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Handwashing and beyond: An autoethnographic account of Obsessive-Compulsive Disorder and stigma management

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Handwashing and Beyond: An Autoethnographic Account of Obsessive-Compulsive Disorder
and Stigma Management

by

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Thesis

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Abstract

Obsessive-Compulsive Disorder (OCD) is a stigmatized condition that affects the communicative process. Using Meisenbach's theory of stigma management communication (SMC), this project demonstrates coping strategies for stigma related to OCD. Research is self-reported in autoethnographic form, where narratives are analyzed in Rambo's layered account format. There are two results of note: SMC is a suitable framework for understanding OCD stigma, and SMC's accepting strategies are more effective at managing OCD stigma when the behavior being stigmatized is readily associated with OCD. Furthermore, this thesis suggests autoethnography is an effective medium for showcasing OCD stigma, and also suggests more research on OCD stigma is needed from a communicative perspective.

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Introduction

It had been three hours since I entered the first-floor bathroom of my university's education building. Three hours I spent sanitizing what seemed like every conceivable crevice. Three hours, evading the side-eyed glances of fellow students wandering in and out. I relentlessly scrubbed with soap, water, and paper towels, taking a passing interest in how red my hands were getting. Gradually, the focus of my rituals shifted to the surrounding area. First, it was the sink I had been using, then the other sinks, then the urinals, and then the stalls. Like a plague I spread throughout that bathroom, eradicating whatever non-existent threat I could find. Of course, no *one* cleaning was good enough, so I repeated my actions several times over.

What allowed me to eventually leave that bathroom? I wish I could attribute my escape to a sudden, dramatic discovery of willpower. I wish I could say my mind was brought triumphantly to submission and my illness vanquished. I wish I could say something other than the truth: I was just too tired to continue.

* * *

As a young adult, I was diagnosed with obsessive-compulsive disorder (OCD), a mental illness characterized by intrusive, recurrent, and unwanted thoughts (obsessions) accompanied by repetitive behaviors which an individual feels driven to perform (compulsions; American Psychiatric Association, 2013; Gyula & Anderson, 2014). The diagnosis was relieving, as I finally had a framework to better understand the disorder that plagued me in relative secrecy for most of my life. Accompanying this relief, however, was an uneasy thought: "How open should I be about my diagnosis?" OCD was not something I wanted to conceal, but I was entirely too familiar with how unsympathetically the world viewed it; what should be done? The answer

came to me several years later while studying *autoethnography*, "...an approach to research and writing that seeks to describe and systematically analyze (graphy) personal experience (auto) in order to understand cultural experience (ethno)" (Ellis et al., 2011, p. 273). OCD is part of my identity, and I elect to share my experiences with it through autoethnography.

The purpose of this autoethnography is to demonstrate coping strategies for stigma relating to OCD, a condition which deserves attention from communication scholars as it inhibits the communicative processes of those afflicted. This not only makes OCD a relevant point of inquiry but, from a critical standpoint, an ethical one, considering the value OCD research would yield (Wood, 2008). The following chapter delves into communicative literature on OCD.

Literature Review

The following review of literature will explore OCD in four foci: rituals, social consequences, environmental influence, and examples of stigmatization.

Rituals

Compulsions can be considered *rituals* that fall into certain categories, such as *cleaning*, *symmetry*, and *hoarding* (American Psychiatrist Association, 2013). With cleaning rituals, the OCD-afflicted try to keep themselves or their surroundings *clean* while avoiding *dirty* items.

The following is an example of an OCD-afflicted child's cleaning ritual:

Any cup she drank from has to stay exactly where she put it down; she can't touch it again and if she's thirsty she needs a new one. By the end of the day, they're all over the house. The same with towels. Any towel she touched has to go straight in the laundry. Every towel in the house has to be washed every single day. Every time I come home there are two loads waiting, just of towels. (Lebowitz et al., 2011, p. 366)

As for symmetry rituals, the afflicted establish an ideal and are protective of it (e.g., folding a bed in an exact pattern). Additionally, hoarding rituals involve possessing items with no clear rationale (e.g., keeping trash in one's bedroom and refusing to throw it away). Other common rituals are derived from obsessions regarding taboo thoughts and fears of harming oneself or others (American Psychiatrist Association, 2013).

Regardless of type, rituals and their related obsessions have an obvious effect on the thoughts and actions of the OCD-afflicted, as the following section will explore.

Social Consequences

OCD is shown to adversely affect the social behavior of its afflicted (De Caluwé et al., 2014; American Psychiatrist Association, 2013; Abbey et al., 2007), and can impair one's

functionality in several ways. To start, simply the act of obsessing and performing rituals is an investment of time, one that can detract from interactions with others. The avoidance of OCD triggers is another impairment, as it requires the afflicted to remove themselves from social situations. Additionally, symptoms can impair the afflicted in specific ways. According to the American Psychiatric Association (2013), "...obsessions about harm can make relationships with family and friends feel hazardous; the result can be avoidance of these relationships. Obsessions about symmetry can derail the timely completion of school or work projects because the project never feels 'just right,' potentially resulting in school failure or job loss" (p. 240).

When OCD manifests during childhood or adolescence, developmental hardships may occur. Such hardships include poor socialization among peers and a lack of independence from one's family. The afflicted also may try imposing rules upon family members in compliance with their rituals. For example, Lebowitz et al. (2011) interviewed parents of OCD-afflicted children who enacted their rituals with aggressive behavior. In these cases, the children could only complete their rituals if immediate family members contributed. Failure to meet a child's ritual could result in violent outbursts and boundary crossing, as was the case of a participant whose child would regularly call them at work demanding assistance in rituals.

OCD affects the behavior of its afflicted, but are there external factors that affect one's experience with OCD? The next section explores just that.

Environmental Influence

Harwood's (2006) perspective on social identity suggests human interactions are shaped by community norms, an assertion of relevance to how OCD manifests. While OCD occurs globally, with the afflicted exhibiting similar symptom typologies, cultural factors may influence how obsessions and rituals are performed (American Psychiatric Association, 2013).

This notion is supported by Pirurinsky et al. (2009) in their examination of OCD within an orthodoxly Jewish community. The study found compulsions “generally [focus] on adherence to Judaism’s detailed religious laws such as dietary restrictions (e.g., not mixing milk and meat), praying and studying correctly, and family purity” (p. 950).

Davis and Kaptein (2006) provide another example of culturally specific rituals in their analysis of anorexia nervosa (AN) with excessive exercise. The authors propose exercise routines may take on obsessive properties when the goal is accommodating cultural standards of beauty. The study further states that, while OCD and AN have a comorbid relationship, the ritualistic nature of these exercise routines may qualify the type of AN observed as an OCD variant.

OCD both influences and is influenced by the environment. The next section explores this relationship further, namely how OCD is stigmatized.

Examples of Stigmatization

When considering socializing agents for OCD, mass media is a point of interest. Through their study of OCD in media, Fennell and Boyd (2014) ascertained the great influence television programs have on stigmatizing OCD. Programs often portrayed the OCD-afflicted as sources of comic relief, the most notable example being *Monk*. The show’s titular character stars as an OCD-afflicted private investigator whose condition is mostly played for laughs. While one of the study’s OCD-afflicted participants lauded *Monk* as a positive depiction of OCD stereotypes, another was more critical:

OCD is a nightmare that cannot be imagined by those who do not have it. It’s usually made light of in the media and frequently misunderstood by clinicians and misdiagnosed

and undertreated or mistreated by physicians. ... I hear professionals joke about OCD all the time...(p. 681).

Coles and Weiss (2013) offer support for the above passage through their study of public knowledge regarding OCD. In a telephone survey of 577 U.S. residents, researchers recited a vignette describing the symptoms of one afflicted with OCD. Results showed “the majority of participants (90.9%) reported that the symptoms were a cause for concern and that the person in the vignette should seek professional help (89.5%). However, only one-third of respondents correctly labeled the disorder as OCD” (p. 781). Additionally, Kimmerle and Cress (2013) conducted two studies on “whether the portrayal of mental disorders on television and in films has an effect on people’s knowledge about and attitudes toward the mentally ill” (p. 931). Their first study found those who watched more television demonstrated less knowledge about OCD, and those with less knowledge assumed OCD-afflicted individuals were more violent than the non-afflicted.

OCD is a disorder which comes in several different-yet-common typologies, adversely affects those it afflicts, and is culturally influenced. Additionally, OCD has been stigmatized as a negligible condition. The following chapter will outline this autoethnography’s theoretical framework.

Theoretical Framework

The framework of this autoethnography is Meisenbach's (2010) theory of stigma management communication (SMC), which describes communication strategies used by individuals affected by stigma. SMC is reliant on three axioms: "Stigmas are discursively constructed based on perceptions of both non-stigmatized and stigmatized individuals; stigmas shift and are shifted by discourses and material conditions, and; stigmas vary by degree in breadth and depth" (pp. 271-272). SMC also proposes that "individuals will make SMC strategy choices based on their attitude toward the stigma's public applicability to them and on their attitude toward challenging or maintaining others' perceptions of the stigma" (p. 277). There are several strategy categories SMC offers, but only one will be examined in this autoethnography: *accepting strategies*.

Accepting Strategies

Accepting strategies are employed by individuals who "accept a societal stigma perception and its applicability to themselves, incorporating it into their sense of self" (Meisenbach, 2010, p. 280). There are seven accepting strategies SMC proposes: *passive acceptance, display/disclose stigma, apologize, use humor to ease comfort, blame stigma for negative outcomes, isolate self, and bonding with stigmatized others*.

With passive acceptance, individuals who are confronted with stigma make no attempt to address it. Meisenbach (2010) considers this option flawed, suggesting it can be employed unintentionally. For example, imagine two individuals having a conversation. The first individual makes an inflammatory remark about those with a certain mental illness, an illness the second individual has. Rather than confront the former, the latter ignores the remark and

continues the conversation. This lack of response defaults to passive acceptance, regardless the latter's intent.

As for the displaying of stigma, an individual openly discloses their stigmatized condition to match how the public views it. For example, an individual afflicted with a stigmatized mental illness may publicly enact their symptoms. This option shows a stigmatized individual is at ease with the stigma. Meisenbach (2010) also suggests that "by displaying ease with their stigma, the stigmatized may ultimately help publics move toward seeing the attribute as non-stigmatized" (p. 279).

When individuals apologize for their stigmatized condition, they do so as a means of earning forgiveness for enacting a stigmatized condition. This strategy is exemplified by an afflicted individual apologizing for enacting symptoms of their illness around others.

With the use of humor, an individual is signaling their acceptance of the stigma they embody. For example, an individual afflicted with a mental illness may joke about the symptoms they are enacting. This strategy affirms the existence of stigma so others don't have to, granting the afflicted a sense of comfort.

When an individual blames stigma, they attribute negative experiences endured as the result of being stigmatized. For instance, a stigmatized individual may blame their stigma for not getting a job. Individuals employing this strategy often do so to protect their self-esteem, as they attribute negative outcomes to "something out of their control" (p. 280).

With isolation, individuals deal with stigma by restricting interpersonal communication. This strategy sees individuals internalizing their stigma, possibly out of shame or unwillingness to defend their stigma. Isolation may cause individuals to employ another coping strategy: bonding with others who are similarly stigmatized.

The next chapter will detail this autoethnography's methodology.

Method

Ellis et al. (2011) consider autoethnography a fusion of autobiography and ethnography; autobiographers often describe life-altering personal experiences (epiphanies), while ethnographers, as participants, “study a culture's relational practices, common values and beliefs, and shared experiences for the purpose of helping insiders (cultural members) and outsiders (cultural strangers) better understand the culture” (p. 275). When conducting autoethnography, researchers “retrospectively and selectively write about epiphanies that stem from, or are made possible by, being part of a culture and/or by possessing a particular cultural identity” (p. 276), expressing epiphanies as narratives that follow storytelling conventions and techniques. Autoethnographers follow their own standards of reliability, generalizability, and validity: Reliability refers to narrator credibility, generalizability is a narrative’s resonance to the reader, and validity pursues verisimilitude.

This autoethnography adopted Rambo’s (1997) layered account approach, “a postmodern ethnographic reporting format that enables the researcher in question to draw on as many resources as possible in the writing process, including social theory and lived experience” (p. 419). In a layered account, narratives are interwoven to form grander, more complex narratives. This process is called *layering*, where each narrative is seen as one of multiple layers. In a layer, the narrator assumes a role within a certain space and time. This layer is then succeeded by another layer, adding to the overarching story being told. It is important to note narrator roles do not need to be continuous. For example, in a layered account of someone experiencing stigma, one layer can portray the harassment of the narrator for embodying stigma, while the following layer can show them overcoming a different instance of harassment. While both are separate cases of harassment, together they amount to a larger story about encountering stigma.

This autoethnography was analytical in form, maintaining “(1) complete member researcher status, (2) analytic reflexivity, (3) narrative visibility of the researcher’s self, (4) dialogue with informants beyond the self and (5) commitment to theoretical analysis” (Doloriert & Sambrook, 2012, p. 84). In adherence to the layered account format, analyses were presented as layers throughout the autoethnography, with each analytical layer examining the narrative layer that came before. This analysis determined which SMC strategies were used in each narrative.

The following chapter showcases my personal accounts of coping with OCD stigma.

Narratives

For two years I served fast food at one of my university's food courts. I can fondly say my tenure there was mostly positive. My coworkers were friendly, the customers were easygoing, and I had a sense of accomplishment in the work I did. So, it is with sadness I recall an experience in which my time at the food court darkened, an experience which saw OCD present itself.

My shift started routinely enough. I punched in, said "hi" to my coworkers, and settled into the Chicken Shop. After serving a round of customers, I went to the nearby sink and began washing my hands. Handwashing was a procedure that typically took me 15 seconds to complete. This time, however, was different. Fifteen seconds came and went, so did a minute, then two minutes. No matter what I did, I couldn't wash my hands *correctly*. It wasn't just about making them clean: I had to wash a certain way, starting over after every failure.

A half-hour went by, and I was on my fourth or fifth session at the sink. It was then I realized my coworkers were aware of my behavior, the first of whom being Mark. Mark would regularly pass through my shop on his way to the stock room, during which he and I would typically exchange friendly banter. Hovering over the sink, I noticed Mark walk behind me. As he disappeared from view, it occurred to me the frequency in which Mark made his rounds had increased. I also realized he had not said a word to me the entire shift.

A short while after Mark's last pass, I was approached by Sandy, who worked in Mark's shop. "Nick, are you okay?" she asked, her face showing concern. "Yeah, just washing the ol' hands," I replied with the most playful-yet-dismissive tone I could muster. Sandy's expression did not change: "Seriously Nick, what's wrong?" I explained that I had OCD, that it had gotten worse, and that excessive handwashing was a product of it. Sandy seemed understanding, albeit

still concerned. “Alright, just know we’re here for you,” she said reassuringly before walking away.

Eventually, my manager Daryl approached. “Nick, can we talk for a minute?” he said with a tone that betrayed his typically jovial demeanor. “Yeah, sure,” I replied defeatedly, like my hands had finally been caught in the cookie jar. I pulled myself away from the sink to give Daryl my undivided attention. Our conversation began with Daryl expressing concern over my newfound washing behavior, with it quickly evolving into conjecture over why my behavior existed in the first place. “You know, we learned in my psychology classes that OCD is one’s response to lacking control in their life,” Daryl said confidently. I nodded in compliance as he carried on. After several minutes of postulation and emotional support, Daryl left to resume his supervisory duties. Standing in contemplation, my mind was fixated on Daryl’s statements: “Are my OCD symptoms simply a means of controlling *something* in my life? Do I really feel so helpless?” The thought both fascinated and terrified me.

* * *

There were three SMC strategies used in this experience: *use humor to ease comfort*, *display/disclose stigma*, and *passive acceptance*.

I used humor to address my handwashing behavior while interacting with Sandy. This was done through a comment about “washing the ol’ hands,” an initial response to Sandy noticing my behavior. I could instantly tell Sandy was worried about me upon her approach, and I figured the quickest way to alleviate her concern was by making my handwashing the subject of a joke. The joke was to signal my acceptance of the handwashing. Of course, Sandy’s was not the only unease I was trying to lessen. To say I felt awkward about Sandy’s approach is an

understatement: diffusing stigma is seldom fun. In assuaging her tension, I hoped to relieve my own.

Stigma was displayed in two ways. First, I openly enacted OCD symptoms through excessive handwashing. This strategy ultimately served to fulfill a ritual. While ritual fulfillment by itself is not a form of stigma management, it *is* a motive for displaying stigma. The decision to disclose stigma based on such a motive, even in the case of OCD, is a conscious one. In my case, I was comfortable enough with the environment to display stigma openly. My second way of displaying stigma occurred when confronted by Sandy, wherein I explained to her my OCD status. This strategy was used when my first attempt at managing stigma in the conversation, using humor, failed. My intent was not only to inform Sandy of my condition, but to elicit in her the comfort I had hoped my joke would have.

Finally, I employed passive acceptance during my conversation with Daryl. This strategy was employed when Daryl presented his views of OCD. To be certain, Daryl meant no harm by sharing his thoughts, and I appreciated the gesture. However, I was unsure whether I agreed with Daryl's statement, and even thought of rebuking it. Instead, I allowed Daryl to espouse his views on the stigma I embodied without *my* thoughts on the matter. My reason for passively accepting Daryl's comments: politeness. I decided to let Daryl say his remarks, rather than potentially cause a dispute.

* * *

My friend Steve and I have been writing and performing music together for years. Every now and then, the two of us get together and attempt to record our music. The recording process

is hard work but ultimately satisfying. I recall one session, however, made unsatisfying by my struggle with OCD.

Steve and I descended the steps to my basement. It had been a while since we last recorded, and both of us were eagerly anticipating the session to come. “Ready to record some tracks today?” I asked. “You know it,” Steve replied enthusiastically, “I have some layering ideas that might bring out the vocals.” “Hey, I’m open to whatever,” I said as we approached the recording space.

The two of us took our usual seats, mine in front of the PC and his adjacent to mine. My focus turned to operating the computer and mixer, and within minutes I had the recording program pulled up. We were almost ready to go; all that remained was to select the song file. My hand froze after positioning the cursor over the file name. I wanted to press the mouse button, but my mind demanded that first a ritual be performed. I thought to myself, “It’s okay, you know this is all in your head. You don’t need to perform *anything*.” I fully knew the attempt at reassurance would itself *become* the ritual I was afraid of, and sure enough the need to rethink it immediately emerged. The temptation to force an end to my ritual was there, but I knew not to entertain it. If I didn’t rethink my thoughts in a certain way, something terrible was going to happen. What should have been the simplest of actions had hideously transformed into an insurmountable task.

My eyes had been fixated on the monitor for easily 10 seconds when I began to vocalize the ritual in my head. “It’s okay Nick, you know what’s up,” I muttered, trying to resolve the ritual. It occurred to me, shortly after the muttering began, that Steve was still right beside me. As if smashing the emergency brake of a truck, I stopped the ritual long enough to turn my head toward Steve; he was aghast. A rush of embarrassment and grief overtook me as I realized Steve

had likely observed the entirety of my ritual. “Hey, sorry about that,” I said without much thought, like a knee-jerk reaction from a body trying to subdue pain. My eyes surveyed Steve’s face during the second or two of silence that had enveloped the room, hoping to find some indication a forgiving response was coming. “Yeah, it’s okay,” Steve replied nervously, the look of shock still on his face. Silence once again surrounded us. I expected a question regarding my behavior to come, but Steve just stared, as if anticipating what I was going to do next. He turned his gaze away after a few seconds. My eyes, however, remained on Steve, his face harboring the same horrified look. Realizing the silence had become a space between us, I turned back to face my computer. I tried convincing myself his lack of inquiry was a testament to our long-standing friendship, that it wasn’t out of fear.

* * *

There were two strategies used in this experience: *Display/disclose stigma* and *apologize*.

I displayed stigma by once again enacting my OCD symptoms in the presence of others. Unlike in the previous narrative, the enacted ritual existed as a string of thoughts, something far less tangible than handwashing. While not as perceptible, the ritual was still noticed by Steve due to my trance-like state. My stigmatized behavior became ever more obvious when I began muttering to myself, as Steve was then able to witness the ritualistic language I was using. The decision to display stigma once again stemmed from my need to fulfill a ritual. As previously mentioned, ritual fulfillment is a motive for disclosing stigma, but the choice to disclose is up to the stigmatized. My experience with Steve was no different. Due to my long-standing friendship with Steve, I had a greater sense of comfort in disclosing my behavior.

I apologized for enacting stigmatized behavior by issuing a verbal apology to Steve. The apology itself was very brief and failed to explicitly address what I was apologizing for. Regardless, it prompted the desired, if not equally brief, affirmative response. I attribute this outcome to the contextual awareness of Steve and myself; both of us implicitly knew what the apology was for and why it was accepted. There are two reasons I chose to apologize. First, I sought to ease the immediate embarrassment felt from Steve noticing my behavior. Though I was comfortable enough disclosing a ritual in front of Steve, I was still generally uncomfortable performing stigmatized behavior in the presence of another. Second, I wanted to resolve the guilt I felt from subjecting Steve to my behavior. From observing his nonverbal cues, I had very obviously made Steve uncomfortable, and I figured an apology was due.

* * *

Around the time of my OCD diagnosis, I underwent a brief period of displacement. I drifted from one couch to another during this stretch, usually staying for a day or two before moving on. Among these temporary sanctuaries was a student housing co-operative (co-op) my friend Ashley belonged to. The members of this co-op welcomed me for a weekend, providing a safe environment in which I could gather my bearings. Unfortunately, my struggle with OCD was near its peak, and I tried not to hinder my hosts with that knowledge. One night saw this endeavor become especially challenging.

I had been standing beneath the cascading water for untold minutes. Leaning against the wall was required at this point, the passage of time continuing to do a number on my legs. The steam, which had been enveloping me slowly, was now a dense fog. Perhaps it was due to the reduced visibility, but it began to feel as if the walls of this standing shower were closing in.

Were they ready to relieve the suffering animal within their confines? I wouldn't have blamed them. With the rashes developing on various parts of my body, it looked as if I needed some sort of reprieve. "When will this be over?" I thought to myself. I had washed my body several times by now, yet the all-familiar nagging of an incomplete ritual persisted. I knew it was never going to be enough. However, fatigue was setting in, and I needed to stop. As if breaking free from a spider's web, I reached out toward the faucet to turn off the scalding water. I could feel my mind contort as the faucet twisted under my hand. I may have been stopping the water, but I knew the agony of an unfinished ritual would persist that night.

Steam poured out from behind me as I exited the shower, like it too was trying to escape. I grabbed a towel, dried off, and walked to my duffle bag to find a new outfit. Sifting through the bag, I came upon my phone. Curious as to how much time had gone by while in the shower, I took my phone out of sleep mode to view its clock. My shower had lasted for an hour-and-a-half, a discovery which failed to shock me; this was not my first shower of that length. I placed the phone back in my bag, threw on a clean outfit, and walked to the sink to brush my teeth.

What I saw in the mirror was a regrettably familiar site: My face covered in red blotches. Showers were becoming more infrequent due to their increased length and effort, and this had an adverse effect on my skin. "Shit, what am I going to do?" I thought. I could not let the residents see me like this. What would they think? No doubt I would need to explain the blotches, and that could turn into a sprawling conversation about me having OCD. My best course of action was to minimize contact with the residents, but even that would not be enough. Obfuscation was in order. I returned to the duffle bag, hoping I would find something to cover my appearance. The search turned up a hoodie that, while not a perfect veil, would offer some concealment. I put the hoodie on, pulled the hood over my head, and exited the bathroom.

As I made my way down the empty hallway, it occurred to me dinner had likely been served. This would mean traversing three flights of stairs to get to the dining hall, increasing the odds of running into someone. Still, there was no other way. I reached the stairs and descended the first flight, then the second, then the third. No one was in sight. My uninterrupted journey came to an end upon reaching the dining hall door. “Yes, nobody saw me!” I thought with relief. However, my elation dissipated after entering the dining hall. Gazing down the sprawling dinner table, I made eye contact with a handful of residents. A couple of them nodded in my direction, and I reciprocated. I did not know what to do. The thought of leaving the room crossed my mind. Instead, I walked to the kitchen where food awaited. I made a plate and turned toward the dinner table. “Should I sit with them?” I deliberated. No, I could not risk showing the residents my face up close. I brushed past them as I headed to the unoccupied side of the table. Taking my seat, I could practically feel the residents’ penetrating stares. They weren’t wrong to gaze upon me, the hooded stranger in their house. It would have been nice to sit among them and socialize. However, my disorder made sure there was no opportunity for that.

* * *

The strategy I employed in this narrative is *isolate self*. There are three ways in which I applied this strategy. First, I covered my face. This was to keep my facial marks from being easily seen. Though a good idea at the time, this was actually the riskiest measure to ensure concealment. I was a stranger to many of the co-op’s residents, so wandering their home in what was essentially a disguise could have easily earned unwanted attention. Second, I was mindful of my surroundings when approaching the dining hall. This was to ensure my preparedness if I

encountered a resident. If an encounter had taken place, my response would likely have been limited in both verbal and nonverbal gestures. Third, I isolated myself by proximity. When I eventually encountered residents, my gut reaction was to put distance between themselves and I. Leaving the dining hall entirely, however, would have drawn attention, and I did not want to deprive myself of food. So my compromise was to be present at the table but separated from the residents.

There are three reasons I chose to isolate myself. First, I was embarrassed. I would like to think experience has shown I am relatively comfortable accepting my stigmatized behavior. In this experience, however, I am particularly embarrassed, ashamed even, due to the blotches on my face. In most experiences, I have some level of control over my behavior. This time, I am literally adorned by stigma in the presence of strangers. Second, I did not want to be a burden to the residents. These were people who graciously provided me shelter, and I did not want them to worry over my mental health. Additionally, I did not want them to *fear* me. It is not every day you put someone in your care who performs stigmatized behavior, so it stands to reason some would feel uncomfortable with my presence. Finally, I did not want to explain the stigma surrounding my behavior. As aforementioned, I am relatively accepting of my behavior, and have displayed it multiple times. However, that does not mean I am always willing to converse over it, and in this experience, I was not.

* * *

I moved into my third co-op in 2014. As with any co-op, labor in the house was divided evenly amongst its members, which meant myself and my housemates were assigned a weekly

chore. My task was to help clean our industrial-grade kitchen. After roughly a month of kitchen work, OCD made itself known in an interesting way.

I was alone in the kitchen when Lindsay entered. As the co-op's kitchen manager, Lindsay oversaw our kitchen's general operations, so I assumed she came to monitor my shift's progress. "Hello, Nick," she said with a tone somewhere between friendly and professional. I returned her greeting with a "hello" of my own, then asked how her day was going. Lindsay replied, "Pretty well. Actually, I was hoping to talk to you about something." Worry engulfed me. Had I done something wrong? "Sure!" I replied, trying to stifle the tension I felt. "I need a new kitchen assistant," Lindsay said, "Are you interested in the position?" My distress gave way to relief, and that relief in turn gave way to surprise. I had only been working in the kitchen for a few weeks, so the thought of being appointed to a leadership position was intimidating. "Can I think about it?" I asked. "Sure," Lindsay replied. As she turned to leave, I decided to voice my astonishment: "Just out of curiosity, why was I chosen?" Lindsay turned back to face me: "We need someone to fill the position soon, and I know how thorough you are when cleaning."

How thorough you are when cleaning. I felt this intended compliment evoke feelings within me that were hard to describe. Was it shame I felt, knowing that my *thorough cleaning* was a byproduct of something I detested? Was it guilt, that I fooled Lindsay into thinking my mental illness was instead a strong work ethic? Perhaps it was pride, that I needed to stand up to some imaginary adversary? The pressure these feelings generated could be felt throughout my body, and it demanded release. "Well, I have OCD, so that kind of explains why I'm so clean," was my reply. I had tried my best to project a humorous tone, hoping that would soften the revelation. Lindsay's face suggested she didn't quite know what to make of my statement. Nevertheless, she gave an acknowledging smile and once again turned to leave. Alone in the

kitchen, I felt the pressure exit my body, only to have it replaced by another feeling:
Accomplishment.

* * *

I used the *display/disclose* and *use humor to ease comfort* strategies for this experience. While I have displayed stigma in prior narratives, my use of disclosure here differs in one fundamental way: My previous displays were the results of rituals being performed, whereas this narrative saw me disclose without enacting a ritual. There were three reasons why I decided to disclose stigma, all of which stemming from Lindsay's praise. First, I felt uncomfortable with my OCD symptoms being valued as a positive quality. I knew it was not Lindsay's intention to cause offense, especially since she had yet to know of my OCD status at the time of her praise. However, I still felt it necessary to correct her view of my behavior, as it misrepresented my illness. Second, I felt guilt over my symptoms being valued positively. To feel guilt in this way was, admittedly, a bizarre feeling, as if I was betraying Lindsay's trust. I was counted on to do a job despite faulty qualifications, so disclosing my condition was almost like an apology: I needed to earn forgiveness. Finally, I found it necessary to challenge stigma through disclosure. I mention standing up to some "imaginary adversary" in this narrative, who is simply a personification of OCD stigma. I very well could have just let Lindsay's compliment stand. However, doing so would have been accepting the control my disorder had over me. By admitting my condition to Lindsay, I projected a sense of acceptance over it, that I was at ease with the disorder.

My use of humor in this narrative was unique in function and, to an extent, purpose. Functionally speaking, this experience saw me use humor in conjunction with another strategy

(disclosure), rather than by itself. There are two reasons why I chose to couple the strategies. First, I sought to ease the *disclosure* of stigma. I figured revealing my OCD status in response to Lindsay's compliment would elicit discomfort, so I combined my disclosure with verbal cues that suggested humor. Meisenbach (2010) describes the *humor to ease comfort* strategy as a way to relieve the stigmatized. This experience instead sees me using humor to comfort another. My second reason for combining strategies falls more in line with Meisenbach's (2010) standard for humor. As I have stated, disclosing stigma is a challenge regardless the situation. Since my relationship with Lindsay did not go beyond supervisor/subordinate, I was not comfortable displaying anything personal, let alone stigmatized behavior. Presenting my disclosure as a joke, however, allowed me to further convey the message of acceptance I was going for.

Discussion

Five out of the seven SMC accepting strategies were used in this study: *display/disclose stigma, use humor to ease comfort, apologize, passive acceptance, and isolate self*.

Displaying/disclosing was present in two narratives, the first of which saw disclosure used to ease comfort when attempting humor failed. As for the second narrative, disclosure occurred to correct a misinterpretation of OCD symptoms and to challenge stigma. Humor was used in two narratives to relieve tension in both myself and others as I performed stigmatized behavior.

Apologizing took place in one narrative, where I hoped to address both the embarrassment of performing stigmatized behavior and guilt of making someone uncomfortable as a witness to stigmatized behavior. Passive acceptance was also used in one narrative, serving as a conflict-avoidance mechanism. Finally, I isolated myself in one narrative to cope with the embarrassment of enacting stigmatized behavior, prevent my stigma from burdening others, and avoid a scenario in which I would have to explain my stigma.

There are two theoretical implications to consider. First, SMC is a suitable framework for understanding OCD stigma, as the stigmas presented in this study adhere to SMC's conceptualization of stigmas: "(a) stigmas are discursively constructed and managed via both non-stigmatized and stigmatized individuals' perceptions, (b) stigmas shift and are shifted by discourses and material conditions, and (c) stigmas vary by degree" (Meisenbach, 2010, p. 285). As evidenced earlier in this study, OCD stigma is created through communication, from face-to-face interactions to mass-media broadcasting. It is through such channels that OCD stigma is also maintained, with shows like *Monk* reinforcing OCD stereotypes, in the process creating protocols for how to treat the OCD-afflicted. The non-stigmatized, however, are not the only actors in this cycle. When exposed to OCD stigma, the stigmatized are informed of how their

behavior should be perceived and may act accordingly. For instance, my avoidance of co-op residents partially stemmed from not wanting to confront stigma. Now, OCD stigma has been presented mostly as a social construct up to this point, but it is also influenced (or shifted) by *materiality*, “physical conditions of the body and the world (e.g., lameness, HIV positive status, or contact with dirt)” (Meisenbach, 2010, p. 271). My interaction with Lindsay best exemplifies the joint effect constructionism and materiality have on OCD stigma. While excessive cleaning is a permanent fixture of my OCD experiences, Lindsay’s appraisal of the cleaning I performed shifted the accompanying stigma, reframing it as something positive. The nature of OCD stigma grows more complex when considering stigmas vary in degree of breadth and depth.

Meisenbach (2010) refers to breadth as the amount of behavior being stigmatized, while depth denotes stigma strength and affiliation with a particular behavior. My narratives portray stigmas with varying degrees of breadth and depth. For example, stigma portrayed at the food court was broader and deeper than the kind present during my encounter with Steve, since the former scenario depicted behavior more readily associated with OCD (i.e., handwashing vs. mental rituals). In addition to adhering to SMC’s conceptualization of stigma, I also chose my stigma management strategies in a fashion detailed by SMC: “Individuals will make SMC strategy choices based on their attitude toward the stigma’s public applicability to them and on their attitude toward challenging or maintaining others’ perceptions of the stigma” (Meisenbach, 2010, p. 277). I was able to relate SMC strategies to moments in which I coped with OCD stigma. Second, SMC’s accepting strategies are more effective at managing OCD stigma when the behavior being stigmatized is readily associated with OCD. Though this inference may seem apparent, a distinction must be made for two reasons. First, OCD stigma is varied. While OCD carries common symptom types, the specificity of ritual content differs among individuals

(American Psychiatrist Association, 2013). This can increase the difficulty of identifying OCD behavior, potentially impeding the efficacy of accepting strategies. An example can be seen in my apology to Steve. Although I could tell my behavior was ritualistic, Steve was obviously unaware. To him, my behavior was likely unidentifiable, or at least emblematic of something other than OCD. Because of this ambiguity, my apology was not received in a way conducive to managing stigma. If my interaction with Steve is indicative of unidentifiable behavior, the opposite is demonstrated with Sandy. When I was approached by Sandy in the food court, I was performing behavior that was easily associated with OCD: handwashing. Because of this strong association, I was able to employ stigma management strategies with ease.

Communication scholars can gain from this research in two ways, the first of which involving the utilization of autoethnographic narratives. Narratives are effective at showcasing OCD stigma, as they allow the afflicted to self-report in a way that facilitates reader empathy. By utilizing storytelling conventions and adhering to unique standards of reliability, generalizability, and validity, narrators have freedom in their expression of OCD stigma. The layered account format, in particular, allows narrators to present stigmatizing behavior in a comprehensive way: Narratives are woven together to form a grand narrative that may be easier for the reader to identify with. Scholars can also gain by studying OCD from a communicative perspective. The vast majority of this research body was assembled using material from other disciplines, namely psychology. This is understandable, given that OCD is a mental illness (which is not to say the study of mental illnesses should be reserved for other disciplines). However, as demonstrated in this project's narratives, OCD inhibits the communicative process in potentially dramatic ways. OCD stigma can be a particular focus of inquiry, as it pushes the understanding of stigma management considering its variation of stigmatized behaviors.

I have learned a couple things from writing this autoethnography. For one, I learned how difficult, yet rewarding, the autoethnographic process can be. The process requires one to dig deep, possibly unearthing experiences that would otherwise stay buried (such was my case). When I first began my narratives, I figured the writing process would be relatively easy. I had accepted OCD stigma as a part of myself, and therefore assumed divulging my experiences with said stigma would be painless. It was not long before realizing I was mistaken. My battles with OCD were indeed difficult to share, so much so that I found myself unable to express them in full detail. It took me by surprise, this trepidation. However, near the end of the process I came to a reaffirmation of this project's agenda: Others may benefit through personal revelation. In dissecting my own struggles, perhaps I could teach someone how to deal with theirs? This autoethnography also taught me the impact SMC can have on those who are stigmatized. I had no explicit strategy for dealing with OCD stigma at the start of this process, just an inherent acceptance of the stigma I embodied. In researching SMC, I was able to identify the ways in which I managed stigma, and with this knowledge, I drew insights regarding how to implement future management strategies. This awareness instilled agency in my approach to stigma management, as I can now more decisively choose which strategies to implement in a given situation. Furthermore, I learned entirely new styles of stigma management that, while not covered in this autoethnography, can serve me going forward.

Limitations

I encountered one notable limitation while conducting this research: applying the *display/disclose* strategy to OCD behavior. SMC is sufficiently applicable to stigmatized behavior. However, it works best when stigma is easily identifiable. OCD can, at times, be hard to identify given that its symptoms are varied, and some of these symptoms are not widely associated with OCD (e.g., muttering during a thought ritual). This creates potential problems when enacting the *display/disclose* strategy, since observers may not understand the behavior being performed. Furthermore, OCD-afflicted are, given the nature of rituals, more likely to unintentionally disclose stigma, limiting the strategy's efficacy.

Conclusion

OCD is a part of me, and while I am now able to successfully manage the disorder, its presence will never truly vanish. That is why my management of OCD stigma is crucial. Through the process of writing this autoethnography and applying SMC to my personal experiences, I have arrived at a better understanding of how accepting stigma can lead to effective ways of coping. It is my hope that, through this project, others can learn to accept and cope with their stigma.

References

- Abbey, R. D., Clopton, J. R., & Humphreys, J. D. (2007). Obsessive-compulsive disorder and romantic functioning. *Journal of Clinical Psychology, 63*(12), 1181-1192.
<http://dx.doi.org/10.1002/jclp.20423>
- American Psychiatric Association (2013). Diagnostic and statistical manual of mental disorders: DSM-5 (5th ed.). *American Psychiatric Publishing, Inc., Arlington, VA.*
- Coles, M. E., Heimberg, R. G., & Weiss, B. D. (2013). The public's knowledge and beliefs about obsessive compulsive disorder. *Depression and Anxiety, 30*(8), 778-785.
- Davis, C., & Kaptein, S. (2006). Anorexia nervosa with excessive exercise: A phenotype with close links to obsessive-compulsive disorder. *Psychiatry Research, 142*(2-3), 209-217.
<http://dx.doi.org/10.1016/j.psychres.2005.11.006>
- De Caluwé, E., De Clercq, B., De Bolle, M., & De Wolf, T. (2014). A general and maladaptive personality perspective on youth obsessive-compulsive symptoms. *Journal of Personality Assessment, 96*(5), 495-502.
<http://dx.doi.org/10.1080/00223891.2013.856315>
- Doloriert, C., & Sambrook, S. (2012). Organisational autoethnography. *Journal of Organizational Ethnography, 1*(1), 83-95. <http://dx.doi.org/10.1108/20466741211220688>
- Ellis, C., Adams, T. E., & Bochner, A. P. (2011). Autoethnography: An overview. *Forum Qualitative Sozialforschung / Forum: Qualitative Social Research, 12*(1), Art. 10.
- Fennell, D., & Boyd, M. (2014). Obsessive-compulsive disorder in the media. *Deviant Behavior, 35*(9), 669-686. <http://dx.doi.org/10.1080/01639625.2013.872526>
- Gyula, B., Anderson, P. D. (2014). Obsessive-Compulsive Disorder. *Journal of Pharmacy and Practice, 27*(2), 116-130. doi: 10.1177/0897190014521996

- Harwood, J. (2006). Communication as social identity. Shepherd, J., St. John, J., & Striphas, T. (Eds.), *Communication as...Perspectives on Theory*, 84-91. Sage Publications, Inc.
- Kimmerle, J., & Cress, U. (2013). The effects of tv and film exposure on knowledge about and attitudes toward mental disorders. *Journal of Community Psychology*, 41(8), 931-943.
- Lebowitz, E. R., Vitulano, L. A., & Omer, H. (2011). Coercive and disruptive behaviors in pediatric obsessive compulsive disorder: A qualitative analysis. *Psychiatry: Interpersonal and Biological Processes*, 74(4), 362-371.
<http://dx.doi.org/10.1521/psyc.2011.74.4.362>
- Meisenbach, R. (2010). Stigma management communication: A theory and agenda for applied research on how individuals manage moments of stigmatized identity. *Journal of Applied Communication Research*, 38(3), 268-292.
- Pirurinsky, S., Rosmarin, D. H., & Pargament, K. I. (2009). Community attitudes towards culture-influenced mental illness: Scrupulosity vs. nonreligious OCD among orthodox Jews. *Journal of Community Psychology*, 37(8), 949-958.
<http://dx.doi.org/10.1002/jcop.20341>
- Rambo, C. (1997). On loving and hating my mentally retarded mother. *Mental Retardation*, 35(6), 417-432.
- Wood, J. (2008). Critical Feminist Theories. Baxter, L. & Braithwaite, D., (Eds.). *Engaging Theories in Interpersonal Communication*, 323-334. Sage Publications, Inc.