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Mental illness disclosure in Chinese immigrant communities

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Abstract

Support from social networks is imperative to mental health recovery of persons with mental illness. However, disclosing mental illness may damage a person's participation in networks due to mental illness stigma, especially in Chinese-immigrant communities where social networks (the *guanxi* network) has specific social-cultural significance. This study focused on mental illness disclosure in Chinese-immigrant communities in New York City. Fifty-three Chinese psychiatric patients were recruited consecutively from two Chinese bilingual psychiatric inpatient units from 2006 to 2010. Two bilingual psychologists interviewed each participant once in a semi-structured interview, including 6 questions on mental illness disclosure. Conventional content analysis was applied to conceptualize the phenomenon. Results showed that participants voluntarily disclosed to a circle of people composed primarily of family and relatives. The decisions and strategies to disclose depended on participants' consideration of three critical elements of social relationships. *Ganqing*, affection associated with relationship-building, ultimately determined who had the privilege to know. *Renqing*, the moral code of reciprocal kindness, further influenced disclosure decisions and what participants anticipated as responses to disclosure. Lastly, concerns over preserving *face (lian)*, a construct representing personal and familial dignity, oftentimes prohibited disclosure. Additionally, in this tight-knit network involuntary disclosure could happen without participants' permission or knowledge. Participants commonly suffered from stigma after disclosure. However, half of our participants reported situations where they experienced little discriminatory treatment and some experienced support and care as a result of cultural dynamics. Recommendations for culturally sensitive practice to facilitate mental illness disclosure among Chinese immigrants were discussed.

Keywords

mental illness disclosure; Chinese/Asian-American; social network; stigma; schizophrenia

Disclosure of a stigmatized identity such as mental illness has a profound impact on a person's well-being. Research found that disclosing concealable identities can have positive

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(e.g., greater cognitive resolution, increased relationship closeness, and decreased feelings of isolation) and negative (e.g., increased trauma-related symptoms, loss of relationships, physical harm) consequences (Derlega, Winstead, Greene, Serovich, & Elwood, 2004; Gidron, Peri, Connolly, & Shalev, 1996; Lepore, Fernandez-Berrocal, Ragan, & Ramos, 2004). For people with mental illness, disclosure of a mental health condition may have benefits, such as increased self-esteem and decreased distress related to secrecy and self-stigmatization (Corrigan et al., 2010; Rüsch, Angermeyer, & Corrigan, 2005). However, a major concern and possible consequence of disclosure is mental illness stigma, which may exert its impact at community, societal, familial, and individual levels (Hinshaw & Cicchetti, 2000). People with mental illness may experience stigma from families, communities, coworkers, and mental health providers, and many tended to conceal their mental illness and were concerned about discriminatory treatment if discovered (Wahl, 1999). Moreover, as the public expresses desire for social distance from people with severe mental illness like schizophrenia, disclosure of the diagnosis is likely to have especially high social costs (Angermeyer, Beck, & Matschinger, 2003).

Mental illness disclosure in social network

Issues of mental illness disclosure have primarily been studied in the context of seeking professional help (e.g., Dewet al., 2007; Nguyen & Anderson, 2005; Prior, Wood, Lewis, & Pill, 2003) and workplace functioning (e.g., Brohan et al., 2012; Jones, 2011; Peterson, Currey, & Collings, 2011). Less research focuses on disclosure to people in one's social network. People may exercise selective disclosure (Corrigan & Rao, 2012) and be more open about their psychiatric diagnosis with doctors, parents, and friends than with employers or police (Pandya, Bresee, Duckworth, Gay, & Fitzpatrick, 2011). The responses from social networks may be paradoxical, simultaneously enacting social support in core networks yet initiating detrimental consequences among peripheral ties (Pandya et al., 2011; Perry, 2011). Because evidence shows that people with larger social network size and higher network satisfaction were more likely to experience mental health recovery than their counterparts (Corrigan & Phelan, 2004), understanding how disclosure of mental illness influences a person's relationships with existing social networks has crucial implications.

Significance of social networks in Chinese culture

Social networks within Chinese-immigrant communities have further social and cultural significance. Fei (1992) describes traditional Chinese society as consisting of "webs woven out of countless personal relationships" (p. 78). *Guanxi*, in particular, is a Chinese cultural construct that refers to a personalized network of people of any type of relationship who exchange support, resources, benefits/gains, and opportunities (Gold, Guthrie, & Wank, 2002). Guanxi, in other words, represents individuals' social capital and access to network resources (Yang & Kleinman, 2008). In this network-based society, family is the core of Chinese identity and the foundation of guanxi. Although family may narrowly refer to people connected by contemporary kinship ties, the idea of family also encompasses a wide range of relatives who are interconnected by blood and marriage over generations. The guanxi network extends from family and relatives, i.e., the inner group of the network, to

people in outer network groups (i.e., co-workers, co-villagers), as a result of the operation of guanxi.

The concept of guanxi involves not only interpersonal relationships and connections, but rules that guide proper interactions. Closely related ideas include *renqing*, *ganqing*, and *face*. Renqing refers to the moral code of interactions to extend care and compassion. Reciprocity of kindness is obligated as part of the moral code (Cheung et al., 1996). Ganqing refers to a subjective measure of affection or depth of feeling towards the other in an interpersonal relationship (Fried, 1953). Ganqing is usually built on mutual demonstration of renqing and growing feelings of liking and appreciation, which over time creates a basis of trust (Smart, 1993). People who are outside of the realm of family may acquire a family-like status via sustained performance of renqing and deep ganqing with members of a family. Face (lian) metaphorically refers to dignity (Earley, 1997). Chinese consider it a fundamental responsibility to preserve their and the family's face by upholding their reputation as a good and moral human being (Ho, 1976), which is also a prerequisite to participating in guanxi (Lai, Lo, Ngo, Chou, & Yang, 2012). The building of guanxi enables Chinese to access and mobilize resources (Yang & Kleinman, 2008). Table 1 summarizes these key concepts.

Guanxi in immigrant communities

Asians are the fastest growing immigrant population in the US, with 46% increase between the 2000 and 2010 censuses. Chinese-Americans, the largest Asian group, consist of 4 million people (Hoeffel, Rastogi, Kim, & Shahid, 2012). Among them, 486,463 resided in New York City (New York City Department of City Planning, 2012). Rooted in existing guanxi resources, the guanxi network continues to grow and extend its influence with migration and immigration (Christiansen, 2003; Hu, 2008). Studies have found that the guanxi network plays a significant role in Chinese migration both in China and overseas (Callahan, 2002; Hu, 2008; Lovett, Lee, & Raja, 1999; Rozelle, Guo, Shen, Giles, & Low, 1997; Zhang & Li, 2001). People in the guanxi network may help with preparation for migration, traveling, and settling after arrival, as evidenced by a study on domestic migration in China where more than three-quarters of the migrant workers were assisted by relatives and friends during their first trip out of their villages to other regions (Zhao, 2003).

Due to unfamiliarity with the host country and language barriers, many Chinese immigrants stay within their original guanxi network and gradually expand it. The guanxi network provides a foundation for immigrants' social and working lives. Many receive help with living arrangements, daily needs, or finding jobs from family friends, relatives, or people from the same hometown. Research has found that in Chinese immigrant communities, greater upholding of Chinese values was positively associated with stronger perceived availability of social support in time of need (Lee, Suchday, & Wylie-Rosett, 2012). Chinese also tend to remain connected with family and friends from the home country after immigration, as immigration is usually seen as family pride that enhances the social status of the family in the guanxi network, in both the home country and the host country (Lai et al., 2012).

Prevalence of mental illness among Chinese immigrants

The National Latino and Asian American Study (NLAAS), a nationally-representative study of Asian Americans, including Chinese, Filipino, Vietnamese, and other Asian American groups, estimated 17.91% lifetime prevalence of any mental disorder (i.e., affective, anxiety, and substance abuse; Takeuchi et al, 2007). NLAAS data also show that Chinese Americans specifically suffer from the highest lifetime prevalence of depression (10.1%) among Asian American groups (Jackson et al, 2011). However, due to unreliable assessment of psychotic disorders common to large-scale psychiatric epidemiology studies (Yang & Link, 2009), currently there is no adequate prevalence estimate of schizophrenia among Chinese Americans.

To gauge approximate prevalence, the National Institute of Mental Health (2013) reported that the prevalence of schizophrenia in the U.S. was 1.1% of the population age 18 and older in a given year, whereas 1-month prevalence of psychotic disorders in China was estimated . 95%, with 95% confidence interval .8%-1.1%, in four provinces (Phillips et al., 2009). Notably, migration is a risk factor for psychotic disorders. First-generation immigrants are 2.3 times more likely to develop a psychotic disorder when compared with native-born populations (Bourque, van der Ven, & Malla, 2011) and social stressors of migration, rather than selective migration of people with greater genetic risk, better explain the high risk (Selten, Cantor-Graae, & Kahn, 2007).

Mental illness in the Chinese cultural context

In Chinese communities, mental illness is widely stereotyped as unpredictable and dangerous (Phillips & Gao, 1999; Tsang, Tam, Chan, & Cheung, 2003) and thus having a mental illness is associated not only with incompetence, but failing to achieve full moral standing in adulthood (Yang & Kleinman, 2008). Culturally, mental illness is also believed to be a “payback” for moral wrongdoing of the individual or the family in a prior life (Stafford, 1995). As discussed above, familial reputation is tied to an individual’s social standing. The impact of psychiatric stigma thus is amplified due to personal obligation to preserve “face” of a family (Hampton, Yeung, & Nguyen, 2007; Shea & Yeh, 2008; Yang & Kleinman, 2008; Yang et al., 2007), and is experienced powerfully as a moral issue in which having a mental illness threatens fundamental social dignity of the person, the family, and associated guanxi network (Yang et al., 2007).

Also in this network-based culture, any information shared in the guanxi network may quickly be disseminated, because confidentiality is not held in high regard in this cultural context (Hampton et al., 2007). Disclosure of mental illness is thus a delicate decision. As a result of disclosure, the guanxi network as a whole might become shamed or devalued, and the person with mental illness might be shunned, banned, or discriminated against within that network as a defensive response (Yang et al., 2007). On the other hand, although less documented, disclosure within the social network may lead to positive results, such as bringing the family closer (Hampton et al., 2007).

Research questions

Given the significant impact of having mental illness on Chinese social relationships and dearth of research on mental illness disclosure in this particular cultural context, this study aims to examine the decisions, practices, and consequences of mental illness disclosure in Chinese-immigrant communities in New York City. Specifically, we aim to address three interrelated questions. First, how do Chinese immigrants decide to whom to disclose? Second, whether and how is the information transmitted across the guanxi network? Finally, what are the social consequences of mental illness disclosure in this network-based context? Through developing a general conceptualization of mental illness disclosure in Chinese-immigrant communities, we aim to enhance the understanding of cultural nuances of this phenomenon and to derive culturally sensitive practice recommendations for clinicians to facilitate decisions of disclosure and mental health recovery.

Methods

Recruitment and Participants

As part of a larger study, participants were recruited based on consecutive admissions from two Chinese bilingual psychiatric inpatient units in New York City from 2006 to 2010. Study protocols were approved by the institutional review boards of the medical schools at Columbia University, New York University, and the Mount Sinai Hospital. Eligibility criteria of participants included: a) Chinese birth or bilateral Chinese descent, b) Mandarin or English speaking, c) 18 to 50 years old, d) hospitalization within 1 month of interview, e) diagnosed with a psychotic-spectrum disorder via the SCID (Spitzer, Williams, Gibbon, & First, 1992) or the SCID-Chinese version (Kam, 2000; Yang and Link, 2009), and f) co-residing with relative after hospitalization. Participants' capacity to consent was first established by a psychiatrist not affiliated with the study. This was followed by complete description of the study and written informed consent. Fifty-three Chinese psychiatric patients participated in the study.

The average age of the participants was 34.3 (SD = 11.2) years. Thirty-four (64.2%) participants were men and 41 (77.4%) participants were not married. They had on average 9.8 (SD = 2.7) years of education. The average annual individual income is $7,870 (SD = 7,520) and 35 (66.0%) participants were unemployed. Thirty-five (68.6%, out of 51) participants reported having a religious affiliation. Moreover, 39 (73.6%) participants were born in Mainland China, 6 (11.3%) participants were born in Hong Kong or Macau, 4 (7.5%) participants were born in the U.S., and another 4 (7.5%) participants were born in other Asian countries. They had on average lived in the U.S. for 12.3 (SD = 11.8) years. Forty-four (83.0%) participants chose to use Chinese in the interview; the other participants used some or all English. Finally, 31 (58.5%) had schizophrenia; 12 (22.6%) had a schizoaffective disorder; 10 (18.9%) had other diagnoses (e.g., bipolar or depression with psychotic features, or psychosis NOS). The illness had lasted on average 8.5 (SD = 8.4) years, and the participants had experienced on average 4.9 (SD = 3.7) hospitalizations.

Data Collection

The last author and a bilingual psychologist interviewed each participant once in a semi-structured interview. Most interviews were conducted in Mandarin Chinese, verbatim transcribed, and then translated to English. This study focused on the question set addressing disclosure, which was based on the Subjective Experience of Medication Interview (SEMI; Jenkins et al., 2005). The first question asked, "Regarding your most recent hospitalization, do people know that you have been hospitalized? Do people know that you have this condition?" If participants answered yes, which all did, the interviewers proceeded with the following five questions: (a) did you tell other people or did the person find out by accident? (b) Do you feel that you are better off not telling people about this and why? (c) Are there certain people who you might tell and certain people who you might not tell? (d) If other people know, how do you think that they will view this or act towards you? (e) Does anybody act differently towards you because of your condition? Additional probes were asked to elicit examples, details, and clarification.

Analysis

Our study followed the postpositivist paradigm (Ponterotto, 2005) in that we believe that understanding mental illness disclosure from the Chinese immigrants' viewpoints is of utmost importance, rather than measuring it with a pre-existing theoretical framework. We aim to generate a nuance-rich cultural representation of the phenomenon. To that end, we adopted the conventional content analysis approach outlined by Hsieh and Shannon (2005). Conventional content analysis is often used to describe a phenomenon, in this case disclosure of mental illness in the Chinese immigrant communities, that has yet to be explored (Hsieh & Shannon, 2005). While unlike grounded theory that develops theory or phenomenological approaches that construct an in-depth understanding of lived experiences, conventional content analysis allows concept development and preliminary model building directly from the data (Lindkvist, 1981). This process does not involve preconceived theoretical perspectives, but uses inductive category development (Mayring, 2000). Therefore, this approach is particularly suitable for analyzing standardized semi-structured interview data to develop conceptualization of mental illness disclosure.

All three authors are bilingual in Mandarin Chinese and English, and have extensive clinical and research experiences with Chinese culture. This background allowed us the perspective to capture cultural nuances in mental illness disclosure. However, we were aware of the biases and assumptions that we brought in this study. As all three authors are well immersed in mental illness stigma research, we had expected that the extent to which disclosure occurs is likely to be confined to close family members. Moreover, we had assumed that mental illness disclosure will predominantly result in negative experiences for participants, as suggested in the stigma literature. Finally, all three authors have postgraduate education. We were aware that this social-economic privilege might result in great differences between our own experiences and the study participants' regarding the reliance of immigrant community resources, and therefore the significance of, and experience with, social network rules.

To enhance credibility of analysis, we adopted two procedures – peer debriefing and referential adequacy (Lincoln & Guba, 1985; Morrow, 2005). First, only the first and second

authors analyzed the transcripts for this study. The last author was later debriefed with the preliminary results. Second, to apply referential adequacy, we analyzed a first batch of two-thirds (36) of the transcripts to construct the preliminary results, which were later checked against the rest (17) of the transcripts as archived "raw data." Additionally, we kept an audit trail of analytical progression and developed a codebook to enhance dependability.

The process of conventional content analysis (Hsieh & Shannon, 2005) may be summarized into four steps. First, the researcher reads all data repeatedly to obtain a sense of the whole. Second, the researcher reads word by word and derives codes by highlighting words representative of key concepts. Third, with the assistance of note-taking on thoughts and initial analysis, the researcher merges and relabels codes to construct the initial coding scheme to be applied to all data. Finally, the researcher sorts the codes into categories and subcategories and organizes them according to their conceptual relationships.

To follow the procedure, the first author began by reading 12 transcripts from the first batch in their entirety to familiarize herself with the phenomenon from the participants' viewpoints. In the second step, the first author reviewed the 12 transcripts line by line to highlight key words and code concepts involved. For example, uncles and cousins were coded as "relatives." Another example, the statement, "He probably knows I am in the hospital because I have gone to his restaurant to eat or buy orders, so they all know about it," was coded with "suspected knowing," "acquaintance," and "prior regular contact."

In the third step, the first author compiled all of the codes and categorized them into four primary categories: guanxi (social) network, decisions and strategies regarding disclosure, involuntary disclosure, and social consequences of disclosure that captured the overall aspects of disclosure represented in the transcripts. For example, parents, relatives, and friends were categorized as guanxi (social) network; ganqing (quality of relationship) and renqing (moral obligation of reciprocity) were coded as considerations for decisions to disclose. With this initial coding scheme, the second author joined the first author and each independently reviewed and marked the same 36 transcripts (including the second author reviewing and confirming the coding of the 12 transcripts done by the first author). During this process, the two authors continued to modify the initial coding scheme based on emerging codes.

Finally, the authors further refined the scheme by merging codes to developing subcategories that represented different dimensions of a primary category. For example, the primary category guanxi (social) network" was divided into subcategories of network composition (people involved) and network operation (roles as the sender or receiver of information and geographic distance). The authors then reviewed across the primary categories and subcategories to finalize their conceptual relationships, and resulted in further integrated connections. Table 2 summarizes the transition from the refined coding scheme to the findings reported below.

The first two authors met on a weekly basis for two months to compare their coding, keep each other's presumptions in check, discuss disagreements, and integrate and revise the coding schemes as described. When compared with the rest of the transcripts, these

preliminary results were confirmed. When debriefed with the preliminary results, the last author confirmed the findings and provided feedback based on expertise and informal recollections from the interviewing process.

Results

Below we will report our findings in five sections. The first section, circle of confidence, reports the way that participants distinguished a group of people in the guanxi network to whom they tended to voluntarily disclose their mental illness. The second section, decisions and strategies regarding disclose, reports participant's decisions and tactics used to disclose or to disguise their mental illness. The third section, involuntary disclosure, reports involuntary disclosure that happened in the circle of confidence and outside of the circle, as well as in situations where participants suspected their mental illness had been discovered. The fourth section, social consequences of disclosure, identifies both negative consequences and support and care experienced by participants after disclosure. The final section, indifference toward disclosure and its consequences, reports participants who were not concerned about disclosure and its consequences, and identifies the characteristics of these participants.

Circle of confidence

Participants described a group of people with whom they usually granted the privilege of knowing their mental health condition and/or hospitalization. This group of people usually included a wide range of family members and relatives by blood and marriage (e.g., grandparents, uncles/aunts and their spouses and children, nieces/nephews and their spouses, and the spouse's family and relatives), mental health professionals, and close friends.

Analyses revealed a main finding that this circle of confidence did not exactly equate with the entire guanxi network as traditionally defined. The formation of this circle was based on the inner group of guanxi network (family and relatives), but *ganqing* and *geographic distance* generated exceptions. Participants generally believed that people with familial relations should be informed of their situation. One participant epitomized this view by stating, "There is no hiding and avoiding among us (family)." Participants granted the same privilege to people outside of family with whom they shared a deep level of ganqing (affection and trust), such as long-term hometown friends, co-workers with a longstanding friendship, selected clients/patients from the same mental health program/hospital, priests, or good friends from school and church. Finally, geographic distance also affected actual information sharing. Family members and best friends sometimes were not informed if they stayed in the hometown in Mainland China or lived a significant distance away (e.g., another state).

On the contrary, other people in participants' guanxi networks were not granted the privilege of knowing of the participant's mental illness status. These people included neighbors, restaurant servers, hometown acquaintances, friends of family members, and people at the workplace, treatment programs, or social groups (e.g., mahjong clubs and internet game groups). Most participants indeed reported few people they considered as close friends, and many fewer of these friends were made in the States.

Analyses thus indicated that the self-identified circle of confidence and appraisal of ganqing were two significant factors on participants' decisions about disclosure. These two factors were also related to how participants perceived the ways their mental health information was disseminated and experiences with the impact of disclosure.

Decisions and strategies regarding disclosure

Decisions and strategies to disclose—Participants primarily decided whom they voluntarily disclosed to on the basis of ganqing (affection and trust). Among family members and relatives who were in the inner guanxi network (network of social connections), participants especially allowed those with whom they had deep ganqing and whom they could reach (e.g., by phone or in person) to know not only about their illness but hospitalization as well. The importance of ganqing in these situations indeed superseded guanxi in the decision to disclose. For example, due to a strained relationship, a participant refused to speak with his brother about anything, including his illness, even though the brother was a member of the inner guanxi network. Similarly, relatives who had not been in contact (through visits, phone calls, etc. as expressions of ganqing), were usually not informed. Among people outside of the circle of confidence, participants were willing to disclose based on ganqing with those who had a similar mental illness experience, who could understand/were accepting of mental illness, and/or who were trustworthy and kind.

Based on renqing – the reciprocity obligation element in guanxi, some participants expressed that they anticipated support and care if they disclosed their condition. They expected that people would initiate contact to express care, comfort them, show sympathy, and make helpful suggestions (e.g., go see doctors and eat well). Some participants further articulated that they disclosed to these people because they wanted instrumental help in monitoring symptoms, as described below.

> [Family members] are safe, so I tell them. They would analyze for me which [thoughts] are realistic and which are unrealistic (when I have delusions). I would know and I would not be afraid.

> I had a feeling that I have been living in a dream and that I wanted to step out of that dream. … [Co-workers] do it (monitoring the participant's condition) because I request it… . They wanted to do it as long as I feel happy and I am comfortable.

Conversely, some participants' decision to disclose focused on both upholding renqing (moral obligation of reciprocity) and cultivating ganqing (affection and trust). A participant disclosed her illness to relatives who exhibited that they did not like her much in past interactions to show that she still cared about them, which exemplified her intent to honor relatives' privilege to know. Some participants spoke of their preference to disclose to someone with whom they would like to develop a genuine friendship or possibly an intimate relationship. Likewise a participant opted to disclose her illness during a job interview, anticipating the need to see the doctors during work days. Both situations illustrated the intent to maintain themselves as a truthful and moral being, virtues that are intrinsic to traditional Chinese cultivation, and to set a foundation for developing relationship and trust, even though they might risk the impact of stigma.

To initiate disclosure, participants usually phoned these people, sometimes as early as when their symptoms began to deteriorate. Participants sometimes strategized the disclosure, including only partially disclosing (e.g., leaving out psychosis), avoiding sensitive terms, or describing the condition as if telling jokes. A participant opted to ease into disclosure by starting with unimportant information and observing the person's non-verbal expressions. If that person showed signs of acceptance, she then discussed her illness more openly. She continued to observe the person's reaction after disclosure to evaluate its impact.

Decisions and strategies not to disclose—Participants likely decided not to disclose due to: (a) a sense of boundaries, (b) concerns of harming renqing, (c) concerns of losing face, and (d) anticipation of negative social consequences. Some participants seemed to intuitively draw an arbitrary line, thinking that only the inner group of the guanxi network-for some, this was represented by only immediate family members - needed to know about their illness. For people outside of this group, participants did not disclose unless directly asked. Participants considered a mental health condition to be a private issue, so there was no need to disclose to others, especially those with whom they were unfamiliar. They similarly discouraged their family members from sharing this information.

Moreover, participants sensed that sharing information of their mental health condition could burden others, so they decided not to disclose. For example, a participant did not disclose illness to his father, knowing the news would disturb and upset him, despite the father being a crucial member in the guanxi network. Participants also wished not to bother people because as dictated by rules of reciprocity in renqing, those who knew would be obligated to visit them or to help. Conversely, participants decided not to disclose if they anticipated a low likelihood of visitation or substantive help. Or, if participants anticipated troubles instead, such as gossip and the need to answer sensitive questions, they often opted not to disclose as well.

Furthermore, participants reported personal and familial concerns of losing face. Participants felt ashamed of having mental illness. Some family members and relatives also consider having a member with mental illness, especially one having the need for hospitalization, to be shameful, a reason to cause the family to lose face, and consequently strongly discourage participants to disclose the illness. A participant described,

> None of my other family members is sick except me… . I am not normal… . My uncle & aunt would feel I am shameful, losing face. [My uncle] does not have illness himself but I have it and I need hospitalization. I [should] not spend the government money. My uncle and aunt think [I] should not have this illness. It is better to get better; to recover and be healthy then everything will be fine.

Not to disclose thus averted loss of face and others feeling sorry for them. Others not knowing of the illness condition helped to preserve a positive image of self and a sense of normality. A participant reported that not disclosing her mental health condition helped protect her dreams of living a normal life.

> I would prefer to keep it (having mental illness) to myself… . because I want to be like other students going to school, to get a job, also able to communicate with them personally.

Finally, participants anticipated negative social consequences as a result of disclosure. For example, participants were concerned about alienation, rejection, and avoidance. They believed that these reactions resulted from false beliefs of mental illness as contagious, and stereotypes of people with mental illness being dangerous or violent. They were also concerned about difficulties in making friends. Moreover, participants anticipated changes in ganqing, such as gradually estranged friendships and not being able to be accepted as who they were without pity. Participants were also concerned about blatant discrimination against them, such as being looked down on, judged as imperfect or incompetent at work, being taken advantage of, gossiped about, insulted, or sexually harassed. They also worried that disclosure could cause the family to be threatened or affect family members' future work or marriage.

With no intention to disclose, some participants gave fictitious, benign explanations for their condition when asked. A participant used studying in another state to cover his disappearance due to hospitalization. Another participant told his wife and friends that he had headaches rather than mental illness.

Involuntary disclosure

Embedded in dynamics of the guanxi network, participants did not always have full control over disclosure. Sometimes participants were unsure whether or how people had been told of their mental health condition. Moreover, even if they wished not to disclose, the news could still spread to others. Such involuntary disclosure happened via vehicles described below.

Involuntary disclosure in the circle of confidence—People within the circle of confidence usually spread words among one another, with or without participants' permission. People who initiated information sharing tended to be those who were close (in regards to guanxi or geographically) to participants. They were relatively more involved in participants' lives than others in the circle and their intent was usually to inform and involve other family, relatives, and close friends. For example, family members who were first involved in crisis intervention sometimes called on other relatives to help.

As a result of how guanxi works, information sharing appeared inevitable in a tight-knit network with high physical proximity and frequent interaction. For example, a participant's wife helped their second son cook in the son's house and his brother's wife was also there to help. Moreover, the house was near their youngest son's place. Therefore, it was easy for the wife to share this information. In another example, the participant had told a close friend about her hospitalization. The friend ran into her cousin in the laundry room of the building in which they all lived and told her cousin of the news. In a third example, a participant's uncle stored things in the apartment where the participant and his parents resided. When the uncle came to retrieve his belongings, the parents told him about the participant's mental

illness. Finally, participants' mental health condition was most likely disclosed in close contacts with relatives during family events such as the Chinese New Year celebration.

While some families restricted information sharing to those within the circle of confidence, there were cases of sharing information with people outside of the circle to elicit help and support for participants. For example, a participant's wife told a friend so the friend could help her to visit the participant in the prison where he stayed at the time. As another example, a best friend of the participant shared the information with other friends within their shared social group to solicit support. Professionals in the mental health program that participants attended sometimes shared participants' hospitalization with other program attendees so they could send their best wishes for recovery.

Also due to the tight-knit community, sometimes people in the circle learned about the participant's situation from people outside of the circle. For example, a participant was recognized by a fellow villager during his hospitalization. That person spread the news and eventually the participant's cousin heard about his hospitalization from a customer in her manicure shop. Similarly, during hospitalization a participant was seen by someone who also knew his best friend. The participant gave the person his best friend's number to inform the friend about his hospitalization. Finally, a participant's fellow residents in a senior housing residence informed his wife about his hospitalization.

The disseminated information was likely limited regarding the extent of the condition or the level of detail. For example, the uncle of a participant told the participant's boss that she was ill, but the boss did not know that it was mental illness, nor did the boss know about the most recent hospitalization.

When asked about feelings resulting from involuntary disclosure, most participants were receptive to this type of information sharing when it remained in the circle of confidence or it was intended to solicit help and support. In some cases, however, participants were displeased. For example, a participant's mother told everyone in the family about the illness, despite the participant's disapproval. The participant worried that news could spread quickly and further affect her already perceived status of inferiority within the family. Some participants did not like to bother with reciprocity obligations associated with renqing, i.e., they did not wish to have visits from others or to worry others by the news.

Involuntary disclosure outside of the circle—Participants also reported their experiences with the spreading of their mental health condition among people outside of the circle. As a participant described, "They (neighbor and acquaintances) mostly all know about it. One [knows] and spreads [the news to] ten people and ten people spread it to one hundred people." This phrase was commonly used by individuals fearful of gossip. Participants oftentimes perceived the spread of words as maliciously intended and were concerned about its impact on their social standing. Additionally, the media occasionally became a channel broadcasting participants' mental health condition when a news-worthy crisis was involved.

Suspecting being found-out—In addition to direct communication, participants suggested that symptoms and changes in regularity of contact with others easily became "clues" in this tight-knit community that gave away their mental health condition. Participants were aware that their strange behavior and appearance could reveal their condition. To people with whom participants had regular contact (restaurant servers, mental health program attendees, etc.), their sudden absence could indicate illness and/or hospitalization, especially if combined with behavioral observation. Participants also suspected that police involvement in involuntary admissions could leave witnesses wondering about their mental health condition.

Social consequences of disclosure

Negative consequences—Some participants reported changes in their interactions with family and relatives that were initiated by the other party. Participants noted subtle differences in the way family members and relatives viewed and treated them, which made participants feel singled out as strange, dangerous, or requiring special attention. A participant shared his insights:

> Once my family members found out that I had this condition, they started to look at [me] funny… . They look at me like there might be something wrong with me… . They pay more attention to [me], looking at [me] like maybe [to] see if [I am] acting in a threatening manner.

Participants also noticed reduced contact by others and felt left out of their relatives' significant life events. For example, while the participant used to meet every girlfriend that his cousin had, he had not yet been introduced to the current girlfriend. Additionally, some participants reported more provocative treatment by their family members and relatives. For example, a participant described being criticized by her mother for weight gain and sleepiness that were in fact due to medication. Another participant experienced name calling during family events.

Some participants spoke about their experiences with alienation, rejection, and avoidance by people in general after disclosure. For some, avoidance was associated with people's fear of them. Moreover, participants shared experiences with acquaintances in which they were laughed at, despised, discriminated against, gossiped about, and bullied. A participant described:

> When they talk to me initially, most likely they are trying to find some stories about me. And sometimes there are people that try to provoke me, saying something bad… . They sometimes can even make you cry. I had experienced being scared like this by some people.

Experiences with support and care—Despite reports of negative experiences, approximately half of the participants reported situations where they did not experience differential treatment due to disclosure. These situations appeared to involve one of several protective elements. Participants described people who were supportive and understanding were those who also had mental illness or who normalized having mental illness, thinking that "Everyone has some form of illness." Some participants considered ganqing, such as

having a strong friendship, as key, as evident in a participant's expression, "Whatever I go through and whatever they go through, we are still friends." A participant believed that her friend's non-discriminatory attitude also came from the Christian faith.

Some participants further reported positive experiences with support and care associated with renqing. They noted family/relatives and friends came to visit them in the hospital, reminded them of taking medication, called to console them, sent regards and well wishes and more frequent greetings than before, or helped them financially. A participant was sponsored by her relative to join a social group after illness. Two reported that their employers made special arrangements to accommodate their hospitalizations.

Indifference toward disclosure and its consequences

Although most participants detailed the conditions of their disclosure decisions, some participants were not concerned about disclosure or being found out about their mental health condition or hospitalization. Or they reported no concern over consequences of disclosure. These participants tended to normalize having mental illness, as one participant stated, "Illness (of all forms) exists." They focused on receiving treatment and getting well, and ignored others' comments. They seemed to be characterized by having better progress toward recovery and reduced visibility of symptoms, or being able to work in competitive settings and being married. Retaining these core capacities facilitated their sense of normality despite having mental illness. Additionally, some participants were not concerned about treatment by people who they did not consider as significant to their guanxi network.

Discussion

Our findings delineate the complexity of decision-making on mental illness disclosure, as well as practices and social consequences of disclosure in Chinese immigrant communities. In the following discussion, we will highlight essential disclosure elements and elaborate on the cultural significance in the findings. We will also articulate implications for culturally sensitive practices to facilitate decisions of disclosure and mental health recovery.

Circle of confidence

This study bridges an important gap in the literature on mental illness disclosure to network individuals in the Chinese cultural context. Compared with models of decision-making on disclosure (Chaudoir & Fisher, 2010; Greene et al., 2012) that describe disclosing a health or mental health issue as an individual decision, our findings show that the decision to disclose mental illness in Chinese immigrant communities is greatly complicated by the unique guanxi network and its operational rules. Similar to the "onion skin" approach to disclosing distressful feelings in Chinese culture described by Ow and Katz (1999), our participants generally privilege members in the circle of confidence, composed predominantly by familial relations and ganqing. Indeed, sharing information is a way to acknowledge connectedness.

Decisions to disclose

The association between ganqing and decisions to disclose mental illness echoes research indicating quality of relationship as a significant factor in disclosure decisions in other cultural groups (Greene, 2009; Greene et al., 2012; Petronio, 2002). Better relationship quality is associated with more positive perceptions of anticipated response (Afifi & Olson, 2005; Greene et al., 2012; Petronio, 2002; Vangelisti, Caughlin, & Timmerman, 2001). Both relationship quality and positive anticipated response, in turn, are related to increased intentions or willingness to disclose (Afifi & Steuber, 2009; Caughlin & Afifi, 2004; Vangelisti & Caughlin, 1997). Our findings further contribute to the literature by identifying that the decision to disclose for Chinese immigrants also depends on renqing, the reciprocal responsibilities among people. Bonded by renqing, the circle of confidence provided a potential safety net for people in need of care. Some participants who made the decision to disclose intended to honor others with the privilege to know and to solicit help and support.

Decisions not to disclose

By the same token, however, participants sometimes decided not to disclose also for the concern of renqing. The mutually responsive and reciprocal nature of renqing creates a dilemma in balancing proclaiming closeness with one another and causing burdens to others, and may lead to seemingly contradictory disclosure decisions, depending on personal decisions in response to renqing. In Chinese culture expression of stress and emotion is oftentimes inhibited for fear of burdening their loved ones (Abe-Kim, Takeuchi, & Hwang, 2002; Ow & Katz, 1999). Knowing what would have to be given in return for the receipt of the information, participants likely decide instead not to disclose so as to not worry others. This phenomenon of renqing is evident in the study conducted by Lee and colleagues (2012). They reported counter-intuitive findings that Chinese immigrants who perceived low and medium social support were more successful in using coping strategies and had a lower cardiovascular response to stress. They suggest that people who do not perceive having support from others can focus on using their own coping strategies rather than being distracted by the impact of their problems on others and coping strategies suggested by their social circle. Essentially, social support perceived through the lens of renqing, because of its emphasis on reciprocity, has the potential to enhance anxiety and distress and to interfere with abilities to cope with stress.

Participants also reported concerns of losing face as a reason not to disclose, which confirms prior research indicating selective disclosure to non-family and intent to remain secretive of the mental health condition (Ow & Katz, 1999). The sense of failure in preserving the face of a family escalated the already devastating impact of mental illness stigma on the individual (Yang & Kleinman, 2008). Furthermore, stigmatization and anxiety over disclosure may cause emotional distress. A meta-analysis (Mak, Poon, Pun, & Cheung, 2007) found that stigma has an observable association with mental health. Across stigmatized conditions (e.g., mental illness and HIV/AIDS), stigma was found to have a stronger relationship with positive mental health indicators (e.g., self-esteem, quality of life, and happiness) than with negative ones (e.g., depression and loneliness). This pattern of relationships indicates that stigma has a slightly stronger impact on adjustment and growth than an exacerbating effect on psychological distress. These studies echo our findings in

which participants stayed away from disclosure due to concern of stigma in order to protect oneself and the family and preserve a space for their growth.

Involuntary disclosure

Our findings indicated situations where involuntary disclosure could happen due to dynamic, interactive communication of this tight-knit community. Personal information was not considered as individual but familial asset in Chinese culture and may be disseminated by family members. As a result, participants sometimes were unsure of whether people had knowledge of their mental health condition. Believing that people have knowledge of their psychiatric condition has long been identified as having negative effects on task performance. An early study (Farina, Gliha, Boudreau, Allen, & Sherman, 1971) shows that people with mental illness experience more difficulties with tasks and perform more poorly when they believe others are aware of their conditions. In addition, other people also tend to perceive them as more anxious and tense. More recently, Henry, von Hippel, and Shapiro (2010) suggested that social skill difficulties among individuals with schizophrenia may be exacerbated by their awareness that others know their mental health diagnosis. Moreover, gossip, as a vehicle for exercising moral judgment and labeling in Chinese culture (Gold et al., 2002), can easily cripple the standing of a person with mental illness and the family in social networks (Yang & Kleinman, 2008).

Social consequences

Consistent with prior research, our participants reported experiences with discriminatory treatment and mental illness stigma after disclosure. For instance, in a study conducted in Hong Kong, Lee and colleagues (2005) found that over half of their respondents with schizophrenia felt that they were of a lower social status because of their illness. Additionally, 40.6% of their respondents deliberately avoided most social contacts and 43.8% had thought of ending their lives. Likewise, impact of stigma potentially is severe and damaging to our participants.

On the other hand, possible gains of disclosure have not received equal attention. Our findings show that participants likely received much needed care and support from people within the circle of confidence should they choose to disclose. This result agrees with research investigating treatment received from people in social network after disclosure. In a cross-sectional survey study on a predominantly Caucasian sample, Pandya and colleagues (2011) found that about approximately 80% of participants reported being treated better or not being treated differently by parents, children, spouse/significant other and friends. Particularly, 34% of participants reported being treated better by their parents. Another study (Perry, 2011) focused on individuals at the initial stage of mental health treatment and found that the core group of supporters in the social network steps up to help in the face of crisis.

Practice Implications

To support Chinese immigrants with mental illness to navigate through the complex decision-making and consequences of mental illness disclosure, we recommend clinicians adopting culturally sensitive approaches to discussing disclosure issues and facilitating

disclosure if the person chooses to do so. Holmes and River (1998) provide strategies for disclosure decision-making and suggest Socratic questioning and cost-benefit analysis to determine the short- and long-term benefits of secrecy versus disclosure. We further suggest that when collaborating with Chinese immigrants on these decisions and conducting the cost-benefit analysis, clinicians attend to the influences of renqing (moral obligation of reciprocity), ganqing (quality of relationship) and face (personal and familial dignity), and explore the Chinese immigrant's personal assessment on these dimensions in relation to the particular individuals or groups in their guanxi network to whom they contemplated disclosure. Such an analysis should also take into consideration this immigrant group's often vulnerable position in society, and dependence upon their guanxi network for continued survival.

Clinicians' awareness of these cultural dynamics provides a new avenue by which clinicians may build on strengths of this network-based culture and help Chinese immigrants mobilize affective and instrumental support within their social networks. For example, clinicians can help them to identify suitable strategies such as reappraisal coping (positive reinterpretation or acceptance; Lee et al., 2012) to manage concerns of reciprocity obligations of renqing in disclosure. Clinicians can also educate family members about the potential harm of involuntary disclosure in order to minimize unnecessary distress and to support recovery.

In addition to facilitating mental illness disclosure, clinicians also need to attend to issues of mental illness stigma and discrimination following voluntary or involuntary disclosure. Possible interventions include helping Chinese immigrants to cope with stigma, empowering them to achieve their life goals, and encouraging them and their families to participate in anti-stigma programs (Gingerich, 1998; Larson & Corrigan, 2008; Yang et al., in press). Psychoeducation programs for Chinese immigrants also need to incorporate issues of stigma (Chan, Yip, Tso, Cheng, & Tam, 2009; Chien, Leung, & Chu, 2012).

Study limitations and future research

This study is the first study to our knowledge to elaborate nuances of Chinese culture that shape experiences and processes of mental illness disclosure. However, our study has several limitations. Our findings might only be applicable to Chinese immigrants who co-resided with family. Presumably, participants who lived with family after hospitalization might be more involved in a guanxi network centered on family and relatives. This might also lead to a greater pressure to attend to the face issue of the family, compared with those who did not live with family after hospitalization. However, this limitation may not affect our findings greatly, as approximately 90% of Chinese with severe mental illness are reported to live with family members (Phillips, Pearson, Li, Xu, & Yang, 2002). Likewise, our findings might only be applicable to Chinese immigrant communities. However, this study exemplifies how specific social/cultural norms might shape mental illness disclosure. Thus the study serves as a template for future research to explore meanings, rules, and operations of social networks in different cultural contexts, and how mental illness disclosure in these contexts may influence people with mental illness in the process of mental health recovery (e.g., Al-krenawi & Graham, 2000).

Also, the depth in developing certain concepts identified in analysis was limited to the available data. For example, we identified that participants tended not to disclose to members in the circle of confidence living far apart. Based on our cultural knowledge, we speculated that this phenomenon resulted from renqing concerns in that geographic distance created practical difficulties to materialize reciprocity. However, we were not able to confirm this speculation.

Moreover, we developed a general conceptualization of mental illness disclosure, which would benefit from further examination by using other research methods. Particularly, identifying prevalence of particular disclosure practices and the implications of such practices merits research in large samples in order to further our understanding of mental illness disclosure among Chinese immigrants. Likewise, research needs to explore sample characteristics and disclosure practices. Our data were derived from participants who varied greatly on several factors important to experiences of disclosure, such as years living in the US (mean= 12.3, SD = 11.8), duration of illness (mean = 8.5 years, SD = 8.4), and number of hospitalization (mean = 4.9, SD = 3.7). Presumably, variance in these factors helped to capture variations in disclosure, and therefore was advantageous to inductive concept development. However, to fully understand individualized practices of disclosure, future research needs to further examine certain sample characteristics, such as acculturation, English proficiency, and social-economic status that may alter opportunities of social participation. As Padilla and Perez (2003) stated, individuals experience different levels of involvement and attachment to the host culture and heritage culture during the acculturation process. Some choose to pursue participation in the new culture, while others choose to continue their attachment to the original culture. Therefore, these characteristics may alter the importance of guanxi, renqing, ganqing, and face to individuals in mental illness disclosure decisions and practices.

Furthermore, future research needs to deepen the understandings of both the positive and negative impacts of social networks on mental health recovery in order to simultaneously address impediments in the network and to promote its capacity to support mental health recovery. To that end, research needs to develop culturally relevant measurements to verify the effects of the guanxi network, and include mental health outcomes in disclosure research, such as experiences with depressive symptoms or acceptance and empowerment. Similarly, research needs to focus on whether or to what extent any guanxi network resource helps Chinese immigrants cope with mental illness and lower social isolation.

Finally, our study identified participants who were indifferent about disclosure and seemingly unaffected socially by disclosure. This preliminary finding suggests possible multi-faceted psychological and functional coping mechanisms used by these individuals. Future research is needed to further investigate the protective factors that may foster resilience to combat mental illness stigma in the Chinese cultural context.

Conclusions

Participating in and maintaining a respectable standing in one’s guanxi network is essential for an individual and the family within Chinese culture. To disclose a stigmatized mental

health condition to people in the network thus risks jeopardizing one's social and moral standing. Our study delineates a general conceptualization of Chinese immigrants' decisions and experiences with mental illness disclosure. Based on our findings, we highlighted the cultural nuances and elaborated on their social significance in Chinese immigrant communities. We hope that with an advanced cultural understanding, clinicians will be more effective in facilitating mental illness disclosure and mental health recovery of Chinese immigrants with mental illness.

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References

Abe-Kim J, Takeuchi D, Hwang W. Predictors of help seeking for emotional distress among Chinese Americans: Family matters. Journal of Consulting and Clinical Psychology. 2002; 70(5):1186–1190. [PubMed: 12362969]

Afifi TD, Olson LN. The chilling effect in families and the pressure to conceal secrets. Communication Monographs. 2005; 72:192–216.

Afifi TD, Steuber K. The Revelation Risk Model (RRM): Factors that predict the revelation of secrets and the strategies used to reveal them. Communication Monographs. 2009; 76:144–176.

Al-krenawi A, Graham JR. Culturally sensitive social work practice with Arab clients in mental health settings. Health & Social Work. 2000; 25(1):9–22. [PubMed: 10689599]

Angermeyer MC, Beck M, Matschinger H. Determinants of the public's preference for social distance from people with schizophrenia. Canadian Journal of Psychiatry. 2003; 48(10):663–668.

Bourque F, van der Ven E, Malla A. A meta-analysis of the risk for psychotic disorders among first- and second-generation immigrants. Psychological Medicine. 2011; 41:897–910. [PubMed: 20663257]

Brohan E, Henderson C, Wheat K, Malcolm E, Clement S, Barley EA, Thornicroft G. Systematic review of beliefs, behaviours and influencing factors associated with disclosure of a mental health problem in the workplace. BioMed Central Psychiatry. 2012; 12(11):1–14. [PubMed: 22230388]

Callahan, WA. Diaspora, cosmopolitanism and nationalism: Overseas Chinese and neonationalism in China and Thailand. City University of Hong Kong; Hong Kong: 2002. Southeast Asia Research Center Working Paper Series No. 35

Caughlin JP, Afifi TD. When is topic avoidance unsatisfying? Examining moderators of the association between avoidance and dissatisfaction. Human Communication Research. 2004; 30:479–513.

Chan S, Yip B, Tso S, Cheng B, Tam W. Evaluation of a psychoeducation program for Chinese clients with schizophrenia and their family caregivers. Patient Education and Counseling. 2009; 75(1):67–76. [PubMed: 18963721]

Chaudoir SR, Fisher JD. The Disclosure Processes Model: Understanding disclosure decision making and post disclosure outcomes among people living with a concealable stigmatized identity. Psychological Bulletin. 2010; 136(2):236–256. [PubMed: 20192562]

Cheung FM, Leung K, Fan RM, Song WZ, Zhang JX, Zhang JP. Development of the Chinese Personality Assessment Inventory. Journal of Cross-Cultural Psychology. 1996; 27:181–199.

Chien W, Leung S, Chu CSK. A nurse-led, needs-based psycho-education intervention for Chinese patients with first-onset mental illness. Contemporary Nurse: A Journal For The Australian Nursing Profession. 2012; 40(2):194–207.

Christiansen, F. Chinatown, Europe: An exploration of overseas Chinese identity in the 1990s. Routledge Curson; New York: 2003.

Corrigan PW, Morris S, Larson J, Rafacz J, Wassel A, Michaels P, Rüsch N. Self-stigma and coming out about one's mental illness. Journal of Community Psychology. 2010; 38(3):259–275. [PubMed: 23970807]

Corrigan PW, Phelan SM. Social support and recovery in people with serious mental illnesses. Community Mental Health Journal. 2004; 40(6):513–523. [PubMed: 15672690]

Corrigan PW, Rao D. On the self-stigma of mental illness: stages, disclosure, and strategies for change. Canadian Journal of Psychiatry. 2012; 57(8):464–469.

Derlega VJ, Winstead BA, Greene K, Serovich J, Elwood WN. Reasons for HIV disclosure/nondisclosure in close relationships: Testing a model of HIV-disclosure decision making. Journal of Social &Clinical Psychology. 2004; 23:747–767.

Dew K, Morgan S, Dowell A, McLeod D, Bushnell J, Collings S. It puts things out of your control: Fear of consequences as a barrier to patient disclosure of mental health issues to general practitioners. Sociology of Health & Illness. 2007; 29(7):1059–1074. [PubMed: 18092983]

Earley, PC. Face, harmony, and social structure: An analysis of organizational behavior across cultures. Oxford University Press; New York: 1997.

Farina A, Gliha D, Boudreau LA, Allen JG, Sherman M. Mental illness and the impact of believing others know about it. Journal of Abnormal Psychology. 1971; 77(1):1–5. [PubMed: 5100122]

Fei, X. From the soil: The foundations of Chinese society. University of California Press; Berkeley, CA: 1992.

Fried, MH. Fabric of Chinese society: A study of the social life of a Chinese county seat. Praeger; New York: 1953.

Gidron Y, Peri T, Connolly JF, Shalev AY. Written emotional expression in posttraumatic stress disorder: Is it beneficial for the patient? Journal of Nervous and Mental Disease. 1996; 184:505–507. [PubMed: 8752081]

Gingerich SL. Stigma: Critical issues for clinicians assisting individuals with severe mental illness. Cognitive and Behavioral Practice. 1998; 5:277–284.

Gold, T.; Guthrie, D.; Wank, DL. An introduction to the study of guanxi. In: Gold, T.; Guthrie, D.; Wank, DL., editors. Social connections in China: Institutions, culture, and the changing nature of guanxi. Cambridge University Press; New York: 2002. p. 3-20.

Greene, K. An integrated model of health disclosure decision making. In: Afifi, TD.; Afifi, A., editors. Uncertainty and information regulation in interpersonal contexts: Theories and applications. Routledge; New York, NY: 2009. p. 226-253.

Greene K, Magsamen-Conrad K, Venetis MK, Checton MG, Bagdasarov Z, Banerjee SC. Assessing health diagnosis disclosure decisions in relationships: Testing the Disclosure Decision-Making model. Health Communication. 2012; 27:356–368. [PubMed: 21992531]

Hampton NZ, Yeung T, Nguyen CH. Perceptions of mental illness and rehabilitation services in Chinese and Vietnamese Americans. Journal of Applied Rehabilitation Counseling. 2007; 38(2): 14–23.

Henry JD, von Hippel C, Shapiro1 L. Stereotype threat contributes to social difficulties in people with schizophrenia. British Journal of Clinical Psychology. 2010; 49:31–41. [PubMed: 19298685]

Hinshaw SP, Cicchetti D. Stigma and mental disorder: conceptions of illness, public attitudes, personal disclosure, and social policy. Development and Psychopathology. 2000; 12:555–598. [PubMed: 11202034]

Ho DY. On the concept of face. American Journal of Sociology. 1976; 81(4):867–884.

Hoeffel EM, Rastogi S, Kim MO, Shahid H. The Asian population: 2010. 2012 Retrieved from http://www.census.gov/prod/cen2010/briefs/c2010br-11.pdf.

Holmes PE, River PL. Individual strategies for coping with the stigma of severe mental illness. Cognitive and Behavioral Practice. 1998; 5:231–239.

Hsieh H, Shannon SE. Three approaches to qualitative content analysis. Qualitative Health Research. 2005; 15(9):1277–1288. [PubMed: 16204405]

Hu B. People's mobility and guanxi networks: A case study. China & World Economy. 2008; 16:103–117.

Jackson, JS.; Abelson, JM.; Berglund, PA.; Mezuk, B.; Torres, M.; Zhang, R. Ethnicity, immigration and cultural influences on the nature and distribution of mental disorders: An examination of major depression. In: Regier, D.; Narrow, W.; Kuhl, E.; Kupfer, D., editors. Conceptual Evolution of DSM-5. American Psychiatric Publishing; Arlington, VA: 2011. p. 267-285.

Jenkins JH, Strauss ME, Carpenter EA, Miller D, Floersch J, Sajatovic M. Subjective experience of recovery from schizophrenia-related disorders and atypical antipsychotics. International Journal of Social Psychiatry. 2005; 51(3):211–227. [PubMed: 16252790]

Jones AM. Disclosure of mental illness in the workplace: A literature review. American Journal of Psychiatric Rehabilitation. 2011; 14:212–229.

Kam, I. Dissertation for Part III Examination of Fellowship. Hong Kong College of Psychiatrists; Hong Kong: 2000. Development of the bilingual (Chinese/English) SCID-I (Structured Clinical Interview for DSA-IV Axis I disorder): A study of its reliability and validity in an in-patient population.

Lai GY, Lo G, Ngo H, Chou Y, Yang L. Migration, sociocultural factors, and local cultural worlds among Fuzhounese Chinese immigrants: Implications for mental health interventions. International Journal of Culture and Mental Health. 2012:1–15. iFirst.

Larson JE, Corrigan P. The stigma of families with mental illness. Academic Psychiatry. 2008; 32(2): 87–91. [PubMed: 18349326]

Lee S, Lee MTY, Chiu M, Kleinman A. Experience of social stigma by people with schizophrenia in Hong Kong. British Journal of Psychiatry. 2005; 186:153–157. [PubMed: 15684240]

Lee YSC, Suchday S, Wylie-Rosett J. Perceived social support, coping styles and Chinese immigrants' cardiovascular responses to stress. International Journal of Behavioral Medicine. 2012; 19(2):174–185. [PubMed: 21472482]

Lepore SJ, Fernandez-Berrocal P, Ragan J, Ramos N. It's not that bad: Social challenges to emotional disclosure enhance adjustment to stress. Anxiety, Stress & Coping: An International Journal. 2004; 17:341–361.

Lindkvist, K. Approaches to textual analysis. In: Rosengren, KE., editor. Advances in content analysis. Sage; Beverly Hills, CA: 1981. p. 23-41.

Lincoln, YS.; Guba, EG. Naturalistic inquiry. Sage; Beverly Hills, CA: 1985.

Lovett S, Lee CS, Raja K. Guanxi versus market: Ethics and efficiency. Journal of International Business Studies. 1999; 30(2):231–248.

Mak WWS, Poon CYM, Pun LYK, Cheung SF. Meta-analysis of stigma and mental health. Social Science & Medicine. 2007; 65:245–261. [PubMed: 17462800]

Mayring P. Qualitative content analysis. Forum: Qualitative Social Research. 2000; 1(2)

Morrow SL. Quality and trustworthiness in qualitative research in counseling psychology. Journal of Counseling psychology. 2005; 52(2):250–260.

National Institute of Mental Health. The numbers count: Mental disorders in America. 2013 Retrieved from http://www.nimh.nih.gov/health/publications/the-numbers-count-mental-disorders-in-america/index.shtml#RegierServiceSystem.

New York City Department of City Planning. NYC: Total Asian population by selected subgroups. 2012 Retrieved from http://www.nyc.gov/html/dcp/pdf/census/census2010/t_sf1_p9_nyc.pdf.

Nguyen QCX, Anderson LP. Vietnamese Americans' attitudes toward seeking mental health services: Relation to cultural variables. Journal of Community Psychology. 2005; 33(2):213–231.

Ow R, Katz D. Family secrets and the disclosure of distressful information in Chinese families. Families in Society. 1999; 80(6):620–628.

Padilla AM, Perez W. Acculturation, social identity, and social cognition: A new perspective. Hispanic Journal of Behavioral Sciences. 2003; 25(1):35–55.

Pandya A, Bresee C, Duckworth K, Gay K, Fitzpatrick M. Perceived impact of the disclosure of a schizophrenia diagnosis. Community Mental Health Journal. 2011; 47:613–621. [PubMed: 20703941]

Peterson D, Currey N, Collings S. “You don’t look like one of them”: Disclosure of mental illness in the workplace as an ongoing dilemma. Psychiatric Rehabilitation Journal. 2011; 35(2):145–147. [PubMed: 22020846]

Perry BL. The labeling paradox: Stigma, the sick role, and social networks in mental illness. Journal of Health and Social Behavior. 2011; 54(4):460–477. [PubMed: 22144733]

Petronio, S. Boundaries of privacy: Dialectics of disclosure. State University of New York Press; Albany, NY: 2002.

Phillips, MR.; Gao, S. Report on stigma and discrimination of the mentally ill and their family members in urban China. Report to the World Health Organization. 1999.

Phillips MR, Pearson V, Li F, Xu M, Yang L. Stigma and expressed emotion: A study of people with schizophrenia and their family members in China. The British Journal of Psychiatry. 2002; 181:488–493. [PubMed: 12456518]

Phillips MR, Zhang J, Shi Q, Song Z, Ding Z, Pang S, Wang Z. Prevalence, treatment, and associated disability of mental disorders in four provinces in China during 2001–05: An epidemiological survey. The Lancet. 2009; 373:2041–2053.

Ponterotto JG. Qualitative research in counseling psychology: A primer on research paradigms and philosophy of science. Journal of Counseling psychology. 2005; 52(2):126–136.

Prior L, Wood F, Lewis G, Pill R. Stigma revisited, disclosure of emotional problems in primary care consultations in Wales. Social Science and Medicine. 2003; 56:2191–2200. [PubMed: 12697207]

Rozelle, S.; Guo, L.; Shen, M.; Giles, J.; Low, TY. Poverty, networks, institution, or education: Testing among competing hypotheses on the determinants of migration in China. Paper presented at the Annual Meeting of the Association for Asian Studies 1997; Chicago, IL. 1997.

Rüsch N, Angermeyer MC, Corrigan PW. Mental illness stigma: Concepts, consequences, and initiatives to reduce stigma. European Psychiatry. 2005; 20:529–539. [PubMed: 16171984]

Selten JP, Cantor-Graae E, Kahn RS. Migration and schizophrenia. Current Opinion in Psychiatry. 2007; 20(2):111–115. [PubMed: 17278906]

Shea M, Yeh CJ. Asian American students’ cultural values, stigma, and relational self-construal: Correlates of attitudes toward professional help seeking. Journal of Mental Health Counseling. 2008; 30:157–163.

Smart A. Gifts, bribes, and guanxi: A reconsideration of Bourdieu’s social capital. Cultural Anthropology. 1993; 8(3):388–408.

Spitzer RL, Williams JB, Gibbon M, First MB. The Structured Clinical Interview for DSM-III-R (SCID). I: History, rationale, and description. Archives of General Psychiatry. 1992; 49:624–629.

Stafford, C. The roads of Chinese childhood: Learning and identification in Angang. Cambridge University Press; Cambridge, UK: 1995.

Takeuchi DT, Hong S, Gile K, Alegria M. Developmental contexts and mental disorders among Asian Americans. Research in Human Development. 2007; 4:49–69. [PubMed: 20150976]

Tsang HW, Tam PK, Chan F, Cheung WM. Stigmatizing attitudes towards individuals with mental illness in Hong Kong. Journal of Community Psychology. 2003; 31(4):383–396.

Vangelisti AL, Caughlin JP. Revealing family secrets: The influence of topic, function, and relationships. Journal of Social and Personal Relationships. 1997; 14:679–705.

Vangelisti AL, Caughlin JP, Timmerman L. Criteria for revealing family secrets. Communication Monographs. 2001; 68:1–27.

Wahl OK. Mental health consumers’ experience of stigma. Schizophrenia Bulletin. 1999; 25(3):467–478. [PubMed: 10478782]

Yang LH, Kleinman A. “Face” and the embodiment of stigma in China: The cases of schizophrenia and AIDS. Social Science & Medicine. 2008; 67:398–408. [PubMed: 18420325]

Yang LH, Kleinman A, Link BG, Phelan JC, Lee S, Good B. Culture and stigma: Adding moral experience to stigma theory. Social Science & Medicine. 2007; 64:1524–1535. [PubMed: 17188411]

Yang LH, Lai G, Tu M, Luo M, Wonpat-Borja A, Jackson V, Dixon L. A brief, anti-stigma intervention for Chinese immigrant caregivers of individuals with psychosis: Initial findings. Transcultural Psychiatry. (in press).

Yang LH, Link BG. Comparing diagnostic methods for mental disorders in China. The Lancet. 2009; 373(9680):2002–2004.

Zhang, X.; Li, G. EPTD (Environment and Production Technology Division) Discussion Paper No. 74. International Food Policy Research Institute; Washington, DC: 2001. Does guanxi matter to nonfarm employment?.

Zhao Y. The role of migrant networks in labor migration: The case of China. Contemporary Economic Policy. 2003; 21(4):500–511.

Table 1

Key concepts in Chinese social network

Concept	Definition
Guanxi	• A personalized network of social connections • Representing individuals' social capital and access to network resources • Extending from family and relatives (the inner group of the network) to people in outer network groups (e.g., co-workers & neighbors)
Renqing	• The moral code of interactions to extend care and compassion • Reciprocity of kindness as obligation in social interactions
Ganqing	• A subjective measure of affection or depth of feeling towards the other in an interpersonal relationship • Built on mutual demonstration of renqing and growing feelings of liking and appreciation, which over time creates a basis of trust
Face/Lian	• Considered as a fundamental responsibility for Chinese to preserving their and their families' face by upholding their reputation as a good and moral human being • Viewed as a prerequisite to participating in guanxi

Table 2

Outline of analysis

Refined Coding Scheme	Findings
Guanxi network (social network) *Composition* Family/spouse Relative Friend Neighbor/acquaintance *Operation* Role as sender/receiver of information Geographic distance	**Circle of confidence** (Integrating observed conceptual interactions between the **guanxi network** category and *decision to disclose* subcategories)
Decisions and strategies regarding disclosure *Decisions to disclose* Ganqing (affection and trust) Renqing (moral obligation of reciprocity) *Strategies to disclose* Taking initiative Partially disclosing Avoiding sensitive terms Describing the condition as jokes Formulating a stepwise process *Decisions not to disclose* Sense of boundaries Renqing Face Anticipating negative social consequences *Strategies not to disclose* Giving fictitious excuses when asked *No concern of disclosure* Normalizing illness Illness has been a chronic condition	**Decisions and strategies regarding disclose** *Decisions and strategies to disclose* *Decisions and strategies not to disclose* (Integrating reports of *decisions and strategies to disclose* or *not to disclose*, and their observed conceptual interactions with the **guanxi network** category)
Involuntary disclosure *Confirmed disclosure* Identified messenger Physical proximity Involved in help and support Family events Limited release of information Reactions to involuntary disclosure *Suspected disclosure* Behavioral symptoms Contacts (frequency/regularity) Police involvement	**Involuntary disclosure** *Involuntary disclosure in the circle of confidence* *Involuntary disclosure outside of the circle* *Suspecting being found-out* (Integrating observed conceptual interactions between the **involuntary disclosure** category and the **guanxi network** category)
Social consequences of disclosure *Negative consequences* Alienation, rejection, avoidance Being looked at/treated differently Change of relationship quality Being criticized, laughed at, gossiped about Being despised, discriminated, bullied *No differential treatment* Ganqing Renqing *No concern of consequences* Focusing on oneself Normalizing illness Less severe symptoms Demonstrating capabilities of living a “normal’ life Sense of boundaries	**Social consequences of disclosure** *Negative consequences* *Experiences with support and care* (Integrating reports of *negative social consequences of disclosure* and *no differential treatment*, and their observed conceptual interactions with the **guanxi network** category)

Refined Coding Scheme	Findings
	Indifference toward disclosure and its consequences (Integrating reports of *no concern of disclosure and no concern of consequences*)

Note: Bold font indicates primary categories; italic font indicates subcategories; regular font indicates codes