Title: "Towards Compulsive Geographies"

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ABSTRACT

This paper presents a spatial imagining of compulsivity. Deconstructing its medicalised conceptualisation and its rendition through the diagnostic system, the paper offers a performative analysis of compulsive body–world formation. It does so by introducing compulsivity as urging the performance of acts that are unwanted, purposeless, and meaningless, and that nevertheless enlace the corporeal with and through the extracorporeal on unchosen terms. This analysis of compulsions not only develops the dimension of urgency to nonrepresentational theory in cultural geography. It also develops the critical

performative understanding of medicalised phenomena in disability and health geography by considering compulsivity as a more-than-human condition. Indeed, reporting on interviews, participant observations, and mobile eye-tracking sessions with 15 people diagnosed with Tourette syndrome, compulsions seem to emerge from particularly volatile compositions of bodies, objects and spaces. The paper then conceives of compulsivity as articulating the material sensibilities emerging with the body's unfolding situation, and propels it beyond the diagnosable in a broader humanity engaging in material interactions that are felt, rather than known. In addition to a geography of compulsivity, a geographical rendering and ontological centring of compulsions creates a compulsive geography. Ultimately, it situates geographical analysis as crucial to understanding this medicalised performance and as potentially generative of therapeutic outcomes.

KEYWORDS

Compulsivity, Tourette syndrome, Non-Representational Theory, Disability and Health Geography, Performativity, Medicalisation

1. INTRODUCTION

This paper develops a geographical understanding of 'urges', feeling compelled, and the uncanny sensations of indeterminate bodily action. These sensations describe the experience of a compulsion. Compulsivity is a badly understood phenomenon, despite, as this paper argues being of vital importance for

understanding body–world formation that shapes personal geographies. Personal geographies as mediated through the body have been developed from the 1970's. Drawing on humanistic approaches, such geographies are synonymous with mappings of meaning (e.g. Buttimer & Seamon, 1980; Relph, 1976; Seamon, 2017). In the last two decades, personal geographies have also been conceptualised as co-dependent and co-constituted by the extracorporeal world. Geographers working with non-representational theories (e.g. Anderson & Harrison, 2010; Thrift, 2004), post-phenomenology (e.g. Ash & Simpson, 2016; 2019; McCormack, 2016; Wylie, 2006) and post-humanist approaches (e.g. Coyle, 2006; Whatmore, 2002) ontologically centred interactions between body and world, rather than placing the person as already constituted subject at the centre of the world, and rendered them vital. Such work has produced new conceptions of personal geographies through a focus on situated practices (Harrison, 2009; Mol, 2002; Schatzki et al., 2001) and explorations of bodily capacities and abilities (Bissell, 2008; Hall & Wilton, 2017; Hansen & Philo, 2007; MacPherson, 2010). This paper seeks to build on and contribute to such work by making visible how body–world formation is urged. It does this by introducing the medicalised phenomenon of 'compulsivity' as a pre-personal body–world interaction in which the bodily surroundings articulate with and through the corporeal.

As a medicalised phenomenon, compulsions comprise acts that neutralise fear in the case of Obsessive Compulsive Disorder (OCD) and/or "vague somatic

tension[s]" that compel bodies to act in the case of Tourette syndrome (hereafter: Tourette's) (Ricketts et al., 2012, p. 92). Such tensions or urges are experienced as unqualified intensities that induce unwanted and unpredictable interactions with extracorporeal materiality (e.g. through touching, ordering and aligning). These interactions are experienced as purposeless, irrational, and meaningless such that the urge to interact is experienced to emanate *with* the body, but not necessarily *originate from* it (Bliss, 1980; Hollenbeck, 2003). For instance, not the experience of one's hand squeezing a round glass, but one's hand and a round glass in a squeezing interaction. Although compulsive interactions can be postponed (Kane, 1994), their performance is not entirely governable by the person. Instead, this paper demonstrates, their performance should be regarded as exceeding the person. Compulsivity, then, articulates an enlacing of the corporeal with the extracorporeal, and could, as such, be conceived of as producing a 'compulsive geography'.

In its consideration of the condition of compulsivity as a geographical phenomenon *and* individual compulsions as underpinning personal geographies, the paper develops two related points. First, in extending critical work in disability and health geography (e.g. Andrews 2018; Davidson & Orsini, 2013; Duff, 2014; Hall & Wilton, 2017; Mcphie, 2019), it argues that a compulsive geography further unsettles the person and the body from their medicalisation. Indeed, the situational constitution of compulsions demands a corporeally excessive understanding of medical conditions. Advocating this performative ontology, this

paper argues for reconceiving medicalised human conditions as *more-than-human conditions*. Second, based on the first point, the paper challenges the pervading immediacy with which body–world relations are rendered purposeful and meaningful in human geography. Instead, a geographical conception of compulsivity calls for a hesitation in understanding body–world interactions as always and necessarily accessible through sense-making processes, and, as such, governable by the human (but see Dewsbury, 2007; Harrison, 2000). Whilst this further undermines the ontological primacy of the human in non-representational theories, compulsivity is proposed as a tool to think human agency differently.

The special interest in compulsion stems from a lifetime of bearing witness to compulsive touching, ordering, and balancing household items by the author's sister. These performances caused her and others like her great anxieties, and, to date, medical and clinical sciences, with their impetus to identify and, to a certain extent, eradicate such 'symptoms,' have been largely unable to do either. Nonetheless, the study this paper is based on demonstrates how a geographical conception of these acts can take these anxieties away, by highlighting the active involvement and therapeutic potential of objects and spaces with which these performances take place. Without denial and in full awareness of its potential to burden, this approach does not iterate an *a priori* assumption of the phenomenon's incitement of suffering or indeed a requirement for erasure. Rather, it adopts a pre-personal ethics of unpicking the compulsive enlacing of

the body through its expression with those who have necessarily been medicalised. It does so by adopting an epistemology that captures the situational and the experiential. In close collaboration with 15 participants, over an 8-month period, the author conducted a combination of semi-structured interviews, participant observations, and mobile eye-tracking sessions. In addition to shedding light on life with compulsions and Tourette's, the paper sets out to enrich independent coping strategies and environmentally sensitive additions to current and future treatment options.

In order to make this argument, the paper first briefly outlines geography's engagements with medicalised human conditions that constitute particular spatial relationships between the body and the extracorporeal. Second, it deconstructs compulsivity from its medicalisation, in order to render visible and problematize the effects of this medicalisation. Third, drawing on empirical data, the paper reconstructs compulsivity as a vital geographical condition, highlighting its three key dimensions; indeterminacy/anonymity, urgency, and affective materiality/compulsive situations. The fourth and final section develops the implications of a compulsive geography for disability and health geography and for nonrepresentational approaches to personal geographies.

2. MEDICALISED HUMAN CONDITIONS IN/AS GEOGRAPHY

The decontextualized understanding that medical and clinical knowledges produce are recognized as problematic by disability and health geographers (e.g. Cummins et al., 2007; Duff, 2014; Gesler & Kearns, 2002; Gleeson, 1999; Imrie & Edwards, 2007; McLaughlin, 2005). Emphasizing the importance of socio-spatial circumstances in the expressions and lived experiences of (ill)health, (dis)ability and disorders, they demonstrate how medicalised human conditions are inherently related to the bodily surroundings (Chouinard, 1999; Curtis, 2010; Davidson, 2003; Davidson & Henderson, 2010; Gleeson, 1999; Michalko, 2002). Through constructions of diagnostic lifeworlds, they challenge the normative structures that are embedded in the medicalisation of human conditions, and work against narratives of mental and bodily 'failure' to meet societal standards. Simultaneously, this scholarship strengthens foundations for political acknowledgement of the difficulties that life with medicalised conditions presents, to harbour appropriate societal receptiveness and support. Some disability and health geographers have developed ideas of non-normative difference (e.g. Hanssen & Philo, 2007) as well as disabling and enabling personal geographies (e.g. Chouinard et al., 2010). Others have sought to reconstruct life with a medicalised condition through psychoanalytical approaches that trace the importance of meaning in expressions, coping mechanisms and diagnostic identities. Such analyses stress the importance of the geographical underpinning of medicalised human conditions through sense-making processes. For instance, the meaning that virtual spaces (e.g. blogs) may hold in expressions of OCD (Campbell & Longhurst, 2013), and the disturbing experiences of a vanishing self

through dissolving bodily boundaries in agoraphobic lifeworlds (Davidson, 2000a; 2000b; Callard, 2006). More recently, nonrepresentational, vitalist, and other new materialist, performative approaches contend that medicalised expressions or 'symptoms' take place as a result of a dispersal of agency beyond the human. Such approaches see medicalised aspects of life (as well as health and disability) as *co-emergence* of the human with the nonhuman through dynamic and unstable assemblages of materialities, sensibilities, and technologies (e.g. Andrews, 2018; Andrews et al., 2014; Bissell, 2009; Duff, 2014; Greenhough, 2012; Hall & Wilton, 2017; MacPherson, 2010). In order to understand how aspects of compulsivity have spatial underpinnings, it is worth exploring these literatures.

Because, to date, compulsivity following unqualified urges, rather than fear, has been neglected in geographical analyses, the paper turns to medicalised performances that resemble compulsive interactions. Motor and vocal tics are closely related to urge-driven bodily interactions with the environment and are also part of the Tourette's symptomatology. They are generally understood as sudden, repetitive, stereotyped movements or vocalisations.[1] As a consequence of their unintentional appearance, they have been conceived of in terms of their potential disruptiveness to the normative order and of public health and public space (Davis et al., 2004). This study show that dwelling in public spaces can invoke tics and that the presence of others is often mediated by performing tics

[1] Academic publications on Tourette syndrome describe tics closely resembling this description.

in a less noticeable fashion or suppressing them altogether. These mediations are strongly related to the particularity of individual tics. Tics can thus be understood to produce an intricate normative geography that reflects social effects of particular urge-driven performances.

Focusing on the affective resonances of everyday life objects and spaces, Segrott and Doel (2004) studied compulsions that are driven by the fear inherent to obsessions, rather than the unqualified urges that are the focus of this paper. Following OCD-sufferer 'Jane's' washing compulsions evoked by a fear of germs, and the objects with which they are performed shows that such compulsions have an inherently spatial character. They articulate particular relations between the body and the house; different body parts and house 'zones' become involved at different times in line with the rhythms of the day. Conceptualised as spatial practices, these interactions emerge as inherently anticipatory, purposive, and meaningful (see Harrison, 2009 for a more general argument). Indeed, washing compulsions driven by fear are always oriented towards something that 'outlives' them. As such, these compulsions actively create 'geographies of fear', around which the body, other people, objects, spaces and other aspects of daily life become meticulously organised. However, in the absence of fear, compulsions are experienced as unanticipated, purposeless and meaningless in their unfolding, as the only 'drive' for these interactions is the urge that dissolves with the interactions. Compulsions therefore take place outside the usual frames of

anticipated practice, requiring apprehension of the interactions on unintelligible sensory terms.

The argument for understanding human conditions in terms of the unfolding of their expressions as unintelligible and sensory resonates with Chouinard's study of 'bipolar worlds' (2012). The bipolar condition pinpoints the experience of body and world collapsing in on each other and subsequently creating a drive for particular activities that cannot be rationalised beyond the 'manic episode' they come to qualify. Writing with the 'sensitive autistic body' to render autism spatial, Davidson and Henderson (2010) infer that rather than bodily activities, for the self-identified ASD[2] authors, the bodily surroundings fail to be anticipated and recognised. Objects and rooms acquire some kind of meaning in the moment and in the situation, but remain incomprehensible beyond the current circumstances. This causes experiential difficulties in relating to spaces, such as with the rooms of a residential house after the moment has passed (Mills, 2008). Gerland (2003, p. 21 as cited in Davidson & Henderson 2010) elaborates;

> *"If my mother said something in a violet-coloured way in the kitchen and two months later used that violet tone of voice in the bathroom, I suddenly realized that the kitchen and the bathroom had something to do with each other."*

[2] Autism is grouped with similar conditions under the heading of Autism Spectrum Disorders (ASDs) in the DSM-5

Describing synesthetic perception, in autism, comprehension of spaces develops on embodied and affective, rather than discursive, terms. In negotiating the absence of other ways of knowing spatial relations, body rocking (Cowhey, 2005), “touching something with continuity” (Lawson, 2005, p. 109 as cited in Davidson, 2010) and keeping familiar objects close and in sight (Davidson, 2010) become dominant means to ‘place’ oneself. These continual sensory reinstatements of the corporeal with the extracorporeal reframe materiality as outside or beyond functionality, aesthetics, or even ‘thingness’ (see Bennett, 2010), and rather as material ‘anchor points’ for such a personal geography. In the absence of anticipated goals and meaning, geographies then emerge on different, radically sensory, strata that further challenge conceptualisation based on spatial practices or cognitions. This suggests that geographies emergent with ASDs, and compulsivity likewise, require a radically different epistemology (see Davidson & Orsini, 2013), one that captures the interaction as a momentary and in situ occurrence (see Author & Anderson 2018). Here, personal geographies emanate, first and foremost, as sensory ‘worldings’, which helps us to imagine personal geographies beyond meaning and consisting of bodily interactions, as would approximate to a geography of compulsivity.

This section has demonstrated the different kinds of disruptions of rationality, purposiveness, and meaning in the body–world formations that produce personal geographies of medicalised conditions. As such, the paper thus far demands a focus on small movements and gestures that cannot readily be conceptualised

as spatial practices, and a focus on perceptions that cannot readily be grasped through maps of meaning. Arguably, these small gestures and fleeting perceptions are vital for better understanding the personal geographies they create, and, by extension, the lived realities of people with a medicalised condition. Therefore, precisely body–world relations that have been medicalised benefit from a nonrepresentational approach because of its affordance to render visible such actions and perceptions (see also Hall & Wilton, 2017; Schillmeier, 2014). Vice versa, this section already starts to demonstrate how the development of nonrepresentational theories in geography could involve medicalised aspects of human life. The next section deconstructs the medicalisation of urge-driven compulsions as associated with Tourette's. It explores both its effects on the current conceptualisation of compulsions, and the ontological implications of understanding compulsivity as a human condition.

3. DECONSTRUCTING THE MEDICALISATION OF COMPULSIVITY

This section analyses and deconstructs the medical conception of compulsivity in order to re-conceive of it as a geographical phenomenon. Whilst compulsivity is associated with diagnoses such as TS, Autism Spectrum Disorders, anxiety disorders, and Attention Deficit Hyperactivity Disorder (ADHD), its formal medical description employs it within the diagnostic context of OCD. The most recent 2016 WHO International Classification of Diseases (ICD-10 F42) describes compulsions as:

"acts[3] *(…) that are not inherently enjoyable, nor do they result in the completion of inherently useful tasks (…) [they are] pointless or ineffectual (…). Anxiety is almost invariably present. If compulsive acts are resisted the anxiety gets worse".*

The most recent (fifth) edition of the American Psychiatric Association's Diagnostic and Statistical Manual (DSM-5) largely overlaps with this, but adds that compulsive acts often involve "repetition", "certain rules that must be followed exactly", purporting the prevention or reduction of "distress", emphasizing that they "are not connected to reality", and "may provide a release from tension". Whilst these formulations might not speak to the imagination, they do clearly reflect a breach with a rational, purposive and meaningful humanity. However, these reflections only conceptualise compulsivity in response to obsessivity, therefore compulsions have exclusively been regarded as a reactive, *ancillary structure*, but never on material terms of their situatedness. As such, their medical conceptualisation seems rather reductive, which potentially omits the development of a richer understanding of them (for more general arguments see Callard, 2014). The medical conceptualisation of compulsions thus frames them in line with the foundations of a biomedical diagnostic system. The discourse guiding diagnostics involves an iterative process[4] of considering collections of different expressions already, or not yet, belonging to individual diagnoses.

[3] These definitions do not distinguish between purely corporeal acts and interactions with extracorporeal entities.

[4] The DSM is published in new editions reflecting the development of the insight in the diagnoses. The DSM-5 was published in 2013, in which the TS diagnoses differed slightly from the its formulation in the DSM-IV-TR, published in 2000.

Stabilising the difference as and in symptoms associated with similar diagnoses is an exclusionary process rather than an exercise in finding the best description of the acts that cause suffering. In other words, the symptoms that form the diagnostic criteria of OCD differ from those of TS, whilst symptoms that are not deemed diagnostic criteria can emerge with multiple diagnoses. Notwithstanding the therapeutic effect diagnoses can have on sense-making processes of individuals diagnosis, a diagnosis as such, thus pins down only a fraction of their everyday experiences.

Reconceiving a medicalised urge-driven compulsivity as a geographical phenomenon that has been developed within the Tourette's diagnosis is problematic and requires consideration in four ways. First, Author (2018) points out that those diagnosed with Tourette's are also prone to experience compulsivity connoting fear in addition to or instead of unqualified urges, despite not being diagnosed with OCD. Therefore, it cannot be assumed that compulsions performed by a person with a Tourette's diagnosis are always urge-driven, which, in turn might explain the wide variety of prevalence estimations. Secondly, clinical debates on the conceptualisation of compulsivity specific to Tourette's are ongoing, and its definition has gone through substantial changes (for an extensive account see Worbe et al., 2010). As compulsivity is not a criterion diagnostic of TS, it is consigned to the status of a 'fringe' phenomenon, receiving far less academic attention than the diagnostic criteria of motor and vocal tics. To date, conceptions of urge-driven compulsivity in Tourette's include

‘compulsions’ (e.g. Robertson & Cavanna, 2007). ‘obsessive/compulsive symptoms’ (e.g. Cavanna et al., 2009) ‘compulsive-like tics’ (e.g. Robertson et al., 2008), ‘repetitive behaviour’ (e.g. Leckman et al., 1994; Neal & Cavanna, 2013), and ‘repetitive phenomena’ (including thought in addition to action) (e.g. Cath et al., 2001). This demonstrates that, to date, capturing urge-driven compulsivity in clinical terms has been problematic.

Thirdly, diagnostic practice requires an articulation of symptoms with a particular frequency and severity, which constitutes an artificially imposed threshold. Both the mobilisation of this threshold in itself, and the dependency on motor and vocal tics articulating with the ‘right’ frequency and severity leaves a conceptual and empirical knowledge gap (see Callard, 2006). This unveils a more fundamental problem of the conceptualisation of human health conditions based on diagnostics, which is particularly pronounced with compulsivity. Whilst diagnostics are premised on symptoms that can be observed from the outset by a medical expert, they are always assumed expressions of an underlying neuropsychiatric problem (for the concerns this raises see Pykett, 2017). Consequently, Tourette’s ‘exists’ as a difference anchored in the brain; neural structures and fluids and brain capacities need to differ from non-Tourette’s brains. This makes Tourette’s an epistemological *constant*. Tracing compulsivity then becomes an affair of the nervous system in which it is *already accomplished*. In other words, the medical epistemology always assumes an *ongoing presence* of Tourette’s in the brain. This renders an ontological dispersal of Tourette’s

beyond the brain, or body, obsolete, which, according to Kushner (1999), could be problematic.

The positivist rejection of the experiential and situational as valid knowledge for medical conceptualisations of compulsions leaves largely unanswered the question of why they take place in the way they do, and why they take place in particular situations (Pykett, 2017). Indeed, Tourette's does not have an ongoing presence because compulsive interactions, or the urge to engage in them, do not occur incessantly. Evidently, compulsivity and other Tourette's related phenomena, such as echolalia – echoing sounds and words upon hearing them – echopraxia – imitating movements of other human bodies – and coprolalia – uttering words and phrases inappropriate to the social context – occur with the immediate bodily situation. Therefore, the ontological constitution of Tourette's needs to be allowed to (also) emerge and vanish on a momentary basis; presencing Tourette's in urges and compulsive interactions, and absencing it in the lulls in between. Therefore, regarding the neural system alone fails to explain the timing and kind of compulsive urges and interactions. Therefore, the changing affective situation of the body could be considered as instigating the process, and opening up possibilities to conceptualize compulsivity as something beyond the brain, and beyond diagnostic boundaries.

Fourthly, current research and treatment of Tourette's render the embodied situation static, and of snapshot duration in the laboratory conditions of doctor's

offices, therapy rooms and hospital chambers, as opposed to the body being mobile in the familiar spaces of the home, classroom or workplace. Such embodied situations tend to bring out purely bodily phenomena, but hardly any compulsive interactions. This appearance of Tourette's then forms the basis upon which medical conceptualisations and treatment are developed, which Turtle regards as potentially problematic; "Only I am with me all the time, however, so only I can see the truly chaotic nature of the day-to-day and hour-to-hour variation in my tics" (Turtle & Robertson, 2008, p. 451). Nonetheless, this "truly chaotic nature" is explicitly reflected in the strong differences of motor and vocal tic occurrence during activities (O'Connor et al., 2003) as well as different places (Goetz et al., 2001). Consequently, compulsivity as rendered through the Tourette's diagnosis escapes conceptualisation through such medical scientific epistemology. Responding to this escape, an approach with onto-epistemologies that include its perceptive, performative and in situ dimensions arguably captures more of its intricacies. Indeed, a geography of Tourette's differs markedly from a geography of compulsivity.

This section has demonstrated how a medical and clinical conceptualisation of urge-driven compulsive interactions severely troubles understanding the actualised performances and the personal geographies they incite. Simultaneously, it has demonstrated how and where a geographical approach would augment medical and clinical conceptualisations of compulsivity. The next section elaborates on the ways in which this study rendered urge-driven

compulsivity spatial by focusing on its experiential qualities and the situatedness of the acts.

4. A GEOGRAPHICAL COMPULSIVITY

After the deconstruction of its medical conceptualisation, the remainder of the paper develops compulsivity as unqualified and urge-oriented body–world formation in relation to its spatial capacities. This conception arises from an empirical study that sought to explore the possibilities for a geographical approach to offer new insights in these unwanted acts where medical and clinical sciences could not provide a solution. It aimed to offer new insights into the lifeworlds of those having to interact compulsively, start considering how everyday spaces may have therapeutic potential, provide recommendations for coping strategies, and improve the effectiveness of behavioural therapies outside treatment rooms. Also, drawing new audiences to the voices of those with a compulsive condition should stimulate more participative studies and develop a vocabulary reflective of experiential aspects.

The research focussed on urge-driven compulsive interactions, which were studied through collaborations with 15 research participants, who were recruited on the basis of their experience with performing compulsions. These participants were necessarily recruited through Tourette syndrome communities (e.g. the Dutch patient organisation, a specialist clinic, and social media forums).

Recruitment excluded people with a Tourette's diagnosis who did not perform compulsions, and the 15 participants all had multiple other diagnoses alongside Tourette's (e.g. ADHD, OCD, ASDs). The study involved in-depth interviews, participant observations, and mobile eye-tracking sessions over an eight-month period in the Netherlands. Mobile eye-tracking is a method that captures the visual and auditory appearance of the bodily situation in real-time. Tracking the gaze of the research participant, wearing glasses incorporating an embedded laser system embedded, it produces an HD recording with an indicative red dot (see Author & Anderson, 2018). Mobile eye-tracking can extend synesthetic vocabularies and enable discussions of "sensory experiences in ways and in detail previously prohibited" (Spinney, 2011, p. 176), as well as envision new microspatialities of the body and invoke new "politics of time and space" (Thrift, 2004, p. 67). However, the method has also raised concerns about ethics and privacy (Wilhoit & Kisselburgh, 2016), and gaze detachment and objectification (Crang, 2003). These concerns were addressed by the provision of written information, discussions, and by giving the participants a decision on the audiences their recordings could be shown to. The method's potential to change 'natural' behaviour (Laurier & Philo, 2006) and overclaim of the authenticity and capture of recorded events (Merriman, 2014) are largely irrelevant for this study. The study was conducted in places familiar to the participants (e.g. the home, shops, cars, public transport, schools, and natural areas), and took place on their terms. All participants appear under a pseudonym, and informed consent on research participation, and the usage of the data was obtained.

The data record compulsions that involve extracorporeal elements on the basis of the participant's memory and through observations by the author during the research meetings. The compulsive aspects of ongoing body–world engagement were identified during and after the observations and eye-tracking sessions in deliberation with participants, as well as through the author's own sensibilities[5]. The analysis focused on sensations, the material and social circumstances of compulsions, usage and set-up of objects and spaces, and implications for 'other-than-compulsive' life. Broad themes derived from the literature were employed as codes in NVIVO in the analysis of the interview, observation, and fieldnote data. This allowed for making connections across the different datasets, and for new themes to arise within these codes, from which spatial and experiential patterns of compulsive interactions emerged. The eye-tracking data was analysed on the composition of bodies, objects and spaces in the participant's perception prior, during and after the compulsive interaction, by playing the recordings at 50% speed. Emerging from connections between, and abstraction of, combinations of analytical codes in cross-examination with perceptual configurations of the corporeal and extracorporeal materialities, three dimensions of a spatial rendition of compulsions appear most striking. Set out as subsections, 'Indeterminacy/anonymity' explores subjectivity in the compulsive performance; 'Urgency' develops the immediacy with which the corporeal becomes 'enlaced'

[5] These had developed over a lifetime of experience with the author's sister, who, as stated above, performs compulsive acts and is diagnosed with Tourette's.

with the extracorporeal; and 'affective materiality/compulsive situations' traces the bodily engagement into compulsive situations with affective extracorporeal entities.

4.1 Indeterminacy/Anonymity

In their quantification of compulsions, medical and clinical sciences have not provided explanations of the *what*, *when*, *where*, and *how* of compulsive interactions. Nonetheless, compulsively touching, ordering and aligning of objects and bodies happens in myriad ways and with a plethora of matter, which makes people like 'Ginny' (44) feel insecure about the effects:

> *"Sometimes I can more easily do it – and that I can just let go of it all*[6] *– than other times. That all depends on the state I'm in, I think… with my being.*
>
> Yes I thought that.
>
> *That's also the ambivalence, that you're never constant (…) and that I find quite difficult."*[7]

Despite routine occurrence, some compulsive interactions are not initiated by the person involved and are experienced as radically unpredictable. Indeed, some compulsions are not consciously performed and/or remembered (Author, 2018),

[6] To clarify, she says that she "can let go of" the anxiety of *having* to perform the compulsive interactions and tics, but not the interactions themselves. She and other participants discuss this in similar terms.

[7] The quotations are translated from Dutch, which often differs from English on its activation and passivation of sentence elements. Objects and spaces were more strongly expressed to 'work on' the person, and preserving the 'thrust' and affections of the statements might affect their readability.

and almost seem to *overcome* the person performing them (see Bliss, 1980). ‘Sage’ (25) reflects on the eye-tracking recording, watching herself touch the TV-stand compulsively whilst cleaning it:

> *“It’s a fraction [of time], you know, that I have to touch the material just that little bit longer, but that is not something… noticeable, you understand?*
>
> Yes.
>
> *So it’s a sensation that I do feel, but it goes so fast that you can’t really register it.”*

Often, such undeliberated interactions leave people like Sage feeling witness to, and unable to assign themselves any dominance over, their compulsions. ‘Mina’ (40’s) argues: “it just runs away with you, it just, you’re just completely powerless”. The ‘it’ in Mina’s remark is sensory and does not involve a demanding inner voice (Bliss, 1980). Compulsivity thus does not seem to mark an ‘overriding’ subjectivity, but rather the *falling away* of one. Indeed, whereas other-than-compulsive touching and ordering interactions often can be made sense of via processes of signification (Paterson & Dodge, 2012), compulsive interactions cannot. ‘Rhys’ (24) elaborates:

> *“Yes, thingies… proclivities of sorts (…) also without reason (…) People who constantly check if the door really is closed… then, maybe then does it have some kind of reason at its core, but then out of proportion? Whilst the things I do really… don’t… have a kind of eh… rationale… meaning”*

More precisely, any inclination towards rationality, meaning, and purpose of compulsive interactions – if experienced at all – does not extend beyond the interaction itself (Dalley et al., 2011). This might contrast with psychological literature that conceptualises the experience of performing compulsions as restorative of situations that are 'not-just-right' (Leckman et al., 1994). Not-just-right feelings imply "an inner drive that is connected with a wish to have things perfect, absolutely certain, or completely under control" (Rasmussen & Eisen, 1992, p. 756). Participants demonstrate that a 'rightness' of the situation is not envisioned *prior to* the interaction, and only exists *on reflection*, if realised at all. During the interview, 'Elisa' (35) shows the spare bedroom that she had designed to be just right; not in terms of aesthetics or function, but in terms of her compulsive sensibilities, which can overlap with these categories, but are distinctly different. Compulsive interactions between the corporeal and extracorporeal thus remain undetermined until they take place, and cannot necessarily be explained other than through 'just-rightness'.

Compulsivity, then, demonstrates that structures of meaning and purpose should not too readily be imposed on body–world interactions. As a consequence, preconceived ideas about how objects, their composition, and spaces are performative should not be adopted over hastily. 'Lowri' (24), for example, argues "if a corner is right in front of me, I evade it", which means that she positioned her sofa accordingly, and 'stepped over' the lines projected from corners when walking through her living room. Spaces thus seem to be engaged with on

radically differently conditions than those in which other-than-compulsive interactions are conceived. A ‘compulsive production’ of space is attentive to ways in which bodies resonate with spaces on material terms. As such, invoking a particular space as living room surpasses its compulsive potentialities, and in turn, compulsive interactions in a living room do not necessarily affirm a 'living-roomness'.

4.2 Urgency

Sensory urges, which often precede compulsions, may be experienced as a tingling or prickly sensation that increases in discomfort with passing time. ‘Alan’ (67) animatedly explains trying to suppress urges:

> *“Now it itches here, now it itches there, then it itches like this, then it itches like that… I’ve tried it before, like; ‘well… just ignore it… just continue living!’ But that is just not possible!”*

For ‘Nora’ (60’s) it is possible to suppress her urges, but doing so for too long feels like a

> *“Volcano… it starts boiling here a bit *points at her chest*, and then it builds and builds and builds until, until, until it can’t no more, and baf! There it is.”*

Urges pinpoint the location of the immanent compulsive interaction in the situation of the body with the extracorporeal, which disrupts ongoing body–world engagements with violent immediacy. Watching his eye-tracking recordings,

‘Siôn’ (41) comments on interrupting setting the table for lunch by re-ordering the cushions on the sofa three times within 10 minutes:

“It’s not that I plan to… an hour before, think, like ‘this is not right, I still need to do this.’

No.

It really just arises in me, or something (…) ‘I am moving this thing <u>now</u>.’

Whilst you hadn’t necessarily finished setting the table.

No, no certainly not!”

Urges can be felt throughout the body, and most often in body parts that require involvement in the compulsion, such as in the fingertips to touch something. Referring to two small stuffed animals, ‘Sara’ (21) argues that she feels her hand “tingling when [she] doesn’t hold them”. Therefore, she always has to have them at hand when awake. Additionally, feeling the threads rolling between her thumb and index finger reduces anxieties of travelling in public transport. Whilst this particular compulsion has a calming effect, the urge to interact compulsively can be very stressful and emotional (Neal & Cavanna, 2013), and can involve having to perform harmful acts. Sage elaborates:

“I always press objects hard in my fingertip.

Your index finger?

Yes, so it’s, I don’t just touch it, but also press it very hard. That’s why I <u>really</u> dislike knives.”

The unqualified aspect of the urge is affirmed within the interaction itself, as the potential for compulsive interaction is prioritised over the object's function. Eye-tracking recordings show, for instance, that Alan repositions long wooden slats to align with the edge of a workbench in his garage. Urge sensations thus denote resonation between particular materialities and sensibilities, and urges address objects in terms of their material qualities, and how these are shared with body parts or other objects (Author, 2018).

The experience of the urge can, then, be considered the becoming-compulsive of the body, of which its tension can only dissipate through engagement with particular extracorporeal materiality. However, whilst compulsive interactions take place with urgency, this in no way indicates a return to environmental determinist notions of body–world engagements. Indeed, urges move the body to act, but remain radically open-ended in terms of what exactly the body is required to do to relieve the urge. For instance, Siôn (41) can be seen to interact with a milk carton seven times, and every time he relocates it, the urge sensation is sufficiently reduced to acceptable levels. Eventually he bins it. He thus actively chooses his involvement. Accordingly, these urges indicate a particular affective composition *between* the body and its constituencies. Interrogating the spatial situation of the corporeal with the extracorporeal upon which urges unfold helps to map a resonance between particular neural processes, bodily sensibilities and capacities, affective extracorporeal materiality, and spaces as a personal geography.

4.3 Affective materiality/Compulsive situations

As the previous subsection concluded, compulsivity incites a particular enlacement of the body with the world that always has the potential to urge a person to interact with their surroundings. This anticipation to be urged into a compulsion produces a bodily disposition that is experienced as 'hyperattention' (Kane, 1994) or 'hypervigilance' (Crossley & Cavanna, 2013) and makes bodies feel "pathologically 'itchy'" (Bliss, 1980, p. 806). This disposition results in an incessantly acute experience of anything touching the skin that is not-just-right (e.g. feeling the label in the back of a shirt) or of an object composition that is not-just-right (e.g. cushions on a sofa). Ginny (44) describes taking small black bits from the sink and binning them, as shown on the eye-tracking recordings:

> *"I find the colour deviating, those black thingies… yes, it's <u>also</u> nice that it's cleaner, but also that these thingies deviate too much in colour…. At least, that disturbs me, you know, more before anything else.*
>
> In colour?
>
> *Yes, just that then there is, that there's just, that you see it, that it deviates from the rest. Say… just like when you see a small skin blemish or something, and that you keep looking at it."*

Here, compulsivity for Ginny is not articulated in terms of cleanliness, 'thingies', or their blackness *as such*, but in their difference from the sink. This hypervigilance renders the body attentive to clothing, other objects, and spaces

as they change composition through movement. For instance, the edge of a table aligning with lines in the laminate floor upon entering the room, and the edges of its legs aligning with the side of a T.V. stand when seated on the sofa. Such movements produce shifts in shared body, object, and space dimensions, which places them always on the cusp of actualising compulsive potentialities. These compulsive potentialities seemingly locate *in* the implied extracorporeal materiality (Karp & Hallett, 1996; Turtle & Robertson, 2008). A recurring compulsive interaction involving 'Bill' (50) encompasses rubbing the door handle to his living room and hallway toilet in an elaborate way every time he walks through the door. Sat in his lounge chair whilst reflecting on the eye-tracking recordings, he says:

> *"Yeah, only when I open or close it [the door].*
>
> Do you still feel them [door handles]? Because during the interview[8] we discussed it and you said 'I feel them... in my hands'.
>
> *Yes, I did <u>feel</u> it."*

He and other participants did not only express being compelled to compulsively interact with materiality, they also felt that these objects had become part of their sensorium, and as such had become powerful. Compulsivity can then be considered as involving the experience of sensations occurring *to* an object (Turtle & Robertson, 2008). Resembling feelings arising in phantom limbs (Bliss,

1980), this extends the body with the capacity to 'feel' – not touch – materiality from a distance, as 'Dylan' (22) describes:

> *"Often it [a chair, bottle, pillow] exerts some kind of power on me or something… it does feel like that a bit, but ehm… that I just really have to grab hold of it."*

In compulsive interactions, extracorporeal materialities can be experienced as provocative, and, according to Mina, can "tempt" the body into interactions. In these kind of ´violent´ compulsions, the human *is interacted with* by the nonhuman. This creates particular spatially dispersed sets of pushes and pulls that work on the body and develop on the basis of perceptions that highlight different dimensions of objects, spaces, and the body. A compulsive geography then emerges from the spatial dispersal of interactions that had urged a person's involvement through uncanny sensations, and affirms an affective register between bodies, objects, and spaces.

In the above engagements and experiences, compulsions seem to emerge from a multiplicity of spatially dispersed phenomena. Therefore, they cannot be ascribed entirely to the body, extracorporeal materiality, or even subjectivity, but are excessive to all. If nonhumans are accepted as being active in the unfolding of a condition (see Grosz, 2005; MacPherson, 2010; Mcphie, 2019), such that the category of the human, in terms of the body, psyche, and brain, is not exclusive in governing it, *human conditions* become *more-than-human conditions*. Indeed, compulsions emerge and dissolve as spatial assemblages that are outside, and

therefore challenge the necessity for premising body–world formation on the functionality, aesthetics, and capabilities of objects, bodies, and spaces beyond the interaction. In conclusion, through the unwanted and meaningless interactions, compulsivity pinpoints body–world formations that highlight dimensions of more-than-human urgency in personal geographies.

5. TOWARDS COMPULSIVE GEOGRAPHIES

Thus far, this paper has developed a spatial account of compulsivity by focusing on its performative and experiential aspects. Doing so, it has shown that compulsive interactions both support and challenge well-established ideas about body–world engagement. The final two subsections develop the implications of a compulsive geography for geographical enquiries into medicalised phenomena, as well as for nonrepresentational body–world relations. To this end, they propose ways in which compulsive geographies could contribute to current debates in human geography and beyond.

5.1 Medicalised compulsivity as a more-than-human condition

Disability and health geographers have demonstrated that medicalised conditions articulate with particular spatial-temporal situations. Developing the foundations for a compulsive geography, this paper further destabilises the requirement for diagnostics and offers a performative and experiential approach to medicalised conditions. It thus does not argue for an abandonment of employing diagnostics

in geography, but supports critical moves to re-evaluate *always* and *necessarily* employing diagnoses when approaching particular sets of medicalised body–world relations. Additionally, the paper emphasizes that rendering compulsivity spatial on performative terms could invigorate new cross-fertilisations between geography and medical and clinical disciplines. This enhances critical reflections of disability and health geography on the psychiatric ordering of bodies and conditions, and further builds on earlier activist work (e.g. Chouinard, et al., 2010; Colls, 2012; Moss & Dyck, 2003; Parr, 2002; 2004) through a qualitative mapping of suffering that emerges between bodies, objects, and spaces. Indeed, such geographies could shed new light on how diagnoses and medication are performative in the realms of everyday life, and what ethical issues this bears (Callard, 2014; Flore et al., 2019).

Mapping compulsive *interactions*, rather than *bodies*, may extend the vocabulary of disability. This might contribute to finding alternatives for potentially oppressive aspects of disability as ongoing identity (Kobayashi, 1997; Singer, 1999), which renders bodies comparable and measurable on potentially false premises (after Canguilhem, 1973 as cited in Philo, 2007; Deleuze & Guattari, 2013). Reconceiving disability as emergent with the embodied situation allows for employing the affected person as inherently capable, which is arguably a more empathetic point of departure to study human conditions (see Hall & Wilton, 2017). Indeed, shifting the normative ontology from a disabled body to a disabled interaction lifts disability as identity and places it on disabling performativity of a

situation, which incites a posthuman ethical appreciation (Coyle, 2006; Mcphie, 2019). As a consequence, the stigma that haunts many conditions would uncouple from the body and reattach to body–world relations (Pinder, 1995), and could therefore, at least partially, lose harmful effects. In affirmation of the experience that the nonhuman as much – or more – than it is the human (biologically, psychologically or otherwise) that incites compulsions, people suffering from compulsivity could benefit from these findings in a number of ways. For instance, as part of current behavioural therapies (e.g. Exposure and Response Prevention) already a greater emphasis on compulsive interactions at home and other familiar spaces, and identification of particularly evocative *and* calming objects in these spaces. Furthermore, as part of a geographically sensitive coping strategy, people who suffer from compulsivity could change the set-up of a room in the house to prohibit certain recurring and/or harmful compulsive interactions from happening.

The ontological shift from compulsivity as human phenomenon to a performance that is co-constituted by the bodily environment suggests that a compulsive geography pertains to a wider humanity. In line with the psychological model of mental illness, phenomena conceptualised as symptoms occur along a continuum. To varying extents, *all* human bodies would have the capacities for experiencing urges to interact compulsively with particular situations. As such, compulsive geographies would render visible the tiny in-between acts that we ‘catch ourselves doing’ and do ‘without thinking’ (but see Bissell, 2011), such as

stepping on the middle of the flagstones in the pavement. Such interactions often fail to last a memory, but can be useful and even enjoyable (Goldman, 2012); for instance, fidgeting is thought to sustain bodily negotiations of stressful situations (Farley et al., 2013). Rendering these acts compulsive would actualise “the inherent and continuous susceptibility of corporeal life to the unchosen and unforeseen” (Harrison, 2008, p. 427).

5.2 Non-representational compulsive geographies

Conceptualising compulsivity as productive of a personal geography can be sustained by and can support non-representational, post-phenomenological, and posthuman approaches to corporeal relations. As the study described a particularly sensitive body that is connected to its surroundings in ways that have previously gone unnoticed in human geography, compulsivity could be posited as another way of attuning to the material environment. Arguably, it may contribute to new understandings of sensuous dispositions (Harrison, 2007; Paterson, 2009) and conducting research with the body (Paterson & Dodge, 2012), despite the study finding that compulsivity can be excessive to human experience (see McCormack, 2016). A compulsive geography therefore sustains ongoing calls to refrain from assuming an already constituted subject (see Dewsbury, 2007). Rather, compulsivity could be conceived of as a particular subjectification process *with* the body, upon which meanings, nonhuman affects, and rationalities could be mapped.

A compulsive geography could also help to revamp geographical approaches to the lifeworld (e.g. McCormack, 2016; Seamon, 2017) through performative ontologies of particular brain structures resonating with particular object and space compositions. This opens up new possibilities of recasting bodily capacities whilst revoking a universal body (see Moss & Dyck, 2003), as differences between bodies can articulate through and within vital interactions. Compulsions furthermore incite rethinking human geographical approaches to objects on different terms: potentially by developing non-essentialist conceptions of objectness (e.g. hardness or sharpness) and considering them as having capacities to demand touching, aligning and/or ordering in correlation with 'allure' (see Ash & Simpson, 2019). This could help thinking through object-oriented ontologies that reimagine human–object interactions and the way they shape circumstances for human worlds (McCormack, 2016). A compulsive geography ultimately responds to Anderson and Wylie's call to identify *what* and *how* materiality "becomes a *question* posed: simultaneously, a provocation, incitement, enigma, and promise (Grosz, 2001)" (2009, p. 332 emphasis original).

This paper has demonstrated that the body becomes enlaced into, but does not instigate, a compulsive interaction. Therefore, the spatialities created with compulsive engagements emerge from, and are bound by, the body–world assemblage territorialised by the urge (after Deleuze & Guattari, 2013). Moreover, with the urgency that expresses in sensibilities, compulsive engagements seem to expose how certain configurations of elements of bodies,

objects and spaces can become volatile beyond the realms of comprehension through existing sense-making practices. Spaces with familiar significations (e.g. kitchens) then become recognisable through the specific *compositions of compulsive potentialities* – actualised with different bodily situations – that recur with different compulsive interactions. This allows for reimagining the body as always performative of the evolving worldly affects. Compulsivity might then illuminate a new kind of affective ordering of bodies, objects and spaces. Such orderings in compulsive moments might, in turn, map where a person is consistently disturbed by urges, and where, in the absence of urges, they thrive. These affective resonances of compulsions create new geographies of therapeutic potentials of ordinary spaces. As such, compulsive geographies consist of micro-ecologies of power differentials that present the capacities of spaces to even interfere with, for instance, superimposed normative power structures from the State (Author, 2019). Therefore, the paper stresses that compulsivity could be seen as part and parcel of unravelling personal geographies through embodiment. Indeed, mobilising compulsion allows Anderson and Stoodley (2018) to analyse the overwhelming necessity for surfers to surf felt as urged embodiment of the wave, water, surfboard and sun.

This begs the question as to what implications urge-driven compulsivity as spatial phenomenon might have for the construction of knowledge in human geography. How could compulsions teach us something about conceptualisations of space, and should we take note when considering processes of body–world formation?

When constructing knowledge about spaces we tend to rely on structures of signification and representation (e.g. kitchen), as well as on sensory information and processes of sense-making. Nonetheless, this paper established that compulsivity cannot be understood through these systems of knowledge construction. Indeed, compulsions *demonstrate* that in the analysis of personal geographies, we cannot necessarily rely on predisposed knowledge of a space (see Harrison, 2000; Dewsbury, 2003). Therefore, the paper encourages to formulate conceptualisations of spaces as articulated in the simultaneous emergence of bodily and worldly materialities and sensibilities (see Wylie, 2006). Whilst such geographical practice of knowledge construction is not new, compulsivity incites us to attune to unqualified sensations of urgency *in* and *with* the body and *in* and *with* the extracorporeal as space-making process. Urges and undetermined bodily interactions with the extracorporeal should be considered as sources of knowledge that underpin spatial understanding upon which personal geographies unfold. Such sensations should, therefore not immediately be inflected as purely psychological phenomenon, or worse, as a psychological phenomenon that is or should be pathologised and is therefore limited in the claims it can make.

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