

## Between Friends, an “Implicit Trust”: Exploring the (Non)Disclosure of Private Mental Health-Related Information in Friendships

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*Friendships are one of our key relationships through life, yet little is known about our communication processes with them, particularly regarding mental health conditions or concerns. In this study, I utilize Communication Privacy Management Theory (CPM) to explore the process of how individuals discuss their mental health conditions or concerns with a friend. Using a CPM-guided thematic analysis of 17 interviews, I found that friends use various disclosure criteria (context, motivation, and risk-benefit ratio) and experience two boundary issues (implicit privacy markers and confidant privacy dilemmas) in their experiences of disclosing their mental health condition(s) or concern(s) with a friend.*

### Introduction

Friendship is one of the most ubiquitous relationships we experience as humans. McAdams (1997) notes that “the intimacy experienced by two ‘chums’ represents the pinnacle of human experience” (p. 157). Although the details of friendships may differ across universally, the idea of the friend seems to not be bound by culture (Adams & Plaut, 2003; Kron, 1993; Ting-Toomey, 1981). Despite the inevitable presence of friendship in our lives, our understanding of friendship processes remains scant.

What we do know about friendship is largely developmental and definitional. By adolescence, Rawlins (1992) describes that individuals understand the “voluntary, mutually accomplished, ongoing personal attachment” aspects of friendship (p. 59). By young adulthood, friends begin to influence our identity, career, dating life, community, and leisurely activities (p. 103). In fact, young people mention friendship as the most salient love they experience (Fehr & Russell, 1991). As such, friends are typically defined by equality, no blood relation or sexual intimacy, enjoyment, trustworthiness, and similar age ranges (Fehr, 1996). Despite the voluntary nature of a friendship, friends continually remain “a core aspect of our lives” (Fehr, 1996, p. 1), particularly regarding social support.

Despite the conceptualization of friendship as a unique close relationship, many studies do not exclusively examine the friendship relationship as opposed to that of familial relationships in mental health-related research. Many researchers use a single item measure to identify the role of friendship in mental health distress (e.g., “frequency friends help you out,” Miller, Rote, & Keith, 2013, p. 7; “how many friends do you have who live nearby, say within an hour’s drive,” Taylor, 2015, p. 54) or place friendship alongside familial relationships (e.g., McLeod, 2015; Rüscher et al., 2014; Rüscher, Evans-Lacko, & Tornicroft, 2012). Although these studies include friends in their studies, friendship is often conceptualized in tandem with family relationships. Even though friends may fill similar relational roles as familial relationships (i.e., siblings), both types of relationships differ when considering various contextual variables (Carr & Wilder, 2016) such as mental health or illness, particularly when discussing social support.

Nonetheless, researchers continually describe social support as a key process inherent within the friendship relationship (Helsen, Vollebergh, & Meeus, 2000; Procidano & Heller, 1983; Walen & Lachman, 2000). Our friends fulfill various supportive needs through instrumental support (Courtois & Verdegem, 2014), emotional support (Crush, Arseneault, & Fisher, 2018), and relational support (Coyle, Malecki, & Emmons, 2019). Within these various supportive processes, friends are essential for our individual and relational well-being (Parks, 2011), particularly in approval-seeking behaviors (Zimmer-Gembeck, Hunter, & Pronk, 2007), mental health disclosure (Venetis, Chernichky-Karcher, & Gettings, 2018), and social strain (Walen & Lachmann, 2000). It is important to note that our friendships become more important as individuals age in seeking social support for chronic conditions (Heinze et al., 2015), particularly as young people move from dependence on parental figures to friends for health-related conditions (e.g., diabetes; Peters et al., 2011). This is particularly concerning as individuals now need to learn how to manage their stigmatized conditions (e.g., mental health condition(s) or concern(s)) without the supervision of a parental role.

When considering the societal stigma regarding mental illness (Corrigan & Fong, 2014), the friendship relationship is an even more important area of inquiry. Vangelisti (2009) describes that social support can moderate the effects of mental health, and researchers note that individuals will discuss mental illness with their practitioners, romantic partners, and/or family members along with the effects of such disclosures (e.g., Knobloch, Ebata, McGlaughlin, & Ogolsky, 2013; Schulze & Angermeyer, 2003; Wilson, Gettings, Hall, & Pastor, 2015). However, our knowledge of the role of friends in health-related research is not well understood. We know that friends disclose their mental illness with other friends (Venetis et al., 2018), and individuals, particularly adolescents, may disclose their mental health to seek social support from friends (Rickwood, Deane, Wilson, & Ciarrochi, 2005). A friend may be among the first interpersonal relationship to notice an individual suffering from a mental health condition like depression (Castonguay, Filer, & Pitts, 2016). However, we still do not fully understand why friends serve this supportive role.

Despite knowing that friends are a pivotal relationship for social support, friendship is unique from other interpersonal relationships, and individuals disclose and seek social support from friends regarding mental health, we do not yet fully understand how and why friends decide to disclose and the aftermath of disclosing mental health condition(s) or concern(s) with a friend. Thus, understanding friendship as a relational context is pivotal in understanding discussions surrounding mental health. Therefore, the purpose of this study is to understand the decisions and processes regarding individuals disclosing their mental health condition(s) or concern(s) with their friends. In order to understand these disclosure processes, I consider communication privacy management theory (CPM) as the guiding theoretical framework for the study.

### **Communication Privacy Management Theory: Criteria and Boundary Processes**

Researchers employing a CPM (Petronio, 2002, 2018; Petronio & Durham, 2015) perspective examined various health contexts in relation to disclosure. To date, social scientific researchers studied various health contexts such as cancer (Donovan-Kicken, Tollison, & Goins, 2011), chronic illness (Rafferty, Hutton, & Heller, 2017), eating disorders (Herrman & Tenzek, 2017), family health history (Hovick, Yamasaki, Burton-Chase, & Peterson, 2015), and miscarriage (Bute, Brann, & Hernandez, 2017). Researchers using a CPM lens recently found that when an individual cannot rely on family and/or friends for mental health-related social support, they often turn to other sources and feel distanced from these close relationships (Wilson et al., 2019). Withholding such disclosure from close relational others could exacerbate mental health symptomology due to less available social support resources (Köhler, Schäfer, Goebel, & Pedersen, 2018). Therefore, understanding how individuals make disclosure decisions on whether to discuss their mental health conditions or concerns, especially with friends, could illuminate the (in)effective strategies for private, mental health-related information management. Thus, I utilize CPM to explore conversational decisions around a stigmatized issue, mental health, with those sought as a support system, friends. To explore these relationships further, I consider both (a) criteria for disclosure and (b) the boundary management process.

#### **Criteria for Disclosure**

Petronio (2002) identified various criteria for disclosure including culture, gender, motivation, context, and a risk-benefit ratio. Although each criterion could have bearings on the disclosure processes of mental health between friends, I focused on context, motivations, and the risk-benefit ratio due to their prevalence in other invisible illness health-related studies (for context, see Bute, 2013; for motivations, see Cacioppo, Cacioppo, & Boomsma, 2014; for risks and benefits, see Romo, 2016). To follow, I specifically discuss (a) life circumstances in context, (b) loneliness and ambiguity in motivation, and (c) relational risks and benefits.

First, Petronio's (2002) criterion of context included life circumstances as one of three types of contexts in CPM. Although the other two contexts, trauma and therapy, may occur during an individual's mental health journey, discussing life circumstances aligned the best with the current study. Petronio cited Braithwaite's (1991) work on disabilities to explicate the life circumstance criterion in which there are two key theoretical aspects to consider for mental health: a waiting period and a need for information. Braithwaite identified that those affected by a disability want to be seen as a person first before identification of the disability. Thus, individuals affected by a mental health condition or concern may wait to gauge their friend's level of acceptance on a topic. Bute (2013), however, conceptualized life circumstances as those events that could prompt disclosure (e.g., divorce), and, therefore, this criterion needs more theoretical evidence for its catalyst nature (Petronio, 2010). An individual receiving a mental health diagnosis may want to seek support from a friend, serving as a catalyst for disclosure. However, these motivations may differ in various aspects.

Second, Petronio (2002) describes motivation in terms of reciprocity and liking and attraction. In describing liking and attraction, she describes a tenet of ambiguity and loneliness. Within this tension, she explains that those who are lonely may not disclose information unless they are able to move from tight control to moderate control of the information. In ambiguity, the driving motivation is wanting information or wanting the other to know information. Cacioppo et al. (2014) described that loneliness (stemming particularly from depression) may invite others into a social support role through physical symptoms (e.g., crying, disclosure). Because friendships are an important facet of social support, motivations for disclosure of mental health in seeking social support merits attention.

Finally, an analysis of a risk-benefit ratio may lead to (non)disclosure (Petronio, 2002). In relational development, Petronio (2002) associated risks with a threat to the growth or maintenance of the relationship while benefits enabled growth or maintenance of the relationship. In her study, Romo (2016) explored the risk-benefit ratio in discussing formerly overweight/obese individuals. Her participants cited discrimination and stigma as a risk that lead to concealment while inspiring others and building relationships as a catalyst for disclosure. Because those affected by a mental health condition or concern face stigma and discrimination as well (Butler, 2016; Kim & Stout, 2010), a risk-benefit ratio analysis is imperative to the understanding of disclosure of mental health conditions or concerns between friends. Given that individuals seek friends for social support in mental health-related disclosures, but we do not fully understand how these disclosure decisions are made, I propose the following research question:

RQ1: What, if any, privacy criteria did the participants use regarding the disclosure of mental health condition(s) or concern(s) with a friend?

### **Boundary Processes**

Petronio (2002, 2010, 2018; Petronio & Durham, 2015) explicated boundaries of private information including concepts such as boundary coordination and boundary turbulence. In exploring the disclosure of mental health between friends, it is important to understand (a) how individuals use boundary linkage rules and (b) experience facets of boundary turbulence due to the prevalence of research citing that disclosures of mental health occur with friends (Venetis et al., 2018), yet how such disclosures occur is not well known.

In understanding boundary linkage rules, Petronio (2002) identified various linkage rules when moving from a personal (self) boundary to a collective (shared with another) boundary. These rules involved selection of disclosure regarding confidant, timing, and topic. In confidant selection, individuals consider gender, age, levels of intimacy, status, and frequency prior to linking boundaries. Particularly, those in symmetrical status (peer) relationships as opposed to complimentary status (higher position) relationships are more likely to perform a boundary linkage (p. 93). Because individuals are likely to disclose private, mental health information to peers in support-seeking behaviors (Rickwood et al., 2005), friendship is a particularly notable relationship in considering boundary linkage to understand the processes of effective (non)disclosure.

While Petronio (2002) mainly discussed sex differences, researchers discovered various aspects of boundary linkage and disclosure surrounding topic selection, highlighting inappropriate disclosures as an aspect of boundary linkage. Shimkowski (2018) studied inappropriate disclosures of parents' marital issues and how this affects their children. She describes Petronio, Jones, and Morr's (2003) conceptualization of the interdependence dilemma in which family members experiencing privacy issues must navigate how the disclosure of information affects the self, family, and relationship. In her results, Shimkowski (2018) found that children's mental well-being and emotional regulation were indeed affected by inappropriate parental disclosure, thus showing that sensitive disclosures could negatively affect relationships. However, because we know that friendships are based on voluntariness, sensitive disclosures could have more of an effect on friendship relationships, which is imperative to understand because as children age, they tend to rely less on parents for support and more so on peer relationships (Furman & Buhrmester, 1985). Sensitive topic coordination could also result in thicker boundaries of which disclosure is more closely regulated (e.g., wa Ngula & Miller, 2010) to avoid failure of private information flow.

When the boundary coordination process fails, boundary turbulence, or the disturbance of the boundary process, occurs (Petronio, 2002). Petronio (2002) identified several potential manifestations of boundary coordination failure, including fuzzy boundaries and dissimilar boundary orientations. Fuzzy boundaries, or boundaries with ambiguous ownership, could occur in various situations, but Petronio (2010) noted that fuzzy boundaries often occurred when one individual in a romantic dyad kept information private that their partner believed to be information belonging to the couple. Knobloch et al.'s (2013) discussion included an analysis of relational uncertainty and depression when a military spouse returns home from war. Although spousal health may be perceived as a collective boundary, mental health can remain in an individual boundary because "face threats are salient" and uncertainty in the relationship can lead to "trouble talking openly about reintegration stressors" and

mental health issues (p. 762). Although uncertainty surrounding the unmapped territory of mental health in family relationships can lead to family and adjustment issues, such applications outside of the family domain remain scant. However, considering friendships when mental health conditions or concerns are the topic of conversation could identify how fuzzy boundaries manifest in this relational context, perhaps demonstrating why individuals may experience stigmatized reactions from their peers in these disclosures (Moses, 2010).

Petronio (2002) also described dissimilar boundary orientations, or what occurs when one partner is not flexible with a boundary change, as an indicator for boundary turbulence. She primarily cited family and cultural background as indicators for dissimilar boundary orientations (e.g., open boundaries vs. closed boundaries) in relationships. As Hesse and Rauscher (2013) described, “boundary turbulence is typically studied when a privacy rule is breached” (p. 95). They described that boundary turbulence could be a reason for nondisclosure if the other individual may not have a similar boundary orientation. This, again, can vary by the orientation of the perceived privacy of a topic. Although these scholars focused on emotional intelligence and alexithymia (inability to identify emotions), Hesse and Rauscher’s (2013) study could help explain issues of the disclosure of mental health between friends in considering privacy regulation of such information.

Because friends are a unique system of support seeking behaviors and are inherently unique relationships based on their voluntary nature, the consideration of various aspects of disclosure between friends, particularly around stigmatized health issues such as mental health, becomes important particularly in noting friends’ pivotal supportive roles in our lives. In order to explore how individuals with a mental health condition or concern choose whether to disclose with a friend, I pose the following research question:

RQ2: How do individuals interact and navigate privacy boundaries with friends regarding mental health condition(s) or concern(s)?

### Methodology

Situated in the interpretive paradigm in order to fully explore the first-hand, lived experiences of individuals’ disclosure of mental health conditions with a friend (Baxter & Babbie, 2004), I used an in-depth, semi-structured interview guide<sup>1</sup> in order to allow for the interview to be adjusted and adapted for each individual participant and tell about their experience in the beset way (Lindlof & Taylor, 2018). I used CPM as a guiding theoretical framework for constructing parts of the interview guide to understand how individuals decide whether to disclose their information and the process of this disclosure, or the central phenomenon of the study (Creswell, 2016). I also conducted a pilot interview with a scholarly colleague who fit the participant criteria to test the effectiveness and flow of the interview guide (Creswell & Poth, 2018). I made no changes to the interview protocol after conducting the pilot interview based on the feedback from my colleague, but conducting the pilot helped me assess my “performance of [interviewing] in real interview situations” (Barriball & While, 1994, p. 333). In order to participate in this study, the participants had to be at least 19 years old, self-reported they sought professional help for a mental health condition or concern, and discussed this topic with at least one friend.

### Procedures

Prior to conducting interviews, I obtained approval from the Institutional Review Board. I used criterion sampling so that my participants were all at least 19 years old, self-reported they sought professional help for a mental health condition or concern and discussed the topic with at least one friend (Lindlof & Taylor, 2018). With the IRB’s approval of the criterion sampling, I recruited participants through an online university research board, social media (Facebook & reddit), a communication listserv, and flyers on campus. To accurately fit within the criterion sampling, participants were required to self-report they sought professional assistance for their mental health condition or concern. Although on the denotative level *conditions* and *concerns* may differ, those merely seeking services for mental health often “have already experienced significant impairment, clinical symptoms, and stigma” (Henderson, Evans-Lacko, & Thornicroft, 2013, p. 777). Therefore, the participants were likely to have similar lived experiences for inclusion in this study.

I conducted both face-to-face interviews and interviews via telephone when participants were in another geographic location (Creswell, 2016). Interviews (N=17) ranged from approximately 18-62 minutes, lasted 35.07 minutes on average, and resulted in 156 pages of double-spaced transcripts. In all instances, participants received and agreed to an informed consent prior to participating in the interview. More females (n=13) than males (n=4) participated, and most were Caucasian (n=14) with one participant identifying as Hispanic-Caucasian, one

<sup>1</sup> Contact the corresponding author for the full interview guide.

identifying as Hispanic, and one identifying as Asian-American. Participants enrolled in a communication studies course were able to receive compensation in the form of research credit with their instructor's approval. Participants ranged in age from 19-47 ( $M=22.125$ ) and most were from the Midwestern United States ( $n=15$ ), one from the West Coast, and one from the East Coast. Participants were either in college ( $n=11$ ), in graduate school ( $n=4$ ), or graduated from college with a bachelor's degree ( $n=2$ ). Participants disclosed a variety of mental health conditions: anxiety ( $n=12$ ), depression ( $n=10$ ), attention deficit hyperactivity disorder ( $n=1$ ), bipolar disorder II ( $n=1$ ), borderline personality disorder ( $n=1$ ), and eating disorder ( $n=1$ ). Some participants reported multiple mental health conditions, which is common as many individuals with mental health conditions experience comorbidities, meaning that multiple conditions often exist simultaneously in one individual (Prince et al., 2007).

### Data Analysis

To understand participant experiences of mental health disclosure with a friend through a CPM lens, I used Braun and Clarke's (2006) six-step thematic analysis. Throughout my analysis, I used CPM as a sensitizing theoretical framework (Bowen, 2006), although I did not use CPM-related terms as a priori categories for thematic development. In this way, I balanced the emic (allowing the participants' experiences to speak for themselves) with the etic (evaluation of these experiences through previous categories or theories) to best make sense of the phenomenon under inquiry (Lindlof & Taylor, 2018). First, to familiarize myself with the data, I listened to and transcribed each interview. Second, I listened to the interviews while reading over transcriptions to ensure accuracy of the participant responses. Third, I generated initial codes through reading through the transcripts and identifying codes I found theoretically satisfying as they related to the purpose of this project. To reflect participant insights, experiences, and voices, I identified those exemplars that explicated general themes and fit my research questions in the results below.

Because I conceptualized the research questions and interview guide utilizing a CPM theoretical framework, I used CPM as a sensitizing framework in identifying themes for the research questions (Bowen, 2006). In identifying these themes, I incorporated Owen's (1984) criteria for inclusion as a theme: recurrence (similar findings across the data); repetition (similar words/phrases across the data); and forcefulness (participant emphasis during the interviews). To fully incorporate this method, I first looked for themes that reflected participant decisions in deciding whether to disclose their mental health with a friend. Second, I identified themes that embodied experiences of navigating privacy boundaries regarding mental health disclosure with a friend. In this step, I first analyzed a subset of the data ( $n=8$ ) to identify initial theoretical themes and concepts. I analyzed the remaining data ( $n=9$ ) with these themes in mind while remaining open to new ideas and insights. Through my analysis of the additional transcripts, I found no new themes demonstrating that I reached theoretical saturation (Creswell & Poth, 2018; Lindlof & Taylor, 2018).

After identifying themes, I undertook a data conference (Braithwaite, Allen, & Moore, 2017), a term developed for defending the interpretive themes I found throughout the data. To conduct this conference, I presented my analysis to scholars in a doctorate-level interpersonal communication course discussing how these themes worked with one another, and I provided justification for their inclusion in this study. After completion of this preliminary analysis, I conducted member checks with participants to further validate the findings of the study (Creswell, 2009), of which participants did not identify any new data or conceptual conflicts.

## Results

In my analysis, I found that participants used three of Petronio's (2002) disclosure criteria (context, motivation, risk-benefit ratio) and demonstrated two aspects of boundary processes (privacy markers, confidant privacy dilemmas). I will first discuss the disclosure criteria and then the boundary processes.

### Contextual Criterion: *We Were There for Each Other*

Petronio (2002) classified life circumstances, or the decision to disclose after an event in life categorized by a waiting period and a need for information, as one of the categories for the contextual criterion. Every participant noted that they did not immediately open-up to their friend about their mental health. Some participants waited until their own friends talked about mental health. Barney<sup>2</sup>, a 19-year old man, said that "we were both going through a rough patch in high school, and were both just there for each other" in which he found out his friend had ADHD,

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<sup>2</sup> I assigned participants a pseudonym to maintain participant confidentiality.

and he reciprocated the same information to his friend (2: 40-42<sup>3</sup>). Other participants decided to wait due to uncertainty regarding the friendship. For example, Josie, a 20-year-old woman, described:

I kept that [support animal] a secret a lot because I didn't want them to ask me why I needed it and all of the questions behind it. So, I kept that to myself just because these were brand new friends, and I didn't want to be like...I just didn't want to tell them that I had a mental health [condition], just in case they started treating me differently. (140-143)

The participants demonstrated the life circumstances criterion because they were uncertain about how their friends would react. The participants required a fundamental context of trust in the friendship before disclosing their mental health condition or concern. Once the participants waited and established their individual threshold of trust, they could identify their motivation for disclosure.

#### **Motivational Criterion: *I'm Here for You***

Participants demonstrated the motivational criterion for disclosure, particularly in terms of support-seeking. While Petronio (2002) noted that individuals are motivated to disclose to alleviate ambiguity through information-seeking disclosure, participants described this criterion more as a method to seek emotional support. In fact, Josie embodied this theme as she said:

I would say for me, when I told one of my friends from back home, and they handled the situation well, responding like, "I'm here for you," you know, "I understand what you're going through even though I might not have the illness." But she [this other friend] kind of just told me that, you know, I should go get help. That there were options for me, which I knew that. But she didn't really seem to offer her support. It was kind of just shoving me off and you should go get some help. (1: 212-218)

Additionally, Kevin, a 28-year-old man, described how "it was interesting to have someone affirm what I had been going through—that it sucked. There was something I could do about it, and it wasn't wholly my fault that I was stuck in the bits where I was stuck" (7: 111-113)

Through these exemplars, we hear how participants disclosed not because they wanted information about mental health, but rather to receive emotional support from a friend. In fact, when participants received informational support, they viewed this as inappropriate or dissatisfying information to receive. Participants were already aware of many of the available resources, and they wanted their friend to support them emotionally. However, participants did not make the decision to disclose based only off life circumstances and motivations, they included analysis of the situation as well.

#### **Risk-Benefit Analysis: *Will They Tell Someone How I'm Feeling?***

Participants echoed Petronio's (2002) risk-benefit analysis criterion considering relational development as the primary factor for disclosure. Once participants did disclose, however, every participant identified *relief* as the primary emotion that they felt post-disclosure, showing a sense of satisfaction that they disclosed this private information with a friend. Karen, a 19-year-old woman, described how "after getting to know her, I knew that I could trust her. I knew that she wasn't going to judge me. I knew that I could tell her anything, and she would be there for me" (4: 52-53). Kevin explicated further:

I knew that he was a good friend, and I knew that anything I told him would be confidential. That's the one thing that comes to sharing things like [mental health] is, like, do I think they will go and tell someone? Will they tell someone how I'm feeling? To just keep that within my smaller circle of friends is ideal (7: 90-93).

As reflected from life circumstances, participants demonstrated a need for trust in deciding to disclose. While Karen's exemplar illustrated a similar concern as Josie as they did not want judgement, Kevin showed a different concern as he did not want his friend to tell other individuals. Kevin's statement reflects most of the participants' concerns in this study, implying that an individual disclosing mental health information requires a level of trust and boundary coordination between friends. These exemplars demonstrated that the risk of stigma would be outweighed by the benefit of relief and social support only if participants felt a sense of trust in the friendship.

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<sup>3</sup> Numbers after quotations reflect interview number and transcript line numbers.

**Boundary Ownership Rules: *It Was Just Kind of Implied***

Petronio (2002) described the process of boundary ownership rules as one in which the interactants create rules to form the boundaries of the information. One such category of boundary ownership rules particularly salient in the data was privacy markers, or the verbal or nonverbal communication about what one can or cannot do with the information. Up until this point, the participants demonstrated cautious disclosure to friends about their mental health, considering various criteria to disclose or withhold the information.

Despite this apprehensive disclosure, most of the participants did not explicitly create boundaries. Alexa, a 47-year-old woman, summarized this experience best when she said, “I never specifically said, ‘Don’t tell anyone,’ but I guess it was just kind of implied as we were both in the same boat” (5: 111-112). Edgar, a 30-year-old male, also described that “I didn’t tell him what he could or couldn’t do with the information. I knew I could trust him, and I wouldn’t have told him if I knew he was going to spread it” (7: 65-66). Janet, a 21-year-old woman, also did not provide privacy markers, but hers was intentional in that “I’m kind of an open book in that way. Sharing my struggles may help someone else. If [my friend] were to tell someone else, it may help them realize they are not alone, too. I only saw it doing good” (6: 72-73).

While it seemed that participants understood the implications from the disclosure criteria when considering mental health a sensitive issue to disclose with a friend, the lack of privacy markers would initially contradict this risk due to the fluidity of privacy boundaries participants created without these markers. However, because participants based the disclosure on strict criteria built around trust, they perceived their relationship with their friend to already have boundaries surrounding private and sensitive information. The participants did not perceive a need to necessarily further define the boundaries of the information between friends. The participants did not expect there to be a privacy dilemma upon disclosing the information.

**Confidant Privacy Dilemmas: *They Needed Support as Well***

Not all boundary coordination went smoothly, and Petronio (2002) explained that sometimes boundaries become turbulent. Although the participants did not demonstrate fuzzy boundaries and dissimilar boundary coordination as prominent themes, the participants embodied one aspect of boundary turbulence: confidant privacy dilemmas. Petronio described confidant privacy dilemmas as the circumstances following a sensitive disclosure in which the confidant, or receiver of the information, is unsure how to handle the situation, and the confidant may need further assistance outside of their abilities in handling the disclosure. Petronio identified two paths that confidants may take when faced with a confidant privacy dilemma: the risky path (talking directly with the discloser) or the cautious path (avoiding the issue entirely). However, the participants did not demonstrate either path, yet described a confidant privacy dilemma. For example, Josie described:

I mean, I was mad [that she told someone without asking me], but then I understood because she was just looking out for me and it wasn’t like she just told anyone, she told one of my close friends that I didn’t tell. But, I also didn’t feel like I was ready to tell her, specifically. (1: 233-235)

Kyle, a 22-year-old man, also described:

She told her parents because she needed someone to talk to about it. I was okay with it because I knew she needed support as well because I was going through a lot. It worked well for me in the long run, but, yeah. (8: 214-217)

The participants’ confidants did not resolve the confidant privacy dilemma with the initial discloser as Petronio’s (2002) paths would suggest. Rather, participants disclosed with a third party to either find further assistance for the friend in need or find a therapeutic source for themselves. Although some participants experienced initial frustration after this privacy dilemma, participants still expressed satisfaction with their friends’ actions after reflecting on the purpose of enacting upon the confidant privacy dilemma.

**Discussion**

My purpose in this study was to understand how persons who experience a mental health condition(s) or concern(s) interact and navigate privacy boundaries with friends regarding their mental health conditions or concerns. Specifically, I explored how friends used criteria for disclosure as described by Petronio (2002) in determining the conditions for which to disclose their mental health condition or concern with a friend. Additionally, I explored the (absence of) boundary coordination and turbulence between friends’ disclosure about mental health

conditions or concerns. I chose to focus on the friendship relationship because friends are unique from other relationships through their voluntary nature while also serving as someone for which to provide social support. In the following section, I provide (a) a summary of the findings, (b) implications of the findings, (c) limitations of the study, and (d) future directions for research.

### **Summary of Findings**

Participants exemplified both disclosure criteria and (a lack of) boundary coordination. In discussing disclosure criteria, the participants demonstrated context, motivation, and a risk-benefit analysis. Contrary to previous research on CPM and health, participants did not show strong tendencies for boundary linkage, fuzzy boundaries, and dissimilar boundary orientation. Rather, when discussing the boundary coordination process, participants embodied (the absence of) privacy markers and confidant privacy dilemmas.

Regarding the criteria, participants reported a waiting period, seeking emotional support, and analyzing risks and benefits. Previous research would suggest that invisible illness disclosures encapsulate these criteria, but the participants in this study demonstrated alternative narratives for conceptualizing these criteria for disclosure. With the waiting period, although it could be assumed that participants wanted recognition as people first like in Braithwaite's (1991) study, the participants focused on the requirement to build trust prior to disclosure. Seeking emotional support and discounting the need for information adds further insight into Petronio's (2002) conceptualization of the motivational criterion. The participants showed that reducing ambiguity could come from removing the feelings of loneliness and isolation often experienced by those affected by mental health condition(s) or concern(s) (Cornwell & Waite, 2009) rather than seeking more information to reduce ambiguity. In considering risks and benefits, this criterion worked in tandem with context and motivations as participants waited until they thought their friend would not share the disclosure with others and feel emotionally supported. Although they acknowledged such disclosure was risky, the participants' follow-up actions post-disclosure did not indicate a need for strict boundary coordination.

Petronio (2002) described that boundary linkage occurs more often in peer relationships. Previous researchers also described that fuzzy boundaries and dissimilar boundary orientation occurs often in health-related privacy situations between relational partners (Knobloch et al., 2013; Knobloch, Sharabi, Delaney, & Suranne, 2016; Petronio, 2010). However, I found very little, if any, evidence in support of this claim when considering the friendship relationship both in the literature and this study. Rather, when discussing boundary coordination, the participants mostly exemplified an absence of privacy markers, which could be counterintuitive in the sense that individuals may experience stigmatization from peers when disclosing mental health information (Moses, 2010). In terms of boundary turbulence, participants described instances of confidant privacy dilemmas rather than fuzzy boundaries or dissimilar boundary orientation, and the dilemmas they reported did not fit within Petronio's (2002) predetermined categories.

Taken together, the participants in this study demonstrated the unique nature of navigating privacy with a friend regarding mental health disclosure. The participants' experiences give important conclusions when considering mental health and friends through a CPM lens. I provide implications of the results to show the consequences of such disclosures.

### **Implications of Findings**

First, the participants' experiences allow for theoretical extension of CPM in considering disclosure criteria for disclosing mental health with a friend. In first analyzing each criterion separately, the participants embodied an innovative demonstration of these criteria. First, the participants provided more insight into the contextual criterion, particularly in discussion of life circumstance. Petronio (2002) cited Braithwaite's (1991) work as the exemplar of life circumstances through visible disability. The participants described similar experiences to what Braithwaite mentioned in her work, such as a waiting period to disclose the information. What the participants of this study add, though, is a notion of similarity, meaning that participants were more likely to disclose when they knew their friend also had a mental health condition or concern. This ties in with Bute's (2013) finding that the life circumstance criterion can be influenced by social factors and that friends typically choose friends who are similar (Burlinson, Samter, & Lucchetti, 1992). This worked into the motivation criterion because friends disclosed to seek emotional support with those whom relational trust or similar situations had been established. These results coincide with the risk-benefit analysis in that participants waited to disclose until they could either trust the friend or identify that the friend had a similar situation.

It may not be surprising that these participants experienced a phenomenon of trust across criteria, especially in the framing of invisible illness. As Hall & Miller-Ott (2019) found in their investigation of women affected by



fibromyalgia in the workplace, their analysis of Petronio's (2002) criteria for disclosure compounded as well through notions of stigma and gender. In similarly assessing commonalities across disclosure criteria, although I identified various criteria in the data, it became clear that the context, motivation, and risk-benefit ratio were all tied together through some aspect of trust, which is not surprising given the voluntary nature of the friendship relationship (Fehr, 1996). The notion that these criteria did not exist in isolation expands upon Petronio's (2010) later conceptualization of disclosure criteria.

Petronio (2010) added the term *critical incident catalyst* to describe what causes individuals to experience privacy boundary shifts, specifically citing unexpected health demands as an example. Although Petronio focused on family relationships, my study of the friendship relationship and mental health draws similar implications. Petronio's analysis of stigmatized health disclosures (e.g., HIV/AIDS) provided further implications for the participants in this study. For example, those affected by HIV/AIDS in a family are likely to target specific others and not tell the whole family based on the circumstance, need for support, and the targeted disclosure made the discussion less risky as opposed to the whole family. Similarly, participants in this study were likely to disclose their mental health condition(s) or concern(s) based on the circumstance of the friendship (i.e., trust and similar experience), need for emotional support, and disclosing to a certain friend, not an entire friend group. As the participants embodied the criteria working in tandem as a catalyst from a critical incident, the initially separate disclosure criteria play out as various decisions and experiences under one enacted experience of disclosure in stigmatized health-related information. However, where Petronio describes the fear of boundary-leakage, or unwanted sharing of private information, the participants of this study were much less stringent about privacy markers in discussing their mental health with a friend.

Second, Petronio's (2002) discussion of privacy markers would lead one to expect that sensitive, private information would have explicit rules such as, "Don't tell anyone about my mental health condition(s) or concern(s)." Petronio (2010) also described that coordinated ownership rules between couples can lead to improved mental and relational health outcomes. One may also expect that individuals would create more strict coordination due to the voluntary nature of the friendship relationship. However, despite the stigmatized nature of mental health conditions or concerns in the friendship relationship, the participants of this study did not use explicit privacy markers. Most participants explicated that they trusted the friend or that previous conversations with the friend on sensitive topics remained confidential, so explicit privacy markers were unnecessary. Other participants did not provide explicit privacy markers because they wanted their lived experience to help others. This result is important because it shows that discussing a mental health condition(s) or concern(s) with a friend provides a unique context for discussing this stigmatized health topic. Because of the strict disclosure criteria (circumstance, motivation, and risk-benefit analysis), individuals did not feel the need to further limit the sharing of information through privacy markers, citing that these were implicit boundaries based on the nature of the friendship.

Another surprising aspect of the data regarding privacy markers was the actual length of participant responses. As previously discussed, when a topic such as mental health is on the table, one would expect strict privacy markers surrounding the conversation. Participants, however, expressed that they did not create such boundaries. Furthermore, explanations for the lack of boundaries was often short in length and duration during the interview. Typically, qualitative researchers provide lengthy and numerous exemplars to demonstrate a theme (Suter, 2009). However, the exemplars provided throughout the results section reflected these parts of the data as most participants had similar short exemplary responses for the lack of strict privacy markers. This further demonstrates that privacy markers were not of cognitive concern for participants during the disclosure of the private information. However, this may be corroborated by the strict criteria participants created when contemplating disclosure of the private information. Once an individual identified their friend as trustworthy, non-judgmental, and supportive, concerns of further dissemination of private information were outweighed by the perceived benefits of disclosing their mental health information with their friend. However, the results showed that some participants' confidants violated the implicit privacy rules.

Thus, in considering Petronio's (2002) conceptualization of confidant privacy dilemmas, there is little surprise that the participants in this study provided experiences of confidant privacy dilemmas. In her work, Petronio detailed the experiences of a family member receiving information about an uncle's addiction as burdensome. However, when discussing mental health with a friend, the participants in this study described that their confidants followed neither path (risky nor cautious) in their dilemma outlined by Petronio. However, Petronio (2010) discussed these dilemmas in that family members may disclose private health information to others to achieve a better health outcome, but this may hinder the relationship with the discloser. Her description of this dilemma fits better with the participants of this study as they discussed their confidants disclosing to others to either find more support for the discloser or for the confidant themselves. Thus, a third path, *the broken path*, may be a necessary

addition to the theory to describe the violated boundaries in the best interest of both/either the discloser and the confidant.

All-in-all, the lived experiences of those affected by a mental health condition(s) or concern(s) and discussing this information with a friend show unique contributions to research on privacy and health. The participants from this study not only demonstrated many of Petronio's (2002, 2010) concepts and ideas, but extended them into better understanding private information processes surrounding mental health disclosure with a friend. Despite the theoretical and relational contributions of this piece, I consider the limitations and future directions for research on mental health and friendship.

### **Limitations and Future Research**

In addressing the limitations of my data, my participants are not inherently diverse. My participants were mostly female, Caucasian, and between the ages of 19-30, with one above that age range. All participants were also college educated to some extent. Due to this homogenous sample, the lived experiences of these participants cannot represent the breadth of voices of those with similar experiences. Thus, the results should be interpreted within the context of this study. Although my recruitment was not limited to college educated, Caucasian individuals, researchers should expand their recruitment calls beyond college study websites, discipline listservs, and personal social networks to achieve a more representative sample.

Second, only participants currently enrolled at the university of study were compensated for their participation in the form of extra credit. The other participants did not receive compensation for their participation. Although participants were aware of this in the recruitment and informed consent, researchers in the future should provide some level of compensation for the participants in the study to ensure an equitable experience and provide incentive for others to overcome barriers (Meth, 2017), particularly in health-related studies (Grady, n.d.).

Third, researchers should further consider the role of the confidant in receiving sensitive health-related information. Petronio (2002) set up the reluctant confidant for future research because reluctant confidants occur frequently in health-related disclosures. The participants in this study demonstrated that confidants experience privacy dilemmas when receiving information about a friends' mental health. One participant even noted that there may be a psychological contagion, or effect that comes from receiving the information, and/or a need to disclose this information to alleviate the burden of withholding the information. Thus, exploring how a confidant feels when receiving information would provide a perspective further building on the various roles that friends may fill as confidants (McBride & Bergen, 2008).

Fourth, exploring the phenomenon of mental health disclosure between friends is not merely a face-to-face disclosure process. In an increasingly digital age, it is pivotal that scholars replicate studies like mine in a computer-mediated context. Previous scholars noted that miscommunication between friends occurs over texting and there should be clear expectations for what is appropriate to text and what is inappropriate to text (Kelly & Miller-Ott, 2018). Thus, future researchers should consider the role of texting and other forms of mediated disclosure in their inquiries about disclosure of mental health condition(s) or concern(s) between friends.

Finally, future researchers should continue to explore the nature of a friendship relationship and how that relates to other close relationships. As seen in the warrant of this study, much of the understanding of health-related disclosures comes from talking with practitioners, romantic partners, and/or family members despite friendship being one of the relationships used for social support. One such question these researchers could answer would be why family members may create more stringent privacy boundaries through privacy markers regarding stigmatized health issues, as seen in Petronio (2010), than friends.

Overall, I provided an analysis of how individuals navigate privacy boundaries in disclosures surrounding mental health with their friends. Although this study is not without its limitations, I provided theoretical extension based on participants' lived experiences of mental health disclosure with a non-family member. The participants in this study provided the field with a basic understanding of how boundary processes manifest between friends discussing a mental health condition(s) or concern(s).

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