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## Adolescents and Disclosure: Influence of Stigma and Knowledge of Psychological Diagnosis

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**Abstract:** Adolescents diagnosed with psychological disorders and their friendship groups are understudied. Factors that help a diagnosed adolescent decide to disclose this personal information to his/her friends is understudied as well. This qualitative study focused on the personal experiences of early and late adolescents who have disclosed mental health information to their friends. This study also focused on factors that would impact why, or why not, this group of adolescents chose to disclose this information. An in-depth interview concentrated on three themes: the quantity and type of diagnosis and treatments, health literacy, and stigma patterns. Health literacy and perceived stigma showed the strongest trends for reasons why participants disclosed or withheld information about their diagnosis and treatments. Adolescents showed that their friendships were a vital asset to their wellbeing and an important source of support during the time of diagnosis and thereafter.

**Keywords:** *Adolescents, disclosure, friendships*

The adolescent experience is a challenging time for all teens because they are changing rapidly throughout many aspects of development. All facets of adolescence are important. However, the most important aspect for this age group seems to be social development and the relationships they develop with others and their peer groups (Bukowski, Hoza, & Boivin, 1993).

Adolescents in general want to be accepted among their peers, including those diagnosed with a psychological disorder. As adolescents grow older, the level of intimacy tends to grow between themselves and their friends (Buhrmester, 1990). Revealing information about one's self (self-disclosure) is a necessity in order to produce an intimate relationship. For some people, this exchange can be fairly easy; however, it could be more difficult for individuals who have a psychological disorder. Disclosing information about themselves to their friends could create acceptance or discrimination, which could lead to a richer or diminished peer adolescent experience, respectively. The daily experience of adolescents diagnosed with a psychological disorder has not been studied extensively, especially the perspective of disclosing information about their disorder to their friends.

### Adolescent Mental Health Disclosure

Disclosure is defined by three qualities: "breadth or amount of information", "depth or intimacy of information", and "duration or time spent describing information" (Cozby, 1973, p. 73). The ability to disclose information between one another allows people to enhance their relationships by engaging in conversation on a deeper level. Kobocow, McGuire and Blau (1983) studied the willingness of adolescents to disclose information about themselves within a counseling setting. Participants were assigned to various conditions of confidentiality during the therapy session: confidentiality explicitly assured, no confidentiality, and confidentiality not assured. Kobocow et al. (1983) found that both male and female participants were more likely to disclose information about themselves in the explicit confidentiality condition. Although the current study is not directed toward counseling, revealing information tended to be increased when there was verified confidentiality. Confidentiality in terms of a friendship context would probably be an important factor in adolescents' decision to disclose this personal information, verifying that discretion is sought when disclosing psychological information with friends. This increase of intimacy also increases the expectancy

that the friend would, in return, give the adolescent support so he/she feels “understood, validated, and cared for” (Clark & Reis, 1988, p. 603). There can be some risks and benefits from such disclosure. Because of the risk involved, the individual would have to be sure that whoever he/she is disclosing the information to is someone he/she can trust to be supportive.

### **Benefits and Disadvantages of Disclosing Information about Oneself**

Disclosing personal mental health information about oneself could be beneficial. Some researchers believe that the Social Exchange Theory, where “reciprocal interdependence emphasizes contingent interpersonal transactions, whereby an action by one party leads to a response by another” (Cropanzano & Mitchell, 2005, p. 876), can be an asset to adolescents disclosing information to others. Worthy, Gary and Kahn (1969) viewed disclosure as an important part of the mental health process, where it is seen as “rewarding to the one who makes the disclosure” (p.63). Furthermore, the authors explain disclosure can benefit an individual with the “freedom it accords to the hearer to reply with equally intimate disclosures about himself” (p.63). Once the diagnosed adolescent discloses information to others, he/she in return would feel supported by receiving some level of reciprocity or feedback. This relays to the person that the disclosed information has been accepted. One other benefit to engaging in this disclosure process would be reducing feelings of stress (Pennebaker, 1997).

Although there are great emotional benefits to disclosing information, there could also be social deficits as well, especially with negative views toward those with psychological disorders. One disadvantage that adolescents could face with disclosing information about their mental health disorder is feeling socially isolated. Connolly, Geller, Marton and Kutcher (1992) studied the interaction between groups of children with and without depression. Participants completed a task where a depressed child, a non-depressed child, and a confederate (i.e., an actor participating in

the experiment) were to get to know each other through conversations about hobbies, such as music and regular conversation. Participants with and without depression completed a questionnaire about their perceived willingness to engage with the other person. The conclusion showed that “compared to normal girls, depressed girls were rated as less popular, less friendly, and less likable” (p. 368). The researchers concluded that people who are diagnosed with a disorder are less likely to be liked by others because of the symptoms of the disorder that they display.

The anticipated reactions that a friend might have after disclosure can be concerning for those diagnosed with a psychological disorder. Dinos, Stevens, Serfaty, Weich and King (2004) found that adult participants were afraid of “personal harassment either verbal or physical” (p. 178) if they were to disclose information about their mental illness to others. Although this study was conducted with an adult population, the same results could potentially occur if an adolescent were to disclose information about him/herself to his/her peers.

### **Diagnosis of Psychiatric Disorders in Adolescents**

An increased number of children and adolescents have been diagnosed with psychological disorders, especially between the ages of 6 and 19 (Costello, Mustillo, Erkanli, Keeler, & Angold, 2003). Although there has been an escalation in the number of adolescent diagnoses, there are few subjective studies that attempt to understand the disclosure process that those diagnosed may endure. This section will show the prevalence of diagnoses among children and adolescents, and explain how stigma of this population could affect disclosure practices of their disorders with their peers.

*Prevalence of disorders of children and adolescents.* Costello et al. (2003) studied children who, at the beginning of the study, were between the ages of 9 and 13. The researchers followed this cohort for three years and concluded that “a representative population of children and adolescents growing up in the 1990s show that at

any time, at least 1 in 6 will have one or more psychiatric disorders by age 16” (p. 843). They also showed that females are more likely to develop a psychiatric disorder than male adolescents. The rate of co-occurrence, or the occurrence of more than one psychiatric diagnosis, varies between different studies. Some researchers suggest that the co-occurrence rate is 25.5% (Costello et al., 2003), while others suggest that the pattern is not prevalent within their sample (Merikangas, He, Brody, Fisher, Bourdon, & Korte, 2010). Although children and adolescents may grow out of their disorders as they mature, it is still important to understand the social relationship that they experience after being diagnosed, including the disclosure process.

#### *Treatments of child and adolescent disorders.*

This increase of diagnoses has led to an increased use of psychiatric services. One aspect of therapy that has changed recently is the increase of psychiatric medications to treat the symptoms of a psychiatric disorder. Cooper et al. (2006) indicated the “frequency of antipsychotic prescribing increased from 8.6 per 1,000 US children in 1995-1996 to 39.4 per 1,000 US children in 2000-2001” (p. 79). Zuvekas and Vitiello (2012) studied adolescents (18 years and younger) who were diagnosed with ADHD, and followed them for 21 years. Results showed there was an increase in the use of medication to treat the symptoms of ADHD. Similarly, after studying a group of children, adolescents, and adults, from 1993 to 2009, Olfson, Blanco, Liu, Wang, and Correll (2012) found that there was an increase of prescribed psychiatric medication among these populations and an increase in prescriptions available for children and adolescents.

*Stigma against adolescent consumers of psychiatric services.* It has been shown that those diagnosed with a psychological disorder, in general, are treated differently because of their condition (Rüsch, Angermeyer, & Corrigan, 2005; Quinn & Chaudior, 2009). Vast numbers of studies have shown stigma exists against those diagnosed with a mental disorder. Link and Phelan (2001) believe stigma is shown when “elements of labeling, stereotyping, separating,

status loss, and discrimination co-occur in a power situation” (p.367). An example of this could be an adolescent diagnosed with a mental illness who is perceived as less important by others, and ostracized or separated from the general population. Moses (2010) studied children who were diagnosed with a mental disorder and the influence that others’ behavior has on the individual. One of the interactions focused on in this study was the interaction between the child and her peers. There were three categories of stigma found, including the experience of no stigma, the experience of a moderate amount of stigma where the child was “judged and discriminated or stopped being a friend” (p. 989), and the substantial amounts of stigma where the child experienced alienation and exclusion from his peers. The choice to disclose information was obviously not a benefit for these groups of children, showing a negative outcome of disclosure. Moses also found that the children “chose to conceal their problems or treatment from peers to protect their peer relationships” (p. 992).

If this stigma occurs in diagnosed children and adolescents, it seems like it would be difficult to disclose this information about themselves to their peers. The fear of this stigma enacted toward them could be a link to the lack of disclosure. In order to protect their friendships and increase likability among their peers, adolescents may not want to communicate personal mental health information to others, including the diagnosis and subsequent treatments.

#### **Consumers’ Knowledge of Disorder and Disclosure**

When a child is diagnosed with a mental disorder and given a treatment plan, the understanding of that information could be confused with what they are actually experiencing. Mental health literacy is defined as the “capacity to acquire, understand, and use information in ways which promote and maintain good health” (Nutbeam, 2009, p. 304). Factors such as development and age could hinder a child from fully comprehending his diagnosis and

treatments. Not knowing this information could prevent clients from revealing information about their diagnosis to others. If the child does not know how to verbally relay information about his or her diagnosis, the child may not feel comfortable disclosing information.

Previous studies of client's knowledge of mental health information focus on the client's ability to comply with taking medicine. These studies provide insight of how knowledge affects compliance, or conforming behaviors. Gray, Wykes, and Gournay (2002) suggest that clients are more compliant with taking their medication when distributors explained information about their illness and treatment to them. By doing this, the clients felt comfortable taking the medications prescribed. What might be taken from this study is that the patients were more content when they understood their diagnosis more clearly. If adolescents diagnosed with mental disorders understood the information given to them about their disorders, it could make them more comfortable with their diagnosis and increase their level of disclosure. They may be more confident within themselves to have a conversation with peers about their disorder and treatments.

*Mental health literacy of late adolescence.*

There have been some studies that have gathered information on adolescents who are in late adolescence and their mental health literacy. Research has focused on the mental health options that are offered for college students and their understanding of mental health literacy as a general population. For example, Lauber, Ajdacic-Gross, Fritschi, Stulz, and Rossler (2005) distributed online surveys and received 225 responses from college students in Switzerland. The survey was designed to help understand students' mental health literacy, trying to comprehend if this population would understand the symptoms of depression and schizophrenia and the prevalence of different disorders. The researchers found that participants were better at identifying depression symptoms, but schizophrenia symptoms were identified to a lesser extent. Reavley, McCann, and Jorm (2012)

explored some of the same concepts of college students' mental health literacy. The researchers gave out vignettes, or short stories, to the general population at an Australian college that simulated a person who had depression. Participants would have to identify the disorder that went along with the story. The researchers also wanted to know how willing participants were to use resources and if they knew what resources were available. This study showed that most participants were able to recognize the symptoms of depression; however, knowledge of where to receive help was very low.

Unfortunately, I found no studies in my search for experiences of those late adolescents who are diagnosed with a mental disorder. The previous studies were completed among the general college population, but it would be interesting to understand the views of late adolescents who are already diagnosed with a mental diagnosis.

*Avenues through which adolescents receive mental health information.* Where adolescents receive information about their diagnosis could be a factor of how much knowledge they acquire about their diagnosis. This topic has not been studied, to my knowledge, in past articles in relation to disclosing information. An adolescent at any age will most likely be diagnosed by a psychologist or psychiatrist, who would then be expected to relay information about the diagnosis and treatment to the client. However, the explanations may be of a higher level of comprehension, which the adolescent may not be able to understand. Technology has enabled adolescents to seek understanding of their diagnosis through the Internet. After studying adolescents diagnosed with mental health disorders, Gray, Klein, Noyce, Sesselberg, and Cantrill (2005) found those diagnosed searched the Internet to find further explanation of their diagnosis. They concluded that "it might be useful for educators and health providers to have knowledge of teen-friendly sites that they could recommend to young people" (p. 243) who have been diagnosed with a mental illness. These results indicate that there is a shortage of comprehensible education of mental illness for



children and adolescents to access and use for their own knowledge.

### **The Current Study**

The importance of this study is to understand the disclosure process that adolescents endure in order to reveal their mental illness diagnosis to their friends. Most of the existing research regarding disclosure has been collected within the population of adults; there is very little qualitative research on the experience of what adolescents go through in such disclosure. In order to learn more about adolescents and their disclosure process, it is important to let them tell their own experiences. By doing so, psychologists and the general public can understand what adolescents endure when they are diagnosed with a disorder, and potentially help them feel more comfortable with their diagnosis.

Through qualitative methods, I attempted to understand the disclosure experiences among early and late adolescents diagnosed with psychological disorders. I wanted to dig deeper into their experiences and understand their personal perspectives when disclosing their information to their friends. By listening to personal stories and comparing and contrasting answers to the interview questions, I wanted to find what factors were involved in their decisions to disclose this information about their diagnosis. Results of this study show what factors influence the disclosure experience of adolescents.

*Research questions.* There are three research questions being explored in this study:

- (1) What is the process used by adolescents when disclosing information about his or her psychological disorder?
- (2) How likely are adolescents to disclose psychological information about their disorder to their friends?
- (3) What factors encourage or discourage adolescents disclosing information to their friends?

## **METHODS**

### **Researcher's Phenomenological Approach**

For this project, I took a phenomenological approach in order to capture the "lived experiences that belong to a single person" (Giorgi, 1997). By conducting interviews with the participants, I had a chance to understand the individual experiences when they disclosed information about themselves to their friends.

### **Researcher's Philosophical Stance**

In order to understand the themes that arise from this project, I took an interpretive philosophical stance. Smith (2008) described the interpretive stance as learning a "great detail about that particular person and their response to this specific situation" (p.43), which will give better insight on "how we and other people might deal with the particular situation being explored" (p.43) by trying to find themes between different stories that will be told.

### **Participants**

Participants were between the ages of 10 and 23 years old at the time of research, and were diagnosed with one or more psychological disorder(s). There were no specific disorder requirements that would exclude participants from being considered for this project. Parents of the minor children were a part of a local parent support group, which gave me permission to ask parents if their children could participate in this project. The older adolescents were college students from a mid-sized university who were enrolled in different levels of psychology courses. All participants received a \$5 Starbucks gift card and equivalent compensation for the younger participants, in return for completing this study.

### **Materials**

In order to address the questions for this project, I conducted semi-structured interviews, in an attempt to understand the disclosure experience from a subjective viewpoint of these adolescents. The interview questions consisted of 14 main questions followed by multiple sub-questions to get more detailed information, if needed. The last

few questions were buffer questions (e.g. “What movies are coming out soon that you would like to see?”) which attempted to revert the participant from thinking about his/her experience as an adolescent diagnosed with a psychological disorder, and ending the interview on a positive note.

### Procedure

*Early adolescence.* I received permission from the local support group to attend a meeting and talk to the parents about the project. After explaining the project, I answered any questions that the parents may have had. I provided copies of the parental consent form and the child assent form at the site of the study group. I left the site afterward, giving parents privacy and time to decide if they wanted to take a consent and assent form. My contact information was available on the consent form allowing the parent to contact me if they desired for their child to participate in this study. Once the parent contacted me, we agreed on a place and time that we could meet, along with their child, to commence the interview. We tried to agree on a location that was comfortable for the adolescent to be able to speak freely, and the interview was arranged on the social viewing site Skype to accommodate for traveling a far distance. Before the interview began, I received both the consent and assent forms via email. I asked the parent(s) to step out of the area to another area where they were not able to hear the discussion between me and the participant, but where they felt comfortable enough to listen if desired. I then asked the participant if he/she had any questions about this study before we began the semi-structured interview. Once he/she had no more questions, we proceeded with the interview questions. When the interview was over, the child received a small incentive and the debriefing form.

*Late adolescence.* The process of recruitment for late adolescent participants began by convenience sampling. I went into psychology classes of any level and asked for participation. After explaining my project to the class and making sure there were no questions, I left my

contact information so that anyone who was interested in participating would be able to contact me confidentially and voluntarily. I emailed copies of the consent forms to those who chose to contact me for participation. We agreed upon a location that was comfortable for the participant to be able to speak freely. Meeting the participant at the scheduled time, I collected the consent forms. I asked the participant if he/she had any questions about this study before we began the semi-structured interview. Once the participant had no more questions, we proceeded with the interview questions. When the interview was over, the participant received a small incentive and the debriefing form.

### Data Analysis

All of the interviews were recorded on a handheld recorder. Afterward, each interview was transferred to a password-protected computer. Once the interviews were transcribed, they were manually reviewed by the interviewer to find themes between the participants of the study.

## RESULTS

Table 1 is a description of the participants for this study. There were 7 total participants who were interviewed; 5 participants were female and 2 participants were male. The current ages of the participants ranged from 10 to 23 years. The mean age was 18 years old. The age at which the participants were diagnosed varied; the mean age at diagnosis was 13.5 years old.

The diagnoses reported included: anxiety (specific diagnosis not disclosed during interview), Posttraumatic Stress Disorder (PTSD), Bipolar Type 1, Attention Deficit Disorder (ADD) and Schizoaffective disorder.

### Interview Themes

There were three main themes that were focused on for this project: the type and quantity of disorders, perceived stigma, and the knowledge of the disorders. After the interviews were typed and read multiple times, their stories revealed that the quantity and type of disorders and treatments did not have much of an effect on disclosure

practices. Stigma and knowledge were the two themes that provoked reasons why participants had or did not have differences in disclosing their psychological disorders. One new theme developed during this interview, which involved the issue of trust within the friendship. It was found that trust within the friendship encouraged them to disclose their personal information more often.

*Type and quantity of disorders in relation to disclosure.* This theme was developed to see if the type of disorder and the quantity of the disorders would result in more or less disclosure practices. The type of disorder presented was not specific to any description. The quantity referred to the number of disorders diagnosed for the participant. There did not seem to be any difference in disclosure practices based on the quantity of diagnoses and type of disorder. Although some of the participants had difficulty in disclosing information, it does not have a direct link to the present theme. For example, one participant reflected:

But I think that bipolar is in this ambiguous position where the general population like has a kind of like assumption of what it is about. They know and say things like mood swings, but they do not have an in depth understanding so I kind of feel like it wouldn't lead someone, saying that I'm like violent or schizophrenic. It's way more moderate.  
(P3)

When participants discussed if they had disclosed information about their diagnosis and treatments to their friends, they all revealed that they disclosed information about their disorders, regardless of diagnosis. Participant 1, stated she had "just recently" told her friends about her diagnosis; however, she doesn't "tell a whole lot of people about [her medication]..." The younger-aged children had also disclosed information about their disorders with their friends. One participant explained that he has "told some of his friends." Having a psychological disorder and treatments did not hinder the individuals from

disclosing information, but disclosure may have been more difficult for some participants. The reasons for why some participants had difficulty disclosing information could be due to the preceding factors of knowledge of their disorders and the perceived stigma of their friends.

*Disclosure of medication to friends.* Participant 1 stated that she does not "tell a whole lot of people about that" but her "best friend knows" about her medication use. Participant 2 commented that she was very rebellious, so she would rather talk about it in a negative way rather than how it affected her. There were some who did not talk about their medications to their friends, especially the younger adolescents, who did not talk about their medication in as much detail as the older adolescents. This could possibly be due to the fact that they were experiencing the medication effects currently and have so for a shorter period of time; in other words, they have not had enough time to fully understand what the effects of the medication are and why they are actually taking the medication. This may inhibit how much they talk about it with their friend groups in general because the comprehension behind their treatments is not available to them. That perspective leads into the next theme of the project, the health literacy of their psychological disorders.

*Knowledge of disorders and the effect of knowledge on the disclosure process.* The participants seemed to have basic knowledge of their disorders and treatments, and explained each during the interview. However, those who were initially diagnosed at a younger age had a harder time understanding the basic knowledge of their disorders and treatments (participants 5 and 7). Participants derived their initial information about their disorders from multiple places. This included the psychiatrist, their physician, and professional online sources. Participant 2 said she "knew what PTSD was long before [she] got it." She was predisposed to it by a family member who was a veteran. But she researched her disorder extensively after being diagnosed. The means of which she researched this information included "EBSCO and the National Institute of Health"



Table 1. Participant Descriptions.

#	Gender	Age	Race/ Ethnicity	Grade /Ed. Level	Diagnosis	Counseling	Medication	Current Treatment	Age of Diagnosis
1	F	20	Hispanic/ Latino	Soph	Anxiety*/ PTSD	X	X	Yes	18
2	F	19	Caucasian	Jr.	PTSD	X	X	No	16
3	M	23	Caucasian	Sr.	Bipolar Type 1/ ADD	X	X	Yes	18
4	F	18	Black/ AA	Fresh.	PTSD/ Anxiety*	X		No	16
5	F	22	Caucasian	Sr.	Bipolar	X	X	Yes	7
6	F	14	Caucasian	7 <sup>th</sup>	Schizo- affective	X	X	Yes	12
7	M	11	Caucasian	4 <sup>th</sup>	Bipolar		X	Yes	8

Note: \*Specific diagnosis not disclosed during interview

because she was a college student and had access to these resources that the general public cannot usually access. Participants 3 and 4 both received information about their medication from a psychiatrist. Unfortunately, there was one child who did not understand much about her diagnosis. Participant 7 said she did not “know about bipolar, actually.”

The majority of the participants knew about their disorders and had multiple places where they could ask questions and find answers if needed. Throughout the interview, there was a link between knowledge and how much they disclosed initially to their friends. When asked “if you knew more about your diagnosis and treatment, would that affect how much you disclosed information,” they responded mostly by saying that it would increase the chances that they would disclose this information to their friends. One way that knowing the statistics and prevalence rates of different disorders would help clients personally, by reducing the feeling of someone being “singled out” (P1). An increase of knowledge of their disorders would also give them a background to help them explain their diagnosis to others. Participant 3 explained:

I was young at the time when this all happened, I had just turned 18...in terms of intelligence, I was young, and if I could have, it seems completely impossible for an 18 year old to have the current banter setting that I do because of psychology and all that stuff...I didn’t have the knowledge or intellect, neither did [my friends].

These patterns were consistent with the younger adolescents as well; most stated that if they knew more information about their diagnosis and were able to understand how their treatments affected them, they would be able to explain it to more of their friends.

*Anticipated stigma and disclosure experiences with peer groups.* Participants had both positive and slightly negative responses to their feelings of initially disclosing to their friends. When participants were asked to reflect on when they initially told their friends about their diagnosis, and if they thought their friends would disown them, most of them had similar responses. Participant 4 said that “...they wouldn’t disown me” and Participant 3 said “my friends would

never do that.” Most participants did not feel like stigma was an issue when disclosing information, but not all of them.

There was one participant who had a different reaction when disclosing this information with her friends. After she had disclosed this important piece of herself, she said that she:

kinda lost connections with [her] friends and like every time I walk by them in the hall they are pointing and laughing at me.

Because of this unfortunate feedback, Participant 6 was not able to talk as freely with her friends as others indicated they were. Others viewed their friends as supportive and easy to talk to about any aspect of their disorders. These friendships that had developed helped participants cope better. Participant 4 reported that her friends would come with her to her counseling sessions. One of the youngest participants felt that he felt a lot of trust between him and his friends, they did not tell anyone about his disorder.

*Trust as a factor in disclosing information.* As the interviews progressed, a new theme emerged among the participants. Most of the participants mentioned that the trust among the friendships they have developed thus far is also a requirement for future relationships. Trust was a very important factor during disclosure. This was explained by participant 1, who stated:

I have to trust you, a lot... So it takes a lot of trust and I have to feel like you are not just going to leave when I tell you.

Participant 3 was also congruent with this concept when saying:

Once people are really interested in kicking it and getting to know you, it's kind of natural that those things come out.

Trust can also be showed in the way that they disclosed information to their friends. When asked what their initial disclosure process was, many said that it was with people who they could trust and within an environment in which they could freely talk about what was occurring. In lieu of making her difficulties seem too serious,

Participant 4 told her friends by telling it the form of a story:

So I would just like, tell them through a story to try to make it not seem like it's not that serious. Like 'oh I remember this one time by the way, I don't know if told you but I had bad anxiety last year' blah, blah, blah...

Others went through the same route by sitting down with a friend after they noticed her behaving differently. Once Participant 2 decided to talk to her friend, she told everything “all at once” while they “were in the basement or whatever and this is what happened.” Participant 2 felt relief afterward because her friend accepted her regardless of what was going on. Other participants said they had similar feelings.

## DISCUSSION

The aim of the current study was to better understand the disclosure process of early and late adolescents who have been diagnosed with a psychological disorder. Because friends are a very important piece of the adolescent experience, it is important to understand how adolescents of this population deal with disclosing a very important piece of information about themselves to their friends. Through the interviews, it seemed that the perceived stigma and the knowledge about diagnoses played roles in participants' process and experience of disclosing diagnoses to friends.

### Type and Quantity of Disorders and Treatments

Based on the interviews, there was not a large difference in the disclosure practices among participants depending on the type of diagnosis. Even though some participants may have had more severe disorders like bipolar and schizoaffective disorder, these participants were still able to disclose their information in some capacity. This suggests that the type of diagnosis and treatment were not major factors in their disclosure. Although Participants 1, 3, and 4 were diagnosed with more than one mental illness, the presence of having multiple diagnoses was not a hindrance in their ability to disclose their

information. This could also mean that the participants had enough support that the type and number of diagnoses were not necessarily factors. All of the participants reported that they disclosed their diagnosis and their treatments to their friendship groups, regardless if they were attending counseling or taking medication. They were not, however, comfortable with disclosing that information to strangers or to people they may not have been close with.

### **Knowledge of Diagnosis**

Knowledge, or health literacy, of the diagnosis was very low among participants when they were initially diagnosed with their psychological disorder(s). Participants expressed that, when diagnosed by a psychiatrist or a general physician, they received little or no information about their disorders. Those diagnosed very early did not understand the contents of their disorder in depth, and adolescents diagnosed in their late teens also had mixed levels of knowledge of their diagnosis, regardless if they received their diagnosis from a psychologist or a general physician. Gray, Wykes, and Gournay (2002) said that clients were more likely to take their medication if they understood the details of the medication and what effects it had on them. In comparison with these findings, it would benefit the consumer if they had knowledge available that is informative but adjusted for each level of understanding. This would make it much easier for adolescents to explain the reasoning for both the diagnosis and treatments to their friends

The avenues through which adolescents acquired their information about their disorders and medications were mostly through the diagnosing psychologists and physicians. They were given booklets or drug sheets that explained their information. In order to find information that they could more fully understand or more details about their diagnoses and medication in general, the adolescents looked up information on the internet, aligning with the findings of Gray et al. (2005). Those participants represented in the college population who were majoring in psychology had their psychology classes' aid in

acquiring more information and better understanding of their disorders.

The participants expressed that they wished they could have had a better understanding of their diagnosis when they were initially diagnosed in order to be able to communicate that information effectively to their friends. Those with the most difficulty were diagnosed at a very young age and did not have the cognitive ability to understand the sophisticated language that surrounded their disorders. In all, participants believed that the lack of knowledge was a great barrier to disclosing information to their friends. If given age-appropriate information and having more conversations with the provider, they could have been better prepared to explain their diagnosis to others. This data could be used in order to help psychologists and psychiatrists develop simpler and tailored pamphlets for their clients, in a way that would be easier to talk to or translate the information, especially to their younger clients.

### **Stigma Presence amongst Friends**

Link and Phelan (2001) defined stigma as the act of being stereotyped negatively and treated differently than others. The adolescents in this sample generally did not think that their friends would stigmatize them after disclosing their psychological information. They may have been a little apprehensive at first when they decided to disclose, but they did not feel like their friends would stigmatize them, or change their behavior towards them. Clark and Reis (1988) believed that adolescents diagnosed with a disorder want to feel acceptance among their friends, regardless of their mental illness. The current study showed exceptional rates of acceptance among their friends. In general, friends responded in a very positive manner, not disowning or departing the friendship, and being supportive of the situation. Not all of the instances were as joyous as the others, where the reaction to the news ended up destroying the bonds within the friendship group. This study reveals that there are various ways that people can react when being disclosed to, and that

clients will not always be supported by others around them.

### **Trust and Confidentiality within the Disclosure Process**

The concept of trust was a theme that developed on its own when conducting interviews. Adolescents thought that trust was a very important aspect when making the decision to disclose information. Even the two youngest participants stated that it was important to develop a trusting relationship with their friends before relaying any information to anyone. Along with Clark and Reis (1988), participants wanted to ensure trust and support among their friendships when describing information.

Not only was trust the main factor, but confidentiality was talked about a number of times. The disclosure experience was mostly done in private. This coincides with the study done by Kobocow, McGuire and Blau (1983). These researchers focused on the confidentiality of adolescents during a counseling session, and their willingness to disclose information. Although the current project did not focus on confidentiality between the adolescent and the counselor, participants reported that the disclosure process took place within a confidential setting or in a private setting with their friends. A person who the adolescent may view as potentially judgmental would most likely not be invited to be in such a specific place. Just as in a counseling setting that is confidential and designated as a “safe place,” it appears that this is what these participants are experiencing with their close friendship groups.

### **Conclusions**

The disclosure experiences of adolescents diagnosed with mental illness has not been studied much throughout the literature. The results of this project reveal that like “typical” adolescents, the friendship bond is even more necessary because of the support that it brings. Friendships could play the role of the mediator to buffer out negative experiences that could occur, making it easier for those with disorders to cope with the issues they face. Friends are more accessible resources for adolescents. The benefits of this bond could help

build upon the friendship, increasing trust and a feeling of acceptance, and providing greater cohesion between the friends or friend groups.

Further studies could be done in order to help psychologists and others who are diagnosing clients within this age group to find ways to help clients disclose this information to those close to them. Providing more understandable information to the child would help them comprehend the information, therefore increasing the chances that disclosure occurs and is not kept hidden. Stigma does occur often, but education about disorders could lead one to being more confident about his and her disorder. Psychologists should be equipped to talk about the stigma that the client could face, and also help their clients develop coping skills to help deal with stigma. Overall, this could lead to helping clients improve their situations in a healthy way rather than not disclosing about it and keeping it hidden.

### **Limitations**

One limitation of this study was the demographics of the participants. Five out of the seven participants were Caucasian. However, there were two participants from African American and Latino/Hispanic descent. That is mostly due to the demographic representation on the campus from which I recruited the participants. Even with the small number of participants, it was a pretty accurate representation of the campus demographics. This is also true in gender, since this campus is predominantly represented by females. The two younger adolescents were also Caucasian, so a better representation of the general population would help confirm or dispute the findings of this study.

Another limitation was that the older participants were recruited were from the psychology department at the university. This could have affected the amount of knowledge that a few of the participants received about their psychological disorders. This could reflect the higher rates of health literacy among the older adolescents.



The final limitation was the interview questions and my inability to confirm my findings with the participants. The focus of the project was to obtain a phenomenological and interpretative stance of the participants, where I decided to develop the questions to ask the participants myself. Because I am a novice qualitative researcher, there may be room for improvement in my development of questions and interviewing technique. Additionally, I would have ideally asked the participants for their input to confirm the accuracy of my interpretations.

### Future Research

In order to get an overall picture of the adolescent disclosure process, it would be valuable to have a larger sample size. It would also be useful to further the research to understand how knowledge of disorders are explained to children, and to understand if there is a uniform protocol that clinicians go through in order to distribute information to young consumers. This would help to better understand if these findings are comparable or different.

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