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The self-disclosure of mental health problems: Its extent, predictors and consequences for people with psychotic disorders

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Summary

Aim. The analysis of the extent, sociodemographic and clinical predictors, and consequences of disclosing mental health problems for people with psychotic disorders.

Method. 147 individuals with a diagnosis of psychotic disorder (ICD-10 categories F20–F29) were examined with questionnaires to assess the extent and consequences of their disclosing of mental health problems to others, as well as their social functioning, depressive symptoms, and the global severity of psychopathological symptoms.

Results. The majority of respondents talked openly about their mental health problems to their parents, spouses or life partners, as well as physicians and other non-psychiatric health care professionals, while a substantial minority (less than one-fifth) talked about these issues to casual acquaintances, neighbors, teachers and lecturers, co-workers, police officers and municipal guards, representatives of the court system, or public officials. Multiple regression analysis showed that the older the respondents were, the less willing they were to disclose their mental problems to others ($\beta = -0.34$; $p < 0.05$). In contrast, the longer they were ill, the more inclined they were to disclose their mental health issues ($\beta = 0.29$; $p < 0.05$). Disclosure of mental health problems had varying effects on the subjects' social relationships, with a significant proportion reporting no difference in the way they were treated by others, while others reported either deterioration or improvement in this area.

Conclusions. The results of the study provide clinicians with practical guidance on supporting and assisting patients with psychotic disorders in the process of making informed decisions about "coming out".

Key words: mental illness, stigma, coming out

Introduction

The stigmatization of people who undergo psychiatric treatment, especially those diagnosed with schizophrenia and other psychotic disorders, is one of the most challenging contemporary mental health concerns [1, 2]. Social stigma is a source of chronic stress for people with mental illness, depriving them of life opportunities, contributing to their social exclusion and having a negative impact on self-esteem, self-efficacy and quality of life while also limiting their access to adequate medical care and leading to worsening treatment adherence. Consequently, it may result in the exacerbation of psychopathological symptoms and constitute a serious obstacle in the recovery process [2–6].

However, people with mental illness are not passive victims of stigma. They use various strategies to avoid rejection and discrimination. One of the most commonly reported is keeping information about their illness secret [7–9]. The large international INDIGO study showed that up to 72% of people with schizophrenia felt the need to conceal their psychiatric diagnosis from others [10]. Similarly, in a Polish study of patients with schizophrenia, two-thirds of respondents admitted that they concealed information about their psychiatric treatment from people outside their immediate family often or very often [11]. This may not come as a surprise if we consider that the vast majority of people in Poland (over 70%) consider mental disorders as an embarrassing problem [12], and a significant proportion of people with mental illness actually experience direct or indirect manifestations of stigma in various areas of their lives [11, 13, 14].

Although concealing mental illness can sometimes protect people against social rejection, it has been shown to be ineffective in reducing the negative impact of stigma on indicators of psychological and social functioning [7, 8]. In addition, as Goffman [15] has observed, the coping strategy of withholding discrediting information comes at large psychological costs, such as persistent tension, anxiety, and fear that the secret might come out at any time. People who withhold embarrassing information are often driven to lead double lives and constantly maintain intense vigilance – continually scrutinizing and analyzing even the most trivial social situations which in others might generate routinely automatic responses. A literature review suggests that concealing a stigmatizing attribute can also result in feelings of shame, guilt, intensified anxiety and depressive symptoms, negatively affecting the person's self-perceptions and contributing to their loneliness and social isolation [16].

Due to the high psychological and interpersonal costs associated with concealing information of this kind, some people with mental illness decide to come out of the closet and disclose their mental illness to others. In practice, however, it is not a matter of a single decision, but rather a complex process which can vary in extent. Although this way of coping with social stigma incurs obvious risks of rejection and discrimination, it can also carry crucial benefits, such as reducing the stress of having to constantly cover up an important aspect of one's identity, improving self-esteem and quality of life, facilitating interpersonal relationships and increasing the possibility of obtaining social support and, finally, raising the political impact the group of affected people might have and increasing its ability to influence stigmatizing social attitudes [17, 18]. Furthermore, although at first glance it may seem paradoxical, in a longitudinal study by Ilic et al. [19] it was selective disclosure rather than concealment of information about mental illness (secrecy) that was associated with less frequent experiences of discrimination at reassessment after 9 months. Selective disclosure also proved to be a predictor of better mental health indicators.

In everyday life, people in psychiatric treatment are constantly facing the dilemma of whether to tell about their situation and, if so, how, where, when and with whom they can talk. To support patients in this regard, clinicians cannot rely only on their intuitions but on the sound knowledge and good understanding of the determinants and consequences of these personal decisions to disclose potentially stigmatizing information in a particular local socio-cultural context. In Poland, these issues have not received enough attention and have not been comprehensively or systematically studied. Therefore, in the presented study, the authors have attempted to explore and analyze the attitudes and experiences of Polish patients diagnosed with psychotic disorders with regards to the disclosure of information about their mental illness. Who do they tell about their illness? What responses do they encounter? What factors influence their decision to openly share their experience?

Research objectives

The study pursued the following objectives:

1. to assess the extent to which people with a diagnosis of psychotic disorder disclose information about their mental health problems, according to the type of a social relationship;
2. to identify sociodemographic and clinical predictors of the extent of disclosure of information about mental health problems;
3. to analyze the impact of disclosure of information about mental health problems on the quality of social relationships.

Due to the exploratory nature of the study, no specific hypotheses were formulated.

Material and method

Participants

The participants were recruited between December 2016 and September 2019 among the patients treated at the Institute of Psychiatry and Neurology in Warsaw (in inpatient and day wards, a community mental health center, and an outpatient clinic). The inclusion criteria were as follows: diagnosis of psychotic disorders (F20–F29 according to ICD-10), age over 18, written informed consent. Exclusion criteria were active addiction to psychoactive substances, documented intellectual disability or clinically significant organic changes in the central nervous system, unstable mental state or increased cognitive deficits in the assessment of the attending physician that prevented the patient from reliably completing the required set of questionnaires.

Finally, 147 patients participated in the study. Their sociodemographic and clinical characteristics are summarized in Table 1.

Table 1. **Sociodemographic and clinical characteristics of the subjects (n = 147)**

Characteristic		n (%), mean (SD)
Sex		
	Men	72 (49.0)
	Women	75 (51.0)
Age (years)		40.8 (13.2)
Marital status		
	Married or in an informal partnership	23 (15.6)
	Single (never married)	103 (70.1)
	Widowed	4 (2.7)
	Separated or divorced	17 (11.6)
Living circumstances		
	Living alone	39 (26.5)
	Living with other people	108 (73.5)
Education		
	Primary or vocational	9 (6.1)
	Secondary	65 (44.2)
	Higher	73 (49.7)
Employment		
	Employed	46 (31.3)
	Unemployed, looking for a job	21 (14.3)
	Students	14 (9.5)
	Retired	11 (7.5)
	Pensioners	52 (35.4)
	Persons running a household	3 (2.0)
Place of residence		
	Village	8 (5.4)
	Town <100,000 inhabitants	21 (14.3)
	City >100,000 inhabitants	118 (80.3)
Diagnosis (according to ICD-10)		
	Schizophrenia (F20)	134 (91.2)

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	Schizotypal disorder (F21)	1 (0.7)
	Delusional disorder (F22)	2 (1.4)
	Acute psychotic disorder (F23)	9 (6.1)
	Schizoaffective disorder (F25)	1 (0.7)
Psychiatric facility		
	General inpatient ward	30 (20.4)
	Early rehabilitation inpatient ward	23 (15.6)
	Day ward	55 (37.4)
	Community mental health center	12 (8.2)
	Outpatient clinic	27 (18.4)
Duration of illness (years)		16.3 (13.1)
Number of inpatient hospitalizations		5.3 (6.2)

Measures

A modified version of the *Questionnaire for Assessing the Disclosure of Mental Health Problems*, previously used in an American study conducted under the aegis of the National Alliance on Mental Illness (NAMI) [20], was used to evaluate the extent to which respondents disclosed information about their mental health problems in different types of interpersonal relationships, and the impact of disclosure on the quality of these relationships. The instrument was designed primarily to identify qualitative aspects of the disclosure process, particularly its dependence on interpersonal context. In the first part of the questionnaire, which contains 15 items, respondents rate, on a scale from 1 (“not at all openly”) to 5 (“completely openly”), how openly they talk about their mental health problems to different people or groups of people, e.g., parents, partners, friends, neighbors, casual acquaintances, public officials, co-workers, supervisors at work. In the second part of the questionnaire, the respondents specify whether, after disclosing information about their mental health problems, they were treated worse, the same or better by the persons or groups of persons mentioned in the first part of the questionnaire. In both parts of the questionnaire, a “not applicable” option can also be selected. The second part of the questionnaire was used only to qualitatively describe the impact of disclosure of mental health problems on the patients’ social relationships. A total score was calculated for the first part (Cronbach’s α coefficient was 0.94) to allow the analysis of predictors of the participants’ disposition to disclose information about their mental problems. A higher score indicated a greater extent of self-disclosure.

The *Personal and Social Performance Scale* (PSP) was used to measure the level of social functioning of patients [21]. It is a simple ordinal scale with 10 defined intervals. The assessment of social functioning is performed by the clinician using a scale from 1 to 100 points. The assessment takes into account 4 main domains: socially useful activities (including work and study), personal and social relationships, self-care, and disturbing and aggressive behaviors. A higher score indicates better functioning.

The severity of depressive symptoms was measured using the *Center for Epidemiologic Studies Depression Scale-Revised* (CESD-R) [22]. The CESD-R is a self-report scale consisting of 20 items relating to various depressive symptoms. Respondents mark the frequency of their occurrence in the preceding few days on a scale from 0 to 4, where 0 stands for not at all or less than 1 day; 1 for 1–2 days; 2 for 3–4 days; 3 for 5–7 days, and finally 4 for nearly every day for 2 weeks. The higher the total score, the more severe the depressive symptoms ($\alpha = 0.93$).

The *Brief Psychiatric Rating Scale* (BPRS) [23] was applied to assess the severity of the subjects' psychopathological symptoms. The BPRS includes 18 symptoms rated by the clinician on a 7-point scale (1 stands for symptom not present, 7 for extremely severe symptom). A higher total score indicates a greater overall severity of psychopathological symptoms ($\alpha = 0.84$).

For all instruments used in the study, total scores were calculated by summing-up the points scored on each item and then dividing the total value by the number of valid responses. In addition to minimizing the impact of missing data, an advantage of this approach is that the global score, calculated in this way, is easy to interpret and immediately provides information about the severity of the measured construct.

Procedure

The current study is part of a larger project. The presented data originate from the first phase of the study *Extent, determinants and consequences of concealing and disclosing mental illness by people with a diagnosis of psychotic disorders: a longitudinal study*. The research was approved by the Bioethics Committee of the Institute of Psychiatry and Neurology in Warsaw (resolution No. 17/2016). The patients who met the inclusion criteria for the study were thoroughly briefed about its objectives, conditions of participation, duration, methods and potential benefits, and were assured of the confidentiality of the collected data, following which they were asked to sign an informed consent form.

The questionnaires used to assess the extent and consequences of the disclosure of information about mental health problems and to assess the severity of depressive symptoms (CESD-R) were completed by the patient alone or, depending on personal preferences, in the presence of the researcher. A clinician, after reviewing the patient's medical records, conducting an interview as appropriate, and examining the patient completed the scales assessing the level of the patient's social functioning (PSP) and the global severity of psychopathological symptoms (BPRS).

Sociodemographic information was obtained from the participants and, when necessary, verified or supplemented with data from medical records.

Statistical analyses

Means (*M*) and standard deviations (*SD*) or percentages were calculated for all variables included in the study, depending on their type. The internal consistency of the scales used in the study was analyzed using Cronbach's α coefficient. Linear multiple regression was used to assess the associations between sociodemographic and clinical variables and the extent of disclosure about mental health problems. Collinearity was assessed by examining the Variance Inflation Factor (VIF); the VIF values above 10 were taken as an indicator of collinearity between independent variables [24]. The analyses were performed in the R environment [25]. A significance level of $p < 0.05$ was assumed in all analyses.

Results

Mean scores on the PSP (*M* = 62.27; *SD* = 15.23; possible range: 1–100), the CESD-R (*M* = 1.15; *SD* = 0.85; possible range: 0–4) and the BPRS (*M* = 1.96; *SD* = 0.56; possible range: 1–7) indicate manifest, but not marked difficulties in social functioning and a relatively low severity of depressive symptoms and other psychopathological symptoms in the sample.

Table 2 summarizes the mean scores obtained by the subjects on each item of the first part of the *Questionnaire for Assessing the Disclosure of Mental Health Problems*, along with the total score.

Table 2. **The extent of respondents' openness about their mental illness according to type of social relationship (n = 147)**

How openly did you talk about your mental health problems to:	Mean	Standard deviation (SD)	Number and percentage of valid responses (excluding "not applicable")	
			n	%
Parents	3.58	1.24	137	93.2
Wife/husband or partner	3.24	1.44	75	51.0
Children	2.00	1.35	35	23.8
Extended family	2.11	1.07	142	96.6
Friends	2.55	1.15	138	93.9
Casual acquaintances	1.49	0.84	143	97.3
Teachers and/or lecturers	1.47	0.77	97	66.0
Co-workers	1.60	0.82	111	75.5
Employers and/or supervisors at work	1.84	1.01	116	78.9
Clergy	1.99	1.19	121	82.3
Neighbors	1.37	0.74	144	98.0

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Doctors and other non-psychiatric health care providers	2.81	1.26	144	98.0
Police officers and/or municipal guards	1.54	1.08	115	78.2
Representatives of the court system	1.70	1.28	103	70.1
Public officials	1.69	0.96	133	90.5
Average total score	2.08	0.59	–	–

1 – not at all openly; 2 – slightly openly; 3 – moderately openly; 4 – very openly; 5 –completely openly

The total score, which was only marginally higher than 2 (“slightly openly”), indicated that the respondents were generally very reluctant to disclose information about their mental health problems. Only in relation to two categories of relationships, i.e., with parents and wives/husbands or partners, did the scores reach the level between 3 (“moderately openly”) and 4 (“very openly”), which indicated a relatively high degree of openness. The respondents were least likely to disclose their mental health problems to casual acquaintances, neighbors, teachers and lecturers, co-workers, employers and supervisors at work, police officers and municipal guards, representatives of the court system, public officials and clergy – results ranged between 1 (“not at all openly”) and 2 (“slightly openly”). Notably, in some items a significant number of participants selected “not applicable”, e.g., one quarter in relation to co-workers, half in relation to wives/husbands or partners, and three-quarters to children.

For a fuller understanding of these results, they have been visualized as Figure 1. Instead of means, percentages of people who answered 3 (“moderately openly”), 4 (“very openly”), or 5(“completely openly”) on each item are presented, i.e., participants who can be categorized as people who are relatively open about their mental health problems.

The results indicate that the vast majority of respondents spoke openly about their mental health problems to their parents, wives/husbands or partners; more than half spoke openly to doctors and other non-psychiatric health care workers, and fewer than half to friends. Only a small percentage of the respondents disclosed such information in less intimate or even casual contacts (neighbors, teachers and lecturers, casual acquaintances, police officers and municipal guards, public officials, or co-workers).

Table 3 presents the results of a multiple regression analysis showing the associations of sociodemographic and clinical variables with respondents’ willingness to disclose information about their mental health problems. The independent variables included in the analysis explained only 10.5% of the variance in the dependent variable. Only two variables, i.e., age and duration of illness, proved to be the significant predictors of the extent of disclosure. The older the respondents were (with all other variables included in the model controlled), the less openly they talked about their mental problems to others ($\beta = -0.34$; $p < 0.05$). In contrast, the longer they were ill, the more willing they were to disclose their mental problems ($\beta = 0.29$; $p < 0.05$). VIF values for individual independent variables ranged from 1.12 to 3.61, indicating no collinearity problems.

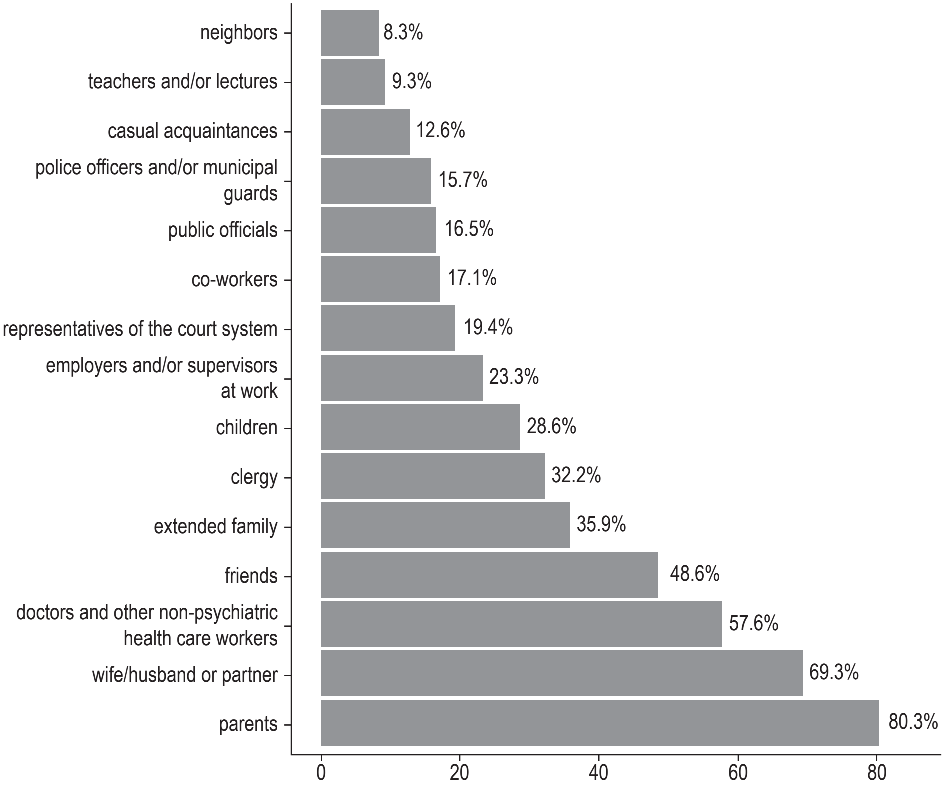

Figure 1. **Percentages of respondents who talked openly about their mental health problems (n = 147)**

The chart includes the percentages of respondents who were at least moderately open about their mental health problems to individuals or groups of individuals.

Table 3. **Results of multiple linear regression analysis showing associations of sociodemographic and clinical variables with extent of disclosure of mental health problems (n = 147)**

Predictor	B	β	sr^2	r	R^2
(Constant)	2.27**				
Gender (0 – female, 1 – male)	–0.09	–0.07	0.00	–0.06	
Place of residence (0 – village or town <100,000 inhabitants, 1 – city >100,000 inhabitants)	0.23	0.15	0.02	0.14	
Age	–0.02*	–0.34	0.03	–0.07	
Education (0 – secondary or lower, 1 – higher)	0.04	0.03	0.00	0.00	

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Marital status (0 – single, widowed, divorced or separated, 1 – married or in an informal partnership)	0.18	0.11	0.01	0.06	
Living circumstances (0 – living with other people, 1 – living alone)	–0.03	–0.02	0.00	–0.03	
Employment (0 – not working, 1 – working or studying)	0.07	0.06	0.00	0.11	
Duration of illness (years)	0.01*	0.29	0.03	0.09	
Number of inpatient hospitalizations	0.01	0.10	0.01	0.09	
Psychiatric facility (0 – inpatient ward, 1 – day ward, community mental health center or outpatient clinic)	0.10	0.08	0.01	0.04	
Social functioning (PSP)	0.00	–0.07	0.00	–0.05	
Psychopathological symptoms (BPRS)	0.04	0.03	0.00	0.06	
Depressive symptoms (CESD-R)	0.00	0.00	0.00	0.03	
					0.105

Dependent variable: total score of the first part of the Questionnaire for Assessing the Disclosure of Mental Health Problems.

B – non-standardized regression coefficient; β – standardized regression coefficient; sr^2 – semi-partial correlation squared; r – Pearson's linear correlation coefficient; R^2 – coefficient of determination. Statistically significant coefficient B at the same time means statistically significant coefficient β and semi-partial correlation coefficient.

* $p < 0.05$; ** $p < 0.01$.

Figure 2 illustrates the respondents' answers to questions of the second section of the *Questionnaire for Assessing the Disclosure of Mental Health Problems*, indicating whether they were treated worse, the same or better after disclosing their problems.

The results of this analysis show that across all types of social contact, a significant proportion of respondents perceived no change in the way they were treated after disclosing their mental health problems (ranging from nearly half – 44% – when it came to talking to their parents, to nearly three-quarters – 74% – to their doctors and other non-psychiatric health care professionals). Most respondents felt treated better when it came out that they experienced mental health problems by their parents (38%), followed by children (24%), clergy (22%), wives/husbands or partners (19%), as well as teachers and lecturers (18%). In contrast, it was most common for disclosure of mental problems to impair relationships with casual acquaintances (42%), neighbors (32%), police officers and municipal guards (31%), employers/supervisors at work and co-workers (30% each).

Discussion

The primary aim of this research was an in-depth analysis of attitudes and experiences of Polish patients with a diagnosis of psychotic disorders regarding the disclosure of information about their mental health problems to other people. Coming out can be an effective method of reducing the stress associated with social stigma, but the

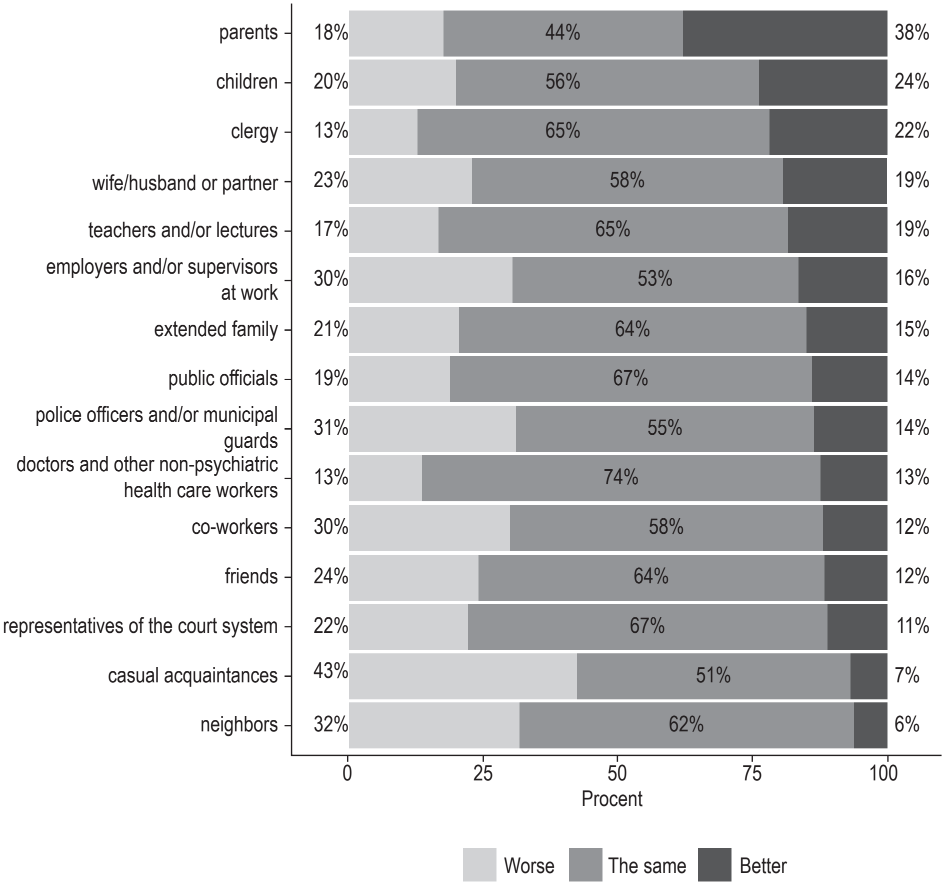

Figure 2. **Percentages of respondents who were treated worse, the same or better by individuals or groups of individuals when it came to light that they had a mental health problem (n = 147)**

Only valid responses are included in the chart (excluding "not applicable").

decision to disclose potentially discrediting information is personal and complex, as it depends on the specific situation and individual characteristics of each person [26, 27]. Understanding the determinants and consequences of these decisions is important for both clinical practice and public health interventions aimed at combating stigma and preventing the social exclusion of people with mental illness.

Extent of disclosure by type of social relationship

The results of the study clearly indicate that patients with psychotic disorders are generally very reluctant to tell other people about their mental health problems. They might in fact be aware that in the Polish society the prevailing belief is that mental illness is an embarrassing problem that should be concealed [12]. However, the scale of openness in this regard shows a very high degree of variation, depending on the type of social relationship. The vast majority spoke openly about their mental health problems to their parents (80%), wives/husbands and partners (69%). In studies conducted in other countries, e.g., the Netherlands and the United States, parents and partners were also among the categories of people with whom respondents were most willing to share information about their illness [20, 28, 29]. Similarly, in an Australian study respondents were most likely to disclose their mental health problems to their spouses/partners (parents were not included in this study) [30]. These results are not surprising, as relationships with parents, spouses or partners are among the most intimate, and generally feature a high degree of mutual trust. Not without significance is also the fact that in such close relationships, concealing information about mental illness may simply be very difficult or even impossible. It is worth noting, however, that even in the case of such intimate contact, 20–30% of respondents did not choose to talk openly about their mental problems.

Only less than half of respondents (49%) disclosed their mental health problems to friends, and even fewer – just over a third (36%) – to extended family. This clearly shows that the shame associated with mental illness, and the fear of rejection, can cause great difficulty in seeking understanding and support, even from people in the patients' close social circle. Moreover, only 29% of respondents openly talked about experiencing mental problems to their children. A similar result (33%) was obtained in an American study conducted among people with schizophrenia [20]. So while patients generally disclose their mental problems to parents and spouses or partners, the vast majority conceal them from children. The motive may be assumed to be the fear of losing parental authority. This example well demonstrates, however, that it is not the closeness or intimacy of the relationship alone that determines the willingness to talk openly about one's experiences of mental illness or of undergoing psychiatric treatment.

Interestingly, only slightly more than half of the respondents (58%) admitted that they talked openly about their mental problems to doctors and other non-psychiatric health care professionals. This is markedly fewer than in a study of people diagnosed with schizophrenia in the United States, in which the proportion of respondents disclosing their mental issues to doctors exceeded 90% [20], but significantly more than in an Australian study in which as many as two-thirds of participants admitted that they did not speak about their mental disorders to healthcare professionals [30]. Keeping mental illness secret from doctors of various specialties can have serious negative consequences for patients, as it makes it difficult to reliably assess their health status (including the somatic dimension) and select appropriate, safe pharmacotherapy (e.g., taking into account possible interactions with medications prescribed by a psychiatrist). Thus, the key question is what might be the reasons for patients' reluctance to disclose their mental problems to health professionals? Of great significance might be the fact that patients are often under the impression that their somatic problems are taken less seriously by physicians after the disclosure of a psychiatric diagnosis [20]. A review of studies suggests that a considerable proportion of medical staff show discriminatory attitudes towards people with mental illness, which may contribute to a reduced quality of the health services provided to them [31]. This indicates an urgent need to counteract the stigma of mental illness among medical students and health care professionals, e.g., through educational interventions or anti-stigma training with people who have experienced mental health crises as “experts by experience” [31, 32].

A distinct minority of respondents could talk openly about their mental health problems to clergy (less than one third), employers and supervisors at work (less than a quarter), representatives of the court system, co-workers, public officials, police officers and municipal guards, casual acquaintances (just over ten percent), and to teachers, lecturers and neighbors (less than one tenth). These results seem to correspond well with the findings of Polish public opinion surveys, according to which most Poles believe that people with mental illness are discriminated against in terms of the right to work/employment, respect for personal dignity, education or protection of property, and almost half perceive discrimination due to mental illness in terms of the right to a fair trial [12]. People with mental illness are likely to share these pervasive beliefs in society, and their fear of coming forward is largely attributable to this. Personal experiences of stigma are probably no less of a factor. For example, Cechnicki et al. [14] showed that as many as 87% of patients with a diagnosis of schizophrenia experienced rejection because of their mental illness.

At the same time, the above results indicate the professional groups (e.g., clergy, employers and people holding managerial positions, public officials, law enforcement officers) that should be instructed in anti-stigmatization interventions. By virtue of their roles, the representatives of these groups can seriously affect the lives of people with mental illness; it must be emphasized in this context that people who are in psychiatric treatment should be able to expect understanding rather than fear worse treatment after disclosing their mental problems.

Predictors of disclosure

In multiple regression analysis, of all the sociodemographic and clinical variables included in the model, only two, i.e., age and duration of illness, proved to be independent predictors of respondents’ willingness to disclose information about the mental problems they experienced to others. The respondents’ inclination to disclose this information about themselves decreased with age. However, no far-reaching conclusions can be drawn from this, as the result contradicts the findings of some studies conducted in other countries, according to which younger patients were more likely to conceal their mental health problems [29]. It is difficult to clearly state the potential role of methodological issues (e.g., related to the measurement of concealment/disclosure), cultural context or the specificity of the studied populations in these discrepancies.

Regarding the duration of an illness, the longer it lasted, the more willing the respondents were to talk openly about their mental problems. One possible interpretation is that a longer duration of illness is associated with longer contact with the mental health system, where patients receive various forms of therapy, including psychosocial interventions. It is plausible that, at least in some cases, these comprehensive therapeutic interventions prevented self-stigmatization, among other things [33], and consequently promoted openness. Moreover, it seems likely that over time, people with a longer experience of mental health illness learn to manage information about their mental problems and disclose it selectively.

Interestingly, in our sample the degree of openness in talking about one's mental health problems showed no relationship with the degree of social functioning, severity of depressive symptoms, or the global severity of psychopathological symptoms. Thus, based on these data no simple relationship between disclosure and current mental status can be concluded. This issue requires further research, as some of the previous studies yielded different results [29].

When discussing the predictors of disclosure, it should be stressed that the variables included in the multiple regression model explained only 10.5% of the variance in the dependent variable. This points to the conclusion that other variables, not included in the analysis presented here, show stronger relationships with patients' decisions to conceal or disclose their mental health problems. The literature review suggests that these may include subjective experiences of stigma, social support, self-esteem, self-efficacy, empowerment or beliefs about mental health problems and psychiatric treatment [29].

Impact of disclosure on social relationships

Disclosure of information about mental health problems had varying effects on the respondents' social relationships. A significant proportion of people in our sample (ranging from nearly half to nearly three-quarters, depending on the type of the relationship) noted no difference in the way they were treated by others, while there were also those who reported worse or better treatment. The respondents were by far most likely to feel better treated by their parents, followed by children and clergy, while worse treatment was most often reported in connection with casual acquaintances, neighbors, police officers and municipal guards, employers/supervisors at work, and co-workers. Thus, a notable trend is that the less intimate and more casual or formal the contact, the more likely is a negative reaction to information about mental health problems. Yet the relationship is not simple; for example, whereas in the case of husbands/wives or partners 19% of patients reported an improvement in the relationship after disclosure of mental health problems, but even more (23%) reported its deterioration.

The obtained results allow us to conclude that patients' fears of talking openly about their mental health problems in fact often turned out to be unfounded; for all categories of people included in the study, the neutral and positive reactions summed up more or less outweighed negative responses. On the other hand, patients' concerns should be treated as fully acknowledged, given that for all types of relationships, a significant proportion of participants (ranging from 13% to 42%) recognized a negative impact of disclosing mental problems. The responses are thus difficult to predict and disclosure always carries the risk of stigmatization.

Limitations of the study

The study presented in this paper has several significant methodological limitations. First of all, it is important to bear in mind that the respondents were recruited at only one psychiatric facility, located in a large city. Thus, the sample may not be representative of the entire population of people with psychotic disorders. Another limitation relates to the instrument used to assess the extent and consequences of the disclosure of mental health problems, which is an adaptation of a questionnaire developed in the United States, and its reliability and validity have not yet been satisfactorily documented. Finally, the research was exploratory in nature and did not include consideration for the motives behind patients' decisions to disclose or conceal information about mental health problems or the relationship between disclosure and various aspects of the subjective experience of social stigma, personal resources, or indicators of the recovery process.

Recapitulation and conclusions

In summary, it can be said that people with psychotic disorders are reluctant to disclose information about their mental health problems to others, and also that they do so selectively. This clearly shows that despite numerous local and national programs and campaigns against stigma [1, 32, 34], in Poland mental disorders remain an embarrassing issue that patients find difficult to talk about openly. It is therefore necessary to intensify anti-stigmatization efforts, keeping in mind that they need to be target-specific [35], which means that they should target the particular stigmatizing attitudes and behaviors of specific groups (e.g., employers, representatives of the court system, doctors) rather than social attitudes towards people with mental illness in general. The results of the current study may be helpful in identifying groups that people in psychiatric treatment are particularly afraid of when it comes to talking openly about their mental health problems, or by whom they feel treated unfavorably when these problems come to light.

The varying responses of the people in the community to information about our participants' mental health problems make it clear that disclosure is not always beneficial, and it is imperative that patients' decisions to keep their illness private be respected [26, 29]; such decisions must be individual and autonomous.

Disclosure is a complex process that depends on the patient's individual characteristics (for example, in light of the results of the current study, on their age or the duration of their illness), their beliefs about mental illness and the meaning they give to it, the situational context, and finally the type of social relationships. Thus, it is not possible to develop universal guidelines or rules regarding the optimal way or extent of disclosing information about one's mental problems. However, preliminary evidence has been gathered that using a structured intervention (*Honest, Open, Proud*), aimed at supporting people with mental illness in their decisions to disclose, can reduce stigma-related stress and the tendency to self-stigmatize [27]. We believe that the presented study can provide clinicians with practical guidance on supporting patients with psychotic disorders to make informed decisions about coming out, and thus in their personal recovery process.

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