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Coordinating Boundaries and Negotiating Mental Health Diagnoses and Disclosure: An Exploration of Stigma and Communication Privacy Management

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COORDINATING BOUNDARIES AND NEGOTIATING MENTAL HEALTH DIAGNOSES AND DISCLOSURE: AN EXPLORATION OF STIGMA AND COMMUNICATION PRIVACY MANAGEMENT

THESIS

A thesis submitted in partial fulfillment of the
requirements for the degree of Master of Arts in the
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at the University of Kentucky

By

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ABSTRACT OF THESIS

Coordinating Boundaries and Negotiating Mental Health Diagnoses and Disclosure: An Exploration of Stigma and Communication Privacy Management

For quite some time, researchers have tried to reduce stigma and misconceptions about individuals diagnosed with a mental illness. Researchers have examined stigma towards individuals diagnosed with a mental illness, and the internalized stigma that can result. Additionally, researchers have analyzed the dialectical push and pull that occurs between privacy and confidentiality for self-disclosures. Past research has explored disclosure of a mental illness in the context of family members, psychiatrists, employers, friends, and in academic settings. However, there is a lack of research examining how risk perceptions are affected by internalized stigma, thus impacting young adults' intentions to disclose their mental illness diagnosis to close friends and coordinate boundaries. To address this gap in research, the purpose of this thesis is to illustrate and extend upon empirical evidence regarding self-disclosure and Communication Privacy Management Theory (CPM) by proposing that internalized stigma is an antecedent of disclosure risk perception.

KEYWORDS: *Communication Privacy Management, disclosure, mental illness, close friends, internalized stigma, disclosure risk perception*

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06/03/2022

Coordinating Boundaries and Negotiating Mental Health Diagnoses and Disclosure: An Exploration of Stigma and Communication Privacy Management

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DEDICATION

To my mom and best friend, there are not enough words in the world to express what your overwhelming love and continuous support have meant to me throughout my academic journey. Thank you for never letting me forget that I am smart, beautiful, and strong. I will always choose to face my fears. You are the reason I believe I can do anything I put my mind to.

To my father, thank you for your support and encouragement. I could not be more grateful for your continued patience and understanding.

To my siblings, thank you for being my rock. I cannot describe how thankful I am for your love, support, and continued patience. Thank you for teaching me that family is forever, no matter what.

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Chapter 1: Introduction and Rationale

For quite some time, researchers have tried to reduce stigma and misconceptions about individuals diagnosed with a mental illness. Additionally, researchers have examined stigma towards individuals diagnosed with a mental illness and the internalized stigma that can result (Corrigan et al., 2010; Mulfinger et al., 2018; Theurer et al., 2015). Implications from past research show that self-disclosures can aid in minimizing the negative effects of internalized stigma (e.g., decreases in self-efficacy and self-esteem) (Corrigan et al., 2010). According to the National Alliance on Mental Illness (NAMI), 33.33% of United States (U.S.) young adults experienced a mental illness in the year 2020 (NAMI, 2020). More importantly, according to the Household Pulse Survey, administered by the Centers for Disease Control and Prevention (CDC) (2022), 41.3% of young adults ages 18 – 29 years have symptoms of anxiety disorder and 35.4% have symptoms of depressive disorder. It is crucial for researchers to acknowledge the growing public health crisis surrounding mental illness and mental health among young adults.

Stigma surrounding mental illness are a direct result of misperceptions about the symptoms, causes, and outcomes relating to mental illness/es (Theurer et al., 2015). These stigmas can become internalized (i.e., self-stigma) and act as a barrier to self-disclosure. Internalized stigma is a process by which an individual applies the stigmas surrounding mental illness to oneself (Corrigan et al., 2010). A young adult may perceive high risk associated with the disclosure of their mental illness to close friends, due to internalized stigma. Internalized stigma may be influencing young adults' disclosures of their mental illness/es to close friends through disclosure risk perceptions. Examining young adult's disclosures of their mental illnesses to close friends is important because

close friendships are different from casual friends or acquaintances (Rawlins, 2017). A close friend can be understood as a person with whom an individual feels emotionally attached, spends time with regularly, and is someone they feel comfortable reaching out to if they require help (Rawlins, 2017). Due to the misperceptions in society surrounding mental illness, it becomes crucial to analyze the negative effects internalized stigma can have on young adults, their disclosures to close friends, and their coordination of boundaries (i.e., rules made surrounding private information) following a disclosure.

There are two key contributors to the rise in mental health issues among young adults in 2022: (1) an increase in social networking sites (Robinson et al., 2018; Berryman et al., 2017; Twenge et al., 2018) and (2) the COVID-19 pandemic (NAMI, 2020; Reppas-Ringlisbacher et al., 2020; Brülhart et al., 2021; Hussong et al., 2021). Each of these issues have contributed to the increase in mental health issues among young adults. The two key contributors will each be discussed. After discussing the purpose for the current thesis, the two key contributors to the increase in mental health issues among young adults will be discussed in the following paragraphs.

The purpose of this thesis is to illustrate and extend upon empirical evidence regarding self-disclosure and Communication Privacy Management Theory (CPM; Petronio & Reierson, 2009) by proposing that internalized stigma is an antecedent of disclosure risk perception. Thus, internalized stigma is proposed to effect disclosure risk perception, which, in turn, will impact intentions to disclose a mental illness to close friends and intentions to coordinate boundary conditions (i.e., boundary permeability, linkages, and privacy rules) among young adults. Multiple tenants from CPM are tested in the context of internalized stigma, mental illness, and self-disclosure to close friends.

The thesis is divided into five chapters. Each addressing a critical dimension of the research process. Chapter 1 is the introduction and rationale for the thesis, which provide a basis for the current study. Chapter 2 reviews the literature that helps to establish the primary hypotheses. In Chapter 3, the methods relating to the study are discussed. Then, Chapter 4 reveals the results of the study. Finally, Chapter 5 provides a comprehensive conclusion on the current thesis including theoretical and practical implications, limitations, and directions for future research.

The rise in social networking sites may be directly related to the increase in mental health issues among young adults. It is important to note is that 84% of adults ages 18-29 years old use at least one social media platform (Pew Research Center, 2021). In a study measuring attitudes towards mental health on social media platforms, researchers found mental health conditions to be subject to more stigmatizing attitudes than physical health conditions (Robinson et al., 2018). Implications from the results indicate there to be more stigmatizing attitudes towards mental health conditions on social media platforms, which may indicate that there is an increase in stigma towards mental illness as a direct result of social media use.

These findings speak to the fact that social media is not eliminating stigma surrounding mental illness, rather it is perpetuating the stigma. Social media is being used as an outlet to continuously reproduce stigmas towards individuals diagnosed with a mental illness (Robinson et al., 2018). Additionally, researchers stated that the trends of stigma observed on social media appeared to be greater than those seen in previous studies examining traditional media (Robinson et al., 2018). This finding is essential as it speaks to the ways in which social media perpetuates stigma towards individuals

diagnosed with a mental illness in society. In another study examining social media use among young adults, researchers found social media use to be a poor predictor of mental health problems (Berryman et al., 2017). Researchers found the exception to be individuals who participated in vaguebooking (i.e., social media posts worded in a way to solicit attention) which predicted feelings of loneliness and suicidal thoughts (Berryman et al., 2017). Berryman and colleagues (2017) found that an individual with a preexisting mental health condition may use some forms of social media as a 'cry for help' (Berryman et al., 2017). These findings speak to the ways young adults diagnosed with preexisting mental health conditions use social media platforms to express their feelings of loneliness or suicidal thoughts. Additionally, implications from the findings show that young adults diagnosed with preexisting mental health conditions may utilize social media platforms to communicate feelings related to their preexisting mental health condition (i.e., loneliness or suicidal thoughts).

Another study analyzed increases in depressive symptoms and suicided-related outcomes among adolescents as it links to increases in new media screen time (Twenge et al., 2018). Researchers found the prevalence of suicide and depressive symptoms among adolescents to coincide with an increase in screen-related activities (e.g., social media use) (Twenge et al., 2018). This finding emphasizes how social media can be linked to an increase in mental health issues for young adults. As previous research stated, social media can be linked to an increase in mental health issues for young adults. If many young adults use at least one social media site, it is crucial that attention is brought to the relationship between social media and mental health issues among young adults.

Although social media is one important contributor to the rise in mental health issues among young adults, the COVID-19 pandemic is also a key contributor.

Recently, because of the COVID-19 pandemic, a mental health crisis has been brought to the public's attention. COVID-19 has brought mental health issues to the forefront of the conversation in society. The COVID-19 pandemic brought time of uncertainty to Americans, and in those times of uncertainty many individuals were left spending time by themselves. In 2020, the NAMI reported that 23% of young adults reported significant negative impacts on their mental health due to the pandemic (NAMI, 2020). The COIVD-19 pandemic brought, and continues to bring, unprecedented challenges to all Americans.

These unprecedented challenges brought on by the COVID-19 pandemic may disproportionately affect individuals diagnosed with a mental illness. The COVID-19 pandemic led to the implementation of social distancing strategies that were crucial to limiting the spread of the virus (Hwang, T-J et al., 2020). These quarantine, isolation, and social distancing procedures were enforced for those infected with or exposed to COVID-19, and amongst the general population to reduce the transmission of the virus (Hwang, T-J et al., 2020). It is important to note that there is high risk associated with quarantine, isolation, and social distancing procedures for COVID-19 due to seclusion from the public (Hwang, T-J et al., 2020). Also, essential to note is that this impact may be disproportionately amplified for individuals diagnosed with pre-existing mental illnesses because they often suffer from loneliness and social isolation prior to enhanced distancing from others imposed by the COVID-19 pandemic public health protocols (Hwang, T-J et al., 2020). Although social restrictions are necessary to prevent the spread

of COVID-19, it is critical to keep in mind that social distancing should never equate social disconnection for individuals in society (Hwang, T-J et al., 2020). In a study examining the mental health of Canadian and U.S. adults during the COVID-19 pandemic, researchers found the prevalence of elevated depressive or anxiety symptoms to be higher in Americans than Canadians (Reppas-Ringlisbacher et al., 2020). Additionally, American adults reported greater mental health challenges relating to the COVID-19 pandemic (Reppas-Ringlisbacher et al., 2020). Findings from the above study speak to the increase in mental health issues among Americans as a direct result of the COVID-19 pandemic. Additionally, it can be interpreted from results that there may be an increase in mental health issues among young adult Americans (ages 18 – 29) as a direct result of the COVID-19 pandemic.

Another study analyzed mental health concerns during the COVID-19 pandemic using telephone helplines (Brülhart et al., 2021). Researchers found there to be an increase in call volumes across all mental health helplines and that most topics discussed surrounded fears and anxieties (Brülhart et al., 2021). Here, it is essential to realize that there was an increase in conversations surroundings fears and anxieties. Those fears and anxieties may have been general, or they could have been brought on because of the pandemic and having to quarantine. Emphasis should be placed on the fact that there is an increase in calls to telephone helplines (e.g., national suicide prevention helplines, mental health helplines, etc.) which coincides with an increase in mental health issues.

Additional research examined coping and mental health in early adolescence during the COVID-19 pandemic (Hussong et al., 2021). Researchers followed young adolescents' (n = 88) mental health six years prior to the COVID-19 outbreak to within

three to five months after the outbreak occurred and found there to be an increase in overall mental health symptoms (Hussong et al., 2021). These findings indicate that individuals with preexisting mental health conditions may have had an increase in mental health symptoms during the COVID-19 pandemic. Overall, each of the above studies speak to the increase in mental health issues among young adults. As a direct result of the rise in social networking sites and the COVID-19 pandemic, the public health crisis of mental illness and stigma should be brought to the forefront of the conversation. There seems to be substantial research indicating that mental health issues have increased for young adults. Thus, it is important to study the growing public health issue surrounding mental illness and stigma.

Interdisciplinary researchers have examined the ways in which an individual discloses or conceals personal private information. Researchers have used Communication Privacy Management Theory (CPM) to examine the dialectical push and pull between privacy and disclosure (Petronio & Reierson, 2009). Past research has examined the interplay between publicly endorsed stigma and internalized stigma, and how it can impede on risk-taking for disclosure in academic settings (Meluch & Starcher, 2020), with peers (Corrigan et al., 2015), and with friends (Venetis et al., 2018). Also, research has examined disclosure of lung cancer to family members following a lung cancer diagnosis (Ngwenya et al., 2016). Results from Ngwenya and colleagues (2016) study directly align with CPM principles, which could potentially mean that individuals diagnosed with a mental illness will believe they have full ownership over the private information relating to their mental illness. However, there seems to be a lack of research examining the interplay of internalized stigma and disclosure risk perception. It may be

that internalized stigma influences disclosure risk perception, thus impacting intentions to disclose a mental illness to close friends and intentions to coordinate boundary conditions among young adults. Additionally, although there seems to be research examining disclosure in healthcare settings, there seems to be little research analyzing the boundary coordination that occurs with close friends after disclosure of a mental illness, which can be considered a stigmatized identity.

Within self-disclosure literature, disclosure risk perception has been identified as a motivational criterion empirically proven to motivate individuals to disclose private information about themselves to other individuals. When examining self-disclosure, it is important to consider the effect stigma or internalized stigma may have on an individual's motivation to disclose information about their mental illness to close friends. Research has shown that individuals diagnosed with a mental illness are more likely to be publicly stigmatized by society. Additionally, research has shown that individuals diagnosed with a mental illness are more likely to face identity threats due to internalization of stigma towards mental illness (Corrigan et al., 2010). When an individual faces an identity threat, there may be more risk perceived with the act of disclosing their mental illness. Interestingly, internalized stigma may affect disclosure risk perception.

For example, Mulfinger and collages (2018) found that individuals diagnosed with a mental illness are more likely to keep their personal health information a secret due to fear of stigma or shame. Results indicated that individuals diagnosed with a mental illness may not want to disclose their mental illness to close friends due to stigma. Internalized stigma may be influencing young adults' disclosure risk perception about

disclosing their mental illness, thus impacting their intentions to disclose their mental illness to close friends and intentions to coordinate boundaries. Although there is empirical evidence showing the effects stigma has on individuals diagnosed with a mental illness, there is a lack of research examining how disclosure risk perception are affected by internalized stigma, thus impacting young adults' intentions to disclose their mental illness to close friends and coordinate boundaries. Examining how individuals diagnosed with a mental illness coordinate boundaries during disclosure with close friends may yield interesting results depending on the degree of intimacy the relationship holds. Moreover, analyzing the relationship between internalized stigma as an antecedent to disclosure risk perception on intentions to disclose will yield interesting results.

In addition, there seems to be a growing body of research analyzing the interplay between disclosure and stigma. Research has examined the social isolation and distress that can arise because of internalization of stigma towards mental illness (Mulfinger et al., 2018). Findings indicate that this social isolation and distress that arises from internalized stigma may impair an individual diagnosed with a mental illness' disclosure to close friends. Importantly, Corrigan and colleagues (2010) conducted research to understand how public and self-stigma can act as barriers to disclosure. Findings indicated that people who were out about their mental illness were less likely to experience negative impacts of self-stigma on their quality of life (Corrigan et al., 2010). Implications from the above findings indicate that self-disclosure may have the ability to mitigate the feelings of social isolation and distress that are created from self-stigma. These findings are important for the context of the current thesis because individuals

diagnosed with a mental illness may choose to disclose their mental illness to close friends to relieve self-stigma.

Stigma is continuously being reproduced and perpetuated in society through misconceptions and skewed ideas surrounding mental illness. These stigmas can detrimentally affect the ways an individual diagnosed with a mental illness navigates through life and daily interactions. Research has examined stigma towards mental illness and how it can impede on risk-taking for disclosure (Mulfinger et al., 2018; Corrigan et al., 2010). Additionally, the decision to disclose a mental illness has been examined with peers and friends. Implications from past research indicate stigma surrounding mental illness may significantly impact an individual diagnosed with a mental illness' decision to disclose their mental illness. These findings indicate stigma may be a significant predictor when trying to understand intention to disclose a mental illness to close friends. Although researchers have examined disclosure of a mental illness in multiple contexts, little research has focused on the interplay of stigma and disclosure. Analyzing the effects internalized stigma has on disclosure may be crucial to understanding how individuals diagnosed with a mental illness coordinate boundaries during disclosure with close friends. This is because internalized stigma may have the potential to affect an individual's evaluation of disclosure risk perception, thus impacting their decision to disclose their mental illness.

As shown above, researchers have tried to eliminate stigma and misconceptions surrounding mental illness. Additionally, researchers have examined stigma towards individuals diagnosed with a mental illness and the internalized stigma that can result (Corrigan et al., 2010; Mulfinger et al., 2018; Theurer et al., 2015). Implications from

past research show that self-disclosure can aid in minimizing the negative effects of internalized stigma (e.g., decreases in self-efficacy and self-esteem) (Corrigan et al., 2010). Within the self-disclosure literature, research has found disclosure risk perception to motivate individuals to disclose or conceal personal private information to other individuals (Petronio, 2002).

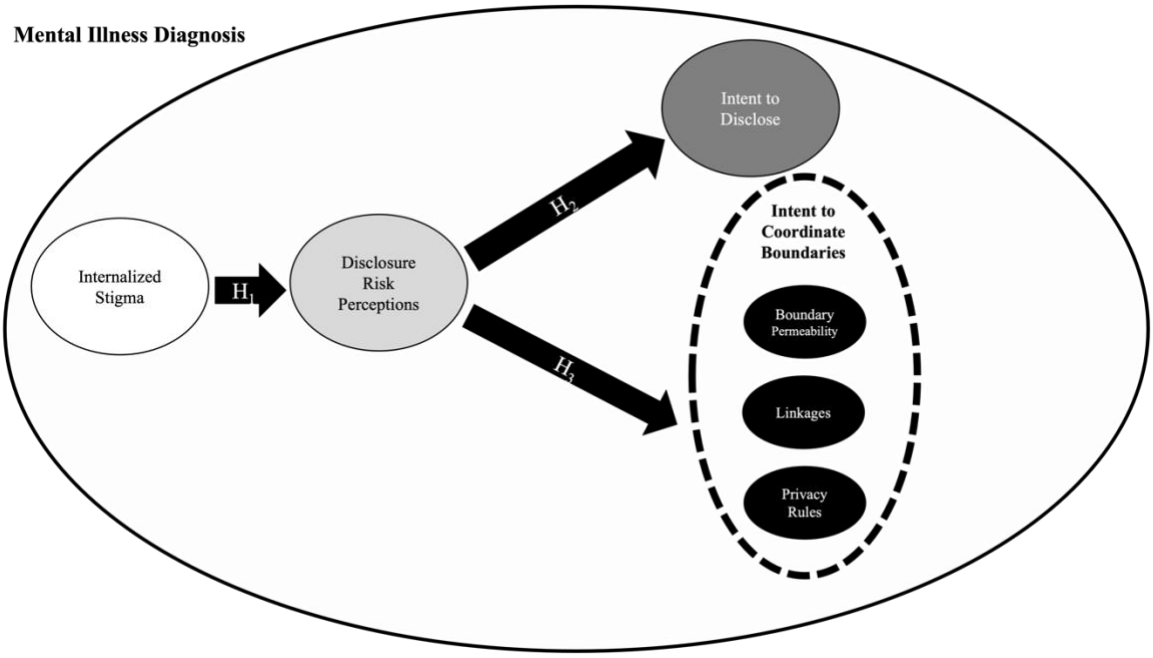
When examining self-disclosure, it is important to consider the effect internalized stigma may have on an individual's motivation to disclose information about their mental illness to close friends. Researchers have used Communication Privacy Management Theory (CPM) to examine the tension that exists between privacy and disclosure (Petronio & Reierson, 2009). There seems to be a lack of research analyzing the interplay between internalized stigma and self-disclosure. Additionally, little research examines how internalized stigma effects disclosure risk perception, which, in turn, effects intentions to disclose and intentions to coordinate boundaries. It is also crucial to examine the constructs relating to boundary coordination. It is important to test these constructs using quantitative research to determine whether these three processes (i.e., boundary permeability, linkages, and privacy rules) are empirically distinct. Using quantitative research to test these constructs, in addition to established qualitative research, could potentially aid help researchers understand if individuals make rules surrounding their privacy in general following a disclosure or based on these three distinct processes that have been identified by Petronio (2002). To address this gap in research, the current thesis draws on Communication Privacy Management Theory (CPM; Petronio, 2002; Petronio & Reierson, 2009) and proposes a causal process model (see Figure 1.1) predicting that internalized stigma effects disclosure risk perception, which, in turn,

impacts a young adults' intentions to disclose their mental illness to close friends and intentions to coordinate boundaries.

Figure 1.1

Hypothesized Model

The hypothesized model extends upon empirical evidence regarding CPM by predicting that internalized stigma effects disclosure risk perception, which, in turn, will impact intentions to disclose a mental illness to close friends and intentions to coordinate boundary conditions among young adults.



Chapter 2 begins by providing a comprehensive literature review framed using the proposed model, mental illness, and stigma. Next, close friends are discussed as a way of better understanding the importance of this relationship during the disclosure process. Also, motivational criteria are defined for the purpose of explaining what motivates individuals to disclose personal private information to close friends. Additionally, CPM framework is explored as it related to the disclosure of high-risk information. Finally,

hypotheses are presented that provide direction for the data collection, results, and discussion of the thesis.

Chapter 2: Literature Review

As mentioned in Chapter 1, the study of mental illness and stigma is not new. Additionally, research on self-disclosure is well established. However, there is a gap in literature examining how, why, and under what conditions individuals diagnosed with a mental illness disclose their mental illness to close friends. Research has shown the benefits of self-disclosures in a variety of contexts (e.g., better life quality and less stigma; Mulfinger et al., 2018; Corrigan et al., 2010). To address this gap in research, the current study draws on Communication Privacy Management Theory (CPM; Petronio, 2002; Petronio & Reierson, 2009) to examine how individuals diagnosed with a mental illness coordinate boundaries during disclosure with close friends. As such, from a communication perspective, it is important to review the literature that helps to establish the primary hypotheses – which are provided at the end of Chapter 2. The following literature review is divided into five parts. First, a comprehensive background on mental illness and stigma is provided. Second, close friends are discussed to better understand the importance of this relationship during the disclosure process. Third, motivational criteria is defined for the purpose of explaining why and how individuals are motivated to disclose personal private information to close friends. Fourth, CPM framework is explored as it relates to the disclosure of high-risk private information. Finally, before results of the study can be discussed, findings from past research studies are discussed as they provide basis for the current study. We begin with a discussion of mental illness.

Mental Illness

To understand how individuals diagnosed with a mental illness coordinate boundaries during disclosure with close friends, it crucial to first provide a

comprehensive background of mental illness. A mental illness is a condition that can affect an individual's feeling, behavior, thinking, or mood (NAMI, 2021). The following conditions can severely impact day-to-day living and have the potential to affect an individual's ability to relate to others: Anxiety Disorders, Attention Deficit Hyperactivity Disorder, Bipolar Disorder, Borderline Personality Disorder, Depression, Dissociative Disorders, Eating Disorders, Obsessive-Compulsive Disorder, Posttraumatic Stress Disorder, Psychosis, Schizoaffective Disorder, and Schizophrenia (NAMI, 2021). Important to note is that each year one in 5 adults in the U.S. experience mental illness (NAMI, 2021). Each year one in six youth aged 6-17 will experience a mental health disorder (NAMI, 2021). In fact, the CDC states that more than 50% of adults in the U.S. will be diagnosed with a mental illness or disorder in their lifetime (CDC, 2021). It may be periodic stress or seasonal depression, or it could be a chronic illness. Here, it is important to understand that mental illness does not discriminate; most of us have someone in our lives who has been diagnosed with one.

Mental health conditions are extremely common (NAMI, 2021), but society does not like to – or is reticent – to talk about these disorders. However, society does not like to acknowledge or talk about mental illness due to the misperceptions surrounding these diagnoses (Corrigan, 2004). Although there are many misperceptions and misunderstandings of mental illness, one of the main reasons mental health illnesses are not discussed in society is stigma. As such, mental illness stigma, internalized stigma, and stigma characteristics are discussed in the next section.

Mental Illness Stigma

Stigma Characteristics

The largest barrier to discussing mental health in society is stigma. The stigma surrounding mental illness is an extremely serious social issue that impacts one of the most vulnerable communities in society (Young et al., 2019). Mainly, this entails misperceptions about the symptoms, causes, and outcomes relating to mental illness that contribute to the stigmatization of those affected by these diagnoses (Theurer et al., 2015). There are two types of stigma: (1) publicly endorsed stigma and (2) self-stigma.

Stigma, or publicly endorsed stigma, is a prejudice and discrimination that emerges when society endorses a specific stereotype towards an individual diagnosed with a mental illness (e.g., an individual with a mental illness is uncapable of maintaining a real job) (Corrigan et al., 2010). Research has found stigma to occur when five interrelated components converge (Perlick et al., 2009): (1) distinction and labeling of human differences must occur, (2) there must be a linkage of the labeled person to undesirable traits (i.e., negative stereotyping), (3) cognitive separation occurs (i.e., the labeled individual is viewed as "them", which is fundamentally different from "us"), (4) both parties have emotional reactions: the stigmatized (e.g., shame, alienation, embarrassment, anger) and the stigmatizer (e.g., anxiety, pity, fear, anger), and (5) discrimination and status loss transpire for the labeled individual (i.e., leading to an unequal outcome) (Perlick et al., 2009). Essential to understand here is the idea that the individual is now seen as being discriminated or stigmatized against. Due to the unequal outcome and status loss, the labeled individual may be placed in the out-group (i.e., being viewed as "them" which is fundamentally different from "us").

Researchers have identified labels as leading to stigmas in two ways (Corrigan, 2004). An individual may obtain a label from another individual (e.g., a friend may inform another friend that Suzie has a mental illness). Additionally, a label may be obtained by association (e.g., an individual may be seen coming out of a psychiatrist's office and someone may assume they have a mental illness). Crucial to understand is that stigmas can be considered cues that elicit stereotypes (Corrigan, 2004). These stereotypes are knowledge structures learned by individuals about a marked social group (Corrigan, 2004). Common stereotypes towards individuals diagnosed with a mental illness include that they are violent, incompetent, and to blame for their diagnosis (Corrigan, 2004). Next, we will discuss the negative consequences of these common stereotypes and stigmas, and how they can be internalized to act as a barrier to self-disclosure.

Internalization of Stigma

Self-stigma, is internalized and can cause individuals to experience a loss of self-esteem, self-efficacy, and limit prospects of recovery (e.g., can undermine pursuit of goals related to independent living) (Watson et al., 2007; Corrigan et al., 2010). If an individual diagnosed with a mental illness is surrounded by other individuals who have misperceptions of mental illness, they may experience loss of self-esteem and self-efficacy. This may lead to the internalization of stigma, which could potentially impact the ways in which an individual diagnosed with a mental illness evaluates disclosure risks before disclosing their mental illness to close friends and coordinating boundaries. Next, the consequences associated with internalized stigma are explored.

Consequences of Internalized Stigma

There are multiple consequences associated with the internalization of stigma. Young and colleagues (2019) stated that the stigmatization individuals face because of their mental illness might be *more* detrimental than the actual illness itself. In addition, an identity threat occurs when an individual is stigmatized against. This identity threat is a direct result of the harm that occurs when an individual's sense of self is challenged by association with a stigmatized group (Corrigan et al., 2013). As a result of this identity threat, individuals diagnosed with a mental illness may experience increased anxiety and vigilance (e.g., being alert and wary towards others) (Corrigan et al., 2013). The identity threats that occur from public-stigma and self-stigma might be detrimental to the privacy management process, forcing an individual to create boundaries that are not as permeable (i.e., thick boundaries) during the disclosure process.

Young and colleagues (2019) define ableism as any type of stereotyping, discrimination, social oppression, or prejudice toward an individual with a disability (Young et al., 2019). Unfortunately, ableism towards individuals diagnosed with a mental illness can create significant barriers to treatment-seeking (Young et al., 2019). If ableism has the potential to create barriers to treatment seeking, ableism might also have the potential to create barriers for disclosure. In the context of ableism, mental illness is an invisible disability (i.e., given that society is unlikely to be aware that an individual has a disability unless they have disclosed it) (Young et al., 2019). Invisible disabilities relate closely to the idea of a stigmatizing affliction, described by Goffman (Goffman, 1963). An understanding of invisible disability can provide information relating to the disclosure or concealment process for individuals diagnosed with a mental illness. If an individual

has an invisible disability, their disability is completely and entirely invisible and only known to the individual (i.e., the owner of the private information) (Goffman, 1963). There is a burden associated with carrying an invisible disability, because no one knows of that disability until it is disclosed. Carrying this invisible burden may significantly impact the privacy management process for individuals diagnosed with a mental illness. This may also lead individuals diagnosed with a mental illness to coordinate boundaries that are not as permeable (i.e., thick boundaries) during disclosure with close friends.

Fear of public-stigma and self-stigma, or shame, has the potential to make an individual with a mental illness decide to keep their personal health information secret (Mulfinger et al., 2018). Although secrecy has the potential to protect an individual diagnosed with a mental illness in the short-term, long-term consequences such as social isolation and distress may arise (Mulfinger et al., 2018). The long-term effects that can result from public and self-stigma make it crucial to examine how stigma might affect the ways an individual diagnosed with a mental illness coordinates boundaries during disclosure with close friends. As previously stated, although disclosure carries risk of being stereotyped or discriminated against, it is often associated with better quality of life and less stigma (Corrigan et al., 2010; Mulfinger et al., 2018). Important to note, however, is that implications from past research indicate that self-disclosures can aid in minimizing the negative effects of internalized stigma (e.g., decreases in self-efficacy and self-esteem) (Corrigan et al., 2010). After our discussion of how public and self-stigma can act as barriers to disclosure, it is crucial to focus some attention on close friends as a way of better understanding the importance of this relationship during the disclosure process.

Disclosure with Close Friends

Distinguishing Acquaintances from Friends and Close Friends

Most research on friendship proposes three core features. For example, Samter (2003) argues that friendship is *voluntary*, a relationship based on *equality*, and that some level of *reciprocity* must be present for the friendship to endure. She goes on to suggest that a voluntary friendship is one that has unrestrained interaction in which participants are allowed to respond to one another personally as unique individuals. Additionally, relationships based on equality and reciprocity are those where individuals like and wish for one another to do well (e.g., good intentions are reciprocated by one another). There is also interdisciplinary agreement that friendship comes in a variety of forms, differing based on demographic features or the level of intimacy (acquaintance vs. close vs. best friend). In addition, in the context of self-disclosures, friends can also be distinguished from nonfriends (e.g., acquaintances or peers) in terms of quality and quantity of disclosure (Samter, 2003).

Rawlins (2017) proposes that close friendships are different from casual friends or an acquaintance by suggesting that a close friend is a person with whom an individual feels emotionally attached, spends time with regularly, and is someone they feel comfortable reaching out to if they are in need of help. Literature on self-disclosure and friendship has noted that pairs of close friends disclose more information than pairs of strangers (Samter, 2003). It was also found that information disclosed by close friends is more likely to be intimate information (Samter, 2003). However, as past research has noted, most studies in mental health-related research examine familial interaction, rather than friendship relationships (Hall, 2020). And, even if friendship is included in the

analysis, it is often done in tandem with family relationships (Hall, 2020). Although friends may fill similar relational roles as compared to familial relationships, these relationships can differ when considering a variety of contextual circumstances and variables (Hall, 2020). It is crucial to include close friendships in the analysis of mental health-related research to gain a deeper understanding of the disclosure process for individuals diagnosed with a mental illness, and how this might differ with friends.

In a study examining the (non)disclosure of private mental health-related information in friendships, Hall (2020) explored how individuals discussed their mental health conditions/concerns with friends (Hall, 2020). Results found that not every participant opened-up immediately to their friends about their mental health (Hall, 2020). Most of the time, participants waited to establish their individual threshold of trust before identifying their motivation for disclosure (Hall, 2020). This finding has important implications for the current thesis. If individuals diagnosed with a mental illness wait to disclose their mental illness until they have established a certain threshold of trust, then they may be more likely to create boundaries that are not as permeable (i.e., thick boundaries) during disclosure. Kennedy-Lightsey and colleagues (2012) analyzed the coordination and ownership of private information between friends. Specifically, researchers noted that as the risk of information increased, so did efforts to coordinate boundaries (Kennedy-Lightsey et al., 2012). However, interesting to note is that this effect was mediated for individuals who had been friends for longer than two years (i.e., the longer amount of time individuals were friends, the less risky their information was to share) (Kennedy-Lightsey et al., 2012). Implications from this study indicate that

individuals diagnosed with a mental illness may coordinate thick boundaries during disclosure with close friends due to the high-risk of information being disclosed.

McBride and Bergen (2008) conducted research on the disclosure of private information and privacy management that occurs when individuals become reluctant confidants in close friendships (McBride & Bergen, 2008). A reluctant confidant is someone who perceives a disclosure as burdensome; that individual may take on the role of the reluctant confidant (Petronio & Durham, 2015). In their study, McBride and Bergen (2008) found only 28 out of 110 participants to identify as reluctant confidants during disclosure in close friendships (McBride & Bergen, 2008). The results show that 82 out of 110 participants in close friendships did not identify as the reluctant confidant and accepted the disclosure (McBride & Bergen, 2008). As a result, it might be close friendships who offer the greatest depth and breadth on understanding self-disclosure.

However, it is important to consider that in some close friendships when an individual discloses their mental illness, their friend may become the reluctant confidant and not want to hear about the mental illness disclosure. Not only might friendships be a potent and viable source of refuge, but they may also serve as an important alternative resource for individuals struggling to maintain their mental health (Parham & Tinsley, 1980). With an understanding of the importance of the role close friendships plays in the disclosure process, it is essential to define the motivational criterion involved with self-disclosure – for the purpose of explaining what motivates individuals to disclose private information to close friends in the first place.

Disclosure Criteria

When making the decision to disclose private health information to others, individuals one main disclosure criteria is disclosure risk perception.

Disclosure Risk Perception. The main criteria, and arguably one of the biggest determining factors in the disclosure process, is disclosure risk perceptions. When deciding to reveal private information to close friends, individuals must weigh the risks and benefits of a particular disclosure. It is here where the risks associated with the act of self-disclosure are evaluated. We are constantly balancing the risks and benefits of revealing private information to others (Petronio, 2002). An individual must calculate the risks against the benefits to judge whether they should keep a disclosure private or reveal the information completely or partially (Petronio & Durham, 2015). For instance, by calculating risks against benefits, an individual is then able to judge whether they want to disclose their mental illness, reveal the information partially, or conceal the information from a close friend.

There are many benefits for disclosing personal private information to others. An individual may want to *express* their feelings to others (Petronio, 2002). Additionally, an individual may need *self-clarification* (i.e., being in need of clarity of thought) or *social validation* (i.e., gaining trust and wanting to fit in) (Petronio, 2002). By disclosing our private information, we may be able to come to terms with an important issue or reinforce our values and beliefs. Another positive outcome of disclosing is *relational development* between partners or close friends (Petronio, 2002). Finally, an individual may disclose information about oneself to gain *social control* over a situation (Petronio, 2002). As

described above, there are multiple positive benefits to disclosure, and these can lead to positive outcomes. However, there are also risks associated with disclosure.

The type of disclosure risk determines whether an individual discloses private information or holds it tightly. The disclosure risk-benefit ratio serves as a factor determining rules as a basis for the decision to disclose personal private information, or for it to remain private (Petronio, 2002). Our private information can change in degrees of risk based on the perceived repercussions of revealing or concealing private information (Petronio, 2002). Each time an individual discloses, they must calculate the risks against the benefits to judge whether they should disclose or reveal information (Petronio & Durham, 2015). When deciding to disclose personal information to another person, individuals are considering the level and type of disclosure risk.

First, we will discuss different levels of disclosure risk. There are three types of disclosure risk: (1) *high-risk episodes*, (2) *moderate-risk episodes*, and (3) *low-risk levels*. For some individuals a disclosure episode may be defined as highly risky, while for others it might not be risky. *High-risk episodes* often involve encounters that may cause severe embarrassment, threat, and/or shame (Petronio, 2002). If an individual diagnosed with a mental illness has high levels of internalized stigma, then the act of disclosing their mental illness to close friends may cause severe embarrassment, shame, or threat. In this case, the act of disclosing a mental illness to close friends may be perceived as highly risky. *Moderate-risk episodes* tend to include attitudes, experiences, or events that individuals find troublesome or uncomfortable for others to know (Petronio, 2002). One example of a moderate risk episode would be if a young adult diagnosed with a mental illness felt like they would make their close friends uncomfortable by disclosing their

mental illness. In this occasion, a young adult diagnosed with a mental illness may perceive the act of isclosure with moderate levels of risk. If a private disclosure episode involves *low-risk levels,* it tends to revolve around situations where the individual is keeping "white lies" or conflicting opinions on an issue (Petronio, 2002). One hypothetical example of this would be if a young adult diagnosed with a mental illness consistently told their close friends that life was going great, when in fact they are struggling with symptoms from their mental illness. In this instance, disclosure of a mental illness to close friends may be perceived with low levels of risk because the young adult has been keeping a "white lie" from their close friends relating to their mental health. After considering the level of disclosure risk, an individual contemplates the types of disclosure risks they may face because of disclosure. Next, we will discuss the different types of disclosure risk.

In addition to the disclosure risk levels, there are disclosure risk types. When deciding whether to disclose a mental illness diagnosis to close friends, an individual may face three types of disclosure risk: (1) *security risks*, (2) *stigma risks*, and (3) *relational risks*. An individual may face *security risks*, where they fear disclosure will result in power shifting away from them (i.e., loss of control over private information) (Petronio, 2002). Another type of risk individuals may face are *stigma risks*, which are specific to self-identity (Petronio, 2002). When an individual faces stigma risks, they fear they could be discredited or cast in a disparaging light by others who may be friends (Petronio, 2002). An individual may also face *relational risks,* where a partner is not supportive of a disclosure, which may result in damage toward the relationship.

In a study identifying attributes individuals use to explain their disclosures, researchers found participants to perceive risks and concerns in close relationships (e.g., fear of losing resect and desire for privacy) (Derlega et al., 2008). This finding is consistent with the dialectical-based theory CPM; individuals weigh multiple goals to maintain the dialectic between needing to disclose versus keeping private information hidden (Petronio, 2002). Additionally, Meluch and Starcher (2020) examined whether students' perceptions of risks for disclosure of mental illness were based off past experiences of disclosure. Researchers found students who had previously disclosed their mental health issues to instructors to perceive much higher levels of risks than students who had not previously disclosed (Meluch & Starcher, 2020). These findings are also consistent with the dialectical-based theory Communication Privacy Management theory; individuals weigh multiple goals simultaneously when determining whether to conceal or disclose personal private information to others. After reviewing the current literature associated with the motivational criterion involved with self-disclosure, we are provided with an understanding of the importance disclosure risk perception play in influencing an individual's decision to disclose personal private information to close friends. Next, for the purpose of the current study it crucial to examine the exploratory power of Communication Privacy Management Theory (CPM).

Communication Privacy Management (CPM) Theoretical Foundations

Communication Privacy Management (CPM) framework identifies a dialectical push and pull between privacy and disclosure (Petronio & Reierson, 2009). This dialectical tension acts as a function to influence the decisions that individuals make to disclose or conceal private information (Petronio & Reierson, 2009). Due to specific

motivations, individuals have to reach a goal or cultural expectation, decision criteria for disclosure is based on judging risk-benefits (Petronio & Reierson, 2009). When an individual discloses private information to another person, that person is made the *confidant.* Decision criteria might also have the potential to influence a confidant's judgement relating to revealing or preserving the confidentiality of the information disclosed by an individual (Petronio & Reierson, 2009). The purpose of CPM is to understand how individuals manage privacy *personally* and with *confidants.*

CPM posits that individuals regulate privacy boundaries as they make decisions relating to the flow of private information (Petronio & Reierson, 2009). This process is guided by six principles: (1) individuals believe they own their private information, (2) individuals believe they have the right to control their private information, (3) the flow of private information is controlled using privacy rules developed based on criteria important to the individual, (4) once an individual discloses their private information it becomes co-owned by the confidant, (5) when information becomes co-owned, it is ideal for parties to negotiate collectively held and agreed upon rules (e.g., in the case of third-party interaction) , and (6) when people do not actively negotiate privacy rules, there becomes a possibility for *boundary turbulence* to occur (i.e., disruptions in the way co-owners control/regulate the flow of private information to third parties) (Petronio & Reierson, 2009).

Decision criteria are used to determine a target's worthiness of sharing private information. When an individual decides to disclose private information, they entrust another individual with information they believe to still be within their control (Petronio

& Reierson, 2009). The decision to disclose is only made if the confidant is judged as 'responsible' by the owner of the private information (Petronio & Reierson, 2009).

Once the information is disclosed, CPM suggests individuals are dependent on criteria to develop privacy rules (Petronio & Reierson, 2009). Privacy rules are developed based on multiple factors (e.g., cultural values, assessment of risk-benefits) and can change based on situation/context (Petronio & Reierson, 2009). Recent developments in CPM argue that these criteria can be categorized into two types: *core criteria* (i.e., reflects stable gauges used to make decisions about privacy rules) and *catalyst criteria* (catalysts influencing changes to privacy rules – such as getting married) (Petronio, 2013). One hypothetical example of catalyst criteria in the instance of close friendships would be if the dynamic of the friendship changed. For instance, if a third or fourth friend was added to the dyad. If this were the case, an individual diagnosed with a mental illness may need to change privacy rules by sharing information with additional close friends in the dynamic of friends. Once expectations are met by co-owners according to the privacy rules established, private information moves from the domain of the original owner into a shared boundary that is controlled (e.g., co-owned) by the original owner and the confidant (Petronio, 2002; Petronio & Reierson, 2009).

Important to note is that the owner sees the confidant having fiduciary responsibility (e.g., acting in best interest of another person) over their private information (Petronio & Reierson, 2009). After disclosure, CPM argues the original owner anticipates privacy rules will be coordinated with the confidant (Petronio & Reierson, 2009). When expectations of privacy rules are discussed, the boundary surrounding the private information disclosed is managed (Petronio & Reierson, 2009).

Additionally, the coordination of privacy rules can reduce the potential for unwanted breaches of confidentiality, conflict, and relational problems (Petronio, 2002; Petronio & Reierson, 2009). As a result of the stigma surrounding mental illness, an individual diagnosed with a mental illness may not want their confidant to breach confidentiality because they view their information as having a high degree of privacy. To accomplish boundary coordination and manage private information, CPM argues three necessary operations: *negotiating privacy rules for linkages*, *permeability*, and *ownership*. Next, the boundary conditions necessary for managing private information after it has been disclosed are discussed.

Boundary Conditions

Linkages. To accomplish boundary coordination, an individual must first create *privacy rules for linkages.* CPM notes, linkage refers to the establishment of mutually agreed-upon privacy rules that are utilized to make decisions about other individuals who might be privy to collectively held information (Petronio & Reierson, 2009). In other terms, linkages are alliances formed between the discloser and the recipient (Petronio & Durham, 2015). There are numerous ways for a boundary linkage to occur. A discloser may target a particular recipient to reveal private information, but an unintended recipient can receive the private information accidentally (Petronio & Durham, 2015). CPM argues that individuals use parameters when making linkages (e.g., characteristics of the target, perceived need for control, type of topic discussed, status of potential confidant, etc.) (Petronio & Reierson, 2009). Once a linkage is made between two personal boundaries, a dyadic boundary is formed to incorporate another individual (Petronio, 2002). When this occurs, the boundary surrounding that private information does not remain personal;

instead, information becomes collectively held (Petronio & Caughlin, 2006). When a linkage is made with an unintended recipient, the discloser will not have the ability to regulate their information using privacy rules and boundary coordination becomes difficult (Petronio & Durham, 2015). There are two types of linkages that might occur. In the case of the first linkage, private information blends and becomes dyadic, or shared jointly (Petronio, 2002). In the case of the second linkage, private information becomes redefined (i.e., belonging to one individual) but both parties have collective responsibility to the personal information (Petronio, 2002). The resulting boundary around the shared information is mutually held by the original owner and the target of a disclosure (Petronio & Caughlin, 2006). A linkage may be long-term or temporary (Petronio, 2013). For example, an individual discloses their mental illness to a close friend. When this occurs, an individual links their close friend into a dyadic boundary where the information is collectively held.

In the context of friendships, linkages may be made differently. An individual's decision to disclose their mental illness to close friends may not determine the same type of decision rules that are made for confessing and opening privacy boundaries (Petronio, 2002). For example, an individual may tell their close friend how much they can tell other people they *know* and *do not know* about their mental illness. Although linkages are important for an individual to establish mutually agreed-upon rules, boundary permeability also becomes important to the individual after disclosure. Next, boundary permeability is explored for the purposed of CPM and self-disclosure.

Boundary Permeability. Boundary permeability represents rule coordination relating to the extent collectively held privacy boundaries are opened/closed once formed

(Petronio, 2002; Petronio & Reierson, 2009). Rule coordination relates to the amount of access to information or openness there is within a privacy boundary (Petronio & Durham, 2015). As an individual increases access to their private information, boundaries become more permeable (Petronio & Durham, 2015). As stated above, boundary permeability signifies the amount or level of access to private information, *thinner walls* represent more openness and access which allows private information to flow more easily (Petronio & Durham, 2015). In opposition to this, when a boundary has *thicker walls* it represents less access or no access (e.g., as with secrets) (Petronio & Durham, 2015). It is here where the confidant and original owner discuss how much access third parties should have to private information (Petronio & Reierson, 2009). It is possible that individuals diagnosed with a mental illness will coordinate thick boundaries during disclosure (i.e., boundaries that are not as permeable). Privacy rules help to drive the amount of information discussed to develop a collectively held boundary and determine what information can be disseminated to third parties (Petronio & Caughlin, 2006).

Private information is managed by the creation of agreed-upon rules for disclosure, where each person in the dyad maintains and protects private information (Petronio, 2002). These rules manage the depth, breadth, and amount of private information third parties are given (Petronio & Reierson, 2009). Permeability rules play an important part in managing private information disclosed because they aim to regulate the flow of private information going outside of the collectively held privacy boundary (Petronio & Caughlin, 2006). The flow of private information can be thought of in terms of thickness/thinness of boundary walls (i.e., these walls allow information to be known) (Petronio & Reierson, 2009). The thicker the boundary wall, the less access is given and,

in turn, less is disclosed about the private information (Petronio & Reierson, 2009). The thinner the boundary walls, the more access is given, and more is disclosed about the private information (Petronio & Reierson, 2009).

Boundary insiders can be understood as individuals within the boundary of private information, who are free to discuss collectively held information with confidants (Petronio & Reierson, 2009). Due to the stigma surrounding mental illness, an individual diagnosed with a mental illness may be more likely to coordinate thick boundary walls during disclosure with close friends. This is due to the high degree of privacy their information holds, as they do not want other individuals to know unless they are the ones disclosing the information. By coordinating thick boundaries, individuals will make very strict rules for the disclosure of their mental illness. For example, an individual may tell their close friend not to tell people they know about their mental illness. Additionally, an individual may tell their close friend not to tell people they do not know about their mental illness. Based on the degree of disclosure risk an individual perceives, they may coordinate thin boundaries and not be very concerned with who knows and does not know of their diagnosis. Rules become developed relating to the amount of information boundary outsiders can know about the private information (Petronio & Reierson, 2009).

As previously mentioned, research has explored self-disclosure in a variety of contexts. Essential to know is that an individual may be more likely to reveal information to friends rather than family members (Petronio, 2002). This is important for the purpose of the current thesis and may provide fruitful results because an individual may be more likely to reveal their mental illness to close friends rather than to family members, teachers, psychiatrics, acquaintances, or therapists. The third necessary operation for

managing private information after it has been disclosed to close friends, which will be discussed in the following section, is privacy rules.

Privacy Rules. The last type of management process CPM posits is the establishment of privacy rules for ownership. This is where co-owners negotiate the degree and type of ownership they have over collectively held private information (Petronio & Reierson, 2009). Assuming ownership rights over the private information is the last sense of ownership co-owners assume (Petronio & Reierson, 2009). Privacy rules govern the parameters of the private information within collectively held boundaries (Petronio & Caughlin, 2006). There are several issues individuals face when it comes to negotiating ownership over private information. First, the world has multiple privacy boundaries which sometimes makes it hard to know where one boundary ends and another begins (Petronio, 2002; Petronio & Reierson, 2009). Second, confidants are co-owners – however, the degree and level of ownership might vary (Petronio & Reierson, 2009). Privacy rules determine whether a confidant has limited partnership or full rights of ownership (Petronio & Caughlin, 2006). A confidant can either be a *shareholder* or a *stakeholder*. A shareholder is a confidant who has knowledge of private information because they have been given access by the owner (Petronio & Reierson, 2009); they reside within the newly formed collectively held boundary (Petronio & Caughlin, 2006). Stakeholders are confidants who are perceived to be worthy of some access, but serve as a functional role (i.e., providing the original owner with a needed outcome) (Petronio & Reierson, 2009). For example, when an individual discloses their mental illness to a close friend, they may become a stakeholder because the disclosure served to provide emotional support or relieve stress for the original owner. The close friend who has now

become a stakeholder is not a shareholder, because they do not reside in the newly formed collectively held privacy boundary and are not privy to new information that results from the disclosure.

Additionally, we can use the attributes of privacy rules to describe their properties (Petronio & Durham, 2015). When certain privacy rules work well for us, they can become routine; however, when privacy rules do not work, we can alter them to fit our needs (Petronio & Durham, 2015). For instance, the notion of gossip can be very threatening in the instance of disclosure. When someone discloses private information to an someone in confidence, and that individual repeats the information against their wishes, they may decide to not disclose information to that person again (Petronio & Durham, 2015). The notion of gossip can violate how a person wants to manage private information (Petronio & Durham, 2015). Once an individual discovers that their confidence has been violated, they are likely to change the rules and conceal information from that person in the future (Petronio & Durham, 2015). For this thesis, internalized stigmas may be very threatening in the instance of disclosure. When an individual is disclosing their mental illness to a close friend in confidence, but the individual struggles with internalized stigma and fears their close friend holds collectively held stigmas towards mental illness, they may create specific privacy rules about how they want to manage their private information relating to their mental illness in their communication with that close friend.

In some instances, an individual may want to reveal private information to a friend to develop a deeper relationship (Petronio, 2002). However, when there is high risk associated with disclosure, an individual may risk carrying their vulnerabilities even

though disclosure would relieve feelings of discomfort (Petronio, 2002). The disclosure risk associated with disclosing a mental illness to a close friend can be considered high due to the attached stigma and internalized stigma. However, to deepen a friendship, an individual may disclose their mental illness and may choose to make strict privacy rules. For example, an individual may make rules regarding how much their close friend has a right to tell people they *know* and *do not know* about their mental illness. Additionally, this is where an individual determines whether they view their close friend as a *co-owner* following disclosure. As stated earlier, when a disclosure is made, the other individual is made a confidant (Petronio, 2002); a confidant can either have full ownership or limited partnership over the disclosed information (Petronio & Caughlin, 2006). After exploring the literature on CPM and the three necessary operations for managing private information after it has been disclosed to close friends, the ways in which the other individual becomes a confidant following disclosure is examined.

Becoming a Confidant

There are two ways to become a confidant. First, an individual may serve as a confidant if they solicit someone else's private information (Petronio & Reierson, 2009). Second, individuals might find they are a recipient of a private disclosure – although reluctantly so (Petronio, 2002; Petronio & Reierson, 2009). For the most part, confidants believe they have a right to know another individual's private information (i.e., an individual pursues disclosure) (Petronio & Reierson, 2009). However, the original owner does not always willingly give their private information (Petronio & Reierson, 2009). As for reluctant confidants, receiving unwanted private information from another individual is sometimes a burden (Petronio & Reierson, 2009). For the most part, reluctant

confidants will try to maneuver through disclosure because of moral obligations (Petronio & Reierson, 2009). In some cases, one might find it necessary to reciprocate the disclosure (Petronio & Reierson, 2009). The focus of CPM is on the dialectical tension between privacy and disclosure. This dialectical tension acts as an obstacle for individuals during disclosure of private information. In addition, disclosure might result in an individual having to manage multiple privacy boundaries to ensure entrusted information is kept private. Next, implications from past research will be discussed.

Private Disclosure and CPM

Private disclosure has a tendency to result in the management of boundaries and explication of relational boundaries (Petronio, 2002). It is important to understand the idea of disclosing or concealing private personal information as a fundamental activity, which is essential to human interaction (Petronio, 2002). The decision to disclose information may be based on what an individual discloses in general to their partner (Petronio, 2002). It is also possible that as a relationship grows (i.e., becomes deeper and more disclosive), relational boundaries surrounding private information will grow and reflect shared intimacies (Petronio, 2002). The way an individual characterizes their relationship also plays apart in how boundaries are managed (i.e., connectedness, shared intimacies, relational definition, time, liking, reciprocity, and goals) (Petronio, 2002), which may reflect how disclosure is utilized in relational development. Before providing an understanding of how the interplay between internalized stigma and disclosure risk perception can effect intentions to disclose a mental illness and intentions to coordinate boundaries, it becomes crucial to understand implications from past research using CPM.

Research has examined the interplay between CPM and disclosure in the context of familial interaction, same-sex couples, and in health contexts (Petronio, 2002). Within the communication discipline, research using CPM to examine health privacy issues has become a growing area (Petronio, 2013). Specifically, CPM research relating to health privacy issues has analyzed choices about disclosure with stigma health-related illnesses (e.g., HIV/AIDS) (Petronio, 2013). Research has examined the interplay between CPM and disclosure in the context of familial interaction, same-sex couples, and in health contexts (Petronio, 2002). Additional research has examined disclosure with friends (Kennedy-Lightsey et al., 2012) and with the reluctant confidant (McBride & Bergen, 2008). Researchers have begun to examine CPM interpersonally in health settings. Their research is reviewed in the following paragraphs. This research has advanced CPM and is important to the current thesis as it relates to the disclosure of high-risk personal information (i.e., mental illness diagnosis/es).

Research has examined health-related disclosure in organizational settings (Steimel, 2021), in online communities (Herrman & Tenzek 2017) and with family members (Ngwenya et al., 2016). For example, Steimel (2021) findings extended upon past literature by examining CPM in an interpersonal and organizational setting. Steimel (2021) analyzed disclosure of pregnancy loss in the workplace (Steimel, 2021). Participants in the study described responses of avoidance and unwillingness to speak about pregnancy loss (Steimel, 2021). This finding indicates that when high-risk information is disclosed, confidants may be avoidant and unwilling to speak of the private information disclosed. Due to fear of responses of avoidance or unwillingness to speak about their diagnosis, an individual diagnosed with a mental illness may be more

likely to perceive risk associated with the act of disclosing their mental illness and be less likely to disclose their mental illness and coordinate boundaries.

Additional research has examined the moderating role emotional competence plays in revealing or concealing (Hesse & Rauscher, 2013). Specifically, by analyzing disclosure and privacy tendencies for individuals with Alexithymia (Hesse & Rauscher, 2013). Researchers found individuals who are more private and more concerned about what another individual might do with their private information to be more likely to conceal private information relating to emotional competence (Hesse & Rauscher, 2013). Individuals diagnosed with a mental illness may be more likely to be private and concerned about what other individuals will do with their private information once it has been disclosed, which could result in the concealment of their diagnosis/es. Researchers have also examined the decision to reveal/conceal eating disorders in online communities (Herrman & Tenzek 2017). Individuals with anorexia have a tendency use online communities in order to communicate with similar others (i.e., pro-ana communities), possibly as a direct result from neglect, uncertainty, and isolation felt from the physical environment (Herrman & Tenzek, 2017). Researchers have found that individuals with anorexia typically conceal their identity, being very strategic in deciding who, when, and how much information is disclosed (Herrman & Tenzek, 2017). This could potentially be the same for individuals diagnosed with a mental illness. Their results found that individuals feel they have personal ownership over their private information (Herrman & Tenzek 2017). In addition, they found individuals to believe they had the right to control whether their private information was distributed in online communities (Herrman & Tenzek 2017). It might be worth noting that this may be the same for individuals

diagnosed with a mental illness, due to the high degree of privacy their information holds and the invisibility of their mental illness diagnosis.

In academic settings, where students feel there is a low risk of disclosure, students resort to concealing their mental illness from their professor (Meluch & Starcher, 2020). This confirms CPM-based predictions based on the idea that individuals will envision the type of response that is received following a disclosure (Petronio, 2002; Meluch & Starcher, 2020). Even though disclosure in academic settings is seen as low risk, there may be individuals who envision the type of response they will receive following disclosure. It is quite possible that individuals diagnosed with a mental illness have internalized stigma, which may lead to envisioning the type of response one might get following disclosure. This may lead individuals diagnosed with a mental illness to conceal information from friends, rather than disclose information to friends.

Anderson and Agarwal (2001) analyzed general willingness to disclose personal health information, due to the digitalization of healthcare. Their results found that emotion played a pivotal role in personal health information disclosures (Anderson & Agarwal, 2001). Specifically, individuals who viewed their current health status negatively were more likely to disclose personal health information (Anderson & Agarwal, 2001). Their results also found disclosures of personal health information to be dependent on healthcare context (Anderson & Agarwal, 2001). These findings indicate that if an individual diagnosed with a mental illness has internalized stigma towards their mental illness (i.e., viewing their health status more negatively), they may be more likely to disclose personal health information. Researchers have also examined the management of private information and disclosure following a lung cancer diagnosis (Ngwenya et al.,

2016). The results of their study directly align with CPM principles. Individuals believed they owned information about their diagnosis (Ngwenya et al., 2016). Individuals believe they control the flow of that information and decide who has access to the information (Ngwenya et al., 2016). Lastly, individuals believed co-owners would abide by mutually agreed-upon privacy rules – but know boundary turbulence may occur (Ngwenya et al., 2016). This might speak directly to the management of private information and disclosure for individuals diagnosed with a mental illness. Individuals diagnosed with a mental illness may view their information to be more private and of higher risk to disclose.

Although there is an abundance of research analyzing CPM interpersonally in health contexts, there is a lack of research examining how individuals coordinate boundaries after disclosure of a mental illness with close friends. Research should examine the interplay of internalized stigma along with the disclosure risk perception associated with disclosure of a mental illness to close friends. It may be internalized stigma that influences intentions to disclose a mental illness to close friends among young adults, through disclosure risk perception. Additionally, there seems to be little research analyzing the effect internalized stigma may have on an individual's intention to disclose their mental illness to a close friend or the ways in which they coordinate boundaries. It is important to understand how individuals diagnosed with a mental illness manage private information relating to their mental illness diagnosis/es in the context of close friends. After reviewing the literature that helps to establish the primary hypotheses for the current study, it becomes crucial to state the purpose of the thesis.

Purpose of the Present Study

As shown above, researchers have tried to eliminate stigma and misconceptions surrounding mental illness. Additionally, researchers have examined stigma towards individuals diagnosed with a mental illness and the internalized stigma that can result (Corrigan et al., 2010; Mulfinger et al., 2018; Theurer et al., 2015). Implications from past research show that self-disclosures can aid in minimizing the negative effects of internalized stigma (e.g., decreases in self-efficacy and self-esteem) (Corrigan et al., 2010). Across disciplines, self-disclosure has been empirically researched. Within the self-disclosure literature, disclosure risk perception have been identified as a motivational criterion shown to motivate individuals to disclose private information to other individuals (Petronio, 2002). When examining self-disclosure, it is important to consider the effect internalized stigma has on an individual's evaluation of disclosure risk perception before the act of self-disclosure occurs.

Researchers have used Communication Privacy Management Theory (CPM) to examine the dialectical push and pull between privacy and confidentiality (Petronio & Reierson, 2009). There seems to be a lack of research analyzing the interplay between internalized stigma and self-disclosure. Additionally, little research examines how internalized stigma effects disclosure risk perception, which, in turn, effects intentions to disclose and intentions to coordinate boundaries. It is important to examine how internalized stigma effects disclosure risk perception which, in turn, may impact intentions to disclose a mental illness to close friends and coordination of boundaries among young adults. This may yield interesting results due to the degree of intimacy the relationship holds. To address this gap in research, the current thesis draws on CPM

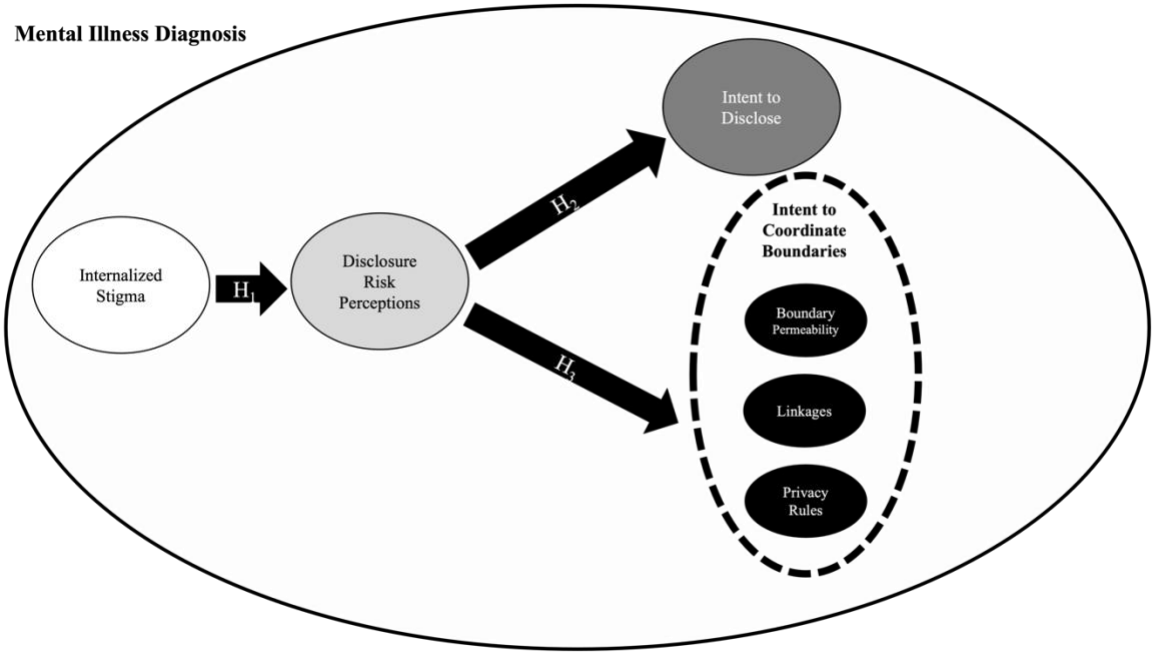
(Petronio, 2002; Petronio & Reierson, 2009) and proposes a causal process model (see Figure 1.1) predicting that internalized stigma effects disclosure risk perception, which, in turn, impacts a young adults' intentions to disclose their mental illness to close friends and intentions to coordinate boundaries.

Hypotheses

The current thesis uses a cross-sectional online survey research design to test the nine hypotheses (presented below). Using CPM (Petronio, 2002; Petronio & Reierson, 2009) the purpose of the current thesis is to examine an individual's intention to disclose their mental health diagnosis to close friends.

Figure 2.1

Hypothesized Model



The hypothesized model extends upon empirical evidence regarding CPM by predicting that internalized stigma effects disclosure risk perception, which, in turn, will

impact intentions to disclose a mental illness to close friends and intentions to coordinate boundary conditions among young adult.

Taken together, the literature review and the causal process model support the following hypotheses:

Internalized stigma positively predicts high degree of disclosure risk perceived by an individual before disclosure. If an individual has a higher amount of internalized stigma, they may perceive more risk before disclosure.

H_1: Internalized stigma is positively related to disclosure risk perception.

Disclosure risk perception may negatively predict an individual's intent to disclose their mental illness to close friends. When individuals perceive more disclosure risk, they will be less likely to disclose their mental illness to close friends.

H_2: Disclosure risk perception will be negatively related to intent to disclose.

Additionally, disclosure risk perception may positively predict an individual's intent to coordinate boundaries (i.e., coordinate privacy boundaries, establish linkages, and negotiate privacy rules) with close friends. When an individual perceives a high amount of disclosure risk, they may be more likely to coordinate boundaries with close friends.

H_{3a}: Disclosure risk perception will be positively related to intentions to coordinate boundary permeability.

H_{3b}: Disclosure risk perception will be positively related to intentions to establish linkages.

H_{3c}: Disclosure risk perception will be positively related to intentions to negotiate privacy rules.

It is possible that disclosure risk perception will mediate the effect of internalized stigma on an individual's intent to disclose their mental illness to close friends. Although hypothesis one predicts that internalized stigma positively predicts disclosure risk perception, when an individual perceives a low amount of risk internalized stigma will not affect disclosure to close friends.

H_4: The effect of internalized stigma on intent to disclose will be mediated by disclosure risk perception.

Lastly, hypothesis five predicts that disclosure risk perception will mediate the effect of internalized stigma on an individual's intent to coordinate boundaries with close friends (i.e., coordinate boundaries, establish linkages, and negotiate privacy rules). Although internalized stigma may positively predict disclosure risk perception, when low amounts of risk are perceived, internalized stigma will not affect intent to coordinate boundaries (i.e., coordinate privacy boundaries, establish linkages, and negotiate privacy rules).

H_{5a}: The effect of internalized stigma on intentions to coordinate boundaries will be mediated by disclosure risk perception.

H_{5b}: The effect of internalized stigma on intentions to establish linkages will be mediated by disclosure risk perception.

H_{5c}: The effect of internalized stigma on intentions to negotiate privacy rules will be mediated by disclosure risk perception.

Chapter 3: Methods

This thesis relies on a cross-sectional survey research design to address the research questions and hypotheses presented at the end of the previous chapter. In health and social sciences, one of the most frequently used methods of data collection is survey research because it allows researchers to provide accurate, credible, and precise measurement of the characteristics relating a population (Lane, in press). This methods chapter is organized into three sections as follows: (a) data cleaning, (b) participants, including subject selection, inclusion criteria, and results from an a priori power analysis, (c) instrumentation, and (d) procedures.

Data Cleaning

The current dataset was subject to data cleaning protocols to ensure accuracy and validity of results. To preserve the integrity of the data and account for extreme variation in student responses, data cleaning protocols were followed (Tabachnick & Fidell, 2019). Criteria for data cleaning included accuracy, outliers, and missing data.

First, descriptive statistics for the 293 students who received research credit for completing the survey were examined to screen for accuracy. Next, if participants took less than 5 minutes (n = 10) or more than 60 minutes (n = 5) they were removed from the dataset leaving a total of n = 278 participants. The final average completion time for participants was 12.60 minutes.

If participants were missing more than 80% of response on the predictor variable (i.e., disclosure risk perception) they were removed from the data set. A total number of n = 8 participants were missing more than 80% of responses on the main predictor variable

and were removed from the data set, leaving *n* = 269 (91.8%) cases to be analyzed. Descriptive statistics for all primary demographic variables are provided below.

Participants

The sample size consisted of *n* = 269 undergraduate college students (*n* = 149 female, *n* = 117 male, *n* = 1 intersex, and *n* = 2 preferred not to reply) currently attending a large public university in Southeastern United States. Participants were recruited using the College of Communication and Information SONA pooling system. Participants reported ages ranging from 18 – 25 years (*M* = 19.71, *SD* = 1.36). The majority of undergraduate college students participating in the study were freshman (51.7%), followed by sophomore (19.7%), junior (17.8%), and senior (10.8%). Participants identified their race as Caucasian (White) (82.2%), African American (5.9%), Asian (4.8%), Mixed (4.5%), and (2.5%) were Hispanic, Native Hawaiian or Pacific Islander, or did not provide a response.

Inclusion criteria required participants to be: (1) at least 18 years of age, (2) diagnosed with a mental illness by a medical professional, and (3) have a close friend with whom they have not disclosed their mental illness/es. Most frequently, participants reported having 3 or more mental illnesses (20.1%), followed by Anxiety and Depression (19.7%), Attention Deficit Hyperactivity Disorder (ADHD) (19.0%), Anxiety (18.6%), Depression (6.3%), Anxiety and ADHD (4.8%), Eating Disorder (3.3%), and ADHD and Depression (1.5%). These eight mental illnesses account for 93.3% of all mental illness's participants reported. Participants also reported when they were diagnosed with their most recent mental illness (ranging from 1 – 7 years ago; *M* = 2.99, *SD* = 1.83). In addition, participants reported severity of mental illness ranging from (1) *not at all severe*

to (5) *extremely severe* (*M* = 2.81, *SD* = 0.91). Finally, participants reported how severe the current symptoms they were experiencing associated with their mental illness on a scale from (0) *not currently experiencing any symptoms* to (5) *extremely severe* (*M* = 2.61, *SD* = 0.96)

Power Analysis

Before collecting data, an a priori power analysis using linear multiple regression with a fixed model and R^2 increase was conducted using G*Power 3.1.9.6 software. Considering the six variables in the regression model to predict intent to disclose and intent to coordinate boundaries (criterion variables), alpha was set at .05 and power at .95. The results of the power analysis were: for a medium effect size, $f^2 = .15$, F (2, 104) = 3.08, Noncentrality parameter $\lambda = 16.05$, minimum $n = 107$; and for a large effect size, $f^2 = .35$, F (2, 45) = 3.20, Noncentrality parameter $\lambda = 16.80$, minimum $n = 48$. Because a medium effect would require 153 participants and a large effect would require 70 participants, any sample with 200 participants should be sufficient to minimize a Type II error and test the hypotheses related to the multiple regression. Given that 41.2% of college students nationally have used mental health service providers (Elflein, 2020) and that 33.33% of U.S. young adults experienced a mental illness in the year 2020 (NAMI, 2020), and given that the data are being collected using an online survey, it is recommended that the recruitment sample be doubled ($n = 400$) to allow for deletion of cases that are missing, incomplete, or not honest.

Measures

Demographic Questions

At the beginning of the survey, participants read the informed consent form and were asked to indicate whether they consent to participate in the study. If participants respond 'no', they exited the survey. Next, participants were asked to provide information relating to the inclusion criteria. Participants were asked a question about their (1) age, (2) if they have been diagnosed with a mental illness by a medical professional, and (3) if all of their close friends know about their mental illness. Next, participants were also asked demographic questions about their sex, gender, race, and class rank which was used to describe the aggregate sample (See Appendix A).

Mental Illness Severity

Mental illness is a condition that can affect an individual's feeling, behavior, thinking, or mood (NAMI, 2021). One question was used to address the type of mental illness diagnosis each participant has been diagnosed with by a medical professional. Utilizing a list of common mental health conditions from the NAMI, participants will be asked if they have ever been diagnosed with one or more of the following: anxiety disorders, attention deficit hyperactivity disorder (ADHD), bipolar disorder, borderline personality disorder, depression, dissociative disorders, eating disorders, obsessive-compulsive disorder, posttraumatic stress disorder, psychosis, schizoaffective disorder, and/or schizophrenia (See Appendix A).

An additional item was added to understand the individual's perceived severity of their mental illness. The statement was rated on a 5-point Likert scale from (1) *not at all severe* to (5) *extremely serve* and is as follows: "I would say my mental illness is…".

Participants will also be asked to indicate how long ago they were diagnosed with a mental illness and if they are currently experiencing any symptoms associated with their diagnosis (See Appendix A).

Internalized Stigma

Self-stigma is conceptually defined as the process by which an individual internalizes the stigmas surrounding their mental illness (Corrigan et al., 2010). The construct can cause individuals to experience a loss of self-esteem and self-efficacy (Corrigan et al., 2010). Internalized stigma was measured using 8 questions from the ISMI-Scale (Ritsher et al., 2003) rated on a 4-point Likert-type scale (1 = *strongly disagree*, 4 = *strongly agree*). Examples of statements include, "I am embarrassed or ashamed that I have a mental illness", "I feel inferior to others who don't have a mental illness", and "Stereotypes about the mentally ill apply to me" (See Appendix A). The four items were subjected to an exploratory factor analysis (principal axis factoring with promax rotation) which yielded a one-factor solution and an Eigenvalue of 3.89, accounting for 41.57% of the variance (Carpenter, 2018). McDonald's omega for the scale was .85.

Disclosure Criteria

Disclosure Risk Perceptions. Disclosure risk perceptions are conceptualized by Petronio (2002) as the constant balancing of the risks and benefits associated with revealing personal private information to others. It is operationalized in the current thesis using 8-items from a modified version Disclosure Expectations Scale, where participants respond on a 5-point Likert scale (1 = *Not at all*, 5 = *Very*) (Vogel & Wester, 2003). The composite scale was subject to an exploratory factor analysis (principal axis factoring with promax rotation) which yielded a one-factor solution for four-items and an

Eigenvalue of 2.66, accounting for 55.68% of the variance. McDonald's omega for the scale was .83. The modified four-item scale had high reliability and was valid after removing four of the eight items. Examples of questions include: "How difficult would it be for you to disclose your mental illness to a close friend" and "How vulnerable would you feel if you disclosed your mental illness to your close friend for the first time" (See Appendix A).

Intent to Disclose

A disclosure is made when an individual communicates personal private information to another individual (Petronio, 2002). When an individual discloses private information to another person, that person is made the *confidant.* Intent to disclose was assessed using three statements rated on a 7-point Likert scale, where participants were required to indicate the degree to which they *strongly disagree* (1) to *strongly agree* (7) with each statement. Examples of the statements include: "I intend to disclose my mental illness to my close friend" and "I plan on disclosing my mental illness to my close friend" (See Appendix A).

An exploratory factor analysis (principal axis factoring with promax rotation) was conducted, which yielded a one-factor solution for two items which resulted in an Eigenvalue of 1.89, accounting for 88.99% of the variance. Cronbach's Alpha for the scale was .94.

Boundary Conditions

Once participants have indicated whether they intended to disclose their mental illness to close friends, they were be asked questions relating to their intentions to

coordinate boundary conditions necessary for managing private information after it has been disclosed.

Boundary Permeability. The management process of boundary permeability represents rule coordination relating to the extent collectively held privacy boundaries are opened/closed once formed (Petronio, 2002; Petronio & Reierson, 2009). Throughout this process, the confidant and original owner discuss how much access third parties should have to private information (Petronio & Reierson, 2009). Boundary permeability was measured using four modified statements based on a 5-point Likert scale derived from Kennedy-Lightsey and colleagues (2012) study exploring coordination and ownership between friends. For each statement, participants rated their level of agreement (1 = *strongly disagree*, 5 = *strongly agree*). The four items were subject to an exploratory factor analysis (principal axis factoring with promax rotation). The EPA yielded a one-factor solution and an Eigenvalue of 2.47, accounting for 48.14% of the variance. McDonald's omega for the scale was .78. Examples of the statements include the following: "I intend to tell with my close friend how I would feel if he/she told someone *I know* about my mental illness", "I intend to tell with my close friend how I would feel if he/she told someone *I don't know* about my mental illness", and "I intend to tell my close friend whom he/she *could* tell about my mental illness" (See Appendix A).

Linkages. When linkages are established, the confidant and original owner have mutually agreed-upon privacy rules that can be utilized to make decisions about other individuals who may be privy to the collectively held private information (Petronio & Reierson, 2009). Two-items from a modified version of the ownership scale (Kennedy-Lightsey et al., 2012) were utilized to assess linkages made between the individual and

their close friend. Participants rated their level of agreement towards each statement on a scale ranging from (1) *strongly disagree* to (5) *strongly agree*. The two items were subject to an exploratory factor analysis (principal axis factoring with promax rotation) which yielded a one-factor solution and an Eigenvalue of 1.65, accounting for 64.77% of the variance. Cronbach's Alpha for the scale was .79. The two statements are as follows: "I intend to tell my close friend how much they can tell someone *I know* about my mental illness" and "I intend to tell my close friend how much they can tell someone *I do not know* about my mental illness" (See Appendix A). Items from the scale had a good reliability ($\alpha = .63$) (Kennedy-Lightsey et al., 2012).

Privacy Rules. When individuals establish privacy rules, they are negotiating the degree and type of ownership they have over the collectively held private information (Petronio & Reierson, 2009). Privacy rules were measured utilizing a modified version of the three 5-point Likert scale measures derived from Kennedy-Lightsey and colleagues (2012) study exploring coordination and ownership between friends. Participants rated their level of agreement (1 = strongly disagree, 5 = strongly agree) on the following statements: (a) "I intend to tell my close friend if they have the right to tell someone I know about my mental illness" and (b) "I intend to tell my close friend if they have the right to tell someone I do not know about my mental illness" (See Appendix A). The three items from the scale were subject to an exploratory factor analysis (principal axis factoring with promax rotation) with only two items loading which yielded a one factor solution and an Eigenvalue of 1.72, accounting for 72.67% of the variance. Cronbach's Alpha for the scale was .84.

Procedures

As mentioned above, participants were recruited from a large public university in Southeastern United States using the College of Communication and Information SONA pooling system. Participants were asked to complete an online, self-administered survey via Qualtrics. Participation in the survey was voluntary. All participants were required to read an online consent form and then click to indicate consent has been given before participating in the survey. If participants did not agree to participate in the survey, they were thanked and exited the survey. Inclusion criteria required participants to be: (1) at least 18 years of age, (2) diagnosed with a mental illness by a medical professional, and (3) have a close friend with whom they have not disclosed their mental illness/es. If inclusion criteria were met, participants were allowed to complete the survey. However, subjects who did not meet inclusion criteria could not participate but were not penalized. As an incentive, students who participated received one research credit in a lower-division course in the College of Communication and Information. Participants were given twelve days to visit the link and complete the survey (April 15, 2022 – April 27, 2022). The survey took no more than 30 minutes to complete. There are no identifiable costs for subjects to participate, and subjects were assured that both privacy and confidentiality were protected. Additionally, this study posed no more risk than that experienced by the individual in everyday life. However, some of the questions may have been perceived as "sensitive" by some of the respondents. As a result, a list of mental health services was provided at the end of the survey. Students were allowed to take the survey using the link from their mobile device, a personal computer, or computers

provided at multiple locations on campus. The design for the current thesis was approved by Institutional Review Board for the sponsoring university (#76776).

The use of survey data allows for the largest number of participants to take part in the current study, due to the low cost, minimal time requirement, and easy accessibility. In addition, CPM has been empirically proven examined using qualitative studies. Although researchers have started approaching CPM quantitatively, there seems to be a lack of sufficient research analyzing the ways individuals manage personal private information from this standpoint. For theory to be falsifiable and parsimonious, it needs to be proven over time using qualitative and quantitative data. The addition of quantitative data results to the study of CPM literature may yield interesting results as to the ways individuals communicate personal private information to others. In addition, analyzing CPM using quantitative research increases our understanding of quantitative measurements that can be used to measure how individual's manage private information. It is important to test the constructs relating to boundary coordination using quantitative research to determine whether these three processes (i.e., boundary permeability, linkages, and privacy rules) are empirically distinct. Using quantitative research to test these constructs, in addition to qualitative research, could potentially help researchers understand whether people coordinate boundaries and make rules surrounding their privacy in general or based on these three distinct processes that have been identified by Petronio (2002). Although researchers frequently use qualitative research approaches when using Communication Privacy Management Theory, the current thesis employs a quantitative approach using a cross-sectional survey research design.

Participants first provided answers pertaining to the three inclusion criteria. Next, participants were asked to provide answers to several demographic questions (i.e., sex, race, and class rank). Additionally, participants were asked to answer questions relating to their mental illness and severity. Participants were also asked questions relating to internalized stigma. Then participants were prompted to think of one of a close friend with whom they have *not* disclosed their mental illness. Participants were given a textbox where they could type the first name or nickname of this person, and it was included throughout the rest of the survey. After this, questions pertaining to disclosure criteria (i.e., disclosure risk perception) were asked and participants indicated the degree to which they agreed or disagreed with each statement. Participants were also asked questions related to intent to disclose their mental illness to close friends. After questions relating to intent to disclose have been asked, questions pertaining to intent to coordinate boundary conditions (boundary permeability, linkages, and privacy rules) were asked (To view survey script, see Appendix A). The measures pertaining to the survey were detailed in the above section. Results are discussed in Chapter Four.

Chapter 4: Results

Hypotheses were tested using zero-order correlations and a series of mediation path analyses using Hayes' (2022) SPSS PROCESS 4.1 Macro (https://www.processmacro.org) . The results below are separated into two sections. Section one provides a summary of the relationships among variables and section two provides the detailed statistical focal analyses based on a series of mediation analyses.

Relationships Among Variables

Descriptive statistics and correlations for all study variables are provided in Table 4.1. As predicted, internalized stigma was negatively associated with intent to disclose and positively associated with each of the three CPM variables (permeability, linkages, and privacy rules). Disclosure risk perception was negatively associated with intent to disclose and positively related to permeability, linkages, and privacy rules.

Table 4.1

Descriptive Statistics and Zero-Order Correlations For All Study Variables (n = 269)

Variable	*M*	*SD*	Reliability	Range	1	2	3	4	5
1. Internalized Stigma	2.09	.56	ω = .85	1 – 4	—				
2. Disclosure Risk Perceptions	2.85	1.06	ω = .83	1 – 5	.44**	—			
3. Intent to Disclose	4.46	1.59	α = .94	1 – 7	-.11*	-.27**	—		
4. Boundary Permeability	3.55	.95	ω = .78	1 – 5	.19**	.16*	.09	—	
5. Linkages	3.52	1.07	α = .79	1 – 5	.16**	.13*	.18**	.76**	—
6. Privacy Rules	3.66	1.14	α = .84	1 – 5	.17**	.15*	.15**	.70**	.75**

Note. * $p<.05$; ** $p<.01$.

Focal Analyses

Hypotheses were tested using a series of mediation analyses via PROCESS treating stigma as the independent variable, disclosure risk perception as a mediator, and the four dependent variables as outcomes in separate analyses. See Figure 4.1 for the

path models and Table 4.2 for unstandardized coefficients and confidence intervals associated with all mediation analyses.

Figure 4.1

Path Diagram for Mediation Analyses

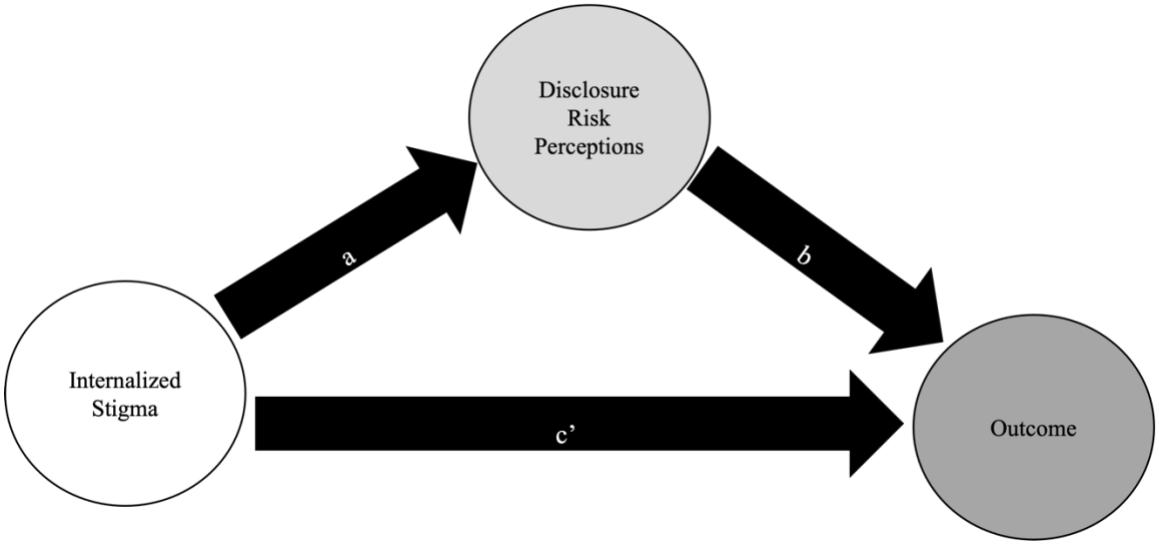


Table 4.2

Unstandardized Coefficients and Confidence Intervals Associated with Mediation Analyses using PROCESS 4.1 for SPSS

Outcome	a	b	Indirect (a*b)	Direct (c')	Total (c or a*b+c')
Intent to . . .					
disclose	.84 [.64, 1.05]*	-.41 [-.61, -.22]*	-.35 [-.55, -.16]*	.03 [-.34, .40]	-.31 [-.66, .03]
coordinate boundary permeability	.84 [.64, 1.05]*	.09 [-.03, .21]	.07 [-.03, .19]	.25 [.03, .48]*	.33 [.13, .53]*
establish linkages	.84 [.64, 1.05]*	.07 [-.06, .20]	.06 [-.06, .19]	.24 [-.01, .50]	.30 [.07, .53]*
negotiate privacy rules	.84 [.64, 1.05]*	.10 [-.04, .24]	.09 [-.05, .23]	.26 [-.01, .53]	.35 [.11, .59]*

*Note. All significant paths are denoted with a single asterisk**

Hypotheses 1-3c Results

Internalized stigma was positively related to disclosure risk perception (*b* =.84*). Thus, hypothesis one was supported. Consistent with the second hypothesis, disclosure risk perception was negatively related to intent to disclose after controlling for internalized stigma (*b* = -.41*). Contrary to H_{3a-c}, after controlling for internalized stigma, disclosure risk perception did not have a significant effect on intent to coordinate boundary permeability (*b* = .09), intent to establish linkages (*b* = .07), or intent to negotiate privacy rules (*b* = .10).

Mediation Results

Consistent with hypothesis four, the effect of internalized stigma on intent to disclose was mediated by disclosure risk perception (*b* = -.35). Thus, hypothesis four was supported. Contrary to H_{5a-c}, no significant mediation effects were revealed on any of the CPM dependent variables. The effect of internalized stigma on intent to coordinate boundary permeability was not mediated by disclosure risk perception (*b* = .07). Additionally, the effect of internalized stigma on intent to establish linkages was not mediated by disclosure risk perception (*b* = .06). Finally, the effect of internalized stigma on intent to negotiate privacy rules was not mediated by disclosure risk perception (*b* = .09). Thus, H_{5a-c} was not supported. There was, however, a significant direct effect of internalized stigma on boundary permeability (*b* = .25). Likewise, the total effect for intent to coordinate boundary permeability (*b* = .33), intent to establish linkages (*b* = .30), and intent to negotiate privacy rules (*b* = .35) were significant. The predicted model only holds true for intent to disclose and not for any of the three CPM dependent variables. Disclosure risk perception has no effect on any of the CPM variables after controlling for

internalized stigma. As such, internalized stigma is the key predictor of all CPM variables.

The results presented within this chapter provide the specific testing of each of the nine hypotheses. Chapter 5 provides an interpretation of the results and presents several important implications related to self-disclosure, mental illness, and internalized stigma. In addition, a discussion of limitations and future directions is provided.

Chapter 5: Discussion

The aim of the current thesis was to illustrate and extend upon empirical evidence regarding self-disclosure and CPM (Petronio & Reierson, 2009) by proposing that internalized stigma is an antecedent of disclosure risk perception. As previously discussed in Chapter 1, there seems to be a lack of research examining the interplay of internalized stigma and disclosure risk perception. Within self-disclosure literature, disclosure risk perception has been identified as a motivational criterion that can motivate individuals to disclose personal private information to other individuals. When examining self-disclosure, it is important to consider the effect internalized stigma may have on an individual's motivation to disclose information about their mental illness to close friends and coordinate boundary conditions. Research has shown that individuals diagnosed with a mental illness are more likely to be publicly stigmatized by society. Additionally, research has shown that individuals diagnosed with a mental illness are more likely to face identity threats due to internalization of stigma towards mental illness (Corrigan et al., 2010). When an individual faces an identity threat, there may be more disclosure risk perceived with the act of disclosing their mental illness. Thus, internalized stigma may affect disclosure risk perception which, in turn, effects a young adult's intent to disclose their mental illness and intentions to coordinate boundaries with close friends. Chapter 5 provides an overview and exploration into the implications of the results, limitations (associated with external and internal validity), and future directions for the current thesis.

Implications

The current thesis revealed that internalized stigma is positively related to disclosure risk perception. This relates to Petronio's (2002) idea of stigma risks influencing perception of risks. As previously mentioned, individuals may face stigma risks, which are specific to self-identity (Petronio, 2002). When an individual faces stigma risks, they may fear they could be discredited or cast in a disparaging light by others who may be friends (Petronio, 2002). In the context of disclosing a mental illness to close friends, internalized stigma negatively effects the evaluation of disclosure risk perception among young adults because they may fear they could be discredited or cast into a disparaging light by close friends. In addition, after controlling for internalized stigma, disclosure risk perception was found to negatively predict intentions to disclose. This may be due to disclosure of a mental illness diagnosis to close friends being classified as a high-risk episode (i.e., encounters that may cause severe embarrassment, threat, and/or shame) and stigma risks (i.e., internalized stigma) negatively influencing disclosure risk perception (Petronio, 2002). When there is high disclosure risk associated with disclosure, due to internalized stigma, young adults diagnosed with a mental illness are less likely to disclose their mental illness to close friends.

The results from the current thesis align with past studies examining CPM and self-disclosure/concealment. Hesse and Rauscher (2013) found that individuals who are more private and more concerned about what another individual might do with their private information to be more likely to conceal private information relating to emotional competence. In the current thesis, young adults diagnosed with a mental illness perceived

more disclosure risk due to internalized stigma. As a result, disclosure risk perception was negatively related to disclose a mental illness to close friends.

In contrast, evaluation of disclosure risk perception was positively related to intentions to coordinate boundaries (i.e., boundary permeability, linkages, and privacy rules). Based on the degree of disclosure risk an individual perceives, boundaries are coordinated differently (Petronio & Reierson, 2009). An individual may not be very concerned with who knows about their diagnosis and coordinate thin boundaries (Petronio & Reierson, 2009). However, an individual may be very concerned with who knows about their mental illness and coordinate thick boundaries (Petronio & Reierson, 2009). Disclosure risk perceptions is positively related to intentions to coordinate boundary permeability, after controlling for internalized stigma. Linkages are made and private information does not remain personal; but instead, is collectively held (Petronio & Caughlin, 2006). Once an individual discloses personal private information, the next step to make linkages. This is where information becomes collectively held. After controlling for internalized stigma, disclosure risk is positively related to predicted intentions to establish linkages.

In some instances, an individual may want to reveal private information to a friend to develop a deeper relationship (Petronio, 2002). However, when there is high risk associated with disclosure, an individual may risk carrying their vulnerabilities even though disclosure would relieve feelings of discomfort (Petronio, 2002). The disclosure risk associated with disclosing a mental illness to a close friend can be considered high due to the attached internalized stigma. However, to deepen a friendship, an individual may disclose their mental illness and may choose to make strict privacy rules. For

example, an individual may make rules regarding how much their close friend has a right to tell people they *know* and *do not know* about their mental illness. In the current thesis, disclosure risk perception was positively related to intentions to negotiate privacy rules.

Results from past research examining the management of private information and disclosure following a lung diagnosis indicate that individuals believe they own information about their diagnosis, individuals believe they control the flow of their information and decide who has access to that information, and individuals believed co-owners would abide by mutually agreed-upon privacy rules (Ngwenya et al., 2016). In addition, the above results directly align with CPM principles and the results from the current thesis. Young adults diagnosed with a mental illness were more likely to believe they owned information about their diagnosis (i.e., linkages), controlled the flow of their private information and decided who had access to that information (i.e., boundary permeability), and believe that co-owners would abide to mutually agreed upon privacy rules (i.e., privacy rules). Thus, disclosure risk perception was positively related to intentions to coordinate boundary conditions (i.e., establish linkages, coordinate boundary permeability, and negotiate privacy rules).

Importantly, the effect of internalized stigma on intent to disclose is mediated by disclosure risk perception. As previously discussed, internalized stigma can cause young adults to experience a loss of self-esteem, self-efficacy, and limits prospects of recovery (e.g., can undermine pursuit of goals related to independent living) (Watson et al., 2007; Corrigan et al., 2010). When stigma is internalized, young adults experience an identity threat as a direct result of the harm that occurs when an individual's sense of self is challenged by association with a stigmatized group (Corrigan et al., 2013). Remember,

each time an individual judges the act of self-disclosure, they calculate the risks against the benefits to judge whether they should reveal or conceal information (Petronio & Durham, 2015). Identity threats and the negative consequences from internalized stigma may be causing young adults to categorize self-disclosure of their mental illness as a *high-risk episode.*

A high-risk episode is when disclosure is perceived as highly risky. These episodes can involve encounters that may cause severe embarrassment, threat, and/or shame (Petronio, 2002). Within a high-risk episode, an individual may be facing stigma risk, which are specific to self-identity and can cause an individual to fear they may be discredited or cast in a disparaging light by others who may be friends (Petronio, 2002). This is important in the context of self-disclosure to close friends, due to the degree of intimacy relating to the information disclosed (Samter, 2003). Self-disclosure of a mental illness to close friends among young adults is categorized as a high-risk episode, where young adults face internalized stigma and identity threats. Internalized stigma is influencing the high degree of disclosure risk perception associated with self-disclosure of a mental illness among young adults. Interestingly, it is internalized stigma that influences a young adult's decision to conceal or disclose their mental illness to close friends.

Internalized stigma is influencing intentions to disclose through disclosure risk perceptions. This finding is crucial as it adds to the current literature using Communication Privacy Management to examine self-disclosure. Specifically, internalized stigma has been identified as an antecedent to risk perceptions, which, in turn, impacts intentions to disclose a mental illness to close friends among young adults.

Internalized stigma is the main predictor influencing intent to disclose a mental illness to close friends. There is more risk associated with disclosure, due to internalized stigma. When there is higher risk, close friends should provide social support to mitigate the risks associated with disclosure. Little research has been conducted examining reducing the risks associated with disclosure of a mental illness. However, close friends may play a key factor in reducing the risks associated with disclosure. If a young adult has high levels of internalized stigma, this negatively impacts their disclosure risk perceptions and lowers their intentions to disclose. Close friends who provide social support may play a crucial role in mitigating the risks associated with disclosure. Close friends can be empathetic, provide support and a listening ear, and be understanding and ask questions to young adults diagnosed with a mental illness.

Additionally, the context of disclosure of a mental illness to a close friend is important due to the nature of the friendship. This may be the first person with whom a young adult has disclosed their mental illness. This may start a conversation relating to mental health or encourage help-seeking behaviors. Moreover, this may even start a domino-effect of disclosures to family, other friends, and mental health professionals. It would be interesting to see the ways close friends may provide social support to try and mitigate the risks associated with disclosure of a mental illness. With an understanding of the most substantive implications, we move to a discussion of the limitations.

Limitations

Great care was taken throughout the data collection process to ensure that potential threats were minimized. As with any study, however, this thesis is not without limitations.

The first set of limitations is associated with the timing and data collection using undergraduate students who were required to complete an online Qualtrics survey for course credit. Data were collected during the last two weeks of the Spring 2022 semester (April 15, 2022 – April 27, 2022). Given that undergraduate students are preoccupied with other demands on their time (e.g., writing final papers and completing assignments) at this time of the semester, there is a likelihood that they may not have taken the survey seriously. This is evidenced by the 46% of responses (n = 251) that needed to be removed from the sample due to missing data. Additionally, the SONA recruitment portal closed all studies on April 27th at 4:00 p.m. Due to the timing in the semester, students were likely under stress to complete their research credit before the deadline. As a result, the average final completion time for the survey was only 12.60 minutes. The lack of attention could have adversely impacted participant responses to the survey.

The next set of limitations are associated with the analysis of the final data. The sample was large enough to meet the conditions established by the a priori power analysis, but the final sample did not meet the absolute criteria for normality—at least not according to the significant Kolmogrov-Smirnov (K-S) statistic for each of the linear regression hypotheses. Because the K-S test was significant, there is concern that the assumption of normality was violated. However, according to Tabachnick and Fidell (2017), this is quite common in larger samples and they recommend using histograms

instead of the K-S statistic to assess normality. Careful inspection of (1) the actual shape of the distributions in the histograms, (2) the normal probability plots (e.g., the Normal Q-Q plot—where a reasonably straight line suggests a normal distribution), and (3) the boxplot distribution scores suggested that the data were appropriate for multiple regression analyses. Likewise, when outliers were revealed using z-scores (+/- 3.29) and Mahalonobis distance statistics, the outliers were removed from the associated analyses.

One of the most important limitations is associated with the variables contained in the model that was tested. While internalized stigma was the focus of the current study and it accounted from almost 20% of the variance in disclosure risk perception, it accounted for less than 8% of the variance in intent to disclose. There are likely other variables that need to be considered to improve the predictive ability of the model. Likewise, only one of the mediations was significant (internalized stigma through disclosure risk perception on intent to disclose). The effect of internalized stigma on intentions to coordinate boundaries (coordinate boundary permeability, establish linkages, and negotiate privacy rules) was not mediated by disclosure risk perception. This may be because boundary conditions were tested after disclosure risk perception. As proposed by Petronio (2002), coordination of boundaries occurs following a disclosure. The current thesis did not test coordination of boundaries following a disclosure.

An additional limitation associated with the current thesis is that data was collected during the COVID-19 pandemic. As previously discussed, the COVID-19 pandemic is one of the biggest contributors to the rise in mental health issues among young adults (Brülhart et al., 2021; Hussong et al., 2021; NAMI, 2020; Reppas-Ringlisbacher et al., 2020). As a result, social distancing guidelines and mask mandates

were still in place on the campus where the survey took place. It is important to note that there is high risk associated with quarantine, isolation, and social distancing procedures for COVID-19 (Hwang, T-J et al., 2020). Crucial to understand is that this high risk may be disproportionately amplified for individuals diagnosed with pre-existing mental illnesses because they often suffer from loneliness and social isolation prior to enhanced distancing from others imposed by the COVID-19 pandemic public health protocols (Hwang, T-J et al., 2020). As a result of the COVID-19 pandemic, there may have been an increase in young adults struggling with mental illnesses. There may have also been an increase in the severity of a young adult's mental illness due to the increases in social isolation and loneliness as a direct result of the COVID-19 pandemic.

The fifth limitation relates to the scale used for internalized stigma. Internalized stigma was measured using 8 questions from the ISMI-Scale (Ritsher et al., 2003) where participants rated statements on a 4-point Likert-type scale (1 = *strongly disagree*, 4 = *strongly agree*). Although the current thesis used an existing scale with items and pre-established response categories, one limitation relates to the use of a 4-point Likert-type scale. When an even number of response categories are used, participants are forced to agree or disagree with the statements because they are not provided with a middle or neutral option.

One final limitation is associated with external validity. The results are interesting and help us to understand how interpersonal theories like CPM can be modified to explores specific contexts (mental illness). However, caution must be exercised not to attempt to generalize the findings to all undergraduate students across institutions. We can be reasonably confident that our results can be applied to other first and second year

students attending classes at the same institution where data were collected. After providing details relating to the limitations of the current thesis and the resulting implications of each, it is important to provide a discussion of future directions for research.

Future Research

Although the current thesis found that the effect of internalized stigma on intent to disclose is mediated by disclosure risk perception, the effect of internalized stigma on intentions to coordinate boundaries (i.e., coordinate boundary permeability, negotiate linkages, and establish privacy rules) was not mediated by risk perceptions. Future research should analyze these constructs sequentially. It would be interesting to see if internalized stigma impacts intentions to coordinate boundaries via disclosure risk perception and intent to disclose a mental illness. Internalized stigma may be affecting disclosure risk perception, which, in turn, may impact intentions to disclose, thus effecting an individual's intentions to coordinate boundaries.

Additionally, the most apparent diagnosis among young adults was that of three or more mental illnesses. Future directions for research are to examine the differences in self-disclosure among young adults diagnosed with a non-serious mental illness and young adults diagnosed with a serious mental illness (SMI). Each participant reported a specific mental illness, but no attempt was made to analyze any of the results using mental illness type. Analyzing these group differences may provide fruitful results, and by figuring out how young adults diagnosed with an SMI disclose their mental illness, it may aid in the implementation and continuation of treatment. Additionally, analyzing the group differences based on gender may provide fruitful results. It may be young women

diagnosed with a mental illness that are more likely to disclose their mental illness as compared to young males.

Future research should also analyze other predictors of self-disclosure. Although the current thesis identified disclosure risk perception as a predictor of self-disclosure, there is other disclosure criteria that may be influencing an individual's decision to disclose or conceal their mental illness. Researchers have identified connectedness, shared intimacies, relational definition, time, liking, reciprocity, motivation, and goals as other factors utilized by individual's when evaluating disclosure (Petronio, 2002; Petronio & Durham, 2015). Although, motivation, reciprocity, and liking may be the most influential disclosure criteria. Motivations have been noted to impact an individual's decision to reveal or conceal private information (Petronio & Durham, 2015). Some individuals may be motivated to seek the opportunity to express their feelings whereas other individuals may find a greater need to wear a mask in conversations (Petronio, 2002). An individual may be motivated to protect oneself from potential stigmatization (i.e., stigma risks) and make the decision to conceal information (Meluch & Starcher, 2020; Petronio, 2002). But an individual may also need self-clarification and disclosure could help them achieve this (Petronio, 2002). Motivational criteria may be an important aspect in determining if an individual chooses to conceal or reveal personal private information because motivation determines an individual's intentions to disclose their mental illness to close friends.

In the context of self-disclosure, reciprocity functions as a motivation that increases rewards and decreases costs for disclosers (Petronio, 2002). By disclosing personal private information to another individual, the individual hopes their disclosure

will be reciprocated. If this disclosure is reciprocated, it can regulate feelings of obligation relieve any indebtedness that is felt from being selected the recipient of the disclosure (Petronio, 2002). Collins and Miller (1994) found that liking others leads individuals to disclose more to them. One plausible explanation for the effect liking has on disclosure was the concept of reciprocity. Collins and Miller (1994) found that individuals may choose to disclose personal private information to others in hopes that their disclosure is reciprocated. Although reciprocity can only be understood as one plausible explanation for the effect liking has on disclosure, it is important to understand that reciprocity should be considered its own individual criterion in the context of disclosure.

It is essential for researchers to examine the ways in which liking may function to motivate individuals to disclose personal private information to others. For example, if an individual likes another individual, they may be more willing to disclose personal private information to that individual (Petronio, 2002). Liking functions as a motivational factor empirically, but is theoretically linked to disclosure (Petronio, 2002). Essential to understand is that people will disclose more to those who are liked, but the nature of revealing may be based on the relationship (Petronio, 2002). Importantly, liking does not always lead to disclosure; however, if two individuals like one another disclosure is more likely to occur (Petronio, 2002). Future research should analyze these three predictors (i.e., motivation, reciprocity, and liking) to self-disclosure, along with disclosure risk perception. It would also be interesting to see if these predictors are influencing the coordination of boundaries through intentions to disclose.

As previously discussed, catalyst criteria influences changes to privacy rules. For example, in the instance of close friendships, a catalyst criteria may be if the dynamic of the friendship changed. For instance, if a third or fourth friend was added to the dyad. If this were the case, a young adult diagnosed with a mental illness may need to change privacy rules by sharing information with additional close friends in the dynamic of friends. It is important for future research to analyze how young adults coordinate boundaries when additional friends are added to the dyad. Additionally, future research should examine a young adult may coordinate boundaries differently if someone of the opposite sex is added to the dyad of friends.

Future research should analyze male and female close friendship dyads to explore whether their disclosures of a mental illness differ from disclosures in same-sex friendships. It would be interesting to see how females disclose to males, and vise versa. Additionally, it is important to explore how these disclosures differ from disclosures in same-sex close friendships. These disclosures may differ due to the traditional gender norms that dictate how girls and boys should act as young adults (Hellström & Beckman, 2021). For males, these gender norms advocate a *macho culture* among young adults (Hellström & Beckman, 2021). On the other hand, girls are encouraged to – if not allowed to – be more sensitive (Hellström & Beckman, 2021). In the context of mental health, it was perceived as more acceptable for girls to talk about mental health problems than for boys (Hellström & Beckman, 2021). Additionally, boys were found to be good at hiding their mental health problems (Hellström & Beckman, 2021). This may mean that male young adults may be less willing to speak about mental health issues than female young adults. It would be interesting for future research to examine gender-differences.

Future research should also examine the three constructs relating to boundary coordination (i.e., coordinating boundary permeability, establishing linkages, negotiating privacy rules. By looking at the correlation matrix, one can see that these constructs are highly correlated. Future research needs to analyze these three constructs to determine if they are empirically distinct. The use of mixed-methods research may be helpful in examining these constructs to determine if they are interrelated. Although the majority of CPM research is qualitative, it is important to utilize quantitative research to help researchers understand whether people coordinate boundaries and make rules surrounding their privacy in general or based on these three distinct processes that have been identified by Petronio (2002). If these three constructs are interrelated, future research needs to identify these as such.

Finally, future research should identify the antecedents to the predictors of intentions to disclose. The current thesis has identified internalized stigma as an antecedent of disclosure risk perception. However, there may be additional antecedents to disclosure risk perception. Additionally, the antecedents to the other predictors of intention to disclose (i.e., liking, reciprocity, and motivation) should be identified as well. Once these antecedents and predictors have been identified, the act of self-disclosure can be fully evaluated in the context of disclosing a mental illness to close friends. This model could then be tested in different contexts to see if it predicts intentions to disclose a mental illness across a wide variety of relationships. If disclosure risk perception mediates the effect internalized stigma has on intentions to disclose with close friends, this may be the case with family members, psychiatrists/therapists, and significant others. Remember, implications from past research show that self-disclosures can aid in

minimizing the negative effects of internalized stigma (e.g., decreases in self-efficacy and self-esteem) (Corrigan et al., 2010). By understanding how young adults diagnosed with a mental illness disclose their mental illness in a wide variety of contexts, we could aid in the implementation and continuation of treatment. By using these future directions, researchers can continue to understand how internalized stigma effects disclosure risk perception, which, in turn, may affect intentions to disclose in a wide variety of contexts.

Conclusion

Within self-disclosure literature, disclosure risk perception have been identified as a motivational criterion shown that motivates individuals to disclose personal private information to other individuals. When examining self-disclosure, it is important to consider the effect internalized stigma may have on an individual's motivation to disclose information about their mental illness to close friends and coordinate boundary conditions. Research has shown that individuals diagnosed with a mental illness are more likely to be publicly stigmatized by society. Additionally, research has shown that individuals diagnosed with a mental illness are more likely to face identity threats due to internalization of stigma towards mental illness (Corrigan et al., 2010). When an individual faces an identity threat, there may be more risk perceived with the act of disclosing their mental illness. The current thesis revealed that internalized stigma is positively related to disclosure risk perception. This relates to Petronio's (2002) idea of stigma risks influencing perception of risks. When there is high risk associated with disclosure, due to internalized stigma, young adults diagnosed with a mental illness are less likely to disclose their mental illness to close friends. Interestingly, it is internalized stigma that influences a young adult's decision to conceal or disclose their mental illness

to close friends. Internalized stigma is influencing intentions to disclose through disclosure risk perception. This finding is crucial as it adds to the current literature using Communication Privacy Management to examine self-disclosure. Specifically, internalized stigma has been identified as an antecedent to disclosure risk perception, which, in turn, impacts intentions to disclose a mental illness to close friends among young adults.

Within self-disclosure literature, disclosure risk perception have been identified as a motivational criterion empirically shown to motivate individuals to disclose or conceal personal private information to other individuals. When examining self-disclosure, it is important to consider the effect internalized stigma may have on an individual's evaluation of disclosure risk perception, motivation to disclose information about their mental illness to close friends, and intentions to coordinate boundary conditions (i.e., coordinate boundary permeability, establish linkages, and negotiate privacy rules). Research has shown that individuals diagnosed with a mental illness are more likely to be publicly stigmatized against by society. Additionally, research has shown that public stigma can be internalized and cause individuals to experience a loss of self-esteem, self-efficacy, and limit prospects of recovery (e.g., can undermine pursuit of goals related to independent living) (Watson et al., 2007; Corrigan et al., 2010).

Research has shown that individuals diagnosed with a mental illness are more likely to face identity threats due to internalization of stigma (Corrigan et al., 2010). When an individual faces an identity threat, there may be more risk perceived with the act of disclosing their mental illness. Findings from the current thesis relate to Petronio's (2002) idea of stigma risks influencing disclosure risk perception; internalized stigma

was positively related to disclosure risk perception. More importantly, when there is high risk associated with disclosure, due to internalized stigma, young adults diagnosed with a mental illness are less likely to disclose their mental illness to close friends. Interestingly, it is internalized stigma that influences a young adult's decision to conceal or disclose their mental illness to close friends. Internalized stigma is influencing intentions to disclose through disclosure risk perception. This finding is crucial as it adds to the current literature using Communication Privacy Management to examine self-disclosure. Specifically, internalized stigma has been identified as an antecedent to disclosure risk perception, which, in turn, impacts intentions to disclose a mental illness to close friends among young adults.

APPENDIX A

Qualtrics Online Survey Consent and Questions

Participant Consent
INTRODUCTION

Thank you for participating in the Mental Illness Disclosure Study. This study evaluates your intention to disclose your mental illness/es to a close friend and the rules you would make following a disclosure. Stigmas surrounding mental illness will also be examined.

WHY ARE YOU BEING INVITED TO TAKE PART IN THIS RESEARCH?

You are being invited to take part in a research study about your intentions to disclose a mental illness to a close friend and the rules that would be made following such a disclosure. You are being invited to take part in this research study given you are at least 18 years of age and have been diagnosed with a mental illness by a medical professional (e.g., anxiety disorders, attention deficit hyperactivity disorder (ADHD), bipolar disorder, borderline personality disorder, depression, dissociative disorders, eating disorders, obsessive-compulsive disorder, posttraumatic stress disorder, psychosis, schizoaffective disorder, and/or schizophrenia), and have a close friend with whom you have NOT disclosed your mental illness/es. For the purposes of this study, a close friend is different from a casual friend or an acquaintance. A close friend is a person with whom you are emotionally attached, with whom you spend time regularly, and is someone you feel comfortable reaching out to if you need help. If you volunteer to take part in this study, you will be one of about 400 people to do so.

WHO IS DOING THE STUDY?

The person in charge of this study is Paige Von Feldt (pavo222@g.uky.edu), an M. A. student in the Department of Communication at the University of Kentucky. She is being guided in this research by Dr. Derek Lane (derek.lane@uky.edu). There may be other people on the research team assisting at different times during the study.

WHAT IS THE PURPOSE OF THE STUDY?

The purpose of this study is to learn more about an individual's intention to disclose their mental illness/es to a close friend, and the rules that would be made following such a disclosure. Also, I hope to learn more about the stigmas surrounding mental illness.

ARE THERE REASONS WHY YOU SHOULD NOT TAKE PART IN THIS STUDY?

Participation in this research study is completely voluntary. You will have the right to withdraw at any time or refuse to participate entirely without jeopardy to your academic status, GPA, or standing with the university. If you desire to withdraw, please close your

internet browser and the survey will be ended. The only inclusion criteria for this study requires you to be: (1) at least 18 years of age, (2) diagnosed with a mental illness by a medical professional, and (3) to have a close friend with whom you have not disclosed your mental illness/es. If inclusion criteria is met, participants are allowed to complete the study.

WHERE IS THE STUDY GOING TO TAKE PLACE AND HOW LONG WILL IT LAST?

The study will be conducted online via the Qualtrics survey platform. Participants will be provided with a link to complete the survey. The survey will take no longer than 30 minutes to complete. Please note: One 30-minute research study is 1 CI SONA research credit.

WHAT WILL YOU BE ASKED TO DO?

As part of this study, you will be asked to complete a brief survey which includes questions relating to your mental illness/es, intention to disclose, and the rules you would make following a disclosure. Additional questions will be asked to try and understand stigma surrounding mental illness.

WHAT ARE THE POSSIBLE RISKS AND DISCOMFORTS?

This study should pose no more risk than that experienced by the individual in everyday life. The researcher does not expect participants to encounter any kind of physical, psychological, social, or legal risks. However, some of the questions may be perceived as "sensitive" by the respondents. The researchers will provide you with a list of mental health services at the end of the survey.

WILL YOU BENEFIT FROM TAKING PART IN THIS STUDY?

There is no guarantee that you will get any benefit from taking part in this study. Your willingness to participate, however, may in the future help society better understand this research topic.

DO YOU HAVE TO TAKE PART IN THE STUDY?

If you decide to take part in the study, it should be completely voluntary. You will not lose any benefits or rights you would normally have if you chose not to volunteer. You can also stop at any time during the study and will keep the benefits and rights you had before volunteering. As a student enrolled in a lower-division course in the College of Communication and Information, you are provided the option to participate in research studies or alternative assignments in order to earn TWO research credits, which is equal to 4% of your grade (TWO credits worth 2% each). If you only complete one of the required credits, you will earn half of the points. If you complete two required credits, you will earn the full points. Please note: One 30-minute CI SONA research study is

worth 1 credit. If you decide to not take part in the study, you will be offered an alternative assignment. Alternative assignments are listed along with actual studies on the CI SONA website. Please note: The Alternative assignment is a written assignment.

IF YOU DON'T WANT TO TAKE PART IN THE STUDY, ARE THERE OTHER CHOICES?

This study is completely voluntary. If you do not wish to take part in this study, please close your internet browser and the survey will be ended. As a student enrolled in a lower-division course in the College of Communication and Information, you are provided the option to participate in research studies or alternative assignments in order to earn TWO research credits, which is equal to 4% of your grade (TWO credits worth 2% each). If you only complete one of the required credits, you will earn half of the points. If you complete two required credits, you will earn the full points. Please note: One 30-minute CI SONA research study is worth 1 credit. If you decide to not take part in the study, you will be offered an alternative assignment. Alternative assignments are listed along with actual studies on the CI SONA website. Please note: The Alternative assignment is a written assignment.

WHAT WILL IT COST YOU TO PARTICIPATE?

There are no costs associated with participating in this study.

WILL YOU RECEIVE ANY REWARDS FOR TAKING PART IN THIS STUDY?

You will not receive any rewards for taking part in this study. However, as a student enrolled in a lower-division course in the College of Communication and Information, you are provided the option to participate in research studies or alternative assignments in order to earn TWO research credits, which is equal to 4% of your grade (TWO credits worth 2% each). If you only complete one of the required credits, you will earn half of the points. If you complete two required credits, you will earn the full points. Please note: One 30-minute CI SONA research study is worth 1 credit. If you decide to not take part in the study, you will be offered an alternative assignment. Alternative assignments are listed along with actual studies on the CI SONA website. Please note: The Alternative assignment is a written assignment.

WHO WILL SEE THE INFORMATION THAT YOU GIVE?

Your response to the survey is anonymous which means no names, IP addresses, email addresses, or any other identifiable information will be collected with the survey responses. If you chose to participate, we will not know which responses are yours.

Your research result information will be combined with information from other people taking part in the study.

No personal identifiable information will be collected as a part of this survey. Please be

aware, while we make every effort to safeguard your data once received from the online survey company, given the nature of online surveys, as with anything involving the Internet, we can never guarantee the confidentiality of the data while still on the survey/data gathering company's servers, or while in route to either them or us.

CAN YOUR TAKING PART IN THE STUDY END EARLY?

If you decide to take part in the study, you still have the right to decide at any time that you no longer want to continue. You will not be treated differently if you decide to stop taking part in the study. You may also skip a question if you are not comfortable answering.

The individuals conducting the study may need to withdraw you from the study. This may occur if you are not able to follow the directions they give you.

WHAT IF YOU HAVE QUESTIONS, SUGGESTIONS, CONCERNS, OR COMPLAINTS?

If you have any questions and do not feel comfortable asking the researcher, you may contact Dr. Derek Lane at derek.lane@uky.edu. If you have any questions about the study, please contact Paige Von Feldt at pavo222@g.uky.edu or 502-794-2246. If you have complaints, suggestions, or questions about your rights as a research volunteer, please contact the staff in the University of Kentucky Office of Research Integrity at 859-257-9428 or toll-free at 1-866-400-9428.

Thank you for your participation.

Sincerely,

Paige Von Feldt, M.A. Student
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Derek Lane, Ph.D.
Paige's Advisor Professor, College of Communication and Information
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235 Blazer Dining

1. I consent to participate in this study.
    - Yes
    - No

Inclusion Criteria Demographic Questions

Thank you for choosing to take part in this survey. In order to participate in the study, you must meet certain inclusion criteria. You will now be asked questions relating to your eligibility for the study. Your responses will be kept confidential.

1. What is your age?
    - Under 18
    - 19
    - 20
    - 21
    - 22
    - 23
    - 24
    - 25
    - 26
    - Other (please indicate)
2. Have you been diagnosed with a mental illness by a medical professional?
    - Yes
    - No
3. For the purpose of this study, a close friend is different from a casual friend or an acquaintance. A close friend is a person **you are emotionally attached to**, who **you spend time with regularly**, and is someone you **feel comfortable reaching out to** if you need help.

    Do <u>all</u> of your **<u>close friends</u>** know about your mental illness?
    - Yes
    - No

Demographic Questions

You will now be asked demographic questions. Please keep in mind that your responses will be kept confidential.

1. What was your sex assigned at birth?
    - Female
    - Intersex
    - Male
    - Not Listed (please indicate)
    - Prefer not to reply
2. What is your race
    - Caucasian (White)
    - African American
    - American Indian
    - Asian
    - Native Hawaiian or Pacific Islander
    - Other (please indicate)
3. What is your class rank?
    - Freshman
    - Sophomore

- Junior
- Senior
- Other (please indicate)

Mental Illness Severity
I am interested in the mental illness diagnosis/diagnoses you have been given.

You will now be asked questions about your mental illness diagnoses. For each question, **consider your diagnoses as a whole**.

Please answer each of the following questions and keep in mind that your responses will be kept confidential.

1. What mental illness/es have you been diagnosed with (select all that apply)?
    - Anxiety Disorder
    - Attention Deficit Hyperactivity Disorder (ADHD)
    - Bipolar Disorder
    - Borderline Personality Disorder
    - Depression
    - Dissociative Disorders
    - Eating Disorders
    - Psychosis
    - Schizoaffective Disorder
    - Other (please indicate)
2. Taken together, I would say that my mental illness/es is/are…
    - Not at all severe
    - Slightly severe
    - Moderately severe
    - Very severe
    - Extremely severe
3. How long ago was your **most recent** mental illness diagnosis?
    - Less than a year ago
    - 1 year ago
    - 2 years ago
    - 3 years ago
    - 4 years ago
    - 5 years ago
    - Other (please specify)
4. How severe are the current symptoms you are experiencing associated with your mental illness/es?
    - Not at all severe
    - Slightly severe
    - Moderately severe
    - Very severe
    - Extremely severe
    - Not currently experiencing any symptoms

Internalized Stigma of Mental Illness Inventory (ISMI Scale; Ritsher et al., 2003)
I am interested in **<u>your thoughts about mental illness.</u>**

For each of the following statements, please indicate the degree to which you agree or disagree in relation to how **<u>you feel</u>** about your mental illness diagnosis.

1	2	3	4
Strongly agree			*Strongly disagree*

1. I am embarrassed or ashamed that I have a mental illness/es.
2. I feel inferior to others who don't have a mental illness/es.
3. Stereotypes about the mentally ill apply to me.
4. I can't contribute anything to society because I have a mental illness/es.
5. Others think I can't achieve much in life because I have a mental illness/es.
6. Nobody would be interested in getting close to me because I have a mental illness/es.
7. I don't talk about myself much because I don't want to burden others with my mental illness/es.
8. Negative stereotypes about mental illness/es keep me isolated from the 'normal' world.

Disclosure Risk Perceptions (Disclosure Expectations Scale; Vogel & Wester, 2003)
Recall that for the purpose of this study, a **close friend** is different from a casual friend or an acquaintance.

A close friend is a person with whom you are **emotionally attached**, with whom you **spend time regularly**, and is someone you **feel comfortable reaching out to if you need help**.

For the next group of questions, please think of <u>one</u> of your **close friends** to whom you have **NOT DISCLOSED your mental illness** and **TYPE THEIR FIRST NAME OR NICKNAME** (or fake name to protect their privacy) **IN THE BOX BELOW:**

Great, thanks! Now, think of _____ for each of the following questions.

Please indicate the degree to which each statement influences your decision to disclose your mental illness/es to _____.

1	2	3	4	5
Not at all				*Very*

1. How difficult would it be for you to disclose your mental illness/es to _____?
2. How vulnerable would you feel if you disclosed your mental illness/es to _____ for the first time?
3. How risky would it feel to disclose your mental illness/es to _____?

4. How worried about what _____ is thinking would you be if you disclosed your mental illness/es to them?

Intent to Disclose
Please continue to keep your close friend in mind. I am interested in **your intent to disclose your mental illness/es with close friends**.

You will now be asked questions about your intent to disclose your mental illness/es with your close friend. **Disclosure** occurs **when an individual shares personal private information with another individual**.

Please indicate the degree to which you agree or disagree with each of the following statements. Keep in mind, your responses are being kept confidential.

1	2	3	4	5	6	7
Strongly disagree						*Strongly agree*

1. I intent to disclose my mental illness/es to _____.
2. I plan on disclosing my mental illness/es to _____.

Boundary Permeability (Kennedy-Lightsey et al., 2012)
Please continue to keep your close friend in mind.

I am interested in **the rules you would make with a close friend following the disclosure of your mental illness**. You will now be asked questions about the rules you would make with your close friend following the disclosure of your mental illness. Remember, **disclosure occurs when an individual shares personal private information with another individual**.

Please indicate the degree to which you agree or disagree with each of the following statements.

1	2	3	4	5
Strongly disagree				*Strongly agree*

1. I intend to tell _____ how I would feel if he/she told someone *I know* about my mental illness/es.
2. I intend to tell _____ how I would feel if he/she told someone *I don't know* about my mental illness/es.
3. I intend to tell _____ whom he/she *could* tell about my mental illness/es.
4. I intend to tell _____ whom he/she *could not* tell about my mental illness/es.

Linkages (Kennedy-Lightsey et al., 2012)

1	2	3	4	5
Strongly disagree				*Strongly agree*

1. I intend to tell _____ how much they can tell someone *I know* about my mental illness/es.
2. I intend to tell _____ how much they can tell someone *I do not know* about my mental illness/es.

Privacy Rules (Kennedy-Lightsey et al., 2012)

1	2	3	4	5
Strongly disagree				*Strongly agree*

1. I intend to tell _____ if they have a right to tell someone *I know* about my mental illness/es.
2. I intend to tell _____ if they have a right to tell someone *I do not know about my mental illness/es.*

Mental Health Services
Please see the list of mental health services below.

Click the "**NEXT**" button to receive credit for participating in this study.

List of Mental Health Services

The following is a link to all mental health services on the University of Kentucky Campus: https://pres.uky.edu/mental-health-resources

Let's Talk: a program providing easy access to informal, confidential conversations with clinicians from the UK Counseling Center. **Let's Talk** is available by Zoom, Mon-Fri. There is also a drop-in group for election anxiety on Thursdays at 10:30 a.m. No appointment or fee is necessary. Located at **104 Mandrell Hall, 635 S. Limestone Lexington, KY 40508**.

UK Behavioral Health Services: If students need continued care for existing psychological condition(s), additional support or guidance with new or unexpected psychological concerns, or have an acute need for psychiatric care – the behavioral health team can help. You can make an appointment to see a board-certified psychiatrist by calling **(859)-323-5511**. UK Behavioral Health Services are located at **1000 S. Limestone Lexington, KY 40536**.

Center for Support and Intervention: The Center for Support and Intervention's (CSI) paramount concern relates to maintaining the safety of all members of the UK

community. The CSI team provides guidance to the CSI staff on students of high concern. To contact the Center for Support and Intervention, please call **(859)-257-3755**.

UK Counseling Center: If you are experiencing a personal crisis, schedule an appointment online or call to speak to a clinician, Monday – Friday, 8 a.m. – 4:30 p.m. If you need to talk with a clinician after business hours or on the weekend, call **859-257-8701**. Located at **104 Mandrell Hall, 635 S. Limestone Lexington, KY 40508**.

Health and Wellness Coaching: A health and wellness coach is an ally who help a student become an active participant in achieving their self-identified health goals. To make an appointment, please the UHS appointment line at **859-323-2778**.

LGBTQ Center: The LGBTQ* Center is UK's central hub for accessing information, groups and services related to diverse sexual orientations and gender identities. Visit the **Dinkle-Mass Suite for LGBTQ* Resources, Bill Gatton Student Center (A-250)**.

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VITA

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EDUCATION

B. A.	University of Kentucky	2021	Human Communication (cum laude)
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PROFESSIONAL HISTORY

2021-Present	Graduate Teaching Assistantship	University of Kentucky, Department of Communication
2020-2021	Hourly Grader	University of Kentucky, Department of Communication

PUBLICATIONS

MANUSCRIPTS UNDER REVIEW

Von Feldt, P. A., & Lane, D. R. (under review). The Köhler effect: Examination of collegiate swimmers' effort. Manuscript submitted to *Kentucky Journal of Communication* on July 13th, 2021.

Scarduzio, J. A., Walker, C., Savage, M. W., & **Von Feldt, P.** (under review). Gender stereotypes and intimate partner violence: Exploring couple dyads with male victims. Manuscript submitted to the *Journal of Psychology of Men and Masculinities* on September 14th, 2021.

BOOK REVIEWS UNDER REVIEW

Von Feldt, P. A. (in press). [Review of the book *Technologies of speculation: The limits of knowledge in a data-driven society*, by S. Hong]. *International Journal of Communication*, *16*, 8-10. DOI: 1932–8036/2022BKR0009

HONORS AND AWARDS

University Scholars Program University of Kentucky 2020-2022

INSTRUCTIONAL EXPERIENCE

COM249 Mass Media / Mass Culture Communication 2020-2022
(Graduate Student Teaching Assistant)

CONFERENCE PRESENTATIONS

Savage, M. W., Scarduzio, J. A., Walker, C., & **Von Feldt, P. A.**, Azzam, K., Pham, B., Stone, H., & Ahn, S. (2022, November*). "Gender stereotypes and intimate partner violence: Exploring perceptions of heterosexual and homosexual male victims."* [Paper presentation]. National Communication Association 108th Annual Meeting, New Orleans, LA, United States.

Von Feldt. P. A., & Lane, D. R. (2022, March). *"The Köhler effect: Examination of collegiate swimmers' effort."* [Paper presentation]. National Communication Association 108th Annual Meeting, New Orleans, LA, United States.