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Authenticity, Vulnerability, and Shame in Peer Relationships among Marginalized Youth Living with Mood and Anxiety Disorders

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ORIGINAL PAPER

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Abstract

Meaningful peer relationships are developmentally important for adolescents and young adults. Yet trauma histories and stigma around mental illness can impede connection for marginalized youth living with mental health challenges. This study was grounded in relational-cultural theory, which posits that relationships characterized by authenticity and supported vulnerability foster growth; however, in the absence of support for vulnerability, people are likely to relate inauthentically. This qualitative study explored how young people living with mental health challenges navigated issues of authenticity, shame, and vulnerability in peer relationships. As part of a broader feasibility study of an intervention providing services to youth living with mental illness, in-depth interviews were conducted with 11 young women, ages 17–20. Participants were ethnically diverse, primarily low-income, and most had histories of child maltreatment. Interviews focused on participants' peer relationships, and were audio recorded and transcribed verbatim. Coders analyzed transcripts using thematic analysis and interpreted results using relational-cultural theory. While nearly all participants identified a friend or romantic partner as a significant peer, their experiences within these relationships varied considerably. These are described as a continuum of authenticity, along which participants varied in their experiences of supported vulnerability, feelings of shame, and willingness to represent themselves authentically in these relationships. Some participants who lived with mental health challenges and histories of trauma experienced close, supportive relationships with friends and intimate partners. The ability of marginalized youth to navigate issues of authenticity, vulnerability, shame and stigma in their peer relationships is a worthwhile focus for both practitioners and researchers.

Keywords Marginalized youth · Peer relationships · Authenticity · Vulnerability · Stigma

Highlights
- Close peer relationships are protective for youth with mental health challenges, but stigma and trauma can impede connection with others.
- Despite barriers to connection, some marginalized youth with mental health challenges and trauma histories experience strong, supportive connections with peers.
- Participants' peer relationship experiences varied in terms of support for vulnerability, authenticity, and feelings of shame.

Both research and theory emphasize the significance of close peer relationships for social and emotional development in adolescence (Collins, 2003; Hartup, 1996; Newcomb & Bagwell, 1995). The centrality of relationships for human development is a core tenet of relational-cultural theory (Miller & Stiver, 1997). Relational-cultural theory holds that growth takes place in the context of mutually empathic, authentic, and respectful relationships (Jordan, 2009); conversely, the absence of growth-fostering relationships leads to painful experiences of disconnection and chronic isolation. In adolescence, closeness in peer relationships is rooted in trust and affirmed when young

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people are able to relate fully and genuinely to each other, including supporting each other and sharing secrets (Way et al., 2005). These kinds of connections are especially important for marginalized youth living with mood and anxiety disorders (Institute of Medicine (IOM) and National Research Council (NRC), 2014; Munson et al., 2010), as meaningful connections with others are a key component of living well with mental health challenges (Ware et al., 2007). The presence of authenticity and supported vulnerability in close relationships is associated with psychological well-being (Theran, 2018); however, trauma, stigma, and shame can function as a barriers to genuine connection for people living with concealable stigmatized identities, including mental illness (Black et al., 2013; Brown, 2006; Downs, 2012; Jivanjee et al., 2008). Relatively little research has explored how adolescents and young adults living with mood and anxiety disorders experience friendships and other close personal relationships (Sapiro & Ward, 2020). This study investigated the relational experiences of young women living with mood and anxiety disorders, informed by three concepts from relational-cultural theory: authenticity, supported vulnerability, and strategies of disconnection.

Authenticity

In relational-cultural theory, *authenticity* is defined as "the capacity to bring one's real experience, feelings, and thoughts into relationship, with sensitivity and awareness to the possible impact on others of one's actions" (Jordan, 2009, p. 101). Authenticity has been studied in both adolescents (Impett et al., 2008; Theran, 2010, 2011) and college students (Han & Theran, 2021; Liang et al., 2002). Scholars have assessed authenticity primarily using two measures: the Inauthentic Self in Relationships subscale of the Adolescent Femininity Ideology Scale (Impett et al., 2008; Theran, 2010), which assesses the tendency for girls to silence their own thoughts and feelings in peer relationships; and the Relational Health Indices (Liang et al., 2002) which measures dimensions of engagement, authenticity, and empowerment in women's relationships with mentors, peers, and communities. Studies of authenticity in close adolescent and young adult relationships have found associations with several measures of psychological well-being, including higher self-esteem (Impett et al., 2008; Theran, 2010) and fewer depressive symptoms (Wenzel & Lucas-Thompson, 2012). A study of college women found that relational health with peers buffered against the development of trauma symptoms in participants with histories of childhood physical and emotional abuse, but not neglect (Han & Theran, 2021). Studies of the relationships marginalized youth form with supportive

adults have identified the importance of authenticity for adult-youth relationships (Ahrens et al., 2011; Greeson & Bowen, 2008; Munson et al., 2010; Spencer, 2006). However, authenticity in peer relationships has not been studied directly in clinical populations.

Supported Vulnerability

Authenticity in relationships depends on the presence of *supported vulnerability*, another concept from relational-cultural theory; this refers to the need to assess the risk of sharing feelings with others, based on confidence in the relationship and an evaluation of the other's trustworthiness (Jordan, 2004). The concept of vulnerability refers to a willingness to share with others personal information that could be used to wound them (Brown, 2006). Relational-cultural theory proposes that relationships in which people can be vulnerable and authentic while feeling supported are more likely to lead to greater intimacy and growth (Jordan, 2004). The presence of supported vulnerability in close relationships has not been studied to date in clinical populations. However, studies of young people with histories of foster care involvement (Eldridge et al., 2020; Steenbakkers et al., 2016) demonstrate that these youth carefully evaluate their listeners when deciding whether and when to confide in others about their painful pasts.

Shame and Strategies of Disconnection

Brown (2006) defines shame as "an intensely painful feeling or experience of believing we are flawed and therefore unworthy of acceptance and belonging" (p. 45). Shame is also frequently characterized by anxiety about negative evaluations from others and a desire to be "unseen" (Black et al., 2013). Research on shame has associated it with psychological disorders including anxiety, depression, and PTSD, as well as lower satisfaction and functioning in interpersonal relationships (Black et al., 2013). While shame is a universal human emotion, it is particularly relevant for people living with mental health conditions who experience the social and cultural ostracism of stigma (Corrigan et al., 2016; Mead et al., 2001). Stigma functions as a barrier to community engagement for people living with mental illness (Corrigan et al., 2016; Jivanjee et al., 2008). Living with a stigmatized identity can lead to internalized stigma and feelings of shame (Downs, 2012; Hartling et al., 2004; Kranke et al., 2010) and feelings of being different from one's peers (Kranke et al., 2011; Mead et al., 2001).

Several studies have identified the effect on adolescent friendships of the stigma surrounding mental illness

(Jivanjee et al., 2008; Khesht-Masjedi et al., 2017; Kranke et al., 2010; Moses, 2010). Moses (2009) conducted a mixed methods study with 56 youth ages 12–18 receiving integrated mental health services with moderate to severe needs for multiple supports. Most of her study's participants, who had diagnoses including affective disorders, disruptive behavior disorders, substance abuse and PTSD, experienced stigma in their peer relationships. Nearly half (44.6%) experienced some peer rejection, while 17.9% reported social isolation or alienation resulting from substantial peer stigma (Moses, 2010).

Shame and internalized stigma lead youth and young adults to decide carefully when and to whom they disclose information about their mental health difficulties (Downs, 2012; Kranke et al., 2010; Venetis et al., 2018). Judith Jordan writes: "Shame arises naturally when people feel that their 'being' is unworthy, that if people knew them more fully, they would reject or scorn them" (Jordan, 2009, p. 29). Relational-cultural theory describes *strategies of disconnection* that are deployed to manage shame, which reflect an effort to seek connection while relating inauthentically. Strategies of disconnection can look like emotional disengagement or "role playing" in relationships in ways that do not allow for authentic representation of the self (Hartling et al., 2004; Miller & Stiver, 1997). Kranke and colleagues (2010) interviewed 40 adolescents ages 12–17 who were taking psychotropic medications for a DSM-IV diagnosis and found a continuum of strategies to manage stigma in their peer relationships. Some adolescents chose to associate only with trusted peers who knew of their diagnosis. A second group associated primarily with other peers who also took medication. A third group limited their interactions with friends who could not be trusted with knowledge of their diagnosis and medication; and the fourth group chose to withdraw completely from peer interaction out of fear of rejection (Kranke et al., 2010). A study of adults receiving treatment for anxiety, depression, and PTSD at an outpatient mental health clinic found that a withdrawal shame coping style was associated with both less effective therapeutic alliances and impaired intimate relationships (Black et al. 2013). Similarly, young people with histories of maltreatment are thoughtful in their disclosures, balancing their need to help others understand them better with their wish to avoid negative emotional reactions in themselves and their listeners (Eldridge et al., 2020; Steenbakkers et al., 2016). While decisions to conceal stigmatizing information are often survival strategies, these strategies of disconnection have the effect of furthering disconnection and isolation, as people feel the only way they can be in relationship with others is by keeping important parts of themselves out of relationship (Hartling et al., 2004).

Internalizing Disorders and Peer Relationships

Mental health challenges in general, and specifically mood and anxiety disorders, are relatively common in adolescence and young adulthood. Indeed, three-quarters of adult mental health difficulties begin by age 24 (Kessler et al., 2005; Pottick et al., 2008). The most recent survey of American adolescents ages 12–17 found that 15.7% had at least one depressive episode in the past 12 months (Center for Behavioral Health Statistics and Quality, 2020), with mood disorders more commonly diagnosed among young women than among young men (Buskirk-Cohen, 2012; Merikangas et al., 2010).

With regard to mental health challenges, supportive friendships are a protective factor for young people: positive connections with peers predict lowered rates of depression (Delgado et al., 2019; La Greca & Harrison, 2005) and social anxiety (Erath et al., 2010). In contrast, adolescents who report social isolation are at increased risk of depressive symptoms (Hall-Lande et al., 2007), and moderate depressive symptoms are associated with peer relationship problems (Buskirk-Cohen, 2012). However, relatively little has been documented about the nuanced relational dynamics around mood and anxiety disorders in adolescent and young adult friendships.

The literature identifies several barriers that function to inhibit connection for youth living with mood and anxiety disorders (Sapiro & Ward, 2020). Symptoms associated with mood and anxiety disorders can negatively affect peer relationships (Narendorf, 2017; Siegel et al., 2015; Wolfe & Mash, 2006); in particular, adolescents with depression may participate in co-rumination and excessive reassurance seeking in conversations with peers (Buskirk-Cohen, 2012). Survivors of interpersonal trauma may also experience difficulties trusting others (Eldridge et al., 2020; Morton, 2017; Sparks, 2004; Wolfe et al., 2006). Research on young people with histories of disrupted attachments describes the tension they face in wanting close relationships with friends, while also wanting to protect themselves from further relational harm (Eldridge et al., 2020; Morton, 2017).

Despite the barriers to connection posed by stigma, trauma, and psychiatric symptoms, mutually supportive peer relationships are a necessary component of recovery for people living with mood and anxiety disorders (Mead & Copeland, 2000). For marginalized youth living with mental health challenges, positive peer relationships can protect youth against suicidality (Czyz et al., 2012) as well as the stigma around mental health treatment (Khesht-Masjedi et al., 2017). Additionally, strong peer relationships can bolster strengths through supporting identity development and providing a context for challenging stigma (DiFulvio,

2011; Tew et al., 2012). Related research on thoughtful self-disclosure about mental illness show positive ramifications for internalized stigma (Corrigan et al., 2016), feelings of shame (Downs, 2012), and social support (Weisz et al., 2016). Brown's (2006) research found that women developed resilience to shame by recognizing and accepting personal vulnerability, developing critical consciousness around sociocultural expectations, and reaching out to form mutually empathic relationships. Strong relational skills also proved beneficial in a study of resilience among young adults who had experienced psychiatric hospitalizations as adolescents. Hauser and Allen (2006) found that participants who manifested resilience as young adults demonstrated a stronger relational orientation than their peers who had also been hospitalized but were not as highly functioning in young adulthood. Resilient young adults were characterized by their sense of personal agency, their ability to reflect on their own and others' thoughts and feelings, and their ability to actively seek out and sustain relationships with others (Hauser & Allen, 2006).

The Current Study

Most of the studies investigating authenticity in peer relationships have utilized surveys and have not focused on clinical populations of marginalized youth. While a few studies have explored friendship intimacy among marginalized youth (e.g. Way et al., 2005), the subjective experience of their close relationships have been less often the focus of study (Delgado et al., 2019). Indeed, most of the research on the relational experiences of marginalized youth focus on their relationships with adults, such as case workers and foster parents, rather than with peers (Sapiro & Ward, 2020). Research on the impact of mental health challenges on adolescent friendships tend to predominantly utilize questionnaires and rely on quantitative data as measures of relationships. Many of these studies have focused on impaired peer relationships, such as experiences of peer rejection and social exclusion (Bagwell et al., 2001; Gardner et al., 2019; Siegel et al., 2015). Qualitative studies of these relationship dynamics in youth have focused on adolescents between the ages of 12–18. Emerging adults ages 17–20 are developmentally able to exercise more agency in their personal lives, both in their interpersonal relationships and in their efforts to manage their own mental health (Munson et al., 2012, 2013). Close friendships carry tremendous developmental and therapeutic significance for marginalized youth living with mood and anxiety disorders; yet numerous factors contribute to social exclusion for these young people. How do they navigate issues of stigma, shame, and self-disclosure in their relationships with peers? How do they balance their desire for closeness against their fears about further relational harm? There is a need for more in-depth, qualitative research that illuminates the nuances of peer relationships in the lived experiences of adolescents and young adults with mood and anxiety disorders.

To address this gap in the literature, this study investigated how marginalized youth living with mood and anxiety disorders describe their close friendships in their own words. Within the larger context of a federally-funded feasibility study of a psychosocial intervention, we explored how young people living with mood and anxiety disorders navigated issues of authenticity, vulnerability, and shame in their relationships with peers.

Methods

Procedure

The first author collected data for this study under the auspices of a federally funded developmental feasibility intervention study (R34-MH102525-01A1; PI: Michelle R. Munson, PhD) called Cornerstone (Munson et al., 2016). The Cornerstone intervention was designed to provide a supportive transition from child to adult mental health services for low-income older youth and young adults, many of whom have histories of maltreatment and involvement in public systems of care. The intervention and research study took place at an urban outpatient mental health clinic in the northeast United States. A combination of case management, psychotherapy, and mentoring was provided to youth through social workers and peer support workers, who met with youth both in the clinic and in the community. Youth were eligible to participate if they were between ages 16–20, English-speaking, and living with a primary diagnosis of a mood disorder, anxiety disorder, or a psychotic disorder. Eligible youth were identified by clinic staff and referred to the Cornerstone research team. A researcher contacted the youth and the caregiver, if necessary, and explained the study and invited them to participate. If the youth and family agreed, an intake assessment was scheduled in which the nature of participation in the research study was explained, including the randomized assignment to either the intervention or control condition. The research assistant obtained signed informed consent (and signed assent, if necessary) and completed the first assessment for the larger study. Once youth turned 18, they had the chance to re-consent their study participation by reviewing and signing an informed consent form. All informed consent forms noted that some youth may have the opportunity to participate in an additional interview on relationships. Fifty-six youth were recruited for the larger study and randomly assigned to either the intervention condition or best available treatment. In addition to living

with a psychiatric diagnosis, all participants came from low socioeconomic backgrounds, and over 80% reported a history of child maltreatment.

For this study, a sub-sample of 13 young women ages 17–20 participated in pairs of in-depth interviews focusing on significant relationships in their lives. The first interview explored relationships with a formal helping professional. Eleven of the 13 young women participated in a second follow-up in-depth interview three months later, focusing on relationships with peers and family; the remaining two participants could not be reached for follow-up interviews. These interviews, which lasted an average of 38 min, serve as the basis for the current analysis. The first author developed and conducted all in-depth interviews. Immediately following each interview, the author completed a follow-up assessment survey for the larger Cornerstone study, which took an additional 45 min and included a range of measures of social support, maltreatment history, depression symptoms, and treatment engagement. Each young person who completed both the interview and the assessment received $40, as well as transit fare to cover their travel costs. Interviews took place in an empty office at the clinic and were audio recorded with the consent of the participants. This study was approved by the IRBs of both the author's institution and the host institution of the Cornerstone study. All names are pseudonyms, most chosen by the participants themselves.

Participants

This study focused on the relational experiences of young adult women living with mood and anxiety disorders. The internalizing disorders of anxiety and depression are recognized to have considerable overlap in symptom profiles, alongside distinct dimensions for each diagnostic category (Buskirk-Cohen, 2012). Mood and anxiety disorders are more prevalent among young women than among young men (Merikangas et al., 2010) and these were the most common diagnoses of Cornerstone participants. These interviews were conducted as part of the larger Cornerstone study; as such, the research design needed to balance robust data collection with concerns about feasibility, participant burden, and respect for the community partners in the mental health clinic. We sought to recruit approximately a quarter of the larger sample for two in-depth, longitudinal interviews. This sample size was appropriate, given the study's specific aim, application of existing theory, and rich data collected in high quality dialogs (Malterud et al., 2016). From the larger group of eligible participants, a purposive sample of young women that was racially and ethnically diverse were invited to participate in in-depth interviews (Miles et al., 2013; Patton, 2002) with the goal of reflecting the diversity of the larger Cornerstone sample.

Interviewees were female-identified participants from the larger study, with a primary diagnosis of a mood or an anxiety disorder according to DSM-5. Diagnostic information was collected from participants' medical charts. Nine of the participants were diagnosed with a mood disorder. Six participants were diagnosed with at least one anxiety disorder. Three participants were diagnosed with both mood and anxiety disorders, while 2 participants also had other comorbid diagnoses. All participants were between the ages of 17–20 and were either current or past service recipients of the mental health clinic.

The mean age of interview participants was 18.23 years ($SD = 1.01$), slightly older than the age of the average Cornerstone participant. Nearly half of the participants were White (46%) with the remaining participants identifying as African American (15%), Latina (15%), and biracial or multiracial (23%). Four out of 13 interview participants (31%) identified as lesbian, gay, bisexual or transgender (LGBT). Participants were low-income (85% Medicaid-eligible), with those not reporting Medicaid eligibility coming from families who were poor or near poor. Data from the Child Trauma Questionnaire (Bernstein et al., 1997) included in the Cornerstone assessment revealed that 85% of the young women ($n = 11$) reported a history of at least one form of child maltreatment (physical abuse, emotional abuse, sexual abuse, or neglect). From this sub-sample of 13 participants, 11 participants completed a second interview, focusing on relationships with peers.

Data Collection

Semi-structured, open-ended in-depth interviews explored participants' relationships with a significant supportive peer, either a friend or a romantic partner. Interview questions explored the nature of support that participants received from both friends and family, acknowledging that relationships often have both supportive and challenging aspects. Interview protocols were developed using the guiding framework of relational-cultural theory (Miller & Stiver, 1997), focusing on sensitizing concepts of trust, mutuality, and disconnection in a significant relationship with a peer. The interviews invited participants to identify a close or best friend and to describe the significance of that relationship ("What makes this a significant or meaningful relationship for you?"). Interviews asked participants about trust in this relationship ("Do you feel like you can trust _____? If yes, how did you come to decide that you could trust him/her? How long did it take? If no: Why not? What would have to change for you to feel like you could trust him/her?") A sample question about mutuality and self-disclosure in the relationship was, "In your relationship with _____, do you feel like you can be honest about your thoughts and feelings? Are there topics you feel you cannot

discuss with him/her?" Participants were also asked to describe an experience of disconnection or disagreement in the relationship ("When you had a disagreement with _____, what happened?") The complete interview guide is available from the study's first author. All interviews were recorded and professionally transcribed.

Participants also completed a measure of depressive symptoms, the Center for Epidemiological Studies-Depression, or CES-D (Radloff, 1977) during each assessment. CES-D scores can range from 0–60, with higher scores indicating greater levels of depressive symptomatology; scores of 16 or higher indicate a person is at risk for clinical depression. For these participants ($n = 11$), the mean depression score at baseline was 34, reflecting severe depression (range 10–46), and 21 at 3-month follow-up (range 4–42), indicating moderate depression.

At the 3-month follow-up assessment, during which most participants completed their first in-depth interview, they also completed an 8-item measure of their level of engagement with services, using items drawn from the "investment" and "working relationship" subscales from Yatchmenoff (2005). This scale was originally developed to measure multiple dimensions of client engagement in non-voluntary child protective services. It consisted of four subscales that measured client investment, the working relationship, client mistrust of the worker, and client receptivity to services. The "investment" subscale measured a client's active participation in services; a sample item from this scale is "I am not just going through the motions. I'm really involved in working with the staff at this clinic." The "working relationship" subscale measured the client's perceptions of mutuality in the interpersonal relationship with the worker; a sample item is "I think the clinic staff and I truly respect(ed) each other." These two subscales were selected by the principal investigator for the Cornerstone study, based on their greater salience to voluntary mental health treatment and previous reliability in studies with youth and young adults with mental health challenges. Items were ranked on a five-point Likert scale from "strongly disagree" to "strongly agree." The mean engagement score for the full sample was 36 out of 40.

Data Analysis

Two analysts (the first author and a doctoral-level research associate with training in qualitative research methods) coded the transcripts, using Atlas.TI qualitative data analysis software. Using thematic analysis (Braun & Clarke, 2006) we sought to identify recurring themes in the data and test the applicability of relational-cultural theory to themes identified across interviews. The first author listened to the audio for each interview and corrected the transcripts. Both coders read each transcript multiple times, making notes on recurring themes, and wrote an in-depth summary of each interview. The two coders then compared summaries of the interviews to identify salient themes in participants' descriptions of their relationships. Both coders discussed the emergent themes and worked to resolve discrepancies through a process of consensus-building. Building on these discussions, the first author developed a codebook for the initial stage of thematic analysis. The code list included both inductive and deductive codes (e.g. "disengagement"), using theory and prior research as sensitizing concepts as well as deriving in-vivo codes from the text itself (Boyatzis, 1998; Padgett, 2008). Using the code list, as well as in-vivo codes, the first author coded all 24 interviews, using Atlas.TI qualitative analysis software. The second analyst double-coded one quarter ($n = 6$) of the interviews with 6 different participants, 3 from the first round of interviews which focused on helping professionals and 3 from the second round of interviews which focused on peer relationships. Both coders met periodically during this phase of the analysis to discuss the application of theoretical concepts and adjust the coding process as needed.

The author grouped the codes into overarching themes and sub-themes, using conceptually-clustered matrices (Braun & Clarke, 2006) to provide evidence for emerging themes in cross-case analysis (see Table 1). This second-order coding (Miles et al., 2013) provided the basis for the findings on the continuum of authenticity described in this paper. We also calculated descriptive statistics of participants' levels of depression and engagement in treatment to examine them side-by-side with the qualitative themes (see Table 2).

We employed several strategies to ensure the rigor of this study, including keeping an audit trail, triangulation of data sources and analysts, peer debriefing, and member checking. Eleven of the original 13 participants participated in the second interview, during which the author shared with them a written summary of the first interview in order to check the accuracy of the interpretation.

Results

Most interview participants described having at least one close friend or intimate partner who knew them well and was in regular, current contact with them. Yet participants also differed in terms of how they described their relationships with peers. We describe these differences as a continuum of authenticity (Table 1). At one end of the continuum are descriptions of peer relationships with fewer or no examples of authentic relating or supported vulnerability ("limited support for vulnerability"). These relationships were more likely to contain examples of inauthentic relating to peers, using strategies of

Table 1 Continuum of authenticity characteristics

Continuum dimension	Characteristics
Limited support for vulnerability	Often associated with feelings of suspicion about others or shame about the self; little to no experience of supported vulnerability in relationships; less authentic relating; more descriptions of strategies of disconnection
Tentative vulnerability	A combination of guardedness and a willingness to be authentic in relationship with one person; some strategies of disconnection
Embraced vulnerability	Little to no shame expressed; a desire to be in connection with others; strong belief in the value of authentic presence and supported vulnerability. Strategies of disconnection are less common.

Table 2 Participant diagnosis, depression symptom severity, and engagement in services

Participant	Continuum of authenticity	Primary diagnostic category, as listed in medical chart	Depression[a] baseline (M = 34)	Depression[a] 3 months (M = 21)	Engagement[b] 3 months (M = 36)
Lola	Embracing	Mood disorder	46	42	39
Yasmine	Embracing	Mood disorder	44	27	38
Thefa	Embracing	Anxiety disorder	38	33	40
Francesca	Tentative	Mood disorder	10	4	40
Flower	Tentative	Mood disorder	16	N/A	N/A
Z	Tentative	Anxiety disorder	35	7	33
Jessica	Tentative	Mood disorder	41	35	34
Ashley	Tentative	Mood disorder	47	22	40
Angela	Limited	Mood disorder	25	8	40
Ocean	Limited	Mood disorder	32	8	39
Rosie	Limited	Anxiety disorder	39	N/A	N/A

N/A = data not available for this participant from this measure. Participants completed measures of depressive symptoms at baseline and at three months post-baseline. Engagement in services was measured at three months post-baseline

[a] Depression symptomatology measured using the Center for Epidemiological Studies-Depression, or CES-D (Radloff, 1977). Scores can range from 0–60; a score of 16 or higher reflects risk for clinical depression

[b] Engagement in services was measured using 8 items from the "investment" and "working relationship" subscales, adapted from Yatchmenoff (2005). Items were ranked on a five-point Likert scale from "strongly disagree" to "strongly agree"; scores can range from 8–40

disconnection. The participants often expressed feelings of shame about themselves and saw peer relationships as limited in their potential to contribute to their well-being. At the other end of the continuum are peer relationships that reflect authentic presence, supported vulnerability, and a relative absence of shame ("embracing vulnerability"). The participants at this end of the continuum saw their friendships as essential to their well-being, with authentic presence a necessary component of these relationships. In between were participants who were cautiously moving into greater connection, generally with one trusted best friend ("tentative vulnerability").

In addition to the qualitative analysis, the first author also examined the participants' diagnoses, depression scores, and measures of engagement to see if there were meaningful similarities or differences that corresponded with the qualitative categories along the continuum of authenticity. Interestingly, these three qualitative categories did not correspond to meaningful differences in participants' diagnostic categories, severity of symptoms, or level of engagement with services.

Limited Support for Vulnerability

At one end of the continuum were those participants who described their relationships with close peers as limited in their ability to offer support. Past negative experiences led them to approach peer relationships with a fair amount of suspicion or anticipation of the potential for hurt or betrayal. These participant's descriptions of their close relationships with peers reflected feelings of shame (Brown, 2006), including questions about their ability to fully and authentically stay in relationship with others.

Angela explained in her interview that she does not like being friends with females: "I don't like girls. Girls like drama. Girls like to fight me. Every single friend I've had that was female has turned on me or has become something else, somebody that's not my friend."

Angela freely acknowledged her need for help and expressed frustration with her existing family and peer relationships: "sometimes people need help and I don't feel like going to strangers for help but I just feel like who I have in my life is not helping me right now." The lack of any relationships that offered a supportive space for her to be vulnerable was very painful for Angela, and made her wonder why sustained relationships seemed so elusive:

> That's why I just don't understand how it's so hard for me to have friends or have a good, happy relationship with somebody, but I think I just need to meet somebody that's more like me, and that's hard.

In the absence of supportive peer relationships, Angela described sometimes opening up selectively to strangers on the street.

Another participant, Rosie, also had difficulty identifying a close relationship in which she felt consistently supported. She mentioned one friend, and expressed doubt about her ability to continually rely on this friend:

> They're like consistently there to like give a hand, but then like I feel bad when I go to them too often because they've been dealing with it for years, and it's just like, it's not fair for them to like always have to be dealing with that, and they haven't been as supportive recently, just kind of silent. And very just like on for the ride, but not that helpful.

Similar to Angela's strategy of opening up to strangers, Rosie described feeling energized when she meets new people as opposed to spending time with people she has known for a long time:

> I thrive on new people… my friend, for example, who I've been friends with, they, I've been with them for so long, my brain doesn't have anything really new to come up with or whatever. …but when I meet new people, like I get an energy. I don't know why I get an energy. I don't know. Maybe showing off. Maybe because they're not quite sick of me yet.

Rosie's concern that others will tire of her reflects the concept of shame, a feeling of unworthiness of being in connection with others (Miller & Stiver, 1997).

A third participant, Ocean, was intentionally guarded in sharing information with her closest friends:

> I just necessarily like, I'm kind of like also very like private, like personal person in some ways. Maybe it's like being secretive, but like there are certain things I

just like don't tell anyone in general. So like there are certain things, yeah, like [Friend A] and [Friend B] don't know. Like it's not necessarily like I don't trust them. It's just I don't like feel like there's a need for me to tell them. I don't like feel like they need to know this about me or stuff like that, so.

When asked how she decides what personal information to share with her friends, she answered, "I think about how it's gonna play out." She elaborated:

> So like if they knew this piece of information, like it's kind of messed up how I think about it maybe. But like I always tell myself like okay, if they know this piece, piece of information of me, like what are the consequences from it, what are like, how would they react to it?

Ocean's concern was about a friend using her disclosure against her. She added that she was guarded in sharing information about her family and experiences with substance abuse with close friends, anticipating that others would not be able to understand the significance of her experiences.

> Yeah, like my addiction I like never really like, I know I've told [Friend] before, but I feel like, like I'll still like, if you don't know much about like how addiction works, like you're not gonna like take it as serious.

These statements also reflect a sense of caution around being authentic in relationships, as well as a questioning about whether she would be understood and accepted by her closest friends.

These participants reported high levels of engagement in treatment and showed a reduction in depression symptoms over three months (Table 2). Yet participants at this end of the continuum were more likely to describe strategies of disconnection in their relationships with peers. These are ways of relating that seek to preserve the relationship while keeping important parts of the self out of connection (Hartling et al., 2004). These strategies can be understood as reactions to experiences of shame or humiliation, but they also preclude authentic participation in relationships and can often lead to further disconnection (Hartling et al., 2004).

For example, Angela described one response to the disappointing actions of others was to try to keep to herself: "So I don't know, I just keep my thoughts to myself, I try to just stay to myself." She described how she stays connected to people in her life while maintaining a degree of emotional disengagement:

I love these people but they're just not the relationships that, that I'm looking for right now. It's not like I'll kick 'em out of my life or whatever or I ignore them or I just disregard them, it's just their relationship stands where it does and I know how to handle these people, they don't know how to handle me and I'm aware of that.

She also described herself as quick to end friendships that seemed likely to disappoint her: "When it's like friends and stuff, people I'm not related to, I really don't care."

These participants also described themselves as sometimes playing the role of caretaker or advice-giver with others. Rosie referred to a significant person in her life whose heartbreak eclipsed Rosie's own distress: "it was terrible having to take care of her when I'm feeling terrible." Angela also found herself caring for others in ways that was not reciprocated:

I care so much and I try to make everybody happy and it just makes me not happy. And my friend called me a people pleaser the other day and I said don't call me that. She's like, but that's what you are. Because I'm always trying to make somebody else happy and at the end of the day I'm always the one that's sad and nobody's ever there for me.

Ocean described herself as someone who likes to analyze and observe people ("I just like analyze a lot") and share her observations with others. She observed some patterns in a friend's behavior that concerned her and tried to point them out to her: "I always like try to explain to [friend] like and like, like hope that like she sees like what's wrong with that." But this kind of support is not mutual in her friendships; when asked her how her friends support her, she answered, "I never like really thought of anyone like supporting me." In each of these examples, the participants kept important parts of themselves out of connection by performing a role that kept them relating inauthentically.

Tentative Vulnerability

In the middle of the continuum of authenticity were participants who valued their ability to be honest and vulnerable with their best friends; at the same time, they expressed a considerable amount of wariness and hesitation in the process of assessing trustworthiness and making decisions about what and when to disclose. These participants also varied in the severity of their symptoms and their engagement in services (Table 2).

Several participants described themselves as generally guarded, but authentic and open in their relationship with their best friend. Francesca described a very close relationship with her best friend. She explained that one thing that sets this relationship apart from her other close friendships is her comfort with expressing strong emotions to her best friend. She explained that with other close friends, she often prioritizes understanding their feelings over expressing her own:

Like when I get into arguments with them, I still like try to remain, like, collected, like I'm very like da-da-da-da-da and like try to hear everything out… Even when I feel like they're not like listening to me as much. Like I'll like okay, but da-da-da. But then when I'm with her for example, like, like I'll be like, "No! This doesn't make sense! I don't understand!" and like I'm just very like, 'cause I guess I'm not like afraid to be angry around her, like I know it won't ruin our relationship, so like that's one thing. And I guess I'm also like not afraid to like just generally have like loud emotions, like really sad or really happy or like, or angry and like that's something.

Francesca admitted that she tested her friend's trustworthiness with a disclosure about a crush; when her best friend kept her secret, Francesca felt more confident in her ability to share secrets with her. Similarly, Flower described the uniqueness of her relationship with her best friend:

So me, like I said I'm not someone who trusts, like I don't talk to a lot of people and I don't trust a lot of people. There are some things where I always hesitate to tell her but I always end, like with her it's always like I'm comfortable, I literally just say my thoughts and I'd never done that before… I know she won't ever use it against me.

For Ashley, it took time for her to feel comfortable sharing personal information about herself with her friend:

It took me a while to like get to that point of comfort with her…Not because I wasn't close with her or I wasn't comfortable around her. That's just how I am, like I don't share everything with people.

Ashley explained that this friendship is especially meaningful because it has lasted several years:

Mostly the fact that we've known each other for so long, because I haven't had a friend that like stuck with me for this long… Or I've stuck with them for this long. So it's like it's new and it's important.

Jessica also described needing time to "get to a certain point to trust" her best friend. Their friendship deepened

when her best friend disclosed about her own anxiety: "she was telling me that she has anxiety and like oh my gosh, like I could connect to you because I also have anxiety." Another participant, Z, referenced her anxiety as a barrier to meeting other people. She met her best friend online and explained that "the reason why I made such a connection with her is because it's through the Internet, so we weren't like in person, so it was easier."

All of the participants in the "tentative vulnerability" category described relationships with close friends characterized by trust and understanding. However, for these participants, developing close, trusted relationships with peers was a gradual and often effortful process. Most of them described making conscious decisions about when and whether to disclose their emotional struggles with their closest friends. For example, Flower reported talking to her best friend "about almost everything… it's never gonna be like I tell her every specific detail." She also emphasized that she was not inclined to talk about her feelings with either her best friend or anyone else: "Like me, I'm never gonna like let my feelings out on someone else. I never do that, like I don't care who it is." Ashley confided in her best friend about her own distress, and admitted lingering ambivalence:
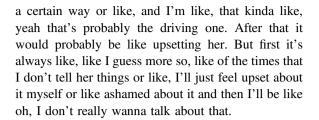
> So I was vulnerable, and I needed someone, and I knew that she would understand, so I shared everything with her…. Sometimes I'm like, "Maybe I shouldn't have shared everything," just because, again, that's just how I am, like I'm a very secluded person, but not because she made me regret it or anything. But it was also freeing to finally like let some of my anger and frustration out.

Francesca also described feeling conflicted about whether or not to confide her distress in her friend:

> But I was like, this happens all the time… like I talked about it a lot before, like I, like I shouldn't like talk about it anymore… I was like why am I telling her, like it just makes everyone upset, it makes me upset, it makes her upset, she's gonna worry… I didn't like tell her about it for a while, and like each day like I got like worse and like worse and like just more upset … eventually she could like see it and like then it was like time and like I was like bursting already and like I had to address it.

She admitted that it is a combination of shame and not wanting to upset her friend that kept her from talking about this sooner:

> No, I guess it's like in myself, like maybe I'll be like embarrassed of something that like, no I shouldn't feel

a certain way or like, and I'm like, that kinda like, yeah that's probably the driving one. After that it would probably be like upsetting her. But first it's always like, like I guess more so, like of the times that I don't tell her things or like, I'll just feel upset about it myself or like ashamed about it and then I'll be like oh, I don't really wanna talk about that.

These close friendships were often the one peer relationship in which participants felt comfortable being their authentic selves, and these relationships were cherished for that reason.

These participants also described patterns of inauthentic relating – in some cases, with friends other than their best friend. For example, Francesca described how she avoids expressing anger in most of her close friendships in an effort to preserve the relationship; she told me the "I'm-really-angry part's usually what I drop and like try to be calm and meditate" in disagreements with most of her friends.

Flower talked in both interviews about how she doesn't believe in relationships: "in general like, just me, I don't do relationships. I don't do any of that. Like I said, I don't open up, and I don't believe in love or like labels." Towards the end of our second interview, the first author asked her if she saw herself as selective in the way she related to people and she clarified:

> I'll always talk to everybody, I was never like oh, I don't wanna talk to this person, I won't, but it's just if you don't catch, like I just don't wanna get close, I don't wanna start a connection or a relationship you know, I'm very mutual with everybody and that's it….You know, like if I see you a lot, but that's only if it's with friends, like I know that's just a mutual thing. If you, I don't know, I just don't wanna have a lot of people in my life. I'm very like closed up, I guess and that's it.

For these participants, their tentative efforts at sharing their authentic thoughts and feelings in their closest relationships co-existed alongside more general experiences of guardedness with other peers.

Embracing Vulnerability

At the other end of the continuum of authenticity were those participants who described their peer relationships as essential to their well-being. They emphasized the importance of being authentic with their friends, whom they felt understood and supported them. In contrast to many of the other participants, their reports about these friendships did not include statements reflecting shame or questions about

their own worthiness of being in relationship with others. These participants were also quite engaged in treatment and reported relatively severe levels of depression (Table 2).

Lola described how when she was first becoming close with a good friend, they each talked about a major loss they had endured in their lives. The decision to be open with her friends about her struggles with mental illness came later in the friendship:

> I had a hard time opening up them about my mental illness. Originally like they knew I was very sad and they just assumed I had depression, but they didn't know like I had a mood disorder and they didn't understand why I had like PTSD and why there are days where I can go outside and I can be okay. But like, there are days when I can't go outside without someone being next to me or just can't go outside at all. And I think it happened where I had a really bad panic attack a couple – I think it was a year ago or so. And I was just really open with them. I was like this shit really sucks.

Lola admitted that it has historically not been easy for her to open up to others and trust people. However, her close-knit relationships with her small group of friends have shown her the value of being open, even about difficult subjects. She explained that there are no "off limits" topics amongst her and her friends:

> We're, I feel that we are a generation, like me and my friends, that are so, like, open about everything. Like we talk about sexuality, we talk about sex, we talk about politics. And there are people in our friend group that don't necessarily agree with the same things and we can get into arguments. But it's like it's such a powerful thing to be able to disagree with someone in a way that usually ends friendships… And it's things like that that make you really understand each other, because we talk about race, we talk about racism, we talk about like body issues. I feel like there's not really anything that's taboo with us, you know.

Like Lola, Yasmine also believed in the value of being honest and authentic with her close friends. She explained how she and her boyfriend maintain a policy about honesty:

> We have a policy and that is straight up honest. You know how people say honesty is the best policy? No, we straight up, if you're feeling not okay for a minute and you know it's gonna go away later telling people that you felt like that and you know, we just have to, we tell each other everything.

She explained that she trusts him because they have been open with each other about their emotions from the beginning of their relationship:

> I realized like if I can tell him anything like personally, like emotionally, I can tell him anything, you know…I'm already the most vulnerable when I'm talking about my emotions and things in my life like that.

Yasmine presented as a strong believer in the value of talking openly in trusted relationships: "'Cause like between the therapist and [boyfriend] and [friend], I'm just like I'll talk to anybody, I'll talk as long as I don't think I'm gonna hurt your feelings, I'll talk to you." Yasmine explained that she is not indiscriminate with her disclosures; for example, she does not talk about her depression with colleagues:

> You know, I go to work. And I don't tell them I'm depressed because I know they're judgy people. And if I tell them I'm depressed, they're not gonna understand, they're not gonna think I'm stupid, they're just not gonna understand…And they're gonna be like, what do we do with the information? There's no point in pressuring people.

But with friends, Yasmine believed fervently that "you can only gain a support system" by opening up to them:

> Yeah, and most people are understanding, you know, there's a, there's a, there's a brilliant human creation that's called the brain and it understands people and there's the heart, which understands on a deeper level, you know, and then people, people will get things. People aren't really mean, people are not mean.

Thefa also deeply valued her relationships with her close friends: "when I form a friendship with somebody, that's really important to me, and I'll fight to keep it." With her closest friends, "I mean, for the most part, though, I can share pretty much anything." She explained the connection for her between trust and honesty:

> If I can't be honest with you, it's really difficult to be your friend because I'm a very, you know, open and honest person and I, you know, say what I feel. I express my thoughts, and while I usually do it in like a kind way, like I never say to someone's face like "I hate you" or anything like that, I'd be like "Hey, this thing you did made me uncomfortable, but it's okay, just try not to do it again." You know, it's just, I feel like if there's no trust, there's no relationship. And that goes for like all relationships… And I think that's

why I'm able to make relationships so easily. It's 'cause my trust of, my ability to trust is very lax despite like, you know, the trauma and all the craziness that I've been through.

For these participants, their willingness to share their thoughts and feelings with their close peers was associated with a lack of shame around their experiences and past difficulties. Lola explained how she and her friends work hard to combat the stigma associated with mental illness:

Yeah, like my friend will say everyone has problems. Your problem doesn't make you any weirder – like, you're weird on your own – but it's like the problem doesn't make me. I make me.

Similarly, Yasmine reported that she does not feel ashamed of having depression:

And you know, like depression and like I've talked to different people who have depression, like my friends, so when I describe my depression to [my boyfriend], he's like oh, this sounds like this thing that I have, and it's just like, oh, this is like this thing that I had, which is like, it's kind of like a part of you. Like depression like, people say like it's (inaudible), you gotta get rid of it, I'm like it's something you deal with, if like people are angry, they deal with it. You're sad, you deal with it, you know, you have to learn parts of yourself. And it's like people who are afraid to say, "I am depressed", "I am sad", "I am angry" and things like that, then it's just like you're afraid to tell people who you are.

Yasmine described how her relationships with her friends have helped her become more confident in herself. Referencing a survey question about stigma, she elaborated:

I hang out with different people because like I think, like I saw one of the questions there like, do you think that if you open up to people then like they'll think you're stupid or whatever and I'm like no, because there's nothing wrong with what, like with being either depressed or like mentally ill or something, there's nothing wrong with that….It's not a weakness….No, if you open up to people, then they just understand you better.

The participants who embraced vulnerability with their close friends felt comfortable sharing their thoughts, feelings, and struggles with these friends, and perceived this authentic, supportive connection to be an essential component of their closest peer relationships.

Discussion

This study expands on the existing research confirming the importance of authenticity in close relationships for adolescents and young adults with mood and anxiety disorders. While most participants reported having at least one close friend, their experiences of these close friendships varied considerably. Participants' experience in friendships fell along a continuum of authenticity, in which some friendships supported vulnerability and authentic presence, while others were more likely to reflect inauthentic patterns of relating. Relationships characterized by limited support for vulnerability offered participants little to no experiences of mutual empathy, and so participants were disinclined to relate authentically. Participants described more examples of strategies of disconnection in these relationships, and often expressed feelings of suspicion about others or feelings of shame about themselves. In keeping with the tenet of relational-cultural theory that growth-promoting relationships are characterized by mutuality (Jordan, 2009), relationships that lacked mutuality were experienced by some of the participants as less fulfilling. Relational experiences characterized by tentative vulnerability reflected a combination of guardedness and a willingness to be authentic in relationship with one person, generally a best friend. These participants also described utilizing some strategies of disconnection in their close relationships. Among these participants, those friendships that allowed for authenticity were uniquely valued, particularly in contrast to other relationships characterized by more inauthentic relating. Finally, those participants who embraced vulnerability in their peer relationships expressed a strong belief in the value of authentic presence and supported vulnerability in their relationships with close friends. These participants also expressed relatively little shame about themselves and described a strong desire to be in connection with others.

The qualitative nature of these findings complements and adds nuance to the existing predominantly quantitative literature on friendships among adolescents with mood and anxiety disorders. Like the findings of Hauser and Allen (2006) on the protective effects of a strong relational orientation, these findings suggest that relationships that allow for authenticity and vulnerability play a key role for youth in living well with mental health difficulties. These findings also add texture to the research literature on authenticity in peer relationships, which has primarily used quantitative measures to evaluate theory (Impett et al., 2008; Theran, 2010). In addition, this study demonstrates the variations in experiences of authenticity with peers among a clinical sample of older adolescents and young adults. This study's emphasis on experiences of authenticity in relationships with peers fills a gap in the literature on the relational experiences of marginalized youth. Most of this

existing literature focuses on the relationships marginalized youth form with adults, generally service providers, rather than with peers (Sapiro & Ward, 2020). Relational-cultural theorists have identified authenticity as necessary for participation in growth-fostering relationships (Jordan, 2009) and scholars have demonstrated the importance of authenticity for youth relationships with service providers (Ahrens et al., 2011; Greeson & Bowen, 2008; Munson et al., 2010; Spencer, 2006). These findings expand on the existing literature by demonstrating the depth and range of authenticity marginalized youth can experience with peers.

These findings also contribute to the research on shame, stigma, and self-disclosure among young people living with mood and anxiety disorders (Black et al., 2013; Kranke et al., 2010; Venetis et al., 2018). The literature suggests that internalized stigma of mental illness can contribute to feelings of shame (Downs, 2012; Kranke et al., 2011), leading some adolescents and young adults to conceal aspects of their disorder or limit their interactions with others (Khesht-Masjedi et al., 2017; Kranke et al., 2010). These findings demonstrate the variability in how participants experienced and navigated concerns about vulnerability, self-disclosure, and feelings of shame. Echoing Downs (2012) and Brown (2006), some of the participants in this study had positive experiences with interpersonal openness and authenticity in their close relationships. The descriptions of relationships from these participants suggest that their experiences of authenticity and supported vulnerability in relationships helped them challenge feelings of shame and self-stigma (Brown, 2006; Downs, 2012). This also echoes a tenet of relational-cultural theory, which describes growth-fostering relationships as promoting self-knowledge and self-worth (Miller & Stiver, 1997). Other participants struggled more with decisions about how much personal information to disclose in their relationships with close friends, like in studies of youth with maltreatment histories (Eldridge et al., 2020; Morton, 2017; Steenbakkers et al., 2016). These participants were also more likely to describe patterns of inauthentic relating in relationships, known as strategies of disconnection (Hartling et al., 2004). Relatively few existing studies have documented use of these strategies in marginalized youth, including young women in a juvenile detention facility (Sparks, 2004) and adolescents taking psychotropic medications (Kranke et al., 2010). These findings suggest that authenticity and supported vulnerability are valuable in close friendships for marginalized youth, but in their absence, strategies of disconnection are likely to be present.

These findings contribute to the literature documenting the significance of positive connections with peers for marginalized youth living with mood and anxiety disorders (Czyz et al., 2012; Delgado et al., 2019; DiFulvio, 2011; Erath et al., 2010; La Greca & Harrison, 2005; Mead et al., 2001; Tew et al., 2012). For the participants whose friendships embraced vulnerability, their experiences echo the literature on the benefits of self-disclosure for concealable stigmatized identities (Corrigan et al., 2016; Weisz et al., 2016). Much of the literature on the relational experiences of youth with mental health challenges focuses on the negative impacts of stigma and mental health symptoms as barriers to connection (Bagwell et al., 2001; Downs, 2012; Gardner et al., 2019; Moses, 2010; Siegel et al., 2015). In a welcome contrast, some of the participants in this study with severe depression described positive, growth-promoting friendships characterized by authenticity. Similarly, the research on interpersonal trauma and relationships suggests that trauma survivors are likely to encounter difficulties with trust, intimacy, and fears of abandonment (Herman, 1992; Kulkarni, 2009). Most of the young women who participated in these in-depth interviews were trauma survivors. However, they reported a wide range of approaches to being in relationships with others. Some, like Rosie and Angela, seemed to prefer new or fleeting relationships to existing ones; they found talking with strangers easier and less painful than trying to relate to people they had known for a long time. Other participants (such as Thefa, Lola, and Yasmine) described strong, positive, and lasting relationships with peers, characterized by supported vulnerability and authentic self-disclosure about their own mental health challenges. These findings also contribute to the research on peer support (Mead et al., 2001), illustrating how healthy, supportive relationships with peers can strengthen the growth and development of young adults with trauma histories and mood or anxiety disorders.

Limitations

This study is subject to several limitations. The in-depth interviews with participants rely on self-reports, which can be limited by concerns about social desirability, biases in recall, and difficulties in describing and articulating interpersonal processes. Indeed, several participants referenced the idea that relationships are hard to talk about (for example, Flower: "You know what I'm saying? I don't know how to explain it.") Additionally, these interviews are limited by the extent to which participants were willing to share personal information with the researcher, a relative stranger. In some cases, respondents spoke freely about certain areas of their life experiences (such as their mental health histories) and were circumspect about other areas (most often family history). We addressed the expected reticence of participants by conducting two interviews with each youth participant. In general, participants were more engaged and more forthcoming during the second interview, which are the basis for this analysis.

Relationships are dynamic and ever evolving, meaning that any interview about a relationship is a snapshot in time from one person's perspective. Subsequent research on peer relationships would benefit from conducting in-depth dyadic interviews. The choice to focus on specific supportive relationships in the interview had advantages by inviting participants to reference specific people, but it also may not have provided a complete relational picture for many of these young people. In fact, several participants mentioned additional people in their lives that they wanted to discuss; some also explained that they had important people in their lives who were not necessarily supportive. Using interview questions focused on support meant that interviews were less likely to explore other relationships that were unhelpful, unhealthy, neutral, or complicated. Interviews were necessarily time-limited, which precluded the exploration of other dimensions of participants' identities, such as gender or racial identity, which may well have been relevant to the ways they navigated feelings of shame and vulnerability in relationships (Burke & Brown, 2021; Emslie et al., 2006). Additionally, these interview participants were all engaged in outpatient mental health services, and so the results of this study may be less applicable to the to the two-thirds of American young adults who live with mental illness without receiving treatment (IOM & NRC, 2014).

Implications

These findings have implications for both research and practice. Building on this study as well as existing scholarship (DiFulvio, 2011; Tew et al., 2012), future research should further explore the roles that close peer relationships can play for marginalized youth in supporting health, strengthening connection, and challenging stigma. Future studies should look more closely at participants' experiences with specific dimensions of marginalized identity (such as racial identity, sexual and gender identity, and trauma history), in order to better understand the role of authenticity in peer relationships. To better represent the diversity of this age group, future studies should also focus recruitment on those young adults not enrolled in college, as well as those not currently engaged in treatment. More in-depth studies could also draw on concepts from relational-cultural theory to investigate additional dimensions of growth-promoting relationships, as well as illuminating the dynamics of inauthentic relating (Miller & Stiver, 1997). A quantitative study with a larger sample could explore the factors associated with experiencing supported vulnerability in relationships with peers, leading to the development of measures for use in both research and treatment. More in-depth and longitudinal qualitative research could investigate the extent to which young people move along the continuum of authenticity and the factors that contribute to their

decisions to confide in one or more close friends. Echoing Buskirk-Cohen (2012), research could also inform the development of both prevention and intervention approaches that help friends effectively support each other with their mental health challenges. There is also a need for research on culturally responsive interventions focused on thoughtful self-disclosure and challenging both public and internalized stigma (Corrigan et al., 2016), particularly among marginalized youth. Given the inherent challenge in capturing the nuances of relationships through interviews, this topic would also benefit from the use of qualitative methodologies such as photovoice, case studies, and community-based participatory research.

Findings support the assertion of relational-cultural theory that authenticity and supported vulnerability are characteristic of growth-promoting relationships (Jordan, 2009), and are thus worthy topics for practitioners working with marginalized youth. In this study, level of depressive symptoms was not associated with the quality of participants' friendships as they described them. In general, these findings are a reminder for practitioners to avoid relying on diagnoses as heuristics for individuals' relational capabilities (Mead et al., 2001). Practitioners should not assume that clients with specific diagnoses or histories of trauma will necessarily struggle with close interpersonal relationships; rather, they should help youth reflect more critically on the role of relationships in their lives, assessing the quality of their peer relationships and exploring whether and when they choose to share details of their lives with others. Similarly, practitioners should explore clients' experience of stigma and shame in interpersonal relationships and consider how these might function as barriers to connection. There is also a need for more research on the ways that supportive peer relationships can be incorporated into treatment for mood and anxiety disorders. These findings suggest that young people could benefit from opportunities to connect with peers with lived experience, to counter both loneliness as well as the stigma around mood and anxiety disorders. Opportunities for authentic connection with trusted peers can help young people make meaning of their experiences (Steenbakkers et al., 2016), bolster their own emotional well-being (Brown, 2006) and counter oppressive discourses that perpetuate isolation, shame, and stigma (Jordan, 2009).

Compliance with Ethical Standards

Conflict of Interest The authors declare no competing interests.

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