THESIS

BALANCING ACTS: NAVIGATING DISCLOSURE OF MENIERE'S DISEASE DURING WORKPLACE SOCIALIZATION

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In partial fulfillment of the requirements

For the Degree of Master of Arts

Colorado State University

Fort Collins, Colorado

Summer 2025

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ABSTRACT

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This study explores how people with Ménière’s Disease (MD), an episodic invisible disability, navigate disclosure during initial workplace socialization. Despite its profound impacts on communication, identity, and work-life balance, MD is unexamined within organizational communication literature. Drawing on theories of organizational socialization (Jablin, 2001) and Communication Privacy Management (Petronio, 2002), this qualitative study explored how people with MD constructed and managed privacy boundaries as they engaged with the first stages of the socialization process. Fifteen participants were recruited by an online support group and engaged in semi-structured interviews. Interview transcripts were analyzed through a phronetic iterative approach (Tracey, 2018; 2020), cyclically comparing participant responses with theoretical constructs. Data analyzed fell under two overarching categories: a) disability-influenced socialization; and b) the disclosure processes of people with MD. Themes under the socialization category included a) the influence of healthcare on the anticipatory socialization process; b) workplace communication about illness and disability; and c) the newfound process of conditional organizational identification. Findings under disclosure highlighted varying responses, including a) the refusal to disclose; b) the concept of involuntary disclosures; c) communication barriers to privacy management; d) reciprocal disclosures about chronic illness; e) opportunities to educate others on MD; and f) the renegotiation of boundaries following a privacy breach. Findings underscored the unique challenges that participants faced in the workplace. Disclosures were often influenced by previous medical experiences and the observed treatment of others with disabilities. This study contributes to scholarship by bridging organizational socialization and CPMT. A Model of Episodic Socialization is employed to understand theoretical intersections between invisible episodic disabilities, organizational socialization, and disclosure. Practical implications are offered for improving disability discourse in organizational contexts.

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Introduction

For individuals living with invisible disabilities (IDs), maintaining a professional presence amidst unpredictable symptoms can be overwhelming. Amber, a participant diagnosed with Ménière's Disease (MD), captured a powerful example of how people with invisible disabilities (PWIDs) assert agency in the face of uncertainty:

> Don't let it control your life. It is such a demanding disease, and—if you let it—it'll ruin your life. If you give it the potential to take over, it will. Even if you wake up and you're kind of dizzy and you think, "Oh, I don't know if I'm gonna have an attack today or not," go in. Just take it day by day, hour by hour, minute by minute, whatever you need to do. No one climbs a staircase in five seconds. It's one step at a time.

As the above quote illustrated, living with an ID can create complex scenarios for individuals. Many PWIDS must tread a delicate balance of managing disclosure decisions during professional integration. In organizational settings, those who live with the burdens of IDs report feeling detached from the able-bodied world (Kattari et al., 2018; Slattery, 2021). IDs are also a point of contention for making sense of a newfound life and body inhabited after diagnosis (Brown, 2002). PWIDs may identify communication obstacles with coworkers, managers, or customers (Boucher, 2017). Additionally, there exist many types of IDs, but some are more studied in academic and scientific spheres. Ergo, certain IDs are more societally recognized and legitimized (Kattari et al., 2018; Lash, 2023). This is especially true in the field of communication, where certain disabilities or conditions (i.e., HIV; Restall et al., 2019) have been the center of focus for understanding workplace disclosure.

One such branch of IDs are vestibular conditions. Vestibular conditions are seldom recognized in public discourse and understudied by scholars. Vestibular dysfunctions concern the intricate inner-ear and brain connection, which results in symptoms such as vertigo and dizziness

(Smith et al., 2023). Additionally, vestibular conditions can affect the auditory systems, resulting in hearing loss (McNiven et al., 2021; Smith et al., 2023; Story et al., 2020). Specifically, MD has received scant medical attention (Abohelaibah et al., 2021; Kıroğlu & Dağkıran, 2020) and no research in the communication discipline. MD is characterized as a vestibular condition that encompasses low-to-medium frequency hearing loss, tinnitus, and episodes of extreme incapacitating vertigo, which often last several hours (McNiven et al., 2021). Those with MD may have continuous fluctuating symptoms, even when not experiencing vertigo, that can deteriorate quality of life (Abohelaibah et al., 2021). These frightening symptoms can also create mental and psychological distress. Feelings of anxiety, stress, and panic oftentimes accompany physical symptoms of MD (McNiven et al., 2021; Smith et al., 2023). A byproduct of MD are impacts to mental aptitude (i.e., brain fog; Bigelow & Arawal, 2015), which can further complicate professional image and workplace relationships.

MD is classified as an ID because, unless experiencing vertigo, those with the condition appear to others as able-bodied. This can produce unique scenarios concerning how people with MD disclose their condition in organizations. Research has examined relationships of those with general vestibular disorders (Smith et al., 2023; Story et al., 2020); however, scholarship has yet to explore how individuals with these conditions—MD specifically—navigate organizational contexts. Thus, this study seeks to bridge that gap in understanding disclosure practices of those with MD as they engage in workplace socialization.

Organizational socialization is a sensemaking process during the navigation of a new workplace (Jablin, 2001; Louis, 1980; Miller & Jablin, 1991). Before and during the organizational socialization process, newcomers often engage in researching workplace norms, values, and culture (Miller & Jablin, 1991). These practices aim to reduce uncertainty about this new life change (Kramer & Miller, 2013). Early stages of socialization offer opportunities for individuals to learn the job roles, tasks, and expectations (Jablin, 2001). Thus, the goal for organizations during this period is to set up newcomers for success. Socialization into a new workplace does not exist within a vacuum. That is, the identities and backgrounds of individuals affect the organization's culture in return. Indeed, prior communication scholarship has examined the influence of personal identities during the transition period (e.g., race; Ferguson & Dougherty, 2018; sexual minorities; McKenna-Buchanan, 2014). However, scant research exists that explores disabilities, namely IDs, as a mechanism of workplace expectations. This study aims to bridge this gap in communication research.

Furthermore, the socialization process provides many opportunities for disclosure. These opportunities give individuals the chance to reshape privacy boundaries. A theoretical framework that explains privacy boundary construction is Communication Privacy Management Theory (CPMT; Petronio, 2002). CPMT posits that certain criteria are considered during the disclosure process whereby boundaries are created. Core criteria are stable, enduring factors that people use to manage privacy information (e.g., cultural or gender criteria) whereas catalyst criteria consider the contextual factors to adjust or break privacy boundaries (e.g., motivations to disclose; Petronio, 2002; Petronio & Child, 2010). While CPMT has been used to assess IDs such as hearing loss (Lash, 2023), there exists no study with CPMT as a theoretical guide for people with MD.

Many people continue to work through their MD symptoms, both out of necessity and personal fulfillment (Ménière's Disease Support Group, 2024). However, this can come with a new layer of communication challenges. Working with the condition can complicate physiological and psychological symptoms. Despite these challenges, individuals on the

Facebook forum “Ménière’s Disease Support Group” (2024) report success in meeting and surpassing expectations within their workplaces. Thus, it is important to understand how living with the condition affects the onboarding process into a new workplace.

When interacting with new colleagues or management, PWIDs must weigh disclosure decisions. This study combines organizational socialization and CPMT to make sense of disclosure decisions and privacy boundaries to explore the narratives of employees with MD. Furthermore, the workplace socialization process is full of opportunities to disclose or withhold information (Rush & McNamee, 2020). Not only can research on the intersection of CPMT and socialization be theoretically rich, but it can build a practical tool for organizations, especially figures in leadership roles, to better understand and support staff with IDs. At the same time, this thesis serves to increase awareness of MD and vestibular disorders at-large. Participant stories in this study provide a resource to people living with MD. This can assist in decision-making of workplace disclosures.

The structure of this thesis is as follows: First, a thorough review of the literature is explored. Both organizational socialization and CPMT are grounded, and gaps in research are identified. Then, the qualitative methodology for this study is introduced and data analysis is outlined. This segues into an exploration of findings, which are then discussed for building upon theoretical and practical implications.

Literature Review

Making sense of a new workplace is a noteworthy professional and personal adjustment (Jablin, 2001). During the entry stages of socialization, employees are faced with decisions on whether to disclose life topics and identities. Disclosure decisions can depend on multiple factors, including the workplace culture, vocation, and members (Santuzzi et al., 2014). For those with marginalized identities, such as PWIDs, the disclosure process can become complicated as they cross uncharted territory of sharing a health condition. Those with MD, an invisible vestibular condition, stand out as a demographic that may experience unique disclosures in the workplace. Due to the impact of MD on one's life, they may prioritize learning about their organization's attitudes on disability and treatment of disabled employees. However, the symptom flux of MD may be an indicator of disclosure and its extent. Additionally, those with MD may engage in constructing privacy boundaries to safeguard certain degrees of their disability status. Management of health-related privacy involves maintaining openness for fostering relationships while withholding topics that could form doubts of job competence (Lash, 2023). This literature review examines the past and present research of IDs and where MD has been overlooked in communication scholarship. Theories of organizational socialization and CPMT are utilized as a framework for this study. Afterward, gaps in the research are identified, a research question is posed, and study goals are mapped. First, terminologies of ID and MD are defined and explored.

Invisible Disabilities

IDs are defined as health-related impairments that impact one's daily lifestyle or activities, yet are not physically noticeable (Invisible Disabilities Association, 2024). IDs can oftentimes impede upon quality of life and erode relational strength between PWIDs and their counterparts (Brown, 2022). IDs constitute a vast spectrum of health conditions, each carrying their own complexities (Prince, 2017). For instance, 74% of PWIDs do not utilize mobility devices (i.e., walkers, wheelchairs, canes, etc.; Invisible Disabilities Association, 2024, in press). IDs encompass an immense spectrum, including intellectual disabilities (Roper, 2023), mental health disabilities (e.g., anxiety or post-traumatic stress disorder; Flink, 2017), or episodic disabilities, such as MD (Gürkov et al., 2016). In fact, about 40% of the global population lives with an ID (Matthews & Harrington, 2000). This signifies the large population that must consider managing disability disclosure in workplace settings.

IDs oftentimes vary in symptoms and their intensity. While certain disabilities remain stagnant in symptom expression (e.g., intellectual disabilities; Roper, 2023), others may become episodic, where symptoms are prone to fluctuate (Gignac et al., 2021; Prince, 2017). In times of low symptom expression, PWIDs may feel an increased sense of ability and confidence, even mentally shifting their identity from disabled to able-bodied (Prince, 2017). MD specifically falls into an episodic disability, fluctuating in symptom presence and intensity. Spikes in symptoms, dubbed “flares,” create additional challenges or barriers for lifestyle activities due to their unpredictable nature (Slattery, 2021). Episodic symptoms may impact individuals across their entire lives, accounting for financial challenges, mental health struggles, and social isolation (Brown, 2002).

Ménière's Disease: An Understudied Invisible Disability

One ID that has received scant communication research is MD. Being a vestibular disability, MD impacts the auditory and balance systems of the body (McNiven et al., 2021). MD is an incurable condition, requiring sufferers to adapt via management strategies (Kurz et al., 2020). Symptoms include episodes of vertigo, aural fullness, tinnitus, and hearing loss in the affected ear/s. According to those afflicted with MD, the most debilitating symptom is the sporadic and violent attacks of vertigo. These episodes can last between twenty minutes and twelve hours (Gürkov et al., 2016). These events of vertigo are dubbed “attacks” or “episodes” by MD sufferers. Oftentimes, those with MD begin with symptoms of intermittent hearing loss following sporadic vertigo episodes. During this stage, hearing ability returns to normal post-attack (McNiven et al., 2021). Over time, symptoms develop into permanent hearing loss in the affected ear/s, while the episodes of vertigo become predictable and milder (Kurz et al., 2020).

Lack of discourse on MD may be attributed to difficulty in establishing a formal diagnosis. MD affects every 200-500 people out of 100,000 (Gürkov et al., 2016); however, the unknown causes of MD make the condition challenging to diagnose (Kıroğlu & Dağkıran, 2020), suggesting that the prevalence of MD may be higher than reported. Many with MD frequently undergo aggressive vestibular testing to confirm the condition (Saeed, 1998). This can produce financial barriers and hesitancy from the patient to seek a formal diagnosis. Lack of an MD diagnosis may open the possibility that the condition is illegitimized by others, such as work colleagues or management. Furthermore, a lack in diagnosis may create hardship in attaining proper accommodations (Santuzzi et al., 2014).

Like many IDs, those afflicted with MD experience the illness on a spectrum. Some may have mild and infrequent attacks, whereas others may experience more routine episodes. Upwards of 70% of patients experience periods of remission between episodes, with 30% having frequent repetitions of attacks (Saeed, 1998). Such fluctuations of symptoms fall under the scope of an episodic disability (Prince, 2017). Despite having the same disability, the wide-ranging frequency and intensity of MD symptoms may result in nuanced workplace behaviors.

Despite the idiopathy of MD (McNiven et al., 2021), medical interventions can potentially regulate symptoms. Potential remedies for MD include lifestyle changes (e.g., low sodium diet, stress management), medication (e.g., diuretics, betahistine, steroids), and, if necessary, surgery (e.g., section of vestibular nerve; Gürkov et al., 2016; McNiven et al., 2021). Because there is no known cure for MD (McNiven et al., 2021), the goal of treatment is to best manage the disease and prevent significant disruption to one's life. The primary goal of treating MD is to reduce episodes of vertigo and slow hearing loss deterioration (Abohelaibah et al., 2021).

MD can also create mental or psychological effects on those afflicted. Such effects may include depression, anxiety, panic disorders, and cognitive challenges (i.e., brain fog; Smith et al., 2023) which require their own associated treatments through medication and lifestyle adaptations. Feelings of worthlessness, isolation, and, at worst, suicidal ideation are common amongst MD patients, especially during a symptom flare. Individuals have reported mental ramifications of MD impacting their work lives, including limited professional relationships and decreases in job satisfaction (Ménière's Disease Support Group, 2024).

While MD is not life-threatening, it can considerably deteriorate quality of life for those afflicted (McNiven et al., 2021). There is scant communication scholarship that observes how people with the condition engage in relationships, especially in the workplace. People with MD oftentimes face challenges in social contexts. Negative social interactions may occur due to high stress, increased uncertainty, and communication challenges (Abohelaibah et al., 2021). Primarily, individuals report that navigating hearing loss in social situations can be a particularly difficult moment of communication (Ménière's Disease Support Group, 2024). Literature has pointed to the stigmatization of hearing loss challenges in social settings (Lash, 2023), but added layers of symptoms makes the challenges people with MD face especially unique.

Societal misunderstandings may arise from those without an ID. For instance, individuals with MD state how workplaces do not understand the symptom severity, especially the intensity of vertigo episodes (Ménière's Disease Support Group, 2024). PWIDs in organizations have experienced an array of negative reactions, such as downplaying or neglecting their condition (Boucher, 2017) or microaggressions (Kattari et al., 2018).

Those with MD face additional considerations of disability disclosure within organizational interactions. Because MD is used to describe a culmination of symptoms (i.e., vertigo, tinnitus, and hearing loss), individuals may choose to withhold or disclose different types of symptoms. For instance, those who identify as Deaf or hard of hearing (HoH) may choose to first disclose their hearing loss, rather than its cause (Lash, 2023). Seeing that communication research has not focused on people with MD, studying the disclosure process can better prepare organizational newcomers to make decisions on sharing disability status. In turn, the study of MD disclosure can guide organizational leaders to better support their employees with MD and improve organizational understanding of IDs.

People with MD are a demographic that deserve extended study. The nuance of MD forms diverse challenges and symptoms. People with MD must balance the complicated ties of fostering workplace relationships, adhering to organizational culture, and remaining competent with role expectations. This argument of extending communication research to people with MD exists within the broader scope of inclusive organizational discourse (Larson et al., 2023) and can benefit from the critical examination of workplace culture regarding IDs.

Invisible Disability and Workplace Norms

Critical perspectives arise within the landscape of organizational communication, focusing on the influence of power dynamics on self-identity (Pal et al., 2022). Since disability status is an influencing factor in identity formation (Boucher, 2017; Prince, 2017), communication research can grow from critical perspectives on disabilities in the workplace. This study helps examine how people with a vestibular health condition engage in workplace socialization. In exchange, it is important to explore organizational attitudes around disability to better understand and support employees with MD.

PWIDs are also subject to medical, social, and political influences (Patton, 2022) within the workplace (Santuzzi et al., 2014). Critical disability scholars argue that industrialized societies have adopted a Western Medical Model concerning IDs. This model conceptualizes disabilities, visible or not, as permanent and unfluctuating, and framed as a tragic loss of self (Patton, 2022). This current framework of viewing disability fails to consider the episodic nature of health conditions such as MD. A critique of the Western Medical Model for is that PWIDs struggle to have agency over their own societal labeling (McLeod, 2023; Patton, 2022). Instead, the dominant, able-bodied culture places notions of IDs onto them, rather than PWIDs being able to advocate for their own needs. Thus, scholarship has suggested to distance from the Western Medical Model and transition towards a Social Model of Disability (Bricher, 2000). The latter model was constructed by disabled people, for disabled people “in response to the medical hegemony that has traditionally shaped their lives” (Bricher, 2000, p. 782).

In comparison to a Western Medical Model, the social model places an “emphasis on terminology, dignity, and resources” (Patton, 2022, p. 1156). This newer approach contests viewing disability as an impairment or disorder, which can produce an othering effect on disabled individuals (Patton, 2022). Most arguably, a social model gives the disabled individual or group the chance to identify how they wish to communicate their disability. For instance, PWIDs may help explain that one condition expresses itself variably, rather than seeking a single criterion for diagnosis (Flink, 2017). A Social Model of Disability can be beneficial for building productive and honest conversations, giving voice to disabled employees, and eliminating stigma in organizations (Baron-Cohen, 2017). Because of the nuances of maintaining MD symptoms, examining whether organizations utilize a Social Model may bestow voice to this demographic of PWIDs and allows for their voices to be heard, especially in the context of work.

Incongruency between workplace norms and ID accommodations may cause conflict. While behaviors from able-bodied colleagues may be well-intentioned, it may result in the policing of PWIDs (Kattari et al., 2018). Colleagues may argue that PWIDs should be able to complete certain tasks or roles because they visibly appear as healthy. Moreso, colleagues may downplay the impact of an ID or give unsolicited advice to PWIDs (Olkin et al., 2019). Examples from ID scholarship include telling an individual with POTS that their physical symptoms are “all in their head,” (Slattery, 2021) or saying that the afflicted individual is not disabled because they physically appear fine (Kattari et al., 2018). The infantilization of PWIDs is a commonly reported workplace occurrence (Hein & Ansari, 2022; Kattari et al., 2017; Olkin et al., 2019). Posts on support groups for MD have mentioned work colleagues delegitimizing MD symptoms because they are invisible (Ménière’s Disease Support Group, 2024). In addition, PWIDs may experience self-stigmatization, or internalized ableism, because of negative interactions surrounding their condition (Boucher, 2017; Kattari et al., 2018). Episodic symptoms may lead those with MD to struggle over whether to identify as able-bodied versus disabled. These numerous examples of negative workplace interactions regarding IDs showcase (in)advertent displays of power imbalances within an organizational context, to which this study sought to inspect further.

The episodic nature of MD can further complicate workplace disclosures and accommodations. In fact, the lack of legal and medical categories for episodic disabilities forms challenges around accommodation-seeking (Santuzzi et al., 2014). People with episodic illnesses may find themselves in a liminal space within the professional sphere; they are not able-bodied yet not disabled, which accommodations may not account for (Lightman et al., 2009). In comparison to visible and/or stagnant health conditions, individuals may struggle to attain legitimacy of their disability, due to gaps in medical and societal terminology.

Despite potential negative outcomes of sharing a health condition, PWIDs may also face challenges if they do *not* disclose their condition. Non-disclosure of an ID can still subject individuals to organizational attitudes or norms. Even if PWIDs secure accommodations, commentary from organizational members may still be negative. For instance, a new employee with an ID may receive accommodations to park closer to the office building, where upper-level management parks. Coworkers, unaware of the employee's ID, may view this as preferential treatment without justification (Santuzzi et al., 2014). The invisibility of a condition can prevent understanding of accommodations, whereas a visible disability (e.g., wheelchair use) likely does not require disclosure and explains requested modifications.

PWIDS may react to differently to negative workplace reactions. This may include taking on the role of an educator to inform others of the condition (Olkin et al., 2019). Additionally, PWIDs may codeswitch language to align themselves with the organization (Kattari et al., 2018; Olkin et al., 2019). Individuals may attempt to pass as able-bodied, which shields their disability from becoming a topic of discussion at work (Boucher, 2017). Surface acting—conveying a more positive emotion than in reality—is a common tactics when navigating power dynamics in the professional landscape (Boucher, 2017).

The organizational communication field has examined the impact of company policies on feelings of support for PWIDs. Scholarship has cited an “inherent complexity of the response process” that leads to certain decisions which either support or disaffirm employees with IDs (Gignac et al., 2021, p. 160). Specifically, participants have expressed their observations on how workplaces do or do not contribute to value on investment (VOI) practices, such as intangible measurements of workplace cohesiveness and morale, compared to traditional notions of productivity such as return on investment (ROI) and company profit (Gignac et al., 2021). Because of systemic beliefs associating disability with unproductivity (Santuzzi et al., 2014), organizations may be quick to brush off how VOI can bestow long-lasting benefits to their workplace. Such study of VOI versus ROI can be beneficial for reducing MD-related stress and improving feelings of belonging within a workplace. Furthermore, measures in place to support people with MD holistically can positively influence their output into the organization, especially though the onboarding process.

Organizational Socialization

Entrance to a new workplace can be fraught with uncertainty, ambivalence, and even role shock (Miller & Jablin, 1991); thus, processes are set in place to set clear expectations. For newcomers to become an accepted member of an organization, they first must “learn the ropes” of how the organization functions (Allen, 2006). Organizational socialization has become a framework to explain how employees make sense of their job role. Initially referred to as organizational assimilation (Jablin, 2001), it is a process whereby organizations take steps to familiarize employees with new values, goals, and cultures. That is, it is a process that establishes meaning of roles in the workplace. As individuals undergo a transition from being a workplace outsider to insider (Bauer et al., 2007), it is also a time of sensemaking as one begins to comprehend a new culture (Louis, 1980). Certainly, previous background, identities, and experiences shape the socialization process (Miller & Jablin, 1991). IDs, for instance, greatly sway how a newcomer will make sense of a new work culture; however, further research is required to assess how disability status impacts the socialization process. This signals why the study of PWIDs and their socialization process is necessary to develop.

The sensemaking of newcomers during socialization is regarded as an uncomfortable process that generates uncertainty (Weick et al., 2009). The newcomer is focused on making a good impression with unfamiliar people in a new space (Weick et al., 2009). Over time, the newcomer finds better grounding as relationships develop and the role expectations become embedded. Socialization, while necessary (Jablin, 2001), can still be a challenging period because of newfound uncertainty during an important part of one's social and financial well-being (Miller & Jablin, 1991). In fact, scholars argue the socialization process can be traumatic as individuals make sense of a completely unfamiliar environment, although "if one becomes 'successfully socialized,' the trauma recedes" (Gilmore & Harding, 2022, p. 584). However, this claim does not acknowledge the personal traumas that newcomers may already hold. MD, for instance, is a condition known to cause mental effects from the high levels of uncertainty around diagnosis and symptoms (Smith et al., 2023). PWIDs may balance mental impacts of MD with disorientation that comes from initial onboarding.

Organizational socialization champions the concept of bidirectional influence. The organization and newcomer simultaneously shape one another through their own goals, skills, and needs (Jablin, 2001). This dual exchange results in each party being changed by one another;

the newcomer becomes versed in workplace functions, while they themselves reshape the organization's culture. As they engage in role-setting expectations, PWIDs may concomitantly alter how organizations view IDs; this may be especially true for conditions such as MD, which are relatively unheard of and misunderstood.

Despite the high emotional labor required for onboarding, socialization literature strongly suggests that this process is essential for workplaces. Scholarship credits organizational socialization for reducing turnover (Allen, 2006), forming a collective identity, and establishing knowledge-sharing systems (Adil et al., 2023). Organizations may exhibit certain types of cultures that communicate ways of behaving in the workplace (e.g., competitive versus humanistic climates; Jablin, 2001). While some organizations may not place much value on socialization strategies for newcomers (Myers & Woo, 2017), socialization is necessary for worker productivity and reducing uncertainty (Jablin, 2001). These positive outcomes for organizations congruently impact the new employee, as well. Effective socialization processes may improve the sense of belonging and relational development with their colleagues (Jablin, 2001).

Organizational socialization, as posited by Jablin (2001), is a 4-step process by which individuals become an insider (Miller & Jablin, 1991). These steps include 1) anticipatory socialization; 2) encounter; 3) metamorphosis; and 4) disengagement, commonly referred to as exit. While work by Jablin (2001) combines both the encounter and metamorphosis (formally dubbed assimilation) phases together, extended scholarship has enunciated these stages to be their own independent steps (Kramer, 2010). Therefore, this study is rooted in the extended, four-step model of socialization that is often employed in current research.

Anticipatory Socialization Phase

First, newcomers prepare to enter the workforce through anticipatory socialization (Jablin, 1985). During this stage, individuals are influenced by a wealth of sources that determine their work lives. These diverse sites of information advertently and inadvertently shape an individuals' sense of work, career interests, and organization choices (Jablin, 1985; 2001). Socialization literature has largely studied the various ways individuals are conditioned to develop ideas of the workforce (e.g., digital presence and identity; Handley, 2018; social media searching; Hecht, 2023; asking questions to those in similar job roles; Jablin, 2001).

Incoming members may investigate an organization's digital presence to gather impressions of its culture. In preparation for this, organizations may shape their digital presence to espouse certain values or stories to pique the interest of applicants (Handley, 2018; Kramer, 2010). Social media is an accessible tool that newcomers may utilize to further inspect potential workplace colleagues and supervisors (Hecht, 2023). However, in-person networks, such as family or friends, may be utilized to inquire about experiences in similar companies or occupations (Jablin, 2001).

Jablin (2001) posits two forms of anticipatory socialization: a) organizational choice and entry; and b) vocational choice and socialization. First, organizational choice and entry considers a meso-level focus between the newcomer and specific organization they anticipate entering. The anticipatory phase is the first exposure the new member has to the organization (Miller & Jablin, 1991) and the first chance that organizations have to provide the newcomer with information (Kramer, 2010). Therefore, the anticipatory phase is one that can mutually benefit both the employee and employer (Kramer, 2010). This stage builds a set of expectations that the individual has for the company and their job role/s (Korte et al., 2015). Job seekers may engage with literature available from the organization or have access to members that reside within the organization (Jablin, 2001).

Vocational socialization refers to the lifelong experiences and factors that shape decision-making of one's career path. Through interpersonal communication with family and peers (Jablin, 2001), one's prior work experiences (Dailey, 2016), and societal messaging (Vangelisti, 1988), individuals generate notions of what constitutes "work" in a specific career path. Vocational socialization is a lifelong and progressive process that shapes one's occupational worldview (Dose, 1997; Jablin; 2001; Van Maanen & Schein, 1979). These interactions with what constitutes work may overlap with one another. For instance, one may learn about organizational culture in a part-time job while also hearing of a friend's experiences working elsewhere.

Organizational socialization scholarship has expanded application of the framework to various occupations. Traditionally, organizational socialization was applied solely to white-collar corporations (Jablin, 1985). Researchers have since applied this framework to historically overlooked workplace populations. Diversifying the demographics studied through this theoretical lens have provided excellent results. For instance, young people in part-time work have been the subject of how socialization impacts not only the job role, but their career outlook (Feij, 1998; Herrygers & Wieland, 2017). Internships have been found to decide whether their short introduction to a company is an attractant or deterrent from future full-time positions (Dailey, 2016). Analysis of blue-collar organizations revealed employees' generational ties to the workplace, which altered the traditional socialization process (Gibson & Papa, 2000). These studies speak to the importance of how past work experiences influence the job selection process. This is an important branch of socialization literature to emphasize. People living with

MD may use prior jobs to identify their needs and wants in a new prospect to accommodate their condition. Thus, this study must consider the role that previous work experience has in the job selection process.

Anticipatory socialization is an important step for all potential newcomers, especially when balancing personal identity and workplace expectations (Ferguson & Dougherty, 2022). Those that are ostracized from dominant cultural frameworks, such as racial minorities, engage in anticipatory research to observe how an organization discusses racial equity and inclusion (Ferguson, 2017; Austin & Bisel, 2023). Similar practices may be used by PWIDs in researching messages about disability. Extended focus on this demographic during anticipatory socialization would aid in understanding why and how PWIDs engage in information-seeking activities, such as choosing whether to disclose their disability status in the application or interview process.

Encounter Phase

After anticipatory socialization, newcomers enter the encounter phase and engage with the organization directly. The encounter phase gives the opportunity to learn about workplace dynamics, attitudes, and relationships on a deeper level (Jablin, 2001). Here, the organization focuses on instilling expectations, such as the training of job duties and level-setting of goals (Louis, 1980; Miller & Jablin, 1991). In turn, the individual can informally study the workplace's culture through information-seeking behaviors.

The encounter phase allows for organizations to better promote beliefs about the job setting and tasks. This includes the implementation of training programs or mentoring systems that instill expectations in newcomers from early on (Jablin, 2001). Because of the "shock" derived from uncertainty and expectations (Louis, 1980), these formalized trainings and structures can be beneficial to the new member. Formal onboarding and training may inform people with MD in how they will manage their condition alongside role expectations.

Informal methods of sensemaking are necessary within a new professional environment. During the encounter phase, newcomers now have additional resources for information-seeking strategies (Miller & Jablin, 1991; Jablin, 2001). Such activities include asking overt or indirect questions (Miller & Jablin, 1991), observation (Jablin, 2001), or the inspection of workplace resources (i.e., work databases or orientation videos; Cooper-Thomas et al., 2012). Newcomers may interact with third parties that are apart from primary (e.g., supervisor) or secondary (e.g., coworker) sources when exploring a workplace culture. They may also use conversations as a façade for gathering information (Jablin, 2001). These strategies may allow for people with MD to begin mapping a richer understanding of workplace attitudes on disability.

Newcomers may take advantage of relational networks to seek information pertaining to cultural norms of the workplace (Cooper-Thomas et al., 2012). Those with MD may inquire about organizational attitudes on disability, such as reactions to workplace accommodation requests. In addition to informing the newcomer about disability-related resources, it allows for them to surveil colleague reactions. For instance, there may be cases in which the disclosure of an ID can receive support from a supervisor, but coworkers may view the accommodation as favoritism (Charmaz, 2010; Santuzzi et al., 2014).

The encounter phase is necessary for newcomers to feel both practically knowledgeable and socially connected (Miller & Jablin, 1991). In fact, a motivator for newcomers to learn role expectations and tasks is to earn social approval and acceptance from colleagues (Miller & Jablin, 1991). People with MD may feel encouragement to center the building of workplace relationships during the encounter phase. This may lead to more positive reactions and increased resources in the chance of disclosure, as workplace friendships may yield increased support (Nifadkar & Wu, 2022).

The main goal of organizations during the encounter phase is to train and retain new employees (Miller & Jablin, 1991). Depending on its mission, climate, and style, the organization may be more or less open towards allowing the newcomer to utilize previous workplace experiences (Jablin, 2001; Mornata & Cassar, 2018). Some organizations may accept newcomers and their past work experiences holistically, whereas others may push to reduce or eliminate previous influences. For example, organizations such as military academies demand adherence to “a rigid hierarchy” with employees having little to no agency to disclose or express uniqueness (Cepale et al., 2021). Totalistic organizations limit the ability for individuals to influence the culture and may point to how uncompromising organizational structures complicate disclosure processes. Inflexible organizational structure may also restrict people with MD from information-seeking practices during the encounter phase.

The encounter phase may determine how someone with MD chooses to incorporate their condition in professional spaces. Informal means of information-seeking may encourage people with MD to inquire about organizational stances on IDs. The organization, set in its goal to condition newcomers for the job, may approach this in varying ways. Training methods are contextual on organizational structure, leadership styles, and cultural anchors located within the company. These factors are essential to explore as people with MD transition from an outsider to insider.

Metamorphosis Phase

The metamorphosis stage marks the individual’s enculturation with an organization (Jablin, 2001). This stage establishes a harmony between individual and organizational identities

(Kramer, 2010). Thus, this stage can build cohesion with the individual and their organizational members (Bauer et al., 2007). In the metamorphosis stage, the newcomer reaches a state in the organization in which they individualize their job role “to better satisfy their values, attitudes, and needs” (Jablin, 2001, p. 36).

The process of organizational identification is oftentimes found throughout the metamorphosis stage. Organizational identification ensues when the employee feels they are a part of the organization (Jablin, 2001). This state of alignment, or “oneness,” with an organization is deeper than simple affiliation. Rather, it reflects deeper meaning-making and a sense of purpose (Alessandri et al., 2020). Organizational identification may become established when the employee has strong a command of job role knowledge (Cepale et al., 2021). Organizational identification often results in affirmed mutual trust with colleagues and greater commitment to the organization (Alessandri et al., 2020). Signs of organizational identification can be observed in key words and behaviors. Calling one’s workplace a family (Rush & McNamee, 2020) or a team (Dailey, 2016), for example, suggests organizational identification has taken place.

Organizational identification was originally praised for positive workplace outcomes, such as lower turnover rates (Cepale et al., 2021) and reduction of uncertainty (Miller & Jablin, 1991). However, potential negative outcomes can surface from organizational identification practices in the workplace. High levels of organizational identification have shown to result in lowered expressions of dissent when unethical workplace behavior occurs (e.g., abusive management, illegal practices; Conroy et al., 2017).

Organizational identification research has examined one’s locus of control— the agency that one feels they have in life events— on the socialization process. Indeed, one study has shown that higher levels of *internal* locus of control (i.e., "I control my future") results in increased organizational identification (Lee, 2013). With the anxiety caused by MD, individuals may sense a higher *external* locus of control (i.e., "Things happen to me without my control") and find challenges in successfully establishing organizational identification. This may impede upon PWIDs socialization process as they attempt to transition into a metamorphosis stage,.

The metamorphosis period is not a static time for the individual. In fact, relationship dynamics and job expectations oftentimes develop and change throughout this time (Lee et al., 2019). Despite the employee's comfort during this stage, the workplace culture can still fluctuate over time. Changes to leadership, structure, or events outside of the organization can alter workplace dynamics, although the individual is more equipped to make sense of them (Jablin, 2001). In addition to changes in symptoms, people with MD also must continue to reevaluate cultural implications within their workplace as relationships change and policies are altered.

Disengagement/Exit Phase

Inevitably, there comes a period where individuals disengage from their workplace membership. Departures from a workplace may be voluntary (e.g. quitting/renouncing job role, retirement, or transfers; Jablin, 2001) or involuntary (i.e., layoffs, termination; Miller & Jablin, 1991). Individuals must make several considerations in the preparation and execution of their disengagement, regardless of motivations (Elfenbein & Knott, 2014). Organizational exit is divided into three sub-steps: 1) preannouncement; 2) announcement/exit; and 3) post-exit (Jablin, 1987; 2001). For people with MD, their exit may arise from planning an early retirement due to difficulty working through their symptoms, or they may disengage from the workplace by pursuing short or long-term disability leave. In the latter case, individuals with MD may consider how to balance their exit with some degree of organizational involvement. This strategy both expresses interest in future work with the company and to maintain social connections.

Post-departure, the absence of the former employee is felt by those still at the organization. The post-exit period may become a stressful time for the departed member and their colleagues alike. Support practices can alleviate the stressor of relearning organizational functions with a missing member (Davis & Meyers, 2012; Jablin, 2001). Over time, emotional labor in the organization shifts from the departed member to recruiting and onboarding a newcomer (Jablin, 2001). Thus, the socialization cycle becomes repeated. For those leaving an organization, this phase may contain feelings of inadequacy and shame, whereas others may feel content or joyful in their disengagement (Klatzke, 2016). This could be applied to the focus of people with MD, where feelings of incompetence may arise from (in)voluntary exit because of their symptoms, communication from colleagues, or cultural outlook on IDs.

Organizational socialization is an essential framework for exploring the process of becoming an insider of a company. However, this study does not solely use socialization as a theoretical tool. As newcomers engage with the socialization process, consideration must be given to the disclosure decisions that are made regarding one’s personal life or background. Disclosure of a personal topic, and its extent, shapes the socialization process, and associated privacy boundaries that open or restrict personal information. As such, this study explores the theoretical base of CPMT to fully analyze privacy management and boundary creation as people with MD engage in socialization.

Communication Privacy Management Theory

Like any personal information, disability status is a topic that must be carefully navigated in workplaces (Lash, 2023). CPMT explains that the choice to share private information, and to what extent, is dependent on several factors (Petronio, 2002; 2010). Five theoretical principles are posited by CPMT, including a) the ownership of private information; b) one's control and distribution of private information; c) the rules and norms constructed around the sharing of private information; d) the co-ownership practices of private information; and e) the turbulence that follows privacy rule breaches. This section recounts the literature on CPMT and poses its application to people with MD in this study.

First, CPMT states that individuals feel a sense of ownership over the private matters in their lives (Petronio, 2002; 2010). Even if individuals relay personal information to organizations (e.g., social media networks; Cho et al., 2018; healthcare data; Terry, 2017). They still feel entitled to control this information (Petronio, 2010). Through this principle, people with MD may also feel as though they have a right to control private information, even if shared with colleagues, supervisors, or human resource departments. Furthermore, the breadth and depth of information may be shaped by the owner in privacy boundary construction (Petronio, 2002; 2010). It may be that one individual with MD discloses their hearing loss but refrains from sharing the full extent of MD symptoms (Lash, 2023). MD-related information may be withheld due to fear of rejection from colleagues or management. Disclosure may result in altered reliability and trustworthiness to accomplish tasks (Lash, 2023). Regardless of the disclosure of MD, or lack thereof, individuals regardless sense that they want ownership of this personal information.

Individuals also construct norms and regulations about private information. While privacy boundaries are established by the information-owner, their decisions can be influenced by interpersonal or organizational considerations (Petronio, 2010). Workplaces are a site for establishing cultural influence and building relationships (Sias et al., 2020). Relational closeness in workplaces can influence privacy boundaries around deeply personal health information. For instance, those living with HIV were more inclined to disclose their positive status to work colleagues when a visible figure in the organization had done so (Restall et al., 2019). This may suggest that representation of MD can lead to individuals expanding their privacy boundaries.

Disclosure of private information may break previously established rules. The non-consensual sharing of another's private matters is known as boundary turbulence (Petronio, 2002). Regardless of the intentionality of the breach, this oftentimes results in feelings of betrayal from the original information owner. Such transgressions can be due to the "fuzzy" boundaries constituted between information holders, especially concerning individual definitions information-sharing rules.

Recent scholarship has critically approached how power dynamics and imbalances manipulate an individual's privacy boundary. For instance, women facing the loss of a pregnancy did not have full jurisdiction over whom to withhold or share with. Participants' boundaries around their pregnancy loss were contingent on the hierarchical power differences in the organization. Namely, the network of how health-related information flowed through their organization combatted against the desired privacy boundaries that women wished they could construct. In other words, the disclosure of miscarriage felt expected when explaining incomplete work or absences to managers, as did the explanation to colleagues when they were depended on to accomplish job tasks. As participants facing a pregnancy loss planned ways to draw boundaries of the topic in their organization, the norms of the workplace itself altered these boundary expectations (Steimel, 2021). A focus on health disclosures can offer insight into how people with MD may find that, regardless of desired boundaries, the workplace culture can have power structures that limit the ability to withhold private information.

Socialization, Disclosure Management, and Ménière's Disease

Newcomers are faced with many decisions on how to engage with the organizational socialization process. For PWIDs, the process is further complicated by the building of privacy boundaries to enact or remove disclosure. In a new workplace, PWIDs may balance the tension of building colleague relationships and learning job information while delicately choosing when and how to disclose disability-related information. While scholarship has utilized CPMT as a framework for ID-related privacy turbulence (Lash, 2023; Slattery, 2021), researchers have yet to conduct a cross-theoretical examination of organizational socialization and CPMT. Plus, there is a paucity in the discipline of communication episodic disabilities like MD.

Additionally, this project contributes to the study of disability within the organizational communication field. Due to historical notions of disability equating to helplessness (Patton, 2022), this study can counteract preexisting beliefs and illuminate the competencies of PWIDs at work. To develop relational closeness during socialization, the disclosure of personal identities and backgrounds oftentimes must be utilized. The addition of CPMT in this study can help to explore this interaction. CPMT may explain how people with MD choose to disclose their condition with others as they become an organizational insider. Therefore, the choice to combine organizational socialization and CPMT is justified for the purposes of this study.

There also exists an opportunity to explore the tension between employees' lived experiences with MD and the norms of their organization. Throughout the socialization process, members gain a sense of belonging through organizational identification (Jablin, 2001). As such, people with MD may engage in bidirectional influence with their organization. That is, disclosures of MD may have the potential to sway the attitudes of how one's workplace views episodic IDs, even while a newcomer is still learning organizational norms. With these considerations, the following research question is proposed:

> *RQ: How do individuals with Ménière's Disease navigate disclosure boundaries during initial stages of workplace socialization?*

Methodology

There is insufficient research on workplace experiences of people with MD. As such, this study aimed to address that gap. This thesis was a qualitative inquiry of how people with MD practice disclosure during the socialization process, and how the frameworks of organizational socialization and CPMT interact in this context. Utilizing an online support forum for people with MD, participants were recruited for semi-structured interviews to answer the proposed research question. The following sections detail the researcher's positionality, participant recruitment, and the data collection and analysis process.

Role and Positionality of the Researcher

Consideration of the researcher's lived experiences may better enrich communication scholarship (Tracy, 2018). As such, my lived experience contributed to the motivations for this study. I was diagnosed with MD in the summer of 2022; however, my symptoms had been ongoing for many years prior, ever since I was twelve years old. I have undergone waves of vertigo episodes, some lasting as long as ten hours. During these episodes, I am unable to eat, drink water, or simply move my head without getting sick. My symptoms became exacerbated over the summer of 2022 when I was diagnosed, and I quickly lost hearing in my right ear. Alongside my physical decline, my mental wellbeing was nonexistent. A fear and grief I never knew possible overtook all facets of my life, afraid of when the next attack would strike, or when my affected ear would become fully deaf. Like many who are hit by relentless episodes from MD (Ménière's Disease Support Group, 2024), I considered suicide.

I received a great deal of social support from loved ones and professional counsel; however, others are not always so fortunate following an MD diagnosis. My ENT doctor prescribed me medication that significantly reduced my attacks and reversed most of the hearing loss. Due to the high variability of symptom expression and intensity, the management options for people with MD are vast (Kıroğlu & Dağkıran, 2020) and treatments may only be so effective, thus creating more uncertainty. While my experience has been lucky due to fast diagnosis and effective intervention, I acknowledge that others' experiences navigating this illness are likely diverse.

I also met increased uncertainty when I began my transition into a new workplace post-diagnosis at my current graduate program. During my socialization, I engaged in information-seeking tactics to uncover the academy's perceptions of IDs. In turn, I began to disclose more to those I became closer with throughout my time in the organization. The episodic nature of symptoms was a crucial factor in how I engaged with my organization and made disclosure decisions. While my MD disclosures were well-received, I pondered how others' workplace stories compared to mine. Therefore, the unique process of how people with MD make sense of a workplace culture must be studied further in communication scholarship. People with MD deserve to have their voices, triumphs, and struggles shared as they navigate disclosure processes at work.

Participants

This study used a non-probability purposive sampling method to invite participants. In this method, "samples are selected because the researcher has logically determined that they reflect the characteristics that form the basis of their research" (Scharrer & Ramasubramanian, 2021, p. 84). Because of MD's lengthy diagnosis process, invisibility, and sensitivity of subject (Gürkov et al., 2016), an accessible and cohesive subset of the population was required to recruit participants and collect data. Hence, the recruitment of participants was conducted through a specific online support group. Many of the selected forum's members are actively working while experiencing MD symptoms.

An online support group was chosen for participant recruitment. A forum titled "Ménière's Disease Support Group", hosted on Facebook, has amassed 39,000 members since its 2013 conception. The stated purpose of this group is "to share experiences, treatments, and hope with each other so that we all may have a fighting chance" (Ménière's Disease Support Group, 2024). I have held membership in the group since 2022, when I was first diagnosed. Because of my personal membership affiliation, I have made online connections with multiple members and developed a rapport. I first posted a message to the group forum requesting participants for this study. The post detailed the project's purpose and a link to submit a screening survey (see Appendix A). A script was utilized for the initial recruitment post (see Appendix B), as was a follow-up message reminding members about the study (see Appendix C). Both posts to the site contained a recruitment flyer, which contained the eligibility criteria and study description (see Appendix D).

To qualify, participants had to meet two criterion: First, participants had to have experienced MD symptoms before starting work. The focus of this study was to identify the ways MD influenced the entry stages of organizational socialization. By ensuring participants had prior awareness of symptoms and the impact of MD on daily life, the study could more accurately explore how these experiences shaped their workplace transition.

Additionally, eligibility required participants to have started their current job no longer than four years ago. The purpose of this qualifier was twofold: First, it allowed for memory recollection to be clearer, minimizing distortion that may arise over longer periods. Moreso, establishing this criterion accounted for changes in organizational and societal discourses. As attitudes surrounding health and illness have shifted following the Covid-19 pandemic (Fuentes & Lindsay, 2023), this criterion helped situate participant experiences under a similar context.

Participants brought diverse professional backgrounds to the study, encompassing a wide range of occupations, job roles, and companies. The duration of MD symptoms reported by participants varied considerably, ranging from two to twenty years (M = 8.57). Participants' tenure at their current workplace ranged from six months to four years (M = 2.01). Together, these figures illustrated a sample characterized by personal and professional trajectories, which shaped the results for this research. A participant chart (Table 1) was created to reflect participant details.

Table 1

Participant Chart

Name	Occupation	Time at Organization	Time with MD Symptoms	Interview Length	Pages of Transcript
Amber	ICU Nurse	1 year	2 years	33:08	16
Clarissa	Homeless Outreach Coordinator	2 years	4.5 years	49:42	20
Dylan	Realtor	3 years	4 years	36:29	14
Grace	Welding and Power Mechanics Instructor	1.5 years	8 years	55:40	32
Helen	Education Support and Tutoring (remote)	2 years	6 years	42:36	20
Jackson	Municipal Government Employee	1.5 years	3 years	49:26	42
Jay	Academic (remote) and Financier (remote)	8 months	20 years	37:21	15
Jim	Security Guard	6 months	20 years	49:24	23
Krista	School Psychologist	3.5 years	15 years	1:02:33	41
Lily	Youth Intervention Specialist	1 year	5 years	43:21	25
Maria	PhD Candidate in Neuroscience	3 years	6 years	40:08	15
Meghan	Mental Healthcare Practitioner, U.S. Air Force	2 years	8 years	48:39	18
Robert	CEO of Housing Authority	4 years	16 years	1:15:27	50

Ruby	Teacher at Dentistry College	4 years	8 years	45:49	23
Sophia	Agriculture Office Administrator	6 months	3 years	37:49	19

Procedures

Semi-structured qualitative interviews were used to answer the research question. This methodology allowed participants to communicate meanings through prompted questions, which helped the researcher to recognize patterns across responses (Charmaz, 2006). Interviews were conducted virtually through Microsoft Teams. This not only assisted with a wider recruitment base, but it allowed participants to take their interview wherever was convenient and private enough for them. Interviews were selected for data collection as they can generate thematic data from the lives and experiences of the participants (Tracy, 2020). Interviews have previously collected data of people living with vestibular disorders (Smith et al., 2023) and of spouses whose partner lives with a vestibular disorder (Story et al., 2020). However, it was important to gather experiences of people living with MD specifically. Semi-structured interviews allowed for organized data collection while allowing room for participant elaboration. This interview format left room for participant elaboration and gave the opportunity for the researcher to ask probing questions.

A screening procedure was utilized to filter eligible participants for interview. The survey was created through Qualtrics and shared with interested individuals. The screening asked for background on how long participants had experienced MD symptoms and their time with their organization. The names of individuals were only used for determining eligibility and were shared only between the researchers. Participants who matched eligibility criteria were then given pseudonyms in the findings of this paper. Eligible participants were provided with a $20 gift card in compensation for their time.

To best facilitate data collection, an interview protocol was developed (See Appendix E). The questions were guided by the theoretical bases of organizational socialization and CPMT. The goal of these questions was to uncover how participants managed MD-related information during the socialization process, balancing their health autonomy and job roles through privacy management.

Data Analysis

The analysis used a phronetic iterative approach (Tracy, 2020). This was a methodological tool that complimented both the research question and theoretical frameworks. Tracy acknowledged that "Social action is always changing; therefore, situated meanings are crucial for making sense of any given social phenomenon" (2018, p. 62). As such, the phronetic iterative approach was fitting for the meaning-making processes when collecting participants' stories. Phronetic iterative methodology is a process whereby the data and literature are continuously compared as themes are derived (Tracy, 2020). The revisiting of existing literature alongside the data helped to reinterpret initial findings through code cycles. This also allowed for codes to become more thematically succinct while adhering to participant quotes.

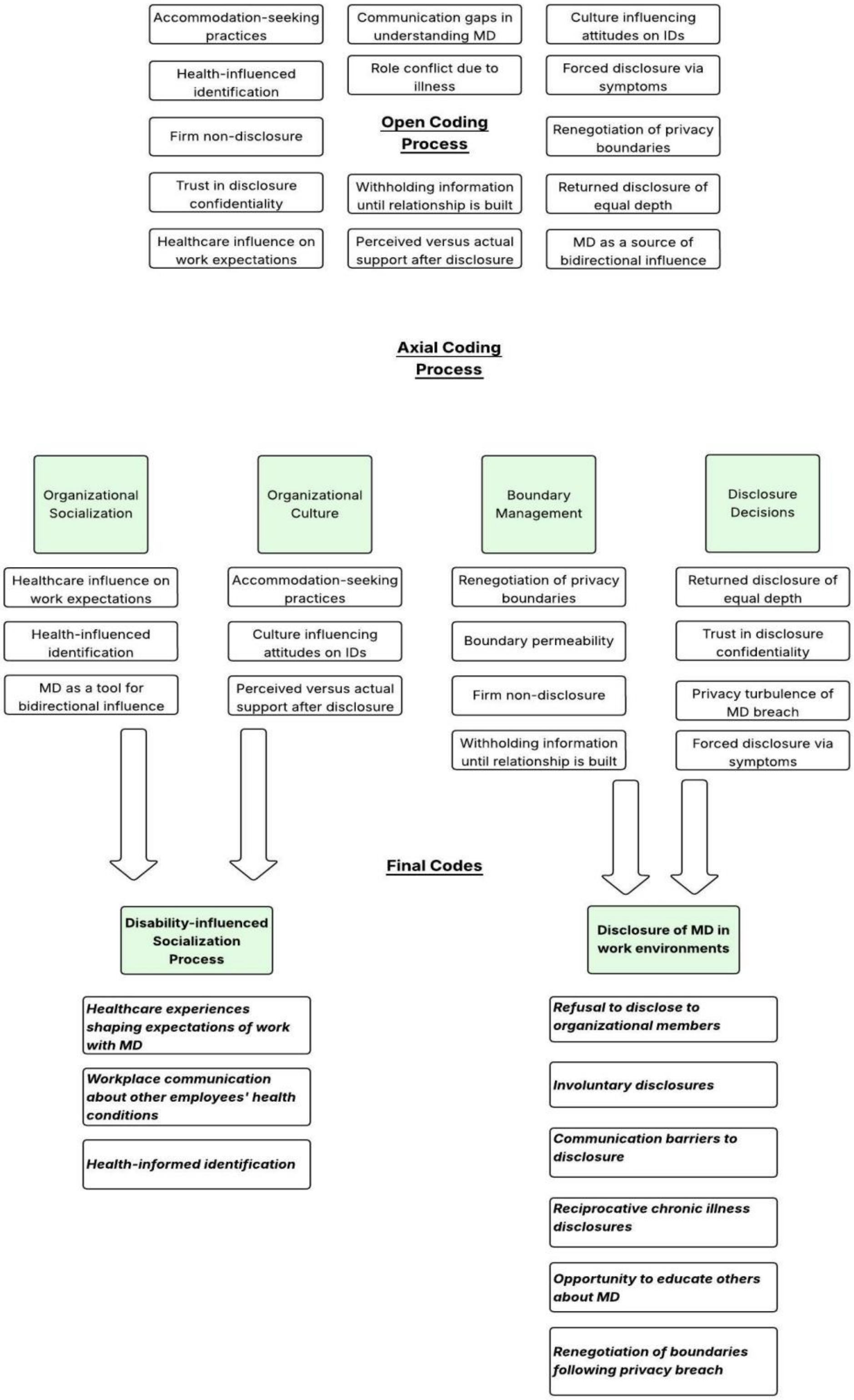
Making sense of the data began with an open coding process. Initial words and phrases were examined and selected for their pertinence and repetition across interviews. Commonalities across interviews (e.g., "I'm an open book") were signals during this process for locating codes. Participant transcripts were read multiple times during this stage, which allowed for an interactive process between the guiding theories and data. This process focused on directly communicated emotions and behaviors that were explicitly stated by the participants. For instance, if a participant directly stated they were frustrated with an interaction, their words would be marked and interpreted as such in that section. In this stage, fourteen codes were initially collected.

Following the open coding process, secondary cycle (also referred to as axial coding; Charmaz et al., 2018) was used to categorize codes into similar categories. The fourteen initial codes from the open coding phase were grouped across the categories of “organizational socialization,” “organizational culture,” “boundary management,” and “disclosure decisions.” These categories situated codes into whether they were better guided by organizational socialization or CPMT concepts. This stage assisted in making sense of the code’s fit in answering each component of the research question.

In the final coding cycle, codes were collapsed and refined to accurately capture data trends. For instance, “returned disclosure of equal depth” and “bidirectional influence” were merged into the single code of “reciprocative chronic illness disclosures.” Codes resided under two overarching categories: “disability-influenced socialization process” and “disclosure of MD in workplace environments.” A visual was created to illustrate the process of all three coding phases (Figure 1).

Figure 1

Data coding process



Results

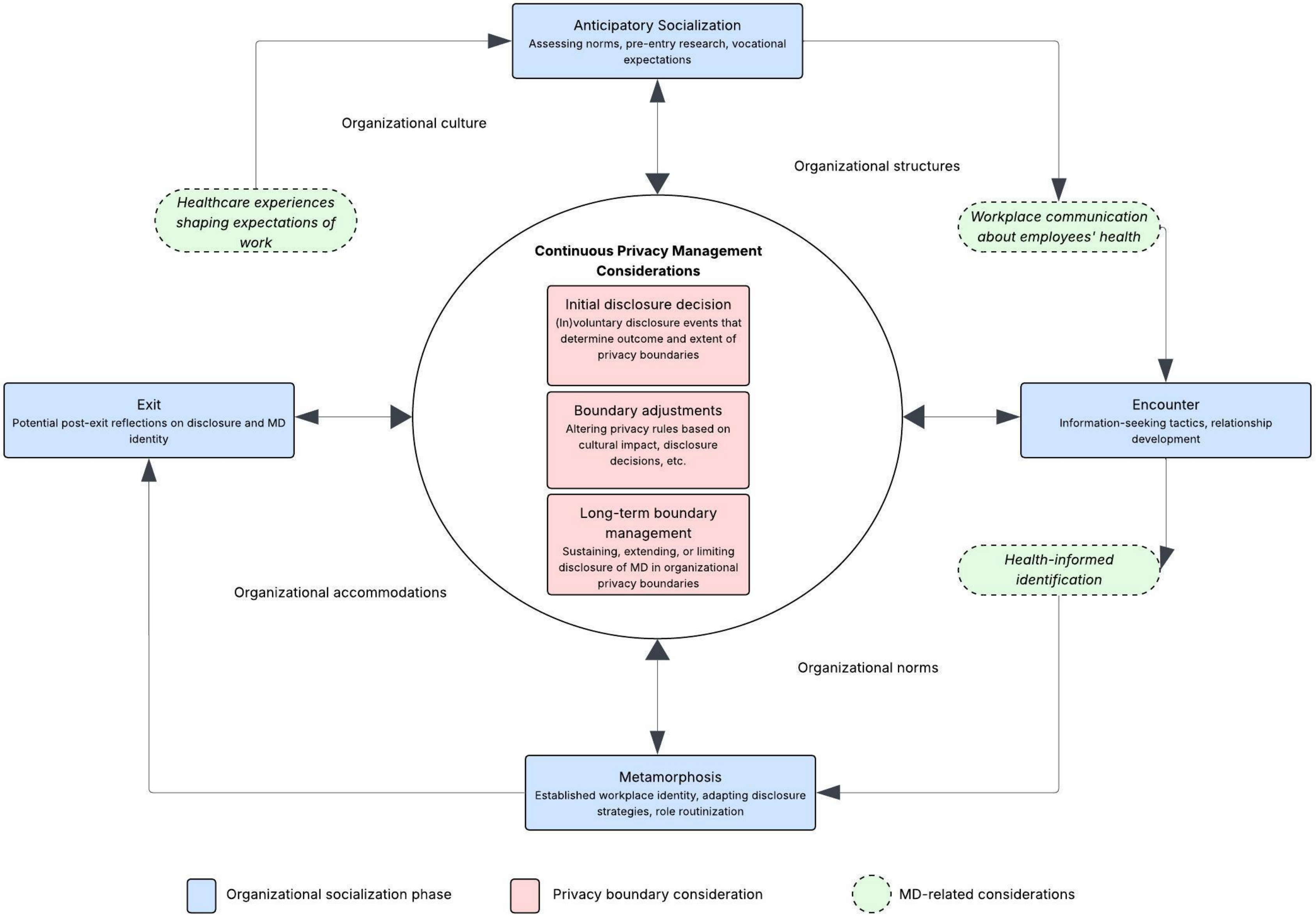
Fifteen semi-structured interviews generated a unique data set reflecting the lived experiences of people with MD in their workplaces. Guided by organizational socialization and CPMT, this research sought to answer the question: *How do people with Ménière's Disease navigate disclosure boundaries during initial stages of workplace socialization?* Through the collection and coding process, nine final codes were identified, which were categorized across two categories: a) the disability-influenced socialization process; and b) the disclosure of MD in workplace environments.

Findings helped to construct an episodic model of socialization (Figure 2) that reconceptualizes the organizational socialization process in conjunction with disability disclosure at the forefront of participants' concerns. Rather than following a linear flow of the process, this proposed reconfiguration allows for more fluid movement across and between phases. Additionally, this model also intersects with privacy management strategies that are continuously considered during the individual's time at the organization. This model also introduces how organizational norms, values, accommodations, and culture are considerations made throughout the socialization and disclosure process.

The proposed model involves three color-coded markers that showcase the factors people with MD consider during their socialization process into a new workplace. In between the blue-colored phases of socialization are the contextual MD-related elements that this study identified in the findings. These markers, noted in green, are common experiences shared by many of the participants that built their understanding of their organization's attitudes towards IDs, thus making sense of the individuals' place within the socialization process. During this entire process, individuals are also making continuous decisions around how to construct, manage, and redraw their privacy boundaries, which are highlighted in red within the center of the model and influenced by studying the disclosure process of MD in workplace environments. Finally, throughout this process the model acknowledges that organizational culture, structure, norms, and accommodations heavily influence the socialization and disclosure process of those with MD.

Figure 2.

Model of Episodic Socialization



This section examined findings that emerged from interviews with participants who navigated their workplaces after the onset of MD symptoms. First, results that reflected the socialization process with MD are introduced. This category reflected how disability largely influenced the socialization process for people with MD. This included healthcare's role on the anticipatory socialization process and information-seeking through observation of workplace communication. Additionally, the process of health-informed organizational identification was noted by participants. The second category was introduced and encompassed disclosure strategies of employees with MD. Six themes were found in this category that displayed the nuanced disclosure strategies utilized by participants. While some individuals chose to withhold all MD-related information, others experienced involuntarily disclosures due to symptoms. Communication barriers to disclosure were also identified, limiting agency over privacy boundaries. In some disclosure examples, colleagues or managers would reciprocate this vulnerability with a health-related disclosure on a similar depth. Individuals found the opportunity to educate others on MD through their disclosure. Finally, participants expressed the renegotiation process of privacy boundaries in the wake of a breach.

Disability-influenced Socialization Process

Participants in this study expressed that their organizational socialization process was guided by their experiences with MD. This influence of disability and health was a contributing factor throughout anticipatory socialization, encounter, and metamorphosis stages. MD-related experiences were a determinant for one's behaviors as they entered the organization. Furthermore, the attitudes towards MD—and disability in general—influenced organizational identification that one had with their job, career, and organization. Three themes were grouped under this category: a) healthcare experiences shaping expectations of working with MD; b) workplace communication of other employees' health conditions; and c) The health-influenced organizational identification process of someone with MD.

Healthcare Experiences Shaping Work with Ménière's Disease

Participants described how their diagnosis and treatment process played a pivotal role in their workplace transition, namely by shaping expectations during the anticipatory socialization phase. That is, the past healthcare experiences of individuals attributed ideas of what working with their condition could entail. The effect of healthcare on organizational socialization impacted one's vocational and organizational anticipatory socialization choices. Indeed, this finding was quite pronounced in the findings that the proposed revision of the socialization model labels this experience as a marker for navigating from the anticipatory socialization to encounter phases. The attainment of an MD diagnosis, or lack thereof, altered both vocational and organizational choices in the socialization process.

On one hand, healthcare experiences led participants to rethink vocational decisions. Challenges in receiving an MD diagnosis influenced individuals to consider suitable employment paths. For example, Dylan, a realtor, continued to have a troublesome time receiving a formal MD diagnosis. Not only did this change expectations for prior job and organization choices, but it led him to pursue an entirely different career in real estate:

> I started to, you know, go from a regular doctor to an ENT [ear nose & throat]. And they're still unwilling to label it Ménière's Disease because they haven't been able to detect the hearing loss while I've been there. So, they're stuck between vestibular migraines or Ménière's Disease [...] I understand the hesitancy of some physicians to issue a diagnosis, but I feel like there's a need to, you know, have a diagnosis of, "Hey, it's unconfirmed for now."

The lack of diagnosis for Dylan had not only been a frustrating period, but its impacts spread across professional outcomes:

> The lack of diagnosis really put me in a position where I felt like I had to leave my other job […] Because of the lack of diagnosis, which I think a lot of individuals fall in that, there were a lot of programs and things that were unavailable to me. Because of the lack of diagnosis, it didn't matter that I was bedridden.

Dylan’s challenging attainment of an MD diagnosis had direct implications in the legitimization of his symptoms from his previous job. Because there was no documentation, Dylan could not receive accommodations at his old workplace. As he “began thinking about job alternatives, real estate was a big draw” to Dylan due to its flexibility and self-directed style. Furthermore, the lack in diagnosis guided Dylan to filter through what jobs were sustainable with his MD symptoms:

> I just wish there was a better way to check the right boxes and be able to qualify for some of these things. Again, I don’t feel like I could hold a regular 9:00 to 5:00 because it’s four years later, and I still don’t have a diagnosis. Even when starting real estate, the lack of diagnosis really put some stressors on the career change.

Dylan expressed how no concrete diagnosis led to stressors in potential job prospects. Deficient documentation was a direct correlator the 9:00 to 5:00 job sustainability. Thus, Dylan’s prior healthcare experiences shaped both vocational and organizational choices during anticipatory socialization. The missing diagnosis was instrumental in outlook on a professional future, which led him to a new career field entirely. Even as Dylan pursued a more flexible occupation, he still felt uncertainty during this anticipatory socialization phase because of the undetermined diagnosis.

Similarly, others shared how healthcare accounted for impacts to the socialization process. Meghan, an active-duty member and mental health provider in the United States Air Force, shared her experience with the lengthy healthcare process as she was actively working through a symptom increase:

> The healthcare system that we have within the US—its sick care related in a lot of ways, you know? So, you're not doing things as much from a prevention standpoint, but more as

> a reactionary […] I've been on every single regimen that you can literally imagine, starting from Genesis to Revelation. Every diuretic, every steroid. I've had intratympanic injections. I've seen various neurotologists, various ENTs, and their advisement varies a lot. It's super subjective, so you're open for whatever they may suggest. They all have what they think is going to be the thing that helps you […] I'll speak for myself, you're kind of like a human pincushion or a science experiment. You know, it's "let's try this, let's try that."

Meghan established the uncertainty that she felt in the treatment of her idiopathic, fluctuating illness. Indeed, she tied this experience with how time-consuming the healthcare process is, which impacted her work abilities:

> As much as that's very admirable in terms of the healthcare system, it's not helpful for the patient. It just really depletes you and your energy for work and life, and you also have side effects from the medications that you try.

Meghan described how the intensive medical process to address MD also pervaded into her work life. Not only did MD symptoms complicate her work already, but medical treatments exacerbated these uncertainties. Furthermore, Meghan shared how healthcare created a direct impact on her job outlook:

> I am going to be shifting out of the military because it's had such a significant impact on my life. I'm going through what's called a medical board. The medical board is something that the military does to determine whether or not you meet criteria for sustainment, and if they can't sustain you, meaning in layman's terms, they can't deploy you—which is your entire responsibility of being in the service—then they have to figure out what the best plan is.

Like Dylan’s anticipatory socialization process, Meghan reported a crossroads in her socialization path. The medical board is a direct determinant of whether Meghan’s job role and career path can be properly sustained. In fact, this medical board is a direct correlator to shaping her occupational future in the military. This led her to reassess her future career options. This dilemma placed her in conflict of prioritizing anticipatory socialization as she was within the metamorphosis phase in the military. Meghan elaborated further:

> So, I'm in the middle of doing that. That's very stressful and that's one hundred percent related to Ménière’s and the impacts of that. I’m also not seeing patients right at this moment due to the unreliability of the disease. Not in a punitive way, but just in an admin function so that I can attend all these specialist appointments.

The intrinsic relationship between Meghan’s healthcare and job role illuminated the extent to which healthcare greatly altered the socialization process. Increased doctor’s appointments, testing, and management determined Meghan’s tasks and job expectations. Meghan’s healthcare impacted the way she was able to do her work as a care provider. Additionally, her sensemaking during this phase honed on potential career and job opportunities that could coexist with her MD symptoms.

Certainly, healthcare experiences also fueled positive outlook on career prospects. While some shared difficulties that medical care had on their workplace roles and expectations, others stated how positive interactions with their healthcare were reflected in anticipatory socialization practices. Amber, an ICU nurse, shared the story of her diagnosis:

> I explained what I was going through, and I checked off all the boxes. He was like, "You have Ménière’s disease." And I was like, "fuck." Like, I started crying […] I mean, it was the one thing I didn't want. I immediately came home, told my parents and my husband. It was really scary because you don't know how it's going to progress. I mean, there's no cure or anything, and my doctor told me, "The minute you let it rule your life is the minute you will go downhill." And so, I've kind of held on to that. I try to push through it as much as I can.

Even though the diagnosis was frightening and uncertain, her doctor’s supportive advice helped to maintain a positive mindset. Experiencing this healthcare dynamic continued to shape Amber’s professional expectations:

> What my doctor told me—that really shaped how I handle this disease. I go into work all-in and still want to do my best. Plus, I think this mentality helped me with explaining to others about Ménière’s. Like, I don’t mind if it got around. At the hospital, I work in the ICU, and we’re always so short-staffed. So, I want people to understand why I called out, or why I needed to take breaks, or why I had to keep stepping away.

Amber's hopeful MD prognosis heavily informed how she navigated the initial socialization phases. Her doctor's influence contributed to an open, carefree attitude about discussing MD. Amber learned through her socialization process that the ICU unit can be short-staffed. This, coupled with her healthcare influence, directed the extent of Amber's transparency around her MD.

Taken together, these findings highlighted the powerful role of healthcare experiences in shaping the workplace socialization processes. Whether through tumultuous diagnosis or empowering clinical interactions, each participant's healthcare history guided how they navigated job and career transitions. This theme underscored, among the myriad of anticipatory socialization factors, that healthcare can often be a role in shaping ideas of work and organizations.

Workplace Communication About Other Employees' Health Conditions

Participants charted the socialization process by surveilling how organizational members talked of other employees and their health conditions. These conversations helped participants identify their organization's attitudes towards chronic illness. Some participants noted how individuals engaged in toxic communication about others, including bullying practices. Others shared instances where health discussion was open and nonjudgmental. Some were a part of these conversations, whereas others simply observed behaviors to draw conclusions. These experiences were essential during the encounter phase specifically; information-seeking through this method refined understandings of how colleagues viewed disability and illness. This finding became a grounded marker in the proposed model of episodic socialization. Participants' observations about the treatment of health and illness at work was a determinant of organizational inclusivity, shaping their path from encounter to metamorphosis phases.

Unfortunately, participants observed unsupportive communication about colleague’s and their health conditions. Ruby, a dentistry educator within a large university, had been navigating a spike in MD symptoms. Ruby reflected on information-seeking tactics that informed her view of the organization’s values. Namely, Ruby overheard discussions about colleagues who were absent for health-related reasons:

> We have a doctor that's been out and she typically, you know, has had a lot of issues with her back and neck since I've been there. And she left… probably last summer. And I mean, people talk about her constantly, you know? “Why doesn't she just give it up? Why are we holding this job for her?” […] I mean, people talk about that, talk about her. I don't know what they say on the HR level. But I can tell you that my boss and others, who are a step down from the dean's office, make fun of it in a, you know, “Does she really have that problem?” kind of way.

Ruby’s account exemplified how discourse of colleagues with health conditions can significantly shape the socialization process. Observing how colleagues are discussed—often with derision—served as a powerful cue about the social risks of being perceived as unreliable. Furthermore, Ruby observed that coworkers and supervisors alike engage in toxic workplace discourse, which pivoted her socialization process:

> You know, it's made me start thinking about retirement, or even just workplace changes. I’m trying to understand what that looks like. I can't really stop right now, and I understand it's hard to get disability. I'm managing it the best I possibly can […] I know that some of the doctors have had to have surgery, like I mentioned, and that's just not looked really well on. It really isn't. All they care about is what they need. As far as people they just want warm bodies doing the job.

Skepticism about coworker performance due to health made Ruby weigh possible outcomes as her MD evolved. These observations, coupled with symptom challenges, resulted in changes to Ruby’s socialization process. Whereas Ruby may have engaged further in the socialization process, toxic communication about colleagues pushed her to reconsider exiting the organization. Even if Ruby were to attain accommodations through her workplace, the way health conditions were discussed provoked an added stressor within the workplace environment. These information-seeking tactics informed Ruby that the organizational goal is to have "warm bodies doing the job," and is devoid of concern for well-being.

Another instance of unsupportive workplace relationships arose in Krista's interview. Krista worked as a school psychologist assisting children in special education. While Krista expressed direct support from her direct team, stating that "they don't care" and "don't ask questions." She acknowledged how others in her organization were not as lucky:

> I heard about my friend who has cancer. She's in another building, and I haven't kept in close contact with her, but I know that she didn't experience a lot of great support from her direct admin when she was going through that either, and that just breaks my heart. And to me, cancer is something that is more understandable, right? Where, like you say, this is much more of an invisible illness. It makes me wonder if my Ménière's will even matter if it becomes a problem.

Like Ruby, Krista engaged in observation and surveillance as two methods of information-seeking tactics. In doing so, she identified that certain parts of the organization are less supportive in health accommodations than others. The barriers in her friend receiving assistance for her cancer diagnosis guided Krista's navigation of MD management while upholding professionalism. Referencing the invisible nature of MD, Krista concluded that the misunderstanding of IDs may negatively impact if she were to expand conversation around her condition. This exchange taught Krista that certain groups, such as her direct team, would be more supportive than those in other branches.

Conversely, in some instances, workplace communication about illness and health were welcomed; in fact, participants reported being part of these conversations to build rapport through the socialization process. Jackson, a municipal worker, identified that health is a common topic in team discussions:

> One of them, Gail, my coworker, she's in her early sixties. And we joke on her all the time because she's never had a colonoscopy. We'll be like, "Gail! Just go get it!" You're supposed to start getting them at, like, 45. Everyone has it. We all gotta get through it.

> Just go get the colonoscopy. But all jokes aside, we talk about that kind of stuff. I mean, how often can you talk about a colonoscopy with a sixty-year-old woman in a setting where she's not a family member? But it set the tone for how close we all are. I just have a great group of people that I work with. They get it.

Jackson's open team dynamic allowed for health-related talk to populate. The humorous nature of joking with one another conveyed the casual nature of the organization and permitted personal matters to be discussed. This transparency in communication allowed for closer relationships and for Jackson to understand the level of support that he may receive regarding his MD:

> You know, I think part of this team I work with is that I've explained some pretty serious stuff with them. Like, there's no getting rid of this. There's no cure for Ménière's disease. You just kind of have to manage things. I think having the camaraderie in my team opened conversation of that up.

In his socialization process through the workplace, Jackson identified how his team's close-knit dynamic allowed for health to be a conversational topic. Organizational attitudes towards health and illness became clear through stories, jokes, and disclosures shared amongst the team. Thus, it influenced Jackson to understand how his MD management fit in the organizational landscape.

Despite the open and supportive communication observed in workplaces, individuals still chose not to share their MD. Lily, an intervention specialist for at-risk youth, witnessed a health-related disclosure from a colleague. Rather than open MD privacy boundaries, it strengthened her decision to withhold her condition from the organization:

> Health is a topic of discussion. I mean, we just had a clinician have a stroke and it got heavily talked about. Everyone modified for her. Like, that's the thing, where everyone modified for her. "Let's do what we have to do, let's help you get better." […] it wasn't a shameful thing at all. And yet I still wouldn't [disclose MD diagnosis]. And maybe that's because it feels so finite. It's like, "Okay, you had this thing, and then we're going to get you over it and then you'll be fine," versus, like, Ménière's... It's so episodic.

During this observation, Lily noticed the inclusive tone of her workplace when it came to the health of a colleague; however, this information led her to solidify a separation between MD boundaries and work. A serious, seemingly temporary health issue is met with collective support.

The colleague response “let’s help you get better” framed the illness as a one-time event. In contrast, Lily expressed hesitation to disclose her MD diagnosis, citing the episodic and unpredictable nature of the condition:

> It's just incredibly frustrating sometimes. Because, like, you look fine. You look like you are functioning. And Ménière’s is episodic, and it can come, and it can go. And you are always, like, analyzing every freaking factor. I think that’s what challenging for others to fully grasp, because it is so different from most people’s ideas of a health condition.

The recurring element of MD made it more difficult to present a condition that can be fixed, and thus, Lily determined that it would be difficult to garner that same support. This dynamic revealed how health-related communication in the workplace influenced navigation of the socialization process. Individuals may be more likely to center health conditions that fit within the accepted narrative of a temporary illness. When undergoing the socialization process, Lily concluded that MD does not fit into this organizational assessment of health and treatment.

This theme identified how participants determined organizational attitudes towards illness based off conversations overheard or participated in. These observations were a large factor for many individuals in applying certain communicative strategies through the socialization process. The unique characteristics of MD guided participants to conclude that health was not an appropriate topic of discussion in their workplaces. Conversely, others found that health-based information was helpful for relational closeness. Participants also shared their sensemaking process during socialization that felt they could not disclose MD, despite organizational attitudes towards other illnesses. This behavior was a key information-seeking tool that established individuals’ better understanding of workplace dynamics and culture. Thus, the proposed episodic model of socialization utilized this as mechanism for generating continuous privacy management decisions when navigating the encounter phase of organizational socialization.

Health-Informed Organizational identification

Participants surfaced the organizational identification process as being influenced by their MD. That is, symptoms shaped the sense of “oneness” that individuals felt within their workplace. On one hand, the management of unpredictable symptoms led participants to rely on organizational policies. This created a cycle of reliance on the organization and strengthened the organizational identification process. Furthermore, participants in this theme articulated how organizational identification can be fortified through flexible organizational policies. For others, organizational structures and styles contributed to organizational identification while pushing back the individual needs that come with MD. Like the previous two findings, this theme was considered a crucial step for the proposed episodic model of socialization. Specifically, this process of strong health influence on organizational identification was an essential factor organizational affiliation during metamorphosis.

There was an explicit link between how MD symptoms influenced the ability for participants identified with their organization. Participants described a connection between symptom management and a sense of belonging with their organization. Moreso, the possibility of unpredictable symptoms deepened emotional commitment to organizational policies and accommodations. Grace, a welding and power mechanics teacher for teenagers, first stated that the fluctuation in symptoms caused uncertainty in job-related impacts:

> That's the biggest thing too, especially in the beginning, like, you don't know what your triggers are. So, if you have no idea what your triggers are, how are you gonna know how this will affect your job, right? So at least if I, you know, have a night where I've gotten two hours of sleep and I still have to go to work, at least I can tailor my day for that.

Grace reflected on the different targets of organizational identification that she related to. Anchoring to personal and professional identities (i.e., motherhood and educator) became main considerations when working while experiencing MD symptoms. Grace's organizational identification with the latter was further exemplified:

> I can think, "Okay, I've got this lesson plan in my back pocket for days like this where we're gonna be doing some, you know, interactive modules on the laptop," or whatever. Or "You know what? Hey, I wanted to show you guys this video of, you know, limited slip differential. So we're gonna take fifteen minutes and do that." So, I honestly try not to be super solid with my agenda [...] I teach between four to five classes a day, and at the end of each class, we do a really good clean up [...] because I'm like, "Hey, what if I'm having a bad day tomorrow or I need a sub?" At least it's organized. Everything is, you know, somewhat taken care of. That way, you're starting with a fresh slate.

Grace explicitly connected her role as a teacher with detailed MD preparation. Her job identity was partially shaped by her need to be prepared for MD symptoms. Her ability to meet the demands of the role, even in the face of unpredictable symptoms, strengthened organizational identification with her work, but also reflected reliance on the organizational support system (i.e., options for a substitute teacher) that allowed her to perform the job. Grace's ability to prepare and adapt to MD symptoms was a direct consequence of organizational flexibility. The dynamic between achieving both personal well-being and organizational goals enhanced organizational identification.

Similarly, Maria, a PhD candidate in neuroscience, shared how her ability to manage MD affected her ability to identify with her organization. Being a graduate student, she relayed how time management as a student and someone with MD go together. When asked how she managed the demands of work with MD management, Maria replied:

> I think being well-prepared gives me peace of mind. I'm a graduate student, right? I'm in my last year of PhD, so I have to be very organized. I plan for everything. Knowing that I am prepared if something happens, like having a kind of safety net, helps a lot.

Maria established a clear link between the professional planning to health management. That is, the ability to plan for MD scenarios shaped Maria's process of identifying with her role in the organization. These lifestyle habits complemented one another and guided Maria to develop a stronger connection with her lab:

> For example: I have a security bag. It's almost like a first-aid kit but tailored for me. It has rescue meds, electrolytes, water […] I keep one next to my bed, one in my backpack, and another near my workspace. If I ever have an attack, I know there's everything I need within reach. That level of preparation really reduced my anxiety and helps me just feel more in control. I feel like with that prep, I can focus on my work and my interactions with the people I work with. It's always in my mind that an attack can happen, but I know I'm covered with everything I'd need.

Maria's reduced anxiety and increased sense of control affected how she identified with her role as a PhD student. Much like Grace, the peace of mind Maria gained from preparedness is an essential component that allowed mental headspace to establish organizational identification. This example from Maria suggested that her program required structure and preparation for success, especially during her final year of graduate school. The preparedness of managing potential MD attacks had a direct influence on her ability to identify with these requirements for the job. Indeed, Maria reflected on how "being proactive rather than reactive" helped her with attacks at work. One of these proactive strategies is to carry strong relationships across her lab:

> I feel like everybody that I've shared this with has made me feel very supported. One of my lab mates once had to take me to the hospital. She dropped everything […] came to pick me up and took me to the hospital. I feel like our lab has been very understanding and helped to support me, especially with the increase of my symptoms.

Maria's story suggested how, even when preparedness cannot fully prevent a bad attack, organizational identification is strengthened through the relationships built throughout her time in the program. Despite the horrible experience Maria faced that day with an MD attack, the aid received by her lab mate revealed the level of support that was given within the workplace setting.

Results also showed how flexible leave policies implemented by organizations increased one's organizational identification with their work. In fact, these flexible policies raised organizational identification levels regardless of disclosure decisions. Lily’s workplace protocol for taking leave allowed her to call out if needed for MD-related events without disclosing her condition. Because this type of work required high emotional labor, flexibility was frequently an option that Lily could count on:

> I'm in a fortunate position. Because my job is so stressful, people have to take their own mental health days a lot. We all kind of understand that, like, you can only be in crisis mode with people for so long, and then you're like, "I need a break” [...] So, fortunately in my job, they don't really question you taking mental health days, 'cause they know you need it. Especially, like, if the youth you're working with just went to jail. And we set our own schedules. There have been days where I will just have to reschedule people, and then I'll just do, like, catch up on my computer. So, in that regard, it's very fortunate.

Lily expressed gratitude for the openness that her organization provides. In encountering the organization, Lily concluded that the flexible leave policy allowed for her to manage MD while never having to disclose the condition. Here, Lily withheld all MD-related information from her organization while using widely available mental health days for achieving success and managing symptoms. At the same time, this flexible policy granted Lily the chance to navigate her MD and allowed for her to increase organizational identification with the organization in return. This sense of organizational identification was exemplified further through the nature of her work and her team’s shared challenges:

> Our team is really close. Like, we share a lot with each other, just stuff going on in our lives. Things like our kids, and stuff we do. It’s the kind of environment where, because we work with such high acuity people, that we all kind of have a bit of a jaded sense of humor. Trauma is part of our work, and we openly express our traumas to each other.

Even though Lily never revealed her MD in this organization, she still identified strongly with her team. The traumatic nature of youth crisis intervention called for strategies like dark humor to build camaraderie and alleviate stress. The communal language around trauma and its expression resulted in a higher organizational identification with the organization. This, in conjunction with a flexible time off policy, simultaneously protected Lily from needing to disclose while allowing workplace organizational identification to occur.

Conversely, Jackson's story exemplified how flexible work policies fuel open communication and team organizational identification. As a state government employee, Jackson expressed the close relationships developed within his work team, comparing it to other fields which demonstrated his own alignment with the organization and its adaptability:

> I mean, one of the benefits to my job specifically being a public employee is we get pretty good benefits. Like, I get personal days, sick days, vacation days… If anything happens, I'll text one of my coworkers and be like, "Yo, if I have anything scheduled, clear it. I need the rest of the day off." And nobody bats an eye, you know? I'm sure a lot of corporations are like that, but you know, some people, like police, they might not be able to do that. If you're on, that's your job. Like, you got to deal with it in that space. I'm fortunate enough to have that flexibility. If something happens, I can disappear, you know, or take the day off even.

A feeling of gratitude for one's organization was shared throughout several interviews, such as Jackson's. The organizational identification with work was reflected through clear communication with colleagues regarding his MD. The option for his team to clear his schedule if he had an attack, plus the communal support, helps developed workplace relationships. Instances where Jackson had to use sick or personal days helped him manage his MD. Additionally, the flexibility to use these days worked in tandem with a supportive network and job field where he utilized these advantages. In contrast, he noted how other positions may not be as fortunate because of their task requirements. Jackson elaborated further on his organizational identification with the workplace and the reception from others after disclosing his MD:

> So, I mean, they [coworkers] get it, and they understand. Like I said, they've seen me take meds. If I'm starting to feel something coming on, they've always been supportive […] And I mean, I got a lucky group. I'm good with people and there's only like four people in our team that I work with all day long. Other people come and go. You know, we're tight. I mean, I spend more time with them than I spend with my wife, right? It's 40 hours a week. Like, I see my wife for like, 20 hours a week, you know? I mean, maybe that's an

> exaggeration (laughs). But you create a work family, and we all look out for each other. It's a unique scenario.

While he identified with the organization, Jackson also established alignment with his specific team. Here, Jackson used communal language (i.e., “we’re tight”) and humor to compare the hours spent with his team versus his wife. The family metaphor also suggests that Jackson experienced high organizational identification with his team. Not only did his colleagues extend support in high-symptom moments, but the support was reciprocated to his colleagues (i.e., “we all look out for each other.”) This clear communication and mutual support suggest that Jackson was well-established in the organization.

Amber had a similar approach concerning gratitude and comparison of her work to other disciplines. Working in a medical setting, many coworkers understood the nature of Amber’s MD and its challenges, which opened the opportunity for further organizational identification with her team. She explained in further detail:

> I think their policies with invisible illness—because I work in a hospital—I’m grateful for that. Not a lot of people know what Ménière’s is, but as soon as I'm like, "Oh yeah, I have Ménière’s,” they're like, “Oh shit, I'm so sorry.” They know I struggle with vertigo. They know I struggle with my hearing sometimes, so they kind of have to yell at me a little. I guess I'm pretty thankful for where I work. If I worked at a place like McDonald's or something, I probably wouldn't have as much grace.

Like Jackson, Amber made comparisons to other workplaces and assumed the treatment of IDs there would differ greatly from a hospital setting. Furthermore, Amber’s coworkers understood the scope of what MD entailed. Not only did colleagues empathize with her navigating MD without having to explain in detail, but they were also aware of considerations during interactions, such as speaking up louder. This made Amber feel like she is a part of the organization and established organizational identification while undergoing the socialization process.

The relationship between organizational identification and flexible work policies were exemplified across both in-person and remote job formats. Piper was a participant who worked in an education technology firm that provides tutoring and homework assistance services. Despite the virtual format, she felt a closeness to the organization, in part because of their adaptability with chronic illnesses, including her MD symptoms. During her job interview, she inquired:

> "You know, what do you do for accommodations if people has a chronic illness? What if they have a learning disability?" Because I have an auditory processing thing, obviously. That was one of the things that attracted me to the job, that none of it is auditory, it's all written. So they said, "Oh, we're fully accepting of accommodations." And the interviewer said, "Here are some accommodations that we have given our workers," and he listed off a bunch. There were things like transcriptions, different types of computer screens and layouts, flexible work hours. If someone was having a flare-up, they could call in that morning and say so. And we get a certain amount of sick hours, even as a part-time worker. But if it's part of your chronic illness, they don't take it off your sick leave.

Even in the interview process, the flexible work hours on top of the virtual format appealed to Piper as it allowed her to best manage her symptoms. This preliminary information-seeking revealed the flexible conditions that allowed her to thrive in the company.

Additionally, while not interconnected with other participant responses, organizations with collective missions and goals greatly impacted the organizational identification process—sometimes at the expense of one's own MD-related needs. For instance, Meghan described her experience of workplace socialization reinforced a mission-driven identity. Despite worsening MD symptoms, she maintained a strong organizational identification with her organizational role:

> I don't want to be super judicious and dodge your question, but, like, it's hard in my field. Not just in my career field, but I'm saying like, in the service. Because we have a mission, and that one mission is to defend the national security of our country. And there's a standard by which you have to do that, and it's not personal. And there's a certain acceptance that you have to have when you arrive at something like Ménière's Disease, for example, or for other diseases and disorders.

Although Meghan's symptoms posed barriers to performing duties in the military, she did not express any hesitation in alignment in the organization's mission. Her response highlighted a culture that valued a collective mission over personal circumstances. Her comments suggested that personal struggles, like managing chronic illness, are subordinated to the expectations of service and conformity. She elaborated further:

> I think no matter what career field you're in, no matter where you work—and this is where I'm gonna be sort of dodgy—is that you'll find that some people are gonna be supportive and other people are not. They're just not gonna get it. And that's part of the individual's journey through that. I'm not super prepared to talk about mine and how and why, because I serve, and I serve willingly. And I serve with honor, and I feel proud to be able to serve in the U.S. Military, so I want people to have a very healthy perspective of what that looks like, regardless of what I may have individually experienced.

Here, Meghan articulated a profound alignment with the organization's values and set aside the need for centering her own MD symptoms. Her sense of duty overrode the willingness to discuss support—or lack thereof—for her MD. This form of organizational identification was cultivated through socialization in a hierarchical and totalistic environment. Thus, Meghan de-emphasized personal health challenges in favor of the organization's collective ethos.

This category of themes uncovered how individuals with MD underwent the early stages of workplace socialization. Results showed that participants in this study relied heavily on previous healthcare experiences and observations of health-related communication in their professional environments. MD-related medical history, especially the diagnosis and management process, reflected a deep influence on formed expectations and behaviors during the socialization process. Whether through the emotional labor of an inconclusive diagnosis (as in Dylan's case) or the moderating role of Amber's physician on her work-oriented mindset, participants' healthcare shaped how individuals interacted with organizational norms. All three themes were identified as markers for individuals' understanding of the organization and, depending on positive or negative experiences, guided their socialization process while simultaneously determining their disclosure decisions.

Furthermore, the organization's climate concerning health disclosures emerged as a crucial factor in forming norms and expectations through initial socialization phases. Engaging in passive observation, surveillance, and or informal conversations allowed for individuals to assess perceived stigma around chronic illness in the workplace. When individuals identified moments of open support, they expressed higher feelings of organizational identification with their organization, work team, and or job role. On the other hand, individuals expressed a reservation of MD information during the socialization process to achieve organizational identification within mission-driven, totalistic organizations.

Disclosure of Meniérè's Disease in Work Environments

Disclosure of MD in workplace settings was greatly nuanced and depended on several contextual factors. Because of the episodic nature of a condition such as MD, the presentation of symptoms were a factor in participant's disclosure decisions. Disclosure extent was impacted by structures and norms of the organization, which influenced how private information was handled by managers and coworkers. The lens of MD disclosure in professional spaces yielded six themes from the data, which included: a) refusal to disclose to organizational members; b) involuntary disclosure; c) communication barriers to disclosure; d) reciprocative disclosures about disability; e) opportunity to educate others on MD; and f) privacy renegotiation following turbulence. These themes conveyed the complexities of sharing an invisible and episodic condition. Not only were personal privacy boundaries influenced by both colleague relationships and the symptoms of MD itself, but also by organizational policies that hindered or supported MD disclosure.

These six themes informed the construction of an episodic model of socialization. While individuals were engaging with the socialization process, they were also presented with opportunities to shape their disclosure decisions and boundary structures concerning MD-related privacy. These findings did not necessitate their own position on the proposed model, as not all participants underwent the following interactions; however, these experiences were condensed into three privacy management strategies: a) an initial disclosure decision that shaped privacy boundaries across one's workplace; b) boundary adjustments that were made due to organizational or interpersonal changes; and c) long-term boundary management that reflected participants' choices about firm choices on disclosure decisions, including which symptoms were discussed and with whom.

Refusal to Disclose to Organizational Members

Participants expressed cases where they chose to withhold all disclosure of MD in professional spaces. Even as Lily began the anticipatory socialization process of applying and interviewing for her new job role, she knew that disclosure was not an option she was willing to take:

> I do crisis intervention for behavioral health, for youth. I have to drive to the hospitals. I have to drive to schools. I'm driving to people's homes. And, like, I 100% was not going to tell them about Meniérès. Like, there's no way. Because I didn't want them to be like, "Wait, you could get so dizzy that you don't feel safe driving?"

The job expectations for Lily's work-related travel were a crucial factor in her choice not to disclose MD. This component of her work was essential to determine withholding disclosure. Lily shared her worries that "regardless of how they feel about equality in the workplace," she was opposed to MD disclosures during the application process:

> When you're doing the applications and it asks, "Do you have a disability? We promise we won't tell anybody." I'm like, "Bullshit." I always put no when I was searching for a job and stuff, and I still—yeah, with my new job I've just always said no.

Lily's conscious decision to avoid all disclosure of her MD was to achieve security in her workplace. As voiced by Lily, she did not wish to risk concern from colleagues or managers if discomfort with driving was shared. This is akin to Amber's comments on refusing disclosure as she applied for job openings, including her job as an ICU nurse:

> You fill out the application form, and it asks, "Do you have any disabilities?" And I was like, "no" […] Now, I don't know what to put because I feel like people won't hire you if you put "yes" on it or something, you know?

These two quotes illuminated hesitancy of disclosing such an intimate subject during the application process. Refusal to disclose was heavily situated in motivational criteria. Thus, individuals prioritized attaining financial security through employment over self-disclosure. While some individuals, like Amber, eventually chose to disclose, they made this decision once grounded in the organization's culture.

In contrast, Lily had continued not to disclose her MD because of the uncertainty over disclosure reactions. Despite non-disclosure, Lily's organization offered a flexible time-off schedule to allot for mental health days when dealing with emotionally fraught events. Lily utilized this adaptable leave policy when navigating higher MD symptoms; however, the organization did have a practice that gives Lily some trepidation:

> But the part that's not so easy is that one day a week and one weekend a month we are on for extreme crisis calls and you *have* to go out. Like, you can't take a mental health day that day, and those are the days I have just been crossing my fingers and have not had to deal with yet. And even if I did have to deal with it, I wouldn't tell them [workplace]. And not because I don't think they're great people. It's because I think it would be in the back of their minds […] I myself am unwilling to see if they would because I need the job. I'm a single mom now. Like, I cannot not have this job. Especially my direct supervisor, I think he would be fine. I do. But I'm unwilling to roll the dice in case they're not.

As she has encountered the organization's protocol of extreme crisis calls, Lily still made the choice to not disclose her MD with others in the workplace. She reiterated that, otherwise, she felt supported and overall enjoyed the people that she worked with; however, her personal circumstances as a single parent were a major consideration in her choice to not disclose. Even with certainty that her supervisor would be supportive, that is a boundary with which she was not willing to experiment.

Prioritizing the withholding of specific symptoms was noted throughout responses. Notably, non-disclosure was centered around hearing loss over vertigo symptoms. Certain symptoms were of higher concern to conceal. Robert, the CEO of a government housing program, stated that nobody knew of his MD diagnosis. Specifically, he emphasized priorities of withholding information specifically about hearing loss:

> I've not disclosed to anyone in my organization that I have Meniérès. I mean, certainly not with my colleagues when I first joined there. I did talk about how sometimes I can get dizzy. That I've had vertigo, you know, just kind of small talk. And people usually say, "Oh, I've had that before, and my mother had vertigo" and stuff like that. And, so nobody, even if you went into my workplace and asked the people, they wouldn't even know that I wear these [hearing aids]. And I've been working with them for years. You can't see them. The go right in deep inside your ears. There's nothing there to see and they work great. They're more expensive than over the ear, of course, but I wanted something that, you know, they're not visible.

Robert chose to construct rigid privacy boundaries that only allowed for discussion of basic symptoms regarding his MD. In fact, while he shared surface-level explanation of dizziness and vertigo, he did not address that MD was a cause to these symptoms. In concealing his condition, Robert also methodically selected management devices, such as hearing aids, that would be hidden to minimize opportunities for inquiry about his hearing loss. Robert detailed his reasoning:

> It's kind of like a lot of things in your life, right? When you have a situation and then you kind of tell somebody, like, a lesser version or interpretation of it and then it doesn't come up very often. Then that's just what it is. I mean, I could do it if I started having severe symptoms, but there's no real benefit for me to say, 'Hey, remember when I told you two years ago that I would have vertigo sometimes?' So, there's not really a rationale or opportunity for me to disclose that.

Robert's limited disclosure in the workplace configured tight privacy boundaries around his condition. Robert reasoned that he did not see clear reasons for making a formal disclosure due to the lack of motivational criteria. That is, Robert's MD symptoms were well managed, not necessitating the explanation of a diagnosis. CPMT may argue that Robert's risk-benefit analysis of disclosure determined that a disclosure would make potential reactions and explanations more troublesome than productive. In addition, Robert has spent previous time and energy constructing privacy boundaries around his MD (i.e., investing in cross-over hearing aids versus over-ear hearing aids). Thus, some individuals utilized lifestyle choices to conceal potential conversation of MD.

Findings in this sub-theme revealed how communication privacy boundaries resulted in a refusal to disclose some or all elements of MD in the workplace. Some participants, such as Amber, eventually chose to disclose when learning of the communal understanding of MD, thus altering her contextual criteria for boundary construction. Others, such as Lily, made firm decisions throughout the socialization process to refuse disclosure. In fact, organizational policies such as Lily's mental health days were a way for her to manage her MD and handle her work effectively. Participants also shared their sensemaking behind non-disclosure, citing certain parts of MD as requiring tighter boundary constriction. While his overall privacy boundaries were restrictive, Robert allowed for very limited sharing of vertigo symptoms while withholding any mention of hearing loss symptoms. Individual and organizational factors alike can determine why an individual may choose to refuse disclosure of MD, or to share some symptoms without disclosing the condition itself. Specifically, organizational structures such as values and norms were labeled on the episodic model of socialization to showcase the influence that one's workplace had on disclosure choices.

Involuntary Disclosures

While some individuals chose to withhold conversation of MD in their workplace relationships, this was not always an option due to MD's episodic and unpredictable nature. Thus, "involuntary disclosures" arose when participants' symptoms resulted in unwilling disclosures of MD. These involuntary disclosures often occurred when the worst of their symptoms surfaced, typically in the form of vertigo attacks. Due to the unpredictable nature of these episodes, individuals had to make sudden changes to their privacy boundaries, attempting to make sense of catalyst criteria while trying to manage physical and mental incapacitation. Involuntary disclosures also surfaced regarding symptoms apart from vertigo episodes. In fact, in some cases observations made by other individuals in the organization led to commentary about the participant's behavior. This resulted in the participant feeling pushed to disclose and explain their MD diagnosis.

Participants in this study who experienced an involuntary disclosure received some level of positive support in the midst of their episodes. While these involuntary disclosures often began in the context of interpersonal or group disclosures, they became a stepping-stone for larger, more formal disclosures of one's MD. Krista, a school psychologist, shared an event where she experienced an episode at work, and the timeline of how this led her to involuntarily disclose with others:

> Well, the first time it happened, I'm in a school building. I was feeling okay. I walked down the hall. I was actually going to go use the gym at work and as soon as I, like, opened the door to go to the gym, I was like "*oh,*" so then I start to walk back to my office and I was like, "I don't know if I'm going to make it," so I literally like, just sat down and I like, voice texted for one of my teacher friends, who I knew was still in the building. Well, and that's the thing. I work with her, but no, I had never told her about it either. So, I was like, "I need you to help me." So she got a trash can and she-- and it was bad. It was like two hours. I sat there and we were after school. And then finally, she called someone to come and get me. But after that happened, I did tell my administrator,

> and they were kind. She was like, "Well, why didn't you tell me? One of us was probably still in the building."

While having an episode at work, Krista's instant reaction was to expand her privacy boundaries by specifically telling a coworker whom she had a developed friendship with. While she did not initially reveal her MD to her friend, the urgency of this situation expanded her threshold for sharing this condition. The graphic nature of some attacks, such as vomiting, was a personal event for another to witness. Viewing such a violent episode vastly expanded Krista's privacy boundaries during this interaction. Despite Krista's supervisor not being present during the attack, this involuntary disclosure made Krista feel the need to share more about her condition, to which she received a sympathetic and supportive response.

The experience of coworkers witnessing an attack in the workplace came up often as a reason for disclosure among participants. As a result, this also reconfigured the privacy boundaries that were in place before the in-office episode. These public attacks were frequently cited by participants as the reason for disclosure. Similarly, in her graduate program, Maria indicated that the disclosure of her MD was not fully understood. It was only when she experienced an attack in front of her supervisor that the full scale of the condition was understood:

> Even my supervisor, when I first told her, was still messaging me and expecting work from me on days I told her I was out. I eventually, like, explained to her, "I literally cannot, like, look at a screen or respond to emails right now." Once she saw me during an attack, she finally understood.

Even though Maria's supervisor was a confidant in her disclosure of MD, there was still a miscommunication in understanding MD's "brutal" attacks, as Clarissa had described in her interview. Once Maria involuntarily disclosed the full scope of an MD episode, her supervisor was better able to empathize. As illuminated by these two examples, it appeared that oftentimes the most intense and uncontrollable of symptoms are what required an unplanned disclosure to help the confidant understand MD.

When individuals faced involuntary disclosures due to vertigo episodes, the structure or norms of their organization impacted how they responded to and disclosed their MD. Jay, who worked two remote jobs in academic and finance fields, traveled to conferences for each position. When he had the unfortunate experience an attack at a conference, the virtual structure of his organization informed his decision-making:

> I travel a bit for both jobs. Once, I had to attend a conference in September of 2023. I had a horrible attack later during the day of the conference. My coworkers saw me and were like, “Hey, what's going on?” So I explained, “This is what this thing I have looks like. I just have to wait it out” [...] They were super chill about it. Depending on how bad I feel I can sometimes sit with my eyes closed and feel okay, as long as I don't move. We just sat and talked after hours, and I told them, “I'm going to sit here with my eyes closed, but I want to be around everyone since we rarely see each other in-person.

After encountering this episode in front of coworkers while at this conference, Jay fortunately had a supportive reaction to his episode. Furthermore, because he did not have the opportunity to socialize and network with work colleagues in-person due to the remote structure, he wanted to fully engage with his workplace relationships, even if that meant having to hold a conversation while waiting out an episode.

Involuntary disclosures also occurred when organizational members made observations and comments on the participants’ behavior. While MD is invisible, participants shared how their hearing loss resulted in inquiry from others in their workplace. Grace, for instance, felt that comments from her students on her hearing loss resulted in the requirement to explain her hearing loss in further detail:

> And people, I think, noticed. Because some days, I couldn't hear anything. I'd be like, "What?! Say it in my ear! Yell it!" And I started explaining this to my students, too. 'Cause, like, kids, especially teenagers, they're so observant. They're like, "Hey, you're super deaf today, Mrs. Green." And I'll go, "Yeah I am. That's what happens, I have this

> thing where this just happens to be one of my symptoms. Sometimes my hearing cuts in and out. So, if I'm saying ’what’ a whole bunch of times, you gotta like, come up and yell it at me." I'll go, "This is the one class where you can yell."

Observations made by Grace’s students made her feel the need to share more about her condition, whereas if these remarks were not made, the relationship between MD and hearing loss may have never been disclosed. Comments from others about symptoms inadvertently reshaped privacy boundaries, as the privacy owners felt obligated to explain the impacts of MD in more depth. These observations made in Grace’s classroom resulted in the explanation of another MD symptom apart from vertigo, which expanded privacy boundaries of MD and its all-encompassing symptoms. Continuous privacy management choices, central to the proposed model in this study, are potential strategies used by individuals in the wake of a sudden, involuntary disclosure that required quick adaptations to initial boundary creations.

Communication Barriers to Disclosure

Participants revealed how, in several instances, their ability to disclose was limited. These limitations to disclosure arose from an array of factors. On one hand, organizational norms and structures played a role in how participants were able to properly disclose their MD. Across workplace relationships, a common barrier to disclosure was the misinterpretation of MD and limited knowledge of the condition. This misunderstanding of MD led participants to share frustrations about the disclosure process, or formulated better ways that explained the unique characteristics of MD.

Participants felt the need to minimize their condition and its full scope of symptoms. Not only did disclosure of MD feel very intimate, but individuals had not heard of the condition previously. Participants then used language that considered the confidants’ scope of understanding. For instance, Grace said that “I usually call it Meniérès Disorder when talking with someone about it, because it’s not really a disease and when you say ‘disease,’ people are like, “What? Are you a biohazard?” Even the use of the word “disease” in MD painted a depiction of the condition, or that it suggested notions of transmission like a pathogen. This was echoed in Robert’s strategy concerning MD, stating “I prefer to call the condition Meniérès Syndrome. It’s not really a disease—you don’t catch it from someone or something.” This is to suggest that even the medical terminology of the condition hindered how individuals communicated the nature of the condition when disclosing.

Apart from the medical terminology itself, participants struggled to depict the full scope of MD, especially in a professional environment. In her lab, Maria shared the challenges faced when describing the condition to her boss. Notably, she initially had a miscommunication about the severity of an attack because of how difficult it is to describe to someone who has never faced a vertigo episode:

> One of the hardest things is making people understand the level of impairment a Meniérès attack can cause. Most people have never heard of it unless they know someone who has it. When I say I have an inner ear disorder, they assume I just get a little dizzy and need to take a moment. But they don't realize the debilitation can be. Like, I can't stand, I can't look at a screen, I can't read, I can't talk.

On top of MD’s underrepresentation, confidants of MD disclosure struggled to fully grasp the full impact MD may have on quality of life. Here, Maria shared how even though she wished to disclose the condition, the lack of contextual background information made it difficult for the confidant to effectively understand what MD is like.

Even if a confidant knew what MD is, participants still indicated the confidant did not fully comprehend the invisible and episodic nature of the condition. Many participants shared input from organizational members regarding their MD. Comments such as, “You look fine!” Or “I can’t even tell you have something wrong,” were echoed throughout interviews. While participants like Robert took no offense to such comments, others who received these comments acknowledged that it imposed upon workplace disclosure decisions. Sophia, who worked for a government organization, recalled comments that would impact privacy boundaries to understanding MD:

> I don't remember specific comments, but I think people would say things like, “Oh, you look really good today,” and on the inside, I'm like, “Yeah, I feel like crap, but that's okay.” So, it's just one of those things. They just can't tell very easily how you're doing or what's going on or what might trigger you the next time. Or just because one thing triggers me this time, it might not trigger me the next time. And, you know, those kinds of things. But I think people try to understand, but it's just a weird thing, you know?

A motif across the data was the communication barrier of MD’s invisibility. That is, when not experiencing an episode, it was challenging for others to tell that one is still experiencing MD symptoms. Even if the participant made prior disclosures about their MD, like Sophia, commentary from co-owners illuminated the obstacles of fully comprehending an episodic illness. Well-intended compliments showcased that many symptoms of MD were unexpressed and thus challenging to articulate.

Likewise, interviews struggled to disclose in proper language that would promote a deeper understanding for the confidant. For instance, Ruby applied analogies of how she wished others could better understand the daily task of managing MD:

> I just wish they could put on some virtual goggles and walk around for a day in the life when you have an attack. What that physically makes you feel like, and afterwards, how it left you feeling. In that horrible episode I talked about when I was driving, I still went to work the next day. I was one of only two people in the clinic, and I knew I had to be there. As long as I wasn't spinning, I was going. But I was exhausted from all that.

Participants shared that invisible symptoms of fatigue, hearing loss, and disequilibrium were present, even in between vertigo attacks. Ruby explained the instance where she persevered through the next day of work following an intense attack but still felt symptoms long after its end. She reported confliction in how to best disclose those unobservable symptoms. Robin noted how difficult it was to capture in words living with MD. In this same predicament, Grace painted a picture of how to best articulate the scale of vertigo that people with MD uniquely experience:

> I think if you mentioned to someone that, "Hey, I, you know, get vertigo," lots of times you'll hear, "Oh yeah, I get that sometimes too," or "Oh yeah, I know someone who had vertigo once," or whatever. And it's like, no, I deal with this on a regular basis and just the thing of- you can go, like, several months and be perfectly fine, and then you could go a whole year and it affects you almost every day, right? And so, I think it's a matter of going more in-depth. Maybe like, "Yeah, so I do get vertigo, but I actually have this condition that kind of takes it a step further," you know? It affects my hearing" […]

In her interview, Grace analyzed how to grapple with communicating disclosure in a way that would best be received to someone who had previously never experienced an MD episode. By conveying its episodic nature and symptom fluctuation, she helped her confidant understand the information being shared.

Barriers to understanding MD affected the disclosures of people with MD, especially within their workplaces. Individuals identified obstacles due to variations in lived experiences regarding IDs, namely around the interpretation of vertigo. Participants shared the ways they communicated symptoms to leave an effective impact on their confidants and ensured that symptoms were legitimized. Even if participants did not feel fully heard or acknowledged in their disclosures, they still brainstormed ways that colleagues could learn about the condition and empathize with an MD sufferer better. Reframing language and disclosure strategies fell under boundary adjustments that would allow for colleagues to best receive a diagnosis, which is reflected in the episodic model of socialization.

Reciprocative Disclosures of Chronic Illness

While there were grievances from participants about disclosure barriers, this study identified insightful and uplifting strategies that restored privacy ownership of MD disclosure to the participant. One key finding from this study was how workplace colleagues reciprocated disabilities of their own or of loved ones when the participant disclosed their MD. This dialogue made individuals feel supported and allowed them to share the full extent of their MD. In some cases, participants received a reciprocal disclosure from colleagues also afflicted with MD. Across the board, these instances of reciprocal disclosure expanded the degree of privacy that participants were willing to disclose.

Even if colleagues were not afflicted with a health condition of their own, they referenced chronic illness of family members to relate with the participant. Jay, who worked two different jobs, shared that “Both my bosses are wonderful. In fact, my boss at the due diligence company has a son with special needs, so he’s very in-tune with my accommodations.” The full understanding from his helped Jay understand the flexibility of his work culture. Even if Jay’s manager is not managing a disability himself, the care of his child certainly built a better understanding of needs for employees managing health conditions.

Similarly, Sophia shared that her boss’s chronic illness expanded the breadth of privacy boundaries within this relationship. She stated that “I’m lucky that my boss from the beginning has just been a very understanding person. She also happens to have a chronic health condition, and so I think she’s just more supportive than maybe some might be.” While these chronic health conditions or disabilities were insinuated to be different than MD, the mutual understanding of working with a disability improved relational closeness, thus making it easier to share health-related topics. This reciprocal disclosure opened future conversations for participants to discuss their condition if desired.

Individuals also shared times when MD disclosure resulted in a reciprocal MD reveal from another colleague. Mutual understanding of MD symptoms substantially opened privacy boundaries for participants. In Amber’s interview, she reflected upon when she chose to seek accommodations for her shift schedule:

> I got so lucky because the head of our HR department—well, I mean, this isn't luck, I feel bad for the woman. She has Ménière’s, too. So, I got all the support from HR. They were like, “Oh shit, we know what you're talking about.” Because her attacks get so bad that she'd be crawling on the floor at work. So, again, because of where I work, I think I got really lucky [...] And that's when they opened up that they had it as well. I was like, “Oh, I'm really sorry, but that's cool because you know what I'm going through. You know that I'm not just talking out of my ass, you know?”

Amber’s privacy boundaries were vastly expanded after this interaction. Not only did Amber’s colleagues know medical details of MD due to the field of work, but another individual in the workplace was afflicted with the same condition. This mutual understanding of lived experience with MD allowed for Amber to expand her privacy boundaries and feet an even greater sense of support in the workplace. The legitimization of her MD, shown through the formal HR paperwork, opened the privacy boundaries in which Amber can discuss this condition. This gave her more ownership of the condition and her ability to share it across the organization.

Like Amber, Krista approached her HR department to seek accommodations for intermittent leave to best manage any symptom flares in the case she was to have an attack. Upon disclosing her diagnosis with MD, she received a reciprocal disclosure as well:

> So, then that's when I stopped into my HR office and asked about disability, or what that looks like. Well, thankfully my HR person had kind of like, undiagnosed Meniérès as well. And I was like, "What?!" So, she was obviously very, very kind and just kind of explained the process to me. She said, "Yeah, you should just fill out the paperwork in case you need it." So we did, and then I did end up needing it.

The mutual overlap in MD between Krista and her HR liaison, like Amber’s story, led to more open accommodation-seeking. This reciprocal disclosure of MD altered the catalyst criteria for Krista’s privacy disclosure. It allowed for her to seek accommodation advice directly from someone experiencing the same condition.

This theme revealed how disclosures resulted in similar health-related exchanges from another organizational member. Reciprocal disclosures included MD specifically, in addition to other chronic illnesses and disabilities. All participants who experienced this exchange expressed increased levels of support from their organization. Furthermore, personal interactions such as these altered privacy boundaries of the participants that were initially constructed. Following these reciprocal disclosures, the participant was more comfortable discussing their condition and any work-related needs (e.g., accommodations).

Opportunity to Educate Others about MD

While some individuals chose not to disclose some or all MD symptoms, others had open privacy boundaries that allowed for open conversation of their condition. In addition to seeking support for their condition, participants took it as an opportunity to educate others on the mechanisms and symptoms of MD. Participants expressed the need for explaining how to respond to symptoms such as vertigo episodes. The understated awareness of MD was cause for participants' commitment to remain as open as possible about their condition. Throughout this theme, many utilized the metaphor of being an "open book" when it came to questions about their MD. This perspective reflected their willingness to raise awareness of the condition and helped others in understanding MD better.

Some individuals made decisions to disclose their MD because it ensured colleagues would follow wishes and requests in the case of an episode in the workplace. For instance, Krista disclosed her MD to a school health clerk, which gave insight to the best support practices in the event of an attack:

> I think I am an open book, so it doesn't really bother me in terms of who knows. I think it's one of those tricky things because in some ways I almost wanted people to know in terms of… Like, it you see me laying on the floor, this is what's going on, you know? I actually went and talked to a health clerk. She's not even a nurse, but she, you know, has

> practices and protocols […] I basically said, "If something happens, please don't call an ambulance because they can't help me. It's going to look very bad, but there's nothing anybody can do for me."

Krista made plans to expand her privacy boundaries with the school health clerk to proactively plan for potential future episodes. In responding to motivational criteria, Krista sought to establish a common expectation for the proper protocol in the case of a potential MD scenario at work. Catalyst criteria of risk-benefit analysis explained this change in privacy boundaries during disclosure. While non-disclosure may have prevented momentary discomfort, Krista did not wish to risk potential negative ramifications if expectations were not outlined before a potential flare-up at work.

Participants stated that a desired outcome of disclosing MD was to educate others on the condition and raise awareness. Jackson gave detailed insight to how his open communication about MD resulted in workplace support. He spoke to enhancing the representation of MD among his work team.

> I mean, I'm pretty open. I was an EMT for eight years, so I'm very comfortable with medical stuff. I've found that when you talk about things like this people have no clue what it is. No one's ever heard of it, you know? So, you kind of educate people once they understand what it is and what they're dealing with. Then they get it. They accept it. And for the most part everyone's been supportive. No one's like, you know, put me down for it. Everyone understands. It's just something that you live with.

Jackson felt that disclosing his MD to others was not just a means of receiving support and understanding, but also a chance to educate others on the topic. Like Jackson, Jay echoed the same feelings of support received following his disclosure. He stated, “I’d say I’m an open book. I haven’t had any negative experiences, so I don’t feel the need to be private about it. I’d imagine if I encountered prejudice, I may reevaluate, but so far there’s never been a problem.” Both Jackson and Jay established open privacy boundaries to answer any questions about the condition. Upon explaining the condition in more detail, Jackson found that people better understood why he adhered to certain behaviors to manage his MD:

> But even in my new job, my current guys, like, I've told them, like, "Look, I have this inner-ear disease. If I disappear for hours, I will text you and let you know what's going on. But it is what it is. I try to control it the best I can. There's no cure for it." So, every now and then they'll see me pop my meds, if I feel something coming on. And they're like, "Are you okay? Do you need us to do anything?" And I'll be like, "No, no, no. I'm good."

Jackson clearly communicated the episodic nature of MD to his colleagues, thus maintaining low privacy boundaries. In disclosures, Jackson had no qualms detailing the full scope of MD symptoms, including their unpredictability. The awareness of his condition allowed for his coworkers to be more in-tune with his symptoms and engaged in asking questions to ensure Jackson was alright. Krista also used disclosure of her MD as an opportunity to connect with students that she interacted with in her line of work. Working with special education students, she found that her MD was a topic which could be used to support her students through their disability-related challenges:

> We're gonna do a weird pivot, because you asked me in terms of me influencing other people with silent illnesses. Again, because I work with kids who are in special education. Every once in a while, it will come up with students where I'm able to share, "Hey do you know I have hearing loss in this side? Do you know that I am on medication to manage a situation? That this thing I have causes me anxiety because I can't plan or predict things?" […] So, I've been able to talk to my students about it.

Krista's MD disclosures allowed for her to use it as means of support for her students. Children struggling to manage their own disabilities could feel acknowledged by Krista as an adult and support figure who was living with a chronic health condition. Furthermore, the varying symptoms of MD (e.g., vertigo, brain fog, hearing loss) and its secondary effects (e.g., anxiety, depression) applied to a wide spectrum of students Krista serves in relating to them and their disabilities.

The topic of education through disclosure was not solely focused on MD and its symptoms. In fact, was observed how open privacy boundaries were a tool for advocacy and education of disabled individuals in general. For instance, Clarissa centered her identity as a Deaf woman. She stated that "I consider what I have to absolutely be a disability. I say it all the time. I'm Deaf. I'm disabled. I wear it as a badge of honor." As such, she stated that she felt a responsibility to be a figure for others to consult, especially when interacting with someone in the Deaf community. Not only did this give her the opportunity to discuss MD as a chronic health condition, but it allowed for her to educate others about being deaf on a larger capacity:

> I am very much passing as an able person until I can't walk. It's important, I think, when somebody is passing, to be that voice, because, like, they're not listening to the deaf people who sound like deaf people.

Clarissa pointed to maintaining open privacy boundaries to educate others on multiple layers of MD. In this quote, Clarissa identified how she was not only a voice for people with MD, but for people in the Deaf community as well. The invisible nature of MD is referred to, which highlighted how colleagues were unaware of her condition until an attack were to strike. The multifaceted symptoms of a condition such as MD offered the opportunity for Clarissa to discuss the vestibular element of this disability, in addition to the impacts on her hearing health.

A prime motivating criterion was to educate others on MD through the disclosure process. Not only did participants brief their work colleagues on the medical functions of the condition, but they explained what to do in the case they were to experience an attack at work. Furthermore, participants shared how MD impacted several health components, such as hearing and balance. This transparency made participants feel more prepared for their workplaces in the case of potential symptom flares. Moreover, participants such as Clarissa found that advocacy for marginalized groups (i.e., the Deaf community) was another motivational criterion for open privacy boundaries.

Renegotiation of Boundaries Following a Privacy Breach

Last, participants identified times when disclosures were followed by privacy breaches. Thus, individuals were faced to renegotiate the extent they were willing and able to disclose within their organization’s culture. Participants identified how co-owners of an MD disclosure breached their privacy by telling another individual without the participants’ consent. This resulted in the participant reconfiguring their privacy rules and boundaries. This renavigation was done with the consideration of the workplace’s now existing knowledge of the MD disclosure.

Many expressed a reduction in support following the wake of privacy breaches regarding their MD. This is specifically due to an increase in mistrust following an MD-related information breach. Ruby shared experiences with her boss using the MD disclosure as fodder for conversation with others:

> My boss is the town crier. If I don't explicitly say, “Don't repeat this,” she will. She's 68—what is she still doing at work? But this is her life. You start talking about yourself, and she flips the conversation to her. She always has it worse or better. She's a one-upper. And I don't feel supported. When I first told her, she listened. But then once, in front of others, she brought it up.

Following the breach of her privacy boundaries, Ruby learned to reevaluate the conditions before sharing personal information. In retrospect, Ruby identified the use of key words or requests so that her private information was not leaked. Ruby may initially have felt acknowledged when her boss listened to the disclosure; however, the breach in privacy that followed forced Ruby to renegotiate what MD-related information is shared, and the rules surrounding it.

While some, like Ruby’s manager, did not respect her wishes to maintain a level of privacy, others did not allow for any talk of Ruby’s condition. This put Ruby in a double bind; the privacy breach removed her agency to construct her own privacy boundaries. In fact, Ruby mentioned that “Another time at a luncheon, she [supervisor] asked about my doctor's appointment, and a coworker cut in. ‘That's enough of that. We're here for lunch.’ And I just thought, ‘Okay.’” This privacy breach can reflect the ownership of Ruby’s information being stripped away. On one hand, her manager had leaked personal information to other members; on the other, unsupportive comments from coworkers silenced any discussion of her MD. Ruby did not have jurisdiction of the information she wished to share following the privacy breach. Rather, the degree of her privacy management was at the behest of her boss and colleagues.

Others shared times when supervisors breached MD privacy boundaries to colleagues without permission. Maria shared the story of a privacy breach at an academic conference, where colleagues were told of an episode experienced on the trip:

> My supervisor has seen me during an attack because I had one at a conference. We were at a long-Covid conference, and I had an episode there, and made my way up to the hotel room. I felt ashamed of not being able to be present for the day. The next morning, I came down to say hello to everyone, and they were like, *'Oh, hiiii!'* I realized then that she had told them what happened. And I felt weird about it, but it didn't really have an impact beyond my discomfort. If I had told them myself, it wouldn't have had an issue, but I wasn't prepared for them to already know about it.

Maria’s initial privacy boundaries were to omit disclosure of MD from her colleagues; however, the privacy breach by her supervisor forced a reevaluation of constructed privacy boundaries with her lab mates. The context of the privacy breach (i.e., occurring at a work-related event) were instrumental in the reshaping of these privacy boundaries.

Factors such as competitiveness in work settings also influenced the level of support that one felt when looking to share their MD in the workspace. Following Krista's disclosure to the health clerk at her work, she was advised of other figures she may not receive support from:

> The weird thing is the admin in my building. The principal, the vice principal, those women I that I work with—and a male colleague pointed this out to me—he said, "You will never get empathy and understanding from those women because their attitude is such that they have to prove themselves as women. That they are working harder and spending more time than anyone else." And that's not even just with my Meniérès, just in general.

The preexisting relationships in Krista's work shaped the extent that she can disclose. Krista was faced with analyzing her core criteria, especially gender criterion, in disclosing MD as a woman to other women. Hearing of past reactions made by these women set a precedent for how Krista's own privacy boundaries will be handled. Where Krista had developed open privacy boundaries with other organizational members (e.g., health clerk, coworkers, students), this unsupportive environment in administration forced her to reevaluate the extent that she would be willing to expand these privacy boundaries. Although Krista felt comfortable sharing her MD diagnosis and symptoms with everyone else in the organization, she was forced to renegotiate restricting disclosure to this one specific department.

Like Krista, Amber identified individuals in her organization that contradicted the open and supportive communication received following her disclosure. Specifically, Amber identified that the invisibility of MD was difficult for some of her organizational members to grasp its impact on her life. This led them to formulate comments, to which Amber was confronted with and segued into her reevaluation of privacy boundaries:

> There are some coworkers, like in their 80s, who don't understand. Because it's an invisible disease, they're like, "Oh, you're just calling off to call off." They don't really believe that something's wrong with me. So, when dealing with them, I just do what, you know the Penguins from *Madagascar?* What they do: Just smile and wave. That's the only way to handle it. There's one person I work with who's very direct but also passive-

> aggressive about it, at like, the same time. So, I try to just let it roll off my back. She's very much like, “Well I can't see it, so you don't have it.” And I'm like, “Alright girl, whatever you say.” Because, at the end of the day, there's nothing you can say to those people to make them understand. They're never going to be like, “Oh my God, I'm so sorry.” And, frankly, I don't want their sympathy—I just want them to treat me normally. But I do want them to understand that sometimes I need a little grace, just like everyone needs a little grace sometimes.

Amber’s nod to the “smile and wave” response in the face of an unsupportive reaction to disclosure allowed for her to create distance from colleagues who were not as understanding. The existing conditions set by older member of Amber’s workplace dictated how an ID disclosure was to be received. Despite the overall supportive atmosphere, certain colleagues’ interpretations of MD were unlikely to be altered. As such, Amber was confronted with renegotiating these privacy boundaries to best maintain how her condition is viewed and managed in a workplace setting. Approaching negative comments from an apathetic viewpoint allowed for Amber to reclaim privacy ownership of MD and its personal impacts on her life.

Unfortunately, participants shared cases in which they had to renegotiate their privacy boundaries following a privacy breach. Cases such as Ruby’s demonstrated how a privacy breach may result in a limitation of her own privacy ownership. This led individuals to be caught in a tension between organizational members who overshare personal information, and others who seek to silence any communication about MD. Others, such as Krista and Amber, identified how preexisting dynamics in the organization determined the renegotiation of privacy boundaries. Even if the organization is supportive and accommodating to MD, one department or branch shaped the boundary to be more restrictive than initially desired.

These findings illuminated how times of disclosure for people with MD served as pivotal moments during the socialization process. As individuals transitioned from insider to outsider, their identity as someone with MD carried a substantial role as they simultaneously developed job expectations within the organization. Results reflected persistence of barriers to full disclosure due to the invisible and episodic tendency of MD. Additionally, miscommunications in language and stigmatizing medical experiences arose. Disclosures were extremely nuanced; where individuals reported clear and open privacy boundaries in one case, other instances resulted in the renegotiation of boundaries. Notably, reciprocal disclosures from colleagues—relating to MD, other chronic conditions, or caregiving experiences—served as meaningful interactions between the participants and their organizational colleagues and managers. These reciprocal exchanges often rebalanced privacy dynamics. This allowed participants to feel more validated and legitimized in the context of their organization's culture.

Discussion

This thesis sought to answer the research question *how do people with Ménière's Disease navigate disclosure boundaries during initial phases of socialization?* In sum, the findings suggested that people with Ménière's Disease (MD) must consider unique factors that impact disclosure decisions and the extent of those disclosures, especially while navigating a new workplace. Although one set of disclosure strategies benefit an individual's work life, it posed challenges for someone within a different professional space. Environmental, social, and political facets largely affected how someone with MD engaged in organizational socialization.

These wide-ranging strategies used by individuals derived themes from this study contributed to the communication field in theory and practice. In this chapter, theoretical implications are discussed, highlighting how the utility of both organizational socialization and Communication Privacy Management Theory (CPMT) can be extended to consider invisible disabilities (IDs). Additionally, a model of episodic disability is proposed for understanding the socialization process of an employee with MD. Following this is a discussion of practical suggestions that organizations can utilize to best handle the disclosure of someone with an ID, especially conditions like MD, which challenge notions of what disabilities may look like. Finally, limitations of the study and future research directions are analyzed.

Theoretical Implications: Contributions to Organizational Socialization

This study argued for consideration of health-related experiences as a factor in organizational socialization. Organizational socialization helps frame employees' experiences of pre-entrance to exit in an organization, and how workplace norms are established through social interactions (Miller & Jablin, 1991).While organizational socialization has been applied through studies in various occupations (Dailey, 2016; Gibson & Papa, 2000; Kramer, 2010) and across marginalized identities (McKenna-Buchanan, 2014; Ferguson, 2017), the current study pioneered scholarship on organizational socialization of PWIDs. Even without the management of an illness like MD, individuals entering a new organization faced high levels of uncertainty (Miller & Jablin, 1991). Participants' prioritization of MD management heavily impacted their integration into a new job, which added nuance to understandings of organizational socialization.

To navigate the culture of a new workplace, those with an ambiguous illness like MD simultaneously managed both their symptoms and newfound job demands. This study surfaced several findings that reframe how the organizational socialization process is experienced. Participants voiced the role of previous healthcare experiences in developing expectations and encounters with the organization. For participants, information-seeking tactics on workplace communication about health was an essential component of the encounter phase in order to understand organizational attitudes towards disability. Additionally, this section delves into how episodic disabilities such as MD may provoke episodic organizational identification within their workplace.

Healthcare's Influence on Anticipatory Socialization

During the anticipatory socialization phase, participants centered how MD-related healthcare influenced the socialization process. Literature on organizational socialization has examined multiple pathways that individuals make sense of job and career paths. This may be through talk with family and friends (Daily, 2016) or media and popular culture (Miller & Jablin, 1991). That said, little research has inspected the role of health-based experiences during the anticipatory socialization phase. This study illuminated how health plays a role in the anticipatory socialization process. Participants' interactions with their healthcare providers, success of MD treatment, and ongoing symptom management shaped their outlook on job and career prospects. Participants shared that making sense of their symptoms and undergoing the diagnosis process was the first glimpse at how they would learn to manage MD. Moreover, their healthcare experience led them to make sense of managing this lifelong condition on top of work responsibilities. While some experienced questioning of symptom legitimacy by their healthcare providers, others stated that positive or motivational counsel from doctors shaped their focus for success in a new workplace.

Apathetic medical reactions during MD diagnosis negatively impacted participants' anticipatory socialization. The diagnosis process was oftentimes a lengthy and frustrating undertaking, given the idiopathy of MD (Kıroğlu & Dağkıran, 2020). The first interaction that many participants shared was poor bedside manner and prognosis outlook from healthcare providers. Here, doctors chalked up vertigo episodes or dizziness to be of banal cause, rather than attempting to understand the patients' experiences. Participants reported their medical providers assumed that episodes were caused by allergies or a result of stress, rather than considering MD as a possibility. In some cases, doctors even concluded that the individual's symptoms were made up or an overreaction. While this experience has been documented in literature (Charmaz, 2010; Slattery, 2019), this study directly demonstrated how the medical encounter shaped anticipatory socialization outcomes. A dismissive attitude by a health provider influenced how individuals believed their condition would limit their occupational trajectory when performing research during the anticipatory socialization phase.

These distressing first interactions with medical professionals and MD left individuals uncertain about whether their illness will be believed in workplaces. This lack of believability from the medical world created hesitancy about sharing about MD in the workplace. The underrepresentation of MD also resulted in doctors misrepresenting the severity of symptoms. Participants expressed on numerous occasions how difficult it was articulating their symptoms not only to coworkers or supervisors, but to their medical practitioners as well. Because the participants' colleagues had rarely or never experienced the full extent of vertigo with an MD episode, confidants of the participants applied their own lived experience to these disclosures, such as being "dizzy" when responding to a vertigo attack disclosure.

Participants expressed how their diagnosis process reflected societal viewpoints of healthcare, specifically within the United States. Participants reflected on the reactive, rather than proactive, practice in treating health conditions nationwide. Individuals' perceptions of workplace norms are influenced by society at-large, in addition to interpersonal relationships (Miller & Jablin, 1991). This study showcased how perceptions of healthcare can also influence the anticipatory socialization process. These macro-level factors, such as the U.S. healthcare system, can significantly impact the type of work that one might be able to pursue following the diagnosis of an ID. Here, the shortcomings of the Western Medical Model of Disability were observed as a systemic influence across health-based experiences during anticipatory socialization (Patton, 2022). The attempt to remediate individuals' MD symptoms, rather than address the root cause, shaped their ideas of work that was achievable. Seeing as vocational socialization as a lifelong process that shapes overall occupational outlook (Dose, 1997; Van Maanen & Schein, 1979), participant responses reflected the need for recognition of healthcare experiences as a contributor to anticipatory socialization.

This study crystallized how a lack of diagnosis created uncertainty about future career paths. This uncertainty shaped participants' vocational socialization during the anticipatory socialization phase. Even if individual's concerns were legitimized with their healthcare providers, the testing process was oftentimes tedious and overwhelming. Even after rigorous testing procedures, two participants in this study still did not receive a formal diagnosis. Literature reflects how doctor reactions sway disclosure willingness across personal relationships (Slattery, 2019). This exchange was also recognized in this study. Specifically, it was noted how individuals expressed disclosure hesitancy across workplace relationships. This study revealed that a lack of diagnosis made individuals likelier to question whether certain career fields were sustainable. The uncertainty about attaining formal diagnosis swayed their vocational socialization during the anticipatory socialization phase, which led them to pursue new occupational fields. Thus, the doctor-patient relationship and condition legitimization were core factors in their long-term vocational choice outlook. Negative healthcare experiences, such as poor bedside manner and inconclusive diagnosis, shaped a dismal outlook on career trajectory.

Participant stories in this study illuminated healthcare experiences shaping positive anticipatory socialization outlooks as well. Participants shared motivational anecdotes from their healthcare providers that formed an optimistic outlook on work. Uplifting phrases and words of advice impacted individuals' outlooks on work that they were still able to perform. This suggested that healthcare experiences can instill positive interpretations of career fields someone with MD can find success in. Moments of affirmation allowed for participants to imagine themselves as capable professionals, fostering their agency despite medical uncertainty. The encouragement that participants received from their doctors had an influence on their career optimism. As a result, their vocational socialization choices were drastically changed by hopeful advice. Doctor-patient relationships, and healthcare at-large, should be a central factor to analyzing the anticipatory socialization phase.

Healthcare experiences also shaped the disclosure process across organizational relationships. Indeed, participants cited doctors' diagnoses (or lack thereof) as instrumental in validating their illness. Not only did a proper diagnosis give backing for requesting accommodations (Santuzzi et al., 2014), but it made individuals feel legitimized that their condition is "real." Positive dialogues between participants and their healthcare providers aided taking control of the narrative surrounding the individual's illness. Validation made participants feel more secure in managing disclosures with supervisors and coworkers. In contrast, participants shared how poor doctor-patient experiences, or failure to diagnose, relayed uncertainty about whether their experiences would be believed within the organization upon entering.

To summarize, this research suggested that the healthcare experiences around MD, including the attainment of diagnosis, altered the expectations that people have about their organizations. Implications of organizational socialization include how healthcare networks, doctor-patient relationships, and believability of illness and disability impacted one's expectations of work as they explore career and job prospects. An episodic socialization model suggests that these healthcare experiences are integral to individuals' perceptions of vocational and organizational opportunities. In fact, this healthcare interaction is a reflected marker on the model that influences the anticipatory socialization phase.

Conditional Organizational identification

This study found that individuals with MD engage in a process of what will be coined as conditional organizational identification. The alignment that individuals felt with their organization was contingent on several organizational factors to allow space for personal agency over their chronic illness. Individuals felt a sense of “oneness” within their organization when experiencing organizational identification (Conroy et al., 2017), and while organizational identification is influenced by workplace relationships (Rush & McNamee, 2020) and organizational training (Jablin, 2001), literature does not account for episodic illness and disability influencing this process. This study located key theoretical expansions to the metamorphosis phase of organizational socialization and organizational identification. Findings showcased how proactive symptom management, flexible organizational policies, and organizational communication about health impacted the organizational identification process, all of which are illustrated through the model proposed in this thesis.

This study reflected how participants’ management of their MD was related to organizational identification. Individuals’ planning for their MD directly guided preparation for navigating a new job and workplace. Proactive actions were taken to manage one’s symptoms. Adequate management of MD symptoms translated to the effective management of not only job roles and tasks, but helped individuals establish footing in their organizational identification. Literature cites that individuals utilize previous job experiences to make sense of a new organization (Dailey, 2016; Miller & Jablin, 1991); however, this study illuminated how personal histories, like MD symptom management, swayed organizational identification.

Participants discussed how they “tailored” their days to accommodate potential MD flares and therefore accomplish job expectations. Whether through lesson-planning backups or carrying symptom-response kits, individuals felt that these preparations aided in meeting job duties—thus, solidifying organizational identification through their job role and professional self-concept. This study argued that reaching the metamorphosis stage and establishing organizational identification were contingent on the preparation of MD symptoms. The conceived model of episodic socialization utilized conditional, health-informed identification as a marker for a transition between encounter and metamorphosis phases.

Research from this project suggested how organizational policies acted as symbolic indicators to convey workplace support of IDs. Organizational policies were a gateway to establishing organizational identification. Indeed, this study showed how individuals foreground organizational identification regardless of MD disclosure, if organizational policies are flexible. While policy initiatives are essential in the socialization process to promote organizational identification through shared organizational knowledge (Jablin, 2001; Louis, 1980; Miller & Jablin, 1991), organizational identification may be conditional on the flexibilities these policies may offer. Specifically, this study identified how flexible scheduling and time off can lead to enhanced organizational identification, regardless of one’s MD disclosure extent.

Freedom for participants to schedule their hours and take leave resulted in a heightened sense of organizational identification. When agency was granted to individuals in taking leave if episodes arose, they were able to tend to MD-related needs. This allowed participants to return to work ready to handle their job role, alleviated of stressors of judgment towards their ID. These open communication networks were a signal of inclusion for individuals to balance personal and organizational needs. In contrast, rigid or totalistic organizations were shown to limit the autonomy, even if organizational identification is fostered, and force individuals to sacrifice self-prioritization and disclosure of personal identity (Cepale et al., 2021; Howe & Hinderaker, 2016). For those who disclosed their MD to colleagues, flexible arrangements allowed for enhanced organizational identification due to the transparency of their needs. The proposed model of episodic socialization reflects these observations as markers for understanding the organizational norms, cultures, values, and accommodations in more detail. When organizational policies were easily accessible, individuals were able to maintain a sense of continuity throughout symptomatic periods, simultaneously strengthening their alignment with the organization and controlling their symptoms.

Even if individuals did not disclose their MD, adaptive organizational policies still contributed to their organizational identification during the metamorphosis phase. In absence of MD disclosure, flexible policies served as conduits for organizational identification. Previous workplace policy research notes the cultural taboo of utilizing organizational policies, resulting in discouraged use from management (Kirby & Krone, 2002). In contrast, participants in this study described how open and adaptive policies were symbolically supportive. Indeed, work policies built trust and belonging for participants, regardless of their workplace disclosure history. While disclosure of an ID is often a requirement for accommodations (Hastuti & Timming, 2021; Kattari et al., 2018; Santuzzi et al., 2014), this study revealed that some organizations have open policies that allow for individuals to take leave or seek flexibility without disclosing their ID. While individuals had not “tested” the organizational policies through disclosure, the mere presence of such adaptive structures allowed for the individual to feel supported, building organizational identification without a direct disclosure. The presence of organizational policies was a conditional element for individuals to fully engage with the metamorphosis phase, whereby the bulk of organizational identification unfolds (Jablin, 2001).

Finally, this study uncovered how organizational identification can be a conditional process through workplace communication about health and disability. The culture of an organization greatly impacted the extent to which individuals with MD identified with it. Some participants reflected their sensemaking process through information-seeking tactics; their organizational identification formation was conditional upon whether they believe their MD will be a supported part of their identity in the workplace. Organizational identification had been examined through the study of information-seeking to comprehend job roles (Cooper-Thomas et al., 2012; Hecht, 2023; Miller & Jablin, 1991) and navigate identities (e.g., race; Ferguson & Dougherty, 2022), yet this study expounded upon that knowledge by arguing that this information-seeking may conditionally impact the organizational identification process depending on organizational culture. Negative commentary about other employees and their health conditions reduced connection to the organization. Krista's story, for instance, interpreted how her colleague's lack of support for a cancer diagnosis may result in her MD disclosure to upper administration may fare just as poorly. Her conflicting organizational identification (Conroy et al., 2017), between the direct team but not the upper-level administration was a conditional form of organizational identification whereby support from administration was needed for her to align closer with the organization's values.

In sum, this study expanded the process of organizational socialization in two regards: a) by introducing prior healthcare experiences as an indicator of anticipatory socialization; and b) considering the concept of conditional organizational identification. For people with MD, health-focused interactions played a quintessential role in the development of their anticipatory socialization phase. Early interactions with the healthcare system and doctor-patient relationships shaped future occupations, work roles, and desired organizational cultures. Where positive, affirming interactions aided in positive professional outlook, uncertain or invalidating exchanges, especially lack of diagnosis, foregrounded doubts about some career trajectories. In addition to organizational socialization scholarship that considers the role of past jobs, relational networks, and media in anticipatory socialization (Miller & Jablin, 1991), this study urged a reconceptualization of anticipatory socialization to consider medical experiences as part of these influences.

This study repositioned organizational identification for PWIDs as a conditional process shaped by the individual's chronic illness. Organizational identification emerged when organizations espoused values of flexible work environments, workspaces allowed for talk of MD, and a sense of autonomy were allowed for managing MD. This study showed that organizational identification can also be developed no matter the extent of MD disclosure, as long as organizational policy was flexible. Hence, organizational identification, particularly during the metamorphosis phase, was not simply the result of internalization, but moderated by organizational structures and decisions that shaped the socialization process during this stage and either enhance or restrict organizational identification.

Theoretical Implications: Contributions to Communication Privacy Management Theory

Findings from this study also expanded upon the theoretical constructs of CPMT. Concepts of privacy boundary construction, negotiation, and turbulence were challenged through this study of managing privacy around an episodic ID like MD. This study evaluated how core and catalyst criteria (Petronio, 2010) can be reoriented to address MD disclosure in professional spaces. This study yielded rich theoretical implications for CPMT. The concept of involuntary disclosures reframed how privacy boundaries are suddenly and reluctantly recalibrated. Additionally, reciprocity of health disclosures—namely a mutual MD diagnosis—was a situational catalyst for boundary reconfiguration. A final implication derived from this study is how organizational privacy boundaries impacted disclosure of MD and what hierarchal dynamics influenced the privacy boundary negotiation process.

Impact of Involuntary Disclosure on Privacy Management

Individuals with MD did not have the opportunity to decide their disclosure process, further complicating privacy boundary configuration. A theme from the data was that several individuals felt their symptoms forced them to disclose MD to avoid confusion at best and ostracization at worst. For those that fell into this category, the stimulus for most disclosure alterations was an episode of vertigo at one's workplace, especially when in front of other organizational members. Although research exists of individuals experiencing the process of "coming out of the closet" with a marginalized identity (McDonald et al., 2020), this concept can be challenged by considering episodic factors found in disabilities, where there may be no option *but* to "come out" with this identity in the moment. Additional anxiety, panic, and confusion that occurs during the episode (Smith et al., 2023) impacted one's decision-making and made them more likely to ask for assistance through this period. In turn, this reconceptualized how privacy boundaries and turbulence form at work.

Moreover, involuntary disclosures in CPMT were a disruption to privacy ownership and control. CPMT traditionally posits that individuals view themselves as the owners of information, and work to ensure their information is not shared in undesired ways (Petronio, 2002; 2010). However, symptoms of MD unpredictably controlled how one's ID suddenly became visible, thus stripping away the ownership of the condition. CPMT can benefit from considering how personal health events can lead to involuntary disclosures. When the body itself disclosed sensitive information without the volition of the owner, privacy management quickly became reactive, rather than proactive.

Involuntary disclosures reframe impressions of privacy turbulence in CPMT. Scholarship views privacy turbulence as an interpersonal occurrence—oftentimes when someone mishandles the constructed "rules" of the original owner's privacy, regardless of intentionality (Lash, 2023; Smith & Brunner, 2017; Steimel, 2021). This study posed how privacy turbulence can occur without use of interpersonal communication in the workplace. Involuntary disclosures, through a vertigo episode, forced those with MD to quickly recalibrate privacy rules and boundaries in real-time. Not only did turbulence arise from rule violations through communication amongst organizational members, but physical symptoms caused unexpected boundary renegotiation. This study challenged the notion that privacy turbulence always involves interpersonal mishandling of sensitive information. Privacy management following an involuntary disclosure involves the use of boundary adjustments based on reactions from the organization and its members, as well as learning how to manage these sudden boundary shifts long-term. The episodic model of socialization reflects these continuous adjustments that must be made by individuals managing their condition's privacy, and considers how disclosures that are not planned may be navigated through the socialization process.

Fortunately, many of the participants expressed overall supportive reactions to involuntary disclosures. While the disclosure was not previously contemplated, it still led to positive privacy boundary outcomes. For instance, Krista's episode resulted in the disclosure to both a colleague witnessing the event and her supervisor following the involuntary disclosure. Without the episode, Krista may not have chosen to disclose her MD with other organizational members. While the episode was of course unwelcome, the disclosure formed co-ownership of the information and established shared understandings of MD and Krista's needs. Krista request for assistance from others established an understanding of the condition during this shift in privacy boundaries. Compared to prior CPMT health communication literature (e.g., lung cancer; Ngwenya et al., 2021), involuntary disclosure posed new disclosure processes that otherwise have not been considered within the field. This helped to present a newfound intersection between the mutual effects CPMT and organizational socialization have on one another, reflected in the proposed model.

Overall, involuntary disclosures challenged CPMT preconceptions. MD symptoms disrupted the agentic state of privacy ownership and resulted in unplanned disclosure results. Additionally, privacy turbulence stemmed from the manifestation of physical health symptoms, rather than rule violations from organizational members. This required a reframing of what other scenarios may dictate privacy boundaries without consent of the information owner.

Reciprocity of Health-Based Disclosures

Second, this study suggested that individuals who disclose MD in an organization receive a similar depth of health-related disclosure from the co-owner. Echoing results from studies on workplace ID disclosure (i.e., HIV/AIDS; Restall et al., 2019), similar levels of information were returned to the initial discloser. This study revealed that reciprocal disclosures of MD were also present, which became a catalyst for reworking the range and permeability of privacy boundaries concerning the illness. Mutual disclosures of health reduced the hierarchal tone of an intimate disclosure, balancing vulnerability and empowerment.

Reciprocal disclosures gave participants a sense of validation. Not only were reciprocal disclosures a means of revealing health but also building relationships. When information is disclosed, co-ownership is established, which oftentimes includes an explanation of disclosure rules, such as mutual understanding or mutual confidentiality (Petronio, 2002). When reciprocative disclosures ensued, participants reflected a mutual understanding of confidentiality. Participants oftentimes described the encounter as “lucky” and expressed relief in knowing their symptoms would be heard. Individuals felt as though their condition and its associated privacy needs were real. This study illuminated how a reciprocal disclosure in CPMT lowered boundaries through signaling shared experiences, reducing emotional labor, and increasing trust.

This study showcased the alleviation of organizational tensions through reciprocal disclosures in the workplace. Normally, disclosures of health concerns in workplace environments can produce intimidation for the discloser (McKenna-Buchanan et al., 2015; Steimel 2021). Power dynamics in organizational relationships can influence the agency of privacy boundaries (Santika & Sukandar, 2023; Steimel, 2021). Specifically, Amber and Krista’s stories of a mutual MD disclosure normalized the illness and granted the participant increased ownership of their condition in an unexpected exchange. These interactions mellowed traditional power dynamics that are often situated within formal workplace disclosures.

Whereas a formal disclosure to an HR department or manager can feel one-sided, the reciprocal nature in which these disclosures played out developed a dialogic tone. The CPMT process, while certainly still focused on privacy ownership and rule-setting (Petronio, 2002; 2010), also suggests the co-construction of privacy boundary development, specifically across subjects like chronic illness. Mutual disclosure established legitimization to MD and its hidden symptoms, reframing the privacy boundaries often constructed during this process. The initial disclosure decisions and following boundary adjustments are central to the model of episodic socialization, which inform each stage of the socialization process and participants' transitions between each phase.

Organizational Privacy Boundaries

Results revealed that workplace disclosure is a multi-tiered process. Not only did this study examine interpersonal disclosures of MD but extended them into the organizational context. While ID literature examines power dynamics in organizational structures (Olkin et al., 2019; Santuzzi et al., 2014), it does not center on IDs specifically. Alternatively, CPMT scholarship on health in organizations (Steimel, 2021) does not inspect episodic, idiopathic, and incurable illnesses like MD. Therefore, this study merged these two rich fields of disclosure research to address episodic IDs through organizational communication. This study began the trajectory of examining organizational privacy boundaries that CPMT should account for in its modeling.

Privacy regulations are not just an interpersonal construction but are subject to organizational values, norms, and cultures. These components articulated the extent to which individuals can share their MD with others. Organizational hierarchy and structure influenced the flow of information and alter the boundaries to which individuals are able to share information, coinciding with previous literature (Steimel, 2021). Despite his position as an executive leader, Robert still opted to use hidden hearing aids to conceal his hearing loss, and consequently, his MD. Self-managed privacy boundaries were informed by strategic choices that centered conceptions of professional authority—a byproduct of organizational privacy norms that impact an episodic socialization process.

Several organizational typologies influenced the way privacy is protected or disclosed. Embedded structural influences, such as accommodation policies, signaled the potential that an

ID disclosure has for risk versus support. Cultural privacy boundaries in organizations can also impact the norms about IDs and disability stigma (Kattari et al., 2018; Olkin et al., 2019). Such examples illuminated how disclosure is not only about individual preferences but is shaped by affordances and constraints of the organization in which the disclosure resides. Thus, boundaries were created and sustained in relation to perceived organizational norms, structures, and climates. These powerful organizational systems swayed the disclosure decisions and socialization process alike; the episodic model of socialization illuminated how policies and norms can impact disclosure decisions and extents.

Organizational structures were also intersected with legal frameworks. Employees with MD found themselves in a legal grey area. Formal policies such as the Americans with Disabilities Act (ADA; 1990) offered protections; however, accessing them often required participants to formally disclose. Participants expressed worries about how an official disclosure, even during the application process, carried social and professional risks as they continued to integrate with a new organization. Therefore, these findings suggested that privacy boundaries were not only socially constructed, but institutionally enforced by the organization.

This study underscored several important contributions to CPMT in the context of MD disclosure in professional settings. Participants' experiences with involuntary disclosure reflected how physical symptoms of MD—namely vertigo episodes—breached privacy boundaries and forced individuals to make quick reactions to privacy boundaries. Furthermore, individuals were likelier to open privacy boundaries when a reciprocative disclosure occurred between themselves and an organizational member. This suggested how CPMT may utilize reciprocal disclosures more closely. Finally, this research also implicated privacy boundaries as influenced by organizational standards and cultures for which private information travels. Privacy decisions were not merely interpersonal but strategically shaped by institutional practices. Together, these theoretical branches curated a more layered meaning to how privacy boundaries were formed, disrupted, and reevaluated for people with MD in the workforce. Thus, this study proposed a model that reflected the close relationship between organizational socialization and CPMT in MD management within the workplace.

A Model of Episodic Socialization

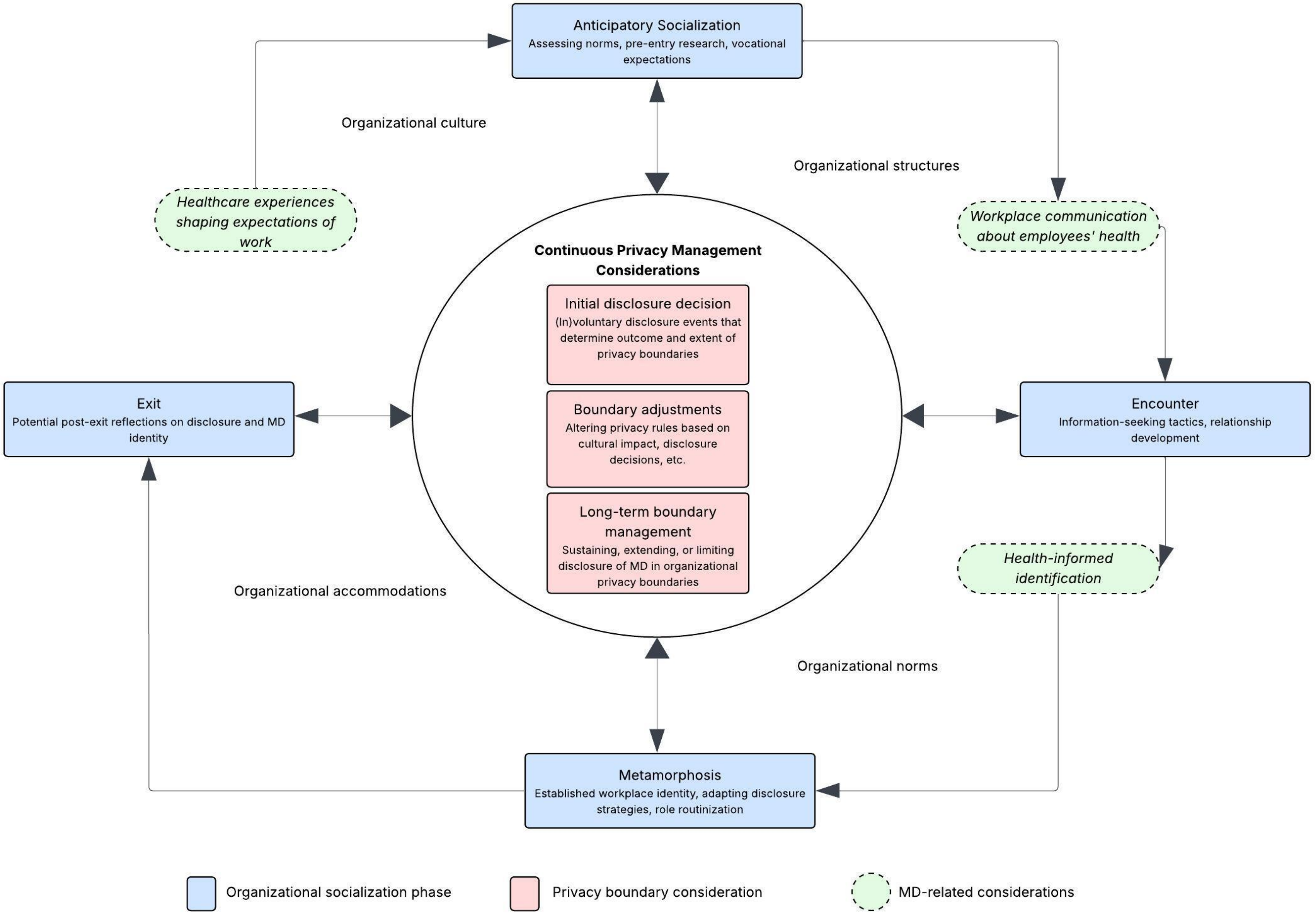
To address the nuanced ways that employees with MD navigated disclosure during the organizational socialization process, this thesis introduced a model of episodic socialization (Figure 3). Rooted in organizational socialization and CPMT, this model reconceptualized socialization to be non-linear. Furthermore, this model accounted for pivotal moments of decision-making, organizational identification, and relational calibration, all of which were heavily influenced by health as a primary motivator throughout this process. This model also illuminated how the episodic nature of MD disrupted the normally sequential organizational socialization process.

While the model incorporated the four-step sequential process of organizational socialization (Jablin, 2001), it also considered the themes derived from this study as milestones for PWIDs as they transition through each stage. During anticipatory socialization, this model argued how PWIDs utilize experiences of healthcare to shape expectations of career and organization choice. Information-seeking through observing the workplace communication of health was an integral component for PWIDs to understand the encounter phase. Finally, as individuals entered the metamorphosis stage, their organizational identification was largely informed by organizational policies on health and disability, in addition to the relationship between their MD management and job role and tasks.

Furthermore, the model also introduced how CPMT boundaries served as critical inflection points throughout the socialization process. These markers illustrated moments during socialization where boundary rules were often modified. CPM boundaries regulate the flow of information based on ownership and rules around privacy (Petronio, 2002; 2010; Petronio & Child, 2020). This model, however, viewed these moments of privacy management as recurring. These moments of privacy boundary construction and renegotiation determined how an individual with MD navigated through organizational socialization. For instance, a boundary adjustment in the encounter phase (e.g., an involuntary disclosure due to an episode at work) may accelerate or curtail the transition into metamorphosis.

Figure 3.

Model of Episodic Socialization



The model of episodic socialization suggested that employees with MD navigated organizational entry and metamorphosis through a dynamic interplay of health prioritization, and privacy boundary management. By embedding socialization considerations and CPM boundary markers into the model, it is reframed as a non-linear, adaptive process, with episodic health experiences taking priority throughout. This model expanded upon both organizational socialization theory and CPMT to accurately reflect the lived realities of those managing invisible and episodic disabilities in professional settings.

Practical Implications

This study spearheaded the exploration of navigating IDs in workplace settings. While research has examined communication of people with vestibular disorders in personal relationships (Smith et al., 2023) and of their spouses (Story et al., 2020), results from this research centered people with an underrepresented ID in the professional context. Furthermore, pragmatic insight was gained for promoting organizational support of employees who happen to live with IDs Participants noted a high level of mistrust in condition disclosure for several reasons. The following suggestions identify several pragmatic suggestions for organizations seeking ID inclusion practices: a) through increased transparency in the disability reporting process; b) providing resources for MD explanation; and c) forming employee resource groups (ERGs). These pragmatic integrations can account for MD while fostering a sustainable and productive workplace climate.

Transparency of Disability Reporting and Networks

One finding derived from this study was how individuals expressed distrust in disability reporting during the application and interview process. This discovery was expressed on a wide spectrum. While some shared their ambivalence in whether to disclose or not ("I never know what to put,") others were definite in their dismissal of organizational promises to withhold information ("…it asks, 'Do you have a disability? We promise we won't tell anybody.' I'm like, 'Bullshit'"). Across most participants, there was an uncertainty over how organizations shared this information and with whom. This hesitancy to declare a disability may be a mutual feeling across disabilities, especially those that are invisible and or episodic. Thus, organizational leadership can create initiatives to communicate the outcomes of disclosing an ID to the organization.

Even if the organization briefly states that this information will not be shared, PWIDs may be especially alert of their information being leaked. This can particularly stem from prior work and healthcare experiences where individuals were left feeling inadequate because of their chronic illness. Thus, organizations should not just state that information will not be shared. Rather, workplaces can provide a more detailed guide explaining the securing of private information across departments and individuals, even during the application process. Providing a more thorough reference for applicants and newcomers alike can increase transparency in reporting so that PWIDs can receive proper support.

Resources to Communicate IDs to Organizational Members

PWIDs would benefit from additional resources that can assist them in explaining the condition to other organizational members. Medical providers equipping patients with ID resources can bolster self-advocacy by having a "script" or "guideline" for how to best communicate their illness. This is especially helpful if the individual finds themselves in a flare, where invisible symptoms such as brain fog may be increased and hinder clearer communication (McNiven et al., 2021). Additionally, providing opportunities to practice disclosing an ID at work can help employees feel better prepared.

Creating in-depth materials to educate organizational members on MD can help to better understand the realities of employees that live with it. Logistics for providing such resources can build off previous ID scholarship. Slattery (2019) suggests the use of medical cards that link to websites about the distributor's chronic illness; this could be applied to PWIDs and connect those unfamiliar with the illness to resources for enriching their understanding. These links could lead to either sites specific to MD (e.g., The Ménière's Society) or to resources for vestibular disorders in general (e.g., Vestibular Disorders Association; VeDA). Communication researchers can build off the insights from this thesis and partner with healthcare professionals to co-develop materials that accurately reflect the symptoms and lives of people with MD. This strategy would assist in deepening the understanding of MD beyond clinical definitions and vernacular. In turn, these initiatives can give PWIDs in general reprieve from repetitively sharing their condition and bear the full weight of that emotional labor that is required for disclosure. Finally, healthcare providers who diagnose or help manage an ID might consider incorporating coaching on professional disclosure into patient care. This could include helping patients describe episodic disabilities in accessible terms, navigate common workplace questions, and articulate that despite the condition is often invisible, it does not equate being symptom-free. Such support practice can prepare PWIDs to confidently advocate for their needs in a professional environment.

Employee Resource Groups

Organizations can improve workplace climate for PWIDs by forming employee resource groups (ERGs). ERGs have proven to be excellent initiatives that bridge research with practical implementation, resulting in increased wellbeing and reduced levels of stress (Welbourne et al., 2017). To the organization's benefit, ERGs can lead to an improved sense of cohesion with one's workplace (Welbourne et al., 2017).

This study suggests that the implementation of ERGs for employees with disabilities can improve alignment with the organization. Interviewees shared that their disclosure of MD surprisingly resulted in similar levels of health-based disclosure and, in several cases, a reciprocal disclosure of MD. Every participant who experienced a reciprocal disclosure in return voiced their relief and increased comfort levels. In some cases, it may be possible that the participant had not heard of others at work with MD because there were few opportunities to open discussion. Thus, organizations could benefit from utilizing employee resource groups (ERGs) that allow for those with disabilities, regardless of visibility, to meet and discuss navigating work with their conditions. For PWIDs in general, these ERGs would offer a space for this demographic to discuss best practices in their work whilst disclosing their condition, if desired. This can establish camaraderie among PWIDs and establish community withing a work environment, thus strengthening organizational relationships and goals.

Limitations and Directions for Future Research

As with any scholarship, this study did not come without limitations. First, the research conducted did not encapsulate all experiences of PWIDs, as organizational experiences are wide-ranging. Although results gathered rich description from fifteen semi-structured interviews, perhaps other stories of people with MD, if collected, may surface other themes. Additionally, MD is just one invisible and episodic ID of many. Thus, similar veins of research on disclosure and organizational socialization may produce differing outcomes based on the demographic studied. More scholarship is necessary to examine how the experiences of workplace socialization and privacy management apply to other PWIDs.

This study requested participants to tell their MD experiences upwards of four years ago. Participants had to engage in retroactive sensemaking, meaning that time had passed since these interactions. The events retold by interviewees were recalled from the past, and at times not in recent memory. Results may differ based on a selected methodology that allows for collection of data in present time without needing to evoke older memories, such as through a diary study or video/audio logging one's experiences. Researchers can utilize these methodological tools to gather more recent recollections.

There are plentiful routes communication research can pursue by exploring IDs in organizations. This study was well-received by participants who shared their experiences living with an underrepresented disorder. Future research can explore underrepresented IDs in the workplace, using MD as a demographic to examine communication about chronic illness. Scholarship can also examine the correlation between PWIDs and mission-driven, totalistic organizations. Finally, development of the Model of Episodic Socialization can further inform how organizational socialization and CPMT interplay within organizational communication contexts.

Primarily, this thesis served as a launchpad for communication research on MD to flourish. Participants recurrently commented on how unheard of the condition is and the underrepresentation of vestibular conditions. With increases in vestibular symptoms following the COVID-19 Pandemic (Piotrowski & Nowińska, 2023), the need for more awareness is key to bring about effective organizational support for this demographic. Communication research on MD can be conducted using varying communication theories and concepts. Organizational communication scholarship can focus on people with MD to expand ideas of organizational culture, information networks, and conflict resolution. Aside from this communication context, interpersonal communication scholarship can study how MD impacts relationship development. Applying theories such as uncertainty reduction, social identity, or relational dialectics can enrich the understanding of communicative behaviors in people with MD.

This study also documented individuals' strong organizational identifications with organizations (e.g., the military, first responders, etc.) that influenced how they communicated about their MD. This suggests that hierarchical and organizational identification-driven organizations can reinforce missions of national security or safety of the public. These organizational objectives take highest priority, even when support for the individual may be sparse, Scholars can investigate how hierarchical structures and power dynamics affect employees' openness to discuss personal identity traits versus collective values. Additionally, there is an opportunity to extrapolate how organizational operations, such as leadership style and espoused values, allow for greater negotiation and renegotiation of organizational identification, particularly through the focus of an episodic or fluctuating disability such as MD.

Finally, building on this study with future research using organizational socialization and CPMT in tandem holds promise. For individuals to engage in organizational socialization, they must disclose elements of themselves to establish relational closeness with their colleagues, supervisors, and or employees. Similarly, CPMT can explain the process of disclosure across interpersonal relationships in organizational contexts. Bridging these two theories opens the door to developing theoretical frameworks that combine organizational socialization concepts of privacy ownership and disclosure. Future models may explore how specific disclosure events redirect the socialization process, in addition to changing privacy boundaries. This could give further insight to the correlation between socialization phase transitions and privacy disclosures. Perhaps a significant disclosure with a colleague is a catalyst that furthers or restrains the individual along the organizational socialization process.

Conclusion

The purpose of this thesis was multifaceted. First, it was designed to answer how people with an invisible and episodic disability traverse the professional environment to achieve expectations while managing their condition. The study also sought out to see how individuals "come out" about this aspect of their lives, and how to continually construct boundaries around this subject within the workplace. On a theoretical level, this thesis combined the bases of organizational socialization and CPMT to achieve a deeper understanding of an underrecognized condition and applying it to the realm of communication research.

Additionally, this project was designed to be a resource for people with MD and those with vestibular disorders at-large. Having a condition of this nature and seeking information, only to find little support, is a heart-wrenching feeling. Results from this study serve as a pragmatic tool for learning to thrive in the workplace. Hearing the experiences of others with MD can bolster one's decision-making. This thesis allowed for others battling the illness to review which available options are appropriate for their distinctive workplace situation and relationships. Not only does this study serve as a guide for people with MD, but inspired research can elaborate further on organizational socialization and disclosure scholarship to explore this subset of organizational and health communication.

I asked all participants a question that was purposefully placed last: "If you could tell someone with Ménière's Disease entering your line of work, what would you want them to know?" While everyone gave sound pragmatic advice, Clarissa gave a reminder reflecting the insurmountable strength people with MD operate with: "Also, we can do anything. This does not have to be—this is not the end. This is not the beginning of a downhill spiral. This is the beginning of finding out exactly what you're made of." Each of these individuals, giving their time and stories out of pure generosity, showcased their resilience in continuing to do their best, in and out of work. Clarissa’s quote transports me back to when I was sitting in the ENT office, face buried in my tear-soaked hands, when my doctor told me that I would still achieve everything I set my mind out to do. In the moment, I was too despondent to recognize the truth in his message. Contemplating that memory nearly three years later, I am overjoyed to tell my former self from that day just how much we as people with MD can truly accomplish.

References

Abohelaibah, F. H., Almaleki, F. A., Aladwani, A. A., Alrashidi, A. N. K. Q., Al Karni, A. F., Basamad, S. W., Khabti, S. S. A., Al Sharya, S. M. , & Altalhi, H. H. (2021). Ménière's disease management & diagnostic approach, literature review. *Pharmacophore*, *12*(5), 38-40. https://doi.org/10.51847/TOnH66w3rB

Adil, A., Kausar, S., Ameer, S., Ghayas, S., & Shujja, S. (2023). Impact of organizational socialization on organizational citizenship behavior: Mediating role of knowledge sharing and role clarity. *Current Psychology*, *42*(7), 5685–5693. https://doi.org/10.1007/s12144-021-01899-x

Alessandri, G., Perinelli, E., Robins, R. W., Vecchione, M., & Filosa, L. (2020). Personality trait change at work: Associations with organizational socialization and identification. *Journal of Personality*, *88*(6), 1217-1234.

Allen, D. G. (2006). Do organizational socialization tactics influence newcomer embeddedness and turnover? *Journal of Management*, *32*(2), 237-256. https://doi.org/10.1177/0149206305280103

Americans with disabilities act of 1990, as amended. ADA.gov. (n.d.). https://www.ada.gov/law-and-regs/ada/

Austin, J. T., & Bisel, R. S. (2023). The influence of colorblind and race-acknowledged organizational socialization messages during offer consideration. *International Journal of Business Communication*, *60*(3), 892–911. https://doi.org/10.1177/23294884221118909

Baron-Cohen, S. (2017). Editorial perspective: Neurodiversity- a revolutionary concept for autism and psychiatry. *Journal of Child Psychology and Psychiatry,* 58(6), 744-747.

Bauer, T. N., Bodner, T., Erdogan, B., Truxillo, D. M., & Tucker, J. S. (2007). Newcomer adjustment during organizational socialization: A meta-analytic review of antecedents, outcomes, and methods. *Journal of Applied Psychology*, *92*(3), 707—721. https://doi.org/10.1037/0021-9010.92.3.707

Bigelow, R.T., & Agrawal, Y. (2015). Vestibular involvement in cognition: visuospatial ability, attention, executive function, and memory. *Journal of Vestibular Res*. 73-89. doi:10.3233/VES-150544

Boucher, C. (2017). The roles of power, passing, and surface acting in the workplace relationships of female leaders with disability. *Business & Society*, *56*(7), 1004-1032. https://doi.org/10.1177/0007650315610610

Bricher, G. (2000). Disabled people, health professionals and the social model of disability: Can there be a research relationship? *Disability & Society*, *15*(5), 781-793. https://doi.org/10.1080/713662004

Brown, F. M., III. (2002). Inside every chronic patient is an acute patient wondering what happened. *Journal of Clinical Psychology*, *58*(11), 1443—1449. https://doi.org/10.1002/jclp.10091

Buzzanell P. M. (2020). Gender and feminist theory. In Nicotera A. (Ed.), *Origins and traditions of organizational communication: A comprehensive introduction to the field* (pp. 250–269). Routledge.

Cepale, G., Alessandri, G., Borgogni, L., Perinelli, E., Avanzi, L., Livi, S., & Coscarelli, A. (2021). Emotional efficacy beliefs at work and turnover intentions: The mediational role of organizational socialization and organizational identification . *Journal of Career Assessment*, *29*(3), 442-462. https://doi.org/10.1177/1069072720983209

Charmaz, K. (2006). *Constructing grounded theory: A practical guide through qualitative analysis.* Thousand Oaks, California: Sage Productions.

Charmaz, K. (2010). Disclosing illness and disability in the workplace. *Journal of International Education in Business*, *3*(1/2), 6-19. https://doi.org/10.1108/18363261011106858

Charmaz, K., Thornberg, R., & Keane, E. (2018). Evolving grounded theory and social justice inquiry. In N. K. Denzin & Y. S. Lincoln (Eds.), Handbook of qualitative research (5th ed., pp. 411443). Thousand Oaks, CA: SAGE.

Cho, H., Knijnenburg, B., Kobsa, A., Li, Y. (2018). Collective privacy management in social media: A cross-cultural validation. *ACMT Comput-hum Int*, 25:1-33 https://dx.doi.org/10.1145/3193120.

Cooper-Thomas, H., Anderson, N., & Cash, M. (2012). Investigating organizational socialization: A fresh look at newcomer adjustment strategies. *Personnel Review*, *41*(1), 41-55. https://doi.org/10.1108/00483481211189938

Conroy, S., Henle, C. A., Shore, L., & Stelman, S. (2017). Where there is light, there is dark: A review of the detrimental outcomes of high organizational identification . *Journal of Organizational Behavior*, *38*(2), 184–203. https://doi.org/10.1002/job.2164

Dailey, S. L. (2016). What happens before full-time employment? Internships as a mechanism of anticipatory socialization. *Western Journal of Communication*, *80*(4), 453-480. https://doi.org/10.1080/10570314.2016.1159727

Davis, C. W., & Myers, K. K. (2012). Communication and member disengagement in planned organizational exit. *Western Journal of Communication*, *76*(2), 194-216. https://doi.org/10.1080/10570314.2011.651250

Dose, J. J. (1997). Work values: An integrative framework and illustrative application to organizational socialization. *Journal of Occupational and Organizational Psychology*, *70*(3), 219–240. https://doi.org/10.1111/j.2044-8325.1997.tb00645.x

Elfenbein, D. W., & Knott, A. M. (2015). Time to exit: Rational, behavioral, and organizational delays. *Strategic Management Journal*, *36*(7), 957-975. https://doi.org/10.1002/smj.2262

Feij, J. A. (1998). Work socialization of young people. In P. J. D. Drenth, H. Thierry, & C. J. de Wolff (Eds.), *Handbook of work and organizational psychology* (2nd ed., pp. 207—256). East Sussex: Psychology Press.

Ferguson, M.W. (2017). (Re)negotiating organizational socialization: Black male scholarship and the closet. Management Communication Quarterly. doi.org/10.1177/0893318917741990

Ferguson Jr, M. W., & Dougherty, D. S. (2022). The paradox of the Black professional: Whitewashing Blackness through professionalism. *Management Communication Quarterly*, *36*(1), 3-29.

Flink, P. J. (2017). Invisible disabilities, stigma, and student veterans: Contextualizing the transition to higher education *2*(2). https://doi.org/10.21061/jvs.v2i2.20

Fuentes, K., & Lindsay, S. (2023). Workplace accommodations during the COVID-19 pandemic: A scoping review of the impacts and implications for people with disabilities. *Work (Reading, Mass.)*, *74*(2), 381–406. https://doi.org/10.3233/WOR-220129

Gibson, M. K., & Papa, M. J. (2000). The mud, the blood, and the beer guys: Organizational osmosis in blue-collar work groups. *Journal of Applied Communication Research*, *28*(1), 68–88. https://doi.org/10.1080/00909880009365554

Gignac, M. A. M., Bowring, J., Jetha, A., Beaton, D. E., Breslin, F. C., Franche, R.-L., Irvin, E., Macdermid, J. C., Shaw, W. S., Smith, P. M., Thompson, A., Tompa, E., Van Eerd, D., & Saunders, R. (2021). Disclosure, privacy and workplace accommodation of episodic disabilities: Organizational perspectives on disability communication-support processes to sustain employment. *Journal of Occupational Rehabilitation*, *31*(1), 153-165. https://doi.org/10.1007/s10926-020-09901-2

Gilmore, S., & Harding, N. (2022). Organizational socialization as kin-work: A psychoanalytic model of settling into a new job. *Human Relations*, *75*(3), 583–605. https://doi.org/10.1177/0018726720964255

Gürkov, R., Pyykö, I., Zou, J., & Kentala, E. (2016). What is Menière's disease? A contemporary re-evaluation of endolymphatic hydrops. *Journal of Neurology*, *263*, 71-81. https://doi.org/10.1007/s00415-015-7930-1

Handley, K. (2018). Anticipatory Socialization and the Construction of the Employable Graduate: A Critical Analysis of Employers' Graduate Careers Websites. *Work, Employment & Society*, *32*(2), 239-256.

Hastuti, R., & Timming, A. R. (2021). An inter-disciplinary review of the literature on mental illness disclosure in the workplace: Implications for human resource management. *The International Journal of Human Resource Management*, *32*(15), 3302-3338.

Hecht, E. (2023). *Workplace Transitions: The Role of Social Media and Boundary Management* [Ph.D., Colorado State University]. https://www.proquest.com/docview/2820210368/abstract/230DB86E9B46487APQ/1

Hein, P., & Ansari, S. (2022). From Sheltered to Included: The Emancipation of Disabled Workers from Benevolent Marginalization. *Academy of Management Journal*, *65*(3), 749—783. https://doi.org/10.5465/amj.2020.1689

Herrygers, K. S., & Wieland, S. M. B. (2017). Work socialization through part-time work: Cultivating self-efficacy and engagement through care. *Journal of Applied Communication Research*, *45*(5), 557-575. https://doi.org/10.1080/00909882.2017.1382712

Howe Jr, W. T., & Hinderaker, A. (2018). "The rule was the rule": New member socialization in rigidly structured totalistic organizations. *Atlantic Journal of Communication*, *26*(3), 180-195.

Invisible Disabilities Association. (2024). What is an invisible disability? Retrieved June 4, 2024, from https://invisibledisabilities.org/what-is-an-invisible-disability/

Jablin, F. M. (1985). An exploratory study of vocational organizational communication socialization. *Southern Journal of Communication*, *50*(3), 261-282.

Jablin, F. M. (2001). *The new handbook of organizational communication*. SAGE Publications, Inc. https://doi.org/10.4135/9781412986243

Kattari, S. K., Olzman, M., & Hanna, M. D. (2018). "You look fine!": Ableist experiences by people with invisible disabilities. *Affilia*, *33*(4), 477-492. https://doi.org/10.1177/0886109918778073

Kirby, E., & Krone, K. (2002). "The policy exists but you can't really use it": communication and the structuration of work-family policies. *Journal of Applied Communication Research*, *30*(1), 50–77. https://doi.org/10.1080/00909880216577

Kirk, S., & Hinton, D. (2019). “I’m not what I used to be”: A qualitative study exploring how young people experience being diagnosed with a chronic illness. *Child: Care, Health and Development*, *45*(2), 216–226. https://doi.org/10.1111/cch.12638

Kıroğlu, M., & Dağkıran, M. (2020). The role of mobile phone camera recordings in the diagnosis of Ménière’s disease and pathophysiological implications. *The Journal of International Advanced Otology*, *16*(1), 18–23. https://doi.org/10.5152/iao.2019.6605

Klatzke, S. R. (2016). I quit! The process of announcing voluntary organizational exit. *Qualitative Research Reports in Communication*, *17*(1), 44-51. https://doi.org/10.1080/17459435.2015.1088894

Korte, R. (2010). 'First, get to know them': A relational view of organizational socialization. *Human Resource Development International*, *13*(1), 27-43. https://doi.org/10.1080/13678861003588984

Korte, R., Brunhaver, S., & Sheppard, S. (2015). (Mis)interpretations of organizational socialization: The expectations and experiences of newcomers and managers. *Human Resource Development Quarterly*, *26*(2), 185—208. https://doi.org/10.1002/hrdq.21206

Kramer, M. (2010). Organizational socialization: Joining and leaving organizations (1st edition). Polity.

Kramer, M. W., & Miller, V. D. (2013). Socialization and assimilation: Theories, processes, and outcomes. In L. L. Putnam & D. K. Mumby (Eds.), The SAGE handbook of organizational communication: Advances in theory, research, and methods (pp. 525–547). Thousand Oaks, CA: Sage.

Kurz, A., Auinger, A., & Arnoldner, C. (2020). Long-term vertigo control after cochlear implantation in patients with end-stage menière's disease: A retrospective questionnaire-based cross-sectional study. *Wiener Klinische Wochenschrift*, *132*(17-18), 521-525.

Wilhoit Larson, E., Linabary, J. R., & Long, Z. (2022). Communicating inclusion: a review and research agenda on inclusion research in organizational communication. *Annals of the International Communication Association*, *46*(2), 63–90.

Lash, B. N. (2023). Disclosing hearing loss: Managing boundaries surrounding a stigmatized identity. *International Journal of Communication,* 17, 5336-5353.

Lee, H. W. (2013). Locus of control, socialization, and organizational identification. *Management Decision*, *51*(5), 1047-1055.

Lee, S. K., Kramer, M. W., & Guo, Y. (2019). Social media affordances in entry-level employees' socialization: Employee agency in the management of their professional impressions and vulnerability during early stages of socialization. *New Technology, Work and Employment*, *34*(3), 244–261. https://doi.org/10.1111/ntwe.12147

Lightman, E., Vick, A., Herd, D., & Mitchell, A. (2009). 'Not disabled enough': Episodic disabilities and the Ontario Disability Support Program. *Disability Studies Quarterly*, *29*(3). https://doi.org/10.18061/dsq.v29i3.932

Louis, M. R. (1980). Surprise and sense-making: What newcomers experience in entering unfamiliar organizational settings. *Administrative Science Quarterly*, 25: 226-251

Matthews, C. K., & Harrington, N. G. (2000). Invisible disabilities. In D. O. Braithwaite & T. L. Thompson (Eds.), *Handbook of communication and people with disabilities: Research and application* (pp. 405-421). Lawrence Erlbaum Associates.

McDonald, J., Harris, K. L., & Ramirez, J. (2020). Revealing and Concealing Difference: A Critical Approach to Disclosure and an Intersectional Theory of "Closeting." *Communication Theory*, *30*(1), 84–104. https://doi.org/10.1093/ct/qtz017

McKenna-Buchanan, T. P. (2014). *Communicating "Out" at Work: Exploring Co-cultural Theory in the Context of Organizational Socialization*. ProQuest Dissertations & Theses.

McKenna-Buchanan, T., Munz, S., & Rudnick, J. (2015). To Be or Not To Be Out in the Classroom: Exploring Communication Privacy Management Strategies of Lesbian, Gay, and Queer College Teachers. *Communication Education*, *64*(3), 280–300. https://doi.org/10.1080/03634523.2015.1014385

McLeod, J. D. (2023). Invisible disabilities and inequality. *Social Psychology Quarterly*, *86*(1), 6-29. https://doi.org/10.1177/01902725231153307

McNiven, N. D., Deutsch, P. G., Carlin, J. E., & Trotter, M. I. (2021). Ménière's disease: Management in primary care. *British Journal of General Practice*, *71*(713), 571–572. https://doi.org/10.3399/bjgp21X717989

Ménière's Disease Support Group (2024). https://facebook.com/groups/1393512130871030/?hoisted_section_header_type=recently_seen&multi_permalinks=3893081100914108

Miller, V. D., & Jablin, F. M. (1991). Information seeking during organizational entry: Influences, tactics, and a model of the process. *Academy of Management Review*, *16*(1), 92-120. https://doi.org/10.5465/AMR.1991.4278997

Mornata, C., & Cassar, I. (2018). The role of insiders and organizational support in the learning process of newcomers during organizational socialization. *Journal of Workplace Learning, 30*(7), 562-575. https://doi.org/10.1108/JWL-06-2017-0045

Myers, K. K., & Woo, D. (2017). Socialization. In C. R. Scott, J. R. Barker, T. Kuhn, J. Keyton, P. K. Turner, & L. K. Lewis (Eds.), *The international encyclopedia of organizational communication* (1st ed., pp. 1-17). Wiley. https://doi.org/10.1002/9781118955567.wbieoc192

Ngwenya, N., Crang, C., Farquhar, M., Rintoul, R. C., Mahadeva, R., Calvert, L. D., ... & Barclay, S. (2021). Communicating uncertainty: contrasting the communication experiences of patients with advanced COPD and incurable lung cancer. *Family practice*, *38*(5), 637-643.

Nifadkar, S. S., & Wu, W. (2022). Newcomers as unwitting victims? Examining department leaders' denial of information support and team leaders' resentment during organizational socialization. *Journal of Organizational Behavior*, *43*(1), 52–68. https://doi.org/10.1002/job.2561

Olkin, R., Hayward, H., Abbene, M.S., & VanHeel, G. (2019). The experiences of microaggressions against women with visible and invisible disabilities. *Journal of Social Issues, 75*(3), 757-785. https://doi.org/10.1111/josi.12342

Pal, M., Kim, H., Harris, K. L., Long, Z., Linabary, J., Wilhoit Larson, E., Jensen, P. R., Gist-Mackey, A. N., McDonald, J., Nieto-Fernandez, B., Jiang, J., Misra, S., & Dempsey, S. E. (2022). Decolonizing Organizational Communication. Management Communication Quarterly, 36(3), 547-577. https://doi-org.ezproxy2.library.colostate.edu/10.1177/08933189221090255

Patton, E. (2022). To disclose or not to disclose a workplace disability to coworkers: Attributions and invisible health conditions in the workplace. *Equality, Diversity, and Inclusion: An International Journal, 41*(8), 1154-1180. https://doi.org/10.1108/EDI-09-2021-0228

Petronio, S. (2002). Boundaries of privacy: Dialectics of disclosure. SUNY Press; eBook collection. https://exproxy2.library.colostate.edu/login?url=https://search.ebscohost.com/login.aspx?direct=true&AuthType=cookie,ip,url,cpid&custid=s4640792&db=nlebk&AN=103660&site=ehost-live

Petronio, S. (2010). Communication privacy management theory: What do we know about family privacy regulation? *Journal of Family Theory & Review*, *2*(3), 175–196. https://doi.org/10.1111/j.1756-2589.2010.00052.x

Petronio, S., & Child, J. T. (2020). Conceptualization and operationalization: Utility of communication privacy management theory. *Current Opinion in Psychology*, *31*, 76–82. https://doi.org/10.1016/j.copsyc.2019.08.009

Piotrowski, J., & Nowińska, B. (2023). Balance disorders and vertigo as a complication of COVID-19. *Family Medicine & Primary Care Review*, *25*(2).

Place, K. R. (2022). Toward a Framework for Listening with Consideration for Intersectionality: Insights from Public Relations Professionals in Borderland Spaces. *Journal of Public Relations Research*, *34*(1–2), 4–19. https://doi-org.ezproxy2.library.colostate.edu/10.1080/1062726X.2022.2057502

Prince, M. J. (2017). Persons with invisible disabilities and workplace accommodation: Findings from a scoping literature review. *Journal of Vocational Rehabilitation*, *46*(1), 75–86. https://doi.org/10.3233/JVR-160844

Restall, G., Simms, A., Etcheverry, E., Roger, K., James, D., Roddy, P., Porch, W., Potts, J., Skitch, D., & Yates, T. (2019). Supporting choices about HIV disclosure in the workplace: A cross-Canada survey of strategies. *Work*, *64*(4), 731–741. https://doi.org/10.3233/WOR-193035

Roper, L. D. (2023). How self-advocacy strategies help students with 'invisible disabilities' flourish beyond high school. *Journal of Human Behavior in the Social Environment*, *0*(0), 1–28. https://doi.org/10.1080/10911359.2023.2251554

Rush, K. A., & McNamee, L. G. (2020). Family identity and short-term organizational memberships. *Qualitative Research Reports in Communication*, *21*(1), 88-96.

Saeed, S. R. (1998). Fortnightly review: Diagnosis and treatment of ménière’s disease. *BMJ: British Medical Journal*, *316*(7128), 368–372.

Santika, A. A., & Sukandar, R. (2023). Me and My Secrets: A Phenomenological Study of Communication Privacy Management of Atheists in the Indonesian Context Regarding Their Identity. *KOMUNIKA: Jurnal Dakwah Dan Komunikasi*, *17*(1), 115–135. https://doi.org/10.24090/komunika.v17i1.7787

Santuzzi, A. M., Waltz, P. R., Finkelstein, L. M., & Rupp, D. E. (2014). Invisible disabilities: unique challenges for employees and organizations. *Industrial and Organizational Psychology*, *7*(2), 204–219. https://doi.org/10.1111/iops.12134

Scharrer, E., & Ramasubramanian, S. (2021). *Quantitative Research Methods in Communication: The Power of Numbers for Social Justice* (1st ed.). Routledge. https://doi.org/10.4324/9781003091653

Sias, P. M., Tsetsi, E., Woo, N., & Smith, A. D. (2020). With a little help from my friends: Perceived task interdependence, coworker communication, and workplace friendship. *Communication Studies*, *71*(4), 528-549.

Slattery, E. C. (2019). *"POTS Equals Uncertainty": Exploring Uncertainty and Privacy Management of People with Postural Orthostatic Tachycardia Syndrome (POTS)* [M.A., Colorado State University]. https://www.proquest.com/docview/2378945188/abstract/D7D59CB2AD284AF0PQ/1

Smith, L. J., Pyke, W., Fowler, R., Matthes, B., de Goederen, E., & Surenthiran, S. (2023). Impact and experiences of vestibular disorders and psychological distress: Qualitative findings from patients, family members and healthcare professionals. *Health Expectations : An International Journal of Public Participation in Health Care and Health Policy*, *27*(1), e13906. https://doi.org/10.1111/hex.13906

Smith, S. A., & Brunner, S. R. (2017). To reveal or conceal: Using communication privacy management theory to understand disclosures in the workplace. *Management Communication Quarterly*, *31*(3), 429-446.

Steimel, S. (2021). Communication privacy management and pregnancy loss in interpersonal workplace communication. *Women's Studies in Communication*, *44*(3), 397–418. https://doi.org/10.1080/07491409.2020.1843579

Story, L., Barr, C., Dowell, R., & Vitkovic, J. (2020). An exploration of significant others' experience with ongoing vestibular disorders. *International Journal of Audiology*, *59*(3), 179–185. https://doi.org/10.1080/14992027.2019.1678075

Terry, N. P. (2017). Regulatory disruption and arbitrage in health-care data protection. *Yale J Health Policy Law Ethics* 2017, 17:143-207.

Tracy, S. (2018). A phronetic iterative approach to data analysis in qualitative research. *Journal of Qualitative Research, 19*(2), 61-76.

Tracy, S. J. (2020). *Qualitative research methods: Collecting evidence, crafting analysis, communicating impact*. John Wiley & Sons.

Vangelisti, A. L. (1988). Adolescent socialization into the workplace: A synthesis and critique of Current Literature. *Youth & Society*, *19*(4), 460–484. https://doi.org/10.1177/0044118X88019004007

Van Maanen, J., & Schein, E. (1979). Toward a theory of organizational socialization. Research in Organizational Behavior, 1, 209–264.

Weick, K., Sutcliffe, K., & Obstfeld, D. (2009). Organizing and the process of sensemaking. *Handbook of decision making*, *16*(4), 83.

Williams, J., & Patterson, N. (2019). New directions for entrepreneurship through a gender and disability lens. *International Journal of Entrepreneurial Behavior and Research*, *25*(8), 1706-1726

Welbourne, T. M., Rolf, S., & Schlachter, S. (2017). The case for employee resource groups: A review and social identity theory-based research agenda. *Personnel Review*, *46*(8), 1816–1834. https://doi.org/10.1108/PR-01-2016-0004

Appendix A: Eligibility Screening Survey

Thank you for your interest in contributing to the experiences of people with Ménière's Disease in the workplace. Please view and complete the survey below to determine criteria for eligibility.

1) How many years have you worked at your current place of employment for?

2) How many years have you experienced Ménière's Disease symptoms (including before a formal diagnosis)?

3) Have you been formally diagnosed with Ménière's Disease?

4) What is a good email for follow-up about this study? You will be notified with an update regardless of if you are eligible for an interview or not.

Appendix B: Recruitment Script

Hello all: I am a graduate student at Colorado State University studying organizational and health communication. Having Ménière's Disease myself, my goal when starting grad school was to help others understand what us with MD endure daily. As such, my thesis is looking at how we choose how, when, and with whom we disclose our MD status to at work. Additionally, I'm looking to see how your lifestyle managing MD is balanced with the expectations from your work colleagues.

I would love to set up a 45-60 minute interview with anyone interested who experiences MD symptoms and have entered a new job (within the last 4 years) after the start of their MD symptoms. You must be 18 years of age or older for interviewing.

A $20 Amazon gift card will be awarded following our interview. Please see the link below to complete a short four-question survey to determine if you're eligible for interviewing. It will only take 2-3 minutes. It does not require you to share personal information except for an email address for following up.

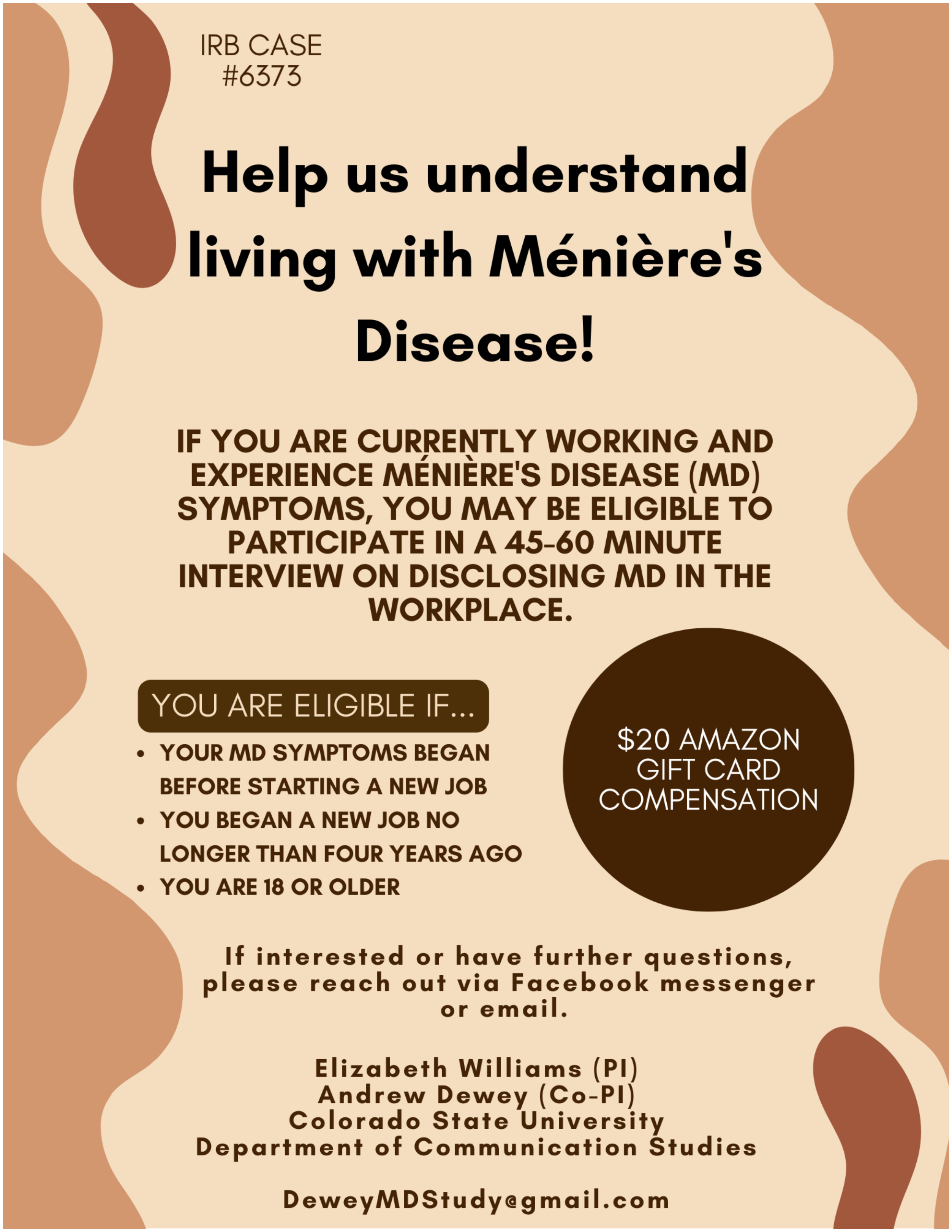
If you have additional questions or concerns, please reach out by email (DeweyMDStudy@gmail.com). With your help, we can make our lives with MD better understood.

Kindly, Andrew

Appendix C: Recruitment Script Follow-up

Hi everyone,
I wanted to reshare this information about my research study for my graduate school program. I am focused on how people with Ménière’s Disease choose to share information about their condition in their workplaces. As someone who is currently working and living with Ménière’s, I'd love to hear others' experiences on the matter and help organizations learn how to best support people with MD.
Those eligible will be able to share their experiences in a 45-60 minute interview with me. Your time will be reimbursed with a $20 Amazon gift card following the interview. If interested, please complete this short 2-minute survey to determine if you are eligible for interviewing:
https://qualtricsxmx4h9wpl7d.qualtrics.com/.../SV...
I will follow up with you personally to invite you to a video call interview. Please comment on this post or email me at DeweyMDStudy@gmail.com if you have any questions. Thank you!

Appendix D: Recruitment Flyer



IRB CASE
#6373

Help us understand living with Ménière's Disease!

IF YOU ARE CURRENTLY WORKING AND EXPERIENCE MÉNIÈRE'S DISEASE (MD) SYMPTOMS, YOU MAY BE ELIGIBLE TO PARTICIPATE IN A 45-60 MINUTE INTERVIEW ON DISCLOSING MD IN THE WORKPLACE.

YOU ARE ELIGIBLE IF...

- **YOUR MD SYMPTOMS BEGAN BEFORE STARTING A NEW JOB**
- **YOU BEGAN A NEW JOB NO LONGER THAN FOUR YEARS AGO**
- **YOU ARE 18 OR OLDER**

$20 AMAZON GIFT CARD COMPENSATION

If interested or have further questions, please reach out via Facebook messenger or email.

Elizabeth Williams (PI)
Andrew Dewey (Co-PI)
Colorado State University
Department of Communication Studies

DeweyMDStudy@gmail.com

Appendix E: Interview Protocol

Introductory:

Thank you so much for taking the time to talk over your experiences with having Ménière's Disease in the workplace. I have Ménière's Disease too, and I was curious in how other people navigate this while actively working. We will start by discussing your life before entering your work. Then we'll talk about occurrences with you and your Ménière's Disease experiences after joining a new workplace.

Job search and interview process

1. Walk me through your journey with Ménière's Disease from your first symptoms to diagnosis (if you have one). What stands out most from that period? How did it affect your thinking about your career path?
2. Tell me about the research you did before your first day of work to determine what the workplace culture was like for people with Ménière's Disease.
3. How did having Ménière's Disease influence your job search strategy? Were there specific roles or companies you pursued or avoided because of it?

Initial entry period

1. I've heard from others on how much they chose to share about their Ménière's Disease. Tell me about whether you chose to share your Ménière's Disease with, and if so, who at work was appropriate to share your Ménière's Disease diagnosis with?
2. Tell me about a time when having Ménière's Disease condition made you feel more included in your workplace, regardless of whether you've shared this part of yourself with others.

3. As we both know all too well, Ménière's Disease can really fluctuate in symptoms. Can you talk about the extent you wished to share changed depending on the intensity or length of your symptoms?

Ongoing management

1. What “rules” did you want colleagues to follow when you told them of your Ménière's Disease? Were there situations where you were or were not comfortable with them sharing this information?
2. How do you balance the demands of work with your Ménière's Disease condition?
3. What do you wish your colleagues understood about working with Ménière's Disease that's hard to explain?
4. Tell me about a time when you had to advocate for yourself at work because of Ménière's Disease. What was that experience like?

Impact/outcomes

1. Share what ways that you have or have not changed your organization’s attitudes towards invisible disabilities such as Ménière's Disease.
2. Tell me about your workplace’s leadership styles. In what ways does it influence your decision to disclose having Ménière's Disease?
3. Tell me about whether you identify MD as being a disability or not in your own life.

Reflection

1. Looking back, are there things you would tell someone else afflicted with Ménière's Disease that are looking to start a new job?
2. What resources or support systems have you found most valuable in navigating work with Ménière's Disease?

Clearinghouse:

1. Is there anything we have not covered today that you'd like to share your thoughts experiences on?