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Running head: Indoor air suffering and identity strategies

**“It was not me that was sick, it was the building”: Rhetorical identity management strategies in  
the context of observed or suspected indoor air problems in workplaces**

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## Abstract

Suffering from a contested illness poses a serious threat to one's identity. We analyzed the rhetorical identity management strategies respondents used when depicting their health problems and lives in the context of observed or suspected indoor air (IA) problems in the workplace. The data consisted of essays collected by the Finnish Literature Society. We used discourse-oriented methods to interpret a variety of language uses in the construction of identity strategies. Six strategies were identified: respondents described themselves as normal and good citizens with strong characters, and as IA sufferers who received acknowledge from others, offered positive meanings to their in-group, and demanded recognition. These identity strategies located on two continua: 1) individual- and collective-level strategies and 2) dissolved and emphasized (sub)category boundaries. The practical conclusion is that professionals should be aware of these complex coping strategies when aiming to interact effectively with people suffering from contested illnesses.

Keywords: indoor air problems; rhetorical identity management strategies; membership categorization analysis; rhetorical analysis; contested illness; identity threat; Nordic country

## Introduction

People often experience delegitimation and stigmatization when they are suffering from an illness whose existence is questioned and that is subject to scientific and public dispute (i.e., a contested illness; Armentor, 2017; Oldfield et al., 2017; Ware, 1992). For example, sufferers of chronic fatigue syndrome and chronic pain report that their morality and mental health are questioned, and that they feel rejected (Dickson et al., 2007; Mengshoel et al., 2017; Werner & Malterud, 2003).

In this study, we focus on indoor air (IA) sufferers. These people attribute their ill health to a specific building or buildings where they live or work. Although a growing body of evidence shows that problems in the indoor environment (e.g., mold, chemicals) are associated with respiratory illnesses such as asthma (WHO, 2009), the effect of the indoor environment on health is still contested (Norbäck, 2009). IA sufferers frequently suffer from etiologically contested or medically unexplained symptoms, and thus have many similarities with other such groups. However, there are also some important factors that make them special. First, while patients suffering from contested illnesses and medically unexplained symptoms usually actively seek a diagnosis and hence “permission to be ill” (Kornelsen et al., 2016; Nettleton, 2006), IA sufferers also demand that the “sick” building should be “diagnosed” and repaired (Finell & Seppälä, 2018). These demands may face resistance and cause social conflict due to the potentially heavy financial costs to the property owner. Second, although IA sufferers can suffer serious symptoms, the symptoms appear only in specific buildings, and hence can be hard for those who do not share the experience to understand. In these respects, the logic of building-related illnesses differs from many other forms of suffering, as well as from what individuals usually require to heal.

In Finland, where this study was conducted, IA problems and their health effects are a subject of heated debate. For example, it is estimated that dampness and indoor mold are present in 24% of schools and 10–50% of kindergartens (Reijula et al., 2012). However, the official

healthcare system does not recognize any causal relationship between indoor environments and health (Current Care Guidelines, 2017), and it is difficult to receive an occupational asthma diagnosis (Oksa et al., 2015). Moreover, IA sufferers report more injustice experiences in the workplace than employees do on the average, and their symptoms are easily attributed to mental health problems (Finell & Seppälä, 2018). In this context, it is likely that IA sufferers are highly motivated to present themselves in a positive light (Goffman, 1963). This article studies IA sufferers who attribute their health problems to a building where they work or have worked. It analyzes how they use rhetorical identity management strategies to protect their threatened identities: that is, how people try to produce themselves as understandable and moral agents by means of language.

#### *Identity management strategies and the social identity approach*

People suffering from contested illnesses can rhetorically manage identity threats by using individual- and collective-level strategies. Previous studies have shown that at the individual-level, people typically present themselves as ordinary and moral individuals (Clarke & James, 2003; Radley & Billig, 1996; Richardson, 2005), and distance themselves from other similar sufferers (Werner, Isaksen, & Malterud, 2004). By contrast, when people use collective-level strategies, they try to build and maintain group boundaries between their own ‘genuine’ cases and others’ ‘less genuine’ cases (Giles, 2006; Horton-Salway, 2007). However, no studies have analyzed how these individualistic and collective strategies are positioned in relation to each other. Furthermore, little is known about other collective rhetorical strategies besides the definition of group boundaries. It follows that the research remains fragmented and there is a lack of understanding of the whole variety of strategies that sufferers use in specific rhetorical contexts. Furthermore, no previous studies have examined strategies used by IA sufferers.

We regard the social identity approach (Tajfel & Turner, 1979; Turner et al., 1987) as an obvious theoretical standpoint from which to understand the relationships between these strategies. Social identity theory (Tajfel & Turner, 1979) states that people can use both individual- and collective-level strategies to acquire or maintain a positive identity. The choice of strategy depends on the perceived permeability or impermeability of group boundaries. If the boundaries are perceived as permeable, a low-status group member will favor individual-level strategies. In a health context, for example, this might mean that people suffering from stigmatized health problems will try to promote their own recovery (Haslam et al., 2009). When the boundaries are perceived as impermeable, people will define themselves through group memberships and favor collective-level strategies (Tajfel & Turner, 1979). They may create a more positive identity by comparing the in-group with a lower-status out-group. This is achieved by creating new comparative dimensions or changing the value attached to the in-group. A low-status group member may also seek a positive identity by trying to change the existing social hierarchy. In a health context, this might mean active participation in patient organizations, and attempts to influence legislation and treatment practices (Haslam et al., 2009).

This study applies the ideas provided by the social identity approach (i.e., the (im)permeability of group boundaries, and individual and collective strategies) and discourse analytical methods. The social identity approach has its roots in cognitive social psychology, whereas discursively oriented approaches focus on language use (Wetherell & Potter, 1992); it is therefore relevant to ask whether the two traditions can be combined. Previous literature has shown that they can be used in tandem. First, discursive psychologists do not deny the “existence of an extra-discursive realm” (Edley, 2001, p. 437), although they do not study it. Second, as Wetherell (1996) explains, Tajfel’s socio-psychological meta-theory contains many elements that either preceded or are in line with discursively oriented social psychology, such as Billig’s (1987) work on rhetoric. Therefore, although the social identity approach emphasizes basic cognitive processes

such as self-categorization, it does acknowledge that the meanings of categories are constructed through social interaction (Haslam et al., 1997).

In this article, we focus on how boundaries between IA sufferers and other categories or groups are rhetorically constructed, and how these constructions are linked to the management of threatened identities. In the social identity approach, the level of boundary permeability between groups is usually understood to influence the choice of identity strategy. Nevertheless, Tajfel (1978) also states that the levels of boundary permeability are based on belief systems that are products of societal processes. Therefore, there may be various ways to construct (im)permeability, especially in the context of “health” and “illness.” For example, illnesses are often invisible, and their effect on one’s ability to work can vary, as in the case of IA suffering. Hence, although the factual impermeability can be very concrete (e.g., an IA sufferer cannot go to her workplace), this does not prevent individuals from rhetorically dissolving or emphasizing the boundaries between health and illness categories and from using these reconstructions as part of their positive self-presentations (Goffman, 1963).

To sum up, this study contributes to previous qualitative research on how people suffering from contested illnesses rhetorically manage their threatened identities. It addresses the following two research questions:

Research Question 1: What kinds of rhetorical identity strategy do respondents use when depicting their lives as IA sufferers?

Research Question 2: How are these strategies related to each other?

It focuses exclusively on positive identity strategies, the kinds of individual- and collective-level strategies that are used, and how the (im)permeability of boundaries between IA sufferers and other categories is constructed.

## Method

### *Data source and participants*

The research material consists of 20 essays, which are a subsample of 56 essays collected through a nationwide writing event organized by the Finnish Literature Society (SKS) and Eerika Finell in 2014.<sup>1</sup> The SKS is a research institution, and a national memory and culture organization. It organizes writing events on different subjects, and archives this material for future generations and for research purposes. We used this method of data-gathering for three reasons. First, the respondents could freely report the information that they wanted to share, and the process was not influenced by other respondents or an interviewer. Second, we could recruit hard-to-reach respondents, such as individuals that were not involved in any patient organizations or medical care systems. Finally, this practice guaranteed a geographical distribution of respondents that would not otherwise have been possible. The writing events have been used before as a method of data-gathering (Tymczuk, 2013).

The writing event was promoted in non-profit public health organizations, magazines, and online news sites (e.g., Finnish Broadcasting Company). The announcement on the SKS website introduced some optional stimulus questions for respondents (see supplementary materials). Respondents were made aware that their essays would be used as research material and then archived by the SKS. They were instructed to post their essays or save them on the SKS website, either anonymously or to fill in a form in the SKS website giving their name, address, gender, and age. Two books were raffled as prizes among the respondents. An official of the Tampere Region Ethics Committee approved this study.

The analyzed subsample (18 females and two males) included essays that focused on IA problems in the workplace. The remaining essays discussed these problems in other contexts, and were therefore excluded from the final data. Only 11 (55%) respondents reported their age (mean

age 53 years). All respondents attributed their various reported symptoms or illnesses – such as asthma or other respiratory illnesses or symptoms, skin and eye irritation, nausea, rheumatism, chronic fatigue, headaches, multiple chemical sensitivity, and infections – to their previous or current workplaces. The shortest essay was 179 words, and the longest 9,440 words. All the essays were written in Finnish.

### *Analytical strategy*

The analysis combined rhetorical analysis (Billig, 1987) with membership categorization analysis (MCA) (Sacks, 1972, 1992; for synthesizing methodological approaches, see Wetherell, 1998). The rhetorical approach suggests that language use is a social practice through which individuals confirm and protect their worldview (Potter, 1996). Illness narratives as a form of social practice are quests for moral status and respect (Charmaz, 1983). Thus, although illness narratives may reflect the respondents' initial experiences, they are also self-presentations in a specific ideological and historical context (Radley & Billig, 1996). MCA too focuses on descriptions. It suggests that the description of activities that people offer in their accounts (i.e., category-bound activities (CBA)) (Sacks, 1972) should be studied in order to understand the full meaning of categories in action. For example, when a category device such as "family" is potentially salient in a verbal interaction, participants attach the activity "crying" to the category "baby". In the original version of MCA (Sacks, 1972), CBA signifies activities that are associated with certain categories. This has since been expanded to include other kinds of predicate besides activities (Psathas, 1999). In the rhetorical context of accounting for their potentially stigmatized positions, IA sufferers do not necessarily use explicit categories, but they may refer to certain activities or other predicates that imply explicit categories. That was why we utilized MCA to identify relevant categories that were constructed in our data.



After carefully familiarizing ourselves with the data, we analyzed each argument in its wider textual context by asking whether it contained a positive self-presentation. The unit of analysis was a phrase, sentence, or paragraph, depending on the argument. If a positive self-presentation was present, we used CBA analysis (Sacks, 1972) to determine what kinds of social categories were being constructed in the chosen units. In addition, we analyzed how the boundaries between IA sufferers and other social categories or groups were rhetorically constructed, and the other kinds of rhetorical devices the respondents used to provide positive self-presentations. All of the chosen units were copied onto an Excel spreadsheet in order to find potential similarities and differences in the ways they were constructed. At this point, the units were categorized into five identity strategies, and we formed the theoretical model. Finally, we reanalyzed the data and conducted a deviant case analysis (Patton, 1999) on the anomalies that did not match the model. On the basis of this analysis we ultimately divided one strategy into two. The first and second authors worked together closely to conduct the analyses. In cases of disagreement or ambiguity, the third author made the final decision.

## Results

We identified six positive identity strategies that our respondents used. We have named these strategies using labels that refer to different positive self-presentations: “normal individual,” “good citizen,” “ideal individual,” “real sufferer,” “awakened sufferer,” and “promoter of in-group rights.” These strategies can be located on two continua (see Figure 1). The first continuum, “dissolved category boundaries – emphasized (sub)category boundaries,” sorts the strategies according to boundary construction by analyzing the degree to which each strategy dissolves or emphasizes boundaries between IA sufferers and other social categories or groups. We used the term (sub)category because even when respondents emphasized the distinctiveness of IA sufferers (e.g., demanded recognition for their in-group), many of them simultaneously underlined the in-group’s superordinate category memberships. The second continuum, “individual-level –

collective-level,” sorts strategies according to the degree to which each strategy emphasizes individual-level characteristics or attributes (“*because of my strong character...*”) or group memberships with either “healthy” people or other IA sufferers (“*there are already thousands of us who have fallen ill*”).

We discuss these strategies in more detail below.

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Figure 1

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### *1. The normal individual*

When using the “normal individual” strategy, the respondents dissolved the group boundaries between healthy, ordinary individuals and IA sufferers. They did this by denying that their ill health resulted from the malfunctioning of their bodies. Instead, they defined their symptoms as normal bodily reactions to an unhealthy environment, unrelated to their own being or behavior. The following extracts are examples of how respondents avoided categorizing themselves as sick people.

#### **Extract 1**

*I was visited by constant severe colds with coughs. I was annoyed, because I was unable to go to work. It was inconceivable to me that it was the workspace that was really sick. I had symptoms just because of the place. I was transferred to another workspace. In my small mind, it did not occur to me that the symptoms were caused by a sick workspace. Changing the workspace seemed to fix my situation. Now, with hindsight, I remember how tired I was in a sick workspace.*

At the beginning of Extract 1 the respondent, who reports that she had to retire due to occupational asthma, distances herself from the sick category by writing that she was “*visited*” by respiratory infections, meaning that they were only temporary. She goes on to write “*it was the workspace that was really sick. I had symptoms just because of the place.*” Here, she uses the term “symptoms” as a self-defining attribute, which could be interpreted as a CBA for a sick person. However, she simultaneously strongly underlines the category of “a sick workspace”. In addition, she further emphasizes this distance by using the words “*really*” and “*just*”. In these ways, she distances her membership category from that of a sick person.

The statement “*In my small mind, it did not occur to me*” is also important. The respondent explains that she did not initially blame the building for her ill health. These kinds of descriptions were common in the data, and reflected respondents’ attempts to present themselves as non-paranoid individuals. .

The respondent in Extract 2 also distances himself from the illness category.

### **Extract 2**

*My new mold acquaintances aspergillus, penicillium, chaetomium, geotrichum, paecilomyces, and actinobacteria were waging a chemical war, and I just happened to be in the same premises as a bystander.*

Here, the respondent refers to different species of mold and soil bacteria by using their scientific names. Then, he defines his former symptoms as a result of a “*chemical war*” between these IA contaminants. By using the war metaphor, naming the contaminants as “*my new mold acquaintances,*” and using the label “*bystander,*” he distances himself from the actual situation. He presents his suffering as unrelated to his own characteristics or actions, and hence as incapable of defining his identity. Another respondent expresses this idea even more directly: “*An indoor air problem is specifically a problem of the air, not mine. The fault is not mine [...].*” These

respondents argue that it is not their body–mind that has failed, but the built environment. In this manner, they verbally protect their moral status, and dissociate their identity from their bodily symptoms and stigmatized category.

### *The good citizen*

In the “good citizen” strategy, the respondents managed their threatened identities by using self-defining labels other than IA sufferer (e.g., a diligent employee). They depicted themselves as decent citizens who were competent and respectful, and who cared for their own health, often using extreme case formulations (Pomerantz, 1986) such as “*I always enjoyed coming to work, because I knew that I could help all of the incoming patients.*” In this way, they dissolved the category boundaries. Some respondents went one step further by strongly emphasizing their other group memberships unrelated to IA suffering. This makes the strategy more collective than the previous one.

#### **Extract 3**

*Now I work in a nursery as a [...]’s village grandmother two times a month in two groups. I take care of my health by going to the gym two times a week and then exercise for an hour afterwards. I am part of a senior citizens’ group, I go to meetings and line-dancing practices. We have performed at nursing homes and other events.*

#### **Extract 4**

*I am a happy, energetic, excitable, child-loving children’s instructor, and I am excited and interested in my work. The work was versatile and interesting, and the children were lovely and energetic with a sparkle in their eyes; bubbly children interested in everything.*

In Extract 3, the respondent, who reports suffering from occupational asthma and chronic laryngitis, struggles to maintain the status of a good citizen. First, she provides a self-defining category that has a positively value-laden meaning: the “*village grandmother.*” Then she explains how she cares for her own health “*by going to the gym.*” Finally, she reports being a member of a

“*senior citizens’ group*” outside of the patient group. It is notable that the respondent tends to give detailed information about how often she performs these activities (“*two times a month in two groups*”). This quantification is a rhetorical strategy that is often used to present oneself as a confident person (Potter, 1996). It is also worth noting that the respondent constructs herself as a good citizen without explicitly mentioning the category of citizen, by only articulating CBAs that are strongly associated with it. In all these ways, the respondent dissociates herself from the stigmatized category.

In Extract 4, the respondent manages her identity in two ways. First, she dissolves the category boundaries by arguing in the present tense that she is not just an ill person but also belongs to a higher-status category (“*I am a [...] children’s instructor*”). In her essay, she reports receiving a workers’ compensation pension due to occupational asthma. Second, she makes an effort to present herself as a good worker. She does this by listing positive self-defining attributes (“*child-loving*”), and by expressing a positive orientation toward her work (“*I am excited and interested in my work*”) and children (“*the children were lovely*”). Using these CBAs, she highlights her difference from stereotypical members of the ill person category.

## 2. *The ideal individual*

The “ideal individual” strategy manifested itself in accounts of contention with insurance companies and medical professionals, difficult choices or material sacrifices, and autonomy, dignity, and perseverance in the face of difficult symptoms and suffering (“*I coped through the school day, when I kept eating Sisu<sup>2</sup> pastilles [...] I didn’t acquire any absences even under threat*”). Thus, although the respondents did not dissociate themselves from the contested category as in the previous strategies, they still dissolved the category boundaries by presenting themselves as ideal and strong characters who had survived under difficult conditions and distress.

The two respondents below describe how they overcame adversity and continued their work in a context where recovery, or at least the relief of symptoms, was perceived as possible.

#### **Extract 5**

*My state of health gradually improved after I was able to leave my damaged workspace and throw away, according to instructions, all of the items contaminated by mold [...]. I threw into the garbage, for example, all of my field notes from explorations I made to various places in [ ].<sup>3</sup> Luckily, I had copies of some of them elsewhere. [...] Only later did I start getting irritated by small things, such as the fact that my fieldwork documentation had gotten lost [...]. In this way, the moisture damage also affected my career. It did not seem sensible to continue to do research on materials whose basic data had been lost. Luckily, I was able to focus my energy on other things and, above all, continue my life – without the fool's mold house.*

#### **Extract 6**

*I have eliminated things from my life, debated my symptoms and choices with my partner and family, I avoid certain buildings, I keep a respirator mask on my face if I must be in a moldy building, I keep to a strict diet, and I take care of myself in general with the previously mentioned things. Now [...] I am starting to feel like the recovery phase has started.*

In Extract 5, the respondent, who worked as a researcher, reports that his health improved after he changed his workspace and disposed of his research materials. He emphasizes this sacrifice in many ways. First, he uses extreme case formulations (Pomerantz, 1986), describing how he disposed of “*all*” the materials. Second, he explains how valuable and unique the material was, writing of “*my field notes from explorations.*” Then he rhetorically strengthens his argument, first mitigating his proposition by specifying that “*Luckily, I had copies of some of them elsewhere*” and referring to these losses as “*small things,*” and then reprising the proposition “*my fieldwork documentation had gotten lost.*” Finally, he reports that he was unable to continue his research. By explaining how severe the sacrifice was, this respondent illuminates his own character as an ideal individual that acts rationally (“*It did not seem sensible*”), creatively (“*I was able to focus my energy*”), and in a self-disciplined manner (“*throw away, according to instructions*”).

In Extract 6, the respondent explains that her recovery is due to her disciplined lifestyle (“*I keep to a strict diet*”), her ability to face criticism, and her persistence regardless of others’ opinions. By describing her extremely healthy and self-disciplined life, she emphasizes her strong character and dissociates herself from the attributes attached to the stigmatized category. Thus, both respondents’ descriptions of their activities (i.e., they are autonomous, able to make difficult decisions, and show great self-discipline in the context of being threatened) work as CBAs for the category of the “*ideal individual.*”

Although not all respondents were able to report such narratives of recovery, they nonetheless explained how they faced their problems with perseverance and dignity. The respondent in Extract 7 reports that she suffered from a difficult multiple chemical sensitivity that severely restricted her daily life.



## **Extract 7**

*The continuation of being sick reduces your energy levels unnecessarily, but I try to stay strong! [...] I believe that strong humans are given more ordeals to face. Although my life has occasionally been challenging, I try to somehow accept things that have taken place, and I look to the future with confidence.*

Here the respondent presents the suffering itself as a sign of strong character or moral status: “*I believe that strong humans are given more ordeals to face.*” Although the respondent defines herself as permanently ill, she dispels the boundaries between low- and the high-status categories by categorizing herself in the most inclusive superordinate category of human beings. Thus, even when the boundaries between the ill and healthy categories are perceived as impermeable in physical “reality”, an ill person can pursue the ideal of the autonomous and strong individual and find a way to the higher-status category – at least rhetorically: “*I try to stay strong.*”

### *3. The real sufferer*

In the “real sufferer” strategy, the respondents managed their threatened identity by describing how they received support from significant others. Instead of emphasizing their own role in their survival, they underlined the roles of others. The significant other (or others) was not another IA sufferer but a member of an out-group (e.g., medical personnel, colleagues, friends) that showed a positive attitude toward the respondent and often shared the same superordinate category membership as the IA sufferer (“*My friends supported me*”).

In this strategy, there was no attempt to dissolve the category boundaries as in the three strategies presented above. Instead, the category boundaries were emphasized through the support of others and their acknowledgement of the IA sufferer category. However, this strategy was still more individualistic than collective. In the accounts, the understanding received from significant

others was used to validate only the respondent's experience and worth ("*During the worst symptoms, I was dating, and the man also understood very well*"), not that of the whole group.

In Extract 8, the respondent, who has retired because of occupational asthma, describes the different kinds of support she received during her serious illness.

### **Extract 8**

*The doctor also encouraged and comforted me. S/he<sup>4</sup> said to try to cope, even though these occupational diseases are very tough and studies take an extremely long time [...]. I still gratefully remember, for example, meeting my ex-colleague at the fruit counter. S/he didn't know about my situation, and just asked how things were at work. I began to cry, and quickly explained the situation I was in. S/he was very understanding.*

The respondent starts by reporting that the doctor treated her with empathy and defined her illness as an occupational disease. She uses similar logic in depicting her encounter with a colleague. This encounter is especially important, given that her illness and symptoms were contested in her workplace and her contract was terminated, as she reports in her essay. Empathy and support received from such a high-status out-group member (a healthy individual), who also shared a superordinate category membership (colleagues) with a low-status category representative (an IA sufferer), has two functions: the reported positive gesture toward the respondent indicates that she is valued in a social system, and it also recognizes the category she represents. Thus, the respondent's reference to the out-group member's acknowledgement works as a CBA for the "real sufferer" category.

#### 4. *The awakened sufferer*

In the “awakened sufferer” strategy, the respondents emphasized their spiritual maturation, heightened morality, and new social relationships due to their experiences of suffering: *“I have found a new world, which isn’t distressing after all, [...]”* In this manner, the IA sufferers underlined the category boundaries and defined a new shared identity that – at least among some respondents – was associated with new interpersonal relationships with other IA sufferers. Indeed, while the previous strategy emphasized positive relationships with significant out-group members, this strategy emphasized those between the respondents and other IA sufferers (*“Without this difficult disease, I would not have been able to get to know the lovely people [...]”*). Thus, this strategy had a stronger collective aspect than the “real sufferer” strategy.

The respondent below depicts discussions of a forthcoming move to a new workspace. She suffered from asthma, but she was able to work in another building, and the illness did not seriously restrict her life. In her essay, she reports that there was an observed IA problem in her workplace.

##### **Extract 9**

*Sometimes I have felt enraged sitting in meetings regarding moves, and listened to people whine about [losing] a few moldy books. I also appreciate books, and it’s irritating to have to give them up, but breathing is even more valuable.*

This extract exemplifies the use of the “awakened sufferer” strategy. The respondent describes her feelings about her colleagues’ disapproval of discarding contaminated books. She compares the colleagues’ materialistic attitude (*“people whine about a few moldy books”*) with her own awakened understanding of what really matters in life (*“breathing is even more valuable”*). The comparison between materialistic and “true” life is also apparent in Extract 10 below. After her serious illness, this respondent’s symptoms were relieved and she returned to work.

## **Extract 10**

*A negative thing, i.e., falling sick, can also be a positive thing, that's how I feel. I have new friends who have had an even tougher time than I have. My own life values have completely changed, and I have gotten out of a materialistic way of life, I value real matters and people and, above all, I enjoy one day of my life at a time. That's a great deal, because during [years <sup>5</sup>], I lived one minute at a time. I am no longer afraid of death and, above all, I love this life of mine, because I have been able to continue it with my loved ones.*

In this extract, the respondent defines falling ill as “*a positive thing*” and makes various comparisons in order to support her argument. First, she refers to her new friends, “*who have had an even tougher time than I have.*” In this social comparison, the amount of suffering defines the group positively. Then she makes a temporal comparison. She compares her previous life with the current one by contrasting her previous “*materialistic way of life*” with her current concern for “*real matters and people.*” Moreover, she contrasts different lifestyles and judges their value. Finally, she compares her earlier fear of death with her present ability to love her life – the life she has earned through suffering. Expressions of her joy in life, her valuing of authenticity, and her criticisms of materialism work as CBA for the category of the “*awakened sufferer.*” Thus, suffering from IA gains a positive new meaning.

### *5. The promoter of in-group rights*

In the “*promoter of in-group rights*” strategy, the respondents requested social support, a diagnosis for IA sufferers, and the inspection and repair of buildings, among other things. However, these respondents were not only fighting for their in-group’s rights (e.g., financial support), but were also validating their own past or current suffering by referring to other IA sufferers. Unlike in the previous strategies, the pronoun “*we*” was commonly used in this most collective strategy.

The promoter of in-group rights represented an identity strategy in which category boundaries were emphasized. Construction professionals, insurance companies, medical personnel, and supervisors represented “villainous” out-groups. However, the boundary constructions were seldom based on direct social comparisons. Instead, out-group members were presented as agents that exacerbated the respondent’s suffering. In this way, respondents constructed even more impermeable category boundaries. In spite of these sharp boundaries, many of the respondents simultaneously categorized their in-group as part of a superordinate category (e.g., workers, human beings).

The following extracts illustrate this complex boundary construction. In Extract 11, the respondent explains the situation in her workplace. Elsewhere in her essay, she reports that her ability to work is seriously threatened, she is not able to access a new workspace, and her relationships in the workplace are problematic.

#### **Extract 11**

*My actual workstation is situated on the lower floor of the [ ], in a large office, where there are a total of seven permanent employees. We all have symptoms that can be considered indoor air symptoms. Almost all of us have been in touch with our occupational healthcare [provider] in regard to our symptoms (one of us has been to see their own doctor at their place of residence). In May [year], I visited the occupational nurse to tell [her] about the visible moisture damage in the [ ], which I had noticed together with my colleague, on the ceiling of the large office downstairs.*

The respondent is doing three things simultaneously in this extract. First, she reports that all other permanent employees also suffer from IA-related health problems. Reference to the in-group and its collective experience (“*We all have symptoms*”) is a means to validate the illness’s existence. Second, this respondent seeks recognition of the group’s difficult situation and she uses the

rhetoric of quantity to justify her demands for action (Potter et al., 1991): it is not only for her own sake, but for the sake of all “*seven permanent employees*” . Third, she protects the in-group’s status and her threatened social identity by defining her in-group (i.e., AI sufferers) as part of a superordinate group of employees, instead of a group of sick people. This emphasis is especially apparent in another respondent’s extract, below.

### **Extract 12**

*Although I am just one patient case, I know that there are thousands of us who have fallen ill. Almost everyone has a similar story in the background, although the location of falling ill and the symptomatology varies a lot on a case-by-case basis. We are not hypochondriacs, but truly seriously organically ill human beings who currently have hardly any human dignity or security. A surprisingly large number of us are very highly educated, because, for example, so many schools, colleges, and offices suffer from indoor air problems. So far, not a single entity has even attempted to identify the number and situation of those who have fallen ill.*

This respondent is unemployed, and she believes she will not be re-employed in the future because she was severely sensitized in her previous workplace. In Extract 12 she does several things. She begins by defining herself as a “*patient case*,” and like the respondent in Extract 11, she uses the rhetoric of quantity. She validates her self-categorization by referring to other sufferers who have similar experiences to her own (“*there are thousands of us*”). Then she seeks a positive identity by presenting the out-group (“*not a single entity*”) as indifferent, contesting the negative stereotypes attached to her in-group (“*We are not hypochondriacs*”), and providing a compensatory definition. This compensatory definition has three parts: 1) it distinguishes the in-group sufferers from others by defining the former as “*truly seriously organically ill*”; 2) it positions the in-group within a superordinate entity, “*human beings*”; 3) it emphasizes the in-

group's high status (*"A surprisingly large number of us are very highly educated"*). The respondent demands two things from the other members of the superordinate entity: they should recognize the in-group's specificity (*"to identify the number and situation of those who have fallen ill"*) and accept this group as part of the superordinate entity (*"who currently have hardly any human dignity or security"*). Thus, when the respondents in Extracts 11 and 12 present themselves as members of a stigmatized group and emphasize its special characteristics, they simultaneously represent their in-group as part of a superordinate category shared by both IA sufferers and those who are not affected by IA problems.

In other words, the "promoter of in-group rights" strategy combines three categories in a special way. First, the category of "a building-related somatic disease" is constructed by CBAs in terms of having clear symptoms and being part of a like-minded collective. Second, this category is framed by another category, "a legitimate interest group", which is constructed by the CBA of "being mistreated by authorities." Finally, these categories are framed by a superordinate category of "employees" or "human beings". In these ways, respondents both protect their spoiled identity (Goffman, 1963) and legitimate their demands for rights and support.

## Discussion

This study identified six strategies that IA sufferers use to protect their threatened identities. These strategies can be located on two continua adapted from the social identity approach: 1) between the individual and collective levels, and 2) between dissolved and emphasized (sub)category boundaries. These findings represent important contributions to previous qualitative health research on contested illnesses, which has lacked an integrative model of rhetorical identity strategies. The model is also valuable because it reveals the complexity of respondents' argumentation. First, the respondents used both individual-level and collective-level strategies simultaneously. Second, they both dissolved and emphasized the category boundaries by using multiple superordinate and subordinate categories and group memberships. Finally, they used these boundary constructions as identity strategies. By emphasizing the category boundaries, for example, they sought recognition and help for the in-group (i.e., fellow IA sufferers). Thus, the identity strategies and boundary constructions were inseparably linked.

The analysis revealed both similarities and differences compared with previous research on contested illnesses. For example, in Tucker's (2004) study, respondents suffering from chronic fatigue syndrome constructed a "normal identity" by separating their minds from their bodies and attributing their illness to the latter. Our "normal individual" strategy shared the same dissociative logic, although it differed in one important respect: our respondents attributed their illnesses to a building that was outside of their minds and bodies. This made the "normal individual" strategy very specific, and distinguished it from strategies used by many other patient groups. The "good citizen" strategy can be seen as another way to present one's ordinariness (Radley & Billig, 1996). It was especially common among respondents whose work-related identities were challenged due to their IA suffering, such as those who were no longer able to work. This may reflect the fact that these people experienced the greatest stereotype threat. Further, previous studies have shown that those suffering from contested illnesses tend to report their everyday practices (Johansson et al.,



1999). This was also evident in our data, although our respondents often presented themselves as not only ordinary but also good citizens of high morality. The respondents' descriptions of their self-care practices can be interpreted as such demonstrations (Higgs et al., 2009). Although both the "good citizen" and the "ideal individual" strategies included descriptions of everyday practices, the respondents who used the "good citizen" strategy dissociated themselves from their suffering, while those who used the "ideal individual" strategy emphasized their strong and extraordinary characteristics in the face of suffering. This latter strategy was the most used, and it is widely documented among other patient groups as well (Richardson, 2005; Werner et al., 2004). Interestingly, Werner et al. (2004) have proposed that such self-presentations might reflect the medical narrative of the hysterical woman. Given that almost all of the respondents in the current study were women, the "ideal individual" strategy might also work as a counternarrative to this medical narrative.

The "real sufferer," "awakened sufferer," and "promoter of in-group rights" strategies show less convergence with previous literature on contested illnesses. Although the importance of a diagnosis for legitimizing one's illness has been deeply analyzed among many patient groups (Clarke, 2000; Nettleton, 2006), there has been less discussion of how an out-group's (e.g., medical professionals) appreciation and approval can be used as a positive identity strategy. Its common use among our respondents may reflect the fact that IA problems and their health effects are a subject of heated debate in Finland. It is more meaningful to report an out-group's approval in this context than in contexts where opposing views do not exist, or where the contest is weaker. Moreover, the construction of a positive new group identity, as presented by the "awakened sufferer" strategy, has received little attention in the context of contested illness. However, it has been widely acknowledged in studies examining other chronic illnesses and stigmatized groups (Frank, 2013; Stanley, 1999; Toyoki & Brown, 2014). In our data, this strategy was the least used, and the logic of its use was unclear. Future research should analyze which individual- and

collective-level factors facilitate the use of this positive strategy in the context of contested illnesses.

Our analysis showed that in-groups may play different roles in IA suffering than in other contested and chronic illnesses. Since there could be many sufferers in the same building, they could easily form face-to-face groups and become dependent on each other's support. Hence, the respondents who used the "promoter of in-group rights" strategy frequently referred to colleagues in their workplace who had similar symptoms. This is not possible in the context of contested and chronic illnesses that are unrelated to specific environments, such as chronic pain syndrome. Unlike patients suffering from chronic fatigue syndrome (Horton-Salway, 2007), our respondents did not maintain category boundaries between different subgroups of IA sufferers. This may reflect the fact that only a few of our respondents had received a diagnostic label.

Contrary to the predictions of social identity theory (Tajfel & Turner, 1979), our respondents did not construct a positive identity by using explicit intergroup comparisons. Instead, they referred to superordinate categories and group memberships. As Goffman (1963) states, stigmatized individuals seek smooth interactions with "normal" individuals. The smoothness of interaction is important, because low-status membership frequently goes hand-in-hand with a lack of material resources, making these individuals dependent on the goodwill of others. Extensive literature shows that a shared social identity promotes social support and assistance (Haslam et al., 2004). Thus, it is possible that while emphasizing their superordinate category memberships, for example, our respondents were creating a shared identity with an imagined audience (Jetten et al., 2014).

Our findings have some practical implications. Previous research shows that patients perceive treatment to be respectful when medical personnel treat them as individuals (Clucas, 2008). The literature also demonstrates that contesting a patient's self-categorizations and

experiences of illness is humiliating (Armentor, 2017; Dickson et al., 2007). Thus, at least in some cases, individuals with stigmatized health problems want to present and perceive themselves simultaneously as respectable human beings and as awakened representatives of a stigmatized category. This is precisely what our analysis demonstrated. Although it might be difficult to balance these opposing self-presentations, medical professionals as well as authorities in workplaces should consider this when interacting with IA sufferers. Respectful communication is essential for effective interactions (Bies & Moag, 1986).

This study has certain limitations. Most of our respondents were women. This may reflect previous findings that women are more sensitive to environmental exposures than men, or it may be due to gendered norms (Clougherty, 2010). It is also important to remember that our respondents provided a “public” account of their suffering (Cornwell, 1984); the results might be different if the accounts had been intended to be more “private.” In addition, since our participants were willing to report their experiences publicly, they may have differed in many respects from those who did not want to participate the writing event. Therefore, further research is needed among different populations and in different contexts.

To conclude, our study offers insights into the large variety of rhetorical identity strategies used in the context of IA suffering. It shows that respondents protect their threatened identities in complex ways, using individual-level and collective-level strategies simultaneously, as well as strategies that dissolve and emphasize category boundaries. This is important information for medical professionals and other authorities seeking effective interaction with IA sufferers.

### Declaration of conflicting interests

The authors declare that there is no conflict of interest.

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## References

- A patient suffering from damp and mould damage. (2017). Current care guidelines. Working group set up by the Finnish Medical Society Duodecim and the Finnish Cardiac Society. Helsinki, Duodecim. Retrieved from [http:// www.kaypahoito.fi](http://www.kaypahoito.fi)
- Armentor, J. L. (2017). Living with a contested, stigmatized illness: Experiences of managing relationships among women with fibromyalgia. *Qualitative Health Research*, 27(4), 462-473. <https://doi.org/10.1177/1049732315620160>
- Bies, R. J., & Moag, J. S. (1986). Interactional justice: Communication criteria of fairness. In R. Lewicki, B. Sheppard, & M. Bazerman (Eds.), *Research on negotiations in organizations* (pp. 43–55). Greenwich, CT: JAI Press.
- Billig, M. (1987). *Arguing and thinking*. Cambridge: Cambridge University Press.
- Charmaz, K. (1983). Loss of self: A fundamental form of suffering in the chronically ill. *Sociology of Health and Illness*, 5(2), 168–195. <https://doi.org/10.1111/1467-9566.ep10491512>
- Clarke, J. N. (2000). The search for legitimacy and the “expertization” of the lay person: The case of chronic fatigue syndrome. *Social Work in Health Care*, 30(3), 73–93. [https://doi.org/10.1300/J010v30n03\\_05](https://doi.org/10.1300/J010v30n03_05)
- Clarke, J. N., & James, S. (2003). The radicalized self: The impact on the self of the contested nature of the diagnosis of chronic fatigue syndrome. *Social Science & Medicine*, 57(8), 1387–1395. [https://doi.org/10.1016/S0277-9536\(02\)00515-4](https://doi.org/10.1016/S0277-9536(02)00515-4)
- Clougherty, J. E. (2010). A growing role for gender analysis in air pollution epidemiology. *Environmental Health Perspectives*, 118(2), 167–176. <https://doi.org/10.1289/ehp.0900994>
- Clucas, C. (2008). *Influences on and consequences of patient’s experiences of feeling respected in doctor-patient relations*. Doctoral dissertation. Bristol: University of Bristol.

- Cornwell, J. (1984). *Hard-earned lives: Accounts of health and illness from East London*. London, UK: Tavistock Publications.
- Current Care Guidelines. (2017). Kosteus- ja homevaurioista oireileva potilas [*A patient suffering from damp and mold damage*] (Working group set up by the Finnish Medical Society Duodecim). Helsinki, Finland: Duodecim. Available from <http://www.kaypahoito.fi/web/kh/suosituksset/suositus?id=hoi50111>.
- Dickson, A., Knussen, C., & Flowers, P. (2007). Stigma and the delegitimation experience: An interpretative phenomenological analysis of people living with chronic fatigue syndrome. *Psychology & Health, 22*(7), 851–867. <https://doi.org/10.1080/14768320600976224>
- Edley, N. (2001). Unravelling social constructionism. *Theory & Psychology, 11*(3), 433–441. <https://doi.org/10.1177/0959354301113008>
- Finell, E., & Seppälä, T. (2017). Indoor air problems and experiences of injustice in the workplace: A quantitative and a qualitative study. *Indoor Air*. <https://doi.org/10.1111/ina.12409>
- Frank, A. W. (2013). *The wounded storyteller: Body, illness, and ethics* (Second edition). Chicago, IL: The University of Chicago Press.
- Giles, D. (2006). Constructing identities in cyberspace: The case of eating disorders. *British Journal of Social Psychology, 45*(3), 463–477. <https://doi.org/10.1348/014466605X53596>
- Goffman, E. (1963). *Stigma. Notes on the management of spoiled identity*. Eaglewood Cliffs, NJ: Prentice-Hall Inc.
- Haslam, S. A., Jetten, J., O'Brien, A., & Jacobs, E. (2004). Social identity, social influence and reactions to potentially stressful tasks: Support for the self-categorization model of stress. *Stress and Health, 20*(1), 3–9. <https://doi.org/10.1002/smi.995>

- Haslam, S. A., Jetten, J., Postmes, T., & Haslam, C. (2009). Social identity, health and well-being: An emerging agenda for applied psychology. *Applied Psychology, 58*, 1–23. <https://doi.org/10.1111/j.1464-0597.2008.00379.x>
- Haslam, S. A., Turner, J. C., Oakes, P. J., McGarty, C., & Reynolds, K. J. (1997). The group as a basis for emergent stereotype consensus. *European Review of Social Psychology, 8*, 203–239. <https://doi.org/10.1080/14792779643000128>
- Higgs, P., Leontowitsch, M., Stevenson, F., & Jones, I. R. (2009). Not just old and sick – the “will to health” in later life. *Ageing and Society, 29*(5), 687–707. <https://doi.org/10.1017/S0144686X08008271>
- Horton-Salway, M. (2007). The “ME Bandwagon” and other labels: Constructing the genuine case in talk about a controversial illness. *British Journal of Social Psychology, 46*(4), 895–914. <https://doi.org/10.1348/014466607X173456>
- Jetten, J., Haslam, C., Haslam, S. A., Dingle, G., & Jones, J. M. (2014). How groups affect our health and well-being: The path from theory to policy. *Social Issues and Policy Review, 8*(1), 103–130. <https://doi.org/10.1111/sipr.12003>
- Johansson, E. E., Hamberg, K., Westman, G., & Lindgren, G. (1999). The meanings of pain: An exploration of women’s descriptions of symptoms. *Social Science & Medicine, 48*(12), 1791–1802. [https://doi.org/10.1016/S0277-9536\(99\)00080-5](https://doi.org/10.1016/S0277-9536(99)00080-5)
- Kornelsen, J., Atkins, C., Brownell, K., & Woollard, R. (2016). The meaning of patient experiences of medically unexplained physical symptoms. *Qualitative Health Research, 26*(3), 367–376. <https://doi.org/10.1177/1049732314566326>
- Mengshoel, A. M., Sim, J., Ahlsen, B., & Madden, S. (2017). Diagnostic experience of patients with fibromyalgia – A meta-ethnography. *Chronic Illness*. <https://doi.org/10.1177/1742395317718035>

- Nettleton, S. (2006). "I just want permission to be ill": Towards a sociology of medically unexplained symptoms. *Social Science & Medicine*, 62(5), 1167–1178.  
<https://doi.org/10.1016/j.socscimed.2005.07.030>
- Norbäck, D. (2009). An update on sick building syndrome: *Current Opinion in Allergy and Clinical Immunology*, 9(1), 55–59. <https://doi.org/10.1097/ACI.0b013e32831f8f08>
- Oksa, P., Palo, L., Saalo, A., Aalto-Korte, K., Pesonen, M., Mäkinen, I., & Tuomivaara, S. (2015). *Ammattitaudit ja ammattitautiepäilyt 2013. Työperäisten sairauksien rekisteriin kirjatut uudet tapaukset*. [Occupational diseases and suspected occupational diseases in 2013]. Helsinki: Työterveyslaitos. Retrieved from  
[https://www.julkari.fi/bitstream/handle/10024/126928/Ammattitaudit\\_2013\\_julkaisu.pdf?sequence=1](https://www.julkari.fi/bitstream/handle/10024/126928/Ammattitaudit_2013_julkaisu.pdf?sequence=1)
- Oldfield, M., MacEachen, E., MacNeill, M., & Kirsh, B. (2017). "You want to show you're a valuable employee": A critical discourse analysis of multi-perspective portrayals of employed women with fibromyalgia. *Chronic Illness*.  
<https://doi.org/10.1177/1742395317714034>
- Patton, M. Q. (1999). Enhancing the quality and credibility of qualitative analysis. *Health Services Research*, 34(5), 1189–1208.
- Pomerantz, A. (1986). Extreme case formulations: A way of legitimating claims. *Human Studies*, 9, 219–229.
- Potter, J. (1996). *Representing reality. Discourse, rhetoric and social construction*. London, UK: Sage.
- Potter, J., Wetherell, M., & Chitty, A. (1991). Quantification rhetoric--cancer on television. *Discourse & Society*, 2(3), 333–365. <https://doi.org/10.1177/0957926591002003005>



- Psathas, G. (1999). Studying the organization in action: Membership categorization and interaction analysis. *Human Studies*, 22(2–4), 139–162.  
<https://doi.org/10.1023/A:1005422932589>
- Radley, A., & Billig, M. (1996). Accounts of health and illness: Dilemmas and representations. *Sociology of Health and Illness*, 18(2), 220–240.
- Reijula, K., Ahonen, G., Alenius, H., Holopainen, R., Lappalainen, S., Palomäki, E., & Reiman, M. (2012). *Rakennusten kosteus- ja homeongelmat. [Buildings' dampness and mould problems]*. Helsinki, Finland: Eduskunnan tarkastusvaliokunnan julkaisu 1/2012 Helsinki.  
Retrieved from  
[https://www.eduskunta.fi/FI/tietoeduskunnasta/julkaisut/Documents/trvj\\_1+2012.pdf](https://www.eduskunta.fi/FI/tietoeduskunnasta/julkaisut/Documents/trvj_1+2012.pdf)
- Richardson, J. C. (2005). Establishing the (extra)ordinary in chronic widespread pain. *Health*, 9(1), 31–48. <https://doi.org/10.1177/1363459305048096>
- Sacks, H. (1972). On the analyzability of stories by children. In J. Gumperz & D. Hymes (Eds.), *Directions in sociolinguistics: The Ethnography of communication* (pp. 325–345). New York, NY: Holt, Rinehart, and Winston.
- Sacks, H. (1992). *Lectures on conversation*. (G. Jefferson, Ed.). London, UK: Blackwell.
- Stanley, L. D. (1999). Transforming AIDS: The moral management of stigmatized identity. *Anthropology & Medicine*, 6(1), 103–120.  
<https://doi.org/10.1080/13648470.1999.9964576>
- Tajfel, H. (1978). The social psychology of minorities. In *Minority Rights Report*, 38. London: Minority Rights Group.
- Tajfel, H., & Turner, J. (1979). An integrative theory of intergroup conflict. In W.G. Austin & S. Worchel (Eds.), *The social psychology of intergroup relations* (pp. 33–47). Monterey, CA: Brooks/Cole.

- Toyoki, S., & Brown, A. D. (2014). Stigma, identity and power: Managing stigmatized identities through discourse. *Human Relations*, 67(6), 715–737.  
<https://doi.org/10.1177/0018726713503024>
- Tucker, I. (2004). “Stories” of chronic fatigue syndrome: An exploratory discursive psychological analysis. *Qualitative Research in Psychology*, 1(2), 153–167.  
<https://doi.org/10.1191/1478088704qp008oa>
- Turner, J., Hogg, M. A., Oakes, P. J., Reicher, S. D., & Wetherell, M. S. (1987). *Rediscovering the social group: A self-categorization theory*. Oxford: Blackwell.
- Tymczuk, A. (2013). The morality of transnationalism: Children of Ukrainian labor migrants write about migration, homeland and abroad. *Children’s Geographies*, 11(4), 490–503.  
<https://doi.org/10.1080/14733285.2013.812310>
- Ware, N. C. (1992). Suffering and the social construction of illness: The delegitimation of illness experience in Chronic Fatigue Syndrome. *Medical Anthropology Quarterly*, 6(4), 347–361.
- Werner, A., Isaksen, L. W., & Malterud, K. (2004). “I am not the kind of woman who complains of everything”: Illness stories on self and shame in women with chronic pain. *Social Science & Medicine*, 59(5), 1035–1045. <https://doi.org/10.1016/j.socscimed.2003.12.001>
- Werner, A., & Malterud, K. (2003). It is hard work behaving as a credible patient: Encounters between women with chronic pain and their doctors. *Social Science & Medicine*, 57(8), 1409–1419. [https://doi.org/10.1016/S0277-9536\(02\)00520-8](https://doi.org/10.1016/S0277-9536(02)00520-8)
- Wetherell, M. (1996). Constructing identities: The individual/social binary in Henri Tajfel’s social psychology. In P. W. Robinson (Ed.), *Social groups and identities: Developing the legacy of Henri Tajfel* (pp. 269–284). Oxford, UK: Butterworth-Heinemann.

Wetherell, M. (1998). Positioning and interpretative repertoires: Conversation analysis and post-structuralism in dialogue. *Discourse & Society*, 9(3), 387–412.

<https://doi.org/10.1177/0957926598009003005>

Wetherell, M., & Potter, J. (1992). *Mapping the language of racism: Discourse and the legitimation of exploitation*. New York, NY: Columbia University Press.

World Health Organization (Ed.). (2009). *WHO guidelines for indoor air quality: Dampness and mould*. Copenhagen, Denmark: WHO Regional Office for Europe. Retrieved from <http://www.who.int/indoorair/publications/7989289041683/en/>

Figure 1

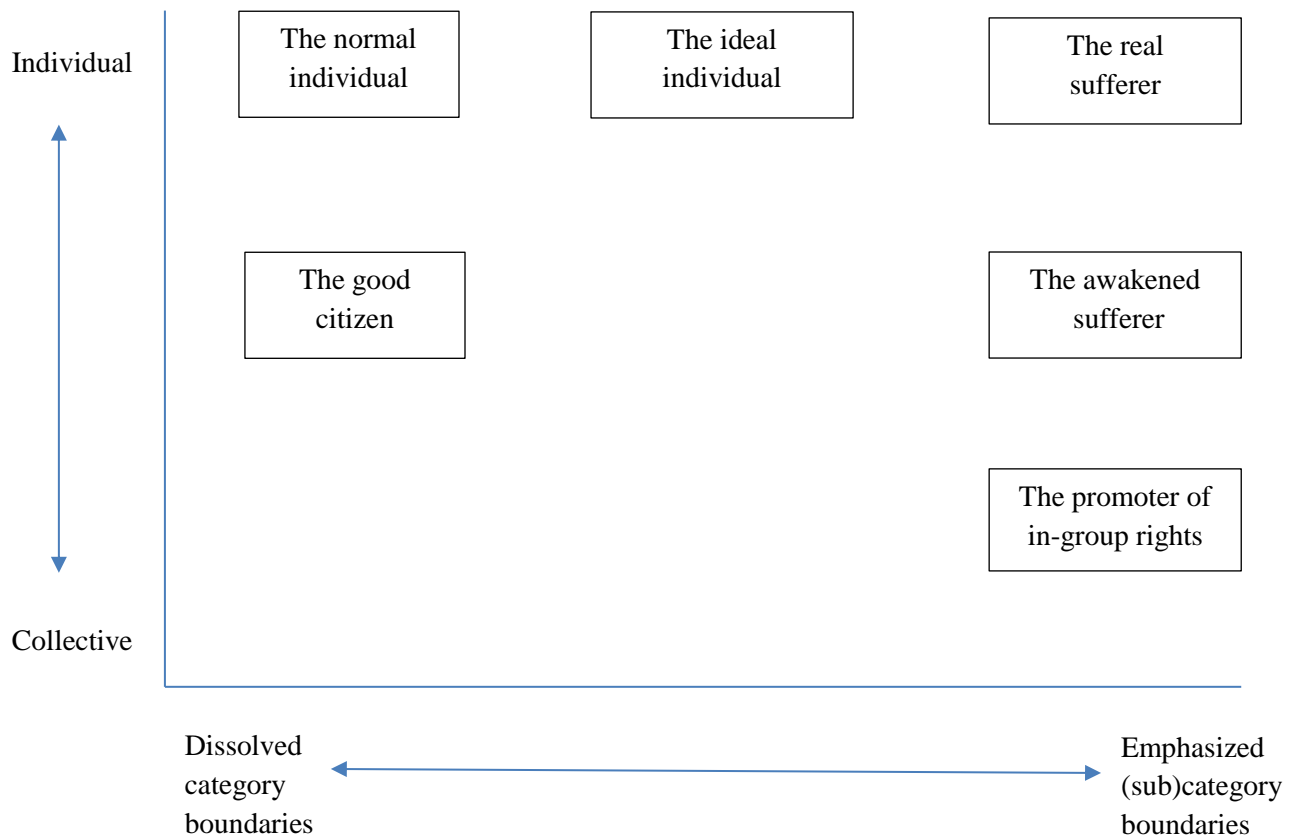


Figure 1. The location of identity management strategies along two basic dimensions.

## Endnotes

<sup>1</sup> Finnish Literature Society (SKS) states that the sample size is 62. However, six essays were originally written in another context (Hengityслиitto, the Organization for Respiratory Health in Finland) and later filed with the SKS, with the respondents' permission. These six essays' content and structure were very similar to the other data. However, because their rhetorical context was not exactly the same, they were removed from the analysis.

<sup>2</sup> The word "sisu" has two meanings here: it is the name of a pastille, and it also means "perseverance."

<sup>3</sup> Reference to a continent.

<sup>4</sup> The Finnish language has gender-neutral pronouns.

<sup>5</sup> The exact dates have been deleted.