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"Woman Problems": Superior-Subordinate Communication of Endometriosis

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“WOMAN PROBLEMS”: SUPERIOR-SUBORDINATE COMMUNICATION OF ENDOMETRIOSIS

A Thesis
Presented to
The Faculty of the Department of Communication
Western Kentucky University
Bowling Green, Kentucky

In Partial Fulfillment
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Master of Arts

By
Mary Madison Lyons

May 2020
“WOMAN PROBLEMS”: SUPERIOR-SUBORDINATE COMMUNICATION OF ENDOMETRIOSIS
I dedicate this thesis to Lilly. Thank you for giving me the inspiration to make this my “topic of choice” for the past two years. This is also for the one in ten. I hope that one day your struggles are only something we read in history books.
ACKNOWLEDGEMENTS

I appreciate all of the women who shared their vulnerable stories with me. It is my sincere hope that this piece will create a bit of awareness that our society desperately needs. Thank you to my family, friends, and loved ones for teaching me the art of storytelling and listening, even when you do not understand my interests. You support me nonetheless, and for that, I am grateful. Dr. Mize Smith, thank you for your guidance and feedback. You have been an exemplary Thesis Chair. Your encouragement means the world to me. Also, I appreciate Dr. Payne and Dr. Sterk for their enthusiasm, support, and wisdom. I owe all of my professors in the Department of Communication an acknowledgement. Thank you all!
# TABLE OF CONTENTS

Chapter 1: Introduction............................................................................................................. 1

Chapter 2: Literature Review.................................................................................................. 6  
  Communication Privacy Management................................................................................. 6  
  Interpersonal Disclosure.................................................................................................... 7  
  Workplace Privacy and Disclosure..................................................................................... 9  
  Superior-Subordinate Communication............................................................................ 15  
  Summary............................................................................................................................. 20  

Chapter 3: Methodology........................................................................................................ 22  
  Participants and Recruitment.............................................................................................. 22  
  Data Collection Procedures............................................................................................... 24  
  Data Analysis Procedures................................................................................................ 25  
  Verification Procedures..................................................................................................... 26  
  Role of the Researcher....................................................................................................... 27  
  Summary............................................................................................................................. 28  

Chapter 4: Findings............................................................................................................... 29  
  Dialectical Disclosure........................................................................................................ 29  
    Openness......................................................................................................................... 30  
    Closedness.................................................................................................................... 34  
    Determinants of Openness and Closedness.................................................................. 37  
  Real and Imagined Consequences.................................................................................... 41  
    Positive Outcomes......................................................................................................... 42  
    Negative Outcomes....................................................................................................... 44
Anticipated Outcomes.................................................................47
Relational Closeness.................................................................50
Gender.......................................................................................50
Commonalities............................................................................52
Summary......................................................................................56
Chapter 5: Discussion...............................................................58
Summary of Themes.................................................................58
Practical Implications..............................................................65
Strengths, Limitations, Future Research.................................67
Conclusion..................................................................................68
Appendix A: Participant Recruitment Flyer.................................70
Appendix B: IRB Approval..........................................................71
Appendix C: Informed Consent Form.........................................73
Appendix D: Interview Protocol..................................................75
Appendix E: Member Check Attestation.....................................78
Appendix F: Peer Examination Attestation.................................79
References..................................................................................80
The purpose of this study is to understand how working women with endometriosis communicate with their superiors about their chronic health condition. An interpretative approach was taken through the use of semi-structured interviews. Data were analyzed by using a constant-comparison method of thematic coding, resulting in three themes that answered the research questions. The findings revealed that working women communicate about endometriosis with their superiors via a dialectical tension of openness and closedness. Women perceived the outcomes of disclosure positively and negatively, but the anticipated outcomes were highly prevalent. Relational closeness between superior and subordinate was a key factor in the decision to disclose. Practical implications for both superiors and subordinates dealing with illness in the workplace are provided, as well as avenues of future research, strengths, and limitations.

*Key words: Communication Privacy Management theory; Superior-Subordinate Communication; Relational Dialectics theory; Invisible Illness; Endometriosis*
CHAPTER 1
INTRODUCTION

Women are now a strong presence in the American workforce and increasingly so. Women account for 47% of the working population in the United States, totaling 74.6 million women (12 Stats, 2017). Not only are women working more than ever before, but they are also holding greater power at work, as evidenced by the fact that in 2015, 42.7% of senior-level positions were held by women (Friedman, 2015). However, a majority of supervisory roles are still held by men.

Female workers, unlike their male colleagues, bring a unique set of health issues to their jobs. Women with any type of chronic illness, including but not limited to women’s health, automatically enter employment at a disadvantage as women often find flexibility hard to come by at work, although it could make dealing with health conditions more manageable (Werth, n. d.). Due to more career shifting than was typical of previous generations (Denning, 2016), working women are likely to encounter multiple superiors. With more superiors comes a variety of challenges and methods of communicating about feminine illnesses. Consequently, more thought must be given to women’s health-related concerns in the workplace.

While there are no data on how many working women have a women’s health condition, it is certainly not an anomaly. This study focuses on only one of the many health issues a woman can have, which is endometriosis. Endometriosis, commonly shortened to “endo,” is a severe chronic pain condition in which uterine lining-type tissue grows outside of the uterus, leading to further complications. In the United States, 11% of
women are believed to have endometriosis. The majority of diagnosed women are in their 30s and 40s (Endometriosis, 2018), which are prime working ages of many women.

Endometriosis has harsh repercussions for women who work. Their ability to have a career in their area of choice may be negatively impacted in a number of ways. For example, the chronic pain these women experience makes them take more sick days than those who do not have the disease, which in turn makes them more susceptible to lower productivity. Annually, $22 billion dollars is lost due to productivity losses related to endometriosis (Taylor, 2018). Women with endometriosis often have to make choices about their careers based on their limitations (Sperschneider et al., 2019). This is something the average woman does not have to do. Norman (2018), an endometriosis survivor, writes about her struggle with the disease,

I was raw with disappointment that I wouldn’t be able to go back to Sarah Lawrence, that I probably wouldn’t graduate from college at all, that I’d never be the woman I wanted to be, or have the life I’d promised myself. (p. 225)

Stories like Norman’s are not uncommon.

What makes discourse about endometriosis all the more confusing at work or any other setting is the fact that the disease is largely misunderstood. Over the course of the last couple of centuries, women’s bodies have mystified health professionals. Women used to have their reproductive organs removed for no reason at all, other than they were blamed for just about every nuanced health problem. Painful treatments such as bloodletting and leeching have also been common throughout history (English & Ehrenreich, 2005). Fortunately, English and Ehrenreich (2005) have noted, “More and more women were rejecting the doctors’ passive, sickly model of femininity and carving
out activist roles for themselves” (p. 138). We may have progressed as a society in the way we handle women’s health, yet there is still a lack of understanding when it comes to endometriosis.

As English and Ehrenreich (2005) suggested over a decade ago, women’s health is often left up to women to advocate for themselves. It is clear that governmental and academic institutions are somewhat lackadaisical in their efforts to pin down the enigma that is endometriosis. For example, the National Institutes of Health (NIH) provided about $7 million for endometriosis research in 2018 (Taylor, 2018). At first, this seems like a lot of money and effort. However, when compared to their pledged $755 million for breast cancer and $1.6 billion for acquired cognitive impairment, it is obvious that endometriosis is low on the totem pole of funding priorities. A lot of fundraising efforts are performed by nonprofit organizations as well as individuals who host events to raise awareness and capital for endometriosis (Taylor, 2018). There is a strong theme in fundraising of women being advocates for themselves.

It is not uncommon for women to go years with painful symptoms of endometriosis before receiving an official diagnosis, provided they are fortunate enough to get one. The disease manifests itself so differently among women that the diagnosis often comes after an invasive procedure. There is disarray in how medical professionals suggest women treat endometriosis. Some suggest having a child is the way to stop the disease, yet many women are infertile due to the same disease they are trying to eradicate (Norman, 2018). If professionals are confused about how to deal with endometriosis, it is not surprising that women may be unable to discuss their condition in an informed and comfortable manner with their superiors at work.
The advice for an employee initiating a difficult conversation with a superior is to “share your facts, tell your story, ask for their view, talk tentatively, and encourage testing” (“How to have a difficult conversation,” 2019, p. 4). Coming from human resources at the University of Texas, this is sound advice for difficult topics such as workplace bullying and asking for a salary increase. However, the efficacy of these steps for a topic as sensitive as endometriosis is questionable. Women are aware of the stigma endometriosis carries and feel the shame of being viewed as hysteric or a hypochondriac (Zacharopoulou, 2018). Coupled with knowing that their invisible illness causes productivity to wane, the subject is hard for female workers to broach even with the most understanding and familial of superiors. The issues women have with disclosing illnesses to their bosses are often generational and may be compounded over a long period of time. Sexism, for many women, begins when a woman is born and impacts her work later in life (Tankersley, 2018).

There appears to be a lack of consensus surrounding management of endometriosis in general, as well as a lack of research exploring communication about the disease in the workplace. Therefore, the purpose of this research project is to explore how women communicate about endometriosis-related topics to their superiors, the outcomes of that communication, and the relational characteristics that may influence their disclosure decisions. Based on the facts provided, it is apparent that women are a significant presence in the workplace, and many of them may be dealing with the effects of having endometriosis. An inherent power differential exists in a superior-subordinate dyad, and women with chronic illnesses are already disadvantaged, which is why this research matters. Having the freedom and comfort to discuss a health concern with a
superior can make a positive difference in how women manage both their health and their
careers. This study will provide insight to working women who may be suffering from
endometriosis, as well as to superiors whose employees may disclose and seek support
for this common female disease.

This thesis encompasses five chapters. The current chapter serves as an
introduction into the current state of endometriosis and women’s health as well as
workplace culture for women with gynecological illness. The next chapter provides an
extensive review of related literature regarding communication privacy management
theory and superior-subordinate communication. The third chapter describes the
methodology employed in the project, including the research design, process,
participants, and analysis procedures. The fourth chapter presents the findings that
surfaced from the interviews. The final chapter interprets the themes of the data, as well
as discusses the implications for both theory and practice.
CHAPTER 2
LITERATURE REVIEW

This chapter reviews literature of the theoretical frameworks and current research related to women’s health in the workplace. Specifically, endometriosis is largely shrouded in secrecy and confusion. Therefore, there are numerous communication processes at work that have not been previously studied.

First, communication privacy management theory (CPM) was reviewed. CPM’s history as a health communication framework suggests its usefulness for this inquiry. Because endometriosis is a private health diagnosis, women must make decisions about disclosure and privacy. Second, superior-subordinate communication literature was reviewed. This was the particular workplace dyad of interest in this qualitative study, so having an understanding of how the communication between the two affects the relationship at work was necessary. A female employee’s decision to reveal or conceal an endometriosis diagnosis in a professional setting could be a function of the relationship with the superior.

Communication Privacy Management

Communication privacy management (CPM) examines how people make decisions about the sharing of private information. When people choose to disclose information about the self, they must negotiate rules or boundaries with those with whom they have shared the information. The recipients of the information become co-owners of said information, as the knowledge cannot be taken back once it is shared (Petronio, 2002). With the sharing of personal information comes risks. Particularly with health-
related topics, disclosures have the potential to stigmatize those who reveal facts about themselves (Knapp & Daly, 2011).

CPM includes five propositions. First, owners of information believe it belongs to them. Secondly, owners of information believe it is their right to control the sharing of said information. Third, owners use individual privacy boundaries and collective privacy boundaries as the rules-based criteria for controlling the sharing of information. The fourth proposition states that boundaries are extended to others when disclosure occurs. Those with whom the information was shared become co-owners. Within the fifth proposition, the co-owners collectively agree on implicit or explicit rules for sharing the information with others. These rules can be about permeability, linkage, or ownership. The sixth and final proposition is that boundary turbulence often occurs when boundary rules are not effectively followed (Child, Pearson, & Petronio, 2009).

Because of the normalization of women’s pain and the taboo aspect of all things regarding menstruation, women often do not seek support and therefore do not disclose information about their endometriosis symptoms (As-Sanie et al., 2019). Women may be less inclined to share information about their endometriosis condition because they do not have the power to set proper boundary rules after disclosing to their supervisor. The lack of control of how the information will be used and shared may make them less likely to disclose at all.

**Interpersonal Disclosure**

Naturally, because health information can be stigmatizing, one would consider the risk of sharing before doing so with anyone, even a friend. Kennedy-Lightsey, Martin, Thompson, Himes, and Clingerman (2012) examined CPM in friendship dyads and found
that an evaluation of risk in sharing was important to participants. In the dyad, if the sharer wants the disclosure to stay between the pair, they need to make the risk of information known to the other party so it will not be spread throughout the entirety of the social network. Therefore, the sharers in the study coordinated boundaries more when the risk level of the disseminated information was thought to be higher.

Likewise, Petronio, Sargent, Andea, Reganis, and Chichocki (2004) suggested that if the discloser’s idea of ownership with the receiver is not met, there will be boundary turbulence. According to Petronio (2004),

> When people disclose to each other, they essentially link others into a privacy boundary. Once that happens, there are expectations that disclosers have when others are privy to their information. In addition, the recipients essentially become co-owners or shareholders of the information because of concomitant expectations that they will keep the information confidential. (p. 203)

With risky information, there is more fear surrounding the choice to make another person whom cannot be controlled a co-owner of that information.

Boundary turbulence is experienced via six types of information violations. These are intentional rule violations, boundary rule mistakes, fuzzy boundaries, dissimilar boundary orientations, boundary definition predicaments, and privacy dilemmas (Petronio, 2002). These violations range from overt offenses to accidental sharing due to confusion. Further research has been done to understand how boundary turbulences affect individuals on emotional, cognitive, and behavioral levels.

Aloia (2018) discovered that when private information was shared when it should not have been, according to the initial sharer, participants experienced strong emotions,
namely, sadness, fear, and anger. Likewise, when the information was kept confidential, the participants did not feel a similar level of happiness. Negative emotions are generally more powerful and prominent. Linked to the experience of fear and sadness were the behaviors of concealing and withdrawing from the co-owners after the turbulence occurred. Rumination was found to be the key cognition between emotional and behavioral experiences. With more anger, participants were more likely to attack or argue with the co-owner, which is based on verbal rumination (Aloia, 2018).

Boundary turbulence about health issues is not uncommon. Campbell-Salome (2018) found that young women under their parents’ insurance policies were largely uncomfortable sharing about the services rendered by healthcare professionals in relation to stigmatized health problems, even though they may have recognized that the parents have a technical right to know. These young women liked to feel as though they, as the sharer, had the control of the information. To retain control, they often deceived their parents or let their health go to the wayside to avoid potential turbulence (Campbell-Salome, 2018). Even in families, there is a reluctance to disclose women’s health issues.

**Workplace Privacy and Disclosure**

Because most people spend the majority of their hours per week at work, the workplace is a context in which one must often manage private information. Several studies have explored how employees choose to reveal personal information at work, whether regarding their health or other issues. According to Smith and Brunner (2017), organizational culture, risk/benefit analysis, and the need for feedback help employees decide how to manage their privacy boundaries in the workplace. Organizational culture was related to how close-knit employees perceived relationships to be. Employees felt
more at ease disclosing private information when they had a sense the relationship was familial in nature. As part of risk/benefit analysis, employees weighed the potential risks before disclosing. Risks that deterred participants from disclosing were a fear of having their performance or life in general become misconstrued. Another way to frame feedback is as advice. Employees claimed to disclose personal information more when they sought insightful commentary about troubling personal issues from other workers.

Perceived appropriateness of information for the workplace context is a significant determinant of the type of information that is shared by employees. As noted by Westerman, Miller, Reno, and Spates (2015), for health information, there are “rules for sharing private information, boundary coordination, reasons for permeable boundaries, reasons for impermeable boundaries, and organizational environment and conditions” (p. 378). Norms related to culture and gender also affect the formation of privacy rules between sharer and receiver. In research on voluntarily childless couples, cultural norms and societal expectations create guilt and shame that made participants want to conceal their private choices. As for gendered rules of disclosure, women’s identities are tied to parenthood much more than men. Therefore, women are more likely to talk about reproduction. As compared to men, women are also more critical of other women (Durham, 2008). The findings of these studies suggest that the reasoning behind an employee’s choice to reveal or conceal is not based on a single, isolated factor. Rather, past experience, environment, and personal needs allow the sharer to reach a conclusion of how to manage boundaries at work.

Smith and Brunner (2017) found that privacy expectations are often implicit more than explicit, which can explain how boundaries become ambiguous and lead to
turbulence when information is shared that the primary owner did not wish to be dispersed. Particularly in a workplace setting, people are often under the impression that laws such as HIPPA, a health-information protection law, will keep them and their respective cache of health stories private. This is an implicit understanding because they feel the law speaks for itself, and they should not have to.

Core and catalyst criteria are part of CPM. Core criteria are the consistent reasons that people choose to disclose or not disclose. Boundary maintenance and organization culture were found to be primary sources of core criteria (Smith & Brunner, 2017). Core criteria are the same as gauges of disclosure with high levels of stability. Catalyst criteria, on the other hand, alter a person’s preference for privacy rules via outside influences. Desire for feedback and the risk/benefit analysis change how privacy is managed by reasoning of disclosure choice, resulting in atypical circumstances and actions when compared to the core criteria (Smith & Brunner, 2017). Related to the organizational context and the present study, disclosure criteria can vary among individual employees as catalyst criteria in particular are dependent on organizational culture factors.

Disclosing invisible illnesses in the workplace may be particularly difficult because there is no apparent problem to onlookers. Invisible illnesses are what they sound like– a chronic illness that no one would know about if not made aware by the sufferer. In order for invisible illnesses such as endometriosis to be accommodated at work, the suffering employees have to “out” themselves, which can lead to stigmas and stereotypes (Butler & Modaff, 2016). Stigmas and stereotypes are naturally unpleasant, so there must be a strong motivation for employees to share about their illnesses. Managing health information is burdensome (Ancker et al., 2015), as hegemonic workplace norms can
lead people to not disclose important information, even health safety hazards at work (Zoller, 2003). Thus, clearly, it is difficult for employees to speak out about issues that might place them under an unwanted spotlight, even if it means that their working conditions could in some ways become better.

Butler and Modaff (2016) used a qualitative questionnaire to generate responses from workers with chronic health conditions about how they would choose to disclose or not disclose their illness to superiors and coworkers. The researchers identified three themes of disclosure motivations related to chronic illness. The first motivation was to facilitate continued employment by voluntarily disclosing. Participants attempted to get FMLA accommodations and/or shape the views of colleagues about them. As mentioned earlier, CPM is about maintaining a level of control over personal information. The second voluntary disclosure theme was enacting values, specifically educating peers and maintaining positive, open relationships. The third theme was involuntary disclosure related to a necessity in explaining the workers’ absence or condition. These participants often overcompensated for missing work and kept the information they shared on a strictly need-to-know basis. In essence, no matter which route the suffering employees took, they did so with the intent to maintain friendly work relations and security in their careers (Butler & Modaff, 2016).

Research suggests a variety of workplace consequences that may arise after an employee’s voluntary or involuntary disclosure of a chronic illness: reduction of work, disassociation, questioned ability, resentment, dismissiveness, social faux pas, and bullying/teasing (Kelly & Romero, 2019). Based on the nature of the consequences, diversity training was proposed to help colleagues better understand invisible illnesses,
and thus respect privacy boundaries (Kelly & Romero, 2019). Even so, potentially negative consequences that workers have either observed or feared may motivate them to conceal their private health information in the first place.

Privacy management at work is also enacted through mediated channels. Laitinen and Sivunen (2018) examined how employees managed private information via enterprise social media (ESM). ESM is an offshoot of organizational culture because it allows for sharing and collaboration internally in the organization, and in many ways is like social media with news feeds and message boards. However, ESM sites are maintained by organizational guidelines and are intended to be work-related only. Audience members (hopefully) do not exist outside of the company. The research showed that employees liked to keep anything they shared about themselves on the sites related to their professional lives only. What constitutes professional versus personal, however, is a bit nebulous. Employees also had a fear of information being leaked online, another way of saying there was a fear of boundary turbulence. Team leaders were expected to post more in order to be viewed as an at-arms-length leader, while other employees were even more hesitant to share about themselves. Smith and Brunner (2017) recommended that a work environment should welcome openness with disclosing aspects of personal life as it increases the quality of relationships and workplace satisfaction. However, Tardy and Dindia (2006) recommended that sharing should be a personal decision based on the individual’s own analysis of the risks and benefits.

Organizational surveillance is an issue that has brought additional challenges to CPM as employees’ personal and professional lives become more entwined with technology. According to Allen, Walker, Coopman, and Hart (2007),
Working together, socialization plus the giving up of control creates a condition that legitimizes organizational surveillance over employee claims regarding the right to privacy. CPM theory was initially developed to better understand communication and privacy in interpersonal relationships, and the situation appears to be very different for employee communication and privacy. (p. 192)

There seems to be little real resistance to using technological surveillance to make organizational members co-owners of information, although many believe it is a form of coercive control (Allen et al., 2007). Since this research was focused on work-related information, this leaves many questions about how employees and employers should handle the sharing of protected health information.

In relation to the study at hand, women with endometriosis have to make similar decisions about communication privacy management with their superiors and colleagues. These women must negotiate rules and boundaries about the content of private health information, including when and with whom to share. Because endometriosis is an invisible illness, the rules of disclosure are typically ambiguous. Superiors and colleagues may not recognize how the illness affects work culture/relationships and vice versa.

However, at least one thing about women’s invisible illnesses is certain, and that is that health disclosures are gendered. When women disclose diagnoses such as endometriosis, they are simultaneously reflecting and constructing gender roles. Women with endometriosis and other invisible illnesses have days of feeling fine and days of suffering with no external symptoms (Edley & Battaglia, 2016). This further confuses the situation and makes disclosure difficult. According to Defenbaugh (2013) on invisible illness, when revealing the diagnosis to others, a person recognizes they have an identity
of an Other, which can be stigmatizing. Defenbaugh (2013) described her struggle with Irritable Bowel Disease, an invisible illness. Interestingly, she recognized the water closet (i.e., bathroom) as a metaphoric disclosure boundary. She wrote, “The result is continuous hiding and concealing to prevent any leakage of an ill identity and to maintain a sense of healthy (looking) normalcy” (p. 162). In an organizational context of a woman dealing with endometriosis, similar conclusions and experiences could be drawn.

**Superior-Subordinate Communication**

Employees manage a number of relationships in the workplace, but perhaps none more important than the relationship with their bosses, which largely depends on the quality of superior-subordinate communication (SSC). Superior-subordinate communication has ties to social support as well. Allen (1992), studied the relationships among communication, perceived organizational support, and organizational commitment in a workplace setting and found the strongest relationship between all of the factors to be the perceived communication relationship with top management. Top management (superiors) was described as holding the values of the organization, thus having the power to make employees feel valued or unvalued through their communication. Employees who do not feel supported at work are unlikely to have a strong sense of commitment to the organization.

Lybarger, Rancer, and Lin (2017) studied the perceived credibility of supervisors. The actions of the supervisors determined the credibility, namely nonverbal immediacy, which is “smiling, eye contact, proximity, body orientation, gesturing, vocal inflections, and appropriate physical contact while communicating” (Lybarger at al., 2017, p. 126). The better superiors used these immediate behaviors, and they were believed to be more
trustworthy. Likewise, if superiors were verbally aggressive, they were less credible, resulting in a less positive relationship with their employees (Lybarger et al., 2017). Immediate superiors are also a resource to employees during times of change that other levels of management cannot compete with (Tanner & Otto, 2016).

Credibility and trustworthiness were also two of the emergent themes in Winska’s (2010) research. Job satisfaction was tied to the quality of superior-subordinate communication, and most of the responsibility for having positive communication was on the superiors rather than the employees. “The most important elements still remain the skills and behaviour of the supervisor: leader oral communication, perceived supervisory communication competence, perceived leader’s effectiveness, and the behaviour of the supervisor” (Winska, 2010, p. 5). Trust and organizational culture were also important to the quality of the communication within the dyad, of which the superiors had a huge part in creating (Winska, 2010). These findings are similar to those of Lybarger et al. (2017) with the added emphasis on the role of the superiors within the organization. All of the findings are relevant to the present study as the relationship between superiors and subordinates is under scrutiny.

When superiors at work are nonverbally immediate (e.g., smiling, affirming gestures), employees perceive them as emotionally supportive. Nonverbal behavior is a primary way people show their emotions. Consequently, superiors who are nonverbally immediate tend to have stronger superior-subordinate relationships and make their employees more satisfied with their jobs because of the emotional support they give (Jia, Jiuqing, & Hale, 2017).
The quality of superior-subordinate communication does not necessarily have to depend on the actual communication. Intrapersonal aspects can be important as well, namely the human need for control and predictability. Avtgis and Kassing (2001) emphasized that fact with findings about organizational controllability and relational predictability. Essentially, if an employee finds that his or her superior is predictable relationship-wise at work, he or she will also find the behavior to be regular. The superior’s regularity and predictability of behavior gives the employee a sense of control over the situation. The subordinate may feel the relationship is of high quality when he or she can use predictable relationship tactics such as persuasion.

More specifically related to this study, female employees may seek social support from superiors to help them manage their health concerns in the workplace. For example, a woman’s choice to breastfeed may impact her work. The Affordable Care Act attempted to create more opportunities for women to be comfortable breast pumping at work. However, the organizational culture of the company is a huge determinant of how the mothers actually feel about their worth at work and as a breastfeeding mother. A survey revealed that women can feel both supported and unsupported in their breastfeeding endeavor at work. Most messages were found to be supportive from superiors and colleagues. However, negative messages such as devaluing breastfeeding and questioning the process were also prevalent. Male superiors and colleagues were most likely to use negatively framed messages about breastfeeding (“Nursing Mothers”, 2018).

Part of the communication between superiors and subordinates deals with deception when concealing information. Escape and control motives can halt positive
communication in the superior-subordinate dyad. This could be because the relationship revolves around defensiveness when control is the main factor rather than affection, which is positively correlated to quality communication and relational satisfaction (Walter, Anderson, & Martin, 2005). In all, these characteristics decrease the quality of work relationships and thus negatively affect superior-subordinate communication.

Similarly, Theory X and Theory Y have been used as theoretical frameworks for research on superior-subordinate communication. Theory X orientations assume that employees despise work and require constant direction. Theory Y, on the other hand, assumes that employees want to do quality work and are self-directed (McGregor, 1960). In the modern workforce, it is common for all employees in an organization to take evaluations about their personality styles, communication styles, attitudes, etc. Sager’s (2008) findings indicated that superiors with a Theory X orientation are perceived as cold and dominating, while those with a Theory Y orientation are warm and welcoming. These attitudes can have an effect on the quality of the relationship and the satisfaction a subordinate has with the superior.

Satisfaction in a superior-subordinate dyad has also been found to depend on gender in some research participants. Lamude, Daniels, and Graham (1988) studied superior and subordinates in four gendered combinations (i.e., male superior + male subordinate, male superior + female subordinate, female superior + male subordinate, and female superior + female subordinate). Same-sex dyads had higher relational satisfaction related to communication than did different-sex dyads. Within different-sex dyads, male superiors and female subordinates had more satisfaction than female superiors with male subordinates.
Similarly, Lee (1999) studied leader-member exchange theory (LMX) in a
gendered context. LMX is a theory related to superior-subordinate communication.
Superiors at work are selective in what they share with others at work. Due to limited
resources, the quality and maturity of exchanges from leaders vary among members.
According to Lee (2019), members had expectations of the communication they received
from leaders, which became a self-fulfilling prophecy. Those with high expectations for
positive communication acted in a way that put them in a high LMX relationship. Those
with low expectations also behaved in way that placed them in the low LMX group. The
most important aspect of Lee’s (1999) research in relation to the study at hand is that the
most disadvantaged workers (i.e., low satisfaction, poor performance ratings, etc.) were
women in the low expectation group. A more recent study, however, suggests that gender
may not be as much of an issue within superior-subordinate communication as once
thought. Bakar, Mohamad, and Mustafa (2007) studied a single Malaysian company in
depth and found that men and women alike in the organization used both instrumental
and relational communication tactics to build a rapport with their superiors on the job.
These findings bring into question what previous research had led academics to believe
about the dyad in terms of gender.

On the other hand, gender does seem to play a significant role in superior-
subordinate communication when it relates to a women’s health issue. Liu and Buzzanell
(2004) found that working women who become pregnant often experience a lot of
discouragement and confusion about where they belong in the organization. They often
have difficulty negotiating and advocating for themselves. Part of the problem is due to
“differential supervisor-subordinate expectations, different perceived rights and
responsibilities, and divergent ethical stances indicating what various stakeholders should and could do at times of workplace pregnancies and maternity leaves” (Liu & Buzzanell, 2004, p. 340). When expectations for women are not clearly communicated between the superior and subordinate, female employees can become easily discouraged about negotiating their work roles.

According to extant research, superior-subordinate relationships are one of the most important of all workplace relationships. How the subordinate perceives the superior affects the quality of communication and resulting relationships. Therefore, much of the relationship depends on the superior. Women’s health issues such as pregnancy, breastfeeding, and perhaps endometriosis may create barriers to negotiating women’s needs at work, depending on the relationship they have with their immediate superior.

**Summary**

This chapter has reviewed literature related to communication privacy management and superior-subordinate communication. More specifically, connections across the literature point to probable difficulties that working women with endometriosis could face. The communication and relationship a female employee has with her immediate supervisor would seemingly play a role in her choice to reveal or conceal private health information affecting her work. Having an invisible illness rather than a visible illness could likely compound issues from an organizational standpoint. Therefore, this study explores the following research questions:

**RQ1:** How do working women with endometriosis communicate about their condition to their immediate supervisor?
RQ2: What outcomes do working women experience after disclosing their endometriosis condition to their superiors?

RQ3: What qualities of supervisor relationships influence working women’s disclosure of their endometriosis condition?

The next chapter outlines the specific methodology used in this study, including the research design, participants and recruitment, data collection, data analysis, and the role of the researcher.
CHAPTER 3

METHODOLOGY

The purpose of this study is to understand how working women with endometriosis communicate with superiors about their health condition. Therefore, this study used qualitative methods to answer *how* questions in a way that only qualitative research can. A rich, thick description of the context surrounding the data is one of the benefits of using such methods (Tracy, 2013). More specifically, a series of face-to-face and phone interviews were completed to allow the researcher to gain a rich, thick description in a way that surveys or emailed questions cannot.

Participants and Recruitment

Following Western Kentucky University Institutional Review Board (IRB) approval, purposeful sampling was used to recruit participants. Purposeful sampling is often used in qualitative research to ensure participants are knowledgeable about the content of the questions or have personally experienced the topic of interest (Palinkas et al., 2015). Therefore, flyers were distributed to gynecology offices in the Southcentral Kentucky area. The flyer asked working women who have endometriosis to reach out to the researcher via phone or email to set up a time and location for the interview. A copy of the flyer can be found in Appendix A. Ten potential participants contacted the researcher through this recruitment process.

In addition, convenience and snowball sampling were also used due to the researcher’s extensive system of contacts with working women who suffer from endometriosis. A post on social media was created and shared to solicit the researcher’s
network of contacts for participation. Additional participants were recruited using these methods, for a total of ten participants in the study.

To be eligible for this study, participants had to meet the following criteria: a) be female, b) be 18 years of age or older, c) have diagnosed or self-diagnosed endometriosis d) have or have had a direct supervisor in the workplace while managing endometriosis. Due to the nature of the disease, people can live with symptoms of endometriosis for years without receiving an official diagnosis. In order to allow for inclusion of women in this category, women had to have more than one symptom of endometriosis. Symptoms included pelvic/abdominal pain, subfertility, pain with excretion, chronic constipation/bloating, and abnormal bleeding (“Endometriosis,” n.d.). The most important aspect of a self-diagnosis was whether or not the participant believed her symptoms affected her professional work. The selection criteria for participation were chosen in order to achieve the aforementioned goal of the research (Tracy, 2013).

Participants ranged from 20 to 53 years of age with a median age of 36 years and an average age of 37 years. Eight of the participants had official diagnoses while the remaining two had unconfirmed diagnoses. The women reported having dealt with the issue at work for a median of 17.5 years and an average of 16.7 years. However, most of them struggled to define the beginning of their endometriosis journey. Their work positions and titles varied, including multiple teachers and nursing healthcare workers, but all reported having had experience of reporting to a direct supervisor. Eight participants reported having both female and male supervisors, while two participants reported having only female supervisors. No participants mentioned having only male supervisors.
Data Collection Procedures

Semi-structured interviews were conducted after receiving approval from the Institutional Review Board (IRB) (see Appendix B). A copy of the IRB Consent Form can be found in Appendix C. Rather than following a rigid set of prepared questions, semi-structured interviews follow an interview protocol and allow for more in-depth questioning. Based on the answers to the interview questions, the interviewer can ask follow-up questions and probe further if there seems to be more information of value on the subject. Asking open-ended questions is a hallmark of semi-structured interviews as it is vital for the storytelling aspect unique to qualitative inquiry (Keyton, 2006).

Furthermore, according to Barriball and While (1994), semi-structured interviews are an excellent choice for gaining better perspective from respondents when the topic is sensitive. Health information is largely considered sensitive information, which is characterized by health status and individual traits (Syn & Kim, 2016). Endometriosis is certainly a sensitive topic for most women who struggle with the condition on a chronic basis.

Interviews began with general questions regarding the nature participants’ work and the work environments with the aim to establish rapport and make participants feel comfortable talking. Questions became increasingly more specific, asking about how they disclosed or concealed their private health information, the outcomes experienced, and relational characteristics that may have influenced their disclosure decisions. The interview ended with demographic questions. For the complete interview protocol, see Appendix D.
Interviews lasted for an average of 21.9 minutes and a median of 24.5 minutes, which is around the same time as a typical interview for qualitative research purposes (Keyton, 2006). All ten interviews totaled 4 hours and 51 minutes. While one interview was conducted by phone on FaceTime, the data from that interview was not found to be different than the data from in-person interviews. FaceTime allowed the interviewee and interviewer to see each other’s nonverbal cues. The majority of interviews were conducted in person at locations chosen by the participants to make them more comfortable. The goal was to create a private environment where participants could openly discuss personal information.

All interviews were audio recorded using a cellular device and later transcribed verbatim for further analysis. Transcriptions ranged from 8 to 30 pages in length double-spaced. Total transcription length was 175 pages double-spaced. Transcriptions were also paired with notes that the researcher took to capture the interview.

**Data Analysis Procedures**

A constant comparison method was utilized by the researcher to conduct a thematic analysis. Coding the data occurred in three distinct stages (Lindlof & Taylor, 2011). First, line-by-line open coding was performed. Most of the conceptual ideas were identified in this stage (Strauss & Corbin, 1998). During line-by-line coding, the researcher broke down the data into smaller units of words, phrases, and sentences and then gave those units a name or code. A total of 1,049 codes emerged. Next was axial coding in which the open codes were collapsed into larger categories based on similarities (Strauss & Corbin, 1998). Eight categories were created. The last stage of coding was selective coding where relationships across the categories were identified.
until overarching themes emerged (Strauss & Corbin, 1998). The goal of selective coding is to find a few themes that speak to the research questions of interest, while representing a majority of the data. A total of three themes representing the entire data set were created.

Themes had to meet two of the three possible criterion (i.e., recurrence, repetition, and forcefulness) in order to be constituted as a theme (Owen, 1984). Each theme also had to be present in the responses of at least half of the participants or represent a high level of importance (i.e., forcefulness) to the overall interview. The selected themes are discussed in the following chapter. Finally, transcripts were reviewed to find quotes exemplifying each theme and/or any contradictions or outliers in the data.

**Verification Procedures**

Member-checking and peer debriefing were used as procedures in the verification process to ensure that participant voices were accurately represented in this interpretation of the data (Creswell & Miller, 2000). The purpose of member-checking is to establish a better understanding of what the interviewee meant to communicate to the researcher (Lincoln & Guba, 1985). The researcher asked a participant to verify the findings. She was given an opportunity to review the write-up, ask questions, and clarify any of the interpretations. The participants gave positive feedback and agreed with the three themes. The member check attestation can be found in Appendix E.

Peers were debriefed on the researcher’s interpretation of findings as well. Two Master’s students in communication who were peers of the researcher were asked to review the findings. They offered an outside perspective and added credibility to the interpretations of the data. Biases that the researcher was unaware of had the opportunity
to appear to peers in this process (Lincoln & Guba, 1995). Overall, the peers found the interpretations to be clear, coherent, and consistent based on the extant research and supporting data provided. A copy of the peer attestation form can be found in Appendix F.

**Role of the Researcher**

Although neither I nor any of my closest family members or friends has endometriosis, I have had an interest in women’s health for many years. Part of this interest stems from my own separate and less severe women’s health condition. I am also an advocate at a rape crisis center. As sexual assault is a problem that adversely affects women and has inadvertent connections to women’s health at large, it is fair to say that I empathize with issues that are unique to women.

This study expanded on a previous research project in which I examined how women communicated any women’s health condition to their male superiors. One of the participants had endometriosis, and that interview stuck with me emotionally much longer than most. Admittedly, her experience could have shaped my preconceived notions about other women’s experiences with endometriosis at work. These truths about may create natural biases in how I believe women are treated generally, and in the workplace specifically, that could slip into my interpretations. This is why verification procedures were necessary and relevant.

To keep my potential biases in check, I used exact quotes from the participants when taking notes and writing the findings. This helped to ensure the participants’ voices were heard above mine. I also kept a journal about the expectations I had before
beginning each interview. I reviewed the journal when working on the data analysis in an attempt to prevent my preconceived notions from coloring my interpretations.

**Summary**

This chapter has summarized the research methodology, including process, research context and participants, data collection procedures, data analysis procedures, verification procedures, and the role of the researcher. The interviews from the ten participants provided a range of data related to the purpose of the study. Although the researcher expressed some bias, plenty of research safeguards will allow the data to be presented true to how it was uttered from participants. The next chapter presents the findings of the study, organized by themes that address each of the research questions previously posed in Chapter 2.
CHAPTER 4

FINDINGS

This chapter summarizes the various themes that were found to address the three research questions exploring working women’s disclosure of endometriosis in the workplace, specifically their communication with supervisors, the outcomes experienced, and qualities of the superior-subordinate relationship that influence disclosure of endometriosis. After extensive coding and analysis, three themes emerged from the data, and each theme corresponds directly to one of the questions: (a) Dialectical Disclosure (RQ1), (b) Real and Imagined Consequences (RQ2), and (c) Relational Closeness (RQ3). The following sections review each theme, their multiple categories, and examples of participant quotations that support the findings.

Dialectical Disclosure

The first research question examined how female employees communicate their endometriosis condition to their immediate superior at work. Participant interviews revealed a dialectical tension when women disclosing their endometriosis condition to their supervisors. Often, the participants would express openness or a desire for openness but would remain closed in communication. It was common for the participants to contradict their statements about how they communicated to their superiors at work. A number of factors contributed to how the condition was revealed and the dialectic. Thus, the participants revealed the categories of Openness, Closedness, and Determinants of Openness and Closedness as being vital to Dialectical Disclosure.
Openness

Openness, for the purpose of this study, refers to the women’s perceived freedom to share their diagnosis with supervisors in the eyes of employees. For some participants, they experienced genuine openness in sharing their struggle with endometriosis to their supervisors. For others, openness was something they craved but did not receive. However, openness was mentioned by all ten of the participants in one of the two capacities. Candie, an occupational therapy assistant at a nursing home, verbalized the salience of open communication when asked about the point at which she decided to disclose her illness, which she expressed as moderate symptoms. She stated:

Um, I, I, think it was just over open communication. Just talkin’ about other health issues and things like that. But she’s super easy to talk to, and we have a very open line of communication, so it wasn’t… It was very easy to disclose it with her.

Haley, a nursing student working in retail, shared Candie’s sentiments. She proclaimed to have only experienced positive messaging regarding illness from her supervisors. She recalled, “So, anything that I say has always been open with, welcome with open arms. So, I’ve never had to um deal with any negativity, I should say.” Open communication was a reciprocal action to Haley and many of the other participants. She felt the supervisor was an open person before disclosure, which encouraged her to be open, too.

Loren, a former state government administrative assistant, reflected on the nature of her communication with her boss as well. She reported, “If something didn’t feel right, I would tell my supervisor quite often. I mean, we had pretty open communication.” She described her disclosure of her condition as volatile, indicating that she did not hold back
her thoughts and emotions. Although she took a different approach than that of the other participants, her disclosure still exemplifies truly open communication.

The feeling of acceptance was important to participants’ openness. Kylie, a certified nursing assistant, detailed her experience of initial disclosure to her supervising nurse. She recalled, “And I was like, ‘I’m having abdominal surgery for endometriosis, or possible.’ And she was like, ‘Oh, okay.’” The exchange did not reveal any disdain for the lack of further questioning about the surgery. Kylie viewed it as the total acceptance that she expected to receive from a healthcare professional, which made her be fairly open in disclosure. She actually preferred minimal discussion because she did not want to garner pity.

Donna, an elementary school teacher, explained that she had never kept quiet about important information concerning her condition to the principal. She insisted, “Um I can’t think of a time that I didn’t… I mean, he knew that I was always gonna be at work unless I had a very good reason.” Although the principal usually asked all employees to explain absences, Donna did not take the questioning as an affront. If anything, the questioning provided more opportunity for further discussion about her symptoms and how the principal could help. She felt easily accepted by her boss, so she felt she could remain open on this topic as well.

Openness was achieved in a number of participants by remaining matter-of-fact in their delivery during disclosure. Their matter-of-factness was marked by brevity in conversation about the condition following disclosure. Ann, a school nurse, recalled her disclosure in this way:
I mean, it was just blunt [laughs]. ‘I need these days off and this is why.’ And they were like, ‘Okay. We’ll put you on leave for those few days.’ I mean, it was not anything. There wasn’t any… Matter-of-fact. No details. Just, ‘Okay.’ That’s it.

Although the lack of details may nod to closedness at first glance, to Ann, this was being open. According to her, it is her nature to not share a lot of details and keep her struggles to herself. Therefore, revealing the diagnosis at all was a huge step in being open. Her matter-of-fact delivery is her personal version of openness.

Whereas Ann had a supervisor she felt she could share her condition with when needed, Faith, a former Medicare compliance associate at a physical therapy clinic, had the opposite experience. Faith did not get the feeling that openness about endometriosis was welcome by her boss. Nonetheless, she remained open in her delivery. She was the one who had to approach any conversation about her condition and resulting absenteeism. She explained, “And once I kinda went through my vacation time was when I went to her and was like, ‘Hey, here’s the deal.’” Faith remained purely factual in her attempts at disclosure to her superior. Like Ann, she also admitted that she has a natural tendency to keep issues to herself, but that did not translate to being anything but open during disclosure.

Maddie, a former healthcare receptionist and nursing student, and Tanya, a special education teacher, both alluded to the act of sharing their needs as part of openness. As witnessed in Faith and Ann’s previous accounts, it can be difficult for many people to share their needs with people in positions of power in the workplace, often due to inherent personality traits. This held true for Maddie and Tanya as well, with Maddie
verbalizing this trait and Tanya’s emerging through her timidity during the interview.

These participants did not let their nature affect their openness in disclosure. For instance, Maddie expounded on one of her disclosures about her condition to her boss after hemorrhaging related to endometriosis:

So, I got to work and, uh, called my doctor in Lexington and was like, ‘Hey, this is what’s happening. I don’t know why.’ And they were like, ‘We really need to see you.’ So, I had to leave. I wasn’t even there [work] for an hour, and my supervisor wasn’t even there yet. And I had to call her and tell her, ‘Hey, I haven’t even been here an hour, but I’m gonna have to leave because this is what’s going on, so…’

Although the situation was dire, Maddie exhibited a high level of openness with her supervisor by sharing exactly what she needed from her in order to take care of her health. In turn, her boss was open to letting Maddie’s schedule be flexible and even take time off.

As for Tanya, her disclosure occurred due to an emergency bleeding situation at work as well. Although her discomfort with talking about her specific symptoms was palpable in the interview, she asserted that she was open in sharing her needs. Tanya stated, “I mean, we just know here that if there’s a problem, we can talk about it. We openly, no matter if it’s a health problem or anything… Yeah, it’s a culture. It’s a cultural thing.” It is clear that her school values the employees sharing their physical needs with the principal. In fact, Donna works at the same school. She recapped an endometriosis pain-induced incident at school in which her principal watched her classroom so she
could seek medical attention immediately. Donna also explained that the school nurse has created a culture of sharing needs that opens up disclosure:

And you know, she [nurse] said, ‘Don’t… if you’ve got something going on, you need to let others know.’ Just so they can be aware. If somebody’s diabetic, they need to tell that. If they’ve got problems, you know. I might have to go to the bathroom extra… And so that they can get somebody to watch my class while I run to the restroom to take care of things.

The expression of openness is undoubtedly made easier for women with endometriosis when they feel like their needs will be welcomed and sufficiently met by their superiors.

Closedness

The other end of dialectical disclosure is closedness. This category represents contradictions that were present in half of the interviews. None of the women expressed a desire to be closed in their disclosure to their bosses, but depending on their framing in the moment, a level of closedness emerged. Closedness was put into practice typically without the participants recognizing it as such.

As a recently unemployed woman due to short-term disability related to endometriosis, Addison, a former account executive, admitted to being closed in her disclosure before securing a job. When asked about her response to the disability question on job applications, she said she has always chosen the option not to answer. Not answering is still a form of evading disclosure, even though that is her right. Addison explained:

Yeah, it’s almost like that or just, uh, tell later and ask for forgiveness at that point. You know, because you want to get the position or you want to do certain
things, and if that’s gonna be a deterrence from doin’ it, why do it? You don’t wanna do it.

To Addison, it is best practice to evade disclosure if given the option. Of all of the participants, she spoke the least about having open communication with supervisors in the workplace. Her career was in sales, so the priority was always to perform at a high capacity.

Faith and Kylie both described themselves as being open when disclosing but simultaneously admitted to leaving out important aspects of their condition. For example, Faith, who is a real estate agent, considered her clients as her superiors. She admitted that instead of telling them her endometriosis symptoms were causing her to postpone meetings, she would say she had a migraine. With laughter, she conceded, “So I guess I have fudged the truth a little bit.” Similarly, Kylie, a nursing assistant, recounted this interaction with her supervisor:

I was like, ‘Oh, I’m taking two weeks off, and then I’ll be back on your shift. And she was like, ‘Oh, where are you going?’ I was like, ‘Uhhhh, nowhere. I’ll be here.’ And she was like, ‘You’re lying.’

This exchange between Kylie and her supervising nurse spurred the open disclosure recounted previously. Although she was open eventually, evasion came first. Without the prodding of her supervisor, she likely would have continued to evade the full truth about her condition.

Eight of the ten participants described their eventual disclosure as forced in a roundabout way. Much like Kylie’s interaction with her supervisor, the women only revealed having endometriosis once they had to do so. Tanya clearly put forced
disclosure into perspective when asked about the point at which she chose to disclose. She quipped, “Um you know, classrooms, havin’ to call someone to watch my classroom if something happened. So I had to talk to my supervisors.” Her condition affected her ability to perform her job duties, which made the decision to disclose feel not like a decision at all. Maddie concurred, explaining that she only disclosed “when my symptoms got to the point where I was debating calling into work multiple times.” The emphasis on disclosing to explain absence and sick leave was a common thread through the majority of the interviews.

Fortunately for Ann, she seems to be in remission since having surgery years ago. When she disclosed to her supervisor at the time, she recounted that as the only time endometriosis was discussed. She has never brought it up to more recent supervisors because she only discloses on a need-to-know basis. Her symptoms do not actively influence her work, so she does not bring it up. However, even when she was dealing with it, she only told her supervisor because she was part of the small group of people who needed to know. In her words, “That was it.”

Candie has an outlook much like Ann’s. She has moderate symptoms and has not had a flare-up for an extended period of time. When asked about the messaging she has received about the acceptability of endometriosis in the workplace, she maintained, “I don’t feel like there would be any backlash or that there would be a problem if I did; we just don’t really talk about it.” If the symptoms or interference from the disease is not on the mind of the superior or subordinate, conversations about endometriosis will most likely occur only on a need-to-know basis with those who are directly affected. As Candie explained, people do not really just sit around and talk about it for fun.
Determinants of Openness and Closedness

Whether or not the participants spoke of their disclosure experiences in terms of openness or closedness depended on factors they perceived in the workplace or society at large. This category lays out what those determinants are to these women who suffer from endometriosis. The first determinant that was acknowledged by the majority of participants was a lack of knowledge. While the participants largely admitted to still not knowing much about the disease themselves, they recognized that their superiors probably knew even less, which can lead to closing off to some extent. Loren insisted about her previous supervisors, “But then I think she would actually have to actually have to suffer from it as well to actually have any compassion.” This led her supervisor to simply placate her when she disclosed rather than taking the opportunity to ask more questions and gain understanding.

Faith, who had undoubtedly the most closed disclosure with her superior, extrapolated the fact that her boss simply did not know about her condition or even care to learn. Her description of societal knowledge of the condition was bleak. She offered, “I don’t think, people just don’t even know what it is in general.” Seeing as her boss was no exception, Faith retreated even further into closedness. She pondered how one can expect to be open to an unwilling boss when even many doctors are nearly impossible to convince of the reality of her symptoms.

Maddie, with extensive background in healthcare as a worker and student, noted the disparity of knowledge in the field. She lamented, “Um while there are a lot of people in the medical field that know some about it or a lot about it, there are a lot of people who have no clue about it.” Maddie has used this lack of knowledge she perceives as a force
for being more open in disclosures and conversations about the topic. The same
perception was a wildly different type of motivating force for disclosure among
participants.

Stigma was also a formidable determinant of whether or not the participants
expressed openness or closedness. Tanya, as mentioned previously, works at an
elementary school. The school reflects the gender makeup of many elementary schools
around the country as being female-dominated. When questioned on her opinion of
whether or not there was a stigma about women’s health at work, she thoughtfully
replied, “Not here. I don’t feel like it… It’s probably this type of environment. And it’s
mostly females, so I don’t feel like we have a lot of issues with that.” Tanya’s situation
would be unique to most working women around the world, but there were a number of
elementary school employees in this sample who reflected the ability to be open in
disclosure.

On the other hand, some participants felt highly stigmatized, which led to
closedness. Haley provided an excellent example of how societal stigmas can be reflected
in work disclosures. When asked the same question, she readily noted,

Oh yeah, I do think there is a, uh, stigma. You know, as women, we are, I feel like
we are always seen as the weaker, the, uh, weaker sex. And I feel that like, um,
with any illness, not just endometriosis, um, we try to act tougher so we’re not
perceived as weaker… I feel like we hide these things and we’re embarrassed of
these things, and we shouldn’t be because it’s a real problem. And it’s a real, it’s
somethin’ that we need to discuss.
Haley felt like she was able to disclose to her manager but admitted she is usually reticent. The stigma she feels from society and previous work experiences motivated her to be open and do her part to destigmatize the illness.

Endometriosis is an invisible illness, a fact the participants are well aware of in their work lives. Most of the women who explained the role of invisibility in their condition accepted it as a part of life and related it to the feeling of being stigmatized. Candie pointed out,

But, yeah, it’s like I said, you can’t see it, so it’s like people can’t understand it. Like, you either have it and you understand that, cuz people just… I feel like people just… People think that if something’s wrong, then you can just physically see it, and if you can’t physically see it, then there’s nothing there.

Knowing this, Candie was more open with her boss because she wanted her to be able to have an understanding of the condition. Ann also felt the invisibility was inextricably tied to stigma. She stressed, “I think it’s because it’s something people can’t see… You can see somebody havin’ a heart attack.” Although Ann never had a reason to have to open up about her symptoms because she works in healthcare, she recognized that for many women, having an invisible illness could lead them to be either more open or closed.

Donna treated having an invisible illness as an opportunity to be open with her boss. She echoed Candie, “But just so he kinda knows what’s goin’ on with you and that he doesn’t have to think, ‘Oh she just dudn’t wanna work…’ Yeah I mean, to look at me, you would not think that I have that.” Donna consistently expressed pride in being a dependable employee with excellent attendance. Her appearance would not explain her condition, so she felt the need to defend herself and open up to her boss about her issues.
Also, the support received from people other than the supervisor served as an impetus for being closed or open. The majority of the women who expressed receiving outside support were more open because of it. For example, Addison received support from both her family and coworkers and admitted to having a good support system. She recounted one day in which she was bawling in her office from endometriosis pain. She divulged, “A couple of my coworkers were like, ‘We’re gonna get you home and we’ll tell him if he has anything to say.’ You know. They were basically like, ‘We’ll tell him to f*ck off at that point.’” It is obvious that her coworkers wanted Addison to stand up for herself and her needs. Although she often mentioned staying mum about her pain to her boss, the support from others encouraged her to be as open as she felt she could.

Kylie’s family also gave her support in her decision to disclose that helped form the outcome of initially evading. Unlike Addison and other women who had support, Kylie was encouraged to remain closed if and when she told her supervisor about her possible endometriosis diagnosis. She rationalized,

I’m a firm believer in, like, you have your life, and then you have your work life. And those things should be separate… But telling her [the supervisor], I felt ok with it because I trust her… But like having to tell them, I felt like straight off the bat, even my family was like, ‘You don’t need to tell them too much cuz you’ll lose your job.’

Although Kylie’s family was supporting her, they did not think that being open was the best approach. Kylie’s job as a CNA requires a high level of physical abilities, and if she could not reasonably perform those duties, she would be looked down upon. Throughout
the interview, she expressed the value of pushing through, just like many of the participants. For Kylie and her family, there is strength in silence.

Generally, the participants described the communication of their endometriosis condition through the dialectic of openness and closedness. Many of the women claimed to be open when discussing the illness, and if not, they valued openness from their supervisors. Even when the participants were open by sharing their needs, remaining matter-of-fact, and working in a culture of acceptance, they were closed to some extent. Nearly all of the participants were forced into disclosing to those on a need-to-know basis only when they felt they could no longer get by at work without explaining themselves. Participants were simultaneously both closed and open about their health for fear of supervisors’ lack of knowledge about endometriosis and the stigmas of invisible illnesses.

**Real and Imagined Outcomes**

Next, the second research question explored what outcomes women face after disclosing their endometriosis condition to supervisors. Half of the women reported the consequences to be neutral or positive. The other half recalled consequences that erred on the side of negativity. Still, the majority of women emphasized consequences that they expected before making the choice to disclose but did not actually experience. Sometimes, there was a mixture of both, especially if the participant had multiple supervisors. The participants were able to compartmentalize interactions with the same boss, which were sometimes framed positively or negatively. The Real and Imagined Outcomes are established in three categories: Positive Outcomes, Negative Outcomes, and Anticipated Outcomes.
Positive Outcomes

First, participants evaluated many of their disclosures and resulting interactions with their supervisors as positive consequences. Many noted that they were met with kindness after disclosing their health issue. Haley described her retail managers as “friendly, kind” when asked about their qualities. In particular, she described the following result of her disclosure:

So, she was very flexible and understanding about that. Um, she didn’t say, ‘Well, you have to work these days, and you can’t call out.’ Anything, nothing in that nature. All of the managers are super sweet. Um, but yeah, she’s very understanding about it. She told me to come and confide in her anytime I needed anything.

When probed further, Haley noted that disclosing strengthened their relationship as superior-subordinate. Her manager’s kindness signaled that they are equals in the workplace, no matter the health condition.

Donna also experienced kindness and respect from her principal at work after disclosing that she had finally been diagnosed with endometriosis after having emergency surgery for what she was originally told was appendicitis. She offered, “He was very nice about it. I mean, you know, he appreciated me tellin’ him.” Her principal would later offer instrumental support by personally watching her class during an episode of intense endometriosis pain.

The women also classified themselves as lucky to be an employee of their boss based on the feedback and actions taken after disclosing. Maddie and Candie recounted similar experiences of feeling fortunate and blessed to have the bosses they had when
they first disclosed. According to Maddie, “She was really, really, really there for me during that time I think. I think if I would have had any other supervisor during that time, it would have been a terrible situation.”

Candie appraised her situation by saying, “She’s really easy to work for. I would feel horrible to be in the situation to where like it was problematic, you know what I mean.” For these two women, the consequences of disclosure were everything they could have hoped for, and they recognized that many women are not given the luxury of an accommodating supervisor.

Ann appreciated the accommodations she was given without having to advocate for herself and felt lucky to have her boss. She explained,

You know, if you ended up havin’ to take a lil longer break, she didn’t care as long as you got the job done and stayed a lil longer and got the job done. I mean, so, I was lucky to have a job where I wasn’t stuck in one spot.

Although her supervisor did not necessarily verbalize support or provide instrumental support, Ann still felt like she was fortunate to have a boss who made her life easier by offering a flexible schedule after disclosure.

Still yet, some women looked at the outcomes of disclosure most favorably when there was no real change at all. Business and work life went on as usual without further questioning or special accommodations. Loren summed up her experience with one of her supervisors after disclosing by noting, “With him, there wasn’t any [change].” That particular supervisor was no better or worse than he had been in the past as far as his treatment of Loren, and she appeared to be content with that idea. Tanya was just as pleased that her positive relationship with her principal did not change either. When
asked what consequences she perceived, she purported, “None. None.” The concern she
received from her supervisor was relatively the same both before and after disclosure.

Kylie reiterated Loren’s sentiments when probed about the outcomes following
her disclosure. She affirmed,

Um, nothing really. Like, I don’t see him a whole, whole lot. Like, he only comes
up on the floors, like, maybe five minutes every shift. But nothing really ever
happened. It was just like an, ‘Oh, okay’ type thing. So, that’s good.

The utter lack of change was viewed as a positive consequence. Kylie mentioned
throughout her interview that she likes to tough things out and keep tight-lipped about her
problems at work. Based on her personality, it makes sense that she would prefer her
work relationship to remain unchanged by the information she shared.

**Negative Outcomes**

Although most of the participants recognized at least some positive outcomes
after disclosing their endometriosis to their superiors, a few women were met with
negativity. However, the negative consequences were not always immediate. In fact, they
were usually described as more of a build-up over time. Three of the women were on the
receiving end of snarky comments, otherwise known as being ‘thrown shade,’ according
to Kylie. Upon Kylie disclosing that she would need time off for her surgery, her boss
dismissed, “Oh if you need that.” His tone of voice, according to Kylie, sounded like he
distrusted her, which was a negative consequence.

Addison recounted when she disclosed her condition to one of her supervisors
after being called to the floor for a performance review and was reprimanded for missing
too much work:
I didn’t really have a choice at this point to disclose, ‘I do have two different diseases that have no cure to ‘em, and, uh, I try to manage with it the best I can. And I, you know, but there’s not a lot offered at this point to help with that and…’ Uh, confusion kind of set over him, and he’s like, ‘Well, you’ve never mentioned it before. You look healthy.’

Addison felt like her boss was trying to shame her not only for having comorbid conditions but also for not speaking up, although she had not felt like open discussion was encouraged at the office. Faith’s supervisor took ‘throwing shade’ to the next level by asking her coworkers about the content of Faith’s character and work ethic after Faith admitted her absence was due to endometriosis. The supervisor’s behavior was reported to HR, which then made Faith’s boss retaliate against her even more.

Nearly all of the women pointed out the lack of understanding of endometriosis throughout society, which also permeates the workplace. Even though a few participants spoke of their personal mission to educate others and advocate for research funding, they also seemed to accept that a lack of understanding from their bosses was typical. As Donna confessed, “I’m sure he didn’t understand it all the way, but he was understanding.” She appreciated the attempt while wishing his response would have consisted of more understanding.

Maddie, who worked in the medical field, was in a similar position after disclosing her sudden prolonged absence. She proclaimed,

So, I think she was frustrated in the sense that she was gonna have to find someone to fill that role for that time, but I think they truly knew the severity of what was going on, and, you know, that I just needed to have it [surgery] done,
you know, so. I mean, she was good about it, but the frustration was a little frustrating for me.

Although Maddie credited her boss for handling the disclosure well, it is tinged in hurt feelings. Maddie knew the frustrated response was only due to worries of managing the team. However, her boss’s frustration was a hurtful response to Maddie and was perceived as a negative consequence of her disclosure.

In the most severe cases of negative consequences, women were inspired to make a career shift. Two participants, Faith and Loren quit their jobs, largely due to the response they received about their endometriosis and resulting attendance. Although this only happened to two participants, it was vital to their narrative as a working woman with an invisible illness. Loren left a government office position to start her own electrolysis business from home. She now works with a lot of women who also have hormonal imbalances like her, which is rewarding. Her superiors were not helpful with her endometriosis-related struggles, and she often did the job of two people. She asserted, “I mean, I moved on because I had to change the situation… I was lookin’ at decades and decades more of this.” Negative consequences resulting from her health challenges were not something she wanted to tolerate.

Faith also left her office job as a young woman with a child largely due to the negativity, undermining, and retaliation from her supervisor. She reasoned,

It’s funny because, because of that ordeal, um, combined with some other things, that job just wasn’t meant for me anyway, but a big part of how she was with me, I ended up quitting not too long after that and got into real estate.
Being her own boss seemed like an opportunity to escape the grasp of her negative supervisor or any she could have had in the future.

**Anticipated Outcomes**

A number of women shared scenarios of the expected consequences of disclosure to their superiors. Often, however, those consequences never came to fruition, and they were treated ideally. The most severe of these imagined consequences was the threat of losing their jobs. Although some of the participants left their jobs due to pressure, they were never forcibly removed. Donna even had tenure at her school and still expressed this fear. She noted, “I think I’ve heard of people that’ve lost their jobs because they had to miss so much. So I, I was very grateful.” However, she never felt an insurmountable cause for concern.

On the other hand, others did feel constant pressure from their bosses and doubted their job security. Addison supported, “There’s just times when I couldn’t perform. I couldn’t do it. I couldn’t be in the office. I couldn’t sit in a chair for five hours that day and be able to do anything. And I better, you know…” Addison was often reminded that her supervisor had the power to dismiss her at any time if she did not measure up to expected metrics.

As mentioned previously, Faith found herself in a toxic situation that caused her to shift careers. For her, she left as a way of staying one step ahead of her supervisor, who posed a real threat of firing her, as she explained,

I actually went back to work way too quickly [post-surgery] and ended up just, just kind of stalling my um recovery because I was trying to just make her happy.
And I was scared I was gonna get fired… She was kind of just preparing me indirectly for letting me go.

Faith also described in detail how her superior would tell her that if she could not perform her duties, alternative arrangements would need to be made to train others how to do her job.

Even without the looming threat of being fired, the participants expressed disdain at the idea of being perceived differently after disclosing their condition to their supervisor. Kylie described the dynamic that she dreaded but thus far had not received. She remarked, “I still want to be like, ‘Oh we can call her to have her pick up shifts and rely on her,’ and not be like, ‘Oh, we can never rely on her cuz she’s in constant pain.’” The consequence of being seen as ‘less than’ of an employee remained in the back of her mind.

Haley expressed a strikingly similar inner dialogue when asked about the outcomes of disclosing and how they had affected her work life. She shared,

Um, I’d say if anything at all, I just don’t wanna be perceived as like a coworker that would constantly have to call out or miss work. I don’t wanna be seen as not dependable, so. That’s why I try to keep it to myself; so people don’t think, ‘Oh, she’s gonna have to call out a lot or she’s sick a lot. Can’t count on her.’

The participants took pride in their jobs, and their image of a ‘good worker’ could be shattered by admitting they have a chronic illness.

Likely due to the fear of being perceived negatively, many of the women agreed that they would have to push through difficulties that others would not. Whether or not the need to push through was real or imagined is irrelevant because they did it regardless.
Sometimes the pain of pushing through showed itself physically. Faith recognized,

“There were days that I cried on the way there and cried on the way home.” She went
about her work miserable but showing no signs to avoid consequences.

Likewise, Addison would do everything in her power to not show weakness to her
boss because she feared the outcome. She indicated,

Uh, it was just getting’ out of control. You know, I mean I was grittin’ and bearin’
it, trying, because I’m in sales, so I was on the road traveling. I think at one point
one day I was in like Tennessee somewhere, and I started getting, like, very sick
to where I had to pull over, go to a gas station, throw up.

She admitted that she would hide heating pads in her car or chair to get through the day
without being noticed. Addison’s employer was largely kept in the dark on how much she
did to cope other than the initial disclosure. This was true for several women because
they anticipated the consequences to not be favorable.

In short, all of the participants experienced a myriad of outcomes after disclosing
their endometriosis condition to their supervisor. Fortunately, most of the women were
able to recount some positive outcomes ranging from receiving kindness to feeling lucky
to have their specific supervisor. Even when they perceived no change from their
supervisor, it was framed favorably. The negative consequences, though less frequent,
were powerful. The participants recalled being ‘thrown shade’ and feeling a lack of
understanding, which led a couple of the employees to change careers. Still, a lot of the
outcomes were anticipated but did not occur. The fear of losing their job due to the illness
and being judged as weak were fears, and the women recounted pushing through pain to
avoid such instances.
Relational Closeness

The final research question explored the qualities of the superior-subordinate relationship that influenced disclosure. The close nature of their relationships with their supervisor was found to be highly important to these participants. Relational closeness was differentiated from distant relationships based on gender and shared commonalities.

Gender

When participants described having a close relationship with their boss that allowed them to disclose easily, the closeness was often framed in gendered terms. Perhaps unsurprisingly, women generally preferred to disclose having endometriosis to another woman, or at least someone who had traditional feminine attributes. Candie and Addison admitted to preferring disclosing to a woman. When asked how the gender of her boss affected the way she communicated about the topic, Candie enumerated that simply being a woman makes a boss more sympathetic. She added, “Not that a man is not, but it’s a lot harder to like, verbalize that.”

In a similar fashion, Addison made the case for a closeness with female bosses that is lacking with men. She echoed, “Males, they don’t want to hear about it. They don’t care about your periods. They don’t care about your feelings.” For these women, being of the same gender means that you physically deal with similar situations, which creates a sense of camaraderie.

Relational closeness to a superior was aided by the fact that many of the participants worked in female-dominated organizations. Tanya, Ann, and Donna all worked for the same organization, although their disclosures did not occur with any of the same superiors. Donna liked being able to work in a place without stigma surrounding
women’s health, even when the principal at the time was a man. He was the outlier in the organization. She joked, “There’s not really a stigma in my workplace cuz there’s not a man in the buildin’.” Even though she felt comfortable with her male boss, the female-dominated culture helped the cause.

Tanya disclosed her health condition at a later time after a woman became the principal. She reiterated sentiments of other participants by saying,

I think with a female you are more open and more apt to approach um easily, or easier. I think with a male it’s sometimes, you know, still. I feel it’s still okay to approach ‘em. You just gotta word things differently.

This quotation shows that Tanya, as others suggested, must code switch between male and female bosses. Kylie contributed, “They’re all women so they know about this, so that’s helpful.” They appear to have been their most comfortable and natural self when disclosing to a female rather than a male.

A few of the participants described having a close kinship with their supervisor that bordered on familial or motherly, which naturally made disclosure an easy decision. When probed if disclosing strengthened her work relationship, Haley remarked, “Oh yes. Definitely yes. I talked to her about everything. She’s like my second mom at work.” Being able to see her supervisor as a mother-figure set her relationship apart from the other supervisors, who were also described positively.

Maddie had a high-quality and close relationship with one of her supervisors in the past. Again, this fact made disclosure a natural part of the work experience. She described her supervisor as “almost motherly at times,” and then added,
[She’s] the only other person that I’ve ever, that’s like, ‘Okay, what’s wrong?’ when you’ve said nothing, you know. She was that way. My mom is the only other person that’s ever done that with me. I’d be like, ‘I’m fine.’ And she’d be like, ‘No, but really?’

Haley and Maddie experienced a relational closeness with their supervisors that was beyond the norm for most people. In Maddie’s case the supervisor was instigating disclosure before Maddie, making her feel more approachable.

In contrast, not all of the women had a close relationship with female bosses. Loren, who had both a male and female boss, spoke more highly of the male. She commented on how she was able to bring work issues up with him, and when it came to any talk of endometriosis related symptoms, he was preferred for his feminine trait of listening. Her female boss would question, “Oh, they can’t really say what’s wrong with you, right?” Loren summed up her deduction of relationship closeness among genders this way:

I don’t know. It seems like men are easier to talk with than female bosses because I think that female bosses have worked really hard to get to where they are, and their, um, empathy is really low, and they don’t have a lot of tolerance.

Loren’s male boss had a feminine communication style, whereas her female boss had a masculine communication style that seemed counter-intuitive to Loren on some level.

**Commonalities**

In addition to gender, participants also described the closeness in their relationships based on other commonalities they shared with their superiors. For some, knowing that they had similar experiences/knowledge was enough to make them
comfortable with the relationship and improved disclosure. For example, when Haley initially disclosed, she recalled announcing, “‘Hey, I have a condition called endometriosis. I’m not sure if you’re aware of what it is.’ And she said she did because she had other family members that had it.” That tidbit of information signaled to Haley that the relationship could go deeper with even more disclosure since her boss had some experience dealing with this mystifying condition.

Donna concurred with the meaningfulness in shared previous experiences. After applauding her boss for being kind and understanding, she mentioned, “And then he was very nice because I think his wife had had problems with that [feminine health], you know.” Even though her boss did not have experience via his wife with endometriosis necessarily, Donna felt more confident in the decision to disclose because he had a comparable experience.

Unlike some of the other participants, Addison felt that her supervisor’s experience with endometriosis served as a detriment to the closeness in their relationship. She testified,

A comment was by one of my superiors that was female was, ‘I mean, like one in ten have it. It can’t be that bad.’ It’s like, that’s ignorance right there… And I think she had said she knew somebody who had it. They only had one surgery. Well, that’s great for them.

Although Addison’s supervisor seemed to share knowledge about the condition, her negative comments dismissing the pain and discomfort of endometriosis made Addison want to distance herself from the supervisor.
Despite shared knowledge, Addison did not receive understanding from her boss. Fortunately, other participants did. Feeling like their supervisors understood them as a person and their condition did a world of good for relational closeness. For example, when Tanya was asked about her principal’s response to disclosure, she offered,

Oh! Very open. Very understanding. Very, ‘Yes, I understand. Whenever anything like that happens just let us know…’ The supervisor, we’re about the same age, so we experience a lot of things close.

Beyond gender, Tanya’s supervisor is close to her in age, so they have worked together and gone through many stages of life together. Tanya knew she could count on her supervisor to understand this as well, and she did.

Although Loren’s boss was not similar to her in age or gender, she appreciated his level of understanding. She recounted the day she disclosed her issue, saying, “I remember, I was drag down tired, and he was like, ‘I understand.’ I mean, he was very understanding as he could be.” The opportunity to have similar backgrounds does not always present itself, but superiors and subordinates like Loren can mitigate that through understanding that will help disclosure processes.

For Candie, there was another commonality that made her feel like she was understood by her boss. Candie often framed her illness in terms of being “blessed.” Faith was highly important to her, and it served as the foundation for her disclosure. She remembered, “I actually had to go get a biopsy, and so I left work, and I asked for her prayers…Umm, honestly I think it just made her see that I am more of Christian faith cuz I asked for prayers.” Candie related that her boss was prayerful for her, and she has since in turn asked Candie to pray for her on occasion. Shared faith is a deep understanding
that is often unspoken in the workplace, but it helped Candie develop a unique closeness with her supervisor.

Ultimately, the participants valued the empathy that their supervisors gave them before and after the disclosure. Knowing they could expect to be met with empathy made the relationship feel closer and gave them more confidence in their decision to disclose their condition. The premise of empathy is that one is able to take on someone else’s issues as his or her own. Therefore, when the participants received empathy, it signaled to them that they had more in common with their supervisors than they initially thought.

Ann always felt like her supervisors cared for her as she claimed she has had “great” supervisors. She knew that after disclosing, her supervisor at the time would support her. She articulated, “I guess I got what I asked for, what I needed. I’m not the kind to ask for a whole lot of accommodations either.” The simple act of lending a helping hand meant that Ann’s supervisor understood her feelings, and they had a high-quality relationship.

Kylie seconded Ann’s thoughts, but she specifically related empathy to her work in healthcare. She affirmed, “So then having that healthcare background, they know it’s not like super serious, but like it can impact me.” Working in healthcare signified to Kylie that her nursing supervisor would better understand her pain and feelings. She was better able to connect with her nursing supervisor than her administrative supervisor, partly due to the empathy she had always been shown, even prior to her endometriosis disclosure.

Not everyone was fortunate to have an empathetic boss at the time of disclosure. For instance, that was something Faith longed after. She compared her first boss to her boss she disclosed the condition to as…
I just hoped she would’ve been like my first boss that was just, just listened to me. Hopefully showed a little bit of empathy for me. Um and you know, worked with me on maybe shifting my schedule around a little bit.

Faith had a job she could have done entirely from home, but her supervisor would never allow it, even after it became clear that it would be advantageous for her health. Her supervisor lacked empathy, their relationship was strained, and disclosure was therefore stilted.

The theme of relational closeness answers the question of what superior-subordinate relationship qualities influence the disclosure of endometriosis. Specifically, gender was a quality that heavily influenced the disclosure process. Many of the participants preferred having a female supervisor with whom they could share the information with, although a few participants felt that female supervisors were not receptive or helpful. Having other commonalities such as previous experiences, understanding, and empathy also generated a sense of relational closeness with the supervisor, which influenced their decision to disclose.

**Summary**

In summary, this chapter described three themes in relation to each of the research questions. The women communicated about their endometriosis condition to their supervisors via a dialectical disclosure of openness and closedness, which was the most unexpected finding. This theme highlights the inner struggle women face to disclose to their supervisor. After the disclosure act, women faced a combination of real and imagined outcomes, both negative and positive. No disclosure is the same, and there are many factors in regard to the outcomes from the subordinate’s perspective. The final
theme found that gender and other commonalities were the qualities of the superior-subordinate relationship that influenced disclosure. Participants clung to the idea of the closeness of the relationship being important to their decision to disclose and when to do so. The next chapter summarizes the findings and how they relate to existing literature. It also outlines the strengths and limitations of this study, as well as suggests areas for future research.
CHAPTER 5

DISCUSSION

The overall purpose of this study was to explore aspects of communication between women with endometriosis and their superiors at work. With this purpose in mind, three research questions developed. The research questions were as follows: 1) How do working women with endometriosis communicate about their condition to their immediate supervisors? 2) What outcomes do working women experience after disclosing their endometriosis condition to their superiors? 3) What qualities of supervisor relationships influence working women’s disclosure of their endometriosis condition? This chapter discusses the findings in the previous chapter as well as areas of strength, limitations, and suggestions for future research.

Summary of Themes

In relation to RQ1, the theme of dialectical disclosure emerged as participants recounted their communication with their bosses. More specifically, participants expressed an openness-closedness dialectical tension. While the participants did not appear to be cognizant of the tension, many utilized communication patterns that were simultaneously open and closed. When asked about their disclosure, all of the women claimed to openly talk about their health issues, although some reported being more comfortable than others. However, upon further probing, even the women who described themselves as open communicators or having had open communication with their superiors disclosed in a way that also reflected a degree of closedness. For example, in most cases, the women only revealed their illness when it became apparent that they had to do so for the sake of the job, for example, when they needed a break or time off from
work. Although they valued open communication, they often evaded the truth, withheld information, or told small lies about their illness when they could have been open about it.

Relational dialectics were not an initial focus of the study, and therefore, were not included in the literature review. Thus, for background knowledge, Baxter and Braithwaite (2008) state, “Relational Dialectics Theory (RDT) is a theory of the meaning-making between relationship parties that emerges from the interplay of competing discourses” (p. 349). A dialectic is a push and pull between two dissimilar tensions. In other words, there is a both/and quality in which seemingly opposite poles occur simultaneously. For example, openness and closedness is one of the many tensions that has been identified in interpersonal communication where the relationship is both open and closed at the same time. Most research on RDT has been confined to romantic relationships and family communication (Baxter, 2004). However, superiors and subordinates also constitute an interpersonal relationship, so the theory can be applied to this organizational context as well.

According to Bridge and Baxter (1992), the openness-closedness dialectic was one of five dialectics that were identified in a study of friends who worked together. The higher the level of formalization (i.e., emphasis on positions instead of people in the positions) in the organization, the more dual-role tension of being a friend and coworker was perceived by participants (Bridge & Baxter, 1992). A superior-subordinate relationship is inherently hierarchal, formalized, and shaped more by those norms than perhaps relationships between coworkers of equal status. Therefore, the participants in this study, like those reported by Bridge and Baxter, also felt an open-closed tension.
Participants’ desire for a favorable response when talking about an unfavorable disease created feeling of fear and uncertainty. Consequently, they had to rely on their own comfort level along with cues they attempted to pick up on from the supervisors regarding the appropriateness of sharing and their own attitudes. While most of the participants wanted open communication, they perceived their bosses, for various reasons, as more closed. They felt the need to both reveal (openness) and conceal (closedness), which explains why they described their disclosure paradoxically. Therefore, a dialectical tension was established.

The participants’ involuntary disclosure may also be explained by Communication Privacy Management theory, which suggests that the sharing of risky information creates a co-owner of information that may or may not follow boundary rules (Petronio, 2002). These boundary rules can be explicit, but with participants in the current study, they were typically implicit. As Smith and Brunner (2017) described, privacy expectations are ambiguous. In this case, the way to go about disclosing endometriosis and handling the information after was uncertain for both parties. The inherent power imbalance in the superior-subordinate relationship leads to questions of control and perhaps the inability for participants to create any disclosure rules. Consequently, when disclosing their invisible illness of endometriosis, many participants fell into the theme of involuntary disclosure by disclosing only when the need became imminent. Similar to Butler and Modaff’s (2016) findings, participants employed involuntary disclosure to disclose the minimum in order to remain on good terms with their colleagues, and in this case, also with their supervisors.
Next, RQ2 explored the outcomes of disclosure about endometriosis and found both *real and imagined outcomes*. By and large, these women generally received little backlash from their supervisors at work. Several reported having been met with kindness and unrequested accommodations which made them appreciate their boss and work situation. Others reported no real change after their disclosure, which, to these participants, was a positive. They did not want any added attention.

In a few cases, however, participants found themselves facing negative outcomes such as snide remarks and lack of understanding. Negative consequences, such as questioned ability, resentment, and dismissiveness, following the disclosure of a chronic illness, aligned with the findings of Kelly and Romero (2019), who found the same consequences in their study of employees disclosing health issues.

While negative instances were rare with this set of participants, it is important to note that nearly all of the participants had anticipated possible negative outcomes. In other words, the women did not have to experience any sort of negativity from the workplace or their supervisor directly in order to have those fears. The stigma and horror stories surrounding endometriosis were in their collective cultural understanding of the illness and informed their decisions to disclose. Expectations of the outcomes of disclosure can cloud how the real consequences are perceived, as supported by Greene et al. (2012),

Anticipated relational outcomes predicted greater confidence in response, which, in turn, predicted greater disclosure efficacy. If potential recipients are expected to be supportive (e.g., watching children, listening, or helping search for information), then the discloser would expect a positive effect of disclosure on the relationship. Patients do
examine what reaction they are likely to receive prior to sharing and if unsure about potential responses or outcomes, weigh this factor into decisions. (p. 366)

In the context of the current study, the women interpreted cues from their supervisors and society at large to help formulate their approach to disclosure, which may explain why they were often surprised by what they recounted as positive, rather than negative, outcomes.

The outcomes the participants feared and the negative consequences that a few actually experienced can be framed again in terms of Communication Privacy Management theory and the concept of boundary turbulence. That is, when private information is shared with another party such as a superior, there are no guarantees about how the information will be used. These participants clearly expected and feared turbulence, thus their reluctance to be truly open about their health condition.

In an attempt to avoid turbulence, individuals often create rules about how much information can be shared to whom and when. According to Steuber and McLaren (2015), women tend to have implicit privacy rules more so than men, which may help account for the participants’ surprise when the disclosed information was actually properly handled, particularly by male supervisors. In addition to gender differences of privacy rules, these participants were also in lower-status positions than their supervisors. Therefore, it is logical to assume they would not be giving their supervisors rules for how to manage the information they shared. Their lack of control of the information and how it would be used contributed to their initial closedness and fears of negative repercussions.
For RQ3 exploring the superior-subordinate relationship, participants described *relational closeness* based on gender and perceived commonalities with their supervisor as relationship qualities that affected their disclosure decisions. Most of the participants purported that they would prefer to have a female superior when discussing women’s health. This finding aligns with Lamude, Daniels, and Graham’s (2008) study, which found that same-sex superior-subordinate dyads had greater relational satisfaction than different-sex dyads. The current study participants explained that it is easier to divulge personal women’s health information to another woman due to shared anatomy and common experiences. The familiarity of another woman was enough to make the nature of the relationship more comfortable in which to disclose personal health information.

Similar preferences related to sharing gynecological personal information have been found in a medical setting. According to Ports, Reddy, and Barnack-Tavlaris (2013),

Our finding, that patients with female health care providers indicated that the medical interaction was more patient-centered than did patients with male health care providers, may explain why patients have greater preferences for female health care providers in sensitive situations. (p. 1446)

The women in the current study admitted that feminine health this is a taboo and sensitive topic. Therefore, their preferences for female supervisors may be similar to patient preferences for female healthcare providers in “sensitive situations.” The feminine communication trait of relational communication/patient-centered approaches could be archetypal across sensitive health contexts.

In contrast, some participants revealed that female supervisors actually were less receptive to understanding their disclosure of endometriosis. In a few cases, female
supervisors were described as less apt to be flexible with the participant’s needs. They were characterized as disdainful of the diagnosis. Although perhaps surprising at first, this revelation reflects Trethewey’s (1999) study which examined how the female body is disciplined in workplace settings. She found that women were disciplined for being a woman in the workplace by both men and women. However, it was women who were often more overtly tough on employees whose femininity flowed into the workplace itself. Endometriosis is distinctly a woman’s disease and similar to the “leaky” female conditions that Trethewey outlined as being judged in the workplace.

Finally, relational closeness between a subordinate and her superior also hinged on perceived commonalities between the two. Specifically, supervisors who reciprocated with a common knowledge of or shared experience with endometriosis made it easier for participants to disclose more details of their condition. Interestingly, even superiors who could not personally relate to the disease but exhibited empathy were viewed by participants as sharing commonalities. Because some superiors responded with an ability to take the employee’s problems as his or her own, participants attributed a greater relational closeness to their relationship. According to Lee and Queenie-Li (2020), employees value transparent communication with their employers. When communication is transparent, the relationship is perceived as good quality. Thus, when sharing health information, Lee and Queenie-Li found that employees focused more on potential benefits of disclosure rather than risks. In the current study, empathetic supervisors were portrayed as being transparent and mitigating the risks involved with disclosure of endometriosis, which made the participants more likely to want to share with them.
**Practical Implications**

Ultimately, the findings of the current study and extant literature combine to create several practical implications to help navigate the disclosure of endometriosis in the workplace in ways that are beneficial to both the employee and employer. Most importantly, supervisors must realize they are the privileged party when women come to them with an endometriosis disclosure. These women are disadvantaged in several ways beyond the nature of holding a lower status position in the workplace. Namely, those disadvantages are the historical downplay of their health condition and the strict discipline of their bodies at work. Knowing this information will hopefully make them more empathetic to the situation, which will likely make the relationship more satisfactory in the subordinate’s eyes. Thus, the subordinate may be more likely to share health information again in the future, which can relieve them of the stress and energy put into hiding their condition. Instead, the employee can receive the support she needs to be more productive, which will benefit the entire organization. Loss of productivity as an individual and work group is one of the many downsides of endometriosis. Empathy training for supervisors would also be a good step for organizations to take so that they may be better equipped to respond to this and other employee health challenges. Empathy is a learned skill for many, and it is a disservice to assume a supervisor with technical skills has the soft skills to cultivate strong relationships with his or her subordinates.

Supervisors, however, are only half of the dyadic relationship. Much of the responsibility for the success of disclosure of endometriosis lies directly with the women who are experiencing the problem. When it comes to disclosure, women should not close off from their superiors at work. This is a dynamic and reciprocal relationship. As
uncomfortable as disclosure is, if working women do not let their supervisors fully know the extent to which their health is causing problems, supervisors cannot provide the needed support. All of the women in this study valued open communication, yet many of them allowed their fear of anticipated negative outcomes to dictate their disclosure experience.

The fears of disclosure that these participants experienced are valid. There are countless examples of women being reprimanded or judged in the workplace for having similar health issues (Rapana, 2018). Therefore, change needs to occur at higher organizational and societal levels to remove the stigma from this disease. According to Taylor (2018), government funding in the U.S. for endometriosis continues to be less than that of other health issues, even considering the large number of women affected. Many of these participants believed this lack of public support contributed to the sustained idea that endometriosis is taboo. More funding and more research would increase the attention given to endometriosis and perhaps educate workplace decision makers about the challenges for employees who suffer from this chronic illness. Until that happens, however, there will continue to be a more pressing call to action on women to make endometriosis a familiar concept by starting the conversations and sharing their experiences. Working women must advocate for their health and gain support along the way in a cyclical manner to get the treatment they deserve.

In summary, these findings showcase the tensions in communication, the variety of outcomes, and the qualities of work relationships in relation to disclosing endometriosis to a superior. Consequently, this study offers insight into how each member of the superior-
subordinate dyad can negotiate the disclosure process in ways that may enrich both of their work experiences.

**Strengths, Limitations, and Future Research**

One strength of this research is its contribution to the conversation about the invisible illness of endometriosis. This study sheds light on the growing number of women who struggle with managing pain that no one sees, much less can even imagine. Many of these women continue to work, even on the bad days, and often hide their chronic condition in fear of how they will be perceived by others in the workplace. Consequently, another strength of this research is the freedom it provided for at least these women to fully express their opinions about women’s health. This is a sensitive topic for most women, which is why the topic was chosen. Because the researcher was a woman who expressed the fact that she had researched endometriosis extensively and had an interest in women’s health issues, the participants saw that the researcher was a trusted ally. Most expressed their relief to have an outsider with whom they could share their medical and organizational issues. Finally, the participants represented a large range in age and severity of the disease, which offered breadth of experiences and perspectives.

However, this research study also had limitations. Four of the participants chose to be interviewed in a private room at their workplace. While the participants were reminded that all personal information would remain confidential and identifying information changed, some of them might have withheld negative information about their superiors due to the location. Although, in most cases, the supervisors of these four participants were discussing no longer worked for the organization, they still could have felt pressure to be a team player and leave out potentially tarnishing information.
Another limitation is the fact that many of the women worked at the same organization. Although all of them initially disclosed to different supervisors and at different points in their careers, they certainly had similar experiences due to the public school system environment in which they all worked. Similarly, due to the small sample size of ten participants, there was not much variety in the types of jobs the women held. The majority worked or had worked in healthcare or education. Those organizational cultures are typically much different than sales, retail, IT, or nonprofits, marketing/communications cultures, which makes it more difficult to transfer insights to other sectors.

Future research could use quantitative methods to ask similar research questions as those in the current interview protocol through surveys but with more questions about the role of gender of the supervisor and the type of sector in which the participants work. Ideally, quantitative research would allow for more responses due to electronic distribution and quick analysis. Future research could also build on these findings to discover how women disclose endometriosis to other audiences and the role of online support communities in encouraging disclosure. Several of the participants organically elaborated on how online communities were vital to their journey. Finally, relational dialectics emerged as an unexpected salient concept. Thus, future research could also consider the role of relational dialectics in sensemaking during invisible illness disclosures.

Conclusion

This study contributes to superior-subordinate communication, communication privacy management, relational dialectics, and invisible illness literature. Employees with
endometriosis value open communication yet tend to be closed in their disclosures. The consequences of disclosure can be construed as either positively or negatively, depending on the framing techniques and desires of the employee. Often, the negative archetype of what a significant health disclosure will result in is feared without coming to fruition. The closeness of the superior-subordinate relationship influenced disclosure decisions, and a perceived relational closeness resulted in more positive disclosure experiences for the employee. Gender of the superior was found to be important to the participants but sometimes in counterproductive ways. The superior’s knowledge of the disease and more feminine communication tendencies seemed to result in closer relationships following disclosure.

While women have grown as forces to be reckoned with in workplace settings over time, their unique health conditions, such as endometriosis, have also brought a set of challenges for many. These challenges must be navigated by multiple parties, largely superiors and subordinates. This study sought to gain understanding of how employees with endometriosis disclose, the consequences they face after, and the factors that influence their decision. Ultimately, the goal is not only to add to the body of literature but also to make the disclosure and the management of the disease more positive for both superiors and subordinates. While endometriosis is traditionally thought of as a “woman problem,” it truly affects everyone in the workplace when an employee suffers from it, and it is the responsibility of all to attempt to understand the disease and its ramifications at work.
APPENDIX A

Participant Recruitment Flyer

PARTICIPANTS NEEDED

If you or someone you know is:
• A woman
• 18 or older
• Have diagnosed or self-diagnosed endometriosis
• Currently or have had a direct supervisor (a boss) at work

Please reach out for a 30-minute interview.

Call/text 270-819-0148 OR
Email mary.lyons795@topper.wku.edu.

Your participation will help working women with endometriosis and add to research about the condition!
Thank you for your submission of New Project materials for this project. The Western Kentucky University (WKU) IRB has APPROVED your submission. This approval is based on an appropriate risk/benefit ratio and a project design wherein the risks have been minimized. All research must be conducted in accordance with this approved submission.

This submission has received Expedited Review based on the applicable federal regulation.

Please remember that informed consent is a process beginning with a description of the project and insurance of participant understanding followed by a signed consent form. Informed consent must continue throughout the project via a dialogue between the researcher and research participant. Federal regulations require each participant receive a copy of the consent document.

Please note that any revision to previously approved materials must be approved by this office prior to initiation. Please use the appropriate revision forms for this procedure.

All UNANTICIPATED PROBLEMS involving risks to subjects or others and SERIOUS and UNEXPECTED adverse events must be reported promptly to this office. Please use the appropriate
reporting forms for this procedure. All FDA and sponsor reporting requirements should also be followed.

All NON-COMPLIANCE issues or COMPLAINTS regarding this project must be reported promptly to this office.

This project has been determined to be a MINIMAL RISK project. Based on the risks, this project requires continuing review by this committee on an annual basis. Please use the appropriate forms for this procedure. Your documentation for continuing review must be received with sufficient time for review and continued approval before the expiration date of May 15, 2020.

Please note that all research records must be retained for a minimum of three years after the completion of the project.

If you have any questions, please contact Robin Pyles at (270) 745-3360 or irb@wku.edu. Please include your project title and reference number in all correspondence with this committee.

- 1 - Generated on IRBNet

This letter has been electronically signed in accordance with all applicable regulations, and a copy is retained within Western Kentucky University (WKU) IRB’s records.

- 2 - Generated on IRBNet
APPENDIX C

Informed Consent Form

INFORMED CONSENT DOCUMENT

Project Title: Superior Subordinate Communication of Endometriosis
Investigator: Mary Madison Lyons, Dept. of Communication, mary.lyons795@topper.wku.edu

You are being asked to participate in a project conducted through Western Kentucky University. The University requires that you give your signed agreement to participate in this project. **You must be 18 years old or older to participate in this research study.**

You are being asked to participate in a project conducted through Western Kentucky University. The University requires that you give your signed agreement to participate in this project. **You must be 18 years old or older to participate in this research study.**

The investigator will explain to you in detail the purpose of the project, the procedures to be used, and the potential benefits and possible risks of participation. You may ask any questions you have to help you understand the project. A basic explanation of the project is written below. Please read this explanation and discuss with the researcher any questions you may have.

If you then decide to participate in the project, please sign this form in the presence of the person who explained the project to you. You should be given a copy of this form to keep.

1. **Nature and Purpose of the Project**: It is my understanding that the purpose of this project is to explore aspects of communication between women with endometriosis and their superiors at work.

2. **Explanation of Procedures**: It is my understanding that the researcher will conduct individual interviews, approximately 30 minutes in length, during which I will be asked about how I did or did not disclose my illness to my superior, the consequences of such disclosure, and the relationship I have with my superior.

3. **Discomfort and Risks**: It is my understanding that this study places me at little to no risk. The probability of harm anticipated is no greater than I would encounter in everyday life.

4. **Benefits**: While this study offers no direct benefits or compensation, it is my understanding that I will have an opportunity to give my opinions and experiences which will help generate knowledge that will help the discipline better understand how women communicate about endometriosis at work and provide insight to others in similar situations.

5. **Confidentiality**: It is my understanding that my responses will be kept strictly confidential. Records will be viewed, stored, and maintained in private, secure files only accessible by the researcher and faculty sponsor for three years following the study, after which time they will be destroyed. All participants will be assigned pseudonyms to ensure confidentiality, and any other subject identifiers will be altered or reported only in comprehensive form.

WKU IRB # 20-163
Approved: 12/09/2019
End Date: 5/15/2020
EXPEDITED
Original: 12/09/2019
6. **Refusal/Withdrawal:** Refusal to participate in this study will have no effect on any future services you may be entitled to from the University. Anyone who agrees to participate in this study is free to withdraw from the study at any time with no penalty.

You understand also that it is not possible to identify all potential risks in an experimental procedure, and you believe that reasonable safeguards have been taken to minimize both the known and potential but unknown risks.

_________________________________________    ____________
Signature of Participant                          Date

_________________________________________    ____________
Witness                                          Date

- I agree to the audio/video recording of the research. *(Initial here)*

THE DATED APPROVAL ON THIS CONSENT FORM INDICATES THAT
THIS PROJECT HAS BEEN REVIEWED AND APPROVED BY
THE WESTERN KENTUCKY UNIVERSITY INSTITUTIONAL REVIEW BOARD
Robin Pyles, Human Protections Administrator
TELEPHONE: (270) 745-3360

WKU IRB# 20-163
Approved: 12/09/2019
End Date: 5/15/2020
EXPEDITED
Original: 12/09/2019
APPENDIX D

Interview Protocol

Opening Questions

- When did you start working for him/her? OR How long were you in the position in which you had a supervisor?
- Tell me about your endometriosis symptoms.
- How long have you dealt with endometriosis?

Generative Questions

- What characteristics would the ideal supervisor possess in order for you to openly discuss your health condition at work? RQ3
- At what point did you decide to disclose your health condition to your supervisor? Why? RQ1
- Describe at time when you discussed your health issue with your supervisor. RQ1
  1. Probe: How did you feel about it?
  2. What strategies did you use?
- How did your supervisor respond? RQ1
  1. Probe: How, if at all, could he or she have responded better?
- Describe a time when you chose not to discuss your health issue with your supervisor. Why didn’t you? RQ1

Directive Questions

- What was the result of your disclosure to your supervisor? RQ2
- OR What do you think the consequences of disclosure would have been? RQ2
• How did the consequences or perceived consequences affect your professional life? RQ2
  1. Probe: How do you feel about that?

• What did you hope the result of disclosing your personal information would have been? RQ2

• To what extent do you feel these consequences are unique to endometriosis/women’s health disclosures? RQ2

• What determines the quality of your relationship with your supervisor? RQ3

• How comfortable are you talking with your supervisor about women’s health? RQ3
  1. Probe: What makes you feel this way?

• Tell me about a time when you had to miss work or leave work early due to your health issue. RQ1
  1. Probe: What did you say?
  2. Probe: How did your supervisor respond?

• OR If you had to miss a day of work due to your health issue, what would you say to your supervisor? RQ1
  1. Probe: How do you think he or she would respond?

• How, if at all, has the way you discuss women’s health to your boss changed with time? RQ1

• To what extent do you feel there is a stigma surrounding women’s health at work? Please elaborate. RQ1
• What, if any, messages have you received indicating that it is acceptable to talk about female issues at work? Give an example. RQ3

• What, if any, messages have you received indicating that it is not acceptable to talk about female issues at work? Give an example. RQ3

• How, if at all, does the gender of your boss affect the way you communicate about the topic? RQ1

Closing Questions

• What is the most important thing you hope I take away from our interview?

Demographic Questions

• What is your age?

• What is your position/title?

• How long have you worked in this position?

• How long have you worked in this organization?

• How long have you had endometriosis?
APPENDIX E

Member Check Attestation

The role that I played in Mary Madison Lyons’s research was that of a participant who also provided a member check as described by Lincoln and Guba (1985). I was asked to review the findings and interpretations of the study and offer feedback on the extent to which I believed the summaries represented my own views, feelings, and experiences.

The central purpose of the member checking procedure was to establish authenticity and credibility by allowing someone other than the researcher to confirm the accuracy and completeness of the data and interpretations. Through the process, I had the opportunity to assess the adequacy of data, to correct perceived errors, to confirm and/or challenge interpretations, and to offer additional information as necessary.

Attested by: ________________________________

(Participant Name)

Date: ________________________________

APPENDIX F

Peer Examination Attestation

The role that I played in Mary Madison Lyons’s research was that of the disinterested peer during the peer debriefings as described by Lincoln and Guba (1985). The debriefings occurred at the end of the project where I was provided information about the study. As part of the process, I listened to Mary Madison Lyons’s oral explanation of transcriptions; in addition, I read the master code list and reviewed the open coding, axial coding, and themes of the data.

The central purposes of the debriefing sessions were to establish credibility and explore aspects of the research that might otherwise have remained implicit in the researcher’s mind. Through the process of playing devil’s advocate, I attempted to probe potential biases, explore meanings in the data, and clarify basis for interpretation of the data by studying the coding procedures and categories.

Attested by: ________________________________________

(Peer Name)

Date: ________________________________________

REFERENCES


Friedman, M. (2015). There are only 3 countries in the world with more female bosses than male ones. *Marie Claire*. Retrieved from


How to have a difficult conversation with your supervisor. (2019). *The University of Texas at Austin Human Resources*. Retrieved from https://hr.utexas.edu/current/services/difficult-conversations-supervisor


