Are Those Germs in Your Pocket, or Am I Just Crazy to See You? An Autoethnographic Consideration of Obsessive-Compulsive Disorder

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Abstract
This autoethnographic account chronicles my experiences living with obsessive-compulsive disorder (OCD). OCD is generally framed as a chemical imbalance. I advocate a phenomenological, narrative-based understanding of the illness and emphasize its communicative characteristics. I also consider the ways in which creative writing strategies associated with OCD treatment might inform qualitative research practices.

Keywords
autoethnography, communication, mental health and illness, narrative inquiry, obsessive-compulsive disorder

Being here.
I began writing an autoethnographic book in the summer of 2012. The text chronicles my summer stay in an adolescent behavioral hospital called West Oaks at Cypress Creek. In 1988, sustained homophobia I endured in middle school caused me to act in inappropriate ways, like cutting class and experimenting with drugs and alcohol. Using French philosopher Michel Foucault’s History of Madness and The History of Sexuality, Volume 1 as a theoretical foundation, I considered how authorities in the psychiatric-industrial complex rendered my homosexuality as irrational, turned to psychotherapy to rationalize my senselessness, and, through institutionalization, claimed to exorcise the very madness they invoked.

I spent the first half of 2012 buried neck-deep in discourses of psychological abnormality. Following Foucault’s lead, I examined brochures from L’Hôpital Général, lists of rules followed in the House of Saint-Louis de la Salpêtrière, different classes of mental illness, 17th- and 18th-century paintings of madhouses, and inventories of mentally ill men and women in Paris. I also sifted through my personal archive and re-discovered documentation from my stay at West Oaks. Reacquainting myself with past confinement incited me to ask questions anyone in my shoes might pose, like, “Was I ever really crazy?” and “Might I ever go mad again?”

Being there.
August 24, 2012. I sit in front of my computer and author an explanation of autoethnography, focusing on why the method is a good fit for a qualitative investigation of the psychiatric-industrial complex. Fingers dance across the keyboard as I write:

Traditional case studies of mental illness tend to objectify patients. Autoethnographers rely on creative writing to confront seemingly ineffable lived experiences. As a result, autoethnography frequently requires “confronting things about yourself that are less than flattering.” (Ellis & Bochner, 2000, p. 738)

Ellis and Bochner’s (2000) sentiment resonates as I prepare to share a number of embarrassing confessions about my psychological history.

“Bing, bong,” the doorbell screeches. I stop typing and collect a cardboard box from a UPS driver. Panic grips me the minute I shut the front door and lock my deadbolt. The doorbell’s scream echoes in my head, getting louder with each repetition. I try to start writing again. My fingers clumsily crash down on the keyboard: A-u-t-o-e-t-h-n-o-g-r-a-p-h-y—

—BING! BONG! Tune it out, Fox. Keep typing: i-s a-n—

—BIIIIIING! BOOOOONG! What is wrong with me?

Sweat shimmers over my paling skin. My stomach feels like it is crawling up my esophagus. My heartbeat provides a percussion beat to the “Bing! Bong!” horror tune playing

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in my head. I feel as if my child psychologist’s evaluation of my sixth-grade self was a foretelling. I fear that I am—
BIHHHHHIIING! BOOOOOONG!—coming unraveled. Each ring of the bell signals all that I might lose. Bing! Madness wants to devour the tenure I was just awarded. Sweat drenches my hair. Blood rushes away from my fingertips, causing them to tingle. Bong! After years of being single (and hating it), I finally have an amazing boyfriend. Mental illness wants to ravage our relationship. My arms shake and eyes spit tears to the wooden floor. My dog Bella cocks her head to the right and looks at me with wide, brown, concerned eyes. Bing! Bong! I will lose everything! BING BONG! I am going crazy! BinG! BOnG! BING! BONG!

Being here. August 24, 2012, marked the first day of a long, treacherous, mental, and emotional breakdown. I had struggled with intrusive thoughts sporadically throughout adulthood. I spent the last 20 years worrying that my morbid thoughts were a sign of something more serious, like schizophrenia. The August 24th panic attack seemed to prove my greatest fear. By the end of the week, a man named Dr. Schmidt diagnosed me with obsessive-compulsive disorder (OCD). OCD takes many forms, including perfection-oriented ordering, debilitating double-checking, obsessive washing and cleaning, hoarding, and thinking intrusive, horrific thoughts. I am a checker and washer, and often struggle with frightful images. Other people with OCD may only show a singular sign of the illness, like perfectionism or hoarding.

In this essay, I chronicle my 20-year-long struggle with OCD. I specifically consider how a nuanced theory of interpersonal communication might enrich discussions about OCD in two key ways. I first investigate how a communication-oriented model of OCD provides a fitting lens through which patients and practitioners may conceptualize obsessive ideation. Then I explicate the ways in which a phenomenological conceptualization of narrative may enhance OCD-related diagnostic procedures. Throughout my discussion, I detail a productive and dialogic relationship between autoethnography and treatment of OCD.

A Method to My Madness

My early education of OCD came from the movie As Good as It Gets and the TV show Hoarders. I assumed OCD was limited to people who compulsively washed their hands or hoarded dirty diapers and animal carcasses in dilapidated homes. I did not understand the condition until I grounded the ailment in terms of communication.

OCD is a chemical imbalance characterized by “exaggerated concerns (obsessions) as well as one’s repetitive thoughts and behaviors (compulsions)” (Brooks, 2010, p. 252). Imagine that the logic-driven and emotion-oriented portions of my brain are bodyguards hired to keep me safe. Both protectors (Emotion and Logic) have been given a different missive.

Message to Emotion: Don’t listen to Logic. Logic does not care about you. Logic wants you to hurt yourself and other people. Logic is persuasive but evil. Keep Ragan and his loved ones alive and safe.

Note to Logic: I told Emotion that you’re a liar. Convince Emotion and Ragan otherwise. Good luck!

Most people with OCD realize their thoughts are irrational but are more persuaded by an internal pathos, or anxiety-producing “gut feeling,” than by logos.

Take, for example, my compulsion to check deadbolts. Before I go to sleep each night, I lock my front door and spend a minute or two staring at the vertical thumbturn, which indicates the door is locked. I then inspect the space between the doorframe and door to make sure I see the slick metallic bolt. The logic-driven portion of my brain understands that the door is secure. After I slip into bed, my heart’s rhythm increases. Pathos and Logos enter into a heated debate:

Emotion: Ragan, you need to make sure your front door is locked.

Logic: We already locked it.

Emotion: Don’t listen to Logic! He’s lying. Are you 100% sure we didn’t stare at the deadbolt last night? What if you didn’t lock the door tonight?

Logic: Ragan, you just locked the door 5 minutes ago. Remember yanking on the knob three times?

Emotion: What if tonight’s the night a serial killer enters your apartment through an unlocked front door? Ragan, how much do you value your life? Enough to make sure your apartment’s secure?

At the peak of my disorder, I returned to my door five times a night. Chanting, “Don’t think about the front door,” only heightened my obsession. The thought-suppression paradox is one of OCD’s defining characteristics. Thought suppression tends to augment OCD symptoms because the coping strategy “leads to a paradoxical increase in thought frequency” (Purdon, Rowa, & Antony, 2005 p. 94; see also Clark & Purdon, 1993; Rachman, 1997). In earlier drafts of this report, I found it difficult to vivify the thought-suppression paradox in reason’s prosaic conventions. Foucault (2006) argued that, throughout madness’ history, scholars and medics have not been able to use reason’s language to capture the experiences of an irrational mind.
Like many people writing about mental illness, I utilize metaphors to understand OCD. Illness metaphors structure our perceptions of the conditions we aim to describe. Comparisons also lay the foundation for how clinicians treat abnormal anxiety. Numerous metaphors have been used to explicate OCD. Analagous include a “pathway (e.g., as suffering an impediment or a breakdown), a possession (e.g., having attracted a contamination or an attack), an imbalance” (Stein, 2007, p. 5), and a schoolyard bully whose antagonism grows the more a person with OCD complies with its ridiculous, anxiety-producing demands (Salkovskis, 2007). Some patients and clinicians liken OCD-related thought suppression and ritualizing to “digging to get out of a hole” and “trying to put out a fire with gasoline” (Salkovskis, 2007, p. 253). Most of these associations obfuscate OCD insofar as pathways, bullies, and fires depict the ailment as a force outside a patient’s mind and body.

I reference communication as a root metaphor to understand encumbering anxiety. OCD represents flawed interpersonal communication, or unproductive chatter that occurs inside a person’s mind. The illness incites a gloomy form of internal narration. People with OCD imagine the worst possible endings in the tales they craft. I turn to phenomenological models of narrative to explicate how people with OCD frequently construct faulty stories about the world in which they live. Phenomenology is a “science [that] studies appearances, and specifically the structure of appearing—the how of appearing” (Moran, 2002, pp. 4-5). How, for example, does an OCD brain experience the world?

Phenomenological models of narrative exemplify Edmund Husserl’s (1964) theory of “internal time consciousness” (p. 50). Husserl (1964) believed that “retention” (quoted in Moran & Mooney, 2002, p. 111), or memories of past events, and “protention” (quoted in Moran & Mooney, 2002, p. 120), or anticipations of what the future might bring, shape our consciousness in the here-and-now. Humans rely on retention and protention to fill in the “missing blanks” of a setting or situation. I feel compelled to lock my door each night because past stories of home invasion (retention) make me believe criminals might break into my West Hollywood apartment while I sleep (protention). “It makes no difference,” argued Husserl (1970), whether the object of my obsession “exists, or is fictitious, or perhaps is completely absurd” (quoted in Moran & Mooney, 2002, p. 82). The story I construct about a locked door grounds my consciousness in fear and incites particular reactions from me, like double-checking, triple-checking, and sometimes quadruple-checking a deadbolt. Echoes of the past (retention) and “future narrative possibilities [or protention] work in a concomitant, dialogic fashion to mold human perception while we are in the midst of making decisions” (Fox, 2013, para. 17). This phenomenological process is called “narratization” (Jaynes, 1990, p. 63). Narratization, in this article, characterizes OCD patients using anxiety-ridden memories and fears of the future to make sense of current experiences.

Autoethnographers are uniquely positioned to provide detailed accounts of how an illness like OCD is narratized. Autoethnography is rooted in a form of self-representation that proves particularly commensurable with phenomenological insofar as both critical impulses “prioritize lived experience, descriptiveness, and variation in the ways in which we make sense of experience” (Berry, 2006, para. 10). In addition, autoethnography’s emphasis on unconventional textual representation enables me to more richly represent the complexity of my irrational thinking patterns. Using “creative analytic practices” (Richardson, 2000b), an ethnographer may write field observations in poetic form, or make sense of interactions by typing them up as dramatic dialogue (Richardson & St. Pierre, 2005). For instance, I use super-script text to convey particular OCD triggers nagging at me. Anxiety producers take the form of ambient sounds and unrelenting, irrational thoughts. Innovative reporting strategies function as an exploratory method, a means by which a researcher produces knowledge “between the epistemic and aesthetic poles” (Gingrich-Philbrook, 2005, p. 312). Put differently, an author’s mode of writing (aesthetic) constrains and enables the knowledge claims he or she produces (epistemic). Experimenting with style and form yields knowledge that cannot be accessed in the American Psychiatric Association’s (APA) *Diagnostic and Statistical Manual of Mental Disorders*.

## Narratizing Obsession

**Being there. August 31, 2012.** My mother and I sit in a psychiatrist’s office. Dr. Schmidt speaks in a whispery tone and with a German accent, making it sometimes difficult to understand his jargon-laden take on my breakdown. “Describe what you’ve been experiencing,” he states. I have come to his office prepared. I compiled a list of events and habits that may have caused my downward spiral. I have come to his office prepared. I compiled a list of events and habits that may have caused my downward spiral. I unfold a piece of typing paper and begin a monologue: “I was on a reality show in the summer of 2010. After I got off the program, I started smoking pot every week. I read something online that said marijuana can lead to anxiety disorder.”

“Do you consume other drugs,” he asks. My mother plays with an old receipt. The sound of crinkling paper makes it difficult for me to focus on Dr. Schmidt.

“Not now. I used to take Ecstasy when I was in my early twenties. I read that Ecstasy depletes serotonin and crinkle anxiety problems have been linked to low levels of serotonin crinkle. I turn to my mother and glare.

“Why did you just give your mother a dirty look,” Dr. Schmidt inquires. “She obviously loves and supports you.
Be kind to her.” Blood rushes to my cheeks. I feel embarrassed by his question and humiliated by the callousness with which I have just treated Mom.

“I apologize.” Salty tears slowly inch down my cheeks, leaving shiny snail trails. “It’s like I’m trapped in a bad mood. What if my condition gets worse? What if it turns into schizophrenia?” Light sniffles have given way to sobs. Mom grabs my hand and squeezes it.

“Ragan,” Dr. Schmidt assures me, “OCD is not like a cold that might turn into pneumonia. OCD doesn’t lead to schizophrenia. The two disorders affect different neurotransmitters.” His words calm me. “What are some of your most troubling thoughts,” he inquires.

Blood burns my cheeks and perspiration moistens my underarms. How does one share his or her darkest secrets with a stranger? “I sometimes think I might hurt a person and then feel terrible for the thought. When I was a student, I imagined punching some of my favorite teachers.” I scan Dr. Schmidt’s face for signs of disapproval. He smiles and nods his head, indicating he is either a weirdo (like me) or is not surprised by my disclosures. I go on to confess my fear of sitting in airplane emergency exit rows. “What if I lose control of my body when we’re up in the air? What if I open the emergency exit? What if I cause the plane to crash?”

“What you’re describing is harm OCD,” Dr. Schmidt says,

It’s a common symptom of the illness. Your brain has a difficult time distinguishing between the implications of thoughts and actions. OCD patients are some of the safest people to be around because they feel guilty for things they haven’t even done. Do you ever have these sort of daydreams about people you dislike?

Never. Destructive ideas are always directed at strangers, people I admire, older men and—

Men and women you find innocent or kind. See how the illness works, Ragan. The more inoffensive the person, the greater the guilt you feel for the thought.

Being here. Macabre thinking is not the exclusive headache of OCD patients. 90% of people without abnormal anxiety experience morbid, intrusive thoughts (Craighead & Nemeroff, 2004; Rachman & DeSilva, 1978), but men and women with OCD assign special meaning to their thinking patterns and spend more than an hour each day consumed by them (APA, 2000). Most of my friends sometimes have menacing daydreams. The difference is that the emotional center of my brain is convinced harm-related thoughts are (a) prophecies and (b) a reflection of my moral character. Moreover, abnormal anxiety “significantly interferes with [my] normal routine, occupational functioning and social activities” (APA, 2000, p. 458).

Earlier in this essay, I used a dialogue between Emotion and Logic to theatricalize inner-torment OCD has brought to my life. Understanding OCD’s “brain lock” (Schwartz, 1996) necessitates a more sophisticated theory of intrapersonal communication that calls attention to the concomitant roles past and future fears play in shaping OCD patient’s consciousness. A brain struggling with OCD distinguishes itself from a “normal” brain in how it narratizes experience. Narratization is how we make sense of the world in light of partial knowledge. “A stray fact is narratized to fit with some other stray fact. A cat is up in a tree,” Jaynes (1990) explained, “and we narratize the event into a picture of a dog chasing it there” (p. 64).

Narratization is at the heart of OCD sense-making, insofar as past traumas and future-oriented worries situate an OCD brain in an anxiety-ridden present (obsessions). Worry then incites an OCD sufferer to act in particular ways (compulsions). Narratization is perhaps best exemplified by my fear of catching a cold. Sick students trigger OCD-related narratization. A pupil’s cough and runny nose remind me of how miserable I have felt when pummeled by a cold. I consider the implications of catching a flu bug: I will feel terrible. Will my pay be docked for missing a day or two of work? How will students pass the final exam if I have to cancel class? I fall into a sticky web of past experiences and future concerns. I have narratized viral doom, or embedded my student’s snot-filled nose in a larger, yet-to-be-actualized tale that affects my communicative behavior in the present moment. Rituals include slathering sanitizer on my hands every hour, asking ill men and women to sit in the back of the room, using paper towels to open and close classroom doors, and avoiding snacks that require hand-to-mouth consumption.

My performance of contamination-circumvention is especially animated when I do not have an audience. Cooking chicken in the privacy of my apartment results in theater of the absurd. Pulling from past media stories about salmonella poisoning and anticipated future illness, I narratize the raw poultry that sits before me. One false move and slick and slimy chicken juice will drip down my esophagus. The rod-shaped bacteria will enter my digestive tract and multiply. Twenty-four hours later, my head will hang in a toilet bowl. Papers will not be graded. Appointments will be missed. These are the thoughts racing through my mind before I even dip the breast in egg and throw it in a frying pan. I wash my hands no less than five times when I fry chicken. Even after my palms are rubbed raw, I use fingernail tips and elbows to open and close cabinet doors. OCD is co-author of my fried chicken special recipe. Whereas most cooks extol the virtues of plump, juicy poultry, I repeatedly feast on bone-dry meat. Sandpapery chicken is a proof-positive sign that I successfully incinerated microorganisms that might cause me harm.
A phenomenological interpretation of intrapersonal, OCD-related storytelling is consistent with psychotherapeutic research that argues OCD is the result of an “imaginary narrative fiction” (O’Connor & Robillard, 1999, p. 359). The phenomenological model proposed in this article specifies a first-person, in situ, and nuanced way to narratively sketch the cognitive maneuverings of OCD patients. Interpretive devices mentioned earlier in this account (e.g., abnormal anxiety as pathway, fire, and bully) separate patient from illness. The analogues wrongly position the disorder outside of the sufferer, when OCD resides within, or intrapersonally. External triggers do not cause obsessions and compulsions. Interiorization/narratization of chicken and germs result in abnormal anxiety.

Narratization is a form of “cognitive mapping” (Tolman, 1948), or, in this context, spatial and temporal representations of OCD thought. Typically, therapists ask patients to engage in “cognitive restructuring” (Meichenbaum, 1977, p. 183), a process by which people with OCD identify anxiety-producing triggers (e.g., coughing students) and associated thinking errors. When I reflexively narratize OCD, I take restructuring a step further by charting dialogic relationships between past habits and traumas, current mind states and rituals, and an irrational sense of impending doom. I learned these skills in group cognitive-behavioral therapy (CBT).

**Lessons Learned in Group Therapy**

**Being there.** November 20, 2012. Dr. Jung hands me a green binder. “This is your group therapy workbook. It contains literature about OCD and homework exercises designed to help you restructure your cognitions and grow less dependent on rituals.” I take the documents and sit next to a 50-something woman with salt-and-pepper hair that lies in a loose bun atop her head. She clears her throat and looks the other way when I try to make eye contact. I open my workshop materials and turn to page 5, titled “OCD Facts.” The lady seated next to me once again lets out an emphatic, “Ahem!” I scan the page, reading a bullet-point list of information about my illness. OCD is fairly common, chronic without treatment, affects the family, and has genetic roots. Another “Ahem!” disrupts my reading. God, that’s annoying.

Dr. Jung joins the circle and begins our first meeting. “Hello,” she says, “I’m Dr. Jung. Most of you are here because you have been diagnosed with obsessive-compulsive disorder. I realize that meeting for the first time can be intimidating but research shows group therapy is one of OCD’s most effective treatments.” I smile at Dr. Jung. The woman to my right coughs again. As if cued by stage direction, my eyes roll and teeth clench. Is she going to cough throughout the entire meeting? Is she ill? Of course, I have to sit next to the sick person. What if her germs infect me right before finals? Who is going to proctor my exams “Ahem”? Ten minutes and eight raspy hacks later, Dr. Jung discusses the genetic aspects of OCD. “Roughly 3 million people in the United States suffer from obsessive-compulsive disorder. 20-40% of those men and women have relatives with obsessive-compulsive disorder,” she explains. Jung’s overview helps me establish a connection that should have been obvious to me for years: My mother may have OCD.

My parents divorced when I was an infant. I lived with my father and spent one weekend a month with Mom. I hated going to my mother’s house. Compared to Dad’s place, Mom lived in a museum. Everything had to be in order, which proved to be a nightmare for a messy kid like me. She placed wooden boxes on coffee tables with a surgeon’s precision. Perfectly fluffed pillows sat in exact spots on her couch. Her face turned crimson when I accidentally got crayon on her beige carpet or played with the bric-a-brac that adorned her home’s surfaces. I regularly returned to my father in tears. “I hate going over to her house,” I cried. “Please don’t make me go back.”

Dr. Jung’s speech about heredity also reminds me of Mom’s ritual with car doors. Ever since I was a kid, my mother has made a big to-do out of securing vehicle doors. She exits her car, presses the automatic lock, and then yanks on each door handle. The performance comes to a close after she is certain the trunk is latched shut. When I was a child, I remember being annoyed by her routine. Nobody in my family ever assumed that Mom’s eccentricities were the result of OCD.

Yet another “a-a-hem” wrenches me loose from a moment of reflection. I wish I could move to another seat. Sharing space with Lady Clear Throat frazzles my nerves. Her croaks are a double-sided equation: ahem = cold + proximity = contagion. She has transformed the room into a germ petri dish.

**Narratization as a Diagnostic Metaphor**

**Being here.** I did not realize that my mother and I likely suffered from the same mental illness until I began extensive treatment for OCD. Diagnosing OCD is no easy task, which explains why “on average, it takes 14-17 years from the time OCD begins for people to get the right treatment” (Obsessive Compulsive Foundation, 2013, para. 1). Misdiagnosis is primarily a matter of botched communication. I initially had a difficult time accepting my diagnosis because, by my own faulty reasoning, some of my symptoms did not fit OCD images to which I had been previously exposed. I narratized a checklist of reasons I did not have OCD:

1. I rationalized that my fear of germs was normal—healthy, even.
2. I did not believe destiny doomed me when I stepped on cracks or crossed train tracks.
3. I was not a perfectionist.
4. I did not hoard, nor mentally record the proper space to place objects.
5. I never felt compelled to count.

I affirmed my rationality by proclaiming I was not a perfectionist, nor a counter. I allowed absences and gaps to speaker louder than the multiple OCD symptoms with which I intermittently struggled. Put in terms of communication, OCD speaks many languages. This may be confusing to people who lack mental health support because conventional diagnostic mechanisms often require a person to rule out maladies via negating symptoms. The process-of-elimination diagnostic method is commonly referred to as differential diagnosis. Each time I wake up sneezing and feeling lethargic, for instance, I rely on a game of exclusion to determine the nature of my sickness. Is my throat scratchy? No. Am I running a fever? Nope. Do I feel achy? Not at all. A list of negative responses leads me to believe I do not have the flu. Unlike a common virus, OCD describes any combination of a long list of obsessions and compulsions.

After Dr. Schmidt suggested I attend CBT classes, I combed the Internet, looking for personal stories that might resemble my own. Most people who treat OCD would discourage patients from playing compare and contrast on the Internet, because horror stories and anecdotes shared in digital chat rooms often amplify obsessive fears. The narratives I discovered online bolstered terror-based narratization, or a phenomenological process by which OCD patients use anxiety-producing stories to structure current experience. One woman in an online forum, for instance, detailed how she struggled with intense abnormal anxiety for 20 years. I thought, “I can’t survive two decades of this despair. I’ll kill myself.” I used the chat room narrative as a retentional lens through which I saw my protentional, future-oriented horizon. I became afraid of knives and guns. What if I hurt myself? What if I lose control and hurt somebody else? When I closed my eyes, I imagined crashing a car into a wall and my lacerated body flying through the windshield. I felt trapped in what seemed like a never-ending horror movie. Terror-based narratization partially contextualizes why 27% of OCD patients attempt suicide (Kamath, Reddy, & Kandavel, 2007).

My condition gradually improved after I attended Dr. Jung’s weekly group therapy sessions. Sitting in a room with 12 other OCD patients helped me understand that OCD is a shape-shifting illness that takes different forms based on the individual. One lady in CBT class obsessed over her garden.

Patient W: I spend at least eight hours a day pruning and perfecting.

I’m not happy until all the yellow leaves have been cleared.3

A 23-year-old man discussed his discomfort with disability.

Patient W: I can’t even dine in a restaurant that has a handicapped sign on its door.

A dark-haired woman seated next to him confessed her obsession with checking.

Patient W: I used to run outside every day.

I don’t jog anymore because I’m convinced I’ve stepped on a small animal.

I run 30 feet, then have to retrace my steps to make sure I didn’t cause harm.

Another man in the class struggled with a paralyzing fear that he might molest or hurt a child.

Patient W: I was boiling water when my nieces and nephews came over for Christmas.

I worried I might pour scalding water on one of them.

Terror-based narratization helps explain why such varied manifestations of OCD fit under the same diagnostic umbrella. I liken the process to the climactic scene of the 1984 movie Ghostbusters. Toward the end of the film, a demon asks the paranormal exterminators to author their own destruction. The first thought that emerged in their head would destroy the team. “Clear your minds,” demanded one of the protagonists. Of course, asking a person to avoid
a particular thought results in the aforementioned thought-suppression paradox: The more you try to evade an idea, the more you think about it. One of the Ghostbusters imagined the Stay Puft Marshmallow man, a larger-than-life humanoid figure that came to life and attempted to kill the men. The admittedly trite movie scene proves to be a fitting analogue for OCD’s individuating manifestations. The illness latches onto a person’s greatest fears and anxieties. Via thought suppression, OCD patients conjure the forces that make them come undone.

Because unpleasant thoughts and rituals are symptoms of multiple mental illnesses, differential diagnoses often obscure “a patient’s specific symptoms to the respective disorder” (Lewin & Piacentini, 2010, para. 11). Narratization is not simply an interpretive lens but may also be used as a diagnostic tool that better traces symptom topography as it relates to individual men and women living with OCD.

Using Creative Analytic Practices to Combat OCD

Although OCD’s symptoms are similar to that of depression, generalized anxiety, and tic disorders, the ailment is generally unresponsive to conventional psychotherapeutic treatment. The sort of storytelling practiced in talk cures, or psychotherapy, is “rarely successful in reducing the severity of obsessions and compulsions” (Goodman, 2006, para. 1). CBT with an emphasis on fear exposure is the only non-pharmaceutical treatment recommended by the Obsessive Compulsive Foundation (2013). Planned exposures combat the suppression paradox by encouraging OCD patients to confront, rather than avoid, anxiety triggers. Dr. Jung taught me that exposures should start simple, be planned in advance, and gradually become more difficult. Exposure-and-response therapy required me to confront fears while systematically decreasing my dependence on rituals.

Dr. Jung assigned class participants homework tailored to their particular terror-based narratization. The assignment sheet asked us to complete the following tasks:

1. Decide which aspects of your OCD you’d like to tackle first. I want to battle my fear of contamination.

2. Make a list of specific situations that make you anxious. Growing up during the apex of the AIDS pandemic, I was certain I would contract HIV after I pierced my ear, after my first same-sex kiss, after my first one-night stand, after I realized my first boyfriend cheated on me. I am afraid of most things that come after “after.” Disaster after a student coughs. Catastrophe after I shake a man’s hand. I’ve got an aversion to the prefix “post-.”

Exposures should be planned, structured, and gradual. I will not wash my hands before breakfast. I will limit hand washing to 30 seconds. I may only use hand sanitizer or wash my hands today but am not allowed to do both. I will not use the bottom of my shirt to open restroom doors. I will plant a closed-mouth kiss on my boyfriend after he coughs.

Exposures should last long enough to experience a significant decrease in anxiety. I WILL GET SICK. MY THROAT HURTS. What if I become ill AFTER the exposure? Will that AFTER derail my progress? What if I don’t catch a cold? What if my worry is worse than the after?

Exposure-therapy techniques were particularly helpful when challenging my least favorite manifestation of OCD: sensorimotor OCD. Sensorimotor obsessions characterize sustained, interruptive focus on automatic body processes, like blinking, swallowing, and breathing.

Being there. January 8, 2012. My dentist gave me a deep cleaning today. Bloody spit made my jackhammered jaw glimmer a ruby grin. The local anesthetic wore off about 2 hr ago. Saliva oozes out both corners of my mouth. I swallow sticky spit, hoping to return my gums back to their relatively dryer, normal state. Close your eyes, Ragan, and go to sleep. Count sheep, if necessary. One sheep. Two sheep. Three sheep. So much saliva! I feel compelled to spit, to eradicate imagined excess slobber from my mouth. How will I deliver lectures if I am drooling? How can I kiss my boyfriend with so much dribble? It has been almost a month since I have felt abnormal anxiety. Just when I thought I had won the war, OCD has re-emerged.

Dr. Jung explained to me that I would periodically have to use exposure therapy to keep OCD at bay. “Keep exposing yourself to triggers and delaying or eliminating rituals you associate with them,” she explained. “Write poetry, short stories, and dialogues about sensorimotor phenomena,” she recommended. “Keep typing until you notice an incremental and significant decline in your anxiety.”

I move to my computer and write a poem about spit obsession and the exposures I utilize to combat my fear of saliva. I type,

Translucent fluid bubbling at my lips,
flowing down my chin like clear lava.
I stand in front of a mirror, forcing myself to repeat the word “saliva.”
I say it fast for a minute:
saliva, saliva, saliva, saliva, saliva—
until ocean waves of fluid syllables crash together.
I say it slow:
Sa-lie-va, saaaaaa-LIE-vaaaaaa, saaaaaah-lyuh-eeeee-
yaaaaah-vaaaaah.

I say it like George W. Bush: “salivinate.”
Repetition is the key to eliminating this obsession.

I force a tsunami of spit to break the damn of my lips,
which spew sticky streams as I say saliva, saliva, saliva,
over and over and over again.

Even this poem is an exercise
at rewiring my brain back to what it was
when I only thought of spitting and swallowing
in a very particular context.

**Being here.** Reflecting on my disorder in poetic terms enabled me to reflexively detail obsessions, laugh at my flawed cognitions, and re-narrate a future free of spit preoccupations. The writing style exposes “the mechanics of its own production” (Rhodes, 2001, p. 32), and, in doing so, reveals the myths upon which many of my obsessions were premised. “Poetic representation,” argued Richardson (2000b),

... displays the role of the *prose trope* in constituting knowledge. When we read or hear poetry, we are continually nudged into recognizing that the text has been constructed. But all texts are constructed—prose ones, too; therefore, poetry helps problematize reliability, validity, transparency, and “truth.” (p. 933)

A dialogic, poetic approach to therapy helps patients reposition themselves in relation to OCD. Imaginative strategies privilege role-play, “language, and narrative rather than [the condition’s] discrete cognitive biases” (Hallam & O’Connor, 2002, p. 333). In other words, creative modes of communication allow a patient to defy OCD-related thinking errors. Dialogic methods also enable a sufferer to take greater control over his or her recovery tale. The tactics allowed me to more reflexively look at myself and productively evaluate my thoughts.

**A New Protentional Horizon**

**Being there.** January 21, 2013. I navigate my browser to Facebook and send a message to four of my closest friends.

Howdy,

I’ve got a strange request. One of my OCD symptoms is a fear of deadly weapons. I’ve been working on exposure activities and my therapist wants me to go to a gun range. Small problem: The business’ website explains that, “Two or more people are needed for all gun rentals.” This exercise will help me progress in my battle against OCD. Let me know if you’d be willing to help out.

xoxoxo,

Rag

**Being here.** Two weeks after writing the above email, I arrived at the Los Angeles Gun Club. The event fused many of my anxiety triggers, including guns, confined space, crowds, and loud, sudden noises. I made my way to the firing point BANG!, gripped a Glock pistol, inhaled BANG!, and pulled the trigger BANG!. Shot by shot, the gun spit 100 rounds BANG! into a paper target. Each impossibly loud blast startled me BANG! and made me BANG! more determined to narrate BANG! my life BANG!, rather than let OCD narratize it for me BANG! BANG! BANG!.

From time to time, strange, anxious thoughts pick and prod at me but I am now better equipped to deal with them. I credit communication research, poetry, and narrative inquiry to my recovery. The creative writing exercises featured in this essay help expose the prose trope’s limits regarding what can be said about abnormal psychology. My experience with mental illness has taught me that irrationality rarely *speaks for itself* in terms of linearity, objectivity, reason, and tidy conclusions. OCD provokes me through dialogue, incomplete thoughts, and poetry. Not surprisingly, these were the same forms of voice I used to comprehend OCD cognitions and improve my outlook.

OCD is as much a communicative phenomenon as it is a psychological one—not that the two modes of study are mutually exclusive. Communication plays a crucial hand in diagnosing and treating the illness. A communication-oriented model of OCD demystifies the ailment in two important ways. First, communication metaphors highlight the disorder’s intrapersonal and temporal dynamics. Many popular analogues used to make sense of OCD perpetuate
the inaccurate assumption that a patient and his or her mental illness are discrete. Narratization, on the other hand, properly displays how OCD is built into a sufferer’s cognitive maneuverings. Moreover, framing the disorder as a fire What if I leave the stove on and the house burns as I sleep?, bully What if somebody brutallyizes when I walk out of my front door?, or blocked pathway Did I accidentally step on a small animal on my nightly jog? grounds the illness’ logic in potential OCD triggers. Metaphorical depictions of OCD should be of central importance to communication and health scholars because illness analogues directly impact a “patient’s quality of life and treatment by cultural members” (Fox, 2007, p. 17).

Second, the study may be used as a “narrative blueprint” (Fox, 2007, p. 8) for other people recently diagnosed with OCD. Narrative blueprints are “personal tales made public with the intent of inspiring identification among audience members seeking a narrative model to help guide future actions and behaviors” (Fox, 2007, p. 8). This narrative account exemplifies how OCD is often hard to diagnose and takes on radically different forms based on individual patients. I wholeheartedly advocate a more dialogic relationship between people who study OCD and those who live with it. Men and women undergoing treatment for this particular mental illness are uniquely positioned to map OCD cognitions and articulate innovative ways of looking at the disorder.

Finally, OCD has inspired me to critically reflect upon sense-making protocols that others might deem nonsensical, overly personal, or too far removed from post-positivism’s objectivity. I am surprised by how much OCD breakdowns and recovery have taught me about ethnographic methodology. Sound qualitative research and successful autoethnography require a heightened sense of self-reflexivity. Ellis and Bochner (2000) wrote, “Honest autoethnographic exploration generates a lot of fears and doubts—and emotional pain. Just when you think you can’t stand the pain anymore, well, that’s when the real work has only begun” (p. 738). Self-reflexivity sounds a lot like exposure therapy. Both require practitioners to confess, self-interrogate, and question epistemologies they cite (Richardson, 2000a). For the last 10 years, I have understood self-reflexivity in an abstract manner. I only systematically engaged in the practice when I began CBT and abandoned modes of logic that, at one time, served me well. As the saying goes, you sometimes have to get lost to find yourself. My OCD adventures have been an exercise in getting lost. Lost in anxiety. Lost in therapy. Lost in understanding the complexities of my illness. Lost in writing about OCD. Lost in a scary fiction called After.

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**Notes**

1. To help distinguish between reconstructed moments of the past presented in situ (“being there”) and instances of scholarly reflection (“being here”), I borrow Tami Spry’s (2001) “being there”/“being here” sequencing from her essay “Performing Autoethnography.” Spry’s organization is an adaptation of Geertz’s (1988) celebrated distinction of “being there” and “being here.”

2. Pseudonyms have been used to protect the identity of doctors and people with obsessive-compulsive disorder (OCD) mentioned in the essay.

3. Stories have been modified to insure the anonymity of group members.

**References**


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