NEGOTIATING ORGANIZATIONAL IDENTITY WITH OBSESSIVE-COMPULSIVE

DISORDER

by

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Negotiating Organizational Identity with Obsessive-Compulsive Disorder

Dissertation directed by Professor Timothy R. Kuhn

Abstract

Negotiating Organizational Identity with Obsessive-Compulsive Disorder

This organizational communication research study investigates the ways in which individuals with obsessive-compulsive disorder (OCD) narratively negotiate their organizational identities. Thirty-four adults with OCD were interviewed, and the findings from this study suggest that participants drew on a particular set of discursive resources to account for, justify, or explain their organizational behavior, organizational or career position, manifestations of OCD, misconceptions of OCD, and the stigmatic identity of being "mentally ill." These discursive resources include *normalcy*, *organizing and economy*, *medicine*, and *personal life scripts*. Theoretically, this study has implications for the ways in which OCD, identity, and organizational communication are studied. The practical application of this study is a communication intervention for adults in intensive treatment for OCD, which includes recommendations for the meaning management of discursive resources in the workplace.

Dedication

This dissertation is dedicated to my participants and adults suffering from obsessive-compulsive disorder. You are not alone or forgotten.

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[1] Pseudonym

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CHAPTER 1

INTRODUCTION

Obsessive-compulsive disorder (OCD) is a "neuropsychiatric disorder characterized by obsessions or compulsions (or both) that are distressing, time-consuming, or substantially impairing" (Grant, 2014, p. 646). OCD affects 2-3.5% (Marques et al., 2010) of the population and has shown to be a significant barrier for gaining and maintaining employment (Neal-Barnett & Mendelson, 2003). Furthermore, individuals with disabilities (like OCD) tend to face identity management issues in the workplace, like managing the visibility or privacy of their illness (Skully, 2010). Consequently, individuals with OCD face many problems in the workforce and workplace.

As will be discussed in further detail later, medical research has addressed these problems by investigating ways to improve clinical OCD treatment, with the assumption that an improved mental health condition will improve employment opportunities (e.g., Abramowitz, Taylor, & McKay, 2009). Disability research has investigated these issues by theorizing generally about hidden disabilities, identity management, and agency (e.g., Braithwaite, 1991). Organizational communication research has addressed the problems individuals with OCD face in the workplace by advising managers and employers on how to handle the potential threat to productivity these individuals with problems may present (e.g., Tyrer, 2014). However, research has failed to adequately examine the communicative, qualitative experiences of individuals with OCD when it comes to their relationship to processes of organizing, and more specifically, how individuals with OCD account for their organizational behavior and outcomes. This type of investigation is needed to better understand the issues and problems that plague individuals with OCD in the

workplace and workforce, as well as conceptualize how individuals with OCD negotiate their identity in relationship to processes of organizing, which this dissertation is seeking to address.

Perhaps the most famous (at least in scholarly literature) example of an individual experiencing problems associated with their OCD in the workplace is Carolyn Humphrey, who was fired from her position as a medical transcriptionist at Modesto Memorial Hospital after consistently showing up late or sometimes not at all (Humphrey v. Memorial). She was a great transcriptionist, but just couldn't manage to show up on time. Before her termination, she was given a letter of warning, and later, a sterner warning. The situation did not improve, and eventually she was fired.

At first glance, this situation sounds reasonable: if an employee is unable to show up for work on time, time to find a new employee. However, the reason that Humphrey had been showing up late repeatedly for work was due to compulsive rituals surrounding her grooming. Try as she might, she was having the hardest time getting out the door in the mornings due to obsessions with cleanliness and compulsions related to grooming. She didn't understand at the time why she was experiencing the urges to shower over and over again; she just knew she had to do it. Understandably, her supervisors at the hospital became concerned as Humphrey came into work later and later. After all, Humphrey had been a good, loyal worker at the hospital until her recent streak of tardiness. As per organizational policy, Humphrey's supervisor issued her a warning every time she showed up late. Once the first warning was issued, however, the stress and fear of failure made the compulsions even harder to control, which caused her to show up even later and start to miss work altogether.

Convinced that something was wrong with her, Humphrey asked her supervisor if she could see the hospital's contracted psychiatrist about her obsessive grooming. When she did, she

was informed that her obsessions and compulsions were related to a condition of (fairly severe) obsessive-compulsive disorder. Humphrey was relieved to have a diagnosis and immediately started therapy. Together, she and her psychiatrist decided that it might be best if Humphrey could work from home, as several of the other hospital's medical transcriptionists did. That way, she could avoid the contamination of the outdoors while she was working through therapy.

According to the hospital's policies though, an employee who had received several tardiness warnings was not eligible to work from home. Subsequently, her request was denied due to her discipline record and the hospital insisted she maintain her current hours and try to show up on time. Because she was still new to therapy and managing her obsessions and compulsions, this was an impossible task. After a few more tardiness warnings, Humphrey was fired.

Humphrey's termination in not necessarily surprising, as many workers and supervisors are "unaware of [obsessive-compulsive disorder], its consequences, and its treatments" (Neal-Barnett & Mendelson, 2003, p. 170), and consequently, "supervisors and co-workers often see [workers] with obsessive-compulsive disorder as disorganized, unproductive, bizarre, or strange. As a result, the work environment can become hostile, and the worker might be reprimanded, and in some cases, terminated" (Neal-Barnett & Mendelson, 2003, p. 170). Neal-Barnett and Mendelson (2003) point out though, that "with appropriate treatment, education, and support, [workers] with [obsessive-compulsive disorder] bring unique and valuable assets to their jobs" (p. 170) and recommend that these workers seek to reclaim their own empowerment through asking for accommodations and seeking support.

Fortunately, Carolyn Humphrey's story has a happy ending; she sued the hospital for wrongful termination and won because she was deemed to be a "qualified individual with a

disability" (Humphrey v. Memorial). However, most stories do not end with such a bang; most fizzle out in a slow burn and result in unemployment and struggle to figure out how to make the next job work.

Humphrey's story is an example of an individual who struggled not only with employment, but who also struggled managing the negotiation of what it meant to be a competent, dependable worker. The set of problems that Humphrey faced (and many other problems that will be discussed in more detail later) are the issues that this dissertation seeks to address: identity management of individuals with OCD in the workforce and the workplace (or "organizational identity"). Even further, this dissertation seeks to address practical ways in which communication interventionists might apply theoretical findings in order to help individuals with OCD find organizational and identity empowerment which may lead to increased employment.

In this introduction chapter, I will begin by discussing the characteristics of OCD and how OCD has been researched in the medical community to illustrate the breadth of the medical and clinical problems individuals with OCD face in and out of the workforce and workplace. Then, I will discuss organizational communication research on OCD to illustrate some of the problematic ways in which OCD is studied. Finally, I will provide an overview of the rest of the dissertation.

Obsessive-Compulsive Disorder

Obsessive-compulsive disorder, which is more commonly known by the acronym *OCD*, is a mental illness identified by the *DSM-V*, that is, the fifth edition of the *Diagnostic and Statistical Manual of Mental Disorders*. For someone with OCD, obsessions (unwanted, intrusive thoughts and fears) and compulsions (rituals to ease the anxiety produced by the obsessions) are incredibly distressing and "substantially interfere with normal functioning"

(Abramowitz, Taylor, & McKay, 2009, p. 491). The most common manifestations of OCD involve washing (hands or otherwise), obsessing, hoarding, ordering, checking, and mental neutralizing (Foa et al., 2002). OCD is usually measured using the Y-BOCS, that is, the *Yale-Brown Obsessive Compulsive Scale*, which indicates the severity of an individual's OCD. Typical treatment for OCD includes a combination of medication and cognitive-behavioral therapy (Marques, et al., 2010), specifically a therapy called Exposure and Response Prevention therapy (ERP). ERP is one of the more difficult psychiatric treatments to practice: it involves intentionally *exposing* a patient to the very thing they fear, be it germs, unwanted intrusive thoughts, or social situations, in order to habituate the patient to the trigger and anxiety itself (Abramowitz, Taylor, & McKay, 2009). When the patient is exposed to the trigger, they[2] are then *prevented* from performing their compulsions to ease the anxiety; rather, the patient lets the anxiety go down with time. Both the exposure and the response prevention are key features of this therapy; patients are even encouraged to expose themselves to triggers that are beyond what the average person would encounter, if only to aggressively prove that the triggers lack danger. Treatment levels can range from occasional therapy sessions and no medication to full-time residential or inpatient treatment along with multiple medications. One study asked 175 (36 male, 139 female) respondents (M Y-BOCS = 21.69, the high end of moderate) with obsessive-compulsive disorder about the types of things that are barriers to their treatment (Marques et al., 2010): only 60.4% of respondents were in treatment. One of the commonly reported reasons people don't or can't get treatment is the cost of treatment and lack of insurance.

Unfortunately, OCD typically indicates a lower quality of life for those who suffer from it, and the worse the symptoms, the lower quality of life the individual experiences (Eisen et al.,

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[2] I am using the pronouns *they, their*, and *theirs* to indicate the gender-neutral generic.

2006). People with OCD tend to have lower quality physical well-being, psychological well-being, social relationships, environment, and overall quality of life as compared with the general population (Stengler-Wenzke, Droll, Matschinger, & Angermeyer, 2006). In fact, those who suffer from OCD have been found to have a lower quality of life than even patients with schizophrenia, which is "regarded as one of the most devastating psychiatric illnesses" (p. 666). Perhaps the most telling analysis of quality of life is found when comparing an OCD patient to a heroin addict; the heroin addict tends to have a higher quality of life when it comes to all categories tested: general health, vitality, social functioning, emotional condition, and mental health (Bobes et al., 2001). Specifically, the most adverse effects involve an OCD sufferer's career and their relationships with their family and friends (Bobes et al., 2001; Koran, 2000).

While the medical diagnosis, symptoms, and distress are in and of themselves a challenging undertaking, the social aspect and stigmatic nature of being obsessive-compulsive are quite difficult to navigate and situate the identified individual in a disadvantaged place in society. One of the main reasons those with disabilities attempt to keep them hidden is the ever-present loom of stigma: someone who is, by other standards, a capable and agreeable human might be seen otherwise once a stigmatic trait is revealed. Goffman (1963) argues that disability in and of itself is a stigmatic trait and "an individual who might have been received easily in ordinary social intercourse possesses a trait that can obtrude itself upon attention and turn those of us whom he *[sic]* meets away from him, breaking the claim that his other attributes have on us" (p. 5). Subsequently, "as a general rule, an individual may make considerable effort to keep a hidden disability private" (Lynch & Gussel, 1996, p. 353).

Obsessive-Compulsive Disorder and Work

OCD is the 10th leading cause of disability in the world (Murray & Lopez, 1996). According to statistics on the number of cases filed under the American Disabilities Act, psychiatric/mental impairments are second only to back/spinal injuries, accounting for 11.7% of all ADA claims (Kirshman & Gradgenett, 1997). It is difficult to manage working life for someone with a psychiatric disability, which include illnesses like bipolar disorder, generalized anxiety disorder, schizophrenia, borderline personality disorder, and obsessive-compulsive disorder. OCD is the fourth most frequent diagnosis in psychiatry (Stengler-Wenzke et al., 2006), with an estimated lifetime prevalence of 2-3.5% (Marques et al., 2010).

Among personality disorders in the workplace (which are slightly different than psychiatric disorders), an obsessive-compulsive personality (along with antisocial and paranoid personality disorders) are the conditions most often associated with being fired, laid off, chronically unemployed, or experiencing problems with co-workers or bosses (Ettner, Maclean, & French, 2011). Adults with OCD are more likely to be unemployed and more likely to report significantly impaired social and occupational functioning (Torres et al., 2006).

OCD brings along with it many specific problems when it comes to employment; adults with OCD often have trouble finding and keeping jobs (Neal-Barnett & Mendelson, 2003). First, it is difficult for an individual with OCD to find a job that is congruent with his or her particular symptoms. For example, Gunnar Rolland, a man whose OCD symptoms included needing to repeat things over and over, found he could not function in his desired career, engineering, because he had to re-read the pages of his textbooks so many times that he couldn't finish an assignment (Chorley, in press). He settled on a career in construction, which was still not suited

to his needs, as he would repeat lifting heavy boulders three or four times as his colleagues lifted them just once.

There can be many organizational interactions in which managing an obsessive-compulsive identity becomes a salient communicative concern. One possible location of concern is the negotiation of organizational meaning, particularly what it means to be "disabled" or a "competent worker." Workplaces are not ability-neutral, similar to how Acker (1990) asserts that workplaces are not gender-neutral. The workplace is designed for the abled and when a worker with OCD attempts to manage or negotiate this designation, it can be a specific site of conflict. Second, instances of punitive action related to a worker's OCD symptoms can be a particularly concerning communicative situation. In fact, OCD is one of the conditions most often associated with being reprimanded, as well as being fired, experiencing chronic unemployment, and having problems with co-workers and supervisors (Ettner, Maclean, & French, 2011). Punitive action can be especially disheartening when a worker with OCD is qualified for the position they are in and is doing well at work otherwise and is still being reprimanded for factors related to her condition, similar to Humphrey's case mentioned above.

Finally, individuals with mental illness are in a unique position to be the subject of micro-aggressions in the workplace in at least two ways; first, a co-worker or a supervisor can interact with the individual with mental illness by referring to them in terms of popular discourses on their particular illness (e.g., "you have OCD? Like Monk from TV?"). Additionally, a mental illness may be misappropriated to describe common phenomena around the office. For example, a co-worker might straighten a crooked picture frame claiming, "I have to have this straight. I'm so OCD." Being placed in these key organizational interactions necessitates that workers with mental illness or OCD will be drawing on the resources they have available to them to help them

make sense of their situation. Unfortunately though, resources in scholarly literature that these workers have to draw on for help are sparse, and the ones available are not often evidence-based or helpful.

OCD has generally been largely under-researched in the field of organizational communication, and what is there tends to come from a managerial perspective on what makes an organization successful. While other areas of organizational communication are telling the stories and perspectives of other marginalized groups (e.g., the recent surge of research around the inclusivity of LGBTQ organizational actors), workers with mental illnesses are not being featured as readily, and subsequently not enjoying the same benefits of increased awareness and equality.

On the track of a managerial lens on OCD comes a "research brief" called *Personality Disorders and Dysfunctional Employee Behavior: How can Managers Cope?* (Sidle, 2011) advising managers who have employees with mental illness. Sidle specifically addresses OCD as a disorder with which employees can "have trouble" at work. The author suggests that "a better understanding of personality disorders and their potential effects on productivity may allow managers to make informed decisions regarding how to intervene when faced with difficult employees who are causing problems on teams" (p. 77). The article is framed as a journey toward productivity, with employees with mental illnesses being a stumbling block to this goal.

Another example is a brief section of a periodical called *Legal News for Supervisors*. The section on mental illness is titled *How to Accommodate Those with Obsessive-Compulsive Disorder*. The article briefly describes OCD in terms of abnormal anxiety, and then makes three suggestions that managers should "consider" using when accommodating workers with the illness: first, set daily goals, as goals can help staffers "stay on track." Second, permit good

distractions such as a white noise machine, as they block out "other environmental sounds while not occupying the person's full attention" (p. 3). Finally, the article suggests managers can change the lighting, as natural lighting can be soothing so some sufferers of OCD. Additionally, managers can "allow" the person to step outside during breaks.

Tyrer (2014) addresses the issue of mental illness in the workplace by suggesting that someone with an illness (he refers to them collectively as "personality disorders") find an occupation that is most suited to their symptoms and accommodations required. He offers the example that "a person with personality disorder with the detached domain may be highly effective working alone in a laboratory, but when moved to a post involving people management skills, they become grossly dysfunctional" (p. 567). What he refers to as "personality disorder" is an un-delineated lump of ten mental disorders: antisocial, borderline, impulsive, obsessive-compulsive, histrionic, narcissistic, schizoid, schizotypal, and anxious; when discussing their effects on the workplace, he makes little distinction between the disorders. While his advice could be somewhat helpful to those who are looking for a job from scratch, it does little for the worker who is already in a position in which they are experiencing problems.

Ettner, Maclean, and French (2011) took more of a quantitative approach to their research on mental illness and attempted to go about answering the question: *Does Having a Dysfunctional Personality Hurt Your Career*? The study "used nationally representative data for 12,457 men and 16,061 women to examine associations of [personality disorders] with any employment, full-time employment, chronic unemployment, being fired or laid off, and having trouble with a boss or co-worker." They found that paranoid, antisocial, and obsessive compulsive disorders were the "conditions most often associated with adverse work outcomes such as being fired, laid off, or chronically unemployed, or experiencing problems in interactions

with co-workers and their bosses" (p. 167). While the authors do focus on the plights of the oppressed group of workers with mental illness, they are still coming from a managerial perspective and not actually examining the perspectives of those affected. A study of women in the workplace that suffer from obsessive-compulsive disorder takes a step toward sharing the stories of workers with mental illness (Neal-Barnett & Mendelson, 2003). They use public data and describe the difficulties that women with OCD face in the workplace, including being fearful that their illness will be used against them. However, they do not actually interview or talk to any women who suffer from OCD in their methodology.

Organizational communication research has attempted to tackle the challenges that mental illness brings to a workplace. For example, Meinert (2014) offers advice to managers on how they can help to create "a stigma-free workplace," which includes tips like "educate employees about the signs and symptoms of mental health disorders," "encourage employees to talk about stress, workload, family commitments and other issues," and "send the message that mental illnesses are real, common and treatable" (p. 29). The author also offers a section on "what not to say" and then offers suggestions on what to "try instead." These suggestions include not saying things like "how's your health?" or "you seem depressed," but rather saying things like "how can we help you do your job?" or "you're not your usual self" (p. 28). The article also indicates that workers with mental illness can get better with the correct diagnosis and treatment. It finally wraps up with recommendations for managers and employers to make accommodations for their employees with mental illness and to respect all of their workers.

While these studies address issues of OCD in the workplace, they do not address the actual experiences of the organizational member with OCD. In fact, none of the studies mentioned here reported even interviewing or observing anyone with OCD. Therefore, this

organizational communication study will be departing from the typical organizational communication study of OCD; I will be exploring how organizational members with OCD discursively make sense of, account for, and frame their future in relation to their organizational memberships, involvement in organizational processes, and employment. Additionally, I will be exploring a potential application of my findings in order to make a "difference" through this research (Frey, 2009).

Organization and Overview of Chapters

This dissertation is organized into six chapters, including this introductory chapter. The second chapter reviews scholarly literature and theoretical foundations for this study, including disability and disability theory, narrative organizational identity, a special case study of Goffman's *Asylums,* and applied communication research. Chapter three focuses on the research methods utilized to conduct this study. In chapter four, I present and analyze the ways in which participants discursively negotiated their organizational identity by engaging with discursive resources. Chapter five features four vignettes, which illustrate the interactional aspects of four different participants' narrative identity work. Finally, chapter six focuses on the theoretical implications and practical applications of my findings.

CHPATER 2

LITERATURE REVIEW AND THEORETICAL FRAMEWORKS

Before investigating organizational identity with OCD, it is essential to establish and review theoretical foundations from which to base such a study, and the work that has been done by others to make such a study appropriate. In this chapter, I review issues related to disability and disability studies, including hidden disabilities and visible disabilities, agency and identity management, perception, response from others, disclosure, stigma, and the effects of a hidden disability. I also review issues related to narrative identity, including the narrative paradigm, narrative organizational identity, agency, and discursive resources, both organizational and cultural. I then do a case study of Goffman's *Asylums,* featuring his characterization of institutionalized psychiatric treatment. Finally, I will be reviewing applied communication research, including the relationship between theory and intervention.

Disabilities and Disability Theory

When discussing a specific disability like obsessive-compulsive disorder, it is important to situate that illness within the more general context of disability studies, both social and organizational. The fields of communication and disability studies have made considerable efforts to theorize about the human experience of disability, including how it affects a person's life, how it is socially framed, and the stigmas associated with it. Within this vast array of literature is a subfield of study on *hidden* or *invisible* disabilities. In this section, I will discuss some differences between the negotiation of a hidden disability (as OCD is currently understood) and a visible or detectable disability, examine the consequences of disclosing a hidden disability, and review how a hidden disability can influence a sufferer's life.

Hidden Disability vs. Visible Disability

A hidden disability is a disability that is "unapparent to the unknowing observer" (Valeras, 2010). Hidden disabilities can include those in the physical (e.g., multiple sclerosis, Crohn's disease, diabetes, epilepsy), psychiatric (e.g., major depression, bipolar disorder, post-traumatic stress disorder), and cognitive (e.g., learning disorders, ADHD) genres. While hidden disabilities may be revealed to others over time, the symptoms are generally hidden when first meeting someone.

A hidden disability is juxtaposed with a visible or noticeable disability. Visible disabilities tend to have symptoms that are apparent when first meeting a person, such as wheelchair use, the use of a sign-language translator, or a visibly missing limb. Many factors contribute to the differences in experience among individuals with visible disabilities and those with hidden disabilities, including agency and identity management, perception, and response from others.

Agency and identity management. In general, people attempt to manage how others see them (Goffman, 1959). Identity management for most people is a complex task, given that there are many aspects of identity and many ways to present them (more on identity will be discussed later). However, individuals with disabilities tend to do even more identity management work (Skully, 2010). While most people tend to do a fair amount of work to manage how they are perceived by others, "disabled people exercise an enhanced degree of practical and moral agency in their management of social interactions" (Skully, 2010, p. 32). When comparing visible disabilities with hidden disabilities, there is a varying degree of work and agency, depending on the level of the disabilities' visibility; those with a hidden disability may have more of a choice when it comes to where and when to disclose their impairment. With a visible disability, an

individual may have a much harder time trying to appear as someone who is abled, but they still has some agency in how the disability is presented (Skully, 2010): it can be done via *normalization* (downplaying the difference between themselves and abled people), *parading it* (deliberately making an impairment more obvious), or *performing it* (enacting a disability in a way that is culturally recognizable). However an individual chooses to disclose their disability, this disclosure may serve as identity management, as the individual, at times, gets to manage the meaning of their disability (Thompson, 1982).

Olney and Brockleman (2005) argue that there are comparable amounts of agency between those with visible disabilities and those with hidden disabilities: yes, it may appear that people with hidden disabilities have more control, but there are certain situations in which people with visible disabilities can hide them (like only conducting business over email), and there are certain situations in which a hidden disability is revealed. Consequently, people with visible disabilities, although more of their condition is visible, still actively control the disclosure of disability-related information where they can.

Perception. While visible disabilities are widely recognized to be life-altering situations, hidden disabilities carry no less of a burden, even though it might not be as well-known:

Such factors as how observable an impairment is, what physical, sensory, or cognitive/emotional functions are affected, whether it is static or progressive, whether it is predictable or unpredictable in its manifestations, and whether it affects longevity, all may influence the experience of disability for the person who has the condition, as well as for those around such an individual. In different circumstances, the visibility of a characteristic—be it femaleness, weight, hair color, skin color, or navigating in a wheelchair—may influence someone's experiences. Persons with characteristics such as

diabetes or asthma that may not be readily observable may sometimes find that their impairments affect a given set of activities and life decisions, whereas at other times they find life flowing smoothly with no thought to their medical label. Although appearing nondisabled when one first meets people professionally or socially may permit the person with diabetes or asthma to avoid the often adverse reactions of others to observable orthopedic, visual, or speech impairments, these so-called hidden disabilities may influence social life such as the food one eats, the places one visits, the activities one pursues for recreation, and so forth. (Asch, 2001, p. 6)

Furthermore, organizations and employers tend to be more knowledgeable about visible disabilities than hidden ones (Sharp, 1996). Organizations are required to comply with the Americans with Disabilities Act, but hidden disabilities often get pushed under the rug; many organizations are reluctant or even unwilling to provide such accommodations for disabilities that are not visible or well-understood. To this end, Weber, Davis, and Sebastian (2002) conducted a focus group with human resource practitioners, asking them about what sort of issues they observed concerning mental illness in their respective workplaces. These HR workers reported four primary issues concerning mental health: underreporting of mental health disabilities (workers are reluctant to request accommodations), the impact of demographic differences on mental health (older workers rather than younger workers; female rather than male are more likely to report a mental illness), misreporting of mental health disabilities (HR workers feeling like they had to diagnose a problem), and the impact of the environment on mental health (e.g., a robust economy may lead organizations to hire those they normally wouldn't).

Fitzgerald and Paterson (1995) found that people with hidden disabilities struggle more with their disabilities being legitimized by others than people with visible ones and that "the recognition that the condition and its associated complaints are 'real,' is often a problem for people with hidden disabilities" (p. 15). One of their research participants with a hidden disability expressed that people don't tend to believe her when she disclosed she had Temporomandibular Joint Syndrome (a nerve condition involving chronic jaw pain):

> I mean nobody can see that you're hurting. Nobody sees anything disformed *[sic]*. Nobody knows, you know, what, how to deal with it. Nobody can see that. All they see is a healthy person on the outside. And, so they don't know that you're hurting. And see then, you know, like any time you tell them what's wrong, they're like, [they can't believe it]. How can you be hurt? They won't believe you. So it's kind of like that, you know, that makes you kind of upset. But what can you do, you know, you look perfect on the outside. (p. 14)

Legitimization is one of the social struggles experienced by individuals with hidden disabilities that is not as often faced by those with visible disabilities, as a visible disability is usually accompanied by some sort of legitimizing feature such as a wheelchair or guide dog. Visible features or accessories can assist abled others in making sense of a disability, whereas invisible pain or struggle often must be explained or emphasized when expecting others to understand or accommodate.

Response from others. People with disabilities must often face interactional consequences of their disability, like judgement, questioning, pointing out, or mockery, especially for aspects of a disability that are noticeable. When it comes to discriminatory responses from others, they can be considered *conscious*, *nonconscious*, or *unconscious* (Skully,

2010). In conscious discrimination, the discriminator is fully aware of their actions and attitudes toward disabled people. Nonconscious discrimination, on the other hand, involves beliefs and behaviors that are perhaps habitual or unexamined. Finally, unconscious discriminatory behavior may come from a place in which a person is not generally aware of their behavior or even actively disavows such beliefs. While all three kinds of discrimination function to oppress individuals with disabilities, the latter two types are often trickier to define to others and subsequently counter. When confronted with discrimination, stereotypes, or not being accommodated, those with disabilities may react *passively* (e.g., silence, agreeing, nodding, etc.) or in an *accusatory* or *emotional* way (Blockmans, 2015). Both responses have consequences for the individual with a disability: reacting passively may be seen as approving of the stereotype or reinforcing it. On the other hand, overreacting might "cut the interaction short and [reinforce] stereotypes of people with disabilities being bitter and oversensitive" (Blockmans, 2015, p. 161).

Research is robust when it comes to the rejection and ridicule of individuals with visible or noticeable disabilities (Olney & Brockelman, 2005). However, research around the ridicule of those with hidden disabilities gets a bit more difficult. When a specific disability label is unknown to others, the sufferer of a hidden affliction often faces ridicule over the symptoms of the disability rather than the disability label itself (Riddick, 2000). Others notice only that an individual is unable to perform certain tasks or performs odd rituals and have few readily available resources to make sense of the inability or abnormal behavior. For example, if a person in a wheelchair is unable to scale the stairs in front of the library building, others around them can easily make sense of this shortcoming – it is because of the disability the individual cannot perform the specific task. In contrast, if a person with obsessive-compulsive disorder is unable to check out library books and hold them in their bare hands, an observer has no resources to make

sense of the situation; all they see is a "normal" looking person who is holding library books through the barrier of a stack of tissues. This deviation of normal behavior can prompt questions, teasing, and ridicule.

This difficulty for others to make sense of or understand a hidden disability can have more ramifications than just being socially ostracized; it can also influence a supervisor or instructor's perception of an individual, and consequently, their attention to or care for that individual. For example, Cook (2001) surveyed a set of elementary school teachers whose classrooms included students with visible and hidden disabilities. The author found that teachers reported overwhelmingly that they would be relieved if the students with hidden disabilities were to leave their classroom; in many cases, the teacher was either unaware of the full extent of the severity of the disability or failed to fully understand the hidden disability. This lack of understanding or knowledge contributed to inappropriate expectations, which led to classroom problems. In contrast, the teachers reported an indifference to the students with visible disabilities, meaning they didn't necessarily even notice they were in the class. This difference points to students with hidden disabilities being seen as more of a "problem" in classrooms, and therefore are treated accordingly.

Disclosing a Hidden Disability

In general, abled individuals enjoy a relative amount of privacy, in the context that Braithwaite (1991) describes privacy as "the right of individuals to have selective control over access to the self" (pp. 255-256). People, for the most part, have quite a bit of control over who knows what about their personal information. For example, it is not common for our acquaintances or supervisors to know our heath and medical history. Comparatively, individuals with disabilities "often live in a world of reduced privacy" (Lynch & Gussel, 1996, p. 353).

Using that same example, a person with a disability who needs an accommodation at work is required to disclose their disability and, to some extent, their medical history to their supervisor. According to the Americans with Disabilities Act, this disclosure is mandatory to receive accommodations. When a person with a hidden disability reveals their shortcomings, they "assume a socially devalued self-identity, that of sick and disabled, and all that these identities entail" (p. 13).

Disclosure, then, can be defined as "an intended release of personal information by individuals regarding their tastes, interests, work, money, education, attitudes, opinions, body, and personality" (Lynch & Gussel, 1996, p. 353). When individuals with hidden disabilities disclose their disability to a demanding party, they are revealing information an able-bodied person would not normally disclose about their own health and body (Braithwaite, 1991). This need for accommodation requires a person with a hidden disability to disclose their defect to people and organizations that they might not necessarily trust or would not tell their stigmatic traits to otherwise. Accommodations can come in many forms: perhaps a person would need extra time on a work assignment or shifted working hours. This necessary disclosure of a hidden disability creates a power distinction: able-bodied or able-minded people have the privilege of concealing their medical and health history, while those needing accommodations do not.

Interpersonally, "the act of revealing one's disability can dramatically change one's relationship with others" (Olney & Brockelman, 2003, p. 43). Once a person is made aware of an individual's disability, the relationship then carries the potential for immeasurable change: once a change in perception occurs, the subsequent changes can mount. Ryan, Bajorek, Beaman, and Anas (2005) present a cycle of the "communication predicament of disability," in which they theorize about the patterns between people with disabilities and without disabilities, which

include stereotyped expectations held by the person without the disability, modified communication behavior by the person without a disability, passive or aggressive reactions by the person with a disability, negative consequences for the person with a disability, and an increase in stereotypical behavior and cues. The authors argue that without a disruption in this cycle, the person with a disability tends to face the most negative consequences of those in interaction.

Stigma. One of the main reasons those with disabilities attempt to keep them hidden is the ever-present loom of stigma: someone who is, by other standards, a capable and agreeable human might be seen otherwise once a stigmatic trait is revealed. Goffman (1963) argues that disability in and of itself is a stigmatic trait and "an individual who might have been received easily in ordinary social intercourse possesses a trait that can obtrude itself upon attention and turn those of us whom he meets away from him, breaking the claim that his other attributes have on us" (p. 5). Stigma is "one of the most profound barriers to the full social inclusions and community participation of persons with mental illness" (Krupa, Kirsh, Cockburn, Gewurtz, 2009, p. 413).

According to Goffman (1963), the term *stigma* was originated by the Greeks, who used it to "refer to bodily signs designed to expose something unusual and bad about the moral status of the signifier" (p. 1). This categorization implies that if a trait carries a stigma, that trait carries with it moral and social correlations of the signifier's character: that person with the disability is not only not able to perform like their counterparts in society, but they also are marked with shame and integral inadequacy. Goffman's main thrust in his 1963 piece is that a stigmatic trait "spoils" an individual's identity. This trait "has the effect of cutting him *[sic]* off from society and from himself so that he stands a discredited person facing an unaccepting world" (p. 19).

While Goffman argues that all disabilities carry stigma, that stigma is contextual and depends on the audience and the situation. Goffman offers the example of someone without a college degree wanting to hide that fact in a position in which a college degree is expected, and the lack of one would be a discrediting trait. Contrastingly, someone with a college degree in an organizational position lower than someone of that status should have, there would be motivation for them to hide their degree in that organizational context lest they be stigmatized as a failure.

With the phenomenon of obsessive-compulsive disorder, context is indeed a factor for the level of stigma that is assigned to it. For example, if someone with OCD were in a job position that required high-level cognitive functioning (such as an academic position), the level of stigma associated with a mental illness like OCD may be quite high, with the level of stigma directly correlated to the severity of the illness (i.e., the worse the illness, the higher the stigma). In this case, the signifier's intelligence, capability, and functionality might be questioned. In contrast, if someone with OCD were at an OCD support group, the label of the illness would not carry any stigma at all; in fact, the more severe the illness, the more likely it would be that the group would embrace the signifier as a member.

This stigma and risk of rejection by others makes disclosing a hidden disability problematic. Furthermore, the stress and psychological consequences of not being able to be authentic "may turn out to be as problematic as the feared responses from disclosure." (Asch, 2001, p. 6). Subsequently, "as a general rule, an individual may make considerable effort to keep a hidden disability private" (Lynch & Gussel, 1996, p. 353).

While there has been much research about not disclosing a disability due to stigma and possible negative consequences, Olney and Brockelman argue (2003) that there are many reasons that a person with a hidden disability might choose to strategically conceal or disclose

their disabilities and "appear to adapt their mode of self-preservation to specific situations" (p. 35). The reasons to disclose can vary widely and those who are making that decision go through an "intricate decision-making process about revealing disability information" (p. 49). Olney and Brockelman (2003) list four reasons why a person might decide to conceal their disability: others might not believe they have a bona-fide disability, others might see them as less competent, they wish to be viewed as consistent and trustworthy, and that others might see them as only needing help, not as someone who can give and take in a relationship.

Effects of a Hidden Disability

There are many consequences of having a hidden disability. This section will address two of them: consequences for the personal self and one's work.

Personal self and inner conflict. Individuals with a disability can often struggle to find a feeling of self-worth (Olney & Brockelman, 2003). Additionally, they may also wrestle with their identity and self-concept (which will be addressed in more detail below); a person's self-concept tends to be negatively affected by disability regardless of whether that disability is visible or hidden (Valeras, 2010). Each person's experience with a disability is different. However, each disability tends to bring with it some sort of psychological and emotional effects (Reeve, 2002).

Since disabilities carry such stigma, people with a disability often feel like they should try to "pass" as someone without a disability in order to fit into society and avoid social ridicule (Goffman, 1963). This idea of "passing" carries with it the privilege of being able to fit in: when one can pass as able-bodied or able-minded, they are perceived as a "normal" part of society. However, when a person feels forced to hide their disability to pass, is can lead to a "profound sense of misrecognition and internal dissonance" (Samuels, 2003, p. 239). Samuels compares

disability passing to racial, gender, and queer passing: it helps to attain a certain level of privilege, but also carries with it the consequence of feeling like one is living an inauthentic life. Additionally, people with hidden disabilities can sometimes feel that others see them as imposters when they try to pass (Olney & Brockleman, 2005). They know that the hidden state of their disabled identity is only temporary; anyone could find out at any time. As juxtaposed to those with visible disability who tend to have a more "stable self-concept as persons with disabilities," (Olney & Brockleman, 2005, p. 84), those with hidden disabilities wrestle more with their identities as "a person with a disability." Goffman (1963) gives a detailed look at the inner conflict that plagues those with hidden disabilities; he uses the example of a mental patient who is trying to reintegrate himself back into the abled world:

> When his [*sic*] differentness is not immediately apparent, and is not known beforehand (or at least known by him to be known to the others), when in fact his is a discreditable, not a discredited, person, then the second main possibility in his life is to be found. The issue is not that of managing tension generated during social contacts, but rather that of managing information about his failing. To display or not to display; to tell or not to tell; to let on or not to let on; to lie or not to lie; and in each case, to whom, how, when, and where. While the mental patient is in the hospital, and when he is with adult members of his own family, he is faced with being treated tactfully as if he were sane when there is known to be some doubt, even though he may not have any; or he is treated as insane, when he knows this is not just. But for the ex-mental patient the problem can be quite different; it is not that he must face prejudice against himself, but rather he must face unwitting acceptance of himself by individuals who are prejudiced against persons of the kind he can be revealed to be. Wherever he goes his behavior will falsely confirm for the

other that they are in the company of what in effect they demand but may discover they

haven't obtained, namely, a mentally untainted person like themselves. But intention or

in effect the ex-mental patient conceals information about his real social identity,

receiving and accepting treatment based on false suppositions concerning himself. (p. 42)

Struggle over whether to try to "pass" or not in an abled society can feel like a no-win conflict:

as Goffman points out, revealing a "real," tainted identity can lead to being discredited by

society, but concealing it can lead to the constant fear of being found out and acting under false

assumptions.

Work. Having a disability is a barrier to employment (Lindsay, 2010); many industries

are not very accommodating for people with hidden illnesses. Beretz (2003) posits that academia

is one such industry, with many professors with disabilities pressured to resign, and those who

don't can face a delay or decrease in productivity that affects promotion, salary, or professional

reputation.

In order to have a productive integration into the work force, the person, the job, and the

work environment all have to be considered (Kirsh et al., 2009). While it is difficult for a person

of without a disability to find a job and career, the difficulty is much more difficult for someone

with a disability when attempting to find the perfect career that suits not only the individual's

career interests, but the disability and its symptoms, not to mention trying to find an organization

that is willing to provide accommodations. Employers are often resistant to giving reasonable

accommodations because they perceive it to be negative to the bottom line (Harlan & Robert,

1998). Employers often discourage employees from requesting accommodations, and deny about

one in three requests.

Disclosing a disability in the workplace is "risky," especially for those with a hidden disability (Charmaz, 2010, p. 14). The reasons for the precariousness of a disclosure are many:

> Employers and co-workers may misunderstand or misinterpret the reason for a person's disclosure. They may view the disclosure as manipulative rather than as offering an explanation. Ill people are particularly likely to be disbelieved and discounted if they do not look sick. They risk being refused accommodation or being terminated. The risks of disclosing weigh on the minds of people who have stigmatized conditions (Charmaz, 2010, p. 14).

Therefore, some organizational members chose not to disclose their illness. The consequences of choosing not to disclose can include individually improvised accommodations or adaptations that may be risky to their health or compromise the amount or quality of work performance (Charmaz, 2010). Choosing to disclose also has consequences: lowered supervisor expectations, isolation from co-workers, and an increased likelihood of termination (con Schrader, Malzer, & Bruyère, 2013).

While the fields of communication and disability studies have indeed examined a variety of issues related to chronic illness, stigma, disclosure, and outcomes, what is still missing from this literature is a specific investigation of the organizational experiences, interactions, and sensemaking of individuals with OCD. This gap in the literature is an important one because of both theoretical and practical reasons: theoretically, it is essential to not just lump multiple mental illnesses together when theorizing about hidden disabilities. Also, not much is theoretically known about this population's lived experiences at work. Practically, this population is chronically underemployed and needs communication interventions specific to OCD for the maximum effectiveness.

As discussed above, having a disability is a unique experience that tends to invade nearly every aspect of a person's life. One of the key aspects of disability mentioned above was *identity management*, which becomes exponentially more complex when an individual is coping with a disability. In fact, disability is an issue that often implicates a re-examination of how individuals and scholars alike view, identity both in personal and organizational contexts. In this next section, I will be discussing identity from a narrative perspective and incorporating the experience of disability, specifically OCD.

Narrative Identity

Identity is a topic that has been heavily researched in the context of navigating social and organizational life. In fact, much attention has been paid to investigating, prodding, and exploring aspects of identity and how they influence the way we organize. Identity, that is, the "conception of the self reflexively and discursively understood by the self" (Kuhn, 2006, p. 1340), is elusive and existential; scholars have been asking questions about it for ages. And yet, there are multiple perspectives on it and what it means for organizing. What is identity? Why does it matter? How does how we see ourselves (and the ways others see us) affect what we do, what we say, how we are treated, and how we treat others in the organizations to which we belong?

One perspective on identity comes from the idea that each human reflexively conceptualizes themselves through narratives or stories, which is the conceptualization of identity that this dissertation ascribes to. This perspective assumes that "we live, move, and have our being, marinated in our own stories" (Sims, 2003, p. 1196), and has been underused in health-care communication scholarship (Cardillo, 2010). These stories are the contextually appropriate answers to the existential, self-referential questions of "who am I?" and more

organizationally, "who are we?" (Ashforth, Harrison, & Corley, 2008, p. 327). These stories are not only beneficial to the self, helping make sense of life and organizing; they also dictate, to some degree, how we act in organizations and respond to others (Lutgen-Sandvik, 2008, p. 98).

The Narrative Paradigm

Identity from a narrative perspective is broadly situated within a *narrative paradigm,* that is, a view of communication as stories and humans as storytellers. Fisher (1984) proposed this paradigm as a "theory of symbolic actions – words and/or deeds – that have sequence and meaning for those who live, create, or interpret them" (p. 2). In other words, humans make sense of the world around them through narrative means and the *story* is a key unit of analysis for communication research. Consequently, Fisher refers to humans as the Latin *homo narrans,* roughly translating to "storytelling person." From this perspective, narratives and stories are the means through which humans interpret the past, present, and future (Ricoeur, 1979; 1980).

Fisher (1984) frames the narrative paradigm in contrast to a *rational world* paradigm, which presupposes that humans are rational beings, generally making decisions based on clear-cut reasoning and arguments, and that the world is a "set of logical puzzles which can be resolved through appropriate analysis and application of reason conceived as an argumentative construct" (p. 4). Contrastingly, a narrative paradigm assumes that humans are "essentially storytellers" who use "good reason" to make decisions based on history, biography, and culture. The world from this perspective is a "set of stories which must be chosen among to live the good life in a process of continual recreation" (Fisher, 1984, p. 8); this "good life," for Fisher, is the social realization of oneself as a reasoning-valuing human as opposed to a purely rational being. Rather than just focusing on logic, a focus on story emphasizes that narration,

much like metaphor, has power precisely because it captures complex experiences that

combine sense, reason, emotion, and imagination. Narration stirs all those elements

together and preserves their interactions in a compact summary that can be reconstructed

starting from any one of its parts" (Weick & Browning, 1986, p. 250).

Communication, then, is the "*recounting* or *accounting for* human choice and action" (Fisher,

1984, p. 6. Emphasis in original).

Metatheoretically, the narrative paradigm is fundamentally grounded in ontology, that is,

the materials that make up communication: symbols, the communicative expressions of social

reality, and signs of consubstantiation (Fisher, 1984), which are the "commonalities or common

meanings shared by individuals in a given culture" (Johnson-Cartee, 2005, p. 152). Grounding

the paradigm in ontology rather than epistemology "presumes that ordinary discourse consists of

symbolic action that creates social reality. In other words, stories are everything" (Weick &

Browning, 1986, p. 249). These presumptions imply direction for how communication research

should be employed in that humans "should be studied in terms of their narratives of life stories"

(McAdams, 1996, p. 308). These stories, McAdams claims, should be understood in terms of a

few key features: narrative tone, imagery, theme, ideological setting, nuclear episodes, endings,

and "imagoes (an idealized personification of the self that functions as a main character in

narrative)" (1996, pp. 308-309). To that end, communicative research from a narrative

perspective analyzes human behavior using both recalled and in situ stories.

Narrative Organizational Identity

A narrative perspective on organizational identity begins with taking on some of the

assumptions of the aforementioned *narrative paradigm*, that is, that organizations and the

individual identities that are created in their context are socially constructed through stories and

narratives. Identity is a *reflectively developed narrative of the self* (Giddens, 1991).

Subsequently, identity cannot be viewed as a trait or even collection of traits that a person is born

with; rather, an identity narrative is created over time.

    Organizational identity, then, will be used here to describe one's life-long reflectively

developed narrative of the self in relation to processes of organizing, encompassing relationships

to specific organizations, occupations, industries, career, and sense of employability. This is not

the way "organizational identity" is traditionally used; rather, it is commonly used to describe the

identity of an organization itself or an individual's identity in relationship to a singular

organization. However, there is not necessarily a term for "one's life-long reflectively developed

narrative of the self in relationship to processes of organizing," so I am commandeering the term

"organizational identity" for this purpose.

    Examining organizational identity from a narrative perspective begs the question: as

opposed to what other perspectives? Organizational identity scholarship can more or less be

discussed in four groups of theories: narrative, Social Identity Theory, critical, and post-

structural. Social Identity Theory is a social psychological conceptualization which argues that

organizational actors tend to classify themselves into various social categories, such as

organizational memberships, gender, and age (Ashforth & Mael, 1989). The unit of measurement

from this perspective tends to be focused on cognition or perceptions, and is mainly focused on

what is thought, not what is said. From this viewpoint, the role of communication is to express

something that already exists, for example, a thought or a feeling (Scott, 2007). Our *social

identities*, subsequently, are aspects of an individuals' self that are derived from the social

categories with which one affiliates (Scott, 2007). Organizational actors from this view are

"soldiers" who respond to available categories of social and organizational identification they find attractive as self-defined and socially acceptable (Alvesson, 2010).

Critical notions of identity tend to focus on issues of power. Critical conceptualizations of identity are based on a "discourse of suspicion" (Mumby, 1997) and question the power structures through which individuals engage in identity work. For example, Costas and Fleming (2009) examine how employees distance themselves from managerially-dominated discourses by constructing authentic identities, conceptualizing the power structures at work through a lens of Marxist theories on worker exploitation and alienation while emphasizing the struggle between individual and organizational meaning. Rooting an analysis in historical and material assumptions of inequality functions to critique, question, and cast doubt on existing structures of domination that are typically taken for granted in a more functionalist view like Social Identity Theory. A critical perspective on identity offers an "analytical promise" to "bridge the micro-political and the wider organizational, socio-cultural and temporal context" (Thomas, 2011, p. 178). Subsequently, critical examinations of identity "draw attention to how power relations operate in organizations and wider society to construct and stabilize identities within specific historical periods" (Thomas, 2011, p. 178). From this view, organizational members are "strugglers," managing contradictions and conflicts toward a "sense of coherence and distinctiveness" (Alvesson, 2010, p. 201).

On the other hand, post-structuralist conceptualizations of identity view meaning as partial, incomplete, and subject to slippage (Mumby, 1997). Often drawing on Foucauldian ideas of power, a post-structuralist perspective views the individual as necessarily subject to constantly shifting contexts, which implies that the organizational, the social, the historical, and the personal can only be understood in terms of the interconnectedness of personal reality and the

social world (Collinson, 2003). Referring to identity as a "subject position," post-structuralist scholars view organizational actors as "surfers," whose moves made between subject positions encompass "temporary identities take place without all that much friction or contest between forces and 'interests'" (Alvesson, 2010, p. 199).

In contrast to these alternative stances, a narrative perspective on organizational identity views the organizational actor as a "storyteller" (Alvesson, 2010) whose self-reflexive story (or narrative) is constantly being formed, reformed, constructed, resisted, and maintained (Alvesson & Willmott, 2002). From this view, narrative is a "privileged meditation" for the interpretation of the self (Ricoeur, 1991). Identity from this perspective is "conceptualized as a reflexively organized narrative, derived from participation in competing discourses and various experiences, that is productive of a degree of existential continuity and security" (Alvesson & Willmott, 2002, pp. 625-626). Identity work, likewise, is the "capacity to keep a particular narrative going" (Giddens, 1991, p. 54) which is driven by a desire for reflexively-aware biographical coherence and social acceptability, which varies socially and culturally. Identity work:

> is prompted by social interaction that raises questions of 'who am I?' and 'who are we?'.
> In attempting to answer these questions, an individual crafts a self-narrative by drawing
> on cultural resources as well as memories and desires to reproduce or transform their
> sense of self" (Alvesson, Ashcraft, & Thomas, 2008, pp. 14-15).

In the context of organizational communication, identity work involves managing not only social discourses but managerially-defined discourses of meaning which function to influence how an organizational actor sees herself.

Humans keep these narratives going as a "potentially effective way of dealing with the openness and uncertainties of life" (Alvesson, 2010, p. 212). Therefore, a narrative perspective is

not just a way to study identity; it is an explanation that organizational actors use identity narratives as sensemaking devices and "proceeds from an interest in understanding how individuals deal with their complex and often ambiguous and contradictory experiences of work and organization" (Alvesson et al., 2008, p. 14). These narratives help to connect experiences and reduce fragmentation in feeling and thinking and "[close] the possibility of responding to contingencies with limitless plasticity" (Alvesson & Willmott, 2002, p. 625). In addition to helping an organizational worker make sense of the world around him or her, a narrative identity "provides a subjective sense of self-continuity as it symbolically integrates the events of lived experience in the plot of the story a person tells about his or her life" (Ezzy, 1998, p. 239).

A narrative perspective of identity is most appropriate for this study in contrast to the other perspectives discussed above, as this study is especially interested in retrospective and prospective accounts of individuals with OCD when it comes to their relationship with organizing. As opposed to a Social Identity Theory perspective, a narrative conceptualization of identity focuses more on an individual's discursive sensemaking of themselves rather than cognitive constructs. A critical view of identity may indeed be appropriate for the study of OCD in the workplace, as it would integrate concepts of power, privilege, and historical context. However, for this study, a narrative approach is *more* appropriate because it takes into account the personal interpretation of the participants as it makes sense for their own identity. Post-structuralist perspectives on identity are not particularly as useful as narrative for this study because those views would focus more on the power-infused *subjection* of identity workers, rather than the eventual *empowerment* of them (more on identity empowerment is discussed below).

The communicative character of narrative identity. One of the foundational properties of a narrative identity is that it is *communicatively constituted,* that is, constructed, challenged, resisted, and enacted in talk and text; this view rejects the idea that discourse "merely" transparently transmits something within a person that exists prior to expression (Taylor, 2006). Ashforth et al. (2008) identify three general categories of organizational identity enactment: identity markers such as dress and office décor, performance outcomes, such as the quality and quantity of output, and behavior itself including task behaviors, conformity to identity norms, and organizational citizenship behaviors. Any one of these categories can provide fodder for a disruption to an organizational identity narrative. For example, if a worker who consistently produces high-quality work starts to produce work of lesser quality, the worker must then account for this threat to their identity narrative, which thus far has been one of a "worker with high-quality output."

Looking beyond the boundaries of an organization itself, other life events can disrupt, threaten, or trigger an adjustment to an identity narrative. For example, the diagnosis of a serious illness like cancer may act as a catalyst for a compensating narrative (Mathieson & Stam, 1995). In their study, Mathieson and Stam found that their participants compensated for their stigmatic cancer diagnosis by revising their biographies to incorporate both the diagnosis and their new perspective as an "ill" person: with illness, "self-narratives must be transformed. It is of paramount importance that an ill person re-evaluates this revised position from which she speaks. And to evaluate one's illness necessitates articulation of this ongoing revision" (p. 301). With this re-evaluation, the authors claim it is important that individuals "renegotiate their identity status" with the people in their life, including co-workers.

Beyond life events, *tensions* can additionally be triggers for identity work. For example, Wieland (2010) identifies a tension between desires to be unique and a desire to "assimilate and be accepted by others" (p. 504). Since identities are constructed and not inherent, "identities becomes sites of struggle at which various values and interests meet and are negotiated" (p. 504). These sites of struggle reiterate the importance of looking beyond the "container" of an organization to find threats to identity that also influence organizational communication, as organizations are not demarcated islands; rather, they are communicatively constituted (Ashcraft, Kuhn, & Cooren, 2009).

When threats to identity occur, organizational actors respond to them in a variety of ways, as these threats can shift, change, restructure, or cement an identity narrative. Lutgen-Sandvik (2008) suggests that responses to threats happen in phases, which the author discovered by examining the self-narratives of workers who had been bullied: first is *first-level stabilizing*, which can occur when there is some sort of threat to an organizational worker's identity. For example, if an organizational actor is confronted with conflict by a "threatening other" (p. 106), they might make adjustments to the image they convey to that particular person. Second is *sensemaking,* when a worker might interact with other organizational members to resolve ambiguity or validate perceptions, which functions to validate the self. Third, *reconciling* may occur when an organizational member's actions do not align with the image they has of themselves; in this case, the member might justify the action to herself to regain equilibrium. Fourth, *repairing* can involve altering others' perceptions about themselves, their perspective, organizational events, or challenging other organizational actors. Fifth is *second-level stabilizing,* which is a response to the undermining of one's core values or beliefs. Sixth is *grieving*, which can include dealing with perceived loss, perhaps of one's reputation or self-confidence with the

goal of acceptance and. Finally, *restructuring* can be the positive reemergence from a negative experience and merging that experience into one's restructured narrative. Each of these communicative processes demonstrate organizational moments in which self-narratives are adjusted to "ground human actors in a world that is in constant flux" (Lutgen-Sandvik, 2008, p. 116). This identity work "seeks to buttress preferred identity narratives, preserve narrative coherence, repair and restore image, neutralize 'othering' discourse and/or stabilize existential beliefs" (Lutgen-Sandvik, 2008, p. 113), as each phase involves an organizational actor taking communicative steps to reflexively craft a narrative to order their experiences and make sense of what they have been presented with. Because each part of narrative identity work is communicative, recognizing the "multiple ways that stories can be told encourages a view of organizations as actively constructed through discursive activity" (Rhodes & Brown, 2005, p. 178).

A focus on these "temporal issues" of communicative construction (Rhodes & Brown, 2005) spotlights the "unfolding of a story of events and experiences over time" (p. 177) and turns away from what "lies beneath talk to what is happening now" (Taylor, 2006, p. 96). This complex process of story writing is

> thus grounded in at least a minimal amount of self doubt and self openness, typically contingent upon a mix of psychological existential angst and complex or problematic social situations. This may be due to a mismatch between self-understandings and the social ideals promoted through discourse" (Alvesson et al., 2008, p. 15).

Consequently, an identity is not something that is essential, inherent or fixed. It is constantly being formed, repaired, maintained, strengthened, or revised by interactions involving "specific events, encounter, transitions, experiences, surprises, as well as more constant strains" (Alvesson

& Willmott, 2002, p. 626); virtually all activity involves active identity work. Each identity encounter is both expressive of identity and constitutive of it as well (Ibarra & Barbulescu, 2010).

While a narrative perspective on identity does focus on the "here and now," it is also focused on the ways in which identity stories change over time. In each situation in which an identity narrative is constructed or modified, the organizational actor is not starting from scratch; rather, they are "presenting a version of what has been said before, albeit one shaped to do work in the particular circumstances of the telling" (Taylor, 2006, p. 98). A narrative can therefore be considered a "construction which is resourced by previous constructions which aggregate over time. This suggests that an analysis of identity work should "look beyond a single instance of talk to consider the work done across multiple interactions" (Taylor, 2006, p. 98). Looking at the sum of narrative episodes can be considered analysis at the "repertoire" level (Ibarra & Barbulescu, 2010); identity at this level is dynamic over the course of an individual's life as they shifts between organizations, roles, tasks, relationships, and titles.

Narratives not only communicatively constitute identity both in the moment and retrospectively; they also become a discursive resource for future talk and identity construction in a relationship Ashforth et al. call *retrospective-prospective* (2008):

> the retrospective– prospective nature of narratives enables individuals to simultaneously accomplish change and consistency. They accomplish change by adapting the narrative to accommodate the new episode—by introducing new aspects of themselves and affirming desires to change or deepen identities. They generate consistency by looking back at past episodes to generate a plot line that naturally suggests their current station. In other words, narratives are constantly being rewritten to incorporate evolving perceptions of

self, but where a new self is a natural outgrowth of past selves, promoting a sense of

continuity. These narratives then serve as a foundation from which individuals enact

themselves during future episodes" (p. 345).

In other words, individuals construct an identity narrative "as a way of linking…moments over

time, generating a story that integrates 'who I am now' with 'who I have been,' while suggesting

'who I might become'" (Ashforth et al., 2008, p. 340).

Agency and discursive resources. From a narrative perspective on identity, it can be

tempting to imagine that organizational actors have complete agency and control over their

stories, consciously picking and choosing each single narrative strand. After all, if each actor is

the author of their own "resourceful and autonomous" identity story (Brown, 2015, p. 25), what

is stopping them from crafting the most favorable and exciting narrative they can come up with?

On the other hand, it can be enticing to picture organizational actors as "cultural dopes,"

unconsciously accepting any identity that has been ascribed to them by an organization, society,

friend group, historical force or institutional structure (Brown, 2015). As citizens of a society

with countless sources telling us who to be, what to buy, and which work is most valuable, how

can a person possibly have the conscious wherewithal to resist the influences to which they are

subject?

While these black and white answers to the question of agency seem simple, narrative

identity theory tends to come down in the grey middle rather than siding with either polar edge.

From a narrative perspective, identities are formed in the tensions among agency and structure

and

are neither simply chosen nor merely allocated, but are instead the effects of identity

work that occurs in the interstices between domination and resistance. Organizational

members may accommodate the identities on offer to them, but also modify and redefine

them, distance themselves from them through irony, humor and cynicism, or contest

them. (Brown, 2015, p. 26)

Identity is both reflexively and unreflexively crafted as a narrative by organizational

actors from the discourses and narratives at their disposal (Alvesson, 2010), or the "limited

repertoire of available and sanctioned stories that they can use to interpret their experience"

(Ezzy, 1998, p. 176). As an organizational actor lives their life and experiences events, emotions,

tragedies, and successes, they use the discursive resources that have been made available to them

to make sense of what they has experienced and to put together a retrospective narrative of their

life and identity as both a human and an organizational member; this narrative is a result of the

person's "selective appropriation of past, present, and future" through the filter of available

discursive resources (McAdams, 1999, p. 486), which come from an "interpretive repertoire"

that is "made up from meanings which prevail in a wider social and cultural context of a society

and culture" (Taylor, 2006, p. 96). The restraint placed on actors by discursive resources

necessarily implicates that the actor does not have "carte blanche" in the telling of their identity

stories, but rather are constrained by the "cultural resources at their disposal and the expectations

of others" (Rhodes & Brown, 2005, p. 176). Therefore, from a narrative identity perspective,

organizational actors craft their identity story from available discursive resources to account for

their organizational choices and situation. The interpretive repertoire the individual has at their

disposal can be constructed from many different sources; two that have some of the greatest

impact on personal narratives are organizational discourses and social/cultural discourses

(Alvesson et al, 2008), which are both discussed in more detail below.

Organizational discourses. Organizational discourses are "narrative formations at the organizational level regarding, for example, strategy, leadership, entrepreneurship, teams, and professionalism [that] provide seductive and normalizing subject positions for individual appropriation" (Alvesson et al., 2008, p. 18). These discourses shape and influence and individual's identity both as an individual and as an organizational actor (Humphreys & Brown, 2002). Consequently, when the identity of an organization changes over time, the individual actor's relationship to it can also change. Organizational members can be encouraged by management and coworkers alike to develop self-images and work orientations that are congruent with organizationally-defined objects and discourses (Alvesson & Willmott, 2002) that "create complex webs of mutable interdependencies and interconnections" (Brown, 2006, pp. 735-736).

Therefore, it is appropriate to conceptualize the organizational member as an *identity worker* who struggles between individual and organizational goals and identity markers (Alvesson & Willmott, 2002). Because identity is constructed by both individual agency and organizational structure, a person's identity narrative is dynamic and changing over the course of their (working) life and evolves with the stories and discourses of each organizational role they inhabit and each organization they are a part of (Ibarra & Barbulescu, 2010).

Organizational discourses may carry various levels of institutional and managerial support (Alvesson et al., 2008). *Identity regulation* is a form of normative organizational control in which associated organizational structures enjoin actors to align themselves with managerially-sanctioned meaning. In other words, identity regulation is the "discursive practices concerned with identity definition that condition processes of identity formation and transformation" (Alvesson & Willmott, 2002, p. 627). Identity regulation can come in many

forms: direct personal definition and organizational title, defining others in contrast, ascribing

motives, explicating morals and values, knowledge and skills, group categorization and

affiliation, hierarchical location, establishing rules and norms, defining the context of work,

among many other communicative forms (Alvesson & Willmott, 2002). Identity workers are

> enjoined to incorporate the new managerial discourses into narratives of self-identity. A
>
> common- place example of this process concerns the repeated invitation – through
>
> processes of induction, training and corporate education (e.g. in-house magazines,
>
> posters, etc.) – to embrace the notion of 'We' (e.g. of the organization or of the team) in
>
> preference to 'The Company', 'It' or 'They'" (Alvesson & Willmott, 2002, p. 622).

An individual's response to identity regulation is *identity work,* which is the "interpretive

activity involved in reproducing and transforming self-identity" (Alvesson & Willmott, 2002, p.

627). Self-identity, then, is the "precarious outcome of identity work comprising narratives of the

self" (Alvesson & Willmott, 2002, p. 627). Organizational self-identity is indeed the result of a

reflexive struggle through a dense fog of "raw cultural materials" (Alvesson & Willmott, 2002,

p. 626) such as language, symbols, meanings, values, or stories that result from interactions with

organizational others and exposure to messages and experiences. It "forms a complex mixture of

conscious and unconscious elements, an interpretive and reflexive grid gradually shaped by

processes of identity regulation and identity work" (Alvesson & Willmott, 2002, p. 626).

Societal and cultural discourses. In addition to organizational discourses, organizational

actors are subject to *societal and cultural discourses* to which they have been exposed. For the

organizational actor with OCD, identity may be much more complex than it is for the average

member. Not only is the individual subject to organizational and social discourses about what it

means to be an abled worker, but they are also subject to the discourses of what it means to be

"disabled" and to "have OCD;" conceptions of both complicate an organizational actor's identity.

American society is not hurting for discourses about OCD, from television and film portrayals, reality shows and stars, and social media; these discourses and portrayals all influence how OCD is conceptualized and invoked in interaction (Fennell & Boyd, 2014; Wahl, 2000) Many television shows have found OCD to be a bubbling spring of fodder to create a character, some more biomedically accurate than others. Perhaps the most popular example of this phenomenon come from USA's *Monk*, the "obsessive-compulsive detective." Adrien Monk was a full-time detective who, when his wife passed away, was unable to maintain employment due to his OCD symptoms surfacing. With the help of an assistant, he is able to work as a consultant for the police force while still performing all of his compulsions. These compulsions come from a wide range of OCD classifications, some dealing with symmetry and order, some with contamination, and some from phobias like a fear of heights. They are portrayed as adorable and eccentric while occasionally causing discomfort. Monk appears to do just fine with his life and seems content to accept his OCD. This portrayal of OCD is outside the realm of the experiences of most people, as the show presents OCD as pretty hilarious; Monk's physical comedy as he completes his rituals is a consistent source of amusement for the television audience. For example, in a season two episode, Monk attempts to carry on a conversation while walking down a cobblestone sidewalk, simultaneously trying to avoid stepping on cracks. The women with whom he is walking are befuddled by his behavior, making the scene even funnier. The visual humor of this scene, with Monk hopping around while talking about a murder, is an example of the type of comedy this show uses as the expense of making light of OCD. Moments of "comic eruptions are often qualified, even in such a broad situation comedy, but both the viewers' and

Monk's peers' curiosity, embarrassment, even ire at Monk's intense awareness of his obsessions but maddening inability to shut them down when duty calls" (Cefalu, 2009, p. 50).

Whereas Monk takes a relatively light look at OCD, HBO's *Girls* takes on a heavier one. In episode eight of season two, Hannah Horvath, the series protagonist, begins to perform counting rituals by doing each task in her day in series of eight: touching her chin to her shoulder, slamming doors, eating chips, all in sequences of eight. In a restaurant, we see Hannah accidentally bump into a stranger and then have to bump him seven more times before she is satisfied. Hannah's OCD is labeled as such, but hasn't been bothering her since high school; recent stress from a book deal has triggered some of her symptoms to return. Her parents insist she see a psychiatrist, to whom Hannah discloses intrusive thoughts about sexuality and death.

Perhaps the most raw and painful moment for Hannah's OCD is when she has been cleaning out her left ear with a Q-tip and, in the spirit of decontaminating to feel just right, accidentally pushes the swab too far and punctures her ear drum. She screams in pain and rushes to the emergency room. There, a physician gently removes the Q-tip and chastises Hannah for her carelessness. Hannah begs the doctor to clean out her right ear so that they might feel symmetrical, but the doctor refuses. When Hannah returns home, the episode concludes with her jamming a Q-tip into her right ear to puncture that ear drum. This incident spotlights the pain sufferers of OCD feel when they act against their own best interests in order to appease their illness. While *Girls* presents a picture of the pain and suffering caused by OCD, they do not feature all the steps the disorder requires to improve. We see Hannah begin to take medication at the beginning of the show's third season and the illness is not brought up again as a problem in the rest of the series. This is not a typical path to recovery for OCD; usually regular therapy is also required for improvement (Abramowitz, Taylor, & McKay, 2009).

Obsessed is a reality show that mimics the style of commodifying human suffering and redemption featured on other programs like *Extreme Weight Loss* or *Hoarders.* Each episode of *Obsessed* begins with the miserable condition of each sufferer, moves to treatment using therapy, and concludes with each patient optimistically looking toward the future. The show is dramatic, using intense music to exaggerate the patient's poor situation. This exploitation of the human condition has become commonplace for reality television, and *Obsessed* does not disappoint. It's often difficult to judge how realistic these portrayals are, given the overly-dramatic special effects.

One of the most heartbreaking portrayals of OCD come from the film *The Aviator,* in which Leonardo DiCaprio stars as the real-life Howard Hughes, who famously suffered from severe OCD. In the film, Hughes's OCD is played out in a nuanced and complex way, providing the viewer with every agonizing detail of his demise from an aviation innovator and movie director to a recluse who was consumed by his illness.

Another area of discursive resources that can be used to make sense of an OCD identity is the public misuse and misappropriation of terminology. To see one example of this, we can turn to one of America's most famous (and infamous) families, the Kardashians. Three of the Kardashian siblings wrote a book, in which the following excerpt is featured:

> I hate folding laundry. It's really tedious because I'm so OCD about it, and it takes me much longer than the average person. But I'm really good at cleaning, because I'm very efficient and meticulous. I'm the world's best bed maker. Kim actually offered once to pay me to be her housekeeper (Kardashian, Kardashian, & Kardashian, 2010, p. 59).

The above quote comes from Khloé Kardashian in a section called "OCD in the DNA," discussing her meticulous house-keeping by describing it as "so OCD." On the surface, this

claim seems harmless—cute even. Khloé, the party girl, is in fact a neat freak, as juxtaposed to her sister Kim, the former closet-organizer, who is actually a bit messier than Khloé. As of this writing, Klohé Kardashian has not disclosed that she has been diagnosed with the debilitating illness; rather, she seems to be appropriating the phrase to describe her routine cleanliness habits.

Likewise, OCD is often trivialized in social media and popular culture (Pavelko & Myrick, 2015a; Pavelko & Myrick, 2015b). Pavelko and Myrick (2015a) point out that there is a widespread use of the Twitter hashtag #OCD indicating minor desires for perfection or order, rather than the illness. Over the holiday season in 2015, Target sold a sweater that read: "I have OCD: Obsessive Christmas Disorder." These misappropriations of mental illness can have the effect of delegitimizing the pain and stigma of those who actually suffer when accounted for in an identity narrative.

The popular discourses of OCD presented here are merely a sample of the wide array of available talk and text about the disorder; not discussed in detail here are discourses like actual biomedical facts, the real-life well-known sufferers, popular portrayals of other mental illnesses and psychiatric care facilities, and the experiences of individuals with others who have OCD. Some portrayals of the disorder like *The Aviator* may be beneficial for helping the general public understand the pain that can accompany OCD. Portrayals like *Monk*, on the other hand, can trivialize and delegitimize the seriousness of the disorder. Some portrayals, like *Girls*, are somewhere in the middle. Shows like *Obsessed* exploit the human experience of OCD for entertainment and hashtags like #OCD are a misappropriation. But no matter how helpful or harmful any of these popular media are, they are still each subject to interpretation and function to socially construct discourses of OCD. These available discourses are drawn on for reflexive identity story creation for the self to help make sense of one's own social and medical situation.

However, they can also be invoked by others in interactions when they are discursively making sense of what they are encountering. For example, if an organizational actor with severe OCD were to reveal their illness to a coworker, the coworker could respond with, "oh yeah! Like that Monk guy from TV! That's hilarious." Whether the organizational actor had seen the show or not, they are nonetheless subject to the portrayal when they are confronted with it in organizational interaction. At that moment, they are faced with the choice of how to respond to the invocation: they can agree with the coworker (e.g., "exactly! Monk and I are practically the same person"), reject the invocation and risk conflict (e.g., "actually, that show isn't very accurate. My experience is quite a bit different from his"), display ignorance (either real or feigned) of the portrayal (e.g., "is that a show? I've never heard of it."), or a whole host of other options for response. Whatever response is chosen, the organizational actor's identity narrative is *necessarily* shifted in this interaction, both for the individual and the coworker.

As demonstrated here, organizational actors have agency in the construction of their self-narrative while at the same time are limited and constrained by the discursive resources available to them. The organizational identity is crafted through individual interpretation and sensemaking, interaction, and exposure to experiences and messages and therefore is a dynamic and shifting communicative process.

Case Analysis: *Asylums*

In this section, I will be discussing Goffman's *Asylums* (1961) as an example of an analysis of both personal and organizational identity from a narrative perspective and additionally drawing parallels between Goffman's study of "mental hospitals" to residential OCD treatment facilities.

In *Asylums*, Goffman presents an analysis of life in "total institutions," that is, a "place of residence and work where a large number of like-situated individuals, cut off from the wider society for an appreciable period of time, together lead an enclosed, formally administered round of life" (1961, p. xiii). The total institution featured in *Asylums* is Saint Elizabeths Hospital in Washington D.C., which Goffman labels a "mental hospital." Goffman spent about a year at Saint Elizabeths, which housed over 7,000 "inmates" at the time, from 1955-1956. Goffman disguised himself to the patients as an assistant to the hospital athletic director and sought to "learn about the social world of the hospital inmate, as this world is subjectively experienced by him [sic]" (p. ix). Each inmate is at the hospital because they have been deemed unable to function outside of a clinical setting, either by a physician or a judge; some inmates were at the hospital because they had committed a crime and had plead "not guilty by reason of insanity."

The analysis of identity in a psychiatric care facility is a particularly unique and surreal venture. This setting is one that most humans will not experience and few settings, as Goffman characterizes, "could be so destructive of self-stories" (p. 153).

Goffman describes in detail the painful steps in which patients engage in the process of admission and assimilation into Saint Elizabeths: upon arrival, each patient realizes "justified or not – that he has been deserted by society and turned out of relationships by those closest to him" (p. 146). This notion of total abandonment lead to feelings and responses of shame: *what does that say about me that I have no one left*? In order to alleviate this overwhelming state, "he may very strongly feel the desire not to be known to anyone as a person who could possibly be reduced to these present circumstances, or as a person who conducted himself the way he did prior to commitment" (p. 146).

Practically every step a patient goes through in the hospital admission process contributes to this feeling of shame, or what Goffman calls *mortification:*

> Beginning with admission, of a kind of contaminative exposure occurs. On the outside, the individual can hold objects of self-feeling – such as his body, his immediate actions, his thoughts, and some of his possessions – clear of contact with alien and contaminating things. But in total institutions these territories of the self are violated; the boundary that the individual places between his being and the environment is invaded and the embodiments of self profaned (p. 23).

The *contamination of autonomy* is one of the key processes through which Goffman identifies mortification: each patient finds themselves "cleanly stripped of many of his accustomed affirmations, satisfactions, and defenses, and is subjected to a rather full set of mortifying experiences: restriction of free movement, communal living, diffuse authority of a whole echelon of people, and so on" (p. 148). As each piece of a patient's autonomy is slowly contaminated and stripped from them, the patient's self-image correspondingly sinks.

It is not only the processes of admission that break down the patient, but the very idea that he has been labeled by society as an outcast who is incapable of living on their own. Additionally, the hospital setting and the established rules

> press home to the patient that he is, after all, a mental case who has suffered some kind of social collapse on the outside, having failed in some over-all way, and that here he is of little social weight, being hardly capable of acting like a full-fledged person at all. (pp. 151-152)

When analyzing the identities of those who have found themselves in this situation,

Goffman argues that each of the patients are actively engaged in crafting their own self-narrative of *who* they are and *why* they are *where* they are. One particular narrative being constructed was for patients to allow themselves permission to be at the hospital. He provides two types of stories that patients compose: the *success story* and the *sad tale*. When telling a success story, a patient manages to "present a view of his current situation which shows the operation of favorable personal qualities in the past and a favorable destiny awaiting him" (p. 150). For this type of story, the patient reframes the seemingly negative things that have happened to him at the hospital simply as stepping stones to success; they were a quality person when he arrived and they will be a quality person when they leaves. Alternatively, the sad tale is appropriate when the "facts of a person's past and present are extremely dismal, then about the best he can do is to show that he is not responsible for what has become of him" (pp. 150-151). In identifying these two types of stories, Goffman highlights the *narrative construction* of identity: identity is formed, reformed, conceptualized, resisted, and presented in stories. Whether a patient presents their story as a success or a sad tale, either presentation is a narrative. Goffman argues that in any person's life, "one typically finds that he constructs an image of his life course-past, present, and future-which selects, abstracts, and distorts in such a way as to provide him with a view of himself that he can usefully expound in current situations" (p. 150). This claim indicates that one's self-story not only helps a patient make sense of the situation they are in, but also provides fodder to consider when making choices in the future.

The analysis presented in *Asylums* emphasizes that "people are constrained by the limited repertoire of available and sanctioned stories that they can use to interpret their experience" (Ezzy, 1998, pp. 247-248); essentially all available discourses can serve to influence, shape and constrain one's identity narrative. The interpretive repertoire of discursive resources (Taylor,

2006) available to the patients of Saint Elizabeths were at least three-fold: the conceptions and

"basic values" of society, the biomedical and physical facts of their situation, and identity

regulation from hospital staff. First, each patient's identity narrative is subject to social

conceptions of mental illness, incarceration, and "culturally acceptable plots for constructing a

self-story" (Ezzy, 1998, p. 247). This is evident in the patients' tendency to create "success

stories" or "sad tales," as each of these stories are acceptable to the public: one has had some

setbacks but will succeed someday or one is in a tough situation through no fault of his own.

Each of these plots may find grace in society's eye as opposed to a tale of an "insane" person

who is committed due to his own incapacitations.

Second, the biomedical and physical facts of each patient's situation, which themselves

are socially constructed, are significantly restrictive to their respective stories. Being committed

to an institution is an "extreme instance of how the physical facts of an establishment can be

explicitly employed to frame the conception a person takes of himself" (Goffman, 1961, p. 150).

Medical statements, charts, and diagnoses also serve to shape a patient's story and frames of

reference: a single "official sheet of paper" can attest that the patient is of "unsound mind, a

danger to himself and others–an attestation, incidentally, which seems to cut deeply into the

patient's pride, and into the possibility of his having any" (pp. 153-154).

Finally, Goffman recognizes *identity regulation* as a significant and specific set of

discursive resources, although not in those terms. He observed that in order to "succeed in

managing his daily round without complaint or trouble from [the patient]," (p. 154), a staff

member might find it useful to "be able to point out to him that the claims about himself upon

which he rationalizes his demands are false, that he is not what he is claiming to be, and that in

fact he is a failure as a person" (p. 154). Essentially, staff would break down the patient's esteem

as an autonomous, capable human and recreate him into a malleable, self-perceived failure; if the patient recognizes that they are incapable of improving on their own, they will be easier to treat and control. This identity regulation, subsequently, is an "integrally political and power-laden process" (Ezzy, 1998, p. 250). Staff needed to

> disabuse [the patient] of his view of their purposes, and cause him to appreciate that they know what they are doing, and are doing what is best for him. In brief, the difficulties caused by a patient are closely tied to his version of what has been happening to him, and if cooperation is to be secured, it helps if this version is discredited. The patient must 'insightfully' come to take, or affect to take, the hospital's view of himself. (Goffman, 1961, p. 155)

The crafting of an identity narrative, then, is not just about an individual making sense of the discourses available to them; it is also about the organizationally-defined sense-giving discourses which serve to purposefully guide the patient's identity in a certain direction in processes of managerially-framed identity regulation (Alvesson & Willmott, 2002). Consequently, identity work here involves a struggle between individual and organizational meaning when crafting or adjusting an identity narrative.

Goffman's analysis serves as an example of communicative identity construction from a narrative perspective. In that vein, I will now discuss the setting of St. Mary's Hospital[3], the location where I collected the majority of my data, and provide parallels to Saint Elizabeths Hospital in order to demonstrate the appropriateness of a narrative perspective on the obsessive-compulsive identity during ad post-intensive treatment, as both analyses focus on adults treated in an isolated setting.

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[3] Pseudonym

St. Mary's Residential OCD Facility, which will later be discussed more in this study, bears similarities to Goffman's Saint Elizabeths in many respects. While it is not considered to be a "total institution," that is, a "lock-down" facility in which patients are physically prevented from leaving, many of the "mortifying" practices are analogous. When a patient first walks through the doors of St. Mary's Residential OCD Facility, they have with them possessions that will sustain them for an indefinite amount of time; they are not given a discharge date when they arrive, they are only told that they will remain in the facility until they are better. They are physically able to leave the property and program, but is informed that if they choose to do so, they will not be allowed back. Their suitcases are then subjected to a thorough search to rid them of any item "banned" from the facility – scissors, knives, razors, needles, alcohol or any liquid containing alcohol (such as mouthwash), glass (including picture frames or perfume bottles), mirrors, pottery; anything that could be broken and used to harm herself or others. They may access them if they, say, needs to shave their face or legs, but must check them out from staff and return them promptly; if the sharps are abused, they lose check-out privileges. Along with their sharps, their cellular phone is taken from them which they can check out from the staff during the allotted time period determined by the schedule.

After their sharps are taken from them, they are escorted to their modest dormitory which they must share with another patient who has been assigned to them by the administration. They are shown the bathroom which they must share with other patients. In the bathroom, the single towel racks collapse if they are burdened with more than about 5 pounds; this is so a patient is prevented from attempting to hang themselves by looping a belt or towel around the rack and then their neck. Additionally, the void between the safety railings and the wall have been filled with plaster for the same preventative purpose.

Seven days every week, the patient engages in the above-mentioned *exposure and response prevention* therapy in which they must actively expose themselves to the obsessive object, idea, or action that triggers their compulsions and is then prevented from performing the compulsions, all under the supervision of a therapist. Every few days, the patient is sequestered for "vitals," that is, weight, temperature, blood pressure, and, if a psychiatrist has requested it, a blood test. Every hour, a staff member must physically monitor their well-being and check their name off a list of patients that are still alive and well that hour.

As do those at Saint Elizabeths, each of these contaminations strip patients of autonomy: the patient can't be trusted with a small cosmetic mirror as the staff is not confident they won't break it and mutilate their body. They can't be left alone for more than an hour, as they are not trusted to be able to take care of themselves. They are unable to use bathrooms with unattached safety railings because they are not trusted to preserve their own life. They are asked to be in their most vulnerable state performing humiliating acts in front of relative strangers. They are isolated from the general public except for weekly "outings" and accompanied trips to the local shopping mall to practice exposure and response therapy. Residential OCD treatment consistently delivers blow after blow to the autonomous self-story; at every turn there is "mortifying" evidence that the patient can't be trusted with their own safety and well-being similar to Goffman's Saint Elizabeths. And it's true – they can't be trusted; the hospital has these restrictions in place because other patients have demonstrated a need for them. So during treatment and after a patient leaves this facility, one can imagine that their self-story is irrevocably changed.

Often, biomedical facts and staff framing go hand in hand. While patients here might not experience quite the same level of disabuse of ideas as those as Saint Elizabeths, it is certainly a

staff practice to get patients to "buy into" the treatment program through identity regulation. Each patient is encouraged to quickly assume that the treatment program and practitioners are acting in the patient's best interest; any ideas that a patient can improve on their own is squelched. This is necessary, as the patient is most often seriously disabled and must complete the treatment in order to improve.

Each patient's story is constrained and constituted by the discursive resources they have available to them; however, they also have agency when reflexively and unreflexively engaging in the identity work of selective appropriation (McAdams, 1999). The discursive resources available to a patient are vast and complex; they include the social discourses about OCD mentioned above, and like Goffman suggests, biomedical facts and identity regulation framing discourses from hospital staff. Biomedical facts and constructs abound in health care facilities like residential OCD programs: when a patient arrives, they studied and given a sub-diagnosis to OCD, that is, the type of OCD they have (e.g., contamination, scrupulosity, harm, etc. These categories are quite vague and often involve many more explaining details when assigned. Rarely does one patient only experience one kind exclusively). When given the sub-diagnosis (which may already be known to the patient), this label then becomes fodder for identifying oneself to other patients. It is not uncommon for patients to ask one another, "what kind of OCD do you have?" At this time, the asked has the opportunity to contribute to their narrative, to take the discourses at their disposal and craft an acceptable presentation as conversation and interaction serve as a site for identity construction. That presentation, then, becomes a discursive resource for the next time they present or reflexively consider their story. Other biomedical facts a patient has access to are their psychological testing scores of that particular week, their

quantified progress in the program, and the medications they take. All of these resources are opportunities for identity reformation.

One area of research that has not been appropriately addressed by literature is the influence of an organizational actor's narrative identity when it involves a residential or partial stay in a psychiatric care facility for severe obsessive-compulsive disorder. Each patient leaves the facility with a story, whether is it is Goffman's success story, sad tale, or another socially acceptable explanation of their time away from society. This self-narrative, this identity, undoubtedly permeates the former patient as they merge their way back into working life, or sometimes, get a job for the first time. What is needed now is an *investigation of how this story is crafted by the OCD patient* as they go about organizational life: performing everyday tasks, disclosing their disability, requesting accommodations, performing rituals, managing those rituals, practicing ERP therapy at work, among many other struggles.

Applied Communication Research

As previously stated, it is my aim to create a practical career counseling curriculum to be used in intensive OCD treatment facilities. This goal is situated in a more general context of applied communication research, that is, communication research that takes place in an applied setting and addresses a real-world, practical problem (Frey & SunWolf, 2009).

Applied communication research primarily serves at least two purposes (Seibold, 1995): first, it functions to address an applied agenda--that is, putting the primary focus of research on addressing a practical problem in the field with a secondary focus on theory development. For example, Hecht and Miller-Day (2009) addressed a rising trend of teen drug use and crafted a practical intervention to address it. In the report of their research, they indeed made some

theoretical contributions to narrative theory; however, these contributions were subordinate to their main goal.

Second, applied communication research functions to test or apply a theoretical proposition to an applied setting or problem with the primary focus being on theory development. For example, Keyton et al. (2009) conceptualized this type of study to produce conclusions like, "X theory is an explanation for Y phenomenon, especially in the setting of Z." In this type of study, the main goal is developing theory X, with setting Z being somewhat arbitrary.

Applied communication research generally tends to fall into a continuum proposed by Frey and SunWolf (2009): on one end of the spectrum lies research in the category of *observation and recommendation,* and on the other end, *intervention*. On the observation/recommendation end is research that, according to Frey (2009), makes a difference *from* research. That is, this type of study will observe and address a practical problem and subsequently make recommendations for the management of that problem. These recommendations can be made directly to a research site or in the publication of the research report. For example, Bisel et al. (2011) set out to address the practical problem of the Moral Mum Effect, that is, the phenomenon of subordinates refraining from objecting to an unethical or immoral request made of them by their supervisor. The authors surveyed workers from a variety of organizations to get an idea of the specific struggles being faced associated with the Moral Mum Effect. The article subsequently featured a set of ten suggestions for actual responses subordinates could use in these ethical dilemmas, rooted in Politeness Theory. For instance, one of the recommended scripts to use was, "do you remember when George did something that was similar to what you're asking me to do, and we all concluded that it was unethical? Do you think

this situation at all resembles what happened with George?" This suggestion was made based on the Politeness Theory assertion of appealing to others' face needs.

On the intervention end of the spectrum, studies are conducted that make a difference *through* research (Frey, 2009). In this type of research, scholars implement a particular theory-based program for the management of a specific problem and then assess the outcomes. The purposes of a communication research intervention can fall under a wide range, from a paid communication consultation to improve the communication skills of workers in a Fortune 500 company to a social justice intervention to improve the communicative ways in which a community acquires clean water. Frey and SunWolf (2009) identify a variety of ways in which an intervention may be implemented, including communication skills training, communication counseling, inoculations, and theatre performances, among many others. For example, in a series of articles called "Saving Sex for Later," scholars sent out training videos to parents on how to talk to their teenaged and pre-teen children about sex and persuade them to abstain from it until a later date (O'Donnell et al., 2007). The videos contained directed ways in which parents could engage with their children that were suggested through research to produce positive outcomes. Because the intervention was a part of the research process, this study meets the criteria of making a difference *through* research (Frey, 2009).

The communication discipline has history of health-care interventions for intellectual and developmental disabilities, which tend to affect communication skills (for a more detailed exploration of these interventions, see the meta-analysis from Snell et. al, 2010). There have also been interventions designed to help individuals with mental illness or a family member with mental illness cope with the communicative issues that arise due to the illness (e.g., Reuper & Maybery, 2007). Additionally, there have been clinical communication interventions to address

the symptomatic issues related to OCD (e.g., Steketee & Van Noppen, 2004). However, there is a clear gap in the intervention literature when it comes to communicative interventions for organizational identity with OCD.

Generally, most interventions takes a deductive approach to their relationship with theory: theory is "driving" the intervention. This relationship is crucial, as interventions may be ineffective when solely based on, say, good intensions or common sense (Kreps, 2012). They must be based in evidence in order to make a difference; interventions driven by theory are far likelier to have positive outcomes than those that are not (Kreps, 2012). For example, the aforementioned Hecht and Miller-Day (2009) study on teen drug use employed the use of Narrative Theory when implementing their intervention, which asserts that when an individual integrates a value into their personal identity narrative, that integration can lead to behavior change based on that value. When designing the intervention, the authors gathered contextual data by asking high school students how they had previously been able to successfully resist drugs in the past. Drawing on Narrative Theory, the authors transformed the techniques they had gathered in the data collection phase into story-based scenes and skits that could be acted out for teens and also scripts that could be read to teens. Similarly, Bisel et al. (2011) incorporated the idea of face needs from Politeness Theory to shape the suggestions they made to subordinates in resisting unethical requests from supervisors.

When theory drives an intervention, the intervention also performs the function of creating a feedback loop to theory; that is, when an intervention is utilizing a theory and then assesses outcomes, the outcomes then serve to either confirm or adjust the parameters of the theory. Using the Hecht and Miller-Day (2009) study mentioned above as an example, since they found their intervention to be effective, the authors could also contribute to narrative theory by

asserting their results suggest that when an individual integrates a value into their personal identity narrative, that integration can lead to behavior change based on that value, *especially in the case of high school students resisting drugs.* Since the applied goal of this study is to help people with OCD manage their organizational identities, subsequent research in this agenda will contribute to theories of communication, identity, and organizing, *especially in the case of individuals with OCD.*

Chapter Summary

The fields of communication and disability studies have made great strides in the area of managing a disability, including topics of hidden and visible disabilities, the problems associated with identity management and disclosure, and stigma. However, there is a clear gap in the scholarship when it comes to dealing with OCD at work. Narrative identity scholarship has also addressed issues of disability, organizational membership, and the use of discursive resources, but has not specifically addressed the identity management of OCD and the discursive resources engaged to managed an obsessive-compulsive identity at work. Goffman's *Asylums* addressed the experiences and effects of institutionalized treatment, but falls short when it comes to more modern forms of institutionalization. Finally, applied communication research has created many interventions to improve health care, but hasn't approached the problems individuals with OCD face as they attempt to function in the workplace and workforce. In light of the issues addressed and theoretical frameworks discussed, I now present my research question:

RQ: How do individuals with OCD negotiate their organizational identity?

In investigating this question, I will be seeking to explore ways in which individuals with OCD negotiate their organizational identities, specifically narratively. In the next chapter, I will be identifying the methods I used to explore this question.

CHAPTER 3

METHODS

Methodological Considerations

Conducting research that addresses issues of both disability and narrative identity brings

up methodological questions about the precedence of both. In this section, I will be examining

methods that have been used to study both issues respectively and indicating what implications

these studies had on my own choice of methods.

Qualitative Disability Research

There are many ways to explore issues of disability from a qualitative perspective.

O'Day and Killeen (2002) suggest four underlying assumptions through which qualitative

disability research has set itself apart from more quantitative, post-positivist disability research;

these assumptions give qualitative methods their "capacity to reveal the processes underlying

subtle and complex interacting phenomena" (p. 10). First, qualitative disability researchers

generally assume that a value-free perspective is not possible in any kind of research.

Subsequently, these scholars "attempt to discover and report on their own assumptions, values,

and biases so that their conclusions can be understood and critiqued within that framework" (p.

10). Second, a qualitative perspective on disability research assumes that there is no attempt on

the part of the researcher to distance themselves from the participants of their studies. In other

words, an *empathetic* stance is preferred over an *objective* stance. This view allows for discovery

rather than seeking confirmation of pre-conceived hypotheses. Third, a qualitative disability

researcher assumes the role of *active learner* who seeks to tell the story from the participant's

point of view rather than acting as an expert with more expertise than those living with a

disability. Qualitative methods indeed allow for participants to use their own voices when telling

their story rather than conforming to the vocabulary or categories pre-determined by the researcher. Finally, reality is assumed to be both contextual and socially constructed. From this perspective, a researcher's aim is not to uncover a pre-existing truth, but rather, to uncover meaning and how people make sense of their lives and experiences.

Brantlinger, Jimenez, Pugach, and Richardson (2005) identify "quality indicators" within qualitative research, that is, sets of guidelines that indicate credibility and methodological rigor. For interview studies, the authors suggest that a project should feature appropriate participant selection (participants who are purposefully identified, effectively recruited, in adequate number, and are representative the population of interest), reasonable interview questions (clearly worded, not leading, appropriate and sufficient for exploring the domain of interest), adequate mechanisms to record and transcribe interviews, confidentiality measures, and sensitive and fair reporting. Likewise, credible data analysis should include systematic and meaningful coding, sufficient rationale, documentation of methods, reflection of a researcher's personal position, conclusions that are substantiated by sufficient participant quotes, and logical connections between evidence and conclusions.

Empirical examples. Many empirical disability studies have approached data collection and analysis from a qualitative perspective. Below, I will present two such studies and describe their methodological strategies. Then, I will discuss what implications these studies have on my own research methods.

Vedeler and Shreuer (2011) explored the differences between experience with workplace accommodations in Norway and the United States. The authors conducted interviews with 29 participants: 14 from the US and 15 from Norway. They used "semi-structured" interviews to "offer interviewees the opportunity to give responses in the form of stories" (p.

98). The interviewers were guided by "main themes" like schooling, education, welfare services, entrance into working life, and accommodations, but also followed up with interviewees on issues they raised as important for their career. The data collection resulted in rich stories of participant's experiences with accommodation processes and navigating organizational life.

When discussing data analysis, the authors describe using a "categorical-content analysis." They focused on emerging themes and used a circular process involving reading the data, suggesting categories, and generating ideas for new categories or refinement of the existing ones. They concluded that three categories of workplace accommodations "emerged:" types of accommodations, employee adaptation to the workplace, and interviewee's experiences and interactions.

Secondly, Lebowitz, Vitulano, & Omer (2011) interviewed the parents of ten children who were exhibiting violent and/or coercive behaviors associated with their OCD. The interviewers used pointed probes like, "please tell me about any behavioral difficulties you have had with your child." The parents were also asked about the history of the child's OCD, the parents' reactions to the child's disruptive behavior, family environment, and parenting style. The authors describe using grounded theory strategies for data analysis including constant comparison analysis. The analysis began with coders identifying disruptive or coercive behaviors and then moved to creating categories for the behaviors.

Implications for my research. Both of the studies mentioned above have implications and provide direction for the ways in which I conducted my study on adults with OCD. First, Vedeler and Shreuer's (2011) study provides an example of a study which utilizes interviews which yield rich, detailed stories. I collected data in a similar way to gather similar data: I

conducted in-depth interviews with adults with OCD and asked them questions about their stories and experiences, specifically regarding navigating organizational life. Second, like Lebowitz et al. (2011), I utilized a structured grounded theory approach (discussed more below).

Narrative Identity Research

Alvesson et al. (2008) offer directions on how organizational identity has been and should be studied, as "the study of identity work in organizations involves a focused examination of specific processes and influences entailed in individual identity construction (p. 15). The authors organize methodological possibilities in terms of categories: *interviews, observation*, and *reading texts*. For this study, I utilized *interviews*; since I was only collecting interview data, I was unable to observe the participants in their respective places of work, as that would have created countless issues related to privacy.

Through interview accounts, Alvesson et al. (2008) suggest a researcher can access the "sense-making of individuals" concerning their identity (p. 20). Conducting interviews is a largely popular approach, in no small part due to their ease and efficiency. The authors also find that interviews can also been seen as identity crafting in and of themselves, as calling attention to "who one is" in relation to "what one does" (p. 21) can provoke intense identity work. While the interview has been widely used and is indeed critical for accessing the sensemaking processes of organizational workers, some social science perspectives like neopositivism privilege interview data as a way of tapping into organizational "reality" or "facts" and value objectivity and neutrality (Alvesson, 2003). It is important, Alvesson (2003) argues, not to

> simplify and idealize the interview situation, assuming that the interviewee – given the
>
> correct interview technique – primarily is a competent and moral truth teller, acting in the

service of science and producing the data needed to reveal his or her 'interior' (i.e.,

experiences, feelings, values) or the 'facts' of the organization." (p. 14)

Alternatively, Alvesson (2003) offers many metaphors through which we may conceptualize

interviews, the most appropriate for this study being "the interview as identity work." When

participants are called on in the context of certain identities, their interview responses might

reflect such a label; for example, if someone were to be interviewed as a *woman*, a *leader*, a

middle manager, or *a worker with OCD,* "different identities are invoked, as well as different

inclinations to interpret the entire interview situation and different specific questions and

evaluations of what kinds of answers are appropriate" (Alvesson, 2003, p. 20). A researcher can

often err on either side of the spectrum of clarity: being too vague about what facets of identity

are being explored can lead a researcher to be unaware of "how language use and other signals

may operate on the person being interviewed in terms of identity" (p. 20). On the other hand,

being too "explicit about the identity position optimal for the research project may be

counterproductive since it fixes the responses too firmly" (p. 20). Therefore, interviews must be

read taking into account many situational factors, including the influence of the identities being

called upon in that interview, and should not be read as an expression of "reality" or

"organizational fact."

Identity may also be revealed in such texts as artifacts, offices, dress, and other consumer

objects. In most cases, the authors argue, interviews and/or observations are still necessary for

interpreting and understanding the context of these artifacts.

Ezzy (1998) also offers suggestions on how narrative identity should be studied. He

argues that there must be a focus on the interpretive process that takes place in identity work and

warns against assuming interview texts to be unproblematically reflective of reality and

"orientations that disregard references to reality as epistemologically problematic" (p. 251):
beyond the fact that different people interpret different things and events in different ways,
research should be "directed toward the ongoing cyclical interaction between narration and
action" (p. 251). A narrative approach, Ezzy claims, would methodologically imply a focus on
"how the interpretive resources that people bring to situations interact with the events they
experience to shape the narrative that is then produced" (p. 251).

Clearly, identity research is a nuanced endeavor in which many factors must be taken into
account; the research process is not unproblematic and should not be assumed to be an
uncovering of truth. Rather, each collection and interpretation of data should be carefully
considered in its situational context.

Empirical examples. Many organizational studies have examined identity from a
narrative perspective. Each of the studies featured here takes a bit of a different approach to data
collection and analysis for the purpose of covering a variety of methodological possibilities for
the study of narrative organizational identity.

The first example featured here comes from Lutgen-Sandvik (2008), who studied the
narrative identity work that takes place as a response to the trauma of workplace bullying. In her
analysis, she discovered several phases through which narratives can transform and confirmed
theories that identity narratives function are driven by desires for stability, equilibrium, and
predictability. Methodologically, Lutgen-Sandvik interviewed over 200 adults affected by
workplace bullying from the US, Canada, the UK, the Netherlands, and South Africa. Most of
the interviewees were targets of bullying; others were coworkers, family, friends, and bullies, in
that order. From that interview data, she chose 20 transcripts of bullied workers, selecting an
equal number of men and women to feature in the article. She chose to gather most of her

participants from the US because up until the date of her article, that population had been the least studied in this area of research. She also chose that location because of prevalent victim-blaming discourses in the US.

Lutgen-Sandvik chose to conduct "in-depth" interviews because it is an "approach epistemologically based on the principle that humans are self-reflexive and make sense of their lived experience by recounting that experience" (p. 102). The author refers to Lindlof and Taylor (2002) when she claims that interviews locate verbal awareness, from a participants' standpoint, as the "pertinent starting place for understanding the phenomenological nature of lived experiences" (Lutgen-Sandvik, 2008, p. 102).

The author approached her data from a "grounded perspective" (p. 102), calling on Charmaz (2001) and Glaser and Strauss (1967) as theoretical bases. She clarifies that by "grounded theory," she means that "initial data coding of identity work came entirely from the data rather than being sensitized by any set of *a priori* identity work categories" (p. 102). Lutgen-Sandvik coded the data using first person pronouns like *I, I'm, my, mine*, etc. because these words "pointed toward implications of self-identity in relation to the experience and participant responses in light of self-identity narratives" (pp. 102-103). She used a constant comparison analysis to add new codes if existing codes failed to capture new data characteristics and continued to code interview data until she found no new types of identity work and open codes were saturated which resulted in 84 open codes for identity work.

Toward the end of the article, Lutgen-Sandvik qualified her use of interviews and emphasized their interpretive and sense-making nature:

Although interviews do not render objective 'truths', they do provide a window for

phenomenological understanding for comprehending experiences from the perspective of

affected persons. In fact, I cannot objectively know whether participants were bullied; I

know only that participants believed they were bullied. However, the perception of

bullying was sufficient, given the study's focus, since descriptions of perceived bullying

illustrate the reflexive process of identity work. In fact, identity work appeared to direct

interviews. Underlying researcher- participant interactions was a sense that participants

wanted information, empathy, and, more than these, to be believed. As such, interviews

provided many examples of how targets performed identity work (p. 115, emphasis in

original).

The next empirical example of a study of narrative identity is from Sveningsson and Alvesson

(2003), who sought to deeply explore the narrative of one manager to describe "empirically and

make sense of the construction of managerial identity in the context of a multitude of

organization/work-based identifications, identity regulations, and identity work, illuminating

fragmentation as well as integration" (p. 1166). To this end, the authors methodologically

focused on one single individual, a senior manager at a large research and development

company, and studied her in "considerable depth, as well as in context" (p. 1165). Their aim in

doing so was to "produce a thick or rich case, in opposition to the rather thin notion of identity

expressed in, for example, most social identity and organizational identification studies" (p.

1165). Therefore, they advertise their study as an example of the "advantage of choosing a

limited site, a manager, to study somewhat wider organizational processes and the importance of

using a multi-level intensive study in order to understand identity constructions" (p. 1166). In

other words, the authors sought to understand one organizational worker's identity by watching

her identity play out at multiple levels.

Sveningsson and Alvesson took a "multi-angled" approach to the study of their "heroine," the manger whose identity they were examining. They conducted six interviews with her personally and 40 interviews with other managers at the organization about the heroine and her position. They also had many informal discussions with the heroine and her colleagues about role expectations, identity work, and the development of the organization. They made observations at various managerial and employee gatherings where issues of role expectations and identity were discussed, including 14 meetings.

The authors emphasize that communication with the heroine got deeper as the interviews and informal talks progressed; they also found that interviewees felt they could speak more freely when they were in "neutral" zones, like university offices as opposed to the company grounds. Similar to Lutgen-Sandvik (2008), Sveningsson and Alvesson also qualified their interview data and warned against the assumption that they were presenting objective truths:

> independent of when and where, interviews are problematic as media for the communication of 'truths' or 'genuine experiences' because of the existence of a multitude of contextual influences as social norms, scripts for talking, value-laden language, expectations of both the interviewee and interviewer, political interests (p. 1170).

The authors argue that gathering interviews from "a multitude" (p. 1170) of employees strengthened the credibility of the data. They claim that if scholars truly want to understand identity, they "need to listen carefully to the stories of those [they] claim to understand and to study their interactions, the discourses and roles they are constituted by or resist – and do so with sensitivity for context" (p. 1190).

Humphreys and Brown (2002) explored issues of narrative identity and identification at a university in the UK, working from the notion that organizational actors make sense of their world and read meaning into their lives from personal and shared narratives. The authors lead their methodology section by establishing that they are conducting research from an "interpretive perspective," which they emphasize by explaining that the "authors were immersed in a stream of organizational events" (p. 426). Their primary goal was to "produce an ethnographic account of the working lives" of organizational actors in particular factions of the university.

Their principal data consisted of 42 semi-structured interviews and an unspecified number of more informal interviews and observations that had been conducted over a 15-year time span. They also looked at a "huge range" of documentation, including internet pages, published articles, official working documentation such as committee minutes, letters and memos, and newspaper and magazine reports referring to the institute.

One key factor to Humphreys and Brown's methods was that one of the authors worked at the university that was being studied (which author was not specified); the authors found this setup to have its advantages and disadvantages. On one hand, the employed author found incredible access to the organization, to both its formal and informal communication. Acting as a participant observer, the employed author discovered that "participant observation methodology exposed for us the extent to which the authoring of an organizational narrative is an artful process of selective re-appropriation designed to produce a representation that others will find authentic, plausible, and verismilitudinous" (p. 427). In other words, the employed author had access to the organization that he might not have if he were an outside researcher.

On the other hand, the authors found that being an "organizational insider" posed difficulties as well; the access process alone took over a year to complete as the employees of the

university were "intensely" suspicious of the researchers (p. 426). One of the employees even went so far as to file a written ethical objection to the research. However, they were able to overcome this obstacle to gain access.

Sims (2003) set out to better understand the lives of middle managers by "considering the special pressures on them to tell stories about their organization that make sense" to a variety of different audiences (p. 1195). Branching away a bit from traditional data presentation, Sims framed the presentation and analysis of narrative data as both an artistic and scientific endeavor. Rather than repeating the interview and observation he collected from participants word for word in his article, Sims takes artistic license with the data, summarizing stories, combining stories, creating new characters, and creating an overall impression:

In this article, I have selected four stories. In each case I have known several participants who could have told stories about the events covered. In common with all qualitative approaches to research, I have not had room to relay to the reader everything that I have heard. I have presented the stories as vignettes, and done my best to piece together, in each case from many hours of listening to participants in the situation, a version of the story which would be fair and recognizable to many of those involved, and which, like many stories, reflects the view of more than one participant. This means that not all my processes of summary and analysis are visible to the reader, and no doubt there are aspects of those stories that I have edited to convey a realistic impression of the stories that I heard (Watson, 2000). My claim for the stories is that they have 'narrative truth' (Bruner, 1990), described by Spence (1984) as the truth that, though it might be only a screen memory or even a fiction, was still close enough to the real thing to start a reconstructive process going. The stories presented are designed to evoke for the reader,

as closely as possible, the events and stories experienced by participants and told to the

author. (p. 1198, citations in original)

Sims presents dramatic and catchy stories in his article. While he is not specific in his exact data

collection and analysis procedures, Sims still manages to make his point about the character of

managerial identity and clearly qualifies the artistic nature of his data.

Finally, Kuhn (2006) investigates how identity work and identity regulation are

constructed and influenced by discursive resources, both those specific to geographic and social

locations and organizations. In order to explore how "locale-specific" Discourses ("capital D"

discourse in the vernacular of Alvesson & Kärreman, 2000) influenced and constrained identity,

the author collected data from two different organizations in different parts of the United States.

At one organization, Kuhn made observations for nine months and conducted 22 interviews; at

the other, he conducted 31 interviews. Like other identity scholars, Kuhn also acknowledges that

interview responses "cannot be assumed to provide unmediated access to psychological states or

external organizational realities" (p. 1344) and qualifies his data as best being understood as a

product of local context. To that end, the author viewed his data as "accounts…that are portrayed

not as private experiences, but as expressions of commonly held discursive resources involved in

identity regulation and identity work" (p. 1344). This recognition, Kuhn argues, is important

because narrative identities are "considered discursive constructions realized and negotiated in

interaction, and the interview is one relevant forum for this" (p. 1344).

Kuhn is transparent and detailed about his data collection and analysis; he describes

having a "moderate" knowledge of the organizations and professions he was exploring, which

was instrumental to his interview and analysis process. Next, he describes each interview event

as a "joint activity," (p. 1345) in which certain "communicative moves" were required to

"maintain attention on workplace discourse and identity" (p. 1345) that included both directed and follow-up questions. When discussing data analysis, the author frames the interviews not as "private reactions" to organizational pressures but, rather, as the "result of typified discursive resources shaped by organizations and locales" (p. 1345), again emphasizing the discursive nature of identity. To this end, Kuhn takes an interpretive approach to data analysis, utilizing Straussian (1987) based coding. As the author identified particular discursive resources that appeared across multiple interview contexts, he coded each of these discourses as "statements," rather than attempting to code each interview as representative of an individual.

Implications for my research. Even though each of these empirical articles takes a different approach to data collection and analysis, each of them have implications for the way I am chose to conduct this research. Addressing Alvesson et al.'s (2008) recommendations for identity research (interviews, observation, and reading texts), I utilized one of their suggestions: interviews.

Interviews. First, I conducted interviews at a psychiatric treatment facility, which resembles the data collection strategy used by Lutgen-Sandvik (2008), in that she gathered interview data from participants who were from all over the world, only specifying that the participants only needed to have experienced workplace bullying, committed workplace bullying, or be the family member, friend, or co-worker of someone who had. For my data collection, I solicited interviews from participants who are or had been employed in different organizations, but all are all part of the same respective treatment organization or type of treatment organization. This strategy was employed following the example of Sveningsson and Alvesson (2003), as the interviews took place in a location that was completely separate from the participants' workplaces; their potentially stigmatic identities as adults with obsessive-

compulsive disorder would not be revealed to their place of employment. Lutgen-Sandvik also chose her population based on where the research had been the thinnest (most of her participants were from the United States), and I will be following this example by researching a population that has largely been ignored in organizational communication research.

To analyze interview data, I will be taking a grounded approach in the tradition of Glaser and Straus (1967), but more closely following the constructivist interpretivism of Charmaz's take on grounded theory (2001, more on this below). To that end, I will employ the use of open coding, selective coding, and constant comparison analysis, not placing any *a priori* theoretical constructs onto the coding of the data, with the exception of categorizing types of OCD symptoms, as there are already well-established categories. I also approached the data from a qualified perspective, as utilized by Kuhn (2006), Lutgen-Sandvik (2008), and Sveningsson and Alvesson (2003). Each of these studies acknowledge that interview data is not necessarily a reflection of objective truth or organizational reality, but rather interview data is a construction of discursive resources that is influenced by a multitude of factors like expectations, self-presentation desires, and social norms.

Drawing on Sims (2003), I will be presenting some of my data later in this paper as an impression of an interview, as I was only able to record the Skype interviews of former patients. At my primary data site, I was not given access to record interviews. Therefore, I did my very best to take verbatim notes during each interview. Some notes were shorthand or paraphrasing what each participant said and was fleshed out directly following the interview so that my memory of the encounter was fresh. I will be "presenting a realistic impression of the stories that I [have] heard" (Sims, 2003, p. 1195). While I will not be making up new characters or

combining stories, it is important to have a precedent for presenting impressions of interview rather than verbatim transcripts.

Research Setting

St. Mary's Hospital flagship campus is in the United States. St. Mary's treats only mental illness and psychiatric issues, including OCD, mood disorders (such as depression or bipolar disorder), addiction, eating disorders, and post-traumatic stress disorder. Each of these categories of treatment has its own specific department and range of treatment options. St. Mary's is one of only three hospitals in the United States to offer intensive residential treatment exclusively for OCD. In addition to residential treatment programs which involve a patient living on campus, the hospital also offers a Partial Hospitalization Program (PHP) in which a patient is in treatment for about six hours a day, four days a week, and Intensive Outpatient Treatment (IOP), in which a patient is in treatment for three hours a day, five days a week. If a patient is in a state of crisis or is a risk to themselves or others, there is also inpatient treatment available at the flagship campus. Across the state in which the flagship hospital is located, St. Mary's has five other campuses that offer IOP and PHP treatment.

A hospital that treats severe OCD is especially appropriate for exploring my research questions in at least three ways: first, I am seeking to investigate the identity narratives of adults with OCD. A clinic that treats the most severe cases is an ideal place in which to do interview data collection as this is the very population I am targeting. Second, a hospital that treats OCD is the most practical place to find a large collection of adults with severe OCD in one physical location. While 2% to 3% of the population has the disorder (Marques et al., 2010), this group of adults is scattered throughout the world; an organization in which this group is self-identified is a key location for data collection. Finally, the applied intervention I am creating will ideally

eventually take place at a hospital that treats severe OCD, as patients there will likely need the most help when it comes to navigating work life.

I chose St. Mary's specifically for two reasons: first, as mentioned above, this is one of the three hospitals in the United States that offers the highest levels of intensive treatment for OCD. The hospital is renowned for its treatment and even has a rather prolific research center at the flagship campus. I wanted to collect data in a location that is on the cutting edge of treatment and research in the field of OCD, as the research faculty and staff are very familiar with researchers coming in and requesting access to their patients. Also, a research-oriented facility might be the most willing to implement any practical interventions that may come out of my research. Second, I have a congenial relationship with the clinical director of OCD treatment at St. Mary's. Before requesting access for research, I had met the director several times and he and I connected over academia and treatment ideas. Therefore, when it was time to choose a research site, St. Mary's seemed to be the most appropriate and the most likely to grant me access. I also requested access to another hospital system, but was not granted access.

The other research site I utilized was virtual. I was able to contact several individuals who had previously engaged in intensive treatment for their OCD. I conducted those interviews over Skype, and therefore those 12 participants were in their respective homes during the interviews.

Access and Human Subjects

On September 7, 2016, I contacted the clinical director of St. Mary's to begin requesting access. The director and I negotiated back and forth via email about what sort of access I could have. I requested to be able to do recorded interviews of patients in the IOP, PHP, and residential OCD programs at three clinic locations. He countered by insisting that the hospital would not

allow any researcher to record (audio or otherwise) any of the patients. I responded that I could

just take notes during interviews rather than recording them. He seemed satisfied with this, and

subsequently, I submitted the agreed-upon data collection methods to the University of Colorado

IRB. The protocol was met with several amendments, but was eventually approved on

September 29, 2016 (protocol number: 16-0611).

After I received the IRB notification that my protocol had been approved, I sent the

protocol to the clinical director of St. Mary's. From there, the research had to be approved by the

St. Mary's Human Subjects Committee and then the Clinical Effectiveness Committee. This

process took several months, as the committees had various meeting schedules. The research was

approved by the Human Subjects Committee on October 14, 2016 and the Clinical Effectiveness

Committee on November 21, 2016. While most of the data collection was approved outright, the

Clinical Effectiveness Committee asked that I only collect data from the IOP and PHP clinics, as

there were several ongoing studies in the residential clinic and they didn't want to overwhelm the

patients. Therefore, I was granted access to interview patients in the IOP and PHP clinics in three

cities.

When first completing the IRB forms for the University of Colorado, I was curious as to

whether adults with OCD would be considered a "vulnerable population," which are "individuals

who are unable to give informed consent or who are susceptible to coercion" (Ruof, 2004, p.

412). When it comes to adults with mental illness, the University of Colorado IRB includes

"cognitively impaired/educationally disadvantaged individuals" as a vulnerable population; the

Common Rule (a 1981 code of ethics which generally governs human subjects research) mirrors

this category by citing that "mentally disabled" individuals would be considered a vulnerable

population. I emailed the CU IRB social science review coordinator (Doug Grafel) for some

clarification: how do mental illnesses fit into the guidelines for vulnerable populations? Doug explained that there are generally two factors involved in decided whether a group of people are a vulnerable population with it comes to mental illness: first, are the patients in treatment by their own choice or have they been involuntarily institutionalized? Second, does the mental illness in any way impede an individual's ability to understand the consent process and make a free and autonomous decision to participate?

Addressing the first guideline, if a patient has been involuntarily institutionalized, they would be comparable to an imprisoned subject, who might be particularly affected by the institution when it comes to "free choice," that is, they might be more easily coerced to participate in a research project than an un-imprisoned individual. At St. Mary's, each patient in the residential, IOP, and PHP clinics are there by their own free will; they are free to leave at any time. There are no physical restraints on any patients and the doors remain unlocked from the inside at all times. Therefore, the adults in my study would not qualify as "vulnerable" from this perspective.

The purpose of the second guideline is to ensure that individuals with intellectual impairment aren't taken advantage of. In general, research is quite mixed on the exact cognitive impairments associated with OCD; even a meta-analysis of 50 studies of cognitive correlation with OCD cited that there is not a "clear and specific neuropsychological profile" (Kuelz, Hohagen, & Voderholzer, 2004, p. 230). The most common cognitive deficits cited among sufferers are memory, set-shifting (the ability to shift attention from one aspect of a stimulus to another), response inhibition (executive control over motor responses), and attentional processing (ability to shift attention away from distressing cognitions) (Chamberlain, Blackweel, Fineber, Robbins, & Sahakian, 2005). However, there is no suggested correlation between OCD

and intelligence or ability to process information (Schmidtke, Schorb, Winkelmann, & Hohagen, 1998). Therefore, individuals with OCD would not be considered to be "vulnerable" according to general guidelines. Through discussion with Doug Grafel, we decided that the patients at St. Mary's would not be considered a vulnerable population and the IRB protocol was approved with this classification.

That being said, this data collection was not a straight-forward endeavor. Even though patients in intensive OCD treatment do not have any intellectual impairment, they are still in an incredibly sensitive and vulnerable chapter in their lives. While the University of Colorado IRB may not consider them technically a vulnerable population, they are indeed more vulnerable than the average research participant. OCD is an illness with no clear set of manifestations; in fact, much OCD research has been limited due to the illness' heterogeneous symptomatology (Abramowitz, Taylor, & McKay, 2009). Therefore, this data collection was approached with sensitivity and thoughtfulness. As an example of such a need, I encountered a PHP patient who, as part of his OCD, had an intense fear of stigma associated with his illness. I met with him in his therapy room, which is a tiny office space each patient is given to practice their exposures. I went over the informed consent procedures with him and he agreed to be interviewed and signed the consent form. As he signed the form, he asked me, "you're sure you're not going to use my real name?"

"No sir, I promise I won't," I replied.

He expressed his fear over stigma: he is a health care professional himself and would be very disturbed if it got out that he himself was mentally ill. We started the interview, and he shyly asked me again if I was going to use his real name.

"No sir, I will definitely change it."

We continued the interview and he revealed where he went to college.

"Now, you're not going to put in there where I went to college, right?" He questioned.

"That's correct, I will not include any proper names in the paper." I said. He still seemed uneasy. A few minutes later, he asked me a third time if I was really sure I wasn't going to use his real name. I responded, "Do you really not know if I am or not? Or are you needing reassurance?" One of the typical symptoms of OCD is seeking reassurance for things one knows is true but feels compulsed to have confirmed (as an illustration of this, I witnessed a patient with a fear of poisoning asking a therapist over and over again, at least 30 times, if the hospital psychiatrist would ever prescribe her any medications she didn't need). When I approached my interviewee about reassurance-seeking during the interview, he seemed to have a small moment of revelation, like he hadn't realized his line of questions was rooted in OCD. He responded calmly, "yes, it's reassurance. We can keep going." He ended up asking me again if I was going to use his real name a few days later, but I just reassured him again.

This example shows one of the unique issues that arose during data collection of this specific population. My knowledge of the symptoms and treatment of OCD well prepared me to handle these types of situations with thoughtfulness and care.

Participants

The participants in this study consist of 12 PHP patients from various St. Mary's clinics, 10 IOP patients from St. Mary's, and 12 adults with OCD who had previously completed intensive OCD treatment at St. Mary's or another similar institution. Ten of the former patients had attended St. Mary's residential program, and two had attended other programs from different hospitals, one IOP and one residential. This made for a total of 34 participants. Nineteen of the participants are female and 15 are male. Participants ranged in age from 19 to 66 years of age.

Treatment duration at the time of each interview varied from one week to seven months. In addition to their OCD, participants reported co-morbid diagnoses of suicidal ideation (n=9), major depressive disorder (9), generalized anxiety disorder (8), borderline personality disorder (2), attention deficit hyperactivity disorder (2), trichotillomania (2), excoriation (1), and Tourette's (1).

Participants reported being in various states of employment. Of those employed full time (n=10), occupations included retail, project management, nursing, accounting, real estate, customer service, mechanics, grocery, and education. Of those employed part-time (n=9), occupations included food service, grocery, law, education, custodial work, and fitness. Of those not traditionally employed, eight were unemployed, two were full-time students, two were involved in university internships, one was on government disability, one was retired, one was a stay-at-home parent, one was a student on a leave of absence, and one was a volunteer.

Participants reported a variety of OCD symptomatology, which generally fit into the four DSM-V categorizations. First, participants reported obsessions and compulsions related to *harm*, like fears of physical damage (n=9), loss of property (2), getting in trouble (2), judgement of others (2), flawed performance with dangerous consequences (8), bodily harm (12), and personality or "inner" harm (6). Second, participants reported obsessions and compulsions related to *symmetry*, like ordering and arranging (n=6), needing a "just right" feeling (7), perfectionism (6), and counting and numbers (9). Third, participant cited obsessions and compulsions related to *contamination*, including general contamination (n=16), contamination causing bodily harm to the self (7), and contamination causing harm to others (4). Finally, participants reported obsessions and compulsions related to *intrusive thoughts*, including general distressing thoughts (n=8), religious scrupulosity (9), violent intrusive thoughts (6), and sexual

intrusive thoughts (5). Other participants cited symptoms of related disorders, such as body dysmorphic disorder (1), hoarding disorder (3), and trichotillomania (2), and excoriation (1).

Participants reported their OCD manifesting at work in a variety of ways, both relating to work tasks and unrelated to work tasks. Manifestations of OCD related to work tasks include sub-standard work performance, avoiding specific work tasks, missing or skipping work meetings or events, lessening of work intensity, performing compulsions through work tasks, planning work tasks around obsessions or compulsions, work tasks triggering obsessions or compulsions, and work tasks helping with OCD symptoms. Manifestations of OCD unrelated to work tasks include avoiding work or employment altogether, OCD symptoms negatively affecting joy and general mood at work, performing compulsions unrelated to work tasks, tardiness, distraction, being reprimanded, requesting or taking a leave of absence, others suggesting alternate employment, work environment triggering obsessions or compulsions, OCD symptoms influencing job or occupation choice, quitting, getting fired, scheduling around OCD symptoms or therapy, and general unemployment.

Recruitment and Requirements

In order to be considered for my study, participants must have had an official diagnosis of OCD (either primary or secondary) and be in or have completed intensive treatment specifically for their OCD. To recruit current patients, I first met with the clinical director of St. Mary's, who accompanied me to the flagship IOP and PHP clinic location. The clinical director facilitated introductions between me and the behavior specialists and therapists at the clinic, and stayed while I explained my research project. Each respective behavior specialist or therapist approached patients who met my criteria them with the idea of doing an interview with me, and I then introduced myself directly to the patients who wanted to participate. This kept the identity

of patients who chose not to participate completely anonymous. To recruit former patients, I announced my project at a 2017 International OCD Foundation conference panel on which I was presenting. Adults in the audience who wanted to patriciate approached me after the panel, and I collected their contact information. I also utilized a variety of network contacts I had via social media to recruit more former patients.

Sampling

Thirty-two of the 34 participants are in some way associated with St. Mary's hospital. All participants had access to treatment, either through insurance or otherwise. Most the participants are white. Though this seems like a fairly homogenous group, there were specific reasons for the recruitment methods I used. First, I wanted to specifically target the population of adults in intensive OCD treatment. This particular group is incredibly difficult to access. I requested access from two different hospital systems, and only one allowed me to interview their patients. Therefore, I only collected data from one hospital in person. Second, data collection was time-consuming and expensive. To interview the 22 patients that were currently in treatment, I spent a total of three months on location, living in another state, as the total number of patients being treated in one place at one time is limited by the hospital. Even if I had access to other hospitals, I would likely not have had the time or resources to collect data from a larger sample for this dissertation. Because I had connections through St. Mary's, I mostly conducted Skype interview with former patients from that hospital. However, patients at St. Mary's were from all across the United States. And even though the racial and economic profiles of the participants are pretty homogenous, the symptomatic profiles of the set are anything but. From my sample, no two participants had exactly the same symptomological profile, which indicates an incredibly

medically diverse group. Even so, in future research, a more socially diverse sample should be sought out if possible.

Data Collection

Interviews

Qualitative interviews are a key way of understanding a social actor's experience and perspective (Lindlof & Taylor, 2002) and "provide opportunities for mutual discovery, understanding, reflection, and explanation via a path that is organic, adaptive, and oftentimes energizing" (Tracy, 2013, p. 132). Interviews are particularly appropriate for studying narrative identity, as "recounting narratives of experience has been the major way throughout recorded history that humans have made sense of their experience" (Seidman, 2006, p. 8). As a basic mode of inquiry, the primary purpose of an interview is to "understand the lived experience of people and the meaning they make of that experience (Seidman, 2006, p. 9).

On the surface, interviewing may seem like a simple, commonsense venture: a researcher asks questions and a participant responds. However, I was careful to not approach this method in such an un-critical way. Taking a nuanced view of interviews is essential because "the validity of a great deal of what we believe to be true about human beings and the way they relate to one another hinges on the viability of the interview as a methodological strategy" (Briggs, 1986, p. 1). As previously mentioned, interviews must be seen not as the uncovering of some objective, "true" knowledge, but rather, a researcher's aim should be "one of interpreting the subtle and intricate intersection of factors that converge to form a particular interview" (Briggs, 1986, p. 22).

The interviews I conducted can be generally grouped in the "narrative interview" category (Lindlof & Taylor, 2002). Interviewing for story is a meaning-making process in which

participants "select details of their experiences from their stream of consciousness (Seidman, 2006, p. 7). In these stories, participants not only recount events, but also provide accounts, rationales, explanations, or justifications for their actions and perspectives (Tracy, 2012).

Each interview began with securing informed consent, including a discussion of the confidentiality procedures. I highlighted the key features of the informed consent form and then asked each participant to read the form carefully and ask any questions they may have. Once I secured informed consent, I proceeded with the interview itself. The introduction and informed consent was roughly scripted as follows: "My name is Sarah Chorley, and I am currently working on my doctoral degree in communication from the University of Colorado. I study the ways in which people with OCD function at work. As a part of my dissertation, I am interviewing adults with severe OCD in intensive treatment. During the next 30-45 minutes I'm going to ask you some questions regarding your work experiences with OCD. Before we begin, however, I would like to make sure you are comfortable and consent to your participation. Your information will primarily be used for the dissertation I am writing; however, the information you provide may also be used in future academic presentations and/or publications. Your information is entirely confidential. Only I will know your name. You will be identified by a number on any notes I make of our interview and will be reported in my study and in any future publications using a pseudonym. I will not report any specific information that may allow a casual reader to identify who you are; however, your sex will be identified and associated with your story. In addition, your participation is voluntary and you may withdraw at any time. You may choose now not to participate; you may choose during the course of the interview not to participate, at which point I will immediately destroy my interview notes; or you may at some later date that you do not want your contribution used, at which point you would contact me.

Before we begin, I'd like you to carefully read the informed consent form and if you decide to participate, sign and date both copies, keeping one for your future reference. Before we begin, do you have any questions about the project?" A full list of interview questions may be found in the appendix of this document (Appendix A).

I conducted at total of 35 interviews with 34 participants (I interviewed one participant twice; one interview during treatment and one interview six months after the first). Interviews ranged from about 20 minutes to two hours. The interviews I conducted with current patients were not recorded, but were transcribed by me in real time and fleshed out later in the day of the interview so my memory would be fresh. The interviews conducted with former patients were audio recorded by me with the full knowledge of the participant and transcribed by a third party.

Data Analysis

Grounded Theory

Grounded theory is "an approach to research that aims to discover and develop formal theory about social life through an examination of data" (Treem & Browning, 2016, p. 1045) or even more simply, "the discovery of theory from data" (Glaser & Strauss, 1967, p. 1). As opposed to a theory-driven *a priori* approach, which attempts to code the experience of the researched into the researcher's "language system" and definitions (Deetz, 2001, p. 13), grounded theory "evolves during actual research, and it does this through continuous interplay between analysis and data collection" (Strauss & Corbin, 1994, p. 273). Grounded theory "begins with observed evidence, whereas other kinds of theories begin with researchers' ideas about how communication happens, ideas tested in subsequent data collection and analysis or in logical argument and reasoning" (Merrigan & Huston, 2009, p. 233). This approach is advantageous for organizational communication (Martin & Turner, 1986), as it does not enforce

"blinding dictates" on the data (Sousa & Hendriks, 2006, p. 335). Some of the key features of grounded theory are data collection proceeding in tandem with analysis, constant comparison analysis, "the systematic asking of generative and concept-relating questions, theoretical sampling, systematic coding procedures, suggested guidelines for attaining conceptual…density, variation, and conceptual integration" (Strauss & Corbin, 1994, p. 273). These procedures of grounded theory are "designed to develop a well integrated set of concepts that provide a thorough theoretical explanation of social phenomenon under study" (Corbin & Strauss, 1990, p. 5).

Grounded theory was originally used by Glaser and Strauss (1967) with the intention of developing a system of theory building that distanced itself from *a priori* assumptions. However, throughout its development, the earliest forms of grounded theory are now more closely associated with a positivist approach to research is sometimes referred to as "objectivist grounded theory" (Ong, 2012; Charmaz, 2006). When refining the theory, Corbin and Strauss (1990) even warned scholars against the "dangers that lie in their positivistic connotations" (p. 4). In response to the objectivist criticisms of grounded theory, Charmaz (1990, 2003, 2006, 2008), in a series of essays and collaborations, proposed an alternative view of grounded theory that "lies squarely in the interpretive tradition" (2006, p. 130): *constructivist grounded theory*. This approach rejects grounded theory's emphasis on generality and objectivity, and instead focuses on relativity and reflexivity, as it "encourages researchers to make measured assessments of their methods and of themselves as researchers" (Charmaz, 2008, p. 408). This perspective

> views the process of categorization as dialectical and active, rather than as given in the
> reality and passively observed by any trained observer. Hence, a social constructionist
> perspective assumes an active, not neutral, observer whose decisions shape both process

and product throughout the research. In short, the research report is also a social

construction of the social constructions found and explicated in the data." (Charmaz,

1990, p. 1165)

Mentioned earlier, quite a bit of identity work can take place in an interview setting (Snow &

Anderson, 1987), as questions asked in an interview can prompt a participant to critically reflect

on their own identity. Therefore, a constructivist approach is most fitting for this study as this

approach "places priority on the phenomena of study and sees both data and analysis as created

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The research question listed above clearly fits into the category of questions that are "open-ended" and "focus on processes, patterns, and meaning within context." Consequently, this data analysis method is ideal for exploring my research question.

CHAPTER 4

ENGAGING DISCURSIVE RESOURCES

This chapter addresses my research question, *how do individuals with OCD negotiate their organizational identity?* In a typical identity narrative, organizational actors must *account* for certain factors: their actions, their organizational performance, their output, their productivity, their personal attire, sets of artifacts, etc. As discussed in the literature review, organizational actors account for these aspects of their identity narratively, engaging with certain discursive resources to justify or explain their actions, which *keeps a particular narrative going.* In this data set, participants reported not only having to account for the average aspects of an organizational worker's life, but for aspects specific to their OCD. Participants reported having to account for, make sense of, explain, justify, or in some way manage the meaning of their OCD manifestations at work (which are reported as mostly disruptive to organizational performance), their social location pertaining to work and organizations, their hospital stay, misconceptions about OCD, and the stigmatic identity of being "mentally ill" or a "former mental patient."

Taking these factors into account, each participant kept their particular narrative going by engaging with a particular set of *discursive resources* in a variety of ways, which had consequences for their outcomes. Therefore, in this chapter, I will be identifying ways in which organizational identity with OCD is reportedly (by my participants) negotiated through which discursive resources are engaged with in identity construction, maintenance, and negotiation. In arriving at these categories, I utilized grounded theory (Charmaz, 2006) and constant comparison analysis (similar to Lebowitz, Vitulano, & Omer, 2011) and when coding the data for discursive resources, I utilized Kuhn's (2006) definition: "concepts, expressions, or other linguistic devices that, when deployed in talk, present explanations for past and/or future activity that guide

interactants' interpretation of experience while molding individual…action" (p. 1341). In coding for these discursive resources, I looked not only at what the participants said about their actions or their jobs, but how they *accounted* for their actions. For example, reporting an action, in and of itself, is not necessarily utilizing a discursive resource. However, when cultural, social, or organizational scripts were in some way drawn upon to explain, justify, clarify, or account for organizational behavior, those *scripts* were categorized as discursive resources. Defining these scripts as *discursive resources* is advantageous because it does not simply point out the cultural, social, and organizational scripts that may be observed in communication; but rather, it illuminates the *interactional use of these scripts to manage the meaning of one's identity*. The purpose of utilizing the conceptualization of discursive resources is not merely to identify them, but to examine how these resources are made available, used, drawn on, engaged with, combated, contested, redefined, and otherwise utilized in the process of identity negotiation in relationship to organizing.

To this end, I looked for ways in which discursive resources were used by participants to account for past actions or situations, future plans, and present circumstances, both when discussing their identity at work and doing identity negotiation work with me. The interview functioned in two ways: first, it allowed me to see how participants made sense of reported interactions as they were recounted to me. Second, the interview functioned as an identity management interaction in and of itself, as the participants were managing how I, an outside researcher, viewed them (this was discussed earlier in the dissertation). I chose to code the discursive resources altogether, rather than in two separate categories: "accounting for reported interactions" and "identity management with the researcher," as this delineation was not necessarily the aim of this research. To acknowledge the interview as a site of identity

negotiation is to also acknowledge the limitations of my own standpoint; I can only code for the discursive resources to which I myself have been exposed. As a scholar of both OCD and organizational communication, I consider my own repertoire of discursive resources to be quite vast; however, it must be acknowledged that there are probably some discursive resources used in interviews that went over my head.

As I discovered discursive resources in the transcripts of the interviews, I engaged in constant comparison analysis, and looked for the discursive resources in other interview transcripts to build enough evidence for an argument. I will be discussing them in four categories: 1) normalcy, 2) organizing and economy, 3) medicine, and finally, 4) personal life scripts and the physical body. At one point during the coding process, I had developed over 65 categories of discursive resources. As the coding process went on, I found similarities between some, distinctions between others, and repetition of still others. So I eventually arrived at the four categories mentioned, utilizing constructivist grounded theory methods.

Normalcy

Participants engaged with discursive scripts of being "normal" in a variety of ways to account for, explain, or justify their organizational behavior, choices, or position. Discourses of normalcy tended to fall on a spectrum: the middle of the spectrum is complete *normalcy*, that is, someone whose story aligns fairly well with the social expectations of what the progression of life "should" look like. One extreme of the spectrum is *excellence* and going above normalcy to achieve great things. On the other extreme of the spectrum is *deviance*, in which participants describe communication and behavior associated with character defects and deviance, such as laziness and weakness. In between normal and deviant is *abnormal,* which is what participants described as "weird," "different," or "freaking other people out." Below, I discuss illustrative

examples of participants who engaged with discourses of normalcy to account for, explain, or justify their work identity, including a "normal" diagnosis, what a "normal" life "should" look like, avoiding obvious abnormalities, framing the abnormal in terms of the normal, OCD as indicative of a character defect, and stigma.

A "Normal" Diagnosis

For some, "normalcy" can come from a diagnosis. Selina,[4] who works as a real estate agent and part-time parking attendant, struggles with contaminated-based OCD which restricts what she can ingest. She can't eat certain foods, take certain medications, or drink certain beverages without significant distress. When her symptoms first became severe, she had no idea what was wrong with herself. She was having panic attacks over feared allergies, poisonings, and reactions to food or drugs and couldn't figure out why. She went to her primary care physician, who recommended a counselor who would offer Selina a diagnosis: OCD. She felt relieved when she had a name for what she was experiencing.

> That made sense to me. I had assumed that to have OCD, you would have to touch or tap things. I thought it was stereotypical. But it's actually me, and that made me feel better. There was something - a "normal" something. I know how it feels to be normal – I can get back there.

Selina struggles with feeling ostracized at work; at real estate events and meetings, she eats and drinks nothing while others stand around her with their wine glasses and plates. Her colleagues and clients alike often ask her if they can get her anything, and she politely declines. Even so, she is glad to be able to make sense of what is happening in her own narrative of who she is: what she is going through is a *type* of "normal." She also said it would be helpful in an

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[4] All participant names are pseudonyms

intervention workshop to hear from someone who has OCD but is living a "normal" life; in her opinion, this would indicate to the patients receiving the intervention that "you can be happy and healthy, you can be living a life."

Selina can make sense of herself as "normal" because she has a "normal" diagnosis rather than unknown, unexplained struggles. Yes, she has to miss work occasionally, but she can justify this absence to herself through her "normal" diagnosis rather than symptoms that are difficult to make sense of. Selina's identity work functions to "normalize" her abnormal behaviors at work.

A "Normal" Life

Jack, who is currently unemployed, used to work at a golf course picking up range balls, answering phones, filling divots, cleaning golf carts, and maintaining the pro shop, among other duties. At first, Jack thrived in the position. But as time went on, his contamination-based OCD interfered more and more with his job.

> Cleaning carts became a problem – I had to use barriers. Cleaning bathrooms was also a problem, as I would excessively wash my hands after doing so. I had most of the problems when I was going home – I struggle with a fear of cross-contamination. I had to keep my work stuff completely separate. My shoes, belt, hat, and other non-washable things couldn't come into the house and no one else could touch them. My clothes came off and went directly into the hamper and someone else would have to wash them – I couldn't touch them after that. Then I would get into the shower for about a half an hour. An eight-hour shift would turn into a 12-hour shift because of all the before and after shift rituals I had to do just to make it through the day. I didn't get very much sleep.

Jack left the golf course job about a year before starting intensive treatment. He now describes

his story and circumstances in terms of what a "normal" 25-year-old might be doing now, as he

currently depends on others to live a "normal" life.

> To me, for me to be living a "normal" life, I would be graduated from college by now,
>
> have a nine to five job, and should be living on my own. As it is now, I live with my
>
> parents, my sister, her husband and their kids, and my girlfriend in one big house.
>
> Multiple generations under one roof. I'm not as social as I used to be; I had to drop out of
>
> college because of my OCD. I'm much more reserved now. I used to be the outgoing kid
>
> who could do whatever he wanted, but all that went away.

For Jack, he looks at the "normal" things he isn't able to do and defines himself through those as

opposed to what he can do. "I can't pick up after my dog, I can't cook meat, I can't take out the

garbage, and cleaning is a problem," Jack laments. Jack plans to return to the golf course after he

leaves treatment and eventually go back to college.

Jack compares his story to that of a "normal" 25-year-old to make sense of his own life

path and perceived abnormalities at the golf course; he makes sense of his career and work

failures and struggles by discursively situating them in contrast to the "normal" 25-year-old. This

identity work serves as an explanation of where Jack's OCD has taken him at work and in his

career.

Avoiding Obvious Abnormalities

One of the ways in which discursive resources of normalcy were engaged was

participants describing how they actively avoid visible or telling abnormalities so others at work

would not suspect difference or be taken aback, and therefore avoiding having to account for

those abnormalities. For example, Leslie, who suffers from intrusive sexual thoughts of

pedophilia as well as contamination-based symptoms, works at a retail craft store. To cope with her contamination-based fears, she will often use barriers to complete cleaning or cashiering tasks, or avoid doing them altogether. For a while, she wore gloves while checking customers out at the register to put a barrier between her and pennies, which she avoided because of her OCD. "People looked at me like I had some disease," she recalls. "They'd open their wallet like, 'here you go,' but they didn't know [why I was wearing gloves]." Leslie's co-workers also noticed her odd behavior, gossiping that she was "kind of awkward" and "a little bit weird." She balances out the criticism of the negative co-workers by insisting to me that there are a lot of people at work that like her, "but just notice some weirdness." She's had to "learn to be okay" with the fact that she's a "little weird."

> It's hard, and it makes it harder to make friends because they're kind of, like, 'what's wrong with you?' but certain people, I've found out are just, like, that's just her and that's okay – so I enjoy that at least.

One of Leslie's therapy goals is to *feel* "normal," which her therapist encourages her to do.

> My therapist said, "the more you treat yourself as abnormal, the more abnormal you will become," so yeah. She's like, "if you treat yourself like a normal person, you go out, you work, you do what you need to do and she's like, you'll feel normal when you start doing that" and it was true.

When Leslie thinks of herself as normal at work, the more normal she feels. Through lots of difficult therapy work, Leslie is now able to handle pennies without gloves, which helps her feel much more comfortable conducting cashier interactions in front of customers. She's okay with not being completely normal, but still works toward that end.

As an example of this phenomenon in practice with me during an interview, Selina, who I mentioned earlier as not being able to eat in front of others because of her OCD, didn't want to order anything at the Starbucks at which we did our interview. As we were walking to our table, I said, "I'm going to set my stuff down and grab a coffee and a snack. What can I get for you?" She sweetly responded that she was fine and didn't want anything.

"Are you sure?" I asked. In all the previous interviews I had conducted at places that offered food, I had ordered something for myself and also paid for whatever my participant wanted.

"Yes, it's okay," she said. "Really, it's okay."

I got my coffee and snack anyway (I was hungry, as I had anticipated getting something to eat and drink during the interview), and felt a little awkward as I sat down and ate in front of her, which felt rude. She could tell that I was uneasy eating in front of her, so early on in the interview, she explained her aversions to certain foods and beverages. She said she felt comfortable telling *me* about her OCD symptoms, since I told her I was familiar with the disorder. However, she said she doesn't want anyone at work to know so she just does her best to avoid all situations with food so she doesn't "out" herself. Not only does she avoid eating at her real estate job, but she also refrains from all eating and drinking during her six-hour long shifts as a part-time parking lot attendant. She justifies her choices by plainly stating that, "they don't know I have OCD."

When it comes to Leslie and Selina, they engaged with the discourse of "normalcy" by attempting to avoid obvious abnormalities. Leslie has worked hard in therapy to be able to handle pennies without gloves, but cuts herself slack when she isn't able to do everything completely "normally." Managing her identity in this way first avoids having to account for an

abnormality in the first place (wearing gloves at the cash register), but also explains any abnormalities she can't avoid by insisting that it's "okay" to be a little abnormal. Selina doesn't want to be seen as abnormal when she has food in front of her and doesn't eat it, so she avoids having food in front of her at work. Leslie is more okay with being "abnormal," but for Selina, there is no wiggle room, as she does not want to have to account for the abnormality.

Framing the Abnormal in Terms of the Normal

Another way participants engaged with normalcy was by framing their abnormalities in more "normal" or acceptable terminology or concepts. For example, Rebecca, who deals with perfectionism, body dysmorphia-based checking, and trichotillomania (compulsive hair-pulling), works at a recreational center as a janitor. In treatment, Rebecca learned how to keep track of her "bans," that is, the compulsions that aren't healthy for her. Each patient is given a small (2" x 4") notebook to carry with them called a "ban book," and is instructed to draw a tic mark in every time they catch themselves doing one of their bans. For instance, for trichotillomanic OCD symptoms, the "banned" behavior would be compulsive hair-pulling. Therefore, every time Rebecca engages in compulsive hair-pulling, she is to put a tick mark next to "hair pulling" in her ban book. As she has been instructed, she carries her ban book with her everywhere, including work. Rebecca's colleagues at work noticed her ban book and asked her what it was.

> My friends at work noticed my ban book. When I brought it out, I framed it as "I'm just keeping track of bad habits" and others were like, "oh, that's good." They admired the ban book; they saw it as self-improvement and said that it was a positive thing. Another supervisor noticed it as well and thought it was good thing.

Rebecca not only framed her ban book as something normal someone might do (keep track of bad habits), but she was perceived as being proactive and conscientious as a result. By

accounting for an abnormality as not only normal but *admirable,* Rebecca was able to achieve the positive outcome of praise in her organization through her identity work.

As another illustration of this, J.D., who is currently unemployed, has a variety of OCD symptoms like intrusive thoughts, contamination, hoarding, and checking. J.D.'s most recent job at which he spent a significant amount of time was reading meters for an energy company which triggered many of his symptoms. He became obsessed with making sure he was at the right address and recording the correct meter outputs: "I had re-check the number many, many times to make sure I'd gotten it right," he recalls. He also obsessed over plugging each meter into the reading device correctly, and spending disproportionate amounts of time making sure the magnets on each component were lined up perfectly. Before that, J.D. worked a few weeks for a landscaping company, which triggered his contamination fears of chemical poisoning. And before that, J.D. worked the job he was at the longest, which was in package and mail delivery, for 11 months. His obsessions and compulsions were taking up a great deal of time on this job; he repeatedly came back late from his assigned delivery route. For each delivery, J.D. had to make sure the address on the package matched the address of the establishment, which he checked excessively. J.D.'s boss started to notice his tardiness.

> When I was at the post office, if I took half an hour longer than I was supposed to, I had a supervisor who was very "by the book," and sometimes she would ask me why I took longer. When she did, I would just say things like "oh, there was a lot of mail." Or, "I had problems, I struggled with delivering the mail in the apartment buildings." I wouldn't tell her it was because of OCD; instead I would say something like I couldn't find the address, or I had to deliver a package that had to be signed for – I would use excuses I know they would believe. I would never say it was because of my OCD.

J.D. only had problems on the job because of OCD; however, instead of telling his boss about his disorder, he explained away his use of time in terms of "normal" hold-ups that the boss would be sure to believe.

Both Rebecca and J.D. framed their abnormal actions or materials in terms of the "normal," subsequently reaffirming their identity as a "normal" worker instead of an "abnormal" one. For Rebecca, that meant framing her ban book as a "self help" journal, which is not a terribly uncommon accessory. For J.D., that meant excusing his taking extra time to deliver mail using "normal" excuses. Rebecca faced positive consequences for engaging with "normalcy" in this scenario of identity work; her friends at work admired her for wanting to improve herself. However, J.D. faced negative consequences; rather than being able to tell his supervisor about his OCD, he chose to only use "normal" discursive resources in accounting for his slowed productivity, therefore limiting his repertoire and risking his supervisor perceiving him as slow or lazy. J.D. was eventually let go from his job as a mail carrier because of his use of time.

OCD as Implying Character Defect

Participants engaged with discourses which indicate that *OCD or OCD symptoms imply other, separate character defects*. For example, having or claiming OCD implies one is weak or lazy. Participants engaged with the equalization of having OCD and having a character deficiency in several ways, including general character defects, laziness, and weakness to justify, explain, or account for their organizational choices like not requesting accommodations, disclosing a diagnosis, and hiding a diagnosis.

J.D., mentioned above, has moved from job to job due to his OCD. Since his OCD symptoms have affected his ability to perform essential tasks at each of his job in a timely manner, I asked J.D. if he would ever consider asking for accommodations in a future position,

like scheduled time off for therapy. He thought for a moment, and said that he probably wouldn't even consider it.

> I probably wouldn't request any. It's not that it's wrong, because if you need accommodations, you need accommodations. But, I don't know if that would affect my supervisor's view of me and my job. If there's an opening for a promotion, they probably wouldn't pick me because I "have issues." I would be compromising my potential promotions, progressing in the company, and doing better. I would be risking promotions and raises.

Even though J.D.'s work performance has been self-admittedly poor due to his OCD symptoms, he would rather face the consequences of poor performance than have a potentially higher performance with accommodations because he frames the baggage of accommodations equivalent to the baggage of a character defect. Because he wants his identity to be that of a "normal" worker, he chooses to conceal his diagnosis with anyone at work or request accommodations.

Nick is currently employed as a city mechanic and deals with checking and mental reviewing. He works on repairing city vehicles like dump trucks and struggles with only doing each task once. For example, when tightening bolts on a truck, Nick would have the tendency to tighten them over and over, some until the point they broke. Nick told his boss about his OCD about a month before I met him; he decided to enter IOP treatment and needed the time off. "It went better than I expected," Nick recalls of telling his boss about his OCD. "I told my boss I would have to be out for a few days, that I was going to inpatient treatment. I told him that I deal with OCD, and he just said, 'I'm really honored that you chose to tell me that.'" Nick also told the two workers with whom he works the closest about his diagnosis. "That way," he explained,

"if I'm just like standing and staring at papers, they know what's going on; I'm doing mental rituals." It's important to Nick that the workers around him know he isn't lazy. When I asked him what advice he had for other workers with OCD, he strongly suggested that they disclose their illness, if only to avoid the appearance of a character defect.

> If you haven't already, tell whoever you're comfortable with. At the very least, your closest higher-up. I have felt, like, I have felt very self-conscious about my slowness. But once I told people about it, it didn't make me go any faster, but I wasn't looked at as lazy. Rather, they knew that something was going on.

With a disclosure, Nick has been able to work on his recovery and keep his job.

Nance has a master's degree in communication and taught public speaking at a community college. She has religious and moral scrupulously-based OCD symptoms as well as intrusive thoughts. She loved her job; she's retired now that she's in her mid-sixties. Her most recent retirement activity was writing a public speaking textbook with a few of her colleagues and she now volunteers at a local humane society.

During her years of full-time work, she felt intense shame about her OCD because she saw it as a character defect in herself. "If I had better character," she said of her former conceptions, "if I were stronger, I could overcome the anxiety myself." For Nance, the shame she felt about her condition was born in ignorance: "the reason [for the shame] was that I didn't realize OCD was a physiological, genetic problem," she reflects. "That led me to years of needless suffering because I didn't know what was going on." These conceptions festered at home; Nance's husband repeatedly told her that she could overcome the OCD if she really tried hard enough.

[My husband] wasn't very supportive of my anxiety issues. He wanted to be, but he never

understood what was at the root of it. His advice was often, 'if you just stop worrying

about it, you'd be fine.' That caused me a lot of shame – I felt he was right. I had that

same sense, and when it was reinforced by him, I felt shame. It's part of why I didn't

seek treatment earlier.

Shame has a powerful influence on self-identity, as it "is essentially anxiety about the adequacy

of the narrative by means of which the individual sustains a coherent biography" (Giddens, 1991,

p. 65). Because of the shame she felt and fear of being associated with stigmatic traits, Nance

refrained from telling most of her co-workers about her OCD because they too might find her

irredeemably flawed. She did tell the dean of her department, though; the dean was a licensed

clinical social worker, so Nance thought she might be sympathetic. The dean was, and was able

to recommend a therapist to Nance, which actually led her to getting intensive treatment.

J.D., Nick, and Nance all engage with the discursive resource that others associate an

OCD diagnosis, OCD symptoms, or mental illness with other character defects to account for

their organizational behavior. J.D. uses this association to explain his reasoning for not asking

for accommodations at work. Nick defends his disclosure of his OCD to his supervisor by

insisting that he didn't want to look lazy. Nance frames her not getting treatment for so long

because of the shame she felt with the association of OCD with weakness.

Stigma

Stigmatic traits mark identities as abnormal and unusual and may spoil them for normal

social acceptance and interaction (Goffman, 1963). Just above, I discussed participants that

feared their OCD would incite assumptions of other stigmatic traits (like laziness or weakness).

However, many participants feared the stigma that might be associated with their *OCD itself*.

Subsequently, stigma was one of the most commonly referenced concepts among participants; many participants fear they will be judged negatively because of their OCD or that certain assumptions will be made about them because of their symptoms, which would be an ultimate deviation from normalcy. Mental illness carries with it an incredible quantity and variety of stigma (as discussed in the literature review), often much more than a physical illness. Therefore, when stigma is feared, participants adjust their narrative. For example, Peggy, who was trying to get a job tutoring online during her treatment, followed up with me about six months after our first interview for another talk after she had secured a job as a barista. She struggles with contamination obsessions and compulsions around waste elimination; when she needs to evacuate her bowels, she spends anywhere between 30 and 90 minutes in the restroom making sure there is no waste cross-contamination on her hands, clothes, or other personal effects. She does her best to avoid a restroom situation at work; she regularly takes Imodium before a shift to dodge the time-consuming and anxiety-inducing rituals. When restroom needs do come up at work, she goes into panic mode. She takes excessive amounts of time in the restroom cleaning and dealing with the subsequent ruminating thoughts that follow.

Peggy considers her OCD symptoms to be stigmatic and is afraid of being judged by others. Peggy is a young millennial, and feels more comfortable telling people in her age range about her OCD than older people, because she thinks they'll be less judgmental and associate less stigma. In her barista job, she shared her diagnosis and symptoms with a 16-year-old co-worker, who was very supportive, which Peggy attributed to her age.

> I think that—maybe it's also something that's in my generation; maybe it's a little easier for people to be less judgmental about that. I think that stigma can come a lot with families and societies but particularly the older generations.

Therefore, Peggy justifies her only telling co-workers around her own age about her OCD by engaging with the discursive resources of stigma and generational associations with stigma.

Rebecca, mentioned earlier, has faced the sting of stigma repeatedly in her janitorial position. "Be careful what those doctors diagnose you with," her boss replied when she told him about her OCD diagnosis. Rebecca had called him from her treatment facility and was taken aback by his condescending reaction, thinking it "extremely inconsiderate." He thought being in treatment for OCD was "ridiculous." She had previously told him about another diagnosis of body dysmorphic disorder (BDD), and he told her it sounded made up. I asked her why she told her boss about the OCD diagnosis after he had been insensitive about the BDD diagnosis; she said she needed time off to go to treatment, and she thought she *had* to tell him why she was going to treatment. She wasn't aware of any other options, like an HR department or even asking for accommodations. She feared her boss "spreading around" her diagnosis and the fact that she was in treatment, because she saw him as a "gossipy person." She is afraid of "being called out" and judged for her rituals. When she goes back to work full time, she uses the discursive resource of stigma to explain that she won't be discussing her diagnosis nearly as much at work.

Gary, a part-time shelf-stocker at a small grocery store, avoids interactions with customers, as he "doesn't want to look stupid" or "get made fun of" for being lost in thought over an obsession. When asked, Adam couldn't think of any accommodations that might make his job more manageable, he just wants there to "be less stigma" around OCD, although he doesn't think it possible.

While many of the symptom profiles of OCD may be stigmatized as illustrated above, certain profiles tend to carry even more stigma because of the social connotations with what the individual fears. Three participants in this study suffer from POCD (pedophile OCD), which is a

fear that the individual will develop sexual feelings for or perform sexual acts with children. POCD is never accompanied by actual pedophilic acts; that set of behaviors is outside the POCD diagnosis. In this data set, POCD was uniquely feared as exceptionally stigmatic, so much so that the participants with POCD were more reserved in sharing their POCD diagnosis and symptoms with even their closest family compared to other participants in the set.

Leslie, mentioned earlier, has shared her general fear of contamination with her co-workers. She also has a contamination-based fear of AIDS; she shared that fear with one co-worker so she could avoid having to change feminine waste bins in the bathrooms. For a long time, she didn't tell anyone about her fear of AIDS because she knew it wasn't rational. "I was a little embarrassed at that time because it's so irrational. I thought people were going to be like, she's crazy," Leslie recalls. Since she told the co-worker, she has been able to pass off that particular cleaning duty. Right after Leslie shared this with me in our interview, I asked her if she'd every told anyone at work about her POCD fears to avoid tasks that involve children, like she'd shared her AIDS fears to avoid cleaning the feminine waste bin. She visibly stiffened, as though the POCD fears were in a stigmatic class of their own.

> Sarah: Do they know anything about like—if a family with ten kids comes in, do they know that—would they be like, I'll take the cash register?
>
> Leslie: That one is one that I haven't told many people about because I'm afraid they'll take it the wrong way. That one is one that my sister, mom and dad and immediate family knows about and my husband but not a lot of my friends do.
>
> Sarah: I've interviewed about 30 people total and you're the third one that has that. It's super common, that's 10%.
>
> Leslie: It's a hard one.

Sarah: The people that I've interviewed feel a lot of shame and a lot of…

Leslie: Exactly.

Sarah: Even though it's so common.

During the interview, when I sensed I might be making Leslie uncomfortable by asking about her POCD symptoms, I used discourses of normalcy to encourage her and help her feel more "normal." She shared that she'd had a bad experience telling one of her closest friends about the POCD intrusive thoughts and received a negative response.

> I told one of my best friends about the intrusive thoughts and she was kind of like, 'ew.'
> It was kind of like, it made me scared again. I thought, 'oh god, there's something wrong
> with me.' It got my mind going again. I know she didn't mean it like that but she's just a
> very abrasive person anyways but that's just her. It threw me off and my mom was there
> and she could tell immediately that I, like, shrunk down. I was like, 'oh my god,' but
> yeah.

Rob, who also suffers from POCD intrusive thoughts, is currently on government disability due to a physical workplace injury at the grocery store at which he cashiered. During our interview, he began by describing his intrusive thoughts as simply "fears he would harm someone." When I asked for more details, he said it was still hard for him to admit, "but I guess I can tell you." Because he considers his symptoms to be so stigmatic, he has only told three people about them other than me.

> Only my dad, my mom and my ex-girlfriend knew. I could not tell people. It was even
> just hard for me to tell you but it's just so taboo and so horrible. I would never…no, you
> would never want to be that so it just makes you so much more scared because it's the
> worst thing. There's rape and murder like there's way worse things that another person

could do to a person but it was just so… like waking up with headaches. At night, I'd be scared that I might have a dream and that would mean….so I was scared to go to sleep, I was scared to wake up. A kid came through my line, I was terrified.

When Rob needed to take a day off of work to cope with his OCD or his co-morbid suicidality, he would often explain his absence using reasons like chronic stomach issues. When he had to go to the emergency room after suicide attempts, he would still only "ambiguously" tell his co-workers and supervisors that it was a "hospital visit."

> Sarah: Did your boss ever know?
>
> Rob: No, I've had certain problems in the past but I just prefer to use like, systemic problems to keep it ambiguous.
>
> Sarah: So if you needed to go home because your thoughts were overwhelming, you'd just be like, my stomach is acting up again, I've got to peace out.
>
> Rob: Yeah, so it was just easier to say that than explain hey, I'm crazy and I'm embarrassed that I'm not functioning.

Stigma appeared in the data set time after time as a discursive resource accounting for or making sense of actions, secrecy, and future plans. For Peggy, it helped her make sense of who might be more sympathetic to a mental illness. Rob uses stigma to explain why he hasn't shared his POCD symptoms with many people why he would choose to cover his symptoms with the excuse a physical illness. Stigmatic traits signify an abnormality, a stain spoiling an otherwise socially acceptable identity. While OCD can be a catalyst for others to associate other negative traits (like laziness or weakness), stigma is called on more often for explaining or accounting for *OCD itself*: not only is a negative trait in question, but odd, abnormal fears and actions are involved.

Subsequently, *stigma* was engaged by participants when justifying their organizational actions around their OCD disclosure.

Summary

This section discussed how participants engaged with discursive resources of normalcy, including a "normal" diagnosis, what a "normal" life "should" look like, avoiding obvious abnormalities, framing the abnormal in terms of the normal, OCD as indicative of a character defect, and stigma. Each discursive resource utilized or drawn upon was done to engage in identity work to accomplish a variety of goals. Selina draws upon her "normal" diagnosis to help her make sense of her abnormal OCD manifestations at work. Jack makes sense of his story and identity by engaging with how a "normal" life "should" unfold for someone his age. Leslie avoids abnormal behavior related to her OCD at work the best she can, but justifies her abnormal actions by citing the idea that "everyone is a little weird." Rebecca draws on the normality of keeping track of bad habits to explain her ban book at work. J.D. drew on the normality of tardiness to explain his OCD rituals and lowered productivity. Nick accounted for abnormally standing around at work using his diagnosis. Nance accounts for hiding her diagnosis at work using the discourse of abnormal weakness. Gary uses the discourse of stigma of the abnormal to explain his avoidance of customer interactions. Finally, Leslie and Rob drew on the discourses of severe stigma when accounting for hiding their POCD diagnosis.

Each participant discussed in this section faced a variety of outcomes and consequences for their identity work. Rebecca, explaining her ban book by using normal habit tracking, was praised by her coworkers for her attentiveness to self-improvement. J.D. used "normal" reasons to explain his taking excessive time on tasks, and was subsequently fired. Nick used his diagnosis to explain his odd behavior and is still employed. Rob accounts for using a physical

illness to explain his abnormal work behavior using discursive resources of stigma, and therefore gets to be seen without the staining mark on his identity. These discursive resources function to help the participants be a part of a "normal" working world by justifying, explaining, accounting for, helping make sense of, or managing the meaning of their OCD, social location in the working world, and behavior at work.

This section also indicates that participants perceive a clear difference between *their identity* and *normal*, although "normal" tends to look different among participants. OCD reportedly manifests in abnormal ways and participants are then accountable for distinct abnormalities related to OCD that are uncommon among (what they perceive to be) the typical organizational actors.

Organizing and Economy

Participants engaged with discourses of organizational expectations, industry, and economy, categorized here as under the umbrella of "organizing and economy." For discursive resources of organizing, participants discussed general expectations of competency, professionalism, and stress to account for, explain, or justify their organizational behavior or position. Participants also explained the influence of discursive resources specific to their respective organizations, which include organizational narratives, organizational culture, and managerially-defined scripts and positions. Scripts of specific industries were also discussed when managing identity. Finally, participants referred to economic scripts and discourses when justifying their narratives.

General Expectations of Organizing

Competency. Many participants engaged with discursive resources related to ideas of competency and the capabilities to perform well at work when engaging in identity work. They

discussed the expectations of workplace competency in relationship to their OCD in order to manage their identity as a competent worker.

For example, Peggy, mentioned earlier, wants management to know that her shortcomings are not a part of who she is as a capable worker. "I would want people [at work] to know that if something comes up at the last minute, or if I'm not able to show up, it's not that I'm flaky," she earnestly insists. "It's not that I don't respect their time. It's because of OCD." Peggy very much sees her OCD as something that is outside of her personhood, a separate entity that takes up her time and constitutes a "special circumstance:"

> I'm dependable, but just not in those time-specific ways. If I say I'm going to get something done, I'm going to get it done. People can definitely trust me to stand by my work and whatever it is I'm doing, I'm not going to half-ass it. If I stepped out of my body and knew who I was as a person and I was giving myself an assignment, I would trust that it was in capable hands but I would also know that there are special circumstances.

She even claims that OCD is a disorder that specifically targets smart, capable people and attaches itself to a person's best qualities, an assertion that is not necessarily backed by scientific evidence. Even so, Peggy maintains that employers should focus on a worker's good skills and work around their OCD:

> People with OCD tend to have a lot of strengths and be very smart. OCD feeds on good traits. Oh, you're worried about safety? It means you care about people. Perfectionism feeds on being detail-oriented. They are good workers. They have skills. If someone has OCD and they have reached a good level of functioning but there are still occasions

where there could be a problem, these are things bosses should be aware of. They should

be open to working around it.

Peggy uses her distance from her OCD to explain her inability to consistently show up on time,

as well as using the "fact" that "OCD feeds on good traits" to justify her stigmatic trait with

positive ones. By engaging with discourses of capability and competency when managing the

meaning of what it means to have OCD, Peggy is engaging in identity work that, in turn, frames

herself as a competent worker. And by insisting that her OCD is *not really part of her,* and that

who she really is is trustworthy and capable, she is positioning herself organizationally to be seen

as a good worker.

Participants also used their capabilities outside of their OCD symptoms to frame

themselves as competent workers. For example, Toby, a former residential patient and part-time

volunteer with severe, co-morbid Tourette's, approached the director of the volunteer program at

which he wanted to work with the skills and capacities he knew he had. Instead of listing the

number of tasks he is *incapable* of doing, he said, "I can shine bright like a diamond. Like in this

job, in this type of area. Can I still qualify for this job?" And they agreed. Toby now teaches

social skills to adults with Down's Syndrome one day a week, which is about the work load that

Toby can handle at this time. He acknowledges that he knows he isn't like the average worker;

he "positions" himself as a "casual, part-time" employee to others at work, in contrast to other

workers whom he sees as "staff" or "support workers." By doing this, he can manage the

expectations of his performance and his identity as a capable worker.

For Peggy, competency describes her personality and who she is outside of OCD; OCD is

merely a blemish on her *true* work ethic. By discrediting OCD in this way, she is able to position

herself as organizationally competent and as even having positive traits that others might not. For

Toby, narrating his identity using his competency helped him get a job and lay the groundwork for what would be expected of him. In both cases, identity work was done to position the respective participant as competent and capable of doing their job, using discursive resources to circumvent the implications of incompetency possibly implied by their OCD manifestations.

Professionalism. Jess often contemplates the idea of *professionalism*. "How can you explain OCD in a professional manner? How can you explain disability in a professional manner?" she wonders. When Jess had to miss a few classes due to her OCD the year before our interview, she disclosed to the course TA that she had disability accommodations where she could occasionally miss class for her OCD. The TA responded kindly, told her not to worry, and encouraged Jess to try to "stay on top [her] work" the best she could. Jess also ended up working with that same TA in her advisor's research lab this semester. When she's had to take more time to do one of her research lab duties like reading through articles or writing up an annotated bibliography, she's let the TA know, and he has been accommodating, encouraging Jess to "take her time." They only talk about her OCD when "there's an issue at hand…because I think he respects my privacy and wants to keep a professional relationship." I asked Jess what it meant to have a "professional" relationship or to talk about OCD in a "professional" manner. She thought about it carefully.

> Well, it's one thing for me to tell a friend and be like, I just took some time off because of mental health issues, like, I have OCD, and if they judge me then it's their loss and I lose a friend and it sucks. But if it's a professional setting, then there's that whole dynamic of private versus public personas and I would probably wish that—to say that I have a disability I think is a way to say it ambiguously and hope people to be more understanding so I just—I can't really articulate it that well but it's definitely—like they

have… there was a program that my school did through a company that was talking about how to explain a disability to employers and honestly just being able to present it in a way that seems in your favor rather than not, I think that—even though we all want acceptance, there's still a bit of realism thrown in there and expectations and I think having a—even though there are anti-discrimination laws and everything, there still is discrimination and it might be conscious, it might be subconscious, you don't know. But presenting it in like a strong way that includes having OCD would be something that I would look for.

For Jess, *professionalism* involves keeping the public and the private separate as much as possible. When the two need to intersect, the topic must be approached in a positive manner so OCD will not be seen as a workplace problem. Jess is realistic; she knows that there are anti-discrimination laws, but still knows discrimination is a possibility and therefore seeks to mitigate it as much as possible. "I'm sort of nervous for employers or even [school] programs to still take me seriously even though I deal with OCD," she worries. To be taken seriously, for Jess, is to be professional. Jess' identity management relies heavily on her conceptions of professionalism, and subsequently, she justifies her reticence to disclose her OCD at work using the discursive resource of professionalism.

Stress. Elliot, mentioned earlier, wants to go to graduate school after she finishes her undergraduate degree. However, she fears her perfectionism will fuel the already stressful nature of academia. "That's always freaked me out," she says. "I'm afraid I won't be working hard enough." During our interview, Elliot made a thoughtful comparison: "OCD matches up with the American idea that if you're not stressed, you're not working hard enough." Certainly, perfectionism in the workplace can be seen as a positive trait, even when it may be hurting the

individual who suffers from it. Therefore, Elliot struggles with the decision to go to graduate school since she knows she will feel pressure to appear stressed while fighting the actual stress that accompanies her OCD. For Elliot, the discursive resource of *stress* as it relates to OCD functions to help her make sense of her experiences as an undergraduate student and her struggle with her future decision to attend graduate school.

Both professionalism and stress are organizational concepts that can be generalized to more than one organization or industry. Jess worries about being professional enough, and if bringing up her mental illness might not fit into the professional identity she wishes to craft for herself. Elliot, on the other hand, doesn't want to be so associated with stress to craft her identity. While stress is an "American" correlation with success, she doesn't want to feel the pressure to conform to it. For both participants, organizational expectations are discursive resources used to account for their choices or struggles, and thus have implications for their identity.

Organizational Scripts Specific to Respective Organizations

Organizational narratives. Participants reported that organizational stories and narratives influenced the ways in which they negotiated their identities with OCD at work. For example, Karen is a part-time public defendant who handles about five cases per month from home. When she worked full time, Karen worked about fifty cases per month, mostly defending juvenile offenders. Karen enjoyed and was good at her job, but she had overwhelming anxiety about the outcomes of her clients; she obsessed over if she had indeed done her best or if she had made mistakes. She found herself constantly checking and rechecking small details of her cases to help reassure her that she had done the right things. Around the time she was struggling the most with her OCD, a colleague of Karen's had an emotional moment in the courtroom and "ran

out of the courtroom crying." The colleague was in a managerial position and been working in the court system for 25 years.

> People looked at her like she was crazy…they made her step back from her managerial position. How could she give other people advice if she can't handle her own stuff?...
>
> Everyone was kind of mad at her after this incident – the judge was mad at her.

When Karen heard about this incident, she had also been thinking about taking a step back from her fifty-client per month load and go to part time. "hearing about that incident really influenced me to scale back at work," she remembers. "Seeing all the stress from the lady who ran out crying, I thought, I can't live like this." Karen scaled back to five clients per month and is currently on maternity leave while she is in intensive treatment.

Similarly, Jim, who worked as a journalist in a newsroom, heard about a colleague who was chastised for spending too much time in the bathroom due to an illness. "It was a problem for him," Jim recalls of the colleague. "How can you defend yourself? What do you say when people approach you like that?" Because he heard about his colleague being reprimanded, Jim put together that it wasn't safe to ritualize at work.

Karen and Jim work at different organizations in different industries. However, they both drew on the discursive resources of specific organizational stories to account for their own respective organizational choices. Karen cites the story of her colleague being chastised for a mental illness breakdown when justifying her scaling back to five clients per month; Jim uses the story of his colleague being reprimanded for extended bathroom use to defend his choice to conceal his OCD symptoms at work. In both cases, stories of a respective organization function as fodder for identity work.

Organizational culture. Respective organizational culture was discursively invoked by several participants when referencing their choices related to negotiating their OCD and organizational identity. Though organizational scholars have conceptualized *organizational culture* in a multitude of ways, what is represented here are the explicit references to organizational culture by participants, in the ways the participants framed it. Participants tended to engage with culture as something an organization *has*, which is a popular way to conceptualize organizational culture, whether or not it is on the cutting edge of scholarship (e.g., organizing *as* culture rather than organizations *having* culture).

For example, Roz works at an organization with "old-school" employees from older generations than herself. "[The company I work for] is a business where people come and stay for their whole careers; people get promoted based on their reputation. I don't want my reputation to be a 'sick person.'" One reason Roz specifically hides her OCD from her colleagues and most supervisors is to avoid the "sick person" reputation in what she describes as an organizational culture that values status and good standing. "The [organization's] culture definitely influences who I want to tell," she asserts.

Hannah also cites her organization's culture as influencing how she manages her identity at work. Hannah is a reading sufficiency teacher for a high school and middle school. "Where I work is really sensitive to the kids' mental needs, but not the teachers," she says of the school system. "It's a culture of self-sacrifice; you have to do things that aren't good for your own mental health. It's their needs before yours." In one particular meeting, Hannah was helping decide which teachers should take over for summer sessions with her boss and her "boss' boss."

My boss' boss was scoffing that one of my colleagues had requested time off for self-

care. The colleague had been getting calls from her parents and couldn't get them out of

her mind. The head boss was recalling this story and said, "that's not my problem. I have

50-something people working here. I can't let her take that time off. Why would we do

that?" The librarian was there, who I know, and later he said, "that's not okay." But if I

were going to have to ask for time off, that's the person I would have to ask.

Hannah's school's reported culture of "self-sacrifice" lets her know that it "isn't safe" to divulge

a need for self-care. Therefore, she feels a need to hide her OCD diagnosis and rituals.

Both Roz and Hannah cite "organizational cultures" that discourage disability disclosure;

for Roz, her organization's values and traditions constitute a culture that is unwelcoming, and

therefore she cites it when defending her choice to avoid appearing as a "sick person." For

Hannah, her organization's attention to student needs and mocking of adult needs constitute an

organizational culture of "self-sacrifice," and she subsequently discursively uses that culture to

justify her "self-sacrificing" organizational decisions. For both Roz and Hannah, the discursive

resource of "organizational culture" functions to account for their organizational decisions.

Organizationally-defined scripts and positions. Participants cited many ways in which

organizational management implemented rules, regulations, policies, and positions when

discussing their identity management. For example, Martin, who used to work in a video rental

store, remembers an employee handbook by which all employees had to abide.

There was an employee handbook that basically said, if you have struggles, leave your

problems at home. It seemed like no emotions were allowed in the workplace. That

wording really shaped my actions at work and my opinion about being open about my

OCD at work.

Martin cites his organization's official handbook when justifying tendencies to hide his OCD

symptoms and diagnosis at work. Similarly, Jack, who at one time worked at a day camp for

children, referred to his organizationally-sanctioned position and seniority when discussing whom he had to tell or not tell about his OCD. He had explained to his boss about his symptoms, and how he was uncomfortable cleaning up bloody noses and bathrooms. He also told others about his fears so they wouldn't be resentful about his lack of assigned chores. After that boss left, he said he didn't have to explain his OCD to his new boss because he "had seniority at that point." Because his co-workers were willing to pick up the slack due to his seniority, he could fly fairly under the radar with the new boss. For both Martin and Jack, organizationally-defined scripts and meanings functioned to explain organizational behavior and thus, craft their identity.

When it comes to organizational discursive resources, participants reported engaging with them in a variety of ways. When it came to organizational narratives, Karen chose to scale back on her work load and accounting for it by telling the story about her colleague who was called "crazy." Jim did his best to hide his rituals at work, and accounted for this choice by telling the story of the colleague who was chastised for spending too much time in the bathroom. When it came to organizational culture, Roz uses her organization's culture to explain why she limits her disclosures at work, and Hannah uses her organization's culture to explain her hiding her need for self care. When it came to organizationally defined scripts and positions, Martin used the employee handbook wording to explain his reasoning for not talking about his "struggles" at work. Jack cited his seniority in an organization to account for his ability to avoid certain tasks.

While each participant mentioned here works for a *different organization with different organizational-specific discursive resources*, they each used their respective organization as a discursive resource for identity negotiation, be it using narratives, culture, or organizationally-defined scripts or positions, to *account for behaviors concerning the same illness*. The discursive

resources drawn upon varied, but most dealt explicitly with illness or mental illness (with the exception of Jack's discursive use of organizational seniority). Karen's colleague was called "crazy." Jim's boss chastised another colleague for using excessive amounts of time in the bathroom, which Jim made sense of as getting chastised for dealing with an illness. Roz interprets the "sick person" reputation to be unacceptable in her workplace. Hannah's boss mocked self-care. Martin interpreted his organization's handbook as instructing employees to "leave their personal problems at home," including emotions and illnesses. Regardless of which specific organization each participant worked, they each cited organizational discursive resources to account for themselves, with most discursive resources dealing explicitly with illness.

Industry/Profession

References to industry were quite common among participants. Individuals reported conceptualizing their own identity in relationship to their respective industry as well as conceptions of what is and is not appropriate organizational behavior in relationship to their respective industry. Participants cited their respective industries when explaining, justifying, defending, or accounting for their organizational choices and positions.

Karen, the public defendant, claims "mental illness is rampant in the law profession." Even so, any trace of it is not tolerated. To Karen, the courtroom is a place where accommodations and difference are especially stigmatic and should be avoided. During our interview, I asked her if she would ever consider asking for any accommodations from anyone in the law profession. She thought for a minute, and said that good accommodations might include time extensions and adjournments. After suggesting those though, she toughened and thought again. "Some judges might accommodate," she said, "but I wouldn't really want to show that

kind of weakness in front of a judge. I didn't even tell judges when I got pregnant." Karen used

the discursive resource of the behavior appropriate for her profession to defend her choice to

hide her symptoms.

Jim, mentioned earlier, used to be a journalist and thinks often about the field, its

relationship to his identity, and the behaviors that are considered acceptable in it. "In the field of

journalism," he asserts, "you kind of have to be a perfectionist. You make a typo, and that's the

only thing they focus on. You have to do everything perfectly. You can't make mistakes." Jim

has worked for many journalistic outlets, and has found similarities between organizations and

their support of their journalists on the ground.

> They don't want to spend money on you; they're not Google. We need breaks. If we had
>
> a massage therapist that came in a massaged everyone for like two minutes once a month,
>
> what would that really cost? It's 100 miles an hour, and they don't give a shit about you.
>
> We would joke like, what if we had a break room with a couch? Never! That costs
>
> money! They make all kinds of money from ads, but they won't spend money on stuff
>
> that makes people comfortable.

From Jim's perspective, the industry in which he worked contributed to his felt need to conceal

his OCD by regulating what behavior and talk is appropriate and valued. Therefore, when

accounting for his choices to conceal his OCD, he cites "journalism" as a profession as culpable.

Similarly, Hannah, who works as a reading specialist, laments how focused the education

industry can be.

> What I do is so specialized, it's hard to get substitutes. When things were really bad in
>
> March, I couldn't *not* go to work. I have a legal obligation to complete an intervention
>
> with my students. I don't know how they could make that a possibility for me to leave to

go to therapy. It's summer now – I had to hold it together from March until the summer. It was really hard.

Because of the industry in which Hannah is employed, her behaviors surrounding the management of her illness and identity were complicated. Had she worked in an industry where she was more expendable, it might have been more appropriate to attend treatment sooner. Consequently, when Hannah how discusses not being able to miss work, her industry functions discursively as accountable for her decisions.

Karen, Jim, and Hannah all discursively engaged with their respective industries to account for their behavior and decisions at work. Karen explained her hiding her symptoms using the law profession as a reason. Jim blamed the field of journalism for exacerbating his OCD symptoms and need to hide his OCD, which may be perceived as a weakness there. Hannah claims that she did not seek treatment earlier because of the nature of her profession as a reading sufficiency teacher. In each case, a different industry was used to justify or explain actions or perceptions related to the same illness.

Economy

Discursive resources of economy were used to account for participants' organizational choices and employment patterns. For example, Ron, who works part time in both the food and fitness industries, wouldn't characterize himself as a stellar performer at work. In fact, he openly acknowledges that he has been let go from several jobs due to poor performance. He also concedes that his OCD and ADHD have played significant roles in his ability to complete work assignments and stay focused on the tasks at hand. However, when being reprimanded in the past for getting distracted or missing a deadline, he has never shared with anyone at work that his

shortcomings are related to mental illness symptoms. He justifies this decision with an evaluation of capitalism as relates to disability.

> Sarah: When you had those conversations with some of your employers about productivity, did you ever think to tell them about the OCD or the ADHD and did you ever want to be like, it's not me that's being unproductive, it's these things that are causing me to be unproductive?

> Ron: I don't think they'd ever really buy that excuse so easily.

> Sarah: So you never went there, you never told them the reasons why?

> Ron: No, because in the employment world, they're not sympathetic. In school situations teachers can be sympathetic but employers won't be. I mean, that's not always true because you can find one that is occasionally, but my experience in the business world is cutthroat. They screw people over in an instant in order to survive, for the company to survive and for them to find profits. It's a really shitty environment in that regard and that's part of the reason why I hated it and you don't escape it by going into the food industry or the fitness industry at all even though that was sort of my hope. But at least I feel a little bit more like my own boss now. Kind of, like, I feel very in control of my life.

Ron had been working in finance when he was repeatedly reprimanded for low productivity and let go from "a lot" of jobs. He decided to try a new direction for his career and got two part-time jobs, one as a cook in a restaurant and one as a group fitness instructor. He attributes his success in these fields to the hands-on nature of his new jobs, but also to the slightly lessened capitalistic pressures of the restaurant and fitness industries.

J.D., mentioned earlier, used to work in parcel delivery, among other short-term jobs like meter reading and landscaping. Throughout the last few years, J.D. has been unable to "keep a job for more than, like, a week or a couple of weeks" at a time because of his severe OCD symptoms. During our interview, he brainstormed ideas for the American economy to better take care of those with OCD.

> I just wish there was something for people with OCD – people who can't keep jobs. Maybe if the government could compensate you for that so you don't have to go on disability. The government needs to recognize that. Other people might think you are lazy, like you just want to stay at home. While you're seeking help, there should be a way for the government to provide for your family. If you stay in the job and you suffer, it's miserable. But thinking about staying at home and having financial problems, that's also bad. Either way you have anxiety. Having that compensation would help to make it easier. I don't want to go on disability; I want to be productive. It's hard to go on disability and then go back into the workplace.

For J.D., government assistance would not only be financially helpful for him and his family, but it would also help to alleviate the stigma associated among mental illness and laziness.

Ron and J.D. both used monetary value to explain how they perceived themselves. Ron explained his inability to hold down a job to the "business world," which would, to him, rather focus on profits than taking care of their employees. J.D. would like to think of himself as more of a valuable human, but thinks monetary, government assistance would help others think of him as more valuable as well. In these cases, *money, economy,* and *value* were discursive resources drawn upon to justify different aspects of their choices or personal value.

In both cases, social value was associated with monetary and economic value. Ron admits he isn't valued in the workplace because of his low productivity, but at the same time, blames his social devaluing on the economically cutthroat "business world" that doesn't have time to deal with disabilities. J.D. attempts to build his own social value by proposing that the American government should provide monetary assistance to those with mental illnesses to demonstrate their social worth. The use of economy as a discursive resource implies the interpretation of a direct correlation between monetary value and social value, as well as accounting for social and organizational location. For the purposes of the latter, economic scripts function for both Ron and J.D. to explain and justify their lot in life in relation to work, as neither is in the position he thought he would be at this point in his life. By blaming the economy for their career location, the discursive resources of monetary value function to soften the blow of unemployment to the identity.

Summary

This section discussed how participants engaged with discursive resources of organizing and economy when accounting for themselves, including general expectations of competency, professionalism, and stress, discursive resources specific to participants' respective organizations like organizational narratives, organizational culture, and managerially-defined scripts and positions, industry, and economy. Each discursive resource drawn upon was done so to accomplish a variety of identity goals. Karen cited the story of her colleague who was deemed "crazy" and the law profession itself to justify her scaling back on her work load. Jim used the story of his colleague who was chastised and the industry of journalism to defend Jim's choice to quit his job. Roz accounts for hiding her OCD diagnosis and symptoms from most of her colleagues on her organization's "old school" values and overall culture. Hannah cites her

organization's culture of "self-sacrifice" and the specialized nature of her industry when accounting for her not attending to her OCD sooner than she did. Martin draws on his organization's official employee handbook when defending his choice to keep his symptoms to himself. Jack used his seniority at his organization to account for not doing some of his assigned work. Ron used scripts of economy to justify his being fired from multiple jobs. J.D. drew on scripts of government assistance to defend his unemployment.

Each participant discussed in this section faced a variety of outcomes and consequences for their identity work. For example, Jack, who used his seniority to defend not cleaning up after children's messes and bathrooms, doesn't see himself working in either of his dream occupations: a zookeeper or a kindergarten teacher. He doesn't foresee himself having seniority in either of those occupations anytime soon, so he figures he will be required to do cleaning work, which he is convinced he cannot do at this time. Consequently, he has decided to return to his job at the golf course after intensive treatment, as he has seniority there and can avoid cleaning chores. Jim used both an organizational narrative and industry scripts to defend his choice to quit his journalism job, and he doesn't see himself ever working in journalism again. Martin, taking his organization's employee handbook to heart, faced the outcome of unemployment.

This section indicates that participants engaged in identity work by utilizing organizational and economic discursive resources to account for behaviors surrounding the same illness (OCD) while working in a variety of different organizations and industries. In fact, no two people in the data set worked for the same organization. Organizational, industrial, and economic discursive resources seem to transcend any single organization, industry/profession, or economic system when accounting for OCD in an identity narrative.

Medicine

Many participants discursively utilized medical scripts to account for themselves, often in relation to misconceptions encountered at work. One of the main medical scripts drawn upon was a conceptualization of what OCD "is" or where OCD "comes from." Participants made claims about OCD itself as an illness and disorder and the ways in which it affects individuals who "have" it. I am using so many quotation marks here to indicate that the medical scripts discussed in this section are *participant interpretations* of medical "facts," that is, conceptions of medicine that are considered to be or framed as true by certain groups or populations. For example, it is commonly cited as "fact" among the medical community that OCD is at least somewhat genetically influenced. In this section, I am not framing this script of genetics to be Fact, but rather, a script of "fact" that is engaged with by participants. Many times though, participants made claims about OCD that I could not find to be specifically supported by medical research, but still framed as Fact.

In this section, I will be reporting on participants who used medical scripts to account for, justify, explain, or clarify organizational behavior, decisions, or locations. Participants used a variety of medical scripts to define the self and explain behavior, legitimize OCD, address misconceptions, and educate organizational others.

Defining the Working Self and Explaining Behavior

"I was born with it," Toby says of his OCD and Tourette's. As mentioned earlier, Toby is not only questioned about his tics at work, but anytime he goes out in public, as his tics are quite noticeable and a bit startling. When explaining his odd behavior, he uses his Tourette's diagnosis most often as a discursive resource, as he sees Tourette's as more publically understood. Describing OCD as something that one is born with is a common way participants chose to

frame their condition; Leslie and Nance specifically point out that OCD is "genetic." For Leslie, claiming OCD is genetic helps her separate herself from her disturbing, intrusive thoughts she experiences at work: "that's not me," she says of the thought she might be a sexual predator. "I'm not worried. That's fake. Those feelings are fake, all of it." For Nance, learning that her OCD was genetic was eye-opening, in that she no longer thought of herself as being weak for not being able to overcome her OCD on her own.

So when explaining why she spent excessive time in the bathroom at work, Peggy said of OCD, "it's sporadic. When it gets to its worst, you can't function. When a certain trigger comes up, you don't know when and where." By using the generic "you," it seems as though Peggy is describing how the "objective" disorder affects people in general when explaining her own organizational behavior. For Peggy, her intermittent bathroom trips are due to the nature of OCD itself, not her interaction with or expression of the disorder.

Here, the script of what OCD "is" functions to defend, justify, or explain organizational behavior or selves. For Toby, being "born with" OCD and Tourette's is a discursive resource he commonly draws on to explain his abnormal workplace behavior. Leslie, claiming OCD is genetic, is better able to separate herself from her disturbing thoughts in the workplace so she can still think of herself as a good worker, despite this separate, genetic disease she can't help. Peggy uses the discursive resource of what OCD "is" (here, it is sporadic) to justify her excessive time spent in the bathroom at work, by again separating herself from the "nature" of the disorder. What OCD *is* seems to be different for many participants respectively, but more importantly, what is most *salient* about what OCD "is" can be drawn on differently for a variety of accomplishments and outcomes.

Legitimizing OCD

Since "OCD" is a term that is often used loosely, many participants use medical scripts to add some weight to their condition, as it is often described as trivial (as discussed in the literature review). I asked Jack what advice he might have for others with OCD who want to work, and he recommended they "treat [OCD] as an illness" and to take it seriously. "It *is* an illness," he continued. "If you were diabetic or had cancer, you would have no problem saying you can't come in. You don't have to go to work if it's going to mess you up. Be willing to give yourself time off." By comparing OCD to more well-understood illnesses like diabetes and cancer, Jack is discursively borrowing the seriousness of those diseases and loaning it to OCD. He encourages others to think of OCD in this serious way so they feel like they can give themselves time off when they need it, as would someone with a more well-understood illness. In this way, he can justify his own intentions of taking time off for his own OCD without having to think of himself as a lazy worker.

Liz uses the seriousness of taking medication to indicate the gravity of her condition. She has told others at work that she is on medication for anxiety, which signifies that a physician has deemed her ill enough to merit a prescription, which not all illnesses merit. Likewise, Lucy has referred to the emergency room when explaining her absences; she wanted her T.A. to know that her OCD was "really bad" and that she couldn't come in, but rather than telling him the details of her condition, she is more likely to tell him that she had to go to the ER (only when it is truly the case though).

Each of these medical scripts functions as identity work. For Leslie, the explanation of genetic causation helps her separate herself from her disturbing thoughts at work, allowing her to think of her shortcomings at work as separate from her *real* organizational identity. Peggy uses a

similar discourse of OCD being sporadic to explain her tardiness at work. Jack uses the medical script of physical illnesses to legitimize his own intense struggle with a mental illness. In each case, participants used medical scripts to add weight to their diagnosis and manage their identity.

Addressing Misconceptions

Participants engaged directly with what they perceived to be misconceptions or misunderstandings about OCD. Many participants claim that others generally "don't understand" OCD, and especially not the severity of it. Liz, in particular, compared the sense-making process that individuals experience when seeing someone in a wheelchair or other serious conditions compared to knowing someone with OCD.

> If people don't understand something, then they don't care—but if somebody can be educated on something and really understand—like, everyone understands how being in a wheelchair affects somebody or how cancer can affect somebody, and how hard those things are and how bad they are.

Not only does Liz point out the comparison in sense-making, she also discusses the consequences of "not understanding," which she claims is not caring.

Kenneth, a shelf stocker at a big box store, is frustrated with the misconception that OCD is a surface-level condition that only concerns handwashing.

> A lot of people know about [OCD], but whenever they think about it, they just immediately go to, "oh so you wash your hands a lot?" They immediately go to the stereotype. "He has OCD so he probably as a thing washing his hands," but most people don't even know how deep it goes.

At his previous job, Kenneth bussed tables and washed dishes at a restaurant. He remembers his co-workers joking about how many times he would excessively scrub down a table, a symptom

of his OCD: "oh yeah, do you think that's enough?" Kenneth recalls wondering why they thought his symptomatic actions merited something to joke about, because he knew he was struggling. Leslie also claims there is a "stigma" that OCD is only about "cleanliness." After disclosing to one of her co-workers, they asked, "does that mean you clean a lot?" Leslie responded with, "no, I wish."

Lucy once disclosed to a friend about her OCD, to which her friend replied, "oh, that's not a big deal." Lucy felt invalidated by her friend's conception that OCD is not a big deal. Selina also feels helpless when others seemingly misunderstand the seriousness of her disorder, which has had "debilitating effects" on Selina's life. "If you can't do something," she says, "you can't do it. It's not like you can just do it – it's not that easy."

Jess blames the media for misconceptions about OCD. "Most people have only heard of the handwashing, like, the Hollywood version of it, perfectionism, et. cetera," claims Jess. She doesn't like to tell people at work about her OCD, because she thinks "they would perceive it in a very stereotypical way" and misjudge her own OCD. Jess also notes that she thinks people presume OCD can't be that bad of an illness if a sufferer is able to function in specific ways, like showing up at work in the first place.

One commonly mentioned misconception is that "everyone has some OCD." Liz chastises those who use the term "OCD" too loosely.

> I think even to this day, people are like, I have such bad OCD. I have to make everything on my desk in my room is straight. It's like, no. I think it's a term even now that's used really loosely. Like 'oh my gosh, I have such bad OCD with needing to make sure'—I think that's very true that every person has things, but when it's like, ugh 'I just have really bad OCD,' where your necklace needs to be—it's like, no.

Elliot cites media portrayals of people with mental illness in TV or movies that are awarded some sort of super power along with their disorder. "You have OCD, you're probably really creative; you're really efficient," Elliot was once told at work. Titus' mother expressed a desire for him to go into accounting, a field with which his OCD might "help," because she believed OCD was "just about checking and counting."

Participants described using medical scripts to address various misconceptions, describing and explaining how OCD "is" in contrast to the misconception. In doing so, the medical scripts functioned as identity work, in that when a participant corrects a misconception about OCD, they are also defining who they themselves are as a person with OCD.

Liz clarifies her stance on what makes OCD a disorder, rather than just a personality quirk. Quirks, she says, can be "obsessive or compulsive, but [they're] not obsessive-compulsive *disorder.*" During our interview, Liz asserted that there is a specific way OCD *is*, which is "like a chameleon. It can be whatever it wants," assigning a bit of agency to the disorder. "It's good at shifting forms." Hannah also distinguishes between "obsessive-compulsive tendencies" and "obsessive-compulsive disorder:" OCD is "unhealthy." Similarly, Kenneth insists that OCD "goes a lot deeper than people realize."

When Leslie disclosed her OCD to a co-worker and the co-worker asked if OCD just meant that Leslie cleaned a lot, she responded in a "straightforward" way by drawing on scripts of what OCD "is."

> I'll usually just be like, "well, I have OCD and I'll just say right off the bat now, [mine] is not a cleaning thing, there's different types" and I'll let them know that there's a lot of different types of OCD. And when you have one, you usually have a couple. So I'll

>explain the details so they understand because I want them to understand when they meet
>
>someone else that there are multiple types.

By Leslie using the generic "you" (as in, "when *you* have one, *you* usually have a couple"), it seems as though she is making a statement about OCD and how it affects people in general, not just her own experiences. For Liz, citing her knowledge of medical scripts is doing her part to dispel stigma and stereotypes about OCD to benefit not just her own experience at work, but the experience of the next person with OCD her colleague might meet. And helping the person who may follow her path after her is part of who she wants to be today.

Educating Others

Several participants insisted that workplaces should be educated about OCD; if only others *understood* what OCD is like, the work experience for the sufferer might be better. For example, Liz wants supervisors to be more "educated" about OCD using medical scripts, and not just about OCD in general.

>I think on the employer side, education and not just like, here's a one page [handout] with
>
>bullet points of, people with OCD do this and people with OCD do that. Maybe it could
>
>be really tailored to that person's specific way it affects them.

Liz previously mentioned that when people don't understand, they don't care; she thinks this apathy can be mitigated by education. Relatedly, when I asked Nance about what she might like in a workshop on how to succeed in the workplace with OCD, she said she wanted resources she could give to her boss and draw on to help explain OCD and mental illness to others.

>In the workplace, there is not enough information about mental health – we need services
>
>that focus on the mental health issues that people conceal because of shame of that it
>
>might put their job in jeopardy, they need resources in the workplace if they have OCD,

anxiety, etc. that emphasize open and honest communication between coworkers if

people are suffering, they need to feel like they have a support system.

For Nance, if more individuals in the workplace had more education on mental illness, there

might be less stigma about sharing a diagnosis with supervisors and colleagues.

Liz wants others to "understand" OCD, and therefore is calling on the discursive resource

of what OCD "is" to justify her organizational identity. Because if others at work understood

OCD, they would in turn understand *her,* and she might subsequently have a better shot at being

seen as a competent worker, which is what she ultimately wants. Nance draws on educating

others using medical scripts so that a more open workplace can be created at different respective

organizations. By doing this, she is accounting for her own experiences of shame and feeling like

her job might have been in jeopardy. For Nance, medical scripts are functioning to justify her

choice to conceal her OCD to the majority of her colleagues and her feelings of shame at work.

Authority

While most claims by participants were made without any direct reference to a source,

some participants referred to specific physicians when making their assertions. For example,

rather than just stating that "OCD is genetic," Titus relies on the authority of his physician when

he says, "my doctor told me OCD is genetic." During our interview, he referred early on to his

psychiatrist, and then had a great deal to say about the nature of OCD: "It's a really bad disease

if you have it," he declared using the generic "you." He continued, "it can ruin your life if

possible, if you let it. It's not just about checking and counting and stuff, it's a lot more than

that." His early reference to his doctor added a bit of weight to his claims, as he was presumably

ventriloquizing an assumed expert on the topic. Similarly, C.J. describes her experience with

OCD in terms of what her psychiatrist told her about the "nature" of the disorder:

[My psychiatrist] would always tell me, mine was "Disney magic" she would always call it, because it developed when I was so young. They say that people when they develop it when they're younger, their fears are more unrealistic. When you develop it when you're older, you have more realistic fears. People who develop it later in life are afraid of their houses burning down, they're afraid of their children dying, things that can actually happen. For me, I was afraid of things that weren't real, but it's because I was young and thought they were real. So being able to lose your essence or that obviously is more mystical, magical than people who afraid of [more practical outcomes].

C.J. is embarrassed of the mystical fears associated with her OCD. When referencing her psychiatrist and her explanation of her fears though, she is able to somewhat mitigate the embarrassment because there is a medical explanation for the odd symptoms of her illness. Also noteworthy, C.J. refers to the generic "they," when indicating the authority of medical experts.

Whether or not participants called on an outside authority or not when citing medical "facts," they seem to be utilized with equal emphasis in identity work. When Peggy claims that "OCD is sporadic," she says it with no less confidence than Titus when he claims, "my doctor told me OCD is genetic." Both medical scripts that reference a medical authority and those that don't function to account for OCD and organizational behavior.

Summary

This section discussed how participants engaged with discursive resources of medical scripts, which functioned to define the self and explain behavior, legitimize OCD, address misconceptions, and educate others. Toby called upon a script that OCD and Tourette's are present at birth to justify his inability to control his symptoms now. Leslie and Nance cite the genetic influence of OCD to separate themselves from the negative traits they perceive about

themselves; having disturbing intrusive thoughts and being too weak to overcome OCD, respectively. Peggy uses the medical script that OCD is "sporadic" to explain her unanticipated time spent in the bathroom at work and take some of the blame off of herself. Jack discursively uses the weight of cancer and diabetes to justify his own struggle with OCD and excuse the times when he may need to leave work in the future. Liz uses the script that medication equates to illness severity to explain the strong extent to which her OCD symptoms interfere with work. She also dispels the misconception of OCD being a personality quirk with medical scripts to those same ends. Lucy discursively borrows the severity of the "emergency room" to explain her absences from work, rather than relying on OCD alone. Hannah cites medical scripts when she insists that OCD is "unhealthy" while simple quirks are not, which helps her convey her own unhealthiness and severity of OCD. Nance insists that others should be educated using OCD medical scripts to excuse her own perceived shortcomings at work; she now looks back and doesn't like the way she hid her OCD from almost everyone at work, and implies that if she herself had been educated, she may have made different choices. This use of medicine as a discursive resource helps her make sense of the hardships she faced at work by attributing it to a lack of education.

Each participant discussed faced a variety of outcomes and consequences for their identity work. Liz used medical scripts to justify the severity of her symptoms to others at work and she subsequently claims that "people care" more about her condition. Hannah cited medical scripts to distinguish between her disorder and a simple personality quirk in her identity work with me during our interview, but she still struggles with how exactly to frame her OCD at work because of feared stigma.

This section displays efforts to frame OCD in a particular way in order to frame the *self* in a particular way. Describing OCD as "sporadic," for example, is not a benign way for Peggy to describe an illness; it is a way of excusing her own "sporadic" workplace behavior. A call for others to be educated about OCD is not just an altruistic desire of Nance's; rather, it is a discursive way of accounting for her own perceived mistakes in the handling of her OCD at work. Even though participants defined the way OCD "is" in many different ways, each used those definitions as discursive resource for organizational identity work.

Personal Life Scripts and the Physical Body

Unlike medical scripts that were claimed more "factually" and called upon to generalize about medicine itself for identity work, participants reported engaging with stories from their *personal life experiences* to account for themselves, including stories to frame their work ethic, account for their organizational behavior, and promote their successful organizational performance. In particular, the participants' hospital stay was commonly drawn upon to account for organizational position and choices. Additionally, the physical body was discursively engaged when participants referred to their bodies in the identity negotiation process, including discursively using the body to explain unemployment, defend organizational choices, and account for organizational mistreatment.

Personal Life Scripts

Many participants discursively engaged with events and stories from their own personal life experiences to negotiate and manage their identity. For example, C.J. wants others to know she is a hard and persistent worker. During our interview, she was describing to me how hard she works on her OCD, and how relentless she is to maintain her OCD recovery and succeed in her career. I asked her what kept her so driven, and she responded with a story.

I remember when I was younger, I wanted to be a lifeguard because my friend was and [I'd] never swam. Like I could swim around pools and I could doggy paddle under water and all of that but [I'd] never done any of that. I wanted it so bad that I learned how to swim and I passed it to be a lifeguard. And I'd never swam before, but every day doing it. I was going to any pool that I could and I was like, I'm so nervous, I don't know if I'm going to be able to do all of those laps. I did it, I wanted to be a lifeguard and I did. This was years ago but it was just one of those things I guess.

C.J. used this story to illustrate her work ethic and drive, which she wants people to know about when it comes to her fight with OCD and success at work. "I haven't been broken," she says of her journey. In the past, she used her drive and energy for compulsions. Now, she uses it to resist compulsions and achieve career goals. When I asked C.J. if she had advice for others with OCD who wanted to work, she suggested that they use their own personal stories of success in other areas of life to inspire their success over OCD and in the workplace.

Maybe you could ask them for an example of a non-OCD time where they've done something, put their mind to something and conquered it. It's the same thing, it's just uncomfortable. I'm sure there's been times anybody—like there was an exam you had to study for but you didn't want to, but you pushed hard and did it. Even though it's not really OCD, I think the drive can be used anywhere for any different part of your life. It's not the knowledge of the therapy of the stuff, you learn that, but to do it, it's you. No one can teach you motivation. You can teach somebody until their ears fall off how to do the therapy, but you have to do it, you have to do it. I always think, take life, the reins of your life. No one else will.

For C.J., personal life scripts and experiences may and should be used to define the personal and organizational self and motivate future action. In doing so, discursive resources of personal experience function to account for organizational action and desired career trajectory.

Liz, on the other hand, very much sees herself in relationship to her religious journey. When I asked her about her current job and what's made it more manageable than her previous jobs that ended, she started by describing working conditions, but quickly moved into telling her story of religious redemption.

> So I think what's different is just like, learning to push the thoughts out of your brain. When you know that you have the tools that you need—the main thing is that I truly feel like Christ has done truly miraculous work in my life. I was just debilitated, so I think it's His medication and my strength with medication and like, tools I've been equipped with, with strategies I can use mentally to stop the madness is I think what's different. Just time, like my savior Jesus Christ, time, medication, and just like tools, good friends.

As a person and a worker, Liz sees herself as someone who has been healed by Christ. While she still struggles with her OCD a great deal, she often recounts the story of her healing, which she considers to be ongoing. Liz is quite comfortable sharing her diagnosis with others because she is able to tell the story of Jesus' healing in her life, which is very important to her.

> I think maybe—the thing about it is that I'm very comfortable letting people know, hey, this is something I've really struggled with and just like, praise Jesus that I'm not in that place anymore because I am in a way better place.

Even though Liz may not be medically considered "healed," she makes the claim of being so using her religious life experiences. In doing so, she can not only reframe how she wants to be seen (as "healed") but excuse any organizational missteps or OCD manifestations; even though

she's not perfect, she is still "healed." Therefore, her spiritual experiences can help account for her improvement, but also frame any current OCD manifestations at work as still a part of being what it means to be "healed."

Laura is an acting major in college and she uses her OCD experiences to fuel her acting performances. She wasn't sure about it at first; she was afraid conjuring up painful experiences might upset her on stage. She told her acting professor about her OCD so that she could get accommodations, and that professor urged her to use the pain of her story to propel her characters forward. I asked her if this made her uncomfortable, that her organizational senior was asking her to use her disability for work performance; she said it didn't.

> I think it was good. I liked it because I have always kind of done that with characters and stuff. I try to find ways that they relate to me in some way but I hadn't really been willing to use that experience with it yet because I was scared that if I thought about it too much it would upset me. But she was like, the thing with acting is that you can put it all out in the stage and get it all out on the stage and then you don't have to think about it after.

Laura's story and life scripts became a part of her organizational performance. To her, it made her performance stronger and helped her better manage the trauma of her illness by giving her an outlet of expression. But also, using her personal experience to propel her organizational performance frames her as an overcomer and willing to use her pain to her professor, which functions to manage her organizational identity.

C.J., Liz, and Laura all use their personal experiences to attempt to frame how others see them. C.J. uses her stories of overcoming obstacles in her past to explain her drive to be the best accountant she can be and hopes others see her as an excellent worker. Liz uses her religious journey to account for her living in recovery from OCD and position herself as "healed" from

OCD. Laura uses her struggles with OCD to position herself as a good actor, which propels her organizational status in her department. In each of these uses, discursive resources of personal experiences function to account for, explain, or somehow justify organizational choices or positions, and managed to frame their stories as that of an "overcomer."

Hospitalization. One common experience between all the participants in this study is intensive OCD treatment, some intensive outpatient, some in a partial-hospitalization program, and some residential, but all require spending a great deal of time in an institutionalized setting. This experience was drawn on in a variety of ways when participants were discussing their identities now.

When Pam first arrived at St. Mary's residential treatment facility, she was "freaking out." Her father had driven her to the remote location, and Pam begged him to stay with her. "I was like a toddler," she remembers. "I was like, please don't leave." Pam struggles with the fear that others might harm her, and now she was going to have to stay in a dormitory-style building with 20 other people. *What if people hurt me?* she wondered when she arrived. During her stay, Pam recalls being afraid to go to sleep in her room because she feared she might be stabbed through the night. To get a bit of rest, she would take daytime naps in well-lit common rooms while a residential counselor sat next to her the entire time to reportedly ensure Pam's OCD that she wouldn't be harmed. As Pam's stay at St. Mary's progressed, she did incredibly difficult work in therapy and was gradually able to sleep in her own room without anyone supervising. Even though Pam has improved a great deal, her hospital stay was traumatic and excruciating. But as much trauma she faced at the hospital, she was even more afraid to return home.

> As scared as I was going into it, I was even more terrified to leave because it's the
>
> transition back into the real world that's really hard…when I saw [some] people leave,

they're kind of like, I'm going to leave residential and then I'm going back to work. I've

always thought like, that's heavy treatment, being in residential 24/7 care and then going

back to work. There's got to be some in-between, you can't just jump back in…I think

you definitely have to have a specific plan moving forward because it's also easy to fall

apart.

After Pam left St. Mary's, she took a bit of time off to process her experience at home, and then

returned to the university she had been attending before treatment. She found that she needed to

miss a few classes here and there to maintain her life of recovery. She first approached the

university's disability office with her diagnosis and faced a disability officer who refused her

accommodations, even though she had documentation from her doctor, so she decided to go

straight to each professor. When approaching her professors to ask for accommodations, she

decided not to tell them she had OCD.

So I went to the teachers, I didn't say I had OCD but I just said, "I've been in the

hospital." I left it at that, didn't say "mental hospital," just "in a hospital." They were

great, they worked with me and gave me extensions for assignments and tests and that

was awesome because that meant I didn't have to go through [the disability office].

Obviously, they're not all going to be like that, I just got really lucky.

For Pam, using her hospital stay to negotiate her organizational identity and position seemed

more effective than using her diagnosis. By telling her professors that she was in a condition

which required a hospital stay, she was able to ventriloquize a bit of the organization's authority

to accomplish her goals at the university. Therefore, the discursive resource of her hospital stay

experience functioned to account for her occasional absences.

Pam has been doing well in school. I interviewed her about three years after her intensive treatment, and she was actually doing an internship at St. Mary's, which meant I could talk to her in person on location. She is majoring in Psychology, and applied at St. Mary's to help facilitate a research project developing an app that patients with OCD can use after they leave the hospital to help them maintain recovery. In this internship, Pam gets to work with patients with OCD, and she uses her stories of success at the hospital as a discursive resource to encourage the current patients, as well as organizationally frame herself as an "insider."

Ron felt lost before, during, and after his hospital stay. Before he started his treatment at St. Mary's, he had just finished an MBA and had plans to find a job using his new degree. However, as his OCD worsened, he realized that rather starting a job, he would need to start intensive treatment. He remembers sitting on a couch in his parents' home, researching hospital programs. "I was tripping out," he recalls. "I should be trying to get a job right now," he says of the time before treatment. He spent the better part of two months on that couch, consumed by depression and waiting for St. Mary's to call to tell him there was a spot for him in the residential program. Before St. Mary's called, he enrolled in a half-day program near his home and that pulled him out of his funk for a bit. After completing residential treatment at St. Mary's, Ron went back to his parent's home and hid out from society in an attempt to replicate the relative isolation of the hospital. He felt dejected, as though he wasn't where he was supposed to be in life. He felt that the right time to get a job was when you leave college, not when you leave a hospital. "It's going to be harder and harder to get a job," he remembers thinking as time went by. "If I can't get a job out of college or from scratch, like, those are the points where you're going to get a job." For Ron, his hospital stay was a punctuation in his life story that didn't

belong. He now works part time in both a kitchen and recreational center, which he partially attributes to trying to get a job directly following a hospital stay rather than college.

Both Pam and Ron use their hospital experience to account for their current organizational positions. Pam uses her hospital experience to negotiate university accommodations, explain her reasoning for taking an internship at St. Mary's, and also to comfort and encourage patients she encounters at the hospital, thus solidifying her own identity as someone who went through a traumatic hospital stay and came out on the other side a functioning human. Ron, on the other hand, uses his hospital stay to account for his perceived career downslide, that is, why he isn't working in the occupations he thinks he should be working. Pam and Ron are in perceived different places in their career, but both use their hospital experience to explain why they are where they are.

The hospital experience was also used in a variety of other ways, including C.J. using her hospitalization to legitimize OCD as a serious illness, similar to how medical scripts were used earlier. "I've been hospitalized for my OCD!" C.J. told me as she was stressing how harmful misconceptions can be when trivializing the disorder. Finally, Elliot claims that her hospital stay and St. Mary's specifically has made "feel allowed" to tell people about her OCD, as being in a hospital setting with others helped her realize she wasn't so alone. In all, hospital treatment was used in a variety of ways to accomplish a variety of ends. Overall, the intensive treatment hospital experience was one of the more commonly referred to personal life scripts by participants in this data set.

Physical Body

Participants discussed how their bodies may be both catalysts for identity work and be called on discursively to account for themselves. For example, Toby, who suffers from quite

visible Tourette's and OCD symptoms, references his physical body when accounting for his lack of employment opportunities. He refers to his physical body when he told me he would like to work from home so that he doesn't have to face the consequences of his body in the workplace. Eventually, once his tics are more under control, he would like to work in retail because he thinks it will improve his social skills. He has interests in telecommunication, fashion, and retail. When searching for jobs, he communicates with potential employers over email and lets them know he would like to work from home due to his Tourette's and OCD. He hasn't had many bites.

Sarah: Have you pursued anything in fashion?

Toby: …I reached out to a company that I applied—I guess in that area, you can't really do well from home. You kind of can but…they haven't responded or they're "not hiring yet" or what not…basically they're saying "we don't want you," but they're, [like], "not hiring right now," but I'm still trying to reach out to different companies and stuff. So far I haven't really been [very] successful.

Sarah: So kind of your ideal job is working from home? Is that the ideal setting?

Toby: Well, for now it is because of the tics. I would like to do retail hopefully one day because I really could improve my social skills and everything, socializing, but now like I said, it's kind of difficult with the tics and everything so I'd rather just do work from home. It's easier, yeah.

Toby attributes his inability to work in telecommunication to his body as well. He's "really into" the idea of working for a telecommunication company, but doesn't see himself being able to work over the phone. "The struggles of having tics and OCD will interfere," he states plainly.

Therefore, Toby's discursive engagement with his physical body functions to account for his career location and future trajectory of organizational choices.

Rebecca is self-conscious about her body in more ways than one. Her OCD had reportedly latched on to the idea that her body must be perfect at all times and in all places. Her job at the recreation center has often been difficult, as many of the patrons of the center have what she perceives to be beautiful or perfect bodies. As part of her therapy, she tries to resist comparing herself to them in obsessive or compulsive ways. Most times she passes a mirror or reflective surface at work, she finds herself checking her appearance, a compulsive habit she is trying to break. Rebecca also suffers from co-morbid trichotillomania (compulsive hair-pulling), which has resulted in bald spots all over her head. Her colleagues at work noticed the hair-pulling and bald spots, and Rebecca noticed them noticing. She decided to wear a wig to work to attempt to prevent her symptoms from giving her away at work. She has had to negotiate other aspects of her OCD at work (like her ban book, mentioned earlier), but she does her best to hide her body symptoms when she can to maintain a more normal identity. When recounting the decision to wear a wig to me, she calls on her physical body to explain that organizational choice, and therefore the discursive resource of her physical body functions to account for her organizational decisions.

Before intensive treatment, Pam's body started to turn against her. Whenever her OCD was triggered, she would experience horrible stomachaches. This was especially distressing during her college classes and affected the way she interacted with others.

I'm sitting in a class and I get overwhelmed, my stomach would start hurting, specifically in psych classes. Like I took an adolescent and adult class and at the end, it kind of goes through the lifespan like development psych. We were talking about suicide and death

and dying and that was obviously really triggering. So I would just have to leave the classroom and I'd kind of pace and walk outside the classroom. Because that was so specific to my obsessions, that was kind of a special case where I would just have horrible stomach aches for the rest of the day and I wasn't hungry at all. Eating is always weird for me in front of my friends in the cafeteria because I don't like doing that. So it just kind of—once I was triggered by that, it affects the rest of the day and people seeing me. I think I can hide it really well so they wouldn't know, but it just really changes your mood. I wouldn't feel like doing anything at the end of the day or hanging out with friends, I'd just want to sleep.

Pam's stomachaches not only affected her organizational performance (getting up and leaving class), but also affected how she thought others saw her, her mood, and the ways she interacted with others. In another incident, Pam remembers her OCD being triggered when she found out one of her friends had been raped.

I just remember freaking out. Anyways, I had a test on Monday, a psych test, and I just could not study over the weekend. I did so bad, I got like a 65 or a 75 and that really sucked because I reached out to my teacher saying hey, stuff has come up and I'm really nervous about it. Because I wasn't physically sick, I appeared fine, and I didn't have accommodations either so I ended up just taking the test anyway.

In this case, Pam claims that her body's lack of visible symptoms prevented her from obtaining the accommodations she needed, and thus negatively affected her ability to excel on the exam. When defending her poor grade to me, she drew on the discursive resource of her physical body to account for her organizational performance.

Summary

This section discussed how participants engaged with the discursive resources of personal experiences and the participants' respective physical body. C.J. used the story of how she became a lifeguard to reaffirm her gritty work ethic and frame herself as an overcomer. Liz used her story of religious experiences to frame herself as "healed" and subsequently excuse any organizational missteps. Laura used her experiences with OCD to propel her acting performance and also to frame herself to her professor as someone who is willing to go the extra mile at work. Pam, to one professor, used her hospital stay discursively to obtain accommodations, but also blames her body for "not being sick enough" to get accommodations from another professor. She also uses her hospital experience to frame herself as an "insider" in her internship at St. Mary's. Ron uses his hospital stay timeline as a discursive resource when defending his social and occupational location; he is not where he wants to be, and his hospital stay is partly to blame. Toby discursively refers to his body when explaining the reasons why he has limited employment opportunities. Finally, Rebecca uses her physical body as a discursive resource when defending her choice to wear a wig to work.

Each participant discussed faced a variety of outcomes and consequences for their identity work. C.J., who used her lifeguarding experience as a discursive resource to explain her work ethic, considers herself to be quite successful at work and reported being praised for her organizational performance. Toby attributes his lack of employment opportunities on his body, and therefore gets to think of his unemployment as a product of the physical rather than his personality and *who he really is.* Liz claims that she is "healed," but doesn't necessarily open herself up for constructive criticism of her OCD manifestations at work, as she seems to resist the idea that they are a problem, but rather an expression of a "healed" person.

This section first indicates that a hospital stay for intensive OCD treatment is a major life event for someone who experiences it, as evidenced by the emphasis placed on it by participants when engaging in identity work. Second, since OCD is an illness that manifests in the physical body, it makes sense that participants use their body as a discursive resource to account for, defend, justify, or clarify organizational behavior, career choices, or organizational position.

Chapter Summary

This chapter has laid out the data that explores my research question, *how do individuals with OCD negotiate their organizational identity?* I have categorized identity negotiation into groups of discursive resources that were reportedly engaged with both at work and in each participant's interview itself. Within each category of discursive resources, I have discussed how each discursive resource may be called upon, engaged with, or drawn on in different ways that accomplish different goals or lead to different outcomes.

The first section discussed the discursive resource of "normalcy" and the subsequent discussions engaging with it. "Normalcy" was described and defined many ways, including what a "normal" diagnosis looks like, how a "normal" life unfolds, what is abnormal, and what is stigmatic. However "normal" is defined by each participant, it is clear that there is a delineation between "having OCD" and "being normal." Participants had to account for this delineation, be it by explaining their abnormalities, insisting the abnormalities were not a part of *who they really are*, hiding their abnormalities, or insisting that their symptoms aren't *that* abnormal. This separation between "normal" and "having OCD" is a distinct and unique catalyst for identity work that must be accounted for.

The second section addressed how "organizing" and "economy" were discursively drawn upon and engaged with in identity work. The data indicates that OCD is indiscriminate to

particular organizations, industries/professions, and economies and, moreover, that it permeates identity work across the working world. Narratives, cultures, and hierarchies from a variety of organizations were called upon to account for organizational choices related to OCD, actions, positions, or OCD manifestations. To be sure, different organizational sites, situations, and setups influence which discursive resources may be utilized, but it is clear that OCD is not something that only must be accounted for in certain organizations, industries, or economies. Rather, *every single participant* reported that OCD influenced their work or organizational participation in some way that had to be accounted for.

The third section examined how participants utilized medical scripts in identity work. Participants engaged with discourses of what OCD "is" and where OCD "comes from" to account for themselves. These medical scripts functioned to define the self and explain behavior, legitimize OCD as a serious illness, address misconceptions, and educate others at work. The data presented in this section indicate that defining and describing OCD is not a benign effort to educate others about a disorder; rather, it is identity work that defines and describes the *organizational self*. Participants described OCD in a variety of ways, citing a variety of authorities (or none at all). Therefore, the content and availability of medical scripts the general working public, and individuals with OCD specifically, have access to, are important, because they are often what is drawn on to defend the individual with OCD against organizational accusations, misconceptions, and assumptions.

The fourth section explored how participants draw on their personal experiences and their physical body as discursive resources for identity work. This section implies that among other experiences, the institutionalized treatment for OCD is a major life event that permeates organizational identity work. Even though most participants cite positive medical outcomes of

intensive treatment, many are traumatized by their experience with an institutionalized treatment setting and the jarring nature of *exposure and response prevention* therapy. The hospital stay functioned discursively for a variety of identity management situations, including organizational inclusion, framing a need for accommodations, and excusing unemployment. Therefore, this is a unique life experience that influences organizational identity work that should not be ignored.

Finally, in each interview, as participants recounted conversations of diagnosis or symptom disclosure and subsequent identity work in the workplace, I asked each respective participant why they chose to reveal their stigmatic identity to that particular person. The most reliable predictor of whom the participant chose to disclose was a sense that the other person might be on the "same page" when it came to the meaning of discursive resources, like *OCD* or *mental illness*. In other words, the participants *communicatively sought out shared meaning*. Many participants even expressed that they felt comfortable sharing with me because I "understood" OCD. Different participants have different ideas of what indicates that someone might share their own interpretations of discursive resources: for example, Roz knew that her sister's best friend had post-partum depression, so Roz figured she would be a good person to confide in. Laura told her psychology professor about her diagnosis because she reasoned that since he studied mental illness, he wouldn't think she was crazy. Hannah knew that her supervisor would *not* be sympathetic because she overheard him mock another employee who needed time off for mental self-care. Peter decided not to disclose his diagnosis to his HR department because he "didn't know if they could even understand" OCD. Additionally, some participants made sense of others' ability to sympathize with their struggle by attributing their reaction to the person's respective relationship with the illness or another similar illness. For example, Kenneth told his boss he had OCD and his boss reacted kindly; later, Kenneth found

out that his boss has a family member with OCD and now attributes his kind reaction to the boss's relationship with the family member.

This sensemaking to decide whether someone is "on the same page" indicates a vulnerability, a reliance, that the individual with OCD is somewhat at the mercy of the interpretations of organizational others. After all, it is riskier to disclose to someone with undiscovered interpretations of mental illness, much less someone who has explicitly condemned it. Therefore, this chapter indicates that identity work, specifically for workers or organizational members with OCD, is a complex social activity with precarious outcomes.

Therefore, returning to my research question, *how do individuals with OCD negotiate their organizational identity,* the evidence presented here indicates that individuals with OCD negotiate their organizational identity by engaging with a particular set of salient discursive resources (normalcy, organizing and economy, medicine, and personal life scripts and the physical body) which function to account for, explain, justify, or clarify organizational choices, actions, communication, and position. This chapter has organized the discursive resources into categories and analyzed the functions, goals, and outcomes of their use. However, this chapter does not go into detail on what it might look like for these discursive resources to be used cohesively, that is, how an interconnected story might play out in an interview. After all, the interview is a distinct site of identity work. Therefore, in the next chapter, I tell four stories of my interpretation of four cohesive identity narratives.

CHAPTER 5

STORIES OF LIFE, WORK, AND OCD

In the previous chapter, I teased out and discussed a variety of discursive resources with which participants engaged and discussed them individually within distinct, labeled categories.

While these categorizations are useful, it can be difficult to imagine how the discursive resources may be used together to create a cohesive story. In this chapter, I do some narrative work myself: I tell four stories of four individual participants according to how I made sense of how they narrated themselves to me. As discussed before, the interview is an important site of identity management and negotiation. From each participants' interview, I was able to patch together a relatively cohesive story, that is, the story they were telling about who they are. Here, I tell four of those stories. This chapter is important because discursive resources are rarely used alone; they are engaged in tandem with other discursive resources to craft an organized story of consistency.

In this chapter, large sections of interview transcripts are featured, as well as some blog posts written by a participant. I wanted to include these large sets of texts to illustrate the layered characteristics of identity negotiation.

C.J.

C.J. is animated, vivacious, and completely charming. I connected with her over Skype; we had to work hard to find a time due to her busy work schedule. When we finally did our interview, her personality exploded over the Wi-Fi and into my office cubicle. I explained to her that I was working on a project about identity negotiation at work with OCD, and she was thrilled to participate. Her story is one of pain, perseverance, and good, old-fashioned grit.

When C.J. was six years old, she lived with her recently-divorced mother, who had just married a man with children. One child was a girl who was, to C.J., frustratingly messy. C.J. watched as her previously pristine possessions became fodder for her new step-sister, who "messed up" everything in her path. C.J. felt new pangs of protective instincts; she had suddenly and sharply been dethroned as the sole user of her belongings and now had to constantly worry

about her toys, home, and space to make sure they remained un-contaminated. During this time, C.J. also found herself hyper-sensitive to touch and textures, a sensitivity commonly associated with OCD. She refused to wear a variety of now-offensive clothing, like thick socks or undershirts. Instead, she altered pieces of her clothing to suit her particularities, like stretching out the armpits of her t-shirts to avoid touching seams that might irritate her young skin. She also avoided anything warm; the feeling of heat gave her a sensation that there might be "cooties" from another person on the warm object that could be transferred to her.

The most significant development of C.J.'s OCD came when she saw Disney's *The Little Mermaid* for the first time as a young child. In the film, there is a scene in which Ariel, the main character, has her voice taken from her by the story's villain, a sea witch named Ursula. In the scene, Ariel watches as a dark, ghoulish hand reaches into her mouth and down her throat to steal her voice, which is represented by a small beam of light that is then handed to Ursula. Ariel clutches her throat as she realizes her voice is gone, and hurries to the water's surface, as she is no longer able to breathe underwater. To C.J., it was as if Ariel's "essence" had been taken away. C.J. remembers watching the scene, transfixed, as new anxieties and worries entered her mind for the first time. *What if that could happen to me? What if someone or something took away what makes me who I am? My "essence" or good traits could be taken away or messed up at any time, by anything.* The film was one of the triggers to the nightmare that would torture her to this day: her personhood, her essence, her positive traits could be contaminated or taken from her. C.J. told her mother about the more tangible parts of her worries and fears, like her toys being ruined by her step-sister. However, she kept her fears of mystical contamination a secret until she was 13 years old, when she couldn't handle the "bad feelings" or fears of "essences" on her own

anymore, a tipping of the scales she attributes to her ever-growing depression. At that tender age, she began therapy to address her uncontrollable thoughts.

Throughout C.J.'s teenage years, her OCD hit somewhat of a plateau. In therapy, she was able to discuss her depression and as a result, her OCD thoughts and symptoms were moderately subdued. When she went off to college, C.J. was feeling fairly optimistic about her future. However, as the four years of her undergraduate degree in accounting unfolded, her obsessions and compulsions returned with a vengeance, compounding into new, distressing symptoms that took up most of her time. By the time she finished college, she was virtually incapacitated. She moved in with her biological father after graduation and remembers being overcome with depression which subsequently contributed to her OCD symptoms getting "worse and worse." While she was still in college, she had secured an accounting job to begin after graduation; she managed to make it in to work every day, but she recalls the misery of her world becoming "smaller and smaller." Her father's house seemed contaminated, her car seemed contaminated (her boyfriend at the time put the "wrong" kind of gas into it), and her clothes seemed contaminated by merely being in the car.

> At my dad's, when it was the worst, it was just so much and everything needed to feel just right, the 'just right' OCD. So I kind of had that mixed with contamination OCD about my world closing in around me. There was one spot upstairs that I would sit in, one, only one spot on the couch and only in my bed. I wouldn't go in the rooms in my dad's house. There were multiple rooms that I would not even go into. And then it was my car, and this will even get into the work thing; I was only driving my car to get to work and that's it and it was unbearable almost… everything was getting contaminated. I kept getting rid of things and it felt like my world was closing.

Once she got to work every morning, her contamination fears followed her around like a persistent ghost making extravagant, ritualistic demands. Since her car felt contaminated, her clothes had to be "de-contaminated" once she got to her office, but done in secret.

> I would get to work and I would go into the bathroom, take all my clothes off, and spray them with Febreeze from head to toe and my body, like, doused it and put my clothes back on and then worked…and there would be so much Febreeze on the floor. I'd get all the paper towels and I'd clean it up. It was a single-person bathroom which was really cool, awesome for helping me with that because I could do that [without anyone noticing].

Soon, her work cubicle felt contaminated as well. When the obsessions over her cubicle became unbearable, she asked to switch work areas. When asked *why* she wanted to switch, she had to "suck it up" and tell her boss what was going on. However, when describing how she felt in her cubicle, she framed the feelings as "bad vibes" rather than obsessive-compulsive fears.

> I had to ask my boss to switch cubicles and I had to tell her—what did I say—I said that I'm just really weird about things sometimes and I get a really bad vibe from things. I had to suck it up and tell her. It was really hard to do that and they were going to switch me [but] I ended up leaving that accounting firm…because my OCD was really bad.

Even when C.J. left the job, she never disclosed her OCD diagnosis to anyone at the firm. On occasion, she would take days or even a full week off to cope with her illness, but never told her employers about the disorder. Instead, she claimed she had "medical issues." She got "really, really good at hiding" her OCD. "No one knew," she recalls. "Even when it was really, really bad, no one [in my life] knew unless I told them because I was so embarrassed."

When C.J. left that job, she found a temporary accounting job at a different agency working under the firm's portfolio controller. In this position, C.J.'s ritualistic behavior to alleviate her obsessions became an issue with her employers.

> They even said to me, they were like, "[C.J.], you're one of the best workers and we really like you, but we keep having an issue because you keep coming in late." I was coming in late because I was, like, barely getting by. I was barely scraping by to keep my head above water. I was miserable and I would go and work and come home…that's when I told them, I have to go. I'm going to leave here because I have to go.

Even though C.J. describes herself as fiercely private about her disorder, her health was failing her so aggressively that she told her temporary employer about her diagnosis and her desire to enter intensive treatment for her OCD.

> It was at the point I didn't even care. I barely had my head above water, I was barely getting by. So I was like, I've just got to let it out, it is what it is. I'm pretty sure I told [my boss] like, this is in confidence, this is very serious. And at the time, I was seeing [my psychiatrist], but it wasn't [enough]—I needed a kick in the ass. I think it was getting to the point where I could barely walk up the stairs without crying. I couldn't drive my car at all, I was just going to work and coming home and that was it. My friends would pick me up because I couldn't even drive. My car was so contaminated and it took me so long to go up and down the stairs...so it was just getting to the point where my quality of life was slipping.

To get the "kick in the ass" C.J. needed, she called St. Mary's OCD intensive treatment facility and got on the waitlist to enter residential treatment.

C.J. spent just under three months in residential care for her OCD. Seven days a week, for twelve long weeks, C.J. engaged in often-grueling *exposure and response prevention* therapy. She worked hard and slowly began to improve. After she moved out of the treatment facility, she moved back in with her father, into the house that had triggered so many of her obsessions. But, she continued with her recovery so she could achieve as close as she could to a "normal" life. Her therapist came to her house twice a week and worked with C.J. on continuing her exposure and response prevention regimen.

C.J. got a job offer three months after leaving St. Mary's. She would be working for a public accounting firm, under the condition that she get her Certified Public Accountant (CPA) certification, which involves passing a notoriously difficult, four-part exam. After intensely studying for about a year while working at the accounting firm, C.J. took and passed each section of the CPA exam on her first try. In October of 2016, C.J. found a new job at a private accounting firm where she could leave tax accounting behind and work in the field about which she was passionate: real estate accounting. Around the same time, C.J. bought her first home, a condo within walking distance of her new job at which she still works at the time of this writing.

During our interview, I asked C.J. about whom among her employers, past and present, ever knew about her OCD. She confirms that she only disclosed her diagnosis to her direct supervisor at her temporary job right before treatment. We spoke at length about why she chose, and still chooses, to keep her diagnosis a secret at work.

> Sarah: What do you think they might have thought? What was in your mind, like I don't want them to think I'm "blank" if they know I have OCD.

> C.J.: I think just the stigma, like something's wrong with me. I think when I explain it to people that I have it, I either want them to not know that I have it or fully know

the actual full— I'm not like 'I have OCD. Everyone has OCD, everyone has ADHD.' No, no, I've been hospitalized for my OCD. It's not that I'm trying to show off, I just don't want people to think, 'oh my gosh, I'm so anal, my pens have to be alphabetized.' No, I actually have struggled with this for a while. So I've never just lightly told somebody that I've had OCD. Either they get the full conversation about it or they don't know.

Sarah: Because if you just said, 'I have OCD,' they're not going to understand what you're talking about?

C.J.: Yeah, and all of the negative I guess. People are like, 'I can't concentrate today, I'm so ADHD.' I'm careful to even use the word depressed, because sometimes I'll be like, just having a bad day or sad and I don't like to say I'm depressed. When I *am* depressed, I want to say I'm depressed but kind of take time to use the word. If you use it all the time, it doesn't mean—sad and depressed are not the same thing and it's similar to that. I didn't just want to tell people, 'oh, I have OCD' and just like…

Sarah: Leave it there.

C.J.: Yeah. I've always been that way for some reason, but I just think too, when I explain to people that I have it. I'm like, my personality is not affected at all. I am still myself, I just feel like people will think that I'm weird now. That I'm weird. I'm exactly the same as I would be but things bother me that don't bother other people; that's really what it comes down to. I'm the same, except I'm hyper bothered by things that other people aren't bothered by. So that's what my fear

was or is about letting people know. They're going to think I'm strange and
weird.

Sarah: Did you fear any other organizational consequences? Like, maybe I won't get
promoted or maybe I won't be assigned the really big companies to do their
accounting on?

C.J.: I guess I hadn't thought of it that far because the people that I would have told
would be more like my friends at work. When I put myself in that situation
hypothetically, my boss is a man—well at that company—he was a man and a
little older and he's kind of stuck in his ways, so I would be afraid that he would
start to treat me differently. Maybe a younger person, maybe a woman, who has
compassion—not saying that men aren't, but he's just a little old and into
accounting, dry, typical partner of a firm. Like if my manager or something knew,
we were friends and she cared about me, I wouldn't have been—she wouldn't
have *not* given me work because of it, but I could see the higher ups thinking it's
weird. Especially the partners of the firm, like the older generation.

On a typical day at work, C.J. can be found in her cubicle, a place she humorously likes to call
"cube-ville." She works at the headquarters of her agency, but manages real estate throughout the
United States. From three-story buildings to 32-story buildings, C.J. manages the finances and
expenses of those structures for the agency. Her day-to-day work can get a little repetitive, but
C.J. doesn't mind. She runs reports, conducts variance analyses, and makes journal entries. Each
month, she closes out her books and makes sure that all the expenses she has managed are in the
"correct period," which is a "big thing for accounting." At this month-end time, she also goes out
to the buildings to meet with property managers in her geographical area, who are employees of

her company. I asked C.J. what it's like to have OCD at this job and how she manages how others see her.

Sarah: How does your OCD show up at work, in good ways, bad ways, neutral ways?

C.J.: Sometimes I'll be weird about—the other day, like in this conference room, we have these weird chairs. If you don't get there early enough when we have a meeting, there's a lot of other chairs but there are these weird chairs that have a desk connected to them. I hated sitting in that, I felt gross. I didn't sit back the whole time; I mean it was definitely connected to my OCD. I was like, not liking it and I sat there but I was not happy. It's a lot of stuff like that. Like choosing a piece of paper, sometimes I'm like, this one doesn't feel right, this one doesn't feel right. I need to catch myself and not do that. Sometimes in the bathroom, I only use two of the stalls, I don't want to use the other stalls so I'll walk in and they'll both be taken so I'll go to a bathroom on a different floor because I don't want to use the first stall. So little things like that definitely do pop up but not things that anybody would ever notice. Nobody would notice any of that.

Sarah: So does anybody at this job know that you have OCD?

C.J.: My best friend there knows, but we're very close. I wasn't that close to anybody at my last job. I had a lot of work friends but she's not just my work friend, I would consider my friend. We're friends now. She has two kids and she's—I think she's 30 but she's my best buddy there, so I told her. We talk about a lot of stuff, like she's really into church so she'll have religious conversations with me sometimes and we talk about everything. Like I know her family problems, we're really close. So it's not like a coworker knows, it's like my friend knows, but no one

else has any idea. I told her, I don't really want to talk about it and we've never

brought it up; I told her once and we don't bring it up.

Sarah: Have you ever been tempted to ask for accommodations at work?

C.J.: [No]. I always think about it too, like in college, how people get extra time for

having disorders and stuff like that. I've never used it like that because it's

embarrassing to me. It's embarrassing because I think people think you're weird,

whereas other disorders—if you have, not a mental disorder but like an allergy,

like a severe allergy. Oh, that's fine, they're not teaching that peanut butter

because they're allergic. But for me, it's like, she's not sitting that chair because

she thinks her essence is going to be taken away from her. It's embarrassing in

nature because people don't understand what your specific fear is, I guess. So I

wouldn't want anybody to know, because I wouldn't want them to think

differently of me, that's why.

Sarah: And then like the consequences after that. Like the possibility of not getting a

promotion or not getting work or whatever?

C.J.: Definitely, yeah.

Sarah: Have you ever considered going to the HR department and telling them you have

OCD and having them just tell your boss that you have a disability?

C.J.: I would think not because, I guess, that's not my nature. I don't know, I just don't

want anybody to know. So maybe I would ask but I'd probably be private about

it. I'd say I need—I have a doctor's appointment that I have to attend, but I

wouldn't go into it like that. I do think I'm that embarrassed about it. I don't think

I should be embarrassed about it, it's not like, oh, you have OCD, it's not like I

think that, I just really, really don't want somebody to start to treat me differently. Because things bother me more than they bother other people and that's really what it comes down. I know I keep saying that but I can't reiterate it enough because it doesn't change—I'd be just the same as I am if I didn't have it, personality wise. It's just that people don't know enough about it for me to want to offer up that information, I guess.

C.J. is by far one of the most extraordinary people I've ever met. Her OCD is clinically severe, and yet she is maintaining professional success higher than even the average individual with "normal" levels of ability. Despite her disorder, C.J. has a rare, gritty drive to succeed. Even at her lowest, she went to work almost every day and did her job. I asked her what it was that kept her going in that painful time before intensive treatment, and she couldn't put her finger on it. "I don't know how I did that. I don't why I kept going to work," she said. "It wouldn't break me. I could have just been like, okay, screw this but I kept going." Even though she couldn't quite describe her exact motivation for seeking success, she knew she had it.

C.J. faces a conundrum of wanting people to know about her struggle with OCD, but at the same time, wanting to maintain privacy so that people don't treat her differently. She has not only succeeded in her career, but she has done it with OCD. She sometimes becomes frustrated when she thinks that no one at work will ever know what she had to go through to get where she is now.

I was talking to my friend about the CPA exam…I did it and I also had OCD and for a while, it's like I was almost upset because I was like, no one will know this untold story that I have of what I've dealt with, except the people that I care about. My mom was like, it doesn't matter, the people that you care about know…so I'm like, 'yeah, I guess.' So

the world doesn't know but my best friends, my family, they know and they appreciate it. So I got over that, I needed to get over that whole—not pity party but kind of like just really deeply thinking about how no one will ever know. Well yeah, the only people who I care about knowing do, and really appreciate what I've done. So I was quick to get over that pity or whatever. Not pitying myself, but it's kind of weird that no one will understand. I was talking about my friend at work about doing it and she has two small kids, I was like, girl, you've just got to grind it every day.

And "grind it" she does. C.J. even uses her experiences with OCD to motivate her to do non-OCD related tasks. Recently, C.J. has started running for exercise and thinks of her accomplishments related to OCD as she pushes toward her exercise goals. She thinks to herself, "'C.J., you beat OCD, you can run to that light pole' and I always do. I'm like, 'you beat OCD so you can kick your ass to that light pole.'"

C.J. texted me recently to let me know she has recently received a promotion at her job, that of "Portfolio Controller," a position she had been working toward at the time of our interview.

Martin

Martin is funny, determined, and delightfully sarcastic. We met at St. Mary's flagship IOP unit; he was finished with his programming work for the day and had agreed to do an interview with me. We planned on meeting in his "office," which was a small room in the IOP wing of the building that was shared with the PHP unit; PHP used the offices from morning until early afternoon and IOP used them from mid-afternoon until early evening. Martin's office, like about a dozen others, had two chairs and a desk covered in therapy assignments and exposure

homework. He pushed the paperwork to the side of his desk and agreed to answer my questions, happy to have a break from his exposures.

Martin struggles with OCD, generalized anxiety disorder (GAD), major depressive disorder (MDD), and sensory hypersensitivity; just one of these diagnoses is difficult to manage. His family and friends know about his health issues, but not all of them understand the complexities and consequences of each disorder, especially OCD, which has been Martin's main source of complication. "Oh, everybody's like that," one of Martin's friends had responded to his diagnosis disclosure; Martin curtly shared with me, "I don't talk to that friend anymore."

The combination of Martin's co-morbid conditions made his teenage years unpleasant. He hated wearing jeans or structured pants to high school due to his hypersensitivity, so he donned pajamas every school day, of which he only attended half days. He became known as the "Pajama Man," which he enjoyed. In contrast to the bullying he endured for his "weirdness," being known as "Pajama Man" was a welcomed identity. He had been struggling with his school identity and performance for a while; suicidal at 10, Martin had been "thrown on" many medications that he deemed to be "inappropriate" that affected his social and educational performance. He was tormented by his peers throughout his teenage years and actively tries to "block out" that part of his memory. He dropped out of school the fall semester of his senior year and instead earned a high school equivalency certificate, which he says is "more than a GED."

During these painful teenage years, Martin's health was rapidly declining. He went from an average teenage boy who didn't like to shower to taking two long showers per day due to contamination obsessions and not feeling "just right." He transformed from being disorganized to being obsessed with perfection, from not thinking about contamination to washing his hands

excessively. While he had just been dealing with depression and hypersensitivity, he was additionally being bombarded with "accelerated" OCD development.

At 20, Martin is now unemployed while in IOP treatment. His most recent job lasted for two months at a video rental store, which he quit the month before our interview to attend treatment. He had attempted to work night hours and attend treatment during the day, but found that he could not keep up such a stressful pace. He started at the video store with high hopes – he had actually been a frequent guest of the establishment when he discovered they were understaffed. One of his friends had been working there, needed to quit, and suggested that Martin take his place. They were "so desperate" for employees that Martin "basically just had to show up and interview" to get the job. When he showed up for the interview, he sat down with the man who would be his supervisor who was joined by the district manager. During the interview, Martin shared an "anxiety disorder" diagnosis (not specifically OCD) while also expressing enthusiasm for the work he would be doing at the store. The district manager was impressed: this new potential employee seemed excited about stressful work all while dealing with an anxiety disorder. Martin felt that this juxtaposition helped him get the job; he knew it must sound impressive to be able to work with an anxiety disorder.

Once he got the job, Martin felt himself struggling. He had obsessive, intrusive thoughts about customers that were incredibly distressing. On top of that, he obsessed over "self-loathing" because of the terrible thoughts. *Surely if the customers knew about these thoughts, they wouldn't like me. They wouldn't be nice to me.* Even with the difficulties, Martin still considered himself to be good at customer interactions on a surface level. He describes himself as "animated" with them and prided himself on being able to joke around with customers to help them feel at ease. However, he was internally miserable. When he got home from work every day, he was

exhausted. He finished his assigned tasks, but "was really stressed out" about each customer interaction. At the end of the day, each register was closed out by other employees, but Martin felt a need to re-do each accounting task after other employees did them, just to make sure they were done perfectly, even though this was not part of his job.

Martin felt intense pressure to keep his problems hidden at work. "I didn't bring it up," he recalls.

I just did my job. On an appearance level, I function pretty well. I get my stuff done and I work hard. I've been in distress at work, but I haven't wanted to call attention to it. Even if I'm feeling upset at work, I wouldn't talk about it.

I asked Martin why he chose to keep his struggles hidden at work or if he had ever requested any accommodations; he physically stiffened in a determined, almost defensive pose.

I know it may be an old-timey opinion, but I don't think that stuff should come up at work. If you're just a wage worker, you shouldn't be complaining. That's a good way to get yourself fired. They offered to give me accommodations, but I couldn't think any to ask for. If you're special in a company and, like, a higher-up worker, you can get accommodations. In a different work situation, I might feel differently. Making accommodations is a good way to never get better. I should be intentionally challenging myself – accommodations are like cheating. I don't want to be a special snowflake.

The culture of the organization itself also had a lot to do with Martin's decision to hide his distress. The store's employee handbook "basically said, 'if you have struggles, leave your problems at home.'" He recalls, "it seemed like no emotions were allowed in the workplace there. That wording in the handbook really shaped my actions at work and my opinion about being open about my OCD at work."

He also made note of the differences between the ways "upper management" conceptualized employees and customers. For the customers' benefit, Martin had to wear a neck tie and "nice clothes" on the weekends, but he didn't think the customers cared. To Martin, it "seemed like old people ran the company at the expense of the employees." As further supporting evidence, Martin was not allowed to take breaks from work, even though the organization was legally obligated to grant him breaks. Martin knew this was illegal, but he complied anyway, figuring that this was just the way the "minimum-wage" working world operated.

> Most of the upper management seemed tone-deaf. I wasn't allowed to take breaks. No lunch breaks. I know that's illegal not to allow breaks, but lots of minimum wage places do illegal things. One of my friends likes to tell me: "this is how the world is. You can't complain. You're just lazy. They're not going to pamper you." So I got in a mode where I didn't want to rock the boat.

I asked Martin if he considered sharing his OCD struggles with some of his work tasks with his manager would be considered "rocking the boat," and he nodded saying, "they probably would just fire me." He does admit that while it was a "pretty good job at first," if he were older, the job "would probably just be a waste of time and money. I was making minimum wage."

Martin relies heavily on government assistance; he receives Supplemental Security Income (SSI) checks every month and, as a part of vocational rehabilitation programs, is at the "front of the line" when it comes to job applications. He hopes to qualify for and move into low-income housing when he starts college, which he adamantly intends to do. He loves his art work, but pragmatically insists that it's "not a career." So in college, he is interested in studying library sciences so he can get a job doing archival work when he graduates and do create projects on the

side. "I want a low-stress job," he says, "something that pays the bills." After talking further about his dreams and ambitions, Martin admits that his real passions lie in the criminal justice system. However, he still plans on pursuing library sciences in college because

> there's less human interaction and more independent work. OCD has 100% influenced my career and college choices. I'm planning to accommodate my own issues by choosing the right career. I want a low possibility of having issues in the workplace. I'm good at organizing; I could do that in a library. Library sciences seems like an attainable career; criminal justice doesn't. I would crumble really quickly. I don't think I could do the job itself – I have bad memory problems and I don't know how fixable that is. It's beyond just my OCD. OCD comes into a lot because of human interaction. I have an intent to fight my OCD though – that's why I'm here at [St. Mary's].

If OCD weren't a factor, Martin says he would like to be a criminal justice lawyer. However, he thinks he would need accommodations as a lawyer and according to him, "no amount of accommodations" could help him become a working lawyer – not that he would accept them anyway. "You're either good at your job or you shouldn't be doing that job," he says of the law profession. "It's not a line of work that should have accommodations."

Realistic beyond his years, Martin seems very practical about his career. "There are lots of things I'd be content doing," he says easily, "I'm trying to be flexible about it." Enigmatically though, he also asserts that he's "not going to settle" when it comes to his jobs. While he doesn't see criminal justice as a "strong, concrete dream," he emphatically states that if he did consider it as such, he "wouldn't give up on a concrete dream because of a disability." That's Martin though – a dreamer and a realist trying to work and overcome OCD at the same time. He has a solid idea of who he is as a worker, but that has been shaken up since he has been in OCD treatment.

I'm someone who does what they are told to do. I'm dependable. I'm not someone who climbs the ladder. I'm not interested in competition. I would rather be personally content than be the best at something. My low self-esteem probably contributes to this. A lot of this treatment stuff is still pretty new to me. I'm still figuring out what parts of what I do are OCD.

As Martin and I worked through my list of interview questions, I paused when I came across what I thought seemed to be another paradox: "why does it feel okay to accept government assistance but not work or school accommodations?" He responded thoughtfully:

My problem is – I don't know what to ask for at school or work accommodation-wise and I don't feel like I deserve anything. I just want to be normal. I would take accommodations reluctantly if no one knew about them. They would have to be suggested to me. If you tell me to come up with something, I'm not going to tell you anything.

The private nature of the government assistance seems to alleviate the shame of accepting help, an emotion which brings up strong resistance to what accepting help might say about him.

I hope to find a meaningful job. I don't even just want a job; I want to make a meaningful mark on the world, I want meaningful structure. I don't want to be a mooch. I don't want to just consume. I want to do positive things for people. I want to make people think about something. If I have a job, it proves people wrong that think I'm lazy. I want to prove to people that I'm not a basement-dweller and that I'm an active member of society.

Martin's identity as a worker is complex, contradictory, and messy. However, Martin fully intends on pushing through to become a working, productive member of society.

Lucy

Lucy is bright, generous, and talented. I first met her at an OCD conference – I had been giving a talk on how to succeed in college with OCD and made an announcement at the end of the talk requesting participants for my research. Lucy waited patiently as I answered questions from other audience members who had gotten to me first and approached me offering her gracious participation. Not having much time in the moment, I collected her contact information and sent her an email a few days after the conference asking if she was still interested in doing an interview with me. She said she would be happy to and so we set up a time to chat over Skype.

Lucy always knew something was off. When she was a child, she remembers having intrusive thoughts about a family member dying and instinctively knocking on wood to prevent the untimely death from happening. She used complicated mathematical algorithms to determine what was safe and what was dangerous – anything that was a multiple of three was acceptable but anything related to the number six was to be avoided, even though it is a multiple of three. Every time she turned right, she had to turn left before she could turn right again; it was as though she had to "undo" any turn she made so that she would never make a full rotation. Light switches must be tapped (not just turned off) to prevent a fire from starting. Growing up, these rituals weren't necessarily distressing, but Lucy knew that not everyone had to perform these tasks. She was different.

During her first year of college, Lucy's obsessions "exploded" out of control. No longer living at home with her parents, she turned her new dorm room into a site of constant ritualizing. Lucy re-read every assigned text over and over, convinced she had not absorbed the information correctly. She started making lists of "nonsense" words and memorizing it because she felt she had to. She made stacks of lists and post-it notes all over her dorm that couldn't be thrown away,

much to the chagrin of her roommate. Everything in the room had to be tapped every time she left it; if she didn't tap it, it might catch fire. Everything (*everything)* had to be unplugged whenever not in use; anything less would surely result in a fire.

I asked Lucy when she started first seeking treatment, and she chuckled. "I had actually been in therapy for two years in high school and, ironically, they had never done a general screening," she said. "They never figured it out and I never knew to bring it up." When the rituals became distressing in college, Lucy did her own research. She had practically diagnosed herself when she took her research to the campus clinic and asked about OCD specifically. "Is this what I have?" she asked the practitioner. "How do I treat this?" The campus clinician helped Lucy discover exposure and response prevention therapy, which helped considerably with her rituals. However, it wasn't quite enough to relieve the significant distress she was experiencing. So what should have been the first semester of her junior year of college turned into her semester off to attend just over two months of residential OCD treatment at Southern OCD Institute[5]. Like St. Mary's, Southern focuses heavily on ERP, and Lucy felt herself getting better.

Now, at 22, Lucy is back in college as a senior and is registered as a "student with a disability" through the disability services department at her university, which does not sit well with her idea of herself as "such a good" student. "It messed with my identity," she says of the contrasting labels. To her, a "good" student shouldn't need time-and-a-half on exams, so she often forgoes the accommodation: "I'm a top student and how can I possibly need more time on an exam?"

Further complicating the juxtaposition between her identity as a top student and a student with a disability, Lucy also works in the disability services department as a tutor for students

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[5] Pseudonym

with disabilities. In her capacity as an employed tutor, Lucy receives emails about her appointments with her clients with disabilities. But since she is also registered with the department as a student with a disability, she also receives emails about the availability for free tutoring. Seeing both sets of emails in her inbox "was just the weirdest thing to be on both sides…and not that those are incompatible, but when it's your own sort of identity, it can feel that way."

Since Lucy has been dealing with her status as a student with a disability for a while now, she has discovered ways to manage her school identity to match how she sees herself. I asked her if she felt her place at the university had shifted at all when she took on the label of "disabled," and said she did at first, but she "pretty quickly stop caring. You hand in the form enough times that you just don't care, and they don't care because they get fifteen forms a semester, probably more than that." In order to help her stop caring, Lucy started turning in the disability accommodation form during the second or third week of classes, "so they actually know my name and [the disability form] is not the first impression." For her, it "gives it a little more distance" to get to know a professor a bit before letting them know she has a disability: she can let her identity as a "top student" shine before it may possibly be tainted by the form.

Lucy is majoring in biology and works in her advisor's lab at the university. She told her advisor about her OCD when Lucy needed to take the time off to go to Southern. "[My advisor] is super open about having anxiety so it makes it so that we can have just totally causal conversations about it which is pretty amazing," Lucy says. Her advisor had spoken to Lucy several times about her own anxiety, so it made it much easier for Lucy to open up about her struggles with OCD. In response to Lucy's disclosure, her advisor "was super supportive." She asked Lucy about ways in which she could help, and told Lucy about resources available on

campus like the Dean of Students office. She also discussed the stresses of academia and how she handles them with anxiety, which was a comfort to Lucy. I asked Lucy if she thought her advisor's view of her changed at all once she found out about the OCD and she said no, with the caveat that her advisor is "one in a million in terms of being supportive."

An average day at her job in the biology lab doesn't bring much structure with it, which has been an issue for Lucy. Since there isn't much supervision or time parameters, Lucy spends much of her time in the lab ruminating over OCD thoughts rather than reading papers, writing protocols, and changing the tank water for crustaceans like she is supposed to be doing. Rather, she is tortured by continuous thoughts that she should quit academia. She fears "that it's not going to be fulfilling. That it's hard but it isn't worth it." Often, she can't recall some days spent in the lab, because she doesn't remember hours of time spent ruminating; she worries she is on the wrong life path. Consequently, she puts off answering emails or doing her assigned work. She is expected to attend an academic conference in the coming week, but she is dreading it.

> I hate packing because then everything is out of its designated spot. It's just like being away from your little comfort space and having to socialize. I also don't like spending money. So having to spend money [on the conference makes me nervous], even though it's mostly paid for [by the university].

Since being home from Southern, Lucy has spent several non-consecutive days in the emergency room for suicidality. When she ends up there, she contacts her advisor, who is understanding and supportive; she can usually get back to work shortly thereafter.

"Pretty much everyone" knows about Lucy's OCD; she is an accomplished author who writes her own blog on OCD and is a freelance writer for other outlets, all about OCD and her experiences. She has published essays in her university's official newspaper, various websites

(both mental health-related and general interest), OCD organizations' newsletters and blogs, and treatment facility websites. In one essay Lucy wrote for a mental health website, she addressed her identity head-on by titling the essay *Who am I? A Student with OCD & Anxiety*[6]. In the article, she identifies herself not only in terms of her organizational status, but also by her diagnosis:

What would you say when someone asks "Who are you?"

The first word that comes to mind when I think about this question is Student. I'm a student, an academic, a professional learner for life. Thanks to a lifetime of perfectionism, from painting "perfectly" in kindergarten to being valedictorian in high school, my life is very centered on school. Sometimes several days will go by and I realize I hadn't thought of anything besides school.

What happens when one piece of your identity grows too large and starts to consume you? What happens when you become too zoomed in on excellence and it collapses onto itself? Obsessive-compulsive disorder and anxiety did this to me.

That's always what OCD does; it points an arrow at who or what you love most, and for me that was school. I was the kid who skipped through the school supply aisles. I was the kid who read a book through dinner. I love and have always loved learning. Perfect bait for OCD.

Throughout the course of the article, Lucy walks the reader though her struggles with OCD, treatment, and life in recovery. She ends the essay by coming back to identity asking, *So who am I? What do I believe? I believe it is okay to have goals for yourself. It is okay to have high standards and to set your goals even higher. It is also okay, and inevitable, to be imperfect.*

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[6] Exact title names and blog excerpts referenced with permission. I informed "Lucy" that this might make her identity more easily discoverable by readers, and she agreed for the actual text to be included despite these risks.

She concludes that while OCD wanted her to be perfect, she has chosen to be okay with imperfection.

Lucy uses her story and experiences to explain other aspects of OCD; according to her blog website, her goal is to "raise awareness about what OCD truly is, something that has grown increasingly important to me. Most importantly I hope that perhaps what I write can help someone else struggling through something similar. I think being able to know others have had similar experiences is incredibly important." In the spirit of education, Lucy wrote an essay on list-making OCD, one subset of OCD from which she personally suffers. She uses her stories along with medical texts (the DSM, specifically) to explain the tenants of the symptoms. In an rather poetic post, Lucy makes a list of what OCD is by beginning each sentence with "OCD is when…" in an essay of the same name:

OCD is when you have little free time because you spend so much time on rituals and compulsions. OCD is when you get trapped in cycles of fear. OCD is when it's 2am and you want to go to bed but you can't stop checking you unplugged everything. It's when you don't want to be the cause of an impossible fire. OCD is when you can't trust your own thoughts and beliefs. OCD is when your thoughts repeat themselves two, five, or maybe even ten times. It's when you get stuck saying the same sentence over and over in your head to unsuccessfully try to calm down. OCD is when you have gruesome and inappropriate scenes replay in your mind, even though you are the type of person who deeply dislikes violence. OCD is when you sometimes forget who you really are since you have little time for family, friends, or hobbies. OCD is when your desk is cluttered (yes, people with OCD can have clutter) with old lists, post-it notes, and calendars. It's when you can't throw away paper because you are too afraid of losing the information. OCD is when you have to shy away from romantic relationships because

you are terrified of getting pregnant. OCD is when you don't make many of your own choices. It's when anxiety often gets to decide what you do or who you talk to. OCD is when what seems like a small task may in fact be a huge achievement. OCD is when you feel responsible for keeping your family alive. It's when you fear one ritual done wrong may kill those you love. OCD is when you keep your anxiety and rituals a secret for a decade because you don't know what's wrong with you, but you are too scared to ask for help. OCD is when you try to open up to someone about your struggles and in return they shrug and laugh, "I'm OCD too." OCD is when you can only read a few pages an hour because you have to keep rereading what you read. It's when you have to take time off from school for treatment because the anxiety is so intense. OCD is when you doubt your own sexuality. It's when you have to spend several hours a day reassuring yourself you are who you think you are. OCD is when uncertainty is your archenemy. It's when the question "What if?" makes you weak. OCD is when you use courage and dive into the unknown when you take the risk of facing your fears. OCD is when you have a panic attack at 1 in the morning. It's when it takes an hour to breathe normally again and to have feeling return to your hands. OCD is when you have a serious disorder but you hear jokes about it almost daily. OCD is when even though you feel anxious, depressed, inadequate, and weak you are phenomenal, loving, brave, and hopeful.

In several posts, Lucy uses common myths and misconceptions about OCD to frame her subsequent explanation the topic. For example, in one post titled *Debunking Myths about OCD,* Lucy lists myths about OCD like "everyone with OCD is clean and organized" and "OCD is not a big deal" and breaks down each one with her experience on OCD and also refers the reader to the International OCD Foundation website to learn more. She also addresses communication around OCD in posts like *What to Say When Someone Tells You They Have a Mental Illness* and

"OCD Freak:" How to Confront Someone About Misusing the Term "OCD." In another

communicative move, Lucy interrogates the stigma around mental illness in the essay *Stigma:*

How Society Too Frequently Views Mental Illness:

> *Why is it that society feels so disconnected from those with mental illness? Why do we*
> *seem so different from them, like crazies who are no longer normal people? One word. Stigma.*
> *Those with mental health issues are often seen as just making it up, not trying hard enough, or*
> *simply crazy and not able to be helped (none of which is true!). We are all still normal people,*
> *with hobbies, family, friends, goals, and normal emotions and thoughts too.*

> *I said this in a tweet recently and I'll say it again: Why is it common sense to be*
> *sympathetic toward physical illnesses but not mental illnesses?*

> *This enduring stigma is why it is so necessary for everyone to keep talking about mental*
> *health and how we should treat mental illnesses. We need to earn these disorders the respect and*
> *attention they deserve so one day they can be treated equally with physical illnesses. No other*
> *organ is so discriminated against as the brain. But conversation can change this.*

Lucy also takes on popular culture when she insists that *Van Gogh was not Crazy* in a

post about the painter and gives her take on Scrub's portrayal of a surgeon with OCD, Dr. Kevin

Casey (spoiler alert: she thinks they did a good job!).

Through her blog, Lucy defines her identity as a "student with OCD and anxiety," and

then goes on to define exactly what is meant by "OCD" and "anxiety." She lays out how a

person with a mental illness should be treated and how the general public should talk about the

subject. But more than posting essays on the internet, Lucy brings her writing into her

organizational life. She says she refers co-workers and supervisors to her blog "all the time." For

example, Lucy was discussing anxiety with her advisor and they were mulling over the idea of if

anxiety could ever be seen as productive. She emailed her advisor a link to the essay *Success Because of or in Spite of OCD?* Her advisor read the article, and that spurred on even more conversation about anxiety and OCD. Rather than try to express her entire position in person, Lucy uses her writing to define who she is and what she has. In another article published on a general interest web site, Lucy wrote an open letter to her advisor, thanking her for treating her well.

Dear [Advisor],

Thank you for not asking too many questions last year when I handed you my testing accommodations form, but thank you for kindly listening when I wanted to explain more. Using accommodations was something new to me that year and was still nerve-wracking, but you treated it like something I shouldn't be ashamed about. Thank you for believing me when I told you I have OCD and not viewing it as a joke. It's unfortunately not the most common response I get, so when it does happen it means a lot. Thank you for treating it like no big deal when I took longer than the other students to finish exams, instead of acting annoyed that I might have been wasting your time. Thank you for believing I could do well in your class. At the time it was stressful because I didn't want to disappoint you, but it certainly pushed me and helped me believe in myself. Thank you for being encouraging and hopeful when I told you I was taking time off from school to do more intensive treatment. Your advice that "School isn't going anywhere and it will still be here when you're feeling better!" helped me feel more comfortable with the tough decision. Thank you for asking "How are you?" or "How are classes going?" and truly meaning it. Thank you for casually mentioning your own stress in conversations from time to time. It helped normalize something that can often feel isolating. Thank you for once telling me you weren't very good at math. At the time you might not have realized the enormous

effect that simple sentence had on me, but I did. Hearing you are imperfect made it feel OK for

me to be imperfect. (I am horrendous at geography and history.) Thank you for being a role

model as a female scientist and professor. I look up to you immensely and something that

motivates me through exposures is the dream to one day be like you. Thank you for treating me

like a person (who just happens to have anxiety), instead of something less than that.

And last but not least, thank you for teaching me about parasites and ecology.

Sincerely,

[Lucy]

In this letter, Lucy not only thanked her professor for her actions, but set parameters around how individuals with mental illness should be treated in an organization. She highlights the good that her professor did and published it to encourage others to treat the people in their life the same way. For Lucy, writing gives her "distance" from her OCD. Objectifying it and getting it down on paper helps Lucy realize that her OCD thoughts "are just thoughts." Writing also helps Lucy feel like she is helping others, perhaps making their journey through OCD a bit better.

I asked Lucy about her hopes and dreams for the future. Despite her success in school and writing, things seem bleak. She once had a dream to be a biology professor, but she no longer thinks that career will be fulfilling enough "to be worth all the stress" of becoming one. If it weren't such an "anxiety provoking dream, then the enjoyment of it wouldn't need to be so high to match it" she figures. She doesn't even see herself living past 30 having to face every day with OCD and co-morbid major depression (MDD) and borderline personality disorder (BPD): "I just can't do it for that many more years."

However, I sensed a determination in her voice that sounded like she would make it. She still plans on attending graduate school, although not in biology. In a recent catch up, Lucy informed me that she is now writing an honors thesis and "doing well." She had a relapse with her depression which led to a lengthy, inpatient hospital stay, her third overall. But she is fighting. She is about to finish a class on "dialectical behavioral skills training" class (DBT) at her university and feels more prepared to take on the future.

Jim

Jim is frank, passionate, and creative. I first met Jim at one of St. Mary's satellite IOP treatment facilities. I was leaving town the week after we met, so he and I agreed to do a phone interview when I got back home. We spoke for a couple of hours; once Jim got started, he fervently spoke at length about life, OCD, his career, and the book he had just finished writing.

Jim's first memory of his OCD was around the age of eight. He was walking in a park with his parents, and his mother made an off-hand comment about the flowers they were walking past: "too bad those are all going to die soon," she said nonchalantly. Jim remembers panicking on the inside. *What do you mean they're going to die? Does that mean people are going to die too?,* he thought. He hurried back to the flowers and picked every one of them, thinking that if he could take them home, he could save them. This was Jim's first experience with associating his actions with the prevention of death. He practiced all kinds of nighttime rituals to prevent the death of those close to him: flipping light switches on and off, straightening things, getting in and out of bed. Jim remembers feeling sick with anxiety as a child, but he was able to "just stop doing the rituals" at that age.

Fortunately for Jim, his OCD laid dormant for about 25 years; it wasn't until he was about 33 that it came back with a vengeance. Jim was working a newspaper event when he got

the phone call that his mother had a heart attack. This event reminded him of the rituals he had performed as a child, and for some reason, he thought they might work now. While his mother was sick, he started turning lights on and off, over and over before bed to prevent her from dying. He got married a year later, and two years after that, his wife's step-mother died. The year after that, his mother got meningitis, and a few years after that, his wife's father died. It seemed as though as hard as he tried, Jim couldn't escape sickness and death all around him. Over the years, he continued to do his nighttime rituals, but they slowly morphed into what he calls "mental rituals."

> For example, getting up and out of a chair, if I get out of the chair, maybe someone died. If I think of death, like if I think of [my wife] dying when I get up, I have to re-get up out of the chair and think of something else…it was hard to eat – if you take a bite [while thinking a bad thought], you think you are ingesting the thought. It would take me twice as long to do everything. When I pass a graveyard, it's like I left someone there. I once passed a graveyard and then my uncle got sick.

Until a few years ago, he worked as a journalist for a medium-sized county. On an average day of work, Jim moved at a fast and furious pace.

> First, I would go into the office and get there around 9:30 or 10 [a.m.]. Then, I would plan out my day. I would plan out my own stuff, which might be an in-person interview, a phone interview, setting up a photo shoot, working with reporters, working on one of the reporters' stories, picking stories, or writing stories. At the newspaper, an average day went so quickly. Say an ice storm happens – that becomes a highlight of the daily coverage. You have to get story angles, and you never knew where it was going to be blowing up. At the end of the day, all these things had happened, and then you go home,

and you're still pretty wired. If nothing happened that day, I might be there until about 6. If something big happened, you're there until midnight. It's a burnout job.

Jim was working as a journalist when his OCD hit him hard and progressively got worse. "I was just go, go, go. I didn't stop to think," he remembers. However, in 2013, the stories "started sticking with [him]." If he covered a story about a car accident in which someone died, the sense of death followed him home and haunted him. Soon, he started choosing the stories he covered based on his OCD symptoms: "it affected the stories I chose," he recalls.

> If my boss came in and asked, who wants to cover a story where someone was shot? I wasn't raising my hand on that one. A person died in a car accident, want to interview the family? No thanks. I stopped taking those jobs.

Not only did Jim's OCD affect the stories he chose to cover, it also affected his day-to-day tasks like typing. If he typed a specific word and had a "bad" thought while typing it, he would have to re-type it. He avoided being in the newsroom alone, as he found his rituals would run wild.

> I asked Jim if anyone at work knew about his OCD. "Never," he said emphatically. "Zero." I asked him what his motivation was for not telling anyone. He quickly replied, "shame. You're supposed to have it together. You're supposed to be perfect. There would have been extreme shame if anyone found out. I spent my whole life trying to get to a certain point in my career." Jim asserts that the pressures on journalists are especially trying. "If you talk about struggle or burnout, they'll think you're weak," he says of others in the industry.

> As his OCD got worse and worse, Jim was "getting to the point where [he] was going to get caught." One day, he remembers getting up and down out of his chair 10 times in succession while scanning the newsroom to make sure no one saw him. "At some point, you just have to…walk away." And walk away he did; he quit his job to work from home full-time on a book

he had been writing for a decade. But life didn't get much better working from home; his OCD still bothered him, begging him to end every act on a "correct" thought.

I talked to Jim a few weeks into his intensive treatment, which he thinks is working. He is fighting his obsessions and compulsions using exposure and response therapy and resisting negative thoughts.

Jim has had a successful career so far. He did a story on the war in Afghanistan the AP picked up and published across his state, which ended up helping the soldiers he was writing about. He's had a photo published in the New York Times. He finished a book that will soon be on sale on Amazon. So what's next? "I might be a barista for a year," he said when I asked him. "I don't want to go back to journalism yet; I'm burned out. I have seen things I shouldn't have seen." He stopped reading the paper last year, as it triggered his OCD too much to tolerate. However, when he does go back to journalism, he plans to tell at least a few people at work to create a network of support. He knows he can never get back to a place where he doesn't struggle with OCD, but hopes to create a tolerable new normal.

Chapter Summary

C.J., Martin, Lucy, and Jim all engage with multiple discursive resources to create and maintain a cohesive narrative. C.J. drew on discursive resources of misconceptions, competence, and normalcy to craft a story of resilience: she calls on and then rejects the misconceptions others cite, because they function to discredit her own pain and struggle. She strongly engages with discursive resources of capability, and even beyond capable: she sees herself as excellent. Not only has she attainted a coveted career in accounting, but did it while dealing with her constant fight with OCD. C.J. cites the idea of normalcy – she has worked too hard to get where she is for people to treat her differently because of a "mental illness." C.J. has succeeded *despite*

her OCD and balances between sharing her struggles and maintaining a sense of normalcy at work.

Martin draws heavily on social conceptualizations of organizing, economy, and normalcy to justify his unemployment and preferences for future work. He says he is undeserving of accommodations not because of his own characteristics or behavior, but because of his organizational position as a "wage worker." Making minimum wage meant he couldn't complain; that would be a "good way to get fired." He relied on the video store's handbook to explain why he kept his difficulties with OCD at work to himself. Martin explains that it's okay to receive government assistance and not organizational accommodations using scripts of normalcy; it's okay to accept help if it's in relative secrecy.

Lucy, through conversation and through her blog posts, engages with discursive resources of medicine, personal life scripts, and misconceptions to explain her behavior to organizational others and to clarify exactly who she is in her position as a student with a mental illness. In her blog post *OCD is when…*, she teeters back and forth between personal life scripts and medical scripts to clarify what OCD "is," which then clarify who she herself "is." In her essay *Debunking Myths About OCD*, she explicitly calls on misconceptions of OCD and challenges them one by one using medical scripts, which have implications for her own identity, as she identifies herself as a "student with OCD." In her essay *Dear [Advisor]*, she outlines how a student with OCD should be treated using scripts of normalcy, indicating how she herself would like to be treated.

Jim relied on scripts of normalcy, stigma, and industry when explaining *why* he is *where* he is in life. He chooses now to work from home and is explicit in his attribution of this choice to the shame he felt at work as a journalist due to stigma. He blames the field of journalism

specifically when discussing this stigma, and thinks he would someday like to work a field with less pressure to be "normal." He also uses scripts of normalcy to explain his choice for not asking for accommodations at work.

In sum, these four stories demonstrate the use of discursive resources to *keep a particular narrative going*. While each participant used discursive resources differently and in different combinations, they all managed to construct a narrative to account for themselves. I used my own narrative sensemaking to put together these stories based on my interview experiences with these four participants. This chapter not only gives a closer look into the stories of individuals with OCD in relation to their career and organizations, but illustrates the tendency to use discursive resources in tandem with one another to create and maintain a cohesive identity narrative.

CHAPTER 6

DISCUSSION

This chapter will focus on the theoretical implications and practical application of my findings, as well as the limitations of this study, future directions for this line of research, and my final conclusions. First, I will be building on my analysis to craft theoretical arguments. In doing so, I will highlight the relationship between discursive resources and narrative identity, differentiate between what I am calling a "struggle" story and a "normal" story, and address issues related to agency and empowerment, organizational identity, organizational communication, obsessive-compulsive disorder, and disability studies. Second, I will be identifying potential practical applications for my findings. In doing so, I will outline the rationale behind a practical communication intervention, discuss what an intervention would entail, and describe two hypothetical scenarios of the intervention being applied. Finally, I will be addressing the limitations of this study, as well as future directions for research and my conclusions.

Theoretical Implications

Discursive Resources

As illustrated in chapters four and five, participants engaged with a variety of discursive resources in different ways to negotiate their organizational identity, including normalcy, organizing and economy, medical scripts, personal life scripts and the physical body. Each discursive resource has consequences for identity work on its own, but when viewed as a whole, the *set* of discursive resources utilized by these participants has implications for the ways in which identity work is done for individuals with OCD.

The set of discursive resources with which participants engaged indicates a tension between a desire for privacy and to be treated "normally" and a desire to be recognized for their experiences and difficulties. After all, as indicated in chapter 4, there is a clear reported delineation between "normal" and "having OCD." In each category of discursive resources, strategies to indicate being seen normally were evident: for *normalcy*, Rebecca re-framed her ban book as an average self-help activity to emphasize her normalcy. For *organizing and economy,* Peggy insists she is a competent worker despite her shortcomings, which are not a part of her *true identity*. For *medicine*, Toby claims that even though he has Tourette's and OCD, he can still function normally in certain aspects of a job. For *personal life scripts*, Liz uses the more average tale of religious redemption rather than psychiatric care to emphasize a normal experience. Similarly, in each category of discursive resources, strategies to indicate a desire for struggles to be understood were also evident: for *normalcy*, Jack emphasized his struggle by comparing his own life experience with those of average expectations of a life trajectory. For *organizing and economy,* Ron highlighted his own difficulties with unemployment by drawing on discourses of the "business world." For *medicine,* Lucy borrows the gravity of the emergency room to stress the seriousness of struggle with OCD. For *personal life scripts,* Pam utilized her hospital stay to accentuate her deep difficulties with OCD.

C.J., whose story was featured in the vignette section, expressed an explicit struggle with this very tension; she demands to be treated "normally" at work, and therefore refuses to tell anyone about her diagnosis except for very close colleagues under the condition of secrecy. On the other hand, though, it feels frustrating to her that not many people in her life or at work know about the struggles she has been through to get where she is today. As she said about the CPA

exam, "it's like I was almost upset because I was, like, no one will know this untold story that I have, of what I've dealt with."

Being understood and respected for one's experiences is complex with OCD. When wanting their narratives to be heard and understood at work, participants who chose to disclose sought out specific others they thought might "understand," be it because the other person had a relative with mental illness, studies mental illness, or is in a position of social service (e.g., a social worker). Seeking out sympathetic others is not terribly surprising; Goffman (1963) makes the same claim. However, this communicative process is complicated by discursive resources that mean shifting, different things to different people.

As an illustration of this, during our interview, Liz told me that while she worked at a gas station, she asked one of her coworkers to check under her car because Liz was convinced she had run someone over. "How insane is that?" Liz asked me. As I heard her describe her experience with OCD as "insane," I immediately responded by reassuring her: "it's not insane; it's textbook OCD tendencies." In the moment, I felt that I was doing the right thing. "Insane" sounded so…negative. So stigmatic. So self-deprecating. I honestly felt sad for Liz in that moment, and wanted to comfort and reassure her that no, she was not "insane." She was dealing with an illness, and that is different than being insane. *"Insanity" is reserved for people with psychotic or sociopathic tendencies, not OCD*, I thought.

Months later, as I was analyzing our interview for this project, I kept reading this section over and over. *Insane* – what does that even mean? I did a quick Google search to see what I could find. From the Latin "insanus," *insane* translates to *not healthy.* Oxford English Dictionary (the source that Google chose to show first) defines "insane" as "in a state of mind that prevents normal perception, behavior, or social interaction; seriously mentally ill." Urban Dictionary

(listed second by Google) cited an oft-misattributed quote using colloquial vernacular and punctuation: "the definition of insanity, is, doing the exact same fucking thing over and over again, expecting shit to change. That. Is. Crazy." The People's Law Dictionary, which Google also chose as a first-page feature, defines "insane" as "mental illness of such a severe nature that a person cannot distinguish fantasy from reality." Merriam-Webster preferred "exhibiting a severely disordered state of mind: affected with mental illness."

No wonder Liz and I engaged in negotiation over the meaning of "insane," I thought, pondering all the options Google provided. From some of these definitions, "insanity" and "textbook OCD tendencies" could be considered one in the same. However, my instincts in the moment to reassure Liz that she wasn't "insane" is indicative of the social connotations with mental illness being a character defect, as illustrated by the Urban dictionary definition (associating "insane" with "crazy"). Her description of her actions as "insane" sounded self-deprecating to me, but I *really couldn't tell* if that's what she was doing.

As I kept digging around Google, I found many other definitions of "insane," like "outrageous" and "shocking." It could be that Liz was using hyperbole to describe her behavior as particularly astounding. Even so, the negative connotations that fueled my reassurance were still there. In that moment, we were negotiating what constituted "insane" in the context of her identity. And whatever meaning we settle on has consequences for her identity. My interaction with Liz is telling of the array of meanings assigned to discursive resources, and this was among two people who are familiar with OCD and mental illness. Even among those who *have* OCD, meanings of what OCD "is" can differ, as discussed in chapter four.

This study suggests that the discursive resources available for organizational identity work are, at the same time, *vast* and *limited*, specifically in the case of adults with OCD. They

are *vast* in the sense that there are countless portrayals, descriptions, depictions, mentions, and appropriations of *OCD* as a discursive resource, many of which have been discussed in this dissertation. Even further, there are just as many and more of *mental illness.* They are *limited* in the sense that only a certain number of them are made available to any given person at any given time. An individual is only exposed to particular discursive resources throughout their lifetime, and therefore, only have those at their disposal when doing identity work. Moreover, discursive resources are limited in organizational interaction by those that are *encountered* from colleagues, supervisors, or subordinates. For example, an individual with OCD may encounter a misconception about OCD in the workplace; from that point forward, the individual must respond to, react to, ignore, accept, agree with, contest, or in some way contend with the misconception, as it is a trigger or threat to their identity, first in interaction, and second, in their own reflexive narrative. The limitations of available discursive resources imply that individuals with OCD are not completely autonomous actors, picking and choosing exactly how they would like to portray themselves from an unlimited list of discursive resources; rather, they have partial, restricted, and contextual options that may be reflexively or unreflexively engaged with that may or may not carry the same meaning for their interaction partners. Meanwhile, other assumptions and identifying claims may be being made about the individual by other organizational members drawing on a completely different set of discursive resources and/or meanings, the consequences of which the individual with OCD is then accountable.

Narrative Identity

Given what has been suggested here about discursive resources, it can be argued that organizational identity with OCD is negotiated by engaging with available discursive resources in a variety of ways that makes sense for an individual's personal narrative. This aligns with

Giddens' (1991) claim that identity work is the "capacity to keep a particular narrative going" (p. 54) fueled by the desire for reflexively-aware biographical coherence and social acceptability.

Drawing on the phases of narrative identity work proposed by Lutgen-Sandvik (2008) mentioned earlier in this dissertation, participants engaged in *sensemaking* (making sense of perceived tensions, misunderstandings, or OCD manifestations), *reconciling* (regaining equilibrium when actions or events do not align with a pre-conceived image of the self), *repairing* (attempting to alter others' perceptions about the self), *grieving* (dealing with and accepting perceived loss, which can be one's reputation or self-confidence), and *restructuring* (the positive reemergence from a negative experience and merging that experience into one's narrative). As an example of participants engaging in *sensemaking* identity work, Leslie realized that doing cashier work in gloves might be startling to customers, as evidenced by the confused look on customers' faces when she wore them. Making sense of the befuddled customer responses involved putting together wearing gloves with the normal script of bare-handed retail interactions. An illustration of *reconciling* identity work might be Lucy juxtaposing herself as both a student with a disability and a tutor for students with disabilities when she received emails targeting both groups. For Lucy, it was a real "identity crisis" to have to reconcile these two images of herself. An example of *repairing* identity work may be Peggy wanting her future management to know that her potential shortcomings are not a part of who she is as a capable worker. "I would want people [at work] to know that if something comes up at the last minute, or if I'm not able to show up, it's not that I'm flaky," she says of her identity as a good worker. "It's not that I don't respect their time. It's because of OCD." As for *grieving,* Ron laments his reputation as a poor performer. He knows his work has been less than stellar because of his OCD and co-morbid conditions, and seems to have come to terms with his past, although it is still

painful to remember. Finally, as an example of *restructuring* identity work, Pam now folds her traumatic experience of her stay at St. Mary's into her success story. She let her supervisor know that she had a "hospital stay," and considers it to have made her stronger in the long run. As mentioned in the literature review, this identity work "seeks to buttress preferred identity narratives, preserve narrative coherence, repair and restore image, neutralize 'othering' discourse and/or stabilize existential beliefs" (Lutgen-Sandvik, 2008, p. 113).

With Lutgen-Sandvik's (2008) phases in mind, the ways in which individuals negotiate an acceptable identity narrative may vary depending on the *type* of story they are crafting (be it reflexively or unreflexively). As proposed above, the discourses resources engaged shows a tension between privacy and understanding, which is a clash between identity narratives; in this instance, a clash between a "normal" story and what I am calling a "struggle" story. The "struggle" story can be broken down further by Goffman's (1961) categorizations of the "sad tale" and the "success story:" both involve a struggle, but have different ways of accounting for life's events. With each tale, there are consequences and risks.

Maintaining a "normal" (whatever that means for the respective participant) tale risks access to accommodations, the availability of certain discursive resources (like medical scripts) to explain telling or stigmatic OCD manifestations (e.g., J.D. only had "normal" resources at his disposal for explaining taking extra time delivering mail to apartment complexes because he didn't want his supervisor to know about his OCD), being understood or sympathized with, and the opportunities for managing the meaning of one's illness. Those maintaining a "normal" tale keep their identities from being spoiled by an OCD diagnosis, but still risk their identities being spoiled by unexplained, negative OCD manifestations. On the positive side, though, a worker with OCD who maintains a "normal" tale stands a better chance of being judged on their merits

alone, especially if their OCD is relatively concealable. With a "normal" tale, an individual with OCD gets to enjoy the relative anonymity of the average worker and the privilege of crafting their narrative with relatively "normal" life scripts.

Maintaining a "struggle" story, on the other hand, moves the individual into a more vulnerable position; with a disclosure of struggle and diagnosis, the individual is then subject to the stigma of mental illness and psychiatric hospital stays and possible misconceptions (e.g., Pam's professor told her she didn't seem "sick enough" for accommodations). Crafting a tale of "struggle" may prompt actual or feared negative organizational consequences, such as not being promoted, not being trusted with as much work as other employees, or having one's reputation sullied by gossip. All organizational actors are subject to whatever discursive resources are encountered in the workplace, but in this case, there is a specific set of damaging misconceptions that may be encountered by an individual with OCD. On the plus side though, maintaining a "struggle" story opens one up to potential accommodations, feelings of authenticity and "being oneself," and the possible respect or sympathy of understanding others. A "struggle" story also may afford the individual the opportunity to strategically manage the meaning of their illness and experiences by using discursive resources like medical scripts or personal experiences.

From the data, both tales are evident. However, most "struggle" stories are caveated with discourses of normalcy and most "normal" stories are caveated with discourses of struggle, which is what manages the tension between these two tales. For example, C.J. clearly desires a "normal" tale, especially when it comes to her organizational identity. However, she manages the tension of maintaining this normalcy by disclosing her struggles to a few, trusted co-workers and friends about her OCD so she feels like her OCD story is heard and she can feel like her accomplishments may be respected in their proper context. On the other hand, Jaqueline

maintains a "struggle" tale at her job at the grocery store so she can get the accommodations she needs (short breaks to stay calm). However, she manages the vulnerability of disclosure by crafting her career story to me and other trusted people in her life: the grocery store job isn't forever. She's going to get a job in nursing and live the "normal" life she's imagined for herself because she has capabilities for more. This tension between the "normal" tale and "struggle" tale reflects Wieland's (2010) assertion that identity work is a site of struggle between tensions of desires to be unique and desires to "assimilate and be accepted by others" (p. 504). Therefore, I argue that *adults with OCD manage their organizational identity, keeping a particular narrative going, by managing the tensions among a "normal" tale and a "struggle" tale by engaging with a particular set of available discursive resources, fueled by desires for reflexively-aware biographical coherence and social acceptability*.

Like Alvesson and Willmott (2002), my argument aligns with the idea that organizational members are constantly engaging in identity work, managing the tension of organizational-defined meanings and self-constructions. However, this study is unique in that here, organizational-defined scripts can concern not only corporate values and priorities, but the personal conceptions held by organizational others, including hierarchical superiors (e.g., Rebecca's boss claiming *body dysmorphic disorder* sounded made up). This, in turn, functions to craft the expectations for the identity of the "appropriate individual."

This study also reflects the arguments made by Bersten and Rubin (2003), who claim individuals make sense of their own identity in contrast to "life scripts," which mirrors what an "average" person is doing at certain life intersections. For example, Jack made sense of his story and identity by engaging what a "normal" life "should" unfold for someone his age. This study expands that idea in that individuals who have experienced intensive OCD treatment often

consider their hospitalization as an odd punctuation in their lives, as intensive OCD treatment is not part of many "normal" life scripts. Therefore, this comparison of "OCD life" to "normal life" is perhaps a more significant factor in organizational identity than for the average working adult.

Many of Goffman's (1961) arguments are supported by this study. Ron, who crafts a near-classic Goffmanian "sad tale," is an example of a "former mental patient" who uses his experience in a "mental institution" to account for his perceived life's downfall. Jack's story is also a "sad tale," where identity work serves as an explanation of where Jack's OCD has taken him at work and in his career. C.J.'s tale, on the other hand, is a gleaming example of Goffman's "success story," in which a stay in a "mental hospital" is framed as what propelled her forward. However, this study expands Goffman's ideas of these two types of stories: here, I have described a "zooming out" from the "sad tale" and a "success story" to broaden the horizon into "normal tales" and "struggle tales," with "struggle tales" encompassing Goffman's claims of "sad tales" and "success stories."

The ways in which tensions between a "normal tale" and a "struggle tale" are managed by the participants in this study also reflect other scholar's claims of identity work. For example, Gotsi, Andriopoulow, Lews, and Ingram (2010) cite a "paradox lens" when examining identity work, claiming that a more "holistic, fluid, both/and" (p. 799) framing of tensions allows for a more "empowered" view of identity work. Kreiner, Hollesbe, and Sheep (2006) claim that when organizational actors feel their identity leaning too far toward one end of a tension, they compensate and move back the other way. For example, they propose that when organizational identity leans too far toward individualism, this throws off the "optimal balance" of identity, and therefore organizational actors employ "integration tactics." Perhaps the most congruent with my arguments is Meisenbach (2008), who asserts that organizational actors manage and maintain

identity tensions rather than trying to eliminate or avoid them. The author uses the theoretical foundation of "framing" and claims that her participants, who are fund-raisers trying to craft a positive occupational identity, discursively rely on and "simultaneously accommodate and resist" different frames as they "attempt to make meaning of their work and form occupational identities" (p. 267). Meisenbach's study also insists that no one frame is used in singularity with much effectiveness; rather, "it became apparent that fundraisers who primarily articulated only one frame were also the fundraisers who more strongly expressed difficulties in negotiating, embodying, and presenting a positive occupational identity." (p. 278) This study reflects Meisenbach's assertions of tension management and supports her arguments about the simulations discursive use of multiple "frames" or resources.

Many studies have also examined identity work as it relates to difference, that is, having a potentially stigmatic trait or identity that is not necessarily as valued as another identity. For example, issues of race, sexuality, disability, gender, class, and religious affiliations, and other such populations in which there are distinct stereotypes about the group. One such study examined how homosexual men manage their "professional identity" at work in tandem with their identity as a gay man (Rumens & Kerfoot, 2009). Participants in this study reported having to negotiate a professional identity while managing the social and discursive constructions of male homosexuality as a sin, disease, psychological disorder, or "unprofessional." In response, the participants of this study tried to "blend in," but also sought to make their places of employment more "gay friendly," which happened to also be a cultural and organizational trend at the time. The authors concluded that "as gay men, like other sexual minority groups, benefit from being successful and open about their sexuality within professional arenas, discourses that emphasize the separation between sexuality and professionalism are likely to come under

increasing criticism" (p. 782). This assertion about sexuality relates to this study in that many participants discursively attempt to make their workplaces more "OCD friendly" by educating their co-workers and supervisors. However, sexuality as difference has had relatively more success becoming de-stigmatized in American culture, as many recent laws have reflected (e.g., the Supreme Court ruling on gay marriage). Contrastingly, mental illness advocates have enjoyed much less traction when it comes to convincing the public to de-stigmatize; for example, the recent discussions on mass shootings that directly correlate gun violence with mental illness.

Allen famously explores the experience of black womanhood as an organizational "outsider within" (2003). As a black woman, Allen writes from her own personal experiences in academia coming up against stereotypes and discrimination of being both black and a woman. As a result, Allen reports an exhausting amount of identity work:

> "I…expend energy monitoring my emotions, masking them, or both. For instance, a high-ranking administrator told what I considered to be a derogatory job about football players. I was the only person of color at the meeting, and the only person who did not crack a smile at his joke. I wanted to tell him that I was insulted, but I held my tongue. I often am careful not to display negative emotion (e.g., sadness, despair, anger, disagreement) because I do not want to enact negative stereotypes. For instance, I might suppress my anger because I do not want to be seen as a militant Black person or as a domineering, loud Black woman, or as a bitchy woman" (1998, p. 580).

The present study reflects Allen's assertions of tiring identity work, not by comparing black women to individuals with OCD, but rather by claiming that those in positions of difference may experience having to engage in more intense identity work than those who are not.

This dissertation also supports assertions made by Dyck's 1999 study of women with MS: the interaction of illness disclosure depends on how organizational others "read" or interpret the discursive resources used to disclose. Dyck's participants used medical scripts to frame their MS, and found that "disclosing their biomedical scripting may close off employment opportunities or open up possibilities for renegotiating their work tasks and conditions, depending on how employers 'read' and interpret such an inscription in relation to the work practices of a particular workplace" (p. 133). This study also reflects Dyck's claims that discourses of illness permeate processes of organizing without regard to the type of organization, industry, or economy, as culturally produced scripts of illness may be "powerful, attaining a hegemony of understating of the body, inclusive of ideas of ability or disability" (p. 134). Identity management strategies for Dyck's participants included "concealing their MS whenever possible" (p. 133), as was a prevalent identity management strategy for my participants as well.

Agency and empowerment. Identity scholarship consistently addresses the concept of agency, that is, how much autonomy and control an organizational actor has over their identity. As discussed in the literature review, narrative identity scholars have more or less settled in the grey area of acknowledging that organizational actors are not completely autonomous over their own story, but nor are they "cultural dopes" who are unreflexively subject to any identity thrown their way (Brown, 2015). Rather, as is confirmed by this study, organizational actors are constructing, managing, and maintaining their narratives betwixt and between the discursive resources to which they have been exposed, both reflexively and unreflexively.

That being said, I want to push the idea of narrative agency with OCD a bit further by engaging with the concept of *identity empowerment*. Meisenbach (2008), whose discussion of tension management was addressed above, claims that when organizational individuals are in a

position to frame and manage the meaning of the discursive resources they are drawing on to craft their identity, the individual engages in interactional empowerment. Meisenbach notes that public images of fund-raisers (her participants were all fund-raisers) can be negative and *dis*empowering, like the discursive construction that fund-raisers are "money-grubbers." However, when the fund-raisers engaged in managing the meaning of fund-raising as "pursing a higher cause," they claimed they were interactionally able to "[trump] concerns about fund-raisers as beggars or false friends," which resulted in a sense of empowerment over their identity narratives. Likewise, Agarwal and Buzzanell (2015) argue that when disaster-relief workers were able to discursively manage the meaning of resources defining their identity, it was empowering for the workers, which in turn sustained a sense of resilience for them. Gotsi et al. (2010) claim that a "paradoxical" perspective that highlights the discursive management of tensions "may recast identity regulation as [a] more empowering" effort, rather than one that seems more controlled or alienating. Ryan, Bajorek, Beaman, and Anas (2005) argue that "by exercising control, choice, and assertiveness, one can move effectively beyond the limits imposed by stigmatization and environmental barriers (p. 132).

Indeed, participants in this study described meaning management as empowering. Jack, who struggles with contamination obsessions and compulsions, got tired of getting made fun of in high school for his handwashing, cleaning, and sanitizing. "What the hell are you doing?" he remembers his classmates asking him. And so, when Jack had the opportunity to give an informative speech in his public speaking class, he chose to give a speech about OCD, explaining the symptoms and causes. After that, he recalls his friends and classmates being much more "understanding" of his rituals, and the bullying subsequently lessened. Jack directly attributes his organizational empowerment to his speech, where he discursively and intentionally

defined OCD in precisely the ways in which he thought might benefit his identity and organizational experience.

Therefore, I argue that *intentional and reflexive meaning management of salient discursive resources can lead to organizational and identity empowerment for individuals with OCD*. Certainly, my participants are subject to the same agency tensions that are managed by other organizational actors, but they are unique in that they seem to gain a sense of organizational and identity empowerment through the opportunities for the intentional meaning management of specific discursive resources related to OCD and mental illness.

"Organizational" identity. In the literature review, I expressed a struggle over what to call what I investigated in this study. I settled on *organizational identity*, in the capacity that identity is in relationship with processes of organizing. Sidestepping the issue of insufficient terminology works for only so long, and therefore, I argue that scholars need a new way to describe the type of identity that has been explored in this dissertation. *Organizational identity*, the term I have been using, is typically used in two ways: collective organizational identity, that is, the identity of an organization as a whole, and individual organizational identity, that is, identifying oneself in relationship to an organization (Alvesson & Wilmott, 2002). This dissertation is concerned with the latter, but has also investigated other aspects of identity. First, aspects of *career identity* were discussed, which involve "one's self-definition in the career context, describing 'who I am' or 'who I want to be'" (Fugate, Kinicki, & Ashforth, 2004, p. 17) and conceptualizations of employability. Second, participants explored issues associated with *occupational identity*, which is an association with a profession or occupation (Ashcraft, 2005). In an effort to combine occupational and organizational identity, Walsh and Gordon (2008) suggest the idea of the *work identity*, which integrates both organizational and occupational

identities. However, the concept of career identity is left out, as work identity is primarily concerned the shifting roles and priorities between the self as an organizational member and the self as an occupational member. I am not suggesting a new, specific terminology here, as the creation of this new terminology could be its own article. But, I maintain that organizational communication and identity scholars do need a terminology for conceptualizing the entirety of the identity work explored in this dissertation.

Organizational Communication

Narrative identity organizes. When organizational actors keep a particular narrative going, they keep *organizing* going. Narratives help workers "deal with their complex and often ambiguous and contradictory experiences of work and organization" (Alvesson & Willmott, 2002, p. 625). The narratives of identity workers with OCD organize in unique ways and have specific implications and consequences for organizing, many of which have been discussed in this dissertation.

Given what has been argued about discursive resources and narrative identity, I claim that *OCD organizes.* Through OCD manifestations, discursive resources engaged, and narrative identity work, OCD communicatively *makes a difference* in a multitude of organizational processes. As suggested by my data, OCD influences who works where and in what industry. It influences who discloses to whom. Who does which task. Punctuality. Attendance. Scheduling. Hierarchical structures. When present, OCD permeates processes of organizing without concern for profits, productivity, or satisfaction.

By taking a discursive resource approach to studying narrative identity and organizational communication, this dissertation reflects the assertions of Kuhn (2006), who claims that such a perspective helps to blend together work and non-work domains. The participants discussed in

the present study crafted their respective organizational identities not only using discursive resources specific to an organization, but also scripts of normalcy, economy, medicine, personal life, and the physical body. A more "container" approach to organizational communication tends to neglect non-work domains, but this study supports a more constitutive model of organizing that uses *organizing* as a verb (Weick, 1969) and that verb as a unit of analysis.

Much of the work on OCD done in the field of organizational communication come from a more managerial perspective, that is, focusing on how management might cope with employees with OCD, as though disorders like OCD are stumbling blocks on the road to success and productivity (e.g., Sidle, 2011). This perspective, at first glance, seems appropriate for researchers who are concerned with the bottom line: how can OCD be managed so that workers are productive as possible? After all, it seems like common sense to deal with OCD like any other impediment to efficiency: have a manager deal with it. However, this study indicates that method of management may not be effective for OCD. Recalling some of the suggestions from the introduction, *How to Accommodate Those with Obsessive-Compulsive Disorder* recommends managers should install white noise machines to help workers with OCD concentrate, set daily goals to keep workers with OCD on track, and incorporate more natural lighting. While I'm sure the authors of this brief had good intentions, the recommendations seem offensively tone-deaf in light of the findings from this dissertation. So while doing organizational communication research from the worker with OCD's perspective might seem counter-intuitive to some managerial scholars or organizational scholars concerned with the bottom line, I argue that such an approach would actually be more beneficial to both the workers *and* the bottom line, as participants here described themselves to be at their best when they are the healthiest.

Moreover, organizational communication studies, when studying mental illness at work, tend to broaden their focus more on "mental illnesses" as a whole rather than specific conditions (e.g., Ettner, Maclean, & French, 2011). This study suggests the importance of studying specific conditions at work, as discursive resources available for different conditions may vary widely. For example, the discursive resources available for bipolar disorder are quite different than those available for borderline personality disorder, but they are often studied in the same category (e.g., Tyrer, who generalized about "personality disorders" as a whole, including the "obsessive-compulsive personality").

In the literature review, I made a special case study of Goffman's *Asylums* (1961). I compared St. Elizabeth's hospital to St. Mary's for its procedural mortification and organizationally-defined sense-giving discursive resources. Beyond these comparisons, it feels tempting to treat *Asylums* as a historical piece. After all, it was written in 1961, what feels like a lifetime ago. Goffman uses phrases like "mental patient" to describe those in psychiatric treatment. *Do people even talk like that anymore?* This study suggests that some indeed do, and that the stigma surrounding a stay at a psychiatric treatment facility is still alive and well. For example, Pam, when disclosing her hospital stay to her supervisor, was very careful not to disclose that she had been in a "mental hospital." Many patients described reticence toward revealing psychiatric treatment. Dowdall (1996) describes the stigma of a "mental hospital" stay as identity-spoiling. Schneider, et al. (2012) experimented to see if different types of psychiatric treatment hospital stays were more stigmatic than others. Dobransky (2018) insists that practitioners should be helping patients combat the stigma of hospitalization for a mental illness. Clearly, the stigma of being a former "mental patient" has stuck around since 1961. This

indicates a necessity to keep researching this particular issue to understand the full impact of this stigma at work.

Some ideas on the forefront of organizational communication at the time of this writing (2018) are those of *new materiality*, that is, a flat ontology that privileges discourse and the material equally in communication (e.g., Kuhn, Ashcraft, & Cooren, 2018). Materiality perspectives have been making waves throughout organizational communication studies of the physical body, and since disability typically involves the physical body, material perspectives have become popular for the study of disability at work (e.g., Chaudhry, in press). Indeed, participants in this study spoke often of the material consequences of their physical bodies. However, this study is more interested in how individuals with OCD *discursively* make sense of, craft, and maintain their identities through narrative, therefore privileging the discursive over the material. One reason for this choice is the location of most of my participants and all of my future intervention subjects: they are physically and socially in a psychiatric treatment facility. As materiality approaches are generally focused on practice, this frame would not be appropriate for this study, as the *actual practices of organizing* are not my units of analysis. I also chose a discursive approach so that I could study the discursive resources of OCD as they pertain to organizing across many organizations, industries, and economies, and this study accomplished just that. Finally, I focused on the discursive over the material because my intervention, to be used in intensive OCD treatment facilities, will be centered around talk; that is, I will be counseling patients on ways in which they may be able change their talk, not change their bodies.

That being said, yes, I do think OCD could be studied from a materiality perspective in future research. In fact, Borgenson (2017) argues that narrative identity and materiality perspectives are somewhat "compatible." Dyck, who has already been discussed in this

dissertation, has taken materiality, embodied, and geographical approaches to studying MS (e.g., 1995; 1999; Dyck, Kontos, Angus, & McKeever, 2005). She chooses a more material approach, as she claims that "the corporeal body is continually in the process of 'becoming'" (1999, p. 134). This claim certainly applies to the body with OCD, as many participants cite their OCD morphing and changing over time. Therefore, while a discursive approach was the most appropriate for this study, a material approach could easily be an appropriate choice for future research on OCD at work.

Obsessive-Compulsive Disorder

This study qualitatively confirms that OCD is, overall, difficult to manage. OCD is 10th leading cause of disability in the world (Murray & Lopez, 1996) and the fourth most frequent diagnosis in psychiatry (Stengler-Wenzke et al., 2006). Adults with OCD are *ten times more likely to die by suicide* than those without OCD (de la Cruz et. al., 2017). Twenty-six percent of my participants had either suicidal ideation or had attempted suicide (compared to 4% and .6% of the rest of the population, respectively). A heroin addict tends to have a higher quality of life than adults with OCD when it comes to general health, vitality, social functioning, emotional condition, and mental health (Bobes et al., 2001). Adults with OCD are more likely to be unemployed and more likely to report significantly impaired social and occupational functioning (Torres et al., 2006). And when they *are* employed, identity management is complicated, as suggested by this study.

Therefore, OCD researchers cannot quit. In an unexpected blow to the OCD community in 2018, twin sisters, both with severe OCD, died by suicide together by apparent self-inflicted gunshot wounds. Sarah and Amanda Eldritch were pioneers and icons in the OCD community; they were two of the first Americans to undergo Deep Brain Stimulation (DBS) surgery for the

treatment of OCD. Their surgeries were so successful in treating their debilitating OCD, they were invited and appeared on the nationally-syndicated television show *The Doctors* to discuss their recovery. I even had the pleasure of meeting the two women, as they lived in the Colorado area. We talked for a while, and they expressed their pleasure with the DBS outcomes, but they both admitted they still suffered at the hands of OCD, depression, and co-dependency.

The quality of life for those with OCD improves with paid employment (Remmerswaal, Batelaan, Smit, Oppen, & Balkom, 2016; Rodriquez-Salgado, et al., 2006). Therefore, it is essential that OCD researchers study the specific issues adults with OCD face in the working world and work to help those with OCD manage paid employment.

It is my hope that this project is a step in a new direction for the study of obsessive-compulsive disorder. The majority of OCD research is conducted in the medical field using quantitative methods. Moreover, it seems that is the way some would wish it to stay; for example, when I proposed presenting this project at the International OCD Foundation conference research symposium in 2018, it was rejected for using many of the methods and theoretical foundations utilized in communication research. One reviewer commented:

> This proposal addresses a clinically important and under-researched issue, the impact of OCD on work. However, the methodology is *purely qualitative*, the N is modest, and the findings are not particularly surprising to anyone who has worked with OCD patients. This could be the *first step* in an important research and clinical development program. (emphasis mine)

I italicized the phrases "purely qualitative" and "first step" to illustrate the larger issue of the medical community's preoccupation with quantitative methods. It is the opinion of many quantitative researchers that qualitative methods are useful merely as a "first step" that leads to a

quantitative study with a statistically significant N. I have found this to be a common response to interpretivist communication studies such as this from those who conduct more post-positivist or positivist research; unless a study contains an experiment, some researchers aren't interested. Furthermore, this reviewer criticizes my communicative findings that are "not particularly surprising" to anyone who works with OCD patients. It is important to share the control of communicative data among practitioners and researchers, as most practitioners who work with OCD patients are not studying OCD on a larger scale. I hope that this project and its subsequent research agenda will someday be a catalyst for more recognition from the medical community that communication research is vital to the exploration of OCD. This study follows in the footsteps of two examinations of OCD from a communication perspective: Brooks' (2011) autoethnographic dive into OCD using Goffman's performance theories and Fox's (2014) narrative autoethnography focusing on the communicative characteristics of OCD. This study extends their communicative inquiry of OCD by using communication theory to make arguments about OCD, using communication as a unit of analysis.

Medical OCD literature, on the whole, seeks out ways to better treat OCD. When work is involved, it is typically framed in one of two ways: first, that paid employment would improve the overall quality of life for the individual with OCD (e.g., Remmerswaal, Batelaan, Smit, Oppen, & Balkom, 2016) and second, when OCD symptoms are improved, the individual with OCD should be able to go back to work (e.g., Olsen, Mais, Bilet, & Martinsen, 2008). This study implies that individuals with OCD not only struggle with symptoms, but also with *managing their identities at work*. Medical research has generally agreed that OCD is not "fixable," that is, it is not an illness that can be "cured" and disappear, like, say, an infection. Rather, it is a life-long condition that may be managed through exposure and response prevention therapy and

cognitive behavioral therapy and must be consistently maintained throughout the individual's life. I'd like to argue here that, like the medical consensus of OCD, organizational identity with OCD is not "fixable," in the Giddensian sense that identity is constantly being maintained, crafted, contested, and negotiated in interaction and is never in a stagnant, "fixed" state. Subsequently, OCD is not a condition in which an individual can gain skills to manage the illness and then go back to work without incident or conflict, and medical scholarship must stop treating it as though it is. On the contrary, as laid out in this study, negotiating work and employment with OCD is complicated and exhausting, so much so that many are unable to keep a job. Therefore, when researching work issues with OCD, medical scholarship should encompass organizational identity negotiation, if for no other reason than to help individuals with OCD manage their employment and work expectations. Going back to work (or working for the first time) after institutionalized psychiatric treatment for OCD is difficult, as evidenced by this study, and framing it like it isn't does a disservice to those who are attempting it.

Disability Studies

My study continues the pursuit of the qualitative inquiry of disability. Long studied at the quantitative level, qualitative methods have been making strides in the last few decades and this dissertation follows that path.

This study supports Fitzgerald and Paterson's (1995) assertions that hidden disabilities take more work to be legitimized than visible ones. For example, participants in the present study utilized medical scripts and personal life scripts to help legitimize their OCD, as many of their organizational counterparts trivialized their illness. Liz even addressed this issue when she insisted that supervisors and coworkers should be educated on OCD to get them to "care" about the disability, and subsequently, her. However, this study is unique in that OCD is, as evidenced

by the data, sometimes more hidden than other times. Some participants were able to hide their OCD symptoms without too much trouble; others could hardly function at work because their symptoms were so obvious. For example, when Rebecca had to respond to others noticing her hair-pulling, she faced the consequences of a visible disability, and when C.J. can control who knows about her OCD at work, she faces the consequences of a hidden disability, even though both have the same disorder. Therefore, this study indicates a need for disability studies to research conditions and symptoms that are in the grey area between "visible" and "hidden," particularly those with visibility that changes over time.

Disability studies have addressed issues of stigma frequently, as discussed in the literature review. And Goffman specifically addresses the stigma of those who have experienced institutionalized psychiatric treatment (1961). However, the present study indicates that disability studies needs to not only study the *stigma* of institutionalized psychiatric treatment, but the *trauma* of it as well, as it pertains to organizational life. As many participants discussed, there is a specific, heavy weight that accompanies a psychiatric hospital stay (e.g., Ron felt his life plan was damaged by his hospital stay, and struggled to gain and maintain employment afterwards). Exposure and response prevention therapy is especially traumatizing, as reported by participants (e.g., Pam, who feared being stabbed, had to hold a kitchen knife to her wrist for prolonged periods of time in order to habituate to the panic). Therefore, this study emphasizes the need to expand the exploration of work after intensive psychiatric treatment to not only include the stigma of the stay, but the trauma of the stay.

Practical Application

Translation

The practical application of this research may be drawn from the theoretical discussion, because, as mentioned in chapter two, theory drives applied communication research. As argued earlier, individuals with OCD negotiate their organizational identities by managing the tensions between a "struggle" story and a "normal" story using the discursive resources of normalcy, organizing and economy, medicine, and personal life scripts and the physical body. Additionally, it seems as though when participants were able to communicatively manage the meaning of the discursive resources they interactionally engaged with, *they were able to keep a more cohesive narrative going*. For example, when Lucy was able to discursively call on blog posts she had written defining OCD, her symptoms, and how someone with OCD should be treated, she subsequently felt more secure and empowered in her workplace. This idea of cohesiveness and security aligns with Meisenbach's (2008) discussion of identity empowerment, that is, when an individual is able to manage the meaning of the discursive resources they are drawing on for identity negotiation, the individual may be more organizational and interactionally empowered. Along those same lines, Ryan et al. (2005) posit that by using "selective assertiveness," persons with disabilities can break cycles of toxic organizational communication with persons who don't have disabilities. For Ryan et al., "selective assertiveness" can come in the form of social creativity (re-defining what it means to have a disability) or social competition (advocating for political status gains). For this study, it seems most appropriate to translate the theoretical findings into practical applications by recommending the *intentional and reflexive meaning management of salient discursive resources that contribute to managing the tensions between a "struggle" tale and a "normal" tale.*

Recommendations

Given this assertion, this research has implications for practical recommendations to a variety of audiences, which aligns with Frey and SunWolf's (2009) suggestions that applied communication research may function in the form of "observation and recommendation." The audiences that I will be making recommendations to are the lay person with OCD and employers.

The first recommendation for the lay person with OCD, who may or may not have experienced intensive treatment, is to decide on the level of communicative disclosure they may want in the workplace. This may later change, but it is important to, in any job, decide with whom to share a diagnosis. This decision may be made alone or with the help of a therapist or behavior specialist. Second, individuals with OCD should brainstorm ways to define salient discursive resources to account for disruptions to their narrative's cohesiveness. If an individual with OCD were to decide to be more private and tell more of a "normal" tale, the individual should then brainstorm discursive ways to account for OCD manifestations, absence from work, abnormal behavior, or other factors that may disrupt the cohesion of a narrative using more "normal" vernacular to explain these factors. For example, when explaining an absence due to intensive treatment to a supervisor, an individual wishing for a more "normal" tale could account for their absence using general terms of "medical leave," rather than mental illness or OCD. If an individual were wanting to tell more of a "struggle" tale, they could brainstorm ways in which to define salient discursive resources to account for the disruption of a cohesive narrative. In this case, the definitions could involve medical scripts around OCD, their hospital stay, or dispelling misconceptions. Finally, individuals with OCD should brainstorm ways in which their meaning management may be challenged in interaction, and be prepared to respond. This, again, could be done alone, with a friend or family member, or with a health care practitioner. It may be

advantageous for an individual were to choose to involve someone else, as they could practice hypothetical scenarios of future organizational interaction or challenges to their narrative.

This study also has recommendations for employers, and not necessarily only employers who have employees with OCD, as this may not be apparent to all employers in such a situation. When an employer is approached with a narrative of disability from an employee, they should do everything they can to help the employee maintain the narrative that is crafted by employee. For example, if an employee were to approach an employer asking for accommodations and explain that they needed reasonable, appropriate accommodations for an unspecified disability (and could provide the proper paperwork), the employer should provide the accommodations to the best of their abilities while respecting that the employee's wishes to keep their disability private. This may include not asking what the specific disability is, and, if it is required by certain organizations to ask what the specific disability is, keeping it as private as the employee asks. As another example, if an employee shares with an employer that they have OCD, the employer could ask questions about what the employee needs, rather than asking questions associated with popular cultural scripts about OCD.

In sum, the recommendations from this study are to promote the empowerment of individuals with OCD to maintain their desired, cohesive narrative at work. Both individuals with OCD and employers can help accomplish this by being prepared, respectful, and accommodating. While these are general recommendations, the next section discusses a specific intervention that may be implemented at intensive OCD treatment clinics to prepare patients to become organizational members who strategically, intentionally, and communicatively manage the meaning of the discursive resources that construct their identities.

Intervention

In every interview, I asked each respective participant what they would like to see in an intervention to help patients in intensive OCD treatment return to work or enter the workforce for the first time. One of the main issues participants discussed was a desire to know how to broach the topic of OCD at work. Some wanted to know how to disclose their OCD at work so they could acquire accommodations, some so they could explain their symptoms to their supervisors, and some so they could share with their coworkers so they felt like they had an understanding friend at work. With these desires known, an applied intervention at the intensive treatment level seems particularly appropriate, guiding patients through the future interactions they may face in the workplace.

Given the arguments made in this study, a practical intervention at the treatment level should feature strategic ways in which patients could craft their organizational identity narrative using specific discursive resources, while explaining these discursive resources in specific ways. Organizational scholars often resist referring to discursive resources as though they're on a "menu," and this study supports that resistance, as the reference tends to ignore the cultural impact of which discursive resources are available to individuals at a given time and context. However, engaging with the idea of *identity empowerment* discussed earlier, and continuing with the "menu" metaphor*,* I'd like to suggest that communication interventionists could potentially supply patients with OCD a small, tri-fold, to-go menu with a few, particularly salient dishes and descriptions. This menu could be memorized, rehearsed, and ready to go at a moment's notice. In having access to and using such a menu, individuals with OCD could be *discursively empowered to negotiate their organizational identity in interaction*. The discursive resources on the menu would be tailor-made for each patient and could include normalizing scripts, organizational

scripts, medical scripts, and personal life scripts that could prepare patients for potential challenges and threats to their organizational identity.

With the need for such specific exploration of discursive resources, a one-on-one setting for the intervention seems most appropriate. For example, a communication scholar could sit down with a patient in intensive OCD treatment for one hour increments at a time, first asking questions about the level of disclosure they would like to present at their job (this may change later, when they are actually working at the job, so all levels of disclosure should be discussed), that is, what they want others to know about their OCD diagnosis and symptoms. Once the level of desired disclosure has been determined, the interventionist would then ask the patient about their specific OCD manifestations and how they might come up at work. The patient and interventionist would then work together to determine exactly how they want to present the patient's OCD, deciding on what discursive resources should be used, and how those discursive resources should be explained. If a patient were to decide on a more "normal" tale, that is, doing their best to hide all manifestations of OCD and not disclose their diagnosis to anyone, the interventionist should discuss ways to manage this tale. Strategies for managing the tension of a "normal" tale might be eventually sharing the diagnosis with one trusted person at work or meeting with a support group outside of work to discuss their struggles with OCD at work. If a patient were to decide on a "struggle" tale, that is, disclosing their OCD diagnosis and/or explaining their OCD manifestations using medical discursive resources or personal experiences, the interventionist should discuss ways to manage this tale. Strategies for managing the tension of a "struggle" tale might be keeping an activity log at work to turn into a supervisor weekly or monthly, to not only provide management with proof of competence, but to also help maintain a sense of normalcy for the patient.

The interventionist would then create a written plan of strategy. Each discursive resource for the "to-go menu" should be explicitly defined and explained in the written plan. The definitions and explanations should be decided upon together by the patient and the interventionist. The definitions and explanations could be memorized by the patient or could be turned into a professional-looking pamphlet that could be given to a supervisor or human resources department. Below are two examples of hypothetical, potential intervention scenarios. The first features Sean, who expresses a desire to tell a more "normal" tale, and the second showcases Beverly, who wants to tell a more "struggle" tale.

Scenario one. Sean is in PHP treatment for his severe OCD. Fearing radiation poisoning, Sean avoids anything that he thinks might have been made in Japan after the Fukushima Daiichi power plant disaster in 2011. His fears of poisoning have also extended into obsessions of harm and loss, and therefore Sean fears that his dog may run away which would leave Sean completely alone. Having spent eight weeks in residential treatment and six in PHP, Sean and his treatment team feels that he is almost ready to go back to work. Using exposure and response therapy, Sean has been able to leave his dog at home unsupervised by friends or family for up to six hours at a time. He has also been able to eat food that was manufactured in Japan, but still avoids Japanese-made vehicles and clothing.

The interventionist (let's call her Sarah) is invited by Sean and Sean's treatment team to discuss his return to work. Sarah learns in her session with Sean that before intensive treatment, Sean worked in the restaurant industry. Sean has decided that he no longer wants to work in food service, but would like to get his foot in the door in the personal training industry. Before he started waiting tables, Sean finished his personal trainer certification, but had been unable to hold

down a job at a gym because of his fears of products manufactured in Japan, which many

workout machines were at the gym at which he had previously worked.

Sarah asks Sean if he would like to request any specific accommodations at work.

"Yes, I would," Sean replies. "I would like to be able to take breaks from a personal

training session if I get too overwhelmed by OCD obsessions. I plan on using exposure and

response prevention at work so I can be around items manufactured in Japan, but I would like to

be able to step away for a few minutes if I start to feel upset. I really don't want anyone to know

that it's because of OCD though; it's so embarrassing. I also need to check in on my dog every

six hours. I'm trying to get it up to more time, but right now six hours is all I can do."

In this situation, it seems like Sean would like to receive accommodations in case his

OCD manifestations interrupt his work day, but would also like to maintain a more "normal"

tale. So Sean and Sarah start working on a "back to work" plan. Since Sean wants

accommodations but doesn't want to tell his colleagues about his OCD, it seems like a larger

gym with a human resources department might be the best way to go. But in case that job

situation isn't available, Sean and Sarah talk about ways Sean can get accommodations while

maintaining a more "normal" tale. Since Sean doesn't want to reveal his OCD, they discuss ways

in which they could describe an illness using more "normal" vernacular, like medical scripts of

physical illnesses. They write out a script that Sean can memorize for a conversation with his

new boss:

I am so happy to be working here at XYZ gym. Since I am new, I thought this would be a

good time to let you know that I have a chronic illness that will requires some

accommodation. I want to let you know up front that I am qualified and capable to do this

job (discourses of normalcy and competency), but just need to do things a little bit

differently to accommodate for my health (lets the supervisor know he needs assistance for an illness, but does not disclose its potentially stigmatic nature). First, I may need to take a five to seven-minute break during personal training sessions. To compensate for the lost time to the client, I thought we could brainstorm some ideas; for example, I could have a fellow trainer take over for me during those five to seven minutes, or I could schedule my clients for an hour and five minutes, rather than just an hour, to make sure they get their whole time. I will also need to work in no more than six-hour shifts, or need a 30-minute break every six hours. Thank you so much for helping me with accommodations. I know you might have to share with others that I have accommodations, like if you need someone to cover five minutes of my shift, but I would appreciate if you didn't go into any detail with them about my illness, as I would like that to remain as private as possible. Again, I am so excited to be working here and can't wait to do a great job for you, the gym, and my clients (more discursive resources of competence).

Since Sean will be using discursive resources of medical scripts and competence, those discursive resource definitions should be defined in detail. For example, if the supervisor were to challenge Sean and say, "that's a lot of accommodations. Are you sure you can do this job? What makes you so capable?" In this case, "capability" or "competence" could be defined in advance as having the proper qualifications (a current personal training license), experience in the personal training industry (he has worked at a gym before and has had a few satisfied clients), and the physical capacity to carry out his tasks (Sean works out almost every day and is in great shape). Challenge scenarios such as these would be practiced in the intervention session, using the agreed upon definition of the discursive resources.

Sarah tells Sean that this meeting with his boss should take place in private (as to maintain as much of a "normal" tale as possible), and that Sean should have his paperwork ready from his physician (not psychiatrist, as that might give away a mental illness) that outlines his accommodation requests. While he might face some pushback from his supervisors, Sarah reassures Sean that he has the right under the Americans with Disabilities Act to request reasonable accommodations. Sarah explains to Sean that it might feel trying at times trying to keep up a "normal" façade at work; after all, he struggles with a difficult illness and has just completed a trying hospital stay. That is traumatic stuff! To compensate for possibly feeling exhausted from hiding his illness, Sarah recommends that Sean find a support group in which he can vent about his struggles at work, or to maybe make a friend at work that he feels he can eventually tell about this OCD (to manage the tension of maintaining a "normal" tale). Sarah writes up their plan and makes sure to give Sean, his PHP treatment team, and his new outpatient provider a copy of the plan so that Sean can have support to complete his "back to work" plan from multiple sources.

Scenario two. Beverly has struggled with contamination OCD as long as she can remember. At first glance, she has some of the more stereotypical manifestations of OCD; she washes her hands often, makes sure her food has been washed thoroughly, and doesn't like to shake hands with anyone. However, she also has some non-stereotypical manifestations; Beverly tries to avoid sexual intercourse, but when she does choose to engage in it, she compulsively scrubs her body with harsh chemicals like Lysol as a response to an obsession that she has contracted HIV. Because of that fear of HIV, Beverly avoids any possible contact with blood, such as stepping on a Band-Aid or using the waste bin in a public restroom.

Beverly is a professor, and managed to stay employed (and even excelled) throughout graduate school and her first couple years as an assistant professor, even though she was struggling with obsessions and compulsions daily. However, she found herself only leaving her house to go to work and then performing excessive cleaning rituals when she got home, so she decided it was time to seek hospitalization. Beverly has been in residential care for six months and she and her treatment team have decided it is a good time to discharge, so they invite in a communication interventionist (again, let's call her Sarah) to help Beverly develop her plan to go back to work.

Sarah asks Beverly about what she would like to do for work when she leaves the hospital.

"Well, I'd like to go back to the University, where they've been holding my job for me." Beverly replies. "I'm technically on sabbatical right now, and no one at school knows where I've been. But you know what? I want them to know. I want people to know about what I've been through. I've been hiding my OCD for so long, and frankly, I'm tired of it. I've accomplished so much in my life, and I want people to know that I had to fight through so many struggles to get where I am today."

Sarah asks Beverly if she would like to request any accommodations from the university, and Beverly says, "no. I don't think I'll need them. I have a flexible enough job where I can cancel a class if I need to or make my schedule around my therapy appointments." Sarah then asks how Beverly would like others to see her at work.

"You know," Beverly says thoughtfully, "I really do want my colleagues and department chair to know about what I've been through. I mean, most of them are my friends! But I really don't want them to think I'm crazy or something. Some of the people in the department are

gossipy. Some of them know I wash my hands a lot, but they don't know why." Beverly stiffens. "I don't want them to know everything though," she insists. "Like the HIV stuff, that's too personal. But I would like people to know that OCD is a serious thing and not just, like, what they see on TV."

Sarah and Beverly discuss how Beverly might like to explain OCD to her colleagues (using discourses of medical scripts and personal experiences), and Beverly decides that she would like to have a paper pamphlet to hand to her colleagues at work. So the two of them begin to work out exactly how Beverly wants to manage the meaning of OCD. First, she wants people to know that OCD is a serious illness. Second, she wants them to know that OCD doesn't affect intelligence. Finally, she wants them to know that OCD is about more than just hand-washing.

On the pamphlet, Sarah and Beverly decide to use the title, *What is OCD?* and subsequent bullet points that read *A Serious Illness*, *What OCD Affects,* and *More than Monica.* Sarah and Beverly do research together and choose which medical scripts about OCD to include under the *A Serious Illness* bullet point. They decide to use an analogy of diabetes and insulin use to describe the steps needed to maintain OCD recovery. Under the *What OCD Affects* bullet point, Beverly wants to put things generally things that OCD affects (like overall anxiety levels) but also things that specifically relate to her situation (like time spent on rituals). She also wants to emphasize that OCD does not affect intelligence, so they make sure to put that under the bullet point as well. Under the *More than Monica* bullet point, Beverly want to use the popular culture example of Monica Gellar from *Friends*, who has quirky but non-distressing desires for cleanliness, to dispel the trope that OCD is not a big deal. Sarah and Beverly describe an episode of *Friends* in the pamphlet, and use medical scripts to counter the television portrayal.

When it comes to her hospital stay, Beverly want to talk about it in person with her friends at work without the use of a pamphlet. So Sarah and Beverly create a script that Beverly might use when talking to her colleagues:

What did I do with my sabbatical? I spent it in a hospital that treats severe OCD. You may have seen the pamphlet that is circulating about what OCD is. It was really trippy; we did this thing called exposure and response prevention where I had to do all kinds of hard things like put my silverware on the floor before a meal (medical scripts, personal experiences). It's funny, when I first thought about going to a psychiatric treatment center, I had all these ideas of what a "mental patient" was; can you believe some people still use that phrase (redefining a stigmatic discourse)? But I discovered that these so-called "mental patients" are just people who suffer from an illness who are trying to get better (normalizing a psychiatric hospital stay). I feel so much stronger having been through this experience and I really want to share more with you when we have the chance (framing the hospital stay as a triumph, not a failure).

Sarah and Beverly run through possible challenges to her discursive resource meanings. For example, a colleague might reply, "wow, you were in the loony bin? And you're admitting that?" For such a challenge, Beverly would need meaning-managing definitions and explanations ready for the discursive resource of "normalcy" when it comes to a psychiatric hospital stay. She could reply, "it's about the same as someone who stays in the hospital for cancer treatment. Would you be making fun of them right now?" Because Beverly will be maintaining a sort of "struggle" tale, discourses of normalcy will be important for managing the tension of this type of narrative. Beverly may additionally want to feature her accomplishments at work by displaying her diplomas and published books prominently to emphasize her competency and capability.

Since they are making a pamphlet and running through challenges, Sarah and Beverly might need a few sessions together before Beverly feels ready to go back to work. Sarah writes up their plan and makes sure to give Beverly, her residential treatment team, and her new outpatient provider a copy of the plan so that Beverly can have support to complete her "back to work" plan from multiple sources. Sarah also prints out multiple pamphlets for Beverly to take back to work with her, making sure they look professional enough for a workplace.

Applied Communication Research

In the literature review, I discussed the spectrum of applied communication as stretching from *observation and recommendation* to *intervention* (Frey & SunWolf, 2009). For this dissertation, my contribution as an applied scholar will remain mainly on the *observation and recommendation* side of the spectrum, as I have observed the process and reports of narrative identity crafting and made recommendations for application based on my findings. However, it is not my intention that this study stay on the *observation and recommendation* side of the spectrum. I used the name "Sarah" as the interventionist on purpose; the next step in this line of research is to implement the aforementioned intervention myself at the intensive treatment level and evaluate the outcomes. As theory drives intervention (Kreps, 2012), the theoretical dive into narrative identity and discursive resources in this project was integral for the design and implementation of an intervention at the practical level. The intervention proposed here fits best in the "communication counseling" category (Frey & SunWolf, 2009), as the interventionist would be doing one-on-one counseling with patients about communication strategies to be used when discussing OCD at work.

That being said, not just any communication scholar would be an appropriate applicationist for this particular intervention. Counseling patients with a mental illness takes an understanding of the illness and its treatment (as illustrated in the methods section as I encountered a patient experiencing obsessions and compulsions during the interview). A counselor of patients should also be trained on boundaries, privacy, and other issues pertaining to the treatment of individuals with mental illness. Therefore, this intervention should be approached with thoughtfulness and care when applied.

This study furthers the agenda of intervention design for the purpose of teaching the targets of the intervention ways of communicating, specifically, communication counseling. The intervention from O'Donnell et al. (2007) is somewhat of a template for this intervention: the authors of that study described teaching parents how to talk about sex with their children and subsequently measuring the result. Like that study, this intervention will be teaching OCD intensive treatment patients how to talk about their identity in the workplace, and measuring outcomes. I envision measuring outcomes by following up with the patients three, six, nine, and twelve months after their hospital discharge for a casual chat about work, in which I would ask them how they have employed the use of the discursive resources we chose for the "menu" and how those interactions went. I would also be measuring basic employment outcomes, like what kind of employment the patient has gained or maintained.

Limitations

Since this study utilized a narrative theoretical framework, the data I collected were all recounted to me via interviews. This data set is rich and dense, but it doesn't involve observing any actual talk and text of organizational interaction. Alvesson et al. (2008) suggested using

three modes of analysis when studying identity: interviews, reading texts, and observation. In this study, I was able to explore identity using interview and reading texts, but not observation.

I was also limited to interviewing patients at one hospital. I had a relationship with the clinical director of St. Mary's, and was therefore able to gain access, but this does lead to only having access to the patients of one hospital system. Also, I was limited to a specific time frame, as the hospital runs several studies at any given time and they only allowed me to conduct interviews for a specific amount of time as not to overwhelm the patients.

This study faces the challenge of a fairly homogeneous sample. All of my participants had access to intensive OCD treatment, which is incredibly expensive. For example, residential treatment at St. Mary's costs just under $1,000 per day. Therefore, all participants either had access to insurance to cover the treatment (which often still comes with a deductible payment) or money to pay for treatment. This has implications for the average socioeconomic status of my participants, which means my participant set as a whole only represents a certain segment of the population with OCD. This choice to only interview those in intensive treatment or formerly in intensive treatment was both intentional and circumstantial, as described in the methods chapter. Even so, it must be acknowledged that further research should be done with a more diverse sample.

Finally, this study is limited by, well, me. Yes, it is part of my methods to be the sole collector and interpreter of data and they are sound modes of exploration with much theoretical history and support. But, it still means that my arguments are limited by what I can see, make sense of, and theorize.

Directions for Future Research

Since this study dove deep into the discursive resources with which individuals engaged during and after intensive OCD treatment, it seems to be a logical next step to investigate the discursive resources used and drawn on by practitioners of these intensive treatment facilities. This study has reaffirmed that people are limited to the repertoire of discursive resource to which they have been exposed, so it is important to learn to which discursive resources patients might be exposed during treatment. This research could be done using several methods, including interviewing intensive treatment practitioners, conducting focus groups among practitioners, and/or conducting an ethnographical observation of interactions between practitioners and patients.

Overall, this dissertation generally takes on an interpretive epistemological perspective. The theoretical foundations and methods built upon in this study are largely uncritical, and subsequently, the findings, theoretical implications, and practical applications are generally uncritical as well. They do not necessarily interrogate intersectional standpoints of social location like most critical studies do. Rather, this study examines only the condition of "having OCD." I chose this approach for a couple reasons: first, this is the first study of its kind to communicatively and qualitatively examine narrative organizational identity with OCD. Because of this, there is only so much one dissertation may accomplish when breaking new ground. Second, I wanted to produce practical applications that could be transferred to the treatment of *most* patients with OCD, despite their race, nationality, gender identity, religion, or sexual orientation. Is this approach potential problematic? Yes. After all, many social movements are the result of backlash against as assumption that all people in a particular group have the same experiences. For example, bell hooks (1984) famously criticized Betty Friedan (1963) for

assuming *all* women experience the "problem that has no name," that is, the problem of women wanting more than just a household to tend and children to raise. hooks claimed instead that this problem "actually referred to the plight of a select group of college-educated, middle- and upper-class, married white women" (p. 270) and framed Freidan's argument as tone-deaf to the struggles of black women who were more concerned with survival rather than curing their boredom. Certainly, I do not want to fall into the category of making recommendations that are ignorant of social location. However, the problems of unemployment, underemployment, and loss of jobs are *massive* in the OCD community and the available solutions are *miniscule*. Therefore, my starting point was interpretive: *what's going on* with people with OCD at work? *Why are so many of them unemployed?*

Communication scholars have indeed taken critical perspectives on disability and organizing: for example, Kurt Lindemann not only examines the organized use of rugby as a rehabilitation activity for individuals with quadriplegia, he interrogates the ways in which ableist norms of masculinity complicate the sport (Lindemann & Cherney, 2008). He investigates the ways in which people with disabilities narrate their bodily control, but also critically and reflexively questions masculinity and its communicative functions (Lindemann, 2010a). Not just describing how people with disabilities talk about sexuality, Lindemann problematizes abled heteronormativity (2010b). With these studies and the like in mind, there are many possibilities for future research from a more critical epistemological perspective. For example, the experiences and opportunities of a straight, white male with OCD are surely different than a gay, Latinx woman with OCD, and their narratives should be interrogated accordingly. Future investigation of OCD and organizing could be focused on social location, standpoint, intersectionality, and privilege to accomplish even more social and organizational change.

Finally, an additional direction for future research in this agenda is positive organizational deviance, that is, what are individuals with severe OCD who consider themselves successful doing right? This type of inquiry would begin with quantitative data collection analyzing OCD severity (using the Y-BOCS) and job and career satisfaction and commitment. Following quantitative data collection, the few individuals at the point of positive deviance, that is, those with the most severe OCD who are the most successful, should be interviewed. Their strategies for success could potentially be folded into the practical intervention. For example, C.J. is one participant in this study whose OCD is clinically severe, yet she considers herself successful in her field. As pilot data for a positive deviance inquiry, I asked her questions about her success strategies during our interview. Her responses included the concept of *grit*, which could easily be incorporated into a career counseling program.

Conclusion

This study explored ways in which organizational identity with obsessive-compulsive disorder is negotiated. The theoretical foundations for this study are rooted in narrative identity, organizational communication, and disability studies. The findings from this study provide insight into how individuals with OCD construct, manage, and negotiate their identities using a specific set of discursive resources in a variety of ways. The theoretical implications of this study address organizational identity, organizational communication, obsessive-compulsive disorder, and disability studies. Finally, the practical application of this study is a potential career counseling program that may be implemented at the intensive treatment level.

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APPENDIX A

INTERVIEW PROTOCOL FOR PATIENTS

1. When were you first aware of what was eventually diagnosed as OCD?
    a. Were you ever diagnosed differently?
2. Who in your life knows you have OCD?
    a. Is there a specific conversation you remember in which you disclosed your OCD that went particularly well?
    b. Particularly poorly?
3. How does having OCD affect your daily life?
    a. Does it inhibit anything you do?
        i. In what ways?
4. What do you think about the ways in which OCD is portrayed in the media?
    a. Are there any portrayals you find particularly accurate or inaccurate?
5. Are you employed?
    a. If not, what are the factors that led you to not working?
        i. Have you worked before?
    b. If yes, tell me about your job.
    c. What do you do at work every day?
    d. What led you to this job?
6. Think back to a job you've had or currently have. Which job are you thinking of?
    a. In this particular job, what impact did OCD have on your every day activities?
        i. What sort of conversation happened as a result of OCD causing difficulties?
    b. Did anyone at your job know you had OCD?
        i. If yes, how did this person react when you told him or her?
        ii. How did this conversation go?
        iii. Did anything change as a result of your disclosure?
    c. Did your direct supervisor know you had OCD?
        i. If yes, how did you tell him or her about it?
        ii. How did that conversation go?
        iii. Did anything change after you revealed your OCD?
    d. Do you receive any special accommodations at work?
        i. If yes, how did you negotiate those?
    e. If you could magically make this job easier, what would you have requested to make it so?
        i. What specifically could have make your job more manageable with OCD?
    (continue this line of questioning with each job the participant has had)
7. What job do you think you would be really good at?
8. If you could have any job in the world, what would it be?
    a. Do you think this job is attainable with OCD?

APPENDIX B

PARTICIPANT CONSENT INFORMATIONAL HANDOUT

Title of research study: Negotiating Organizational Identity with Obsessive-Compulsive Disorder
Investigator: Sarah K. Chorley
Why am I being invited to take part in a research study?
We invite you to take part in a research study because you are an adult who is being treated for obsessive-compulsive disorder.

What should I know about a research study?
- Someone will explain this research study to you.
- Whether or not you take part is up to you.
- You can choose not to take part.
- You can agree to take part and later change your mind.
- Your decision will not be held against you.
- You can ask all the questions you want before you decide.
- This study is being conducted by a researcher at the University of Colorado and has no connection to [St. Mary's Hospital].
- Your responses will remain confidential; you will be identified by a random number.
- Your responses will not in any way jeopardies your relationship with [St. Mary's Hospital] or health care staff.

Who can I talk to?
If you have questions, concerns, or complaints, or think the research has hurt you, talk to the research team at sarah.chorley@colorado.edu.

This research has been reviewed and approved by an Institutional Review Board ("IRB"). You may talk to them at (303) 735-3702 or irbadmin@colorado.edu if:

Your questions, concerns, or complaints are not being answered by the research team.
You cannot reach the research team if:
- You want to talk to someone besides the research team.
- You have questions about your rights as a research subject.
- You want to get information or provide input about this research.

Why is this research being done?
The purpose of this study is to explore the working lives of adults with obsessive-compulsive disorder (OCD). I (Sarah Chorley, Principle Investigator) am researching the experiences of those with OCD at work: succeeding at work, failing at work, struggling at work, negotiating accommodations, revealing his or her disorder, hiding his or her disorder, getting hired, getting fired, etc. The end result of this project will be a career counseling curriculum tailored specifically to adults with severe OCD. This curriculum will be made available to residential facilities who treat OCD and will feature evidence-based means of helping patients choose careers and occupations, helping patients design creative ways to incorporate elements of *Exposure and Response Prevention* therapy into their work routines, and guide patients through the complicated world of accommodation negotiations. The end results will also potentially be a popular press book that helps people with OCD find success in the workplace.

How long will the research last?

We expect that you will be in this research study for an initial interview time of about 30-45 minutes. You may then possibly be asked to answer follow-up questions or participate in a follow-up interview.

How many people will be studied?

We expect about 75 people will be in this research study from [St. Mary's Hospital]. We expect about 150 people in the entire study nationally. This study will be extended to other OCD treatment facilities.

What happens if I say yes, I want to be in this research?

You will be asked to participate in a 30 to 45 minute interview about your experiences with work. You will be asked questions like, "how has OCD affected your working life?" and "what accommodations might have made your past jobs easier?"

What happens if I do not want to be in this research?

You can leave the research at any time and it will not be held against you.

What happens if I say yes, but I change my mind later?

You can leave the research at any time it will not be held against you. If you decide to leave the research, contact Sarah Chorley at sarah.chorley@colorado.edu. If you make this decision, your data will be deleted from the study.

Is there any way being in this study could be bad for me?

It is possible that during the interview, you might experience discomfort while recalling more painful memories associated with OCD. If this happens, let the interviewer know so you can either take a break from the interview or discontinue the interview.

What happens to the information collected for the research?

Only your sex and age will be included in the final study; your name and any other identifying information will be kept confidential.

Efforts will be made to limit the use and disclosure of your personal information. We cannot promise complete secrecy. After the study concludes, interview notes will be destroyed. Until this date, interview notes will be kept in a password-protected computer file.

Signature Block for Capable Adult
  Your signature documents your permission to take part in this research.

_____	_____
Signature of subject	Date
_____	
Printed name of subject	
_____	_____
Signature of person obtaining consent	Date
	9/29/16
_____	
Printed name of person obtaining consent	IRB Approval Date

APPENDIX C

UNIVERSITY OF COLORADO IRB LETTER OF APPROVAL

University of Colorado
Boulder

APPROVAL

29-Sep-2016

Dear Sarah Chorley,
On **29-Sep-2016** the IRB reviewed the following protocol:

Type of Submission:	Initial Application
Review Category:	Exempt - Category 2
Title:	The Obsessive-Compulsive Life at Work: Struggle, Negotiation, and Triumph
Investigator:	Chorley,Sarah
Protocol #:	16-0611
Funding:	None
Documents Approved:	16-0611 Protocol (29Sep16); 16-0611 Consent Form (29Sep16);
Documents Reviewed:	Consent Form; Protocol; HRP-211: FORM - Initial Application v7;

The IRB approved the protocol on **29-Sep-2016**.

Click the link to find the approved documents for this protocol: Approved Documents. Use copies of these documents to conduct your research.

In conducting this protocol you must follow the requirements listed in the INVESTIGATOR MANUAL (HRP-103).

Sincerely,
Douglas Grafel
IRB Admin Review Coordinator
Institutional Review Board