Akademika 95(3), October 2025
https://doi.org/10.17576/akad-2025-9503-34

Understanding Openness: Factors Influencing Individuals' Willingness to Share Mental Health Experiences

Memahami Keterbukaan: Faktor-Faktor yang Mempengaruhi Kesediaan Individu untuk Berkongsi Pengalaman Kesihatan Mental

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Received: 16-6-2025 /Accepted: 7-10-2025

ABSTRACT

Despite increasing global awareness of mental health, many individuals remain hesitant to disclose their struggles. Understanding the factors that influence openness is critical for fostering supportive environments and reducing stigma. While prior research has examined mental health stigma broadly, less attention has been given to the nuanced internal and external influences on individuals' willingness to share their experiences. This study explores the barriers and enablers to mental health disclosure among young adults diagnosed with anxiety, depression, or personality disorders. Using a descriptive phenomenological qualitative approach, semi-structured interviews were conducted with five participants in their twenties who had received clinical diagnoses. Findings revealed a complex interplay of psychological, relational, and sociocultural factors. Barriers included fear of judgment, internalized stigma, and unsupportive reactions from family, peers, or professionals. Negative experiences, such as being dismissed as "dramatic" or "unstable," further reinforced silence. Enablers included trusted relationships, emotionally safe environments, and a motivation to challenge stigma through openness. These findings highlight the need for culturally sensitive interventions that address both personal and societal aspects of stigma. Promoting mental health literacy, empathetic communication, and psychologically safe spaces, particularly in families, workplaces, and educational institutions is essential. By identifying the conditions that foster openness, stakeholders can design more effective strategies to support mental health disclosure, reduce stigma, and enhance recovery outcomes for young adults. This study contributes valuable insights into the lived experiences of those navigating the complex decision to speak about their mental health.

Keywords: Openness; Stigma; Social Support; Qualitative study; Young Adults

ABSTRAK

Walaupun kesedaran global terhadap kesihatan mental semakin meningkat, ramai individu masih berasa ragu-ragu untuk mendedahkan perjuangan yang mereka harungi. Kefahaman terhadap faktor-faktor yang mempengaruhi keterbukaan adalah penting untuk mewujudkan persekitaran yang menyokong dan mengurangkan stigma terhadap kesihatan mental. Walaupun banyak penyelidikan meneliti stigma kesihatan mental secara umum, namun terdapat jurang terhadap pengaruh dalaman dan luaran yang mempengaruhi kesediaan individu untuk berkongsi pengalaman mereka. Kajian ini meneroka halangan dan keterbukaan dalam berkongsi pengalaman kesihatan mental dalam kalangan belia dewasa yang didiagnosis dengan kebimbangan (anxiety), kemurungan (depression), atau gangguan personaliti. Menggunakan pendekatan kualitatif fenomenologi deskriptif, temu bual separa berstruktur dijalankan bersama lima peserta berusia lingkungan dua puluhan. Dapatan menunjukkan wujudnya interaksi yang kompleks antara faktor psikologi, hubungan sosial, dan sosio-budaya. Halangan termasuk ketakutan terhadap penerimaan, stigma, serta kuran sokongan daripada keluarga, rakan sebaya, atau profesional. Pengalaman negatif seperti dilabel "dramatik" atau "tidak stabil" turut mendorong untuk berdiam diri. Faktor yang mendorong keterbukaan pula termasuk hubungan yang dipercayai, persekitaran emosi yang selamat, serta motivasi untuk mencabar stigma melalui perkongsian pengalaman. Dapatan ini menekankan keperluan intervensi yang peka budaya bagi menangani aspek peribadi dan sosial stigma. Usaha meningkatkan literasi kesihatan mental, komunikasi empatik, dan ruang psikologi yang selamat — terutamanya dalam keluarga, tempat kerja, dan institusi pendidikan — adalah amat penting. Dengan mengenal pasti keadaan yang mendorong keterbukaan, pihak berkepentingan dapat mereka strategi yang lebih berkesan untuk menyokong pendedahan kesihatan mental, mengurangkan stigma, dan meningkatkan hasil pemulihan dalam kalangan belia dewasa. Kajian ini menyumbang pandangan berharga terhadap pengalaman hidup individu yang bersikap terbuka untuk berkongsi tentang kesihatan mental mereka.

Kata kunci: Keterbukaan; Stigma; Sokongan Sosial; Kajian Kualitatif; Belia Diwas

INTRODUCTION

Mental health is a significant global concern, with an estimated 970 million people affected in 2019, particularly by anxiety and depression (Moitra et al., 2023). Global crises such as the COVID-19 pandemic have further intensified these challenges, contributing to increased rates of anxiety, depression, post-traumatic stress disorder (PTSD), and sleep disturbances (Nochaiwong et al., 2021; Mohamad, 2022; Li et al., 2022). Despite growing awareness, stigma and limited access to affordable care continue to prevent many from seeking help, leaving millions untreated and affecting families, workplaces, and communities (World Health Organization, 2022; Omidoyin, 2024).

Disclosure of mental health experiences is often essential for accessing support, fostering understanding, and combating stigma (Corrigan, 2004; Fino et al., 2019). Yet willingness to disclose remains limited, particularly among individuals with anxiety, depression, or personality disorders. Existing literature highlights stigma as a major barrier, where fear of judgment, rejection, or negative stereotyping fosters internalized shame and withdrawal (Vogel et al., 2006). However, less attention has been paid to the wider range of influences shaping disclosure decisions, such as interpersonal experiences, perceived social support, cultural norms, and the safety of the environment (Vogel et al., 2007; Corrigan & Rao, 2012; Rüsch et al., 2005).

In Malaysia, where mental health remains a sensitive topic, cultural and societal expectations further complicate openness (Hanafiah & Van Vortel, 2015; Ibrahim, Amit & Che Din, 2019; Aris & Zubaidah, 2022). Disclosure may be seen as a source of shame or dishonour, particularly within collectivist family structures, often reinforcing silence. Yet little research has examined how these cultural factors intersect with individual experiences to shape disclosure.

This study addresses this gap by exploring barriers and facilitators of mental health disclosure among Malaysians diagnosed with anxiety, depression, or personality disorders. By centering lived experiences, it aims to extend current literature and inform culturally sensitive interventions, family and community support, and stigma-reduction strategies.

LITERATURE REVIEW

The decision to disclose mental health issues remains complex and multifaceted. A growing body of research has explored the psychological, social, and organizational factors that influence individuals' willingness or reluctance to disclose their mental health status. Several key themes consistently emerge in the literature.

Firstly, stigma remains one of the most significant barriers to mental health disclosure. Individuals often fear being judged, marginalized, or facing discriminatory treatment upon revealing their mental health struggles (Corrigan et al., 2010; Hanafiah & Van Bortel, 2015; Chan et al, 2022). Public stigma, self-stigma, and anticipated stigma have been found to shape disclosure decisions negatively (Clement et al., 2015; Dagani et al., 2023). This concern is especially pronounced in workplaces where mental health conditions may be perceived as a weakness or a liability (Brohan et al., 2012; King et al., 2020).

Secondly, the nature of the work environment plays a crucial role in shaping disclosure behavior. Research indicates that psychologically safe workplaces, where employees feel supported and respected, are associated with higher mental health disclosure rates (Milligan-Saville et al., 2017; Bondevik, 2011). Conversely, environments characterized by job insecurity,

high stress, or unsupportive management may drive employees to conceal mental health issues for fear of retaliation or loss of status (Evans-Lacko et al., 2013).

Thirdly, disclosure is further influenced by individual identity factors such as gender, ethnicity, cultural background, and professional roles (Kreps, 2017). For instance, men and individuals from collectivist cultures may be less inclined to disclose mental health struggles due to normative expectations around emotional expression and strength (Vogel et al., 2011; Han & Pong, 2015). Intersectionality theory suggests that multiple identity dimensions affect individuals' experiences and decisions, including those related to disclosure (Crenshaw, 1991).

Fourthly, decisions about when and to whom to disclose mental health issues are highly strategic. Individuals often assess the potential benefits of receiving support against the risk of social or professional repercussions. Studies have shown that disclosure is more likely when individuals trust the recipient and believe the context is appropriate (Bos et al., 2009; Nowell et al., 2023). Timing also plays a role; individuals may delay disclosure until a crisis point is reached or until they perceive sufficient psychological safety.

Finally, organizations that actively promote mental health awareness, provide access to mental health resources, and demonstrate leadership commitment are likelier to foster cultures where disclosure is normalized (Martin et al., 2016; Sampaio et al., 2022). Policies such as Employee Assistance Programs (EAPs), mental health training for managers, and anti-stigma campaigns have increased employees' willingness to seek help and disclose mental health issues (Dimoff & Kelloway, 2019). Collectively, these themes illustrate that mental health disclosure is not solely an individual decision but is deeply embedded in social contexts, workplace dynamics, and cultural norms. Understanding these interrelated factors is essential for developing effective interventions and policies supporting mental health transparency and reducing stigma in professional and community settings.

Mental health disclosure is a complex decision-making process influenced by multiple contextual and individual factors. The Disclosure Decision-Making Model (DD-MM) by Greene (2009) provides a valuable framework for understanding how individuals assess the potential risks and benefits of revealing mental health conditions. According to this model, decisions are shaped not only by personal readiness but also by perceptions of the anticipated response from the recipient. This is especially salient in collectivist cultures, such as those in many Asian or Middle Eastern societies, where mental illness is often perceived as a source of shame and family dishonour (Ng, 1997; Umeh & Chukwuorji, 2020). As such, individuals from these backgrounds may be more inclined to conceal their mental health status, fearing ostracism or damage to familial reputation. Conversely, in individualistic cultures where autonomy and self-expression are valued, disclosure may be seen as a step toward empowerment and recovery (Kim et al., 2006). Empirical studies show that disclosure can lead to both beneficial and adverse outcomes. For instance, research by Rüsch et al. (2005) found that while some individuals experienced increased social support and access to mental health services post-disclosure, others faced stigma, social rejection, or workplace discrimination. These mixed outcomes underscore the need for culturally sensitive approaches and supportive environments encouraging safe and informed disclosure practices.

Cultural, societal, and organizational factors influence the disclosure of mental health in Malaysia (Hanafiah & Van Vortel, 2015; Ibrahim, Amit & Che Din, 2019; Aris & Zubaidah, 2022). Despite growing awareness, stigma remains a significant barrier to open discussions about mental health. A study by Ibrahim et al. (2019) highlighted that low mental health literacy among Malaysian youth contributes to reluctance in seeking help, with only 47% correctly identifying key symptoms of depression. This lack of awareness, coupled with societal stigma, often leads

individuals to conceal their mental health struggles. In the workplace, the fear of discrimination further complicates the disclosure process. Zolkefli (2021) found that healthcare professionals in Malaysia grapple with the dilemma of disclosing mental health issues to employers, balancing personal privacy against professional obligations. The absence of clear policies and support systems exacerbates this challenge, leading many to remain silent about their conditions. However, initiatives are underway to address these concerns. The Malaysian Ministry of Health, in collaboration with the Ministry of Human Resources, has launched programs such as KOSPEN-WOW to promote mental health awareness in the workplace (WHO Malaysia, 2023). These efforts aim to create supportive environments that encourage open discussions and reduce stigma.

Furthermore, cultural nuances play a pivotal role in disclosure decisions. Ng (1997) emphasized that in collectivist societies like Malaysia, mental illness is often viewed through a lens of shame, deterring individuals from seeking help. This cultural backdrop necessitates tailored interventions that respect societal values while promoting mental well-being. In summary, significant challenges persist, despite strides made to improve mental health literacy and reduce stigma in Malaysia. Addressing these requires a multifaceted approach that encompasses education, policy reform, and culturally sensitive interventions to foster an environment conducive to mental health disclosure.

METHODOLOGY

RESEARCH DESIGN

This study adopts a qualitative phenomenological approach to deeply explore the lived experiences of individuals with mental health challenges and the factors that influence their willingness to disclose those experiences. The phenomenological approach to studying mental health issues focuses on understanding individuals' lived experiences, emphasizing subjective perception rather than objective measurement (Fuchs, Messass & Stanghellini, 2019). This method is particularly valuable in psychiatry and psychology, as it provides deep insights into how individuals experience mental health conditions, emotions, and interactions with the world (Brinkmann, 2014). Semi-structured interviews serve as the primary data collection method, with questions crafted to elicit rich, nuanced insights into the enablers and barriers to mental health disclosure. A semi-structured interview is a valuable method for studying mental health experiences, as it balances structure with flexibility, allowing researchers to explore participants' perspectives in depth (Brinkman, 2014).

PARTICIPANTS

The participants in this study comprise individuals who have personally experienced mental health challenges and have, at some point, encountered internal or external dilemmas related to disclosing their experiences to others. Their insights are vital in understanding the complex interplay of personal, social, and cultural factors that influence openness about mental health. To ensure the relevance and richness of the data collected, participants were selected through purposive sampling, a method that allows for the deliberate inclusion of individuals whose lived experiences align closely with the study's objectives.

Several inclusion criteria were applied: participants were required to have a formal diagnosis of a mental health condition made by a qualified professional, be 18 years of age or older to ensure legal consent and cognitive maturity and hold Malaysian citizenship to maintain cultural

consistency within the study's scope. Efforts were also made to ensure diversity in demographic and psychosocial backgrounds, including variation in age, gender, ethnicity, socioeconomic status, and type of mental health condition. This diversity was sought to capture a multifaceted understanding of the ways intersecting identities and life contexts shape disclosure decisions.

Given the qualitative and exploratory nature of this research, the sample size was intentionally kept relatively small to allow for in-depth exploration of participants lived experiences. This approach facilitated rich, detailed narratives and deeper thematic analysis, which may not have been possible with a larger cohort. However, the modest sample size should also be acknowledged as a limitation, as it may restrict the generalizability of the findings to wider populations. Future studies with larger and more varied samples would be valuable to test the transferability of these insights across different groups and settings.

INTERVIEW QUESTIONS

The interview questions in this study were designed in alignment with the research objectives and organized into several key thematic areas. These include: (1) the participants' background, covering their mental health history and lived experiences; (2) factors influencing their willingness to disclose or withhold information about their mental health; (3) strategies and coping mechanisms used to navigate fears and challenges related to disclosure; and (4) participants' suggestions and aspirations regarding societal awareness and support for individuals facing mental health issues. The interview protocol employed open-ended questions to facilitate in-depth, reflective responses, allowing participants to articulate their experiences in their own words. This method was chosen to capture the complexity and depth of each individual's perspective. However, for this article, only the first two thematic areas, participants' background and the influencing factors on disclosure, are discussed in detail. The remaining themes will be explored in future publications.

DATA COLLECTION AND DATA ANALYSIS

Data collection was conducted through both face-to-face and online interviews, depending on the comfort and preferences of each participant. This hybrid mode was adopted primarily to respect participant comfort, allowing them to choose the format in which they felt most at ease. All interviews were audio-recorded with the participants' informed consent to ensure data accuracy and were subsequently transcribed verbatim. Strict adherence to research ethics was maintained throughout the study, including obtaining informed consent, ensuring the confidentiality of all information, and upholding participants' right to withdraw from the study at any point without penalty. Additionally, interviews were conducted in safe, non-threatening, and supportive settings, allowing participants to feel at ease and share their experiences openly. Interviews continued until data saturation was reached, when no new themes emerged and information began to recur.

The collected data were analyzed using thematic analysis. This process involved several stages: (1) initial reading of the transcripts to gain a general understanding of the content; (2) preliminary coding to identify recurring themes and patterns; (3) development of core categories, particularly those related to factors facilitating or hindering disclosure; and (4) organization of findings according to the identified themes. Emerging themes were later examined with existing literature to enhance the findings' interpretive depth and contextual relevance. Triangulation was achieved by comparing responses across participants and aligning emerging themes with existing

literature. To ensure trustworthiness, member checking was conducted with selected participants, researcher discussions reduced bias in coding, and an audit trail was maintained to document analytic decisions. These strategies enhanced the credibility, dependability, and confirmability of the findings.

RESULTS AND DISCUSSION

PARTICIPANTS' PROFILES

Five (5) participants participated in this study, comprising one male and four females, aged 23 to 27 years. Their diverse backgrounds provided a broad spectrum of perspectives relevant to the study's focus on mental health disclosure. Regarding occupation, the participants held various roles, including a data analyst, a therapist, a homemaker, and two students. Their residential locations also varied, representing different regions within Malaysia: Bangi, Ipoh, Kuala Lumpur, Puchong, and Shah Alam. Educationally, all participants had attained at least a degree, with three holding a Master's qualification and two a Bachelor's degree. Most participants were single, except for one who was married. Participants were also presented with a range of mental health conditions. Two individuals reported experiencing panic attacks, while others were diagnosed with more complex conditions, such as Major Depressive Disorder (MDD) and Bipolar Disorder (BD), Anxiety and Depression, and Borderline Personality Disorder (BPD). The variety in diagnoses allowed for a nuanced exploration of the factors influencing openness in mental health disclosure. The diversity in demographic and psychosocial backgrounds among the participants enriched the data. It contributed to a more comprehensive understanding of the disclosure experiences of individuals living with mental health conditions.

TABLE 1. Demographic and clinical characteristics of study participants

Participant	Gender	Age	Occupation	Level of Education	Marital Status	Types of Mental Health Conditions
P1	Male	27	Data Analyst	Master Degree	Single	Panic Attack
P2	Female	23	Therapist	Bachelor Degree	Single	Major Depression/Bipolar Disorder
P3	Female	27	Housewife	Bachelor Degree	Married	Panic Attack
P4	Female	24	Student	Master Degree	Single	Anxiety/ Depression
P5	Female	26	Student	Master Degree	Single	Borderline Personality Disorder

Drawing from rich interview data, the analysis identifies key internal and external themes that shape decisions around disclosure. While mental health advocacy efforts have grown in visibility, many individuals continue to conceal their struggles due to a range of psychological, interpersonal, and societal pressures. This study offers an in-depth examination of those barriers. This study sheds light on the nuanced and context-dependent nature of mental health disclosure, echoing existing literature while highlighting unique cultural, interpersonal, and intrapsychic barriers faced by individuals in the Malaysian context. Consistent with the Disclosure Decision-

Making Model (Greene, 2009), participants in this study engaged in complex cost-benefit evaluations shaped by internal vulnerabilities and external realities. Although disclosure can lead to increased support, many participants found the perceived risks too high, ultimately choosing silence as a form of self-protection.

BARRIERS (INTERNAL FACTORS)

Reluctance to disclose mental health issues is rarely a product of a single influence. Rather, it reflects the intersection of personal vulnerabilities and contextual realities, both of which reinforce the silence around psychological distress. Two major thematic domains emerged: *internal factors*, which arise from individual cognitive and emotional processes, and *external factors*, which are rooted in sociocultural and environmental dynamics.

1. Fear of social stigma

At the heart of many disclosure dilemmas lies a deep-seated fear of being misunderstood, rejected, or pathologized. Even in the absence of actual negative experiences, several participants described being haunted by the possibility of stigma, which prevented them from seeking emotional or social support. As explained by P1:

> "I have not received any negative reactions; I am just afraid I might. That is why I chose to remain silent."
>
> (P1)

P1 highlights the internal struggle with anticipated stigma and fear of judgment. It reflects a conscious decision to seek help in isolation due to concerns that disclosure might lead to negative perceptions from others, even close connections like family and friends.

> "When I sought treatment... I went alone. I did not want to talk about it with family or distant friends because I did not want to be judged or evaluated for having this illness."
>
> (P1)

This anticipatory anxiety about judgment highlights how internalized stigma, the absorption of societal stereotypes into one's self-concept, can silence individuals. P3 added:

> "I hid it because I feared people would look down on me... I feel like people think, 'you are useless,' you know? That is why I hide it."

Such reflections point to how the imagined reactions of others can be as powerful as real ones, leading individuals to self-censor to protect their dignity and identity.

2. Absence of acceptance

Participants also frequently reported that they did not believe others could truly understand their emotional reality, even if they were willing to listen. Perceiving mental illness as trivial or exaggerated diminishes the legitimacy of individuals' experiences of distress.

> "Even if I told someone, they would not understand. Like when someone talks about anxiety, people respond, 'It is just anxiety.' But when you experience it, it is harrowing."
>
> (P3)

The emotional labor involved in educating others or defending one's experience often made disclosure feel more exhausting than liberating. For some, previous attempts to be open had eroded their trust:

> "Because I self-harmed, someone looked at my wrist and said something about her own, 'My wrist is smooth.' I thought, 'What do you want me to do? Help you cut it?' Honestly, I do not mind showing my wrist; it proves I survived, even though sometimes I feel I was being stupid."
>
> (P5)

This quote illustrates a failure of empathy and a mocking trivialization of pain, which can solidify an individual's decision never to disclose again. Empathic failure and ridicule can severely damage trust, leading individuals to withdraw and avoid future disclosure. Studies show that anticipated stigma and fear of judgment often result in self-silencing and long-term avoidance of help-seeking (Corrigan et al., 2010; Hanafiah & Van Bortel, 2015).

3. Embarrassment

Shame emerged as a powerful silencing force. For some, their mental illness became a source of internalized inferiority, reflecting a belief that their condition made them fundamentally flawed or unworthy.

> "After I quit my job, I did not talk about it because I was ashamed. I felt ashamed of myself and my health."
>
> (P3)

This sense of shame is often intertwined with societal role expectations, such as the pressure to appear competent, cheerful, or emotionally resilient, which can discourage individuals from expressing vulnerability:

> "I am known as the most happy-go-lucky person in my friend circle. So, I do not want people to know I have MDD."
>
> (P2)

For many, disclosure risks disrupting their social persona, which can threaten their identity and social belonging. Research shows that mental health disclosure often challenges individuals' carefully maintained social identities. According to Goffman's theory of stigma, people manage impressions to avoid being discredited, and disclosure can disrupt this balance (Goffman, 1963). Corrigan et al. (2010) further emphasize that fear of losing social status or being excluded can deter disclosure, especially in cultures where emotional resilience is idealized. In Malaysia, Hanafiah and Van Bortel (2015) found that stigma and societal expectations lead individuals to conceal mental health struggles to preserve social belonging.

4. Discomfort of sympathy and intervention

Participants' aversion to pity or performative concern was a subtler but equally significant barrier. Some rejected the idea of being perceived as fragile or needing special treatment. This indicates a need for dignified, non-intrusive support, rather than unsolicited intervention:

> "I do not want people to feel sorry for me...if they find out, they will suddenly be overly kind and cautious with their words. I do not want that. I do not want anyone to pity me."
>
> (P2)

Some individuals shared that their emotional struggles felt too overwhelming or complicated to put into words, making them feel even more alone. As P4 expressed:

> "My life and problems are too complicated. Even now, in this interview, I worry I am not answering properly because everything is connected and jumbled."

This highlights how internal chaos and fear of miscommunication can reinforce isolation, especially when individuals feel that their experiences defy simple explanation or structured dialogue.

BARRIERS (EXTERNAL FACTORS)

While internal factors reflect the individual's cognitive and emotional process, external factors often reinforce or exacerbate the decision to remain silent. Dominant cultural norms, family dynamics, and institutional practices shape these.

1. Cultural Stigma

Across participants, a common theme was the pervasive societal stigma around mental health, particularly the view that psychological distress is a sign of personal weakness or exaggerated emotionality.

> "People do not treat mental health the same as physical health... They will say, 'You are being dramatic."
> (P2)

Participants with more stigmatized diagnoses, such as Borderline Personality Disorder (BPD), faced additional scrutiny:

> "The stigma around BPD is that you are just being dramatic... 'Can't you control your emotions?'
> (P5)

These views are not only invalidating but also delegitimize suffering, positioning individuals as emotionally unstable rather than as persons in need of care. For some, workplace culture also contributed to silence:

> "I have heard coworkers call people with depression 'attention seekers'.' That made me want to keep it to myself."
> (P1)

Such narratives do not exist in a vacuum; they are products of collective discourses that reward emotional restraint and penalize vulnerability. Studies show that cultural and societal discourses often valorise emotional control while stigmatizing vulnerability, shaping how individuals narrate and manage their mental health experiences. For instance, Hanafiah and Van Bortel (2015) found that in Malaysia, public and familial expectations discourage open emotional expression, reinforcing silence and self-concealment. Similarly, Zhang et al. (2024) argued that stigma is deeply embedded in social norms, where emotional restraint is equated with strength, and disclosure is seen as weakness—further marginalizing those who struggle.

2. Familial Taboo

Families emerged as both potential sources of support and significant sites of invalidation. For many participants, family members were often dismissive or critical, especially in cultural contexts where mental illness is stigmatized or viewed through a religious or moral lens.

> "This experience is more about the family context. They completely deny the stigma, saying things like I am being dramatic or " I have forgotten my faith. It hurts, and when they try to downplay my pain, it just makes it worse, especially because they are family. So, I have just kept my distance. It is impossible to make them understand."
>
> (P5)

Some participants described being silenced by comparison, with their emotional pain minimized to their parents' experiences:

> "My parents say, 'Our problems are worse than yours,' so I never told them."
>
> (P2)

Others learned to suppress their mental health struggles after witnessing how poorly family members were treated:

> "After seeing how my cousin with MDD was treated, I knew I could not tell my parents."
>
> (P2)

These patterns reflect more profound intergenerational silences, where mental health becomes a taboo or misunderstood topic, handed down through attitudes of denial and avoidance. In some cases, efforts to seek help were met not with care, but with punishment:

> "My parents brought me to a psychiatrist friend, and after the session, I was scolded badly... I never opened up again."
>
> (P5)

These experiences highlight emotional distancing as a self-protective response, a way for participants to manage the pain of being misunderstood or invalidated by those closest to them. Previous studies have shown that emotional distancing often emerges as a coping mechanism in response to interpersonal invalidation. Kennedy-Moore and Watson (2001) found that individuals who felt misunderstood or unsupported tended to suppress emotional expression to avoid further distress. Similarly, Overall et al. (2013) observed that distancing behaviors in close relationships can serve as protective strategies, helping individuals shield themselves from rejection or judgment. In the Malaysian context, Hanafiah and Van Bortel (2015) noted that stigma and lack of empathetic support often lead individuals to withdraw emotionally, reinforcing isolation and silence.

3. Risk to Livelihood and Daily Functioning

The potential impact of disclosure on participants' livelihoods and everyday functioning emerged as a significant deterrent. Many feared that revealing their mental health struggles, particularly in professional or institutional settings, could lead to negative consequences such as job rejection, limited career progression, or social stigma in the workplace.

> "Some employers ask about mental health... If I share it, I'm afraid they won't accept me."
>
> (P3)

This fear of discrimination was often rooted in lived or observed experiences, where mental illness was equated with weakness, instability, or incompetence. As a result, some participants felt compelled to maintain a façade of normalcy, prioritizing job security and acceptance over personal authenticity and seeking help. Beyond the workplace, disclosure was also seen as risky in daily social functioning. Participants described how their symptoms were often misinterpreted or minimized by peers, leading to emotional invalidation and further isolation.

> "Even when I showed signs of suicidal thoughts, my friends brushed it off. It confirmed the idea that I was just being dramatic."
>
> (P5)

The lack of empathetic response from friends or colleagues discouraged further disclosure and contributed to internalized shame. Some began to doubt the legitimacy of their own experiences, questioning whether they were indeed overreacting, a phenomenon linked to self-stigma and perceived invalidation (Vogel et al., 2007; Corrigan et al., 2010). Additionally, participants shared how the mental burden of managing symptoms in silence affected their productivity, concentration, and motivation. However, the fear of judgment prevented them from requesting accommodations or support, consistent with findings that anticipated stigma impedes help-seeking and workplace disclosure (Brohan et al., 2012). For those in high-performance environments, the pressure to "function as usual" despite psychological distress led to emotional exhaustion. Concealing their condition became a coping strategy, but one that carried its own cost: chronic stress, burnout, and a sense of invisibility. In sum, the perceived and real risks to employment, social credibility, and day-to-day functioning formed a powerful barrier to disclosure, reinforcing silence as a means of self-preservation in environments perceived as unsupportive or unsafe.

DISCLOSURE OR CONCEALMENT IN THE FUTURE

The decision to be more open or to continue concealing one's mental health status in the future depends on a range of factors, including individual readiness, past experiences, and perceptions of societal acceptance. For some individuals, the choice to remain silent stems from a sense of unreadiness, driven by fear, anxiety, or a feeling that they are not yet strong enough to handle others' reactions. Others feel that mental health stigma is still very much present, making silence the safer option to avoid judgment or misunderstanding. As P1 shared:

> "I think I will continue to keep it a secret because I am not ready to tell my family or friends about my condition. I am worried that they still carry stigmas, as I mentioned earlier, even people at my workplace hold strong views, which only happened this year. So, if they think that way, surely other Malaysians might too. So I choose to keep it hidden. I am just not ready to talk about it."

Others echoed this concern, believing people would treat them differently if they knew, either with excessive sympathy or by distancing themselves. This led to a cautious, guarded approach when it came to disclosure, as described by P2:

> "I do not see the need for everyone to know. Like I said, people will treat me differently, and once they know, they will feel obliged to care about me. They will feel responsible for me."

Participants were also aware that not everyone could understand their situation. While some people may genuinely care and be supportive, others may dismiss their struggles or fail to fully grasp what they are going through. To avoid additional complications or emotional stress, they often chose to stay silent. As P3 explained:

> "I think I would rather keep it to myself because some people understand mental health issues, but others do not. Before I went to the hospital, I used to talk to my ex-boyfriend—he is a psychiatrist—so I turned to him a lot. However, now, I think it is better to stay quiet. I do not want to make it a big deal and have people think, 'Why are you telling me this? Are you just trying to get attention?' I do not want that. So I should keep it to myself and stay silent."

However, some individuals expressed a desire to be more open about their mental health, motivated by the awareness that mental health is still widely misunderstood. They saw sharing their experiences to help correct misconceptions and reduce stigma. As P4 stated:

> "Hmm... I think I would be more open, because much misunderstanding still surrounds mental health in our society. I think it is crucial to correct those misconceptions for the sake of the future."

In some instances, disclosure was context-dependent. Some individuals adopted a selective approach, choosing to be open with trusted people or in safe spaces, while remaining silent in environments perceived as judgmental or unsupportive. P5 shared:

> "It depends on the context, because I have proof: my wrist. I could not hide it, no matter how much I wanted to. Perhaps I wouldn't discuss it with anyone, because not everyone can accept the idea that your family was the cause. I open up only when I can sense someone is genuinely open-minded. Why share? Because maybe they have gone through the same thing, and if they can take something good from it, I hope it helps. If not, then perhaps it serves as a lesson of some kind. That is my only intention."

A dominant theme in the findings was the enduring influence of stigma, which aligns with past research identifying stigma as a primary barrier to mental health disclosure (Corrigan et al., 2010; Clement et al., 2015). Participants expressed fears of being perceived as weak, dramatic, or unstable; concerns that often led to anticipatory anxiety and internalized shame. This reflects how anticipated stigma can function as a powerful deterrent, even without overt discrimination. Some participants shared that they had never personally experienced negative responses but still chose not to disclose, fearing what *might* happen. This underscores the need to address not only public stigma but also internalized and perceived stigma through targeted mental health education and normalization efforts.

The workplace emerged as a particularly high-risk environment for disclosure, echoing international findings (Brohan et al., 2012; Milligan-Saville et al., 2017). Participants feared job insecurity, reputational damage, or being viewed as incompetent. A lack of psychologically safe environments, compounded by dismissive or derogatory remarks from colleagues, reinforced these fears. While government initiatives such as KOSPEN-WOW have aimed to raise awareness, the findings suggest that institutional culture change and structured support systems, such as Employee Assistance Programs, remain insufficient (Dimoff & Kelloway, 2019).

Cultural factors played a decisive role in shaping disclosure decisions, underscoring important contrasts with Western contexts. In collectivist societies such as Malaysia, mental illness is often seen as a moral failing or source of shame (Ng, 1997; Umeh & Chukwuorji, 2020). Many participants worried about burdening their families or dishonouring them—concerns less frequently reported in Western, more individualistic settings, where disclosure may more often be

framed in terms of personal coping or individual rights (Rüsch et al., 2009). This cultural emphasis on family honour helps explain why, in Malaysia, disclosure is tightly bound to relational and social expectations. The pressure to maintain a socially acceptable image was especially acute for participants whose outward persona conflicted with inner struggles, often leading to emotional isolation or withdrawal.

Family dynamics further reinforced these cultural patterns. Participants described being invalidated, compared to others, or punished for disclosing. Such experiences resonate with Ibrahim et al. (2019), who documented low levels of mental health literacy among Malaysian youth and families. Unlike findings from some Western contexts, where disclosure can generate social support and validation (Rüsch et al., 2009), in Malaysian family's disclosure often resulted in misunderstanding, moralistic interpretations, or emotional harm. This suggests a pressing need for family-based psychoeducation to address intergenerational stigma and promote empathetic listening. Another nuance was participants' rejection of pity and performative concern. While some feared judgment, others were equally averse to excessive sympathy, which they perceived as condescending. This adds a more complex layer to the disclosure dilemma: for some, both rejection and overprotection were distressing. The implication is that support must be grounded in respect and dignity rather than either dismissal or overcompensation.

Consistent with Bos et al. (2009), disclosure in this study was often strategic, selective, and context-dependent rather than an all-or-nothing act. Participants disclosed only when they perceived the recipient as trustworthy and the environment as safe. While Western studies often highlight disclosure as a step toward empowerment or improved relationships (Rüsch et al., 2009), the Malaysian context suggests a more cautious, conditional process, shaped by cultural values of collectivism, family honour, and relational harmony. Nevertheless, a few participants aspired to be more open, motivated by the desire to correct misconceptions and contribute to advocacy. For these individuals, disclosure was seen not merely as self-expression but to challenge stigma and promote social change. Yet even this openness was framed as contingent on safety and mutual understanding, reflecting a deeply relational orientation.

Ultimately, these findings affirm that disclosure in Malaysia is not solely a personal act but is mediated by trust, institutional culture, and broader cultural norms. Compared to Western contexts, where disclosure is often framed as an individual right or empowerment, Malaysian experiences highlight the weight of family expectations and collectivist values. For mental health professionals, employers, and policymakers, this underscores the need for culturally sensitive approaches that foster empathy, psychological safety, and dignity. Efforts must move beyond raising awareness to reshaping social and institutional contexts so that disclosure can lead to genuine support rather than further harm.

CONCLUSION

This study provides important insights into the multifaceted nature of mental health disclosure, particularly within the Malaysian socio-cultural context. Despite growing public awareness, the decision to disclose mental health challenges remains deeply personal and often fraught with fear, shame, and concerns about judgment or misunderstanding. Internalized stigma, perceived lack of support, unsympathetic work environments, and invalidating family dynamics emerged as significant barriers. These findings align with existing literature while emphasizing the cultural specificity of disclosure decisions in collectivist settings. Participants often made strategic,

context-dependent decisions about when, where, and to whom to disclose. For some, silence was a means of preserving dignity and avoiding further harm, while others expressed a desire to break the stigma by being more open in the future. The nuanced nature of these decisions underscores that disclosure is not a binary act but a dynamic process shaped by trust, psychological safety, and cultural values.

These findings carry several implications. Mental health practitioners should adopt culturally sensitive and non-directive approaches, viewing reluctance to disclose as a self-protective strategy rather than resistance. Training in trauma-informed and flexible counseling techniques can help practitioners create safe therapeutic spaces where autonomy is respected. Families also play a critical role; targeted psychoeducation and skills-based workshops can reduce intergenerational stigma, promote empathy, and normalize help-seeking as a shared responsibility. At the organizational level, workplaces must move beyond awareness campaigns by embedding concrete support mechanisms. This includes implementing and enforcing anti-discrimination policies, establishing confidential reporting channels, and offering accessible employee assistance programs. Leaders should receive specific training in mental health literacy so they can model inclusive behaviors and foster psychological safety within teams.

At the national level, strategies should prioritize culturally tailored initiatives rather than generic awareness campaigns. Public health efforts can be strengthened by engaging community and religious leaders as allies in destigmatization, promoting recovery narratives, and incorporating lived experiences to challenge stereotypes. Investment in community-based support programs that address cultural barriers will also enhance accessibility. Education policy should ensure that mental health literacy is embedded within school and university curricula, equipping younger generations with resilience, coping strategies, and empathy. At the same time, funding should support longitudinal research that captures disclosure patterns across diverse populations, ensuring that policies remain responsive to evolving needs.

Ultimately, future research should investigate disclosure patterns across diverse populations and contexts, employing longitudinal and mixed-methods approaches to understand how decisions evolve. Including voices of those with lived experience in shaping research and policy will be key to ensuring relevance and impact. In sum, fostering a climate of empathy, respect, and safety, rather than pressuring individuals to speak out, will better support those navigating the complex and deeply personal journey of mental health disclosure.

ACKNOWLEDGEMENT

The authors would like to thank all the participants who generously shared their experiences for this study. We are also grateful for the support provided by the Faculty of Social Sciences and Humanities, Universiti Kebangsaan Malaysia. Special thanks to those who contributed their time and insights during the research process.

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