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"I felt like it was the right thing to do": How college students' decisions to disclose COVID-19 diagnoses reflect privacy preferences, perceptions of stigma, and cultural norms

Jenna R. LaFreniere[1]
Emma Bedor Hiland[2]

NAME OF DEPARTMENTS AND INSTITUTIONS:

[1] Department of Communication Studies, Texas Tech University, USA

[2] Communications Department, The College of Saint Rose, USA

CORRESPONDING AUTHOR:

Jenna R. LaFreniere. E-mail: jenna.lafreniere@ttu.edu

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ABSTRACT

Background: COVID-19 diagnoses can be difficult to share, as COVID-19 faces ongoing stigmatization. **Aim:** Framed by communication privacy management theory, this study examines how college students make decisions to disclose their COVID-19-positive statuses (or why they may not), and how those decisions are affected by perceptions of stigma and cultural norms. **Methods:** This study utilizes a qualitative, interview-based methodology with twenty undergraduate student participants. **Results:** Responses are analyzed for themes relating to communication privacy management, noting information control and co-ownership, boundary coordination, and forced/required disclosures. Responses demonstrate that a stigmatized view of COVID-19 has largely subsided, but still affects disclosure preferences and decisions. In addition, several cultural factors also shape beliefs about disclosure practices. **Discussion:** These findings illuminate how perceptions of COVID-19's stigma and cultural norms shape college students' notions of privacy, information control, co-ownership, and ultimately disclosure practices. Highlighting implications for how best to respond to future pandemics, the data presented herein provides an exploration of the relationship between privacy strategies, stigmatization beliefs, and cultural norms. **Conclusion:** This information will be useful in generating institutional, education, and public health responses to future pandemics, as findings suggest an under-theorized relationship between the areas of privacy management, stigmatization, and cultural norms.

KEYWORDS

Communication privacy management theory, COVID-19, culture, disclosures, stigma

BIOGRAPHIES

Jenna R. LaFreniere is an Associate Professor and Graduate Director in the Department of Communication Studies at Texas Tech University in Lubbock, Texas, USA.
E-mail: jenna.lafreniere@ttu.edu. ORCID: 0000-0003-0651-9172.

Emma Bedor Hiland is an Assistant Professor of Communications at the College of Saint Rose in Albany, New York, USA and is the author of Therapy Tech: The Digital Transformation of Mental Healthcare.
E-mail: bedore@strose.edu. ORCID: 0009-0008-0936-9695.

Introduction

Since the onset of the global COVID-19 pandemic in 2020, it has become widely accepted that the novel coronavirus is stigmatized (Bagcchi, 2020; Dayton et al., 2022; Murray, 2021). Research demonstrates that its stigma continues, despite the existence of vaccines proven to reduce the likelihood of serious illness and/or death from contracting the virus (Des Jarlais et al., 2023). While stigma is often understood as individualized, efforts have also been made to understand the "stigma systems" (i.e., broader context) within which stigmas exist and operate (Friedman et al., 2021). One such context necessitating deeper exploration is that from which individuals decide to share (or not to share) their diagnoses of COVID, and what leads them to make those decisions. This study therefore explores how persons infected with COVID-19 navigate a difficult predicament: whether to keep their diagnoses of a stigmatized illness from others, or to disclose that private information. In particular, we examine how beliefs about COVID-19's stigma, practices related to privacy management, and cultural factors affect individuals' decisions to disclose or withhold their diagnoses.

Attitudes about and toward COVID-19, including beliefs about its stigma, are culturally contingent, as previously established by a variety of research on different countries' responses to the pandemic (Ugidos et al., 2020; Xu et al., 2023). Here we focus upon the context of the United States by examining the experiences of students at a large, southwestern university, and how those undergraduates navigated COVID disclosures for several reasons. First, the United States' response to the COVID-19 pandemic has notably emphasized the narrative that its citizens must learn to live alongside the virus (e.g., Albarracín et al., 2022), facilitating the emergence of a cultural norm wherein individuals are responsible for making personal choices regarding COVID-19 behaviors. Others have noted that this includes whether to wear masks (Cherry et al., 2021) and, as explored in this study, the decision of whether to share COVID-19 diagnoses with others. In addition, the educational institution participants attended had what might be described as "relaxed" norms and regulations regarding COVID-19. For example, the university dropped classroom masking requirements after the spring 2021 semester, prior to the Centers for Disease Control's (CDC) guidance supporting such a change. This might be understood as reflecting the political climate of the geographic region where the university is located, a notoriously conservative area of the country. This study therefore represents a contribution to other research examining the effects of political values and ideologies upon perceptions of (and behaviors related to) the novel coronavirus (e.g., Kerr et al., 2021).

Taken together, it was anticipated that participants' decisions to disclose or withhold diagnoses would be affected not only by their perceptions of COVID-19's stigma, but also dominant cultural norms in the region, reflected not only by institutional policies but also shaped by perceptions of what is considered private information. The results of this study therefore contribute to an under-researched area: how individuals respond to cultural and institutional imperatives and norms when it comes to forming attitudes about the stigma of coronavirus, and how those attitudes affect disclosure-related behaviors. Building off of prior research by Kelley and colleagues (2020), Roelen and others (2020) previously posited that, "responses to pandemics often suffer from a narrow biomedical focus and overlook the social, economic, political and cultural contexts in which they take place" (p. 1593). Our findings address this gap in existing research and demonstrate how a number of factors (beyond the biomedical) shape not only perceptions of illness, but also whether to share diagnoses.

Literature review

Communication privacy management theory

As one of our primary interests is how diagnoses are shared or kept hidden, we turned to Petronio’s (2002) communication privacy management (CPM) theory to conceptualize and articulate how individuals balance their desires for privacy with disclosure practices. A hallmark feature of CPM is that it imbues individuals with the ability to maintain the right to own and/or control what they deem private information; when they do share that information, others are granted co-ownership of it, which then necessitates coordination of the boundaries of the private information that is now collectively owned (Petronio, 2002). In the context of co-ownership, then, multiple individuals can own and can control the flow of information.

CPM also posits that individuals generate privacy rules to manage private information, including choosing who they disclose to, how much information to disclose, and when and where they disclose (Petronio, 2002). In constructing communication boundaries, which demarcate ownership of information, individuals regulate how open and closed their boundaries are to control their privacy; for instance, tightly controlled and/or thicker boundaries limit information access and vulnerability (Petronio, 1991; 2002). As Petronio (2002) further notes, however, boundary turbulence may occur when an information co-owner violates established (or expected) privacy boundaries and rules. This may include sharing outside of an agreed upon boundary, whether purposely or accidentally.

Prior scholarship regarding health and medical matters has sometimes utilized CPM to explore boundaries and their coordination. In this study, CPM is used to examine participants’ decisions to disclose (or withhold) what might be perceived as sensitive and/or stigmatized medical information with others, and how boundaries are negotiated and coordinated, thereby placing this research in conversation with other scholarship on CPM in health and medical contexts. The communication of health information, or the withholding of it, goes hand-in-hand with CPM, as one’s health information may represent the height of desires for privacy.

Privacy management in health contexts

Health contexts have long represented an area ripe for examining privacy and information control. In the United States, where this study took place, there are laws and regulations intended to safeguard medical information (“Your Rights Under HIPAA,” 2022), contributing to a culture wherein it is understood that one’s medical information is meant to be private. Privacy management in relation to health has been examined in a variety of studies, such as blogging about personal health matters (Smith & Brunner, 2016), mental health and illness disclosures (Meluch & Starcher, 2020), the sharing of lung cancer diagnoses (Ngwenya et al., 2016), how parents of chronically ill children disclose medical information about them

(Rafferty et al., 2019), and more. Regardless of context or medical issue, studies involving CPM demonstrate the complexities of navigating the desire to share (or withhold) health information when there may be benefits from doing so or, more generally, social, cultural, and/or political pressures to do so.

In one study of college-aged students, for example, Campbell-Salome (2019) noted that individuals 18 to 26 years of age who remain on their parents' health insurance plans may feel obligated to provide their parents with private, health-related information. Nevertheless, this leaves students' other family members, co-workers, and/or friends as parties to whom they can choose to make disclosures. In another study of breast cancer patient and survivor communication, Weber and Solomon (2008) noted a different tension: between desiring honesty in relationships by sharing with family and friends, but also not wanting to worry others by sharing their diagnoses. Ultimately they suggested that co-ownership of the breast cancer experience may be helpful for families, noting that, "Although relinquishing control may be difficult for some members, allowing other members to take responsibility for particular parts of the disease may create opportunities for both support and validation" (Weber & Solomon, 2008, p. 557). Others have studied disclosures of medical information in the context of non-familial relationships, suggesting that employees share health information with those outside their families to allow colleagues to support them (Westerman et al., 2015).

The novelty of coronavirus was without precedent when it came to diagnosis sharing. In the early days of the pandemic, large-scale contact tracing was intended to prevent the spread of the virus, but the CDC later revised its guidance, instead encouraging health departments to focus their contact tracing efforts only upon high-risk settings (Hassan, 2022). Today many who test positive for COVID using rapid, at-home tests do not even share that information with their doctors, and at-home test results are not included in public health data (Ducharme, 2022). These changes facilitated the ability to keep one's COVID diagnosis a private matter and, by extension, individuals can decide whether to allow others co-ownership of their private medical information.

Communication about COVID-19

Due to the recency of the onset of the COVID-19 pandemic, few studies have placed CPM in direct conversation with coronavirus disclosures and behaviors (e.g., Hong & Jo, 2023). One relevant study did find, however, that when individuals conceal information about COVID-19, they are likely to find others' concealment more acceptable (O'Connor & Evans, 2022). In a study of Chinese citizens, researchers found that one of the most significant reasons individuals refrained from disclosing a COVID infection was the fear of discrimination and stigmatization (Sun et al., 2021). However, in order to receive social support from friends, colleagues, or family members, Sun and colleagues (2021) noted individuals still would have to disclose their positive COVID-19 status. These authors noted that among Chinese individuals, culture and government policies influenced decisions to disclose, as China upheld "a series of rigorous control strategies to halt the spread of the virus" (Sun et al., 2021, p. 789). The United States, by contrast, maintains a more individualistic response, further warranting this study.

The aforementioned study by O’Connor and Evans (2022) suggests that although honest disclosures regarding COVID-19 are crucial for public health, those infected likely experience conflicting desires for honesty to protect others and dishonesty to protect oneself from scrutiny. Putting this in conversation with CPM, motivations underlying privacy rules involve consideration of broader contexts such as the risks associated with disclosure, one’s culture, and one’s motivations for concealment or revelation (Petronio, 2002). It is therefore all the more important to understand the role of cultural norms alongside stigma in creating the contexts from which students make disclosures of (or withhold) COVID-19 diagnoses. Nabity-Grover and colleagues (2020) claimed that researchers should re-examine assumptions regarding self-disclosures in order to understand information about, and reasons for, communicating information in health emergencies. This extends to pandemics, with an eye toward building effective pandemic responses in the future.

Considering the existing research, as well as the nuances of the COVID-19 pandemic and its effects, the following research questions were created to guide this investigation:

> RQ1: What role did college students’ ideas about communication privacy play in disclosing a positive COVID-19 diagnosis?
>
> RQ2: What role did stigmatization of COVID-19 play in disclosing a positive diagnosis?
>
> RQ3: What role did cultural norms have in shaping ideas and behaviors related to privacy and COVID-19 stigma?

Methods

After receiving review board approval, the authors (both instructors) interviewed a total of twenty undergraduate students enrolled at a large research university in the southwest United States during the 2021-2022 academic year. Interviewees were recruited through a university-managed research participant system, an online website for faculty researchers to post information about their studies to recruit student participants. Students could participate in the study to fulfill course requirements or for extra credit. During the fall semester interviews were held in a private room in a research lab, whereas during the spring they were conducted virtually via Zoom. This change was made to encourage student participation in the project due to the ongoing nature of the pandemic. In total, five male and fifteen female student participants were interviewed.

Although demographic information about participants was not collected, the university where the study took place is a designated Hispanic Serving Institution (HSI). According to the U.S. Department of Education, this means that at least twenty-five percent of full-time undergraduate students are Hispanic (“Hispanic Serving Institutions (HSIs),” n.d.). During interviews, participants revealed information about themselves and their identities as a result of their responses to questions. Some were international, older and/or returning students, employed, parents (or single parents), and student athletes. Some interviewees were students (or former students) of the researchers. Although these students were provided the opportunity to be interviewed by the other author of this project, they still chose to be interviewed by those they already knew. This did not seem to present an impediment to the interview process, as those students were assured their privacy and anonymity.

The researchers developed fifteen interview questions designed to explore how COVID disclosures are decided and acted upon in light of CPM, the virus's stigma, and the cultural contexts within which students operate. They conducted interviews separately following the same, semi-structured interview protocol, which contained primary and secondary questions, and allowed for follow-up questions as needed (see Appendix A for the full interview protocol). Interview lengths ranged from approximately ten to 32 minutes, averaged roughly 17 minutes, and yielded 73 pages of transcription data. Initial transcriptions were generated using the automated platform otter.ai, following which the interviewers each re-listened to and altered transcriptions to fix any errors they contained. The transcripts themselves were then modified for clarity (such as adding clarifying words where needed) and the data was anonymized by assigning pseudonyms and removing potentially identifying information, such as hometowns or individuals' names when referenced.

Results

Research question 1

This study's first research question focused upon the relationship between interviewees' beliefs about privacy and their COVID-19 diagnosis disclosures. Our analysis indicated that students' decisions to disclose or withhold information involved ideas related to control and co-ownership of private information, boundary coordination, and forced/required disclosures.

Private information control and co-ownership

Several participants described and understood their diagnoses as private information they controlled and, as such, they could either keep secret or share. Their stated preferences for maintaining thick and/or thin privacy boundaries, establishing rules regarding privacy boundaries, and/or believing there were norms for safeguarding or sharing their diagnoses, reflect the spectrum of boundary preferences and boundary coordination which Petronio (2002) and others have described in prior research. Eleven participants' statements and preferences revealed that they had "moderate" boundary preferences regarding their COVID-19 diagnoses, eight had "open" boundaries, and only one revealed a "closed" boundary (see Appendix B for detailed information and exemplary quotes demonstrating privacy preferences).

Participants with open boundary preferences described being more than willing to share their diagnoses with others, and to invite others into co-ownership of that information. In these cases, responses demonstrated thin boundaries for diagnostic information and, as a result, an increased likelihood for disclosing that information according to the CPM framework (Braithwaite & Schrodt, 2015). For example, Luke explained, "I told everyone. I just thought it was really interesting news... I told anyone that would listen," while Jenn said, "I felt like if word got around that I got COVID, I mean, it didn't really bother me."

Others, whose boundary preferences ranged from moderate to closed, were decidedly more cautious in who they selected as co-owners of their health information. Chloe noted that she wanted to keep the number of people aware that she had COVID-19 “kind of small, I guess... not like, broadcasting that I've got COVID.” Emphasizing the private nature of diagnoses, as well as individuals’ power to control their information according to CPM (Petronio, 2002), some also emphasized that their diagnoses were their business, and that they held control over who might receive that information. Joe, for example, told “[His] parents. And that’s it... ‘Cause no one else needed to know... my parents needed to know because they’re family, but my friends didn't need to know. Because I didn't want people in my business and stuff.” Peter was willing to share his diagnosis with his local community, but refrained from sharing it with his family in another country, concerned that it would cause them distress: “the fear of you having COVID would create a lot of tension, so I struggled with it. And it was a hard decision… But I made a deliberate decision, just not to share that information.” Jenn was the sole interviewee who expressed not wanting to share her diagnosis with anyone: “I honestly did not want to tell anybody that I got it… Like, I just wanted it to be me, myself, and I.”

As evidenced by participants’ statements, some were generally more closed and particular in selecting co-owners of their diagnostic information. Others preferred thicker boundaries with some groups and individuals while for others those boundaries were thinner. While these statements reflected participants’ stated preferences for sharing and/or non-sharing of their private information, participants were not always able to adhere to those preferences for a variety of reasons.

Forced and/or required disclosures

As noted in Appendix B, participants’ boundary preferences were not always adhered to. While some shared their diagnoses because they felt that others should know, others did so out of necessity, to be in compliance with explicit rules and guidelines from employers, organizations (such as sports teams), or schools. Lindsey, for instance, would have preferred to continue working despite contracting the virus. She knew that if she revealed her diagnosis to her employer, they would not allow her to return when she wanted: “I didn't want to tell my work about it because I had to make money... But then I had to tell them because I couldn't go to work because I was so sick.” Here we see the predicament in which many found themselves: needing to earn money through work, but being unable to do so once revealing their COVID diagnoses to employers. Although the CDC revised its guidelines for COVID-positive persons in August 2022, reducing the recommended number of isolation days for diagnosed persons down to five (Hetter, 2022), this change had not gone into effect at the time of the interviews. The mandated time away from work once Lindsey disclosed her diagnosis presented an economic hardship.

Peter’s disclosures reflected his desire to adhere to established protocols and norms, both at the university and his workplace:

> ...within the university community, I didn't have much trouble doing that [disclosure]... There is clear, you know, messaging around COVID. So it was very, very clear, the protocol to follow… even my work place, they were also very, very supportive. They asked for documentation…. And then they sent me a few forms from the HR office, just to confirm that I had to stay out…

Another participant, Sarah, disclosed her diagnosis due to a legal obligation. She stated, “I work with children and there's some health risk, so she [her closest co-worker] did have to report it [my diagnosis] to the Health Department, because we had to report [positive cases].”

While none of our interviewees explicitly stated that they had negative feelings as a result of feeling forced or obligated to disclose, they were nevertheless precluded from having a choice or say in co-ownership of their health information. This sometimes left participants powerless to control the extent to which their private information was then shared with others.

Chloe, for instance, was in high school at the pandemic's onset. She shared that her school would request a list of close contacts from anyone with a positive diagnosis and then take action: "you [had to] give the school a list of like, these are the people that I've been in contact with, and [then] they [would] go contact those people." Another participant, Camila, worked in a healthcare setting. She described feeling "obligated to share [her diagnosis] with others because of course it is putting other people's health at risk." She added that "it was also something that I was like, no one really needs to know about this. My name does not need to be thrown across the mud." Because her employer called the nurses she had worked with, saying, "Camila is positive just so you know, like, disinfect your area and everything", Camila may possibly have experienced feelings of boundary turbulence at being identified by her employer and having that information shared (see Petronio, 2002). Yet the context of the pandemic required that individuals adjust their normative desire for privacy in accordance with rules and regulations from schools, government, and employers.

Boundary coordination

While some participants stated they did not care who found out they had COVID, others actively engaged in boundary coordination with information co-owners. Sometimes this included creating rules, such as who else co-owners could share their diagnoses with (if anyone) (Kennedy-Lightsey et al., 2012; Petronio, 2002). Sofia, for instance, asked one of her family members to tell other relatives about her diagnosis: "I was around my sibling's in-laws at the Christmas party. And so I actually told my sibling just to inform them that I did have COVID in case they needed to go get tested." Yet Sofia was also explicit in communicating with her sister that she did not want information about her diagnosis shared in a way that would violate her sense of ownership and control: "I did ask her not to just post it on social media," she also revealed during her interview. Similarly, participant Amy asked some of those whom she disclosed not to share her diagnosis, explaining "I didn't want a lot of people to find out how I was, you know, with COVID and everything… I guess I'm a very reserved person."

Other interviewees revealed that boundaries were sometimes more explicitly discussed and negotiated, involving communication regarding the perceived risks and benefits of sharing private information. This supports prior research on the flexibility of privacy rules, and their ability to change as a result of communication (Braithwaite & Schrodt, 2015). Brook, for instance, shared that a discussion with a friend and co-worker helped her determine when to share her diagnosis with her employer. Similarly, the chosen confidant of interviewee Luke helped him determine whether to disclose his diagnosis to a girl he had dated while (unknowingly) COVID-positive. Luke's friend encouraged him to share his diagnosis, emphasizing that:

> It's very important that you tell these people that you've had contact with because you don't know who they come in contact with. So even though this girl is twenty two and young and healthy, she could be on her way to see her grandparents.

Another participant, Sarah, also spoke about revealing her diagnosis to a coworker. Yet her statements demonstrate that verbalized boundary coordination is not always a necessity for information holders (or co-holders). Even without explicit requests, persons may believe and/or assume their private information will not be shared further. For example, while noting that she and her closest co-worker had not discussed “rules” regarding sharing her diagnosis, Sarah stated that they had “worked together for 18 years… I think she's a pretty private person, too. And so, I just think she just kind of respects that [I wouldn’t want the information shared].” This boundary coordination did not require verbalization; rather, it was premised upon a long-term relationship and mutual understanding of Sarah’s generalized privacy interests. This supports prior research that those who share trust that their confidants will not betray them or, if they do share information, it is only ever done with the best of intentions (Kennedy-Lightsey et al, 2012).

Research question 2

This study’s second research question explored the role of COVID-19’s stigmatization, and whether that stigma affected participants’ decisions to disclose or withhold their diagnoses. Most participants’ responses suggested that they did not perceive the virus as stigmatized, in contrast with prior scholarship demonstrating that its stigmatization persists (e.g., Des Jarlais et al., 2023). Yet for eight interviewees (nearly half), COVID-19’s stigma did affect beliefs and behaviors related to diagnosis disclosures (see Appendix C).

The effects of COVID-19’s stigma

Throughout interviews there was a general sense from participants that, in their view, the stigmatization of COVID-19 had largely subsided. This attitude likely resulted from the prevalence of the virus itself amongst the U.S. population at the time of the interviews, in tandem with the sense that contracting it is inevitable and reflecting the ethos that we must learn to live alongside it (Albarracín et al., 2022). Participant Jenn noted that, as compared to 2020, she had come to view others diagnosed with COVID-19 less negatively: “Last fall, when everything was blowing up... in that moment I was like, oh my gosh, that's so irresponsible. Like how did you get COVID?... But now that I got it, I'm kind of understanding towards it...” Stacy similarly stated that “right now with like, all the vaccines and the amount of people that have got it already, I think it’s just like, normal. Well, maybe not normal, but it’s part of our living, I guess, unfortunately.”

Ruby, like many other interviewees, shared that if the topic of COVID-19 came up in conversation, she was willing to talk about her experience being diagnosed with the virus. Otherwise, though, she would not “just tell people that [she] had COVID… I'm not embarrassed or anything to admit that I had it... just because it is like the norm now in society. Like, it's been going on for the past two years.” Sarah’s comments also echoed Ruby’s: “It's not looked at [now] as it was in the very first year, [when] I think it was, you know, of course, the doom and gloom of it... but now I feel like it’s like, more like a flu.” Later during her interview Sarah noted that “now the quarantine is not ten days, it's five days.” The change in her feelings, and her perceptions of others’ feelings, reflects the changes wrought by evolutions in CDC guidance. Stigmatization and a lack thereof, then, was likely influenced by CDC communication about the virus.

Nevertheless, according to interviewees, there remains a perception of persons as being irresponsible when they contract COVID-19 (see Appendix D). Chloe discussed how one of the negative effects of that stigma is reluctance to reveal a positive diagnosis, particularly if a negative response or judgment is anticipated:

> ... just the stigma of being careless. Especially if someone is the more social type, and they're out at a lot of different gatherings, [with] lots of people... according to society, they got what they deserved or whatever, because they were with a lot of people when we've been told to be careful.

While many participants claimed the stigma of COVID-19 did not prevent them from disclosing a diagnosis, despite acknowledging the existence of the virus' stigma, Luke revealed a different perspective about why he chose not to disclose his positive status. In reference to a discussion of the girl he had dated while having COVID, he noted:

> This is going to be absolutely atrocious, what I'm going to say... I just remember she was like, pretty nervous about it [COVID-19]... And I remember I told my mom [I was positive], but I was terrified to tell [the girl] because I liked her at the time, and I didn't really - I didn't know how that conversation was gonna go down. Like, if she was gonna accuse me of infecting her. That would have been an odd talk... I was worried about how she was going to react... I was worried that it was going to like, torpedo that relationship.

Luke kept his diagnosis private and withheld that information in an effort to protect a new relationship. Yet at the time of the interview, he seemed to regret that choice. Nevertheless, his deliberate shielding of his COVID-19 status from the girl in question, while experiencing no hesitancy in telling his mother, suggests he anticipated a negative response from the former. Sarah, too, considered the stigma of COVID when deciding who to disclose to. While she told her children, she tried to keep her children's friends and their parents from knowing, worried that there would be negative repercussions for them.

While all of our research participants did share their positive diagnoses with others, who those others were, and how and why they shared, varied. Interestingly, no participants kept their diagnoses entirely to themselves regardless of when they were diagnosed with COVID-19 (i.e., early on during the pandemic or during subsequent years). Despite interviewees' comments suggesting shifting perceptions regarding COVID-19's stigma over time, particularly that it lessened as infection (and re-infection) have become more routine, some still expressed hesitancy to share that information due to fears of being negatively perceived by others.

Research question 3

The third research question explored the role of culture and cultural norms in shaping participants' ideas about and behaviors related to disclosing COVID diagnoses, particularly related to privacy norms and COVID-19's stigmatization. Interviewees articulated a sentiment we describe as belief in the right to know (RTK) that one has been exposed to COVID, which overrides the privacy preferences which might otherwise be held. We also noted that concern for others (including particularly vulnerable persons) and the normalization of COVID infection as part of life were common refrains amongst interviewees.

The right to know and care for others

Many interviewees' statements and stories about their COVID-19 diagnoses reflect a belief that others, particularly those with whom they came in contact with while positive, had a right to know that information. This motivating factor to disclose may at times have operated in tandem with legal and/or institutional requirements regarding disclosures, yet remains markedly different. Rather, the belief that individuals possess a right to know of others' positive status, and that they were exposed to them while ill, reflects an ethical imperative rather than a regulatory one. Student-athlete Stacy, for example, shared that while the university maintained a policy that "if you get COVID or you're sick, you've got to tell your trainer immediately… I didn't feel like it was an obligation, I felt like it was the right thing to do…"

Another interviewee, Sofia, spoke about how, upon learning of her diagnosis, one of her foremost concerns was the possibility that she had spread the virus to others. This was a sentiment she repeated throughout her interview, and eventually revealed the reason she believed so strongly in sharing a positive diagnosis was due to the death of a family member, a death caused by COVID. She stated, "...with other people having health issues, and you don't know if they had health issues or not, that can affect them from being either more sick, or maybe not going to the doctor… for me, it was important [to tell]." In fact, Mae, who worked at a restaurant franchise, felt that her manager was unethical for not sharing Mae's diagnosis with other employees:

> …my higher up manager actually got mad at me for telling… And he was like, I'm gonna say you're on vacation. And he didn't tell anybody… I thought that was very unprofessional of him to not tell anybody the truth and that they were exposed.

Mae believed that deliberately withholding exposure-related information put not only her co-workers at risk, but also their customers. Others, in her view, had a right to know that she had exposed them to COVID. She later described her belief in the necessity of sharing such information as reflective of her "values and like, stuff like that."

When participants' statements reflected the right to know, it often occurred while discussing groups deemed "high risk" by the CDC, due to such factors as age or chronic illness ("People with Certain Medical Conditions," 2023). Describing her actions after learning she was diagnosed, Anita shared, "I told my mom and then I called my friend, because I'd seen her Friday night. I told her because she works in a different healthcare facility." Anita was mindful of her friend's potential to spread COVID to potentially vulnerable persons at that facility. Jenn, too, felt compelled to disclose her diagnosis to her family due to her parents' vulnerabilities, even though she anticipated (and received) a negative response from her father. "He was upset because I put him at risk…" she stated. Jack, who contracted COVID during the winter holiday, was cognizant that sharing his diagnosis with others he had been in contact with was valuable information. "I didn't want to be responsible for, like, killing my friends' grandparents or anything," he stated.

That multiple interviewees framed their decisions to disclose as being at least somewhat motivated by concern for those with increased vulnerabilities indicates a cultural norm that emerged during the COVID-19 pandemic: the public has grown sensitive to the needs of those deemed categorically vulnerable by the CDC. A distinction has been drawn in the public's imagination between those for whom it is simply useful to know they were exposed versus those whose health conditions require increased vigilance to prevent transmission. Yet one interviewee, Amy, revealed that she had been hospitalized due to COVID and was continuing to experience long-term side effects at the time of her interview. Even so, participants' comments focused upon those with increased vulnerabilities rather than the potential that any person develop Long COVID as a result of infection ("Long COVID or Post-COVID Conditions," 2023).

Discussion

This study of COVID-19 disclosures utilized CPM as a theoretical framework, examining college students' statements about their decisions and actions in the wake of receiving positive diagnoses. In addition, this research explored the impact of COVID-19's stigmatization upon disclosure-related behaviors and communication, as well as the role of culture in shaping their behaviors and attitudes. Several findings are particularly noteworthy.

In response to research question one, our findings show that students held a variety of preferences for the type of boundary they placed around their private COVID-19 diagnoses. Some shared information more freely, and others were more selectively open. Even those who would have preferred to keep their diagnoses entirely secret and private found themselves unable to, due to the regulations and rules imposed upon them by their workplaces, the school they attended, and according to socio-cultural norms they believed should guide their actions. As the data presented in Appendix B reflects, only one interviewee expressed the desire to maintain entirely closed boundaries (i.e., she preferred boundaries with no permeability, to use CPM terminology). Eight interviewees maintained highly permeable, open boundaries (wherein they wanted to – and did – share their diagnoses freely with others), and eleven held moderately permeable boundaries, preferring to disclose selectively (e.g., some wanted to disclose only to certain people or groups, or wanted different boundaries for different people).

Our findings relating to forced and/or required disclosures resonate with previous research regarding forced disclosures of HIV information (e.g., French et al., 2015) as well as the Chinese government's policy advocating COVID-19 disclosures (Sun et al., 2020). Though our participants were generally more open than closed in creating information and privacy boundaries, many preferred to maintain at least some form of boundary. This demonstrates a normative value ascribed to privacy management, a hallmark of CPM, even in the context of the COVID pandemic. While prior CPM scholarship notes that privacy boundaries may be more easily breached if a person's well-being is at risk (Petronio et al., 2004), our analysis underscores the importance of privacy breaches to protect others' health too, particularly in the context of transmissible viruses.

These findings also suggest that future public health messaging regarding COVID-19 (and/or other viruses that lead to pandemics) should emphasize the need to share positive diagnoses regardless of individual privacy preferences, to promote the health and safety of the communities to which individuals belong. Researchers have found that concealing information about one's COVID-19 social distancing practices (such as socializing in person with others) decreases with age (O'Connor & Evans, 2022). As such, it is important that public health entities emphasize honest and expedient disclosures from adolescents and young adults. Additionally, with infections such as COVID-19 wherein immediate quarantine is necessitated to prevent transmission, receiving support from social networks is often important, as the sick may need their assistance while isolated (Sun et al., 2020). However, receiving that support more than likely requires disclosure of one's positive diagnosis. Given that individuals are often first educated on privacy from family members (Serewicz, 2013), parents today may also consider teaching their children how privacy rules differentiate when considering personal secrets and public health/safety.

Regarding research question two, twelve interviewees did not believe their choices to disclose (or not disclose) were related to COVID-19's stigmatization (see Appendix C). The eight remaining participants, however, noted that they experienced embarrassment, fear of judgment, nervousness, and other negative feelings (see Appendix D). Stigma surrounding COVID-19 may be decreasing, but it still impacts many people's decisions surrounding infection disclosure. Though the U.S. post-vaccine has seen large shifts in overall stigmatization of this illness, perhaps there are still lingering memories and implications from its initial presence and societal reactions. Building upon prior research on college students' disclosures of mental disorders to course instructors, which found that students choose whether to share based upon what they imagine the instructor's response will be (Meluch & Starcher, 2020), we suggest that educational institutions consider training faculty and staff on how best to respond to students' disclosures of not only mental illnesses but also easily transmissible illnesses such as Tuberculosis, Flu, or COVID-19. Creating a culture wherein students feel comfortable to share without anticipating negative responses would encourage faster disclosures, better protecting the health of students' classmates, faculty, and staff members. Such an approach is supported by the results of this study, wherein many participants described how imagining others' responses to disclosures of their COVID-positive status affected their decisions to disclose.

Just as Meluch and Starcher's (2020) research suggested that as mental distress and disorders become less stigmatized among college students, they may not view their mental health as needing concealment (or, to use CPM terminology, requiring thicker boundaries), many participants similarly indicated that as COVID-19 has become more common, sharing positive diagnoses has become easier. Prior research has found that conversations around stigmatized topics can facilitate bonding, a benefit that outweighs the potential risk of stigma (Foulke & Romo, 2021). Similarly our findings suggest a potential upside to revealing diagnoses: by including others within one's privacy boundary, one can establish connections with persons who can relate to their experiences.

Taken as a whole, educational institutions should encourage discussions of COVID-19 experiences and best practices, not only diminishing COVID-19's stigma, but also facilitating student bonding and encouraging open communication regarding other health concerns. Moreover, if students are encouraged to share with one another by having more permeable privacy boundaries regarding COVID-19 diagnoses, they will likely find support not only in the context of illnesses, but also in terms of decreasing loneliness and/or feeling like an outsider, both of which are common for college students. Several participants in this study, in fact, shared that COVID-19 had become a way to connect with others. This supports Logie's (2020) suggestion that while COVID-19 produced stigma akin to HIV's stigma, it has also produced solidarity and community. Creating more spaces to safely disclose and share information about stigmatized illnesses among college students would help bond students and create supportive communities, while also decreasing stigmatization.

Research question three revealed several important findings regarding culture and cultural norms. First, it is apparent that communication (originating from the CDC and other health and medical entities) normalized heightened concern for those deemed at higher risk of negative COVID-19-related outcomes (e.g., the elderly, persons with heart conditions, diabetes, asthma, and more). This suggests that CDC messaging (2023) highlighting increased vigilance to protect members of vulnerable groups was successful. As multiple interviewees discussed their concern for these persons, and how those concerns influenced their choices to disclose diagnoses, it is clear that this ethic of care has become normative in the context of the COVID pandemic.

Many participants framed disclosures of their positive diagnoses as reflecting their belief in the right to know (RTK) (i.e., that others have a right to know that they were exposed to a COVID-positive person). This framing of disclosures as an ethical right for exposed persons, as opposed to legal or policy directives targeted at those who are COVID positive, presents an opportunity for further public health and medical messaging to frame disclosures as a matter of ethical behavior regarding treatment of others. Widely establishing this ethic as a cultural norm would be applicable not only to pandemics, such as COVID-19, but also to other communicable diseases, including sexually transmitted infections. Our interviews suggest that the RTK either supersedes what individuals’ boundary preferences would otherwise be (that is, opening otherwise thicker boundaries) or reifying their preference for already-permeable boundaries. Thus, it is important to continue finding ways to emphasize that individuals’ personal health information boundaries may need re-examination when considering the greater good of society, particularly when quick disclosures (e.g., maintaining thinner boundary walls) may save others’ lives.

While the contributions made by this study are many, there are several limitations and suggestions for future research. First, our student participants attended a university in a politically conservative area and with relaxed COVID-19 policies. A more representative sample of students from across the country may have felt differently about COVID-19 disclosures, particularly if they were from areas with stricter enforcements of protocols or where the political climate differed. As such, the relationship between political and cultural norms should be more explicitly interrogated in future research on attitudes toward COVID-19, as this study’s interview protocol did not contain explicit questions about politics and other cultural elements. While our hope was that students’ responses to questions about how and why they disclosed their diagnoses might contain information about politics, media representations, or other cultural factors, for many this never arose during interviews.

Second, demographic data about participants was not collected, as we preferred to allow participants’ narratives and experiences to explain their identities. Participants were predominantly female, as is often the case in student-based samples, but future research should aim to collect a more even representation by sex. While we did not inquire about gender or political beliefs, such information could be of use in understanding participants’ socio-cultural values and ideologies, and how those differences manifest in privacy boundaries through the lens of CPM.

Time presented both an advantage and disadvantage to this study. Participants were not interviewed during the initial stages of the pandemic and interviews took place only after vaccines were made available to the public. As such, responses to the interview protocol may have varied had we had the opportunity to interview them earlier during the pandemic. Yet, conducting the interviews during 2021 and 2022 allowed participants space to reflect on societal changes and norms regarding COVID-19 and how their social circles related to the illness. In this way, it is possible that the passage of time allowed participants to reflect more deeply upon their experiences in sharing.

Conclusions

Taken together, this study examines COVID-19 disclosures, relating participant interview responses to CPM's ideas of information control, disclosures, co-ownership, and boundary coordination, while also investigating the impact of stigmatization and culture on disclosure behaviors and attitudes. By understanding college students' thoughts and behaviors surrounding disclosure of positive diagnoses, this research can help generate public health and institutional policies that might prevent further spread of COVID-19 as well as other easily transmitted diseases emerging in the future. Findings provide a path for those seeking to create effective health messaging interventions, particularly for easily transmissible viruses such as COVID-19. Utilizing CPM in the context of health communication research for stigmatized illnesses also illuminates the benefit of transdisciplinary communication research, demonstrating the value of interpersonal communication theories in the context of health communication.

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Appendix A

Disclosures of COVID-19 diagnoses to friends and family

Semi-structured interview protocol

1. Can you tell me about your experience learning that you were diagnosed with COVID-19? This is a broad question, so you should feel free to share anything you feel is relevant or that you think I should know.
    a. Follow-ups asked as needed.
        i. Examples:
            1. What led you to get tested?
            2. How did you receive your diagnosis (phone, email, text, etc.)?
            3. Where were you when you learned that you had been diagnosed?
2. After learning of your diagnosis, what did you do?
    a. Follow-ups asked as needed.
        i. Examples:
            1. Did you tell anyone?
            2. Did you go anywhere?
3. Can you tell me more about how you felt at the time that you learned that you had tested positive for COVID-19?
    a. Follow-ups asked as needed.
        i. Examples:
            1. Were you embarrassed? Why?
            2. Were you scared? Why?
            3. Were you worried about anything?
                a. This could have been your health, how others might perceive you, treat you, and so forth?
4. How have your feelings about being diagnosed changed, if at all, since then?
    a. Follow-ups asked as needed.
        i. Examples:
            1. What changed your feelings?
            2. Did learning about others’ diagnoses, whether friends or family, change your feelings about your own diagnosis?
5. Was your positive diagnosis something you *wanted* to share with others? Or did it feel more like private information? Did you feel *compelled* to share your diagnosis, that it was important information to share, even if you didn’t want to?
    a. Follow-ups asked as needed.
        i. Examples:
            1. What made you feel that way?
            2. What were you concerned about, if anything?
            3. What was your thought process when you weighed the pros and cons of sharing?
6. In the end, did you end up telling anyone that you had been diagnosed with COVID-19?
    a. Follow-ups asked as needed.

      i. Examples:
         1. Who did you tell?
         2. Why did you tell?
         3. Did you tell any family members?
            a. If so, which ones?
         4. Did you tell any friends? Friends can include romantic partners.
            a. If so, which ones?

7. Can you tell me about your thought process when you decided whether or not to share your diagnosis with members of your family?
   a. Follow-ups asked as needed.
      i. Examples:
         1. Did you think different family members might respond differently?
            a. Which ones? Why?
         2. Did you feel like it was important to share your diagnosis, even if you thought there might be a negative response?
8. What were your family members’ responses? Were they what you expected?
   a. Follow-ups asked as needed.
      i. Examples:
         1. Were those responses what you expected? Why or why not?
         2. How did their responses make you feel?
            a. Did they impact your decisions about who to disclose to, or how to disclose, in the future?
9. Can you tell me about your thought process when you decided whether or not to share your diagnosis with friends or romantic partners?
   a. Follow-ups asked as needed.
      i. Examples:
         1. Did you think different friends or romantic partners might respond differently?
            a. Which ones? Why?
         2. Did you feel like it was important to share your diagnosis, even if you thought there might be negative responses?
10. What were your friends’ (and romantic partners’) responses? Were they what you expected?
   a. Follow-ups asked as needed.
      i. Examples:
         1. Were those responses what you expected? Why or why not?
         2. How did their responses make you feel?
            a. Did they impact your decisions about who to disclose to, or how to disclose, in the future?
11. Did you *ask* anyone that you shared your diagnosis with not to share that information?
   a. Follow-ups asked as needed.
      i. Examples:
         1. Why or why not?
12. Even if you did not ask them not to tell, did you *prefer* that they not tell?
   a. Follow-ups asked as needed.

        i. Examples:
            1. Why or why not?

13. Do you think that sharing the information that you were diagnosed with COVID-19 changed any of your relationships, with friends or family?
    a. Follow-ups asked as needed.
        i. Examples:
            1. Why or why not?
14. Now that more time has passed, how do you feel about discussing your diagnosis with friends and/or family?
    a. Follow-ups asked as needed.
        i. Examples:
            1. Are you open to sharing that you were diagnosed?
                a. Why or why not?
            2. Do you try not to discuss or share that you were diagnosed?
                a. Why or why not?
15. Is there anything that we have not discussed, or that I have not asked, that you think I should know about your decisions to share your diagnosis with other people?
    a. Follow-ups asked as needed.

Appendix B

Participants' boundaries preferences and outcomes regarding COVID-19 diagnoses

Participant	Exemplary quotes	Boundary preferences[a]	Preference upheld[b]
Amy	I think after when I was hospitalized, that's when I did tell friends what was going on with me." "It was more than anybody family members that I was around [that I told]... as a precaution for them to go get tested in case they started feeling ill."	Moderate	No[c]
Anita	"I shared it with others, because, I mean, most of my friends had already had it or got it after I did... we're all bound to get it so I don't think it's something to hide."	Open	Yes
Brooke	"I pretty much just told anyone around me... my friends that were around me, my family. My work I told eventually."	Open	Yes
Camila	"... the people I did tell were close to me so I didn't mind if they shared it with anybody else. Because I knew they wouldn't just be, you know, be sharing it on Facebook, it'd be with their families.... I had trusting relationships with them." "I felt obligated to share with others because of course it is putting other people's health at risk. But it was also something that I was like, no one really needs to know about this. My name does not need to be thrown across the mud." "...my boss called the nurses that I was working with, and they're like, Camila is positive just so you know... disinfect your area and everything."	Moderate	No[d]
Chloe	"... I was like, telling just people I had to. The people I was next to... You give the school a list of like, 'these are the people that I've been in contact with,' and they go contact those people. But outside of that, I kind of tried to just keep it kind of small... not like,	Moderate	No[e]

	broadcasting that I've got COVID.” “… my parents, and then two stepparents, stepmom, stepdad, all of them knew. My immediate family. And then I think we even told my grandparents, like my aunts, uncles.”		
Evelyn	“I just thought it would be better to let everyone know that I had it. Just so they could get tested, even if they didn't have any symptoms.”	Open	Yes
Jack	“I just told my close friends that I wouldn't be seeing during that break. And then we told our family members… ‘Hey, this is why we're like not going to see y’all for Christmas.’”	Moderate	Yes
Jenn	“I honestly did not want to tell anybody that I got it, I didn't even want to tell my dad, because I knew my dad was gonna just go insane and crazy. Which he did… I didn't want to tell my friends, but I was like, I'm just gonna tell them because they're gonna notice that I'm not here… I honestly didn't want anybody to know. Like, I just wanted it to be me, myself, and I.”	Closed	No[f]
Joe	“Well, my parents needed to know because they’re family, but my friends didn't need to know… I didn't want people like in my business and stuff.” “I’m pretty sure they told their friends, but I don’t care really… Cause they’re my parents they have the right to tell their friends that I had COVID.”	Moderate	No[g]
Lindsey	“I felt like I wanted to tell my family about it. But I didn't want to tell my work about it… then I had to tell them because I couldn't go to work because I was so sick.”	Moderate	No[h]
Luke	“I told everyone. I just thought it was really interesting news… Everyone in my friend group wanted to know… I told anyone that would listen.” “I feel like the only people that I was kind of nervous to tell were probably the only two	Moderate	Yes[i]

	people that I should have told the first day, which is my mom and that lady [he had been romantically involved with].”		
Moe	“… my higher up manager actually got mad at me for telling my other manager [I was positive], and he was like, I'm gonna say you're on vacation, also. And he didn't tell anybody… I personally wouldn't have cared if he told anybody but I thought that was very unprofessional with him to not tell anybody the truth and that they were exposed.”	Open	No[J]
Norah	“I told my boyfriend at the time, I told my extended family… just the people that were close to me. I didn't necessarily feel like I had to post it on social media like other people have… I mean, I'm being safe, and I'm letting my closest people that I have been around know.”	Moderate	Yes
Peter	“So just the fear of you having COVID would create a lot of tension, so I struggled with it. And it was a hard decision. You know, at some points I regretted what I was doing. But I made a deliberate decision, just not to share that information.”	Moderate	Yes[k]
Ruby	Just because since it was my family, like, knew they would be like understanding about it…I actually told everyone that I was with on New Year’s that like, I would advise them to get tested since I tested positive… I wasn't necessarily embarrassed. But I did feel maybe some guilt just in case they would test positive. And [if] they spread it more.”	Open	Yes
Sarah	“I just didn't make it public knowledge, basically. I mean, I told my closest coworker, and I think she might have told people that we work together [with] that I was out with the flu… she just let me be in charge of that… I just told my parents, you know, my parents and my mother-in-law, and,	Moderate	Yes

	of course, my kids. Other than that, I didn't tell anybody... I'm a pretty private person anyway... I'm not one that's putting everything on Facebook or Instagram or anything like that and so it's just more my nature, you know what I mean?"		
Simon	"I let my immediate management know, my management partners. And of course, the salesmen around me, and I just stayed at home. It was kind of a need-to-know basis, I guess you could say... there was probably 100 people I could have texted let them know, 'Okay, I met you two weeks ago, but I've just tested positive for COVID.' And that is, you know – I didn't want to create a mass hysteria."	Moderate	Yes
Stacy	"I did tell everyone in my surroundings. I mean, the first people that I obviously told were my coach and my trainer because I didn't know what to do... after that of course I had to tell my teammates... I told my roommates too, like the only ones who were not [positive] with COVID like, 'Get away from me.' ... I called my parents... I didn't want to keep it a secret really. Like if I had close contact with others, I was gonna let them know. Like, I emailed my professors individually like, 'Hey, I got a COVID,' and like I don't sit really close to them [in class] but still I sit close to people and I don't use masks so. So yeah, I mean I just let everyone know really."	Open	Yes
Sofia	"... my first time [testing positive] I shared it with everybody... as far as my family again, I was just kind of nervous. I didn't want to scare them. I wasn't in contact with them... I didn't really feel the need to tell them, yet [so I waited]. The second time [I tested positive], I did feel the need to contact and tell everyone... my sibling had an annual party that we had attended... And when I tested positive I	Open	Yes

	was freaking out, like, hey, there were kids there, you know, older family members, and so I instantly just sent a message out, like, 'Hey, I'm so sorry, but I ended up testing positive' … we had a [family] member pass away because of COVID… so I, I yeah - for me, it was important [to share]."		
Violet	"I immediately called my parents… And then I went through the COVID procedures through school… Emailed all my teachers… told my friends… so yeah, I had no problem sharing the information. I honestly, am just a pretty straightforward person."	Open	Yes

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[a] Interviewees could have expressed the desire to maintain closed boundaries (wherein they did not want to disclose to anyone), open (wherein they wanted to share openly and freely), or moderately permeable boundaries (wherein they only wanted to disclose to certain people or groups, or might want different boundaries for family, friends, romantic partners, and/or colleagues).

[b] Participants were not always able to follow their preferences. For example, workplaces and schools sometimes shared their positive diagnoses beyond what they desired. Other participants preferred not to share with anyone because they were worried how others would react, but felt compelled to do so nonetheless. There were, therefore, incongruencies between the boundaries participants desired to create and maintain, and what they were actually able to do. If "yes" is written, then the interviewee was able to have their preference upheld. If not, this category is labeled "no."

[c] Amy wanted to only disclose to her family, not her friends. She eventually felt forced to do so due to her hospitalization.

[d] Camila was comfortable having an open boundary with friends and family, but her place of work shared her diagnosis with co-workers based on protocol, which she understood.

[e] Chloe was fine disclosing her diagnosis to her family. When she had to notify her school, however, she felt not only forced to do so due to its protocols, but also that she could no longer control the information.

[f] Jenn shared that she did not want to disclose to anyone, including her parents and immediate family, despite describing them as "very close." However, she had told her parents she was feeling symptomatic during a prior conversation, and so disclosing her diagnosis became "just a follow up" to that conversation. Importantly, Jenn conveyed that she had explicitly asked her family not to tell anyone else that she was symptomatic: "I was like no, don't tell anybody. Like, this is so embarrassing. Because my mom, she'd think - she was like, my daughter was being very safe… And then I got COVID. And that's totally the opposite of what she'd been telling her friends."

[g] Joe did not want to create a boundary between himself and his parents. Although he stated repeatedly during his interview that he did not want other people in his business, he accepted that his parents likely shared his positive diagnosis with their friends. In fact, he believed they had a right to do so as his parents.

[h] Lindsey initially stated that she wanted to share her diagnosis with her family, but later she said, "I didn't really like want to tell my family because I didn't want to concern them. But also I knew if I told them that they would, like be willing to help me."

[i] Luke shared that while he was nervous to tell his mother, he felt it necessary to do so ("I felt really responsible for having brought [COVID-19] into her home… just like such a shitty son for having like brought something potentially life threatening… I'm supposed to kind of watch out and protect her, and I had done accidentally the opposite and it felt really awful."). He did decide not to disclose his diagnosis to a woman he was

romantically involved with, and never felt it was a necessary disclosure. This is discussed in greater depth in our analysis.

[j] Mae revealed that she was fine disclosing her diagnosis to her family, teammates, coaches, and anyone else she had exposed, including co-workers and work managers. Yet while Mae had no problem with her colleagues knowing her diagnosis, it was her manager who wanted to prevent that information from being shared widely.

[k] Peter decided not to share his diagnosis with his family members in another country, out of concern that it would worry them. He did speak at length about his decision to disclose his diagnosis to his church community, friends, and other family located in the United States.

Appendix C

Participants explain why their disclosures were not affected by COVID-19 stigma[a]

Participant	Exemplary quote
Anita	“I wasn't worried about how others would perceive me because, I mean, it's going on. I mean, everybody's bound to get it.”
Brooke	“I didn’t really feel any reason not to share [my diagnosis] with people. Because I didn’t think it was like a bad thing. Like, you get sick. It just happens.”
Chole	“I have a really supportive family… So in my case, I was fine to share and not worry about judgment, or negativity from them as much as like it would have been at school.”
Mae	“So it was very important to me to make sure everybody is like healthy and knows that if I exposed them, then they know. Because everybody reacts differently to COVID. So, I thought that was very important for me to share with everybody I exposed.”
Ruby	“… if the conversation is brought up, I'm not like, embarrassed or anything to admit that I had it... it is like the norm now in society… the more you talk about it and discuss your experiences, the better understanding we can get to like, kind of not finding a cure, but like, helping everyone else about the situation.”
Simon	“I feel like different geographics absorbed the information totally differently… in this area, it was taken more flippantly and passively than say, [if] you're New York… I think it was a geographic difference that politically you got to see like, ‘Hey, you got it , wish me luck, see you in a little bit,’ you know?”
Stacy	“… I didn't know that people were ashamed of saying that they had COVID… probably, a few months ago or a year ago when it [the pandemic’s start] was so recent… back then like yeah, I get that, but like right now with like, all the vaccines and the amount of people that have got it already, I think it’s just like, normal. Well, maybe not normal, but it’s part of our living, I guess, unfortunately. And I don't think anyone should be ashamed of saying that they have COVID.”
Violet	“It wasn't something that I was embarrassed about… I had no control over getting it in the first place… it was something similar, if I had the stomach bug, and people are ‘Oh, you weren't in class, like, where are you? Are you okay?’ And I'm like, ‘Oh, I'm sick.’ I felt like that was the same kind of thing.”

[a] Evelyn, Joe, Lindsey, and Peter believed their disclosures were unaffected by COVID-19’s stigma. Evelyn preferred that others not share her diagnosis because, “it's like my personal information to share with people and I don't need other people telling everyone my business.” Joe’s reasoning was similar: "my parents needed to know because they’re family, but my friends didn't need to know… I didn't want people like in my business and stuff.” Lindsey wanted to keep her diagnosis from her employer because she wanted to go to work: “I felt like I wanted to tell my family about it. But I didn't want to tell my work about it. Because I had to make money. And I was like, concerned about, oh, if I'm sick, they're not gonna let me work. But I, then I had to tell them because I couldn't go to work because I was so sick.” Peter emphasized that in his view, sharing his diagnosis was necessary, and he simply followed a reporting procedure that had been laid out for him: “I just took some time to, you know, gather myself, and then I was like, okay, let me just go ahead and send out the email [letting people know].”

Appendix D

Interviewees whose thoughts about disclosing were affected by COVID-19's stigma

Participant	**Exemplary quote**
Amy	"I thought that some family members were probably gonna think I was careless… I didn't choose to get COVID. It just happened."
Camila	"I of course was scared of what others would think of me… I just remember like, on Facebook, everybody putting like, you know, mean things… I remember calling my boss crying and being like, we didn't do anything wrong."
Jack	"… it's a little embarrassing, like yeah, it's a pandemic and everyone is getting it, but you still don't want to get it and it's kind of like a failure on your part."
Jenn	Last fall, when everything was blowing up... in that moment I was like, Oh my gosh, that's so irresponsible. Like how did you get COVID? Like, what the heck? ... But yeah, I feel like now that I got it I can feel more like understanding towards those that got it or are going to get it."
Luke	"I feel like I dropped the ball with that romantic partner because I liked her a lot… I was worried about how she was going to react... I was worried that [disclosing] it was going to like, torpedo that relationship."
Norah	"I was [nervous to disclose] just because I was like, oh, no, like, everybody's gonna think like, I'm gonna be the spreader now… every time like, somebody came out that they had COVID they'd be like, 'Oh, my God. Like, now it's all your fault. Now I'm at risk.' … So yes, I was a little bit nervous to tell them, but I felt like I had to."
Sarah	"It was more like [I was concerned for] my kids… It was just the fear that everyone had… but then that fear turns into the fear of how they'll handle it… or how long they're going to want their kids to be away from your kids, or - you know what I mean?"
Sofia	"I just think informing people is a bit scary. And embarrassing… And that may put them at risk… I was kind of nervous and scared, and embarrassed that maybe even though I didn't know I had it, that could lead to somebody's death, somebody else's death."

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