Understanding Psychosis and Stigma in Chinese Canadian Patients and Their Families

Ting Wang

Division of Social and Transcultural Psychiatry

Department of Psychiatry

McGill University, Montreal

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Dedication

参与我的研究的人，你们愿意分享个人经历让我十分感激。我希望我的研究可以扩大你们的声音，为你们和其他面临类似挑战的人提供一些安慰。没有你们的参与，这一切都是不可能的。非常感谢你们。

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Contribution of Authors

This thesis is the original work of Ting Wang.

I developed the research project in collaboration with my supervisor, Dr. G. Eric Jarvis, and advisory committee members, Drs. Kenneth Fung, Melissa Park and Andrew Ryder. I independently completed the literature review, conducted the interviews, analyzed the data and wrote the manuscript. Dr. Jarvis edited the manuscript, and the thesis underwent external review by Dr. Francis Lu.

Abstract

Background: Psychosis refers to a collection of symptoms in which a person experiences a disconnection from reality. It is often accompanied by stigma, which has negative effects on access to care and mental health outcomes. Stigma is influenced by cultural norms and values. Research indicates that Chinese Canadians with severe mental health conditions face more stigma and worse mental health outcomes than their White counterparts, exacerbated by the limited availability of culturally sensitive mental health resources and services.

Aims: This study seeks to (1) document the lived experiences of early psychosis and stigma in Chinese Canadian patients and their families; (2) investigate cultural influences that contribute to heightened stigma within the Chinese Canadian community; (3) propose negotiated solutions to reduce stigma.

Methods: This study took place at three early intervention clinics in Montreal, Quebec. Semi-structured interviews were conducted with Chinese Canadian patients and their families using the McGill Illness Narrative Interview (MINI) and the Semi-structured Interview Measure of Stigma (SIMS). Interpretative Phenomenological Analysis (IPA) was used to identify and describe key themes that emerged from the interviews.

Results: This study included ten participants, consisting of six patients (2 males, 4 females) and four parents (3 males, 1 female). Three key themes emerged: mental health beliefs (common views and attitudes to care), cultural values (filial piety and face) and communication (diagnostic labels and emotional expression). Endorsement of all superordinate themes was demonstrated in each interview, indicating their significance across all cases.

Discussion: The neglect of Chinese Canadians by psychiatric research has resulted in a lack of understanding of their mental health challenges. This study explored the lived experiences of early psychosis and stigma in Chinese Canadian patients and their families in Montreal. There is an urgent need to work closely with Chinese service users to better understand their culture in relation to the diagnosis and treatment process. More culturally sensitive care and increased mental health awareness within the Chinese Canadian community are required. Solutions (i.e., interpretation and translation services, culturally adapted psychoeducation and peer support) can reduce stigma, improve access to care, enhance mental health outcomes and alleviate family burdens, thereby fostering a healing environment for Chinese Canadian patients with first episode psychosis and their families.

Résumé

Contexte : La psychose fait référence à un ensemble de symptômes où une personne éprouve une déconnexion de la réalité. Elle est souvent accompagnée de stigmatisation, qui a des effets négatifs sur l’accès aux soins et les résultats en santé mentale. La stigmatisation est influencée par les normes et valeurs culturelles. La recherche indique que les Canadiens d’origine chinoise souffrant de troubles mentaux graves font face à plus de stigmatisation et à de moins bons résultats en santé mentale que leurs homologues blancs, aggravés par la disponibilité limitée de ressources et services en santé mentale sensibles à la culture.

Objectifs : Cette étude vise à (1) documenter les expériences vécues de psychose précoce et stigmatisation chez les patients canadiens d’origine chinoise et leurs familles ; (2) étudier les influences culturelles qui contribuent à une stigmatisation accrue au sein de la communauté chinoise canadienne ; (3) proposer des solutions négociées pour réduire la stigmatisation.

Méthodes : Cette étude a eu lieu dans trois cliniques d’intervention précoce à Montréal, Québec. Des entretiens semi-structurés ont été menés avec des patients canadiens d’origine chinoise et leurs familles en utilisant l’Entrevue Narrative sur la Maladie de McGill (ENMM) et la Mesure Semi-Structurée de la Stigmatisation (MSSS). L’Analyse Phénoménologique Interprétative (API) a été utilisée pour identifier et décrire les thèmes clés qui ont émergé des entretiens.

Résultats : Cette étude a inclus dix participants, composés de six patients (2 hommes, 4 femmes) et quatre parents (3 hommes, 1 femme). Trois thèmes clés ont émergé : les croyances en santé mentale (points de vue communs et attitudes envers les soins), les valeurs culturelles (piété filiale et face) et la communication (étiquettes diagnostiques et expression émotionnelle). L'approbation de tous les thèmes susmentionnés a été démontrée dans chaque entretien, indiquant leur importance à travers tous les cas.

Discussion : La négligence des Canadiens d'origine chinoise par la recherche en psychiatrie a entraîné un manque de compréhension de leurs défis en santé mentale. Cette étude a exploré les expériences vécues de psychose précoce et stigmatisation chez les patients canadiens d'origine chinoise et leurs familles à Montréal. Il est urgent de travailler en étroite collaboration avec les utilisateurs de services chinois pour mieux comprendre leur culture par rapport au processus de diagnostic et traitement. Des soins plus sensibles à la culture et une sensibilisation accrue à la santé mentale au sein de la communauté chinoise canadienne sont nécessaires. Les solutions (telles que les services d'interprétation et de traduction, la psychoéducation adaptée à la culture et le soutien entre pairs) peuvent réduire la stigmatisation, améliorer l'accès aux soins, renforcer les résultats en santé mentale et alléger les charges familiales, favorisant ainsi un environnement de guérison pour les patients canadiens d'origine chinoise avec un premier épisode psychotique et leurs familles.

Introduction and Literature Review

Psychosis

Psychosis refers to a collection of symptoms in which a person experiences a disconnection from reality (National Institute of Mental Health, 2023). Approximately 4% of the Canadian population will go through a psychotic episode at some point in their lives (Lecomte et al., 2022). The first experience of psychotic symptoms, often arising in late adolescence or early adulthood, is called first episode psychosis (Anderson et al., 2014). Symptoms of psychosis fall into the classification of positive and negative. Positive symptoms include hallucinations, delusions, paranoid ideation, as well as disorganized thoughts and behaviours. On the other hand, negative symptoms include reduced emotional expression (blunted affect), diminished attention to personal hygiene, social dysfunction or withdrawal, as well as a lack of pleasure or disinterest in life's experiences (anhedonia) (American Psychiatric Association, 2013). Psychosis has multifactorial causes and results from a combination of biological, psychological and environmental factors (Radua et al., 2018). These factors comprise genetics, stress, immigration, urban living, infection, postpartum conditions or other causes (Ayano et al., 2019; Calabrese & Khalili, 2023; Nielsen et al., 2017). Research shows that psychosis can not only reduce social, educational and occupational functioning but also strain relationships with family and friends (Cowman et al., 2021, 2023). If left untreated, psychosis may cause lasting deficits (McKenzie, 2014). Importantly, psychosis may manifest as an antecedent of a severe mental illness, such as schizophrenia, bipolar disorder or major depressive disorder with psychotic features (National Institute of Mental Health, 2023). Some individuals, however, may experience psychosis without receiving a diagnosis for another disorder. Fortunately, psychosis is treatable, with many individuals experiencing recovery, and recurrence of symptoms can be prevented (National Institute of Mental Health, 2023; Yung et al., 1998). Early intervention is key not just for enhancing psychological well-being but also for curbing the progression of psychosis, ultimately minimizing the duration and intensity of symptoms (Malla et al., 2021).

Early Intervention

Early identification and intervention of mental illness can be difficult, especially in young people. However, services are available in Canada to aid in this process, such as early intervention clinics. These clinics provide evaluation, treatment and support through a multidisciplinary team of mental health specialists, including psychiatrists, psychologists, case managers and nurses. The goals of early intervention clinics are to decrease the duration of untreated psychosis, alleviate symptom severity, as well as improve social, educational and occupational functioning (McGorry et al., 2021; Oliver et al., 2018). These clinics typically offer diagnostic assessment, medication, psychosocial interventions and case management (Nolin et al., 2016). A meta-analysis by Correll et al. (2018), which synthesized findings from ten randomized controlled trials, demonstrated the superior effectiveness of early intervention compared to routine care.

In Montreal, early intervention clinics include, but are not limited to, the First Episode Psychosis Program at the Jewish General Hospital (FEPP-JGH), the Prevention and Early Intervention Program for Psychosis at the Douglas Mental Health University Institute (PEPP-Douglas) and the Prevention and Early Intervention for Psychosis at the McGill University Health Centre (PEPP-MUHC). Each of these clinics caters to a different sector of the city, determined by postal code, to ensure that individuals in need can readily access professional help. These three clinics served as the setting for this study.

Stigma

One of the most well-documented barriers to early intervention is stigma (Knaak et al., 2017). Coined by Goffman (1963), stigma refers to a visible mark that distinguishes a discredited group from the rest of the population, associating them with a ‘spoiled identity.’ It encompasses three components: negative beliefs (stereotypes), attitudes (prejudice) and behaviours (discrimination) directed at oneself or others (Corrigan & Watson, 2002). In the context of mental health, this phenomenon takes three forms: (1)

public stigma, involving prejudice, stereotypes and discrimination from the general public; (2) self-stigma, involving the internalization of perceived public stigma by individuals with mental illness; (3) stigma by association, where prejudice, stereotypes and discrimination are directed at someone having a connection with an individual with mental illness, such as a family member or even a psychiatrist (Committee on the Science of Changing Behavioral Health Social Norms, 2016; Corrigan & Nieweglowski, 2019; Zhang et al., 2020). Another form of stigma, called structural stigma, implicates policies and practices that lead to the unfair treatment of individuals with mental illness (Livingston, 2020). While many studies have delved into stigma, most are biased toward WEIRD (Western, Educated, Industrialized, Rich and Democratic) societies (Dabby et al., 2015; Heibach et al., 2014; Pavon et al., 2017; Smith et al., 2017; Stuber et al., 2014). This study explored public stigma, self-stigma and stigma by association but did not examine structural stigma.

Stigma operates as a cycle. Individuals with psychosis are often subjected to common stereotypes portraying them as dangerous, unpredictable and unreliable (Yang et al., 2020). These negative beliefs can give rise to prejudice, characterized by negative emotions, such as anxiety, contempt and fear. Subsequently, these negative attitudes may translate into discrimination, such as disparagement or social isolation, based on perceptions of dangerousness and unpredictability. Discrimination can extend to other aspects of life, such as employment. Rössler (2016) found that individuals with psychosis sometimes feel excluded from job opportunities due to the perception of unreliability. These factors, in turn, perpetuate stereotypes and create a self-reinforcing cycle, contributing to a higher perceived stigma among individuals with psychosis.

The ramifications of mental health stigma are devastating, particularly in help-seeking. Alarmingly, among ethnic minority individuals who report fair or poor psychological well-being, fewer than half get help from a mental health specialist (Chiu et al., 2018). Specifically, for early psychosis, Malla et al. (2021) determined that the mean duration between onset and first contact with early intervention was 25.64 ± 59.00 months for 747 patients admitted to clinics between 2003 and 2016 in Canada. Cabassa et al. (2018) attributed this duration to the ‘misattribution of symptoms, stigma and self-reliance, creating a cloud of uncertainty in which individuals experiencing early psychosis and their family members struggled to make sense of what was happening, when to get help and what to expect from treatment’ (p. 651).

Stigma can vary among different ethnic groups, a difference that may be due to cultural factors. A systematic review by Misra et al. (2021) found that stigma has similar and unique cultural aspects across different ethnic groups. These aspects include family experiences, lack of knowledge about mental illness, specific cultural beliefs, negative emotional responses and coping mechanisms related to stigma. For racialized communities facing heightened stigma, there is a dire need to engage them in research. This research allows us to establish culturally sensitive approaches and foster a supportive environment for individuals in those communities (Ran et al., 2021; Yang et al., 2007).

Chinese Community

Canada, a country known for its multiculturalism, welcomes hundreds of thousands of asylum seekers, immigrants and refugees each year (Immigration, Refugees and Citizenship Canada, 2023). According to the Census Profile, 2,140,920 Canadians trace their origins to China, making up 4.7% of Canada’s population and one of the largest ethnic minority groups in Canada (Government of Canada, 2021).

Despite the significant presence of Chinese Canadians in the population, mental health disparities persist when compared to their White counterparts (Chiu et al., 2018; Na & Hample, 2016). Chiu et al. (2018) analyzed Statistics Canada's Canadian Community Health Survey (CCHS) conducted between 2001 and 2014. They found that only 19.8% of Chinese Canadians sought professional help, in stark contrast to the 50.8% among their White Canadian counterparts. They also noticed that Chinese residents reported the weakest sense of belonging to their local community and the lowest self-rated mental health compared to White, South Asian and Black residents. The latest CCHS data shows that the self-rated psychological well-being of Chinese Canadians remains one of the lowest among racialized communities in Canada. During the COVID-19 pandemic, it plummeted from 63% to 55% (Public Health Agency of Canada, 2022). One reason for this disparity could be the Euro-Canadian orientation of most mental health services. Chinese Canadians may assume that mental health clinicians are not familiar with Chinese culture, and consequently, may not appreciate or understand their experiences (Gao, 2021; Li & Browne, 2000). The resulting distress and isolation may worsen the self-reported mental health of Chinese Canadians, as they may feel unable to get help for their suffering. This situation underscores the urgent need for cultural safety in healthcare. Kirmayer (2012) defined cultural safety as acknowledging differences between healthcare providers and patients that could impact care and working to reduce undue harm to the patient's identity. It emphasizes the importance of culturally sensitive approaches to treatment and services (Curtis et al., 2019). Furthermore, the underrepresentation of Chinese Canadians as participants in psychiatric research, including studies on psychosis, limits understanding of their experiences before intake and during treatment, thereby making it challenging to develop culturally appropriate interventions.

Another element contributing to these disparities is the issue of mental health stigma in the Chinese community. Kleinman (1988) proposed that people from different cultures will vary in their sense-making of the experience of illness and distress. Cultural beliefs and attitudes related to illness profoundly influence individuals' willingness to discuss symptoms, get help and engage with mental health services (Office of the Surgeon General, 2001). Evidence suggests a higher prevalence and intensity of stigma toward mental illness in the Chinese population compared to the White population. For example, Tse & Haslam (2021) discovered that Asian Americans reported higher levels of stigma and narrower concepts of mental illness compared to White Americans. These factors contribute to less positive attitudes toward seeking help, including reduced awareness of the need for professional help, lower tolerance of mental health stigma, decreased openness to discussing problems and less confidence in mental health clinicians. This heightened stigma is also reflected in the findings of Bhui & Bhugra (2002), who reported that Chinese psychiatric patients present with more severe symptoms upon hospital admission than White psychiatric patients. Such severe symptom presentations may suggest a delay in help-seeking, with mental health stigma as a regularly cited reason (Chiu et al., 2018). To address these disparities, greater efforts are required to combat stigma in the Chinese community.

Chinese Culture

Cultural beliefs and values can contribute to mental health stigma. In traditional Chinese philosophy, mental illness is often attributed to a lack of inner harmony or the influence of evil spirits (Kramer et al., 2002). This perspective is supported by Yang and Wonpat-Borja (2012), who found that Chinese immigrants caring for relatives with psychosis were more inclined to attribute the condition to spiritual disturbances and possessions rooted in traditional Chinese beliefs, rather than to biological and physical factors (i.e., genetics, head injuries, fatigue and other physical illnesses or problems).

In line with traditional Chinese philosophy, Yang et al. (2015) found that higher levels of acculturation among Chinese immigrants were linked to greater acceptance of biological and physical causal beliefs regarding psychosis. However, social and spiritual causal beliefs (i.e., bad methods of upbringing, problems in studies, conflict among patient’s relatives, fate, spirit possession and effect of previous lives) remained unaffected. These findings highlight the persistence of traditional Chinese cultural beliefs despite adaptation to a new milieu and openness to new ideas. They also emphasize the importance of cultural humility in practice. Kirmayer & Jarvis (2019) defined cultural humility as the mental health clinician’s capacity to be open-minded, recognize their own limited insider cultural knowledge and respect the patient or family member’s understanding of mental illness.

Cultural values, particularly filial piety (孝) and face (面子), can shape the lived experience of mental illness and stigma. Filial piety refers to a child's duty to honour and obey their parents or elders. In certain circumstances, it can intensify the challenges faced by individuals with mental illness. These circumstances include rigid familial expectations, harsh family relationships and punitive consequences for failing to meet expectations, which may increase burden and distress (Lam et al., 2022). In Chinese students, a prevalent family expectation is to strive for academic and professional success, with failure being negatively perceived by the family (Costigan et al., 2010). Face, on the other hand, refers to an individual's social standing, reputation, dignity and honour. Disclosing a mental health diagnosis to others can influence perceptions of employability, family lineage or marriage suitability—adverse consequences for Chinese people with mental illness and tantamount to a loss of face (Lin & Lin, 1981; Tsang et al., 2007; Yang et al., 2015). As a result, they may choose to conceal their mental health issues to maintain their image, avoiding potential embarrassment, shame or loss of respect in the eyes of others (Yin et al., 2020; Yang & Kleinman, 2008; Wong et al., 2018). The fear of social repercussions and desire to conform to cultural norms often hinder open discussion about mental health within Chinese families, inner circles and wider communities.

Language plays a pivotal role in shaping individual outlooks on mental illness. Negative connotations coupled with medical terms can be perceived as condescending or isolating for Chinese patients and their families (Volkow et al., 2021). For example, when describing psychosis, many individuals resort to the broad term 精神病 (jīng shén bìng), despite it encompassing various mental conditions. This oversimplification and the use of inaccurate labels can lead to misunderstandings (Chung & Chan, 2004). Moreover, cultural norms can impede a specific form of communication: emotional expression (Chen et al., 2015). In Chinese culture, it is important to strike a balance between emotional restraint and suppression in emotional expression (Su et al., 2015). Emotional restraint refers to the act of exercising discretion in expressing feelings, while emotional suppression refers to the act of inhibiting emotions altogether. In cultures where individualism is valorized (i.e., Western), emotional restraint and suppression often lead to adverse outcomes in psychological functioning. In contrast, in collectivist cultures (i.e., East Asian), they are perceived as beneficial for preserving social harmony (Butler et al., 2007; Soto et al., 2011; Wei et al., 2013; Yuan et al., 2014; Zhou et al., 2016). However, even in cultures where collectivism is valorized, lower emotional expression was not always linked to better psychological health (Cheung & Park, 2010). Instead, lower emotional expression was beneficial only when individuals were content with their decision to restrain and suppress emotions (Tsai & Lu, 2018). These findings suggest that individuals who desire to express emotions but fear the consequences may experience poorer psychological health. Chinese individuals with psychosis may hesitate to express their distress or get help, afraid of disrupting social harmony within their family or community. Conversely, they may feel compelled to speak out inappropriately, thereby bringing embarrassment, shame or loss of respect upon themselves and their family. Hence, language, especially in diagnostic labels and emotional expression, can influence the experience of psychosis and contribute to stigma.

Family Caregivers

In Chinese culture, family members bear the responsibility of caregiving for their loved ones with physical or mental conditions—a cultural norm rooted in the collectivist nature of society (Pharr et al., 2014). Family involvement has proven effective in assisting individuals with psychosis, reducing relapse rates, hospital admissions, improving medication adherence and alleviating distress (Hansson et al., 2022). However, up to 80% of individuals with psychosis face a high risk of relapse within the initial five years after the successful treatment of the first episode (Tibbo et al., 2014). During treatment and recovery, they often rely on continuous support from their families. While many studies on Chinese families have explored caregiving experiences, they predominantly focus on children caring for their elders (Bífárìn et al., 2021; Chan & Chui, 2011; Li & Dai, 2019; Miyawaki et al., 2020; Xie et al., 2016). The role of elders in providing care for their children with psychosis has received minimal attention. Available research on this topic reveals subjective and objective burdens accompanying the caregiving journey. Firstly, the caregiving role imposes a subjective burden, such as the emotional strain experienced by caregivers, including feelings of anxiety and depression (Chen et al., 2016). Secondly, the caregiving role imposes an objective burden, manifesting as tangible disruptions to the caregiver's life. These disruptions can take the form of financial burdens, such as taking time off work to care for the ill family member, or logistic burdens, such as relocating to be in closer proximity to care for the ill family member (Leng et al., 2019). Moreover, the objective burden includes social challenges, such as the stigma coupled with caring for someone with psychosis, resulting in isolation and loneliness (Chien & Chan, 2007; Kamaradova et al., 2016; Karnieli-Miller et al., 2013; Park & Park, 2014; Wong et al., 2018). These findings support the concept of stigma by association, as described by Corrigan and Watson (2002). Families may experience similar levels of stigma as individuals with mental illness, encountering prejudice and discrimination due to their relationship to the stigmatized person. In research, family involvement becomes essential for providing insights into caring for the ill loved one and addressing the ongoing necessities of those providing care. Research enables the development and implementation of strategies to reduce mental health stigma, ultimately working toward creating a supportive atmosphere for everyone involved.

Local Barriers

In Montreal, approximately 210,000 people trace their origins to China, constituting about 4.3% of the immigrant population (Government of Canada, 2021). However, despite their significant presence, Chinese immigrants face considerable challenges in accessing and engaging with mental health services in the city. Cultural and structural barriers contribute to these difficulties and underscore the need for improved understanding and support. Research by Li & Browne (2000) sheds light on the myriad challenges Chinese patients encounter when seeking culturally sensitive mental health interventions. Cultural barriers, such as healthcare providers' lack of understanding or disregard for cultural beliefs and values, can result in mistrust of the mental healthcare system and contribute to unfavourable mental health outcomes (Bowen, 2001). Stigma surrounding mental illness treatment further complicates the situation. Chinese patients may perceive stigma associated with taking medication or receiving psychotherapy, which can lead to non-compliance and strain the doctor/patient alliance. Even services such as family psychoeducation, offered by the three hospital sites serving as the setting for this study, see minimal attendance among Chinese family caregivers, indicating the need for additional support measures. Structural barriers also play a pivotal role, especially during the acute phase of mental health crises. Issues such as insurance coverage, cost, confidentiality concerns, as well as limited accessibility to psychological health information and services, hinder the ability of Chinese patients and their families to navigate the healthcare system effectively (Shi et al., 2020). Moreover, recent events, such as the implementation of Bill 96, which mandates medical communication in French, present additional challenges. Particularly impactful for English-speaking Chinese Quebecers, a small minority in a predominantly French-speaking province, the implementation of such policies can pose challenges in various settings, including medical situations (Bowen, 2001; Kirmayer et al., 2011). The younger generations of Chinese Quebecers tend to prefer English over French, influenced by the emphasis on learning English in their home country and its global prominence (Lin, 2018). English being the language of instruction in bilingual academic institutions in Quebec reinforces this preference. For newly arrived immigrants who cannot communicate in English or French, accessing suitable care and conveying details about their psychological well-being becomes even more daunting. Overcoming these obstacles requires concerted efforts to overcome language barriers, foster effective communication and build trust among Chinese patients, their families and their clinical teams. This study addresses the cultural and structural barriers faced by Chinese patients with first episode psychosis and their families as they navigate the healthcare system in Montreal.

Research Question

What is the experience of psychosis and stigma like for Chinese patients and their families, and how do they make sense of this experience?

Objectives

This study aims to achieve three objectives in understanding the experience of psychosis and stigma in Chinese patients and their families: first, to document the unique experience of psychosis and stigma in the members of this community and to reveal the specific challenges they face; second, to investigate cultural influences that contribute to heightened stigma in the Chinese community; third, to propose negotiated solutions to reduce stigma and provide insights for devising culturally sensitive interventions for Chinese patients with first episode psychosis and their families.

Rationale

The rationale of this study is two-fold. First, there is a lack of representation of Chinese patients and their families in studies on psychosis compared to White and Black subjects. This underrepresentation results in a limited understanding of the specific psychosocial challenges and needs of the Chinese population (Burkhard et al., 2021). Previous studies show that East Asian patients often face various psychosocial challenges, leading to a longer duration of untreated psychosis, underutilization of mental health services and premature termination of treatment (Abe-Kim et al., 2007; Li et al., 2013; Na et al., 2016; Ryder et al., 2000; Shea and Yeh, 2008). Second, research often assumes that stigma arises and functions in the same way across all cultural groups. However, its causes and effects vary drastically (Ahad et al., 2023). This study aims to fill the literature gap by considering the lived experience of stigmatized individuals within the local cultural context by focusing on Chinese patients and their families in Montreal and exploring their lived experience of psychosis and stigma (Kleinman & Hall-Clifford, 2009; Yang et al., 2007).

Methods

Overview

This study took place at three hospital sites in Montreal, each equipped with clinical teams that facilitated participant recruitment. The data collection involved conducting semi-structured interviews with Chinese patients and their families, using the McGill Illness Narrative Interview (MINI) and the Semi-structured Interview Measure of Stigma (SIMS), to explore the meaning they ascribed to their lived experience of psychosis and stigma. Interpretative Phenomenological Analysis (IPA) was the method used to analyze the data.

The methods are divided into three sections:

- Phase 1: REB submission and approval
- Phase 2: Recruitment, consent and data collection
- Phase 3: Data analysis

Phase 1: REB submission and approval

Ethics. This study was approved by the Research Ethics Boards of the CIUSSS du Centre-Ouest-de-l’Île-de-Montréal (MP-05-2023-3551), CIUSSS de l’Ouest-de-l’Île-de-Montréal (MEO-05-2023-757) and Centre universitaire de santé McGill (MEO-05-2023-9203).

Confidentiality. In this study, all participants provided informed consent through electronic documentation on SurveyMonkey. I transcribed the audio recordings, ensuring the omission of personal identifiers. All documentation (i.e., email correspondence and signed consent forms) and audio recordings were placed in a secure data folder on OneDrive provided by CIUSSS du Centre-Ouest-de-l’Île-de-Montréal. Participation was voluntary and participants could retract statements or request omission from the final report. They also had the option to withdraw from this study at any time without consequence. Throughout the research process, I could disclose information to the clinical team if the patient was in imminent danger of harming oneself or others.

Research design. This study adopts a descriptive exploratory qualitative framework, frequently used in health science research, to investigate psychosis and stigma among Chinese patients and their families. Qualitative research involves in-depth exploration of participant experiences, allowing for a nuanced understanding of the meaning that people ascribe to their experiences (Sutton & Austin, 2015). The descriptive aspect involves capturing these experiences without manipulating any variables and by using the participants' own language (Sandelowski, 2010). The exploratory aspect involves allowing findings to emerge directly from collected data to ensure the generation of reliable and valid results (Thomas, 2006). Given the significant impact of culture on lived experience and the limited attention in psychiatric research on Chinese patients and their families, this design is well-suited for exploring cultural factors related to psychosis and stigma. This approach fills the literature gap and enhances understanding of the 'biological, psychological, social, cultural, ethical and political dimensions of human lives' (Fossey et al., 2002, p. 717). It also aids in the formulation of a health belief model of psychosis in the Chinese community, offering insights for mental health clinicians.

Study setting. Three hospital sites in Montreal were selected for recruitment: the First Episode Psychosis Program at the Jewish General Hospital (FEPP-JGH), the Prevention and Early Intervention Program for Psychosis at the Douglas Mental Health University Institute (PEPP-Douglas) and the Prevention and Early Intervention for Psychosis at the McGill University Health Centre (PEPP-MUHC). These sites were chosen due to their involvement in a pre-existing collaboration on a Health Canada-funded study led by G.E. Jarvis, MD. His study focused on the cultural adaptation of family psychoeducation for the families of loved ones with psychosis in English-speaking minority communities (2020-2023). I had prior connections with FEPP-JGH and PEPP-MUHC, having served as a research assistant and site coordinator, respectively. These positions allowed me to establish relationships with members of both teams, which was helpful for this study.

Sample. This study employed homogeneous and purposive sampling, which involves selecting individuals with the same or very similar characteristics (homogeneous) and choosing them intentionally based on traits relevant to the topics of interest (purposive). This study included a total sample of six patients and four family members. Further demographic details about these participants are provided in Table 1 and in the appendix.

Patient participants. Eligible patients referred to the clinic after January 2018 must have experienced their first psychotic symptoms for more than three days, be between 18 and 35 years old, as well as not have severe substance abuse, developmental or intellectual impairments, or medical conditions explaining their symptoms or limiting their participation in this study. Additionally, eligible patients must be international students, immigrants or children of immigrants from China.

Family member participants. Due to the collectivist nature of Chinese culture, family members often assume the role of caregivers for loved ones with mental illness. This responsibility can impact their energy, time, as well as their mental and physical health (Liu et al., 2007; Sales, 2003). Mentally healthy family members may face mental health stigma related to their association with an individual with mental illness (Chien, Chan & Morrissey, 2007). To fully grasp the concept of stigma, this study explored stigma by association. Eligible family members must be at least 18 years old and immigrants or children of immigrants from China.

Tables 1A and B show the demographic information of participants.

Code	Gender	Age*	Immigrant (1st/2nd gen.)	Religious affiliation	Intake date	Interview language(s)
P01	M	29	SG—Born and raised in Montreal	N/A	06-07-2015	English
P02	F	20	FG	Buddhist	12-10-2021	English
P03	F	25	SG—Born and raised in Montreal	Buddhist	23-09-2019	English & Mandarin
P04	F	30	FG	N/A	17-12-2021	English & Mandarin
P05	M	31	FG	N/A	23-05-2023	English
P06	F	19	FG	Buddhist	19-07-2022	English & Mandarin
*Age of the participant at the time of the interview						

Table 1A. Demographic information of patient participants.

Code	Gender	Immigrant (1st/2nd gen.)	Religious affiliation	Child's intake date	Interview language(s)
FM01	M	SG—Born and raised in Vancouver	N/A	23-01-2023	English
FM02	F	FG	Buddhist	23-05-2023	English & Mandarin
FM03	M	FG	Buddhist	23-05-2023	English & Mandarin
FM04	M	FG	N/A	31-10-2023	Mandarin

Table 1B. Demographic information of family member (parent) participants.

Phase 2: Recruitment, consent and data collection

Recruitment and consent. Recruitment and obtaining consent from patient and family member participants occurred as follows:

> *Patient participants*. I attended weekly clinical rounds at all three hospital sites. I introduced this study to clinical teams by sharing information and recruitment materials. Case managers used a script to make initial contact with potential patient participants, pre-screening for eligibility. Upon acquiring permission, I received contact details (phone number and email address) for consenting candidates. I reiterated the voluntary nature of participation, and if patients agreed to participate, I provided them with an electronic version of the consent form via SurveyMonkey. I answered any questions they had and obtained signed consent forms before scheduling appointments at the participants' convenience.
>
> *Family member participants*. In the patient consent form, I sought permission to contact family members. If granted, I contacted potential family member participants, explained the study and invited them to participate. I reiterated the voluntary nature of participation and, if family members agreed to participate, I provided them with an electronic version of the consent form via SurveyMonkey. I answered any questions they had and obtained signed consent forms before scheduling appointments at the participants' convenience.

Data collection. I conducted semi-structured interviews from March to November 2023. At the beginning of each interview, I reviewed the consent form, answering any questions participants had regarding this study and their involvement. I assured participants that everything mentioned during the interview would be kept strictly confidential. To guarantee the comfort of participants, I established rapport by disclosing my affiliations, expressing genuine interest in their experiences and giving them the freedom to share as much or as little as they were comfortable with. Additionally, I had a safety plan in place in case participants experienced distress during interviews. In a unique instance, two parents (FM02 and FM03) preferred sharing their lived experience together, which resulted in a group interview conducted in person at the hospital site. All other interviews were held remotely via Zoom. I made audio recordings for each interview, except for the couple's, where I took detailed notes on my laptop as per their preference. The interviews varied in duration, ranging from 50 minutes to two hours.

To gain a better understanding of patients' current conditions, I sought access to medical files to collect information on clinical and sociodemographic variables. I assured them that denial of access would not affect their participation, as the interviews would still provide sufficient data. All patients willingly gave access to their medical files.

During remote interviews on Zoom, I verified participant locations and phone numbers for emergency purposes. I obtained consent to audio record the interviews. I promptly deleted audio recordings after transcription. In instances of refusal to audio record, I took notes. In-person interviews occurred at hospital sites near staff offices in case of crises. After each interview, participants received a $20 e-gift card as compensation for their time.

Instruments. I selected the McGill Illness Narrative Interview (MINI) and the Semi-structured Interview Measure of Stigma (SIMS) as the interview tools (Groleau et al., 2006; Wood et al., 2016). I used the MINI to collect illness narratives and the SIMS to collect narratives on stigma in psychosis. Both protocols are included in the appendix.

I chose the McGill Illness Narrative Interview (MINI), constructed by Groleau et al. in 2006, for its ability to elicit illness narratives. It comprises five sections. The initial illness narrative explores the participant's first experience of psychotic symptoms and the help they sought at that time. The prototype narrative explores whether the participant encountered a health problem like psychosis in their past, inner circle or through media. If so, they are asked to describe the similarities and differences. The explanatory model narrative explores how the participant explains psychosis, including labels and causes. The section on services and response to treatment explores the kind of help the participant sought for psychosis, their feelings about the treatment and other forms of desired care. Lastly, the section on the impact on life explores how psychosis has changed the participant's life, self-perception, others' perception, as well as the role of religion and spirituality in treatment and recovery. The MINI is well-regarded for its capacity to provide a comprehensive description of the experience of various mental and physical conditions across diverse ethnic communities (Page et al., 2020; Oliveira et al., 2021; Ricci et al., 2021; Wallace & Chard, 2022; Yamaguchi et al., 2021).

I chose the Semi-structured Interview Measure of Stigma (SIMS), constructed by Wood et al. in 2016, for its reliability and validity in measuring stigma. The SIMS is an eleven-item survey created in collaboration with researchers and service users with psychosis (Wood et al., 2016). Various self-report measures for stigma exist, including the Felt Stigma and Concealment Questionnaire (FSC-Q), Internalized Stigma of Mental Illness (ISMI) scale, Self-stigma Questionnaire (SSQ), Skidmore Anxiety Stigma Scale (SASS) and Stigma-9 Questionnaire (STIG-9), among others (Gierk et al., 2018; Laird et al., 2020; Ochoa et al., 2015; Ritsher et al., 2003; Schofield & Ponzini, 2020). However, I chose the SIMS because it allows for a more in-depth exploration of the topic. Its format allows me to ask open-ended questions for details about narratives on stigma in psychosis. It also refrains from solely depending on scores for items on a scale, which might not yield as rich data. A recent study by Wood et al. (2022) used the SIMS to investigate the experience of stigma related to psychosis among Asian, Black and mixed heritage service users, highlighting its applicability in research with diverse ethnic communities.

For patient participants, I administered the original versions of both the MINI and SIMS during the interviews. Family member participants received a modified version of the MINI, redirecting the focus of items related to the experience of psychosis to that of the patient. For instance, questions such as 'When did you experience the psychotic symptoms for the first time?' were adjusted for family members, asking instead 'When did your loved one experience the psychotic symptoms for the first time?'

After each interview, I wrote a reflexive summary that included observations, such as language(s) spoken, non-verbal responses and critical points derived from the narratives. Below is a reflexive summary from the group interview with FM02 and FM03.

Initial Illness Narrative (MINI)

- FM02 and FM03 initially overlooked the seriousness of their son's symptoms.
- Their son exhibited anxiety, fears toward others (i.e., they were planning to harm him) and eventually quit his job.
- His behaviour worsened, leading to an ER visit where he confessed to hearing things.
- Despite taking medication, he struggled with sensitivity to noise coming from the apartment downstairs, affecting sleep and well-being.
- He struggled to adhere to his medication.
- For the first few months, his parents had to watch him take it.

Prototype Narrative (MINI)

- No family history of psychosis and mental illness.
- Both parents talk about media portrayals (i.e., news about someone who committed a murder in New York). → immediate association with psychosis

Explanatory Model Narrative (MINI)

- Both parents struggled to accept their child's diagnosis.
- Spent most of their time at home with him for his safety.
- Supported his career transition (from office job to general labour work) and introduced religious practices (i.e., reading Buddhist tales about virtues).
- Continue to have conversations about spirituality when he is in good health.

Services and Response to Treatment (MINI)

- After a long wait of several hours in the emergency room (did not sound satisfied with how the visit went), their son was prescribed medication.
- Initially refused treatment but eventually adhered.
- Currently seeing a psychologist.

Impact on Life (MINI)

- Their son has returned to work.
- Might find his own apartment in 2024.
- FM03 fainted once and experienced hair loss from exhaustion and stress.

Stigma (SIMS)

- Both parents believe their son faces discrimination due to his ethnicity.
- Their son is very introverted and spends most of his time online.
- Chose not to disclose the diagnosis to family in China to prevent worry among the elders and protect the family's reputation.

Observations

- Both parents were reluctant to share many details in the first ~15 minutes. Had to probe and ask many follow-up questions.
- Slowly opened up, especially toward the middle (explanatory model narrative).
- The father declined having a religious affiliation at first. The mother used to be a practicing Christian.
- Both parents revealed later on that they are Buddhists.
- Offered to maintain contact in case I needed any additional information or clarification during the write-up.
- A mix of English and Mandarin was used, with Mandarin noticeably being used more in the end. → sign of a greater comfort level with me or a preference for sharing information in their native language

Phase 3: Data analysis

Interpretative Phenomenological Analysis (IPA). In this study, I used IPA, an inductive 'bottom-up' research method. IPA integrates three main theoretical foundations: idiography, phenomenology and hermeneutics (Pietkiewicz & Smith, 2014). The underlying philosophy of IPA revolves around understanding the lived experience of individuals, by prioritizing an insider perspective to unveil the subjective meaning of those experiences (Willig & Stainton-Rogers, 2017). Firstly, the idiographic aspect entails examining the detailed lived experience of each case. Secondly, the phenomenological aspect entails producing separate accounts of lived experience and the individual processes of meaning-making associated with each case. Thirdly, the hermeneutic aspect entails acknowledging that the researcher attempts to make sense of the participant's sense-making process related to their lived experience. Another important point is that the researcher must exhibit a combination of creative, critical and reflective thinking to conduct this type of data analysis correctly (Maher et al., 2018). Therefore, they must 'recognize, note and own what they are doing with the data and why' (Engward & Goldspink, 2020, p. 4).

Furthermore, codes are generated from the data itself, rather than being imposed on the data. This approach ensures that the findings closely match what is important and genuinely shared by the participants. Several studies have used IPA to address their research objectives related to complex and sensitive topics in mental health (Larkin & Thompson, 2011; McGlinchey et al., 2021; Murphy et al., 2023; Peisah et al., 2022; Sandford et al., 2023). Thus, the combination of idiography, phenomenology and hermeneutics makes IPA well-suited for exploring and interpreting the lived experience of psychosis and stigma among Chinese patients and their families.

Nine interviews were conducted with ten participants. Eight of these interviews were transcribed verbatim using NVivo (Release 1.7.1), except for the couple's interview, where I took notes with their consent. None of the participants withdrew from this study. The interviews were conducted in the following manner: in English with three patients (P01, P02 and P05) and one parent (FM01); in a combination of English and Mandarin with three patients (P03, P04 and P06) and two parents (FM02 and FM03); in Mandarin with one parent (FM04).

I followed the steps outlined by Smith et al. (2009) for data analysis. To start, I carefully read through one transcript for content familiarity. While exploring the semantic context, I added comments and highlighted quotes that were significant to the participant. These elements formed the basis for initial coding. Subsequently, I searched for connections among these codes, creating subordinate themes. To maintain an unbiased angle and uphold the uniqueness of each case, I practiced bracketing during the transition from one interview to the next. This technique ensures an open-mind and respects the individuality of each case. The same steps were repeated for each subsequent interview, involving individual coding followed by the search for patterns across cases to create superordinate themes. I highlighted idiosyncratic instances, including unique challenges and situations shared by each participant. To preserve cultural nuances, I kept transcripts in the participants' spoken language throughout both the data analysis and final report, supplemented by English translations where necessary.

Sample size justification. There is no set rule to determine the appropriate sample size in qualitative studies. In IPA research, it is common to use smaller sample sizes, typically ranging from eight to ten participants. Various factors explain this variability in sample size, including the depth of analysis required for each case, diversity among cases, necessity for comparisons or contrasts and practical considerations, such as time constraints and sensitivity of topics (Smith & Fieldsend, 2021). Smith et al. (2009) argue that a smaller study size allows the researcher to gain a more thorough and useful understanding of each individual case. In contrast, a larger study size may result in a shallower and less useful understanding of the topics under investigation. As such, data saturation is not a requirement in IPA (Miller & Minton, 2016). IPA researchers appreciate the emphasis on smaller sample sizes, asserting that the resulting data are 'poignant, emotive and interesting' (Wagstaff & Williams, 2014, p. 4). In this study, having ten participants aligns with the usual sample size in IPA research.

Quality. Braun and Clarke (2013) and Yardley (2017) outlined principles for assessing the quality of qualitative research. These principles include sensitivity to context, commitment to rigour, coherence, transparency and the importance of the topics of interest. Sensitivity to context involves upholding participants' voices by respecting their perspectives and maintaining their contributions in their original form. Commitment to rigour involves full immersion in research through the development of methodological skills, data collection and data analysis. Coherence involves ensuring that the research question, research design, data collection and data analysis are all sensible and appropriate. Transparency involves making collected data (with participant consent) and choices visible in a way that allows others to evaluate them (i.e., by having an audit trail, holding advisory committee meetings and including original extracts in the final report). The topics of interest in this study are important, and I provided a list of reasons for their significance in the rationale.

Lastly, I adhered to the double hermeneutic nature of IPA by incorporating reflexive practices throughout the research process (Engward & Goldspink, 2020). I was mindful of my biases and made sure to take notes on my own feelings and thoughts both after data collection and during data analysis.

Researcher positionality. I am a Chinese Canadian woman currently pursuing a Master of Science degree in Psychiatry, with a Bachelor of Science in Psychology. My cultural and academic background fuels my interest in studying the intersection of culture and mental health. Growing up in a Chinese family and immigrating with my parents to Canada at a very young age has afforded me a dual Eastern and Western view on how traditional beliefs and cultural values influence mental health and well-being. In my approach to data collection, I avoid imposing my ideas or using medical jargon with participants. I strive for open and relaxed discussions about the lived experience of psychosis and stigma. However, I recognize potential challenges stemming from my cultural background, particularly in establishing rapport. The shared in-group identity might lead to the fear of being outed or breach of confidentiality, resulting in the withholding of personal information. Discussing sensitive topics like mental illness and stigma with a stranger can further complicate these interactions. During interviews, I respect participants' autonomy in choosing to withhold sensitive information. During data analysis, I am careful to avoid confirmation bias and any unintentional influence on the findings in order to authentically represent participants' voices. Remaining open-minded and continually reflecting on my role throughout the research process is crucial to maintaining research integrity. Recognizing my positionality, I am committed to producing culturally relevant findings that can support Chinese patients and their families affected by psychosis, as well as the mental health clinicians who help them.

Results

This section provides an overview of three superordinate themes derived from the nine interviews, as depicted in Tables 2 and 3. It discusses each theme, exploring the similarities and differences in sense-making among participants. The first theme focuses on mental health beliefs, including common views and attitudes to care. The second theme focuses on cultural values, including filial piety (孝) and face (面子). The third theme focuses on communication, including diagnostic labels and emotional expression. Endorsement of all superordinate themes was demonstrated in each interview.

Theme		**Patient**						**Family member**			
Superordinate	**Subordinate**	1	2	3	4	5	6	1	2	3	4
1. Mental health beliefs	1.1. Common views	x	x	x	x	x	x	x	x	x	x
	1.2. Attitudes to care	x	x	x	x		x		x	x	x
2. Cultural values	2.1. Filial piety (孝)	x	x	x	x		x		x	x	x
	2.2. Face (面子)	x	x	x	x	x	x	x	x	x	x
3. Communication	3.1. Diagnostic labels	x	x	x	x	x	x		x	x	
	3.2. Emotional expression	x	x	x	x	x		x	x	x	x

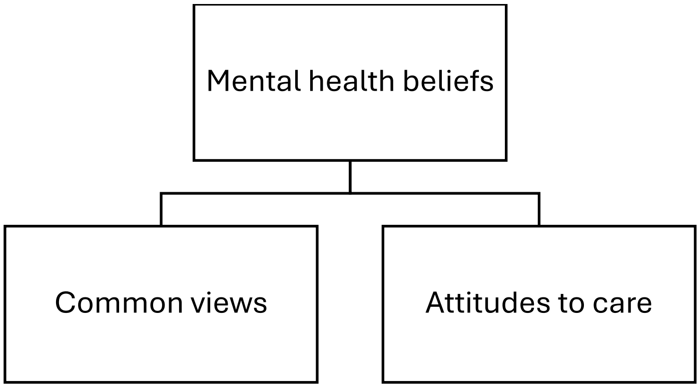
Table 2. Frequency of superordinate and subordinate themes found in the interviews.

Superordinate theme	Subordinate theme	Subcategory
1. Mental health beliefs	1.1. Common views	1.1.1. Misrepresentations of psychosis/mental illness in media and personal experience 1.1.2. Misunderstandings about psychosis/mental illness from limited awareness or education
	1.2. Attitudes to care	1.2.1. Delayed help-seeking (冰冻三尺，非一日之寒) 1.2.2. Treatment decision-making
2. Cultural values	2.1. Filial piety	2.1.1. Following parents' expectations and rules (君君臣臣父父子子) 2.1.2. Prioritizing education and personal achievement 2.1.3. Prioritizing elders' needs and well-being
	2.2. Face	2.2.1. Face and self-identity 2.2.2. Face within the family 2.2.3. Face within the community
3. Communication	3.1. Diagnostic labels	3.1.1. Derogatory meaning 3.1.2. Inaccurate meaning 3.1.3. Implied severity
	3.2. Emotional expression	3.2.1. Language barrier 3.2.2. Emotional restraint (put it in a box and shove it aside) 3.2.3. Strategies for navigating emotions

Table 3. Superordinate and subordinate themes, along with their subcategories.

Researcher's note. I interviewed three patients (P01, P02 and P05) and one parent (FM01) in English. Additionally, I interviewed three patients (P03, P04 and P06) and two parents (FM02 and FM03) using a combination of English and Mandarin. One interview with a parent (FM04) was entirely in Mandarin. While I verified translations with a native Chinese speaker, it is important to acknowledge that translation can be subjective. Hence, to accurately illustrate themes, I included original extracts in the participants' spoken language and provided English translations for select Mandarin quotations.

1. Mental health beliefs



The first superordinate theme is mental health beliefs, which encompass stereotypes about psychosis arising from culture-based misconceptions, as well as outlooks on treatment, whether prescribed or preferred. This theme comprises two subordinate themes: common views and attitudes to care.

1.1. Common views

The first subordinate theme in mental health beliefs pertains to common views, and it emerged in all interviews with six patients and four parents. This theme comprised two subcategories: misrepresentations of psychosis/mental illness in media and personal experience; misunderstandings about psychosis/mental illness due to limited awareness or education.

1.1.1. Misrepresentations of psychosis/mental illness in media and personal experience.
P04 talked about how the media, especially news outlets, shapes public views on psychosis. She mentioned that the news often sensationalizes at the expense of accuracy or objectivity. However, she pointed out that many people with psychosis can lead normal lives with proper treatment and support. Similarly, FM03 made an observation, noting that he learned about mental illness only through the news, but these stories always revolved

around violence. The media’s focus on extreme examples has led to a widespread and one-sided understanding of mental health problems.

> “我觉得大家对这种疾病的了解，社会上对这个病的报道也有点让人摸不着头脑。新闻总是追求那些引人注目的东西，就是那种猎奇的感觉。他们报道的时候，肯定不会选那些普通的事情，而是会挑一些极端的例子，比如有疯子在公车上发病，要杀很多人对吧？这样一来，大家对这种病的认知就被这些负面新闻左右了。那些已经比较控制好病情的人很难改变这个误解。” (P04)
>
> Translation: “I think everyone’s understanding of this disease, the society’s reports on this disease are a bit confusing. When they report, they will definitely not choose those ordinary things, but will choose some extreme examples, such as a madman getting sick on the bus and killing many people, right? As a result, this negative news has influenced everyone’s understanding of this disease. It is difficult for those who have better control of their disease to change this misunderstanding.” (P04)
>
> “我们在新闻中看到，纽约发生了一起疯狂的谋杀案。这个人可能是精神分裂症患者或类似的情况。除此之外，我们以前从未遇到过像那样的精神病患者。” (FM03)
>
> Translation: “We saw on the news that there was a murder in New York. The person could be schizophrenic or something like that. Other than that, we have never encountered someone with psychosis/mental illness like that before.” (FM03)

P01 explained that some individuals may rely on their limited personal experiences to form a mental representation of all individuals with psychosis. They tend to overgeneralize all people with psychosis as having ‘outward problems’ like homelessness and illicit substance use, which are not true in all cases.

> “How does society view people with psychosis? Well, I guess it is usually something like this: based on an interaction with or just seeing someone they suspect might have psychosis, they then think these individuals have a lot of outward problems. You know, like homeless people or those who use substances such as drugs, alcohol, shrooms, cocaine—illicit substances, you know.” (P01)

P03 pointed out that misinformation associating the condition with undesirable traits such as ‘craziness, instability and unpredictability’ could lead people to distance themselves or even reject those with psychosis. These misconceptions reinforce prejudice and discrimination, thereby discouraging patients from sharing their experiences with psychosis.

> "I usually keep it private and do not share it unless I really, really trust someone. Generally, [psychosis] is somewhat similar to how society perceives something like schizophrenia. I have come to realize that when people hear about psychosis or schizophrenia, they often develop a negative view because they hear something from one person that is not always true. They hear things like, 'ohh, it is just people who are crazy, unstable and unpredictable.' Then these people distance or reject themselves from someone, like me, with psychosis." (P03)

Patients commonly express the feeling that society fears them. P05 specifically noted that this fear could arise from concerns about 'being affected' by the person's behaviour, thinking that they might engage in harmful or unusual actions around them. These examples highlight the isolating impact of misconceptions.

> "I think others want to avoid me because they are scared to be around me. How do I put it? They think that my behaviour might affect them, like I might do something to them. How do they perceive me? Well, they probably think I am just strange or weird, with some condition they have never really heard of before." (P05)

1.1.2. Misunderstandings about psychosis/mental illness from limited awareness or education. Many participants (P02, P03, P04 and P06; FM02 and FM03) expressed a shared sentiment that the Chinese population has relatively limited awareness and education about mental illness and psychosis compared with the Canadian population.

As demonstrated in her account, P02 explained that there still exists a disparity in psychological research between China and 'the West.' She mentioned the limited understanding of psychosis, especially among the older generation. She also outlined misconceptions that persist within the community, such as perceiving people with this condition as 'attention-seeking' or 'overly sensitive.' Emphasizing the importance of awareness and education, P02 suggested the need for counseling services on campuses for youth and more accessible 'popular science' resources for the public.

> “因为心理研究在中国不太像西方那样发展，所以人们对此的包容性没有西方那么强。甚至在我来之前，人们对精神病这个群体和这个症状了解甚少。这在学校里也能看到。当我在中国的时候，学生们并没有像在加拿大这里那样经常谈论心理学和心理健康。就是，大部分的人，特别是老一辈的人都认为，很多人的疾病是因为矫情或者太脆弱。好像这是他们的错。当然这也不能怪他们，因为这个社会对这个问题还没有太多关注。中国媒体，我关注的并不是很多，因为那里的事情太过混乱。所以我就选择了眼不见心不烦。干脆不看了。但是我认为，就像校园内的咨询室，然后包括，科普，这对于人群提高对心理疾病的理解非常重要。” (P02)
>
> Translation: “Because psychological research in China is not as developed as in the West, people’s tolerance of this topic is not as strong as in the West. Even before I came, people knew very little about psychosis as a group and its symptoms. This can be seen in schools as well. When I was in China, students did not talk about psychology and mental health as much as they do here in Canada. That is, most people, especially the older generation, believe that many people’s mental illnesses are caused by being pretentious or too fragile. As if it is their fault. Well, of course you cannot blame them, because society has paid little attention to this issue. I pay little attention to the Chinese media because things there are too confusing/chaotic. So, I chose out of sight and out of mind. Just stop reading. But I think, like counseling services on campus, including popular science, it is very important for the population to improve its understanding of mental illness.” (P02)

Many patients, including P03, shared the belief that the fear experienced by others stemmed from the unfamiliarity and rarity of psychosis in firsthand experience and public discourse in the Chinese community. Dispelling misconceptions and ‘[knowing] more about it’ can reduce the public stigma linked to psychosis, helping her and others with psychosis feel more seen, heard and understood.

> “I feel like stigma is when people are unfamiliar with something, and it makes them scared. It is like they are afraid of the unknown. They have not had something like this happen to themselves, their family, their friends, or people around them. I get it. If they knew more about it, I think this would change for the better. […] They would be more understanding and I think I would feel more supported.” (P03)

In summary, the ‘common views’ theme emerged from two codes: misrepresentations of psychosis/mental illness in media and personal experience; misunderstandings about psychosis/mental illness due to limited awareness or education. Participants highlighted how sensationalized media coverage often depicts extreme and violent incidents involving individuals with psychosis, shaping public perceptions and perpetuating stigma. This portrayal leads to stigmatization and stereotyping of people with psychosis, associating them with negative traits and behaviours. Additionally, limited awareness and education about mental illness, particularly in the Chinese school system, exacerbate these misconceptions. Consequently, those with psychosis often face marginalization and social isolation due to fear and negative preconceived notions.

1.2. Attitudes to care

The second subordinate theme in mental health beliefs focused on attitudes toward care. Firstly, participants discussed the influence of Chinese cultural beliefs on help-seeking. Some patients felt that their negative feelings were transient and common to everyone, making them unsure when and where to get help when symptoms were not as severe. Secondly, religious and spiritual beliefs influenced treatment decisions. For some patients and families, Buddhism provided a causal mechanism for psychosis, differing from the biomedical model of medicine. Therefore, these individuals may choose to use complementary health approaches alongside conventional ones. This theme emerged from interviews with five patients and three family members.

1.2.1. Delayed help-seeking (冰冻三尺，非一日之寒). Four patients (P02, P03, P05 and P06) were hesitant to get help despite recognizing warning signs of psychosis and sensing that something was wrong. Across these interviews, a trend became apparent: participants did not anticipate an escalation of the issue and were uncertain about the necessity of seeking help, resulting in delayed intervention. For example, P02 used the Chinese expression ‘冰冻三尺，非一日之寒’ (bīng dòng sān chǐ, fēi yī rì zhī hán; ‘three feet of ice do not form in a single day’) to illustrate the gradual decline of her mental health into psychosis over a prolonged period.

> “我没想到这会成为现在的问题。我想或许学校里的每个人都有和我一样的感觉。我们都面临着类似的挣扎，对吧？就像症状确实是从不久前开始的，而且不断积累。当时，我不知道是否需要寻求帮助，而且对于它可能会自行消失还有些怀疑。所以有点像‘冰冻三尺，非一日之寒。’” (P02)
>
> Translation: “I did not expect this to be an issue now. I thought maybe everyone in school felt the same way I did. We all face similar struggles, right? It is like the symptoms really started a while ago and have been accumulating. At the time, I did not know if I needed to get help and was a little skeptical that it might go away on its own. So, it is a bit like ‘three feet of ice does not freeze in one day.’” (P02)

All patients were prescribed medication as part of their treatment plans, as shared by the participants and documented in medical records. P04 shared an incident involving a family member who, as a doctor in China, had reservations. She followed his advice and believed that overcoming her mental health challenges at the time would be possible by simply ‘continuing with [her] days’ without the need for medication to manage her depression. She supposed that this mindset contributed to delayed help-seeking and eventually led to the onset of psychosis.

> “因为我的家人是医生，当谈到吃药时，他并不是在讨论治疗疾病；他只是在讨论吃药的行为。事实上，长时间使用药物对身体并不利；它只提供暂时的缓解，随着时间的推移，你可能需要越来越多的药物。所以，我当然对药物有点害怕。我也错误地认为抑郁症是可以在不使用药物的情况下处理的。那么，我就继续过我的日子。可惜，我没有意识到情况有多严重，最终被诊断为精神病。” (P04)
>
> Translation: “Because my family member is a doctor, when he talks about taking medicine, he is not talking about treating a disease; he is just talking about the act of taking medicine. In fact, long-term use of medication is not good for the body; it only provides temporary relief, and you may need more and more of the medication over time. So, of course I was a little scared of drugs. I also mistakenly believed that depression could be managed without medication. So, I just continued with my days. Unfortunately, I did not realize how serious the situation was and was eventually diagnosed with psychosis.” (P04)

Two additional reasons were provided for a possible stigma around medication: the fear that it might alter a person’s identity—impacting personality, thoughts and behaviour—and the concern about long-term use. P04 expressed worry about judgment from others regarding the use of medication and the possibility of needing it for life.

> “这个病最关键的一点是，首先，它是一种精神疾病。然后，你知道的，患者可能会因为服药而面临相当大的压力。虽然这种病是可以治疗的，但可能需要终身依赖药物。不过，这应该没什么大问题。毕竟它不会改变我作为一个人的本质，对吧？至于其他人会怎么想，我就不太清楚了。如果他们知道我得了这个病，还得终身吃药，可能会有一些看法吧。” (P04)
>
> Translation: “The most important thing about this disease is that, first of all, it is a mental illness. And then, you know, patients can face quite a bit of stress from taking their medication. Although the disease is treatable, it may require lifelong dependence on medications. However, this should not be a big deal. After all, it does not change who I am as a person, right? As for what other people will think, I do not know. If they knew that I had this disease and had to take medicine for the rest of my life, they might have some opinions.” (P04)

Psychotherapy was sometimes recommended in combination with medication for treatment. P01 raised his parents’ concerns about privacy and doubts about its effectiveness. They were reluctant to have him undergo therapy, expressing worries about sharing personal information. Their skepticism, evident in questions like ‘Why bother seeing a psychologist then,’ reflects a misunderstanding that can sometimes be present within Chinese culture, suggesting that psychotherapy may not be very helpful.

> “You know, talking to a psychologist, well, I realize that even when things are going well, it does not mean you have to stop, right? So, there is that too, you know? For my parents, their perspective is, why bother seeing a psychologist then? They always question if it really works. And they are concerned about sharing personal stuff with a stranger. […] Some people might think these things, but to answer your question, I think everyone should have a psychologist.” (P01)

1.2.2. Treatment decision-making. Some religious patients and family members (P02 and P06; FM02 and FM03) incorporated traditional medicine into their own or their loved one’s treatment plans. For example, FM02 and FM03, who practiced Buddhism, held causal beliefs about psychosis that differed from the biomedical model of medicine. They believed that psychosis resulted from confusion in the ‘spiritual world’ or disruption of inner harmony. The couple engage in specific practices as a family with their son, namely meditation and reading ‘Buddhist stories about caring and living for others’ to help him ‘achieve clarity’ and ‘[become] happy.’

> FM02: “Mental health and the spiritual world are interconnected. We think our son is sick because his spiritual world is confused. His harmony is disrupted. Problems, like stomach problems and mental problems, happen when someone’s spiritual world is confused.”
>
> FM03: “He takes his medication as prescribed now, but we also practice meditation together. He needs to find inner peace so that his mind can be clear. We tell him if he can achieve clarity, he will feel better.”
>
> FM02: “When he is not feeling well, we read stories together, Buddhist stories. Stories about caring and living for others, rather than being selfish. Only then can you be happy.”

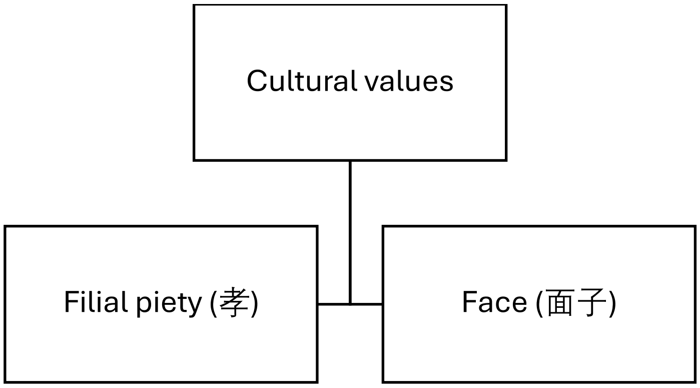
P06, who also practiced Buddhism, shared that when she returned to China, she partook in religious activities with her family, such as praying together at the temple. Despite feeling a sense of connection and support through these practices, she chose not to continue them upon returning to Canada. P06 cited a lack of time and a fear of judgment or disapproval from her treatment team as reasons that prevented her from continuing something she found beneficial for her recovery and well-being.

> P06: “最近，我成为了一名佛教徒。夏天，我和家人一起回到了中国。我们一起去庙里为身体健康祈福。和家人一起祈祷感觉很好，有一种我们都在一起的感觉。这对我帮助很大，我觉得自己正在变得更好。但是在这里，我感到有点孤独。当我在这里的时候，感觉好像我做不到。”
>
> Interviewer: “为什么你会有这样的感觉？”
>
> P06: “嗯，我没有时间，而且不想向我的治疗团队提及冥想和祈祷。我觉得他们可能不能理解和接受。”

> Translation:
> P06: “Recently, I became a Buddhist. In the summer, I returned to China with my family. We went to the temple together to pray for good health. It felt good to pray with my family and have a sense that we are all in this together. This has helped me a lot and I feel like I am getting better. But here I feel a bit lonely. When I am here, it feels like I cannot do it.”
>
> Interviewer: “Why do you feel that way?”
>
> P06: “Um, I do not have the time and I do not want to mention meditation and prayer to my treatment team. I think they might not understand and accept it.”

To conclude, cultural beliefs played a pivotal role in shaping the experience of psychosis. Uncertainty about the seriousness of the issue and the necessity for help, along with skepticism surrounding medication and psychotherapy, often resulted in delayed intervention. Religious and spiritual beliefs regarding the causes of psychosis, as well as an interest in complementary medicine, further influenced the treatment experience. Buddhist patients and family members found religious practices, such as meditation, prayer and reading Buddhist stories about virtues, to be helpful for recovery and well-being. However, some may perceive a potential for misunderstanding or rejection by the treatment team, leading them to withhold their religious and spiritual beliefs.

2. Cultural values



The second superordinate theme was cultural values. Participants elaborated on their experiences of psychosis and stigma in relation to two subordinate themes: filial piety and face.

2.1. Filial piety (孝)

The first subordinate theme in cultural values was filial piety, comprising three subcategories: following parents' expectations and rules (君君臣臣父父子子); prioritizing education and personal achievement; prioritizing elders' needs and well-being. Filial piety refers to a child's duty of honouring and obeying one's parents and ancestors. Interview material from five patients and three family members touched on this theme, exposing the impact of familial pressure and stress on individuals with psychosis in terms of how they perceive it as partially causing their illness and influencing their choice to disclose their diagnosis with others.

2.1.1. Following parents' expectations and rules (君君臣臣父父子子). According to participants from traditional households (P01, P02, P03, P04 and P06; FM03, FM04 and FM05), the hierarchical structure within their families played a role in their experience of psychosis and stigma. P02 described this arrangement using the expression '君君臣臣父父子子' (jūn jūn chén chén fù fù zǐ zǐ; 'rulers, subjects, fathers and sons'). In Chinese families, there can be a strong emphasis on parental authority. When expectations and rules were not met, it often resulted in anger or disapproval from parents, and an act of defiance was perceived as a 'challenge to their authority.'

> "I think the treatment of parents towards their children in traditional Chinese culture is not healthy. I mean, for many people, the parents do not have power in their life, so they try to control their children and find more power within the family. There is a saying '君君臣臣父父子子.' In Western culture, there is more equality between parents and children. In Chinese culture, if you do not obey the expectations and rules from your parents—sometimes I could not do well and I could not tell them. Then they will be very, very angry because that is a challenge to their authority." (P02)

P01 echoed P02, expressing that his experience of psychosis and stigma was related to the pressure of meeting expectations, adhering to rules and refraining from talking back to his parents. He also mentioned the disciplinary approaches in 'raising [a child] right.' P01 hinted that his parents may not value him expressing his feelings in moments like this.

> "[The experience] was because of a combination of factors. I was raised in a household with a lot of stress because my parents were under tremendous pressure, dealing with financial issues and the challenges of raising me right. There were a lot of expectations for me while growing up and I had to respect the rules. It is a lot to take in already, you know? [...] I think I was just not behaving well at school. I got reprimanded by the school. But when my Dad heard that, he snapped really hard and got really angry. The scolding would be three hours on end. I will spare you the details, but it was extremely traumatic and extreme. [...] Then, there is also a cultural side to it. Well, you just do not talk back to your parents, right? You do not bring up how you feel in those moments with your parents. How I felt was that it was not something that was very valued for me, right?" (P01)

2.1.2. Prioritizing education and personal achievement. Many participants expressed 'very high stress levels' related to studies and work. P02 noted that achieving success often required sacrificing one's happiness. For some patients, the pursuit of bringing pride to one's family through academic or personal accomplishments sometimes reached a boiling point where 'it just blew up one day.'

> “Stressed? Yes. I was very stressed. Before I went to university—the goal of parents teaching their children is to attend a good university—so, at one time, I had seven different classes after school per week. That was very stressful. I did not have any time to play or do anything I like. It seemed like they were being very harsh, and I do not know why they do not want to see me happy. If I am very happy, they will push me, force me to not be happy. [...] You will lose your happiness after that. It is like I have been following the rules for too many years, so it is hard for me to change. Studying is the whole thing in my life. [...] But it is still hard to change. If I get a grade not meeting my expectations, I feel very, very bad. It just blew up one day and I guess that kind of shaped who I am today.” (P02)

Especially for international students and recent immigrants, pursuing success in school and work involved additional challenges. These challenges included maladjustment in a new country, language barriers and having to confront personal struggles, which might not have been something they wished to face or chose to avoid in the past. P04 established a link between these challenges and her experience of psychosis and stigma.

> “我的性格是，不知道你有没有听说过。我是 ENTJ，就是非常外向，这种性格的人属于那种对成功和事情有非常执着的信念的类型。我真的很希望在生活中取得好成绩，我想这也与我的文化价值观有关。但是有一个问题，就是经常会出现一种现象，比如说我想要熬夜，但是我的身体不允许我为工作熬夜。但是我意识不到这一点，因为我是自动模式，我沉浸在那个奋斗的过程当中。然后我来加拿大刚上大学。之后我做了非常多的事情，就是在那一段时间一直一边上学一边我还有自己的工作室，然后是在创业过程中，还在线下做 networking，就是做了非常多的事情，然后这些事情让我在那一段时间里面承受了非常大的压力，我想让我自己和我的父母感到骄傲。所以就是过度劳累。再加上就是你也能感觉出来，其实我英语不是很好，所以在学校的学习的过程当中也遇到了一些困难。[...] 当我经历了症状时，我觉得这是一种个人失败，就独自应对了起来。” (P04)
>
> Translation: “My personality is, I do not know if you have heard of it. I am an ENTJ, which is very extroverted. People with this personality are the type who have very persistent beliefs in success and things. I really want to do well in life, and I think it also has something to do with my cultural values. But there is a problem, a problem often occurs. For example, I want to stay up late, but my body does not allow me to stay up late for work. But I do not realize this because I am in automatic mode, and I am immersed in the hustle. Then I came to Canada and just started university. After that, I did a lot of things. During that period, I was studying while I had my own studio. Then, during the entrepreneurial process, I also did networking offline. I did a lot of things and these things put me under a lot of pressure during that period and I

> wanted to make myself and my parents proud. So, it was just overwork. In addition, you can also feel it. In fact, my English is not very good, so I also encountered some difficulties in the learning process at school. […] When I experienced symptoms, I felt like it was a personal failure and dealt with it alone.” (P04)

From a parent’s point of view, FM04 acknowledged the role of excessive pressure to succeed in hindsight. He realized that he did not fully grasp its impact on contributing to his son’s experience of psychosis.

> “就不要再感觉有什么压力啊，就没有问题了啊。也许是我给他太多压力了？[…] 但我认为当时他感受到的压力太大了。如果我当时没有那样做，并更加关注他，也许事情就不会升级到这个地步。” (FM04)
>
> Translation: “Just stop feeling any pressure and there will be no problem. Maybe I put too much pressure on him? […] But I think the pressure he felt was too much at the time. If I had not done that and paid more attention to him, maybe things would not have escalated to this point.” (FM04)

2.1.3. Prioritizing parents’ needs and well-being. Some participants then discussed how prioritizing their parents over themselves during distress contributed to the experience of psychosis and stigma. One example is P03, who expressed disappointment and frustration due to her parents’ reluctance to openly discuss mental health with the rest of the family.

> “It is just that I feel like my parents, they are still… Well, it is personal too. I feel like they are just kind of still shying away from it or just the stigma of mental health. They just do not want to talk about it at all. Actually, they do not enjoy talking about it. When it happened to me, they just wanted to hide it from the rest of the family, which I dislike. I want to be able to talk about it. I think they are worried about how the rest of the family will react and do not want to cause too much burden. […] They might also feel embarrassed about it.” (P03)

As alluded to in P03’s account, people may be reluctant to partake in these discussions due to their concern for the welfare of their elders (i.e., their parents or distant relatives). They may wish not to burden their elders with worry or trouble, fearing it could exacerbate their current health problems. This concern was shared by two parents, FM02 and FM03, who chose to withhold their son's diagnosis from family and friends.

> FM03: "We did not tell our friends or family back home [about our son's diagnosis]. We only share information about our son with the doctors here. No one else knows."
>
> Interviewer: "Oh, why is that?"
>
> FM03: "Well, our parents are old now and they have health problems, 心脏病 (xīn zàng bìng; heart disease)."
>
> FM02: "Yeah, we do not want to cause them any extra worry."

In closing, filial piety was a factor in the sense-making of the experience of psychosis and stigma. Firstly, of top priority was the adherence to parents' expectations and rules. Violations by the child challenged their authority and evoked intense negative emotions. It was customary for a child to keep his or her feelings bottled up until he or she reached a breaking point, at which point they underwent a psychotic episode. Secondly, children strove to bring pride to their parents, particularly through their academic or personal accomplishments. The pressure was immense, and falling short led to a sense of embarrassment, shame or loss of respect. Finally, some participants felt the need to prioritize their parents over themselves during distress by not sharing information about their mental health to prevent worry or trouble.

2.2. Face (面子)

The second subordinate theme in cultural values was face, comprising three subcategories: self-identity; face within the family; face within the community. Face refers to an image of self, with cultural norms determining the attributes judged favourably by a social group. For someone who holds face in high regard, a compromised reputation or unfavourable social standing can cause considerable damage. This theme emerged in all interviews with six patients and four parents.

2.2.1. Face and self-identity. Among certain participants, one's face might have altered after experiencing psychosis. Five patients (P01, P02, P03, P04 and P06) reported that psychosis had a detrimental impact on their self-identities. For example, P01 reflected on the moment he internalized the stereotype that people with mental illness have 'something wrong with [them].' This process led to poor self-esteem and self-stigma.

> "I just feel like, at some point, the label was weighing on me a little too strongly. In the sense that people would sometimes use terms like 'mental illness' or 'mental disorder,' you know, labels. It implies that there is something wrong with me, right? That is what I thought and felt. It affects my identity, my self-esteem quite a bit." (P01)

Similar to P01, P02 heard opinions from various sources portraying psychosis as a sign of weakness or sensitivity. Although bothered by constant exposure to negative chit-chats, she endorsed the idea that people with psychosis are 'too fragile' and 'not strong enough.' This kind of experience added to self-stigma.

> "以前有过这样的情况。它们并不是直接针对我的；它们只是我家庭中的一般性谈话或观点。如果有心理方面的疾病，很多人可能会认为是太脆弱了，或者是经历得太少，或者就是太矫情之类的。[…] 有人表示我们这一代人经历了很多，而对于我们这一代人的问题，有点难以理解。有一些词汇让我感到困扰，我听得太多了，以至于觉得这是在形容我。我感觉我可能还是太脆弱了。我可能不够坚强。" (P02)
>
> Translation: "This has happened before. They are not directed at me; they are just general conversations or opinions within my family. If you have a mental illness, many people may think that you are too fragile, you have too little experience or you are too pretentious. […] Some people say that our generation has been through a lot, and it is a little hard to understand the problems of our generation. There are some words that bother me; I hear so much that I feel like they describe me. I feel like I might still be too fragile. I might not be strong enough." (P02)

Other participants, like P06, outright rejected what the diagnostic labels represented to them, refusing to characterize themselves as implied. Her self-identity remained unchanged due to her aversion to being 'associated with mental illness.'

> "I think it is called 精神衰弱 (jīng shén shuāi ruò; mental decline/weakness). I do not think it is a good term. When I experience my symptoms, it feels like many things in my head seem to be mixed together. But I am not weak. I dislike it when someone says that about me. [...] I am upset because this term is associated with mental illness." (P06)

Regarding parents involved in the treatment process, FM01 drew a comparison between psychosis and drug addiction. There is a tendency to attribute these mental illnesses to the child's upbringing and place blame on the parents as negligent or incapable. This portrayal might lead some parents to have doubts about their competence as good parents, resulting in self-stigma.

> "I guess I would say, sure, OK. The example that comes to mind is actually drug addiction. You know, whenever drug addicts have parents, often people think, 'Oh, why did this person become addicted? What were the issues with how they were raised? Were they looked after?' and so on. Yeah, mental illness, I guess, can have a similar negative impact on a parent's identity." (FM01)

2.2.2. Face within the family. Occasionally, there was a concern for saving face within a family, and the extent of this concern differed depending on the presence or absence of stereotypes. Four patients (P02, P03, P04 and P06) from families with negative preconceived notions about mental illness or with prior experience related to psychosis refrained from openly discussing mental health with other family members to save face. In fact, one patient (P02) had not even disclosed her diagnosis to any family member at the time of her interview.

When discussing her hesitation to talk about psychosis, P03 pointed out two key factors: her struggle to find the right words to explain it and her concern for the family's image of being 'fine.' Both factors fostered stigma by association.

> "I have an aunt with the same condition as me. But I still feel like my parents do not want to talk about it with other family members. Maybe we just do not have the language to discuss it with them because it is very hard to explain the mental illness

> and convey what happened properly. [...] Also, I feel like other family members would not be as understanding, so we want to show that everything is fine." (P03)

On the contrary, two patients from families without negative preconceived notions about mental illness or without prior experience related to psychosis may openly discuss mental health with other family members without the need to save face. For example, P05 stated that nothing hindered his willingness to openly discuss mental health with his parents; thus, there was no stigma by association, at least not in his immediate family.

> "Uh, no. There is nothing like that. I do not think they have any experience of psychosis, nor do they hold any stereotypes of any kind. The entire experience is new; it is new to me and them, so there is no preconceived notion of psychosis or any stereotypes whatsoever. [...] The short answer is no; I have nothing that would prevent me [from talking openly about my mental health]. My parents are pretty open, so I can pretty much talk about whatever with them and I did." (P05)

2.2.3. Face within the community. Moving beyond the family, the concern for saving face could extend to the community. Six patients and three parents (P01, P02, P03, P04, P05 and P06; FM02, FM03 and FM04) provided examples of how and why they saved face in public. One patient talked about advice given by family, while others recounted negative situations from the past when in public. They reflected on how those experiences shaped their approach to similar situations in the future to avoid embarrassment, shame or loss of respect.

P04 shared that her father forbade her from disclosing her diagnosis in public due to the pressure and discrimination it might bring to her and her family.

> "我父亲不让我在公开场合宣扬。在中国，如果你得了这个病的话，你是需要上报，然后小区的管理人员就会知道你这个疾病，然后就会上门去控制，去拜访。说的是为了管控，但是会给那个精神疾病的患者，还有他的家属带来非常大的压力，因为对方就会不把你们当成正常的人，正常人不需要报告任何事情。就是说会有一些对我们的歧视感觉。包括如果别人知道你有这个疾病，你可能考公考什么东西都没有办法正常的参与了。所以说，我父亲是不愿意让我把这个疾病说出来。" (P04)

> Translation: “My father will not let me publicize it in public. In China, if you have this disease, you need to report it and then the management staff of the community will know about your disease and then they will come to control and visit you. They say it is for control, but it will bring a lot of pressure to the patient with mental illness and their family, because the others will not regard you as normal people. Normal people do not need to report anything. That is to say, there will be some feeling of discrimination against us. Additionally, if others know that you have this disease, you may not be able to participate normally in any public examination. So, my father was unwilling to let me talk about this disease.” (P04)

Continuing, she explained her cautious decision-making process for disclosing her condition, particularly in the context of dating.

> “我没有跟别人说过我的情况。我也一直不太知道我怎么样去跟对方说我有这个疾病，因为这个病有一定的概率会传给下一代。从谈恋爱的策略角度来说的话，我不应该在一开始就告诉对方，因为这个比较负面影响。我知道他可能不会接受。对方肯定会有一些偏见。一般可能会觉得在情感比较浓烈的时候，然后再告诉对方我有这个疾病可能会接受的概率会更大。不过，这确实是非常可怕的。” (P04)
>
> Translation: “I have told no one else about my situation. I have never quite figured out how to tell the other person that I have this disease because there is a certain probability that this disease will be passed on to the next generation. From the perspective of love strategy, I should not tell the other person at the beginning because this is relatively negative. I know he probably will not accept it. The other party will definitely have some prejudice. Generally, they may feel that when the emotion is relatively strong, the probability of telling the other party that I have this disease is more likely to be accepted. However, this is indeed very scary.” (P04)

In recalling a negative experience from the past, P06 highlighted a moment from her previous city where individuals teased and questioned her. Given her young age and demeanour, it was natural for her to crave approval from others. Currently, the possibility of others discovering her condition makes her feel nervous and sad.

> “In my old city, they asked me so many questions. They teased me in a special way. I was afraid that they started not to like me. Testing me by asking questions over and over again. [...] Yeah, they [the stereotypes] really affect me. When I watch the news about people with mental illness, I think, ‘I am like those people.’ I worry people might see me the same way, that I am going through what those in the news are

> experiencing. […] I feel very nervous and sad. I do not tell anyone because I am worried about how they will react if they know.” (P06)

Moreover, FM03 compared Canada and China, noting harsher attitudes and behaviours in China and greater tolerance in Canada. Despite this, FM02 remained very cautious, acknowledging gossip as an outcome when disclosing her child’s condition.

> FM03: “You know, in China, when people hear that you have a condition, they can be very harsh. They look at you and your family. They judge you and your family. You are very different from normal people.”
>
> FM02: “If others know about this, neighbours and colleagues will blame us, blame us for the problem. In Canada, people are more tolerant and kinder because by law, you cannot discriminate. People can still gossip rather than do it in front of you. So, we are not going to say.”

Additionally, FM04 talked about his concerns regarding perceptions of psychosis and its impact on his son’s employability. He was worried that future employers would access his son’s medical records, potentially biasing their opinions.

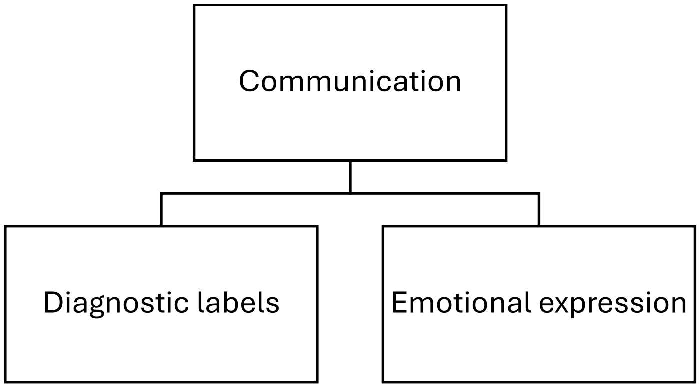
> “我担心社会可能对他有偏见，因为即将毕业后还需要找工作。在找工作的过程中，如果在面试中提到他有这种病，是否会有相关记录？如果有这样的记录，是否会导致雇主对他有偏见？如果真的存在偏见，那找工作可能就会变得相当麻烦。我目前的担忧就是社会是否会对他们有任何不公平的看法。最好是没有任何偏见。我担心别人认为他无法工作，或者突然间会发病。” (FM04)
>
> Translation: “I am worried that society may be biased against him because he needs to find a job after graduation. When he was looking for a job, if it was mentioned during the interview that he had the condition, would it be documented? If there was such a record, would it cause his employer to be biased against him? If bias exists, finding a job can become quite troublesome. My current concern is whether society will have any unfair views on him. It is best to be with no bias. I worry that others will think he cannot work or that he will suddenly become ill.” (FM04)

On a positive note, FM01 gave a differing account. He commented that the perception of mental illness being reasonably well accepted in society meant it was not ‘outlandish or taboo to talk about mental illness.' However, FM01 highlighted concerns about day-to-day interactions with strangers and potential reactions to mental illness, claiming that it really depended on one's ability to assess and gauge these interactions.

> "In terms of stigma regarding mental illness, I would say that mental illness is common and familiar enough, so I would not say that there is a lot of stigma or that it has been a barrier to talking openly or to treatment. There is nothing to be ashamed or embarrassed of in that sense. Beyond the day-to-day issue of being around strangers and trying to assess if they are going to behave normally or not, my perception of society's attitude towards mental illness is that it is reasonably well accepted; it does not seem outlandish or taboo to talk about mental illness. I think for most people, the question would be, is it managed, is it stable?" (FM01)

In brief, the 'face' theme operated on various levels—individual, family and community—playing a role in shaping the understanding of psychosis and stigma. Many patients expressed that psychosis negatively affected their self-identities, leading to low self-esteem and self-stigma. It was sometimes due to receiving the diagnosis or being constantly exposed to negative gossip. Some even outright rejected the diagnostic labels. Parents shared that there is a tendency to attribute mental illness to the child's upbringing and place blame on the parents as negligent or incapable, leading to doubts about their parenting competence and self-stigma. Within families, the presence of negative preconceived notions about mental illness or prior experience related to psychosis determined the openness of discussions about mental health and the need to save face. This concern also extended to the broader community, with several patients and parents sharing instances where they concealed mental health issues to avoid discrimination in various aspects such as protecting oneself and family, dating and employment.

3. Communication



An unexpected theme that emerged from this study was communication. Although not specifically addressed in the questions, many participants brought it up as an important topic. This theme encompasses how individuals feel toward the Chinese diagnostic labels of psychosis and how they talk about emotions with family, friends and others. These communication elements, which also reinforce the stigma faced by patients and their families, influenced the experience of psychosis.

3.1. Diagnostic labels

The first subordinate theme in communication was diagnostic labels, comprising three codes: derogatory meaning; inaccurate meaning; severe meaning. This theme emerged in all interviews with six patients and two family members.

3.1.1. Derogatory meaning. Language shapes cultural perceptions, especially in mental health. Four patients (P03, P04, P05 and P06) and three parents (FM02, FM03 and FM04) used the Chinese term 精神病 (jīng shén bìng; literal translation: spirit disorder) to refer to psychosis. However, the term carries a negative connotation. For example, P02 expressed discomfort with the term, likening it to an insult.

> “‘精神’就像是 spirit，而 ‘病’表示 disease，所以精神有问题就像是精神错乱一样。[...] 我真的不喜欢别人用这个词来形容我。中文给人一种贬低、辱骂的感觉。” (P02)
>
> Translation: “‘Jīng shén’ is like spirit and ‘bìng’ means disease, so having a mental problem is like insanity. [...] I really do not like people using this word to describe me. In Chinese, it comes across as demeaning and abusive.” (P02)

P02’s account brought attention to another issue: Chinese people without professional expertise may use terms like 精神病 (jīng shén bìng) and 神经病 (shén jīng bìng; neuropathy) interchangeably. Note that 精神 (jīng shén) refers to the spirit, whereas 神经 (shén jīng) refers to nerves; both use 病 (bìng) to refer to disease or disorder. The interchangeable usage signifies a lack of precision in terminology. It is also important to recognize that both terms are commonly used in a derogatory manner to slander someone in everyday language.

> “有人可能会用神经病。我认为在中文中，很多非专业人士对于诸如精神障碍和神经系统障碍之类词汇的使用并不十分准确。实际上，它们是两种不同的事物。大多数情况可能受到神经影响，因此精神层面可能更倾向于 energy 层面。只要能够重新掌控这种 energy，就能够康复。比如，在英语中，有一个明确的前缀表示心理层面，就像在‘psycho’一词中看到的那样。在中文中，当你遇到至少影响到心理层面的问题时，理解变得更加困难。” (P02)
>
> Translation: “Some people might use 神经病 (shén jīng bìng). I think in Chinese, many laypeople do not use words like mental disorders and neuropathies very accurately. Actually, they are two different things. Most cases may be neurologically affected, so the mental aspect may be more oriented towards the energy aspect. As long as you can regain control of this energy, you can recover. In English, for example, there is a clear prefix for the psychological dimension—as seen in the word ‘psycho.’ In Chinese, understanding becomes more difficult when you encounter problems that affect at least a psychological level.” (P02)

3.1.2. Inaccurate meaning. Among some participants, the term 精神病 (jīng shén bìng) was perceived as too vague. P05 regarded it as a broad ‘umbrella term’ encompassing various mental illnesses, with the implication that individuals falling under this category were ‘crazy or unusual’ and should be ‘left alone’ or ‘belong in the hospital.’

> "It is very negative. It is like an umbrella term. I do not know if it is the right word, but it just means someone who is crazy or unusual. Just avoid that person. Do not interact with them and just leave them alone. Someone who belongs in the hospital. In Chinese, 精神病 (jīng shén bìng), for some reason, sounds so negative and, truthfully, unclear when I hear it. I mean, different people might understand it differently." (P05)

3.1.3. Implied severity. Many participants emphasized that the seriousness of the diagnostic labels impacted them in various ways. For example, P01 described feeling inherently flawed, expecting a lifetime of medication use and anticipating a permanent disability.

> "At some point, I told myself, 'Well, OK, this label given to me means there is something wrong with me, but it is treatable, right?' But then, I have to take medication for the rest of my life. So, I was wondering, was this the label, the stigma? I am going be disabled for the rest of my life. That is what I thought." (P01)

P04 shared her perspective on the difference in seriousness between depression and psychosis. She was surprised and felt ashamed upon learning about her diagnosis. P04 elucidated the difference in perceptions of severity and stigma attached to different conditions by choosing to share that she had depression instead of psychosis.

> "我觉得这是一个很严重的问题。从描述来看，别人一看到这个病就知道与精神相关。嗯，然后就是说，对于像精神病这种疾病来说，大家会觉得是一个非常严重的问题，会认为我有问题。当我知道我患有这个病时，我感到非常惊讶，但同时也对自己感到羞愧。因为在我的家中没有这方面的历史，我也从未接触过这种疾病。而我自己也从来没有碰到过这种病。最多就是从各处听说过，了解到一些关于抑郁症的事情。所以，这个诊断给我的影响真的非常大，而且是负面的。[...] 我现在也还是没有办法接受。其他人就是开诚布公地说'我得了这个病'，'我有焦虑症'，'我有抑郁症'。一般我都会告诉他们我得了 depression，这样他们可能还没有觉得很严重，或者认为这个人疯了，不会对我进行评判或看待我有什么不同，不像我说我有精神病那样。实际上，用'精神病'这个词表达的病情要严重得多。" (P04)
>
> Translation: "I think this is a very serious problem. Judging from the description, others will know that I have a problem as soon as they see it. Well and that is to say, for a disease like psychosis, people will think it is a very serious problem and they will think there is something wrong with me. When I found out I had this disease, I

> was surprised but also ashamed of myself. Because there is no history of this in my family, I have never been exposed to this disease. And I have never encountered this disease myself. At most, I have heard and learned something about depression from everywhere. So, this diagnosis had a really big impact on me, and it was negative. [...] I still cannot accept it now. Other people just openly say, 'I have this disease,' 'I have anxiety,' 'I have depression.' Usually, I tell them I have depression so that they may not think it is serious or think the person is crazy and will not judge me or see me any differently than if I said I have psychosis. In fact, the term 精神病 (jīng shén bìng) is used to describe a much more serious condition." (P04)

Parents, much like the patients, also struggled with the burden of diagnostic labels. Many expressed shock and denial upon learning about their child's diagnosis, associating it with a grave and overwhelming condition.

> FM03: "Yes, in Mandarin, it is 精神病 (jīng shén bìng). So, when our son received this diagnosis, we were shocked and could not believe it. It sounded serious, of course, not just a common issue like depression. This has never happened before in our family."
>
> FM02: "Never. We had never heard of it before. It took us a lot of time to accept [his diagnosis]."
>
> "以前我对这方面了解不多。然后，医院的医生也经常通过视频和我对话，告诉我他患有精神病。以前我对这个病并不了解。对他、对家人来说，这都是全新的，而且听起来相当严重，所以我当然很震惊，很担心。" (FM04)
>
> Translation: "I did not know much about this before. Then, the doctor at the hospital often talked to me via video and told me that he suffered from psychosis. I did not know much about this disease before. This was all new to him, to the family and sounded very serious, so of course I was shocked and worried." (FM04)

In conclusion, the diagnostic labels held weight in the sense-making process of the experience of psychosis and stigma. One concern was that the term 精神病 (jīng shén bìng), used by many participants, often was harmful to patients and their families. This stigmatizing language might increase prejudice and discrimination. Secondly, with 精神病 (jīng shén bìng) being inaccurate and serving as an umbrella term for various mental illnesses, it had the potential to cause confusion, misrepresentation and incorrect assumptions about psychosis. Thirdly, the implied severity linked to 精神病 (jīng shén bìng) could elicit fear or worry when shared as a diagnosis. The label was not just descriptive for participants; it shaped external perceptions and perpetuated stereotypes about mental illness, emphasizing the need for more precise and sensitive terminology.

3.2. Emotional expression

The second subordinate theme in language was emotional expression, which comprised three subcategories: language barrier; emotional restraint (put it in a box and shove it aside); strategies for navigating emotions. In this study, emotional expression refers to the verbal communication of emotions with family and others. This theme emerged in interviews with five patients and four family members.

3.2.1. Language barrier. P01 highlighted the challenges posed by a language barrier in expressing emotions. He noted that some emotive words were non-existent in his native language or not commonly used, limiting the range of ways he could articulate his feelings.

> "Some of the emotive words [in English] do not even exist in Cantonese [his native language]. Another point is that some of the words do exist; we just need to know how to use them. But then, my parents and I are not familiar with these words, so we have to explain them. I primarily communicate with my parents in Cantonese, but I still need to use some words in French. But then, French is not their first language, so I am a bit stuck. It limits the range with which I can express my emotions, right?" (P01)

3.2.2. Emotional restraint (put it in a box and shove it aside). Adding to the complexity, P01 delved into the cultural influence of emotional restraint. He said that within East Asian cultural norms, expressing emotions in parent-child interactions was both infrequent and prohibited. In such situations, it was considered normal to compartmentalize emotions and keep them under control, as expressed by the saying 'put [emotions] in a box and shove [them] aside.' However, emotional restraint posed a challenge in seeking and receiving support.

> “There is also a cultural aspect to it. You just do not talk back to your parents, right? I think this is something East Asians, or maybe immigrants, have to deal with. But within East Asian cultures, it is even more salient—the idea that you simply do not discuss this with your parents like you would with friends. Expressing how you feel was not something highly valued for me while growing up. Essentially, if I wanted to share my feelings, it was met with a response like, ‘OK, that is how you feel. Now, put it in a box and shove it aside.’ That was a common experience for me growing up and I thought it was normal. But as it turns out, it is not. I think in East Asian families, there is often a lack of emotional support.” (P01)

P02’s account illustrated the ramifications of limited emotional expression during her upbringing. The difficulty she faced in expressing emotions and her lack of self-awareness resulted from a family environment that encouraged emotional restraint. This case demonstrates how cultural and familial influences can shape one’s ability in emotional expression and even comprehension.

> “我第一次尝试寻求帮助是在大学时。我向学校寻求帮助，但他们觉得我的情况太复杂，就把我转到了医院。我在那里和医生们交谈，他们很理解，但当时我不太清楚如何表达我的情感。我无法清晰地表达我的感受，所以感觉没有得到我需要的帮助。我没有一个非常清楚的自我认知，因为，我自己的情况就是关于情绪方面并不是特别敏锐。另外，我在一个不太善于表达情感的家庭中长大，对此感到有些无措。我不知道该怎么处理。” (P02)
>
> Translation: “The first time I tried to get help was in college. I asked the school for help, but they felt my situation was too complicated and transferred me to the hospital. I talked to the doctors there and they were understanding, but I was not quite sure how to express my emotions at the time. I could not express my feelings clearly, so I felt like I was not getting the help I needed. I do not have a very clear self-understanding because my own situation is that I am not particularly sensitive in terms of emotions. Also, I grew up in a family that was not very expressive of emotions and felt a little overwhelmed by it. I do not know what to do with it.” (P02)

P04 further revealed the repercussions of communication gaps with her parents after moving to Canada. She attributed the worsening of her mental health to her failure to communicate with her parents and her reluctance to share personal struggles with them.

> “我刚来到加拿大的时候，我和我的父母几乎没有交流。也就是说，由于我过度封闭，导致我的疾病加重。我没有告诉他们有关我个人困扰的事情。我应该对他们更加坦诚，或许可以防止发生在我身上变得如此严重。” (P04)
>
> Translation: “When I first came to Canada, my parents and I had almost no communication. In other words, my illness worsened because I was overly closed off. I did not tell them about my personal troubles. I should have been more honest with them and maybe prevented what happened to me from becoming so serious.” (P04)

3.2.3. Strategies for navigating emotions. There are various ways participants went about managing emotions when unable to express them. Despite presenting herself as extroverted to others, P04 shared that she was truly introverted and sensitive. When alone, she would become very depressed, yet she refrained from seeking help and internalized these feelings. Over time, this condition worsened, leading to her current state.

> “虽然大家都认为我外向，但实际上我很敏感也很内向。我想告诉你的是在我独自一人的时候，情绪会非常低落，但是我从未寻求帮助，把这些感受都埋藏在自己心里。他们愿意听我倾诉吗？所以我没有任何人可以倾诉。随着时间的推移，我就变成了现在这样，也就是我患上了这种病。” (P04)
>
> Translation: “Although everyone thinks I am an extrovert, I am actually very sensitive and introverted. What I am trying to tell you is that when I was alone, I got really depressed, but I never asked for help and kept those feelings to myself. Will they even listen to me? So, I did not have anyone to talk to. Over time, I became what I am now, which is that I have this kind of illness.” (P04)

P03, sharing a similar experience with P04, delved deeper into the repercussions of isolation and the absence of a confidante. Her strategy for navigating emotions also involved avoiding communication about feelings and problems with others, which led to a hyper-focus on negative thoughts, fuzzy thinking and rumination.

> “My situation is that I never really had people to talk to about my feelings and problems. I think that even if I did, it would be challenging for me. Not being able to share, I feel like I ended up overly focusing on them on my own. It got to a point where I could not focus properly, like I could not think clearly because negative

> thoughts were ruminating in my head. It got to the point where I kind of got disconnected from reality because that is what psychosis is—these thoughts. When I got disconnected, these thoughts about different things got worse and worse. I started to think about delusions and stuff. That is what I think." (P03)

P05 discussed the role of friends in Montreal during his first episode. He mentioned the absence of communication with friends about the situation and that there was neither a need nor a desire to share such personal information.

> "I do not really have any friends in Montreal, so when this occurred, I did not talk to anyone. I do not discuss my problems with anyone, so no one really knows that this happened, and I have not had a chance to speak about it since. Even if I had a chance, I do not want to, nor do I think I need to." (P05)

Different viewpoints emerged regarding the strategies patients employed in navigating emotions. While some perceived emotional expression as unnecessary, relying on coping mechanisms without discourse, others considered it crucial. As shown in the accounts, the absence of emotional expression within the latter group might pose a risk for exacerbating mental health issues. Hence, it was important to cultivate open dialogue within interpersonal relationships, acknowledging and meeting diverse needs related to emotional expression and support.

To summarize, emotional expression played a role in understanding psychosis and stigma. Firstly, a language barrier posed a challenge, particularly for one patient born in Canada (P01) who struggled to articulate emotions with his family members due to a limited vocabulary. Secondly, families that promote emotional restraint might unknowingly discourage the patient from seeking help, thereby contributing to stigma. Finally, approaches to navigating emotions varied; while some chose not to express emotions voluntarily, others found it necessary. For those valuing emotional expression, the perceived inability to do so might have worsened mental health issues. Overall, emotional expression shaped participants' experiences of psychosis and stigma.

Discussion

This section provides a summary of the findings of this study, placing them in the broader context of existing literature on psychosis and stigma in the Chinese community. Upon reviewing the literature, it becomes apparent that most psychiatric research is biased toward WEIRD (Western, Educated, Industrialized, Rich and Democratic) societies, with insufficient attention given to other populations (Burkhard et al., 2021). To fill the literature gap, this study explored the lived experiences of psychosis and stigma among Chinese patients and their families. It adopted a descriptive exploratory qualitative framework, using semi-structured interviews for data collection and IPA for data analysis. This study revealed unique challenges influenced by mental health beliefs, cultural values and communication faced by this demographic.

1. Language-related concerns

During this study, two language-related concerns surfaced. Firstly, most participants (P03, P04 and P06; FM02, FM03 and FM04) expressed a preference for Mandarin or a combination of Mandarin and English during interviews. This observation may indicate language barriers in their clinical interactions. Secondly, I found an inconsistency in the intake notes for one of the patient participants, particularly in the English respellings of Mandarin spoken by the patient. It was written that the patient 'frequently spoke to someone called Shen,' whereas in a later note, the 'name' was spelled differently. This type of inconsistency can pose a risk of confusion and oversight of vital information by the clinical team. My suspicion is that the 'person' might not necessarily refer to a friend or family member. It could be possible that the patient was referring to a higher power (神; shén; a deity or god). It seemed that no follow-up to this possibility was asked of the patient at the time. Such hallucinations can often be troublesome to the person affected and should be considered important in the diagnosis and treatment process. To address these issues, it is recommended that clinical teams use interpretation and translation services when working with Chinese patients and their families who are not fluent in

English and/or French (Act Respecting Health Services and Social Services, 2023). By employing these services, language barriers can be mitigated. Patients should have the freedom to express their experiences comfortably and share vital information in their preferred language. These services not only encourage a medical environment that embraces diversity but also help prevent misunderstandings, harm and adverse events (Horváth & Molnár, 2022).

2. Mental health beliefs

The first sub-theme focused on common views about psychosis and mental illness. These beliefs different from biomedicine contributed to the stigma surrounding psychosis among Chinese patients and their families, impacting their experience with psychosis.

P04 emphasized the detrimental impact of sensationalism in the media, perpetuating misrepresentations of psychosis. The media's portrayal of mental health, through inaccurate or incomplete representations, shapes public opinion about individuals with mental illness, as well as influences societal treatment and their management of mental health. The persistent depiction of negative stereotypes, particularly those that implicate violence, presents a significant challenge in dispelling these ingrained beliefs. As shown in a previous study by Morgan & Jorm (2009), news stories focusing on crime, violence or failures in the mental health system tend to be more salient and memorable than positive narratives about successful recoveries and disclosures of mental illness by respected public figures. As such, many mistakenly associate psychosis with violence because it is easier to recall this specific memory or thought, a phenomenon known as illusory correlation (Aberizk et al., 2017). However, the true likelihood of severe violent outburst among individuals with psychosis is low (Large & Nielssen, 2011). These negative stories are correlated with a decreased willingness to disclose symptoms, get help and engage in mental health services, contributing to heightened levels of stigma (Li et al., 2023; Wang & Liu, 2015). Additionally, P01 highlighted how individuals with limited exposure to people with mental illness might overgeneralize psychosis with 'outward problems' like homelessness and substance abuse. While this association is valid in some cases, it does not universally apply. Understanding the causes of psychosis is challenging since it may result from a single factor or a combination of many, including genetics, stress, migration, urban living, infection, postpartum conditions or other causes (Ayano et al., 2019; Calabrese & Khalili, 2023; Nielsen et al., 2017). When someone from an outgroup (a person with psychosis) presents with ‘outward problems,’ cognitive biases such as the fundamental attribution error cause laypeople to immediately assume that there is something wrong with the person’s nature, rather than considering factors beyond the individual's control that could have influenced their mental state (Corrigan et al., 2003). Furthermore, P03 emphasized that misinformation, often propagated through hearsay, contributes to stigma. She noted that individuals with psychosis might be perceived as ‘crazy, unstable and unpredictable.’ This common misconception, supported by a meta-analysis by Angermeyer and Dietrich (2006), leads to discrimination translated through actions such as social distancing or rejection. As a result, patients may approach seeking help or openly discussing their psychological well-being with hesitancy due to the perceived absence of a supportive community.

Misunderstandings about mental illness often stem from a lack of awareness and education, creating a sense of disconnect between people with psychosis and their community. P02 highlighted that some individuals in the Chinese community label those with psychosis as ‘attention-seeking,’ subjecting them to public blame for their condition. This reaction is supported by research on the fundamental attribution error, indicating that people tend to believe individuals with psychosis should exert better control, be blamed for their disorder, not pitied and be avoided (Corrigan et al., 2003). Moreover, P02 noted that some in the Chinese community perceive those with psychosis to be ‘overly sensitive.’ A survey conducted in Chinese rural towns revealed an attribution of mental illness to personal weakness and lack of willpower, diminishing the perceived need for medical attention (Yu et al., 2015). Consequently, people with psychosis may face prejudice not only from society when experiencing symptoms but also encounter bias when seeking the necessary treatment or support. P03 likened the unfamiliarity with psychosis in the Chinese community to the ‘fear of the unknown,’ leaving her feeling unsupported. A survey conducted in Chinese metropolitan areas builds upon this point, revealing a greater lack of knowledge about psychosis and schizophrenia compared to other mental illnesses when assessing people's understanding of potential causes, treatments and chances of recovery (Yin et al., 2020). Corrigan and Nieweglowski’s literature review also found a negative association between familiarity and public stigma, emphasizing the need for awareness and education to mitigate public stigma toward psychosis (2019). To address these issues, P02 provided some practical suggestions for mental health resources and services she would like to see, including more counseling services and popular science, aiming to educate youth and the general public. These resources and services can foster understanding and reduce stigma surrounding psychosis and mental health in general.

The second sub-theme focused on attitudes to care. The interviews revealed that four patients hesitated to get help for early signs of psychosis. At the time, they perceived their condition as minor and were uncertain about the necessity for help. This finding underscores the importance of resources for awareness and education, as they can provide not only useful information but also encourage help-seeking, as well as facilitate early recognition and intervention (Yu et al., 2015). Additionally, there was noticeable hesitancy toward certain treatments, particularly medication and psychotherapy, possibly rooted in cultural factors. P04 expressed concerns about medication stigma, which encompassed worries about side effects, identity transformations and addiction or dependence, some of which were found in a meta-analysis by Semahegn et al. (2020). P01 shed light on the stigma surrounding psychotherapy, with his parents doubting its effectiveness and expressing reservations about openly discussing personal issues. This finding aligns with previous studies where Chinese youth reported feeling that therapy was similar to ‘casual chatting,’ expressing trust issues in sharing sensitive information, perceiving a lack of professional expertise and harbouring doubts about its effectiveness (Ning et al., 2022; Wang et al., 2020). To address these challenges, it is necessary to have treatment decision-making conversations between clients and clinical teams. These discussions can help dispel misconceptions and foster a better understanding of the available treatment options. It also facilitates the development of a mutually agreed-upon treatment plan for the client and their family.

The influence of religious and spiritual attitudes on the experience of psychosis and stigma is evident in this study. Four participants (P05 and P06; FM02 and FM03) identified as Buddhist, holding causal beliefs that differed from the standard psychiatric framework. For example, FM02 and FM03 attributed their son's psychosis to confusion in his 'spiritual world' and a disruption in inner harmony, which are ordinary causal beliefs in Chinese culture (Kramer et al., 2002). While partaking in religious practices alongside her family, P05 discovered not only support for her recovery but also a strengthened sense of connection. She felt as if they were all facing the experience of psychosis together. In essence, these participants found comfort in practicing meditation, reading Buddhist tales about virtues and praying together. These findings align with research indicating that religious and spiritual beliefs serve as an essential source of hope, correlating with a better outlook, improved quality of life and increased social integration (Chiu et al., 2005; Grover et al., 2014). However, P06 expressed fear that her treatment team might judge or disapprove of discussing her religious practices. In the moment, her hesitancy initially surprised me. I then promptly reassured P06 that we welcome various coping methods. This situation made me realize that other patients may feel the same way, struggling to talk about their coping methods out of fear of being judged or disapproved. It emphasizes the importance of recognizing and respecting the different perspectives of individuals with psychosis and their families. Encouraging open conversations about religion and spirituality promotes collaboration and understanding among Chinese patients, their families and their clinical teams, ultimately contributing to a more holistic approach to mental healthcare.

Researcher's note. The early intervention clinics serving as the setting for this study are committed to delivering culturally sensitive care. Creating a safe space for help-seeking and shared decision-making, where patients and their families feel at ease expressing their opinions and beliefs about psychosis symptoms to their clinical team, is of top priority (Addington et al., 2017). This approach serves the dual purpose of reducing cultural stigma within the clinical setting, as well as acknowledging the diverse cultural backgrounds of clients. By practicing cultural humility and sensitivity, these clinics aim to enhance the overall patient experience and therapeutic relationship, ensuring that mental healthcare fits the unique requirements, preferences and perspectives of each individual and their family.

3. Cultural values

The third sub-theme focused on filial piety. Cultural values impact psychological well-being. When balanced and supportive, they can yield positive effects (Maercker et al., 2015). When overly restrictive, they can yield negative effects (Bedford & Yeh, 2021).

In this study, participants showed filial piety through following parents' expectations and rules, prioritizing education and personal achievement, as well as prioritizing elders' needs and well-being. While many studies have explored the influence of filial piety on the mental health of Chinese populations (Huang et al., 2020; Jen et al., 2019; Lam et al., 2021; Kim & Silverstein, 2020; Zhang et al., 2020), none have specifically examined this concept from the side of Chinese patients with first episode psychosis and their families. This study explored family experiences with eight participants from traditional Chinese households (P01, P02, P03, P04 and P06; FM03, FM04 and FM05), where there is an expectation for children to abide by their parents (Pan et al., 2022). However, some individuals voiced discomfort with the rigidity and strictness of power dynamics within their family, finding it difficult to express their true feelings and address their mental health issues. P01 and P02 said that not conforming to or challenging parental authority could disrupt social harmony within their family. The adherence to expectations and rules, along with the perceived serious consequences for disobedience, creates an environment conducive to distress. Navigating these challenges proves to be an arduous task for many participants. In response, it is crucial for the family to demonstrate a greater willingness to balance the playing field. This act entails fostering an environment where conversations about mental health are not only accepted but also embraced, all while delicately preserving respect for the parents and filial piety within the family.

In Chinese culture, children often perceive academic success and personal achievements as the primary way of honouring their families or repaying their parents for their efforts and sacrifices (Fwu et al., 2016). The expectation to fulfill these responsibilities adds burden to Chinese people and their families who are affected by mental health issues (Lam et al., 2022). The pressure to be a source of family pride may lead individuals to avoid acknowledging and sharing their mental health struggles, fearing that seeking help is a sign of weakness or failure. This fear intensifies as the pursuit of family pride can result in overwhelming pressure and perfectionism—known triggers for relapse and exacerbation of psychotic symptoms (Hassan et al., 2014). These stresses gradually accumulate alongside the challenges of adolescent development, becoming overwhelming for individuals to bear at times (Wu et al., 2023). The burden may subsequently bring a hidden mental health issue to the surface, manifesting as an intense and sudden episode. In this study, all patient participants were university students at the time of their first episode. From their accounts, some mentioned that these familial pressures can discourage seeking mental health services. They strove to comply with the demands of academic and professional accomplishment, reflecting findings from Lee et al. (2009). Recognizing and placing less emphasis on these cultural expectations can help navigate the challenges of academic and professional success without compromising individual well-being.

Participants also highlighted the significance of prioritizing their elders' needs and well-being. Despite a relative having experienced a similar situation, P03 refrained from sharing her condition and hospitalization with her extended family. The decision was made by her parents, who told her not to do so. This situation left her with feelings of shame and liability. These sentiments echoed findings from other studies related to concealment (Bril-Barniv et al., 2017; Carden et al., 2020; Elliott & Doane, 2015). Similarly, FM02 and FM03 discussed their tendency to hide such matters due to the necessity of protecting their parents. Individuals may choose not to share their conditions to spare their elders from stress and worry, as well as to prevent the exacerbation of their current health problems. Hsin Yang and Pearson (2002) note that such behaviour perpetuates a vicious cycle: as the more the family is compelled to hide the existence of the illness, the greater the shame and perceived stigma becomes. It underscores the importance of addressing the cultural dynamics at play in family communication about mental health, aiming to break this cycle of silence and stigma.

The fourth sub-theme focused on face. Interesting discussions centered on self-identity, saving face within the family and maintaining face within the community. Numerous studies have demonstrated the influence of face on the mental health of Chinese populations (Kong et al., 2020; Lwi et al., 2022; Misra et al., 2021; Ran et al., 2021; Wong, 2019). Excerpts from this study accentuate the connection between mental illness and the transformation or preservation of one’s identity. For those for whom change occurred in this study, it highlights self-stigma: individuals who internalized stereotypes found it more challenging to cope with their mental health issues. P01 expressed the belief that their psychosis indicated a personal flaw, while P02 internalized opinions and felt increased vulnerability. FM01 stated that parents might doubt their ability to be ‘good parents’ when their child experiences psychosis, linking it to the child’s upbringing and the parent’s child-rearing. Research indicates that negative stereotypes about mental illness pose significant challenges, leading to self-stigma, as well as poorer self-esteem and self-efficacy (Schwarzbold et al., 2021). Additionally, increased self-stigma may be tied to poor mental health outcomes, including greater symptom severity, elevated risk of psychiatric comorbidity, suicidal ideation, psychiatric hospitalization, reduced employment opportunity and lower functional status in patients with psychotic disorders (Dubreucq et al., 2021). Recognizing and addressing these aspects of face is crucial for promoting psychological well-being and reducing the impact of self-stigma in Chinese patients with first episode psychosis.

The concept of face within the family influences conversations about mental health. Some individuals refrain from discussing their mental health concerns due to worries about stereotypes and a perceived lack of empathy within their family, as exemplified by P03. In contrast, others find it easier to talk in families without such stereotypes, as exemplified by P06. These findings align with research by Corrigan and Nieweglowski, indicating that stigma by association can act as a barrier to open dialogue (2019). Family dynamics, involving the interactions among family members, are crucial in determining whether a family can serve as an environment conducive to the healing and recovery of the patient. Positive family dynamics aid in mitigating the impact of stigma on individuals seeking help (Wang et al., 2021). The cultural norm to save face, even within families, often leads individuals with mental illness to keep their struggles hidden, making it difficult for them to openly discuss their genuine concerns and experiences. Recognizing and addressing these dynamics is vital for fostering a nurturing family environment that encourage open and honest conversations about mental health.

People with psychosis navigate perceptions and responses to their situation within the community, which influences their decisions to share information. For example, P05 received advice from her father against disclosing her situation to others. She also discussed her dating approach, emphasizing her decision not to share her situation with romantic partners. In a similar vein, P07 shared her experience of facing teasing and questioning, while FM02 and FM03 voiced worries about gossip affecting their son and the family. Finally, FM04 voiced worries about job discrimination affecting his son’s employability. These negative influences on interpersonal relationships, marriage and employment are all factors fostering a sense of disempowerment in patients, as indicated in other studies (Chang & Chen, 2021; Li et al., 2018; Yang & Link, 2016). The presence of these specific disclosure strategies demonstrates the prevalence of societal attitudes and their significant impact on individuals' experiences. Conversely, FM01 felt that the Canadian public might be more accepting of psychosis. The diversity in accounts, both supporting and contradicting the existence of public stigma surrounding psychosis and mental illness in the local community, can be attributed to acculturation. Two different viewpoints emerged regarding public stigma surrounding mental health and the importance of saving face. First-generation Chinese immigrants (P04 and P06; FM02, FM03 and FM04), who had stronger Chinese-specific cultural beliefs about mental illness, were more likely to perceive public stigma and be concerned about saving face. On the other hand, second-generation immigrants like FM01, who had weaker Chinese-specific cultural beliefs about mental illness, considered saving face to be unnecessary and did not perceive public stigma. Therefore, the degree of acculturation and adherence to Chinese-specific cultural beliefs may have played a role in shaping individuals’ assessments on the importance of saving face and their views on public stigma surrounding mental illness. These findings are consistent with research that suggests acculturated Chinese immigrants tend to perceive comparatively less public stigma toward mental illness (Li, 2021). Chinese immigrants who experienced shifts in their engagement with English- and Chinese-language media, those with predominantly non-Chinese ethnic friends in their social circles, or those identifying themselves as ‘Westernized,’ were less likely to exhibit stigma consciousness—the belief that one’s group is being prejudiced and discriminated against based on stereotypes. In turn, they were also less likely to perceive public stigma toward mental illness.

4. Communication

The fifth sub-theme theme focused on diagnostic labels. It emphasized how communication through these labels shapes experiences of psychosis and stigma. Three concerns related to labels are their derogatory nature, inaccuracy and implied severity.

Ensuring accurate and sensitive diagnostic labels in mental health is crucial for patient safety and reducing stigma (Volkow et al., 2021). In this study, six out of ten participants (P02, P03 and P04; FM02, FM03 and FM04) use the label 精神病 (jīng shén bìng; spirit disorder) to describe psychosis. As revealed through extracts, this label can evoke dismay, fear or worry from patients and others. Some individuals, such as P05, prefer to use more socially acceptable labels like depression. Concerns raised by individuals like P02 about the interchangeability of terms such as 精神病 (jīng shén bìng) and 神经病 (shén jīng bìng; neuropathy) are also noted. This type of concern may partially arise from the similar pronunciation of the two terms in the Chinese language, highlighting the potential for confusion and misrepresentation. Furthermore, these words are used to belittle or criticize a person regardless of their mental state. Language shapes people's beliefs and attitudes, and scientific communication can sometimes transmit harmful stereotypes and assumptions. Using accurate and sensitive terms that more precisely convey the lived experience in psychosis and affirm individuals' value can improve how society and those around them treat them (Volkow et al., 2021). Adopting this language contributes to creating an atmosphere that fosters understanding and support for individuals dealing with mental health challenges.

A few East Asian countries have taken steps to counteract the stigma associated with the labels of psychosis and schizophrenia by renaming these conditions. The old terms, suggesting a split mind, made individuals perceive the condition as incurable and closely tied to the patient's personal identity (Sartorius et al., 2014). It even prevented clinical teams from disclosing the disease name to patients and their families due to concerns about causing undue harm. In Japan, the term for schizophrenia went from "Seishin Bunretsu Byo" (mind-split-disease) to "Togo Shitcho Sho" (integration disorder) in 2002. According to Sato (2006), the change stemmed from 'the previous term's ambiguity, advancements in psychiatric research, and the history linked to the inhumane treatment of individuals with the disorder' (p. 1). Similarly, in Korea, the term for schizophrenia went from "Jungshinbunyeolbyung" (split-mind disorder) to "Johyeonbyung" (attunement disorder) in 2012. In both countries, the renaming initiatives originated from a request by the families of patients (Sato, 2006; Lee et al., 2013). Hong Kong and Taiwan have also embraced this movement, adopting the term 思觉失调 (sī jué shī tiáo; thought disorder) in 2001 and 2014, respectively, to replace the old terms for schizophrenia (精神病 (jīng shén bìng) and 精神分裂症 (jīng shén fēn liè zhèng)). The new term implies the possibility of recovery, gaining acceptance for being less stigmatizing among both the public and clinical teams (Sartorius et al., 2014). All changes entailed carefully naming diseases to avoid ambiguity, reduce stigma and improve accessibility to mental health services. However, China has not yet proposed any renaming initiatives. To address this matter at a local level, I have produced a brochure introducing the term 思觉失调 (sī jué shī tiáo) to patients at the FEPP-JGH. Copies in English and simplified Chinese are included in the appendix. I hope that patients and their families will have a positive reaction to this brochure when it becomes available and will share it with those in their inner circle.

The sixth sub-theme theme focused on emotional expression. Despite the absence of specific questions about communication patterns in the interview protocols, many participants voluntarily raised the topic in conversation and requested its inclusion in my final report as an element influencing the experience of psychosis and stigma. Numerous studies have explored emotional expression in the Chinese context (Chen et al., 2015; Chen et al., 2020; Gao et al., 2016; Rao & Gibson, 2019; Yik & Chen, 2023). The findings from this study align with those indicating that emotional expression, whether verbal or nonverbal, can impact mental health outcomes (Davis et al., 2012; Suveg et al., 2014). In this study, challenges in emotional expression varied among participants; some had trouble, while others had none in openly discussing their feelings with their families and others. This finding suggests that interventions should not only focus on treating the mental illness but also address other psychosocial aspects of life, such as emotional expression, that contribute to the overall well-being of Chinese individuals with psychosis and their families.

Cultures vary in their emphasis on experiencing, expressing and regulating negative emotions. P01, raised in Montreal and not fully fluent in Cantonese, found it difficult to express his emotions effectively to his parents because of the language barrier. Without all the words at his disposal, they may have struggled to understand his experience with psychosis. Additionally, P01 noted that discussing emotions with parents was less acceptable than with friends. He felt the need to 'put [emotions] in a box and shove [them] aside' when at home. This idea might seem paradoxical, considering that Chinese individuals are generally viewed as collectivist and emphasize family support. However, this reluctance to express emotions within families is common, especially when not highly valued, and aligns with findings in other studies on Chinese families (Cui et al., 2022; Hou et al., 2020; Kyeong et al., 2021; Yang et al., 2020; Yun et al., 2021). Cultural display rules govern the acceptable types, frequencies and intensities of emotions. These rules affect the variance in how individuals from different cultures, such as mainstream Canadians compared to mainstream Chinese, deal with these issues (Malatesta & Haviland, 1982). In collectivist cultures, the tendency to value emotional restraint and suppression for the sake of preserving social harmony is evident (Soto et al., 2011; Wei et al., 2013; Yuan et al., 2014; Zhou et al., 2016). Thus, for some Chinese individuals, not having conversations about negative emotions is considered beneficial as it aligns with cultural display rules. However, this study reveals that inhibiting emotional expression had detrimental effects. For example, P02 and P03 explained how their upbringing resulted in challenges with sharing their feelings during adolescence and young adulthood, leading to impaired self-awareness today. Several studies with Chinese populations highlighted that difficulty expressing emotions is a maladaptive regulatory strategy linked to worsened mental health, as well as troubles with emotional regulation and clarity (English & John, 2013; Lawlor et al., 2019; Lincoln et al., 2015). Cultural influences on communication patterns exacerbate mental health issues, contributing to feelings of isolation and a perceived lack of support, as expressed by P02 and P03. Understanding these dynamics is crucial for designing interventions that address the unique challenges faced by individuals in the

Chinese community, especially those who have difficulty with emotional expression, to instill healthier communication skills.

That said, differences in emotional expression exist among families. Some participants, such as P01, P02, P03 and P04, face challenges in expressing emotions, while others, like P06, freely discuss and share them with their parents. The lack of family support during challenging times, such as experiencing psychosis and stigma, may intensify negative feelings, isolation and mental health symptoms (Yin et al., 2020). In this study, emotional support from relatives emerged as a desired coping strategy for patients in such situations. Encouraging greater openness to discuss emotions in Chinese families may be necessary to address these challenges. Moreover, promoting open communication about distress is crucial for the early detection and intervention of psychosis. It enables relatives to promptly identify signs and seek timely help for their loved ones (Addington et al., 2005; Franz et al., 2010). Family psychoeducation, available at all three hospital sites in this study, empowers families with knowledge about psychosis and coping skills, including communication tips. In some cases, families may also benefit from additional support through family therapy. For example, during his interview, P01 thanked and described the personalized care received from his case manager. She had facilitated communication between his parents and himself, providing a comfortable space for sharing feelings and strengthening their bond. Hence, mental health professionals may need to carefully intervene with some Chinese families to initiate these challenging conversations. In general, establishing a channel for effective communication about emotions can dismantle the stigma surrounding mental health within families. When individuals feel at ease to share their feelings and get help, families can play a pivotal role in promoting psychological well-being and resilience (Bademli & Duman, 2016).

5. Clinical implications and implications for future research

Clinical implications

Several clinical implications arise from this research. Firstly, mental health professionals should practice cultural sensitivity, being mindful of the themes identified in this study when working with Chinese patients and their families. For instance, they can actively listen to family members, show respect to parents, as well as be mindful of diagnostic labels that could be harmful to both patients and their family members. These themes can also be integrated into existing training programs aimed at enhancing cultural awareness among mental health professionals and improving how they deliver care (Multicultural Mental Health Resource Centre, 2019). Secondly, these findings can be used to formulate a health belief model that explains and predicts health-related behaviours and the uptake of health services within this demographic. This model could be a helpful tool for mental health professionals when diagnosing and treating Chinese patients, improving doctor/patient–family interactions and health outcomes (Kagawa-Singer & Kassim-Lakha, 2003; Sun et al., 2024). Thirdly, raising awareness about stigma and providing more education about psychosis to reduce misconceptions through mediums such as handouts and family psychoeducation can make Chinese patients and their families feel more supported. The brochure produced for this thesis serves as the first step in this initiative at a local level. Mental health facilities can partner with local community organizations and religious institutions to disseminate accurate information and offer personalized support to Chinese patients and their families affected by psychosis. Fourthly, introducing discussions about traditional medicine (i.e., meditation and prayer) with Chinese patients and their families lets them know that we are open to their religion or spirituality and respect their beliefs. Additionally, P05 mentioned the benefit of having a mentor or peer supporter to help navigate her recovery journey. Several studies have found that mental health peer support programs are effective in facilitating the exchange of information and experiences, reducing levels of social isolation and providing hope (Chien et al., 2018; Fan et al., 2018). Finally, with a high percentage of participants opting for Mandarin over English during their interviews, it becomes evident that the implementation of Bill 96 poses further obstacles to accessing adequate treatment. Linguistically appropriate mental health services must be made available and accessible. Mental health professionals can advocate for language access in healthcare delivery for limited French- and English-speaking patients by informing them about interpretation and translation services. Overall, applying these changes would create a mental healthcare system that is more inclusive and responsive to the diverse population it serves.

Implications for future research

This study documented the unique challenges faced by Chinese patients and their families. During the interview with the couple (FM02 and FM03), they asked me about the situation in larger Canadian cities with larger Chinese populations. Presumably, cities like Toronto and Vancouver offer more mental health services tailored for the Canadian Chinese population. *Are there variations in mental health stigma between these cities and Montreal? Are there additional contextual or cultural factors influencing mental health perceptions in these cities that were not addressed in this study?* Expanding to these cities presents an opportunity for comparative research to explore variations in mental health stigma and identify any additional contextual or cultural factors influencing mental health perceptions within these cities. It also allows for collaboration with other hospital sites to share knowledge and enhance support for this demographic. Moreover, incorporating the voices of healthcare providers would allow the study of structural stigma, as well as how they approach providing diagnoses and deciding treatment plans for their clients. The Chinese population is very diverse, and the findings from this study can only explain a small subset of those with psychosis. Future research should include as many perspectives as possible, such as distant relatives of Chinese individuals with psychosis, religious leaders and Chinese individuals without mental illness, to foster a more comprehensive understanding of how cultural factors intersect with the experience of psychosis and stigma. For instance, a Likert Scale questionnaire can be constructed based on the themes identified in this study for participants to fill out and explore how cultural factors influence their perceptions and/or experiences related to psychosis. An example question could be: ‘On a scale of 1 to 5, how comfortable do you feel discussing mental health issues within your family?’ By conducting this research, we can develop a more effective and inclusive care approach for Chinese Canadian patients with first episode psychosis and their families.

6. Strengths and limitations

Strengths

There are strengths to this work. I conducted this study following the guidelines of Braun and Clarke (2013) and Yardley (2017) to ensure its rigour. As a graduate student working in a hospital, I was aware of potential power dynamics during interviews. I disclosed my affiliations, clarifying that my role was a learner and not a provider of medical advice. I worked hard to build rapport, creating a comfortable and safe space for participants. I encouraged participants to share their experiences in as much or as little detail as they wished, using their preferred language. I maintained transparency in analyzing, interpreting and presenting findings. In the results section, I included extracts in Chinese and English, allowing readers to compare my coding with their own and draw their own inferences. I plan to share a one-page summary with participants, upload a final report to the institutional repository and publish findings in a peer-reviewed journal. Disseminating this knowledge allows interested students to read about it and may inspire them to conduct research in this field. Mental health professionals can also benefit from reading this thesis, which hopefully enables them to apply the findings in their own care for Chinese patients with first episode psychosis and their families.

Limitations

There are limitations to this work. Participant bias is a concern, as those who partook in this study might be individuals who are further along in their recovery, experiencing relatively less distress in relation to their experience of psychosis or having a more positive rapport with the clinic compared to others. Another limitation is social desirability bias; participants may present themselves or their experience in a more positive light, potentially distorting the true nature of the phenomenon and compromising the accuracy of the findings. Additionally, the qualitative nature of IPA introduces subjectivity, relying on my interpretations of participants' accounts. This subjectivity poses the risk of researcher bias, as personal perspectives and preconceptions may influence the analysis of the data. Furthermore, the emphasis on in-depth exploration of lived experience in IPA means that its findings may lack generalizability to larger populations such that the findings may not extend beyond the specific group of participants in this study.

Researcher's note. Once again, I extend my heartfelt gratitude to all the participants for their invaluable contributions and entrusting me with their personal stories. Together, we were able to shed light on a marginalized population in psychiatric research. As I close this section, I would like to share below an excerpt from one interview that deeply resonated with me. It served as a poignant reminder of why I embarked on this research journey: to help my community.

> “你的初心很好。昨晚你表示你会关注这个问题。因为平时我不太愿意与别人讨论我的疾病，但是看到你专注于这个领域，我感到很惊讶。有人会特别关注这个问题，所以我愿意帮助你。希望通过你的项目，更多人能了解这个问题，为这些患有疾病的人提供更好的帮助。谢谢你。”
>
> Translation: “Your intentions are good. Last night, you said that you would be paying attention to this issue. Because I am usually reluctant to discuss my illness with others, but I am surprised to see you focusing on this area. There is someone who will pay special attention to this problem, so I would like to help you. I hope that through your project, more people will understand this issue and provide better help to these people suffering from the disease. Thank you.”

Conclusion

My study unveiled key factors influencing the experience of psychosis and stigma among patients and their families in the Chinese Canadian community. These factors included mental health beliefs, cultural values and communication. This study assessed the impact of misrepresentations in media and personal experience, as well as the impact of misunderstandings stemming from limited awareness and education on psychosis. Additionally, it explored attitudes toward care: how cultural beliefs influenced delayed help-seeking, as well as how religious and spiritual beliefs influenced treatment decision-making. Cultural values, such as filial piety and face, were identified as sources of high expectations and pressure to portray oneself in a socially acceptable way. These factors exacerbated mental health symptoms and hindered open dialogue about psychological well-being. Communication, particularly the use of diagnostic labels like 精神病 (jīng shén bìng), was found to raise concerns, highlighting the necessity for respectful and sensitive communication to prevent stereotypes and decrease prejudice. Within some families, emotional expression was found to be infrequent and inhibited, emphasizing the need to improve emotional support and understanding from family members. This study highlighted the significance of cultural sensitivity in mental health professionals' interactions with Chinese patients. It also offered insights into the need for culturally sensitive approaches to treatment (i.e., discussing treatment modalities and complementary methods with the client) and services (i.e., interpretation and translation services, culturally adapted psychoeducation and peer support). These aspects are essential for dispelling stereotypes, prejudice and discrimination, as well as for creating a healing environment for Chinese Canadian patients with first-episode psychosis and their families. In summary, this research contributes to the existing literature by enhancing our knowledge of psychosis and stigma, advocating for meaningful changes in clinical settings, families and the Chinese Canadian community.

References

Abe-Kim, J., Takeuchi, D. T., Hong, S., Zane, N., Sue, S., Spencer, M. S., ... & Alegría, M. (2007). Use of mental health-related services among immigrant and US-born Asian Americans: results from the National Latino and Asian American study. *American journal of public health*, 97(1), 91-98.

Aberizk, K., Newman, L. S., & Sargent, R. H. (2017). Attributional Complexity and the Illusory Correlation: A Test of the Inverted-U Hypothesis. *North American Journal of Psychology*, 19(3).

Addington, D., Abidi, S., Garcia-Ortega, I., Honer, W. G., & Ismail, Z. (2017). Canadian guidelines for the assessment and diagnosis of patients with schizophrenia spectrum and other psychotic disorders. *The Canadian Journal of Psychiatry*, 62(9), 594-603.

Addington, J., Collins, A., McCleery, A., & Addington, D. (2005). The role of family work in early psychosis. *Schizophrenia research*, 79(1), 77-83.

Ahad, A. A., Sanchez-Gonzalez, M., & Junquera, P. (2023). Understanding and Addressing Mental Health Stigma Across Cultures for Improving Psychiatric Care: A Narrative Review. *Cureus*, 15(5).

American Psychiatric Association. (2022). Schizophrenia Spectrum and Other Psychotic Disorders. *Diagnostic and Statistical Manual of Mental Disorders*, 5. https://doi.org/10.1176/appi.books.9780890425787.x02_schizophrenia_spectrum

Anderson, K. K., Flora, N., Archie, S., Morgan, C., & McKenzie, K. (2014). A meta-analysis of ethnic differences in pathways to care at the first episode of psychosis. *Acta psychiatrica Scandinavica*, 130(4), 257–268. https://doi.org/10.1111/acps.12254

Angermeyer, M. C., & Dietrich, S. (2006). Public beliefs about and attitudes towards people with mental illness: a review of population studies. *Acta Psychiatrica Scandinavica*, 113(3), 163-179.

Ayano, G., Tesfaw, G., & Shumet, S. (2019). The prevalence of schizophrenia and other psychotic disorders among homeless people: a systematic review and meta-analysis. *BMC psychiatry*, 19(1), 370. https://doi.org/10.1186/s12888-019-2361-7

Bademli, K., & Duman, Z. Ç. (2016). Emotions, ideas and experiences of caregivers of patients with schizophrenia about "family to family support program". *Archives of Psychiatric Nursing*, 30(3), 329-333.

Bedford, O., & Yeh, K. H. (2021). Evolution of the conceptualization of filial piety in the global context: From skin to skeleton. Frontiers in Psychology, 12, 570547.

Bhui, K., & Bhugra, D. (2002). Explanatory models for mental distress: implications for clinical practice and research. *The British journal of psychiatry: the journal of mental science*, 181, 6–7. https://doi.org/10.1192/bjp.181.1.6

Bífárìn, O., Quinn, C., Breen, L., Wu, C., Ke, M., Yu, L., & Oyebode, J. (2023). Stressors and coping mechanisms of family caregivers of older relatives living with long-term conditions in mainland China: a scoping review of the evidence. *Ageing & Society*, 43(4), 952-989.

Bowen, S. (2001). Language barriers in access to health care (p. 120). Ottawa: Health Canada.

Bril-Barniv, S., Moran, G. S., Naaman, A., Roe, D., & Karnieli-Miller, O. (2017). A qualitative study examining experiences and dilemmas in concealment and disclosure of people living with serious mental illness. *Qualitative Health Research*, 27(4), 573-583.

Burkhard, C., Cicek, S., Barzilay, R., Radhakrishnan, R., & Guloksuz, S. (2021). Need for ethnic and population diversity in psychosis research. *Schizophrenia bulletin*, 47(4), 889-895.

Butler, E. A., Lee, T. L., & Gross, J. J. (2007). Emotion regulation and culture: Are the social consequences of emotion suppression culture-specific?. *Emotion*, 7(1), 30–48. https://doi.org/10.1037/1528-3542.7.1.30

Cabassa, L. J., Piscitelli, S., Haselden, M., Lee, R. J., Essock, S. M., & Dixon, L. B. (2018). Understanding Pathways to Care of Individuals Entering a Specialized Early

Intervention Service for First-Episode Psychosis. *Psychiatric services* (Washington, D.C.), 69(6), 648–656. https://doi.org/10.1176/appi.ps.201700018

Calabrese, J., & Al Khalili, Y. (2023). Psychosis. In StatPearls. StatPearls Publishing.

Carden, L. J., Saini, P., Seddon, C., Watkins, M., & Taylor, P. J. (2020). Shame and the psychosis continuum: A systematic review of the literature. *Psychology and Psychotherapy: Theory, Research and Practice*, 93(1), 160-186.

Chan, C. L., & Chui, E. W. (2011). Association between cultural factors and the caregiving burden for Chinese spousal caregivers of frail elderly in Hong Kong. *Aging & Mental Health*, 15(4), 500-509.

Chang, C. W., & Chen, F. P. (2021). Relationships of Family emotional support and negative family interactions with the quality of life among Chinese people with mental illness and the mediating effect of internalized stigma. *Psychiatric Quarterly*, 92(1), 375-387.

Chen, E. S., Chang, W. C., Hui, C. L., Chan, S. K., Lee, E. H. M., & Chen, E. Y. (2016). Self-stigma and affiliate stigma in first-episode psychosis patients and their caregivers. *Social psychiatry and psychiatric epidemiology*, 51, 1225-1231.

Chen, S. H., Zhou, Q., Main, A., & Lee, E. H. (2015). Chinese American immigrant parents’ emotional expression in the family: Relations with parents’ cultural orientations and children’s emotion-related regulation. *Cultural Diversity and Ethnic Minority Psychology*, 21(4), 619.

Chen, S., Burton, C. L., & Bonanno, G. A. (2020). The suppression paradox: A cross-cultural comparison of suppression frequency, suppression ability, and depression. *Journal of Affective Disorders*, 274, 183-189.

Cheung, R. Y., & Park, I. J. (2010). Anger suppression, interdependent self-construal, and depression among Asian American and European American college students. *Cultural diversity & ethnic minority psychology*, 16(4), 517–525. https://doi.org/10.1037/a0020655

Chien, W. T., Bressington, D., & Chan, S. W. (2018). A randomized controlled trial on mutual support group intervention for families of people with recent-onset psychosis: A four-year follow-up. *Frontiers in psychiatry*, 9, 710.

Chien, W. T., Chan, S. W., & Morrissey, J. (2007). The perceived burden among Chinese family caregivers of people with schizophrenia. *Journal of clinical nursing*, 16(6), 1151-1161.

Chiu, L., Morrow, M., Ganesan, S., & Clark, N. (2005). Spirituality and treatment choices by South and East Asian women with serious mental illness. *Transcultural Psychiatry*, 42(4), 630-656.

Chiu, M., Amartey, A., Wang, X., & Kurdyak, P. (2018). Ethnic Differences in Mental Health Status and Service Utilization: A Population-Based Study in Ontario, Canada. *Canadian journal of psychiatry. Revue canadienne de psychiatrie*, 63(7), 481–491. https://doi.org/10.1177/0706743717741061

Chung, K. F., & Chan, J. H. (2004). Can a less pejorative Chinese translation for schizophrenia reduce stigma? A study of adolescents' attitudes toward people with schizophrenia. Psychiatry and clinical neurosciences, 58(5), 507- 515.

Clarke, V., & Braun, V. (2013). Successful qualitative research: A practical guide for beginners. *Successful qualitative research*, 1-400.

Committee on the Science of Changing Behavioral Health Social Norms, Board on Behavioral, Cognitive, and Sensory Sciences, Division of Behavioral and Social Sciences and Education, & National Academies of Sciences, Engineering, and Medicine. (2016). Ending Discrimination Against People with Mental and Substance Use Disorders: The Evidence for Stigma Change. National Academies Press (US).

Correll, C. U., Galling, B., Pawar, A., Krivko, A., Bonetto, C., Ruggeri, M., Craig, T. J., Nordentoft, M., Srihari, V. H., Guloksuz, S., Hui, C. L. M., Chen, E. Y. H., Valencia, M., Juarez, F., Robinson, D. G., Schooler, N. R., Brunette, M. F., Mueser, K. T., Rosenheck, R. A., Marcy, P., ... Kane, J. M. (2018). Comparison of Early Intervention Services vs Treatment as Usual for Early-Phase Psychosis: A Systematic Review, Meta-analysis, and Meta-regression. *JAMA psychiatry*, 75(6), 555–565. https://doi.org/10.1001/jamapsychiatry.2018.0623

Corrigan, P. W., & Nieweglowski, K. (2019). How does familiarity impact the stigma of mental illness?. *Clinical psychology review*, 70, 40–50. https://doi.org/10.1016/j.cpr.2019.02.001

Corrigan, P. W., & Watson, A. C. (2002). Understanding the impact of stigma on people with mental illness. *World psychiatry: official journal of the World Psychiatric Association* (WPA), 1(1), 16–20.

Corrigan, P., Markowitz, F. E., Watson, A., Rowan, D., & Kubiak, M. A. (2003). An attribution model of public discrimination towards persons with mental illness. *Journal of health and Social Behavior*, 162-179.

Costigan, C. L., Hua, J. M., & Su, T. F. (2010). Living up to expectations: The strengths and challenges experienced by Chinese Canadian Students. *Canadian Journal of School Psychology*, 25(3), 223–245. https://doi.org/10.1177/0829573510368941

Cowman, M., Godfrey, E., Walsh, T., Frawley, E., Fowler, D., Alvarez-Jimenez, M., O'Connor, K., Wykes, T., Birchwood, M., & Donohoe, G. (2023). Measures of Social and Occupational Function in Early Psychosis: A Systematic Review and Meta-analysis. *Schizophrenia bulletin*, sbad062. Advance online publication. https://doi.org/10.1093/schbul/sbad062

Cowman, M., Holleran, L., Lonergan, E., O'Connor, K., Birchwood, M., & Donohoe, G. (2021). Cognitive Predictors of Social and Occupational Functioning in Early Psychosis: A Systematic Review and Meta-analysis of Cross-Sectional and Longitudinal Data. *Schizophrenia bulletin*, 47(5), 1243–1253. https://doi.org/10.1093/schbul/sbab033

Cui, L., Sun, Q., Way, N., Waters, T. E., Li, X., Zhang, C., ... & Yoshikawa, H. (2023). Prospective within-family bidirectional effects between parental emotion socialization practices and Chinese adolescents' psychosocial adjustment. *Development and Psychopathology*, 35(4), 1956-1967.

Curtis, E., Jones, R., Tipene-Leach, D., Walker, C., Loring, B., Paine, S., & Reid, P. (2019). Why cultural safety rather than cultural competency is required to achieve health equity: a literature review and recommended definition. *International Journal for Equity in Health*, 18.

Dabby, L., Tranulis, C., & Kirmayer, L. J. (2015). Explicit and Implicit Attitudes of Canadian Psychiatrists Toward People With Mental Illness. *Canadian journal of psychiatry. Revue canadienne de psychiatrie*, 60(10), 451–459. https://doi.org/10.1177/070674371506001006

Davis, E., Greenberger, E., Charles, S., Chen, C., Zhao, L., & Dong, Q. (2012). Emotion experience and regulation in China and the United States: how do culture and gender shape emotion responding?. *International Journal of Psychology*, 47(3), 230-239.

Dubreucq, J., Plasse, J., & Franck, N. (2021). Self-stigma in Serious Mental Illness: A Systematic Review of Frequency, Correlates, and Consequences. *Schizophrenia bulletin*, 47(5), 1261–1287. https://doi.org/10.1093/schbul/sbaa181

Elliott, M., & Doane, M. J. (2015). Stigma management of mental illness: Effects of concealment, discrimination, and identification on well-being. *Self and Identity*, 14(6), 654-674.

English, T., & John, O. P. (2013). Understanding the social effects of emotion regulation: the mediating role of authenticity for individual differences in suppression. *Emotion*, 13(2), 314.

Engward, H., & Goldspink, S. (2020). Lodgers in the house: Living with the data in interpretive phenomenological analysis research. *Reflective Practice*, 21(1), 41-53.

Fan, Y., Ma, N., Ma, L., Xu, W., Steven Lamberti, J., & Caine, E. D. (2018). A community-based peer support service for persons with severe mental illness in China. *BMC psychiatry*, 18, 1-10.

Fossey, E., Harvey, C., McDermott, F., & Davidson, L. (2002). Understanding and evaluating qualitative research. *Australian & New Zealand journal of psychiatry*, 36(6), 717-732.

Franz, L., Carter, T., Leiner, A. S., Bergner, E., Thompson, N. J., & Compton, M. T. (2010). Stigma and treatment delay in first-episode psychosis: a grounded theory study. *Early intervention in psychiatry*, 4(1), 47-56.

Fwu, B. J., Wang, H. H., Chen, S. W., & Wei, C. F. (2017). 'Feeling bad' or 'being bad?' The trapping effect of effort in academic failure in a Confucian cultural context. *Educational Psychology*, 37(4), 506-519.

Gao, M., & Han, Z. R. (2016). Family expressiveness mediates the relation between cumulative family risks and children's emotion regulation in a Chinese sample. *Journal of Child and Family Studies*, 25, 1570-1580.

Gao, Z. (2021). Unsettled Belongings: Chinese Immigrants' Mental Health Vulnerability as a Symptom of International Politics in the COVID-19 Pandemic. *Journal of Humanistic Psychology*, 61(2), 198-218. https://doi.org/10.1177/0022167820980620

Gierk, B., Löwe, B., Murray, A. M., & Kohlmann, S. (2018). Assessment of perceived mental health-related stigma: The Stigma-9 Questionnaire (STIG-9). *Psychiatry research*, 270, 822-830.

Goffman, E. (1963). Stigma; notes on the management of spoiled identity. Prentice-Hall.

Groleau, D., Young, A., & Kirmayer, L. J. (2006). The McGill Illness Narrative Interview (MINI): an interview schedule to elicit meanings and modes of reasoning related to illness experience. *Transcultural psychiatry*, 43(4), 671-691.

Grover, S., Davuluri, T., & Chakrabarti, S. (2014). Religion, spirituality, and schizophrenia: A review. *Indian journal of psychological medicine*, 36(2), 119-124.

Hansson, K. M., Romøren, M., Pedersen, R., Weimand, B., Hestmark, L., Norheim, I., ... & Heiervang, K. S. (2022). Barriers and facilitators when implementing family involvement for persons with psychotic disorders in community mental health centres—a nested qualitative study. *BMC Health Services Research*, 22(1), 1-16.

Hassan, S., Flett, G. L., Ganguli, R., & Hewitt, P. L. (2014). Perfectionistic self-presentation and suicide in a young woman with major depression and psychotic features. *Case Reports in Psychiatry*, 2014.

Heibach, E., Brabban, A., & Lincoln, T. M. (2014). How much priority do clinicians give to cognitive behavioral therapy in the treatment of psychosis and why?. *Clinical Psychology: Science and Practice*, 21(3), 301–312. https://doi.org/10.1111/cpsp.12074

Horváth, Á., & Molnár, P. (2022). A review of patient safety communication in multicultural and multilingual healthcare settings with special attention to the US and Canada. *Developments in Health Sciences*, 4(3), 49-57.

Hou, Y., Xiao, R., Yang, X., Chen, Y., Peng, F., Zhou, S., ... & Zhang, X. (2020). Parenting style and emotional distress among Chinese college students: A potential mediating role of the Zhongyong thinking style. *Frontiers in psychology*, 11, 1774.

Hsin Yang, L., & Pearson, V. J. (2002). Understanding families in their own context: Schizophrenia and structural family therapy in Beijing. *Journal of Family Therapy*, 24(3), 233-257.

Huang, Y. T., Chan, R. C. H., & Cui, L. (2020). Filial piety, internalized homonegativity, and depressive symptoms among Taiwanese gay and bisexual men: A mediation analysis. *American Journal of Orthopsychiatry*, 90(3), 340.

Immigration, Refugees and Citizenship Canada. (2023). 2023 Annual Report to Parliament on Immigration. Retrieved from the Government of Canada website: https://www.canada.ca/content/dam/ircc/documents/pdf/english/corporate/publications-manuals/annual-report-2023- en.pdf

Jen, C. H., Chen, W. W., & Wu, C. W. (2019). Flexible mindset in the family: Filial piety, cognitive flexibility, and general mental health. *Journal of Social and Personal Relationships*, 36(6), 1715-1730.

Kagawa-Singer, M., & Kassim-Lakha, S. (2003). A strategy to reduce cross-cultural miscommunication and increase the likelihood of improving health outcomes. *Academic Medicine*, 78(6), 577-587.

Kamaradova, D., Latalova, K., Prasko, J., Kubinek, R., Vrbova, K., Mainerova, B., ... & Tichackova, A. (2016). Connection between self-stigma, adherence to treatment, and discontinuation of medication. *Patient preference and adherence*, 1289-1298.

Karnieli-Miller, O., Perlick, D. A., Nelson, A., Mattias, K., Corrigan, P., & Roe, D. (2013). Family members of persons living with a serious mental illness: Experiences and efforts to cope with stigma. *Journal of Mental Health*, 22(3), 254-262.

Kim, J. H., & Silverstein, M. (2021). Are filial piety and ethnic community engagement associated with psychological wellbeing among older Chinese American immigrants? A cultural resource perspective. *Research on Aging*, 43(2), 63-73.

Kirmayer L. J. (2012). Rethinking cultural competence. Transcultural psychiatry, 49(2), 149–164. https://doi.org/10.1177/1363461512444673

Kirmayer, L. J., & Jarvis, G. E. (2019). Culturally Responsive Services as a Path to Equity in Mental Healthcare. *HealthcarePapers*, 18(2), 11–23. https://doi.org/10.12927/hcpap.2019.25925

Kirmayer, L. J., Narasiah, L., Munoz, M., Rashid, M., Ryder, A. G., Guzder, J., ... & Pottie, K. (2011). Common mental health problems in immigrants and refugees: general approach in primary care. *Cmaj*, 183(12), E959-E967.

Kleinman, A. (1988). The illness narratives: Suffering, healing, and the human condition. Basic Books.

Kleinman, A., & Hall-Clifford, R. (2009). Stigma: A social, cultural, and moral process. *Journal of epidemiology and community health*.

Knaak, S., Mantler, E., & Szeto, A. (2017). Mental illness-related stigma in healthcare: Barriers to access and care and evidence-based solutions. *Healthcare management forum*, 30(2), 111–116. https://doi.org/10.1177/0840470416679413

Kong, D., Wong, Y. L. I., & Dong, X. (2020). Face-saving and depressive symptoms among US Chinese older adults. Journal of immigrant and Minority Health, 22, 888-894.

Kramer, E. J., Kwong, K., Lee, E., & Chung, H. (2002). Cultural factors influencing the mental health of Asian Americans. *The Western journal of medicine*, 176(4), 227–231.

Kyeong, Y., Cheung, R. Y., & Cheung, C. S. (2021). The role of family expressiveness in American and Chinese adolescents' emotional experiences. *Social Development*, 30(4), 1056-1076.

Laird, K. T., Smith, C. A., Hollon, S. D., & Walker, L. S. (2020). Validation of the health-related felt stigma and concealment questionnaire. *Journal of Pediatric Psychology*, 45(5), 509-520.

Lam, J. S. H., Links, P. S., Eynan, R., Shera, W., Tsang, A. K. T., Law, S., Fung, W. L. A., Zhang, X., Liu, P., & Zaheer, J. (2022). “I thought that I had to be alive to repay my parents”: Filial piety as a risk and protective factor for suicidal behavior in a qualitative study of Chinese women. *Transcultural psychiatry*, 59(1), 13–27. https://doi.org/10.1177/13634615211059708

Large, M. M., & Nielssen, O. (2011). Violence in first-episode psychosis: a systematic review and meta-analysis. *Schizophrenia research*, 125(2-3), 209-220.

Larkin, M., & Thompson, A. R. (2011). Interpretative phenomenological analysis in mental health and psychotherapy research. *Qualitative research methods in mental health and psychotherapy: A guide for students and practitioners*, 99-116.

Lawlor, C., Hepworth, C., Smallwood, J., Carter, B., & Jolley, S. (2020). Self-reported emotion regulation difficulties in people with psychosis compared with non-clinical controls: A systematic literature review. *Clinical Psychology & Psychotherapy*, 27(2), 107-135.

Lecomte, T., Addington, J., Bowie, C., Lepage, M., Potvin, S., Shah, J., Summerville, C., & Tibbo, P. (2022). The Canadian Network for Research in Schizophrenia and Psychoses: A Nationally Focused Approach to Psychosis and Schizophrenia Research. *Canadian journal of psychiatry. Revue canadienne de psychiatrie*, 67(3), 172–175. https://doi.org/10.1177/07067437211009122

Lee, S., Juon, H. S., Martinez, G., Hsu, C. E., Robinson, E. S., Bawa, J., & Ma, G. X. (2009). Model minority at risk: Expressed needs of mental health by Asian American young adults. *Journal of community health*, 34, 144-152.

Lee, Y. S., Kim, J. J., & Kwon, J. S. (2013). Renaming schizophrenia in South Korea. *The Lancet*, 382(9893), 683- 684.

Leng, A., Xu, C., Nicholas, S., Nicholas, J., & Wang, J. (2019). Quality of life in caregivers of a family member with serious mental illness: Evidence from China. *Archives of Psychiatric Nursing*, 33(1), 23-29.

Li, H. Z., & Browne, A. J. (2000). Defining mental illness and accessing mental health services: perspectives of Asian Canadians. *Canadian journal of community mental health = Revue canadienne de sante mentale communautaire*, 19(1), 143–159. https://doi.org/10.7870/cjcmh-2000-0008

Li, H., Friedman-Yakoobian, M., Min, G., Granato, A. G., & Seidman, L. J. (2013). Working with Asian American youth at clinical high risk for psychosis: a case illustration. *The Journal of nervous and mental disease*, 201(6), 484.

Li, J. Y. (2021). Acculturation and social stigma: Mental health communicative action and help-seeking behaviors among Chinese immigrants in the United States. *International Journal of Strategic Communication*, 15(5), 487-503.

Li, J., Zhang, M. M., Zhao, L., Li, W. Q., Mu, J. L., & Zhang, Z. H. (2018). Evaluation of attitudes and knowledge toward mental disorders in a sample of the Chinese population using a web-based approach. *BMC psychiatry*, 18(1), 1-8.

Li, M., & Dai, H. (2019). Determining the primary caregiver for disabled older adults in Mainland China: Spouse priority and living arrangements. *Journal of Family Therapy*, 41(1), 126-141.

Li, S., Shi, Y., Chen, T., & Zhao, M. (2023). An exploratory study on the 10-year dynamic changes of mental health policy development and media stigma reporting in China (2011–2020). *International Journal of Social Psychiatry*, 00207640231162815.

Lin, H. Y. (2018). The Promotion of English in East Asia at the Turn of the 21st Century: A Politico-Economic and Socio-Cultural Review. *Journal of Pan-Pacific Association of Applied Linguistics*, 22(1), 1-17.

Lin, T., & Lin, M. (1981). Love, Denial and Rejection: Responses of Chinese Families to Mental Illness.

Lincoln, T. M., Hartmann, M., Köther, U., & Moritz, S. (2015). Do people with psychosis have specific difficulties regulating emotions?. *Clinical psychology & psychotherapy*, 22(6), 637-646.

Livingston, J. D. (2020). Structural stigma in health-care contexts for people with mental health and substance use issues: A literature review. Ottawa: Mental Health Commission of Canada.

Lwi, S. J., Ford, B. Q., & Levenson, R. W. (2023). Cultural differences in caring for people with dementia: a pilot study of concern about losing face and loneliness in Chinese American and European American caregivers. *Clinical Gerontologist*, 46(2), 207-222.

Maercker, A., Zhang, X. C., Gao, Z., Kochetkov, Y., Lu, S., Sang, Z., ... & Margraf, J. (2015). Personal value orientations as mediated predictors of mental health: A three-culture study of Chinese, Russian, and German university students. *International Journal of Clinical and Health Psychology*, 15(1), 8-17.

Maher, C., Hadfield, M., Hutchings, M., & De Eyto, A. (2018). Ensuring rigor in qualitative data analysis: A design research approach to coding combining NVivo with traditional material methods. *International journal of qualitative methods*, 17(1), 1609406918786362.

Malatesta, C. Z., & Haviland, J. M. (1982). Learning display rules: The socialization of emotion expression in infancy. *Child development*, 991-1003.

Malla, A., Dama, M., Iyer, S., Joober, R., Schmitz, N., Shah, J., Issaoui Mansour, B., Lepage, M., & Norman, R. (2021). Understanding Components of Duration of Untreated Psychosis and Relevance for Early Intervention Services in the Canadian Context: Comprendre les Composantes de la Durée de la Psychose Non Traitée et la Pertinence de Services D'intervention Précoce Dans le Contexte Canadien. *Canadian journal of psychiatry. Revue canadienne de psychiatrie*, 66(10), 878–886. https://doi.org/10.1177/0706743721992679

McGlinchey, E., Hitch, C., Butter, S., McCaughey, L., Berry, E., & Armour, C. (2021). Understanding the lived experiences of healthcare professionals during the

COVID-19 pandemic: an interpretative phenomenological analysis. *European Journal of Psychotraumatology*, 12(1), 1904700.

McGorry, P. D., Mei, C., Hartmann, J., Yung, A. R., & Nelson, B. (2021). Intervention strategies for ultra-high risk for psychosis: Progress in delaying the onset and reducing the impact of first-episode psychosis. *Schizophrenia research*, 228, 344–356. https://doi.org/10.1016/j.schres.2020.12.026

Mckenzie K. J. (2014). How does untreated psychosis lead to neurological damage?. *Canadian journal of psychiatry. Revue canadienne de psychiatrie*, 59(10), 511–512. https://doi.org/10.1177/070674371405901002

Miller, R. M. & Barrio Minton, C. A. (2016). Interpretative Phenomenological Analysis: A Contemporary Phenomenological Approach. *Journal of Mental Health Counseling*, 38(1), 47-61. https://doi.org/10.17744/mehc.38.1.04

Misra, S., Gelaye, B., Williams, D. R., Koenen, K. C., Borba, C. P. C., Quattrone, D., Di Forti, M., Tripoli, G., La Cascia, C., La Barbera, D., Ferraro, L., Tarricone, I., Berardi, D., Lasalvia, A., Tosato, S., Szöke, A., Llorca, P. M., Arango, C., Tortelli, A., de Haan, L., … Morgan, C. (2021). Perceived major experiences of discrimination, ethnic group, and risk of psychosis in a six-country case-control study. *Psychological medicine*, 1–9. Advance online publication. https://doi.org/10.1017/S0033291721000453

Misra, S., Jackson, V. W., Chong, J., Choe, K., Tay, C., Wong, J., & Yang, L. H. (2021). Systematic review of cultural aspects of stigma and mental illness among racial and ethnic minority groups in the United States: Implications for interventions. *American Journal of Community Psychology*, 68(3-4), 486-512.

Miyawaki, C. E. (2020). Caregiving attitudes and needs of later-generation Chinese-American family caregivers of older adults. *Journal of Family Issues*, 41(12), 2377-2399.

Morgan, A. J., & Jorm, A. F. (2009). Recall of news stories about mental illness by Australian youth: associations with help-seeking attitudes and stigma. *Australian & New Zealand Journal of Psychiatry*, 43(9), 866-872.

Murphy, J., Mulcahy, H., Mahony, J. O., & Bradley, S. (2023). Exploring individuals' experiences of hope in mental health recovery: An interpretative phenomenological analysis. *Journal of Psychiatric and Mental Health Nursing*, 30(1), 101-109.

Na, L., & Hample, D. (2016). Psychological pathways from social integration to health: An examination of different demographic groups in Canada. *Social science & medicine* (1982), 151, 196–205. https://doi.org/10.1016/j.socscimed.2016.01.007

Na, S., Ryder, A. G., & Kirmayer, L. J. (2016). Toward a culturally responsive model of mental health literacy: Facilitating help-seeking among East Asian immigrants to North America. *American Journal of Community Psychology*, 58(1-2), 211-225.

National Institute of Mental Health. (Revised 2023). Understanding Psychosis (NIH Publication No. 23-MH-8110). https://www.nimh.nih.gov/health/publications/understandingpsychosis

Nielsen, S. M., Toftdahl, N. G., Nordentoft, M., & Hjorthøj, C. (2017). Association between alcohol, cannabis, and other illicit substance abuse and risk of developing schizophrenia: a nationwide population-based register study. *Psychological medicine*, 47(9), 1668–1677. https://doi.org/10.1017/S0033291717000162

Ning, X., Wong, J. P. H., Huang, S., Fu, Y., Gong, X., Zhang, L., ... & Jia, C. X. (2022). Chinese university students' perspectives on help-seeking and mental health counseling. *International journal of environmental research and public health*, 19(14), 8259.

Nolin, M., Malla, A., Tibbo, P., Norman, R., & Abdel-Baki, A. (2016). Early Intervention for Psychosis in Canada: What Is the State of Affairs?. *Canadian journal of psychiatry. Revue canadienne de psychiatrie*, 61(3), 186–194. https://doi.org/10.1177/0706743716632516

Ochoa, S., Martínez-Zambrano, F., Garcia-Franco, M., Vilamala, S., Ribas, M., Arenas, O., ... & Haro, J. M. (2015). Development and validation of the Self-Stigma

Questionnaire (SSQ) for people with schizophrenia and its relation to social functioning. *Comprehensive psychiatry*, 62, 93-99.

Office of the Surgeon General (US); Center for Mental Health Services (US); National Institute of Mental Health (US). Mental Health: Culture, Race, and Ethnicity: A Supplement to Mental Health: A Report of the Surgeon General. Rockville (MD): Substance Abuse and Mental Health Services Administration (US); 2001 Aug. Chapter 2 *Culture Counts: The Influence of Culture and Society on Mental Health*. Available from: https://www.ncbi.nlm.nih.gov/books/NBK44249/

Oliveira, S. M., Peixoto, M. M., & Serpa Jr, O. D. D. (2021). Religiosity and mental suffering experiences of users of the Brazilian public healthcare system. *Revista Latinoamericana de Psicopatologia Fundamental*, 24, 115-139.

Oliver, D., Davies, C., Crossland, G., Lim, S., Gifford, G., McGuire, P., & Fusar-Poli, P. (2018). Can We Reduce the Duration of Untreated Psychosis? A Systematic Review and Meta-Analysis of Controlled Interventional Studies. *Schizophrenia bulletin*, 44(6), 1362–1372. https://doi.org/10.1093/schbul/sbx166

Page, W., Murray, L., Phun, K., & Turner, R. (2020). Patient narratives of illnesses requiring abdominal surgery in Cambodia: Heroic/stoic, and dealing with ‘the ball of meat’. *Global Public Health*, 15(5), 763-775.

Pan, Y., Chen, R., & Yang, D. (2022). The relationship between filial piety and caregiver burden among adult children: A systematic review and meta-analysis. *Geriatric Nursing*, 43, 113-123.

Park, S., & Park, K. S. (2014). Family stigma: A concept analysis. *Asian Nursing Research*, 8(3), 165-171.

Pavon, G., & Vaes, J. (2017). Bio-genetic vs. psycho-environmental conceptions of schizophrenia and their role in perceiving patients in human terms. *Psychosis*, 9(3), 245–253. https://doi.org/10.1080/17522439.2017.1311359

Peisah, C., de Mendonça Lima, C., Verbeek, H., & Rabheru, K. (2022). IPA and WPA-SOAP joint statement on the rights of older persons with mental health conditions and psychosocial disabilities. *International Psychogeriatrics*, 34(11), 943-947.

Pharr, J. R., Dodge Francis, C., Terry, C., & Clark, M. C. (2014). Culture, caregiving, and health: exploring the influence of culture on family caregiver experiences. *ISRN Public Health*, 2014, 1-8.

Pietkiewicz, I., & Smith, J. A. (2014). A practical guide to using interpretative phenomenological analysis in qualitative research psychology. *Psychological journal*, 20(1), 7-14.

Public Health Agency of Canada. (2022). Self-Rated Mental Health Decreases After Another Year of the COVID-19 Pandemic. Retrieved from the Government of Canada website: https://www150.statcan.gc.ca/n1/en/daily-quotidien/220607/dq220607e-eng.pdf?st=cb4CtWXQ

Radua, J., Ramella-Cravaro, V., Ioannidis, J. P. A., Reichenberg, A., Phiphopthatsanee, N., Amir, T., Yenn Thoo, H., Oliver, D., Davies, C., Morgan, C., McGuire, P., Murray, R. M., & Fusar-Poli, P. (2018). What causes psychosis? An umbrella review of risk and protective factors. *World psychiatry: official journal of the World Psychiatric Association* (WPA), 17(1), 49–66. https://doi.org/10.1002/wps.20490

Ran, M. S., Hall, B. J., Su, T. T., Prawira, B., Breth-Petersen, M., Li, X. H., & Zhang, T. M. (2021). Stigma of mental illness and cultural factors in Pacific Rim region: a systematic review. *BMC psychiatry*, 21(1), 8. https://doi.org/10.1186/s12888-020-02991-5

Rao, Z., & Gibson, J. (2019). Motivations for emotional expression and emotion regulation strategies in Chinese school-aged children. *Motivation and Emotion*, 43(3), 371-386.

Ricci, Cristina, E., Leal, Maria, E., Davidson, L., & Costa, M. (2021). Narratives about the Experience of Mental Illness: the recovery Process in Brazil. *Psychiatric Quarterly*, 92, 573-585.

Ritsher, J. B., Otilingam, P. G., & Grajales, M. (2003). Internalized stigma of mental illness: psychometric properties of a new measure. *Psychiatry research*, 121(1), 31-49.

Rössler W. (2016). The stigma of mental disorders: A millennia-long history of social exclusion and prejudices. *EMBO reports*, 17(9), 1250–1253. https://doi.org/10.15252/embr.201643041

Ryder, A. G., Bean, G., & Dion, K. L. (2000). Caregiver responses to symptoms of first-onset psychosis: A comparative study of Chinese-and Euro-Canadian families. *Transcultural Psychiatry*, 37(2), 255-266.

S-4.2 - Act respecting health services and social services (2023).

Sandelowski, M. (2010). What's in a name? Qualitative description revisited. *Research in nursing & health*, 33(1), 77-84.

Sandford, D. M., Kirtley, O. J., Thwaites, R., & O'Connor, R. C. (2023). Exploring the impact on primary care mental health practitioners of the death of a patient by suicide: An IPA study. *Psychology and Psychotherapy: Theory, Research and Practice*, 96(1), 56-82.

Sartorius, N., Chiu, H., Heok, K. E., Lee, M. S., Ouyang, W. C., Sato, M., ... & Yu, X. (2014). Name change for schizophrenia. *Schizophrenia bulletin*, 40(2), 255-258.

Sato, M. (2006). Renaming schizophrenia: a Japanese perspective. *World psychiatry*, 5(1), 53.

Schofield, C. A., & Ponzini, G. T. (2020). The Skidmore Anxiety Stigma Scale (SASS): A covert and brief self- report measure. *Journal of anxiety disorders*, 74, 102259.

Schwarzbold, M. L., Kern, R. S., Novacek, D. M., McGovern, J. E., Catalano, L. T., & Green, M. F. (2021). Self- stigma in psychotic disorders: Clinical, cognitive, and functional correlates in a diverse sample. *Schizophrenia research*, 228, 145-150.

Semahegn, A., Torpey, K., Manu, A., Assefa, N., Tesfaye, G., & Ankomah, A. (2020). Psychotropic medication non-adherence and its associated factors among patients with major psychiatric disorders: a systematic review and meta-analysis. *Systematic reviews*, 9(1), 1-18.

Shea, M., & Yeh, C. (2008). Asian American students' cultural values, stigma, and relational self-construal: Correlates of attitudes toward professional help seeking. *Journal of Mental Health Counseling*, 30(2), 157-172.

Shi, W., Shen, Z., Wang, S., & Hall, B. J. (2020). Barriers to professional mental health help-seeking among Chinese adults: a systematic review. *Frontiers in psychiatry*, 11, 442.

Smith, J. A., & Fieldsend, M. (2021). Interpretative phenomenological analysis. *American Psychological Association*.

Smith, J. A., Flowers, P., & Larkin, M. (2009). Interpretative Phenomenological Analysis: Theory, Method and Research. In *Interpretative Phenomenological Analysis: Theory, Method and Research SAGE Publications*.

Smith, J. D., Mittal, D., Chekuri, L., Han, X., & Sullivan, G. (2017). A comparison of provider attitudes toward serious mental illness across different health care disciplines. *Stigma and Health*, 2(4), 327–337. https://doi.org/10.1037/sah0000064

Soto, J. A., Perez, C. R., Kim, Y.-H., Lee, E. A., & Minnick, M. R. (2011). Is expressive suppression always associated with poorer psychological functioning? A cross-cultural comparison between European Americans and Hong Kong Chinese. *Emotion*, 11(6), 1450–1455. https://doi.org/10.1037/a0023340

Stainton Rogers, W., & Willig, C. (2017). The SAGE handbook of qualitative research in psychology. *The SAGE Handbook of Qualitative Research in Psychology*, 1-664.

Statistics Canada. 2023. (table). Census Profile. 2021 Census of Population. Statistics Canada Catalogue no. 98-316- X2021001. Ottawa. Released November 15, 2023. https://www12.statcan.gc.ca/census-recensement/2021/dp-pd/prof/index.cfm?Lang=E.

Stuber, J. P., Rocha, A., Christian, A., & Link, B. G. (2014). Conceptions of mental illness: attitudes of mental health professionals and the general public. *Psychiatric services* (Washington, D.C.), 65(4), 490–497. https://doi.org/10.1176/appi.ps.201300136

Su, J. C., Park, I. J. K., Chang, J., Kim, S. Y., Dezutter, J., Seol, K. O., Lee, R. M., Soto, J. A., Zamboanga, B. L., Ham, L. S., Hurley, E. A., & Brown, E. (2015). Differential Links Between Expressive Suppression and Well-Being Among Chinese and Mexican

American College Students. *Asian American journal of psychology*, 6(1), 15–24. https://doi.org/10.1037/a0036116

Sun, K. S., Lam, T. P., Wu, D., Chan, T. H., Browne, G., & Chan, S. W. C. (2024). A Chinese help-seeking model for psychological distress in primary care: An adaptation of Andersen's Behavioral Model of Health Services Use. *Transcultural Psychiatry*, 61(2), 182-193. https://doi.org/10.1177/13634615231225130

Sutton, J., & Austin, Z. (2015). Qualitative research: Data collection, analysis, and management. *The Canadian journal of hospital pharmacy*, 68(3), 226.

Suveg, C., Raley, J. N., Morelen, D., Wang, W., Han, R. Z., & Campion, S. (2014). Child and family emotional functioning: A cross-national examination of families from China and the United States. *Journal of Child and Family Studies*, 23, 1444-1454.

Thomas, D. R. (2006). A general inductive approach for analyzing qualitative evaluation data. *American journal of evaluation*, 27(2), 237-246.

Tibbo, P., Malla, A., Manchanda, R., Williams, R., & Joober, R. (2014). Relapse risk assessment in early phase psychosis: the search for a reliable and valid tool. *Canadian journal of psychiatry. Revue canadienne de psychiatrie*, 59(12), 655–658. https://doi.org/10.1177/070674371405901207

Multicultural Mental Health Resource Centre (MMHRC). Training programs. (2019). https://multiculturalmentalhealth.ca/training/training-programs/

Tsai, W., & Lu, Q. (2018). Culture, emotion suppression and disclosure, and health. *Social and Personality Psychology Compass*, 12(3), e12373.

Tsang, H. W., Angell, B., Corrigan, P. W., Lee, Y. T., Shi, K., Lam, C. S., Jin, S., & Fung, K. M. (2007). A cross- cultural study of employers' concerns about hiring people with psychotic disorder: implications for recovery. *Social psychiatry and psychiatric epidemiology*, 42(9), 723–733. https://doi.org/10.1007/s00127-007-0208-x

Tse, J. S. Y., & Haslam, N. (2021). Inclusiveness of the Concept of Mental Disorder and Differences in Help- Seeking Between Asian and White Americans. *Frontiers in psychology*, 12, 699750. https://doi.org/10.3389/fpsyg.2021.699750

Volkow, N. D., Gordon, J. A., & Koob, G. F. (2021). Choosing appropriate language to reduce the stigma around mental illness and substance use disorders. *Neuropsychopharmacology*, 46(13), 2230-2232.

Wagstaff, C., & Williams, B. (2014). Specific design features of an interpretative phenomenological analysis study. *Nurse researcher*, 21(3).

Wallace, B. H., Chard, S., & Roth, E. G. (2022). The Graying of the Cool Pose: Examining Active Care Strategies Among Older African-American Men With Type 2 Diabetes Mellitus. *The Journals of Gerontology*: Series B, 77(11), 2016-2025.

Wang, C., Barlis, J., Do, K. A., Chen, J., & Alami, S. (2020). Barriers to mental health help seeking at school for Asian – and Latinx – American adolescents. *School Mental Health*, 12, 182-194.

Wang, L., Chen, Y., Hu, C., & Qin, H. (2021). Influence of family dynamics on stigma experienced by patients with schizophrenia: mediating effect of quality of life. *Frontiers in Psychiatry*, 12, 645075.

Wang, W., & Liu, Y. (2016). Discussing mental illness in Chinese social media: the impact of influential sources on stigmatization and support among their followers. *Health communication*, 31(3), 355-363.

Wei, M., Su, J. C., Carrera, S., Lin, S.-P., & Yi, F. (2013). Suppression and interpersonal harmony: A cross-cultural comparison between Chinese and European Americans. *Journal of Counseling Psychology*, 60(4), 625–633. https://doi.org/10.1037/a0033413

Wong, A. (2019). Maladaptive perfectionism, disguised distress, and help seeking in the culture of “Saving Face”: links to anxiety and depressive symptoms among Asian Youth.

Wong, E. C., Collins, R. L., Breslau, J., Burnam, M. A., Cefalu, M., & Roth, E. A. (2018). Differential association of stigma with perceived need and mental health service use. *The Journal of nervous and mental disease*, 206(6), 461-468.

Wong, Y. L. I., Kong, D., Tu, L., & Frasso, R. (2018). “My bitterness is deeper than the ocean”: understanding internalized stigma from the perspectives of persons with schizophrenia and their family caregivers. *International Journal of Mental Health Systems*, 12(1), 1-15.

Wood, L., Burke, E., Byrne, R., Enache, G., & Morrison, A. P. (2016). Semi-structured Interview Measure of Stigma (SIMS) in psychosis: Assessment of psychometric properties. *Schizophrenia research*, 176(2-3), 398-403.

Wood, L., Byrne, R., Enache, G., Lewis, S., Fernández Díaz, M., & Morrison, A. P. (2022). Understanding the stigma of psychosis in ethnic minority groups: A qualitative exploration. *Stigma and Health*, 7(1), 54.

Wu, Y., Chiu, M. Y. L., Wu, W., Han, S., & Wang, J. (2023). What makes Chinese adolescents “trapped” in severe mental illness? An interactionist perspective on self and identity. Int*ernational Journal of Qualitative Studies on Health and Well-being*, 18(1), 2250093.

Xie, H., Cheng, C., Tao, Y., Zhang, J., Robert, D., Jia, J., & Su, Y. (2016). Quality of life in Chinese family caregivers for elderly people with chronic diseases. *Health and quality of life outcomes*, 14, 1-9.

Yamaguchi, S., Lencucha, R., & Brown, T. G. (2023). Multiple Locations of Alcohol Use in the Narratives of the Peruvian Andean Highland and Population with Problem Drinking. *Health Communication*, 38(6), 1127-1135.

Yang, F., Yang, B. X., Stone, T. E., Wang, X. Q., Zhou, Y., Zhang, J., & Jiao, S. F. (2020). Stigma towards depression in a community-based sample in China. *Comprehensive psychiatry*, 97, 152152. https://doi.org/10.1016/j.comppsych.2019.152152

Yang, L. H., & Kleinman, A. (2008). ‘Face’and the embodiment of stigma in China: The cases of schizophrenia and AIDS. Social science & medicine, 67(3), 398-408.

Yang, L. H., & Link, B. G. (2016). Measurement of attitudes, beliefs and behaviors of mental health and mental illness. In *National Academy of Science*.

Yang, L. H., & Wonpat-Borja, A. J. (2012). Causal beliefs and effects upon mental illness identification among Chinese immigrant relatives of individuals with psychosis.

Community Mental Health Journal, 48(4), 471–476. https://doi.org/10.1007/s10597-011-9464-z

Yang, L. H., Kleinman, A., Link, B. G., Phelan, J. C., Lee, S., & Good, B. (2007). Culture and stigma: adding moral experience to stigma theory. *Social science & medicine* (1982), 64(7), 1524–1535. https://doi.org/10.1016/j.socscimed.2006.11.013

Yang, L. H., Link, B. G., Ben-David, S., Gill, K. E., Girgis, R. R., Brucato, G., Wonpat-Borja, A. J., & Corcoran, C. M. (2015). Stigma related to labels and symptoms in individuals at clinical high-risk for psychosis. *Schizophrenia research*, 168(1-2), 9–15. https://doi.org/10.1016/j.schres.2015.08.004

Yang, L., Lo, G., Tu, M., Wu, O., Anglin, D., Saw, A., & Chen, F. P. (2015). Effects of Increased Psychiatric Treatment Contact and Acculturation on the Causal Beliefs of Chinese Immigrant Relatives of Individuals with Psychosis. *Journal of immigrant & refugee studies*, 13(1), 19–39. https://doi.org/10.1080/15562948.2013.856509

Yang, Y., Song, Q., Doan, S. N., & Wang, Q. (2020). Maternal reactions to children's negative emotions: Relations to children's socio-emotional development among European American and Chinese immigrant children. *Transcultural Psychiatry*, 57(3), 408-420.

Yardley, L. (2017). Demonstrating the validity of qualitative research. *The journal of positive psychology*, 12(3), 295-296.

Yik, M., & Chen, C. Z. (2023). Unraveling Chinese talk about emotion. *Frontiers in Psychology*, 14.

Yin, H., Wardenaar, K. J., Xu, G., Tian, H., & Schoevers, R. A. (2020). Mental health stigma and mental health knowledge in Chinese population: a cross-sectional study. *BMC psychiatry*, 20(1), 1-10.

Yin, M., Li, Z., & Zhou, C. (2020). Experience of stigma among family members of people with severe mental illness: A qualitative systematic review. *International Journal of Mental Health Nursing*, 29(2), 141-160.

Yu, Y., Liu, Z. W., Hu, M., Liu, H. M., Yang, J. P., Zhou, L., & Xiao, S. Y. (2015). Mental health help-seeking intentions and preferences of rural Chinese adults. *PloS one*, 10(11), e0141889.

Yuan, J., Liu, Y., Ding, N., & Yang, J. (2014). The regulation of induced depression during a frustrating situation: Benefits of expressive suppression in Chinese individuals. *PloS one*, 9(5), e97420.

Yun, P., Xiaohong, H., Zhongping, Y., & Zhujun, Z. (2021). Family function, loneliness, emotion regulation, and hope in secondary vocational school students: A moderated mediation model. *Frontiers in Public Health*, 9, 722276.

Zhang, M., Lin, T., Wang, D., & Jiao, W. (2020). Filial piety dilemma solutions in Chinese adult children: The role of contextual theme, filial piety beliefs, and generation. *Asian Journal of Social Psychology*, 23(2), 227-237.

Zhang, Z., Sun, K., Jatchavala, C., Koh, J., Chia, Y., Bose, J., Li, Z., Tan, W., Wang, S., Chu, W., Wang, J., Tran, B., & Ho, R. (2019). Overview of Stigma against Psychiatric Illnesses and Advancements of Anti-Stigma Activities in Six Asian Societies. *International journal of environmental research and public health*, 17(1), 280. https://doi.org/10.3390/ijerph17010280

Zhou, T., Shang, Z., & Wang, D. (2016). Emotion suppression in multiple social contexts and its effects on psychosocial functioning: An investigation with Chinese samples. *Asian Journal of Social Psychology*, 19(4), 311- 324.

Abbreviations

CCHS	Canadian Community Health Survey
FEPP-JGH	First Episode Psychosis Program at the Jewish General Hospital
IPA	Interpretative Phenomenological Analysis
MINI	McGill Illness Narrative Interview
PEPP-Douglas	Prevention and Early Intervention Program for Psychosis at the Douglas Mental Health University Institute
PEPP-MUHC	Prevention and Early Intervention for Psychosis at the McGill University Health Centre
SIMS	Semi-structured Interview Measure of Stigma
WEIRD	Western, Educated, Industrialized, Rich and Democratic

Tables

Code	Gender	Age*	Immigrant (1st/2nd gen.)	Religious affiliation	Intake date	Interview language(s)
P01	M	29	SG—Born and raised in Montreal	N/A	06-07-2015	English
P02	F	20	FG	Buddhist	12-10-2021	English
P03	F	25	SG—Born and raised in Montreal	Buddhist	23-09-2019	English & Mandarin
P04	F	30	FG	N/A	17-12-2021	English & Mandarin
P05	M	31	FG	N/A	23-05-2023	English
P06	F	19	FG	Buddhist	19-07-2022	English & Mandarin
*Age of the participant at the time of the interview						

Table 1A. Demographic information of patient participants.

Code	Gender	Immigrant (1st/2nd gen.)	Religious affiliation	Child's intake date	Interview language(s)
FM01	M	SG—Born and raised in Vancouver	N/A	23-01-2023	English
FM02	F	FG	Buddhist	23-05-2023	English & Mandarin
FM03	M	FG	Buddhist	23-05-2023	English & Mandarin
FM04	M	FG	N/A	31-10-2023	Mandarin

Table 1B. Demographic information of family member (parent) participants.

Theme		**Patient**						**Family member**			
Superordinate	**Subordinate**	1	2	3	4	5	6	1	2	3	4
1. Mental health beliefs	1.1. Common views	x	x	x	x	x	x	x	x	x	x
	1.2. Attitudes to care	x	x	x	x		x		x	x	x
2. Cultural values	2.1. Filial piety (孝)	x	x	x	x		x		x	x	x
	2.2. Face (面子)	x	x	x	x	x	x	x	x	x	x
3. Communication	3.1. Diagnostic labels	x	x	x	x	x	x		x	x	
	3.2. Emotional expression	x	x	x	x	x		x	x	x	x

Table 2. Frequency of superordinate and subordinate themes found in the interviews.

Superordinate theme	Subordinate theme	Subcategory
1. Mental health beliefs	1.1. Common views	1.1.1. Misrepresentations of psychosis/mental illness in media and personal experience 1.1.2. Misunderstandings about psychosis/mental illness from limited awareness or education
	1.2. Attitudes to care	1.2.1. Delayed help-seeking (冰冻三尺，非一日之寒) 1.2.2. Treatment decision-making
2. Cultural values	2.1. Filial piety	2.1.1. Following parents' expectations and rules (君君臣臣父父子子) 2.1.2. Prioritizing education and personal achievement 2.1.3. Prioritizing elders' needs and well-being
	2.2. Face	2.2.1. Face and self-identity 2.2.2. Face within the family 2.2.3. Face within the community
3. Communication	3.1. Diagnostic labels	3.1.1. Derogatory meaning 3.1.2. Inaccurate meaning 3.1.3. Implied severity
	3.2. Emotional expression	3.2.1. Language barrier 3.2.2. Emotional restraint (put it in a box and shove it aside) 3.2.3. Strategies for navigating emotions

Table 3. Superordinate and subordinate themes, along with their subcategories.

Figures

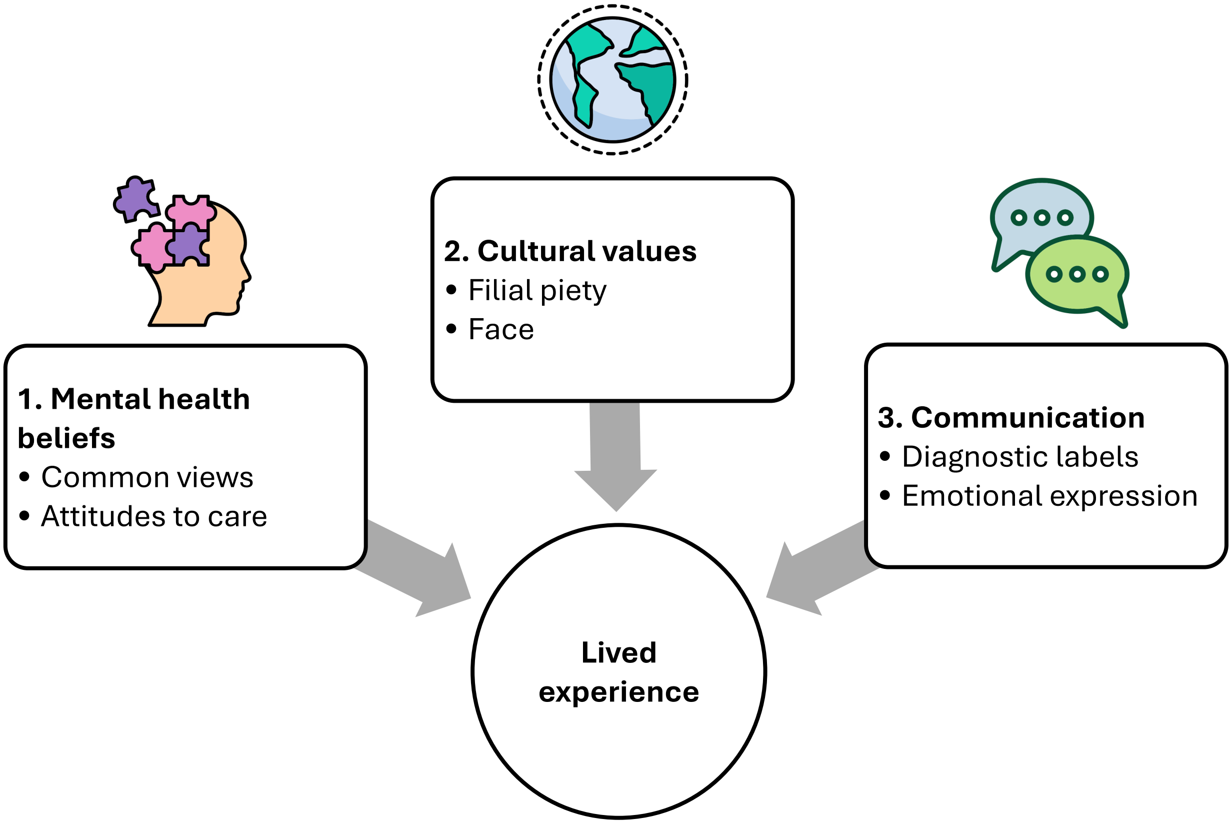


Figure 1. Superordinate and subordinate themes.

Appendix

McGill Illness Narrative Interview (MINI)

Generic Version for Disease, Illness or Symptom

Danielle Groleau, Allan Young, & Laurence J. Kirmayer ©2006

Section 1. INITIAL ILLNESS NARRATIVE

1. When did you experience your health problem or difficulties (HP) for the first time? [*Substitute respondent's terms for 'HP' in this and subsequent questions.*] [*Let the narrative go on as long as possible, with only simple prompting by asking*, 'What happened then? And then?']
2. We would like to know more about your experience. Could you tell us when you realized you had this (HP)?
3. Can you tell us what happened when you had your (HP)?
4. Did something else happen? [*Repeat as needed to draw out contiguous experiences and events.*]
5. If you went to see a helper or healer of any kind, tell us about your visit and what happened afterwards.
6. If you went to see a doctor, tell us about your visit to the doctor/hospitalization and about what happened afterwards.
6.1 Did you have any tests or treatments for your (HP)? [*The relevance of this question depends on the type of health problem.*]

Section 2. PROTOTYPE NARRATIVE

7. In the past, have you ever had a health problem that you consider similar to your current (HP)? [If answer to #7 is Yes, then ask Q.8]
8. In what way is that past health problem similar to or different from your current (HP)?
9. Did a person in your family ever experience a health problem similar to yours? [If answer to #9 is Yes, then ask Q.10]
10. In what ways do you consider your (HP) to be similar to or different from this other person's health problem?
11. Did a person in your social environment (friends or work) experience a health problem similar to yours? [If answer to #11 is Yes, then ask Q.12]
12. In what ways do you consider your (HP) to be similar to or different from this other person's health problem?
13. Have you ever seen, read or heard on television, radio, in a magazine, a book or on the Internet of a person who had the same health problem as you? [If answer to #13 is Yes, then ask Q.14]
14. In what ways is that person's problem similar to or different from yours?

Section 3. EXPLANATORY MODEL NARRATIVE

15. Do you have another term or expression that describes your (HP)?
16. According to you, what caused your (HP)? [List primary cause(s).]
16.1 Are there any other causes that you think played a role? [List secondary causes.]

17. Why did your (HP) start when it did?
18. What happened inside your body that could explain your (HP)?
19. Is there something happening in your family, at work or in your social life that could explain your health problem? [If answer to #19 is Yes, then ask Q.20]
20. Can you tell me how that explains your health problem?
21. Have you considered that you might have *[INTRODUCE POPULAR SYMPTOM OR ILLNESS LABEL]*?
22. What does *[POPULAR LABEL]* mean to you?
23. What usually happens to people who have *[POPULAR LABEL]?*
24. What is the best treatment for people who have *[POPULAR LABEL]?*
25. How do other people react to someone who has *[POPULAR LABEL]?*
26. Who do you know who has had *[POPULAR LABEL]*?
27. In what ways is your (HP) similar to or different from that person's health problem?
28. Is your (HP) somehow linked or related to specific events that occurred in your life?
29. Can you tell me more about those events and how they are linked to your (HP)?

Section 4. SERVICES AND RESPONSE TO TREATMENT

30. During your visit to the doctor (healer) for your HP, what did your doctor (healer) tell you that your problem was?
31. Did your doctor (healer) give you any treatment, medicine or recommendations to follow? [List all]
32. How are you dealing with each of these recommendations? [*Repeat Q. 33 to Q. 36 as needed for every recommendation, medicine and treatment listed.*]
33. Are you able to follow that treatment (or recommendation or medicine)?
34. What made that treatment work well?
35. What made that treatment difficult to follow or work poorly?
36. What treatments did you expect to receive for your (HP) that you did not receive?
37. What other therapy, treatment, help or care have you sought out?
38. What other therapy, treatment, help or care would you like to receive?

Section 5. IMPACT ON LIFE

39. How has your (HP) changed the way you live?
40. How has your (HP) changed the way you feel or think about yourself?
41. How has your (HP) changed the way you look at life in general?
42. How has your (HP) changed the way that others look at you?
43. What has helped you through this period in your life?
44. How have your family or friends helped you through this difficult period of your life?
45. How has your spiritual life, faith or religious practice helped you go through this difficult period of your life?
46. Is there anything else you would like to add?

蒙特利尔疾病叙事访谈 **(MINI)**

针对疾病、病痛或症状设计的一般版本

Danielle Groleau, Allan Young, & Laurence J. Kirmayer ©2006

第一部分：初始的疾病叙事

1. 你在何时首次经历了你的健康问题或困境 [健康问题(HP)] ？ [在这道问句和以下的问题里都以受访者自己的词汇来代称[健康问题(HP/Health Problem)]。] [问法尽量简单，让叙事能够发展得愈长愈好。 例如：「发生了什么事？ 然后呢？ 」]
2. 我们想要知道更多关于你的经验。 可以告诉我们你何时意识到自己有这个[健康问题(HP)]吗？
3. 可以告诉我们你当时经历了这个 [健康问题(HP)] 时，发生了什么事吗？
4. 有没有什么其他事情发生呢？ [必要的话，重复这个问题以厘清是否有其他连带的经验或事件。]
5. 你如果有寻求帮助，或是找过任何的治疗者，请告诉我们你第一次的求助经验，还有之后发生了什么事。
6. 如果你去看了医生，告诉我们你第一次求医 (看门诊/住院) 的经验，还有之后发生了什么事。

6.1 针对你的 [健康问题(HP)] ，你曾经接受过任何检查或治疗吗？ [问这道问题的适切性取决于健康问题的种类。]

第二部分：叙事原型

7. 在过去，你觉得有经历过其他和现在这个 [健康问题(HP)] 类似的健康毛病吗？ [如果回答#7 的答案是有，那么接着问第 8 道问题。]
8. 过去那次的健康问题和现在的 [健康问题(HP)] 有什么样类似或是不同呢？
9. 你有任何家人也经历过和你类似的 [健康问题(HP)] 吗？ [如果回答#9 的答案是有，那么接着问第 10 道问题。]
10. 你认为你的 [健康问题(HP)] 和这位家人的健康问题在哪方面相似或不同呢？
11. 在你的社会环境里面 (朋友或工作圈) ，有任何人也经历过和你类似的 [健康问题(HP)] 吗？ [如果回答#11 的答案是有，那么接着问第 12 道问题。]
12. 你认为你的 [健康问题(HP)] 和这位朋友或同事的健康问题在哪方面相似或不同呢？
13. 你在电视、广播、杂志、书上或是网络上看过有人跟你经历过一样的健康问题吗？ [如果回答#13 的答案是有，那么接着问第 14 道问题。]

14. 你认为你的 [健康问题(HP)] 和媒体上这个人的健康问题在哪方面相似或不同呢？

第三部分：解释模型叙事

15. 你会用其他词汇或表达方式来形容你的 [健康问题(HP)] 吗？
16. 根据你自己，是什么造成了你的你的 [健康问题(HP)] 呢？ [列出主要的原因。]

16.1 有其他你认为的任何原因扮演了角色吗？ [列出次要的原因。]

17. 为什么你的 [健康问题(HP)] 会在那个时候出现？
18. 你的身体里面发生了什么变化，可以用来解释你的 [健康问题(HP)] ？
19. 在你家人之中、工作场合或是社交生活圈之中，有发生过什么事可以解释你的 [健康问题(HP)] ？ [如果回答#19 的答案是有 那么接着问第 20 道问题。]
20. 可以告诉我，那件 (些) 事如何解释你的健康问题呢？
21. 你想过你可能有 [介绍通俗的症状或病痛卷标] 吗？
22. [通俗卷标] 对你而言意味着什么？
23. 有 [通俗卷标] 的人通常发生了什么事？
24. 什么是给这些有 [通俗卷标] 的人最好的治疗？
25. 人们怎么看待有 [通俗卷标] 的人？
26. 你怎么知道谁有 [通俗卷标] ？
27. 你的 [健康问题(HP)] 和那个人的健康问题有什么类似或不同？
28. 你的 [健康问题(HP)] 和发生在你生命里任何特定的事件有什么联结或相关性吗？
29. 你可以告诉我更多关于那些事件的事情吗？ 此外，它们是怎么链接你的[健康问题(HP)]的？

第四部分：医疗服务以及对治疗的反应

30. 在你为了健康问题而求医 (包含寻求其他种类治疗者协助) 的同时，医生 (和治疗者) 说你的问题是怎么回事？
31. 你的医生 (治疗者) 有没有给你任何处置、药方或是其他让你配合的建议？ [列出全部]
32. 你如何看待和处置这些建议？ [必要的话请重复 Q.33 到 Q.36，纪录任何列下的建议、药方和处置。]
33. 你能够配合那个处置 (或建议或药方) 吗？
34. 是什么让那个处置产生了良好的效果？
35. 是什么使你难以配合那个处置，或是使该处置效果不彰？
36. 针对你的 [健康问题(HP)] ，有什么处置是你希望获得但却得不到的？

37. 你曾经群求哪些其他治疗、处置、帮助或是照护吗？
38. 你想要获得哪些其他治疗、处置、帮助或是照护吗？

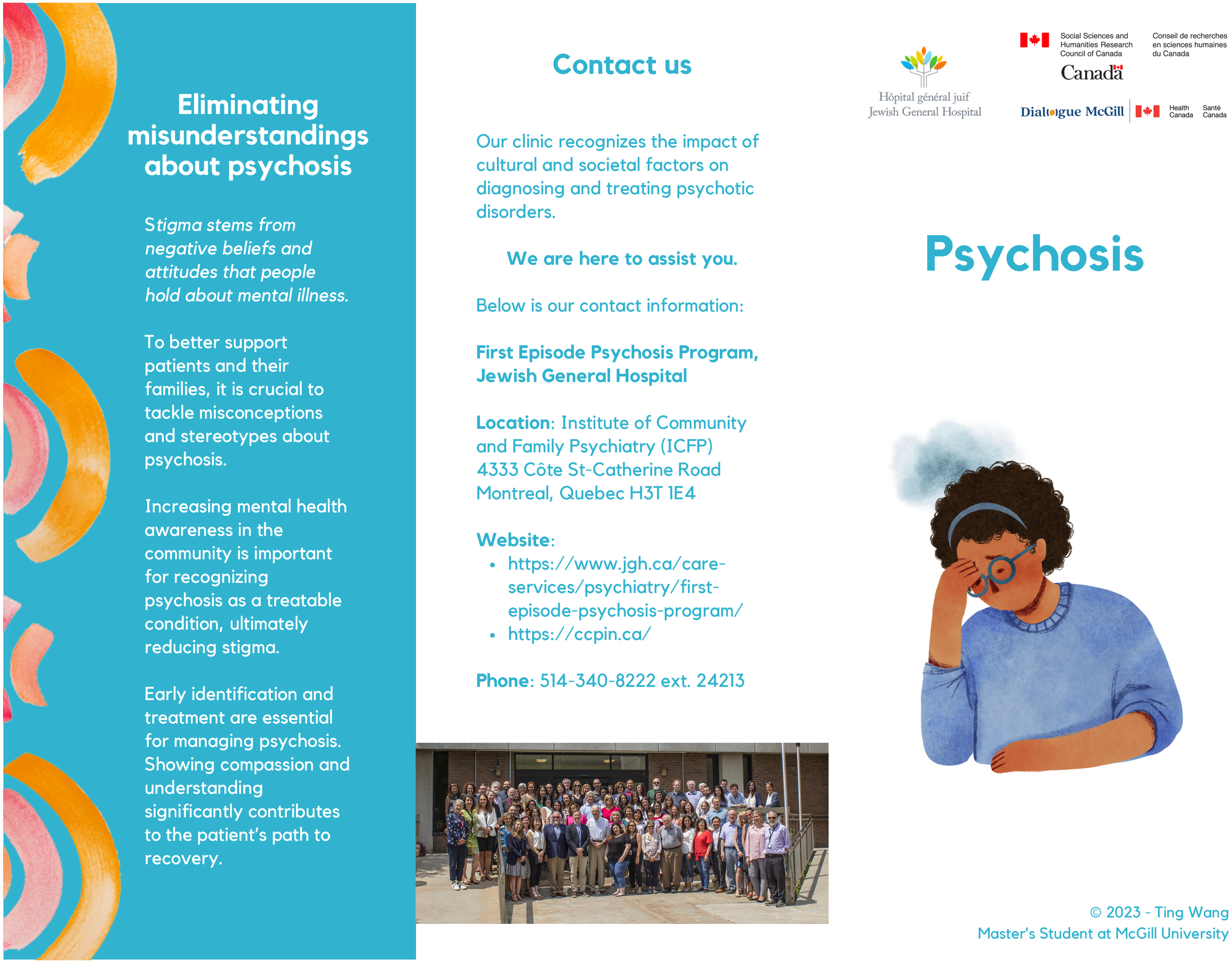
第五部分：对生活的影响

39. 你的 [健康问题(HP)] 对你的生活方式产生了什么改变？
40. 你的 [健康问题(HP)] 怎么改变你感觉或看待自己的方式？
41. 你的 [健康问题(HP)] 怎么改变你大致上对生活的观感？
42. 你的 [健康问题(HP)] 怎么改变别人看待你的方式？
43. 在你生命的这段期间，哪些东西给了你帮助？
44. 你的家人或朋友如何帮助你度过生命这段困难的期间？
45. 你的性灵生活、信仰或是宗教如何帮助你度过生命这段困难的期间？
46. 你想要再多说什么吗？

Translated by Harry Yi-Jui Wu

Appendix 1: SERVICE-USER INTERVIEW MEASURE of STIGMA (SIMS) – Simplified Interview Schedule

1. **Understanding of stigma:** I was wondering if you would be able to tell me about your understanding of stigma? What does it mean to you?
2. **Perceived stigma:** How do you think a person with ___________/ experiences of psychosis is viewed by society? Are they viewed differently from someone who does not have ___________/ experiences of psychosis? In what way?
3. **Experienced Stigma from Psychosis:** Have you had any direct experiences of stigma because of ____________/ you have experiences of psychosis?
4. **Self-esteem:** How do the public's views about people who ___________-/ experience psychosis make you feel about yourself? How do your experiences of stigma/discrimination make you feel about yourself? Has it changed the way you think or feel about yourself?
5. **Emotional responses:** How does stigma make you feel? Have you experienced any difficult emotions over the past month as a result of stigma?
6. **Safety behaviours/Avoidance:** Do you think stigma has impacted upon your daily life? How so? Does it stop you from doing things?
7. **Impacts on relationships:** Do you think that your experiences of stigma have affected your relationships with others?
8. **Impacts on experiences of <psychosis> (positive symptoms):** Have your experiences of stigma impacted on your ____________/ experiences of psychosis? Has it made your <experiences of psychosis> worse?
9. **Impacts on Treatment and accessing services:** Has stigma affected you accessing mental health services? Has it affected your relationships with mental health professionals /services? Has it impacted upon your treatment?
10. **Positive impacts of stigma:** Has stigma had any positive impacts on your day to day life?
11. **Recovery:** What are your hopes for the future/recovery? What are your recovery goals? Do you think experiences of stigma have impacted on your recovery? In what way / what aspects?



Eliminating misunderstandings about psychosis

Stigma stems from negative beliefs and attitudes that people hold about mental illness.

To better support patients and their families, it is crucial to tackle misconceptions and stereotypes about psychosis.

Increasing mental health awareness in the community is important for recognizing psychosis as a treatable condition, ultimately reducing stigma.

Early identification and treatment are essential for managing psychosis. Showing compassion and understanding significantly contributes to the patient's path to recovery.

Contact us

Our clinic recognizes the impact of cultural and societal factors on diagnosing and treating psychotic disorders.

We are here to assist you.

Below is our contact information:

First Episode Psychosis Program, Jewish General Hospital

Location: Institute of Community and Family Psychiatry (ICFP)
4333 Côte St-Catherine Road
Montreal, Quebec H3T 1E4

Website:
- https://www.jgh.ca/care-services/psychiatry/first-episode-psychosis-program/
- https://ccpin.ca/

Phone: 514-340-8222 ext. 24213

Hôpital général juif
Jewish General Hospital

Social Sciences and Humanities Research Council of Canada
Conseil de recherches en sciences humaines du Canada
Canada

Dialogue McGill

Health Canada
Santé Canada

Psychosis

Master's Student at McGill University

Brochure (English) – page 1

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What is psychosis?

Psychosis is a condition where people struggle to differentiate between what is real and what is not. It commonly appears in late adolescence and early adulthood.

Roughly 4 out of every 100 Canadians will experience at least one episode of psychosis in their lifetime. It can affect people of different genders, ethnic backgrounds and socioeconomic statuses.

At times, it may act as a symptom of a more severe mental illness. Psychosis can be effectively managed through appropriate interventions, including medication and psychological counseling.

Causes of psychosis

Although we do not know the exact causes of psychosis, some common factors include:

- Genetic factors
- Substance abuse
- Severe stress or trauma
- Other mental and physical illnesses

Symptoms of psychosis

The symptoms of psychosis vary and can be classified as either '*positive*' or '*negative*.'

People experiencing psychosis often display a variety of symptoms, and certain symptoms may be connected to the root cause of the psychosis.

These symptoms are treatable.

Positive symptoms: These symptoms add to a person's experiences.

Common positive symptoms include:

- Hallucinations: Seeing or hearing things, such as voices or nonexistent objects.
- Delusions: Holding incorrect beliefs, such as believing oneself to be poisoned or followed.
- Disorganized speech and thought: Difficulty in speaking, being hard to understand and having illogical thinking.
- Disorganized behaviour: Difficulty in finishing tasks and experiencing stiff or excessively rapid movements.

Negative symptoms: These symptoms weaken normal thinking, behaviour or actions.

Common negative symptoms include:

- Reduced facial expressions, difficulty in showing emotions.
- Reduced or absent speech.
- Lack of motivation to participate in work, study or family activities.
- Reduced social engagement through distancing oneself from family and friends.

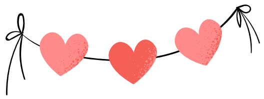
Asking for help

Speaking with a doctor is the most direct way to recognize and address any concerns.

Psychosis is treatable, especially when detected early and treated promptly. Many people can recover after one episode, though the outcome may depend on the diagnosis and underlying causes.

Treatment for psychosis includes:

- Medication
- Psychological counseling
- Social services support
- Support and education for family members



Supporting a loved one with psychosis

In the early stages of psychosis, it is important to offer support to a loved one experiencing these changes. Give them space when needed, be open to listening to their concerns and encourage them to attend appointments with their treatment team.

Please offer your support gently.

消除思觉失调的误解 Eliminating misunderstandings about psychosis

污名源于人们对精神疾病持有的负面信仰和态度。

为更好地支持患者及其家人，重要的是解决有关精神病的误解和刻板印象。

在社区中增加心理健康意识对于将精神病视为可治疗的病症，最终减少污名感，至关重要。

早期识别和治疗对于管理精神病至关重要。表现同情和理解力对患者康复的道路有显著的促进作用。

联系方式 Contact us

我们的诊所在思觉失调的文化表现以及文化和社会因素如何影响思觉失调障碍的诊断和治疗方面具有特殊的专业知识。

我们在这里为您提供帮助。

以下是我们的联系信息：

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Health Canada Santé Canada

思觉失调 Psychosis

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麦吉尔大学硕士研究生

Brochure (Simplified Chinese) – page 1

什么是思觉失调?
What is psychosis?

精神病是一种使人难以区分现实和虚构的状况，通常出现在后期青春期和早期成年期。

大约每100名加拿大人中就有4人在一生中至少经历一次精神病发作。它可能影响不同性别、种族背景和社会经济地位的人。

有时，它可能成为更严重精神疾病的症状。通过适当的干预措施，包括药物治疗和心理咨询，精神病是可以得到有效管理的。

思觉失调的原因
Causes of psychosis

虽然我们不知道精神病的确切原因，但一些常见因素包括：
- 遗传因素
- 物质滥用
- 严重的压力或创伤
- 其他心理和身体疾病

思觉失调的常见症状
Symptoms of psychosis

精神病的症状各异，可分为"阳性"和"阴性"两类。

患精神病的人通常表现出各种症状，某些症状可能与精神病的根本原因有关。

这些症状是可治疗的。

阳性症状：这些症状增加了个体的经验。

常见的阳性症状包括：
- 幻觉：看到或听到不存在的事物，如声音或虚构的物体。
- 妄想：持有不正确的信仰，例如相信自己被毒害或被跟踪。
- 思维和言语紊乱：言语困难，难以理解，思维不合逻辑。
- 行为紊乱：难以完成任务，经历僵硬或过度迅速的动作。

阴性症状：这些症状削弱了正常的思维、行为或行动。

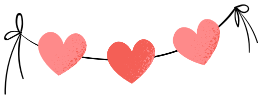
常见的阴性症状包括：
- 面部表情减少，表达情感困难。
- 言语减少或缺失。
- 缺乏参与工作、学习或家庭活动的动机。
- 通过疏远自己不参与家庭和朋友之间的社交来减少社交互动。

如何寻求帮助
Asking for help

与医生交谈是认识和解决任何疑虑的最直接方式。

精神病是可治疗的，尤其是在早期检测并及时治疗的情况下。许多人在经历一次发作后可以康复，尽管结果可能取决于诊断和潜在原因。

精神病的治疗包括：
- 药物治疗
- 心理咨询
- 社会服务支持
- 为家庭成员提供支持和教育



如何支持患有思觉失调的亲人
Supporting a loved one with psychosis

在精神病的早期阶段，为经历这些变化的亲人提供支持是很重要的。在需要时给予他们空间，愿意倾听他们的担忧，并鼓励他们去看医生，获得专业医疗团队的帮助。

请温柔地提供你的支持。

Brochure (Simplified Chinese) – page 2