

[**Special Topic: *Research on Multicultural Counseling***]

## **Diagnostic Nondisclosure of Schizophrenia to Chinese American Patients**

Wei-Chin Hwang

Claremont McKenna College

If a patient is diagnosed with schizophrenia, should the mental health practitioner disclose the patient's diagnosis? What role might culture play in influencing this decision-making process? When mental health practitioners do not tell a patient his or her diagnosis, are they being more culturally sensitive and competent or are they feeding into cultural stereotypes and misconceptions? This article examines the controversial issue of diagnostic disclosure and why practitioners may be hesitant to reveal diagnosis of schizophrenia to their Chinese American patients. The impact of the patient's ethnic background on diagnostic disclosure or nondisclosure and practitioner biases are discussed. In addition, results from interviews with four Chinese American psychiatrists are presented as illustrative examples of the diversity of beliefs, opinions, and practices that exist among mental health professionals. Practical implications and recommendations for addressing cultural issues in relation to diagnostic disclosure are provided.

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How many mental health practitioners actually tell patients that they have schizophrenia? Reviewing the limited but extant literature on diagnostic disclosure, a few striking trends emerge. First, very few mental health practitioners tell patients the name of their diagnosis. Second, practitioners are more likely to disclose diagnoses if the disorder is less severe, less stigmatizing, and when the disorder is less readily attributed to a characterological problem. Third, there appear to be professional differences with psychiatrists often assuming a more direct role and responsibility of diagnostic disclosure, and psychologists and social workers assuming a more secondary role.

For example, Gantt and Green (1986) found that when psychiatrists, psychologists, and social workers at a large voluntary psychiatric hospital (inpatient and outpatient) were asked about their practices in revealing psychiatric diagnoses to patients and their families, only 37% of psychiatrists, 20% of psychologists, and 15% of social workers reported telling patients the name of their diagnosis. In addition, only 56% of psychiatrists, 20% of psychologists, and 25% of social workers told the patient's family members that the patient had schizophrenia. In contrast, 78%, 40%, and 62% of patients diagnosed with manic-depression and 76%, 40%, and 52% of family members were told their diagnosis by psychiatrists, psychologists, and social workers respectively. Slightly higher rates of revealing diagnoses to patients with major depression were recorded. Mental health practitioners were least likely to tell patients diagnosed with borderline personality disorder (psychiatrists, 15%; psychologists, 10%; and social workers, 6%) or patients' family members (psychiatrists, 27%; psychologists, 10%; and social workers, 10%) the name of the patients' diagnoses.

Psychiatrists may assume greater responsibility in revealing diagnoses because they prescribe medications to patients and consequently need to educate patients about medication usage, monitor compliance, and check

for side effects. In a study that surveyed 211 psychiatrists in Scotland, Clafferty, McCabe, and Brown (2000) found that 95% of psychiatrists believed that they were the best person to disclose diagnoses, but only 59% reported telling the patients after their first psychotic episode. This increased to 89% after patients experienced their second or third episodes.

Whether or not practitioners should disclose diagnoses to their patients is an important question worthy of exploration. Unfortunately, there continues to be a dearth of research on this topic. In this article, the extant but limited literature on diagnostic disclosure is reviewed, and ethnic and cultural influences on diagnostic disclosure are discussed. In addition, results from interviews with four Chinese American psychiatrists are presented. Recommendations for increasing cultural sensitivity and competence when working with ethnic minority patients are offered.

### **Diagnostic Practice**

Why is there the need to diagnose? The practice of diagnosis is as old as the notion of disease itself. Corey, Corey, and Callanan (1993) stated that medical diagnosis involves the “process of examining physical symptoms, inferring causes of physical disorders or diseases, providing a category that fits the pattern of a disease, and prescribing an appropriate treatment” (p. 219). More than just a label, diagnoses provide physicians with an illness classification system that provides additional information used to infer the common etiology of illness, understand the prevalence of the disorder in the community, and provide a probable course or prognosis of the problem. Diagnostic information utilizes accumulated medical knowledge to inform treatment and allows the physician to plan and tailor interventions to the special needs of the patient.

Diagnosis becomes even more complicated when it involves psychiatric illness. Psychodiagnosis (psychological diagnosis) involves the process of identifying emotional, behavioral, or psychiatric

constellations of symptoms that formulate a psychiatric disorder. Whereas medical diagnosis pertains to the body, psychodiagnosis refers to the mind and the body. Patterson and Welfel (1994) described psychodiagnosis as “a process of identifying and specifying the problem (or set of problems) the client brings to counseling and then deciding whether counseling is an appropriate intervention for resolving it. A diagnosis is determined through a joint process of information gathering and hypothesis testing, conducted until a tentative conclusion about the nature of the problem is agreed to by both counselor and client” (p. 82).

Patterson and Welfel (1994) believed that there are certain role differences involved, with physicians in the medical model playing a more active role in asking concrete questions, conducting physical examinations, making diagnoses, and collaborating with patients in treatment decisions and process. In contrast, psychiatric diagnosis is more of a joint process. Specifically, mental health practitioners cannot determine a diagnosis without consulting the patient as with some medical illnesses. There is an implicit partnership that invariably involves the patient who is an essential player in describing, interpreting, and communicating the problems. Psychodiagnosis may be more prone to error because it is more subjective. Medical diagnoses are usually constrained to a number of identifiable physical causes (e.g., cancerous cells, fractured bone, dysfunction of kidney, etc.), whereas psychological diagnoses are influenced by the multitude of factors preceding the illness. Moreover, the causes of a person’s problems may be entirely outside of the individual (e.g., physically abusive parents, growing up without parents, being exposed to violence and stressful life events). The etiology of psychiatric illnesses may be exacerbated by multiple interacting factors; a single root to the problem and simple prescriptions to treating the problem are seldom available. Nonetheless, having an accurate diagnosis of the problem provides invaluable information that informs

treatment and can also be used as a prognostic indicator (Corey et al., 1993).

### **Advantages of Revealing Diagnoses to the Patient**

As with medical diagnoses, there are a number of advantages to having a diagnostic system and revealing diagnoses to patients with mental illnesses. McWilliams (1994) identified five interrelated advantages of diagnosis, including: (a) its utility for treatment planning; (b) its implicit information about prognosis; (c) its contribution to protecting consumers of mental health services; (d) its value in enabling the therapist to communicate empathy; and (e) its role in reducing the probability that certain easily frightened people will flee from treatment.

There are several reasons why knowing one's diagnosis can be advantageous to the patient. Patients who know their diagnosis are in a better position to learn about their illness and play a more active role in treatment. As a result, patients may be less confused and have fewer misconceptions, fears, and anxieties about their problems. Knowing one's diagnosis can help patients give a label to their experiences and normalize their problems when they discover that other people also share the same illness. While knowing one's diagnosis may also have adverse consequences, patients generally feel relief when they discover concrete explanations for their experiences (Fisher, 2000). Knowing one's diagnosis can also open lines of communication among the patient, the family, and the treatment provider. Moreover, it frees patients from having to conceal their problems out of fear of being labeled "crazy."

Educated patients may also feel more empowered and may be more likely to have realistic appraisals of their problems and likelihood of recovery. More informed patients may also be more likely to comply with treatment because they feel more knowledgeable and involved. Moreover, they and their families are in better positions to access ancillary services

such as support groups, and informed families may be more empathic, supportive, and less critical if they better understand the patient's illness. In a consumer-based model of mental health services, all patients have the right to know the nature of the problem that ails them and to be informed about the advantages and disadvantages of various treatments available.

Practitioners who know the patient's diagnosis have access to accumulated medical knowledge that helps them understand the etiology, prognosis, and available treatments for the problem. Knowing the diagnosis also provides valuable insight that helps confirm, validate, and provide reliability for the practitioner's assessment of the patient's difficulties. In addition, it gives context to the patient's past, present, and future behavior. Finally, knowing the patient's diagnosis is also important and required for billing purposes.

In a survey of psychiatrists conducted by Green and Gantt (1987), psychiatrists who revealed diagnoses to patients believed that schizophrenia is a stress-induced biogenetic disease and felt that psychoeducation shifts blame for the illness away from the family. They believed that knowing the diagnosis facilitates treatment engagement and compliance by family members, reduces stigma and isolation, and helps give patients and their families a sense of mastery. They also believed that empowered families would be more likely to join support groups such as the National Alliance for the Mentally Ill.

In a study conducted by Anderson, Hogarty, and Reiss (1981), psychoeducation was found to help reduce the two leading causes of relapse (noncompliance with treatment and family stress). Informed families were in a better position to identify symptoms prognostic of relapse and bring patients to treatment earlier, thereby reducing the chances of hospitalization.

## **Disadvantages of Revealing Diagnoses to the Patient**

Although there are several advantages of disclosing diagnoses, many practitioners are still reluctant to reveal diagnoses to patients. Diagnostic nondisclosure is not limited to psychiatric conditions. For example, Fitts and Ravdin (1953) found that over 90% of physicians in the 1950s did not inform cancer patients of their diagnosis. This practice appeared to change by the late 1970s where over 97% of physicians reported telling cancer patients their diagnosis (Novack et al., 1979). It seems that as treatments and prognoses improve, the burden for physicians to bring patients irreparably bad news decreases and practitioner willingness to disclose diagnoses increases.

When revealing psychiatric diagnoses, however, a number of additional issues come into play. Green and Gantt (1987) found that many psychiatrists did not tell patients their diagnosis because they felt it stigmatized patients and their families. Some psychiatrists believed that giving patients a label and/or categorizing them stereotypes the patients and detracts from individual differences. Others preferred to focus on symptoms and human relationships rather than focusing on a label. Some held a medical paternalistic view and withheld the diagnosis because they believed that patients did not have the capacity to understand the meaning of their diagnosis or to collaborate in decisions regarding their treatment. Others believed that revealing the diagnosis would demoralize the patient and family.

Green (1984) stated that many practitioners have not responded honestly to patients when patients ask what their diagnosis is because practitioners feel that they are pronouncing a psychological death sentence on their patients. Knowing one's diagnosis may be too overwhelming or threatening to the patient's psychic survival. Therefore, the timing of revealing diagnoses is critical; improper timing can lead the patient to reject the treatment and drop out prematurely.

## **Cultural Considerations in Diagnostic Disclosure**

Few have explored how culture, race, and ethnicity can further complicate diagnostic disclosure. Because ethnic minorities tend to have worse treatment outcomes and drop out of treatment earlier than Caucasian Americans (Institute of Medicine, 2003; U.S. Department of Health and Human Services, 2001), determining whether patients from culturally diverse backgrounds are less knowledgeable about their diagnosis and ascertaining its potential impact on treatment results is an important question worthy of exploration. To date, virtually no research has been conducted to examine how the patient and the practitioner's ethnic and cultural backgrounds influence diagnostic disclosure beliefs and practices. The research that has been conducted has been primarily descriptive.

McDonald-Scott, Machizawa, and Satoh (1992) conducted a study comparing psychiatrists' attitudes and practices in North America and Japan. They found that while over 90% of psychiatrists from both countries informed patients with affective and anxiety disorders their diagnosis, only 70% of North American psychiatrists and 30% of Japanese psychiatrists informed patients with schizophrenia or schizophreniform disorders. The majority of psychiatrists in both groups informed the family, but North American psychiatrists tended to do so only with patient consent, whereas Japanese psychiatrists often did not ask for patient consent.

When asked what they would do if a patient asked them if he or she had schizophrenia, only 78% of North American and 35% of Japanese psychiatrists reported that they would confirm the patient's diagnosis. A small percentage (2% and 5% respectively) reported that they would deny their diagnosis. In addition, some reported that they would instead give the patient a vague diagnostic response (North American, 3%; Japanese, 46%). Japanese psychiatrists who did not tell their patients the diagnosis

of schizophrenia often preferred to give a vague alternative diagnosis such as neurasthenia (33%) (a more generalized somatic form of depression that is less stigmatizing), neurosis (28%), nervous exhaustion (11%), or psychogenic reaction (4%). North American psychiatrists were more ambiguous and preferred to discuss possible differential diagnoses. Interesting, Japanese psychiatrists with more experience were more willing to tell patients their diagnosis.

When Japanese psychiatrists were asked why they chose not to disclose diagnoses to their patients, the most commonly endorsed answer was that informing patients would hurt the patients and negatively influence treatment because of the high level of stigma associated with having a mental illness. Other frequently cited answers included that it would be meaningless for treatment and lead to misunderstanding. McDonald-Scott et al. (1992) described the Japanese culture as being more medically authoritarian, with physicians acting in a more benevolent paternalistic manner. Although patients are allowed to ask questions, frequent questioning or challenging of the doctor's opinion can be interpreted as disrespectful.

## **Method**

### ***Participants***

Participants included four Chinese American psychiatrists working at a Chinese American-focused community mental health clinic. All psychiatrists at the clinic (total = 4) were asked to participate in the study and they all agreed, yielding a response rate of 100%. In addition, all of the psychiatrists were bilingual or multilingual and could speak English plus one or more Chinese dialect (e.g., Cantonese, Mandarin, and/or Taiwanese). Psychiatrist 1 was a male psychiatrist with a self-reported consumer-oriented theoretical orientation and over 25 years of experience. Psychiatrist 2 was a male psychiatrist with an eclectic theoretical

orientation and over 25 years of experience. Psychiatrist 3 was a third-year female resident and reported a psychoeducational, supportive orientation. Psychiatrist 4 was trained in psychiatry and pediatrics with over 15 years of experience; she reported a psychodynamic theoretical orientation.

### ***Analysis***

Qualitative interview methodology was used to evaluate psychiatrist beliefs, thoughts, and attitudes toward diagnostic disclosure (Kvale, 1996; Patton, 1990). This occurred in seven steps, including thematizing (the evaluation of what, why, and how the question could be answered), designing the methods of the study, interviewing, transcribing, analyzing, verifying, and reporting. A standardized open-ended interview approach was used to guide the interview process and provide a more systematic and structured capture of psychiatrist responses (Patton, 1990).

Five questions were developed by the author to address clinical and cultural issues related to diagnostic (non)disclosure. They were developed after a review of diagnostic nondisclosure literature and after focus-group discussions with mental health providers. These questions tapped into five domains, including: (a) the psychiatrist's views on diagnosis; (b) their Chinese American patient's diagnostic and medication self-awareness; (c) reasons for why Chinese American patients may be less aware of their diagnoses and why Chinese American psychiatrists may be more reluctant to tell them; (d) whether diagnostic nondisclosure is associated with trying to be more culturally competent; and (e) whether diagnostic nondisclosure feeds into cultural stereotypes and misconceptions. Each participant was asked to discuss and elaborate on their beliefs, opinions, and practices concerning these domains. The interviewer (a Chinese American psychologist) engaged in discussions with the participants and asked them to clarify and elaborate on their responses.

Participants were not given any time restrictions when responding to questions in each domain.

Data were analyzed and interpreted using three steps: (a) interview condensation; (b) thematic and meaning summary analysis; and (c) discussion and synthesis (Kvale, 1996; Patton, 1990). Below, a summary of responses from each psychiatrist is provided, followed by a summary analysis. Results from the study are synthesized in the discussion section.

## **Results**

### ***What Is the Purpose of Diagnosis?***

*Psychiatrist 1* believed that diagnoses are labels that make it easier for mental health professionals to communicate. Diagnoses are not absolute and labels may not be useful to the patient, especially when practitioners do not always agree on the patient's diagnosis. Diagnoses are helpful for billing and insurance purposes. Knowing one's diagnosis can help reduce stigma only if the patient is stable and ready to know the diagnosis. Otherwise, it could lead to noncompliance, exacerbate family conflict because of shame issues, and lead to premature dropout.

*Psychiatrist 2* believed that a diagnosis is a psychiatric term that allows professionals to communicate and coordinate with each other. In addition, it is a good prognostic indicator. It is often used for billing or insurance purposes. Knowing one's diagnosis can be beneficial if patients are provided with the proper psychoeducation. Part of proper psychoeducation is to tell the patients their diagnosis even if they do not ask because they are taking medications and they need to know what the medication is for and how to properly take it. However, it may be more effective to work with the patient's symptoms first because providing a diagnosis too early in treatment can lead to noncompliance and premature dropout.

*Psychiatrist 3* believed that a diagnosis is part of a classification system that helps treatment providers prescribe different types of medications for different types of illnesses.

*Psychiatrist 4* indicated that diagnoses are useful in treatment planning, and in helping clients access mental health services and benefits.

### *Summary analysis*

All of the psychiatrists agreed that psychiatric diagnoses are important (e.g., useful in the coordination of care among mental health professionals, in treatment planning, and in billing and reimbursement). Two of the psychiatrists spontaneously raised the potential disadvantages of telling the patient the diagnosis prematurely and emphasized the importance of addressing patient symptoms, rather than focusing on diagnostic labels.

### ***What Percent of Your Chinese American Patients With Schizophrenia Know Their Diagnosis and the Purpose of Their Medication? Why?***

*Psychiatrist 1* estimated that only 10% of his patients with schizophrenia can name their diagnosis. Few people in China know the terminology for “schizophrenia” and most people only know how to say *jingshen bing* (mental illness) or *shenjing bing* (crazy). He was unsure how many patients know what their medicine is for, and he remarked that the ones that he does tell often do not remember. He has a do-not-ask-do-not-tell policy toward educating patients about their diagnosis. He believed that those who do not ask do not want to know. If telling patients their diagnosis does not facilitate medication compliance, he is not going to tell them. He is more likely to tell the patients he sees starting from their first psychotic break and less likely to tell his transfer cases.

*Psychiatrist 2* estimated that less than 30% of his Chinese patients with schizophrenia would be able to name their diagnosis. He tells 60–70% of his schizophrenia patients their diagnosis. He uses a more general explanation of psychotic disorder for the remaining 30–40% because he feels it may be too difficult for patients to comprehend, and providing them with a precise label may not be beneficial and can be counterproductive. Instead, he focuses on the constellation of symptoms that make up the diagnosis. He tells patients that the voices they are hearing or hallucinations, stimuli that they experience are real but are not really present. He explains why taking medications would be helpful (reduction of symptoms) and gives the patients translated handouts that explain the purpose of their medication and how to take it. After telling his patients their diagnosis, he feels that only about one-third will remember. In addition, only about one-third ask him for the name of their diagnosis.

*Psychiatrist 3* believed that 95% of her patients would be able to name their diagnosis. However, she qualified her statement by saying that her caseload is filled with more chronic or transferred cases of schizophrenia. She also believed that 80–90% of her patients can articulate why they take medications. In addition, if it is a clear-cut case of schizophrenia, she usually tells the patients within 1–2 sessions and found this psychoeducational approach to be beneficial. She explains the illness and medication using a medical neurobiological model.

*Psychiatrist 4* gave her views on the percent of patients who she thought would be able to name their diagnosis according to her experiences working in China, Korea, Japan, and the U.S. She believed that approximately 25% patients in inpatient units in China can name their diagnosis. In Korea and Japan, she believed that only about 5% of patients can name their diagnosis. She believed this to be only slightly higher, 10–20%, among Chinese patients in the U.S. She indicated that

only about 5% of patients can say how their medication helps reduce their symptoms, and that most can only say that it makes them feel better. If patients were asked why they take medications, she believed that most would answer because they are sick or crazy. In inpatient hospital settings, she believed that patients would answer: “if I don’t eat the medication they will force me to eat it, and if I don’t take it I can’t go home and leave the hospital.”

### *Summary analysis*

Three of the four psychiatrists indicated that relatively few of their patients could name their schizophrenia diagnosis. Moreover, they reported that very few could more precisely explain what their medication is for or remember their diagnosis even if the psychiatrist previously disclosed it. One psychiatrist took a more assertive psychoeducational approach and reported that it was beneficial to her patients.

### ***Why Don’t Chinese American Patients Know Their Diagnosis and Why Might Psychiatrists Be Reluctant to Tell Them?***

*Psychiatrist 1* believed that Chinese patients have a strong sense of denial concerning mental illness because of the stigma and shame associated with it. He provided the Chinese saying *yan er dao ling*, which is an example of a four-word metaphorical saying known as *chengyu* used to educate, convey morals, for satire, and teach people about life. Literally meaning “if you cover up your ears, you won’t hear the bell ring,” it comes from an old Chinese story of someone who covers his ears up while stealing a bell and believes others will not know because he cannot hear the sound of the bell. Applying this to diagnostic disclosure, Psychiatrist 1 believed that people who do not ask for the name of their problem do not want to know what their problem is called because knowing the problem makes it intolerably real. He believed that giving a diagnosis may instill more fear and anxiety in patients, and that if it does

not help treatment compliance, there is no point in telling them. In addition, since community mental health centers are not inpatient or day programs, he believed there is a greater risk of patients dropping out prematurely. He was afraid that patients may go home, brood, and fantasize about their illness, which is especially problematic since they are having paranoid psychotic thoughts.

*Psychiatrist 2* believed that there are several reasons for this. For example, Chinese patients often come in with family members who remember the diagnosis for the patient. Working with families is especially important when explaining medication use to patients. However, he takes a more conservative approach when it is the family's first visit and is less likely to use the label "schizophrenia." He usually uses a more benign label like delusion disorder, or psychotic disorder not otherwise specified, and will often focus on the constellation of symptoms as opposed to the diagnostic label. This often helps patients and families more readily accept their problem. He also believed that the clinical picture is not always clear during initial meetings and it would be unfair to patients if they were given a label prematurely.

In addition, he indicated that Chinese patients have a strong sense of shame and guilt. Sometimes they will not accept the diagnosis and do not want to be *shenjing bing* or "crazy." He believed that you may sometimes need to establish a strong working relationship before you can tell the patient his or her diagnosis. He indicated that some patients may not be ready to accept or know their diagnosis. He believed that telling Chinese patients their diagnosis prematurely can sometimes lead to increased decompensation and decreased medication compliance. If they are more ready but not yet ready to hear the diagnosis of schizophrenia, he will focus on the symptoms and provide a general descriptor for psychosis. In addition, he refrains from telling patients until after he gets to know the patient quite well and is sure of the patient's exact diagnosis.

He also believed that many patients have some idea of their diagnosis, especially since it is on the form of treatment plan that they are routinely asked to sign. Because the form is not translated, however, some of the older immigrants may not know that it says they have schizophrenia unless the therapists read it to them, which he believed many do not. Finally, he also believed that even if mental health practitioners provide the diagnosis and explain it to patients, many patients still do not understand and will simplify it by believing that they have a mental illness. He ended by saying that immigrants may be less aware of mental health issues because cultures often do not promote psychoeducation and they are less exposed to mental health media images (e.g., Dr. Phil).

*Psychiatrist 3* believed that her Chinese patients are very aware of their diagnosis. However, she believed that in general, Chinese patients may be less aware because Chinese families are protective and some Chinese treatment providers are authoritative or paternalistic and do not tell the patient's the diagnosis. Many practitioners feel that telling patients the name of their diagnosis is irrelevant because they will not understand or remember it. Moreover, they believe it can exacerbate the patient's problems and the patient will not be able to tolerate knowing that he or she has a mental illness because of the stigma associated with it. Interestingly, she felt that this problem was even more evident in inpatient units where many Chinese patients are never told their diagnosis.

*Psychiatrist 4* believed that Chinese patients are less aware of their diagnosis and Chinese doctors are less likely to tell their patients. She indicated that few Asian patients ask for their diagnosis and as a result, no one ever tells them. She also believed that Asian clinicians are less willing to tell patients because they believe it will exacerbate their symptoms and because the patients will not accept it anyway. The few practitioners who do tell their patients often wait until the patient is more

stable and will often tell the patient's family instead of the patient. She believed that Caucasian Americans are more aware of their diagnosis, and guessed that approximately 70% of Caucasian American psychiatrists tell patients more directly. She believed that this is partially a result of Caucasian Americans asking and wanting to know.

### *Summary analysis*

All four psychiatrists reported that Chinese American patients are less aware of their diagnosis, are less likely to want to know their diagnosis, and may be more likely to deny their diagnosis. The psychiatrists reported that practitioners may be more reluctant to tell the patients their diagnosis because of cultural stigmas, wanting to protect the patient, and possible adverse reactions and denial that may damage the treatment process.

### ***Are Psychiatrists Trying to Be Culturally Sensitive and Competent by not Taking the Initiative to Tell Patients Their Diagnosis?***

*Psychiatrist 1* believed that he is being sensitive to the patient's needs. In order to increase cultural competence, he uses a cultural twist on the biomedical model to help patients understand why they need to take medications. In order to reduce the stigma associated with having a mental illness, he tells patients that the medication will help them *bu nao* or supplement the brain with nutrients that are missing to help them feel better. He believed that telling Chinese patients their diagnosis often creates a barrier because patients may not want to know. Therefore, he only tells them if they ask, and he felt that his method of focusing on the medical aspects of their problem and treatment reduces treatment noncompliance of his patients which he believed to be very small when compared to other psychiatrists who work with Chinese patients.

He believed that part of being culturally competent is waiting longer

before you tell patients their diagnosis because doing so prematurely may be meaningless for the patient, especially since the patient may not be able to comprehend what is happening to them during the initial stages of schizophrenia. Furthermore, he indicated that a practitioner should not tell the patient the diagnosis until the practitioner has developed a strong and healthy partnership with them. Schizophrenia is associated with paranoia and delusional beliefs. They may not believe the practitioner and may not be able to accept themselves or their illness if the practitioner tells them or their family prematurely. Schizophrenia is a very Western notion of mental illness. Labeling Asian patients with it can lead to intense fear and anxiety that patients may not be able to tolerate.

*Psychiatrist 2* believed that cultural competence requires an individualized approach to treating each patient. He preferred to focus on constellations of symptoms in the initial stages of treatment and gradually work his way to providing the patient with the diagnosis. Although he believed that the more Western method of telling patients their diagnosis may work better in inpatient hospital settings, doing so prematurely in the community mental health arena could be disastrous because it is a less structured environment and patients can easily drop out of treatment. Therefore, he works with his patients at a slower pace and will only tell his patients when he believes that they are ready. Telling the patients too early will be meaningless because they will not be ready to hear what the practitioner has to say and they will not remember too.

*Psychiatrist 3* believed she is more idealistic than other Chinese American psychiatrists in the way she practices being culturally competent. She believed that Chinese people are more resilient and adaptive than many people may think. She indicated that there is no empirical evidence to support more paternalistic protective practices concerning diagnostic disclosure, nor evidence to suggest that telling ethnic minority patients their diagnosis will lead to worse treatment

outcomes or treatment noncompliance. Unfortunately, little research has examined these issues. According to her experience, telling patients their diagnosis actually helps decrease anxiety, shame, and stigma because patients are able to better identify what they are going through and feel less “crazy” because they are not the only one who has this illness. In addition, she pointed out that many Chinese immigrants have suffered much hardship in their life and that as caregivers, practitioners should give them more credit for what they can and cannot handle. In terms of revealing diagnoses, she treats all her patients similarly no matter what their ethnic or cultural background is. She believed that even patients with poor cognitive functioning can understand their illness if the time and care is taken to properly educate them. She did not agree with practitioners who do not tell patients their diagnosis, but agreed that it may need more time to work with patients before they can digest it.

*Psychiatrist 4* believed that part of being culturally competent is educating patients about their illness. She believed that practitioners need to be sensitive to the patient’s cultural beliefs because shame and stigma issues are more salient for Chinese American patients and their families. However, telling patients their diagnosis after they are stabilized and more ready to accept it is very different from the practitioner bias or reluctance that leads to nondisclosure of diagnoses to patients. She believed that issues of diagnostic disclosure are influenced by the difference of beliefs between Asian and American doctors about patient rights, with Asian doctors being less collaborative, involving patients less, and often deciding what is the best for their patients. She believed that psychoeducation about symptoms and medication is particularly important because patients need to be able to understand and assess their symptoms in order to increase help-seeking before relapses occur.

### *Summary analysis*

Two of the four psychiatrists believed that they were being culturally

competent by not disclosing diagnoses and focusing only on psychiatric symptoms. The other two psychiatrists reported that diagnostic disclosure and psychoeducation are integral to cultural competence, and that timing of disclosure is very important.

***Does Diagnostic Nondisclosure Feed Into Cultural Stereotypes, Misconceptions, and Ultimately Increase Stigma Associated With Having Schizophrenia?***

*Psychiatrist 1* did not believe that it does. He stated that his job is not to be culturally revolutionary, but to do what is necessary to ensure that his patients adhere and stay in treatment. He also responded by saying that you cannot teach old dogs new tricks, meaning that it is very difficult to change a person's cultural beliefs and the attempt to do so may be counterproductive. Although patients may not be old dogs, they are bound by a cultural belief system that is largely determined by the people around them. He believed psychoeducation needs to occur at the larger societal level and the attitudes of healthier people needs to be changed and their acceptance be increased before practitioners can be more direct in disclosing diagnoses to Chinese patients. He gave an example of a doctor telling his patient the diagnosis and the possible side effects of psychiatric medications. The patient refused to go back, denied that he had schizophrenia, and refused to take medications. This could potentially make him feel worse. Afterwards, the patient came to see him, and he used his *bu nao* approach to explaining the patient's problem and why medication would make him feel better without getting into the details of the name of the illness or side effects associated with medication. The patient stayed in treatment and he adjusted the medication based on different symptoms and side effects reported.

*Psychiatrist 2* indicated that it will if you never tell patients their diagnosis. However, he believed that timing is crucial and doing so

prematurely will increase stigma, feelings of anxiety, and feelings of being crazy to the extent that patients never return. He preferred a longitudinal individually based psychoeducation plan that can take weeks, months, or years based on what he feels is best for the individual patient.

*Psychiatrist 3* believed that we are feeding into cycles of shame and secrecy by not telling patients their diagnosis. She believed that psychoeducation will increase medication compliance and help normalize the patient's experiences. She believed that this is an important part of patient empowerment and that it is better to be open and honest with patients who may already feel uncomfortable coming into mental health treatment. When she treats patients who deny or reject their diagnosis, she takes extra time and care to properly educate them, reduce stigma, and follow up more regularly. She reported that her patients have never dropped out of treatment because they were told their diagnosis. She believed that being able to communicate and explain the illness and its potential impact on the lives of patients is essential for providing culturally competent and sensitive treatment.

*Psychiatrist 4* believed diagnostic nondisclosure can be detrimental to the patient because it enhances the need to hide the illness. However, she also believed that cultural differences need to be taken into account and that timing is especially crucial in determining whether patients and their families will be able to accept the diagnosis. Nevertheless, if practitioners do not tell patients their diagnosis, the patients may feel more fearful and anxious, and may reject mental health services because they do not understand the problem they are experiencing and feel very alone in their experiences.

### *Summary analysis*

Two of the four psychiatrists believed that diagnostic nondisclosure does not feed into cultural stereotypes and misconceptions. They

considered diagnostic nondisclosure as one of the most effective treatment approaches when working with Chinese American patients, who have a strong sense of denial and who may drop out of treatment if their diagnosis was revealed. The other two psychiatrists believed that diagnostic nondisclosure can be damaging to patients and that it contributes to cultural stigmas and misconceptions.

## **Discussion**

Chinese Americans are among the fastest growing minority groups in the U.S. (Larsen, 2004). In addition, people of Chinese descent make up a considerable proportion of the world's population. Understanding how to improve psychiatric and psychological services for people of Chinese descent is particularly important given that cultural influences affect the treatment process (Hwang, 2006). To date, little research has examined diagnostic (non)disclosure to Chinese American patients. Specifically, it is not sure whether disclosure or nondisclosure is beneficial or damaging to the treatment process, whether it helps increase adherence, or whether it helps improve outcomes.

This article examined the varied beliefs, experiences, and practices of Chinese American psychiatrists treating Chinese American patients diagnosed with schizophrenia. Qualitative interviews indicated that Chinese American psychiatrists have diverse beliefs and practices when working with Chinese Americans diagnosed with schizophrenia. Several themes emerged out of the interviews. First, results indicated that all psychiatrists agreed on the importance and utility of diagnosis for the profession. However, there is wide disagreement on whether diagnoses should be revealed to patients.

Two contrasting ideas emerged. One idea centered on diagnostic nondisclosure as a culturally competent and sensitive practice. Specifically,

the majority of psychiatrists believed that greater stigma and misconceptions toward psychiatric illness are evidenced among Chinese Americans. As a result, these psychiatrists believed that some of their patients would not be able to tolerate knowing their diagnosis and that diagnostic disclosure would impede the treatment process (e.g., their patients would deny their diagnosis and potentially drop out of treatment). These psychiatrists did not voluntarily divulge the client's diagnosis, but would reveal the diagnosis when asked and when they deemed that it would be clinically beneficial.

The other idea that emerged centered on psychoeducation and diagnostic disclosure as a powerful tool for helping the client understand their illness, its treatment, and as a way to reduce stigma and normalize a patient's illness experience. Although two psychiatrists in this study felt this way, only one of them seemed to educate their patients about diagnoses as regular standard practice. This psychiatrist reported being able to effectively educate her patients, and believed that diagnostic psychoeducation is an essential part of culturally competent and sensitive practice. The other psychiatrist did so on a case-by-case basis, and felt that timing and an accurate understanding of a patient's ability to benefit from knowing the diagnosis was the most important.

Second, the study also found that the psychiatrists believed that Chinese American patients are overall less knowledgeable about psychiatric illness and less educated about why they are taking medications. They agreed that this was a result of cultural stereotypes, misconceptions, and lack of exposure to mental illness and its treatment. However, results from this study do not answer unequivocally whether disclosure or nondisclosure should be considered best clinical practice. Instead, they indicated that diagnostic (non)disclosure decisions should be individualized, and that the characteristics of the patient and the timing of the disclosure should be carefully evaluated.

Third, findings also highlight the importance of practitioners evaluating their own therapeutic and culture-related countertransference (Comas-Diaz & Jacobsen, 1991). Specifically, are practitioners not disclosing diagnoses because of the culture-related stigmas and misconceptions that their patients hold? Are they feeding into cultural stereotypes and misconceptions? It is plausible that diagnostic nondisclosure negatively feeds into culture-related stigmas, and in turn, reinforces unproductive psychiatric misconceptions. Patients may feel even more stigmatized if even their “doctor” does not know what their diagnosis is or is not willing to tell them.

### ***Ethical Implications for Psychiatrists and Other Mental Health Professionals***

The results from this study raise a number of ethical issues regarding the provision of mental health services, and also a number of issues that affect nonpsychiatric mental health professionals who provide therapy treatment to the same clients. Specifically, a number of questions are raised such as: Should mental health professionals who are providing psychotherapy tell the patient his or her diagnosis when the psychiatrist does not? To what extent will the patient’s treatment experience be affected if one mental health professional reveals the patient’s diagnosis and the other does not? What happens if the person providing psychotherapy provides the patient with a different diagnosis than the psychiatrist? To what extent should mental health professionals collaborate when designing treatment plans for their patients?

Because this study was conducted with psychiatrists, it also raises the clinically important question of whose responsibility it is to educate patients about their diagnosis. Psychiatrists have a unique role because they hold a position of authority when providing medication to clients. On the other hand, mental health professionals who provide therapy services often have more contact with the patient, know the patient better,

and potentially have a stronger working relationship with the patient. Currently, the American Psychological Association's (1992) guidelines on ethical practices and the American Psychiatric Association's (2008) principles of medical ethics do not explicitly state whose responsibility it is to disclose diagnoses or whether nondisclosure is unethical. Instead, they state that practitioners should make decisions based on the best interests of the client and should also collaborate with other treatment professionals. Because practitioners from various disciplines and theoretical backgrounds have different viewpoints on diagnostic (non)disclosure, there is no standard clinical practice for diagnostic (non)disclosure.

### ***Limitations and Directions for Future Research***

In this study, interviews were conducted with psychiatrists who treat Chinese American patients. Although it seems that some Chinese American psychiatrists may be less inclined to tell patients their diagnosis, there is no empirical evidence that documents the rationale for delayed disclosure or nondisclosure, whether it is done out of cultural competence (e.g., reducing premature treatment failure or improving working alliance) or cultural bias that may not be beneficial to the patient (e.g., patients being more likely to stay in treatment but less likely to make improvements).

As with any study, a number of limitations deserve mentioning. Among them include the small sample size that limits the generalizability of findings. Future research should conduct interviews on a larger scale and also utilize more systematic and sophisticated quantitative and qualitative methodology. For example, prospective quantitative studies could be designed to test psychiatrists' attitudes toward disclosing diagnoses and examine whether this facilitates or impedes treatment progress and outcomes. In addition, more sophisticated qualitative methods could be used to help better understand how knowing one's diagnosis affects one's attitude toward mental health treatment. Moreover, research needs to be conducted to ascertain whether different attributions

to the cause of psychiatric disorders (e.g., fate or supernatural experiences) are evidenced among Chinese Americans (Hwang, 2006).

Another limitation is the lack of a comparison group, the existence of which could help better understand treatment practices across different racial and cultural matches. For example, if Caucasian American psychiatrists were interviewed, would they be less inclined to tell Chinese American than other Caucasian American clients their diagnosis? To what extent would the client's linguistic abilities affect this dynamic? In addition, are Chinese American psychiatrists more likely to tell Caucasian American than Chinese American clients their diagnosis? And, would a Chinese American patient respond differently when a Chinese American psychiatrist versus a Caucasian American psychiatrist or a psychiatrist from another racial group tells him or her the diagnosis? Conducting a larger study that has cross-racial matches could help better understand these issues.

### ***Recommendations for Clinical Practice***

Results of this study provide some insights from which a set of heuristics and guidelines can be constructed for clinical practice recommendations. They are presented below:

1. The notion of mental illness and its treatment is often culturally foreign to ethnic minority patients. Many minority patients feel uncomfortable in treatment and do not fully believe that it will work. It may be helpful to orient and demystify the therapy process for the patient, especially for immigrants and those who are less acculturated (Hwang, 2006).
2. There are shame and stigma associated with having a mental illness. This is partially related to lack of psychoeducation that typically combats stereotyped misperceptions. Minority patients, therefore, may be at greater initial risk for dropping out of treatment prematurely and

may be more likely to conceal their problems and less likely to discuss their problems openly. In addition, once they learn their diagnosis, it may be difficult for them to accept and they may not cope with the label well. Great care needs to be taken to educate patients, normalize experiences, and decrease stigma associated with mental illness.

3. Take a biopsychosocial approach in educating patients about the etiology of their problems. Western cultures tend to place a heavy emphasis on the mind (e.g., thinking and feeling), whereas many cultures focus more on an integrated “mind, body, and spirit.” Using a more balanced approach to psychoeducation can help reduce stigma and facilitate understanding and learning (Hwang, 2006).
4. Many minority patients come from cultural backgrounds that have a greater emphasis on social hierarchy. As a result, patients have great respect for and deference to authority figures. Because they do not want to be perceived as being disrespectful or challenging of authority, they may be less likely to ask questions, clarify misunderstandings, or let the practitioner know when they do not understand. Moreover, minority patients are often less aware of patient rights. It would be helpful to use the status of authority figures to make the treatment process more collaborative and clarify patient-practitioner roles and expectations (e.g., “As your doctor, I want you to ask me questions and tell me if you do not understand ... These are your rights as a patient.”).
5. Integrate extant cultural strengths into the treatment (Hwang, 2006). For example, the family traditionally plays a significant supportive role in many cultures. The family will often come to treatment with mentally ill family members. Practitioners should do their best to forge a positive working relationship with the family, especially since the family can provide valuable additional information that can inform treatment. The family often helps patients remember their

appointments, brings them to treatment, assists in medication management, and is the first to notice when patients are at risk for re-hospitalization.

6. Timing is very important and it may be advantageous to wait until patients are stabilized before telling them their diagnosis. In order to reduce premature dropout, a solid working relationship with the patient should be formed first. This is very important because of the unfamiliarity and stigma associated with mental illness. In the interim, practitioners should focus on addressing the patient's symptoms and the reasons why he or she came to treatment. Do not reveal diagnoses until the practitioner has a clear idea of the patient's diagnosis.
7. Be aware of and assess the practitioner's own tendency to practice medical authoritarianism and benevolent paternalism. Also, be aware of the practitioner's own cultural countertransference (Comas-Diaz & Jacobsen, 1991). Some patients may not ask the practitioner for their diagnosis because they do not want to know. Others may not ask because they are deferent to authority figures and feel that the practitioner will tell them if it is best for their treatment. Evaluate own bias and reluctance in disclosing diagnoses. Some practitioners may feel a need to protect their patients. Many patients are quite resilient and withholding diagnoses can be counterproductive for the patient's recovery. Other practitioners do not believe that patients are capable of understanding or collaborating in treatment. Some practitioners do not want to be responsible or feel guilty for being the bearer of bad news. These issues also apply to transfer patients (e.g., "Their previous practitioner did not tell them, why should I?").
8. If done properly, patients who know their diagnosis and are educated about their illness are better situated to do better in treatment. Most patients do know that something is wrong and practitioners who avoid addressing important issues could increase shame, stigma, and

confusion for the patient (e.g., “My illness is so horrible, even my doctor is afraid to tell me.”). Remember, the end goal is to properly educate patients so that they can develop independence and a sense of mastery.

9. Remember to coordinate services. Specifically, therapists and psychiatrists should communicate with each other and collaborate when deciding when and how to tell a patient his or her diagnosis. Do not avoid disclosing diagnoses and assume that others will take on this responsibility. Psychiatrists may be better positioned to explain the diagnosis of patients and why they are taking medications. However, since therapists may see patients more often and have a better therapeutic relationship with patients, they are in a unique position to assess whether diagnostic disclosure would be helpful and whether patients are ready to understand their diagnosis.
10. After patients become more stabilized, provide them with psychoeducational handouts (e.g., brochures and pamphlets) about their illness. It may be beneficial to read them in session and ask them if they can relate any of their experiences to that reported by others in the handout. Follow-up with patients after telling them their diagnosis and normalize their experiences. It may also be helpful to provide handouts that explain the purpose of the medication and how to take it.

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### 臨床診斷是否適宜告知華裔美籍精神分裂症患者？

如果案主被診斷患上精神分裂症，心理衛生從業人員是否適宜將診斷結果告知案主？在取捨的過程中，究竟文化扮演什麼角色？假如心理衛生從業人員選擇不告知案主其診斷，這是反映了該心理衛生從業人員的文化敏感度與文化知能，抑或反而加劇了該從業人員的文化刻板印象與錯誤觀念？本文探討應否將診斷結果告知案主的爭議，以及心理從業人員對告知華裔美籍精神分裂症患者其診斷結果態度遲疑的可能原因。本文亦討論案主的族裔背景對告知與否之間的影響，以及心理從業人員的偏見。此外，本文並述說與四位華裔美籍精神科醫師的訪談結果，藉以呈現心理衛生專業人員對這議題在信念、觀點與實務上的多樣性。最後，本文對牽涉是否告知診斷結果的文化議題提供實務上的建言與建議。