

**THE RHETORIC OF DISORDER: A CASE STUDY ON THE EFFECTS
OF METAPHOR IN OCD TREATMENT TEXTS**

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ABSTRACT

The Rhetoric of Disorder:
A Case Study on the Effects of Metaphor in OCD Treatment Texts

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Metaphors are a convenient and intuitive means for understanding complex human conditions, but their use comes with both benefits and sacrifices. As in any written media, authors of texts pertaining to mental illness wield *stylistic agency*: they must juggle the tangible compromises that accompany each of their writerly choices. In this paper, I argue that Obsessive-Compulsive Disorder is one such case in which mental illness is affected by the compromises of metaphorical representation. In OCD discourse, the human mind emerges as a system of interchangeable parts on which the individual can operate, and I highlight these implications in Hershfield and Corboy's *The Mindfulness Workbook for OCD*. While these figures of speech are genuinely useful tools that reveal and add specificity to an invisible disease, the shortcomings of these representations are worth observing for their material influences on medical decision-making.

However, this paper is far from the first source to acknowledge the impact of metaphor on illness. I use Susan Sontag's *Illness as Metaphor*, Jay Dolmage's *Disability Rhetoric*, and a slew

of other rhetorical pieces to frame the effect of these OCD-related metaphors within a larger discourse on health and disability rhetoric. For instance, I contemplate the idea that sickness is an exile, the false characterizations assigned to the OCD individual, and the mechanical implications of current metaphors.

Finally, I propose some next steps for how representations of disorder can improve, and I offer a less shame-inducing metaphor for describing OCD as a pathology. Despite my push for improved representation, I also emphasize the importance of celebrating current depictions of disorder for the progress they have made in illuminating unseen mental ailments, and I hope to reinforce a perspective in which empathy is only a starting point to allying with OCD individuals.

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Contributors

I would like to thank my faculty advisor, Dr. Sara DiCaglio, for her extensive support on this project. Because of her insight and commitment to my education, I have benefited greatly and am privileged to feel more connected to a field I am passionate about.

Thanks also go to my friends and colleagues and the department faculty and staff for making my time at Texas A&M University a great experience. The student and faculty bodies at Texas A&M are world-class, and I am immensely gracious to be among them. Moreover, my research is constantly informed by what I learn from them each day.

Finally, thanks go to my parents and grandparents for their encouragement and love throughout my entire academic career. I have received their full support for each of my choices and am thankful to attribute so many of my successes to them.

Many of the readings referenced in this thesis were shared by Dr. DiCaglio, and she was always willing to discuss each in depth and to patiently listen to my ideas. Again, it is largely because of her commitment to this project that I have the knowledge and skills to complete it.

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INTRODUCTION

Background

Obsessive-Compulsive Disorder is a sandbox for rhetorical interpretation. It exists in medical discourse, in popular media, and, of course, in the minds of OCD individuals. Each of these portrayals is a separate incarnation of OCD, and each plays a different part in communicating what the disorder actually *is*, even to those affected. By referencing some prominent treatment resources, I have found that OCD workbooks act as a site of synthesis—one that meshes the lived experiences of the OCD individual with the medical perspectives that seek to deliver a remedy. This synthesis is a complex one for many reasons: it bares the weight of introducing OCD individuals to their lifelong battle with disorder, it is enshrouded within the conventions of storytelling, and it reveals that much of overcoming disease may be rhetorically based, rather than a medical matter alone.

While the medical field idealizes a world in which patients willingly submit themselves as specimens for operation—in a space devoid of language but filled with machines that effectively pierce and rearrange the body—words are still a strong antigen. They are unseen cells of meaning whose likenesses are well-documented in speech and writing but whose physical manifestation is fleeting. People build entire thought-systems around words, whether it be a fast-food chain’s commitment to offering “fresh” ingredients, an Aggie’s aversion to “lying,” “cheating,” and “stealing;” or the TED Conference’s embodiment of “ideas worth spreading.” Should one of these words be replaced, or removed altogether, entire institutions and corporations may alter their actions. Should the Aggie Code of Honor only condemn lying and stealing, cheating may show a measurable increase. If Subway’s slogan proclaimed, “Eat Fast”

instead of “Eat Fresh,” not only might the quality of ingredients drop but workers may instead feel a pressure to provide speedy service. And despite exhaustive attempts to catalog thought systems with all their nuance and complexity, such as in documents as prolific as the United States Constitution and the Bill of Rights, we cannot help but to still truncate their breadth to phrases that the human mind can conjure in moments of indecisiveness. An angry protester might recall the words “freedom of speech” from the First Amendment before spouting slanderous obscenities that warrant their arrest, and, undoubtedly, many have heard a misguided American justify acts of wrongdoing with a single word: “freedom.” A tempting response to these offenders would be a simple reminder that the picture is larger than the one they are painting for themselves, but, in the end, this reprimand will not change how the human brain functions. Instead, we adapt. We settle for fewer words that are intrinsically more nuanced and that instigate emotional responses, and, sometimes, we are better for it. Rather than insist a toothpaste buyer be informed on current studies in fluoride effectiveness or on the benefits of natural ingredients over synthetic ones, companies release products that advertise, “for sensitive teeth,” “all-natural ingredients,” and “enamel health.” While incomplete, these descriptions are accessible, and they mark a starting point for uninformed consumers. But the debate on how informed a consumer should be when making buyer decisions is another conversation. I want to focus on this “starting point.”

John Hershfield and Tom Corboy’s *The Mindfulness Workbook for OCD* demonstrates OCD treatment’s commitment to using workbooks as an adjunct to in-person therapy. As writers Hershfield, director of The Center for OCD and Anxiety, and Corboy, Executive Director of the OCD Center of Los Angeles, mention in their introductions, reading and writing were focal to their establishment within the field. Hershfield claims that he “made two decisions that would

change [his] life forever. [He] sought treatment from an OCD specialist, and [he] began writing about OCD” (1). Similarly, Corboy recalls accepting a client recommendation to read Chödrön’s *The Wisdom of No Escape*, saying he “was immediately taken aback by the clarity of its logic,” and continued to “read many more books that focused on mindfulness and acceptance” in the years after (2). These claims prove that writing is not only a necessary supplement to OCD treatment but a *kairotic* one, being that it is a timely answer to how many of those affected will first make steps towards treatment. Since textual access is currently the most resonant and readily available alternative to in-person treatment, *The Mindfulness Workbook* serves as an approachable starting point for those without any OCD-based knowledge. As stated in David Adam’s memoir, *The Man Who Couldn’t Stop*, “people with OCD typically wait a decade or more before they seek help” (likely due to factors of shame), meaning that books will continue to serve as a discrete and somewhat effective treatment substitute for many struggling individuals” (122). And while the objectification of the human body in modern medicine is certainly problematic, few would deny that it at least offers some reassurance. If your respiratory infection gets out of hand, you can seek antibiotics. If you think you have a broken bone, you can make a late-night trip to the ER. Many can express frustration with the medical system while still holding an appreciation for the fact that it is there. But OCD individuals have yet to cross even that threshold. Beyond therapy, they have few accessible options: seek medication (a lengthy process of its own) or, if they have the means, costly treatments and inpatient programs. Due to these limitations, the OCD individual must understand their options. They must have a *critical* understanding of their disorder—a task for which books are particularly well-suited. So, until a more effective and readily available option changes the OCD treatment landscape, books are worthy of extensive critical review.

Rhetorical Framework

Language has an inherently rhetorical nature. Writing comes with choices to be made—some with benefits and others with sacrifices. It comes with *stylistic* agency. As stated in Holcomb and Killingsworth's *Performing Prose*, "identifying style with choice implies that there are different ways of saying the same thing" (2). Writers may aim for compliance with the rules of grammar for clarity's sake, but grammatical convention can only prescribe so many aspects of the writing process. At some point, the writer must decide whether they "bought a new bedspread, a box of muffins, and a gallon of milk," or if they "purchased a bedspread and a gallon of milk before splurging on the enticing muffins at the check-out counter." While writerly choice may elicit a notable impact of its own, the context of writing also contributes to the impact of choice. The order in which you list the items on your grocery list may have little rhetorical effect, while writing the manager at a Chipotle to say that you were "disgusted with your order" rather than just "unsatisfied" may result in a much quicker compensatory discount. In the latter case, the compromise of word choice is palpable: financial gain for a potentially disgruntled store manager. What about in the case of OCD Workbooks? Or of treatment texts in general? What is the cost of word choice when readers rely on every ounce of meaning to dramatically improve their quality of life? When every word, every sentence, is an opportunity to demonstrate compassion, to spark hope, and to garner understanding. Many would say that the stakes are high, and that the task of a mental health writer is to meticulously refine their words in recognition of the empathic connection that they are forming with their readers. But, in the end, an author can only surmount so many meaning barriers before completely isolating themselves from their work and producing a heap of sterile information. As readers, one way we can contribute to the writing process is by acknowledging the compromises of writerly choices, even

if the overall message is already effective to some degree. We can recognize that a story is valuable, and that it may even serve as the current standard for storytelling in its genre, while still pushing for change. In the same vein, this article serves to critique OCD texts not out of frustration but in appreciation for the headway they have made so far—to celebrate the change that is to come.

Methodology

To initiate this review, I will first analyze several key metaphors used by Hershfield and Corboy to describe OCD to those affected. Then, I will frame these metaphors and their implications within contemporary discourse surrounding health and disability rhetoric. Before my critique, I must emphasize that these descriptions are truly helpful. I have personally benefitted from the authors' portrayal of OCD in this book, and I continue to reference the following metaphors in moments of elevated stress. Still, I—and many others—must combat the underlying beliefs that these figures of speech perpetuate. And while not all these beliefs are negative, they fuel OCD's worst enemy: distorted thinking.

1. OCD IN METAPHOR

1.1 The Spotlight

Beginning with “The Spotlight” metaphor, *The Mindfulness Workbook* implies that the brain is an assembly of standardized parts, such that an overly vigilant light bulb can alone explain OCD’s origin. Hershfield and Corboy demonstrate this mental fallacy with a pair of models, each including a spotlight (the mind’s eye) that shines down onto a shelf of books (one’s possible thoughts). The books on the shelf are categorized from left to right as “Desirable Fringe Thoughts,” “Desirable Interesting Thoughts,” “Everyday Thoughts,” “Undesirable Interesting Thoughts,” and “Undesirable Fringe Thoughts.” The spotlight from the first model, labeled “The Average Mind,” (Figure 1.1), “brightly [illuminates] the books in the center, somewhat illuminating the books to either side of its beam, and leaving what may be additional books obscured on both ends of the shelf.” The OCD mind, (Figure 1.2), on the other hand, contains a beam that illuminates nearly the entire shelf. As the authors say, this model demonstrates that “the problem with OCD isn’t that you think too much. It’s that you confuse the intensity, volume, or visibility of your thoughts with their importance” (Hershfield and Corboy 12). In other words, having too bright of a bulb means that an individual will see all their thoughts with equal priority. While placing blame on a metaphorical light bulb (the faulty cog in the machine) is more reassuring than pointing fingers at the complex issue of thought distortion, it does not alleviate the struggles of dealing with OCD. Instead, it only validates that a problem exists, while also implying that it is a simple one to fix.

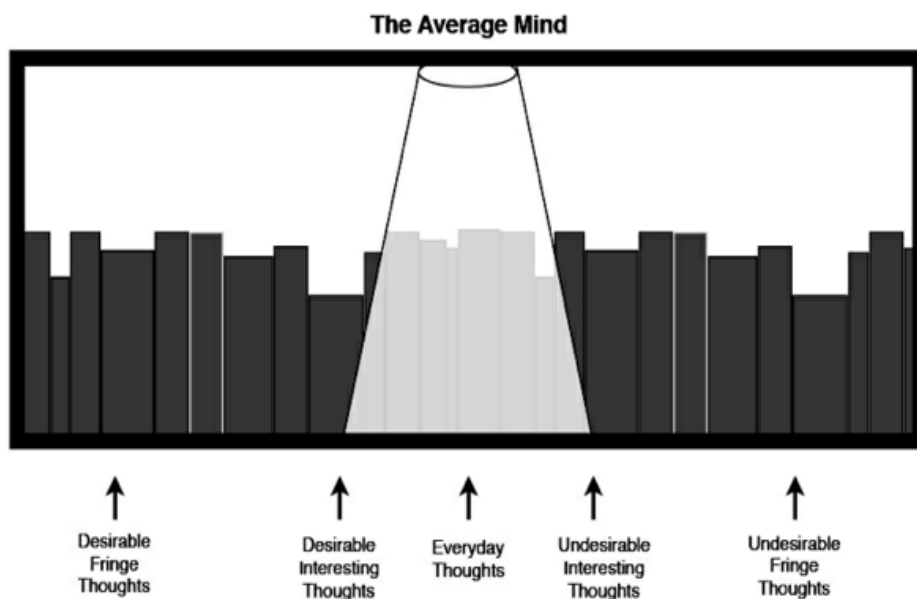


Figure 1.1 The Average Mind

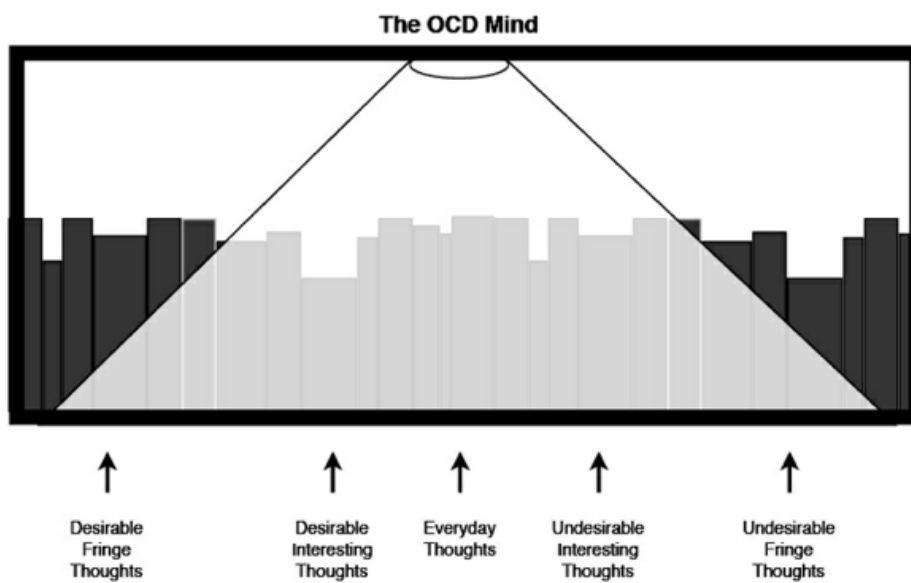


Figure 1.2: The OCD Mind

To dig deeper into this metaphor's faults, we must look at its visual and linguistic implications. Most will acknowledge that the inside of a human skull does not actually consist of some dusty wooden shelves below an incandescent bulb, but few will take notice of how the metaphor encapsulates our thoughts, acting as a framework for how the human mind and an overly lit bookshelf might be the same. We can acknowledge the assumption that the books in the middle are the "everyday thoughts," implying that what is average, median, or more accessible is also more neutral. We can recognize that the books at different extremities of the shelf are either desirable or undesirable "fringe" thoughts, meaning that they act as a threshold to an unknown beyond. In the average mind, these books are in the dark, meaning that the OCD mind is a snooping one that looks at thoughts in the "Restricted Section," while approaching the brink of something unprecedented: shame? Mental breakdown? Insanity? Although, of particular interest is that fact that each thought seemingly pairs to one book, such that our thoughts (even as implied by the word *thought* itself) are discrete entities that we experience individually and separately from one another. They are pre-written accounts inscribed by our brains that we must choose to lift from their slots between other decidedly different books. They are *tangible*. Even just while reading this description, I assume that you are imagining yourself physically interacting with the books on your brain's "shelf." You may also imagine the presence of an annoyingly bright light hanging above your head. This mental scenario is where part of the fallacy resides. The "truth" of this metaphor, being how accurately it depicts the human mind, may not matter as much as some may argue. Sure, convincing someone that an inner-cranial library really exists is problematic, but doing so was already unlikely to accomplish. Instead, the synthesis of reality and figurative language is what matters, and its effects are too little understood. The human mind may be smart enough to distinguish a hardcover dictionary from

the visceral recollections that pervade one's consciousness, but it may gloss over the fact that thoughts may *not* be separate, categorizable, or, in some sense, physical.

With this analysis in mind, the model implies that OCD is a *mechanical* problem—one that must be operated on to resolve. The spotlight is all that separates the average mind from the OCD mind, and, until science provides some means of “changing out the bulb,” OCD individuals are simply normal people operating in a brightly lit room. Further, the brain has a user, *you*, that interacts with the shelf to some extent (whether consciously or subconsciously). This assumption continues to inspire scientists and medical professionals to open the body and rearrange its contents. After all, if the individual is not their brain but instead an entity locked away somewhere alongside their thoughts and their OCD, the urge to crack open the skull seems (somewhat) reasonable: how else can you aid a suffering soul within an unjust body?

In *The Man Who Couldn't Stop*, David Adam speaks at length about just this type of procedure—the history of lobotomy in OCD treatment. “In the grip of OCD,” he says, “there were times when I wanted to tear my skull to reach inside and rip the thoughts from my brain. I was desperate to find the cells that held the intrusive thoughts and to squeeze them between my fingers until they burst” (Adam 167). Adam's quote articulates the human desire for physical interaction as a means of problem-solving, and it also captures the violent urges that accompany the need to dominate what is unseen. With such frustration already present, an OCD individual will find solace in any explanation. They will be hopeful of what can be *done*. And with a name like lobotomy, you might just ignore the fact that “the suffix *-tomy* is from the Greek for slice” (Adam 168). It is an expectedly mysterious name for an operation that sounds dangerous enough to warrant bona fide medical expertise. Many tolerate dosages of radiation and chemotherapy for cancer treatments and submit to irksome incisions for organ transplants. For a disorder that can

feel as hopeless as OCD, “[going] home with two holes in [your] head, each about the size of one of the printed words on this page” almost seems warranted (Adam 167).

But, as Adam claims, this thought process can have consequences at an endemic scale: “In the middle decades of the twentieth century, tens of thousands of people with OCD and other mental illnesses had their brains irreversibly damaged by cavalier surgeons armed with nothing more precise than knitting needles” (Adam 168). While Hershfield and Corboy’s metaphor is certainly not responsible for the actions of these “cavalier surgeons,” and the treatment in their book never encourages an affected individual to participate in unhealthy or unwarranted treatment, it demonstrates the friction caused when trying to view the body as a series of interchangeable parts. The lobotomy surgeons likely had good intentions with their invasive procedures, but the logic of their actions is easily traceable. While you can offer a prosthetic to an amputee or an organ transplant to a recipient in need, the brain is the one human product that seems truly one-of-a-kind—an antique without a warranty. But the medical field continues to apply the system of interchangeable parts to the brain’s structure. In a more recent account, Adam retells his observation of a lobotomy used to treat a Chinese heroin addict:

The surgeon drilled through the man’s shaved skull, inked with two crude crosses, and inserted long needles deep into the brain. With the flick of a switch, the needle tips became hot enough to burn away the surrounding tissue. It took just a few minutes. The target was the nucleus accumbens, part of the basal ganglia. It’s thought to play a role in motivation, desire and reward. It’s been loosely connected to addictive behaviour. So the Chinese surgeons thought the man was better off without it. (169)

While Adam’s description certainly plays on the barbarity of lobotomy, the treatment’s premise still exhibits a desire to conform the brain into something mechanical. Something that can be tampered with at no risk of sacrificing the organ’s integrity. At no risk of sacrificing *you*. Even in Adam’s account, the brain and the man are separate: “the Chinese surgeons thought the man was better off without *it*” (“it” being the basal ganglia). The passage provides little indication as to

what more “the needle tips ... burn away” besides simply the “surrounding tissue.” In the world of manufacturing, this disregard for what is lost during a product overhaul might make sense. We see features trimmed from iPhones on an annual basis, but the new release is by no means any less of an iPhone. A more precise comparison might come from the restoration of a classic car: while cracked leather on the steering wheel would be plastered in a synthetic molding and the exterior’s chipped paint would be matched and resprayed, many would say that the car is as good as new once complete. As long as it *feels* the same, it might as well be. One could argue that new iPhone iteration and the refinished car share the same essence as their old counterparts because the losses were compensated—the iPhone with new features and the car with a cosmetic rebirth. Does the same concept apply to the lobotomized human—all the side effects of damaged brain tissue in exchange for a less OCD-impacted individual? If the same concept does apply, what is to be made of a patient who is so severely affected by brain surgery that their behaviors completely change? Are they lost forever, or should family members simply view the resulting individual as a new iteration upon who they used to know?

With lobotomy in mind, OCD treatment certainly brings its fair share of uncertainties. And while OCD individuals were surely blind to many of the treatment’s risks at the height of its use in the mid twentieth century, any procedure that places a drill and the human brain together requires some degree of fervor to seek out. Part of this fervor undoubtedly comes from the agony of the disorder itself. One only needs to hear Adam’s explanation of obsession to understand its immensity:

It is hard to communicate obsession – severe, clinical obsession, a true monopoly of thought. Just as the human brain struggles to comprehend the magnitude of geological time, or the speed at which electronics can operate, or even the number of times a second the wings of a hummingbird can beat, so it can seem incredible that a single notion, a unique concept, can truly dominate someone’s mind for days, weeks, months, years. (12)

As an OCD-diagnosed individual, I understand that obsession is justification enough to desire nearly any treatment available. However, OCD individuals are still affected by that same urgency, that same need for order, to which all broken things are subject. Just as the pierced tire demands immediate attention, or the leaking faucet must be replaced, OCD is a ticking time bomb. And while not a time bomb ticking towards death (an important aside), OCD ticks away towards a list of uncertainties: insanity, social embarrassment, the collapse of one's personal and professional lives. Some might counter this proposition of urgency after hearing Adam's claim that "people with OCD wait a decade or more before they seek help," but, like any condition that endures despite its harmfulness—no matter for how long—it will only get worse.

1.2 The Broken Dam

In "The Broken Dam" metaphor, OCD individuals are not only malfunctioning; their defectiveness is an urgent threat to the other parts of their mind. Hershfield and Corboy present the mind as "a village," inciting an image of "a valley floor with little huts, people, livestock, roads, and lots of streams of water, like veins connecting one area of the village to another." While the authors claim that the village "is a happy place," they also note that it is "complicated, requiring a lot of attention and cooperation among its villagers" (Hershfield and Corboy 17). After creating this image—along with revealing the stakes of maintaining a village and its livelihood—the authors describe a nearby dam that holds back "the largest body of water in the universe" and contains "all thoughts that are possible to have." This dam has "carefully placed holes that allow for a steady stream of desirable input [those "everyday thoughts" in the middle of the shelf]," but the dam of an OCD mind, of course, has "cracks." Since the village relies on the dam's water to land "safely on the village floor," OCD-affected individuals, again, must compensate for a malfunction in their mind's design. The authors tell OCD individuals that "the

barrier that separates your *wanted* thoughts from the rest of your thoughts seems to be doing a subpar job,” implying that the OCD dam’s overabundance is detrimental to the community for which it provides (Hershfield and Corboy 17). For a moment, you may almost forget that this “community” is *you*. The metaphor offers you no time to think; too much is at stake. You must act. And every wasted second is negligent to those parts of your mind that rely on you to maintain the dam’s “carefully placed holes.” Every second of postponed treatment is an act of self-sabotage. Of self-destruction. After reading about “The Spotlight” metaphor, OCD individuals may be ready to don a construction hat, and, as the authors say, “you may find yourself just taking a hammer to [the dam]” (Hershfield and Corboy 18). What better way to do this than to approach a doctor, especially one with brain-piercing tools? The time for thinking is over.

This sentiment is ironic, of course, and neither Hershfield nor Corboy would ever encourage such a hasty attempt to seek invasive brain procedures. Their book is adamant about self-compassion and the acceptance of uncertainty. The authors emphasize:

Mindfulness isn’t about stopping the flow of unwanted thoughts. It’s about seeing the dam. It means taking a moment to notice that although most things are working as you expected, there *are* in fact some cracks in the dam and there *are* in fact some intruding streams of thought. This leaves you with two options: pound your fists against the dam, hoping this stops the leak, or accept the leak as simply something that *is*. (Hershfield and Corboy 17)

Yet, “The Broken Dam” so easily encapsulates our thoughts with the urgency of something in need of repair that it is difficult to take a step back. This metaphor may serve to make just this point, for as broken as the OCD individual feels, their relief comes from acknowledging what is broken and seeking acceptance. But one cannot help but wonder if an alternative metaphor—one in which the mind never felt broken at all, or where acceptance could occur without images of cracks and flooding and destruction—could make the process all a bit easier.

So, OCD receives two vivid representations that offer at least some tangibility, but upon looking back, you may still be unsure of what OCD is: neither metaphor claims to *be* OCD—only a demonstration of OCD in action. In “The Spotlight,” OCD is *the result* of seeing too many thoughts, but OCD is not the bright bulb. In “The Broken Dam,” OCD is *the result* of water seeping through cracks in the mind’s “dam,” but it is neither the dam nor the cracks themselves. OCD is a *system*, and one with faults, not a singular entity that acts against an individual’s best interests. This “systemization” of OCD is interesting because, for so much of my life, I have seen OCD as something against me. It was something that knew what I wanted but demanded the opposite. It was not me, but something other than and external to myself that just happened to find residence in my mind. This book and many others still reference OCD as something with agency, but in the case of these metaphors, that agency suddenly disappears. This dehumanization of OCD is not an inherently bad thing; it may actually be a good one. What better way to conquer an enemy than to deprive them of their agency? Further, this dehumanization discourages OCD individuals from attacking OCD head-on and instead promotes a methodical, multi-step approach to wellness. They are not well now, but maybe they can be in the future, so long as they stick to a comprehensive treatment plan. Still, where do *we* fit in all of this, and why can these representations be so diverse and conflicting?

2. PLACING OCD WITHIN HEALTH AND DISABILITY RHETORIC

The OCD individual is a normal person . . . with a caveat. They have wants like everyone else, they work and go to school like everyone else, and, for the most part, they think like everyone else. They just have a little trouble here and there—a barrier that isolates them from normalcy. At least, that is the idea these metaphors incite. An OCD individual’s spotlight may shine to varying degrees, but, nonetheless, they have a spotlight and a bookshelf of thoughts. An OCD individual’s dam may have cracks, but they still have a dam and an endless sea of thoughts on the other side. They have all the makings of a great, normal person; those makings just don’t quite come together. So, from what seems to be agreed upon by normative society, it is the divergent individual’s job to acknowledge their differences and rehabilitate. While the main goal of this rehabilitation is to alleviate stress and to reduce bothersome compulsions, a more subdued aim is to assimilate. The OCD individual wants to escape illness, or as put by Susan Sontag, to flee the “night-side of life.” They, along with “everyone who is born,” hold “dual citizenship in the kingdom of the well and in the kingdom of the sick.” But often, the OCD individual can feel trapped in the latter, or in that “more onerous citizenship” (Sontag 3). While metaphor hopes to clearly explain a disorder’s ins and outs, the meaning they unintentionally carry over can reveal underlying social beliefs. What happens when metaphor carries over these ideas to the lived experience of disability?

Susan Sontag offers a firm stance on the matter:

My point is that illness is *not* a metaphor, and that the most truthful way of regarding illness—and the healthiest way of being ill—is one most purified of, most resistant to, metaphoric thinking. Yet it is hardly possible to take up one’s residence in the kingdom of the ill unprejudiced by the lurid metaphors with which it has been landscaped. It is

toward an elucidation of those metaphors, and a liberation from them, that I dedicate this inquiry. (3-4)

Sontag's primary discussion on illness pertains to chronic physical diseases like Tuberculosis and Cancer—diseases that blatantly displace an individual from one kingdom to another.

Because of the dominant convictions that these diseases were and continue to be death sentences, those affected are always on the outside looking in, accepting their permanent exile from healthy life. Similarly, the well see the sick through a pane of preconception, observing the other for fear of contagion when such is unlikely or even impossible. Each “kingdom” is distinctly separate from the other, but OCD is one of many conditions to challenge this binary. The OCD individual can proceed about daily life without complication to then be overwhelmed by isolating compulsive thoughts within moments. Quite detrimentally, rituals give the illusion of power; all it takes is the “perfect” compulsion to return to normalcy. The OCD individual is a kingdom-hopper, and, by deceit of compulsions, one that can teleport at their own will. Of course, the reality is that the OCD individual is both well *and* sick, either intermittently or simultaneously: They may feel completely well in moments of lapsing obsessions, and they may feel irrecoverably sick in moments of monopolized thought. More often, though, they will feel perpetually burdened by OCD, stuck in a world separate from normal life. Sontag's discussion reveals how metaphor is partially responsible for this binary's effect on the OCD individual.

Metaphor assigns the OCD individual the role of “the melancholy character” (Sontag 32). While not socially exiled due to their OCD, they may sense an *expectation* to cast themselves aside and experience their pain in solitude, or to find that other “kingdom.” As Sontag observes of Tuberculosis's history in the mid-eighteenth century, the disease was often romanticized or made interesting: she notes that “it was a mark of refinement, of sensibility, to be sad. That is, to be powerless” (30-31). The tubercular “was a superior [character]: sensitive, creative, a being

apart,” which resulted in their representation as “a dropout, a wanderer in endless search of the healthy place” (Sontag 32-33). Even more astutely, Sontag recognizes that these understandings of Tuberculosis have seamlessly transitioned to the depiction of insanity in the twentieth century, a condition to which OCD has been fallaciously likened. Because of the connotations carried over from TB to insanity, then from insanity to OCD, OCD individuals may seek confinement—the same remedy for TB patients and “insane” patients who were “sent to a sanatorium” (Sontag 35). The OCD individual is encouraged to seek therapy, to meditate, and to be in the present. They can enroll in inpatient programs, seek medication to deaden emotional intensity, or even find a surgical procedure. They have “to be taken out of his or her daily routine” (Sontag 36). They must live a separate life. However, as I will reiterate time and time again, these methods are effective, and it is not them that need to change. Instead, it is expectation—the idea, on behalf of either the OCD-affected or normative individual, that recovery lies in displacement. These expectations can come in many forms, but the greatest appraisal of expectation may come from the very act of storytelling itself.

Individuals with disabilities often have their stories told for them. This phenomenon is not specific to those affected: many of us have idolized fairy tales for how they dispel our fears of the unknown and the undesirable, *hoping* that our stories will align with those of the characters. What is specific to disorder, however, is the confiscation of one’s capacity to author their own experience. As said by John Duffy and Rebecca Dornier regarding autism, “diagnoses of autism are essentially storytelling in character” (qtd. in Yergeau 1-2). Melanie Yergeau expands, “through diagnosis, autistics are storied into autism, [their] bodyminds made determinable and knowable through the criteria of neurodevelopmental disability” (2). From these stories—“rhetorical commonplaces that author autistic people as victim-captives of a faulty

neurology, as rhetorically degraded and rhetorically suspect”—the experience of disorder becomes “canonized by individuals” external to disorder’s experience (Yergeau 3, 2).

Fortunately, many of the individuals I reference in my OCD-based research have experienced the disorder, meaning that their words also contribute to and mold their own lived experiences with OCD. Still, this does not diminish OCD narratives as an act of storytelling. The authors, including myself in this essay, pull from a history of OCD representation and pose even more additions to the ever-growing canon of OCD as a pathology—as a story. While a great resource, Adam’s *The Man Who Couldn’t Stop* is still a story about reconciling public bias with the lived experiences of the individual. *The Mindfulness Workbook* is a story told by the recovered to the impaired, a narrative position that inherently frames OCD as something to overcome. And for as much as we can make efforts to reclaim these stories, they will still be just that. Stories. I make this statement not to call for the elimination of OCD stories but to recognize OCD as something that *can* be storied. OCD is subject to the setting of expectations because of our ingrained need to see it as something that “plays out,” or as something that has a beginning and end. This expectation becomes part of the OCD individual’s experience.

Indeed, many of an OCD individual’s compulsions would be triggering in a social vacuum (compulsions done in fear of physical or mental pain, death, or to rid oneself of sensorial hyperawareness), but much of their anxiety also derives from social construction. OCD can amplify social anxiety, incite fears of uncontrolled acts of pedophilia or physical violence, and inspire aversions to other people. It is a condition exacerbated by civilization, but such can also be said about disability at large. As demonstrated by Sontag’s observation of metaphor, much of disability’s experience exists in the qualities that are projected onto those with disabilities: Cancer and Tuberculosis were seen as death sentences and treated as such. But determining

where one's experience of disorder begins and ends is a difficult task—a task aided by Dolmage's discussion on disability and social constructionism.

As Dolmage explains in *Disability Rhetoric*, the British “social model” of disability from the 1980s and 1990s “stood in opposition to the individual and medical models of disability—which held that disability was located within the individual and that a disability held meaning only as a pathology, defined entirely by its symptoms.” When considering the British model that recognizes disability as a phenomenon of social oppression “stacked ... *on top of* [one's] impairments,” readers can see that OCD's externalization as both a mechanical malfunction and an inner demon is a remnant of the now-dated individual and medical models on disability (Dolmage 97). In the OCD workbooks that I have analyzed, OCD individuals learn how to mask themselves as “normal” to compensate for the social pressures that view the disorder as an *individual* discrepancy. After all, the end goal of the OCD individual is to stop compulsions, which are the only physical embodiment of the disorder that separates an affected individual from a normative one. Even though obsessive thoughts are inherently harmful to the individual, the *need* to stop compulsions becomes a social pressure that is “stacked ... *on top of* [one's OCD-based] impairments” (97). A failure to mask compulsions could mark the OCD-affected as somehow divergent, in turn allowing others to abbreviate their existence to a pathology. Additionally, since there is no medication or mental exercise that can completely eliminate compulsions, the workbooks seem to carry on the prosthesis-based ideology that Dolmage says allowed disabled WWII veterans to work and “kick-start postwar industries” (1). In other words, one should accept their disability as irreparable and proceed in the most productive and joyful way possible. When mechanical intervention (prosthesis) is unsuccessful, one should recognize their problem as a social threat and live around it.

Considering how disability is “stacked” onto an individual’s impairments, I would be remiss to ignore the factor of shame in the lived experience of OCD. Shame is chronicled thoroughly in literature, so I add this next section not to redefine shame but to offer a reminder that it can serve as an enforcer of unspoken social hierarchies. To emphasize beforehand, the following source is chosen for its descriptions of shame as an embodied experience. OCD should be recognized as a remediable condition that is largely exempt from discrimination based on physical appearances and social status; it is invisible. As a result, I do not intend to make light of discrimination based on gender, race, and socioeconomic status but to pull from the thoroughly catalogued history of shame as a human experience.

3. “UNLEARNING” SHAME AND EMPATHY AS A STARTING POINT

Shame governs much of the OCD experience, and a significant effort in treatment is rightly directed towards self-compassion. For every negative self-statement that one experiences, experts encourage the substitution of a positive, or at least neutral, thought. OCD is less of a journey of “solving” each obsessive episode and instead moving away from them: it may do little good to vindicate the previous offenses of their mind, but it *will* do good to instill new, less harmful ideas in themselves and others. The OCD individual may never know if their rituals were completed with perfect accuracy, but they can, and should, know that letting go will offer relief. This section serves two ideas: (1) compensating for the struggle of OCD lies in realignment with a bodymind-positive mindset, and (2) the reduction of shame in metaphor can occur by focusing on empathy as a starting point.

I first look to Heather Adams’s article written in response to the 1973 edition of *Our Bodies, Ourselves*, which “examine[s] the text for references to and invocations of shame related to the female body...” (581). Adams’s work brilliantly defines shame as an embodied experience, but she also speaks to the fact that it is unlearnable. She astutely references Dolmage to justify shame as a source of analysis:

The promise of explorations of shame’s relationship to the body—and in light of a body-oriented project of OBOS—is our ability to rethink sites of agency afforded and/or circumscribed through our gendered relationships with our own bodies, especially as those relationships are constituted by expectations of propriety and normalcy. In other words, as we think about, from, through, and beyond bodies, we are reminded of Jay Dolmage’s claim that “studying any culture’s attitudes and arguments about the body always connects us intimately with attitudes and arguments about rhetorical possibility” (114). (Adams 585)

Readers should acknowledge that whatever embodiments of shame in the OCD individual are compounded and made more complex by gender, but Adams's discussion of its embodiment helps make shame material. It allows us to "see shame as contributing to group identity formation— how it accretes to form a "collective politics of shame" (Ahmed 102) and how the emotion performs "cultural labor" that, in part, "attempts to mark and contain fluid boundaries" such as those of national and group identities (Mendible 9)" (Adams 584). The OCD individual is familiar with the hot-faced, cold-sweat-inducing moment when a compulsion begins, but they may not evaluate how these feelings reveal a deeply instilled sense of shame and fear. While I again want to emphasize the unique experiences of women as separate from that of OCD, Adams's acknowledgement that a woman's "internal body processes are a mystery to her and surface only to cause her trouble" spotlights a divide created between internal and external modes of experience; things that occur inward are often taken and storied on our behalf, and even when such is done with good intentions, it isolates us from our own bodies. Further, "we *cannot* feel [shame] in isolation but experience it, rather 'when we transgress a social boundary or break a community expectation' (Harris-Perry 104)," meaning that significant relief from the OCD experience can come from a wider realignment of public opinion (Adams 585). To reclaim our bodies as both independently *and* socially experienced, and to advocate for less shame-inducing social phenomena, we must deconstruct the aspects of shame in the OCD individual.

To engage the first sentiment (realigning the self away from shame), I will counter the *The Mindfulness Workbook's* "Spotlight" metaphor by posing a more bodymind positive one. From "The Spotlight," OCD individuals may feel over-compensatory, snoopy, or self-sabotaging. They may feel shame for "thinking about things that best go unthought." An OCD individual might imagine sideways glances and whispers of "what kind of person could even

think such unorthodox things?” Aside from these implications, the aim of this metaphor is to pinpoint the “defect” of OCD to a singular entity and, assumedly, to minimize it. Because of this reduction, the OCD individual can attempt to control that singular part of their brain that “wants” to see more than necessary and, in turn, make it less curious. To reiterate Sontag’s feelings on the topic, metaphor may simply not be an optimal method for interpreting and living with illness, so any alternatives that I pose will assuredly host some inaccuracies. But for the sake of argument, think of OCD as that prickly feeling associated with a limb that has “fallen asleep.” The feeling is uncomfortable—even scary if it lingers for a little too long—but it is one that can be remedied with movement. This tingling is also a widely shared bodily experience, so it is doubtful that anyone would feel shameful for its occurrence. “Moving” the sleeping limb can be thought of as a deliberate, mindful effort to reduce an uncomfortable sensation; you are exercising a muscle. At first, the sufferer might sporadically flail until the feeling disperses, but over time, the effort will become more targeted, and the feeling will subside more quickly. This metaphor focuses less on the uniqueness of OCD, as in how it differentiates OCD individuals from a normative group, while still offering a means for understanding their disorder. Further, it deals less with shame by removing the risqué act of snooping in the dark corners of the mind and instead offering a relatively neutral physical sensation. The metaphor could certainly acknowledge that the OCD individual might experience this feeling more often than others, but it does not have to frame the disorder as a bodily experience totally separate and unknown to the average person.

Even when offering alternative metaphors that may have less harmful side effects, I cannot neglect to address the unquestioned sense of empathy that they create. Metaphors used to portray mental illness depict the mind so declaratively that they appear nearly photographic; the authors have *seen* inside your head and are simply doing the honorable work of sharing their

findings. To counter this sense of empathy, I reference Rothfelder and Thornton's article that analyzes Adam's *The Man Who Couldn't Stop* as a rhetoric of proximity. The authors notice instances in which Adam seems "to simultaneously seek empathy and alienation" and to reinforce proximity as "a concept whose very definition suggests degrees." Adam's book "plays with proximity, moving his readers through various feelings of closeness and distance, identification and alienation" (Rothfelder and Thornton 360). He makes a deliberate effort to increase the "imaginative labor required to attempt even a small degree of approach" (Rothfelder and Thornton 373) and contradicts the trope of seeking "uncomplicated acceptance or understanding from [the audience]" (Rothfelder and Thornton 360). Many OCD individuals, including myself, look to *The Mindfulness Workbook* for these very reasons: we want uncomplicated empathy. We want to fall into another's net and relinquish our independence—to be operated on by someone who *completely* understands us. But doing so only yields so many benefits and will ultimately result in diminishing returns. We will be grouped and categorized, our experiences will be abbreviated and falsely represented, and our stories will stop being told. At some point, the OCD individual must acknowledge their experiences as somewhat irreplicable.

Rather than to renounce empathy as a lost cause, we should instead view it as a starting point. When Adam narrates his AIDS-based obsession, weeping alone in his bedroom at the horror and inescapability of the thought, readers should still embrace that feeling of shared humanity (20). And when readers learn of Bira, "an Ethiopian schoolgirl [who] once ate a wall of her house" out of compulsion, they should acknowledge the shock and incongruousness of her experience in relation to theirs (Adam 7). We should aim for some form of human connection, if

flawed, rather than none at all, but we should shy away from monopolizing another's experience as our own.

CONCLUSION

From this analysis, forward directions are difficult to discern. OCD is at the will of language: it is both its victim and its beneficiary. Through language, OCD is a storied phenomenon that carries with it a plethora of meanings from an immeasurable number of literary, historical, and political sources. But OCD also pushes and expands language, extracting nuance from words and inherently stretching our fabric of communication. For every instance that OCD is “boxed in” by language, there exists an authorial opportunity for its reevaluation and, with it, a new representation. Without “The Spotlight” and “Broken Dam,” I may never have seen OCD as something that *is*. Without metaphor, I may never have recognized OCD as measurable and concrete but disregarded it as an enigmatic and untraceable part of the human experience. Still, I have only known OCD through metaphor, meaning that I will forever be biased to how it succeeds, but I will also be left with the endless battle of unraveling my thoughts from metaphor’s tight weave. Even in this writing, I know of few ways to convey meaning without metaphor’s enticing utility; I can only disassemble parts of one metaphor with traces of another. I think the same can be said for metaphor in OCD as Rothfelder and Thornton said of Adam’s book: “some describe the book as a dark tale that offers readers little comfort or closure, while “others find a tale ‘more hopeful than harrowing’ that offers ‘hope’ that OCD ‘can be overcome with medication and therapy’” (359-360). Many may see metaphor as a useful tool in the occasions where it is needed, and only a manageable hindrance in the occasions it is not. Others may see metaphor as an insurmountable burden that plagues language and strips its objects beyond repair. I prefer to view metaphor in the former light, and that is why I write this paper and hope to write others like it.

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