# THE FORM AND FUNCTION OF SELF-DISCLOSURE IN DEPRESSED ADOLESCENTS

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**THE FORM AND FUNCTION OF SELF-DISCLOSURE IN DEPRESSED**

**ADOLESCENTS**

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University of Pittsburgh, 2013

Adolescent depression is a major public health concern, prevalence estimates of which indicate that from 9.5% (Costello, Mustillo, Erkanli, Keeler, & Angold, 2003) to 11.7% (Merikangas et al., 2010) of adolescents may experience at some point; these depressive episodes have been linked to numerous physiological, psychological, educational and general functioning deficits. Although children and adolescents are known to be the subject of harsh stigmatizing beliefs (Perry, Pescosolido, Martin, McLeod, & Jensen, 2007), little research has been conducted on adolescents' perceptions of mental health focused stigma experiences and coping mechanisms.

Stigma experiences such as those experienced by persons with Mental Health (MH) concerns can lead many to manage the disclosure of their potentially stigmatizing feature, often choosing to conceal those features which can be concealed (Wahl, 1999b). The Visibility Management (VM) concept seeks to explain some of the underlying processes in how individuals cope with stigma through the manipulation of disclosure, allowing them to decide who in their lives is emotionally "safe" to disclose to, versus who may react negatively to such disclosure (e.g., stigma), resulting in concealment. This project sought to explore the processes by which depressed adolescents engaged in VM within the relationships of those other persons whom they consider important.

This study of seven female adolescents with depression employed a multi-modal data gathering technique consisting primarily of qualitative interviews and utilized an innovative

hand-on activity focused on the perceived strengths and weaknesses of the adolescent's individualized social network. As a part of this process, I paid special attention to any reported incidences of the concept of a strategizing partner (Safe Other), reflecting a potential socially-based resource to depressed adolescents as originally described in the popular culture literature of the Autism Spectrum Disorder community. Subsequent between- and within-case analyses revealed that participants engaged in a complex decision-making process aimed at balancing their daily needs with the perceived burden their disclosure placed on others in their lives. This process often resulted in partial disclosure of their depression status. Finally, this work identified trends regarding the designation, utilization, and evaluation of a Safe Other indicating relevant directions for future research.

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# PREFACE

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# 1.0    INTRODUCTION

Adolescent depression constitutes a major societal issue warranting psychological, educational, medical, and policy consideration.  Cross-sectional examinations (e.g., Costello et al., 2003) and meta-analyses (Costello, Erkanli, & Angold, 2006) of cross-sectional research of prevalence rates in the United States and various other countries have found a fairly stable range of 2.2% to 2.8% (respectively) of adolescents experience depression at any one given time. However, when they examined the data from their 16 year adolescent study longitudinally, Costello et al. (2003) found that over the years observed, 9.5% of the sample population experienced a depressive episode.   Likewise, in the 2010 report on the National Comorbidity Survey–Adolescent Supplement data (Merikangas et al.), 11.7% of adolescent participants scored positive for depression disorders. These prevalence rates are higher than those found nationally (8.7% of those aged 8-15years; Froehlich et al., 2007) and internationally (5.29%; Polanczyk, Silva de Lima, Horta, Biederman, & Rohde, 2007) for Attention Deficit Hyperactivity Disorder (ADHD), a disorder that garners much attention as a "major public health concern" (Polanczyk et al., 2007, p. 942).

The past three decades have seen a marked increase in the attention paid to depression in children and adolescents among the general public and psychological community (U.S. Public Health Services, 1999) due to the link between adolescent depression and a number of detrimental outcomes such as the  higher rates of cigarette smoking (Fergusson & Woodward,

2002; Franko, Striegel-Moore, Bean, et al., 2005), adulthood obesity and higher body-mass index among females (Franko, Striegel-Moore, Thompson, Schreiber, & Daniels, 2005), and risky sexual behaviors (Mazzaferro et al., 2006). Those who had late-onset adolescent depression experienced generally poorer health, and more impairment in terms of missed work and health care utilization, despite having comparable rates of chronic illness as their non-depressed counterparts (Miller, Constance, & Brennan, 2007).

Psychiatric disorders in general are linked to detriments in global functioning; adolescents with depression have higher probability of evidencing detriments in their current and future academic, socioemotional, economic and even physiological functioning as compared to their non-depressed counterparts. One specific link has been found between adolescent depression and higher rates of school dropout (Vander Stoep, Weiss, Kuo, Cheney, & Cohen, 2003). One review in Canada (Fortin, Marcotte, Potvin, Royer, & Joly, 2005) found four dropout trajectories, three of the four demonstrating rather high depression scores when compared to comparable non-dropout age-mates, and one trajectory pointedly defined by high levels of clinically significant depressive symptomology. A second Canadian study by Janosz, Archambault, Morizot, and Pagani (2008) explored seven engagement trajectories, finding that the four trajectories with the highest prevalence of students with special educational needs (including learning disabilities and emotional and behavioral concerns) also had the highest rates of drop-out. Considering that school dropping out itself has been linked to detriments in health (Freudenberg & Ruglis, 2007 ) and socioeconomic functioning (Fortin et al., 2005; U.S. Public Health Services, 1999; Wilcox-Gok, Marcotte, Farahati, & Borkoski, 2004), the depression-dropout link is troubling.

In terms of mental health outcomes, adults who as adolescents experienced depression have been found to have lower self-esteem, more concerns about their weight (Franko, Striegel-Moore, Bean, et al., 2005), higher incidences of future mental health episodes (Costello et al., 2003; Fergusson, Boden, & Horwood, 2007; Fergusson, Horwood, Ridder, & Beautrais, 2005; Fergusson & Woodward, 2002; Jonsson et al., 2011), higher incidence of suicidal ideation and attempt (Fergusson et al., 2007; Fergusson et al., 2005; Fergusson & Woodward, 2002; Jonsson et al., 2011), and lowered social functioning when depressed (Frojd et al., 2008). These results can vary by severity and frequency of depressive episodes (Fergusson et al., 2007; Fergusson et al., 2005).

Educational and social functioning are also often compromised; those with adolescent onset of depression have higher rates of declining grade-point average, performance and concentration difficulties (Frojd et al., 2008), lower rate of obtaining some form of higher education (Jonsson et al., 2010), general educational under-achievement (Fergusson & Woodward, 2002), higher rates of delinquency (Ritakallio, Kaltiala-Heino, Kivivuori, & Rimpela, 2005), and higher rates of high school dropout (Wilcox-Gok et al., 2004). Such findings are not limited to studies in the United States.  For example, Fergusson and colleagues found that New Zealand youth with depression later achieved lower levels of education, lower general economic outcome, higher utilization of welfare  and unemployment services (Fergusson et al., 2007; Fergusson & Woodward, 2002), and greater risk of becoming a parent earlier than age-mates (Fergusson & Woodward, 2002). Such pervasive potential negative outcomes warrant continuing exploration into those factors that can help to mitigate current depression, and to provide to depressed adolescents those tools which can assist them in daily functioning so as to

head off future depressive episodes or the functional problems so often associated with adolescent depression.

While the cause of adolescent depression is unknown, the severity of this problem among adolescents is undeniable. One known influence of depression impetus, course, remission and intensification, the social environment of a given adolescent can help, and can hinder, a depressed adolescent's recovery. Inadequate amounts of peer and parent social support predict depression (Burton, Stice, & Seeley, 2004). As adolescents progress through a depressive episode, they face an increased risk of erosion to their peer social support (Stice, Ragan, & Randall, 2004). This can be complicated by the stigma commonly associated with mental health concerns, and the ensuing ostracization that many face when others in their lives learn of their mental health issues (Wahl, 1999a, 1999b).

Social contexts are of particular importance to adolescents (Nakkula & Toshalis, 2006). For example, adolescents with limited friendships or who were socially isolated reported more suicidal thoughts than age-mates (Bearman & Moody, 2004). Peer victimization predicts general mental health maladjustment, particularly when an adolescent experiences multiple kinds of victimization (Mitchell J. Prinstein, Boergers, & Vernberg, 2001). Adolescents who face bullying and victimization demonstrate a high likelihood to experiencing depression (Brunstein-Klomek, Marrocco, Kleinman, Schonfeld, & Gould, 2007; LaGreca & Harrison, 2005), and suicidal ideation and gesturing (Brunstein-Klomek et al., 2007). Many persons with psychological concerns or atypicalities opt to engage in concealment or limited disclosure so as to protect themselves from these social repercussions (Hane, 2004; Wahl, 1999b; Willey, 1999). In the gay, lesbian, bisexual, transsexual and queer (GLBTQ) community, this process of managing disclosure, or the visibility, of an otherwise covert potentially stigmatizing feature is

known as visibility management (Lasser & Tharinger, 2003). However, to date the processes of visibility management have not been explored in the mental health community; this investigation constitutes the overarching aim of the current project.

The social networks of the depressed adolescents in question may offer support, aiding the adolescent in coping with and recovering from his or her depression, or they may hinder these endeavors, most often by enacting stigma. Stigma has been defined a number of ways over the years (Link & Phelan, 2001); here, it is used to refer to the belief that due to some undesirable characteristic, the bearer of said characteristic is somehow less than those who do not bear the defiling characteristic. In this exploration, the objectionable characteristic is that of depression. Through stigma, a person's worth is reduced; they are seen as less good, less equal, than others without that stigmatizing feature (Goffman, 1997). Through their interactions within their social environments, adolescents suffering from depression are anticipated to experience both stigma and support. Such interpersonal interactions prompt introspective evaluations of self-other environment fit, which in turn prompt decisions regarding future interactions (Connell & Wellborn, 1991). By exploring the extent and influence of stigma, the potential impact of the social environment, and visibility management as an adaptive technique for rectifying the two, a clear path into the relevance and innovation of this project will be established.

In this study, two innovations will be undertaken in order to further current empirical knowledge about the social contexts of adolescents with depression – specifically, how stigma, support, and disclosure experiences interact in the daily experiences of depressed adolescents. Building upon previous work examining interpersonal closeness, this project's first innovation is the movement of the concept of Visibility Management from solely residing in the realm of the GLBTQ community, and into the incredibly relevant domain of mental health community. The

project's second and primary innovation is the creation of a coherent, concise conceptual definition of the Safe Other, a term inspired by the Asperger Syndrome and Autism Spectrum Disorder (ASD) community applied to disclosure strategizing partners. This project will explore these processes among depressed adolescents, a fairly prevalent mental health concern in a unique developmental period, characterized by unique developmental tasks and needs. The strategies used in the management of the stigma that depressed youth anticipate and experience in their own daily lives, by leveraging the naturally occurring support structures in their social networks, can be used to not only help future depressed youth, but also to add another layer to our understanding of youth social and interpersonal relationships.

## 1.1 SIGNIFICANCE OF THE PROBLEM: THE INFLUENCE OF MENTAL HEALTH STIGMA

Stigma is pervasive (Dinos, Stevens, Serfaty, Weich, & King, 2004; Link & Phelan, 2001, 2006). Ranging from overt features such as skin color, height, or physical disability, to covert features such as socioeconomic status, learning disability or sexual orientation, a plethora of personal characteristics can inspire social rejection, subtle de-valuing, discrimination, harassment, and even hatred and violence. While stigma and prejudice have been found to be two distinct concepts (Phelan, Link, & Dovidio, 2008), both result in an individual or group being maltreated due to a personal characteristic or feature, and therefore will both be discussed together when discussing stigmatizing features.

The execution of stigma itself can be undertaken in a variety of fashions. It can be perpetrated on a dyadic level, such as through hurtful statements; in a group level, such as public

recitation of a hurtful joke; or on an infrastructural level, such as anti-mental healthcare insurance policies (Link & Phelan, 2006; Wahl, 1999a, 1999b). Mental illness in particular is known to have a long history as a stigmatized feature (Link, Yang, Phelan, & Collins, 2004; Wahl, 1999b). Those with mental illness are particularly vulnerable, as their mental health concerns often already render them emotionally and often cognitively vulnerable; confrontation with potentially emotionally harming stereotypes and attitudes can have detrimental psychological and functional repercussions (Perlick et al., 2001). The risk of facing stigma makes navigating one's social worlds a complex task; one can never be completely certain who in their daily lives may harbor stigmatizing beliefs and attitudes.

Using the Bioecological model (Bronfenbrenner, 2005; Bronfenbrenner & Morris, 2005), conceptualizing the expansive impact of stigma on a given individual can be accomplished in a fairly succinct manner. Encompassing biological, environmental, social and temporal features of a given individual and their surroundings, Bronfenbrenner's model begins with the individual at the heart of the system. Biology, genetics, personal history and knowledge – these facets of the individual influence one another, and influence all surroundings rings. Surrounding the individual are the dyadic relationships that he or she is a part of – child with parent, adolescent with teacher, husband with wife; these form the microsystem. The next layer of influence, the mesosystem, is a system representing the interactions between the different relationships, such as the relationship between the home life and the school life. The interplay between these different relationships influences the individual in an equally encompassing yet less direct manner than the microsystem.

As each layer of influence supplements the preceding, it encompasses more yet becomes less direct of an effect on the individual. Comprising such relations as the connection between

the school and the neighborhood, the exosystem can both influence the actors that in turn influence the individual, and can influence the individual directly, such as through an IEP meeting. Finally, the macro system incorporates the cultural and sociopolitical influences that in turn influence the closer rings. Examinations of stigma as structured within and between these layers of influence allow for a fuller understanding of the potential impact of stigma on a given individual by helping to illuminate the complexities of the social world that people facing such challenges must navigate.  Only through a comprehensive understanding of this complexity can we craft appropriate, focused interventions.

### 1.1.1    Stigma in the macro- and exosystems.

Mental health stigma can be found at every layer of interaction within our society. From cultural and sociopolitical expressions to dyadic interactions, people with mental illness (MI) confront a variety of different kinds of stigma on a regular basis. On a societal level, people with MI have reported such institutional discrimination as inadequate to absent healthcare coverage for their treatments (Wahl, 1999a, 1999b). More mainstream-accessible forms of stigma that can be observed include the most frequently cited source of mental health stigma propagation found by one survey was the stereotypical portrayal of people with mental health concerns in the media, with 85.6% of respondents listing it as "much" or "very much" a contributing influence (Wahl & Harman, 1989), followed by media portrayals of violence perpetrated by the mentally ill as the second most cited influence.

The notion that people with mental illness are violent (Phelan & Link, 1998; Wahl, 1999b), despite the low prevalence of violent tendencies among those with mental illness, is frequently found in research on mental health stigma. Adolescents with mental health concerns

in particular are seen as more problematic, and even at times more dangerous, than their adult

counterparts, thereby even warranting forcible treatment (Perry et al., 2007). Researchers in turn

believe that the mentally-ill-as-violent stereotype influences rejection and ostracization of the

mentally ill, robbing them of an important source of support via a now truncated social network.

Additionally, the use of the insanity defense (even though "insane" is a legal term, not a medical

or psychological term), jokes about MI, commercial references to MI, and even news coverage

of the homeless all are believed by research respondents to play a stronger role in influencing

one's opinion of the mentally ill than do personal encounters with MI persons (Wahl & Harman,

1989). In fact, recent research has found that those with increased amount of contact with others

who have mental health concerns tend to have less ostracizing attitudes toward those with such

concerns (Boyd, Katz, Link, & Phelan, 2010).

**1.1.2    Stigma in the meso- and microsystems.**

On a more intimate level, research participants often report that interpersonal interactions in

particular are fraught with complexity and experiences of stigma, some reporting such

experiences as social withdrawal within the extended family, condescension and lack of

understanding in interactions with healthcare professionals, and hostile or rigid reactions by

coworkers, business relations (such as landlords), and authorities (Angermeyer, Schulze, &

Dietrich, 2003; Wahl, 1999a, 1999b).

Stigma can also influence the individual by being inflicted upon the relationship partners.

For example, family members of those with mental health concerns can also be stigmatized

against, or may otherwise experience stigmatizing incidences, simply due to their relationship

with the individual who has mental health concerns. Called "courtesy stigma" in some literature

(Angermeyer et al., 2003), family members of those with various mental illnesses have reported experiencing stigma in multiple domains and in multiple ways. Varying levels of courtesy stigma have been reported; potential factors influencing this may be the relational closeness of the two people (e.g., cohabitation; Corrigan, Watson, & Miller, 2006; Phelan, Bromet, & Link, 1998), or the demography of the person with mental health concerns, such as sex or severity of the symptoms reported (Phelan et al., 1998). Some relatives, particularly children of persons with mental health concerns, report being told that they are "contaminated" by their relatives' troubles, and that their own relationships can be affected such that they are ostracized or relationships dissolve (Corrigan, Watson, & Miller, 2006). Finally, family members report feeling blamed for their relatives' difficulties (Corrigan, Watson, & Miller, 2006). All of these negative experiences can help to explain why those who were interpersonally close to someone dealing with MI could then distance themselves from that same person in their time of need.

Not only do the individuals with mental health concerns face stigma at every level of interaction, but those individuals in their support structures have also reported experiencing stigmatizing comments and actions in their own interpersonal interactions, in sociopolitical structures such as health care systems, and in cultural venues such as media portrayals (Angermeyer et al., 2003). Not only is it possible that the relationships partners harbor the same stereotypes and stigma as are found throughout our society, but these negative courtesy stigma experiences may influence the relationship partners to distance themselves from the individual with mental health concerns. Approximately 1 in 5 respondents reported that they believed stigma negatively affected their relationships within their families, including both with non-ill family members and with the family members who did have mental health concerns (22% and

20%, respectively; Wahl & Harman, 1989). Thus those with mental illness can face stigma at any level, and social distancing at any level, depleting their social contextual support system.

As social context sources are depleted, even those individual who are not depressed or coping with MI can suffer negative socioemotional repercussions. Research on loneliness has suggested the existence of a stigma specifically against being lonely, and research on depressed adolescents specifically has revealed it to be an important factor in suicidality and suicide attempting (Rokach, 2012). Further, lack of social support has been linked to mental health hospitalization (Webber & Huxley, 2004), though other research suggests that this is instead a function of fulfilling interpersonal relationships and attachments, rather than simply global level of support (Webber, Huxley, & Harris, 2011). The individual's emotional and cognitive perceptions of support and stigma, and of the self, can lead to different interactions with the environment, and can elicit different responses from all parties involved.

### 1.1.3   Self-processing systems and socioemotional repercussions.

In each interpersonal situation, individuals decide, consciously or subconsciously, whether or not to engage in the activities going on around them. These decisions are often based on self-evaluations that the individuals perform, determining whether or not they perceive themselves to be competent in the situation, that they can self-direct their actions, and if they have established key relationships with the important other persons within that environment (Connell & Wellborn, 1991; LaGuardia, 2009). The theoretical model of Self-Processing Systems situates the active role of the individual in question within the self-development processes, based upon the foundation of the underlying drive to fulfill these three basic human needs (Connell & Wellborn, 1991) of competence, autonomy, and relatedness (Deci & Ryan, 1985; Ryan & Deci, 2000).

Self-systems contends that the search for need satiation through engagement is not a passive, unidirectional process, but rather that the individual is an active participant (Guay, Boivin, & Hodges, 1999), becoming increasingly cognizant of their role in their own development as they mature. As the individual child or adolescent develops, they actively seek out experiences, contexts, and interactions which will fulfill the three basic needs (Guay et al., 1999; Reeve & Jang, 2006).

Due to the ongoing self-evaluation and re-assessment of need fulfillment, while some individuals may form positive self-evaluations, others form negative self-evaluations. These negative beliefs about themselves (Connell & Wellborn, 1991), and the negative emotions associated with these negative self-evaluations (Schweinle, Turner, & Meyer, 2008), frequently prompt such behaviors as disengagement or disaffection with the socioemotional environs. In school, students who experience academic challenge or failure without adequate support may attempt to manage future experiences by emotionally protecting against such risk, thus self-sabotaging within the learning context (Griffin, 2002; Meyer & Turner, 2006) or disengaging themselves from a damaging context (Davis, 2003; Griffin, 2002), an action which in itself has been linked to worsening of mental health concerns and/or lengthening of mental illness episode (Boyd-Ritsher & Phelan, 2004). In more social contexts, these beliefs manifest as withdrawal and self-isolation and internalization of stigma, a very detrimental potential route for coping with negative interactions and beliefs.

### 1.1.4 Stigma internalization and mental illness recovery.

Different people evaluate and process negative situations in different manners; some opt to rebel against perceived injustices (Corrigan & Watson, 2002a; Nakkula & Toshalis, 2006). However,

when facing stigmatization, many other people internalize these negative beliefs and attitudes, adopting them as part of their self-image (Corrigan & Watson, 2002a). A mental health-specific example would be the belief that people with mental illness are incompetent and need to be taken care of, called paternalism (Corrigan & Watson, 2002b), a particularly common form of stigma experienced by those with depressive disorders (Dinos et al., 2004). This paternalism would then lead to learned helplessness and an erosion of feelings of competence, a fundamental psychological need, which could in turn lead to withdrawal from the social context. Link, Struening, Neese-Todd, Asmussen, and Phelan (2001) found that perceived stigma and subsequent social withdrawal both significantly predicted a negative impact on self-esteem, even after statistically accounting for the impact of initial depressive symptomology and various demographic characteristics such as age and sex, known to impact depression.

Perceptions and subsequent evaluations play a key role in determining whether or not experienced stigma is then internalized. Internalization can even occur when the stigmatized person is not certain that they have been stigmatized against, but rather suspects that they are perceiving subtle cues regarding another's suppressed stigmatizing attitudes (Huws & Jones, 2008). Research has linked simply being preoccupied with or vigilant to incidences of stigma with worse initial symptomology (T. Rose, Joe, & Lindsey, 2011), higher levels of symptomology months into treatment (Perlick et al., 2001), and medication regimen compliance (Sirey, Bruce, Alexopoulos, Perlick, Friedman, et al., 2001). Likewise, when internalization of negative stigmas has been observed, it can have detrimental effects on a person's self-esteem and general mental health (Boyd-Ritsher & Phelan, 2004), willingness to seek help (Barney, Griffiths, Jorm, & Christensen, 2006), and when help is attained, then higher rates of succumbing to attrition (Sirey, Bruce, Alexopoulos, Perlick, Raue, et al., 2001).

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However, research has found that simply being aware of stereotypes about mental health did not significantly predict mental health repercussions (Corrigan, Watson, & Barr, 2006). Findings such as these lead Corrigan's and Watson's research team to hypothesize a three-part model in which the stigmatized individual's: awareness of stigma and perception of stigmatizing actions as intentionally directed; perceptions as to the legitimacy of the stereotype (i.e., their belief that the stereotype and subsequent discriminatory behavior is justified); and affiliation with the stigmatized group all contribute to the psychological consequences, or lack thereof, of stigma on the stigmatized (2002a).

### 1.1.5 Stigma and adolescents: A neglected population?

The research on mental health stigma presented thus far has almost exclusively entailed adult samples. This is not due to oversight; rather, this is representative of the literature in the field – the majority of research studies on mental health stigma to date has been conducted with individuals from emergent adulthood (e.g., college-aged participants) through late adulthood; adolescents as a developmentally unique life stage have not inspired very many studies of mental health stigma to date.

Of the few studies completed using child or adolescent participants or subjects (e.g., as focal object of vignettes), many findings have paralleled those of adult-centric studies regarding impairment (Jaycox et al., 2009) and the relationships of stigma on depression severity (T. Rose et al., 2011). However, in one particularly illuminating study in which vignettes depicting a mentally ill adult versus a mentally ill child, Perry and colleagues (2007) found that respondents endorsed harsher stereotypes and proscriptions for treatment for children than for adults. This bespeaks a greater need to understand the stigma experiences of youth.

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## 1.2 SIGNIFICANCE OF THE PROJECT: THE INHERENT POTENTIAL OF ADOLESCENTS' SOCIAL CONTEXTS

Adolescents face challenges and experience needs that differ from other developmental periods. Changes in biology, neurocognitive structures, and social roles and expectations all place pressures on adolescents to become more adult-like (Steinberg, 2005). In particular, adolescence is a pivotal developmental time for identity development (Erikson, 1968, 1994).

Neurocognitive development has typically progressed such that theory of mind and a conceptualization of self as an individual are in place early in life (Oyserman, 2001). As children continue to mature, the development of hypothetical reasoning allows for the weighting of options in decision-making, so that options for action can be strategized about prior to enactment (Steinberg, 2005). These skills develop such that by engaging in concurrent utilization of new and pre-existing cognitive strategies such as problem-solving techniques, children and especially adolescents can engage in metacognitive exercises, comparing one strategy to another, allowing them to refine their own cognitive performance (Kuhn, 2000). However, during adolescence emotions tend to be intense (Arnett, 1999) which can impair rational, logical thought, so that adolescents often struggle with considering long-term consequences and outcomes over present, proximal concerns (Steinberg, 2005).

The formation of a self-authored, more adult identity involve all of these cognitive (i.e., hypothetical reasoning and decision-making) and emotional (i.e., emotional regulation) abilities, as well as introspection and metacognitive probing into the wants, desires, affiliations and future orientations with which an adolescent identifies (Oyserman, 2001). The process of self-definition can be incredibly stressful to an adolescent, often involving a period of identity questioning and exploration (Erikson, 1968; Marcia, 1966). Likewise, the renegotiation of social roles, such as

the autonomy struggles of adolescent – parent relationships (Judith G. Smetana, Campione-Barr, & Metzger, 2006), or the maturation of the student-teacher relationships (Davis, 2003; McHugh, Horner, Colditz, & Wallace, 2012), can be stressful and even conflict inspiring.

During the gradual transition from childhood into adulthood, the people in a given adolescent's life can impact development tasks such as decision making processes, identity formation and role negotiation by offering support, facilitating in pragmatic manners such as resource provision or strategizing, or hindering decision-making such as by pressuring or trying to control the adolescent or by adding distracting stressors (Collins & Laursen, 2004). Many youth and adolescents have at their disposal a naturally occurring social support system: parents and family members; teachers and school personnel; youth and community leaders; and friends and peers all have the potential to support a youth while going through both normative developmental challenges, and those experiencing particularly trying time (Nakkula & Toshalis, 2006).

As adolescents mature, social relationships begin to shift, with adolescents spending less time with their parents and more with the peers as they exercise their autonomy and seek new, more adult identities. However, each social domain – parental, familial, friend, peer, romantic, and other non-familial adults – can and do still have an important and unique contribution to the development of the adolescent (Collins & Laursen, 2004; Judith G. Smetana et al., 2006). When examining the unique and additive effects of neighborhood, school, friend and familial factors on a composite variable of general student success, Cook, Herman, Phillips, and Settersten (2002) found different effects of each context, though the strongest effects were those found when examining the additive properties of multiple contexts working together.

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However, we know that the influence of social supports manifests as more complex than a simple summation of number of supports would suggest. For example, Cauce, Hannan, and Sargeant (1992) found that different support sources had more or less influence on the stressors of various domains in that when the domain and source were concurrent – such as peer support for peer-based concerns – they observed a stronger buffering effect of the support. Crossing domains, family support showed a strong buffering effect on both general adjustment and various sources of stress. Further, when locus of control was taken into consideration, these results evidenced that even when experiencing negative events, adolescents who reported higher levels of family support suffered less effect on their school competence.

### 1.2.1 Social support as counterbalance to mental health concerns.

Social support, particularly within high-quality relationships, appears to be a protective factor against developing social anxiety and depression, whereas low-quality or negative friend and romantic relationships are strongly correlated to depression (LaGreca & Harrison, 2005). Social interactions between two or more individuals can be beneficial, or detrimental, depending upon several factors of the individuals, the nature of the interaction, and the context in which the interaction occurs. In an effort to explicate some of the complexities of what makes an interaction supportive, Shinn, Lehmann, and Wong (1984) propose a five-dimension model that examines support as an interpersonal transaction in which multiple factors influence one another. These five dimensions – "amount, timing, source, structure, and function" (p. 1) – begin to illustrate the complexity of daily social interactions. Specific to this study, their discussion of source of support suggests that congruency between providers of support and the contextual locale of the source of stress may yield more beneficial, successful support than instances when

the source of support is from a different context than the stressor, or when the support receiver

perceived the provider of support to be inefficacious within the stressor's context.

Adolescents' social worlds can be diverse and complex, and their potential stressors and

supports range across a variety of roles, contexts, and functionalities such as academics to

relationship formation. However, before exploring the potential supports that a given adolescent

may have access to across their various domains I will define exactly what social support is and

describe how social support can aid in combatting stressors such as stigma.

**1.2.1.1** *Social support defined.*

To establish a common vocabulary regarding the facets of social support in terms of the current

project, I will use the model generated by Tardy (1985) in his review of various measures of

social support. This model consists of five different dimensions of social support which the

reviewed instruments examined in varying constellations. These dimensions, called direction,

disposition, description/evaluation, content, and network/source, are illustrated in Figure 1.

While some of these dimensions are fairly straightforward, others are more complex.

Direction refers to whether the individual in question – most often a research participant

or respondent, or a person in a more clinical or applied setting – is receiving or providing the

support. In the current project, the focus is the recipient of the support,specifically the depressed

adolescent participant. Disposition refers to whether support is simply available, or if it is

enacted; within this dimension lay perceived quantity and quality of these resources. Description

verses evaluation refers specifically to the instrument being examined, rather than overlapping

directly with the support. This dimension denotes whether a given instrument is simply

describing the social resources, such as quantities of sources or frequency of contact, or if it

entails an evaluation of quality or satiation. This study will examine both aspects of disposition
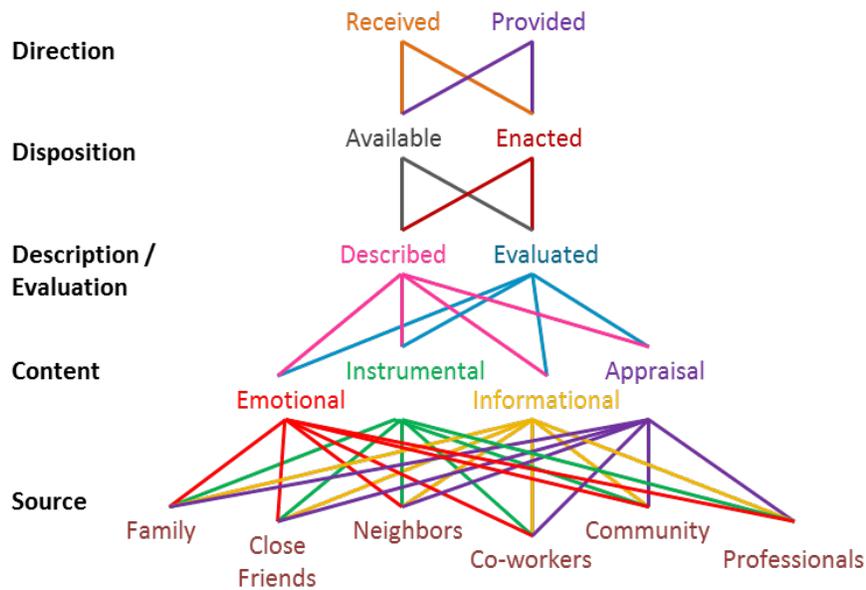
*Figure 1:*

**Figure 1 Tardy's Dimensions of Social Support**

by way of examining the participants' social support descriptively and in regards to the participant's evaluations.

Exploring the fourth dimension, the "content" of social support, Langsford et al. (Langsford, Bowsher, Maloney, & Lillis, 1997) identified four primary attributes of social support which previous researchers have used to explicate social support. These four facets – appraisal, emotional, informational and instrumental – pertain to the utility of social support, the content of the assistance offered or received. Each of these different contents has a different function; different circumstances may call for the enactment of one or more, and different instruments measure different content aspects.

The benefit of tangible forms of support may result in immediately observable outcomes. For example, information often results in decision-making enhancement on behalf of the recipient. Likewise, instrumental support enables a set, intentional outcome such as providing concrete assistance in obtaining a goal, giving money or items, or some other form of concrete assistance so as to yield an observable benefit. Emotional and appraisal support are less concrete,

however. Appraisal support, like informational support, provides the recipient with information, but rather than decision-making enhancement, this information is more self-evaluative in nature. Such information as performance- or attribute-based feedback or compliments can assist the recipient in reflection on the self. Emotional support, however, consists of evaluative information about the support provider, indicating that the provider values the recipient and holds a positive emotional bond to them. To consider the three basic psychological needs in light of these aspects of support, incidences of instrumental and informational support enable autonomous actions, incidences of appraisal support enactment of competence, and incidences of emotional support can lead to relatedness need satiation.

Finally, the fifth dimension of source of support is the largest layer of Tardy's (1985) model, which he calls "network". It is this dimension where the person(s) whom the individual can or does access are described – the source of the support, in this case. Often seen as context-specific, the previous research postulating the support source / stressor congruency and efficacy connection (e.g., Shinn et al., 1984) illustrate the importance of attending to this dimension of social support. While some sources of support are purposefully garnered, such as the emotional and informational support provided to a distressed adolescent by a counselor, many other sources of support occur naturally from the adolescent's social contexts.

### 1.2.1.2 *Why it matters: Social support versus depression.*

The link between social support and depression has been well established for decades. Studies on depressive symptomology in adolescents have found that the lower the perceived social support, the more likely a participant was to report higher levels of depressive symptomology, particularly among females (see for example Abela, Vanderbilt, & Rochon, 2004; Kaltiala-Heino, Rimpelä, Rantanen, & Laippala, 2001).  Kaltiala-Heino et al. (2001) found that this trend

remained even after accounting for known sociodemographic influences on depression. Research has also found that among females with depressive symptomology, lower levels of social support correlate to higher incidence of sexual risk, especially among younger adolescents as opposed to younger adults (Mazzaferro et al., 2006). Additionally, though gender tends to correlate differently with various coping styles, social support and maladaptive coping styles, in this case rumination, correlate with higher levels of depressive symptomology in both genders. Among participants in middle childhood there were no observed mediation effects among these variables; however, among those in early adolescence, both rumination coping and social support mediated the other's relationship with depression. Though the relationship between depression and social support is known, the exact mechanisms are unclear.

In terms of treatment and intervention studies, research on social support and bipolar disorder in adults has found that depressive episodes are more mutable, depending on level of social support, than manic episodes (Johnson, Winett, Meyer, Greenhouse, & Miller, 1999). However, results regarding life stressors are less optimistic, often failing to demonstrate a buffering effect on stressful events' impact on depression (Johnson et al., 1999). One study (Stice, Burton, & Bearman, 2007) compared several different treatment options in terms of depressive symptomology reduction. While all of the interventions examined were associated with reduced symptomology, the typical clinical treatment (Cognitive Behavioral Therapy, CBT), bibliotherapy (in which they read a book about CBT), and supportive-expressive therapy (a non-directive, rapport- and support-based group setting) produced the strongest results. Additionally, the supportive-expressive condition experienced lower attrition than either of the other two conditions. Unfortunately, none of the treatment conditions continued to evidence changes after 6 months.

Though research on the importance of social support for psychological wellbeing has been in abundance for decades, only more recent research has focused on mechanisms by which this relationship functions. As Cornwell (2003) points out, social support is inherently dynamic, with support sources variably being gained, lost, and remaining intact as time passes. Therefore, in his longitudinal examination of over 11,000 adolescents, he examined these changes over time to determine the effect of different patterns of social support on depression in adolescents. His results provided support for the belief that social support in general can have a positive benefit on depression. More specifically, he found that not only does parental support have a larger impact on teen depression than peer support, but also, decreases and increases in amount of social support from parents has a stronger influence on adolescent depression than parallel changes in peer support. Even more interesting, the effects of support decay, or lessening, on depression were much stronger than the effects of support growth, or increase, for both parents and peer support. While this sadly does support the observation that negative often has more impact than positive (Baumeister, Bratslavsky, Finkenauer, & Vohs, 2001), it also lends support to the postulation that the impact of experienced stigma on adolescent depression may be very negative, particularly if that stigma experience results in an erosion of the adolescent's social support network.

Support is not just the domain of professional practitioners, nor is it only vital to those adolescents coping with psychological challenges. Informal support structures are pervasive and integral to the normative contexts in which adolescents develop. Both familial and non-familial interpersonal connections can be highly influential on an adolescent's development (Cook et al., 2002), and a brief review of how these influences may play out is warranted before proceeding to

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the contributions this study can make in terms of exploring subtle yet key interpersonal processes.

## 1.2.2 Naturally occurring resources.

The importance of family, particularly of parents, in the development of children and adolescents is almost beyond debate, and been demonstrated repeatedly in regards to a variety of outcome variables (e.g., Steinberg, 2001), at times even above and beyond those of other potential influences (e.g., Duncan, Boisjoly, & Harris, 2001). Emotionally supportive behaviors such as empathizing and assisting with problem-solving have been linked to positive ego development (Hauser et al., 1984), and generally warm, supportive yet firm parenting styles link to positive youth development (Steinberg, 2001). Negotiating autonomy in order to satiate one of the three primary needs constitutes a crucial process in the positive development of adolescents and may be of particular importance in regards to decision-making processes. This negotiation primarily takes place in the child-parent sphere, and positive relationships with parents during this time can allow adolescents to traverse this key stage of development smoothly, rather than tumultuously (Arnett, 1999; Judith G. Smetana et al., 2006; Steinberg, 2001).

While parents can undoubtedly influence their adolescent offspring for the beneficial, negative ramifications for the relationship are also possible. Adolescents whose parents demonstrate less support face increased risk for depression (Stice et al., 2004). Further, those adolescents who's relationships with their parents are qualitatively negative face not only the increased likelihood of increased negativity in that relationship, but also an increased probability of dysfunction in their other relationships (Kim, Conger, Lorenz, & Elder, 2001). One study found that parents who are over-controlling tend to have offspring with a higher rate of

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psychological dysfunction, including internalizing disorders such as depression (Conger, Conger, & Scaramella, 1997).

However, if anything, the interaction of social support and adolescent dysfunction is not a simple one. Other research (Young, Berenson, Cohen, & Garcia, 2005) suggests that experiences parental support may in fact act as a moderator of the influence of anticipated peer social support on the adolescent's depression. Specifically, when adolescents perceived themselves as having high levels of parental support, then high peer support predicted low depressive symptomology. Conversely, when parental support was perceived to be low, then the higher levels of peer support now predicted higher levels of depressive symptomology, as did the reverse (high parental but low peer support). This is a more complex view than that provided by another set of researchers (Laible, Carlo, & Raffaelli, 1999) who found that simple summation of perceived support available indicated a positive relationship with more beneficial general adjustment (i.e., depression symptomology, sympathy, and aggression).

Relationships between siblings can impact adolescent development both in terms of their interactions with each other, and their interactions with their parents (Judith G. Smetana et al., 2006). For example, Duncan, Boisjoly & Harris (2001) found that adolescents and their siblings had a higher correlation of both verbal achievement and delinquency than the correlations between adolescents and their best friends (though requited best friends demonstrated correlations almost as high as siblings in terms of delinquency), school grademates and neighborhood agemates after adjusting for socioeconomic factors. The same study mentioned above that found that parental over-control can be psychologically damaging found that similar interaction patterns between siblings can have similar, negative outcomes (Conger et al., 1997). Conversely, positive sibling relationships seem to be predicative of higher self-esteem and more

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positive future relationships not only with the sibling, but with peers (Yeh & Lempers, 2004), as well as better global adjustment (Judith G. Smetana et al., 2006). Additionally, other family members such as grandparents (e.g., Pratt, Norris, Lawford, & Arnold, 2010), cousins, etc. can impact an adolescent's development, particularly for non-European American youth, though there exists little research in this area (Judith G. Smetana et al., 2006).

Though some have postulated that peers constitute a stronger influence on adolescent development than parents (Harris, 1998), a belief that is highly contested and contradicts many other works, none contest that peers influence one another immensely. The research reviewed above illustrates a common trend – that of comparing familial (most often parental) to peer influences. This research often finds that both sources of influence are valid, though peer relationships may entail various types of interactions and relationships, such as dyadic or groups (Judith G. Smetana et al., 2006). For example, while self-esteem has been found to be significantly related to relationship quality for both sex of adolescents, regardless of the severity level of their psychological distress, it appears to be more strongly related to peer relationship quality (a dyadic level of interaction) only for female adolescents (Walker & Greene, 1986). Likewise, popularity verses peer rejection (a group level interaction) has been found repeatedly to correlate to general adjustment or dysfunction, respectively (K. H. Rubin, Bukowski, & Parker, 2005).

In addition to peers and other (near) agemates, non-familial adults can offer important sources of influence and potential support. In their general review of the impact of non-familial adult support, Sterrett, Jones, McKee, and Kincaid (2011) found examples within the literature of positive impact on academic achievement and investment, psychological functioning and behavioral indicators such as engagement in risk behaviors, and lower levels of depression.

Regarding teachers, many new works on the impact of a developmentally-appropriate, supportive student-teacher relationship on engagement (Klem & Connell, 2004), achievement (Crosnoe, Johnson, & Elder, 2004; Foster, 2008; Klem & Connell, 2004),  and even health risk behaviors (McNeely & Falci, 2004) have been documented, as have the adolescent students' professed desire to build such relationships (Davis, 2006; McHugh et al., 2012).

Though the literature on mentoring relationships is only just growing, there are promising indications that qualitatively positive mentor/mentee relationships have positive indications for student outcomes. For example, Black and colleagues (Black, Grenard, Sussman, & Rohrbach, 2010) examined risk behaviors ranging from substance use to engagement in violence, and found evidence of a mediational effect that resulted in higher quality relationships impacting investment in academics, which in turn impacted risk behaviors.

Supportive examples of such relationships can afford the adolescent important resources, particularly when confronting such concerns as experienced stigma, anticipated stigma, and the management of disclosure and general visibility of stigmatizing features (Laible et al., 1999). Many people with mental health concerns face social isolation, rejection, stigmatization and discrimination (Wahl, 1999b); adolescents are not immune from facing these concerns. Given the connection between isolation/rejection, victimization/discrimination and depression, the potential impact of stigma on depressed adolescents warrants serious attention. When considering all of these influences on adolescents' emotional wellbeing, understanding the delicate interplay of social interactions and mental health, such as the issues and processes surrounding diagnosis disclosure, are vital to helping depressed adolescents to navigate their social worlds as they focus on healing and overcoming their depression. Through illuminating how these naturally occurring support systems function to assist depressed adolescents in navigating their social worlds in

terms of disclosure decisions, we can begin to create interventions to foster these supports, ultimately easing a depressed adolescent's potential social distress.

### 1.2.3  Developmentally appropriate intimacy, disclosure and advice-seeking.

Disclosure and advice-seeking are normative parts of healthy parent-child relationships; however, the role of disclosure in adolescence is often problematic and risk behaviors remains unclear (Judith G. Smetana, Metzger, Gettman, & Campione-Barr, 2006; Stattin & Kerr, 2000). Studies have found that when it came to intimate concerns, adolescents were more likely to disclose to and seek advice from their mothers than their fathers (Greene & Grimsley, 1990; Judith G. Smetana et al., 2006), when they perceived themselves to have a pre-established trusting and supportive relationship (Almas, Grusec, & Tackett, 2011; Judith G. Smetana et al., 2006), and in general, females and older adolescents disclosed more than male and younger participants (Judith G. Smetana et al., 2006). Concerns that adolescents approached parents regarding included advice about vocations and education, finances (Wilks, 1986), the self and other developmental tasks, social / interpersonal issues, and even philosophical concerns (Greene & Grimsley, 1990).

Parents aren't the only persons in an adolescent's life from who they may seek advice, however. Siblings may be an important source of support, particularly when a younger sibling approaches an older sibling, and if the siblings are both females (Tucker, Barber, & Eccles, 1997) as females tend to engage in advice-seeking more frequently than males (Fuligni & Eccles, 1993; Tucker et al., 1997). Additionally, adolescents who report more controlling relationships with parents also report seeking advice from peers more frequently than their counterparts (Fuligni & Eccles, 1993). Although in one study females reported seeking advice from their

parents more often than males, both sexes reported seeking the advice of their friends more often (Wilks, 1986), and another study revealed that peers are a likely source for advice regarding social and leisure activities, specifically (Wilks, 1986). Previous research has generally looked at categories of general problems or needs; specific circumstances such as mental health concerns or personal feature disclosure have not been frequently examined and warrant further examination, particularly as the one example examining interpersonal quandaries found respondents to be split regarding to whom they would go for advice (Wilks, 1986). However, the specifics of a given participant's social resources must first be understood.

**1.2.3.1** *Social influences and worsening depression.*

Social influences are not universally positive, however. Outside of the consequences of stigma on depression outcome, the influences of the important people in a depressed adolescent's life may have unfortunate, depression-maintaining impact. This can happen when the influence in unintentional, such as the findings by Brent et al. (1998) that maternal depression predicted more depressive symptomology after treatment. Among peer relationships, adolescents with a depressed friend are more likely to experience depressive symptoms than those without a depressed friend (Stevens & Prinstein, 2005), and an adolescent's general peer status can act to protect against, or to intensify, this depression contagion (Mitchell J. Prinstein, 2007). Therefore, it is reasonable to suggest that if a depressed adolescent socializes with other depressed individuals, their bidirectional influence on one another may work to prevent symptomatic remission.

More specifically, in a process called co-rumination, two people repeatedly discuss a problem in a process very similar to rumination, a key feature in many anxiety and depressive episodes. This excessive discussion has been linked to increased reports of relationship quality

(A. J. Rose, Carlson, & Waller, 2007), and even with romantic relationships (Starr & Davila, 2009). However, despite these seemingly positive repercussions of co-rumination, co-rumination has also been associated repeatedly with increased depressive symptoms (Starr & Davila, 2009). Following adolescents for two years, Stone, Hankin, Gibb, and Abela (2011) found that high levels of co-rumination predicted depression onset, particularly among girls (A. J. Rose et al., 2007). Returning to the familial context, Waller and Rose (2010) found that although mother-adolescent dyads that engaged in co-rumination endorsed positive quality, they also evidenced higher levels of depressive symptoms in the adolescents than their non-co-ruminative counterparts. Although relational intimacy and problem-sharing can lead to mutually beneficial, supportive relationships, there may also be repercussions to this intimacy such as co-rumination and depressive symptomology contagion. Therefore, these interpersonal relationships must be examined allowing themes to emerge from the data itself.

**1.2.4    The influence of social networks.**

The other people in an individual's life are often interconnected. One peer knows another, family members are related to one another, and parents know the youth's friends and to an extent their families. These interconnections form social networks, "a function of prior contact, exchange, and attendant emotions" (Burt, 2000, p.348). The availability of information, opportunities, supports and other resources constitute the social capital that an individual has at their disposal. In his review of social capital, Portes (1998) discusses how being a member of such a network provides advantages, and disadvantages, for the entwined individual. For example, the propagation of (sub)cultural norms, social control within groups (such as maintaining safe

neighborhoods), and support within and from without familial systems all fall into the category of beneficial functions of social capital.

However, in tightly-knit social networks, the affiliation may be so strong as to prevent growth to the network, by discouraging new memberships, or within the network, by self-sabotaging growth opportunities of the existing network members. One way in which this process may have implications is through conformity enforcement. Depressed adolescents who's social networks are populated by other depressed individuals may not only face socializing influences such as opportunities to co-ruminate, but may also face more overt pressure to reject treatment, self-definitions as mentally ill, or offers of help in favor of conforming to the group's depression-maintaining norms. Therefore, explorations of a given individual adolescent's experiences, decisions, and meaning-making regarding their depression must take into account whether or not the participant perceived these interconnections as affecting these processes. Simply, does the participant perceive the occurrences within one interpersonal relationship as influencing those of another interpersonal relationship? In order to ascertain this, multiple interpersonal relationships within each participant's life must be interrogated.

### 1.2.5   Previous modes of exploration of interpersonal support systems.

Adolescent lives are filled with important and complex interpersonal relationships. While those relationships can be incredibly beneficial, they can also be detrimental (Nakkula & Toshalis, 2006).  By exploring whom an adolescent designates as important to them, or a "key player" in their life through an 'ego' study centering on the participants (Otte & Rousseau, 2002), we can begin to understand the various socioemotional pressures that the adolescent faces, and the supports that they have at their disposal. Previous work has examined these networks of

naturally-occurring supports a number of different ways, including via the utilization of hands-on activities as both quantitative and qualitative gauges and interview prompts. Therefore, in order to understand the intricacies of the social network of the individual adolescents quickly and efficiently, inspiration has been taken from two previous hands-on approaches to measure interpersonal-closeness.

Strayer and Roberts (1997) used felt and a mirror to help children to determine how close they felt to the characters in emotionally-evocative videotaped vignettes. The children looked into a mirror in the center of a large piece of felt, and placed Velcroed photographs of the characters closer or nearer to themselves, as reflected in the mirror, based on their feelings of interpersonal closeness to the character. Similarly, Popovic and colleagues (Popovic, Milne, & Barrett, 2003) used concentric circles to form a kind of social target with the Self in the center and others radiating outward, to again gauge interpersonal closeness. In their examination of interpersonal relationships, they compared perceived to idealized levels of interpersonal closeness by measuring the differences between the two designations for various people in the participants' lives.

Aspects of both of these approaches can be incredibly useful when examining the subtleties found in social resource systems. The lives of depressed adolescents are anticipated to be replete with subtleties, particularly because, due to potential stigma reactions to disclosure of such a stereotyped personal feature as mental health concerns, anticipation of reaction is a gamble. In other populations, the balancing of such concerns about stigma against the need for support and relatedness has been examined. Unfortunately, this literature tends to be limited in scope, and has not yet been explored in depressed adolescents; one such process of balance is Visibility Management.

### 1.2.6 Visibility management as an adaptation to stigma.

As a result of stigma incidences, Phelan et al. (1998) found that 50% of participants readily admitted to engaging in strategies designed to conceal their mental health status.  Apprehension regarding how they will be perceived and received by "normal" people can plague people of stigmatized groups, resulting in constant self-consciousness and calculations regarding the impression they are making on others (Rush, 1998). Originating in the gay, lesbian, bisexual, transsexual and queer (GLBTQ) literature, Lasser and Tharinger (2003) originated the concept of VM as "the ongoing process by which GLB adolescents make careful, planned decisions about whether they will disclose their sexual orientation, and if they decide to disclose, to whom and how they disclose, and how they will monitor the presentation of their sexual orientation" (p. 237). This process goes beyond the event of "coming out", beginning before and continuing after the instance wherein one's orientation is revealed to any given individual. It is the negotiation between external and internal forces prompting the disclosure, display, concealment and/or denial of one's orientation and sexual identity.

The conflicting societal pressures alluded to above can create notable cognitive dissonance among those facing these dilemmas. As one research participant stated "You acquire all these friends and stuff and in the back of your mind you think, 'they're not really my friends because if they knew who I was they would drop me'" (Lasser & Tharinger, 2003,  p. 240). Adolescent identity work constitutes a major developmental milestone (Erikson, 1968, 1994); as such, this cognitive dissonance can be incredibly upsetting to those experiencing it.  However, the high risks of being stigmatized, harassed or even violently accosted dissuade many GLBTQ youth from disclosing. Recent research found that 51% of participants reported experiencing verbal abuse in high school, with 24% having been threatened with violence, 11% having been

physically attacked, and 5% having been sexually assaulted (D'Augelli, Pilkington, & Hershberger, 2002). The fear of these experiences is palpable to many adolescents facing such socioemotional conflicts, and prompts many to maintain "invisible" statuses in their social circles.

Research on disclosure has not been limited to the GLBTQ community, though. Though some work on the effect on self-identity of receiving a serious diagnosis has been done in the medical field (e.g., Hubbard, Kidd, & Kearney, 2010; Jones, Parker-Raley, & Barczyk, 2011), little research on this topic has been done in the mental health arena (for example, see Huws & Jones, 2008 regarding Autism spectrum conditions). When issues of disclosure have been explored among adult populations of mentally ill, these occurred primarily as a piece of the larger stigma work (e.g., Wahl, 1999b). In the Autism and Asperger spectrum literature, issues of disclosure across the lifespan have been explored as the self-advocacy movement grows. Emotional response upon receiving a mental health diagnosis can range from relief to denial to despair (Georgiou, 2006). Following the diagnosis, though, comes the conflict of disclosure. Adopted from the GLBTQ literature, many are now discussing disclosure in regards to the Autism spectrum as a 'coming out' process. The basic questions inherent in this conflict are two-fold – whether or not to tell a specific person, and the pragmatics of how, when and how much (Barratt, 2006; Shore, 2006).

**1.2.6.1 Disclosure in the Autism Spectrum literature.**

Strategies through which one can engage in this process are being identified. In their review of these strategies as expressed in narratives by persons on the Autism spectrum, Davidson and Henderson (2010) reveal four recurring themes of coming out. In the first, "keeping safe", disclosure is decided against and instead concealment strategies are engaged. The second,

"qualified deception", incorporates strategies that allow the individual's needs to be met without actually disclosing the diagnosis – an example would be telling someone that you have light-sensitive migraines rather than revealing sensory sensitivities of Autism. The third and fourth themes, "like/as" and "education" are self-advocacy oriented, and take inspiration from the GLBTQ and Deaf community movements, seeking to draw parallels of understanding of the unique values and contributions generated by individuals meeting Autism spectrum atypicalities criteria. Using the term "neurodiverse", these themes seek an appreciation for, rather than stigma against, the diversity represented by individuals who due to their neurocognitive processing do not fit the normative model, such as those on the Autism spectrum, and those with Attention Deficit Hyperactivity Disorder (see also Hendrickx, 2010 regarding ADHD). Other authors such as those in Stephen Shore's book "Ask and Tell: Self-Advocacy and Disclosure for People on the Autism Spectrum" (e.g., Hane, 2004; Shore, 2004; Sibley, 2004) offer concrete strategies for enacting these and other levels of disclosure.

**1.2.6.2 Disclosure strategizing partners: Introducing the Safe Other.**

As adolescents develop into autonomous, self-defining adults, the people in their daily lives plan an integral role in shaping the adolescent's behaviors, attitudes, and beliefs about themselves and their world. The balancing act between being autonomous and experiencing relatedness with others such as friends, family, and important non-familial adults like teachers can tax an adolescent's cognitive and emotional faculties. In their discussion of adolescent identity development in educational contexts, Nakkula and Toshalis (2006) discuss at length the beneficial influences that adults in these naturally occurring setting can have on the developing adolescent by fostering emerging identities through positive interactions. They promote the idea

of teachers, parents, and key adults playing the role of naturally-occurring applied developmentalists.

Adolescents who have mental health concerns face the additional challenges associated with mental illness or atypicality, such as coping with their condition, disclosure, and incorporation of this difference into their identity. Though limited research has been conducted in the arena of diagnosis disclosure in adolescents as a unique population with unique experiences and needs, the growing body of work which explores the practical and lived experiences of people who have been diagnosed with Autism spectrum disorders, such as Asperger Syndrome, suggests applications for the adolescent mental health community. From advice to and by parents of children on the spectrum (Jackson, 2006; Krumins, 2008), to personal accounts of adults with an Autism spectrum neurodiversity (e.g., Shore, 2006; Sibley, 2004), and researcher's examination of over-arching themes across personal narratives (Davidson & Henderson, 2010), insightful conversations are occurring regarding disclosure and advocacy.

In the discussions of disclosure among neurodiversity advocates, the recruitment of assistance when confronting issues of disclosure, or concerns regarding visibility management, represents a salient and recurring theme. Using a variety of terms ranging from 'stigma coach' (Schneider & Conrad, 1980) to 'safe person' (Hane, 2004) to 'advocacy buddy' (Shore, 2004), the concept of having a "safe" other person to assist in navigating the task of disclosure recurs in multiple narratives and researcher-lead discussions. However, this concept of 'Safe Other' remains ill-defined, inconsistent terminology and suggestions of applications of assistance even within single articles. In her insightful and encompassing discussion on learning self-advocacy, Sibley (2004) illustrates examples of family members, adult friends, and even classmates filling

this role, a clear example of the benefits of recruiting a naturally occurring developmentalists in a socioemotional, developmental task.

## 1.3    INNOVATIONS AND RESEARCH AIMS OF THE CURRENT PROJECT

The review thus far has covered the importance of studying depression in adolescence, the psychosocial dangers of mental health stigma, the benefits of interpersonal support, the naturally occurring social resources available to adolescents, some manners in which these resources have been studied in the past, and some coping processes that persons with other "invisible", potentially stigmatizing features engage in to protect themselves from the possible ramifications of disclosure. Several area of further study have likewise been identified – the dearth of work regarding adolescent perceptions of stigma and disclosure management among depressed adolescents, and the need for specific information regarding the usage of social supports for advice giving, for example. This then brings us to the innovations of this project, and the subsequent research aims which I will seek to explore.

### 1.3.1   Innovation 1: Visibility Management in the mental health community.

Issues of disclosure are not limited to the GLBTQ population, nor to sexual orientation (Lasser & Tharinger, 2003). Any number of covert, potentially stigmatizing features demand the management of the degree to which the existence of this feature is made visible, or is disclosed, to other key persons in the individual's life. Mental health concerns, being highly stigmatized yet

fairly prevalent among adolescents, are a key example of a potentially stigmatizing yet covert feature, the visibility of which must be managed.

Despite the insightful and invaluable work, issues specifically regarding adolescent identity integration and diagnosis disclosure have been largely neglected. Considering how vital both identity exploration and self-definition within social contexts are to adolescents (Nakkula & Toshalis, 2006), the potentially unique challenges that adolescents in particular face warrant further exploration. When coupled with the potentially severe repercussions of mental health stigma, as well as the troubling societal cost of adolescent depression, both of which can feed into one another perpetuating and even exacerbating mental health concerns, this is an area of research that must be explored. Therefore, in this project I will endeavor to explore both adolescents' phenomenological understanding of their depression diagnoses, and their management of diagnosis visibility over the first few months of treatment immediately following diagnosis.

### 1.3.2   Innovation 2: Developing a conceptual definition of the Safe Other.

Just as disclosure of diagnosis is not limited to the Autism spectrum and neurodiversity populations, so too do I believe the concept of Safe Other is present in other populations facing mental health concerns and the daunting task of navigating social stigma.  The concept of a Safe Other seems to be integral in discussions of managing disclosure, and thus warrants full articulation and exploration. A well-rounded conceptual definition, along with one coherent term, is needed in order to facilitate conversations about disclosure, or visibility management, processes. Therefore, this project will endeavor to fully explore incidences in which the adolescent participants discuss engaging the assistance of another person in negotiating the

disclosure, or visibility, of their diagnoses, thus forming a clear conceptual definition encompassing both the form (whom) and function (how) of this important natural developmentalists in the visibility management process.

### 1.3.3   Innovation 3: Exploring disclosure in adolescent depression.

Finally, understanding the impetus, effect, and processes of disclosure itself in adolescent depression can offer insights into the social influences on adolescent depression recovery or stagnation. While stigma and support can explain a fair portion of disclosure impetus, human interaction is complex and convoluted. Additional motives such as attention, affiliation, shock, or explanation may drive disclosure, whereas not worrying an over-taxed other or avoiding attention may motivate concealment. A well-rounded, thematic exploration of the processes preceding, inherent within, and resulting from adolescent disclosure will be undertaken so as to simply explore these processes as they naturally occur in the daily interactions of depressed adolescents.

# 2.0    RESEARCH AIMS AND HYPOTHESES

This study intends to generate a multimodal, descriptive dataset in order to pursue a well-rounded conceptual understanding of the form and function of the Safe Other in the Visibility Management process.   Collectively, these Aims advance a clear, research-based conceptual definition of the Safe Other as it occurs in the adolescent depression community, as well as advancing a new method for elucidating this data via a focused qualitative interviewing technique, prompted by the hands-on Social Network Evaluation (SNE) activity.   The proposed project has four specific research aims. They are:

## 2.1    SPECIFIC AIM 1:

To explore the concept of a disclosure strategizing partner, referred to as a Safe Other, and thus generate a concise conceptual definition including the form (e.g., role, interpersonal closeness) of the Safe Other.

### 2.1.1   Research question 1a:

What are the most prevalent characteristics of those individuals designated as Safe Others in terms of role in the participant's life and basic demography (e.g., gender, age, etc.)? *Hypothesis:*

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The person designated as the Safe Other most often will be the participant's mother, though in instances where the child-parent relationship(s) are qualitatively poor, this role will be assumed by an interpersonally close peer, as in keeping with previous research by Judith G. Smetana et al. (2006) on adolescent disclosure.

### 2.1.2   Research question 1b:

Can the Safe Other be a person to whom the participant has disclosed his or her depressive status, yet at the time of the disclosure experienced a non-supportive reaction? *Hypothesis:* No: the Safe Other will be someone whom the participant indicates that they are comfortable with the results of this disclosure.   Stated another way, the Safe Other will not be someone whom the participant indicates having generated unsatisfactory disclosure repercussions.   This is based on the literature regarding social withdrawal after stigma experiences (Wahl, 1999a, 1999b).

### 2.1.3   Research question 1c:

What are the most prevalent characteristics of those individuals designated as Safe Others in terms of perceived interpersonal distance from the participant, and from other key players in the participant's life about whom the Safe Other assists in strategizing? *Hypothesis:* The designated Safe Other will be someone whom the participant designates as separate, or not interpersonally close, to the person(s) about whom the strategizing in question regards, but whom is familiar with the person(s) about whom the participant and Safe Other strategize.   For example, the participant will strategize with a peer about another peer, but not if the peer acting as Safe Other

and the peer about whom the strategizing occurs are perceived to be interpersonally closer to one another than to the participant.

## 2.2    SPECIFIC AIM 2:

To explore the decision-making process regarding diagnosis disclosure events, particularly in regards to the function of the Safe Other in this process.

### 2.2.1    Research question 2a:

What experienced or anticipated occurrences will prompt enactment of the Safe Other in terms of seeking strategizing assistance? *Hypothesis:* Situations in which the participant anticipates that their depression status may be vulnerable to exposure (i.e., anticipated visibility incidents) will prompt strategizing with the Safe Other. This is based on the literature from the GLBTQ community regarding Visibility Management (e.g., Lasser & Tharinger, 2003), and that of the ASD community regarding disclosure (e.g., Schneider & Conrad, 1980).

### 2.2.2    Research question 2b:

What specific strategies will the participant and Safe Other discuss? *Hypothesis:* In alignment with the findings from the Visibility Management literature of the GLBTQ community, and the disclosure literature of both the Mental Health and ASD community, strategy themes are

anticipated to include disclosure, display, concealment and/or denial (Lasser & Tharinger, 2003), qualified deception, like/as, and education (Davidson & Henderson, 2010).

## 2.3    SPECIFIC AIM 3:

To explore how incidences of experienced stigma and/or support may prompt change in the visibility management strategies that the experiencing participant engages in when dealing with future visibility incidences.

### 2.3.1    Research question 3:

What occurrences, if any, prompt the initial and subsequent (re)evaluation and (re)designation of the Safe Other? *Hypothesis:*  Regarding initial designation of the Safe Other, the participant will seek the advice of a Safe Other when they experience or anticipate experiencing an upsetting incident of stigma; those participants who do not identify with other depressed individuals or who do not (anticipate or) experience stigma will not engage in disclosure strategizing, and will not have need of a Safe Other. This is based on the research regarding internalization, righteous anger, and indifference to stigma which indicates that those who do not identify with the stigmatized group will exhibit indifference, rather than a cognitive-emotional reaction to experiences of stigma (Corrigan, Watson, & Barr, 2006). *Hypothesis:* Regarding any subsequent (re)evaluation(s) and (re)designation(s) of the Safe Other, if an incident of visibility management, executed as had been strategized with the Safe Other, results in an incident of experienced stigma, then the role of the Safe Other will be reevaluated, and possibly reassigned.

This is based upon the iterative process of engagement and disengagement as outlines in the Self Systems Process model (Connell & Wellborn, 1991).

## 2.4    SPECIFIC AIM 4:

To explore the decision-making processes and occurrences preceding, during, and following adolescent disclosure of their depressive status to important other people in their lives through open-ended, thematic exploration.

To accomplish these research aims, multimodal data will be gathered, incorporating qualitative interview transcripts, participant observations, and survey data. The interview data will be used in pursuit of all four research aims; the observational data will be used to confirm, deny, or elaborate upon the interview data. Demographic information gathered from the survey will be used primarily to describe the sample, but will also be used in pursuing the first research aim. Finally, the remaining survey data will be used in pursuing the fourth research aim, and in the pursuit of multi-modal validity checks.

## 3.0    METHODS

In order to accomplish the project's research aims, I conducted qualitative interviews with observational jottings, and quantitative mood and stigma monitoring surveys during the winter months of 2012 through the spring months of 2013 with depressed adolescents.  The data-gathering methods utilized in this project included qualitative and quantitative instruments gathered in a specific order over a seven-month period. The use of a multiple-case sampling allowed for potentially contradictory experiences and perspectives, and enhanced the robustness of the study's findings (Miles & Huberman, 1994), particularly in instances where convergence was found (H. J. Rubin & Rubin, 2005). The repeated interviews of each participant allowed for the formation of a rapport between the interviewer and participants, and for the observation of any formation, maturation, deterioration, dissolution and /or other dynamic processes of interpersonal relationships after multiple potential incidences of disclosure. Through iterative coding and thematic analysis, allowing for both fine-grain and holistic analysis, I explored these processes for patterns regarding the utilization and decision-making processes embodying visibility management.

# 3.1 PARTICIPANTS

## 3.1.1 Subject recruitment.

Recruitment occurred through a local clinic which offered services to over 7,300 depressed and suicidal adolescents since its inception in 1986. Services offered include: initial assessments which include diagnostic procedures aimed at identifying relevant comorbidities, suicidal ideation and actions, and previous (potentially undiagnosed) mental health episodes, and consent to enter a research recruitment registry; individual treatment plans that may incorporate a combination of Cognitive Behavioral Therapy, Dialectic Behavioral Therapy, Intensive Outpatient group therapy, or pharmacotherapy; and follow-up services including pharmacotherapy continuation and monthly clinical check-ins. Treatment as usual (TAU) procedures such as those outlined guide participants in varying levels of distress (at intake) to either remission or referral to more appropriate treatment options through a combination these treatment features, as the clinical team feels is most appropriate for that individual client's needs.

Clinical personnel identified eligible participants as part of TAU procedures. Inclusion criteria included required Depressive disorder diagnosis, but excluded adolescents with comorbid Eating disorders, or active Psychotic symptoms due to probable distorted perceptions of self or others, confounding symptomology, and relative prevalence minority among the population under study. Clinicians gave an informative letter about this project to eligible adolescent patients and their parents, and requested permission for the researcher to contact them regarding this participation opportunity. The researcher only contacted those participants and parents who expressly gave clinicians permission to share their contact information. In accordance with the local Institutional Review Board's regulations, the researcher obtained informed consent from all

parents and adolescents 18 years of age and older and informed assent of adolescent participants younger than 18 years of age. Many of these consenting procedures occurred via telephone conversation which were audio recorded with the permission of the participants and their parents, and signed consent documentation was collected afterwards.

After weekly discussions with the clinical director and clinicians to identify research-amenable and eligible females, thirteen adolescents were approached and consented as a part of this project during the months of November, 2012 through March, 2013. Six of these potential participants subsequently withdrew from the project prior to conducting the first interview. In these instances: three participants' parents refused to consent citing scheduling constraints or lack of interest in research; two additional families proved impossible to contact for parental consent; and one participant was withdrawn after consent was obtained because her clinical condition had worsened to a degree that the clinician felt it was inappropriate to tax her with research participation (she was subsequently housed in a residential treatment program). The information regarding these families is not included in reported study data.

All interview sessions, between participant and interviewer alone, were audio recorded, and occurred in (IRB pre-approved) clinic facilities. Participants were compensated with a catered snack at every interview (typically a fast-food item or snack food item and a beverage), and all participants' names were entered in a drawing conducted at the completion of the study for pre-paid gift cards of $50.00 (2), $25.00 (3), or $10.00 (2). The website http://www.random.org/ was utilized to select which participant received which gift card.

### 3.1.2 Participant demography.

Seven adolescent participants, ranging from 14.25 to 17.75 years of age at the time of the first interview ($M$ = 16.18 yrs., $SD$ = 1.21 yrs.) both consented to the research project and completed five one-on-one interviews. I limited recruitment to female adolescents only; as gender identity does not necessarily conform to biological sex, when given the opportunity to identify as non-traditionally gendered, all seven reported their gender as female. Additionally, six self-identified as European Americans and one self-identified as African American. (None of the participants self-identified as Latina). This sample was fairly representative of the typical population of this clinic, in that during the recruitment period clinic intake consisted of 13 male and 64 female adolescents, and the mean age of clinical patients during this time was 14.98 years ($SD$ = 1.78 yrs., age range 8.50 - 18.08 yrs.; 1 patient missing age data). Sixty-three of the new clinical patients self-identified as European Americans, 10 as African American, and 2 of biracial ancestry (for the remaining 2 patients racial identification was not reported). Initial diagnoses for all participants[1] included Major Depressive Disorder (MDD), as well as comorbid Anxiety disorders ranging from Generalized Anxiety Disorder ($n$= 5), Social Phobia ($n$= 2), Obsessive Compulsive Disorder ($n$= 2), and one incident each of Post-Traumatic Stress Disorder and Anxiety Not Otherwise Specified.

In addition to the previously reported demographic data, I used the Family Affluence Scale (FAS II; Boyce, Torsheim, Currie, & Zambon, 2006) to gather data regarding family socioeconomic status. As a proxy measure, I selected this instrument rather than traditional income or parental occupation questions as such direct instruments have been shown to illicit

Footnote 1: Due the potentially identifying nature of specific individual participant's diagnoses, I have opted instead to present this data in an aggregate manner, thus further protecting the identities and sensitive information of my research participants.

poor answering rates (Molcho, Gabhainn, & Kelleher, 2007; Wardle, Robb, & Johnson, 2002). The participants reported a mean FAS score of 5.86 ($SD = 1.88$), of a potential range of scores from 0 (least affluent) to 9 (most affluent). Regarding their school functioning, four self-reported that their grades were As and Bs, and one each reported grade that were all As, that grades ranged from As to Cs, or that grades ranged from Bs to Cs. Finally, three of the participants were Seniors, 1 a Junior (these four are designated as Upperclassmen in the Findings section), 2 Freshmen and 1 in late middle school (designated as Underclassmen in the Findings section).

Each participant generated a pseudonym and a participant identification number to label their data; however, due to confidentiality concerns (i.e., many of the participants had selected pseudonyms which could be identifiable to their family members), I generated new pseudonyms for each girl to protect their confidentiality while allowing the reader to track participant statements. Additionally, I re-ordered and re-numbered the participants based on their self-selected identification numbers.

## 3.2    MATERIALS AND PROCEDURE

### 3.2.1    Scheduling

Spanning the months of November 2012 through June 2013, I interviewed each participant five separate times, an average of 25.79 days apart ($SD = 7.34$, range 12.00 - 51.00); for specific interview timing information, see Table 1). Whenever possible, clinical and research schedules coordinated so as to coincide study appointments with pre-arranged therapy visits, so that

**Table 1 Spacing of Interviews, and Depressive Status via Clinician Report**

| | | Days between timepoints (Tp) | | | | Clinical progress | |
|---|---|---|---|---|---|---|---|
| ID | Pseudonym | Tp1-2 | Tp2-3 | Tp3-4 | Tp4-5 | Tp1 clinical status | Tp5 clinical status |
| 1 | Felicia | 28 | 20 | 22 | 28 | Partial remission | Remitting |
| 2 | Zoey | 32 | 14 | 14 | 21 | Partial remission | Remitting |
| 3 | Cecilia | 21 | 51 | 33 | 20 | Actively depressed | Partial remission |
| 4 | Maria | 20 | 22 | 47 | 34 | Partial remission | Remitting |
| 5 | Karen | 49 | 21 | 28 | 25 | Actively depressed | Partial remission |
| 6 | Rene | 16 | 26 | 16 | 12 | Actively depressed | Partial remission |
| 7 | Aggie | 21 | 24 | 41 | 16 | Actively depressed | Partial remission |

participants participated before or after their TAU appointments and thus cause as little disruption as possible to their daily lives.  Several interviews through the course of this project were delayed due to clinical reasons; the clinical wellbeing of the participants was placed as the priority by all personnel involved. This project in no way offered therapeutic services nor interfered with TAU.  Instances in which the participant(s) remitted and decreased TAU prior to the completion of the study protocol did not noticeably influence research timing in that the researcher continued to meet with willing participants.

Staggered so as to prevent fatigue on any one day, the administration of the profile-building surveys and some interview questions varied by Timepoint (Tp), and by participant (see Table 2). The one-hour interview interval was chosen in order to prevent participant fatigue, as was the timing of one interview per three to four weeks (approximately one per month).

**Table 2 Collection of Quantitative Measures by Timepoint (Tp), as Indicated by Participant Alias**

| | | Timepoint (Tp) | | | | |
|---|---|---|---|---|---|---|
| Form | Baseline | Tp1 | Tp2 | Tp3 | Tp4 | Tp5 |
| CES-D (Depression) | | Felicia, Zoey, Cecilia, Rene, Maria, Karen | Felicia, Zoey, Maria, Aggie | Felicia, Cecilia, Karen, Aggie | Zoey, Rene, Karen | Cecilia, Aggie, Karen, Rene |
| Demography | Cecilia, Aggie | Felicia, Zoey, Karen, Rene | Maria | Maria | | |

Additionally, the three to four week spacing of interviews allows for the potential of several visibility incidents to accrue between interview sessions.

I designated five interviews per participant as a protocol goal for several reasons. The first is due to the affective nature of the topic at hand. Personal disclosure of a potentially stigmatizing characteristic (PSC) is an emotional gamble; participants at times appeared to be reluctant to discuss such an emotion-laden topic with the researcher until some measure of rapport had been built. Second, the cognitive nature of the topic at hand suggested a higher number of interviews. Some participants did require gentle prompting to engage in deeper introspection regarding their decision-making processes, and these skills became more refined with practice. In particular, I found myself giving more in-depth and frequent prompts to two of the three youngest participants than I did to their older counterparts.

The final reason was due to the dynamic nature of the topic at hand. Namely, for every social contact in an individual adolescent's life, a number of visibility incidents are possible, the only potential endpoint of this process being complete disclosure after the depressive episode is resolved. Additionally, several participants demonstrated fairly unstable social networks with

fluctuating members who entered and/or exited the social circle of the participants during the time spanned by the interviews. Had I only interviewed each of these participants once, I would not have been able to collect this generative and terminus data.

### 3.2.2 Materials

Though the heart of these analyses focus on the qualitative interview data, in order to obtain a well-rounded profile of each adolescent participant, as well as an in-depth understanding of the sample as a whole, I exploited two quantitative surveys as additional data sources (the FAS, reviewed above, and the CES-D, reviewed below), as well as photographing the participants' SNE (Social Network Evaluation) maps (see Procedures).

### 3.2.2.1 Depression

I utilized one quantitative questionnaire regarding depressive symptomology as a descriptive measure. The participants completed the Center for Epidemiological Studies Depression Scale (CES-D; Radloff, 1977; see Appendix A) several times apiece during the duration of their involvement in the project. Through multiple studies, this measure has been found valid and reliable, most relevantly when used with adolescents (Radloff, 1991; Wilcox, Field, Prodromidis, & Scafidi, 1998).

### 3.2.2.2 Social network evaluation

During the interviews, I utilized a novel manipulable tool designed to aid in the exploration of social resources and detriments. Named the Social Network Evaluation (SNE), this tool incorporates multiple interview questions (see Appendix A). Participants first designated key

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players, so as to gauge the salience of different persons in the adolescents' perceptions via sticky notes labeled with the person's role (rather than name for concerns of privacy, as each 'map' was digitally photographed after subsequent discussion of the placements and participant's perceptions). Participants then placed ten "key players", or important other people in their life, at positions on the board reflecting the interpersonal closeness between the key player and themselves (i.e., the participants). Instances in which omissions of persons previously designated as key players occurred prompted discussion and exploration.

Next, participants placed colored dot stickers on the sticky notes to indicate whether or not the key player has been disclosed to regarding the participant's depression status (blue sticker when disclosure has occurred, absent when disclosure has not yet occurred). Additional stickers designated the degree to which the participant reported feeling emotionally comfortable with the disclosure to the individual key players, using a culturally salient symbol – the colors of a stoplight. Participants designated those key players with whom they are comfortable ("…green for you're ok with it, you're comfortable with it…"), uncomfortable ("…red for you don't want them to know, it makes you really uncomfortable…"), and wary ("…yellow for you're not sure how you feel about it…") of disclosing their depression status; these indicators were applied to every key player represented on the SNE, regardless of disclosure status. These selections were then discussed at length as dictated by the interview questions (discussed below).

### 3.2.3 Procedures

The use of the interactive SNE activity allowed the interviewer to direct and focus the participant conversation toward the concepts of Visibility Management and the Safe Other. I asked these questions in casual, conversational language in order to establish rapport, and promote comfort

and understandability. Before launching into the questions of primary interest, I asked two different kinds of questions, called Additional Demography (at Timepoint 1, to ascertain the social circles in which the participants are embedded), and Orienting Items (at following Timepoints, to build rapport and foreshadow potential conversational avenues). Additional interview items (as outlined in Appendix A) regarded study-relevant topics and varied by Timepoints, participant focus, and available time per interview. Those items relevant to the contained analyses will be reviewed in more detail prior to discussing the associated findings.

### 3.2.3.1 Validity and Reliability Checks

Following the scientific tradition of valuing objectivity in data collection, analysis and the drawing of conclusions (Patton, 2002), I undertook several steps to ensure that this project was conducted at every step in a reliable and valid manner. Regarding reliability, intra-rater reliability was calculated for two non-consecutive coding sessions for a portion of the transcripts. The Mechanical codes are fairly straightforward and concrete, so I only double-coded a small portion (approximately 10%, $n = 4$) of transcripts for these codes; I obtained a rate of 91.85% agreement on these codes. However, the Content codes are more subjective, and thereby demand more extensive safeguards. Therefore, in order to establish coding fidelity, I coded twenty percent of the interview transcripts ($n = 7$), randomly selected (1 per participant), twice with the Content codes, post reduction as specified by the analyses (see below for discussion on dataset reduction regarding Safe Other analyses and emergent themes). I utilized the website http://www.random.org/ to select which transcripts were coded. This second coding was undertaken such that I allowed a minimum of one weeks' time between ratings so as to generate calculations of intra-rater reliability via calculating code-recode co-occurrence. Here, I obtained a percentage of co-occurrence of 62.11% (visibility management codes), 61.70% (functioning

codes such as burden, consequence) and 58.81% (stigma items) agreement between the two rounds of coding. Upon further examination of the discrepancies, I determined that the majority of the problem lay in ill-defied coding unit variation, a problem which due to the nature of the data could not be rectified. Therefore I examined the coding discrepancies thematically and determined that the difference were minor and analytically unimportant.

In order to establish that this project was conducted rigorously, a second key facet is ensuring that a study is valid (Rossman & Rallis, 2012); to this end, I pursued transparency through systematic memoing and annotation of data and analyses regarding emergent themes, discrepancies, and outstanding items to ask/clarify, and strident tracking of alterations made to data, dataset, coding scheme and other analytical artifacts, such as tracking whenever a new code was added to the coding scheme.

One method that I used to establish the validity of the findings based on participants' meaning-making involved presenting the findings to the participants (or members of the context being studied) and gathering their thoughts on the validity of the researcher's interpretations (H. J. Rubin & Rubin, 2005). However, for this project, post-completion debrief was not pragmatically feasible because of the nature of the population (e.g., due to confidentiality concerns and probable limited access to the Safe Others, triangulation did not occur) and timing of the project (adolescent participants were unlikely to be available to comment on conclusions drawn at the beginning of the project several months later, particularly as three graduated high school and completed the clinical program, in addition to the concern that early debriefing could have contaminated later interviews). Therefore, I conducted *in vivo* verification of researcher understanding of participant's meaning as an integrated part of the interview processes by periodically summarizing the major themes I had just gleaned from our conversation. In this

way, at every interaction, I conducted member checks, validating my findings as they emerged from the interview, so as to ensure the validity of the conclusions drawn. Additionally, I frequently generated a summative sentence or two at the end of protocol segments and asked the participant if this was an accurate interpretation of her thoughts, prior to moving on to the next protocol section.

### 3.2.3.2 Interview protocol

As previously stated, I designed the interview protocol to be conversational in tone, while purposefully touching on all of the topics being studied. Although most of the discussion with the participants were very organic, the questions I crafted were integrated throughout our conversations, at times following the intended order while at other times occurring in seemingly random order as dictated by the participant's speech. The prompts regarding this protocol item were as follows:

> So when you look at all of the people in your life, is there anyone that you talk to about this stuff, like, who to tell about your depression, or who doesn't need to know or maybe even really shouldn't know? Or maybe your worries about whether or not to tell someone?

> OR: So is there anyone you go to for help with this kind of stuff [referring to visibility concerns]?

> OR: So who do you go to for advice?

- What kinds of things do you talk about with him/her?

- Does it help?

- What made you chose (this person) to talk with about this stuff? What is it about them that made you feel like you could talk this stuff over with them?

- Is there anyone else you talk to about this stuff?

- Is there anyone else you wish you could talk to about this stuff? (If Yes:) Why don't

  you talk to them? (If they do, same questions as before)

Additionally, several prompts were used later to further clarify the outcome of the SO

usage, such as instances in which this role was re-evaluated:

So when we talked last time, you mentioned that you had talked about stuff like

who to tell and who not to tell about your depression, *(insert specifics from notes on*

*previous discussion here)* with (key player: Safe Other).

- Do you still talk with (key person: Safe Other) about this stuff?

- When was the last time you and (key person: Safe Other) talked about this kind of

  stuff?

- What kinds of things do you talk about with him/her?

- Does it help?

- What made you chose (this person) to talk with about this stuff? What is it about them

  that made you feel like you could talk this stuff over with them?

- Is there anyone else you talk to about this stuff?

- Is there anyone else you wish you could talk to about this stuff? (If Yes:) Why don't

  you talk to them? (If they do, same questions as before)

It is important to note, however, that these interviews were conducted informally, with

rapport-building and interpersonal comfort guiding the exact phrasing of each question. Some of

the relevant topics occurred spontaneously, naturally stemming from the existing discussion; in

other instances, these prompts were executed verbatim – the conversation dictated the approach.

In order to assure that I had captured all relevant data, I therefore bolstered my data culling by

using coding inferences of "advice", and "Visibility Management strategizing", then disregarding the instances of non-VM advice, and solo VM strategizing.

## 3.3    ANALYSIS

Data analysis involved a cyclical qualitative coding process completed with the NVivo9 computer software, as well as various tracking and scoring procedures using Microsoft Excel spreadsheets.  The transcripts of the interviews, augmented with ethnographic fieldnotes, survey data, and digital photographs of the Social Network Evaluation (SNE) exercise, and the quantitative measures discussed above constitute the data of these analyses. I first coded the combined transcripts and ethnographic observations and reducing them to a concise, focused dataset, referencing and updating the Coding Glossary as necessary.

Additionally, I also memoed my own thoughts, emotional reactions, and analytic ponderings so as to transparently capture a description of every stage of my analyses (H. J. Rubin & Rubin, 2005). In addition to informing the generation of participant profiles, I used these memos to note participant variations and similarities, and future questions for participants to clarify points which were not yet clear or to address those items which the participant(s) had not yet organically raised (e.g., directly questioning Rene about burden at Tp3). These memos, and the data and analytic notations generated through their usage, informed further analytical steps. Finally, I endeavored to address the research aims of this project through analytic procedures that examined differences and similarities found within participants, across time, and between participants through both coding the data using the NVivo software package at a fine-grained level, and then thematically exploring the uncovered patterns by re-examining the raw data.

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### 3.3.1 Qualitative coding procedures

Using the NVivo9 software package (see Bazeley, 2010 for review), I coded each transcript in a number of different ways. Using two different coding schemes (Mechanical codes and Content codes; see Appendix B for Code Glossary), I reduced the transcripts into manageable datasets so as to allow for more strategic, economic and precise coding (Guest & McLellan, 2003; Namey, Guest, Thairu, & Johnson, 2008), and coded for recurring themes in order to elucidate the process as it appears in my participants' relayed perspectives.

The first type of codes that I used consists of those referred to as Mechanical codes. Specifically, Mechanical codes are used to designate functional features of a transcript, such as the portion of the protocol that is currently being discussed, or about whom the participant is speaking. For this study, I coded every relayed interpersonal interaction with one or more Interaction code, designating about whom of various other potential interaction partners the participant is discussing.

The second type of codes that I used pertains to the actual substance of the participant's stories and statements. These Content codes were used to designate various interaction patterns and functions; it is within the Content codes that emergent codes were placed. The specific Content code regarding disclosure processes, advice, Visibility Management (VM), and the Safe Other (SO) codes formed the crux of my analyses. To reduce the data into a more manageable dataset, I excised and examined that data coded as pertaining to the protocol items regarding Safe Others and disclosure (Protocol items were part of the Mechanical codes), and the Content codes regarding advice and visibility strategizing. Additionally, I gathered the data regarding specific individuals in specific participant's lives (e.g., Felicia's mother, romantic partner and best friend, as they were all designated as Safe Others) as necessary.

### 3.3.2 Matrices and real-time analyses

Throughout the analytic process, I utilized a variety of techniques to examine the data in a thorough, systematic manner, such as the previously described coding scheme (applied using the NVivo software package) and memoing process. Additionally, I used a variety of matrices, such as an accounting sheet (Miles & Huberman, 1994) to track data collection and processing (e.g., see Table 2). However, analyses are not just rigorous tracking and memoing; therefore, I utilized one additional type of matrix – a Time Matrix – to track and analyze the data collected both within and between participants in order to answer my first three research questions.

Research aims 1 through 3 regard within-participant (across time), and between-participant patterns of SO function; therefore, in order to conduct both between and within participant analyses in a coherent, systematic manner, I used a Time matrix (Miles & Huberman, 1994) to track features of the data gathered. This table allowed for tracking various features of the Safe Others designated and utilized by the participants in a manner which can be easily sorted to examine different features as needed, depending upon the analysis in question.

By first selecting the data coded as "safe other", "advice" or "visibility management: strategizing," I then re-read these segments of original transcript, widening the scope of my attention to any discussion of preceding or following events, and copying verbatim portions of the text regarding the theoretically key features of individuals or events. I also disregarded instances of these codes that were not relevant to the Safe Other analyses (e.g., Maria gaining romantic relationship advice from her elderly coworkers). Annotated in specific columns, these features included any prompting circumstances for each VM incident, or the satisfaction (or lack thereof) the participant experiences after a Visibility Incident (VI), which due to the usage of the matrix could then be examined between participants. One row represents each different SO for

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each individual participant (such as one row for Aggie's clinician, another for her therapy group members), allowing for within-case analyses. In instances where this approach to data gathering did not result in the completion of every cell for each coded strategizing partner, I then used a combination of the "Important other" codes to locate all references to this specific person (e.g., any references to "Mother" in Karen's transcripts, as she was Karen's SO) until I had located the relevant information.

Notations and actual verbatim lines of the transcript in which this feature or event is discussed populated the cells of the matrix, allowing for immediate reference to the appropriate dialogue segment(s) for more in-depth thematic analyses. I used many of these direct quotes in the Findings section to exemplify the themes and trends from the data; for ease of accessibility, the whole table is not included, but rather I included an abbreviated version (see Table 3). The time matrix does not allow for fluid analysis of whole cases or cross-participant / cross-timepoint patterns, let alone emergent findings not contained within the SO framework. Therefore, to answer my final research aim, I also employed thematic analyses.

### 3.3.3 Thematic analyses

Although hypotheses drove many of the analyses in this project, I explored the fourth research aim through primarily emergent codes, particularly those of "burden", "visibility management: partial disclosure" and "stress." These codes emerged from the raw data through repeated review and analysis of relevant portions of the transcripts; the actual terms "burden" and "stress" were participant-generated, as the participants repeatedly referred these cognitions and perceptions. These thematic explorations focused on the impetus and motivations of adolescent disclosure.

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**Table 3 Characteristics of the reported Safe Others (SO), separated by participant.**

| Ppt | Safe Other | Demography | Tps | Overall Tone of Relationship | Initial Disclosure Reaction | SO Utilized | Satisfied with VM Advice? | Re-evaluated? |
|---|---|---|---|---|---|---|---|---|
| Aggie | Clinician | Adult, female | 2 | Positive | NA | General depression disclosure | Yes | No |
| | Therapy group | Youth, mixed | 1 | Positive | NA | General, emotional expression | Yes | No |
| Cecilia | Clinician | Adult, female | 3 | Positive | NA | Unspecified, bad day needs | Yes | No |
| | Mother | Adult, female | 1 | Positive | Unresponsive; Business-like | Specific: understanding a friend's reaction | Yes | No |
| Felicia | Mother | Adult, female | 1; 4* | Tumultuous | Business-like | Specific: disclosure to best friend, stepfather* | No | Yes – replaced |
| | Best friend | Youth, female | 1 | Positive | Supportive, playful | Unspecified | Yes | No |
| | Romantic partner | Youth, male | 1 | Positive | Supportive, accepting | Unspecified | Yes | No |
| Karen | Friend | Youth, female | 2 | Positive | Supportive | General | Yes | No |
| | Mother | Adult, female | 1-4 | Positive | Supportive | General, one specific: disclosing to sibling | Yes | No |

Table 3 *continued*

| Ppt | Safe Other | Demography | Tps | Overall Tone of Relationship | Initial Disclosure Reaction | SO Utilized | Satisfied with VM Advice? | Re-evaluated? |
|-----|-----------|-----------|-----|------------------------------|------------------------------|-------------|---------------------------|---------------|
| Maria | Grand-mother | Adult, female | 1, 2, 5 | Tumultuous | Negative, "hysterical" | Specific: disclosure to mother | No | Yes, now self-reliant |
| Rene | Romantic partner | Youth, male | 1 | Positive | Upset, sad | Specific: disclosure to father | Yes, but disregarded | Yes, now self-reliant |
| | Stepfather | Adult, male | 1 | Neutral, positive | Supportive, understanding | Specific: disclosure to father | Yes, but disregarded | Yes, now self-reliant |
| | Mother | Adult, female | 1 | Positive | Supportive | Specific: disclosure to father | Yes | Now self-reliant |
| Zoey | Mother | Adult, female | 1 | Positive | Supportive, sad | Specific: disclosure to father, sibling | Yes | No |

Note: *References to non-depression or –impetus related disclosures; Ppt is participants, Tps is Timepoints in which discussed.*

This type of analysis is by nature dependent upon the words of the participant and the interpretations of the analyst. Each interviewee and the researcher generated a different understanding of the phenomena; therefore, in order to craft a holistic conceptual understanding of this phenomenon as a whole, I first coded the entirety of the transcript data as with the other analyses, utilizing the codes from the code glossary and adding new codes as necessary, based on repeated recurrence of themes or concepts as noted in my memos. When new codes were added, I tracked these additions in a spreadsheet and noted which transcripts would need to be revisited as they had not been examined for occurrences of these new codes. In this way I ensured that I coded all of the data thoroughly and uniformly.

I then used coding queries to identify the data coded as "burden", "stress", and "visibility management: partial disclosure." Once this data was identified, I revisited the transcripts and re-read the conversations in which these themes appeared, again memoing and noting similarities in the themes therein as well as copying key quotes into a separate, informal spreadsheet. I used repeated iterations, meticulous notations of analytic steps via memoing, and introspection and reflection (Emerson, Fretz, & Shaw, 1995; Jaccard & Jacoby, 2010) to identify the underlying themes that are discussed below. Finally, I undertook rigorous memoing on emergent thematic coding and patterns.

The final selection of quotes proffered in the Findings section entailed selecting the participant statements which I felt constituted either particularly exemplary or explanatory quotes. Identifying quotes that were both succinct and focused was of the utmost importance as often the participants were circuitous in their discussions. What one girl might state over several minutes of dialogue, diverging into explanations of relevant interpersonal relationships or

comparing/contrasting this situation to other situations, another may state much more succinctly, or may provide a clear, concise explanation. So long as these more concise statements reflected a thematic unity with the longer explanations, the shorter quotes were utilized in the Findings section for readability. However, when additional content was necessary for understanding, or when a divergence in cognitive processes was observed, then the more representative quote was utilized regardless of length. In this way, I strove to adequately epitomize the themes presented below as explained by the participants.

# 4.0    FINDINGS

After 35 interviews spanning eight months, findings and themes emerged from participants' narrative accounts of their interpersonal relationships, regarding these adolescents' decision-making processes and their perceptions of their management of a variety of visibility issues. These visibility issues were not limited to those encompassing depression, but conversation emerged managing the visibility of various other covert potentially stigmatizing features. Within depression, participants expressed concern about specific depressive symptomology such as self-injurious behavior, suicidal ideation, and panic attacks.    Also necessitating visibility management, any impetuses (incidents or relationships that the participant designates as the cause of their illnesses) to their mental health concerns prompted strategizing regarding disclosure.

Below, I will first discuss the two extremes of visibility management – that of concealment, and of disclosure – before I delve into these nuances, and the participants' rationales for their visibility decisions, with and without the utilization of a Safe Other. Framing this discussion, a conceptual map (see Figure 2) has been drafted to help to clarify this process; as the discussion progresses, different portions of this conceptual map will be explored. A brief overview is provided here, however, before I explicate specific segments of the model, and review specific examples of some of these processes and concepts. Please note that this model depicts Visibility Management processed in general, allowing for both the use and non-use of a

**Figure 2 Conceptual Map of the Full VM Process**

SO, and aside from the first stage (Depressive Symptoms) is not specific to depression as a PSC, instead being potentially applicable to many PSCs (see Future directions).

This conceptual map begins not with the diagnosis of a depressive episode, but with the building of depressive symptoms, as some level of disclosure typically occurs first in order to receive even an assessment and hence a diagnosis. When studying additional PSCs (see Future directions), this stage could be re-termed, for example, as Impetus Event (such as in the case of entry to the Foster Care system, or a traumatic event), but, as many depressive episodes do not have clear impetus events, this term is not appropriate here.

The next stage in the process, as depicted in this illustration, varies by individual. In this study, all of the participants expressed awareness of the stigma associated with mental illnesses such as depression; reflected in the uppermost path, those who, like these participants, have experienced or anticipate experiencing stigma reactions likely recruit a Safe Other for strategizing purposes. It is important to note that, as discussed earlier, stigma experiences may be personal, observed, or learned about vicariously, and any of these kinds of experiences can have a lasting effect. Not a definitive path, however, even those individuals with stigma knowledge may not have the social resources or acumen to recruit SO assistance (e.g., younger children, those with dysfunctional social connections, or those with cognitive difficulties), unlike the participants of this project. Therefore, an additional outcome shown here would be bypassing the SO recruitment process and proceeding directly to the VM decision-making process.

An alternate route, depicted in the lower portion of the figure, suggests that an individual may not be aware of the stigma associated with their condition or characteristic. While this did not occur with these participants, and given the widespread awareness of mental health stigma in general (Wahl, 1999b) I suspect that while it is not likely that this would occur with frequency in

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the mental health population at large, this is certainly possible again among those individuals with cognitive difficulties, those new to their environs and therefore unfamiliar with the local stigmas, or those with low levels of social acumen. Therefore, to take this possibility into account, this route accounts for the possibility of disclosure events without in-depth strategizing – strategizing is unlikely to occur when the need is unknown. From this low- to absent-strategy disclosure, as with any disclosure event, two possible outcomes may occur: a positive or neutral reaction from the disclosed-to (with low risk of damage to the interpersonal relationship), or a negative reaction (with higher risk of damage to the interpersonal relationship). Positive reactions can be expected to cause no cognitive dissonance – an action was taken, and resulted in a positive (or at worse, neutral) effect, resulting in no need to alter strategizing tactics or lack thereof. Negative reactions, however, would be expected to prompt re-evaluation of strategizing and tactics, which may include the recruitment of assistance in the form of a Safe Other, one of the primary concepts under investigation.

The next stage of this process, and the primary process under investigation in this project, focuses on the process of Visibility Management decision-making. The pieces of this process will be discussed in-depth below, including the various facets of the individual's life that the participants endorsed as playing a role in this mechanism of interpersonal interaction. The results of this decision-making constitute the VM behaviors, in the project to consist primarily of varying degrees of partial disclosure – rather than full disclosure or concealment – an emergent theme not previously represented in the literature and discussed in-depth below.

Similar to the potential pre-strategy disclosure previously discussed in the second stage of this model, the fourth sage of VM behavior (i.e., some level of concealment and/or disclosure) results in a positive to neutral, or negative, reaction from the disclosed-to person. Again, these

different affective, relationship-quality consequences result in specific strategizing outcomes. If the other person reacts positively (or neutrally), and this reaction aligns with any preceding strategizing (be it with the assistance of a SO or unassisted), the then strategizing and/or SO do not need to be re-evaluated, but can be maintained as they currently exist. Conversely, if the reaction, even if positive, does not align with previous strategizing then this can prompt re-evaluation of the strategizing and tactics employed. At this point, if no SO had previously been recruited, the re-evaluation of strategies may include enlisting this assistance; if SO assistance had been previously utilized, then the status of this person as SO may be re-evaluated, and the role re-assigned. Specific examples of both of these kinds of reactions, provided by this project's participants, will be discussed below.

Alternately, the reaction to a VM behavior could be negative. If this reaction is anticipated, whether the anticipation is a result of SO assisted strategizing or of independent decision-making, then again there is no dissonance, and the strategizing technique would be expected to remain intact. This would most likely occur if disclosure is forced or unavoidable, even though strategizing anticipated a negative result; the participants provided no examples of this potential outcome. However, if the consequences to the VM behavior entail unanticipated consequences, the most likely result would be re-evaluations of the tactics enacted during the decision-making process. This could then result in re-evaluation of the SO role, or, it could result in the activation of the SO for assistance in meaning-making or debriefing about the situation, which may not necessarily result in SO re-evaluation, just strategy re-evaluation. An example of this outcome from a participant's life will likewise be discussed below.

Finally, the process repeats, resetting at the VM decision-making stage, with or without the assistance of a strategizing partner. In the following section, I will first discuss briefly the

variable nature of depression as relayed by the participants, and then discuss the findings regarding the utilization, or lack thereof, of the Safe Other (SO), as well as emergent, illuminative findings regarding the VM process more holistically. Nuances such as the varying levels of disclosure that the participants engaged in, and the facets of their lives that they reported considering while deciding whether or not to disclose specific information to specific people at specific times will discussed, as will the roles of important other people in these processes. The conceptual model will be revisited multiple times to illustrate these processes. During this discussion I will integrate the emergent findings regarding Visibility Management (VM) in a broader sense with the results of specific hypotheses regarding SO utilization (Research aims 1 through 3), as the findings from the fourth Research aim (the exploration of the decision-making processes and occurrences preceding, during, and following adolescent disclosure of their depression) inform the results of the other questions, explaining inconsistencies and illuminating otherwise obscure processes.

## 4.1    PARTICIPANT PROFILES

Before advancing into the analyses of what the girls said, a brief overview of who the girls are, as individuals and as members of social circles, will help to orient the ensuing data by assisting in a rudimentary understanding of these participants as individuals, with very different social circles, backgrounds, and current life styles. Over the course of the months during which I interviewed these girls, I grew to know them and care about them as people; knowing for example that Felicia's family situation was very different from Zoey's, and that both were different from Rene's helped me to understand why they tapped the various interpersonal

relationships that they each tapped. Likewise, knowing that Aggie's household assets and even her hobbies afforded her different resources than for example Maria helped me to understand their decision-making and attitudes. Therefore, a concise overview of each of the seven adolescent participants has been included here before proceeding to the discussion of the findings pertaining to the research aims (a concise summary has been provided in Table 4 for quick reference).

In general, family members figured prominently in the conversations regarding social networks, as did friends, regardless of the qualitative tone of these relationships. Less prominent, though still represented, teachers and clinical personnel appeared on SNE maps. To protect against the identifying properties of their ages, participants were split into two groups for this overview – Underclassmen ($n = 3$), defined here as those adolescents in 8th-10th grades at the time of their participation – and Upperclassmen ($n = 4$), the participants in 11th-12th grades. Finally, a few of the participants – Aggie, Rene, Zoey – are characterized by additional PSCs, and several – Felicia, Rene, Zoey and Maria – had also experienced previous potentially traumatic events, repercussion of which depending on the person and their ensuing coping mechanisms.

The youngest of the participants were Cecilia, Karen and Rene. All three reported primarily positive relationships with their families, though their family structures varied, as did their additional social circles. None had seriously begun identity work or planning for the future, and though involved in varying levels of social activities, they also tended to report being more emotionally distant from their friends than their older counterparts, regardless of the graphical representations on the SNE.

Cecilia, the youngest child of her father's second marriage, had two older half-siblings with whom she had little contact. However, she reported being very close to additional extended family members, particularly two adult aunts and one younger cousin. Although she reported primarily positive relationships with her friends, they did not play a central role in her support network. Her primary activities tended to focus on her religious orientation, and she frequently utilized categorizations when discussing other people.

Karen, the youngest of three children from the same two parents, also reported being very emotionally close to her parents, consistently placing both of her parents as her two closest interpersonal supports. She also listed her nearest-aged sibling as consistently close, though she rarely turned that direction for support. Her extended family remained distant through the duration of the study, and though she placed friends fairly consistently she reported hiding the severity of her distress from them, instead confiding almost exclusively in her parents. Very active in an artistic activity, her social groups remained rather rigidly compartmentalized.

Rene's family situation was the most complex of the study, consisting of two full households, four parental figures and four siblings. She primarily lives with her mother, stepfather, and three younger siblings, though one of her main supports is a same-aged sibling residing at her father and stepmother's house. However, her primary support is her romantic partner, followed by a variety of friends, two of whom she interacts with in a purely virtual manner. She lists additional family members in her social circle, though their positions are unstable and she rarely reported confiding in them. Her primary leisure activities revolved around school organizations, primarily artistically oriented.

Maria, Felicia, Zoey and Aggie were the eldest of the participants, and their lifestyles tended to be quite different from their younger counterparts. Three of these participants were

employed, and all discussed romantic partners past, present or both. Far more future-oriented than the younger participants, they all discussed future plans with varying degrees of immediate enactability. However, these girls too varied widely in activities, outlooks, and social networks.

Maria reported being interpersonally close to her family members – her mother, the stepfather who adopted her at a young age, and her younger sibling. However, this closeness varied between timepoints, with others such as a number of close friends frequently being placed as interpersonally close. Driven and focused, she not only participated in a sports activity but also worked for two different employments. However, her earnings often supplemented the family income.

Felicia's family situation proved by far the most tumultuous in the study. She frequently excluded her stepfather and younger sibling from the SNE map, and the position of her mother varied widely, at one point being excluded entirely. The negative situation in her biological family drove her to re-create familial relationships with the parents and siblings of her friends, and these supports instead often inhabited key central places in her social network. The most consistent social contact, however, was that of her romantic partner. Her primary activity was sports-related employment, and she reported finding much value in that setting.

Zoey's family, in contrast to that of Felicia, consisted of extended members in a rather interpersonally close network. Both of her parents, though separated, represented important figures in her life, one relationship maintained as close, the other growing closer throughout the duration of the project. Very close to one of her two younger siblings, the other sibling again grew consistently closer over the project's length. She also reported a fairly consistent closeness to three additional adult extended family members. However, although reporting that her primary supports were one of her younger siblings and her mother, she also consistently placed certain

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**Table 4 Basic Social Information of the Participants**

| Ppt | Grade | Family structure | Social structure | Activities |
|-----|-------|------------------|------------------|------------|
| Aggie | Upper-class | Only child, both parents, not close to extended family | Friends circle is stable, primarily female; former (1) and current (1) romantic partners | Active in arts, sociopolitical group; specific plans to attend college / major |
| Cecilia | Under-class | Two adult half-siblings, both parents, close to extended family adults | Friends circle is stable, primarily female; no romantic partner | Active in religious orientation |
| Felicia | Upper-class | One younger sibling, mother and step-father, not close to extended family | Friends are co-ed, include several adult women; current (1) romantic partner | Active in sports activity; employed |
| Karen | Under-class | Two older siblings, both parents, not close to extended family | Friends are stable, primarily female, compartmentalized; no romantic partner | Active in arts activity |
| Maria | Upper-class | One younger sibling, mother and step-father, close to grandmother | Friends are stable, co-ed; former (1) and current (1) romantic partner | Active in sports activity; employed |
| Rene | Under-class | Three younger and one same-age (varying) siblings, mother & step-father, father & step-mother | Friends are stable, co-ed; former (1) and current (1) romantic partner | Active in art, social activities |
| Zoey | Upper-class | Two younger siblings, mother, father separated, close to grandparents | Friends are co-ed, fairly stable, semi-compartmentalized; former (2) and current (1) romantic partner | Pursuing additional educational opportunities; employed |

*Note:* Ppt refers to participant pseudonym; underclass refers to grades 8-10, upperclass to grades 11-12.

key friends including past, current and prospective romantic partners as her most interpersonally close contacts. Driven like Maria, she was employed as well as engaged in extra college courses.

Finally, Aggie, an only child of a fairly high SES family, reports being close to her parents, though the degree of closeness varies. Unlike many of her counterparts, she also frequently lists teachers as close supports, as well as the more common utilization of a stable bevy of friends, including a past and a current romantic partner. Along with Ceclila, Felicia, Maria and Zoey, she also reports her clinical personnel as interpersonally close, though unlike the others she reports a varying constellation of these personnel as close for all five timepoints. Her primary activities include sociopolitical activism, and a sport-oriented activity.

## 4.2    VARIABILITY OF DEPRESSION

Depression is a nuanced condition, with symptomology differing between individuals, and both experienced symptoms and severity of these symptoms varying on a day-by-day basis (Peeters, Berkhof, Delespaul, Rottenberg, & Nicolson, 2006). A treatment course for depression can show any number of mood rises and dips, as evidenced by the participants' CES-D scores here (see Figure 3). By observing the differences in reported symptomology over the course of the study, this daily variation can be inferred, in that even though different timepoints corresponded to different reported levels of distress, all of the participants were judged to be clinically improved (refer back to Table 1 for clinical statuses) by the final timepoint, when compared to their clinical condition at the first timepoint.

However, it is important to remember that self-report measures such as the CES-D are only as accurate as the perceptions of the reporter on that particular day; for example, Cecilia,
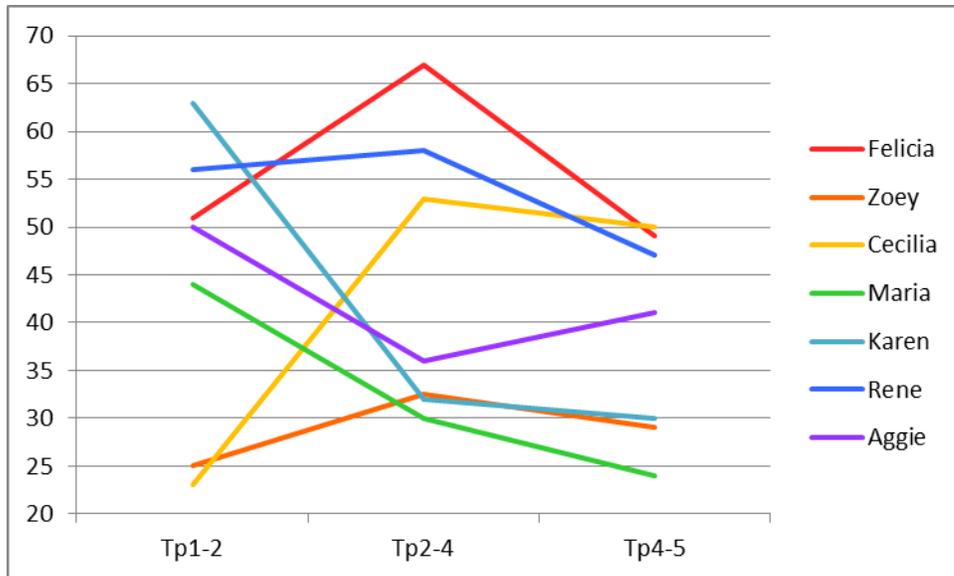
**Figure 3 CES-D Scores of Individual Participants at Beginning, Middle and End Timepoints**

*Note:* **Higher scores indicate reports of worse symptomology.**

clinically judged to be actively depressed at the first timepoint, reported fewer symptoms via the CES-D than she did at the final timepoint, at which point she was clinically judged to be in partial remission. In this case, the difference most likely centers on the refinement of Cecilia's own cognitive processes – during the middle of her duration in the study, she suffered a clinical set back (as suggested by the sharp increase in reported symptomology) and entered into a more intensive therapeutic level of care. This increase in intensity may have led to more discussion of symptomology and accompanying cognitions, allowing for a more nuanced approach to identifying and reporting her current status.

While speaking with these participants it became quickly apparent that the nuances of their daily status, and the way they perceived others to think about them, greatly influenced how they decided whether or not to disclose to another person, and how much they disclosed to that

person. Therefore, this background information, though brief, on the participants proves useful when considering why some of the adolescents reacted one way rather than others ways (e.g., Maria's openness versus Karen's reticence to disclose), or had one type of experience rather than another experience (e.g., Felicia's versus Cecilia's experiences with their mothers fulfilling the SO role).

### 4.2.1   Concealment and disclosure: a continuum.

Although there were some people in the participants' lives who knew nothing about their struggles with depression (e.g., Karen's eldest sibling, Aggie's extended family), the majority of important others did know about the depression. After first designating, then placing on the SNE according to perceived interpersonal closeness, participants then labeled the Important Other (IO) people in their lives according to disclosure status. These initial disclosure / non-disclosure labels (via blue stickers to indicate that an IO had been told about the participant's depression) prompted detailed discussion, with and separate from the disclosure comfort labeling, regarding to whom the participants disclosed, and why.

Concealment and non-disclosure parallel the previous findings in the Autism spectrum community (Davidson & Henderson, 2010) concerning the desire to "keep safe" by not telling others, or even actively hiding a PSC from others. This self-protective strategy, while deeply tied here as well as in other literature on stigma concerns (Phelan et al., 1998), was also used by these participants to defend against repercussions that are not clearly stigma-based. For example, Aggie demonstrated hesitancy regarding disclosing to her extended family which tended toward stigma-based fears, as she described why her grandmother had not been disclosed to and had been noted as a person with whom she would feel uncomfortable disclosing to:

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She would not understand.  She would blame my dad.  I love my grandma, but

she's very controlling of her children...  I used to dye my hair.  She told my dad

that he was a failure as a father because he was letting me go bad. …So, if she

learned that I have depression and have had suicidal thoughts, she would not be

pleased. I'm not putting my dad through that and I'm not putting myself through

that, so they're not finding out. (Aggie, Tp4)

Aggie actually had two PSCs, and had disclosed neither to her grandmother because even

though she reports to "enjoy her company" (Tp2), she believed that her grandmother would be

disapproving and even hostile toward herself and/or her father should she learn of these PSCs.

This opinion was stable throughout her duration in the study in that earlier she stated "she would

have red [indicating discomfort] for basically every significant part of my life" (Tp2), and by the

end of her participation she had not disclosed either PSC to this IO.

Unlike Aggie's stigma concerns, Karen's hesitancy to disclose to her eldest sibling was

not stigma-based, as she explained why she had not disclosed to her sister:

I guess it would affect the way we go about talking.  It could make them more

nervous around me.  I found out that my brother at one point had depression and

was on the verge of being suicidal and so that kind of changed the way I looked at

him in a way that it made me more nervous for him.  So I wouldn't want him to

feel, and my sister, to feel the same way about me. (Karen, Tp2)

Having herself experienced the role of disclosure target, and having exhibited a

somewhat negative reaction to this disclosure, she expressed not wanting to experience a similar

reaction from her siblings. However, rather than a stigma-based reaction, this reaction was

interpersonal in nature, making her "more nervous for him"; her worry was not that they would

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reject her, but that they would treat her differently out of concern. As she stated that "we're having like a really good period right now" (Tp3), she expressed that she would rather not tell them than alter their relationship. Both of these example, though driven by different concerns, resulted in non-disclosure to the IOs in question.

Disclosure and concealment, while one can envision them as opposites, do not represent static features of a concept with two dichotomous extremes. Likewise, decisions regarding visibility were not undertaken once and then resolved. Often, the participants of this study discussed how disclosure and concealment issues arose on a daily basis, more often within the same fairly stable IOs than with new people. While new social contacts did often prompt VM decision making, long-standing social contacts also posed daily decisions, due to the variable nature of depression. In particular, those to whom the participant had previously disclosed their depression status posed continual re-assessment, and it is this daily assessment process that will dominate the latter portion of this section.

### 4.2.1.1 Non-disclosure and concealment: when not to tell.

The varying disclosure statuses of different IOs inspired different degrees of strategizing, as I discovered during the conversations prompted by the SNE-focused questions regarding why certain IOs were indicated to not know about the girls' depression. Those IOs to whom nothing had been told (regarding the participant's depression status) tended to prompt longer-duration consideration, and ultimate participant strategies included both passive (such as non-disclosure, or simply not telling the other person) and active (such as concealment or even lying) behaviors. When concealment occurred, often the girls stated that they chose to do so because they did not want to deal with the other person's emotional reaction. For example, when discussing her lack of complete disclosure to her father, Rene stated:

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He's like big reactions and like overreactions like all the time. Like I'm afraid he'll

like flip out, so I haven't told him. (Rene, Tp1)

Here, Rene articulated her concern that her disclosure would trigger an emotional

reaction from her father, a foreseen negative experience for both of them. Similarly, Karen

described a different, but equally salient, rationale for concealment related to questioning the

other's likelihood of maintaining her confidence, as opposed to exposing her depression status to

other individual from whom she might prefer to conceal this personal information:

[Friend] E knows nothing because she likes to gossip, and she just isn't very good

at holding secrets. And I wouldn't want everyone in the school to know that I'm

having problems. (Karen, Tp1)

Karen's previous experiences with this friend suggested to her that she is not trustworthy,

when it comes to personal information, and while her friend may have taken her concerns

seriously and safe-guard her privacy, Karen was unwilling to chance this given the negative

potential consequences should her friend fail in this regard. A third such social concern voiced

was the belief that should they disclose to a particular IO, they would experience a severe

relationship change, often arguably an example of anticipated stigma, such as the reason Felicia

provided as to why she has not disclosed to one of her friends:

Because with the way that he can be at times, he's sort of judgmental. I'd be

afraid that he'd start looking down on me too, and I'm just really paranoid about

losing people. (Felicia, Tp1)

These fears and concerns prompted participants to not disclose their concerns or even

needs to those around them; in fact, all seven girls reported multiple incidents of non-disclosure,

even among those they denoted as being interpersonally close, such as Zoey's grandfather or

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Karen's eldest sibling, both of whom these participants reported as consistently close. Thoroughly considering the personal characteristics of the other person, the participants made these decisions purposefully, rather than reflexively, even if their actions were in fact non-action. For example, in the case of Zoey's grandfather, about who she stated "And I feel comfortable talking to him…" (Zoey, Tp4), to whom she had not disclosed by the end of the study because, as she had earlier explained:

>…I just think he'll like put even a closer eye on me, and that's one thing I don't
>
>want him to do. 'Cause... he's goofy, and I don't want him to lose his goofiness
>
>trying to like make sure he doesn't hurt me or something so. (Zoey, Tp1)

Her concern that her disclosure would fundamentally change their relationship prompted her to not disclose her troubles to an important recurring social contact. Even if not truly an example of anticipated stigma as her grandfather's behavior would be based on concern rather than negative beliefs or the desire to socially distance himself from her, she found his presence and their casual, "goofy" conversations comforting, and as such she valued their relationship as it was. For her, maintaining their relationship as casual and comfortable and based on a common interest, rather than characterized by the concern and over-cautiousness that she anticipated he would exhibit, was more valuable than a more active form of support. According to Tardy's (1985) model, she was valuing available emotional support more than running the risk of altering the relationship to possibly gain a more instrumental form of support.

However, sometimes non-disclosure was not enough to meet the self-protective needs of the participant. Participants also reported instances in which active deception was necessary to keep others from learning of their problems. Although utilized far less often than passive non-disclosure, all participants also endorsed using active concealment strategies, three of whom

admitted to actions akin to lying. Rather than when discussing who specifically does not know about her depression, as with the quotes reviewed above, it was when discussing who she felt "knows" her as a whole person that Felicia gave a clear example of how she moderated the visibility of her mood:

> A lot of the times the part that I show other people is like a mask. I try to be all happy and I try to be what society wants and all that but on the inside it's just really not. On the inside a lot of times it's really sad and dark and just not very good at all. (Felicia, Tp4)

Though this discussion arose from a prompt regarding what is fundamentally a question regarding identity within interpersonal relationships, this statement speaks to visibility, as well as the expectations she felt that others had of her. Felicia's concern about not fitting into societal expectations aligns with previous research findings (Wahl, 1999b) regarding the influence of culture on how those with mental illness feel they can express, or cannot express, their needs. However, later disclosure – such as after a relationship has been strengthened or a person gauged to be emotionally "safe" – can backfire, as Cecilia discussed what she feared could happen if she now disclosed to some of the people from whom she had previously been concealing her depression:

> Like they just would have… I'm trying to find the right word. I think they would've just taken it as me complaining or something and then everyone would have been like, 'you were lying to us. You told us you had stomach problems,' and then it would have just spiraled out of control. (Cecilia, Tp4)

This statement surfaced from a question that regarded how to educate other people about depression and mental illness in an effort to stem stigma. Cecilia mentioned a senior project that

she had considered doing about adolescent depression in general, but trapped in her deceit, she re-planned the research project for school, deciding not to do a pro-mental health activist project because she feared that level of exposure would reveal her own mental health concerns, thus leading to possible social repercussions. In essence, fear of stigma was the very thing that prevented her efforts to reduce stigma.

**4.2.1.2 Disclosure: not just all or nothing.**

The participants reported that they disclosed to more people in their interpersonal social circles than they concealed their depression from, often relaying some version of "Everyone knows about it, so there'll be a blue sticker on everybody 'cause everyone knows about it." (Maria, Tp1; the blue sticker she referenced indicates that an individual knew about the participant's depression). In this instance, Maria is stating that all of the 10 most important people in her life know about her depression. However, despite repeated assurances that they disclosed their depression status to their families and friends, both verbally and – as in the cases discussed below – while using the Social Network Evaluation (SNE) map, further probing reveals that disclosure was not an absolute state, and that "disclosing" to a person can mean different things depending on the discloser, the circumstances of the disclosure, and who is being disclosed to.

Following Maria, one of the upperclassmen participants and a very independent and driven young woman, her disclosure level varied among the important other people in her life depending on a variety of factors. Sometimes, the nature of the relationship hindered full disclosure, such as with one friend a grade older than her.

…[S]he knows like a lot, but I don't know.  She's also a senior so it's like she's

gonna be leaving, and I don't want to put all of my trust into seniors right now

'cause I'm not gonna have them next year anyways, so it'd be easier just to put it

in my boyfriend maybe and people in my grade or younger than I am so I still have them. (Maria, Tp5)

Not wanting to disclose in this case meant not emotionally investing in a friendship whose longevity is in question. This longevity represents a sense of stability, of being able to re-approach the friend as needed; when the friend instead is gone and thus absent from regular contact, then their support cannot be relied on, and new sources of support must be found. Repeatedly, the participants cited the longevity of their relationships as the reason that certain friendships were perceived as being interpersonally closer than others; shorter-duration relationships seemed, to them, to be more fragile, and often these contacts would be privy to a lower level of disclosure (i.e., more likely to not have been disclosed to, or less knowledgeable). Maria's statement suggested that rather than revisiting this process when this friend effectively leaves her social circle, it is more efficacious to simply turn to those whose departure from her social circle is not a definite upcoming event. However, anticipated longevity of the relationship was not the only decision-influencing factor expressed by the participants.

Continuing to follow Maria's narrative account of disclosure decisions, we see that sometimes the determinant factor regarding disclosure was the interpersonal closeness of the relationship, such as with a friendly co-worker:

Yeah. I've told him. Like I've been like, "Oh, my depression's so bad today," or something like that, but he doesn't like know I cut. He didn't know like a really bad depression. 'Cause when all this happened – I didn't go there [re: workplace] too. (Maria, Tp2)

Maria labeled this coworker as uncertain in terms of her disclosure comfort, and he only appeared once on the SNE map. In this instance, her needs regarded the more controversial

elements of her depression – cutting and severity. Maria's hesitancy to tell others about these depressive symptoms does not represent a stand-alone instance of one participant. Centering on the presence of a particular symptom such as self-injurious behavior (i.e., non-suicidal cutting) or the severity of a particular symptom (e.g., suicidal ideation), this partial disclosure can hinder the participant receiving the support that they need to adequately cope with their depression. Aggie, Cecilia, Felicia, Karen, and of course Maria all endorsed this kind of self-censorship; the decision-making processes underlying much of this behavior will be explored in a later section of this paper. In this instance, however, Maria's period of greatest need – when she was dealing with her most severe symptomology – did not temporally overlap with her association with this social contact, so her statement suggests that because of this non-overlap, in the present she did not feel it necessary to disclose these resolved elements to him.

In other instances, the anticipated reaction of a given IO as foreseen by the participant, outside of stigma reactions, weighed heavily in the decision regarding how much or little to disclose. For example, when discussing whether or not to disclose specific symptomology to her grandmother, she relayed:

And my grandma would just be hysterical anyways with all of it. It's like she was

hysterical when I told her I cut. She just cries about everything. (Maria, Tp2)

While her grandmother's reaction to past events indicated to Maria what further disclosures may provoke, this emotional response did not indicate stigma – rather, it reflected a characteristic of either the IOs personality, or a feature of how these two individuals interact. A number of participants, Maria and Rene in particular, indicated multiple times that the anticipated and previously experienced overly-emotional reactions of others prohibited them from further disclosures.

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These concerns and partial disclosures were not limited to those whom the participants indicated as less interpersonally close. Among even the closest IOs, partial disclosure in the form of self-censoring what was disclosed in a given instance was a common occurrence. For example, with her mother, to whom she indicated that she was emotionally close, Maria had not disclosed certain key facets of her condition.

> And when I figured that I was, it was just like, "No, like she can't find that out.
>
> She can know I'm just a cutter, but she can't find out that I'm suicidal too… [A]t
>
> that point in time, I was like, "No, she can't know about that, because she already
>
> thinks that the cutting is a bad thing.  I can't have her know I'm suicidal too,"
>
> kind of thing.  (Maria, Tp2)

Again as above, Maria's hesitancy centered on whether or not to let her mother know about the specific issue of the severity of her symptomology, rather than the known overall depression status. The potential repercussion of such self-censorship can be to hinder the participant in receiving the proper assistance, whether that support is through informal channels, or even via a more formal relationship. Previously, a similar trend has been addressed when discussing stigma (Phelan et al., 1998), although here it is being applied to a non-stigmatizing relationship. In Maria's case, this tendency toward partial disclosure even culminates in hesitancy to fully reveal distressing circumstances to her therapist, potentially compromising her treatment.

> It's hard, because I don't know, like – I mean there are some things I haven't told
>
> [Therapist], and I don't know, 'cause I'm afraid kind of.  Like – I'm debating on
>
> saying it… And it's like I'm good with what she know and what I'm telling here,
>
> but there are just some things I just don't want her to really know; because it's not

harming me, it's just something I really don't think I wanna bring up kind of thing. (Maria, Tp2)

Though here it was an instance of perceived family privacy, other times it can be downplaying clinical symptoms:

…[W]hen I do start to feel like a little upset or whatever, I really don't tell them and I don't tell like [Clinician] or anything because I don't feel like having to go through because I know I'm going to have one of those down days…It's not to the point where I want to kill myself or I want to cut or anything, but I've had random days where I just cry for no reason… I usually tell her I had a bad day or this was a little upsetting but she'll ask me for a scale from one to ten and I usually don't go lower than a five because than that's alarms and everything and I don't like scaring her for no reason. It's like I just had a sad day. (Maria, Tp4)

This self-censorship was undertaken here based on Maria's belief that her mood fluctuations, even though severe, were not abnormal or clinically significant.

Though the others girls did not endorse concealing symptomology from their clinicians – in fact, many listed these important figures as interpersonally close (Cecilia, Karen, Felicia, and Aggie, even when unprompted, included clinical personnel on their SNEs) – they did acknowledge that lying or hiding things from clinical personnel does happen. When asked to give advice to (non-specified) others going through 'similar problems' to those they had faced/were facing, repeatedly the participants encouraged others to seek help, and to talk about their problems with IOs.

But my only advice I could get help as soon as possible. Get as many support

people as you possibly can. And there's never too many support people.

Never. (Zoey, Tp5)

While Zoey, who reported having a strong, supportive, and wide-spread support network consisting of family, friends, and co-workers, suggests recruiting support from as many different people as possible, Felicia was far more cautious in her advice. Her social network consisted primarily of friends, as her family connections were tumultuous; her previous experiences with unstable support led her to be more cautious in disclosure, often self-censoring even with those she considered her most reliable, closest IOs (her romantic partner and best friend). Her advice to others, consequentially, focused on the support of fewer, individuals chosen with discrimination and restraint:

Well, for the person it'd be find someone that you're comfortable with and

open up to them as much as you can. You do not have to open up to

everyone. I mean if you want to you can, but at least find that one person who

can help you and accepts it and understands it. (Felicia, Tp5)

Even Maria, who in previous quotes admitted that she did not disclose details or even clinically significant information, when asked for advice to others like her professed that one needs to find support, and one needs to open-up and "talk":

You have to talk. You can't keep it in, 'cause that's the main reason you get it

is because you keep everything into yourself. (Maria, Tp5).

By "it", Maria was referring to depression itself, proffering her belief that be holding in the concerns, pain, stresses and negative feelings a person allows depression to mature. Cecilia, however, focused on the stigma aspect of seeking support, facing upfront the concern

that she and others had expressed regarding being harangued about their shared condition. Rather than offering advice on avoiding stigma, or on how many supports to recruit, she instead concentrated on bolstering the advice-recipient's self-image, offering an abstract form of support herself even while advising an unknown stranger to find other supports:

> Don't be ashamed. It's not your fault. You don't have to hide it and even if people treat you badly for it, they're obviously not your friends or people you want to be around so just be open about it but don't hide it from people.
>
> (Cecilia, Tp4)

The participants' desire to help others, and their honest encouragement to seek help through disclosure, stood at odds against their own reported behavior of partial- or non-disclosure, even in self-defeating circumstances. This disconnect between their own advice, including the inherent acknowledgement of the necessity of disclosure and help-enactment, and their personal decision-making processes is explored below via an examination into the VM decision-making process. I accomplish this goal by examining both the reported role of the Safe Other (SO), or strategizing partner, and the factors that the girls reported as being pieces of this process. Assisted decision-making, independent decision-making, and the anticipated repercussions on the other person being disclosed to all feature in the following discussion about the processes of interpersonal interactions that result in the visibility concepts that constitute this project's focus.

## 4.3    EXPLORATION OF THE SAFE OTHER

Throughout the course of the study, the adolescents reported surprisingly few incidents of employing the assistance of a strategizing partner in their day-to-day lives, despite the fact that they often employed VM strategies.  Appearing on the conceptual map (see Figure 2) as a result of stigma awareness or discordant reaction to disclosure, this concept's original form in previous literature needed clarification and systematic exploration. In this study, while every participant reported turning to at least one other person for advice at some point, this person was most often called in for assistance regarding one particular anticipated (or experienced) disclosure event, with the adolescent then stating that they usually relied on their own judgment in such issues.

To pursue these analyses and facilitate this discussion, I generated a detailed table with direct participant quotes examining between and within variation regarding every coding instance of the protocol item "Safe Other."  In this way, I culled the most relevant participant statements regarding their usage of a SO, which I then summarized into Table 3. These data populate this section's discussion.

While the data collected point toward very interesting trends and suggest that this concept warrants further exploration yet, a concise, definitive definition is not possible at this time. The trends revealed, however, offer valuable insight into this phenomenon by elucidating several possible uses for SOs, and suggesting circumstances under which SOs could be recruited, (re)evaluated, and the relationship even dissolved. Below, I will discuss my findings regarding each of the research questions associated with the first three research aims. Additional analytic notes regarding the non-SO results will be discussed as they occur.

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### 4.3.1  Research aim 1: who is the safe other?

Although the adolescents varied by whom they turned to for strategizing advice, and how often they turned to these people, participants relayed definite trends regarding whom in their social circles they turned to for advice. The SO utilized by these adolescent females tended to be adults (9:14) and females (10:14). Also aligned with the hypotheses, of the seven participants and their fourteen strategizing partners, five participants listed their mothers, the most frequent role category of SOs, a finding in keeping with previous work on adolescent disclosure (Judith G. Smetana et al., 2006). Other SOs consisted of clinical contacts (3:14), romantic partners (2:14), friends (2:14), and other adult family members (2:14).

### 4.3.1.1 Mothers, the most common SO.

As seen above, mothers proved to be the most common role category of designated SOs. Karen, Zoey and Cecilia, in particular, reported very positive and repeated utilization of their mothers as strategizing partners. As Karen explained, when discussing why she trusted the advice of her parents (though regarding depression she approached her mother, not her father) more than that of another advice-giver, her brother:

> This is a weird word to use but my parents are very wise, I think, they're like the smartest people I've ever met, and so I – and they're older than my brother so they've obviously had more experience and they know how things will affect you in the long-term and so I trust their advice. (Karen, Tp3)
>
> Satisfied with her relationship with her parents, and the advice that they give her,

her description of them as, "wise," suggests her respect for them, as well as helping to explain her reasoning for approaching her mother in particular when deciding how to deal

with visibility issues – namely, her perceived experience and expertise. During the interviews it became apparent that even in the most satisfied SO relationships, the participants primarily relied on their own judgment regarding daily disclosures, rather than seeking out advice. Even this participant noted that the advice from her SO is not the absolute determinant of her VM behavior.

…(W)e're close, but we're very different.  We've very opinionated in our way.

So I always think it over first… (Karen, Tp1)

Even though she regarded her parents as "wise", and thus positively evaluates their input as valuable, she still independently decides how and to whom to disclose her depressive status. Though not previously explicated, this does not counter the utility of the SO – the SO is fundamentally an adviser, a strategizing partner (e.g., Sibley, 2004). Adolescents in particular, as they develop and use hypothetico-deductive reasoning (Steinberg, 2005), exercise their abilities to make independent decisions (Kuhn, 2000); this is simply an example of that natural maturation evidencing itself.

This theme of independent decision-making proved very common among the girls, in that even when satisfied with the support and advice received from their SO, they only enacted this assistance occasionally. The type of disclosure which prompted the adolescents to strategize with their SO primarily fell into two categories; the first regarded general disclosure issues, such as Karen's advice from her mother "to be very conservative with who I tell" (Karen, Tp2). The other trend regarded seeking advice for one or possibly two specific, particularly risky disclosures, such as when Rene's mother advised her regarding disclosing to her father. Only one participant, Felicia, endorsed repeatedly tapping strategizing partners for disclosure advice.

Similar to Karen's situation, Zoey faced the dilemma of speaking to her younger sister, about whom she says "I don't want to say she's my favorite, but I feel like she understands me more even, and she's more understanding of everything…" (Zoey, Tp1). She valued this relationship, and worried about the impression her disclosure would make on her sister, stating "…I want to be the perfect role model for her…" (Tp1). She approached her mother for advice, in part because of their close relationship and in part because her mother had dealt with a similar situation in the past.

> And my mom was like, "If you just talk to her, like if you're sad and you don't want to talk to nobody else, you know she'll listen to you. You know." Like she saw the relationship me and her had – me and her still have... (Zoey, Tp1)

Her mother's appreciation for the relationship shared by the participant and the visibility target, in this case her sister, as well as the reassurance that their relationship was strong enough to weather the impending conversation, helped Zoey to talk with her sister. Afterwards, she declared her mother's advice as "It was spot on, definitely. Definitely spot on."

Although the first part of the hypothesis regarding Research Question 1 proved accurate – mothers were the most common SOs used – the second portion, regarding additional SO designates – did not necessarily follow the predicted pattern of female peers being the second most common SO category. While Cecilia and Felicia both designated their "best friends" as Safe Others, Aggie, for example, leaned on her clinical contacts for disclosure advice. She listed both her clinician, and the peers in a group treatment setting, as assisting her with issues of visibility and talking with others in her life. Rene and Felicia, in turn, utilized the advice of a romantic partner when strategizing how to manage the visibility of their depression symptoms,

and impetus incidents. Finally, Maria and Rene both turned to adult family members (female and male, respectively) beyond their mothers for disclosure advice.

That the adolescents did not exclusively recruit the help of their mothers did not necessarily reflect a negative child-parent relationship, however, contrary to the second part of the first hypothesis (namely, that if the parent-child relationship is strained, the SO would be an intimate peer, most likely of similar age and same sex). Our earlier example of strong mother-daughter relationships, Karen and Cecilia, also used additional SOs, despite reporting very interpersonally close relationships with their mothers, and satisfaction with their mutual strategizing. Likewise, Aggie consistently reported a positive relationship with her mother, though she did not enact her assistance in decision-making regarding visibility.

### 4.3.1.2 Effect of initial disclosure on SO relationship.

In regards to the question as to whether or not an individual would be designated as an SO if the initial disclosure incident was negative, again the findings are nuanced. Zoey, whose mother was her only SO and with whom she had a positive, supportive relationship, experienced a mixed result when she disclosed an impetus event to her mother:

> "And I told her what happened. She was like, "What?" Like she's in tears out
>
> of anger, and plus she's like really sad 'cause I kept it from her for so long.
>
> She's like, "Why didn't you tell me?" (Zoey, Tp1).

Through talking with her mother, Zoey grew to understand that although her mother's reaction was not positive, it was based on concern for her, and sadness that Zoey had not felt that she could confide in her mother sooner. This disclosure incident, which occurred months prior to her participation in this project, did not negatively affect their relationship quality, despite the fact that her mother's reaction was to be upset and angry. However, over all five timepoints, she

consistently placed her mother as a stable interpersonal contact on the SNE map. Also, she described her mother as "…basically my main line of support next to my youngest sister, so…" (Zoey, Tp1). So this seemingly negative disclosure incident did not negatively impact their relationship quality, nor did it prevent Zoey from turning to her mother when she needed VM strategizing advice.

Likewise, when both Rene and Maria disclosed their circumstances to their SOs (romantic partner and grandmother, respectively), they were met with tears. Rene's romantic partner remained a close confidant, and they were closing in on a milestone anniversary when her involvement in the project ended. Maria's adult family member, however, did not remain a SO. Maria's subsequent re-evaluation of her strategizing partner was not due to her grandmother's initial disclosure reaction, however. Rather, this re-evaluation occurred due to the negative repercussions of a visibility incident (VI); specifically, the grandmother's advice regarding not disclosing to Maria's mother resulted in interpersonal tension. Maria described the repercussions of this experience on both of these relationships:

> And I don't really talk to my grandma about many things because it's always comes back to bite me in the butt with "you told your grandma before you told me." (Maria, Tp5)

This tension with her mother, which Maria believed stemmed from interpersonal relational difficulties between the two women independent of Maria's own problems – "But she's [Mother] just never been as close to my grandma, and like she [Grandmother] is manipulative" (Maria, Tp5) – eventually resolved. During the course of the study, Maria's mother, consistently presented on the SNE, grew steadily closer in placement, whereas her grandmother remained distant.

Therefore, when re-examining this hypothesis, perhaps a better way to describe the observed influence of VI reaction is instead to state that rather than anticipating positive to neutral initial disclosure reactions, the VI should instead not have had a damaging effect on the interpersonal relationship between the disclosing individual and the SO. To be more specific, even if the disclosure reaction is not positive, supportive, or even neutral, the effects of this negative reaction should not translate into negative repercussion such as, for example, leading to more interpersonal distance between the two individuals, less future disclosure, or fewer positive interactions, thus "damaging" the relationship. This re-phrasing encompasses a variety of different initial disclosure reactions, such as positive reactions like those experienced by Rene ("Then we like hugged and stuff", Tp1) and Felicia's disclosure to her best friend and third SO ("She's like, 'Well, why didn't you tell me sooner?  I could've helped you more,'…", Tp1). It also encompasses negative disclosures, such as the experiences of Maria and Rene relayed above, and even neutral experiences such as Aggie's therapy-group disclosures to other depressed peers.

**4.3.1.3 Interconnections between IOs.**

Finally, the third hypothesis associated with the first research question, that a SO would not be used to strategize about a disclosure target if they were interpersonally close to that target, was the only hypothesis to be completely rejected. Re-examining Table 3, the instances of generalized VM advice-seeking offer little clarity in this matter; however, the specific VIs collaboratively strategized clearly show that the relationships discussed with SOs were not limited to cross-context social relations. For example, rather than approaching a peer for advice on disclosing to her sibling, as this hypothesis suggested would occur, Zoey approached her mother. Not only are her mother and sibling in the same social context – immediate family – but

they are also interpersonally close, as Zoey described their relationship as "…it seems like [she] only favor my younger sister…" (Tp1). This case alone clearly contradicts this hypothesis. Alone, it may not be enough to completely reject the hypothesis; however, it is not a lone case. As discussed above, Maria obtained advice from her grandmother regarding discussing her depression with her mother. Another example of same-context advice seeking, Rene sought the advice regarding disclosing to her father from her mother and stepfather (as well as her romantic partner, a cross-context example).

Cases did exist demonstrating the pattern suggested by the hypothesis, however. For example, Cecilia turned to her mother for assistance with understanding a VI reaction, a clear example of cross-context assistance-seeking. Likewise, Felicia's mother served as SO regarding the potential disclosure to Felicia's best friend, another cross-context example; however, this example did not represent an efficacious use of SO advice. Both of these instances are analyzed further below. However, they do serve as potentially discordant examples, seeming to uphold the hypothesis that other examples dissuade.

While other hypotheses are partially upheld with light or seemingly contradictory evidence, I would suggest that this hypothesis is fundamentally flawed, and even the evidence that aligns with these presuppositions do not actually offer support. In the cross-context examples, those of Cecilia's and Felicia's friends, both of these instances involved disclosure to the member of those contexts (friends) to whom the participant was the most interpersonally close. This precluded them from seeking advice from a member of that context – as they could not seek advice from the closest member of that context, they instead turned to another interpersonally close contact, regardless of context. Based on the relationships and interpersonal interconnectedness of those designated as Safe Others in relation to those about whom advice

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was sought, rather than the context being a guiding factor in SO selection, the relationship between the participant and the SO designate determined this selection.

Interpersonal relationships are complex. The personalities, as well as the relational strategies (Davis, 2006), of the persons involved represent just one layer of the complexity. The needs and need satiation (Guay et al., 1999), behaviors, thoughts, and words expressed in the vicinity of another person effect the relationship, and the other person, in a transactional manner (Sameroff, 2009) in that both parties effect each other and the entity that is their shared relationship. This represents a second layer of complexity. When more than one person is involved in a given circumstance or interaction, as is often the case and as is always the case when discussing receiving strategizing assistance from one person (the SO) about a third person (the visibility target), the transactional nature of the interactions becomes correspondingly more complex – a third layer. Now, the same factors mentioned in a two-person relationship are tripled in that person A interacts with persons B and C, and persons B and C interact with each other, even if they only interact through person A, such as in the case where the SO advises about a person with whom they are only peripherally connected.

For a more concrete discussion, revisiting the case of Maria's advice from her grandmother regarding her mother, the pre-existing relationship and relational patterns between the two women complicated the situation for Maria. The grandmother-mother relationship prompted the advice to Maria to not disclose; when disclosure inevitably occurred, the pre-existing relationship between the two women complicated the relationships that both women had with Maria, resulting in Maria's independent decision-making rather than advice-seeking and a general lessening of disclosure on Maria's part with her grandmother in particular.

Based on these cases, as well as the revealed complexities of the interpersonal relationships at play in the participants' lives, I feel that it is most appropriate to reject this hypothesis. Rather, the specifics of SO designation, utilization, and (re)evaluation provide clearer information regarding the reported trends and processes at play compared to the shallow generalizations proffered by this hypothesis. Therefore, the discussion continues in the following sections discussing specific cases and more clearly defined hypotheses and trends.

### 4.3.2 Research aim 2: SO's role in VM decision-making.

Across participants, SO enactment varied. All participants endorsed making primarily solo visibility decisions, though at some point each one sought the opinion of another person before engaging in either specific behaviors, or with a more global approach to disclosure such as Karen's mother's advice to disclose "conservatively." Of the seven participants, three (Aggie, Cecilia and Karen) sought general disclosure advice, while five (Cecilia, Felicia, Karen, Maria, Rene and Zoey) strategized about specific disclosure incidents with another person. Therefore, as the hypotheses associated with this research aim pertain to specific visibility incident strategizing, these five examples will form the focus of this section's discussion. Additionally, these cases constitute excellent examples of various stages of the VM decision-making process, stage 3 of the conceptual model; this step in the process is expanded in Figure 4, and many specific examples are listed in this annotated version of this stage.

Here, the five major components that the participant narratives revealed are represented in ovals. They are: vulnerability to exposure assessment (as was seen in Karen's discussion of non-disclosure to her friend); weighing the disclosure target's personality and their anticipated reaction (this can include the likelihood of a stigma-based reaction); the assessment of the

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**Figure 4 Annotated Close-up Conceptual Map of Stage 3 of the VM Process**

participant's own current needs; the assessment of the burden being placed on the disclosure recipient (an emergent finding to be discussed in depth below); and the SO strategization process. This model will be explored in-depth at the end of this section, though it is being included here to provide a concrete illustration of the undergirding framework of this discussion, and facilitate that attention be paid to the significance of specific illustrative cases.

### 4.3.2.1 Prompting SO utilization: maintaining relationship quality.

Across the various interviews, the participants reported few specific prompts for visibility strategizing. More, their concern seemed to be that of relationship maintenance. This is a clear example of one of the revealed facets of the VM decision-making process outlined in the conceptual model – that of weighing the anticipated reaction of the disclosure target. For example, Rene approached her mother, another adult family member, and her romantic partner for advice on how to disclose an impetus event to a non-residential parent.

> But like I want him to know like the truth about why I am depressed, but I don't
> want to see his reaction, 'cause it's like I know it's gonna be really awkward.
> (Rene, Tp1)

This desire to disclose was not born of a specific incident; she was determined to tell him ("I'm definitely going to tell them." Tp2, referring to disclosure to both non-residential parents), but rather Rene was simply uncertain of the best timing and manner in which to tell him and her own general reticence to discuss the topic. Her main concern regarded what his reaction, and subsequent actions taken, would be:

> …(A)nd I'm like no I just want to like move on with my life.  I don't want to have
> to like go through that in front of all these people.  I don't want to have to like
> repeat myself a thousand times, like have everybody say whether or not I'm lying

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and like do all this stuff. I just want to move on with my life, so and that's why

I'm like hesitant about telling [my] dad too… (Rene, Tp1)

However, after planning for weeks, she did disclose to her father, and received the calm, down-played response that she had hoped for, but not necessarily anticipated.

I waited till a good time… Mainly he was kind of like upset just because of what

it was but he wasn't like majorly mad… And it just kind of like came out. I don't

know. And he was like "Oh, well. I'm sorry that happened." I'm just like I don't

know. (Rene, Tp3)

In this instance, Rene had consulted her mother, the additional adult family member (her stepfather), and her romantic partner, as well as leveraging her own knowledge of her visibility target ("He's like you know just sitting there, we're like alone in the house or whatever, nothing sharp nearby. [Laughter] He['s] like relax, 'cause sometimes he gets like really mad when he's already stressed out, so I'm just like not when he's stressed", Tp1), to accomplish her disclosure goal. Her mother, primarily supportive, did not offer directive advice ("And she's like well just you'll know…", Tp1) and therefore demonstrates again the utility of emotional support over more active forms of support (Tardy, 1985). However, both her additional adult family member and her romantic partner warned of additional potential repercussions from this disclosure; these possible events they both felt were appropriate, but she wished to avoid. When she did disclose, this possible repercussion did not manifest. She did not endorse re-evaluating these SO roles, though she likewise did not seek their help with other visibility management issues.

In another incident of SO utilization, one clear incident of anticipated visibility vulnerability was reported. This single instance, different from the other reported occurrences of SO enactment, was the most closely aligned with the hypothesis for this research aim, namely

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that situations in which the participant anticipates that their depression status may be vulnerable to exposure (i.e., anticipated visibility incidents) would prompt strategizing with the Safe Other. Cecilia learned that there was a high probability of a peer, with whom she had a rocky, peripheral relationship, learning of her depression status.

> …(T)hat's when I was like, 'uh, what if I see her? Oh god, oh god,' so I started getting really panicky.... I didn't but then I was like well I mean I'm bound to see her at some point and I don't want her to go tell all the [popular clique] at school and stuff because I'm guessing that's what she would do because I found out this year that in middle school she'd talk about me a lot. (Cecilia, Tp3)

The possibility of the popular clique learning of her depression was particularly concerning to Cecilia, as these girls were known to be unkind to other students; her particular fear being made fun of for her condition led her to downplay her distress into the butt of a joke:

> I guess the whole… like popular crew I'd be really weary about them just because they're mean but I mean I just like how such…if they find out… [It's the] girls that really feel like they're entitled and that were really rich and feel like they deserve everything and really get everything but don't appreciate it. …(T)hey could completely make fun of me and be like, 'oh, you have no reason to be depressed. You have no reason to be suicidal,' (Ceclila, Tp4)

This concern represented a number of potential concerns. The exposure to an untrustworthy peer alone caused distress, as did the additional possibility that this peer could then inform additional peers. These peers represented another layer of potential consequences, as their reputation for ill-treatment and classism suggested an avenue for harassment, as did Cecilia's fear of stigma realized through symptom dismissal. As with Karen's concerns about

disclosing to her friend, this is an example of the facet of VM decision-making process's which I termed assessment of vulnerability to exposure. In order to cope with this highly stressful situation, Cecilia approached her parents for their guidance, her mother for the second time (the first regarded interpreting a friend's disclosure reaction) and her father for the first:

> So my mom and my dad and me all decided that I should call her up and tell her…
> I've been going through a really hard time, in a more gentler way, you obviously
> are having some problems so can you not tell anyone… because you're obviously
> having some problems… too but obviously in a more gentle way. (Cecilia, Tp3)

> Through a group strategizing session, Cecilia and her parents considered both the best

way to disclose to this peer, and the needs of the peer to not experience a shocking or abrasive "outing" of her own depressive issues. As of the end of the project, she had contacted this peer, but had not yet fully disclosed to her.

These two example cases illustrate both the frequent precursor to SO utilization for VM – that of relationship maintenance – and the rarer incident which matches the associated hypothesis, in which anticipated status vulnerability prompted strategizing. Therefore, though not a common prompt for SO enactment, this hypothesis has been upheld.


**4.3.2.2 VM behaviors: which strategies participants engaged.**

Participants were recruited for this project at varying stages in their distress – some were actively experiencing strong depressive symptoms whereas others had remitted to a point where they had few active symptoms at the time of the interviews (see Table 1 and Figure 3 for review). Consequentially, some of these girls had been dealing with such visibility issues for many months. Unfortunately, this occasionally lead to a dilution of their memories about specific strategy engagement: often, they could not provide specific details about how they strategized

with their SOs, even if they clearly recalled the prompt, subsequent behavior(s), and affective / social repercussions. Therefore, the results of this hypothesis cannot be discussed with the desired level of clarity.

However, enough data does exist on this topic to suggest that certain trends exist, and to warrant the search for further similar trends. By comparing those specific behaviors which the girls reported against those suggested by previous findings (i.e., disclosure, display, concealment and/or denial via Lasser and Tharinger, 2003, and qualified deception, like/as, and education via Davidson and Henderson, 2010), some similarities emerge. For example, above I discussed the tactics of non-disclosure (e.g., Karen) and concealment (e.g., Felicia). Likewise, educational disclosure was entertained when Cecilia considered crafting a large school project about depression, though she later changed her mind due to concerns regarding over-exposure. Additionally, when prompted to think about ways to stop other people from negatively judging (i.e., employing stereotypes against) those with depression, Felicia relayed an instance in which she defended a girl being bullied for self-injury, calling out the aggressive peer on her own insecurities:

> And so it's like well, why do you wear makeup? What's so wrong with your face that you have to cover it up? And she was like, "What?" I mean I sounded a little bit rude but she did too. So that's how I compare it to other people. You have your problems too. You're insecure about how you look without makeup so you cover it. She's insecure about her body so she gets angry at it and cuts hers. Okay. So don't be mad. She quit bullying the girl. (Felicia, Tp5)

Although not a straight-forward instance of 'educating others' about the nature of depression Felicia's words conveyed her frustration with the attitudes expressed by one peer

about another peer's depressive problems, which paralleled Felicia's personal concerns. Educating others, though reportedly frequently contemplated by the participants, was an action that the participants only rarely undertook. This re-framing of the victim's problems into something relatable helped the bullying peer to think about the issue in a new way, and though not precisely educated, she was arguably enlightened. Therefore this incident more closely resembles the like/as technique.

Regarding active disclosure, the strategizing of Cecilia and her parents lends one perspective on how purposeful disclosure can occur. Conversely, Rene relayed that she often impulsively disclosed to others, as thinking about it beforehand (i.e., active strategizing) "…it just makes more anxiety." (Rene, Tp4). Rene was the only participant who endorsed this strategy; all of the other participants instead relayed accounts of in-depth disclosure strategizing, which begs the question of whether this is a more wide-spread, though likely still infrequently utilized, strategy, or whether Rene's behavior is an aberration, pointing toward the need for further exploration with a larger, more diverse sample.

Additionally, third-party disclosure, an emergent type of disclosure event, occurred in the case of Zoey in particular, as one of her siblings disclosed to their mother and grandparents upon learning accidentally of Zoey's depression. "The first person that knew about it was my middle sister, and she found out about it by accident.  Then she was concerned… and told my mom and my mom told my dad, and my mom told my grandma, and then I pretty much told everybody else." (Zoey, Tp1).

Finally, no instances of passive disclosure, such as displaying a disclosing symbol or wearing disclosing clothing (Lasser & Tharinger, 2003), were observed. However, when prompted to give advice to others going through similar circumstances to those that the

participants had themselves faced, Maria advised to seek-out others with self-injury scars; this advice could arguably be a form of passive disclosure as the scars must be visible (and thus a passive disclosure) for this action to be possible. She states, in her advice to others:

> And I think the best thing you could do even if it's just like talk to someone that you see that has scars, and it's like well if you know that they did it be like are you comfortable talking about that, 'cause I know if someone would ever come up to me even if they were older than I was and they were going through it, I'd be like well yes I'm comfortable with anything you ask me. Like I've gone through hell and back… and not have another person go through that, I'm perfectly fine with it. And I think most people at least that I've talk to has felt the same way, that have beaten it and everything. It's not – it's a hard thing to overcome, and it's very addictive. And if you can't overcome it, then you're strong enough to pretty much do anything. (Maria, Tp5)

Maria saw overcoming her problems as conquering an addiction, and here she wished to both help others and to celebrate her own triumph. Therefore, allowing her scars to remain visible by wearing short sleeve shirts instead of the long-sleeve shirts that many active cutters select instead is a form of passive disclosure, particularly as she endorsed this as an invitation for others suffering similar problems to approach her for assistance. These instances are all illuminative of the various forms of disclosure previously documented in other literature. However, the frequency of their occurrence proved limited; the most common form of disclosure among these participants proved to be the novel finding of partial disclosure discussed above in detail.

**4.3.3    Research aim 3: influence of stigma and support on SO utilization.**

Through-out the study, the participants relayed a variety of different reactions that others exhibited to their disclosures. From crying to hugging, daily check-ins to snide comments and increased interpersonal distance, these reactions varied widely. These interactions often affected how the individual participant then approached future VM tasks. However, the majority of visibility incidents (VIs) did not entail the assistance of a strategizing partner. Therefore, the impact of VI consequences on the SO relationship must be examined specifically.

**4.3.3.1 Influence of stigma on SO utilization.**

Two incidents of visibility strategizing due to concerns about stigma were reported by participants; in both instances, the person to whom they turned was a clinician, rather than an important other person in their personal lives. These instances uphold the related hypothesis, namely that the participant would seek the advice of a Safe Other when they experienced or anticipated experiencing an upsetting incident of stigma. While both of these incidents involve generalized stigma rather than specific anticipated sources, the participants apply this strategizing directly to their lives.

Cecilia, after suffering a setback in her depression course, decided to tell some of her peers about her depression, reasoning that "…what I'm doing right now and keeping it a secret and not telling anyone and just my therapist and my parents and some of my family isn't helping… It's not helping.   So, I decided that something needs to change." (Cecilia, Tp3). However, the actual decision process was slightly less straight-forward, as Cecilia acknowledged the possibility of negative reactions to her situation:

All they can do is be like, "That's weird. That sucks." [Clinician] taught me that doesn't mean anything about me. That just means stuff about them. They could also possibly help me or be there for me if they see my looking down. They'll understand more. When [a peer] committed suicide… (e)veryone said, "If she would have told us that she was sad, we had no idea that she was feeling sad. We would have tried to help her. We would have been there for her." So, I'm sure some of those people were just saying that because that's what you say, but I'm sure some of them meant it. Maybe some of them will mean it for me. So, I just decided to tell them. (Cecilia, Tp3)

Fully anticipating that some of the people she disclosed to may reject her or otherwise enact any number of stigmatizing or adverse reactions, she determined that the potential support from those few who won't react negatively outweighed this risk. The statements these peers had previously made in regards to their deceased peer suggested to her that the risk was worth taking, despite the acknowledged reality that some of those same peers may have been in essence lying about their willingness to have helped their friend.

Aggie also discussed similar concern with her clinician, reporting that she too received reassurance that while there will be people who believe negative things about those with mental health concerns, there are others who won't feel that way:

I've talked with my therapist about and like previous therapists about just sort of being more comfortable with, like other people have dealt with this before, it's nothing new to the world, it's not going to be a big ordeal unless they have been living under a rock. (Aggie, Tp2)

Although not specifying a specific stigma element, Aggie's statement implied that those who endorse the concept that mental illness should prompt "a big ordeal" are out of touch with reality, instead "living under a rock." This quote also suggests, as did Felicia's confrontation of the bully, an evening of the playing field in that stigmatizing individuals obviously have their own problems to worry about, in this case their disconnect with the rest of the world and their over-reaction to mental health concerns. When fear of stigma can be almost socially crippling, and can interfere with help seeking and enactment (cite Wahl), finding ways to counteract this influence is key to getting those individuals facing such concerns the help and support that they need in order to recover.

Numerous other related incidents dealt more specifically with experiences of stigma and negative stereotypes of depression and mental illness; in fact, every participant reported at least one incident of witnessed or experienced stigma (the highest being Felicia who reported 14 incidents, the lowest were one incident a piece by Karen and Zoey). Likewise, all of the girls reported anticipating stigma responses should they disclose in certain circumstances. However, only these two incidents directly prompted SO utilization. Therefore, this trend upholds the stated hypothesis, but more research is needed to determine how strong of a trend these instances represent.

### 4.3.3.2 Re-evaluation of a safe other.

Of the fourteen safe others designated, only four were explicitly re-evaluated by their participants, and of those, three were not replaced by a new SO, but rather the participants then reported being self-reliant in these decisions. One exception occurred in the case of Felicia, who experienced a situation where an initial SO was subsequently replaced with another due to the consequences of a disclosure incident. Specifically, Felicia approached her mother for advice

regarding Felicia's best friend, who then advised her to not disclose to the best friend. Months later when she did disclose to her friend, her friend reacted very differently from Felicia's mother's predictions:

> She's like, "Well, why didn't you tell me sooner? I could've helped you more," and I was like, "Well, my mom told me not to or I'll lose you." She's like, "No, you're being silly, you little dummy." We insult each other not seriously, just to get the point across. (Felicia, Tp1)

Her mother's dire warnings of loss convinced Felicia not to disclose; however, Felicia on a particularly emotionally rough day did eventually tell her friend of her problems, saying "one day when I was crying at school and I just kinda spilled it all out" (Tp1) when asked how she approached this friend. Her need to receive a positive, supportive reaction on an emotionally intense day led her to risk this revelation.

This case illuminates SO re-evaluation as Felicia moved on to use the advice of both this best friend and of her romantic partner conjointly, rather than that of her mother. Her friend's reaction does not perfectly conform to the second hypothesis (that should a SO-strategy results in an incident of experienced stigma, then the role of the Safe Other will be reevaluated, and possibly reassigned) in that in this instance a forewarned instance of stigma did not materialize, contrary to the SO's predictions. In fact, by not disclosing to the best friend earlier, Felicia may have missed out on much needed assistance, as she described her best friend as being very supportive to her:

> Well, she helped me a lot when my depression first started getting worse. ...I'm not too good with people, so I don't have too many good friends, ...and she is just

so understanding and she's nice and she listens and she's someone to goof off

with.  I like her. (Felicia, T1)

Again, Felicia's friend primarily provided emotional support (Tardy, 1985), and Felicia expressed appreciation for this form of support. After this event, Felicia found both the support she craved, and a reaction completely contrary to the reaction anticipated by the former SO, undermining the validity of this source of advice. Rather than continue to rely on an unreliable strategizing partner, Felicia, unsurprisingly, ceased approaching her mother for disclosure advice, instead relying on her best friend and romantic partner:

And then I kinda stopped going to my mom and then I started going to my best

friend... I'll go to her and then I'll go to him [romantic partner] and I'll weigh

both of their opinions (Felicia, Tp1).

Ultimately, she owned responsibility for her decision as she takes their opinions as input, but then makes her own decisions rather than simply following what her SOs state, a level of cognition that was not apparent in her VM style while her mother served as her SO. This incident with her mother resulted in either a cognitive maturation, or a willingness to use her existing yet underutilized skills. Now, with the assistance of two supportive, trusted people, she considers their opinions but independently makes her own choices.

Although the forewarned stigma was not experienced, this case does partially support the hypothesis in that the realized consequence did not match the SO proposed consequence and hence prompted an SO re-evaluation. This final stage in this VI illuminates one of the possible outcomes of visibility behavior enactment, as illustrated in Figure 5. This annotated illustration shows the fourth stage of the model – that of visibility behavior and the consequences. While previous literature (i.e., Davidson & Henderson, 2010; Lasser & Tharinger, 2003) outlines

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**Figure 5 Annotated Close-up Conceptual Map of Stage 4 of the VM Process**
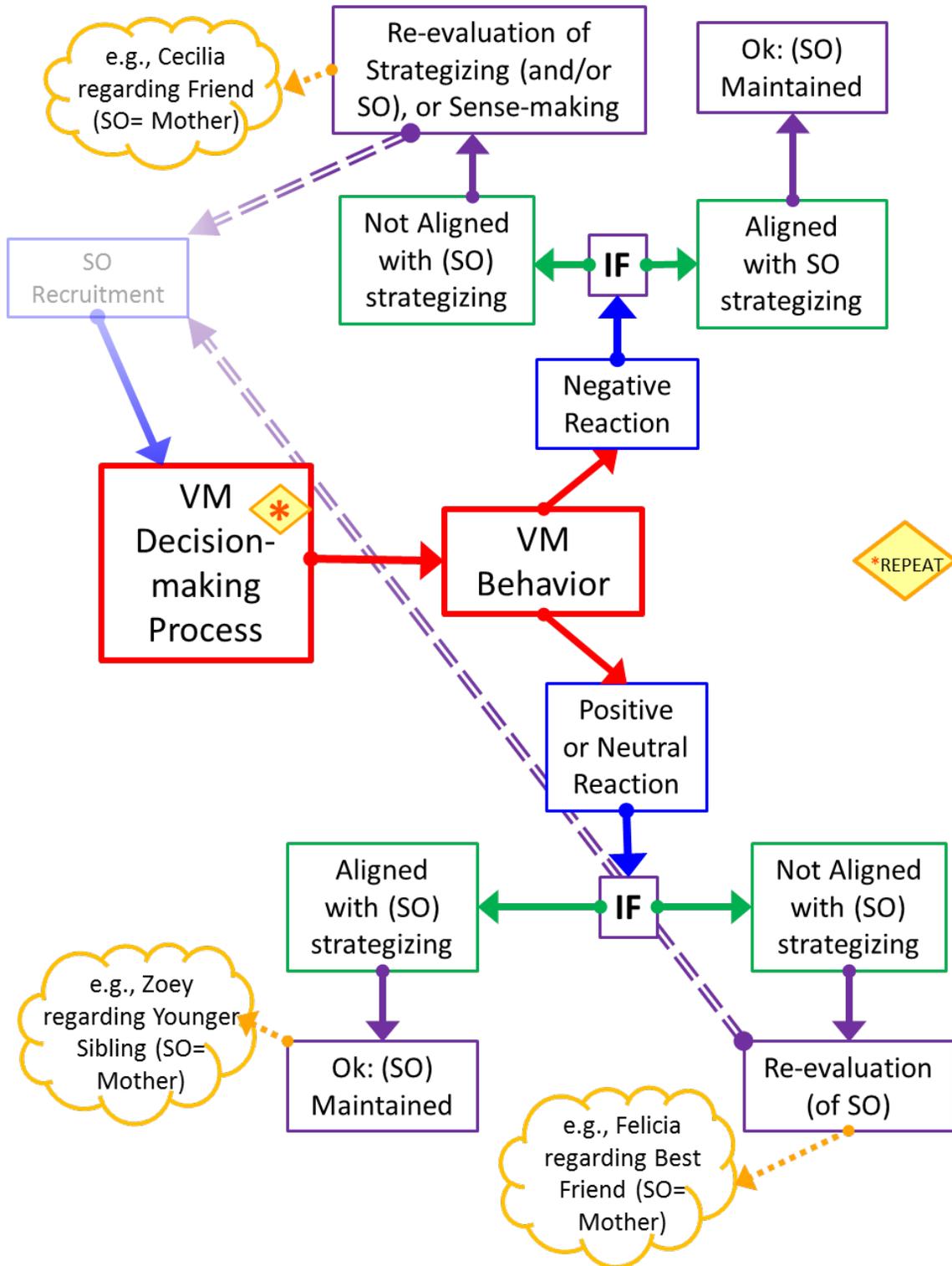
several distinct visibility behaviors, these specific behaviors are not explicated on this model, as this model focuses more on the process of visibility management decision-making, and those interpersonal consequences which affect future decision-making processes. Therefore, after the visibility behavior has been enacted, the four potential interpersonal consequences follow the pattern previously established in stage 2 – positive and negative potential reactions from the VM target, and the impact that these reactions generate on the VM decision-making process.

When outcomes align with pre-VI predictions, be they positive or negative consequences, the strategy utilized is maintained; this can refer to SO strategies, or those strategies undertaken independently. When outcomes do not align with pre-VI predictions then the strategies necessitate re-evaluation. This re-evaluation may eventually result in strategy maintenance, or they may result a change of strategy. Regarding SO utilization, this may be the adoption of a SO, the rejection of a SO, or the re-evaluation yet maintenance of the SO. Regarding the case of Felicia's best friend, the consequences were positive, but they did not align with the pre-VI strategizing she undertook with her mother as SO. This therefore prompted a re-evaluation, and eventual reassignment of the SO role.

Sometimes unanticipated disclose reactions do not prompt SO re-evaluation, but rather SO enactment. Cecilia faced a situation in which her SO performed almost a reverse role – that of a debriefing partner after a confusing and upsetting disclosure experience. After disclosing to a close friend, the friend reacted in a fairly dismissive manner, which had not been the anticipated reaction; Cecilia sought out her SO, in this case her mother, to discuss the situation.

...I've told like Friend F stuff and she just has like tried to blow it off, but I didn't

– at first, I was like, "Why is she doing this?  She doesn't care." But, then I

realized that she's trying to make it seem like less of a big deal so it would help

me, but yeah. (Cecilia, Tp1)

Her statement, prompted by a question regarding negative disclosure reactions, first suggests that this conclusion as to her friend's motivation was independently drawn. When prompted regarding how she came to this conclusion, she revealed:

Just like talking to my mom and then like – yeah, just like talking to my mom

about it, I guess. (Cecilia, Tp1)

The reversal of typical SO interactions, this debriefing allowed her to appreciate a different perspective on why her friend displayed such a minimal reaction to what Cecilia considered an emotion-wrought disclosure. The emotionally close relationship with her mother ("[S]he just made me feel like really connected to her at all times. Like I could tell her anything. I mean, she'd act like a friend and a parent." Tp1) provides as aspect of visibility management that was not anticipated by assisting the participant in making sense of an already undertaken strategy, helping the participant to evaluate her friend's reaction based on a broader perspective than that afforded to her based simply on an emotional reaction to a single incident. In the model, this occurrence illustrates the re-evaluation of a strategy after a negative reaction.

Both of these cases pertained to disclosure incidents that did not meet anticipated expectations regarding realized outcomes. In Felicia's case, her SO warned her of stigmatizing consequences when instead she was met with support, assistance and acceptance. In Cecilia's case, her self-initiated disclosure was met with an unfavorable reaction, one which could have been interpreted as stigma enactment. After debriefing with her SO, however, she came to the conclusion that this disclosure reaction, while not ideal, was in its own way supportive: distracting and downplayed, rather than dismissing and uncaring.

Due to Felicia's experience this hypothesis cannot be rejected outright, as its null stated that it would be disproven if none of the participants re-evaluate SO designation after a post-VI stigma experience. Therefore, based on these two instances – the only instances relayed during the course of the study in which stigma, reaction, and SO utilization and evaluation were clearly interrelated – the phrasing of this hypothesis warrants modification. Originally it stated: if an incident of visibility management, executed as had been strategized with the Safe Other, results in an incident of experienced stigma, then the role of the Safe Other will be reevaluated and possibly reassigned, this statement needs to be made more inclusive. Instead, I propose the following summative statement: if an incident of visibility management results in an unanticipated, negative consequence, then the role of the SO will be re-evaluated in that if it had been a SO-advised behavior, the SO's efficacy will be questioned, whereas if the actions had not been pre-strategized with the SO, the SO will be tapped as a resource for sense-making purposes. This new statement encompasses both of these cases, and provides further direction for future investigations.

## 4.4   BEYOND THE SAFE OTHER: MAKING SOLO DECISIONS

While all participants endorsed using the assistance of one or more persons for some form of disclosure strategizing, they all also stated that they tended to make these decisions independently, often stating that solo decision-making was the norm of their disclosure behaviors. Therefore, in order to explore these trends, I culled data from the "Visibility management: Strategizing code", as well as the emergent code "Burden", as they were found to inform my understanding of this process. Data-generated, the emergent burden theme proved

pervasive across participants (though different participants endorsed these codes to different frequencies). Rather than simply accepting this new theme as an isolated code, I inductively examined it in order to determine the connection between beliefs of oneself as a burden, and the VM decision-making process.

As I explored this data thematically, purposefully searching for patterns and co-occurrences between different themes, I began to form a comprehensive, clear understanding of how these decisions were made, as represented in Figure 4. As can be seen here, estimations of adding to the stress levels of or being a burden on the disclosure target are one of several key elements that participants endorsed weighing as part of visibility strategizing. While not every one of these factors will be weighed in every decision, some configuration of one or more of these factors will be considered. Several of these factors have already been discussed – for example SO strategizing, vulnerability of exposure, anticipated reaction based on personality, and likelihood of stigma reaction (examples are listed in the diagram). Below, these factors appear throughout several relayed instances, illuminating and clarifying this process. In particular, the two remaining VM decision-making factors – burden and need – will be discussed in detail, as this novel finding constitutes a major contribution to the understanding of VM processes among this population.

### 4.4.1 Decision-making: weighing need against burden.

When determining how much to tell the important people in their lives, adolescents gauged a number of different personal and interpersonal aspects. Initial decision-making regarding the blanket "I have depression" disclosure often focused on the relationship with the person and then immediate consequences, such as whether or not the person was trust-worthy (i.e., vulnerability

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to exposure) or if they would enact stigma against the participant such as social distancing or stereotype enactment. However, disclosing the daily struggles of coping with a depressive episode typically required different considerations to be taken into account. As Cecilia explains, she weighed two factors: her own daily need, and the daily status of the other person:

Just like the severity of the problem or whatever... Both, I guess. It's like how

that person is doing and then how severe my problem is. (Cecilia, Tp1)

These two key elements – did they need the other person to know in order to have their own needs met, and what the repercussions of this disclosure would be on the other person – proved to be common decision-making components. This combination of self-focused and other-focused elements at times pitted the perceived needs of different persons against one another, requiring an emotional balancing act.

Emerging from the conversations between myself and the participants over several months, the concern for the repercussions on others preventing or limiting disclosure reoccurred repeatedly between participants and across timepoints. Sometime the participants phrased it as others as making another worry, such as "I wouldn't want to make her worried or upset about how I'm doing" (Karen, Tp2); other instances this concept was posited as an addition to the other person's stress, such as "I don't wanna add any more stress, so that's how I know how much to tell them" (Felicia, Tp1); and lastly, some blatantly stated "…I don't like burdening other people with my problems" (Karen, Tp1). This pre-occupation with the stress-level of others had a restricting effect on what was told to whom pre-emptively, arresting full disclosure. As Aggie stated, when asked why two of her friends knew so little about her daily struggles:

Yes, they have dealt with moderate to severe depression at various times in their

life, so it –. I don't – I try not to I guess dump my problems on them but it's just

sort of – I don't know, I don't feel like I'm going to screw them up if I talk to

them. (Aggie, Tp2)

Aggie's concern for the repercussion of her disclosure on others, particularly those who had also confronted depressive issues, evidenced itself in her word choice. The concern that seeking their comfort constituted "dump(ing) her problems on them", as well as perceiving that this could then "screw them up" suggested that she was taking some responsibility for their wellbeing, if only by not telling them something that she perceived would damage them to some extent. Even when the person(s) had given no indication that they saw the participant as a burden, the youth still reported being concerned about this.

I don't – they've – like I've said before, like my mom said oh, I should go for a run,

I haven't gone yet this week, and I said I'm sorry and she's like, no, it's not your

fault, I haven't felt up to it the days it was nice and then it's been raining and

they've made it very clear that they don't blame me but I blame me. (Aggie, Tp2)

Despite the reassurances of her parents, she still stated that her parents' assistance with her depression – taking her to therapy sessions in particular – was detrimental to their wellbeing in that it consumed their free time, in this instance preventing them from leisure activities (i.e., going for a run). Interestingly, this feeling of burden was not limited to those who the participant saw as being particularly stressed, though that particular subgroup did receive numerous instances of consideration in this regard. Aggie relays being concerned about telling someone who had never dealt with depression, seeking to protect her from that experience:

I know that this friend has never really had to deal with these sorts of thoughts or

any immediate family that I'm aware of that have had to deal with it, and I just –

again, I don't like putting it on other people. And I don't know, I feel like if

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there's a person who has led a life yet untouched by depression it should stay that way as long as possible.  So I'm okay with her knowing from a standpoint of I trust her and I feel close enough to her, but also, again, I just don't want her knowing for her sake. (Aggie, Tp2)

In this instance, Aggie prevented "harming" her friend by choosing not to disclose to her. Her desire to keep her friend "untouched" by depression sounds akin to the wish that someone not be touched by tragedy, disaster, or loss, suggesting that she considered depression something that would unfailingly harm those exposed to it. Two quotes earlier, however, we saw that she likewise did not want to burden those friend who had dealt with depression; be declaring that she would not disclosing to those with a history of depression, nor those without, her pool of potential support was incredible restricted. Concern for the other, outweighing the concern for the self, seems to be a partially other-focused process as Aggie endorses. At times it seems to be an almost a selfish one, as it provides a distraction from the concerns of one's own life, which may be overwhelming and even frightening, too big to handle, as Felicia spontaneously suggested:

It's easier to deal with other people's problems than your own. (Felicia, Tp4)

This desire to concern herself with the problems of others, rather than dwelling on her own problems, sounds like an altruistic motivation; however, Felicia's statement suggests that she used her concern for others at least partially as an escape from her own problems, and as an excuse to avoid focusing on herself. When probed on whether or not others might worry that their problems would burden her, Felicia admitted that this might be the case, but then dismissed this possibility:

Interviewer: Do you think that she might or any of the others might ever not tell you

things because they don't want to burden you?

Felicia: Probably.

Interviewer: Would you rather they told you or are you cool with it?

Felicia: I'd rather they told me.  Don't twist it around.  That's not how it goes.

(Tp4)

Though the words sound angry, her tone was amused and petulant. She could not deny

the logic that others may feel the same way about not wanting to approach her for help as she

reported feeling toward them. However, this probable parallel would not forestall her from

persisting in her intention to conceal her own distress from those who would be available to

assist her. Occasionally, the perceived or anticipated impact of burden caused by disclosure was

assessed by the participant retrospectively. As Felicia stated:

(S)o I get personal with what I share, and then I kinda regret it, because I feel like

I'm bothering them. (Felicia, Tp2)

Although during the disclosure she did not report feeling as though the conversation is

burdensome to the other person, retrospectively she confessed to guilt about the encounter.

This trend of self-reproach was problematic, as disclosing to others allowed her to have her

needs met, be they comfort or support or simple companionship; when attached to negative

valuations, engagement in this disclosure behavior can decrease, consequentially decreasing the

frequency of need satiation (Connell & Wellborn, 1991). Often these needs were fairly

transitory, momentary requests for support through affection or distraction or even a venting

forum. That being said, as mood and emotion are so very integral to the nature of depression

(Lorr, Sonn, & Katz, 1967; Radloff, 1977), this should not be taken as a downplaying of the

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importance of these needs. Further, unlike the transitory nature of the needs, her concerns of somehow having a negative impact on the person that she tapped as a resource persisted, suggesting that the feeling of guilt may prove a stronger influence than the satiation of the need simply due to duration of those feelings.

### 4.4.2 Sheltering children from the impact of depression.

Not all of the participants endorsed this concern of being a burden to their important others with frequency. Both Zoey and Rene only mentioned it very rarely, and most often when calculating whether or not to disclose based on a person's preexisting stress levels. However, both of these participants did evidence a variation on this concept that only pertained to the children or younger persons in their lives. Specifically, Zoey and Rene, as well as Felicia and Maria expressed the specific desire to protect the younger people in their lives from the effect of their depression (Cecilia, Karen and Aggie did not have children involved closely in their lives).

The apparent root of this desire to protect children is difficult to pin down, and in part seems to vary with the individual. Felicia, when discussing the children that she babysits and her ongoing struggle regarding whether or not to tell their mother about the severity of her depression, endorsed cultural stigma as the reason that she felt the need to hide her depression from the family for whom she works.

> (Y)ou see all those like crazy TV shows where they like, I don't want you hanging
> around my kid… And a lot of people don't respond the best to like depression and
> all that, which is understandable, because, you know, I mean, I did go through that
> time where it didn't have the happiest of thoughts about my life and myself and I
> mean, I'm getting better.  I am.  But at that time, I wasn't, and I was just, I really

love the little ones and I was afraid she was gonna take them away because she was

afraid for them.... Like a mother should be, obviously. (Felicia, Tp2)

While she argued against not being able to see these children, who earlier she referred to

as a "little ray of sunshine" (Felicia Tp2), she both acknowledged where she believes the stigma

comes from – mass media – and even endorsed the mother's potential right to be concerned

about her spending time with the children. This juxtaposition created conflict between the

acknowledgement of the positive impact that the children have on her own mood, positioned

against the combination of culturally instilled fear of mental illness with the acknowledgement of

her own illness. These factors argued both in favor of concealment and in favor of revelation of

her condition/needs to the children's mother. Ultimately, the scale tipped toward concealment, as

by the end of the study she had only disclosed the bare minimum to this social contact.

Other participants didn't delve into the origins of their concerns, but rather worried about

the direct cognitive and emotional repercussions on children exposed to their difficulties with

depression. For example, when discussing why she had chosen to conceal her condition from the

children in her life (including the sibling who was only three years younger than herself) Rene

worried that exposed children may believe that depression is a normal thing to go through,

desensitizing them to the problems associated with this disorder.

I don't want them to think its normal... Yeah, and like I don't want them to feel

comfortable with it, 'cause like you shouldn't feel uncomfortable with somebody

who is depressed, but you shouldn't be like oh it's no big deal.  Like you

shouldn't be like it's nothing, and like I just – they're just so innocent and young

and I don't want to make them think that that's like what's going on. (Rene, Tp1)

While trying to counteract the stigma against those with depression (i.e., not wanting them to feel "uncomfortable" with people who have depression) yet simultaneously maintain the seriousness of the disorder (i.e., not wanting them to feel "comfortable" with the depression itself), Rene's conclusion is to simply shelter them, saying "I'd rather like not have to tell them until they're older" (Rene, Tp1). She believed that when older, these children would be better equipped to understand and cope with this complex topic, without internalizing the depression.

Maria's concern, rather than focused on stigma or down-playing the seriousness of depression, centered on a concern that her younger sibling's knowledge of the family history of depression could constitute a self-fulfilling prophecy. When again discussing why she had not disclosed to this particular IO, she stated:

> I think yeah just because I think the more she knows about it, like it runs in the family, so I think the more she knows about it, the more maybe it will be bound to happen kind of thing… (L)ike because if you start thinking like my mom has it, my sister has it, it's going to happen to me kind of thing.  Then I think it starts to happen kind of thing because I don't want her to have depression.  …Like I want her to be a happy child and everything and I want her not to have to worry about that.  So more that she doesn't know about it, the more I think she'll be safe kind of thing. (Maria, Tp3)

Maria expressed hope that by hiding the severity of her depression, she could somehow protect her sister from a family pattern of depression. While both girls suggested that by disclosing to the children in their lives, they could be putting them at emotional risk, rather than focusing on her sibling developing depression, Zoey's concern focused on the notion that her

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depression compromised her ability to be a positive role-model to her younger sister, a role that she took very seriously:

> But, yeah, my younger sister 'cause I was trying to keep it from her because I would feel – I felt as if that my view, my personal opinion and definition of a role model was not what I was doing. And I didn't want her to see that from me. (Zoey, Tp1)

While simultaneously desiring to protect her sister from her depression, this quote also revisits the VM decision-making factor of the other person's personality and potential reaction (see Figure 4). Zoey worried that her revelation of being depressed would negatively affect how her sister saw her, particularly considering her role-model role. As discussed above, however, with the help of her mother as SO she did disclose to her sister, to receive a positive reaction.

All of these adolescents expressed concerns that knowledge of their own depression could negatively impact the wellbeing of these children, and all endorsed that by hiding their depression from these vulnerable children, they were protecting them from this harsh reality. However, often these children provided positive motivation and support to recover, as well as instilling that desire to protect and shelter. When Felicia described her relationship with one particular child, she said "You just get one little smile from her, and your day's just instantly better." (Felicia Tp2). Likewise, as Zoey describes her sister, "(S)he's like pretty much helped me through it, 'cause she's the reason why I'm still here, honestly. 'Cause she looks up to me, and I view myself – I personally believe that I'm her role model..." (Zoey Tp1). Just as those peers and adults who the girls sought to protect from burdening also offered support and comfort, so too did these children in the participants' lives.

In summary, the participants all endorsed disclosure decision-making as being a function of weighing their daily needs against the impact that they foresee their disclosure as having on the people to whom they could disclose. Regardless of whether or not that other person endorses this burden as real or instead dissuades this perception, these evaluations persist. One category of important others whom in particular warranted this consideration, in the participants' perspectives, the children in their lives were seen as needing protection from the perceived detrimental effects of knowledge about and exposure to depression. Of the four participants who listed children repeatedly as important social contacts, all four endorsed this concern, just as to some degree or other, all seven girls endorsed weighing burden on others against their own needs. Apparently not relevant to this gauging process, these evaluations do not appear to be connected to interpersonal distance between the participant and the potential disclosure target.

## 5.0    CONCLUSION

This study's primary hypotheses regarded the form and function of the SO in disclosure, while the final research aim regarded illuminating the VM decision-making process regardless of SO involvement. The findings of this project revealed that while the form and function of the Safe Other have been clarified to an extent, the selection of a strategizing partner and the role that person plays in VM varies by individual, and does not occur regularly enough to warrant hard conclusions despite the revelation of unique trends and clear directions for future research (see below). Conversely, the data regarding the VM decision-making process lead to two intriguing and unique findings. Specifically, I found that participants primarily engaged in partial disclosure, self-censoring what they told to their IOs, and that they made VM decisions by weighing a number of factors, two of which entailed balancing their own needs against the burden they perceived their assistance-seeking behaviors (e.g., disclosure) placed on others.

## 5.1    SPECIFIC ELEMENTS OF THE CONCEPTUAL MODEL.

To facilitate the discussion of the findings of this study, I crafted a conceptual model (see Figure 2) illustrating the VM process and the role of the SO as the analyses indicated. Examining the full conceptual model generated by the findings of this project, a nuanced understanding of the process of VM and the role of the SO within this process begins to emerge. Beginning with an

impetus such as an onset or awareness of a PSC (in this case, worsening depression symptomology, stage 1) leads to either an awareness of the stigmatized nature of the PSC, or an initial naïve disclosure (stage 2). In turn, the repercussions of this first contact with the social world after becoming aware of the PSC leads to active VM decision-making (stage 3), during which five key personal and interpersonal factors are weighed, ultimately leading to the VI, or the behavior selection and enactment (stage 4) before the cycle repeats itself in a loop of VM and VI. While not every participant experienced every example outcome that the model lists (e.g., none experienced an anticipated negative disclosure reaction), this illustration does take into account what the participants reported of their experiences. Generated by attending to the patterns of responses that participants described receiving when they disclosed their depressive status to others, and their subsequent reactions to these consequences, this model not only allows for organization of the findings and delineation of which cases illustrate which concepts or outcomes, but also allows for more global discussion such as the impact of the specific concepts across the elements of the model.

Among the many specific elements delineated on the conceptual model and discussed in the Findings section, three over-arching concepts warrant attention due either to the potential socioemotional repercussions for depressed adolescents, or due to the potential for intervention that these themes suggest. These concepts are stigma, a potentially detrimental socioemotional force working against assistance attainment and even episode recovery for an individual experiencing a Mental Health concern; the Safe Other, or strategizing coach, the framing concept of the analyses and a naturally occurring and thus readily accessible support structure; and the relevance of the emergent findings regarding the role of burden assessments in Visibility Management which again points to possible treatment interventions focused on a specific

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cognitive characteristic of depression. The potential influence, negative or positive, of these concepts merits further exploration in terms of the implications for the findings of this project.

### 5.1.1    The role of burden in the VM process.

The final research aim of this project consisted of the open-ended goal of developing a better understanding of the visibility management process in depressed adolescents on a more global level. While previous research in regards to VM has primarily examined the behavioral aspects of this process (e.g., how and when PSCs are disclosed) this project examined the cognitive and affective elements of the decision-making process leading to the initiation of action (or inaction, as in the case of non-disclosure). The primary finding pertaining to this research goal regards the balancing act that participants repeatedly reported engaging in between their own daily needs for support and the perceived needs / burden of those others to whom they could disclose, leading most often to a new form of VM, that of partial disclosure.

Unique to this project, the participants discussed in-depth that they often engage in partial disclosure of their concerns, problems, symptoms / severity and daily needs based upon how much pre-existing stress they felt the potential disclosure target already experienced, or how negative of an impact their disclosure would place upon the other person should they more fully disclose. Rather than direct, full disclosure, passive disclosure, educational disclosure, etc. (Lasser & Tharinger, 2003), the participants time and again reported disclosing only a part of the relevant depression-related information. This piece-by-piece, varying-by-the-day disclosure has not appeared in previous VM literature, and occurred without SO consultation.  Often, the SOs themselves were subject to this balancing act, with the participants reporting that they did not disclose everything even to these closest IOs.

When examining why they so often chose to reveal only part of their problems to the other people in their lives, rather than stigma concerns or worries about the other person's reaction, the most commonly stated reasons regarded the perceived burden which the disclosure was foreseen to place on the disclosure target. The concerns of stigma and reaction, as well as concerns of exposure vulnerability, figured prominently in the initial decision to disclose the depression diagnosis. However these same concerns figured as a far less prominent concern in the subsequent decisions regarding daily needs.

Due to the estimations of causing stress or burden to those other people who they care about, the participants hesitated to approach others, even very interpersonally close IOs, for daily assistance. When prompted to think about the other person's perspectives and behaviors, the adolescents often admitted that these concerns may not be founded in reality, and that their social contacts almost never actually stated such thoughts. The participants even advised unspecified depressed others to seek out assistance, while not taking that advice themselves. This underlying hesitancy to seek assistance through disclosure, or to preclude full disclosure to others, has obvious relevance to both clinical and non-clinical treatment.

As stated above, this self-deprecating perception seems to be inhibiting help-seeking and help-enactment behaviors (a conclusion supported by the participant's advice to others in which they advocate telling others and finding help for their problems), leading to the conclusion that this phenomenon may be interfering in the help-seeking and help-enactment behaviors of other depressed individuals as well. The utility of this concept may have implications for anyone suffering from anxiety or depression; it may even extend beyond the disorders that these participants evidenced. Conversely, this phenomenon may be limited to adolescent girls. However, the extent to which this phenomena is present in other populations cannot be

established here due to the small, clinically homogeneous sample, and obviously warrants further investigation. Further explorations among other depressed populations, such as among male youth or among females with different comorbidities, can help to clarify the applicability of these findings. However, the preliminary awareness of this phenomenon suggests an increase in mindfulness when approaching a situation in which one is potentially assessing or assisting a depressed person, particularly a depressed adolescent.

The nature of the cognitive elements of depression, a controversial topic for many years (e.g., Coyne & Gotlib, 1983; Coyne & Gotlib, 1986; Segal & Shaw, 1986a, 1986b), remains a topic of research. Neurocognitive studies explore such facets as attention, response time, and planning (e.g., Chamberlain & Sahakian, 2004; Maalouf et al., 2011), and have found an increased vulnerability to negative feedback among depressed adults, prompting an increase in mistakes on cognitive tasks (Chamberlain & Sahakian, 2004). More cognitivist research has likewise found less attention paid to positive social feedback and over-estimated their receipt of negative feedback (Roth & Rehm, 1980), and more readiness to believe in success when others control external circumstances (Golin, Terrell, & Johnson, 1977; Golin, Terrell, Weitz, & Drost, 1979), all indicating that reasoning regarding social cues may be skewed toward self-doubt, and self-attribution of negative interactions within the social relationships of those with depression (Kinderman & Bentall, 1997). However, as with the research on stigma, these explorations are most often completed with adults. Further, research on the self-perceptions of self as a burden have not been conducted with depressed adolescents, leaving a gap in our knowledge base which the present research begins to indicate may be very worthwhile and fruitful in terms of furthering treatment for depressed adolescents.

Previous explorations of perceptions of burdening important others in one's life focused on specific populations, most often those facing chronic or terminal illness (e.g. cancer, serious respiratory disease). This literature most often focuses on caretaker burden – both real and perceived – which in the circumstances of coping with a severe medical condition are both feasible and often realized (Akechi et al., 2004; Carnevale, Alexander, Davis, Rennick, & Troini, 2006), unlike the predominantly faulty perceptions demonstrated by the current participants. Those articles that did discuss perceptions of burden either approached the study of depression through qualitative examinations based in the medical field, in which this theme was one of many (e.g., D. M. Clarke, Cook, Coleman, & Smith, 2006; Rice, Grealy, Javaid, & Serrano, 2011), or focused on models of suicidality in which perceptions of being a burden constituted a major feature of suicidal drive (Joiner et al., 2009). An examination of the literature on depression revealed that although perceptions of being a burden are mentioned in books regarding counseling (e.g., Gilbert, 2000), or among suicidal individuals (Joiner et al., 2009), no empirical studies focusing on this phenomenological aspect of typical, non-suicidal depression, particularly among adolescents, could be found. However, considering the salience of this theme among the current study's participants, and the potential for focusing (clinical) attention during intervention, I feel that this theme warrants much further consideration than it may have been granted previously.

One form of intervention to which the theme of "being a burden" may have particular relevance is that of Cognitive Behavior Therapy (CBT), a common and empirically well-supported treatment for depression and anxiety (Brent et al., 1997; G. N. Clarke, Rohde, Lewinsohn, Hops, & Seeley, 1999). CBT seeks to disrupt faulty cognitive and behavioral patterns, such as those predominantly erroneous perceptions of being a burden expressed by the

current study's participants. Believing oneself to be a burden on those Important Others in one's social circle, while a realistic assessment in some circumstances (e.g., Felicia's family circumstances), qualifies as faulty cognition in others (e.g., Aggie's family circumstances, Felicia's non-familial social network). Failure to enact available assistance due to this misbelief (e.g., Aggie) or over-extension of beliefs (e.g., Felicia) constitutes a negative, potentially depression-perpetuating behavioral pattern. Therefore, identifying this burden avoidance behavior has important clinical implications which may provide guidance for therapeutic interventions, such as CBT, which in turn may increase already impressive efficacy results by focusing further attention to identifying faulty socially-based assessment patterns.

Likewise, group therapies, which one participant (Aggie) identified as key in her own recovery, to the extent that she reported actively seeking the advice of her groupmate peers regarding VM issues, also offer valuable potential treatment venues that may benefit from VM- and burden-oriented attention. Support groups and group therapy session can be facilitated in clinical and non-clinical settings such as schools, religious settings, or peer activity / outreach settings. Though the level of clinical expertise varies widely among the personnel involved in these settings, typically a facilitator guides discussion and moderates the interactions. By focusing occasional discussion on identifying and counteracting faulty burden assessments, as well as group strategizing regarding coping with stigma, negative disclosure reactions and other VM issues, the participants of such group settings may find themselves with more strategies available in their repertoire for dealing with the other people in their social circles. On an informal level, this extrapolation is bolstered through several informal communications with referring clinicians at the time of participants' recruitment who stated that even though this project was in no way therapeutic, they referred specific participants to my project because they

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felt that talking through their social contacts would be beneficial to their clinical progress (e.g., personal communications regarding Karen, Rene).

However, it is important to note that the nature of depression is such that those experiencing a depressive episode often undervalue themselves, and tend to perceive that they cause undue strain on the interpersonal relationships in their lives. Therefore, the concept of "perceptions of being a burden" need a to be further explored in terms of depressed individuals in general, and adolescents in particular, in order to determine the role that perceptions of burdensomeness exist independent of VM, and of this specific population. Disentangling the influence and role of burden requires additional research. Previous research discussing burden focused primarily on suicidal and terminally or chronically ill patients; future research should extend the examination of perceptions of being a burden to non-suicidal, depressed populations.

### 5.1.2    Role of the SO in the VM process.

Looking across the conceptual model once more, we can note several instances when Safe Other involvement can be activated. The first instance is when the SO can be recruited lies in stage 2, presuming that one of two occurrences will follow the impetus, the realization of the PSC. In the first possibility, the individual has some form of understanding of stigma associated with their PSC, and they proactively recruit assistance anticipating that some people may react negatively to them based on their PSC. It is important to note that someone can be stigma-aware without having directly experienced or even witnessed stigma personally – popular media is well known to harbor stigma, particularly regarding mental health (Wahl & Harman, 1989). The other possible recruitment event entails a naïve (in regards to stigma) disclosure event met with a negative reaction. This negative reaction – whether based in stigma or not – could then inspire

the recruitment of a SO with whom the individual could then strategize in order to avoid future such negative reactions.

However, not limited to the second stage of the model, SO recruitment and utilization is represented as one of the elements considered during the VM decision-making process (see Figure 4), and the repercussions of this decision-making process and subsequent behavior selection could also result in the selection and enactment of a SO in the fourth stage. While some negative reactions can be anticipated and strategized for, even if unavoidable (e.g., an inevitable, unavoidable disclosure, such as an explanation of missed school to an unsympathetic school official, or a stigmatizing family member needed for transportation to or from clinical treatment), this predictability does not preclude SO utilization. Likewise, any negative or unanticipated reaction has the potential to inspire assistance-seeking. Finally, if a SO had previously been enacted prior to stage 4, and the consequences of their joint strategizing was met with negative consequences, then the SO role could be re-evaluated, and the SO position maintained, reassigned, or even dissolved.

Although the participants in this project each utilized one or more SOs' assistance at some point, these occurrences were fairly rare in both number of SOs designated, and in reported instances of SO utilization, so while information is available about these cases, they are limited in scope and number. However, the lack of numerous SO exemplars does not undermine the utility of these important social contacts; rather, it simply indicates a need for further exploration. The findings of this study suggest that in instances entailing a covert PSC,  having a SO available for strategizing may be beneficial, as many of the participants reported their experiences with collaborative strategizing as positive.   Previous literature examining PSCs primarily focused on overt characteristics, such as racial stigma, with the coping strategies regarding covert PSCs only

recently undergoing rigorous study (e.g., Lasser & Tharinger, 2003). The scope of such explorations center on limited PSCs, however, and the current research pushes these explorations into a new direction via a new population defined by a new PSC, that of depression. Additionally, previous literature regarding SO utilization exists in the popular culture self-help writings of those among the ASD community (e.g., Hane, 2004; Shore, 2006). The current research likewise pushes this coping-relevant concept into the realm of research literature, enabling the first steps in determining the nature and function of a new potential resource for those dealing with a PSC. Both of these advances constitute preliminary steps, however, and the trends uncovered here necessitate further research to explicate definitive definitions of both concepts.

An additional possible function of the SO that this research could not adequately explore due to the relative infrequency of occurrence among the small sample is the potential role of the SO in assisting the stigma target to counteract the influence of the stigma. Two participants (Cecilia and Aggie) endorsed SO-fostered stigma-countering cognitions, and one (Cecilia) reported an instance of SO-enabled sense-making after a negative disclosure reaction which, with the help of her SO, she determined to be misguided yet based in support, rather than in stigma. While this possible additional function of SOs needs to be explored further, the possibility that this untapped resource may help to counteract the influence of stigma – perhaps, if utilized efficaciously, even reducing treatment attrition or internalization (two daunting repercussions of stigma) – then this could be a very promising avenue of research with implications in clinical and non-clinical settings.

Adolescence, typified by evolving interpersonal relationships, involves role shifts as individuals become more autonomous while still being influenced by, and seeking the attention

of, other key people such as parents (Judith G. Smetana, 2004) and teachers (Davis, 2003). Previously a driving force in childhood decision-making and goal direction, parents and teachers remain influential, although as cognitive abilities mature and adolescents accumulate experiences and additional resources, decision-making becomes a more autonomous process (Arnett, 1999; Judith G. Smetana et al., 2006; Steinberg, 2001). The SO designation and enactment processes discussed here align with these facets of normative adolescent development in many ways. Although participants in this study still relied on their parents as well as other key social contacts when facing VM dilemmas, they primarily rely on their own perceptions and judgments when making many daily decisions. Their concern for the impact they have on others (i.e., assessments of 'being a burden') likewise demonstrates this socioemotional and cognitive maturation in that the relationship has matured beyond one of dependence and into one of more equitable, mutual reliance and support. However, this begs the question: how much of the SO utilization is driven by simple adolescent development, as opposed to the need to manage visibility of the PSC? While beyond the scope of this study, the relative influence of maturation processes versus VM processes is a promising direction for future research. Perhaps by examining depressed adults, or depressed children, the universality (or, conversely, specificity) of these VM features to adolescence can be determined.

### 5.1.3   Role of stigma in the VM process.

Beginning very early in the model, the concerns for interpersonal relationship maintenance begin to be expressed. If the person is aware of stigma (as were all of the participants in this study) then this awareness and the potential social ramifications of stigma (e.g., rejection, maltreatment, or ostracization) factor into the decision-making process by the second stage of the model after

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the impetus event (in this case the building of depressive symptoms). While this awareness could factor directly into VM decision-making, it could also inspire SO recruitment as an assistance-seeking mechanism for coping with potential stigma-oriented interactions.

However, the influence of stigma on this process is not limited to the awareness of stereotypes, prejudices and discrimination in the second stage. In the third stage, assessing the potential for stigma reaction again surfaced as one of the weights that participants endorsed when contemplating different VIs, this time in regards to specific individuals rather than general awareness. Considered an element of many potential reactions that a person could demonstrate when disclosed to, stigma reactions were one of the more commonly reported concerns of participants when deciding whether or not to disclose to a particular IO.

Finally, while not explicitly noted as stigma-relevant, the negative responses noted in the fourth stage may entail stigma-based reactions. These negative reactions have delineated repercussions on strategizing, as well as emotional and social reactions discussed in previous literature (Link et al., 2001; Link et al., 2004; Wahl, 1999b) but not represented here. In this model, these negative reactions were hypothesized to lead to SO enactment. Participants reported two incidents of SO assistance-seeking post stigma occurrence, despite 32 additional instances in which the participant experienced or anticipated stigma but did not endorse seeking the assistance of their SO, if one had been designated by that time. In these 32 occurrences, the immediate action following these incidents could not be gauged for a number of reasons, such as instances in which a long time passed between that negative interaction and further disclosure events (e.g., Rene's experience with an unknowledgeable doctor which lead her to hesitate in further help-seeking), or the stigma interactions were with non-important others such as non-friend peers but disclosure interactions only dealt with important others (such as incidents in

which peers said things about another peer in front of Karen). Due to this lack of clarity, the connection between SO utility and such stigma events remains an item for further exploration.

Given the potential detrimental impacts of stigma, and the already vulnerable cognitive status of depressed adolescents, the implications that SO utilization may assist these youth in coping suggests that future research into this area is warranted. The participants of this study endorsed utilizing strategizing partners for particularly concerning social interactions, whether they were anticipatory or reactionary. Although interactions characterized by such collaborative strategizing occurred infrequently, every participant endorsed such incidents. Therefore, while this technique may not be ubiquitous, it may still be very relevant, particularly as a developmental stage in the VM process of learning to handle such decision-making tasks independently. Further research is needed to clarify the utility of SO enactment.

## 5.2     LIMITATIONS

This project has several key limitations to which attention must be paid. First and foremost, the sample was small, and limited to adolescent female. Perspectives of male counterparts were not available, and could have shed invaluable insight into the generalizability of these findings. Regarding race and ethnicity, more diversity regarding ethnic background could also lend itself to different coping styles and social network patterns. The social network of the one racial minority participant (not identified here due to confidentiality concerns) was very similar to those of two of the non-minority participants in terms of family-to-friend ratio and general reported interpersonal closeness. However, a more diverse sample may have suggested more differences between ethnicities and culturally-based interactions or even coping styles,

particularly as the one minority participant endorsed one of the lowest levels of burden assessments.

A larger sample could again speak, even among the female depressed adolescent population, to how wide-spread these trends apply. Building from this concern, the homogeneity of the sample in terms of comorbidities – that all seven girls had one or more comorbid anxiety diagnosis, and that all had experienced some degree of suicidality – while being typical of the recruitment site, is not necessarily typical of the depressed female population at large (Lorr et al., 1967). In one study, 30% of adolescent surveyed had both depressive and anxiety symptoms of clinical significance (Essau, 2003), and another study found that 20% of depressed females also experienced suicidal ideation (Khalil et al., 2010). So the question regarding generalizability of these findings must take these facets into account – a sizeable minority of depressed adolescent females experience anxiety or suicidality, but how many experience both? And are the visibility management and disclosure behaviors found in the project also undertake by those adolescents who experience only one, or neither, of these comorbidities?

Additionally, as such a homogeneous sample in terms of diagnostic issues was not anticipated, no measure of anxiety symptomology was collected; therefore, the influence of anxiety symptomology on recovery, or wellness, must be discussed. Whether or not the clinical well-being of each participant influenced her responses to the interview prompts cannot truly be known because although the CES-D was collected at several timepoints, no anxiety counterpart was utilized. One participant even suggested as much when discussing how much better she was doing at Tp4 in comparison to Tp1, she stated "Before I was always worried that I'd make them upset or burden them.  Now that I don't really have as much of that to worry about, it's been easier to talk to people in general and just sort of connect without that worry as much.  It's still

there, but it's less overwhelming" (Aggie, Tp4). Therefore, the impact of simply feeling better on disclosure processes is not known at this time.

Finally, the timing of recruitment may have played a role in limiting the generalizability of the findings, and in collection of certain key points of data. As mentioned above, participant recruitment varied in terms of time from onset of symptomology to time of participation in the study. Therefore, some of the disclosure incidents and VM strategizing may have been months prior to the participant's study involvement, and as such some of the details may have been lost. Future studies should be less constrained by time, and efforts should be made to recruit participants closer to the onset of their depressive episodes, possibly following them for longer duration through a clinical reduction in therapeutic interventions (as was evident in the cases of most of these participants).

## 5.3    FUTURE DIRECTIONS

Additional directions for future research, beyond those suggested by the project's limitations, incorporate the specific and the general. Expansions regarding specific concepts, and more general sample limitations, can help to inform on the generalizability and applicability of the findings described in this paper. As a pilot study, the trends and emergent themes illuminated by the words of this project's participants and the analysis then applied point to a number of different directions for study, some of which I intend to pursue and others of which I would encourage others to pursue.

The first direction that these trends point toward regards simply expanding this study's sample. Recruitment of additional adolescent females with depression and anxiety and/or

suicidality, tracked with more regular symptomological assessments (e.g., CES-Ds, an additional anxiety measure such as perhaps the Beck Anxiety Inventory) can help to clarify these trends in terms of stability and universality within this population.

Such explorations furthering the understanding of the form and function of the Safe Other in a known population – that of depressed adolescents – could prove very valuable in the goal of explicating a cohesive yet concise conceptual definition. After the ubiquitousness of SO utilization has been established among this population, additional forays into research with related populations, such as depressed adolescent females with non-anxiety comorbidities or depressed males with comorbid anxiety, can further the generalizability of these concepts. Due to the nature of the development of individuals during adolescence, which inherently lends itself to the conflicting impulses of autonomy in decision-making and the desire to seek guidance from another individual, additional explorations within populations of adolescents can help to clarify the maturational qualities of VM and SO utilization in regards to normative adolescent maturation. Further pursuit of this line of inquiry in a larger, more diverse sample (particularly in terms of age / development) can help to explicate the differing influence of normative adolescent development from the drive to manage disclosure concerns. Due to the existing autonomy– versus –relatedness drives of adolescence, it is possible that even those adolescents without PSCs are driven to conceal certain aspects of themselves within certain social contexts. Therefore, future work should eventually include psychologically healthy adolescents. A study which examined more holistic wellbeing and clinical status, yet still explored the concepts of SO and VM through the participants' perspectives would work to significantly compensate for the acknowledged limitations of the current study's sample.

Regarding the conceptual definition of the Safe Other specifically, further investigations of relevant populations for the SO phenomenon warrant attention. This concept originated in the informal literature of the Autism spectrum community; exploring this concept more scientifically in that community would provide invaluable insight into a conceptual definition of this strategizing partner and function. As observational studies would prove very difficult to undertake since VIs cannot be specifically predicted and do not occur frequently, with this population a multifaceted design would be prudent. Data collection via interviews with Autism-spectrum participants, as well as key IOs in their lives such as any SOs recruited, would allow for a richer understanding of the collaborative strategizing process than one reporter alone, particularly if the sole reporter has difficulty with social reasoning. Additionally, one or two individuals from key social settings, identified through participant reports of emotionally-laden social interactions, would again allow for a richer understanding of the actual social mechanics in which the participant engages.

Finally, in therapeutic settings such as family-oriented treatment settings, exploring and capitalizing on the Safe Other – patient relationship, as well as exploring the social networks of the patient as potential therapeutic bolsters could prove to be clinically valuable; a small treatment study that added these elements to a pre-existing and well-document treatment course such as CBT, when compared to a control group receiving comparable treatment without these additional elements, could add to our understanding of the efficacy and therapeutic potential of these socially-based resources.

In regards to the concept of Visibility Management separate from the Safe Other concept, I likewise intend to eventually expand the populations in which VM may function. Within our society, a multitude of marginalized, concealed populations exist. However, not all marginalized

groups whose members are characterized by PSCs may utilize VM in the same manner, such as which forms of strategizing various populations use. For example, of the five factors that participants noted that they considered when making VM decisions – IO reaction, vulnerability to exposure, SO strategizing, perceived burden, and daily need – the adolescents in this sample reported using the first three primarily during initial disclosure and the latter two during daily disclosure decision-making, which in turn most often prompted some level of partial disclosure. However, certain other PSCs may not prompt the daily decision-making processes endorsed as part of these adolescents' depression experiences. This is because these daily dilemmas reflect fluctuations in need. During depressive episodes, symptomology varies; these variations in symptomology prompt different daily needs – for example, the need for support, the need for distraction, the need for assistance in avoiding acting on self-injurious impulses. PSCs such as sexual orientation, minority language status, or minority religious orientation would not likely necessitate varying levels of assistance or considerations in the same manner that PSCs such as depression or other MH concerns, substance use, victimization, or even tenuous familial situations such as foster care placement may elicit. This divergence in need fluctuations may result in very different actualizations of the VM process, possibly even illuminating two different categories of VM users – those with daily dilemmas based on need, and those whom engage in VM less frequently, perhaps only at the time of initial disclosures.

Further, certain populations may experience differing (daily) levels of need, but may not have the cognitive facilities or self-awareness to acknowledge these variations, and thus may not engage in the daily decision-making processes that other comparable populations utilize. For example, ASD conditions are often typified by deficits in social reasoning, leading to neuroatypical individuals often experiencing difficulties in gauging and understanding the

emotions and intentions of others as well as their own emotions and even intentions. This difficulty could lead to an unawareness of need fluctuations, should they exist, resulting in underutilization of VM strategies and resources such as SOs. The ASD community popular literature, which has explored the concepts of VM though not rigorously to date, often advocates the usage of VM strategies and strategizing partners in particular; however, if the individuals cannot recognize the circumstances in which such actions are appropriate, the VM processes of this population will prove to be quite different from those of comparable populations, even if both share similar need fluctuations. Similarly, children may not have the cognitive maturation necessary to identify and appropriately act on fluctuating needs. Therefore, first the naturally occurring trends in VM utilization and self-evaluation must be explored, before the development of (clinical) interventions can be undertaken. These interventions, then, can focus on assisting individuals characterized by PSCs and cognitive appraisal difficulties in both learning and utilizing assessment and VM strategies.

Finally, this study has methodological implications for future research. In order to explore the Safe Other concept within the process of Visibility Management, I generated a new method of guiding my one-on-one participant interviews. This new tool, the SNE, consisted of a manipulable physical representation of the abstract concepts of interpersonal closeness with IOs and comfort with disclosure. This manner of data elicitation can be used to track differences across time, as well as facilitate the interview conversations.

Aside from the relevance and implications of the findings themselves, this new method of data acquisition holds promise for future applications to research. Future analyses of this project's data will examine the differences in IO placement over time, within participants, as well as the convergences and divergences of the spoken data when compared to the SNE

representations. In this manner, I will establish and refine the utility of the SNE as a triangulation technique for understanding the interpersonal relationships of research participants, particularly in terms of interpersonal closeness. This instrument's applicability is broad, offering both a more quantitative manner of tracking interpersonal relationships as well as interview facilitation benefits (e.g., facilitating discussion of the entrance or exit of an IO, or notable changes in represented interpersonal closeness of one IO across time). Inspired by previous measures used with children as well as adult participants (Popovic et al., 2003; Strayer & Roberts, 1997), this technique is anticipated to be appropriate for a variety of ages / developmental levels, and research intentions.

In conclusion, there is need for further exploration of the visibility management process, and the role of significant others in the visibility management process, in both depressed adolescents and in other populations characterized by additional PSCs. Ultimately, the goal of such research is to empower marginalized communities by revealing and then providing them tools for managing and avoiding the PSC-associated stigma. While the eradication of such stigma is optimal, coping mechanism and techniques enable those facing these concerns to live as productive and positive lifestyles as possible. By examining VM and SOs in these populations, not only will such research allow for a deeper and broader understanding of these strategies and processes, but it will also give voice to traditionally overlooked or even purposefully neglected populations. Only by exploring their lived experiences, listening to their words and attending to the meaning they make of their lives can we find ways to reduce or even abolish the stigmas which marginalize these populations in the first place.

**APPENDIX A**


**PROTOCOL**

# *VMiD Study, Autumn 2012*
## *Contact Information Sheet*

**Participant's Name** (First, Middle initial, Last): _____

    Primary Mailing Address:

    _____

    Primary Phone Number:                   Secondary Phone Number (check ⭕ if none):

    _____             _____

    Primary Email address:                    Secondary Email address (check ⭕ if none):

    _____             _____

**Primary Parent Contact's Name:** _____
              (First, Middle initial, Last)

    Primary Mailing Address (check ⭕ if same as participant's):

    _____

    Primary Phone Number:                   Secondary Phone Number (check ⭕ if none):

    _____             _____

    Primary Email address:                    Secondary Email address (check ⭕ if none):

    _____             _____

**Secondary Contact's Name:** _____
 (First, Middle initial, Last; Relation)

    Primary Mailing Address (check ⭕ if same as participant's):

    _____

    Primary Phone Number:                   Secondary Phone Number (check ⭕ if none):

    _____             _____

    Primary Email address:                    Secondary Email address (check ⭕ if none):

    _____             _____

**Primary Clinican's Name:** _____
(NOTE: Clinician will only be contacted for scheduling purposes or in the case of safety concerns as per the Consent documents).

*Please answer these questions as honestly and completely as possible. Everything you tell us is confidential, and we will keep it private.*

1. When is your birthday? _____ Birth Month _____ Birth Year

2. Gender is flexible and complicated, and depends on your body, thoughts and feelings. Which **one** category best describes your gender? We provided some example of what each one means below.

    ___**Male**= born with male body parts and feel inside like you are a boy
    ___**Female**= born female body parts and feel inside like you are a girl
    ___**Transgender**= born with any body parts, but you think about it and want to become a different gender, sometimes with a doctor's help
    ___**Non-gender**= born with any body parts and does not feel like any one gender
    ___I choose not to answer this question

3. What is your race (based on your parents)? Please mark all that apply.

    ___ American Indian or Alaskan Native     ___ Asian or Asian American
    ___ Black or African American             ___ Hawaiian Native or Pacific Islander
    ___ White or Caucasian                    ___ I don't know

4. Are you Hispanic or Latino/Latina?    ◯ No    ◯ Yes

5. What do you consider to be your ethnicity? _____

6. Where were you born (state and/or country)? _____

7. What grade of school are you in? _____th grade

8. What kind of grades have you been getting this term? _____

9. What kind of grades did you get last year? _____

10. Does your family own a car, van or truck?    ◯ No    ◯ Yes, one    ◯ Yes, two or more

11. Do you have your own bedroom for yourself?    ◯ No    ◯ Yes

12. How many computers does your family own?    ◯ None    ◯ One
                                                  ◯ Two    ◯ More than two

13. During the past 12 months, how many times did you travel away on vacation with your family?    ◯ None    ◯ Once
                              ◯ Twice    ◯ More than twice

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*Below is a list of the ways you might have felt or behaved. Please tell me how often you have felt this way during the **past week**, using the scale below. Please chose 1 number for each statement. Please answer these questions as honestly and completely as possible. Everything you say is confidential, and will be kept private.*

# CES-D

*Answer Key: 1= Rarely or none of the time (less than 1 day); 2= Some or a little of the time (1-2 days); 3= Occasionally or a moderate amount of the time (3-4 days); 4= Most or all of the time (5-7 days)*

| | Rarely or None | Some or a Little | Occasional or Moderate | Most or All |
|---|---|---|---|---|
| 1. I was bothered by things that don't usually bother me. | 1 | 2 | 3 | 4 |
| 2. I did not feel like eating; my appetite was poor. | 1 | 2 | 3 | 4 |
| 3. I felt that I could not shake off the blues even with the help from my family or friends. | 1 | 2 | 3 | 4 |
| 4. I felt that I was just as good as other people. | 1 | 2 | 3 | 4 |
| 5. I had trouble keeping my mind on what I was doing. | 1 | 2 | 3 | 4 |
| 6. I felt depressed. | 1 | 2 | 3 | 4 |
| 7. I felt that everything I did was an effort. | 1 | 2 | 3 | 4 |
| 8. I felt hopeful about the future. | 1 | 2 | 3 | 4 |
| 9. I thought my life had been a failure. | 1 | 2 | 3 | 4 |
| 10. I felt fearful. | 1 | 2 | 3 | 4 |
| 11. My sleep was restless. | 1 | 2 | 3 | 4 |
| 12. I was happy. | 1 | 2 | 3 | 4 |
| 13. I talked less than usual. | 1 | 2 | 3 | 4 |
| 14. I felt lonely. | 1 | 2 | 3 | 4 |
| 15. People were unfriendly. | 1 | 2 | 3 | 4 |
| 16. I enjoyed life. | 1 | 2 | 3 | 4 |
| 17. I had crying spells. | 1 | 2 | 3 | 4 |
| 18. I felt sad. | 1 | 2 | 3 | 4 |
| 19. I felt that people dislike me. | 1 | 2 | 3 | 4 |
| 20. I could not get "going". | 1 | 2 | 3 | 4 |
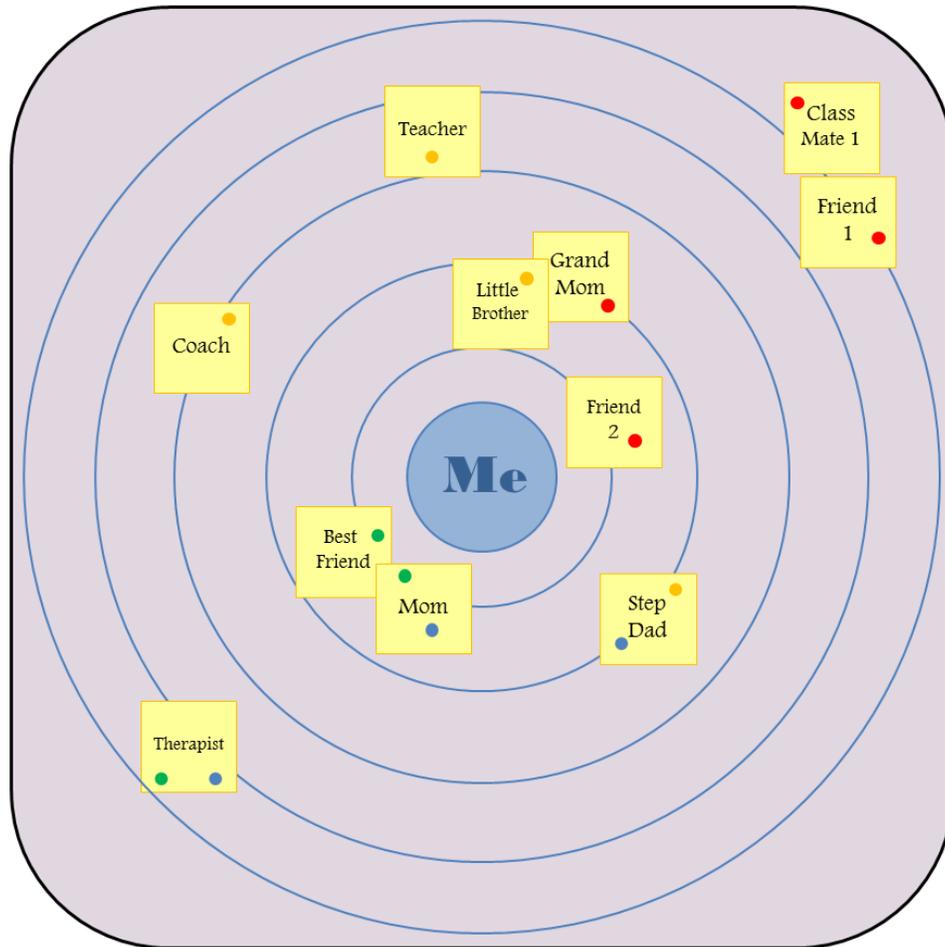
**The Field:** A Square, the concentric circles indicating interpersonal closeness

**The Core:** At the center of the representation is the participant (ppt); their social network spreads out around them

**The Spots:** The color variations signify a) if they have been disclosed to (blue = yes), and b) how safe / comfortable the ppt feels about that person knowing about their depression, red designating uncomfortable, green as comfortable, and yellow as uncertainty

**The Players:** Representing the ppt-designated players in the social network, post-its can be easily moved & (re)positioned so as to represent both the closeness that the ppt perceives (distance from the core) and the relative comfort that the ppt currently experiences regarding diagnosis disclosure

In this example, the hypothetical (male, for ease of reference) ppt has designated ten key players, plus the therapist, and positioned them in varying arrangements around the core, demonstrating how close he feels to each. So for example, he feels much closer to his mother, best friend, and friend 2 than friend 1, the coach and step dad.

In addition to interpersonal closeness, I also want to gauge how comfortable he feels when contemplating disclosure to various people in his life. Therefore, by using the color dots to label both disclosure and concern about disclosure, I can gauge how these processes work. In this example, he feels comfortable disclosing to his mom and best friend (though only his mom knows as of the time of the interview). However, he does not feel comfortable disclosing to friend 2 or his little brother, and is uncertain about his feelings that his stepfather knows about his depression.

CODE GLOSSARY

*Denotes codes utilized in Reliability / Quality Assurance checks

**B.1    MECHANICAL CODES**

**Participants:** Aggie, Cecilia, Felicia, Karen, Maria, Rene, Zoey

**Timepoints (1-5)**

**\*Protocol Item:** Reflection of key or major portions of the protocol

**0)** (Demography) **What do:** discussions regarding what organizations and/or activities that the participant engages in outside of school and the treatment setting

**0)** (Demography) **Who else:** who lives with participant (i.e., family members / household members, and pets)

**1) Daily Orientation** / Checking-In / Rapport building: casual conversation regarding recent occurrences in the participant's life designed to build rapport as well as prompt conversation / glean potentially useful information for further conversation

**2) SNE Key Players:** Identification and placement of key individuals in participant's life, and ensuing discussion of why placements were made

**3) SNE Disclosed:** questions regarding to whom the participant has disclosed their depression

**4) SNE Comfort:** Discussion of affective reactions to hypothetical or realized incidences of visibility, including the discussion of red, yellow and green sticker placement on given key players' indicators

**5) SNE SO** (Safe Other)**:** questions regarding to whom the participant goes for advice, particularly regarding VM; includes any discussion of a designated Safe Other, or instances of SO designation (re)evaluation, even if not specifically prompted by a protocol item

**6) Stigma:** questions regarding what others think about depression / mental health and how to educate those who have erroneous beliefs

**7) Identity and Being known:** asked participant whom they feel "knows" them, what is accessible vs. hidden, what others should know about them, and the differences between those who do vs. don't "know" them

**8) Advice to others:** asked participants for any pointers, advice that they would give to another person currently going through a depressive episode / what they went through

**Important Others:** persons to whom the participant refers to as having some form of interpersonal interaction or relationship with the participant; can be combination of role and demography

**Authority:** Anyone in authority over the participant; may be a legal official, religious leader, etc. (merged with Boss: Person in supervisory role over the participant at the participant's work place - may be simillar in age, but supervisory role is key)

**Clinician:** includes clinical therapist and/or doctor, school counselor, or other counselors, nurse

**Doctor:** high-level clinician or doctor, has the ability to determine treatment course

**Family:** non-parent or –sibling family member, for example grandparent, aunt, cousin; may range in age and salience of role in the participant's life; additional demographics should be designated

**Father:** includes any male parent figure including stepparent, other significant care-takers and/or legal guardians, which may include other older family members, foster care, etc.

**Friend:** those individuals who the participant actively designated as a "friend"; all other same-age persons are "peers" until otherwise stated, regardless of placement on the SNE map

**Mother:** includes any male parent figure including stepparent, other significant care-takers and/or legal guardians, which may include other older family members, foster care, etc.

**Peer:** same-age persons in the participant's life, not including those designated as "friends"

**Romantic partner:** boyfriend-boyfriend, boyfriend-girlfriend, or girlfriend-girlfriend

**School personnel:** includes sport coaches or performance-based directors; principal, vice principal, assistant principal, secretary, etc.;  or other non-teacher school personnel

**Sibling:** includes any applicable sibship relationship, e.g.: full, half, step, adopted & unspecified; locale of habitation does not matter in this designation

**Teacher:** includes tutors, unless same-age tutors, in which case would be peer

**Undefined other:** other persons involved in the participant's life not otherwise categorized

**Demography:** these codes refer to the person about whom the participant is speaking, and their relation to the participant (e.g., Step- when applied to Parent code of the Other tree) or in comparison to the participant (e.g., Older)

**Adult** (per participant designation)

**Child** (per participant designation)

**Ex:** as in former, typically applied to romantic partners

**Female**

**Male**

**Older** (than participant)

**Step:** family relation due to cohabitation or marriage

**Younger** (than participant)

## B.2    CONTENT CODES

**Closeness:**

**Affection:** references to showing or receiving affection such as compliments, hugs, etc.

**Comfortableness:** when the participant discusses their emotional reaction they have toward an Other with regards to how at ease or "comfortable", or conversely how ill-at-ease, "uncomfortable", hesitant or unhappy; this can be global or specific

**Effortful engagement:** references to the other person making an effort or paying attention to the participant, trying to engage them or otherwise actively demonstrating care or concern

**Guardedness:** expressions of cautiousness regarding increasing interpersonal closeness or disclosure regarding an Other in the participant's life; may be global or specific to individual / incident; discussion of the participant protecting, hiding, or simply not discussing parts or aspects of the self

**\*Interrelatedness**: discussions regarding the interpersonal connections between various Others in the participant's life

**Mobility:** refers to changes in interpersonal closeness

    **Barrier:** explicit discussion of circumstances, behaviors, feelings, or communications which impede or act to the detriment of a relationship "deepening" or becoming closer, more intimate, more known, etc.

    **Boundary:** references to how a specific relationship "is", in terms of what is discussed / done together verses what is outside of the relationship

    **Bridging:** any circumstance, characteristic, or event that acts to bring two people interpersonally closer together; expected to correspond to "+" code on the map; may be active, such as through allowing, creating or fostering instances of bringing together two different groups of people or contexts in their life

    **Distancing:** participant refers to or describes the process of becoming more distant from a person whom they once felt "knew" them, or to whom they were once close; any

circumstance, characteristic, or event that acts to move two people interpersonally further apart; expected to correspond to the "-" code on the map

**Map changes:** changes in the closeness of an individual from the participant

**"+":** indicates when a Key Other has moved closer toward the center of the SNE map (i.e., the participant feels interpersonally closer) from one Timepoint to the one immediately following it (e.g., Tp2 to Tp3 location, rather than Tp2 to Tp4 location)

**"-":** indicates when a Key Other has moved further away from the center of the SNE map (i.e., the participant feels interpersonally further) from one Timepoint to the one immediately following it (e.g., Tp2 to Tp3 location, rather than Tp2 to Tp4 location)

**"=":** indicates when a Key Other has not moved notably further from or closer toward the center of the SNE map (i.e., the participant feels interpersonally stable) from one Timepoint to the one immediately following it (e.g., Tp2 to Tp3 location, rather than Tp2 to Tp4 location)

**Openness:** expressions of lack of hesitancy regarding increasing interpersonal closeness or disclosure regarding an Other in the participant's life; may be global or specific to individual / incident; discussion of the participant feeling that they share a lot (or all) of the self with others, that they do not have secrets, or that they discuss in depth many aspects of the self

**Reciprocity:** explicit discussion of mutual sharing (verbal, physical, emotional, etc.); participant describes or refers to a reciprocal act, communication or other such incident in which something is exchanged, given or shared; conversely, an incident in which participant expresses that they felt that reciprocity was appropriate and expected, but was not achieved

**Relaxing:** Expressions or incidents relayed in which participant discusses casual activities with another person, often serving as a pleasurable distraction; discussions regarding what participants do to self-sooth or for enjoyment / leisure time, or the role of an Other person in the participant's life in regards to providing support through entertainment or distraction

**Similarity:** discussion regarding perceived sameness or parallels between the participant and an Other in regards to characteristics, behavior, or circumstances

**Support:** the act of providing or sharing emotional assistance, reassurance or bolstering

**\*Temporality:** references to time, either in duration or in the effect of the passage of time

**Trust:** explicit mention of the word trust or mistrust; the expressed belief or faith that another person will not violate expectations of privacy, confidentiality, or commitment

**Disclosure comfort:** Discussions regarding the SNE color-coding activity

**Comfortable:** when participants disclosed feeling comfortable with the amount of information the Other knew about their PSC/depression and/or if the participant were to learn more

**Partial / uncertain:** when participants disclosed feeling uncertain about the prospect of an Other learning (more) about their PSC/depression condition, or about how they felt that the Other knew as much as they did; also referred to instances where a participant expressed feeling partially (un)comfortable in regards to that person

**Uncomfortable:** when participants disclosed feeling uncomfortable with either the amount of information that another person knew about their PSC/depression, or that they would be uncomfortable with the other person learning more

**Stigma: SI (Stigma Incident):** Any incident relayed, whether through prompt or spontaneously mentioned, that pertains to someone relaying, endorsing or conducting any form of stigma; may include stigmatizing statements, exclusion/avoidance, discrimination, stereotyping, etc.

    **\*Anticipated:** Hypothesized, feared or anticipated stigma, has not (yet) occurred

    **\*Experienced:** Concrete event, participant encountered interaction or incident that was stigmatizing; can be toward the participant, toward another, or generalized

    **\*Internalization:** instances in which the participant relays associating stigmatizing or stereotypical (positive, neutral and/or negative) characteristics associated with PSC (potentially stigmatizing characteristic) with their self image or with themself; see Identity; participant endorses feelings or beliefs of stigma against self, or against others in the same stigmatized group

    **Minimizing:** references to someone down-playing the severity or importance of depression

    **Righteous Anger:** Participant expresses anger, desire confront, educate or empower self or others who are stigmatized so as to decrease stigma, or incident in which participant has actualized this desire

**Stereotype:** when a person is presumed to behave, believe, think, or experience some emotion simply because of some external categorization; while stereotypes may have a grain of truth somewhere, it has been intensified, over-generalized, and frequently reinterpreted to an extreme degree and applied regardless of contrary fact/observations

**Visibility Management:** references to strategies employed to adjust visibility; may include disclosure, partial disclosure, soft disclosure, lying, concealment, etc.

**\*Concealment:** when participant refer to "wearing a mask", acting like something they are not feeling, or otherwise avoiding discussing depression, etc. by passively avoiding stimuli that may increase the PSC (potentially stigmatizing characteristic) awareness of another person

**\*Disclosure:** directly informing another person of one's PSC (potentially stigmatizing characteristic)

**\*Educating:** when participant or other person informs a third party about the nature of the PSC (potentially stigmatizing characteristic), most often to decrease stigma/ increase understanding of the PSC though this may not be the only reason for the information exchange (other expressed reasoning may include seeking support, wishing to inflict guilt, etc.)

**Incident:** Any relayed occurrence in which a person learned of the participant's stigmatizing characteristic (i.e., depression); includes the placement of the blue stickers and any ensuing conversation

**\*Lie:** when participant refers to actively concealing their PSC (potentially stigmatizing characteristic), often through speaking untruths or purposefully / deceiving another person; **Fib** was collapsed into this code

**\*Non-disclosure:** the decision to simply not inform another person of one's PSC (potentially stigmatizing characteristic); the most passive VM strategy

**\*Partial disclosure:** when only a degree of information about the PSC (potentially stigmatizing characteristic) is disclosed, with other information being withheld; an example would be disclosing depression diagnosis but withholding SIB (self-injurious behavior), SI(suicidal ideation), etc.

**\*Strategizing:** Any discussion of advice seeking / co-strategizing with another individual regarding issues of visibility; when a participant talks out deciding how to deal with visibility in relation to another person; may or may not include advice (which itself may or may not include visibility issues)

**Testing:** gauging another's potential reaction to PSC (potentially stigmatizing characteristic) disclosure by: telling a small portion of the PSC but withholding more information until after evaluating their reaction; making a statement about the PSC to prompt a reaction; or manipulating the circumstances around another to increase exposure to the PSC without revealing own PSC status.

**Third party (disclosure):** when another person discloses about the participant's PSC (potentially stigmatizing characteristic) to a third party without consulting the participant first; may be positive, neutral or negative; formerly Non-consensual disclosure

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## B.3    OTHER CODES / FREE NODES

**\*Advice:** any instance in which the participant discusses gathering guidance or opinion(s) from another person regarding a decision-making process; this may or may not relate to visibility issues

**\*Burden:** instances in which the participant makes reference to feeling like a burden, or adding to the (dis)stress of another person, typically a Key Other

**\*Catalyst:** an occurrence or interaction which prompted the re-evaluation or a change in the relationship of two people, or the role played by one person in the other's life; participant may be either person in such an exchange; may be anywhere for a small event that the participant relays as having importance, or a normative event , so long as it prompted re-assessment

**\*Consequence:** the repercussions to an occurrence, action or interaction which altered the relationship of two people, how one person approached (or did not) the other person, or the role played by one person in the other's life; participant may be either person in such an exchange

**Depression (symptoms):** any instance where participant discusses depression symptoms (e.g., low mood, SI, SIB) in the context of interpersonal relationship; may pertain to disclosure, symptom management, support seeking, etc.

    **\*Experiential:** discussions of what depression is "like" or a participant's personal experiences being depressed, regarding the nature of the disorder

    **Getting help:** discussions of seeking assistance or support when coping with depression

**\*Need:** discussions of the participant's daily needs for support, treatment, etc.; very personal and varies highly

**Resources:** references to the participant (or others) accessing reference materials, online sources, etc. to find support or information about their depression

**\*Severity:** discussions of severity of depressive symptomology, either with clinician, when seeking support, or regarding amount disclosed to another; often refers to self-injurious behavior or suicidality

**Future:** references to the participant's life after the session, project, or current phase

**Golden quotes:** something that a participant or other speaker says that is particularly illuminating, illustrating, humorous, expressive, or otherwise may be appropriate for later use

**Identity:** any manner in which a participant talks about how they define themself, imagine themself, describe themself or associate themself as affiliated with

**Being known:** instances in which the participant discusses (Key) Others' beliefs about them (participant) or about the participant's identity

**\*Stress:** discussions of the stresses / worries / concerns in the daily life of the participant or an Other in the participant's life

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