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Research Article

"Motivator or Barrier? The Dual Role of Face Culture in Depression Recovery Among Chinese University Students"

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Abstract

Face culture has been predominantly framed as a barrier to mental health help-seeking among Chinese university students, yet its potential motivating functions in depression recovery remain theoretically underexplored. This study examined the dual role of mianzi across both facilitative and inhibitory dimensions of the recovery process, addressing three research questions concerning how face culture functions as a motivator, how it functions as a barrier, and what contextual factors determine its directional impact. Employing a qualitative research design grounded in a constructivist epistemology, this study conducted reflexive thematic analysis on semi-structured interview data from eighteen Chinese university students — nine female and nine male, aged 19 to 23 years — who had achieved stable functional recovery from clinically diagnosed major depressive disorder in Shandong Province, China. Analysis identified three positive pathways through which mianzi supported recovery: family honour as motivation for treatment, collective mobilisation of family support resources, and face restoration driving post-recovery identity reconstruction. Three negative pathways were simultaneously identified, comprising shame-driven help-seeking delay, stigma reinforcement and social withdrawal, and gendered face pressures as compounded barriers. The functional direction of these six mechanisms was differentially shaped by four contextual variables — recovery stage, family mental health literacy, gender norm internalisation, and social network composition — from which a Contextual Dual-Role Model was inductively derived. These findings challenge the prevailing single-directional barrier paradigm and provide an empirically grounded framework for the design of culturally adaptive mental health support within Chinese university settings.

Keywords

Face culture, Depression recovery, Chinese university students, Contextual moderators, Qualitative research

1. Introduction

Depression has been highlighted as one of the most critical mental health issues currently faced by Chinese university students. Surveillance studies from the China National Mental Health Development Report confirm that 21.48% of this demographic possesses measurable risk of depressive symptoms [1]. This picture takes on special importance when set against the constantly low levels of professional assistance-seeking. Significant research has demonstrated that the majority of affected students fail to seek formal psychological assistance despite the availability of such resources on campus, with cultural factors identified as among the most robust and consistent predictors of this phenomenon [2]. Understanding the reasons behind the low levels of help-seeking among depressed students requires a focus on the role of cultural factors in mediating the experience of depression in Chinese society, a dimension repeatedly shown to extend beyond individual and biomedically-focused analysis.

Face culture and its associated core concept of mianzi are one such factor with strong empirical relevance. The cultural drivers of mianzi, which link personal reputation directly to family honour, dictate disclosure patterns through constructs of shame and group position, and imbue interpersonal relations with moral imperatives extending beyond personal interest, have consistently demonstrated their relevance in determining help-seeking patterns in Chinese samples [3]. The existing body of research, however, has primarily approached this relationship from a unidirectional perspective, describing face culture as a barrier to help-seeking through constructs of stigma, delayed disclosure, and restricted emotional expression in samples where mental illness is associated with personal and familial shame [4]. The current dominant model of face culture as a barrier to help-seeking is highly relevant and accurate in identifying key aspects of this complex phenomenon. Nonetheless, it is problematic in that it fails to acknowledge both the motivating potential of collectivist cultural orientation and the potential utility of harnessing collectivist orientations as intervention resources. The highly prevalent and intractable mental health needs of Chinese university students, further complicated by psychological impact of the COVID-19 pandemic [5], make this current dominant model highly problematic. This model risks failing to engage with the motivating potential of this phenomenon, as well as the broader range of cultural factors available for intervention in this population [6].

Against this background, this study aims to fill three different but related gaps in the extant literature. Firstly, a theoretically well-articulated dual-directional model that explains face culture's

concurrent facilitating and hindering effects on depression recovery is lacking. Such a gap has implications for theory development and culturally informed intervention strategies. A second gap relates to the lack of qualitative research on how mianzi operates as a motivator, especially in the later stages of recovery when identity reconstruction and re-engagement in social life play a critical role in sustained well-being. A third gap concerns the lack of attention to contextual factors that influence the directional pattern of face culture's effects—whether motivating or hindering—as they vary across different stages of recovery, types of families, gender, and types of social networks. Such consideration requires a methodology that can access the dynamic and culturally constructed nature of recovery experience in ways that cannot be achieved by quantitative surveys.

The present study aims to answer three specific research questions. First, it investigates how face culture acts as a motivator in the process of depression recovery among Chinese university students. Second, it investigates how face culture acts as a barrier in the process of depression recovery among Chinese university students. Third, it investigates what contextual factors moderate the role of face culture as a motivator or barrier at various stages of the depression recovery process among Chinese university students. Based on reflexive thematic analysis of semi-structured in-depth interviews with eighteen Chinese university students who had achieved stable functional recovery from clinically diagnosed major depressive disorder, this study identifies three positive and three negative pathways through which face culture acts as a motivator or barrier in depression recovery. It also identifies four contextual moderating variables that shape the influence of face culture in this process. In so doing, this study proposes a Contextual Dual-Role Model of face culture in depression recovery among Chinese university students. This model may advance theoretical understanding of depression recovery and guide the development of culturally sensitive depression support for this population.

The remainder of this study is structured as follows: Literature Review discusses the conceptual underpinnings of face culture and its established relationships with mental health behavioural outcomes, positions depression among Chinese university students within its cultural context, and outlines the theoretical rationale for the dual-role model. In the Methodology section, the qualitative method and associated participant recruitment and sampling strategy, data collection and analysis procedures, and ethical considerations are described. In the Findings section, the three motivating pathways, three barrier pathways, and four contextual moderating variables are discussed and illustrated with participant quotes. In the Discussion section, the findings are interpreted with reference to the literature, the contribution of the Contextual Dual-Role Model to theory is elaborated upon, and implications for practice, policy, and further research are discussed.

2. Literature Review

2.1. Face Culture: Conceptual Foundations

The conceptual underpinnings of face culture within Chinese society begin with a fundamental distinction proposed by Hu [7], where two interrelated but nonetheless analytically separable dimensions of face exist. Mianzi represents the social honor granted to an individual through worldly success, status, as well as the maintenance of social reputation. Lian, in contrast, represents the moral confidence that society places on the character of the individual; a loss of lian constitutes a significant social sanction, excluding the individual from society. The distinction was further elaborated by Ho [8] in his social situational theory of face, which demonstrates that face is not a personal attribute but a relational process constantly negotiated within specific social encounters. This perspective establishes that face is simultaneously a constraint and a resource, such that it drives individuals toward conformity and deception within face-threatening situations, yet simultaneously obligates society to act as a result of a family member's need. The qualitative and interpretive research paradigm is particularly well-suited to examining these issues, because fixed-response methodologies cannot capture the contextual, processual, and relational dimensions of face experience that emerge from participant narratives [9]. Reflexive thematic analysis, in particular, with its emphasis on the researcher's interpretive engagement with data, provides a framework well-suited to exploring the lived experience of culturally constructed concepts such as mianzi in particular recovery contexts [10]. This epistemological approach is a key consideration in the design of the current research. The relevance of face to mental health behaviour has been well-established across a variety of Chinese contexts. Indeed, evidence indicates that concerns about mianzi systematically influence the interpretation, expression, and response to psychological distress [11]. A further body of research has explored the relevance of face in particular contexts of mental health service interaction. Further evidence has suggested that face concerns of both the student and their families extend beyond social networks to mental health service interactions [12]. A further body of research on family relations provides evidence for the mobilizing effects of face. Research also shows that family members often interpret their responsibility for caregiving in terms of the maintenance of their own mianzi, a consideration reminiscent of the motivating effects of mianzi in the current research [13].

2.2. Face Culture in Mental Health: Beyond the Barrier Paradigm

The connection between face culture and mental health behavioural patterns has been investigated most comprehensively in relation to stigma and avoidance of help-seeking patterns. In the former case, the dominant model describes mianzi as an objectively existing barrier to help-seeking and treatment adherence. This model describes an important and impactful dynamic: the cultural construction of depression as a personal weakness or familial failure creates shame-based suppression of symptoms, delayed professional help-seeking, and avoidance of disclosure within social circles. These factors cumulatively prolong the interval between the actual and clinical onset of depression

symptoms. However, this model does not allow for an equally nuanced exploration of the circumstances in which the same cultural dynamic might produce the reverse effect. Research regarding family-based interventions for depression has found that reframing depression recovery as an expression of filial obligation – a means to restore and protect the family's overall mianzi – significantly enhances treatment adherence and sustains treatment engagement over extended periods. This effect is particularly pronounced when families participate in psychoeducational components of treatment [14]. This line of emerging research challenges the theoretical adequacy of the barrier model and points towards a more nuanced understanding of the complex interplay between face culture's normative demands and the stages, relationships, and social compositions through which depression recovery naturally progresses. This study directly engages with this tension between the established barrier model and the emerging motivating model as a conceptual starting point for an analytical framework that incorporates the dual role of face culture.

2.3. Depression Among Chinese University Students: Cultural Specificity

The mental health burden among Chinese university students presents features that are not easily captured by culturally neutral epidemiological frameworks. The psychological disruption caused by the COVID-19 pandemic has accelerated these existing trends. Longitudinal data indicate the prolonged elevation of depression and anxiety symptoms among Chinese university students, persisting well beyond the expected resolution of the pandemic's immediate impact. The effect is particularly marked among those whose academic and social schedules have been most impacted by the pandemic [15]. Cross-sectional data provide evidence of the extent of the burden among university students. These data highlight academic performance pressures, intergenerational expectation discrepancies, and social comparison processes as proximal risk factors that, combined with cultural vulnerabilities, create an environment conducive to distress and delayed help-seeking [16]. Another aspect of cultural specificity concerns gendered face-threat and the cultural tendency towards somatisation as a mode for expressing psychological distress. Male students face cultural pressures around self-sufficiency, which make any admission of emotional distress inherently face-threatening. Female students in high-prestige disciplinary environments, in contrast, confront stigma related to gender performance and perceived mental fragility [17]. Somatisation – the expression of psychological distress through bodily symptoms such as fatigue, sleep difficulties, and bodily pain – acts as a culturally appropriate means of preserving face by avoiding direct attribution to psychological weakness. These forms of expression delay self-recognition and professional recognition of episodes of depression, which supports the epidemiological evidence for the treatment delay problem. Quantitative and narrative methods have become increasingly accepted as crucial for

understanding the cultural dynamics of illness expression and the experience of depression. These methods illuminate cultural dimensions that fall outside conventional epidemiological models [18].

2.4. Theoretical Framework

Two theoretical frameworks serve as the conceptual basis for this analysis. Face Negotiation Theory, as developed by Ting-Toomey, is based on the proposition that members of collectivistic cultures consistently prioritize face concerns for themselves and for important relational partners in social encounters. This yields a set of typical characteristics that include harmony maintenance, indirectness, and avoidance of face-threatening disclosure. Culturally sensitive intervention programs based on this set of principles have shown significantly increased engagement and reduced attrition rates for Chinese-heritage clients, supporting the relevance of Face Negotiation Theory for mental health settings [19]. Findings from large-scale investigations of mental health service systems substantiate that culturally sensitive models, which prioritize face-related communication styles as opposed to viewing them as barriers, yield significantly more favorable outcomes in cultures where mianzi is a primary motivator of engagement with mental health services [20]. The social support buffering model of Cohen and Wills offers another relevant perspective. It suggests that the buffering effect of social support on the psychological impact of stressful events cannot be explained by the availability of support per se, but rather by its perceived acceptability and relational fitness. Studies of loneliness and connectedness in university samples support the importance of network quality, the extent to which relationships are perceived as understanding, non-judgmental, and supportive, over network quantity or density in buffering depression outcomes [21]. In the context of Chinese university samples, the buffering effect of family-based support is qualitatively different from support from peers or institutions. This reflects the importance of relational obligation in Confucian-based relational structures and the importance of mianzi from the family in the motivation to recover from depression [22]. These two models offer a rationale for predicting that face culture's effect on depression outcomes will be neither uniformly facilitative nor uniformly debilitating, but rather dynamic in accordance with the relational context in which mianzi obligation is experienced.

2.5. Research Gap and Study Contribution

While both Face Negotiation Theory and Social Support Buffering Model are theoretically well-founded, past scholarship has failed to adequately address their application to depression recovery, particularly regarding the stage-specific and relational contexts in which face culture operates. Research into guidance and counselling in relation to Chinese university students' help-seeking behaviours has identified a lack of theoretically grounded dual-role theories as a major limitation in both conceptualising and developing effective interventions. Such interventions must be sensitive to face culture's impact on depression recovery in terms of its motivating effects and barrier

effects. This limitation prevents practitioners from relying on empirically supported approaches that harness face culture's motivating potential while mitigating its barrier effects in recovery processes [23]. This study seeks to fill that gap through a qualitative exploration of mianzi's mechanisms and conditions in depression recovery, focusing on both its motivating and barrier effects. It proposes a Contextual Dual-Role Model in which face culture's functional direction is moderated by four systematically identified moderating variables: depression recovery stages, family mental health literacy levels, gender norm internalisation levels, and social network composition.

3. Methodology

3.1. Research Design

This study adopts a qualitative research design grounded in a constructivist epistemological orientation, which is particularly suited to exploring the subjective meanings individuals attach to lived experiences within culturally specific contexts. Rather than seeking to quantify the prevalence of face-related concerns, the research prioritises depth of understanding over breadth of coverage, focusing closely on how participants narrate the role of face culture across their depression recovery trajectories. Reflexive thematic analysis, as developed by Braun and Clarke, provides the analytical framework for this investigation. Its theoretical flexibility aligns closely with a constructivist stance, in which knowledge is understood as co-produced through the interpretive engagement between researcher and data. This approach treats themes not as pre-existing entities waiting to be discovered, but as actively constructed through sustained analytical engagement with participant accounts. This property makes it particularly well-suited to research questions that span descriptive and conceptual levels of analysis, as is the case in the present study.

3.2. Participants and Sampling

The sampling procedure employed purposive sampling. The sampling criteria were as follows: The respondents had a clinical diagnosis of major depressive disorder according to the DSM-5 criteria. The respondents had achieved stable functional recovery for at least six months before being interviewed. The respondents could fluently articulate their experiences in Mandarin Chinese. Respondents were excluded if they were currently experiencing a depressive episode, suffered from comorbid severe psychiatric disorders, or were unable to give informed consent. The total number of undergraduate students participating in the study as respondents was eighteen, and nine of them were females and nine were males, ranging from nineteen to twenty-three years of age. The sampling size was based on the theoretical concept of information power, as described by Malterud et al. This concept states that a small, highly purposive sample rich in informational content can have greater analytical potential than a large, heterogeneous sample oriented toward exhaustive coverage. Four

aspects of the theoretical informational power of the study support the conclusion that a sample of eighteen participants was sufficient for this investigation. Firstly, the research question was clearly delimited by a singular culturally defined construct (face culture) within a delimited cultural group (Chinese university students experiencing stable depression recovery). Secondly, participants were deliberately similar in terms of cultural group, linguistic ability, and depression recovery status, thereby ensuring maximum within-group homogeneity. Thirdly, the theoretical framework of Face Negotiation Theory and the social support buffering model offered sufficient analytical direction to guide the researcher throughout the two phases of thematic data analysis. Finally, the dialogic nature of data collection, wherein the researcher shared the participants' first language and had cultural familiarity, ensured maximum informational richness. Data collection ceased at the eighteenth participant, at which point the researchers determined that informational sufficiency had been achieved to address the three research questions.

3.3. Data Collection

Data collection was conducted through individual semi-structured in-depth interviews entirely in Mandarin Chinese. Each interview was conducted according to a topic schedule designed to elicit participants' experiences of depression onset and recovery, family and social network influence, cultural pressures faced during help-seeking, and face-related concerns at various stages of recovery. The topic schedule was constructed through a critical review of existing literature on face culture and help-seeking behavior in relation to mental health issues, reviewed by a clinical psychologist with expertise in Chinese adolescent depression, and refined through pilot interviews of two participants not included in the study. Sample interview questions were: "Can you describe how your concern for your family's face or social standing influenced your help-seeking behavior?" "Were there times during your depression and subsequent recovery when culture was a source of strength and motivation for you? If so, what were some of the factors at play?" "How did your relationships with family members and social network members change at various stages of your depression and subsequent recovery, and how did these changes influence your face or social standing?" The interviews were conducted in private settings at participants' respective universities, recorded after obtaining consent, and lasted for sixty to ninety minutes. Participants' responses were transcribed verbatim in Mandarin Chinese and reviewed for accuracy against the recorded interviews before analysis began. Quotations used in this article were translated from Mandarin Chinese to English and reviewed by a bilingual scholar for semantic accuracy and contextual fidelity, ensuring the integrity of participants' voices during data interpretation and analysis.

3.4. Analytical Procedure

Analysis of the data was undertaken by the principal researcher, a doctoral candidate trained in qualitative health research and cultural psychology, in close collaboration with two supervisors, one of whom was an expert in transcultural psychiatry and the other was an expert in qualitative research. The analytical process consisted of two distinct phases. In both phases, the researcher collaborated with the supervisors. Disagreements were resolved by discussion. The analytical process was supported by the use of NVivo 12 qualitative data analysis software. The first phase of the thematic analysis was undertaken according to the six-phase approach outlined by Braun & Clarke. In the first phase, the research team became intimately acquainted with the data through repeated reading. In the second phase, data codes were systematically generated across the eighteen data sets. In the third phase, the data codes were organized into candidate themes. In the fourth phase, the candidate themes were reviewed and named. The thematic analysis resulted in the identification of superordinate themes related to the broader context of depression recovery among Chinese university students. Of these superordinate themes, the cultural mediation of depression recovery through face-related processes is the principal theme of the present article. It is the empirical basis of the secondary phase of the thematic analysis.

A targeted secondary phase of analysis was undertaken to specifically address the three research questions that frame the current article. All coding node data associated with face culture and mianzi, shame and embarrassment, family honor and reputation maintenance, stigma perception, disclosure, and help-seeking decision-making were systematically extracted and subject to sustained comparative analysis. A constant comparative method was employed to differentiate between motivating and impeding face-related narratives across the data set, facilitating the identification of three positive and three negative pathways, as described in the Findings section. A further comparative analysis was undertaken to explore differences across participants in relation to stage of recovery, family mental health literacy, gender role internalisation, and social network composition. These data provided the basis for the derivation of the four contextual moderating variables. Throughout both phases of analysis, a reflexive journal was maintained to track interpretive decisions and epistemological positionality, thereby increasing the overall credibility and transparency of the analytical approach. A member checking exercise was conducted with six of the eighteen participants (33%) to assess the resonance of the developing interpretive themes with their experience. Five of six participants confirmed the relevance and applicability of the developing analytical themes to their overall experience. One participant expressed partial reservation in relation to the face restoration pathway, indicating that while she had reframed her depression experience in terms of resilience, this had not been a distinct or clear-cut experience in later recovery phases. This participant indicated that the reframing had been a gradual and non-linear experience. This information was incorporated into the

interpretive account, which was subsequently revised to acknowledge the non-linear and temporally uneven nature of identity reconstruction in later recovery phases.

3.5. Ethical Considerations

This study was granted ethical approval by the Research Ethics Committee of Universiti Malaysia Sarawak (UNIMAS) prior to data collection. A comprehensive informed consent approach was adopted to ensure that the participants were aware of the research aims, the voluntary nature of the participation, and their unconditional right to withdraw from the study at any time without negative consequences. Given the emotionally sensitive nature of the topic a participant distress protocol was designed to enable interview suspension if signs of distress were noted. Such suspension would enable immediate emotional support and professional intervention when deemed necessary. Before the interview, participants were provided with information about local mental health crisis services. Anonymity of the participants was ensured through the use of a unique identifier for each participant. Audio files were encrypted before being stored on the institution's servers, accessible only to the research team. Participant identifying features were removed from the transcript before data analysis.

4. Results

4.1. Face Culture as a Motivator: Three Positive Pathways

The analysis revealed three distinct positive pathways by which face culture functioned as an active motivational resource in participants' experiences of recovering from depression, all of which were related to the social and moral obligations of mianzi. Demographic and clinical characteristics of all eighteen participants are shown in Table 1.

The most dominant factor was the mobilising effect of family honour in facilitating treatment engagement. The need to uphold family honour was seen as a powerful motivator for engaging in professional treatment, reconceptualising the recovery process not in individualistic but familial terms. One participant described this in the following way: "A classmate told me that it takes some courage to seek help and to keep coming. I did not realize that it was talking about courage. This helped change my perspective of the struggle" (P006, Male, 20, International Trade). This quote illustrates how peer support functions not merely as personal encouragement but as a culturally informed cue congruent with the values of mianzi, specifically, the recognition that persistence in treatment reflects social competence valued in the group. This is a notable distinction from individualistic models of recovery, in which motivation is seen in relation to personal autonomy.

A second pathway was provided by the mobilisation of the resources of family support. Once apprised of the diagnosis, the individual drew upon their network of familial relations in a manner that greatly enhanced the support provided throughout the recovery period. Indeed, one of the participants

explained: “I also delayed reporting my health status to my family for an extended period of time because I thought they would worry about me. It was only when my health status became critical that I decided to contact my mother. She was very shocked and decided to come to my school to assess my health status. Initially, my mother did not understand my health status, but after being explained by the physician, she was able to understand how to assist me” (P003, Female, 19, Business Administration). This statement illustrates the full range of mianzi’s mobilising potential, from initial face-related concealment to the ultimate activation of familial obligation. Indeed, the mother’s physical presence at the university, along with the involvement of medical professionals, can be seen as culturally mediated responses to the obligation of maintaining familial integrity.

A third pathway was also noted in later recovery stages, whereby face culture offered a framework for reconstructing social identity. This was represented across all participants in stable recovery stages, as they began to reappropriate their experience of recovery as a source of resilience, thereby transforming it into a source of increased mianzi rather than decreased mianzi. This was exemplified by one participant: “I had hidden my depression as a stigma in the past, whereas I conceptualise it as a part of my human experience story, rather than the whole story, that helped me develop empathy and strength” (P009, Female, 19, Sociology). This shift from concealment to integration highlights how face culture can become a source of identity reconstruction in post-recovery stages, rather than a constraint on self-expression.

Table 1

Participant Demographic and Clinical Characteristics

Participant	Gender	Age	Major	Diagnosis Duration (months)	Recovery Duration (months)	Treatment Received
P001	Female	21	Chinese Literature	15	14	Combined
P002	Male	20	Computer Science	18	13	Medication only
P003	Female	19	Business Administration	8	7	Psychotherapy only
P004	Male	22	History	26	19	Combined
P005	Female	21	Chemical Engineering	16	8	Combined
P006	Male	20	International Trade	9	9	Medication only
P007	Female	22	Visual Communication Design	20	16	Combined

P008	Male	23	Electronic Engineering	25	21	Combined
P009	Female	19	Sociology	10	10	Combined
P010	Male	21	Mechanical Engineering	13	15	Medication only
P011	Female	20	Journalism	7	6	Psychotherapy only
P012	Male	22	Finance	19	13	Combined
P013	Female	21	Biotechnology	14	14	Combined
P014	Male	23	Philosophy	28	22	Combined
P015	Female	22	Product Design	17	20	Combined
P016	Male	20	Physics	13	8	Medication only
P017	Female	21	Psychology	11	7	Psychotherapy only
P018	Male	22	Software Engineering	27	24	Combined

Note. Diagnosis Duration refers to the period in months from the date of initial clinical diagnosis of major depressive disorder to the commencement of stable functional recovery. Recovery Duration refers to the duration in months of maintained stable functional recovery prior to the interview date. These two intervals are operationally independent and do not share a common baseline; consequently, Recovery Duration may exceed Diagnosis Duration for participants whose recovery phase extended over a longer period than the preceding acute illness trajectory. All diagnoses met DSM-5 criteria for major depressive disorder, as verified through documentation review at the recruitment stage.

4.2. Face Culture as a Barrier: Three Negative Pathways

In addition to these motivating effects, face culture also served as a source of structural impediment in the participants' recovery paths, operating through three distinct negative pathways that systematically delayed treatment access and exacerbated psychological distress.

The first and most pervasive form was the shame-induced delay in help-seeking. Within Chinese face culture, the association of mental illness with personal weakness and family shame caused the participants to postpone seeking professional help for extended periods. These cultural values and norms associated with face discourse, in which family shame must be kept hidden and personal

willpower is considered sufficient, created powerful inhibitory effects on help-seeking. One participant described the paralysing effect of these inhibitory concerns: “It took me a while to decide to go for therapy because I wanted to avoid embarrassing my family. Admitting to being ill would make me seem weak and in contradiction to what I was taught in life. I begged both parents not to share information with our entire family. Mental illness sounded even scarier than having depression” (P001, Female, 21, Chinese Literature). This quote illustrates how the cultural construction of depression as a source of shame for the entire family, rather than a medical condition, created a significant delay in help-seeking and treatment access.

Another barrier was created by reinforcing stigma and consequently leading to social withdrawal. Disclosure of depression was seen as leading to peer rejection and labeling, which only compounded the experience of depression. One of the participants was able to describe how this was a vicious circle: “Some of my friends changed their behavior towards me after realizing that I have depression, considering it to be contagious or a trait of unreliability. Stigma of this nature was exhibited through both open and hidden exclusion in social interactions, thus worsening my feelings of isolation resulting from embarrassment. Upon realizing that going for therapy is a sign of weak-mindedness, I decided not to display my recovery” (P012, Male, 22, Finance). This choice of not displaying their improvement was a result of the overall logic of mianzi, not just related to disclosure.

A third barrier involved gender-related face pressures, which presented qualitatively distinct barriers depending on the participants’ gender. Male participants experienced a cultural definition of masculinity wherein being stoic is a core requirement. Therefore, seeking help was behaviorally incongruent with dominant gender norms. “Strength and independence are valued in Chinese society; admitting mental health problems made me feel that I lacked masculinity. My father instead encouraged me to ‘grit teeth and get through it’ instead of seeking medication” (P004, Male, 22, History). Female participants from the STEM group experienced compounded face pressure, as mental health stigma was compounded by discrimination against women. “Women in STEM feel unique pressures that include both academic challenges and gender issues. There seems to be an impression that women, when they choose to study STEM courses, are failing to carry out their real professional duties” (P005, Female, 21, Chemical Engineering). Overall, the above quotes establish the fact that mianzi is not an undifferentiated cultural force. It is mediated by the participants’ genders. The six pathways of mianzi are summarized collectively in Table 2. The six pathways comprise three motivating pathways and three hindering pathways, as perceived by participants.

Table 2

Dual-Role Mechanisms of Face Culture in Depression Recovery

Direction	Pathway	Core Mechanism	Representative Participants

Motivator	Family honour as treatment motivation	Mianzi binds recovery to collective duty, internalising familial obligation as treatment adherence	P006
Motivator	Collective mobilisation of family support	Diagnosis activates culturally scripted caregiving obligations within family networks	P003
Motivator	Face restoration driving identity reconstruction	Recovery reframed as evidence of resilience, restoring and enhancing social standing	P009
Barrier	Shame-driven help-seeking delay	Cultural encoding of mental illness as family disgrace delays disclosure and treatment access	P001
Barrier	Stigma reinforcement and social withdrawal	Peer rejection following disclosure deepens isolation and suppresses further help-seeking	P012
Barrier	Gendered face pressures as compounded barriers	Masculinity norms and intersectional stigma create gender-specific obstacles to service utilisation	P004, P005

Note. Pathways are organised by functional direction. Representative Participants refers to the participant(s) whose interview accounts most directly exemplify the described mechanism. All participants are identified by unique codes; full demographic and clinical details are presented in Table 1.

4.3. Contextual Moderators: What Determines the Direction of Face Culture's Role

The most original theoretical contribution of this study is the identification of four contextual variables that systematically influence whether face culture exerts motivating or impeding effects across various participants and recovery stages. These variables are briefly presented in Table 3 and graphically depicted in Figure 1. These variables do not exert their influence independently of one another. Instead, they interact dynamically to account for the variety of face-related outcomes presented in Sections 4.1 and 4.2.

Recovery stage emerged as a significant factor in determining which moderating effect was most influential. The one constant in all data was that mianzi's functional direction changed over time. Barrier effects were more prominent during the acute symptomatic phase of recovery, whereas motivating effects became more evident as stability was achieved. This dimension of mianzi's functional direction over time was captured succinctly by one of the participants: "At first I had to be helped to come to school and to get food. Later on, I wanted to be encouraged to overcome small hurdles and to rebuild self-confidence. In the final analysis, I wanted to show members of my family that frequent follow-ups are allowed at first; later on, the experience of stress will decrease" (P008, Male, 23, Electronic Engineering). This form of narrative was inevitably retrospective, as all participants had achieved functional recovery prior to data collection. Thus, descriptions of barrier effects during the acute phase of recovery are necessarily a retrospective recollection of a past

experience rather than a current experience of symptomatology. To offset retrospective bias, consistency in narrative across the entire data set for each participant was used as a key factor in assessing the validity of recollections. Thus, recollections that were temporally coherent and highly specific, those referring to specific events or decisions, were viewed as more reliable than a more generalized recollection that had a high level of evaluative content. This trajectory illustrates that mianzi's functional direction can vary over time in response to changing psychological resources and social confidence.

Family mental health literacy emerged as a second moderating variable of analytical importance. In cases where family members had low mental literacy regarding depression, face culture accentuated stigma effects and suppressed help-seeking behavior. Conversely, where literacy levels were high, the collective focus of mianzi in mobilizing support was evident. This is exemplified by one participant: "Their understanding has changed significantly. They used to think that psychological issues were 'overthinking,' but now they think that these issues are real illnesses. My mother has been posting information on her WeChat moments about mental illness, trying to help more people" (P009, Female, 19, Sociology). This illustrates how educational effects in the family system can shift the directional influence of face culture.

The role of gender norms was a third moderating factor that heightened the effect of barriers in individuals with stronger internalisation of traditional role norms. As described in Section 4.2, male respondents such as P004 explained how the cultural stereotype linking masculinity with emotional control rendered help-seeking behaviourally inconsistent with dominant gender norms. This demonstrates how gender-related face concerns can override help-seeking intentions regardless of symptom severity, thus increasing mianzi's barrier effects among male respondents. Social network was a fourth moderating factor, whereby respondents with access to support groups or professional support, in addition to family relationships, were better able to leverage the motivating role of mianzi. One respondent described the development of their network: "At the beginning, I was reluctant to accept any kind of help and preferred to be alone. Gradually, I started to accept the concern of my roommates. Later, I became a member of the school reading club, where I could network with other passionate people. While my list of friends is not extensive, it is comprised of people who care for me" (P001, Female, 21, Chinese Literature). It is noteworthy that the story of P009 covered various analytical dimensions in the data set, including face restoration in Section 4.1, family literacy transformation, and network diversification in the current section. Therefore, her story illustrates the dynamic nature of face culture's dual role. Her story on network diversification reads: "I found online forums for Chinese students who were dealing with depression. This connected me to people who knew both my cultural identity and my mental illness. Through counseling, I found mindfulness groups on campus that gave me a sense of purpose" (P009, Female, 19, Sociology). As shown in

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Figure 1, the four moderating variables exhibit varying levels of directional impact, with recovery stages and family literacy demonstrating the strongest asymmetry in enabling and inhibiting conditions.

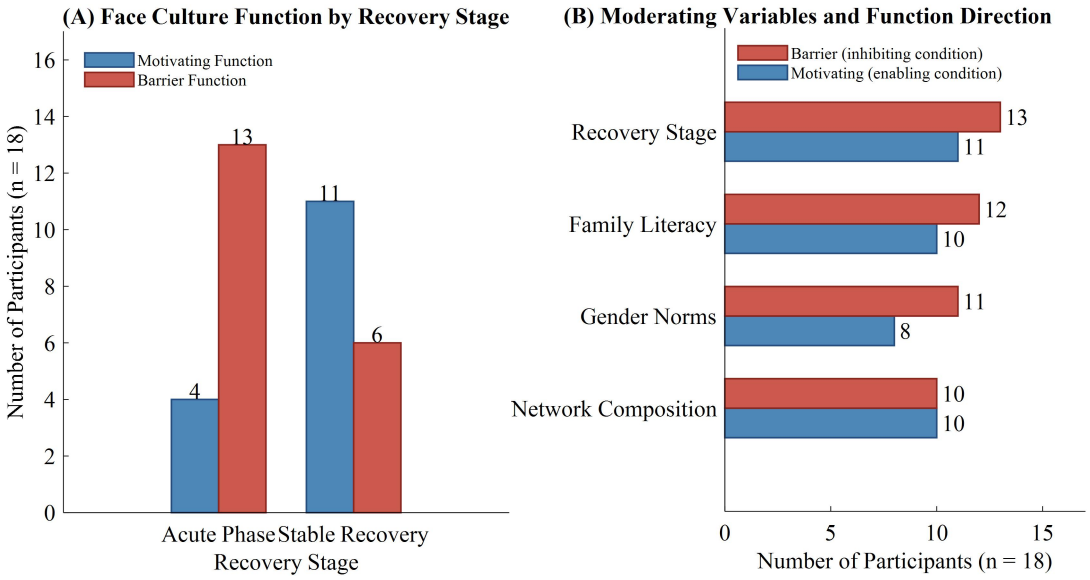
Table 3

Contextual Moderators and Their Directional Effects on Face Culture's Role

Moderating Variable	Condition Activating Motivating Function	Condition Activating Barrier Function	Representative Participants
Recovery Stage	Stable recovery phase; psychological resources consolidated	Acute symptomatic phase; coping capacity depleted	P008
Family Mental Health Literacy	Family members possess adequate knowledge of depression as illness	Family holds stigmatising beliefs; limited mental health awareness	P009
Gender Norms	Low internalisation of traditional role expectations	Strong internalisation of masculine stoicism or gender-based performance norms	P004, P005
Social Network Composition	Diverse network including peer support and professional resources	Homogeneous traditional family network without peer or professional elements	P001, P009

Figure 1

Contextual dual-role model of face culture in depression recovery among Chinese university students



5. Discussion

The findings of this study suggest a theoretically nuanced reconceptualization of face culture's role in Chinese university students' depression recovery, moving decisively beyond the undirectional barrier paradigm that has characterized the existing literature. By identifying three motivating pathways, three impeding pathways, and four contextual moderating variables that determine functional direction, this study proposes a Contextual Dual Role Model of face culture in depression recovery. In this study, mianzi is conceptualized not as a singularly impeding cultural factor but as a complex mechanism whose functional role is systematically shaped by contextual moderating variables. This study extends Ting-Toomey's Face Negotiation Theory into the domain of depression recovery, demonstrating that the identity management imperatives underlying face culture generate both avoidant, barrier-producing outcomes and motivating outcomes, depending on the stage of depression recovery, family mental health literacy, gender norms, and social network. This extension of Face Negotiation Theory is further supported by Cohen and Wills' social support buffering model, where cultural norms determine not only the availability of support resources but also their acceptability. This acceptability, in turn, explains why face culture can both facilitate and impede support seeking, depending on its interpretation within specific relational contexts. The proposed model introduces a culturally contextual alternative to individualistic models of depression recovery, where agency is embedded within collective processes of mianzi rather than personal autonomy. This reconceptualization is particularly pertinent given the consistently low rates of mental health service utilization among Chinese university students despite high symptom prevalence, a phenomenon that existing cultural frameworks have been insufficient to explain [24].

The motivational pathways identified in this study align with, and significantly extend, a limited but increasingly substantial body of evidence supporting the protective and facilitative potential of collectivist cultural orientation in mental health settings. The family honour pathway, in which mianzi links group reputation to treatment engagement, instigating enduring internal motivation, resembles Ning and colleagues' finding that family-based expectations can paradoxically facilitate treatment compliance in Chinese samples. Similarly, Chen and colleagues' work demonstrates how parental investment in group-based academic and social reputation instigates performance-based motivational structures that extend beyond educational domains [25, 26]. The collective mobilisation pathway, in which diagnosis instigates group-based caregiving expectations within family networks, is similar to Li and Xu's qualitative exploration of how Chinese family networks frequently engage in intense collective action in response to mental health crises precisely because inaction would constitute a face-threatening failure [27]. The face restoration pathway, wherein stable recovery is reframed as evidence of resilience and a source of renewed mianzi, has not previously been documented with the clarity afforded by this study's exclusive focus on participants who had achieved stable functional recovery. This focus enabled retrospective reconstruction of the full motivational arc from acute

concealment through identity reintegration, representing a theoretically original contribution to understanding the motivational architecture of later recovery stages.

The three barrier pathways proposed here are consistent with existing research on stigma and help-seeking delay in Chinese contexts, although the current study provides a more detailed mechanistic explanation compared to previous research. The shame-based delay in seeking help is consistent with patterns seen in a variety of provincial samples in China, and the large-scale survey conducted by Chang and colleagues confirmed that shame associated with "face" is one of the strongest predictors of non-use of health treatments in young adult Chinese populations [28]. The pathway of stigma reinforcement and social withdrawal extends the research conducted by Zhou and colleagues on the circular relationship between disclosure, peer rejection, and social withdrawal. It offers a participant-level explanation for how managing mianzi reputation ultimately inhibits not only the help-seeking but also the disclosure of ongoing treatment needs during recovery [29]. The gendered face pressure pathway is analytically the most innovative of the six, as it locates gender-differentiated barriers within a face culture framework that moves beyond the generic stigma literature. Male participants' accounts of the masculinity-stoicism equation align with Syafitri et al.'s cross-cultural evidence of male reluctance to seek psychological help. Female STEM participants' accounts of intersecting gender discrimination and mental health stigma extend Yang et al.'s research on discipline-specific social pressures faced by Chinese women in science and technology disciplines [30, 31].

The four contextual moderating variables represent a theoretically innovative aspect of this study, as no prior qualitative investigation has explored the circumstances under which face culture's functional direction shifts from barrier to motivator, or vice versa. The recovery stage moderator aligns with Fan and colleagues' model of mental health recovery, which also describes how stigma-related concerns vary in salience across illness stages [32]. The family mental health literacy moderator is consistent with Yang and colleagues' intervention study, which showed that psychoeducation targeting family members significantly reduces communication containing stigma-reinforcing content and enhances the quality of community-based support for individuals with depression [33]. The gender norm internalisation moderator is also consistent with Zhang and colleagues' recent quantitative findings, which indicate that individuals with lower traditional gender role beliefs show significantly higher help-seeking intentions. The present study extends these findings by providing insight into the cultural mechanisms underlying this relationship through a qualitative design [34]. The social network composition moderator is also consistent with Lin and colleagues' quantitative findings, which indicate that network diversity, especially among peers with shared mental health experiences, mitigates face-threatening aspects of help-seeking by normalizing such behaviors in culturally appropriate relational contexts [35].

The findings of this study possess important practice implications at various levels of practice. For mental health practitioners, the incorporation of face culture assessments during initial consultations with Chinese university students, including assessments of recovery stage, family mental health literacy, and gender norm internalisation, would help determine how mianzi is likely to influence students' experiences. This would enable practitioners to harness family honour themes as motivational tools, rather than viewing culture as a barrier to practice, as is currently the case. For male students, gender-sensitive approaches to de-stigmatising help-seeking should be adopted by practitioners, so as to align help-seeking more closely with, rather than against, constructions of strength and responsibility embedded in face culture. In relation to practice at the level of universities, universities need to improve their infrastructure of mental health services. This includes developing family psychoeducation programs aimed at improving the mental health literacy of parents and other family members, as well as establishing dual-track models of service provision that maintain confidentiality while providing opportunities for informed family involvement in students' treatment. In relation to policy practice, the identification of family mental health literacy and social network composition as modifiable contextual factors provides policy actors with a clear rationale for directing resources towards community-level literacy programs and social network development, rather than exclusively towards the individual level of practice. This approach aligns with the relational nature of face-oriented cultural contexts.

Several limitations of the present study must be noted. The present study recruited participants only from universities in Shandong Province. Shandong is a region of China with relatively well-established cultural traditions of Confucianism. It is possible that face culture dynamics may be significantly different among participants from cosmopolitan cities or culturally mixed populations. Such participants may include overseas Chinese students or youth from the coastal cities of China [36, 37]. The retrospective approach, in which participants recounted their acute phase experiences from the perspective of their current state of recovery, also runs the risk of memory reconstruction and rationalisation biases. More precise temporal tracking of face culture's evolving functional significance in various phases of recovery would have been possible through prospective longitudinal designs. As a qualitative study, the results cannot be generalised statistically, and the magnitude of impact of the four moderating factors on help-seeking outcomes cannot be quantified. Mixed methods designs using established survey tools would have significantly enhanced causality. Additionally, despite the reflexive practice of journaling and member checking, the investigator's positionality is inevitably implicated in the interpretative constructs created, and alternative interpretative possibilities cannot be entirely discounted [38].

These limitations suggest several promising avenues for future research. Quantitative research that operationalises concepts such as stage of recovery, family mental health literacy, internalisation of

gender norms, and composition of social networks, using them as quantifiable moderators of face culture's impact on help-seeking behaviour, would allow for a rigorous test of the Contextual Dual Role Model with sufficient statistical power. Cross-regional and cross-national quantitative research examining face culture in mainland Chinese, Chinese overseas, and diasporic Chinese would evaluate the boundary conditions of the current model and its generalisability beyond Chinese populations. From a more practical perspective, further development of structured intervention programs that attempt to maximise mianzi's motivating effects, as opposed to its barriers, represents a theoretically sound and practically important next step in this research domain. Such an approach has considerable potential for integration into university-based counseling and community-based mental health services in Chinese-speaking populations.

6. Conclusion

This study provides systematic qualitative evidence that face culture occupies a structurally dual role in the depression recovery of Chinese university students — functioning simultaneously as a motivator and as a barrier, with its directional impact determined by contextual conditions rather than by any inherent cultural valence. Analysing in-depth interview data from eighteen participants who had achieved stable functional recovery from clinically diagnosed major depressive disorder, the study identified three positive pathways through which mianzi actively supports recovery: family honour as treatment motivation, collective mobilisation of family support resources, and face restoration driving post-recovery identity reconstruction. It also identified three negative pathways through which it impedes recovery, namely shame-driven help-seeking delay, stigma reinforcement and social withdrawal, and gendered face pressures as compounded barriers. The functional direction of these mechanisms was found to be contextually configured by four interacting variables: recovery stage, family mental health literacy, gender norm internalisation, and social network composition. Collectively, these findings contest the dominant undirectional barrier paradigm and advance a Contextual Dual-Role Model that situates mianzi as a culturally embedded resource whose recovery-related function is dynamically shaped by the relational and temporal conditions under which it operates. The theoretical implications extend beyond the Chinese context, challenging individualistic recovery frameworks and foregrounding the role of collective cultural dynamics in shaping mental health trajectories. Practically, the model offers a basis for developing interventions that activate face culture's motivating dimensions through family psychoeducation, gender-sensitive destigmatisation, and diversified peer support networks.

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Data availability

No data availability statement is required.

Declarations

Conflict of interest

The author declares that there is no conflict of interest.

Ethics approval

Not applicable.

Consent to participate

Not applicable.

Consent for publication

Not applicable.

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