

TO TELL OR NOT TO TELL:
FACTORS IN SELF-DISCLOSING MENTAL ILLNESS IN OUR EVERYDAY
RELATIONSHIPS

by

Nicole Marie Robinson
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Committee:

G. L. K.

Director

[Signature]

Don M. Beckman

[Signature]

G. L. K.

Department Chairperson

Paul H. Bolton

Program Director

[Signature]

Dean, College of Humanities
and Social Sciences

Date:

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By

Nicole Marie Robinson
Master of Science
Rochester Institute of Technology, 2008

Director: Gary L. Kreps, University Professor
Department of Communication

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Fairfax, VA

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DEDICATION

This work is dedicated to my beloved grandparents Cleophas and Lelia Land, my dearest uncle, Eugene Davis, and the millions who are affected by mental illness. In your darkest hour, know that I care and that you are loved.

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ABSTRACT

TO TELL OR NOT TO TELL: FACTORS IN SELF-DISCLOSING MENTAL ILLNESS IN OUR EVERYDAY RELATIONSHIPS

Nicole Marie Robinson, PhD

George Mason University, 2012

Dissertation Director: Dr. Gary L. Kreps

Kreps (2001) notes an interpersonal dimension to health where there are relational influences to health outcomes. These interactions are further complicated by culture, as various cultures have differing cultural perceptions about mental illness. These perceptions ultimately affect how one communicates (Dutta & Basu, 2008). This study combines Communication Privacy Management Theory (Petronio & Dunham, 2008) which provides a foundation for how people manage and share information, along with Orbe's (1998) Co-Cultural Theory which shows how positions of power between dominant and marginalized group members affect communication practices, to explore co-cultural differences in self-disclosure of mental illness.

In this study, 314 participants who were either disclosers of a mental health diagnosis or recipients of a mental health diagnosis took part in a web-based survey on communicating mental health. Results showed that regardless of co-cultural status, both White and non-White disclosers shared their diagnosis either through direct (straight-forward) communication or by explaining their diagnosis or treatment. Recipients also found out through prior knowledge or observation

(either by observing the discloser's behavior or because they were told by someone else). White and non-White participants also listed similar reasons for disclosing, and similar responses by recipients.

However, while ethnicity or co-cultural status did not play a role in how one decided to tell, there were significant differences between Whites and non-Whites on ethnic effects on choosing to self-disclose and recipient responses to that disclosure. In this instance, non-Whites were more likely than their White counterparts to note that their ethnicity played a role in choosing to disclose or in how they reacted to the disclosure. They cited cultural customs and beliefs as reasons for why they felt ethnicity affected disclosure. Thus, it is implied that co-cultural status does in fact play a role in self-disclosure of a mental illness, and that the stigma of mental illness among various cultural groups is still present.

CHAPTER 1

Introduction

Interpersonal health communication acknowledges an interpersonal dimension to health, as communication about health ultimately affects our relationships with others. Interpersonal health communication inquiry examines relational influences on health outcomes (Kreps, 2001) as communicating about health changes the relational interactions between interactants. For example, telling a partner you have depression allows for the partner to either reject you or offer support. It may allow for the understanding of depression as a disease, or it may open the door for insensitive remarks which may be detrimental to the relationship.

Disclosing about depression to a loved one may also affect how that person treats you moving forward in the relationship, such as taking on the role of comforter when that person senses your emotions are low. Thus, “health is a key component of relational roles” (Duggan, 2006, p. 94). So, health communication on an interpersonal level not only has the potential to change our relationships, but also defines the roles we play in those relationships as we gain personal knowledge about a relational partner’s physical and mental health.

Duggan (2006) notes, “interpersonal communication processes are central to the patient-provider interactions and in relationships with someone who is ill or needs care,” (p. 93). Thus, the relationship between patient and loved one is maintained through interpersonal communication. These interactions influence the understanding of the problem, treatment, likelihood of the patient to follow treatment, and the recovery process (Duggan, 2006). Thus, exploring these interactions using interpersonal communication theory may help us explain, predict, or further understand human behavior and health outcomes.

These interactions are further complicated when we consider culture and differing ethnic backgrounds. In particular, differing cultural perceptions of mental illness may affect how one communicates to others about a mental health issue. In this sense, culture is a dynamic communicative process that consists of socially constructed meanings. It can be looked at as the living framework of individuals and their collectives—a process of learning, evolving, orienting, thinking, and adapting (Dutta & Basu, 2008). Thus, the process of how people communicate about their health, and the meanings they bring to their health issues, is directly tied to their cultural background. So, how individuals choose to self-disclose a mental illness diagnosis may be related to their culture's beliefs about what constitutes a mental illness, how that mental illness should be treated both within the professional and nonprofessional realms, and how society should respond to the mentally ill. Hence, cultural beliefs and cultural understandings may be related to how individuals disclose to loved ones that they are suffering from a mental illness.

This process is also affected by racial status in society. Allen (1997) mentions that race matters in a communication interaction because marginalized groups are more aware of racial issues when communicating than Whites. For instance, marginalized groups are more aware of racial discrimination, whereas Whites tend to imply that race is not important. Where marginalized group members see race as a factor that may possibly work against them, Whites often see racism as a thing of the past. Thus, this study hypothesizes that marginalized or non-dominant group members will disclose a mental illness and react to a mental health diagnosis differently than Whites. Mainly, this may be because marginalized group members take into account race when self-disclosing in addition to the stigma of mental illness.

Allen's (1997) assumptions about race and communication suggest that marginalized groups may disclose information about mental health problems less often than Whites. This assumption is particularly true concerning disclosures to members outside of the family

(Williams, 2008). Essentially, marginalized group members' awareness about race may make them more hesitant about disclosing a stigmatized disease to others. They may have learned at a young age not to disclose personal information or talk about subjects that may serve to further marginalize them in society (Boyd-Franklin, 1989). Thus, marginalized groups may self-disclose differently than Whites, who would not be expected to see race as an issue when communicating about their mental illness.

Problem Statement

While some literature in the social sciences examines self-disclosure of a mental illness, there is a need for more research on how those with a mental illness self-disclose this information to their loved ones. One major study conducted by Hyman (2008) through the Substance Abuse and Mental Health Services Administration, looked at the impact of self-disclosure on those who received mental health services. In this study, interviews were conducted to examine factors that promote or hinder self-disclosure in light of the stigma towards those with a mental illness. The researcher found that given the possibility of rejection and discrimination, most disclosers revealed that self-disclosure had a positive impact on their lives. In addition, it was found that the psychological relief caused by self-disclosing outweighed the risks involved. Questions posed from Hyman's (2008) research provided a foundation for the development of this study's survey instrument.

Specifically, more research is needed on how culture or marginalized group (co-cultural) status influences how individuals share their mental health diagnosis with others, and how this disclosure is received by loved ones. Zheng & McDermott (2007) attempt to examine cultural differences in preferences for self-disclosure of schizophrenia, however, this study was based upon their reported responses to a hypothetical scenario. Participants were asked if they would disclose to a loved one if they were in the character's shoes. Researchers found that there were

differences in preferences for disclosure between the Chinese and U.S. participants. Thus, one conclusion drawn from this study showed that there may be differences in self-disclosure methods among differing cultural groups (Zheng & McDermott, 2007). Furthermore, Williams' (2008) book on self-disclosure of mental illness among African Americans discusses how Blacks handle mental illness given the stigma that surrounds the mentally ill within their community. Due to the absence of scholarly sources on cultural differences in self-disclosure of mental illness, Williams (2008) was heavily relied on in this study. Although Williams (2008) is considered a popular press or non-scholarly source, Williams' personal accounts can be considered highly credible.

Thus, this proposed study will examine methods of self-disclosure among the mentally ill by defining these participants as members of a co-cultural group who are constantly managing whether or not to disclose their personal information regarding their mental health status. This is because the stigma of mental illness causes the mentally ill to be ashamed and embarrassed, ultimately placing them as marginalized or co-cultural group members in comparison to the mentally healthy majority. The embarrassing aspects of public perceptions about mental illness are likely to influence if and how someone with a mental illness chooses to self-disclose (Corrigan, 2010).

In addition, this study acknowledges that an individual's position in the dominant society as a co-cultural or non-dominant member due to race may add a new dimension to understanding if and how that person self-discloses a mental health disorder. Thus, race may become an additional co-cultural factor to self-disclosure. Therefore, racially marginalized group members with a mental illness may be less likely to self-disclose due to their marginalized mental health status and racial affiliation than Whites (Allen, 2007). In addition, non-dominant status may affect how a recipient chooses to respond to someone with a mental illness. It is because certain

ethnic groups are marginalized in society, that they become double co-cultural groups when they also suffer from a mental illness. Hence, they may be more hesitant to further marginalize themselves by disclosing their mental health status. In this respect, these group members may self-disclose a mental illness differently than their White counterparts.

Given this hypothesis, this study examines how the mentally ill decide to self-disclose, and what feedback they receive as a result of their disclosure. This research also examines how those who are recipients of a disclosure recall the interaction, as well as how they responded. Lastly, this study looks at whether or not individuals with mental illnesses who are members of racially marginalized groups as double co-cultural members in society disclose their mental illness differently than Whites who are only marginalized by mental health status.

To fully understand this phenomenon, we must first define mental illness, explain the various types of mental illnesses, describe the relationship between culture, race/ethnicity and mental illness, further explain the concept of self-disclosure, as well as describe how co-cultural status may influence how one talks about and responds to a mental illness disclosure.

Importance of Study

Since the stigma of mental illness causes those afflicted to communicate very little about their disease, more research is needed on how people talk about their mental health issues to loved ones. This is particularly the case for non-dominant group members, as they are reluctant to discuss mental health issues in general, as well as accept the fact that mental health problems could occur among members of their own cultural group (Burnette, 2011). For instance, Blacks may be aware of suicide and depression, but they refuse to talk about it. Thus, there is a growing need for research that examines the factors that influence disclosure about a mental health diagnosis to identify key characteristics that hinder or facilitate these health-related discussions. This is important because by knowing what factors promote or prevent disclosures, we can better

help those with a mental illness open up more about their disease, and inform recipients about supportive measures they can take upon hearing this news.

It is also imperative that research is conducted about how people with a mental illness communicate to their loved ones. This knowledge can assist health communicators in developing campaign and message strategies that can be used to help individuals speak up about their disease, ending the silence that is a result of the attached stigma to having a mental illness. It can also assist health communicators in eliminating communication barriers that may hinder those from seeking help for a mental illness.

Research regarding differences in how marginalized groups talk about mental illness versus dominant group members may be used to assist health communicators in helping empower non-dominant society members to speak up about their disease, which may encourage them to seek help and guidance. Since perceptions of mental illness may differ between dominant and co-cultural group members, it would be wise to study how these perceptions influence mental health disclosure interactions. Such studies can help increase both understanding and awareness regarding how marginalized status influences communicating diseases on an interpersonal level, and how this relates to overall health outcomes.

Theoretical Framework: Communication Privacy Management Theory

Communication Privacy Management Theory (CPM) attempts to describe how individuals reveal and conceal private information. The theory states that disclosure or the process of revealing private information is always in tension with the tendency to want to conceal information. Since disclosing and not disclosing are in a dialectic tension with each other, revealing and concealing information is carefully managed (Petronio & Durham, 2008).

There are six major principles or maxims associated with managing private disclosures according to Communication Privacy Management (CPM) Theory. The first three are assumption

maxims, and the last three are interaction maxims. The first assumption maxim states that the process of disclosure is dialectical in nature, meaning we want to reveal and conceal information at the same time. The second assumption maxim states that we have a concept of privacy where we look at our private information in terms of a possession. We own our private information, and thus we can do with it as we please (including not sharing this information with others). The last assumption maxim states that because we have this conceptualization of private information, we set up privacy rules for regulating the flow of information that we find private (Petronio & Durham, 2008). Ultimately, we decide who and what to tell.

The interaction maxims include the idea of shared boundaries. This maxim states that when we disclose private information, this changes the nature of the information in that it is no longer solely owned by us. In sharing personal information, one makes the other person co-owner of that information. Thus, the next maxim discusses coordination rules, where we explain the rules of how our information is to be discussed with others. It is because the other person becomes co-owner of our private information that we must coordinate with that person how our information is to be handled. In other words, we talk to the other person about our expectations and the rules for handling our information. The other person may be asked not to share our information, or not to tell specific people. When a person violates these coordination rules, boundary turbulence occurs. Boundary turbulence, the last interaction maxim, exists when there are privacy violations or misconceptions about information ownership (Petronio & Durham, 2008).

CPM theory can be used to explore a number of communication issues, including issues related to health. As it relates to mental health, problems can arise when a person receives a stigmatized diagnosis (Petronio & Durham, 2008). For example, the discloser may feel like the recipient will judge him or her negatively because the discloser suffers from a mental health

problem. It is because of this possibility, that one may feel the dialectic tension between wanting to share this private information with someone and keeping it a secret. So, CPM provides a framework for showing how individuals manage their private mental health information in light of this stigma. In particular, CPM can be used to look at how one self-discloses a diagnosis.

Overview of this Study

In Orbe's (2008) explanation of co-cultural theory, which serves in this study as a basis for understanding the mentally ill as a marginalized, stigmatized group in society, Orbe describes how people without societal power function in a dominant power structure. These marginalized or underrepresented groups struggle to achieve success in a society where the dominant group utilizes their position of power either "consciously or unconsciously." Furthermore, Orbe (1998) states that the power differences between the dominant and non-dominant group create a social hierarchy that forces the non-dominant group to adjust to the dominant system to achieve this success. Therefore, this theory offers a framework to understanding how co-cultural or non-dominant members chose to communicate and interact with the dominant group. Specifically, this theory highlights the issues behind why one would choose not to disclose based upon their place in society.

For instance, Orbe (1998) states that groups can be marginalized not only by race and sexual orientation, but by disability as well. Therefore, those who suffer from a mental illness or disability can be seen as a member of a unique co-cultural group. They have their own beliefs and perceptions about the world that sometimes go unrecognized, which may make communication difficult. Therefore, it is by looking at the mentally ill as a co-cultural group that one can begin to further understand self-disclosure methods and even how race compounds whether or not one chooses to self-disclose a mental illness.

While it is fair to say that race does not equal culture, it can be noted that many racial/ethnic groups share similar cultural beliefs and values (Ford & Kelly, 2005). This can be used to draw implications regarding how cultural beliefs and values influence one's willingness to share highly personal information, such as a diagnosis of a mental illness. It can also allow us to understand how people with a mental illness communicate their disease to others, and where culture becomes an important factor for how this communication interaction transpires.

Furthermore, racially marginalized group members, who are considered a double co-culture by race and mental health status, may communicate a mental illness differently than White, dominant members. This perception is formed because these members tend to focus on how people will perceive them on the basis of race in addition to accepting a stigmatized disease (Allen, 1997). Racially marginalized group members may be more aware of racial issues which stop them from opening up about their disease, particularly to members outside of their family (Allen, 1997; Thompson, 2004; Williams, 2008).

Thus, this study attempts to understand how those with a mental illness as a co-cultural group self-disclose their medical diagnosis to a loved one, what strategies or tactics they use for self-disclosing their illness, what responses they receive from loved ones, as well as how loved ones perceive the interaction, and whether or not non-dominant group members as a double co-cultural group differ from their White counterparts in how they talk about and respond to a mental illness disclosure. It is by looking at how one talks about the disease and how well received these discussions are that health communicators can begin to uncover better ways of effectively communicating with those who suffer from a mental illness.

CHAPTER 2

Literature Review

This chapter attempts to explain the various major mental disorders. It provides information about the role that culture plays in defining and understanding these mental disorders. Next, the concept of self-disclosure along with the predictors and reasons for self-disclosure are examined. Finally, the chapter highlights the impact of stigma, culture, and race/ethnicity on self-disclosing a mental illness.

Explaining Mental Illness

According to the National Alliance for the Mentally Ill (NAMI), mental illness refers to a group of disorders causing severe disturbances in thinking, feeling, and relating lasting at least two weeks. The DSM-IV defines a mental disorder as a significant behavioral or psychological pattern that occurs in individuals suffering from distress (American Psychiatric Association, 1994). In addition, the National Institute for Mental Health (NIMH) reports that approximately 1 in 4 adults or 57.7 million Americans live with a severe mental illness, and that by 2020, one form of mental illness called major depressive disorder will be the leading cause of disability in the United States for both women and children.

The National Alliance for the Mentally Ill (NAMI) web site also provides a complete listing of major mental disorders, which include depression, schizophrenia, bipolar disorder, obsessive compulsive disorder, post traumatic stress disorder, and borderline personality disorder. Each illness is treatable with proper medication and an effective recovery treatment plan. However, many people choose not to seek help for their disorder because of the attached stigma

that comes with having a mental illness (Corrigan, Morgan, Larson, et al., 2010). A stigma refers to the presence of devaluating societal stereotypes and unjust perceptions regarding mental disorders (Biernat & Dovidio, 2000).

NAMI reports that 15 million American adults are currently living with major depression, one of the many existing mental disorders (National Alliance on Mental Illness, 2011e).

Depression is characterized by a persistent sad or irritable mood, changes in sleep patterns, difficulty thinking or concentrating, lack of interest in activities, feelings of guilt, worthlessness, or helplessness, and reoccurring thoughts of death or suicide. Usually, a person is diagnosed with major depression when they exhibit a number of these symptoms for more than two weeks.

Schizophrenia, another major mental disorder, affects 2 million American adults (National Alliance on Mental Illness, 2011f). This disorder interferes with one's ability to think clearly, distinguish reality from fantasy, manage emotions, make decisions, or relate to other. Schizophrenics may experience delusions or hallucinations as well. Schizophrenia is also related to other mental illness such as depression and bipolar disorder, as many patients have mood swings or bipolar-like episodes.

Bipolar disorder, another mental illness, is a form of depression (National Alliance on Mental Illness, 2011b). However, what separates someone who is bipolar from someone with major depression (unipolar) is their experience of extreme highs and lows. Patients are either in a happy, elated mood or a low, unpleasant one. They may experience increased physical and mental energy during their high points, which include racing thoughts and excessive risk taking. They may be more prone to excessive spending sprees, sexual indiscretion as well as alcohol abuse at this time.

Obsessive compulsive disorder (OCD) is defined as a disease of doubt (National Alliance on Mental Illness, 2011c). People with OCD feel that they must complete repetitive rituals or else

something bad will happen. Many people with OCD find themselves washing their hands constantly, counting objects, or organizing things in an obsessive or impulsive manner. They may also check multiple times to see if the stove is off or if their alarm clock is set properly. NAMI reports that nearly 1 out of 40 American adults will have OCD at some point in their lifetime (National Alliance on Mental Illness, 2011c).

Post traumatic stress disorder is an anxiety disorder that comes after one has experienced a traumatic event that caused fear, hopelessness, or horror (National Alliance on Mental Illness, 2011d). People with PTSD usually re-experience the event months after the event has ended. They usually have symptoms of excessive emotions, and cannot function as well as they did before the event occurred. It is reported that between 2 and 9 percent of the population have some degree of PTSD (National Alliance on Mental Illness, 2011d). It is more commonly found in veterans who experience traumatic events during war. For instance, it is estimated that 3.5 million men and women who served in Vietnam have PTSD (National Alliance on Mental Illness, 2011d), and experts believe that up to 20 percent of Iraq and Afghanistan war veterans may suffer from this disorder (United States Department of Veteran Affairs, 2012).

The last major mental disorder to be reviewed here is borderline personality disorder. Affecting 1 to 2 percent of the population, this disorder is marked by identity disturbance or an unstable sense of self, mood instability, recurrent thoughts of suicide, inappropriate intense anger or difficulty controlling anger, a pattern of unstable interpersonal relationships, and dissociative symptoms (National Alliance on Mental Illness, 2011a). This disorder usually coexists with other disorders such as major depressive disorder, bipolar disorder, and antisocial personality disorder.

According to NAMI, other less severe forms of mental illness include seasonal affective disorder, in which the change of seasons affects one's mood. Another form of mental illness is dissociative disorder, where one blocks out traumatic experiences. In addition, mental illness also

includes panic disorders, as well as eating disorders such as anorexia nervosa and bulimia. Any one of these disorders can be treated with the proper psychotherapy, which includes behavioral modification, and/or medication.

The Role of Culture and Ethnicity in Mental Health

The meaning of an illness refers to deep-seated attitudes and beliefs a culture holds about whether an illness is “real” or “imagined,” whether it is of the body or the mind (or both), whether it warrants sympathy, how much stigma is attached to it, what might cause it, and what type of person might succumb to it. (Department of Health and Human Services, 2001, p. 40)

The role that culture plays with regard to our mental health is profound. Culture refers to the cumulative deposit of knowledge, experience, meanings, beliefs, attitudes, concepts of self and the universe acquired by a large group of people, which manifests itself both in patterns of language and thought and in forms of activity and behavior (Samovar & Porter, 1972). Thus, our culture is reflected in our health beliefs, attitudes and behaviors. Particularly, the meaning a person attaches to a mental illness has its roots in that person’s cultural background as what he or she believes about a mental illness is culturally bound. This is because people’s culture influences their expression of feelings. We are taught at an early age when to reveal and conceal thoughts and feelings, which affects how we deal with and react to mental illness (Basvanthappa, 2007).

In examining these cultural differences, one tends to look at ethnicity as one factor in determining cultural identification (Ford & Kelly, 2005). According to Ford and Kelly (2005), ethnicity refers to the sharing of a common culture, including shared origin, psychological

characteristics, attitudes, religion, and cultural traditions. Thus, since many ethnic groups are known to share a similar culture, ethnicity is looked at as one factor of culture. Ethnicity can be defined as a shared origin, which may lead to a shared culture or way of life (Gudykunst & Lee, 2002). Nationality serves as a subset of culture, as culture is developed based on ethnic origins and racial politics (Nicotera & Robinson, 2010). Thus, ethnicity is a form of social identity that comes from culture. For instance, many people talk about the African American or Hispanic culture referring to the fact that these ethnic groups share similar customs, practices and beliefs. These cultures share similar guidelines for human conduct and behavior (Gudykunst & Lee, 2002), which may reflect how these ethnic groups react to mental illness disclosures.

Sewell (2009) further notes this in stating that while tied to each other, race, ethnicity, and culture are not the same. However, while culture is not synonymous with race, racial/ethnic identity is a significant part of cultural background. Race is therefore not to be used to provide a genetic explanation for trends and patterns; the benefit of applying the concept of race is strictly social. However, race does affect how people are perceived, and thus race takes on meaning in the social context. Meanwhile, ethnicity is based on self-identification due to a range of factors including language, geographical origin, skin color, religion and cultural practices. Hence, culture is a way of life that should not be confused by race. Yet, racial identification can fall under ethnicity which becomes a factor influencing one's way of life—a factor that heavily affects cultural beliefs, practices, and customs. Therefore, while we can say that ethnicity, race and culture are not one in the same, they are undeniably related to one another.

In this study, ethnicity/race and culture as it relates to co-cultural status are sometimes used interchangeably. However, the terms ethnicity and race are often used in place of one another because ethnic identification has racial implications. Race, as a socially constructed category based upon one's ethnic background, opens the door for racism which may impact

marginalized group members' decision to self-disclose a mental illness diagnosis. Furthermore, this study acknowledges that while ethnicity and race may be a part of the cultural experience, culture is also a result of one's environment (Gudykunst & Lee, 2002). In this case, culture was used in some instances of this study to denote that there is a marked difference between the experiences of the dominant group and the non-dominant or marginalized group. The researcher also honored the terms used by participants in regards to how they self-identified. For example some participants identified as being African American, which relates to ethnicity, while others identified as being Black (a racial classification). Nonetheless, in this study both ways of self-identifying still form the idea that there exists both a dominant and non-dominant (co-cultural) group, and that these groups may have differing cultural beliefs, attitudes, and behaviors regarding mental illness.

In addition, this study also recognizes that there are individual differences even among people who share the same ethnic background. One's identity is thus made up of both individual and group experiences, where ethnicity and race are included (Nicotera, Clickscales, Dorsey & Niles, 2009; Sewell, 2009). To say that African Americans are the same culturally as Native Americans, or even among other groups of African Americans would deny the unique characteristics that are associated with each group's heritage. However, this study argues that culture provides the model environment for human behavior and development by which we can draw conclusions about what one believes or has been taught about mental illness.

Therefore, we are programmed by culture, despite our differences. Although we are unique beings, this environment allows us to share important cultural characteristics (Chen & Starosta, 1998). Thus, in this study, ethnicity can be used as a way of looking at co-cultural status (Orbe, personal communication, 2011). By implying that a participant's ethnicity is one factor associated with their cultural make-up, this study looks at ethnicity or self-identification as an

important factor in determining cultural and racial beliefs about mental health disclosures. Thus, it can be said that being a co-cultural group member, and the beliefs that one holds as a co-cultural group member, differs from the dominant group member.

Race as a Predictor of Health Outcomes

Ford and Kelly (2005) conclude that race is a social construct influenced by social, political and historical factors. It is a variable that may lead to the effects of racism on the individual, in that disparities in health outcomes are essentially related to racism—whether institutionalized or internalized (Ford & Kelly, 2005). The researchers state that institutionalized racism may result in lack of access, services and resources to minority populations. On the other hand, internalized racism is the sense of hopelessness, helplessness, and resignation that these groups feel as a result of experiencing racism at an institutionalized level (Ford & Kelly, 2005). For example, Blacks may not have access to psychiatric services in their communities, which can cause them to doubt whether or not they can achieve a brighter future for themselves. These doubts may in turn hinder them from having the self-efficacy needed to seek treatment for a mental disorder.

Ackerson and Viswanath (2009) argue that race, as it relates to racism, is a strong predictor of health in general. The mortality rate for Blacks who face various health disparities is 30 percent higher than Whites, and the mortality rate for Hispanics are increasing as rates for non-Hispanics are dropping (Ackerson & Viswanath, 2009). Also, overall stress and prejudice may play a role in influencing health behaviors and in unequal health outcomes (Williams, 2010; Ackerson & Viswanath, 2009) For instance, the mortality rate may be higher for minorities because of the health disparities they face as a disadvantaged group battling poverty, homelessness, and incarceration at a higher rate than Whites (Warren & Robinson, 2009; DHHS,

2001). These dire circumstances lead to a higher risk of depression and other psychological illnesses within minority populations (Williams, 2008; DHHS, 2001).

Race also affects the type of care that patients receive. The Department of Health and Human Services (2001) reports that minorities have a higher rate of unmet mental health needs than Whites. They state that this may be due to a number of reasons including a lack of trust in the medical system, differing cultural explanations of the illness, including what it means to be distressed, the meaning and severity of symptoms, and past and present experiences with professionals in the field. As stated by Gurvinder & Dinesh (2011), Blacks and other marginalized populations possess different explanatory models of mental illness. This influences how they seek help, and what services they feel are available to them.

Ackerson and Viswanath (2009) also note that African Americans report lower levels of trust in health care and lower positive affect than Whites, which ultimately affects how and if they decide to receive treatment for their mental condition. In their study, the researchers stated that physicians tend to be more verbally dominant when tending to Black patients than Whites. Ackerson and Viswanath (2009) also found that Asian Americans were less likely to speak up when they received unfair treatment, and Spanish-speaking Hispanics are the least likely to report that their physician explained information to them in ways that they could understand or included them in the decision making process.

It is because of these cultural differences in understanding and dealing with a mental illness, that differences in how consumers choose to reveal or explain their mental illness may arise. For example, because Asian Americans are less likely to speak up about their health, they may be less apt to disclose this information to a loved one. Similarly, because African Americans try to hide any signs of mental illness, they may be less likely to share this secret with others (Thompson, Bazile, & Akbar, 2004; Williams, 2008). Thus, self-disclosure for various co-cultural

groups such as African Americans and those of Asian descent may differ from that of Whites or the dominant group.

Differences may exist because marginalized groups, such as African Americans, must take into account institutionalized and internalized racism when in a communication interaction, in addition to revealing a mental health status. This becomes an additional burden or concern that one must carry. Since marginalized groups are more mindful of race and take this into account when communicating (Allen, 1997), thoughts of racism may hinder them from speaking out about their disease more so than Whites. They may have been taught not to disclose information that may further marginalize them in society, and thus may have a more difficult time self-disclosing a mental illness (Thompson, et al., 2004; Williams, 2008).

However, to further comprehend why these differences may occur, one must first understand the definition of self-disclosure as well as the predictors of self-disclosure. The many ways of self-disclosing a mental illness must also be understood, in addition to how the stigma of mental illness impacts self-disclosure. Keeping this in mind, one can begin to examine how race, culture and ethnicity affect this disclosure process.

Examples of Cultural Differences in Mental Health

As an example of cultural differences in regard to mental health, Anglin, Alberti, Link, and Phelan (2008) conducted a telephone interview consisting of 118 African American and 913 Caucasians who had a family history of psychiatric hospitalization. These participants were told stories about someone who either suffered from depression or schizophrenia. The respondents were asked to complete a Likert-style scale which asked whether or not a professional could help the patient, or whether the patient could improve on their own. Results of the study showed that African American participants were more likely than their White counterparts to believe that

mental health problems would improve on their own. They believed the problem would go away without treatment.

The idea of waiting out a mental illness as a method of dealing with a diagnosis is popular in the African American community because of the belief that mental illness is neither biological nor genetically-based (Schnittker, Freese, & Powell, 2000). Thus, Blacks as an ethnic group are more likely to accept the idea of mental illness, particularly depression, as a character flaw rather than a genetic disorder (Thompson, et al., 2004; Williams, 2008). This is a way of avoiding the historical view of Whites seeing Blacks as genetically inferior (Schnittker, et al., 2000). Instead, Blacks resort to spiritual avenues such as prayer and meditation to cope with their illness as opposed to seeking medical help (Schnittker, et al., 2000; Thompson, et al., 2004; Williams, 2008). Ultimately, when Blacks do seek medical attention, it is more for physical manifestations of a mental disorder. For instance, since African Americans see the problem as physical rather than mental, they will seek treatment for persistent headaches versus anxiety disorder (Burnette, 2011).

Furthermore, since African Americans tend to reject mental illness as a biological disorder, they are also less likely to treat their depression using psychiatric drugs. Schnittker (2003) studied differences in beliefs regarding psychiatric medication for depression between Black and White participants. It was shown that Black respondents were more skeptical of psychiatric medication than White respondents. Medical distrust and misconceptions about psychiatric drugs were among the many reasons why Blacks were less willing to take psychiatric drugs or administer them to their child. This medical distrust stemmed from the historic abuse imposed on African Americans by the medical system (Washington, 2007).

In addition, Blacks were also more concerned than other consumers about drug efficacy and its many possible side effects (Schnittker, 2003). These cultural differences are often ignored.

However, it was found in numerous studies that Blacks metabolize anti-depressant prescription drugs slower than Whites, which lead to a greater sensitivity regarding drug side effects (Schnittker, 2003). So, culture plays a huge role in both perceptions of drug use and physically in drug effectiveness.

Also, Blacks often go undiagnosed because they don't see depression as a disease worth treating (Thompson, et al., 2004; Williams, 2008), nor do they choose to acknowledge the seriousness of their illness (Burnette, 2011). For example, Waite & Killian (2008) studied African American women and found that although they fit the definition of being clinically depressed, they didn't even realize they had the disease. They felt that their feelings were a daily part of life. Similarly, Kendrick, Anderson, and Moore (2007) found that African American men didn't see themselves as depressed, but rather "stressed." This stress came from simply being Black in today's society. They dealt with this "stress" by hanging out with their friends as opposed to seeking medical treatment.

A similar phenomenon is seen among Latinos as well. For Latinos, one form of mental illness, depression, is seen as a personal weakness (Martinez, 2008). Thus, mental illness is not acknowledged to save face. This idea of saving face overpowers the importance of seeking treatment in the Latino community (Martinez, 2008). According to Martinez (2008), participants in one study stated that if they were to seek help for their mental illness, people (including some people within their own families) would consider them to be crazy. Thus, Latinos in the study resorted to seeking advice from trusted family members, using these relatives as counselors or advice givers. They also looked at spirituality as an important factor in dealing with depression, stating that their faith in the Lord would bring them through any ordeal.

The U.S. Department of Health and Human Services acknowledges the spirituality factor when looking at how certain ethnic groups deal with mental illness, stating that both spirituality

and religion play a role in dealing with mental health issues, especially in minorities (DHHS, 2001). For instance, African Americans and Native Americans rely heavily on their spiritual roots to cope with adversity, which causes them to resort to the use of more alternative approaches to heal these disorders such as practicing spiritual healing and herbal remedies (DHHS, 2001). This is also tied to adherence of health-related behaviors and lifestyle as well as the possession of a healthy cognition due to faith and belief. Therefore, differing cultural beliefs as seen among various ethnic groups affects the ways that members of these cultural groups view a mental illness, and may affect how they disclose a mental illness to others.

Defining Self Disclosure

Self-disclosure or the ability to communicate and to share intimate personal feelings (Jourard, 1958) is known to be an essential part of mental health and overall well-being. It refers to how willing people are to discuss information about themselves to other people (Hendrick, 1981). It was this observation that allowed Jourard (1958) to arrive at the conclusion that self-disclosure was fundamental and much needed for satisfying relationships. He believed that mental illness resulted when one did not self-disclose because when we hide ourselves, we tend to lose touch with our real selves. Since self-disclosure was filled with feelings of love and trust, self-disclosure was important to the development of these intimate relationships. In addition, he believed that self-disclosure served two functions to better know the self and to be better known with others. In getting to know ourselves and in drawing close to others, we build healthy relationships.

Levels of Self-Disclosure

Corrigan (2006) describes four levels of self-disclosure about mental illness. These levels are social avoidance, secrecy, selective disclosure, and indiscriminate disclosure. Social

avoidance is when one chooses not to tell anyone through avoiding situations in which the public may find out about their illness. They may avoid spending time with others, especially during times where their symptoms may be intense. However, this level of disclosure perpetuates stigma as it promotes the idea that those with a mental illness should be kept away from society. Another form of disclosure that is similar to social avoidance is secrecy. This form of disclosure occurs when people choose to interact with others, but refuse to tell them anything about their disease. This includes revealing information about hospitalizations, medications, and symptoms.

Selective disclosure, the third form of disclosure, means that one is selective or chooses to whom and what they wish to share. They may only decide to disclose to a set number of friends or acquaintances, while not disclosing to those who they feel may be less supportive. In general, most people who choose to self-disclose will engage in selective disclosure so as to control who knows about their illness (Corrigan & Lundin, 2001). Finally, indiscriminate disclosure means you do not selectively discriminate, but are open to any and everyone that will hear your story. People who disclose indiscriminately are not worried about who finds out about their illness. They are also usually able to cope with those who react negatively or disapprove of their disclosure.

Self-Disclosure and Relational Intimacy

Being multi-dimensional in nature, self-disclosure includes the breadth/amount of information being disclosed, the depth/intimacy of that information, the valence, the honesty/accuracy of that information, and the intent behind the disclosure (Croucher, Faulkner, Oommen, & Long, 2010), which hints at self-disclosure as a means of intimacy and relational development. This means that at each level of self-disclosure there is a decision made about the type of relationship the discloser has with the recipient, and whether or not revealing information

about oneself will affect that relationship—either by allowing for relationship growth or deterioration.

In fact, Altman & Taylor (1973) looked at self-disclosure as relationship development where one moves from a rather impersonal relationship to a more intimate relationship through self-disclosure. It is the process of people revealing their real self to others as they build an ongoing relationship. Thus, it is a gradual means of developing relationships by revealing personal information about one's self. Thus, according to social penetration theory, it is stated that relationships develop as communication goes from shallow (impersonal), to a deeper (personal) level.

It is known that humans make deliberate choices about to whom they choose to self-disclose, which mainly depends upon the perceived relationship that exists with the recipient (Magsamen-Conrad, Greene, Banerjee, & Bagdasarov, 2008). Often, the discloser will examine the relational closeness they share with the potential recipient, along with the anticipated response they expect to receive. For instance, people are more likely to self-disclose when they have a liking for the recipient, and when they feel the anticipated response will be positive in nature.

The discloser is also more likely to disclose when they feel that partner responsiveness, or the degree to which the discloser feels understood and cared for by the recipient, is high (Magsamen-Conrad, et al., 2008). For instance, if the discloser feels like the recipient will understand their bout with a mental illness and genuinely care about their wellbeing, then there is a greater likelihood that the discloser will reveal this information. So, disclosing is a process of relational development in that one must feel secure enough in that relationship to reveal their mental health status, or feel at least confident in the relationship's ability to grow and thrive despite this information being revealed. Thus, most patients will disclose to their partner, mother or father. Hence, they are relatively open towards family members and friends because of the

perceived close relationship, and as a result they receive more support from these individuals. However, they are least likely to open up towards acquaintances and colleagues, and receive less support from these individuals when they do disclose (Bos, et al. 2009).

Nonetheless, research shows that in general people are very reluctant about self-disclosing personal information (Lee, Im, & Taylor, 2008). This may be especially true regarding the self-disclosure of a mental illness because of the lack of reciprocity that often accompanies this type of disclosure. For instance, it is highly unlikely that the recipient of this information will also suffer from a mental illness, and be willing to reveal this information to the discloser upon hearing the discloser's story. While this may occur, the discloser may be under the assumption that they are the only one in the interaction with this disease, which places them in a vulnerable position.

Usually, disclosing of personal information by one relational partner to another makes the recipient obligated to share personal information of their own back to the original discloser. This tends to make one person no less vulnerable than the other, as both have revealed otherwise private information--it is an equalizing of inputs and outputs (Lee, Im, & Taylor, 2008). However, in the case of disclosing mental illness, unless the recipient has suffered from a mental illness themselves, this equalization will not occur. It is because the discloser is revealing their personal information without receiving any equivalent information back from the recipient, that it is even more important that the discloser know that their information will be kept safe (Lee, Im, & Taylor, 2008). The discloser must be certain that the recipient will keep information about their mental illness confidential.

Along with self-disclosure of mental illness comes the idea of the invisible illness. Since most forms of mental illness cannot be detected visually, it is thus easier for those with a mental illness to avoid disclosing this information to others. Hence, since this information only becomes

apparent after a verbal disclosure, it is much easier to keep a mental illness diagnosis a secret. Kundra and Nussbaum (2003) state that most people with an invisible illness do not tell others about this illness unless a situation arises in which another person needs to know this information. They may sense that they will be separated from others in society, and thus try to avoid this from occurring by not telling others until they feel they are "able-bodied" or until a situation arises where they must disclose this information. So, disclosure about a mental illness may only occur after the discloser feels comfortable about who they are despite their illness, or unless they are forced to disclose this information.

Predictors and Reasons for Self Disclosure

Greene, Derlega, and Mathews' (2006) self-disclosure decision making process model describes the who, what, when, and whys to self-disclosure. This decision to self-disclose mainly depends on the costs and benefits of doing so. Greene, et al. (2006) explains that the decision to disclose personal information is based upon culture, social network, and personality. It then involves weighing self, other, relationship reasons for self-disclosure, and examining the context. Thus, the discloser decides to disclose based upon cultural criteria for disclosing, access to a social network, along with whether or not the situation is appropriate. For example, in one situation an individual may say, "I have depression." However, in a different situation, that same individual may simply say, "I have been sick."

Magsamen-Conrad, et al. (2008) studied variables associated with self-disclosure in a sample of college students. These variables included relationship closeness before the disclosure, perceived response to the self-disclosure, timing of disclosure, relationship type, and the perceived effect of disclosure on the relationship. Participants were asked to recall a moment when they shared personal or private information with another person. They were then asked how close they were to the person they shared this information with, what type of relationship they

had with the other person (friend, spouse, parent), and how quickly in the relationship they told this private information to the other person. They were also asked to describe the recipient's response to the disclosure.

The researchers found that partner response and timing were important factors in self-disclosure (Magsamen-Conrad, et al., 2008). So, predictors of self-disclosure were the perceived responses that participants felt the recipient would give. They also reported that the disclosure episode changed the relationship in a positive way when they also perceived the response to the disclosure to be a positive one. In addition, participants were aware of the time that elapsed in a relationship before they decided to share their information. For example, most participants tried to choose the right time to share information with the recipient, whether it took them one month or one year to disclose. Greene, et al. (2006) also discuss multiple reasons for disclosing personal information, not just to build a closer relationship, but rather to relieve psychological stress or as a way of seeking understanding from the recipient.

Pros and Cons of Self-Disclosing a Mental Illness

Many patients may feel like they are hiding a part of themselves, and will chose to share this personal information with others in which they share a close connection. Hyman (2008) also noted that relief of psychological stress is a major reason for self-disclosing a mental illness. For example, one may draw closer to the recipient by venting or sharing a diagnosis.

In terms of self-disclosing a mental illness, Farber (2006) mentions six benefits and six negative consequences for revealing a mental disorder. The six benefits include:

1. Experiencing a greater sense of emotional closeness
2. Being known and affirmed by another, leading to validation
3. Gaining greater insight into one's self

4. Expanding one's sense of self and who you are
5. Achieving a greater sense of authenticity through acknowledging deeply personal secrets
6. Psychological and physiological relief

On the other hand, the six negative consequences of disclosing offered by Farber (2006) include:

1. Being rejected by others
2. Burdening another with our secrets
3. Creating undesirable impressions of ourselves
4. Feeling regret for not having shared the secret earlier
5. Experiencing increased vulnerability
6. Feeling a sense of shame once your diagnosis is revealed.

Corrigan and Lundin (2001) shared a similar set of benefits and consequences for sharing a mental illness. They stated that the pros of sharing include not having to worry about hiding experiences about mental illness and being more open in day-to-day activities, finding others who express approval, finding someone who can provide assistance in the future, and the promotion of a sense of empowerment as one attempts to fight against stigma and discrimination. The costs of disclosing include experiencing disapproval or ostracism, being discriminated against in terms of housing and employment, increased anxiety due to thinking that people will pity you, thoughts that future relapses will be more stressful because people are watching, and experiencing anger from family members and friends that you disclosed to.

According to Hyman (2008), many participants in a study about self-disclosure of mental illness found that the benefits far outweighed the consequences. While there was a risk of being

rejected by others, the benefit of being free from hiding behind their mental illness was well worth it. For example, one participant stated, "It freed me from the burden of having to hide a part of me, and it freed me from the shame that comes from feeling as though you have to hide and keep secret the illness," (p. 13).

Keeping Silent: The Role of Stigma in Self-Disclosing a Mental Illness

"A bold but necessary move, self-disclosure is a first step toward successfully addressing the stigma associated with being mentally ill. Before we can reveal ourselves to others, we have to come out of our own dark closets,"

(Hyman, 2008, p. 24).

The social stigma of having a mental illness is extremely prevalent. This stigma may cause one not to disclose or talk about their depression to others. People may fear that others will see them as crazy or irrational. The stigma associated with mental illness is also the main reason why people do not seek help for their illness (Potash, 2007), which often leads to suicide. Many people are afraid to speak up because they fear they may be seen as weak or defective. Instead, they keep silent to avoid any backlash from others, including backlash from their loved ones.

Historically, the stigma behind mental illness comes about because of the perceived link between psychiatric illnesses and demonic possession (Guimon, 2010). Throughout history, many people who were said to have a mental illness were treated through exorcist practices. In fact, Wesselmann and Graziano (2010) looked at religious-based stereotypes about those with mental illness, and reported that many people of the Christian faith thought emotional problems were attributed to be an influence of the devil. Similarly, others viewed mental illness as a result of a

sinful lifestyle or divine punishment from God. Those with a mental illness were said to harbor a spiritual or moral weakness, and were not praying or asking for healing effectively.

This link between psychiatric illnesses and demonic forces leads to the notion that mental illness patients are crazy, lack self-control, and are extremely dangerous. It is because of these assumptions that many mental illness patients are discriminated against by being denied housing, employment, education, and health care. It also leads to lowered self-esteem as many mental illness patients experience social distancing and rejection from others. Therefore, the stigma of having a mental disorder is an extremely important issue within the mental health field because this stigma against mental illness has persisted even though tolerance for other stigmatized groups, such as those who identify as gay or lesbian, has grown (Stier, 2007). So, while many people are beginning to accept other stigmatized or marginalized groups, the intolerance towards those with a mental illness has continued.

For example, Feldman and Crandall (2007) conducted a study where participants read stories about a character with a mental illness, and found that most of these characters were met with rejecting attitudes. These rejecting attitudes were characterized by how dangerous the character seemed to be, how disruptive they were, how out of touch with reality they were, personal responsibility (how much at fault they were for having the disease), how rare the disease was, how treatable the disease was with medication, and the degree of avoidability, or how likely they could avoid the character. The researchers found that out of these characteristics, the ones that lead to greater social distance are those perceived high in personal responsibility, dangerousness, and/or rarity. For instance, those mental disorders that seemed to be highly dangerous, rare and the fault of the character were met with more social distancing. This social distancing was most relevant to stigma as it is damaging and disruptive to people's lives, affecting their overall quality of life.

El Badri and Mellop's (2007) study about stigma and the quality of life experienced by those with a mental illness found that 73 percent of participants often avoided telling others about their mental illness because of the stigma associated with having a mental disorder. Likewise, 50 percent of the participants felt that when it was revealed that they had a mental illness, they were either shunned or avoided by others. Participants also stated that they refused to seek help due to the attached stigma, and feared that their mental illness could be used against them. Consequently, about two-thirds of the participants were unhappy about the quality of their relationships with parents and others after disclosing their mental illness.

Corrigan, et al. (2010) states that those with a mental disorder have to contend with two types of stigma—public and self-stigma. The public stigma is prejudice or discrimination that emerges when members of the general population endorse specific stereotypes about those with a mental illness. On the other hand, self-stigma occurs when a person internalizes the public stigma and applies those stereotypes to themselves. This internalization results in low self-esteem and self-efficacy as the person begins to take on the stereotypes that they are inadequate and unable to function in the real world.

In light of this stigma, Corrigan and Lundin (2001) state that self-disclosure about a mental health issue is not a black and white event, but a process where people decide who, when, and what to share. They can self-disclose selectively by choosing a particular person to disclose to, or share indiscriminately. They can also decide to tell all at once or gradually. It is because of this mark of shame that those with a mental illness may choose not to self-disclose, but to hide their illness identity completely. They will refuse to talk about their mental illness, and neglect to seek treatment. However, these are decisions that have to be made by the discloser during the self-disclosing process.

For instance, in Hyman's study (2008), interviewees disclosed their mental illness differently across the board. Some people only disclosed in an environment where they felt safe and comfortable. Some disclosed spontaneously, while others planned out what they were going to say. Others stated that it just felt natural to disclose at the moment in which they revealed their mental illness. Thus, how the process takes place is up to the discloser making it hard to pinpoint the best way for self-disclosing a mental disorder to others.

Stigma and the Family

It is not only the mental illness patient that experiences the effects of stigma, but their loved ones as well. Chou, et al. (2009) states that the quality of life for family members who care for a mental illness patient also decreases because of the stigma of having a mental disorder. Family members have to cope with the social difficulties that result from the loved ones devaluation by society. It was found that people who care for those with a mental illness reported less social support and a perceived level of stigma that they had to deal with as a result of being associated with someone with a mental illness (Corrigan & Miller, 2004). Thus, the family member felt somehow tainted by his or her association with the mentally ill.

Corrigan and Miller (2004) also note that many family members reported strained relationships with other family members because of their relationship with the mentally ill patient. In addition, they experienced avoidance by neighbors and friends because of this association. For instance, perceived avoidance was almost twice as high for spouses as it was for parents, and parents who lived with the mentally ill patient experienced avoidance more than those who did not live with the patient. This avoidance led to a sense of shame, leading almost half of the family members to argue that their relationship with the mentally ill patient should be kept hidden to avoid shaming the entire family.

Chang and Horrocks (2006) further noted in their study on Malaysian caregivers of those with a mental illness that caregivers avoided talking about their relative's mental illness to avoid losing face. Hence, they found it most difficult to talk to people outside the family about their relative's illness. These types of conversations were avoided even though many identified the need to share their lived experiences with someone for help and support. These caregivers also believed that the faults of their ancestors caused mental illness within their families, so it was more likely that they felt ashamed for having someone suffering from a mental disorder in their household.

Similarly, Kohinor, Stronks, and Haafkens (2011) looked at the Surinamese cultural customs of disclosure as it related to those with diabetes. In the Surinamese culture, diabetes is a taboo subject. In their culture, most only disclosed their diabetes diagnosis to close family members out of fear of shame, gossip, and social disgrace for the patient and family. Only in rare times did those with diabetes disclose their diagnosis to members outside the family. Such disclosure was when they needed help or support services for diabetes management. This occurred when diabetics were in situations where disclosing their illness was unavoidable, such as when they needed to take insulin injection during work hours. Thus, the cultural customs of the Surinamese discouraged them from disclosing for fear of negative social consequences.

With regards to mental health, the shame of being linked to a mental disorder also creates stress for family members. The family member must not only cope with the burdens of being a caregiver as well as the embarrassment over their relative's behavioral patterns, but they must also deal with the self-blame that comes from being related to someone with a mental disorder. This self-blame has a negative impact on their own mental and physical wellbeing. For instance, today's society tends to blame the family for the patient's mental health problems (Corrigan & Miller, 2004). Society tends to point the finger at faulty parenting or caregiving for mental health

problems, especially in children (Corrigan & Miller, 2004). This creates guilt among family members who see themselves to blame for their relative's mental illness.

Siblings and spouses are also blamed for a relative's disease offset (Corrigan & Miller, 2004). For example, it is said that these family members may fail to help the patient with their mental illness treatment or fail to be as supportive as they should be. This lack of support ultimately causes the patient to relapse. Thus, the family is often looked at as causing or worsening the patient's condition. This blaming the family creates strained relationships even when family members are trying their best to care for the patient. It also causes the family member to fear prejudice and discrimination from neighbors and friends.

It is not only the shame and fear of avoidance that causes loved ones to stress, but also the disclosure itself can cause stress within the family. For instance, the disclosure may drive a wedge between family members when the discloser chooses to tell some family members about their disease and not others (Farber, 2006). When some family members are privileged to know this information and others are kept in the dark, family stress may arise. For example, family members may want to tell other family members but feel that it will be a violation of the discloser's privacy if they decide to do so. Family members who are not told will ultimately feel left out or undervalued because they were not privy to such information. Thus, even the disclosure process aside from dealing with the social stigma puts a strain on the family.

Ethnicity & Cultural Differences in Self-Disclosing a Mental Illness

Croucher, Faulkner, Oommen, and Long (2010) state that culture influences both self-disclosure patterns and important variables affecting decisions to self-disclose. Petronio (2002) further argues that culture, gender, and context all play a role in the self-disclosure process. For instance, research has shown that females self-disclose more than men, especially when the recipient is also female (Croucher, et al., 2010). Typically, Americans are relatively open about

self-disclosure (characteristic of an individualistic orientation) whereas members of some other, particularly Asian cultures, such as Japanese, Chinese, and Indians, view self-suppression of certain topics as an appropriate form of cultural communication (Croucher, et al., 2010).

Even, in terms of religion, Croucher, et al. (2010) reported that there were religious differences between Muslims and Hindus in terms of self-disclosure. The researchers note that religiosity may also affect self-disclosure in that one may feel the need to contain one's beliefs and suppress personal information that contradicts these beliefs or practices. For instance, Blacks who heavily practice Christianity, often times feel that they should not talk about mental illness as it contradicts with their belief that Christians should be happy (Williams, 2008). The Black church creates the belief that God will solve all your problems and that there is no need to be down--a "too blessed to be stressed" attitude that hinders many Blacks from talking about their mental health issues (Williams, 2008).

Talking about mental illness in some cultures, particularly within the African American community, is highly taboo (Williams, 2008). Many African Americans are reluctant to talk about their mental illness even to loved ones. Blacks are taught early on in life to place a high value on family privacy, so that they are not to share the family business (Whaley, 2001; Boyd-Franklin, 1989). This type of family stigma stops them from disclosing personal information such as mental illness to others, particularly to those outside the family. This is similar to the study conducted by Chang and Horrocks (2006), where Malaysian caregivers were also reluctant to share mental health information with non-family members.

In addition, Blacks see depression as a way of life, or something they should learn how to handle without medical intervention (Williams, 2008). They see those with depression as being weak or unable to handle life's daily challenges. Thus, depression within the African American

community warrants no sympathy. Many other forms of mental illness including bipolar disorder and schizophrenia are treated in the same fashion (Williams, 2008).

As an example of how culture affects self-disclosure, Zheng and McDermott (2007) looked at cultural differences in Americans versus Chinese students with regard to talking about schizophrenia. After reading a story about a man with schizophrenia who is unsure about whether or not to tell his new date about his diagnosis, students were asked how and if this character should reveal his illness. It was found that the Chinese students held more negative attitudes about the character disclosing his mental illness. They held the belief that people with schizophrenia were dangerous and that having this mental illness threatened family reputation and face. Similarly, the Malaysian caregivers of those with a mental illness avoided talking about their relative's mental illness to avoid losing face—refusing to talk to people outside the family about their relative's condition (Chang & Horrocks, 2006).

Thus, Zheng and McDermott (2007) stated that participants felt that both the character and his family should avoid discussing the illness. If they did disclose this information, they were more likely to use an indirect method of disclosure such as hinting about it or joking about it versus their U.S. counterparts who were more direct in their disclosure tactics. Those who believed that people with mental illnesses were dangerous and unstable were also more likely to use indirect methods of disclosing a diagnosis (Zheng & McDermott, 2007). Thus, culture may affect how one chooses to self-disclose a mental illness to a loved one, and the responses one may receive upon self-disclosing.

Since it has been established that many ethnic groups share similar cultural beliefs (Ford & Kelly, 2005), one should look at racial/ethnic differences as a means of determining how culture affects self-disclosure. These racial/ethnic differences are important not only in communication studies in general, but specifically to the area of disclosure and mental health.

Allen (1997) states that race is a cue for perceptions about others, which alludes to the idea that each ethnic group has their own core values, beliefs, and attitudes that affect how they perceive others. Members of different ethnic groups may perceive those with a mental illness and their disclosures differently.

Race also matters in self-disclosures not only because it is a marker of identity, but of power which can lead to discrimination. For those with a mental illness, race adds another dimension to the self-disclosure process. For instance, Allen (1997) notes that because of White privilege, Whites maintain the notion that race is not an issue. They tend to make decisions or communicate without keeping race in mind. As Hopson (2007) notes, many White Americans rarely analyze the source and meaning of inequality in society, to the extent that they are aware of how their racial identity is tied to the social order. Furthermore, White Americans do not see how centuries of slavery, segregation, and racial discrimination has granted them social and political privileges and benefits.

On the other hand, Blacks are more conscious of how their race puts them in an inferior position. They are more aware of discrimination, while Whites state that racism is a thing of the past (Allen, 1997). Thus, race relates to mental health disclosures in that marginalized groups may be less likely to disclose their mental health issues to others because of the perceived discrimination they could receive from their recipients. This is especially true if they have thought about disclosing to acquaintances or coworkers outside their family circle. They may feel that they have to account for their race as well as their mental illness when dealing with the majority, which may decrease their likelihood of disclosing.

Since many ethnic groups, particularly African Americans, are taught at an early age that race matters, it does affect how they communicate (Allen, 1997). This is characteristic of African Americans who are taught not to disclose certain information, particularly to White therapists and

psychiatrists who may judge them unfairly because of their race (Boyd-Franklin, 1989). This may also carry over into how they divulge mental health information about themselves to their loved ones. Since they are taught to remain silent with others outside the family, they may then start to hide their mental illness even to people within their immediate family (Williams, 2008). Thus, the issue of not telling becomes a racial issue where one must account for their race in addition to exposing a mental illness.

Co-cultural Status and Disclosure

Since marginalized groups view race differently than Whites (Allen, 1997), there should be a difference in how co-cultural group members (non-Whites) discuss a mental illness, and how the dominant group in U.S. society (Whites) discuss this same information (Orbe, 1998). Since marginalized ethnic members with a mental illness are seen as a double co-culture, being marginalized by both race and mental health status, they may be even less likely to self-disclose their information. They may choose to only self-disclose to family members as opposed to outsiders (Chang and Horrocks, 2006; Williams, 2008), and may choose to be more indirect in their disclosures than Whites (Zheng & McDermott, 2007). They may disclose in this matter as a way of achieving success in the dominant world, and as a way of avoiding the backlash that may occur had they disclosed in some other fashion (Orbe, 1998).

While the literature points out differences between various ethnic groups (Zheng & McDermott, 2007; Williams, 2008; Martinez, 2008), Orbe (1998) states that all of these groups share a similar experience as co-cultural groups. In being a co-cultural group member, they are constantly trying to navigate the dominant power structure. In mainstream U.S. society, the dominant group members are usually Whites. Thus, non-Whites all share a similar experience in that they are all non-dominant members attempting to function in a dominant power structure.

It is because these marginalized group must account for their lack of power in society, that they may more than likely choose not to self-disclose information that may further their already disadvantaged status. For example, Williams (2008) alludes to the notion that Blacks are already looked down upon in society for being Black, so why should they self-disclose that they have a mental disorder as well? Likewise, Allen (1997) states that marginalized group members are more conscious of race than Whites and they are taught at an early age that race matters, which may imply that marginalized groups take their race into account before revealing mental health information to others.

Since many co-cultural groups such as African-Americans, are taught not to reveal certain information at an early age, this behavior may continue well into adulthood (Whaley, 2001; Boyd-Franklin, 1989). As a result of being told to keep quiet as a child, they remain silent as an adult. In the African American culture, individuals are told not to tell anyone about “weaknesses” such as a mental illness. Their ability to hide this information and deal with it on their own or through alternative spiritual means is considered a sign of maturity (Williams, 2008).

Therefore, since co-cultural groups take into consideration their lack of power when dealing with the dominant group (Orbe, 1998), they may be more reluctant to share a mental illness diagnosis than their White counterparts. They are essentially “situated within a field of experience that governs their perceptions of the costs and rewards associated with...their ability to engage in various communicative practices,” (Orbe, 2004, p. 196). Thus, because of their co-cultural status, they may perceive the costs of disclosing as higher than someone who is a member of the dominant culture. It is because of these perceptions that marginalized group members may not share information with others, particularly to individuals outside of their family. In addition, co-cultural groups receiving this information may not respond as positively to the disclosure as Whites. They may see the recipient as violating the social norm by talking about

it to others or even acknowledging that there is a problem (Williams, 2008; Martinez, 2010). So, co-cultural status may play a role in how or if one chooses to disclose as well as how one responds to a mental illness diagnosis.

Summary

Self-disclosure or the process of revealing intimate, personal information about oneself is a complex process (Hendrick, 1981; Corrigan & Lundin, 2001), especially when one wishes to self-disclose a mental illness. For instance, one may practice social avoidance or secrecy, and not tell anyone about their disease. Others may also elect to use selective disclosure in which they selectively choose who to self-disclose their mental illness. They may also feel comfortable in choosing to disclose indiscriminately, in which they share their diagnosis with anyone who is willing to hear their story (Corrigan & Lundin, 2001).

The level at which one self-discloses is usually determined by the perceived relationship the discloser feels he or she shares with the recipient. It is also determined by other factors such as the perceived response disclosers expect to receive, and the effect they believe the disclosure will have on their relationship with said recipient. The discloser also weighs the pros and cons of self-disclosing which can be a feeling of emotional closeness, a sense of empowerment, or psychological relief, versus the fear of being rejected or having the recipient respond in a negative fashion.

These risks to self-disclosure come about because of the attached stigma of having a mental illness. This is derived from psychiatric illnesses and their historic link to demonic possession (Guimon, 2010). This link causes many to stereotype those with a psychiatric illness as being dangerous, disruptive to society, and out of touch with reality. In fact, Feldman and Crandall (2007) showed that these perceived characteristics are what caused people to socially avoid those who were deemed to have a mental illness. So, the more dangerous and disruptive the

participants felt the mental illness patient was, the more these participants socially withdrew from the patient.

Furthermore, the stigma of mental illness that causes people to socially withdraw or react negatively to those with a mental disorder not only affects the patient, but the patient's family as well. Family members have to deal with the stress of being rejected and avoided due to their association with the mentally ill (Corrigan & Miller, 2004). Family members may also feel ashamed because of society's tendency to blame them for their loved one's illness. For instance, bad parenting is sometimes seen as a reason for mental illness in children, while spouses and siblings are often blamed for not being supportive enough. Thus, some family members have resorted to hiding or not talking about their loved one's illness to others out of fear of being rejected, avoided, or criticized by neighbors and friends (Corrigan & Miller, 2004). So, the stigma not only affects the patient in their willingness to talk about the disease and seek treatment, but also the family's willingness to discuss their loved one's illness to the public.

This tension between disclosing or hiding a mental illness can be seen across various cultures. For instance, African Americans tend to hide mental illness or choose to keep this information within the family (Williams, 2008). Similarly, Malaysian caregivers refused to talk about their loved one's condition outside of the family as a way of saving face (Chang & Horrocks, 2006). Also, Zheng and McDermott (2007) found that Chinese students differed from American students in their willingness to disclose a schizophrenia diagnosis to a romantic partner. The Chinese students stated that the character who was said to have schizophrenia should not tell his date about his diagnosis because it would bring shame to him and his family. The Chinese students also noted that people should be more indirect when disclosing a mental illness such as joking about it than their American counterparts. Findings such as these allude to the fact that there may be cultural influences concerning how one chooses to self-disclose a mental illness, as

culture affects disclosure patterns and behavior (Croucher, Faulkner, Oommen, & Long, 2010). Thus, culture should be closely examined as an influence on how, when, and to whom one chooses to self-disclose. Particularly, how co-cultural status affects self-disclosure.

In looking at culture, one must look at the ethnicity of those involved. As Ford and Kelly (2005) notes, while culture is not synonymous with race, many people of the same racial/ethnic background share similar cultural beliefs, attitudes and values. Thus, we should look at ethnicity as one way of examining cultural beliefs, attitudes, and values. In dealing with mental health disclosures, one can see that race/ethnicity matters. For instance, minorities are more conscious of race in their dealings and this affects how they communicate (Allen, 1997). Thus, marginalized or co-cultural groups may avoid disclosing as much information as Whites because they are used to protecting themselves from the backlash that may occur as a result of their race in the form of racism and discrimination. They must then account for their race on top of the fact that they now have a mental illness (which may create additional backlash). Thus, race or power differences in society may also matter when communicating a mental illness disclosure.

Therefore, in an attempt to explain self-disclosure methods among the mentally ill, as they pertain to co-cultural status, the following research questions are posed:

RQ 1: How do those with a mental illness self-disclose their medical diagnosis to a significant other?

RQ 2: What reasons do those with a mental illness give for sharing their medical diagnosis with significant others?

RQ 3: Do these reasons differ for self disclosure when sharing a mental illness diagnosis with family, friends, or a romantic partner?

RQ 4: How do significant others recall the experience of having a mental illness diagnosis disclosed to them?

RQ 5: How do significant others respond to self-disclosure about mental illness diagnoses?

Subsequently, this study also examined whether or not co-cultural status has an effect on disclosure and responses to disclosures. Thus, the following research questions and supporting hypotheses are examined:

RQ6: Do members of co-cultural groups (non-Whites) self-disclose differently than the dominant group (Whites)?

Supporting H1: Co-cultural group members (non-Whites) such as African Americans, Hispanics and Asians will be less likely to disclose to members outside of their family than the dominant group (Whites).

RQ7: Do members of co-cultural groups (non-Whites) respond differently to hearing a diagnosis than the dominant group (Whites)?

Supporting H2: Co-cultural group members (non Whites) such as African Americans, Hispanics and Asians will respond more negatively to a disclosure than the dominant group (Whites).

CHAPTER 3

Methodology

Methodological Paradigm

This study uses the survey method to examine the research questions posed. The survey asks individuals about their attitudes, emotions, beliefs, intentions, and behaviors to examine how participants perceive or evaluate the issue of self disclosing mental illness (Hocking, Stacks, & McDermott, 2003). In this current study, the survey is used to grasp the perceptions of those who either have a mental illness or know someone with a mental illness regarding a mental illness disclosure.

The survey used in this study was delivered as a web questionnaire that included both closed-ended and open-ended questions. The closed-ended questions allowed for respondents to select the most appropriate available answer. The open-ended questions, which are similar to short-answer questions, allowed respondents more freedom to provide an answer by typing in a response. In this way, participants were able to respond in more detail to questions that address the most important issues pertaining to the study—particularly how a mental illness diagnosis was revealed and received.

There are advantages and disadvantages to both open and closed-ended questions. A key advantage to open-ended questions is that they allow respondents to write as much on the topic as they see fit. They are not constrained by pre-set questions that may not be exhaustive (Rubin & Babble, 1997). However, one key disadvantage to using open-ended questions is that the

researcher has to interpret the meaning of responses during the coding process leading to the possibility of misunderstanding and researcher bias. To address this disadvantage, the researcher recruited three coders to assist with the coding of open-ended questions, as well as to ensure inter-coder reliability.

Another disadvantage to open-ended questions is that respondents may give answers to these questions that are completely irrelevant to the topic at hand (Rubin & Babble, 1997). For example, the respondents may be asked to speak about a time when they told someone about their mental illness, but may instead speak on a different subject that was not intended by the researcher. A way of addressing this matter is making sure that all questions on the survey instrument are simple and clear. Answers should be so precise that the “respondents know exactly what the researcher wants an answer to,” (Rubin & Babble, 1997, p. 193). In this respect, survey questions were pre-tested for validity and reliability to address whether or not questions were relevant to respondents, and whether or not questions met respondents’ competence level.

On the other hand, using closed-ended questions also has its share of advantages and disadvantages. The primary advantage to using closed-ended questions is that the respondent is asked to answer from a list provided by the researcher, which limits the danger of respondents giving irrelevant answers. For questions such as ethnicity, it is easier to code and process this information when in a closed format. However, in using closed-ended questions, one must ensure that the items are exhaustive and mutually exclusive (Rubin & Babble, 1997). For example, the response categories should include all possible responses, and these responses should not be able to occur at the same time respectively (Rubin & Babble, 1997). To ensure that response categories are exhaustive, the researcher added the category labeled “other” to ensure that all possible responses would be included. For ensuring that categories are mutually exclusive, the researcher carefully considered each combination of categories. The researcher then asked the

respondent to choose the best or most primary answer for these categories. For instance, question one asks respondents “What is the primary mental illness that you were diagnosed with?” In posing the question in this manner, the researcher attempted to eliminate the chances of someone who was diagnosed with multiple mental illnesses from being compelled to choose more than one category. In this way, if someone has more than one mental illness, they can choose their primary or major mental illness instead.

Overall, whether through the use of closed or open-ended questions, the survey is a good method for collecting original data for describing a population that is too large to observe directly (Rubin & Babbie, 1997). Thus, the survey method was selected to explore how those with a mental illness and their loved ones deal with a mental illness diagnosis. The use of a questionnaire was judged to be more effective than the use of interviews for this study because it would be difficult to generate a large enough sample of the relevant population with interviews to draw meaningful generalizations from the data. Thus, a questionnaire was designed as a more parsimonious research strategy for examining the research questions posed.

While drawing generalizations and conclusions from a large sample of the population is an advantage of using a questionnaire-based survey for this study, there are also some disadvantages to this method. One disadvantage is the dependence on self-reported data. With self-reported data, the researcher is dependent upon respondents to provide an accurate detailed account of what occurred during disclosure of a mental illness. This disadvantage pertaining to self-reports is noted in the study’s limitations.

There is also the possibility of a low response rate with survey research. Rubin and Babbie (1997) suggest that generating a response rate of at least 50% is considered adequate for analysis and reporting (Rubin & Babbie, 1997). To increase the response rate it was decided to use a web survey as opposed to other forms of surveying methods (paper, telephone, etc.). A web

survey was chosen because it may allow for a higher response rate because of the relative ease of responding to questions online versus a mail survey. Respondents can click on the link directing them to the study survey and answer the questions at their own convenience. This also may eliminate a possible self-reporting bias as the web survey is more anonymous and confidential than an in-person delivered questionnaire or telephone-delivered interview which would require the researcher to obtain participant's personal information such as their mailing address or phone number.

Wright (2005) mentions that the web survey is beneficial to use for research purposes because it takes advantage of the Internet's ability to reach people who would otherwise be difficult to reach through other channels. As an example, the World Wide Web opens the doors for us to communicate with people in different parts of the world or those who are in different time zones. In addition, web surveys help to reach stigmatized groups, such as mental illness sufferers, who may be hesitant to participate offline in a face-to-face encounter.

However, Wright (2005) does mention some disadvantages to the use of web surveys, stating that when using these surveys it may be difficult to determine whether potential respondents fit the criteria for your survey. Even though potential respondents may state they suffer from a mental illness or know someone who suffers from a mental illness, does not necessarily mean that this is the case. Therefore, it is hard to determine whether or not one truthfully has a mental illness or knows someone with a mental illness via a web survey. One can only hope that by reaching a large enough sample of the population, that a majority of respondents will fit the study's criteria. In this study, the researcher surpassed the expected sample size needed to draw general conclusions from the data. However, the possibility that all participants may not fit the study's criteria is mentioned in the limitations section of this research.

Finally, while the web allows you to reach unique, stigmatized populations that may not participate in an offline setting, it does not allow you to reach everyone within that population due to the fact that some people may not have an online presence. In this study, those people who did not have a Facebook account may have been excluded from taking the survey. However, in attempts to address this issue and increase recruitment efforts, the researcher used a network or snowball strategy for subject recruitment. In this form of recruitment, participants were able to pass along the survey to those they knew within their own social networks. Individuals within these networks did not have to be a member of a specific online group, listserv or social networking site to participate. These individuals were given the link from someone they knew who has already taken the survey either via email, word-of-mouth, or through a different social networking site such as Twitter. Due to snowballing more responses were generated, and those respondents weren't limited to being a Facebook member to participate. Therefore, despite the small disadvantages to using a web-based questionnaire, it proved to be the best survey method for gathering meaningful subject responses in this study.

Research Design

This 4-month long, 2x2 study design consisted of White and non-White disclosers and recipients of a mental health diagnosis or condition (Figure 1). Disclosers were people who were either diagnosed with a mental health condition or exhibited symptoms of a mental health condition that lasted for two weeks or more. According to the National Alliance for the Mentally Ill's website, exhibiting a symptom of a mental illness for two or more weeks is considered the criteria for making a diagnosis of a mental health condition. Disclosers and recipients were split into four categories: White disclosers, non-White disclosers, White recipients, and non-White recipients. Thus, White disclosers and recipients were compared to those of other ethnic

backgrounds to test whether there were differences between White participants and their non-White (co-cultural) counterparts.

To assess differences in how one chose to disclose and how a disclosure was received, answers to open-ended questions were placed into potential categories by the researcher. From these themes, subcategories also emerged. These themes and subcategories were evaluated by two additional coders for reliability purposes. A Cohen Kappa statistic was performed to examine the consistency between the raters for each category: methods of disclosure categories among disclosers (Kappa=.945, p=.000), discloser accounts on response (Kappa=.980, p=.000), discloser reasons for telling (Kappa=.935, p=.000), recipient accounts on how disclosers told (Kappa=.952, p=.000), recipient account on how they responded (Kappa=.994, p=.000) and recipient reasons on why disclosers told (Kappa=.985, p=.000). Thus, we can conclude that ratings for categories are considered reliable.

A power analysis for a power of .95 and an effect size of .25 concluded a minimum sample size of 176 survey participants was needed to test for statistical differences between four groups (44 participants per group): White disclosers, non-White disclosers, White recipients, and non-White recipients. The medium effect size of .25 was chosen because it can be argued that there will be a large enough difference between the four groups according to the literature on self-disclosure and racial/ethnic differences in communicating (Allen, 1997; Chang & Horrocks, 2006; Williams, 2008; Martinez, 2010).

Co-Culture

Discloser	White	Non-White
Recipient	White	Non-White

Figure 1. Participant Matrix. Respondent groups by discloser of a mental illness and recipient of a mental illness diagnosis, as well as co-cultural status.

Participants

Participants were members of the social networking site Facebook as of November 5, 2011, or given the survey link through someone else in their network via snowballing. This method was chosen as way of generating more survey responses. A message regarding the survey on *Communicating Mental Illness* (Appendix A), along with a link to the consent form (Appendix B) and survey (Appendix C) was posted to the researcher's Facebook page, and potential participants were encouraged to pass the link along to other people in their network who they thought would participate. Consequently, participants shared the link with people in their network via their own Facebook pages, Twitter, LinkedIn (a professional networking site), and email.

Respondents were eligible to complete the full survey if they were someone who was at least 18 years of age, who had been diagnosed with a mental illness or suffered from a mental condition, or knew someone with a mental illness. Those who had a mental illness (disclosers) were asked to complete the first half of the survey regarding who they told about their condition, how they told them, and how that person reacted. Recipients of the discloser (those who knew someone with a mental illness) were asked to complete the second half of the survey regarding

who told them about their condition and how they reacted to hearing this information. All participants were then asked to complete the demographic questions, which asked them their age, sex, ethnicity, marital status, and education level.

Sample Characteristics

Data were collected and recorded for 314 participants (Table 1). One hundred and thirty-one (42%) were disclosers and 183 (58%) were recipients. In this group, there were 268 females (86%), 44 males (14%) and one person who did not reveal their gender. The mean age was 2.57 or between 35 and 44. Thirteen percent were between the ages of 18 and 24, there were 39% between the ages of 25 and 34, 30% were between the ages of 35 and 44, 13% were between the ages of 45 and 54, there were 4% between the ages of 55-64, and 1% were 65 and over. Two people (1%) did not indicate their age.

Forty-seven percent were single, 41% were married, 10% were divorced, 2% separated, 1% were widowed, and two participants did not list their marital status. Thirty-five percent of the sample held master's degrees, 31% held a bachelor's degree, 20% listed some college (which included those with associate degrees), 7% had doctoral degrees, 3% had a high school diploma, 2% had a professional degree, 1% had an elementary school education, and 4 people did not list their education status.

In the sample, 155 participants (50%) were African American, 128 (41%) were Caucasian, 3% were Latino American, 2% were Asian, 1% were Indian, 1% were Native American, and 4% listed themselves as "other." Two respondents did not list their ethnicity. When marginalized (co-cultural) groups were combined, 183 were non-white participants (59%) and 128 were White (41%).

Out of 131 disclosers who stated their diagnosis or condition (Table 2), 58% had depression, 16% had bipolar disorder, 8% had anxiety disorder, 1% had schizophrenia, 7% had

PTSD, 2% had OCD, 1% had Borderline Personality disorder, and 6% indicated “other” or another form of mental disorder not listed. Out of 131 participants, 122 reported that they disclosed to someone (93%). The remaining 9 participants (7%) stated that they did not disclose. Of the disclosers who told someone about this medical condition, 45% disclosed to a romantic partner, 21% disclosed to a friend, 19 % disclosed to a parent, 7% disclosed to their sibling, 3% disclosed to an extended family member, 2% disclosed to a coworker, and 3% checked “other,” indicating that they disclosed to someone not listed such as a grandparent.

Out of 132 recipients who stated the primary mental illness their loved one was diagnosed with, 36% said their loved one had bipolar disorder, 34% said their loved one had depression, 10% said their loved one had schizophrenia, 6% said their loved one had PTSD, 3% stated OCD, another 2% said Borderline Personality Disorder. Two percent stated anxiety disorder, 1% stated their loved one had seasonal affective disorder, and 6% stated “other,” indicating some form of mental illness not listed. However, the difference as to the percentages of specific conditions is not important in this study of mental health disclosures as it is not dependent on the type of mental illness, but rather on the act of disclosing.

Procedures

Pre-test. A web survey was created on the Qualtrics survey program after Human Subjects Review Board approval was granted, and went live on November 5, 2011 via a Facebook post to the researcher’s main page for purposes of testing the survey questions. A pilot test is done when a survey is being used for the first time or has not been tested before on a specific population (Pratt, 2008). In addition to validation purposes, the pilot test will serve to catch potential errors, such as double-barreled or ambiguous questions. For one month testing period, 10 respondents per category (four groups) or a total of 40 respondents were used to test

the survey instrument. For testing purposes, participants were given questions from the survey, along with the following seven questions suggested by Pratt (2008):

1. How long did it take you to complete the survey?
2. What problems, if any, did you have completing the survey?
3. Are the directions clear?
4. Is there any words/language usage that people may not understand?
5. Were any questions too difficult?
6. Did the question choices allow you to answer as you intended?
7. Is there anything you would change about the instrument?

After reaching a total of 40 participants, the researcher reviewed answers to the test questions, and determined that no significant changes to the survey questions were needed. However, one error, concerning the absence of “Associate’s Degree” as an option under education level is noted in the limitations of this research. On the other hand, the survey question listed “Some College” as an option that respondents who fell into the category of having a 2-year degree could choose for education level. Nonetheless, since education level was not imperative to any of the research questions this study wished to answer, it was determined not to change the survey instrument or risk invalidating data by adding an additional category. Test questions from Pratt (2008) were also used to gain participant feedback for improving the survey in the future.

Upon completion of the survey review, it was found that among the 40 participants, 92 percent stated that both the directions and questions were clear. Thus, the researcher continued

with data collection efforts for a period of December 1, 2011 until March 1, 2012. Data analysis began while data collection was taking place, as the researcher examined emerging themes from the data responses gathered. The data collected were monitored daily by accessing the survey program and downloading data responses as they appeared in the researcher's report. The survey data were transferred to an excel spreadsheet on the researcher's computer, which remained password protected. At the end of the study, this data were transferred to SPSS Version 20.0 for analysis, and any survey responses that were not started were discarded.

Table 1: Sample Demographics (N=314)

Variable	<i>N</i>	%
<u>Age</u>		
18-24	41	13
25-34	121	39
35-44	94	30
45-54	39	13
55-64	12	4
64+	4	1
<u>Sex</u>		
Male	44	14
Female	268	86
<u>Ethnicity</u>		
Caucasian	128	41
African- American	155	50
Latino American	10	3
Native American	1	1
Asian	5	2
Indian	1	1
Other	11	4

Education level

Elementary School	1	1
High school graduate	10	3
Some College	64	20
Bachelor's Degree	97	31
Master's Degree	110	35
Doctoral Degree	21	7
Professional Degree	7	2

Marital Status

Single (never married)	147	47
Married	127	40
Separated	7	2
Divorced	30	10
Widowed	1	1

Note: Does not account for missing data as some participants did not note certain demographics.

Table 2: Type of Illness

Variable	Discloser		Recipient	
	N	%	N	%
	131	42	183	58
Depression	76	58	62	34
Bipolar Disorder	21	16	66	36
Schizophrenia	1	1	18	10
Post Traumatic Stress Disorder	9	7	11	6
Obsessive Compulsive Disorder	3	2	5	3
Borderline Personality Disorder	1	1	4	1
Anxiety Disorder	11	8	4	2
Seasonal Affective Disorder	0	0	1	1
Other	8	6	11	6

Note: Does not account for missing data as some respondents did not indicate type of illness.

Instrumentation and Data Collection.

The online survey on communicating mental illness was designed by using past research gathered from the review of literature, along with interview questions taken from Hyman's (2008) study on disclosing mental illness. It was designed through the Qualtrics survey program, and took about 7 to 10 minutes to complete. Upon entering the survey site, participants saw a consent screen along with information about the study. They were then asked whether they were a discloser of a mental illness or a recipient. Respondents who identified as having a mental illness

(discloser) completed the first ten questions along with the basic demographic questions towards the end of the survey.

Revealing a Diagnosis. The first question asked disclosers what type of mental illness they were diagnosed with. The next question asked respondents whether or not they told anyone about their mental illness diagnosis. If they stated they did not tell anyone about their mental illness, they were directed to the question asking them why they decided not to tell anyone about their condition.

Question three asked respondents to: “Please recall the most important encounter that occurred from telling someone you had a mental illness. In this encounter, who did you tell?” The respondents had the option of choosing whether or not their most important encounter occurred with a parent, sibling, extended family member, romantic partner, friend, coworker, or “other.” If they selected “other,” they were then asked to describe who they told.

Questions four and five posed open-ended questions in which the respondents was asked: “How did you tell this person you had a mental illness,” and “What was this person’s response upon hearing your diagnosis?” As a follow up, question six posed a Likert-style question asking the respondent how supportive they felt this person was upon hearing their diagnosis with “0” being not supportive at all, to “5” being highly supportive. The respondent was then asked to rate how supportive they felt the recipient was after the disclosure. Finally, the respondents were asked a series of open-ended questions (7-9) to determine the role that self-disclosure of their mental illness played in their life. Specifically, question seven asked respondents: “What was your primary reason for disclosing this information?”

Question eight asked: “Has self-disclosure had a positive or negative impact on your life?” A follow-up probe to question eight asked the respondent to explain why. Finally, question

nine asked respondents who disclosed their mental illness: “Would you do it differently if you had another chance to tell this person about your mental illness?”

Question (10-13) asked questions about ethnicity effects on disclosure. Question 10 asked, Do you think your ethnicity/racial background had an effect on your choosing to disclose information about your mental health? Respondents were able to state “Yes” or “No”. Question 11 asked, “If you answered yes to question 10, please explain why you felt your ethnicity/race had an impact on your decision to talk about your mental condition?” Question 12 asked, “Do you think your ethnicity/racial background had an effect on how you decided to go about telling the other person you had a mental illness? Finally, question 13 asked, “ If you answered yes to question 12, please explain why you felt your ethnicity/race had an impact on how you decided to disclose.”

For those respondents who did not disclose their mental illness, question 14 asked: “If you answered no to question two regarding whether you told anyone about your mental illness, what was your primary reason for not disclosing this information?” This question was posed to examine respondents’ motives for not disclosing their mental illness diagnosis to a loved one.

Recalling a Diagnosis. For the recipient of a disclosure, or someone who was on the receiving end of hearing a mental illness diagnosis or condition, a specific set of questions was given (15-22). These respondents were asked about their relationship to the discloser, whether it was a parent, sibling, extended family member, romantic partner, friend, coworker, or “other.” If other, they were asked to identify the nature of the relationship they had with the discloser. They were also asked what type of mental illness that person was diagnosed with.

Question 15 asked respondents what relationship they were to the person who had a mental condition, question 16 asks them what was their loved one’s primary illness. Question 17 asked respondents to recall the time when their loved one told them about their mental illness and

to explain how they revealed this information. Then, question 18 asked how the recipient of the disclosure reacted to this information. As a follow up to question 18, question 19 asked them to rate how supportive they felt they were towards the discloser after hearing about the discloser's mental condition. They were asked to rate themselves on a likert-style scale from 0-5 with "0" being not supportive at all to "5" being highly supportive.

Question 20 asked respondents, "Do you think your ethnicity/racial background had any effect on how you reacted to this disclosure?" They were then asked to respond "yes" or "no." Question 21, asked " If yes, how do you feel that your ethnicity/racial background affected your reaction to this disclosure?" Finally, question 22 asked them the primary reason that they feel the discloser had for telling them about their diagnosis.

Demographics. Last, along with questions about the quality of the survey, both the discloser and the recipient of the disclosure were asked basic demographic questions. These included questions regarding the respondent's age, gender, ethnicity, marital status, and educational level. Demographic questions were used to identify the background characteristics of the sample and to see if there were differences in survey answers based upon certain demographics such as ethnicity.

CHAPTER 4

Results

Methods of Self-Disclosure: RQ 1, 4

Responses to the discloser's question, "How did you tell someone you had a mental illness," and the recipient's question "How did this person tell you they had a mental illness," were asked to reveal participant methods of disclosure. To address how those with a mental illness self-disclose their medical diagnosis to a significant other, participant responses were grouped into major categories by the researcher, and judged by two reviewers who were blind to the study hypotheses. Upon agreement, six categories were formed. These categories were similar among both disclosers and recipients.

The six major categories that were revealed through discloser and recipient responses were examined in terms of direct and indirect communication. Direct communication included verbal, written, and electronic forms of communication. Indirect communication refers to the idea that the discloser's non-verbal cues or behavior caused the recipient to come to the conclusion that the discloser was suffering from a mental illness, or someone else besides the discloser revealed the information to the recipient. The six major categories were: *direct (straightforward) communication, explanation of diagnosis or treatment, disclosures during conversations about mental health, disclosures in casual conversation, disclosures due to a mental health episode or event, and disclosures due to recipient prior knowledge or observation.*

Method	Quote (s)
1.Direct (Straightforward) Communication	“I just talked to them about it.”
2.Explanation of Diagnosis or Treatment	“I told them I was taking Paxil so I could go to work”
3.Conversations about Mental Health	“We were talking about PTSD in supervision, and I told them I suffered from it for ten years.”
4.Casual Conversation	“I told them at dinner that I was diagnosed with depression.”
5.Mental Health Episode or Event	“I was hospitalized for a suicide attempt.”
6.Prior Knowledge or Observation (Revealed by someone else)	“I had a list of symptoms a mile long and they thought I was nuts.” “They [the discloser] did not tell me. My grandmother told me.”

Figure 2. Six Methods of Disclosure. Methods of self-disclosure most used by participants with example responses.

A subcategory to the prior knowledge or observation category emerged for recipients, for cases when the recipient was *told by someone else*.

A cross tabulation of categories revealed that both Whites and non-Whites used the same forms of communication. For both groups, out of the 116 responses that were categorized for how the discloser told someone they had a mental illness, direct (straightforward) disclosures (n=44) or explaining a medical diagnosis or treatment (n=25) were the preferred methods of communication. The most popular indirect form of communication was due to recipient prior knowledge or observation (n=17). These disclosures were usually shared with a romantic partner, friend, or parent.

Out of 59 (combined n=116) White disclosers, 28 stated they disclosed to a romantic partner, 13 to a parent, and 12 to a friend. They did so to seek help (n=17), gain understanding and acceptance (n=15) and because the recipient was someone they could trust and confide in (n=11). Out of 57 non-White disclosers whose responses were categorized (combined n=116), 25 spoke with a romantic partner, 13 to a friend, and 9 to a parent. They also disclosed to gain acceptance and understanding (n=16), to get support or help (n=15) and because the person was someone they could trust and confide in (n=14).

Disclosers' Reports on Disclosure. The discloser's view on how they decided to disclose revealed six major categories. Four of those categories fell under direct communication. These categories were direct (straightforward) disclosures, where the discloser initiated or came forward with the information that they had a mental illness without being prompted by the recipient, and disclosures specifically mentioning or explanation a diagnosis or treatment. In this form of disclosure, the discloser decided to reveal their diagnosis or condition by giving a medical report to the recipient, where they explained what illness they had and/or how they were being treated. The other categories were disclosures due to a conversation about mental

health/illness, and disclosures given during a casual conversation. These conversations were usually the result of the discloser and recipient spending recreational time together.

The remaining two categories fell under the indirect communication category: disclosures surrounding a mental health episode or event such as a hospitalization or suicide attempt, or indirect disclosure due to the recipient's prior knowledge or observation of the discloser's behavior. In this case, disclosers claimed that the recipient already knew of their condition because of a behavior or mood change.

Direct (Straightforward) Disclosure. An analysis of the open-ended question, "How did you tell this person you had a mental illness," revealed that most disclosers shared their diagnosis through direct (straightforward) disclosure. A cross tabulation of categorized responses from (combined n=116) disclosers who reported telling someone they had a mental illness, revealed that 21 out of 55 White disclosers and 23 out of 61 non-White disclosers told by direct disclosure. Direct disclosure means that the discloser initiated or came forward with the knowledge that they had a mental illness without the recipient asking for this information. These disclosers reported that they chose to be straightforward with their recipients by stating their condition outright. Many respondents said, "I just said it," or "I just talked to them about it." One discloser stated, "I just said 'I think I'm depressed.'"

While most respondents verbally disclosed in this manner, they did so in various ways. This included face-to-face encounters, waiting until they could talk to the recipient in a private one-on-one setting. Others called the person to discuss their condition over the phone, or used electronic media such as email, instant messaging, or text messaging. One participant even wrote a letter addressed to the recipient telling them about their condition—a form of direct written communication.

Explanation of Diagnosis and Treatment. A second form of direct communication involved disclosures surrounding a diagnosis or treatment. Disclosers revealed their diagnosis by conveying medical reports or treatments that they received from their doctor. These reports were usually given immediately upon hearing the diagnosis from a doctor or psychiatrist, or while the discloser was in the process of undergoing treatment. There were 15 out of 55 White, and 10 out of 61 non-White (combined n=116) who used an explanation of diagnosis or treatment to disclose their condition. For instance, one discloser said that she had just returned from the doctor who diagnosed her with depression and prescribed an anti-depressant as a treatment method. Another stated that she disclosed to her recipient after returning from picking up a prescription. One discloser stated, “I told them I was taking Paxil so I could go to work.”

Recipient’s Prior Knowledge or Observation. In addition, another form of indirect communication was the recipient’s prior knowledge or observation of the discloser’s mood or behavior. Nine out of 55 White disclosers, and 8 out of 61 non-white disclosers (combined n=116) reported that their recipients knew they had a mental illness because of mood swings or behavioral changes. As one discloser exclaimed, “I had symptoms a mile long and they thought I was nuts.” Another discloser stated, “My actions were pretty self-explanatory.”

Some disclosers even felt the need to explain these behavioral changes. They knew that the recipient was aware or concerned about their behavior, and felt the need to disclose as a result. These disclosers felt that the recipient deserved an explanation for witnessing these changes. As one discloser stated, “I need to explain why my mood has been so irregular, honey. I have depression.” In addition, these disclosers also felt the need to forewarn the recipient of what was to come. One discloser told her husband that she would be having unpredictable mood swings as a result of a medication change. In this case, recipients would be aware of why these behavior changes were taking place.

Conversation Surrounding Mental Health/Illness. Four out of 55 White and five out of 61 non-White disclosers felt the need to share their diagnosis during a conversation where the topic of discussion was about mental health or mental illness. These disclosers stated that they were already talking to the recipient about life experiences, which included talking about stress and how they were dealing with those stressors. Other disclosures came about as disclosers engaged in conversations where the recipient was already discussing what they heard about a specific medical condition. For instance, one discloser said he was talking about PTSD with the recipient and decided to tell that recipient that he had suffered from it for 10 years. Another respondent disclosed while she was discussing mood disorder support groups with the recipient.

Casual Conversation. While some disclosers felt the need to share when the topic of discussion was about mental health, 4 out of 55 Whites, and 5 out of 61 non-Whites disclosed in casual conversation. During these times, disclosers told while eating lunch or spending quality time with the recipient. For instance, many sufferers disclosed their situation over dinner. One discloser shared her diagnosis with the recipient while watching TV and eating pizza. The discloser felt that this was either a time where she felt most comfortable sharing or that this was a good time to reveal what the recipient needed to know.

Disclosers Resulting from Mental Health Event. While the majority of disclosers in this study were forthcoming with their diagnosis, 4 out of 55 White and 4 out of 61 non-White disclosers (combined n=116) reported that they indirectly revealed their mental illness as a result of a mental health event, where they suffered a psychiatric episode, hospitalization or attempted suicide. Thus, these participants were forced to share their mental health status with others because of a medical event or because recipients witnessed these occurrences. Disclosers felt that instances where they had a meltdown or were hospitalized for their condition, caused the recipient to find out on their own. Disclosers also felt that these events also forced them to

explain their condition. As one discloser mentioned, “I was hospitalized for a suicide attempt. I just told her I was depressed.”

Recipient Reports on Disclosure. Categories that emerged from recipient responses to how the discloser told them they had a mental illness were similar to discloser reports on how they decided to tell. These categories also fell under direct and indirect forms of communication. Similar to the discloser’s view on self-disclosure, recipients reported that disclosers revealed through direct (straightforward) disclosure, either face-to-face, by phone, written letters, or through electronic communication. They also revealed that disclosers told them by explaining or specifically reporting their diagnosis or treatment plan, in a conversation about mental health/illness, or in a casual conversation not focused on mental health.

In terms of indirect communication, categories were also similar in that recipients stated they found out through a mental health episode or event, and through prior knowledge or observation of the person’s behavior. However, a subcategory of prior knowledge emerged as the recipient explained that they were told by someone else. Usually, this person was another family member who explained to the recipient that the discloser was suffering from a mental illness. In these instances, the recipients already knew about the discloser’s condition without having to be told by the discloser. Whereas the discloser thought the recipient knew based on behavior, recipients revealed that they also found out because someone else had already told them.

Direct (Straightforward) Disclosure. Recipients reported the same as disclosers in that both revealed that most disclosers came forth with the information that they were suffering from a mental illness without being prompted by the recipient. As recipients stated, “They just said it,” or “They just told me.” Out of 174 recipients whose responses could be categorized, 52 recipients stated that the discloser directly told them about their illness. Similar to discloser responses, these disclosures happened via face-to-face encounters, by phone, written communication such as notes

or letters, or electronically (such as via email). Recipients also stated that disclosers pulled them aside or sat them down privately in a one-on-one conversation to explain their condition. They remembered receiving phone calls where the disclosers just decided it was time to let them know they had been suffering or the discloser needed someone to confide in. Other recipients stated that the disclosers wrote them letters or notes explaining their illness or communicated to them online or via text messaging.

Explanation of Diagnosis or Treatment. A cross tabulation revealed that similar to disclosers' reports about telling recipients of their mental illness, recipients confirmed that some disclosers also told in a manner that explained their diagnosis and type of treatment. However, it was not nearly as common a communication method as the use of direct disclosure according to recipient reports. Only 15 recipients (n=174) stated that they found out through an explanation of a diagnosis. These recipients stated that the disclosers revealed their diagnosis similar to giving a medical report. As one recipient noted, "They relayed the information they got from the doctor about depression and associated medications." Another recipient stated, "[the discloser] mentioned that they were taking an anti-depressant."

Prior Knowledge or Observation. Reports from disclosers revealed that they already believed the recipient knew about their condition due to mood or behavior changes. Recipients confirmed these reports in stating that they were already aware of the discloser's condition or suspected something was wrong because of the discloser's behavior. Thirty-two recipients (n=174) stated that the disclosure was not directly told to them, but they could see that the discloser's behavior was not normal. Rather, the recipients stated that they observed these behavioral changes and concluded from those experiences that the discloser suffered from a mental health condition. As one respondent noted, "It was not explained to me, it was an 'experience.'"

However, recipients also revealed that not only did they know about the discloser's medical condition because of changes in behavior, but because someone else had told them. Sixteen of the recipients (n=174) reported that they had been told in this manner. Usually, the person who revealed this information to them was another member of their family. For instance, respondents stated, "My aunt told me about my cousin. He had a lifelong issue with drugs," "I was informed by another family member that he (my uncle) was diagnosed as bipolar," "They [the discloser] did not tell me. My grandmother told me," "I was informed by another relative who explained the diagnosis to me," and "They [the discloser] didn't tell. My grandmother told the whole family." In this case, the discloser did not have to exhibit behavioral changes in front of the recipient, but the recipient had already been given information by someone else—a form of "disclosure" in which the person with the mental health disorder was unaware.

Conversation Surrounding Mental Health. Recipients also revealed that disclosers told them in a conversation that was targeted towards mental health/illness. Twelve recipients (combined n=174) revealed that they were told in this way. One recipient stated that she was talking about the recent deaths in her family and the discloser stated that it was too much to bear. In this case, the discloser felt the need to share her diagnosis as a result of discussing stress and grief. In another conversation, the recipient stated that it became obvious after they discussed with the discloser about hearing voices and seeing things that weren't there. Another stated, "He was telling me about the army and how the war messed him up."

Casual Conversation. While some recipients stated that the discloser told in a conversation about mental health, another 12 recipients (n=174) said they were told in casual conversation similar to what was reported by disclosers. These disclosures happened during general conversations that were not targeted towards mental health. They also occurred when the recipient was communicating with the discloser either over lunch or dinner. One recipient

mentioned that the discloser shared the information while eating pizza, and another mentioned it happened during a casual conversation during lunch. Another recipient mentioned that the discloser just happened to share during a casual conversation on their way to the airport.

Disclosure Surrounding a Mental Health Event. Both discloser and recipient reports revealed that indirect disclosure occurred as a result of a mental health event where the discloser suffered an episode, hospitalization, or attempted suicide. However, this was the second most common form of disclosure among recipients, and one of the least reported forms of disclosures among disclosers. A total of 8 (n=116) disclosers stated that their diagnosis became evident after a mental health episode, while 32 recipients (n=174) reported that they knew because of a mental health episode. For example, one respondent stated that the discloser had attempted suicide after a divorce, another stated that she found out when the discloser was admitted to an inpatient facility. So, many of these disclosures took place in the form of an encounter with the discloser after being admitted or released from the hospital, or when they discloser came to them in distress. Usually, the discloser approached them in tears and the recipient became aware that there was a problem. This also occurred when the disclosers revealed that they needed to seek or had already sought immediate medical attention.

Reasons for Disclosure: RQ 2, 3

Discloser Reasons for a Disclosure. Four major reasons for disclosing for both White and non-White participants emerged from the reported responses of the discloser : the discloser was looking for support or help, the discloser was looking for understanding and acceptance, the discloser felt the recipient was someone who could be trusted and that they could confide in, and the discloser was looking for psychological relief or needed to vent (See Figure 3).

Support/Help. Seventeen out of 59 White and 15 out of 57 non-White (combined n=116) disclosers said they told because they needed support or help. They were looking for the recipient

to be there for them, or in need of support services because they were not feeling well. One respondent stated she was seeking the “help and patience of those surrounding me.” While another respondent said she told to prevent potential self-harm or suicide from occurring. In these instances, disclosers told because they needed to reach out for assistance.

Understanding/Acceptance. Fifteen out of 59 White and 16 out of 57 non-White (combined n=116) disclosers stated that they were looking for understanding or acceptance from the recipient, and this was their reasoning behind disclosing that they had a mental illness. For instance, one discloser stated that they disclosed to “allow my partner to understand me and my past.” Another discloser said they disclosed because they were in a committed relationship and it was something that their partner should know. Thus, disclosers felt the need to share and gain understanding and acceptance from the people in which they shared a close relationship.

Trust/Someone to Confide. Stemming from a need for understanding and acceptance, disclosers stated that another major reason why they disclosed was because they felt the recipient was someone in whom they could trust or confide in. Eleven out of 59 White and 14 out of 57 non-White (n=116) disclosers felt that the person in which they were disclosing was someone that they felt comfortable talking with, and who they felt would not judge them for having a mental illness. For instance, disclosers stated:

“I need someone to talk to that I could trust.”

“I value this person’s opinion and wanted to share what I was going through. I knew she would not judge me.”

“This person was my best friend and I trusted her.”

“I needed someone to confide in.”

“He’s my husband. I share everything with him.”

Psychological Relief. Six White and 5 non-White disclosers (combined n=116) stated that they were seeking psychological relief or comfort by telling the recipient about their diagnosis. For instance, many disclosers were trying to get the information off their chest or to vent. One discloser said, “I needed someone to express myself to,” while another stated, “I needed someone to talk to.” Yet, another discloser stated that she needed to talk with someone who wasn’t a professional.

Other reasons. In some cases, disclosers felt compelled to disclose because they were pressured by the recipient or by someone else. Usually, the recipients wanted them to tell others or seek professional help. For example, one discloser stated that her recipient insisted that she see a counselor for symptoms of depression. Another stated that her friend suggested she might be mentally ill, and she felt the need to answer her concerns. As one discloser put, “I felt convicted to.” One respondent even stated that her doctor told her she should tell the recipient of her diagnosis.

Recipient Reasons for a Disclosure. Recipient responses to “Why do you think this person told you about their mental illness?” revealed five categories. Three of these categories were similar to discloser reports for why they disclosed. The categories that were similar to discloser responses were: support/help, a need for understanding and acceptance, and the recipients felt the discloser thought they were someone they could trust and confide in. Recipient responses also revealed two additional categories that were very different from discloser responses: explanation of mood/behavior and prior knowledge or observation.

Help/Support. Similar to discloser reports on why they told, 11 out of 56 White and 20 out of 103 non-White recipients (combined n=159) stated disclosers told because they were in need of support or help. Most recipients stated that the discloser knew they were someone who would be there for them in their time of need, or point them in the direction of the proper services

to get medical attention. Recipients also felt that the discloser was looking for assistance in getting the help that they needed. As one recipient thought the discloser told her so that she could assist in paying his medical expenses.

Understanding/Acceptance. Twelve out of 56 White, and 17 out of 103 non-White recipients (combined n=159) felt that the disclosure occurred because the discloser was looking for understanding or acceptance. In this case, disclosers wanted to know if recipients would accept them and their illness. One respondent said, “She told me that she felt I would be understanding.” Another recipient stated, “We were discussing the possibility of a long term relationship.” So, the discloser wanted to know if the recipient would be willing to date someone with a mental illness.

Someone to Trust/Confide. Twelve out of 56 White and 15 out of 103 non-White recipients (combined n=159) also felt that the discloser thought they were someone they could trust and confide in, which reflects disclosers’ reasoning that the recipient was someone they felt comfortable divulging information to. Therefore, both disclosers and recipients felt that a major reason for disclosing was due to loyalty and trust. Examples include:

“She trusted me and she knew I would support her.”

“We were being open and honest from the start.”

“I can be trusted.”

“They were very close to me and knew that I wouldn’t turn my back on them.”

Explain Mood/Behavior. In addition, 6 out of 56 Whites, and 19 out of 103 non-Whites (combined n=159) felt that the discloser told because they needed to explain their mood or behavior. The recipients thought the disclosers were aware that the recipients were concerned about their behavior, and felt the need to explain. For example one respondent said, “She wanted

to explain some of her behavior from the past.” Another respondent said, “She was explaining her erratic behavior.” Likewise, another recipient revealed, “He is my brother and for a long time he had confided that he felt ‘different’ like he just couldn’t control any of his emotions.”

Other reasons. Consequently, the recipient felt that the discloser didn’t have a direct reason for sharing or explaining their mood, because the recipient was already aware of their illness. The recipient already suspected that the discloser might be mentally ill. Thus, there was no reason to share as the recipient already had prior knowledge of the diagnosis. A cross tabulation showed that 6 out of 56 White and 11 out of 103 non-White recipients felt the reason for disclosing was due to observation. Therefore, it was only in explaining a mood or behavior that the discloser confirmed what the recipient had already knew or witnessed prior to the actual disclosure. As one recipient concluded, “She can’t lie to me.”

Recipients also felt that disclosers revealed their diagnoses because of a mental health event such as a psychological episode, hospitalization, or attempted suicide. The recipients felt that since the disclosers’ illness had been revealed through such an event, they were forced to share their diagnoses with them. For instance, one recipient said the discloser became very ill and wasn’t taking care of himself, so they knew he was mentally ill. Another recipient said that their discloser had no choice in the matter because of the way he was acting. Another stated that the discloser had to “explain their hospital stay.”

Top Four Reasons For a Mental Illness Disclosure	
Discloser	Recipient
1. Support/Help	1. Support/Help
2. Understanding/Acceptance	2. Understanding/Acceptance
3. Someone Trust/Confide	3. Someone Trust/Confide
4. Psychological Relief	4. Explain Mood/Behavior

Figure 3. Top Four Reasons for a Mental Illness Disclosure. Reasons for a mental illness diagnosis by discloser and recipient reports.

Responses to Self-Disclosure: RQ 5

Discloser Reports on Response. Disclosers' reports on responses to their disclosure revealed four major categories: *understanding/compassion*, *support/help*, *rejection/dismissal (denial)*, and *confirmation*. A few disclosers reported that their disclosures were met with fear and concern. For instance, the recipient became afraid of the discloser or panicked at the thought of knowing the person had a mental health condition. Others stated that the person was shocked or confused about the diagnosis.

Understanding/Compassion. In response to how recipients reacted to their discloser, 14 White and 12 non-White disclosers (out of 119 participant responses that could be categorized)

claimed that the recipient was very understanding and compassionate (accepting) upon hearing of their condition. They stated that the recipients showed a sense of sympathy towards them upon hearing that they were ill. These recipients reacted with sadness towards the discloser when they found out they suffered from a mental condition. Yet, they acknowledged that they understood what was being revealed to them. One discloser said the person they disclosed to was very welcoming and happy they were able to seek help, while another stated that their recipient was supportive considering they had the same diagnosis.

In addition, disclosers reported that these recipients were able to acknowledge that the discloser was mentally ill. They were able to come to terms with the diagnosis and were still welcoming of the discloser. One discloser said the recipient was welcoming to the fact that she had a mental illness because anxiety ran in the family. Another discloser stated that the recipient was “cool with it.” In these cases, recipients welcomed the discloser despite their medical condition, and acknowledged that there was a problem that needed attention.

Support/Help. Fourteen White and 12 non-White (combined n=119) disclosers reported that the recipient responded by offering support such as telling the discloser that they were there for them or by offering advice on how to overcome their illness. One discloser was referred to a local psychiatrist, and another discloser said the recipient suggested they talk to the doctor about their condition. Some recipients even prayed for the discloser upon hearing that they were sick.

Rejection/Dismissal. On the other hand, 12 White and 10 non-White disclosers (combined n=119) reported that recipients rejected or dismissed them altogether. These recipients refused to accept the discloser or the illness itself. Rejection response types are as follows:

“[the recipient] said I was crazy and selfish.”

“They dismissed me. They told me they refused to believe it and that it was all in my head.”

“They told me it was a bad idea to be on this medication and that most people are unhappy-that’s life.”

“No response...glossed over it.”

“She basically said ‘okay’ and went on with her day.”

“My siblings sent me to my parents so they didn’t have to ‘deal with me.’”

As a subcategory of rejection/dismissal, the disclosers stated that the recipients denied their diagnosis. These disclosers stated that recipients didn’t reject them, but told them they didn’t have a mental illness or refused to believe that they needed adequate treatment. One discloser revealed, “[the recipient] said I was being dramatic,” while another stated that her recipient told her she was making excuses for why she was not feeling like herself. Other reported responses included: “You don’t have a mental illness,” “I should not have to be medicated to live my life,” and “He really didn’t believe Black people had depression.”

Confirmation. Confirmation refers to responses where recipients claimed to be already aware of the disclosers’ illness because they found out through other means or by observing the disclosers’ behaviors. Out of 119 responses that could be categorized, 14 White and 12 non-White disclosers stated that their disclosure confirmed what the recipient already knew. For instance, one discloser stated, “He was not surprised.” Another revealed, “He already knew something was wrong,” while another pointed out, “He suspected, and actually thought I might be bipolar.” So, while some disclosers may have thought they were revealing their diagnosis for the first time, the recipient was only waiting to confirm their suspicions.

Other responses. On the other hand, disclosers stated that recipients were shocked or surprised to hear of the diagnosis. One discloser stated, “My husband was surprised and we discussed my need to express when I was depressed.” Another stated, “She [the recipient] was surprised because she had always seen me as a strong person without any problems.” In these

instances, the recipients were stunned to know that the disclosers could have a mental illness because they perceived them as being relatively healthy.

Lastly, disclosers reported a sense of confusion or uncertainty among recipients when they heard about their diagnosis. Disclosers stated that these recipients could not grasp how or why the disclosers had a mental illness. They did not refuse to believe it nor did they dismiss the discloser, but they could not understand how someone could have a mental illness. As one discloser put it, “He was trying to be understanding and supportive, but admits that he doesn’t get it.”

Recipient reports. Recipient reports slightly differed from discloser accounts on how they reacted. Major categories that emerged from recipients’ self-report about how they reacted to the discloser were understanding/compassion (acceptance), confirmation, support/help, shock/surprise, and curiosity. Recipients also said they denied or rejected the discloser, but it was not the most common response reported. However, according to discloser accounts, rejection or dismissal was the third most reported form of reaction.

Understanding/Compassion. Thirty-one out of 179 of recipient categorized responses were seen as being understanding and compassionate. Sixteen out of 61 Whites and 15 out of 118 non-Whites recipients responded in this way. Recipients felt that given the circumstances, they came to accept that the discloser was mentally ill. One recipient said she was “accepting and not judgmental, of course” and another stated, “I accepted it with no judgment and provided support.” One respondent reported that she accepted the discloser “with welcoming arms.” Therefore, unlike those who denied or rejected the discloser or their illness, these recipients reported that they accepted that the discloser was in fact ill and needed help. They also reported that they showed sympathy towards the discloser upon hearing the diagnosis.

Confirmation. Similar to discloser reports, recipient stated that the disclosure confirmed what they already knew. Thirty-nine out of 179 recipients stated their reaction was one of confirmation. Sixteen White and 23 non-White recipients were either suspicious or concerned about the discloser's behavior, or they had been told by someone else that the discloser suffered from a mental condition. One respondent stated, "This was no surprise, just confirmation of what I already knew." Another stated that her reply was, "I know, and I'm happy you went to the doctor." Many respondents reported that they already "saw the signs" or that things "made sense" after hearing the diagnosis.

Support/Help. Twenty-one out of 179 recipients, (7 White and 14 non-White) said that they offered support or help to the discloser as a result of hearing their diagnosis, which reflect disclosers' reports that support or help was given most often. One recipient stated, "I advised her to go to the doctor for further testing," and another stated, "I asked if they needed help finding treatment or if they were already receiving treatment," and another said she comforted the discloser and then proceeded to pray for her.

Shock/Surprise. Twenty-five recipients out of 179 (5 White, and 20 non-White) recipients were shocked to hear the news. This was similar to discloser accounts of recipient reactions. Many recipients stated that they were very shocked or surprised to learn that the discloser was suffering from a mental illness. One recipient stated he/she was "very shocked" and "should not have known because it was something very personal." Another respondent claimed that she was "taken aback" by the disclosure. In fact, a majority of respondents whose suspicions were not confirmed by the disclosure admitted to being shocked or surprised instead. For instance, there were respondents who said that they were surprised initially or would have been in shock had they not suspected something was wrong beforehand.

Other responses. Unlike what was mentioned by disclosers, 10 recipients out of 179 (4 White, 6 non-White) recipients stated that the disclosure was met with curiosity. Although some recipients admitted to being confused about the discloser's disease, they also mentioned that they were curious to know more about mental illness. They either didn't understand the diagnosis or the condition to which the discloser was referring, or they just didn't grasp the idea of being mentally ill. As one recipient put it, "I was upset because I thought it was much like a conventional illness or condition; one and done. A surgery, treatment plan, or rest and he would be back to new. Little did I know about the shock treatments and medications of the day." However, curious recipients started asking questions about the discloser's illness and conducting research on their own. One respondent stated, "I tried to learn everything I could via the Internet." Another stated, "I wanted to know more about the illness and how I could help." So, while these recipients were uncertain about the disease, they were nonetheless willing to learn about it.

Some, recipients also reported that they denied the discloser's diagnosis. These recipients did not know whether the discloser was telling the truth, or if they were just making excuses for their behavior. One respondent stated, "I couldn't fully understand it. I thought it was just a poor excuse." Another said, "I wasn't sure whether it was an excuse or real since I don't know the clinical definition of the disorder." Yet, another recipient admitted that the discloser did not look like someone who could have a mental illness and she was in disbelief because of that. She stated, "He [the discloser] is a very well spoken articulate man. He is neat, clean, nicely dressed and does not fit my image of someone who is impaired with a mental health problem."

Some recipients reported that they outright rejected or dismissed the discloser and/or their diagnosis. One recipient reported that her response was, "Like what is wrong with you? Why do you keep listening and accepting what you are hearing?" and another respondent said that she was "un-phased" by the disclosure. One recipient said he/she remained neutral, which could be taken

as a form of dismissal or refusal to deal with the issue. In this case, recipients were typically unsupportive of the discloser or welcoming of the diagnosis.

More recipients than disclosers reported that they were fearful or became uncomfortable upon hearing the diagnosis. While only two disclosers reported that the recipient was fearful, eight recipients said they were afraid of the discloser or of the diagnosis. One recipient said, “At first I was a little uncomfortable because I had never really met anyone with bipolar disorder,” and another said that they were “always afraid of him,” referring to the discloser. Even a recipient who admitted that she was a professional in the mental health field, stated that her personal involvement with someone who was mentally ill was a “little too close for comfort.”

Top Four Responses to a Mental Illness Disclosure	
Discloser	Recipient
1. Understanding/Compassion (Acceptance)	1. Understanding/Compassion (Acceptance)
2. Support/Help	2. Support/Help
3. Rejection/Dismissal	3 Confirmation
4. Confirmation	4. Shock/Surprise

Figure 4. Top Four Responses to a Mental Illness Disclosure Revealed through Discloser and Recipient Accounts.

Cultural Effects on Disclosing and Receiving a Diagnosis: RQ 6,7

Disclosers were asked if they felt their race/ethnicity had any effect on whether they decided to disclose or not, or how they went about disclosing their mental health information. A chi-square analysis revealed that co-cultural status played a significantly greater role in non-White than White disclosers when choosing to tell $\chi^2(1, N=121)=8.79, p=.003$, but not when deciding how to tell $\chi^2(1, N=119)=1.89, p>.05$.

As an explanation, many non-white respondents noted cultural traditions or customs among their ethnic group as reasons for whether or not they decided to disclose. For instance disclosers stated:

“As African Americans, we are usually afraid to get help because people will think we are crazy.”

“Black people, particularly women, are supposed to be overly strong and independent.”

“I’m Hispanic, and this [mental illness] just assumes I come from a troubled background.”

“Black people growing up in the late 90s, early 80s era are told to hold things in.”

“We keep things to ourselves and do not want to be seen as another crazy Black woman.”

“I think mental illness is seen as a weakness in the Black community.”

However, for White disclosers, any hesitation towards disclosing came from pride not necessarily due to race. One White discloser stated that her pride from her American upbringing made it difficult to disclose. Another White discloser stated that they held a sense of pride from being an upper middle class citizen, and thus didn’t want to disappoint her family. Unlike non-

White respondents, none of the White respondents mentioned their race as a factor for disclosure. These respondents stated that their race had nothing to do with their disclosures:

“I am White. There are less cultural barriers to getting assistance, which is a privilege.”

“I am a White female from a middle class family, so it is very socially acceptable for me to acknowledge depression. There are many models for this behavior in popular culture.”

“I think the cultural influences of some other racial backgrounds might tend to cause people from these backgrounds to feel more pressure to appear stoic and strong and therefore not disclose personal information about mental illness. Thus, I guess my ethnicity made it more likely for me to disclose than others.”

As for race/ethnicity affecting how they decided to go about disclosing their information, there were no significant differences between Whites and Non-Whites. However, non-White respondents who stated that race/ethnicity was a factor noted cultural traditions that posed barriers for talking about mental illness and seeking treatment. These respondents felt that they needed to overcome those traditions by showing others that marginalized group members can address and seek help for mental illness. On the other hand, White respondents stated that race was not so much an issue in that being White presented them with the privilege of easier disclosure.

However, while there were significant differences in whether race/ethnicity affected disclosure, statistical test revealed no significant differences ($\chi^2(1, N=119)=1.89, p>.05$) between groups regarding who disclosers decided was worthy of receiving their information. Both Whites and non-Whites disclosed to people outside the family. Out of 121 disclosers, 55 revealed to a

romantic partner (29 Whites, 26 non-Whites), 26 revealed this information to a friend (13 White, 13 non-White), and 22 (13 Whites and 9 non-Whites) revealed to a parent.

Culture and Receiving a Diagnosis. Recipients were asked if they felt their race/ethnicity had an effect on how they responded to the disclosure. A chi-square analysis revealed a significant difference between White and non-White participants regarding whether ethnicity had an effect on how they received a mental illness diagnosis ($\chi^2(1, N=181)=11.45, p=.001$). Therefore, non-Whites were more likely to report “yes” in answer to whether race/ethnicity had an effect on how they responded to the disclosure than Whites. Similar to disclosers, for non-White recipients cultural traditions and customs as they relate to ethnicity were mentioned as affecting disclosure response. As one Asian respondent noted, “Admitting to depression is shameful in my culture. I know it isn’t. I know better.” Other responses included:

“Black people are told to remain silent about these issues.”

“I might be wrong, but as African-Americans we are more skeptical about these kinds of issues.”

“Minorities are often not quick to disclose mental illness.”

“I said yes because being African American we are constantly discriminated against so I would never want to discriminate against anyone else.”

“I know that in the Black community, mental illness is shunned and not discussed and worse not supportive so I felt it was my duty as her friend and as another Black American women to support her.”

White respondents, again, did not mention specific cultural barriers or customs as it related to race/ethnicity in their responses as often as non-white recipients did. However, some White respondents did acknowledge that race may play a role in how one deals with a mental illness. As one Caucasian female put it, “A demographic such as race plays a huge part of how mental illness has been presented to you and what you know about it, and how it affects your community.”

Cultural Differences in Support

Both disclosers and recipients were asked to rate support of the disclosure on a scale from 0 to 5, with 0 being “Not at All Supportive” to 5 being “Highly Supportive.” For analysis purposes, descriptors on the scale were translated to 0 being “completely unsupportive,” 1 as “very unsupportive,” 2 as “slightly unsupportive,” 3 being “slightly supportive, 4 being “very supportive,” and 5 being “completely supportive.” With these descriptors in mind, the average respondent stated that the recipient as being very supportive (4) with a mean of 3.7 (SD=1.7).

Slightly more than half of the disclosers felt that their recipients were completely supportive (51%). Fourteen percent of the disclosers rated their recipients as slightly supportive. Six percent said the recipient was slightly unsupportive while another 4 percent leaned towards not very unsupportive, and 11 percent stated that the recipient was completely unsupportive. An independent sample t-test revealed that there was no significant difference between Whites and non-Whites in terms of perceived support.

Recipients also rated themselves on the same scale in terms of how supportive they felt they were upon hearing the diagnosis. The average recipient also thought of themselves as very supportive (4) with a mean of 4.07 (SD=1.3). A little over half of the sample of recipients (54%) stated that they felt they were completely supportive. Twelve percent rated themselves as slightly supportive. Eight percent rated themselves as slightly unsupportive, and 4 percent rated

themselves as very unsupportive. Last, only 2 percent rated themselves as being completely unsupportive compared to disclosers, where 11 percent of disclosers said the recipient was completely unsupportive. Thus, it may be quite possible that in some instances, recipients overestimated their actual support of the individual or the discloser underestimated perceived support of the recipient.

However, although disclosers rated recipients lower on the support scale than recipients rated themselves, disclosers did state that disclosing served to be an overall positive experience. Out of 119 responses, 79 participants (41 White, 37 non-White) stated that the experience of disclosing was a positive one. Only 16 disclosers (9 White, 7 non-White) felt that it was a negative experience. Nine participants (6 White, 3 non-White) said it was both a positive and negative experience, while 6 White and none of the Non-White participants put “neither.” Seventy-three percent of disclosers also stated that if they had to do it all over again, they would reveal in the same manner. Therefore, despite co-cultural status, most participants felt that the disclosure was a positive experience.

Summary

An analysis of participant responses found both similarities and differences in methods of disclosure between disclosers and recipients despite co-cultural status. For instance, both White and non-White disclosers used similar methods to disclose their mental illness. These methods included direct (straightforward) communication, explanation of diagnosis or treatment, disclosures during a conversation about mental health, disclosures during casual conversation and indirect disclosures due to a mental health event or recipient prior knowledge or observation. Recipients listed the same methods to how they received the disclosure except they revealed that they were told by someone else, which was later added as a subcategory to recipient prior knowledge or observation.

Also, this study found no significant differences between Whites and non-Whites choice in self-disclosing. Both groups used direct communication and explanation of diagnosis or treatment as the preferred method of disclosure. The most commonly mentioned form of indirect disclosure was recipient prior knowledge or observation among both groups. In addition, both Whites and non-Whites disclosed to others based on perceived closeness as noted in Magsmen-Conrad, et al. (2008). For instance, both groups disclosed to a romantic partner, friend, or parent who they felt would be most supportive, as opposed to acquaintances and coworkers (Magsmen-Conrad, et al., 2008).

Reasons for disclosure were also similar among disclosers and recipients, and were not different between White and non-White disclosers. According to discloser and recipient reports, the majority of disclosers revealed their diagnosis because they wanted support or help from the recipient. They were also seeking understanding and acceptance, and the person they disclosed to was someone they felt they could trust and confide in. Greene, et al. (2006) note trust and understanding as one of the major reasons for disclosure. Disclosers also said they disclosed for psychological relief or to vent, which is noted in the literature as another major reason for self-disclosure (Greene, et al, 2006). However, recipients stated another reason they felt disclosers told, which was to explain unusual mood or behavior.

In terms of responding to a diagnosis, differences emerged between how disclosers and recipients reported how the recipient responded to the discloser. Both groups stated the discloser was met with understanding and compassion and that the recipient was there for support and help. However, many disclosers mentioned that they were also met with rejection, whereas recipients did not mention rejection as a major response. More recipients than disclosers stated that recipients were shocked and surprised or that the disclosure confirmed recipients' beliefs that the discloser was mentally ill.

In addition to methods and responses to disclosure, this study did find a significant difference between Whites and non-Whites in terms of ethnic effects on choosing to disclose a mental illness and reacting to a mental health diagnosis. Non-Whites were more likely to admit that ethnicity had an influence on choosing to disclose and how the disclosure was received. These participants cited negative cultural customs and beliefs concerning mental illnesses as reasons for why they felt ethnicity played a role in disclosure. Whites were less likely to cite such cultural influences, but instead alluded to pride as being a hindering factor to disclosure.

CHAPTER 5

Discussion

In this section, I will examine study findings for methods of disclosure, reasons for disclosures and responses to a mental health diagnosis. We will also examine cultural effects on disclosing and responding to a mental health disclosure. Finally, we will discuss study strengths and limitations, as well as implications for further research.

Exploring Methods of Disclosure: RQ 1, 4

Corrigan and Lundin (2001) state that self-disclosure of a mental illness is not a simple straightforward event, but rather a process of deciding who, when and what information to share. The Communication Privacy Management model provides a theoretical framework to explain the complexities of self-disclosure and the constant negotiations that occur when deciding what information to share, who to share information with, and who to trust as co-owners of one's private information (Petronio & Dunham, 2008). By controlling self-disclosure of a mental health status, disclosers can stay in control of who knows what about their illness (Corrigan & Lundin, 2001).

In this study, much of the sample disclosers reported engaging in selective disclosure, deciding to disclose to a select number of people they felt would be most receptive and supportive of their condition (Corrigan & Lundin, 2001). Many disclosers reported sharing or revealing their illness to a romantic partner such as a spouse, close friend, or parent. This finding supports the contention by Magsmen-Conrad, et al. (2008) that disclosure of mental health status is strongly

influenced by perceived closeness and partner responsiveness. or the degree to which one feels loved, understood, and cared for. Thus, participants were more likely to disclose their mental health status to people to whom they felt a strong personal connection. They were also able to seek understanding and acceptance from people who they were confident would receive them with support and sensitivity, and thus create a positive disclosure experience (Greene, et al., 2006).

While a few people decided to wait to disclose their mental health diagnosis, the major categories that emerged from participant data showed that most disclosers came straightforward with the information without holding back. It may be possible that because they felt a perceived closeness and responsiveness from those they decided to disclose to, they were able to come forward and tell of their diagnosis without hesitation. If they perceived that the recipient would understand or accept them after the disclosure, they would be more confident in telling them about their diagnosis (Greene, et al, 2006). Participants were able to be straightforward with their disclosure and “just come out and say it.” This closeness also allowed for a comfortable space or environment where they felt at ease sharing their diagnosis, such as the case where people discussed their diagnosis during casual conversations over pizza with a good friend or dinner with their spouse. This may also account for the natural ability for participants to share when the topic of mental health was already being discussed.

Another major way of disclosing was by specifically explaining a diagnosis or treatment. While Corrigan and Lundin (2001) note that there is no best method for mental health status disclosure, this may have been a better way of explaining mood or behavioral changes that could not be understood otherwise. The discloser may have felt that by giving the recipient a medical report from their doctor or explaining his/her diagnosis in medical terms, the medical status would appear more credible. In this case, the recipient would be most likely to understand or

accept the seriousness of the diagnosis. This phenomenon relates to self-positive face maintenance under face negotiation theory (Ting-Toomey, 1988), as many people may have used technical or clinical definitions of their disorder as a way of saving face. They may have thought this method of disclosing would avoid the possibility of others seeing them as crazy or unstable. Essentially, they may have used this communication strategy as a way of securing their need to be approved or valued.

Indirect methods of disclosure included disclosures surrounding a mental health event or episode and recipient prior knowledge or observation. These types of disclosures forced the disclosers to tell of their diagnosis or evidence of their diagnosis was given because of psychological episodes or other observations made by the recipients. If the disclosers were hospitalized or attempted suicide, the recipients found out they were mentally ill because of these occurrences. Also, the recipients found out through prior knowledge or observations. In these cases, the recipients already knew or suspected the disclosers were mentally ill because of what they had observed.

In addition, recipients also said they knew about the disclosers mental health status because they were told by someone else, which appears to be a subcategory of prior knowledge and observation not reflected in discloser reports. Thus, these recipients knew before the disclosers revealed their illness because someone else had told them. These were usually family members who felt the need to tell the entire family about the disclosers' disease. This relates to the aspect of boundary turbulence or the violation of privacy conceptualized by CPM theory (Petronio & Dunham, 2008). In this instance, disclosers thought they were in control or properly managing diagnosis information, but they were not. In actuality, other people were disclosing their information for them—an aspect of disclosure that disclosers themselves were unaware of.

In regards to Communication Privacy Management and Co-Cultural Theory, study results suggest that there may be general characteristics common to the mentally ill co-culture, with unique concerns coming from marginalized group members who are also mentally ill. As a double co-culture, members who are marginalized by mental health and racial status in society, reported that they considered ethnicity in the disclosure process more so than Whites. However, despite these concerns, most mentally ill participants stated that they disclosed in a similar fashion. Therefore, the process of relieving the dialectic tension between choosing to reveal or conceal private health information was essentially the same between both White and non-White participants. As members of the mentally ill co-culture, both groups worked through this tension by using the same methods of disclosure—either through direct or indirect means of communication. Orbe (1998) mentions that all members within a co-culture share similar characteristics, so that regardless of race, those who belonged to the mentally ill co-culture worked through the disclosure process in the same way.

Petronio and Durham (2008), also mention the idea of boundary turbulence occurring if information is shared against the discloser's will. In this study, recipients stated that they discovered the discloser was ill because someone else had told them. Usually, this person was another member of the family. While it is unclear whether or not disclosers discussed their illness with the person who told others about their illness, it can be assumed that disclosers did not expect for this information to be shared outside of their knowledge. If disclosers told someone, it was probably told in confidence. In fact, disclosers in this study did not mention the idea that someone else could have revealed their mental illness to the discloser, only that the recipient had somehow figured it out by observing the discloser's behavior. Thus, while disclosers felt that their mental illness was revealed by recipient observation, those disclosers may be disappointed in knowing that someone else had violated their trust by telling others about the diagnosis—an

example of boundary turbulence that may impact a discloser's decision on sharing a mental health status in the future.

Reasons for Self-Disclosing: RQ 2, 3

Jourard (1958) noted that self-disclosure or the ability to share intimate, personal information was filled with feelings of trust and love, ultimately drawing people close to each other towards relationship development. In this study, evidence of this idea is noted in participant reasons for disclosure. Most disclosers and recipients stated that the main reasons for disclosing were not only to gain support or help, but for promoting understanding and acceptance from the recipient— someone the discloser felt they could trust or confide in. These people were usually partners, friends, or parents of the disclosers. More than likely, disclosers believed that these were the people in which they could open up to or rely upon to be there for them in times of need.

In addition, disclosers said they disclosed for psychological relief, while recipients stated disclosers did so to explain unusual mood or behavior changes. This difference in response may be due to a difference in interpretation. To recipients who weren't suffering from this illness, the idea of relieving themselves of the burden of carrying a diagnosis may not have crossed their minds. Instead, they may have felt that the discloser simply needed to explain their behavior. However, to the discloser, an explanation of behavior may have been a way of venting.

Finally, this study found that there were no significant difference in reasons for disclosure between White and non-White participants. Despite co-cultural status, participants had the same reasons for disclosing, which were for support/help and for understanding and acceptance. Therefore, race may not account for the primary reasons for disclosing as it seems that all mentally ill patients have the same need and desire for help and acceptance among those in which they chose to disclose such information. As it relates to CPM theory, when faced with the same tension regarding whether or not to disclose a mental illness, most participants chose to disclose

as a way of seeking similar benefits. Thus, regardless of the risks disclosers faced as either a non-dominant or dominant society member, most participants chose the need for support and understanding from the people they trusted over the desire to keep their diagnosis a secret.

Responses to a Disclosure: RQ 5

The major response from both discloser and recipient accounts revealed that most disclosers were met with understanding and compassion from the discloser. However, the remaining categories that emerged from participant answers were reported differently between discloser and recipient groups. For instance, the disclosers stated that in addition to understanding and compassion, recipients responded with support/help, rejection/dismissal, and the confirmation that they already knew something was wrong. However, recipients reported that in addition to understanding and compassion, the disclosers were met with confirmation that they already knew, support/help, and then shock/surprise. So unlike discloser accounts, rejection and dismissal was not one of the major responses reported by recipients.

When examining recipient answers, it seems as if the recipients were often shocked or confused by the mental health status disclosure, which hindered them from responding in a more positive fashion. Recipients stated that after the initial shock period, they felt that they were more accepting of the illness. They also said that their confusion sparked a curiosity, and they decided to learn more about mental illness on their own. This happened after the diagnosis was revealed, and was probably something they did without the discloser being aware.

The differences in reported responses between disclosers and recipients can be linked to Orbe's (1998) explanation of the differences between dominant and co-cultural group members' world experiences. Many dominant members had never experienced a mental illness, so this may have caused them to react to a mental health diagnosis with shock and curiosity. Thus, it may be

because of differing standpoints that dominant group members responded in a way that co-cultural group members may not have reacted.

Cultural Effects on Disclosing and Receiving a Diagnosis: RQ 6, 7

This study revealed no significant differences between White and non-White participants in how they decided to tell someone they had a mental illness, however, there were significant differences in choosing to disclose a mental illness and in how recipients received a diagnosis. This may be because once disclosers made the choice about whether or not to disclose, how to go about doing so became a personal choice that was unique to the individual regardless of the disclosers' race.

However, race/ethnicity did play a role in the initial decision to disclose because more non-Whites than Whites reported that cultural customs and beliefs related to racial and ethnic identification influenced their decisions about whether it was best to disclose their mental health status. Many disclosers mentioned that ethnicity had influenced their choices to disclose because they believed that their ethnic background would influence whether the recipient perceived the discloser as weak or vulnerable, or would influence the recipients to be less accepting or receptive to their diagnosis. One African American female even mentioned that she disclosed primarily because she wanted to dispel the cultural myth that Black women do not disclose or seek help for mental health issues.

In regards to CPM and Co-Cultural theory, this evidence suggests that while the mentally ill as a co-cultural group disclose in a similar fashion, racially marginalized group members who are mentally ill may be more cautious of talking about their disease. These group members may see themselves as already being marginalized by race, and would thus hesitate at the notion of appearing more vulnerable by exposing their mental illness to others. Hence, this brings further insight into the maxims of possession of information and ownership under CPM theory, as

marginalized group members may take race into account more so than Whites when deciding whether or not to make someone co-owner of their mental health information (Allen 1997; Petronio & Durham, 2008).

White disclosers also mentioned that they felt privileged because they did not have to worry about race being an issue in a mental health disclosure consistent with the perspective on this issue expressed by Allen (1997). White disclosers were less likely to note that race/ethnicity had an effect on their choosing to tell than non-Whites. If they said ethnicity played a role, it was because they were a proud American who did not want to shame their families by appearing weak. In these cases, they looked at their membership in the American culture rather than the color of their skin as a barrier to disclosing their mental health status.

There was also a significant difference between Whites and non-White recipients of mental health status disclosure in terms of how the mental health diagnosis was received. White recipients were less likely to report that their race/ethnicity had an effect on how they received the diagnosis than non-White recipients. Yet again, non-Whites noted cultural customs and beliefs about mental health that affected how they interpreted the self-disclosure. Non-dominant members noted that most people from their cultural background did not often discuss mental health issues or that they were surprised to have mental health status information disclosed to them. One Asian respondent even stated that she wished the discloser had never shared such private information with her. Allen (1997) explains that race may matter when self-disclosing because non-Whites are more aware of racial implications as it relates to culture when choosing and reacting to such disclosures. Thus, as implied by Allen (1997), more marginalized group members thought of their ethnicity/race when debating whether or not to share personal information about their mental health than did Whites. These findings uphold the claims made by

Williams (2008) when she states that African Americans are more likely to remain silent on the issue of mental health so as not to further marginalize themselves in society.

Study Strengths

This study has several strengths in terms of its methodology and practical implications. One of its many strengths is that it uses a web questionnaire to grasp the perceptions of those with a mental illness. The researcher was also able to reach a significant portion of respondents and make the process of completing the survey convenient through the use of a web survey. Through the use of social networking sites and the snowball method, the researcher was able to exceed the targeted sample size needed to test for significance. In addition, more surveys were completed by participants with limited missing data because of the ease of completing a web-based survey at their own pace. Participants were able to take the survey and come back to it at a later time if they wished to do so.

This survey also utilizes both open and closed-ended questions, as a way of combining quantitative and qualitative measures. In combining these measures, the researcher was able to gather more in-depth information regarding disclosure encounters and reactions. Participants were able to write as much as they needed in order to explain this encounter or how they felt about the disclosure. This also created the ability to analyze data statistically, as well as allow for categorization of emerging themes from open-ended responses.

Another study strength is that the survey questions were comprised of questions generated from previous studies in the researcher's review of key literature in the field, as well as interview questions posed by Hyman's (2008) study on self-disclosure among patients receiving mental health services. This enhances content validity as using previously tested questions possesses a greater ability to measure the attributes being studied (Frey, Botan, & Kreps, 2000). In this case, it is more likely that questions from the Hyman (2008) study would measure

individual's perceptions of an encounter where they decided to disclose a mental illness than if questions were created by the researcher without prior reliability testing. Furthermore, the instrument was pre-tested using Pratt's (2008) method of pilot testing, as the complete survey was not used in research before. This allowed for the researcher to assess validity and reliability in terms of whether the instrument measures what it intends to measure, and whether it can be replicated in future studies.

This study also has many practical implications in that it looks at co-cultural or marginalized group effects on self-disclosure of mental illness in addition to exploring various methods, reasons and responses to disclosure. The study also breaks new ground in the area of mental health communication, and builds upon a very limited body of research on the topic of disclosing mental health information. In this case, it implies and promotes the need for culturally-specific methods to psychotherapy. While no significant differences were revealed in how people tell, there is an underlying ethnic/racial dimension to deciding if one should disclose in the first place. Many marginalized group members see race as a factor in whether or not they should reveal their disease, and may be more hesitant to self-disclose. It is because of these ethnic/racial implications, that one must be aware of co-cultural status as a barrier to disclosing and/or seeking out the help of others. Therapists may wish to keep this in mind when speaking with or attempting to treat non-dominant group members.

This study also allows for health communicators to mind the effects of co-cultural or marginalized status when designing and implementing mental health messages and campaigns. It is in understanding that all people both within and among groups are unique, one can best decide what cultural barriers exist in regards to how people disclose a mental illness, and thus how they reach out for assistance and support. This gives campaign planners a guide as to when ethnic/racial differences matter in self-disclosure. For instance, campaigns may focus on how to

work around cultural customs and traditions in terms of when to tell someone you have a mental illness, while knowing that all mentally ill patients regardless of race will disclose this diagnosis to friends and romantic partners.

Similarly, study implications gives those interested in mental health research information on how to best approach and respond to someone with a mental health condition by pinpointing major reasons for disclosure, as well as the many responses that may arise. One can then decide on the best way to respond given the reasons for that disclosure. For instance, given that most disclosers tell because they want to be understood or accepted may spark additional campaign research on how best to generate messages of understanding and acceptance. Without knowing these reasons, it is difficult to explain to recipients how the mind of the discloser operates. If recipients are already aware that disclosers seek acceptance, they will be better prepared to give accepting messages when they are faced with hearing a diagnosis.

On a more personal level, the findings of this study also can help guide family member responses to loved ones confronting mental health issues. If recipients are unsure of how to handle a loved one's diagnosis, this study offers a "behind the scenes" look at discloser needs. In knowing the reasons behind a disclosure, recipients can decide how they can best help the discloser either by offering acceptance, support, or simply allowing the discloser to vent their frustrations. A further more in-depth study may ask disclosers how they would have liked the recipient to respond, so recipients are well-aware of how to better meet these needs.

Furthermore, participation in this study gave respondents a raised awareness of the effects that cultural beliefs and traditions may have on self-disclosure of a mental health diagnosis. Both White and non-White respondents were able to consider this connection as a result of taking the study's survey. Therefore, this study not only raised awareness in participants about the cultural aspects of disclosure, but will also help the researcher in further examining the

relationship between a participant's way of ethnically identifying and culturally-bound perceptions of mental health issues.

Study Limitations

While there are many strengths to this research, there is also a need to address the present study's limitations. These limitations include sample representation, self-reported data, and possible errors from the study instrument and interpretation of data. Although measures were taken to minimize error, there is always a need for improving both instrumentation and data collection efforts.

Sample Representation. One limitation to this study is that the sample of 314 participants are not representative or reflective of the general population. Due to the difficulties in reaching potential subjects and defining a clear sampling frame for this study a convenience sampling method was used to recruit subjects, limiting the representativeness of the study sample. There were also very few male respondents in the sample (See Table 1), so that responses cannot be examined by gender. However, this survey response suggests that females may be more prone to discuss issues of mental health than men.

In addition, there was also limited representation across various ethnic groups. While many African-American responded to the survey invitation, there were a limited number of people in other non-White ethnic groups. These groups were not represented in large numbers, or in numbers reflective of the actual population (See Table 1). They may have also been more hesitant to discuss mental health issues as well, which hindered them from taking the survey. In fact, there may be many people who fit other ethnic backgrounds, including White participants, whose opinions are not reflected in this study either because they did not have access to a computer or Internet to take the web survey, or because they were hesitant about discussing issues

surrounding mental illness. The researcher tried to take this limitation into account by exceeding the minimum sample size needed for the study to gather as many responses as possible.

In addition, when combining ethnicity into co-cultural status, some validity was lost. Many of the co-cultural members were African-American compared to Hispanic, Asian, Indian, or Native American. Therefore, responses may be more reflective of African-Americans than other marginalized groups. In the future, more efforts will need to be taken to ensure that a wider representation of marginalized groups is studied. It may be a good idea in future research to supplement the use of questionnaires with in-depth personal interviews to gain greater insights into the cultural traditions and customs surrounding mental health among these groups. It should also be noted that co-cultural status does not take into account the individual differences both within and among each group included.

Another limitation regarding the sample is the limitation of relying on self-reported data. It is not possible to know whether respondents provided honest responses, especially from those respondents who have a mental illness or who knew someone with a mental illness due to the stigmas surrounding mental illness. Mental illness is also a very sensitive, emotional subject, and many people may not have reported experiences as they actually occurred. They may have underestimated or overestimated these encounters. Therefore, we can only analyze data based on the reports of those who decided to partake in this research study keeping in mind that actual occurrences may vary. Perhaps future observational research can be conducted to help verify the self-report data reported in this study.

Study Instrument and Interpretation of Data. There were also limitations to note concerning the study survey, and the way survey data were interpreted. For instance, while the study survey was pre-tested and no major discrepancies were revealed, minor problems with the survey surfaced after a sufficient amount of data were collected. One of those problems was that

some of the categories may not have been mutually exhaustive. The researcher attempted to prevent this problem by including an “other” category, but a few respondents still wanted to report about more than one illness or recall more than one encounter. Respondents were asked to note their primary illness or recall the most significant encounter with someone they told, but it is quite possible that it was hard for some respondents to pinpoint a primary illness or most significant encounter among many. In addition, for the educational category, the option for “associate’s degree” was missing. However, there was a category for some college, so many respondents with associates degree may have checked this option.

In addition, the lack of descriptors on the support scale could be confusing to the participant. The scaled ranged from 0 to 5, with 0 being “Not at all Supportive,” and 5 being “Highly Supportive.” The participant was to choose the number along that scale. For disclosers, this question asked how supportive they felt the recipient was upon hearing the disclosure, and for recipients this question asked them how supportive they felt they were after hearing the diagnosis. However, without descriptors for each number on the scale, it is hard to determine how participants interpreted the scale itself. Some participants may have felt that 3 on the scale indicated “neither supportive nor unsupportive” while the researcher interpreted this as “slightly supportive” in the descriptors used for analysis. Thus, some may argue that it is only possible to gather perceived support based upon the extreme points on the scale.

It is also important to note that questions within the survey may have been biased to be more positive in nature, causing respondents to report more positively than they would have otherwise. However, the researcher strived to prevent this by having open-ended questions where respondents could explain their thoughts. In doing so, respondents were able to state how they felt whether positive or negative. For instance, in response to the question regarding whether respondents thought self-disclosing was a positive or negative experience, some respondents

wrote that the experience was neither positive nor negative, and some wrote “both” instead. Thus, open-ended questions allowed for participants to elaborate on their responses to clarify their answers to the questions. Responses to Pratt’s (2008) question about whether the survey allowed them to respond as they intended was also asked, and most respondents stated that they were able to do so.

We must also note that due to the survey being web-based it is hard to note whether participants actually fit the criteria for the study. While the consent information told potential participants of the criteria for the study, it is hard to determine whether each individual who took the survey met those eligibility requirements. It is also hard to determine if those who took the survey were the age in which they reported or if they may have taken the survey more than once. There may also be some participants who answered the survey who were not or would not be diagnosed as mentally ill and others who may or may not know someone who had a mental condition. It is the researcher’s hope that by generating as many responses as possible, the majority of the study respondents were eligible participants for this research.

In addition, there was an option for entering a password or code that participants could give to others so that comparisons could be made between discloser and recipients who took the survey together. However, many people did not take advantage of this option and for those who used it, the recipient of that code did not follow through or did not take advantage of the survey opportunity. Thus, this aspect of the survey could not be used.

Finally, when coding categories, it is possible that both the researcher and the coders may have misinterpreted data. Thus, categories may not be entirely correct if this is the case. However, the researcher did allow for two other coders who were blind to the study to code categories and give input for the merging of categories for inter-judge reliability. However, this is based on both the researcher’s and the coders’ interpretation of the data presented.

Heuristic Dimensions

Future studies may provide an in-depth look at various ethnicities and their perceptions on mental illness, and how this affects disclosures and reactions to a mental illness diagnosis. Specifically, using interview techniques as opposed to a questionnaire may prove more effective in looking at similarities and differences between and among these groups. It may also be helpful in looking at the context of the disclosure situation in order to better understand how and why the disclosure occurred. One could also look at how other stigmatized diseases are talked about among various ethnicities or co-cultures.

In addition, future research may focus on type of mental illness, ethnicity, and self-disclosure practices. Type of illness was asked for demographic purposes in this study, but may be used to see if there are differences in how one self-discloses or whether one decides to self-disclose based upon the type of diagnosis. For example, a future study could compare various self-disclosure patterns between depressed and schizophrenic patients.

Finally, future research may also seek to look at the ethnicity of the discloser of a mental illness and the ethnicity of the recipient to see if there is a relationship between self-disclosure methods and the ethnicity of the person who received the information. This idea of discloser/receiver ethnicity can be looked at in terms of other diseases that are highly taboo throughout various cultures.

Conclusion

Petronio & Dunham (2008) provide Communication Privacy Management Theory as a framework for showing how individuals share and manage private information, while Orbe (1998) provides Co-Cultural Theory as a means of showing how positions of power between dominant and non-dominant group members affect communication practices. Together, these

theories build the foundation to understanding methods and reasons of self-disclosure among those who have a mental illness, and in understanding differences in self-disclosure by co-cultural status.

Kreps (2001) notes that there is an interpersonal dimension to health, where relational influences affect health outcomes. These interactions are further complicated by culture, as differing cultural perceptions of mental illness affects how one communicates. In essence, culture involves the meaning people bring to health issues, including mental health (Dutta & Basu, 2008). Thus, culture provides the environment by which people's beliefs towards mental illness are formed.

Disclosure about mental health disorders are also affected by race and power, where race matters in communication (Allen, 1997). Assumptions that race may play a role in self-disclosure, along with a need for more research in cultural differences in self-disclosure provided much insight for this project. In noting that race does not equal culture, we therefore look at racial or ethnic identification as a predictor for cultural customs and beliefs. While there is research on culture's influence on self-disclosure (Whaley, 2001; Zheng & McDermott, 2007; Martinez, 2008; Croucher, et al., 2010), there appears to be more research needed on how co-cultural status influences self-disclosure about mental illness.

This research found that despite co-cultural status, most mentally ill participants disclosed in the same direct manner either by being straightforward or explaining their diagnosis or treatment to a romantic partner, friend, or parent. They did so because these recipients were someone who they felt would understand and accept them, and because they were someone they could trust and confide in. They also disclosed to get help or support from the recipient. Despite co-cultural status, most recipients also responded to the disclosure in a similar fashion.

However, it was found that while co-cultural status did not have an effect on how someone decided to tell someone they had a mental illness, it did have an effect on the initial process of choosing whether to tell and how the recipient received the diagnosis. In both cases, non-Whites were more likely than their White counterparts to admit that their ethnicity had an effect on choosing to disclose and receiving a diagnosis. Non-White participants noted cultural customs and beliefs about mental illness as reasons why they felt their ethnicity affected self-disclosure. These beliefs included the fact that minorities were supposed to not admit to weaknesses such as mental illness, or that people within their ethnic background did not talk about taboo topics such as mental illness. Beliefs such as these show that not only are co-cultural or marginalized group members taking into account their ethnicity when disclosing such personal information such as a mental diagnosis, but that there is still a stigma towards the mentally ill that is very much alive.

APPENDIX A

Facebook Recruitment Message

Hello! My name is Nicole Robinson. I am a doctoral candidate at George Mason University studying health communication. My dissertation topic is on communicating mental illness in our daily relationships. If you are someone who is 18 years of age and older, and has experienced a mental illness (either through diagnosis or by exhibiting symptoms of a mental illness that lasted for 2 weeks or more) or someone who has a loved one who has experienced a mental illness, I am interested in knowing how this medical condition was discussed. In order to further research this topic, you are invited to take part in a voluntary survey on discussing mental illness by clicking on the survey link below. Your answers are strictly confidential. I appreciate your time and please feel free to share the survey link with anyone within your network that wish to participate in this study. If you have any questions or concerns, please do not hesitate to contact me at nrobins8@gmu.edu. You may also contact Dr. Gary Kreps, who is supervising this research, at gkreps@gmu.edu. Thank you!

[Survey Hyperlink]

APPENDIX B

Consent Form

Disclosing a Mental Illness: Communicating Mental Illness in Our Daily Relationships

Dear Study Member,

How do people talk about their mental illness with others? How do receivers of this information respond to hearing about their loved one's mental health status? This is an important topic because these conversations ultimately affect how people view and think about those with a mental illness. However, it is a topic we know very little about.

As a person who experienced a mental illness (either by diagnosis/exhibiting symptoms of a mental illness that lasted for two weeks or more) or a person who knows someone who has experienced a mental illness, you are someone who would be able to help us learn about this topic by participating in an online survey. As always, your help is greatly appreciated.

This questionnaire should take no more than 10-15 minutes of your time.

RESEARCH PROCEDURES

This research is being conducted in order to gather information about how those who are affected by a mental illness discuss this with their loved ones. It attempts to uncover how those who are affected by mental illness disclose their mental health status to loved ones and how their loved ones receive this information. If you agree to participate, you will be asked to complete a questionnaire that asks about your experiences in either disclosing a mental health condition or

receiving information about a loved one's mental health condition. The questionnaire is strictly confidential, and should take no more than 10-15 minutes of your time.

RISKS

Since information obtained from this study may be sensitive in nature, you might feel slightly emotional as you talk about your own mental illness or someone you know who has a mental illness. If you or someone you know is having any discomfort after participating in this survey, there is information at the end of this survey for locating a mental health counselor in your area that may prove beneficial to you.

BENEFITS

There are no direct benefits to you as a participant.

CONFIDENTIALITY

While identifiable information is not directly asked in this survey, any possible identifiable information that may present itself as a result of your participation in this study (such as your computer's I.P. address or any personal information willingly given through survey answers) will be kept strictly confidential. Any codes you create (such as the code you may wish to create to identify your loved one taking the survey) will only be used to match your answers to the survey with your loved one's answers to similar questions. This code will not be used for any other purpose, nor will it be used to identify or contact you or the other person taking this survey under any circumstance. As a reminder, you are asked not to use any identifiable information as a code or password.

Additionally, all information will be stored within the researcher's password protected survey program account and transferred to an analysis program on the researcher's computer, which is also password protected. In order to ensure strict confidentiality of your data, please make sure that your computer with your survey information is secure, password protected and that your computer is free of viruses and spam which may cause your information to be shared with others. For data sharing purposes, any information that would violate confidentiality will be either altered to protect the confidentiality of the participant or will not be used altogether.

CONTACT

If you have any questions regarding this study, you may contact the researcher Nicole Robinson, a doctoral student in the Health Communication Department at George Mason University, at nrobins8@gmu.edu or Dr. Gary Kreps, the supervising researcher, at gkreps@gmu.edu. You may contact the George Mason University Office of Research Subject Protections at 703-993-4121 if you have questions or comments regarding your rights as a participant in the research.

PARTICIPATION

Joining this study is voluntary meaning it is completely up to you whether you chose to participate or not. You may refuse to answer any questions, and you may stop at any time with no consequences to you. In addition, if any questions become too sensitive or uncomfortable for you to answer while you are taking this survey, you may opt to skip that question entirely. If you decide not to participate or if you withdraw from the study, there is no penalty or loss of benefits to which you are otherwise entitled. There are no costs to you or any other party.

This research has been reviewed according to George Mason University procedures governing your participation in this research.

CONSENT

By continuing, you acknowledge that you understand the purposes of this study, have read and understand the information given to you, and agree to be a willing participant in this study.

Thank you for participating!

APPENDIX C

Communicating a Mental Illness Survey

Disclosing a Mental Illness: Communicating a Mental Illness in Our Daily Relationships

DIRECTIONS

First, please identify yourself as either the *discloser* of a mental illness (someone who has experienced a mental illness through diagnosis or by exhibiting symptoms of a mental illness for 2 or more weeks) or as the *recipient* of a mental illness disclosure (someone who knows someone who has experienced a mental illness and was told this information by that person).

Next, please answer the questions that are asked of you based upon your role as either discloser or recipient.

FOR THE DISCLOSER: If you are someone who has been diagnosed with a mental illness or exhibit symptoms or signs of a mental illness and told your loved one about your condition, please answer questions 1-14 and 23-27, along with the “Questions Regarding this Survey” items.

FOR THE RECIPIENT: If you are the loved one of someone who has been diagnosed with a mental illness or the loved one of someone who exhibits symptoms or signs of a mental illness, please skip to question 15 and answer 15-27 along with the “Questions Regarding this Survey” items.

OPTIONAL CODE/PASSWORD

Finally, if you wish for your answers to be compared with the person you had your discussion with (for instance if you are a discloser and you wish to share this survey with the person you disclosed to or if you are the recipient and wish for the person who told you about their condition to take this survey), you may create a password/code to share with your loved one in addition to sending them this survey. Please do not include any personal identifiable information as your password/code (such as your name, address, social security or telephone number). Instead, you may use a generic word or number of any length (Ex: Smile, 1234). You may then share this code along with the survey link with your loved one. Those who receive a code will enter the code they were given in the appropriate box at the end of the survey. Sharing a code with your loved one will not allow your loved one to see or have access to your answers, rather having this code is only a convenient way for the researcher to compare a discloser's answers with a recipient's answers to the survey questions. Codes will be used for this purpose only.

DISCLOSER QUESTIONS:

1. What is the primary mental illness that you were diagnosed with or exhibit symptoms of?
(check one)

- 1= Depression
- 2= Bipolar Disorder
- 3= Schizophrenia
- 4= Post Traumatic Stress Disorder
- 5= Obsessive Compulsive Disorder
- 6=Borderline Personality Disorder
- 7=Seasonal Affective Disorder
- 8=Other (please describe)_____

2. Did you tell anyone about your condition? Yes No
(If you answered no, please skip to question 14)

3. Please recall the most significant one-on-one encounter that occurred from telling someone you had a mental illness. In this encounter, who did you tell?

- 1=Parent
- 2=Child
- 3=Sibling
- 4=Extended Family Member (aunt, uncle, cousin)
- 5=Friend

14. If you answered no to question two regarding whether you told anyone about your mental illness, what was your primary reason for not disclosing this information? (If you answered yes to question two, please leave this question blank).

Please skip to question 23.

RECIPIENT QUESTIONS:

15. Please recall the most significant one-on-one encounter that you had from someone telling you they had a mental condition. What is your relationship to your loved one who told you about their condition?

- 1=Parent
- 2=Child
- 3=Sibling
- 4=Extended Family Member (aunt, uncle, cousin)
- 5=Friend
- 6=Romantic Partner (spouse, boyfriend/girlfriend)
- 7=Coworker
- 8=Other _____

16. What was the primary mental illness that your loved one stated they were diagnosed with or exhibited symptoms of?

- 1=Depression
- 2=Bipolar Disorder
- 3=Schizophrenia
- 4=Post Traumatic Stress Disorder
- 5=Obsessive Compulsive Disorder
- 6=Borderline Personality Disorder
- 7=Seasonal Affective Disorder
- 8=Other _____

17. Recall the time when your loved one told you about their mental illness. How did they reveal this information to you?

18. How did you react to this information?

26. What is your marital status?

Single, Never Married
Married
Separated
Divorced
Widowed

27. What is your highest education level?

Some Elementary School
Elementary School
Some High School
High School Diploma
Some College
Bachelor's Degree
Some Graduate School
Master's Degree
Doctoral Degree (Ph.D)
Professional Degree (J.D, MD)

Optional Code/Password

If you wish to share this survey with the person you had your discussion about mental illness with, please create a password/code and enter it in the space provided below. This code should be a generic word or number (ex. Smile, 1234) and you should not use any personal identifiable information when creating this code.

Also, if you are the person receiving this survey and was given a code or password, you may enter it in the space provided as well.

Questions Regarding this Survey

1. How long did it take you to complete the survey?
Less than 10 minutes
10-15 minutes
More than 15 minutes
2. What problems, if any, did you have completing the survey? Please explain.
3. Are the directions clear? Yes No
4. Is there any words/language usage that you did not understand? Explain.
5. Were any questions too difficult to understand? Yes No.
6. If any questions were unclear, please list the number of the question(s) _____
7. Did the question choices allow you to answer as you intended? Yes No
8. Is there anything you would change about the instrument? Please explain.

IF YOU ARE HAVING ANY EMOTIONAL DISCOMFORT BECAUSE OF PARTICIPATING IN THIS STUDY, PLEASE CONTACT YOUR DOCTOR OR YOUR LOCAL COUNSELOR. TO FIND A COUNSELOR IN YOUR LOCAL AREA, PLEASE CALL 1-800-964-2000 or VISIT THE APA WEBSITE AT WWW.LOCATOR.APA.ORG.

Thank you for participating! Your answers are greatly appreciated!

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CURRICULUM VITAE

Nicole Marie Robinson received her Bachelor of Science in Professional & Technical Communication and her Master of Science in Communication and Media Technologies from Rochester Institute of Technology, Rochester, N.Y., in 2006 and 2008. Her specialization in health communication during her doctoral work sparked her interest in cancer and mental health research. She also served as an instructor at George Mason University, Fairfax, Va.