carefully. Do not hesitate to contact me if there is anything that is unclear or if you would like more information on this project. My name is Louise Boyle and I am a PhD research student from the University of Glasgow. This project is funded by the Economic and Social Research Council (ESRC), which is a higher education funding body. The project will run from October 2015 to October 2017. The research has been approved by the Ethics Committee of the College of Science and Engineering, University of Glasgow, under approval number 300140175.

Confidentiality Your contribution will be anonymous. The research will not ask you to disclose any identifiable information (e.g. your name/online usernames) and you will be assigned a false name if your responses are used in any research-related outputs. Information will be stored on a secure computer. What is the purpose of the study? As someone who lives with Social Anxiety Disorder, I have noticed a significant lack of research that includes the voices of people who experience Social Anxiety Disorder. This project aims to increase public and academic understandings of what it is like to live with Social Anxiety Disorder, through your day-to-day experiences. The research explores several themes including, your daily life, your diagnosis and the impact of your surrounding environment. The project will also investigate your use of the Internet and online experiences.

Your role You will be asked a series of questions relating to your experiences. There are 7 sections covering a range of topics including introductory questions, your everyday experiences, physical symptoms, online communities and wider perceptions of social anxiety. It would be useful for you to provide information about your personal experiences in as much detail as you are comfortable with. Please share what comes to mind there are no right or wrong answers. The more information I can gather, the better. There is no recommended time for completing the questionnaire. If you need some time to gather your thoughts, you will be able to save your answers and come back at a later date to complete the questionnaire by selecting resume later at the bottom of the screen. You can skip questions that you do not feel are relevant to your experience or that you do not feel comfortable answering.

What will happen to the information I collect? The results of the research will be written up in my PhD thesis and in academic journals, as well as for dissemination via websites and other public engagement activities to increase both academic and public awareness about Social Anxiety Disorder. The material collected could be useful for academic studies, service-users, charities and in wider policy-related contexts. Above all else, the research will contribute to raising awareness about Social Anxiety Disorder through the voices of people who experience it; challenging mental-health related stigma by sharing these experiences.

Other information You may contact me for more information about the project at any time. Your participation is entirely voluntary and you can withdraw your consent for me to use your answers any time without having to give a reason. Submission of this questionnaire will be considered as you providing consent for me to use your responses in the thesis and other outputs. Thank you for taking the time to read this information. To download a copy of this information sheet [CLICK HERE](#).

Yours sincerely, Louise Boyle

School of Geographical and Earth Sciences University of Glasgow, G12 8QQ

Project supervisors Prof. Chris Philo E-mail: christopher.philo@glasgow.ac.uk Dr. Cheryl McGeachan E-mail: cheryl.mcgeachan@glasgow.ac.uk

Appendix 5

If you feel you require immediate support, please contact Samaritans www.samaritans.org. Provide a 24-hour service offering confidential emotional support to anyone who is in crisis. Helpline 08457 909090 (UK), 1850 609090 (ROI); e-mail: jo@samaritans.org Anxiety UK Anxiety UK is a registered UK charity and user-led service for people with anxiety. They work to support individuals living with anxiety disorders and provide a range of information and services Breathing Space (Scotland) www.breathingspacescotland.co.uk Breathing Space is a free and confidential phone line service for any individual, who is experiencing low mood or depression, or who is unusually worried and in need of someone to talk to. The phone line is open 24 hours at weekends (6pm Friday - 6am Monday) and from 6pm to 2am on weekdays (Monday - Thursday) 0800 83 85 87.

TO CONTINUE TO THE QUESTIONNAIRE PLEASE CLICK NEXT

A note on privacy This survey is anonymous. The record of your survey responses does not contain any identifying information about you, unless a specific survey question explicitly asked for it. If you used an identifying token to access this survey, please rest assured that this token will not be stored together with your responses. It is managed in a separate database and will only be updated to indicate whether you did (or did not) complete this survey. There is no way of matching identification tokens with survey responses.

Appendix 6

Everyday life with Social Anxiety Disorder

The following questions will ask you about your everyday life with social anxiety. Please give examples, where possible, of past or on-going experiences.

Can you describe, in your own words, what it is like to live with Social Anxiety Disorder?

Are there particular situation(s) and/or place(s) where you experience anxiety? If yes, please state the situation(s)/place(s) and describe your associated thoughts and/or feelings.

What role does your social anxiety play in how you plan your day-to-day life?

Appendix 7

Think about the following places, how safe or unsafe would you feel?

	Very unsafe	Unsafe	Neither safe/unsafe	Safe	Very safe	No answer
Your room	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>
Home	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>
Relative's house	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>
Quiet street	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>
Busy street	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>
Friend's house	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>
Stranger's house (e.g. guest at a party)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>
Campus	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>
Car	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>
Public transport	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>
Shopping centre	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>
Therapy room	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>
GP surgery	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>
Places of leisure (e.g. pub/restaurant)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>

Appendix 8

Opening blurb

- Statement about overall aims of the project (previously sent to participants)
- Statement about confidentiality, anonymity and how the information will be used (previously sent to participants)
- Confirmation of informed consent
- Statement making participants aware of their rights to terminate interview/take a break/not answer questions they are uncomfortable with.

Example of Semi-Structured Interview Schedule

Possible themes to explore regarding obtaining a diagnosis (or not) and significance of this:

Onset

Can you tell be about the period when social anxiety first became part of your life?

Key points:

- Can you describe your first experience or any particular memories that stand out relating to the first time *something happened* - thinking about what, when, where, when, how you felt.
- What factors do you think have played a part in you developing social anxiety? **[get a sense if anxiety developed over-time and of perceived causative factors – potentially sensitive]**
- How did you understand what was happening and how did you interpret the signs and symptoms of your mental health?
- Did you speak to anyone about what you were experiencing at that time – what was their reaction/how did that make you feel?
- [If formally diagnosed] What encouraged you to seek advice from a healthcare professional?

[END OF EXAMPLE]

Appendix 9

Consent Form

Title of Project: The social geographies of Social Anxiety Disorder (SAnD)

1. I confirm that I have read and understand the Research Information Sheet for the above study and have had the opportunity to ask questions.
2. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason.
3. I understand that my participation will be anonymous and I will not be identified by name in any publications arising from the research.
4. I understand participation or non-participation in the research will have no effect on current and/or future relationships with the University of Glasgow.

I agree / do not agree (delete as applicable) to take part in the above study.

Name of Participant: _____ Date: _____

Please don't hesitate to contact me with any questions or queries.

Many thanks,
Louise Boyle (Researcher)
E: L.boyle.1@research.gla.ac.uk

If you have any further questions or queries regarding this research. Please contact my supervisor:

Prof. Chris Philo
E: Christopher.philo@glasgow.ac.uk

[END OF CONSENT FORM]

Appendix 10

okay i have more haha..

It was almost like pins and needles, it was so bad one time that my hands locked into a position and I couldn't move them. All of the symptoms bought more fear, there was the fear of the original situation and then the fear of not being in control and not knowing how far it could go.

Once calm it made me feel ridiculous and embarrassed if there were people around, but it would always tire me out. I would lose a lot of energy and become almost numb. Long term, anytime I did an exercise that increased my heart rate freaked me out because I related it to the panic attacks

Sorry if that's a lot!

No that's perfect! type as much as you like :)

Louise
18:41 PM

okay good, thank you

did your anxiety or the panic attacks have an impact on how you felt about yourself?

Louise
18:43 PM

100%, I felt like a completely different person. Before the accident I was happy with how I was and was very laid back. It made me feel like a completely different person, I couldn't do things I used to love doing, I felt very weak and I became distant to those who I love most because I felt so low about myself and found it hard to interact

I used to tell my counsellor that my main goal was just to get myself back

Appendix 11

Information Sheet

Social Anxiety Disorder Research Project

SCHOOL OF GEOGRAPHICAL AND EARTH SCIENCES East Quadrangle, University of Glasgow, Glasgow G12 8QQ, Scotland, UK *Departmental Office:* 01413304782 / 5436; *Fax:* 0141 3304894 / 4817; *University Switchboard:* 0141 339 8855

Introduction

I am contacting you as you recently completed an online questionnaire for a research project about living with Social Anxiety Disorder and expressed interest in discussing your experience further. Before you decide to participate, it is important for you to understand why the research is being conducted and what it will involve. Please read the following information regarding this project carefully. Do not hesitate to contact me if there is anything that is not clear or if you would like more information. My contact details are below. Please take as much time as you need to decide whether you would like to participate. Participation is entirely voluntary.

My name is Louise Boyle and I am a PhD research student from the University of Glasgow. This project is funded by the Economic and Social Research Council (ESRC), which is a higher education funding body. The project will run from September 2015 to October 2017. This project has been approved by the College of Science and Engineering Ethics Committee, University of Glasgow (Approval Number: 300140175).

Confidentiality

If you choose to participate, your contribution is completely anonymous and no one will be able to identify that you took part in the research project. The information you provide may be used in my PhD thesis and related reports and papers, but you will be assigned a false name to ensure anonymity.

What does this involve?

As you expressed interest in discussing your experiences further, I would like to invite you to take part in an informal and friendly interview. The interview will be conducted online using the service ‘ChatStep’ on a time and date that suits you. The interviews will last approximately 1 hour. In the interview we will cover a variety of topics that were raised in the questionnaire you completed and some other topics relating to your experiences with Social Anxiety Disorder. The topics will include: your experiences across different situations and in different environments for example, social interactions, performance situations or situations where you are being observed; how you manage your experiences with anxiety in certain environments and there will also be a focus on your use of the Internet as a space for communicating, socialising, sharing/gathering information about Social Anxiety Disorder.

What will happen to the information I collect?

All the interview responses remain anonymous. I will type up the information you have provided and extract what seems like the most important points and themes. Information will be stored on a secure computer. Any tape recordings will be destroyed once I have typed up the conversation. Your name will not be used in any of these outputs.

The materials collected could be useful for academic studies, service-users, charities and in wider policy-related contexts. Above all else, the research will contribute to raising awareness about Social Anxiety Disorder through the voices of people who experience it, challenging mental-health related stigma by sharing these experiences. The results of the

research will be written up in my PhD thesis and in academic journals, as well as for dissemination via websites and other public engagement activities to increase both academic and public awareness about Social Anxiety Disorder.

What are your rights?

You have the right to contact me, or the project supervisor (contact details below) for more information about the project. Your participation is entirely voluntary and you can withdraw your participation at any time. You can change your mind about whether you want to be interviewed at any stage. After you have given the interview, if you decide you no longer want the information you have provided to be included in the project, you have the right to withdraw consent for me to use it at any time without having to give a reason. Thank you for taking the time to read this information. Please contact me with any questions or queries.

Yours sincerely,
Louise Boyle
School of Geographical and Earth Sciences
East Quadrangle, University of Glasgow
University Avenue
Glasgow, G12 8QQ
Email: L.Boyle.1@research.gla.ac.uk

Project supervisor:

Professor Chris Philo
School of Geographical and Earth Sciences
East Quadrangle, University of Glasgow
University Avenue
Glasgow, G12 8QQ
Email: Christopher.Phiло@glasgow.ac.uk

[END OF INFORMATION SHEET]

Appendix 12

Table 7: Gender of Participants

Gender	n	%
Female	93	71.54
Male	35	26.92
Transgender	0	0
No Answer	2	1.54
Total	130	100%

Table 8: Participant Age Groups

Age Range	n
16-25	47
26-35	37
36-45	27
46-55	17
56-65	1
66-75	1
Total	130

Table 9: Highest Level of Education Achieved

Education	n
Secondary	22
Additional Training	36
Undergraduate	46
Postgraduate	18
No Formal Qualifications	8
Total	130

Table 10: Living Situation of Participants

Living Situation	n
Alone	23
Partner/Spouse	30
Parents	41
House-share	11
Other	8
Total	130

Figure 19: Sexual Orientation of Participants

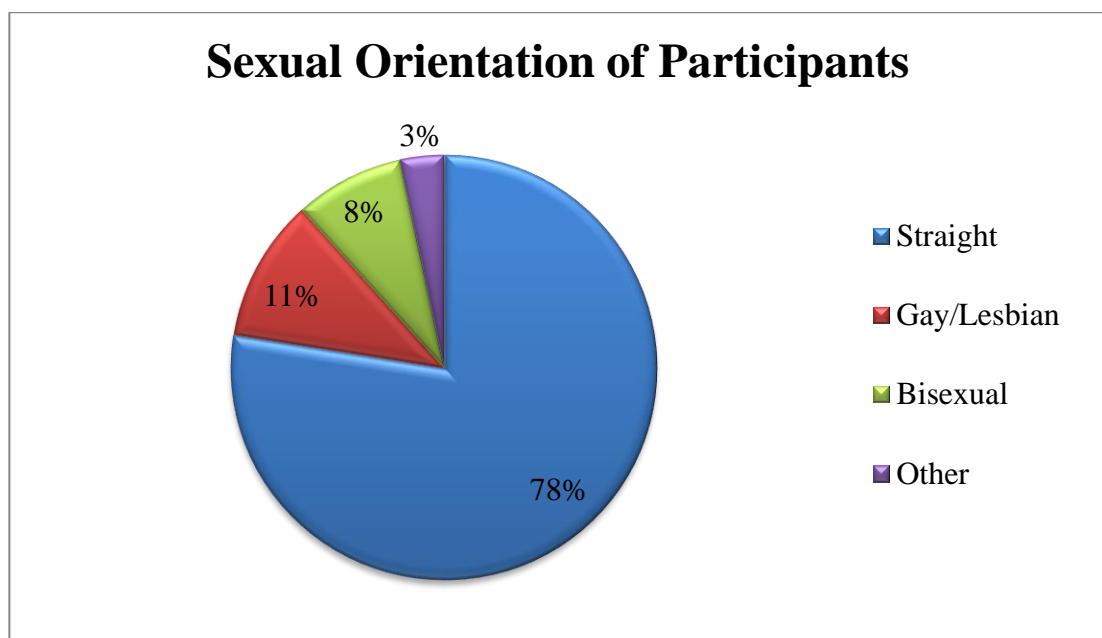


Figure 20: Likelihood of Anxiety when Speaking to Authority Figures

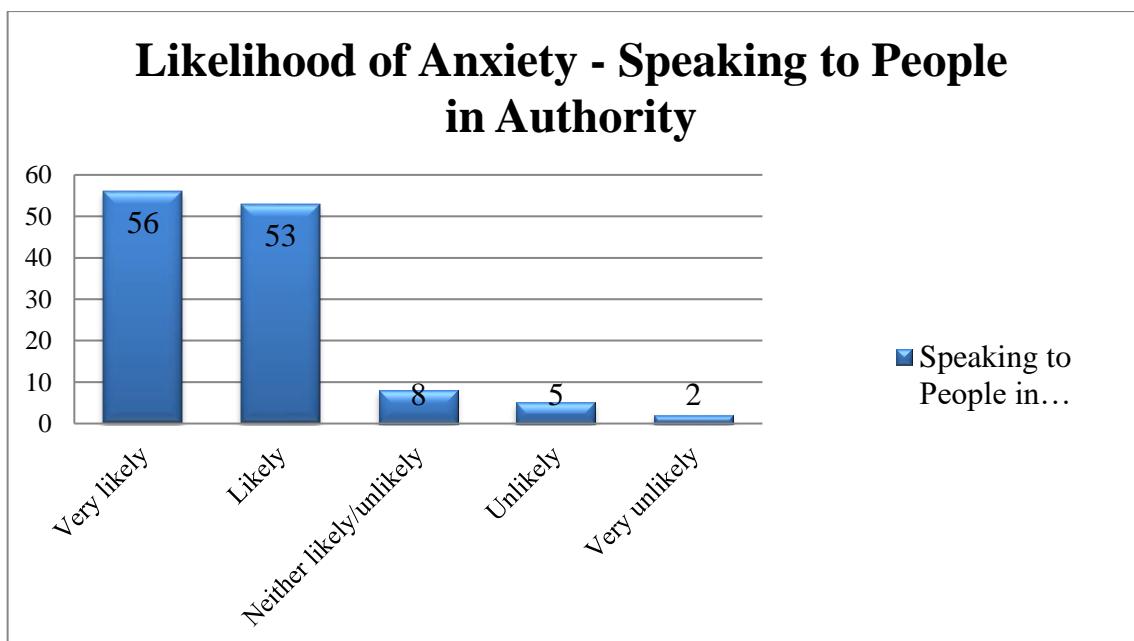


Figure 21: Likelihood of Anxiety while Being Observed

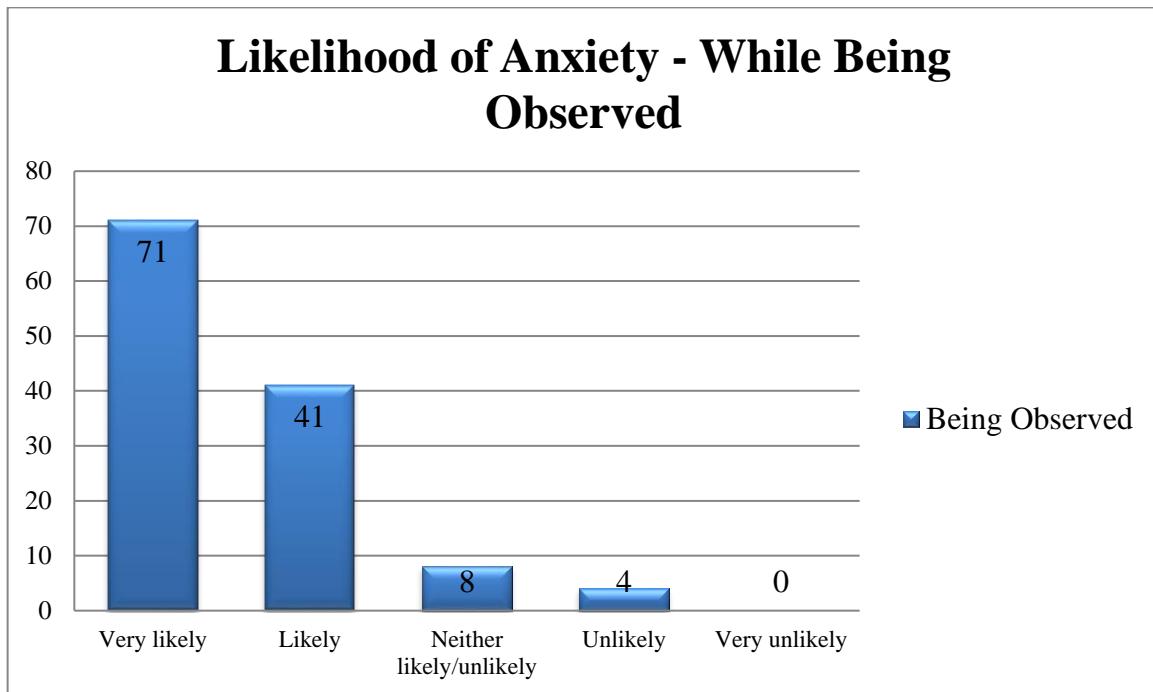


Figure 22: Likelihood of Anxiety – Giving a Presentation

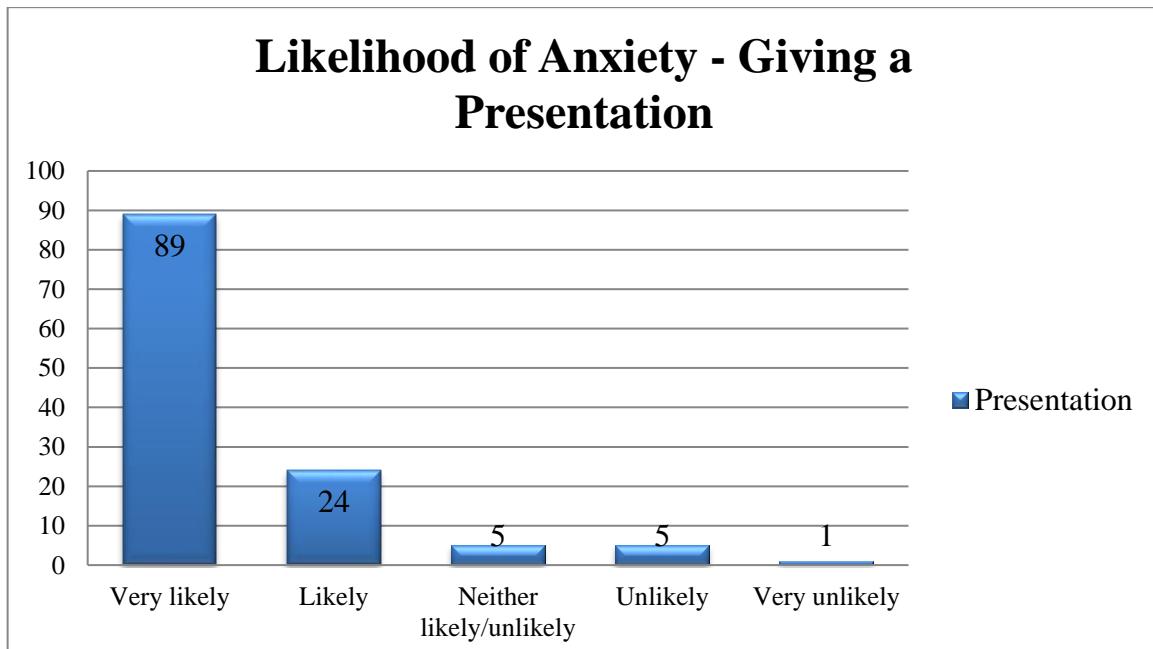


Figure 23: Likelihood of Causing Anxiety – Speaking on the Telephone

