

Disclosure Decision-making Model

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Disclosure in interpersonal relationships involves the intentional process of communicating private or hidden information about oneself to others. Interpersonal self-disclosure provides relational benefits, including increased perceptions of intimacy as communication partners reciprocally exchange personal information. However, communicators often wrestle with competing desires to talk openly about health while protecting themselves and others within a relationship or network such as a family. Thus, disclosers engage in comparative weighing processes that inform their perceptions of risk levels associated with revealing health information. These perceptions of risk are reassessed throughout the course of the health condition as well as throughout a relationship and even within a conversation.

Greene's (2009) disclosure decision-making model (DD-MM) illuminates how disclosers navigate dialectical tensions inherently associated with health disclosure choices by assessing themselves, receivers, and relationships. Dialectical tensions involve balancing opposing desires such as a goal to connect with others by communicating openly about health information while simultaneously desiring to maintain autonomy, avoid negative reactions, and protect one's privacy. The model focuses on the comprehensive decision-making process to provide understanding of information management practices that determine the content, breadth, depth, and target of self-disclosure and nondisclosure actions. Disclosure is an interpersonal and relational process that involves both disclosers and recipients in the context of health communication. Disclosure is often studied from the patient's perspective such as sharing a diagnosis or an update such as a cancer reoccurrence or progressive symptoms; however, disclosure is a broad term that encompasses many types of communicators. For example, disclosers may also be caregivers sharing their experiences of stress and uncertainty with others beyond sharing the patient's health information (diagnosis, symptoms, or side effects). The DD-MM's broad approach allows consideration of conditions that prompt patterns of (non)disclosure across multiple communication goals, health conditions, and situational contexts.

To date, the DD-MM has been predominantly utilized to study how information practices shape disclosers' communication about health including contexts of sharing related to nonvisible illness, mental health, BRCA-related cancer risks, human papillomavirus diagnoses, infertility, concussion symptoms, heart disease, HIV, cancer, transgender identity, and menstruation. From a discloser's perspective, communication about health involves disclosure decisions that reflect the uncertainty and distress disclosers may navigate regarding diagnosis, prognosis, treatment, and health

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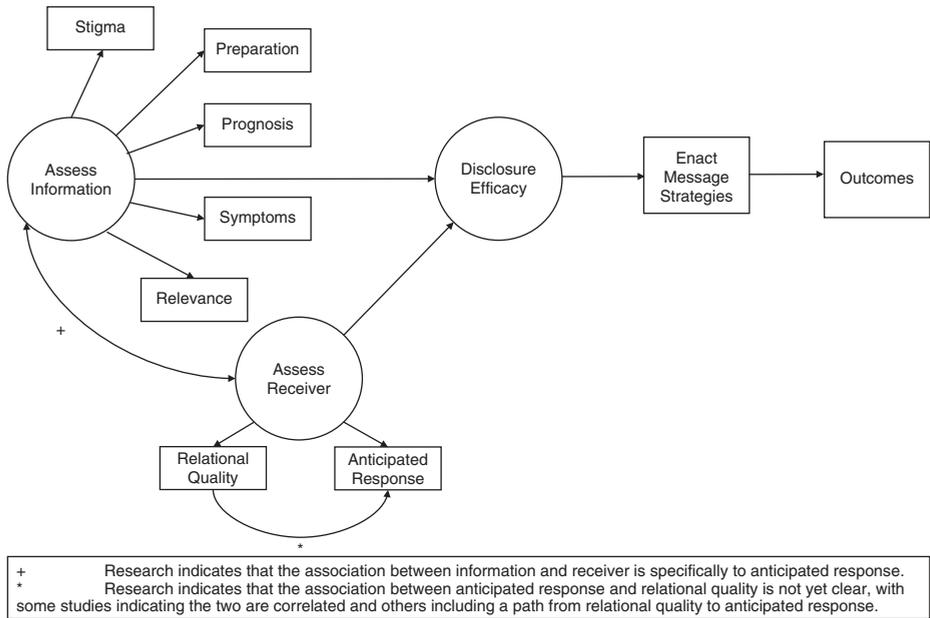


Figure 1 Research findings for the disclosure decision-making model.

outcomes. Therefore, a health disclosure decision involves the process of managing dialectical tensions to cope with competing interpersonal needs.

Throughout the disclosure decision-making process, **disclosers evaluate perceptions of inherent interpersonal risks compared with benefits that could potentially be garnered through the revelation of private health information.** The theoretical rationale underpinning the DD-MM emphasizes that the need to share information with another person does not generate a disclosure event in isolation; rather, (non)disclosure motivations are often preceded by **careful consideration of many personal, relational, and societal factors.** The DD-MM includes components that detail how disclosers cognitively assess three aspects: **the information they desire to share, the potential receiver(s) of the information, and resulting evaluations of disclosure efficacy in sharing this piece of information with the specific person** (see Figure 1).

DD-MM information assessment components

The initial portion of the DD-MM process involves the **discloser's assessment of the information content** under consideration for sharing. In this process, a discloser may evaluate five factors including **stigma, preparation, prognosis, symptoms, and the relevance** of the information to others. Prior to the DD-MM's more detailed information assessment conceptualization, information had generally been operationalized as valence. One qualitative study explored disclosure of transgender identity to healthcare clinicians, reporting reflecting on stigma, visibility, and relevance as significant considerations prior to the healthcare interaction (Friley & Venetis, 2021).

Research analyzing the full range of the DD-MM's information assessment (IA) component is limited. The two published studies measuring all components (Greene et al., 2012; Venetis, Chernichky-Karcher, & Gettings, 2017) provide detail for the information assessment factor structure, but many studies measure a subfactor or an information proxy. Across these studies, IA often predicts anticipated response and disclosure efficacy, but the direction and strengths of associations are complex.

Much disclosure information assessment research includes some aspect of *stigma*. Health-related stigma involves a patient's or discloser's perception that a health condition is *viewed negatively or misunderstood by society*. For example, perceptions of stigma have been demonstrated to influence disclosure decision-making in contexts including communication about infertility, nonvisible illness (Choi et al., 2016), mental health (Venetis et al., 2017), concussions (Cranmer & LaBelle, 2018), transgender identity (Friley & Venetis, 2021), and menstruation (Venetis et al., in press). The general direction of stigma influence is to increase perceptions of negative anticipated responses, decrease disclosure efficacy, and perhaps decrease disclosure enactment.

Preparation addresses *disclosers' expectations prior to a diagnosis or symptom onset* and has been included in several studies where the independent effects are difficult to disentangle based on combining subfactors (e.g., Greene et al., 2012; Venetis et al., 2017). One qualitative study of BRCA cancer risks showed how increased preparation was associated with likelihood of disclosure (Dean & Rauscher, 2018). Further research with preparation is needed.

Prognosis is a *patient's subjective evaluation of the future state of the health condition* (such as chronic, terminal) including treatment and is at times operationalized as illness severity. For example, with nonvisible illnesses, increased information severity predicts more negative anticipated response as well as lower disclosure efficacy (Greene et al., 2012). In athletes' concussion sharing, perceptions of more severe conditions predicted increased efficacy to share (Cranmer & LaBelle, 2018). For cardiac patients, increased prognosis uncertainty predicted increased perceptions of anticipated response of partner support but not of disclosure efficacy (Checton & Greene, 2012). In the cancer context, prognosis negatively predicted aspects of present and future-related topic avoidance for both patients and their partners (Venetis et al., 2015). Thus, prognosis is utilized but with inconsistent results (see also Dean & Rauscher, 2018; Venetis et al., in press).

The *visibility of symptoms to others* complicates voluntary disclosure decision-making by prompting questions (Friley & Venetis, 2021) and thus can vary across the health condition trajectory. In athletes' concussion sharing, perceptions of more symptoms were predictive of increased efficacy to share with coaches during a football game (Cranmer & LaBelle, 2018). Increased symptom uncertainty predicted cardiac patients' increased disclosure efficacy but not perceptions of anticipated response of partner support (Checton & Greene, 2012). In cancer patients, increased symptoms predicted topic avoidance strategies (Venetis et al., 2015).

The *relevance of private information to the well-being of others* is another factor that can influence disclosure decisions. If a discloser's illness or health condition poses a

risk to others, they may be motivated to disclose despite the prevalence of information risk appraisals (i.e., perceptions of stigma, potential face threats, or anticipated negative relational consequences). The relevance component has been operationalized as contagion or disease spread, but others have examined how directly the health information affects the recipient (e.g., Venetis et al., in press; Venetis et al., 2017).

In short, the information assessment research is complex, concluding that disclosers' perceptions of the content of information to be shared are crucial in the decision process. Should a discloser determine that the risk associated with the revelation of health information is too great, they may cease the disclosure decision-making process, exiting the discloser decision process after this stage and favoring communication strategies that limit disclosure events such as avoiding or nondisclosure. However, should a discloser evaluate that the risk associated with sharing the private information is tolerable, they are likely to progress to the second evaluative stage of the DD-MM by assessing the specific target receiver's characteristics.

DD-MM receiver assessment components

The DD-MM also describes how disclosers assess the characteristics of receivers as a part of disclosure consideration through evaluations of relational quality and anticipated response. Relational quality and anticipated response are often positively and moderately correlated (e.g., Greene et al., 2012; Cranmer & LaBelle, 2018; Venetis et al., in press), with some models including a path from relational quality to anticipated response (Cranmer & LaBelle, 2018; Choi et al., 2016; Greene et al., 2012).

Relational quality is a variable that is commonly incorporated across research utilizing various disclosure theories. Research applying the DD-MM consistently identifies disclosers' perceptions of relational closeness with a partner as a predictor of anticipated response (Choi et al., 2016), disclosure efficacy (Greene et al., 2012; Choi et al., 2016), and overall response (Greene et al., 2012). Additionally, relational closeness predicts (non)disclosure or disclosure strategy selection (Venetis et al., 2017; Venetis et al., 2015).

Anticipated responses to disclosure are idiosyncratic predictions utilized by disclosers to predetermine how a receiver may react to private health information after it is divulged. Dimensions of anticipated responses may include emotional reactions, social support, and reciprocity. Negatively anticipated partner responses are commonly cited as reasons for nondisclosure. Anticipated responses are also informed by perceptions of anticipated outcomes for the discloser, the receiver, their relationship, and relationships with others should disclosure be enacted. Anticipated disclosure responses predict disclosure efficacy (Checton & Greene, 2012; Choi et al., 2016; Greene et al., 2012) as well as the intent to disclose (Cranmer & LaBelle, 2018).

Should a discloser perceive adequate relational quality levels and predict a favorable anticipated response from a specific receiver, they may continue considering sharing by assessing perceptions of their disclosure efficacy.

DD-MM efficacy component

Disclosure efficacy is a **communicator's perception of their own skills and ability required for sharing a particular piece of information with a specific potential receiver**. At this part of the process, if someone has favorably assessed both the information and receiver components, a disclosure act may occur, or the consideration of disclosure continues. For example, increased perceived efficacy leads to high school football players' intention to share concussion symptoms with a coach during a game (Cranmer & LaBelle, 2018), couples' disclosure of infertility, and cardiology patients' reports of their breadth, depth, and frequency of disclosing with their partners (Checton & Greene, 2012).

However, disclosers who perceive that they **lack the necessary communication skills or resources** may decide that disclosure is not feasible or not possible at this time; instead, they may opt to conceal or withhold their private information by avoiding disclosure (Venetis et al., in press). When disclosure efficacy is poorly evaluated, the discloser may engage in selecting alternative disclosure strategies (i.e., third-party disclosure or asking another to share the information) that curtail the need to directly communicate private health information. In the context of college students' mental health disclosures to friends, the DD-MM application revealed that efficacy mediates the relationship between information assessment and disclosure strategy selection (Venetis et al., 2017). Efficacy also predicted several types of **topic avoidance** in another study with couples' cancer communication (Venetis et al., 2015), similar to efficacy predicting disclosure avoidance with menstruation (Venetis et al., in press).

Ultimately, disclosure efficacy is predicted by assessments of both the relationship and the health information, in turn, predicting disclosure intentions, the likelihood of disclosure enactment and perhaps specific disclosure strategies. **One note of caution with this component is that the efficacy component has been measured in different ways such as disclosure efficacy, communication efficacy, and also confrontation efficacy. These differences should be scrutinized in future studies.**

Disclosure enactment

If the information, receiver, and efficacy assessments result in a decision to share, the discloser may plan and enact the specific message. Disclosure strategies occur in various forms, including preparation, directness, third-party disclosure, incremental disclosure, entrapment, and indirect mediums (Venetis et al., 2017). This line of research suggests that **efficacy partially or fully mediates the relationship between information assessment and disclosure strategies**. Analyses of the most frequently enacted disclosure strategies utilized by people living with HIV/AIDS revealed three categories, including mode (e.g., face to face, non-face to face, and third-party), context (e.g., setting, bringing a companion, planning a time), and content (e.g., practicing, incremental disclosure).

Research considering disclosures of hereditary breast cancer risk during family planning discussions indicates that disclosers felt more willing to engage in open communication when they believed the recipient was also prepared for the disclosure to

occur. Thus, disclosers are more likely to discuss breast cancer risk with family members who they evaluate as prepared due to shared experience, rather than friends who they deemed less prepared for disclosure (Dean & Rauscher, 2018).

Research utilizing the DD-MM reports that the breadth, depth, and frequency of message formation and disclosure vary resulting from assessments of information, receiver, and efficacy. Additionally, **prognosis uncertainty positively predicts the breadth of disclosure, whereas symptom uncertainty negatively predicts the frequency of disclosure** (Checton & Greene, 2012).

Disclosure enactment has been measured as disclosure intention or willingness, reported disclosure, avoidance, and specific disclosure strategies. Disclosure decisions and strategies are constantly reassessed within the disclosure process, relationship, and even within an interaction. Continued research on disclosure enactment selections will be beneficial.

Limitations and future research

To date, the DD-MM has generated a number of qualitative and quantitative studies ranging across multiple relational contexts and health conditions. Many of these studies utilize patient populations, an improvement over research dominated by US college students, yet most samples remain predominantly Caucasian and heterosexual. Similar to much communication research, scholars could design studies to better address culture and diversity to address priority areas such as health disparities. The qualitative studies where the DD-MM is loosely “applied” to explain findings have generally failed to generate new insights for the theory or the model components, although they do illuminate the specific health contexts. **For qualitative researchers investigating health disclosure as a focus – rather than disclosure challenges as an outcome of the disease process – including specific interview prompts to probe for the DD-MM components would provide greater depth.** Few of the DD-MM studies are hypothetical or imagined, although many rely on retrospective perceptions of health disclosures that can confound assessments such as the information, anticipated response, and relational quality. Further research following patients and partners/caregivers across the illness trajectory would allow fuller understanding of sharing and withholding patterns as they vary.

The **quantitative DD-MM studies often select portions of model components for inclusion in surveys, and this is particularly evident with the information assessment component.** The health condition context could make deletion of the relevance items a logical decision, for example with mental health or cardiology where genetics or transmission are not applicable in the same way as other health conditions. Measurement is available for all five information assessment items, but the exclusion of some subfactors limits the model testing as well as the ability to address questions such as the second-order factor structure and direct/indirect effects. Additionally, some studies have included one relationship assessment component but not both; additional tests are needed where both are included to disentangle the effects as well as if both components are necessary. **Efficacy has also been measured in various ways in the studies, and this critique applies regarding the outcome variable** (disclosure intention or strategy,

willingness to disclose, avoidance, etc.). The prior studies conducted utilize cross-sectional designs, and to test the feedback loops and how anticipated response is formed and affects perceived efficacy requires longitudinal data. The field of health communication would benefit from more focused attention to ongoing health information disclosure decisions rather than the dominant attention to disclosing a diagnosis. **Focus on ongoing disclosure could integrate additional research on relationships because updating a person on managing a health condition or treatments draws more fully** on the cyclical nature of disclosure–response–reassess–additional disclosure. Overall, the DD-MM has generated and continues to generate significant research that expands understanding of both the disclosure and relationship processes as well as how patients and close others manage health information in their illness experiences.

SEE ALSO: Caregiver–Clinician Communication; Communication Privacy Management Theory; Topic Avoidance in Families.

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