User Self-Disclosure on Health Social Networks: A Social Exchange Perspective

Research-in-Progress

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Abstract

Based on social exchange theory, this study develops a research model to examine why people disclose personal information on health social networks. The observations collected from a survey study provide supporting evidence for most of the hypothesized relationships among emotional intensity, informational needs, social needs, informational privacy concerns, social privacy concerns and self-disclosure. The results suggest people made self-disclosure decisions by evaluating perceived benefits in terms of user needs and perceived risks in terms of privacy concerns. It is also found that emotional intensity and disease type regulate and moderate user self-disclosure behavior on health social networks.

Keywords: Healthcare information, user behavior, virtual community, self-disclosure.
Introduction
In recent years, a lot of health social networks have emerged, such as RevolutionHealth, OrganizedWisdom, PatientsLikeMe, and Google Health. Similar with other social network websites, they operate as the platforms for patients as well their family members and friends to establish social connections with each other. For health-related purposes, health social networks also provide useful features for patients, such as user profiles for health record keeping, discussion forums, self-health management tools and education channels. Thus, users can learn about diseases, monitor health conditions, share personal experiences and socialize with other patients.

Researchers have identified several advantages of using health social networks as the source of health information and social support. First, they enable people to reach others with similar health concerns without the barrier of geographic and temporal restrictions (Mickelson 1997). Second, they allow users to access a good amount of online information about various diseases (Adelman, Parks & Albrecht 1987). Next, they facilitate heterogeneous supportive relationships for patients who are in great need of encouragement and comfort (King & Moreggi 1998). In addition, users remain largely anonymous, which reduces people’s stigma/shame of being ill (Bull & David 1986; Coates & Winston 1987) and enables users to disclose more health information at lower risk than in face-to-face communications (Joinson 2001).

On the other hand, the advances of information and communication technologies also raise the security issues. Personal health information has been regarded as highly confidential and sensitive for a long time. Online health-related systems and applications face the challenge of personal health privacy protection. According to the National Consumer Health Privacy Survey (2005), two-thirds of American consumers expressed serious concerns about the privacy of their personal health information, about half of patients feared that health information be seen by their employers, and 55% of chronically ill patients worried about confidentiality.

This study tries to address the question why people are willing or hesitant to share their health information and personal experiences openly through health social networks? In particular, what are the primary motives and concerns for users to disclose themselves on health social networks, and what factors contribute to such motives and concerns? There have been many studies on user self-disclosure on e-business websites, but few on the issue related to the use of health social networks. The findings of this study will help researchers and practitioners figure out how to facilitate user participation in health social networks. The results will also have significant implications for policy makers in terms of how the government should make privacy policies for health social networks.

The theoretical background of this study is organized as follows. First, it identifies constructs relevant to user online self-disclosure based on social exchange theory and literature review. Then, it proposes a research model that contains testable hypotheses regarding the relationships among the constructs. Next, it describes a pilot study and presents the results. Finally, implications of the findings are discussed, followed by the conclusion.

Theoretical Background
To examine why people share their personal information on health social networks, this study adopts the social exchange theory as the main theoretical framework. Rooted in the utility theory in economics, this theory posits that people decide whether to interact with others based on evaluation of potential rewards and costs (Altman & Taylor 1973). Social exchange theory has also been applied to examine user self-disclosure in the context of online environment. To explain user willingness to be profiled online for personalized service, for example, Awad and Krishnan (2006) conceptualize rewards and costs as the functions of degree of personalization received and consumer privacy concerns respectively. Similarly, Posey et al. (2010) propose an online community self-disclosure model based on social benefits (reciprocity) and social costs (privacy risk).
To examine people’s self-disclosure behavior on health social network, it is important to understand the relevant constructs in terms of the predicted variable and explanatory variables. In this study, self-disclosure is the behavioral consequence of the balancing between rewards and costs, which are primarily user needs and privacy concerns respectively. Meanwhile, the emotional intensity due to diseases may regulate user needs and privacy concerns and affect self-disclosure. Based on the literature review, each construct will be discussed separately.

**Self-disclosure**

Self-disclosure is an important concept in social and behavioral research and it generally refers to the behavior of revealing information related to oneself during the interaction with others (Cozby 1973). In the Internet age, it has been used to investigate related behavior of web users when they disclose their own information to websites (Andrade, Kaltcheva & Weitz 2002). In particular, most of the e-business websites require users to provide their contact and credit card information to make online transactions.

Being a dynamic concept, self-disclosure is also situated in specific behavioral settings and it can take different forms (Antaki, Barnes & Leudar 2005). It is generally agreed that there are two types of self-disclosure: factual disclosure that reveals personal facts and data, and emotional disclosure that reveals private feelings, opinions, and judgments (Laurenceau & Feldman-Barrett 1998). When people use health social networks, they may disclose themselves to the websites as well as other users. Thus, both forms of self-disclosure, factual and emotional, are prominent. This distinguishes user self-disclosure on health social networks from that on transaction-oriented e-business websites.

To understand user behavior concerning this form of self-disclosure, it is important to examine relevant psychological constructs that may influence such a behavior. There has been a considerable amount of research on self-disclosure and related behavioral antecedents, such as motives and concerns (e.g. Andrade, Kaltcheva & Weitz 2002; Berendt, Gunther & Spiekermann 2005). The rest of this section will review the literature for the understanding of why people share personal information on health social networks.

**Emotional Intensity**

Diseases and health-related issues are of primary personal concerns. In particular, chronic diseases are long-lasting in nature and can lead to severe physical symptoms (WHO 2011). People with diseases suffer not only physically but also psychologically. Numerous studies have found Parkinson’s disease, cancer, cardiovascular disease and other chronic illness will arouse intensive emotions such as anxiety and depression (Cummings, 1992; Massie & Holland 1990; Musselman, Evans & Nemeroff 1998).

Sonnemans and Frijda (1995) proposed an emotional intensity model that describes the relationship between the arousal of emotions and the nature of events. According to the model, the emotional intensity of an individual depends on the person’s appraisal of an event in terms of its personal relevance and potential consequences. Thus, people are prone to experience high levels of emotional intensity when they have health issues that may have potentially severe impact on the lives of themselves and their family members.

Being exposed to these negative emotional conditions, people tend to have strong motivations to look for disease-related information and seek social support (Luminet et al. 2000). This is especially true when people experience distresses due to diseases that cannot be cured easily or quickly. According to the National Consumer Health Privacy Survey (2005), chronically ill patients are twice as likely to look for health information as other patients, and more than half of them would share their personal health information with those who have similar concerns.

**User Needs**

In the use of health social networks, people have generally two types of needs: informational needs and social needs. First of all, the Internet allows people to access health information by themselves and greatly facilitates the distribution of health-related knowledge (Cline & Haynes 2001). People use health-related websites mainly for two purposes: 1) to keep track of one’s own health conditions, and 2) to obtain disease-related information, mainly how to prevent and control a disease (Lewis & Behana 2001; Pratt et
al. 2006). For the satisfaction of these informational needs, the patients may have to disclose their health and/or identity information. For instance, diabetic patients may enter their blood sugar levels everyday to an online system and monitor their conditions. Researchers have found that the use of such online information can assist people to monitor their health conditions and improve the quality of life through suggested practices (Quintana et al. 2001; Levy & Strombeck 2002; Jadad et al. 2000; Tay-Yap & Hawamdeh 2001).

In addition to informational needs, people use health social networks to meet their social needs, in particular: the needs for social support. Social support is defined as “the existence or availability of people on whom we can rely, people who let us know that they care about, value, and love us.” (Sarason et al. 1983). People tend to seek social support when they encounter some disastrous events that cause emotional impacts (Luminet et al. 2000). Researchers have found that when a person is exposed to a higher level of emotional intensity, the individual is likely to share the experiences and feelings repetitively with more people (Christophe & Rimé 1997). Talking about a specific emotional episode facilitates emotional recovery that is important for physical health (Zech & Rimé 2005). Enabling easy group formation, health social networks provide the platforms for people to seek social support from each other (Shirky 2008). With similar disease concerns, they have common interests and same languages, which provide the foundation for mutual understanding that lead to higher satisfaction from information sharing (Cohen & Wills 1985).

**Privacy Concerns**

The concept of privacy concerns rather than trust is often used as a risk-related factor to explain user self-disclosure (e.g. Awad & Krishnan, 2006; Posey et al., 2010). This may be due to the fact that most online interactions are ad hoc responding to the questions from others) without the need to build personal long-term relationships. Thus, privacy is the primary risk perceived by online users associated with their information disclosure behavior (Li, Sarathy & Xu 2010).

Johnson (1974) defined general privacy as “secondary control in the service of need-satisfying outcome effectance” (p. 91). Corresponding to the informational needs and social needs, there are also two types of privacy concerns related to the use of health social networks: informational privacy concerns and social privacy concerns. In the field of information systems, researchers have examined privacy concerns mainly from the informational aspect rather than the social aspect. Most of the studies address people’s privacy concerns when they disclose information to create, access and utilize personal accounts on websites for e-commerce, e-government or other web services (e.g. Brown & Muchira 2004; Pavlou 2011; Wong, Tam & Cheng 2006; Dayarathna & Zhang 2010).

Smith, Milberg and Burke (1996) suggested that informational privacy concerns mainly include the following four factors: 1) collection: concern that too much persona data are collected; 2) errors: concern that much of the personal data is inaccurate; 3) secondary use: concern that online companies use personal information for undisclosed purposes; and 4) unauthorized access: concern that websites fail to protect access to personal information. Compared with other privacy concerns, errors are mostly under the control of users themselves when they disclose personal information online. For example, some users may intentionally enter falsified identity information (e.g. gender) and they do not even consider it an error. Thus, the informational privacy concerns for people who use health social networks mainly include the other three aspects.

Users of health social networks not only look for health-related information but also communicate with each other for mutual support (Chuang & Yang, 2012). In addition to informational privacy concerns, they have social privacy concerns that stem from the social aspect of usage (Abril & Cava 2007). Because of the lack of discussions on social privacy concerns in the information system field, this study identifies specific social privacy concerns from the general privacy literature. It is generally agreed that there are four dimensions of privacy issues including: information collection, information processing, information dissemination, and invasion (cf. Solove 2006). Among them, information collection is mainly an issue of informational privacy concern. The other dimensions include the elements closely related to social privacy concerns, and they are: identification under information processing, exposure under information dissemination, and intrusion under invasion.
Identification means “the association of data with a particular human being” (Clarke 1994). People may post some personal information and even pictures when they create user accounts on health social networks, which may lead to identification. Exposure involves “the exposing to others of certain physical and emotional attributes about a person... that people view as deeply primordial, and their exposure often creates embarrassment and humiliation” (Solove 2006, p. 533). For this concern, people may not want to publicize that they have certain diseases. Intrusion refers to others’ incursions into one’s real life, such as daily activities, social circles and comfort zones (Solove 2006). This implies that users of health social networks may be willing to share personal stories and emotions with each other as long as their real-world lives do not get disturbed. That explains why the need for privacy is not pronounced when a person talks to a complete stranger who is not going to find out who he/she is (Ben-Ze’ev 2003).

Research Model

To investigate why people intend to (or not to) disclose personal information on healthy social networks in an empirical study, a research model is needed to hypothesize the relationships among relevant constructs. Based on the social exchange theory, self-disclosure intention depends on the balancing between perceived benefits and costs. In the use of health social networks, people’s perceived benefits are mostly the satisfactions of informational and social needs and their perceived risks are mainly informational and social privacy concerns. In addition to the rational and cognitive evaluation, user disclosure of personal information online is also subjective to the emotional and affective influences (Li, Sarathy & Xu 2011). More specifically, researchers have found that emotions regulate both needs and risk-related perceptions (Freshwater & Robertson 2002; Sjöberg 2007). Thus, emotional intensity may have a direct effect on self-disclosure intention as well as indirect effects through the mediation user needs and privacy concerns.

Figure 2 shows the hypothesized relationships in a research model. As for perceived benefits, informational and social needs have positive effects on self-disclosure intention (H1a&b). Regarding perceived risks, informational and social privacy concerns have negative effects on self-disclosure intention (H2a&b). Emotional intensity is an affective driving force of self-disclosure intention (H3a), and it tends to amplify user needs (H3b&c) but reduce the privacy concerns (H3d&e). As previously discussed, whether a user has chronic or non-chronic conditions makes differences in his/her self-disclosure behavior. The last hypothesis (H4) states that disease nature (chronic vs. non-chronic) moderates the hypothesized relationships among all the constructs.
**Methodology**

**Measurement**

Emotional intensity, defined as “the strength of particular emotions when they are experienced” (Diener, Sandvik & Larsen 1985), needs to be measured with items that are closely related to the implications of diseases to the users of health social networks. In this study, it is measured with six negative items adopted from previous studies, such as “angry”, “nervous” and “depressed” (Bachorowski & Braaten 1994; Portenoy, Thaler & Kornblith 1994). Informational needs and social needs were measured with three items and four items respectively adapted from the Internet Motive Scale (Papacharissi & Rubin 2000). Informational privacy concerns were measured with nine items adapted from the Information Privacy Scale (Smith, Milberg & Burke 1996), three each for collection, secondary use and unauthorized access. To measure social privacy concerns, three items were developed for each of its sub-constructs including identification, exposure and intrusion. Finally, self-disclosure intention is measured with seven items adapted from the scale developed by Phelps, Nowak and Ferrell (2000). All measures are of the five-level Likert scale (i.e. 1-strongly disagree; 2-disagree; 3-neutral; 4-agree; 5-strongly agree).

**Procedures**

We conducted a survey study based on hypothetical scenarios to test the research model. Each participant was asked to look around user profiles on a well-established health social network site and find someone who had similar health concerns with his/her (or a close relative’s). Assuming that he/she had the medical conditions, the participant filled out a survey questionnaire. The hypothetical scenario method is appropriate when research involves sensitive subject matters such as ethical behavior (Weber 1992). Health issues and related privacy concerns are highly sensitive, and participants may be hesitant to reveal their true thoughts unless they pretend to be others. Because of this, many studies of privacy concerns employ the hypothetical scenario method (e.g. Malhortra et al. 2004).

**Subjects**

Participants were elicited from the graduate students from a university in southwest USA. We used graduate students as the subjects of this study because their age range matches that of most users of health social networks. Compared with the general population, graduate students are typically heavy Internet users and they are familiar with social network websites. On the other hand, younger college students are relatively healthier and do not have as much life experiences. A total of 81 graduate students participated in this study. Among them, 48 expressed concerns about chronic conditions, and 33 did not.

**Results**

Table 1 reports the reliability coefficient and descriptive statistics of each construct. The Chronbach’s alphas were greater than 0.7, indicating that the measures had acceptable levels of reliability. The descriptive statistics include mean and standard deviation (in parentheses). The mean responses of the overall sample indicate that users of health social networks had quite strong informational needs, moderately strong social needs and somewhat strong emotional intensity. Regarding informational privacy concerns, participants were more concerned about unauthorized access and secondary use than collection. Compared with informational privacy concerns, participants had generally weaker social privacy concerns, yet they still worried about identification and exposure to some extent. Finally, participants had relatively positive intention to share personal information on health social networks.

The split-sample comparison shows somewhat different response patterns across the two groups based on whether users had chronic conditions or not. First, the chronic group had stronger emotional intensity, weaker informational needs and stronger social needs than the non-chronic group. Whereas it was not very clear for informational privacy concerns, the chronic group had consistently lower social privacy concerns than the non-chronic group. Finally, the chronic group showed a higher average self-disclosure intention than the non-chronic group.
Table 1. Reliability Coefficients and Descriptive Statistics

<table>
<thead>
<tr>
<th>Constructs</th>
<th>α</th>
<th>Overall</th>
<th>Chronic</th>
<th>Non-Chronic</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emotional Intensity</td>
<td>.843</td>
<td>3.27 (.81)</td>
<td>3.43 (0.72)</td>
<td>3.05 (0.90)</td>
</tr>
<tr>
<td>Informational needs</td>
<td>.707</td>
<td>4.19 (.59)</td>
<td>4.13 (0.56)</td>
<td>4.26 (0.64)</td>
</tr>
<tr>
<td>Social Needs</td>
<td>.921</td>
<td>3.66 (.99)</td>
<td>3.77 (0.94)</td>
<td>3.52 (1.06)</td>
</tr>
<tr>
<td>Informational Privacy Concerns</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Collection</td>
<td>.936</td>
<td>3.33 (1.12)</td>
<td>3.06 (1.14)</td>
<td>3.72 (0.98)</td>
</tr>
<tr>
<td>- Unauthorized Access</td>
<td>.876</td>
<td>4.19 (.76)</td>
<td>4.17 (0.70)</td>
<td>4.22 (0.86)</td>
</tr>
<tr>
<td>- Secondary Use</td>
<td>.856</td>
<td>4.35 (.79)</td>
<td>4.43 (0.58)</td>
<td>4.24 (1.02)</td>
</tr>
<tr>
<td>Social Privacy Concerns</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Identification</td>
<td>.906</td>
<td>3.47 (1.03)</td>
<td>3.35 (1.03)</td>
<td>3.66 (1.03)</td>
</tr>
<tr>
<td>- Exposure</td>
<td>.949</td>
<td>3.19 (1.19)</td>
<td>3.06 (1.11)</td>
<td>3.37 (1.29)</td>
</tr>
<tr>
<td>- Intrusion</td>
<td>.955</td>
<td>3.00 (1.14)</td>
<td>2.88 (1.08)</td>
<td>3.18 (1.23)</td>
</tr>
<tr>
<td>Self-disclosure Intention</td>
<td>.846</td>
<td>3.46 (.80)</td>
<td>3.79 (0.55)</td>
<td>2.99 (0.86)</td>
</tr>
</tbody>
</table>

Next, we assessed the measurement validity and tested the research model through partial least square analyses. Table 2 reports the average variance extracted (AVE) for each of the construct in the research model and the inter-construct correlations. All AVE values were greater than 0.5, supporting the convergent validity within each construct. The inter-construct correlations were moderate or small, suggesting an acceptable level of discriminate validity across different constructs.

Table 2. Average Variance Extracted and Inter-Construct Correlations

<table>
<thead>
<tr>
<th>Constructs</th>
<th>AVE</th>
<th>SD</th>
<th>EI</th>
<th>IN</th>
<th>IP</th>
<th>SP</th>
<th>SN</th>
</tr>
</thead>
<tbody>
<tr>
<td>Self-disclosure intention (SD)</td>
<td>0.55</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Emotional Intensity (EI)</td>
<td>0.54</td>
<td>-0.02</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Informational Needs (IN)</td>
<td>0.62</td>
<td>0.35</td>
<td>0.16</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Informational Privacy (IP)</td>
<td>0.51</td>
<td>-0.48</td>
<td>-0.15</td>
<td>-0.16</td>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Social Privacy (SP)</td>
<td>0.81</td>
<td>-0.53</td>
<td>0.05</td>
<td>-0.17</td>
<td>0.54</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Social Needs (SN)</td>
<td>0.81</td>
<td>0.36</td>
<td>0.24</td>
<td>0.50</td>
<td>-0.13</td>
<td>-0.14</td>
<td>1</td>
</tr>
</tbody>
</table>

Finally, Table 3 gives the estimates of structural paths among the constructs based on the overall sample as well as the split samples. The estimates based on the overall sample indicated that informational and social needs had positively significant effects on self-disclosure intention, supporting the first research hypothesis (H1a&b). Also, the effects of informational and social privacy concerns on self-disclosure intention were found negatively significant, providing supporting evidence for the second research hypothesis (H2a&b). Among the effects of emotional intensity, only the two associated with user needs (i.e. H3b&c) were found significant. Thus, the third research hypothesis was partially supported.

Table 3. Structural Path Estimates

<table>
<thead>
<tr>
<th>Structural Paths</th>
<th>Overall</th>
<th>Chronic</th>
<th>Non-Chronic</th>
</tr>
</thead>
<tbody>
<tr>
<td>Informational Needs -&gt; Self-Disclosure Intention (H1a)</td>
<td>0.177*</td>
<td>0.188**</td>
<td>0.492***</td>
</tr>
<tr>
<td>Social Needs -&gt; Self-Disclosure Intention (H1b)</td>
<td>0.190**</td>
<td>0.181**</td>
<td>0.020</td>
</tr>
<tr>
<td>Informational Privacy -&gt; Self-Disclosure Intention (H2a)</td>
<td>-0.241**</td>
<td>-0.189**</td>
<td>-0.014</td>
</tr>
<tr>
<td>Social Privacy -&gt; Self-Disclosure Intention (H2b)</td>
<td>-0.332***</td>
<td>-0.410***</td>
<td>-0.315***</td>
</tr>
<tr>
<td>Emotional Intensity -&gt; Self-Disclosure Intention (H3a)</td>
<td>-0.023</td>
<td>0.198**</td>
<td>-0.460***</td>
</tr>
<tr>
<td>Emotional Intensity -&gt; Informational Needs (H3b)</td>
<td>0.158*</td>
<td>0.296***</td>
<td>0.126*</td>
</tr>
<tr>
<td>Emotional Intensity -&gt; Social Needs (H3c)</td>
<td>0.239**</td>
<td>0.159*</td>
<td>0.149</td>
</tr>
<tr>
<td>Emotional Intensity -&gt; Informational Privacy (H3d)</td>
<td>-0.152</td>
<td>-0.367***</td>
<td>(0.427***</td>
</tr>
<tr>
<td>Emotional Intensity -&gt; Social Privacy (H3e)</td>
<td>0.047</td>
<td>-0.107</td>
<td>(0.399***</td>
</tr>
</tbody>
</table>

Note: * - Significant at the 0.1 level; ** - Significant at the 0.05 level; *** - Significant at the 0.01 level. An estimate in parentheses had a significant effect of the opposite direction from what was hypothesized.
Across the chronic and non-chronic groups, the estimates varied in strengths and sometimes even directions. For the chronic group, all but one relationship were significant in the directions as hypothesized. For the non-chronic groups, on the other hand, three relationships were not significant. Among the rest, three were found to have opposite directions from what were hypothesized. As most of the relationships were found quite different across two groups, disease nature did moderate the relationships among emotional intensity, user needs, privacy concerns and self-disclosure intention. Thus, the fourth hypothesis (H4) was supported.

Discussion

Supporting most of the hypothesized relationships, the results suggest that the research model is generally sound. In particular, they justify the use of social exchange theory to explain user self-disclosure decision with user needs as perceived benefits and privacy concerns as perceived risks. In addition, they support the differentiation between informational and social aspects of user needs and privacy concerns. It is important to address both aspects as people use health social networks for not only informational purposes but also social purposes. To the best of our knowledge, it is the first time that the concept of social privacy concerns has been discussed in the information system field. We identified the underlying dimensions of social privacy concerns in terms of identification, exposure and intrusion, and developed measures for each. They exhibited good psychometric properties in terms of reliability and validity.

The results also suggest that emotional intensity regulates user needs and privacy concerns. For the same diseases, different users may exhibit different levels of emotional intensity. The inclusion of emotional intensity in the research model enhances its explanation of individual differences in user self-disclosure behavior on health social networks. In addition, disease nature was found to moderate the relationships among emotional intensity, user needs, privacy concerns and self-disclosure intention. For users with chronic conditions, both informational and social aspects of user needs and privacy concerns matter when they decide whether or not to disclose personal information on health social networks. For those with non-chronic conditions, however, informational needs and social privacy concerns play more important roles than social needs and informational privacy concerns. That is, such users disclose personal information mainly for informational purposes rather than social purposes, and they try to avoid social risks more than informational risks, as the descriptive statistics indicate.

The findings of this study provide useful insights on how to facilitate user participation on health social networks. Most importantly, it is essential to enhance the protection of user privacy from both informational and social aspects. To reduce users’ informational privacy concerns, health social networks may invest on security measures to prevent unauthorized access and provide better assurance of collection and secondary use of personal information. To reduce users’ social privacy concerns, the websites need to implement administrative procedures to protect users from potential harms from others due to identification, exposure and intrusion. Compared with informational privacy, social privacy is an issue that requires the joint effort from users, practitioners and policy-makers.

Conclusion

Based on social exchange theory, this study develops a research model to examine why people disclose personal information on health social networks. The empirical results support most of the hypothesized relationships among emotional intensity, user needs, privacy concerns and self-disclosure intention. However, this study is limited in that it employed hypothetical scenarios and student samples. Though they are considered appropriate for this study that involves sensitive subject matter, the results may not be generalizable to the users in the real-world. The limitation points out the direction of future studies to conduct field studies such as surveys and interviews with real users of health social networks.
References


