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RESEARCH

The effects of trauma non-disclosure on symptoms of posttraumatic stress, anxiety and depression: findings from a prospective, population-based study

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Abstract

Background Individuals who do not disclose a potentially traumatic event (PTE) may receive no (or less) event-related social support after victimization. However, it is less clear whether non-disclosure increases the risk of post-event psychopathology.
Aims The present study aims to examine the effects of trauma non-disclosure or disclosure on post-event psychopathology in adult victims of PTEs in the general population of a western European country.
Method In this prospective study, lack of emotional support along with anxiety and depression symptomatology (ADS) was assessed before participants ($N = 1258$) experienced a PTE (T1). Twelve months later (T2), following victimization between T1 and T2, PTSD symptoms (PTSS), ADS, and the extent of PTE-related social acknowledgment among disclosing participants were examined. Post-event psychopathology was then compared between non-disclosers ($n = 98$) and disclosers with high, fairly high, limited, or low levels of PTE-related social acknowledgment ($n = 1160$).
Results Multivariable logistic regression analyses showed that non-disclosers had a higher prevalence of both PTSS and ADS at T2 than did disclosers with high and fairly high levels of PTE-related social acknowledgment. However, non-disclosers reported lower prevalence of PTSS than disclosers with low levels of PTE-related social acknowledgment. Among disclosers, the prevalence of PTSS and ADS at T2 increased when the level of PTE-related social acknowledgment decreased.
Conclusions Non-disclosure of trauma is not necessarily detrimental to mental health when compared to the effects of receiving low event-related social acknowledgment following disclosure. Rather than promoting disclosure in general, it would be more beneficial to recommend disclosure only when supportive relationships are present.

Keywords Disclosure · Non-disclosure · PTSD · Anxiety · Depression · Prospective design · General population

Introduction

Data of the World Mental Health surveys across 24 countries showed that the majority of adults (approximately 70%) experience at least one potentially traumatic event (PTE) during their lifetime according to the DSM-IV criteria, such as rape, an automobile accident, or a life-threatening illness or injury [1]. Although the criteria for PTEs slightly differ between the DSM-5 and DSM-IV, the overall prevalence of PTEs may be more or less similar [1]. While only a minority of individuals exposed to PTEs develop post-traumatic stress disorder (PTSD), some types of PTEs are associated with a higher risk of PTSD, such as rape (19.0%), compared with automobile accidents [2.6%; 2]. Importantly, post-traumatic mental health problems are not limited to PTSD or PTSD symptoms alone, as many victims also suffer from

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other mental health conditions, such as anxiety and depression symptoms or disorders [3, 4].

Previous research has shown that negative social reactions or a lack of (pre-event) social support, among other factors, can increase the risk of developing post-PTE mental health problems, including PTSD, anxiety, and depression symptomatology [5, 6]. However, for victims to benefit from an emotionally supportive environment, their social support networks, such as family members, friends, colleagues, and service providers (e.g. police or therapists) must be aware of the victim's exposure to the PTE. In most cases, this is achieved by victims sharing their experience with others, a process known as interpersonal *trauma disclosure* [7]. Conversely, some victims choose *not* to tell others of their traumatic experience, for instance because of worries about negative social reactions, shame or avoiding distressing memories of the PTE. This decision is referred to as *trauma non-disclosure*. Research has shown that non-disclosure rates vary across demographic groups and trauma types. For instance, only 7% of college students did not disclose adverse life events such as death of a loved one [8], whereas 49% of veterans did not disclose their traumatic experiences [9]. Non-disclosure is particularly common among those exposed to sexual violence ((childhood) rape, sexual assaults), with rates varying between 19% and 45% [e.g. 10–13]. However, the extent of non-disclosure among individuals affected by other PTEs, such as accidents and serious threats, remains far less clear.

Disclosure is generally considered therapeutic, and non-disclosure is often viewed as harmful [7]. This seems plausible because, when affected individuals do not disclose, their social relationships, as long as they are not informed via others or the media, are not or less activated to show interest and compassion which may result in a perceived lack of emotional support. While non-disclosers may receive general support as usual, they will not receive event-related social recognition or acknowledgment tailored to their specific, current needs following the PTE. However, a key question is whether non-disclosure increases the risk of post-event psychopathology.

Interestingly, the relatively few studies that have examined the effects of disclosure versus non-disclosure on post-event psychopathology in the context of adult victimization showed mixed results. Ahrens et al. [10] found that female sexual assault victims who did not disclose their experience suffered from higher rates of depression and post-traumatic stress symptoms compared to those who did disclose. However, this finding has not been replicated by other studies [14–16]. Similarly, a review of studies by Ullman [17] examining non-disclosure in adult survivors of childhood rape or abuse also reported mixed results. An explanation for these mixed results is (a) that disclosure may not automatically motivate social relationships to be responsive and (b) that responses may not automatically be emotionally supportive and express recognition according to the specific needs of the affected individuals or are simply negative. One well-known example of a negative response is victim-blaming [18], in which reactions imply that the victim, rather than the perpetrator, is responsible for the traumatic event.

When assessing the impact of support network responses, it is important to distinguish between immediate social reactions to trauma disclosure and the general level of event-related social acknowledgment after disclosure. Several meta-analyses have identified an association between negative unsupportive social responses to trauma disclosure (e.g. distracting or controlling responses) and an increase in PTSD symptoms, whereas broader forms of general positive social support (e.g. ongoing supportive social relationships after the event, not just the acute response by disclosure recipients immediately after or during the disclosure) and a higher perceived positive support have been linked with fewer PTSD symptoms [6, 19, 20]. This relationship appears reasonable, as the level of event-related social acknowledgment depends not only on the immediate response at the moment of trauma disclosure but also, more significantly, on the quality of ongoing relationship dynamics.

The effects of non-disclosure and disclosure on post-event psychopathology remain relatively understudied, particularly when considering variations in event-related social acknowledgment. However, among adult survivors of childhood sexual abuse disclosers who faced high levels of non-supportive social responses scored higher on PTSD symptom assessments than non-disclosers *and* disclosers who faced low levels of non-supportive responses [21]. Notably, PTSD symptom scores did not differ between the latter two groups. These findings highlight the importance of distinguishing disclosers based on their level of social support when examining the extent to which disclosure reduces the risk of post-event psychopathology. Rather than treating disclosers as one homogenous group, comparisons need to be made between non-disclosers and disclosers with varying levels of event-related social acknowledgment. Additionally, many studies on the associations between disclosure and post-event psychopathology lack non-retrospective data on pre-event mental health problems and social support. These pre-event factors must be accounted for in order to ensure that the observed post-event associations do not merely reflect pre-existing conditions. The significance of these pre-event variables has been demonstrated in reviews by DiGangi et al. [22], Danese et al. [23] and Scheeringa [24]. Based on the growing number of prospective trauma studies, these reviews reveal that many post-traumatic variables, such as psychopathology and problems in cognitive functioning, that were originally thought to be the effects of

PTEs were actually already present before the index PTE. For example, a recent prospective study showed that the vast majority of victims with post-event psychopathology or lack of post-event emotional support already suffered from these problems two years prior to their PTE-exposure [25].

The aim of the present prospective study is to further unravel the associations between non-disclosure and post-event psychopathology by categorizing the group of disclosers based on their level of event-related social acknowledgment and controlling for prospectively-collected data on *pre-event* psychopathology and lack of emotional support. As previous research on non-disclosure has primarily examined specific populations exposed to sexual violence and childhood abuse, the present study focuses on a more broadly representative sample of adults from the general population who have recently been exposed to PTEs such as violence, accidents and serious threats. The main research question was: to what extent do non-disclosers and disclosers with varying levels of event-related social acknowledgment differ in the prevalence of high PTSD symptom levels (PTSS) and post-event severe anxiety and depression symptomatology (ADS), while controlling for *pre-event* ADS, *pre-event* lack of emotional support, and demographics.

Method

Procedure

Data were obtained from the prospective VICTIMS-study [26] conducted within the Longitudinal Internet studies for the Social Sciences (LISS) panel [27]. This panel is based on a large, traditional probability sample of the Dutch population (aged 16+), drawn by Statistics Netherlands (CBS). Importantly, this panel does not allow individuals to register themselves as panel members, minimizing the risk of selection bias. Panel members receive an incentive of 15 euros per hour, and members without access to a computer and/or internet are provided with the necessary equipment at home for free. The LISS panel was established through a grant from the Dutch Research Council (NWO), with ongoing maintenance costs covered by the Social Sciences and Humanities sector plan and ODISSEI (https://odissei-data.nl/en/). In accordance with the General Data Protection Regulation, all respondents provided explicit digital consent for the use of their data in scientific and policy-relevant research. With respect to data security, Centerdata is ISO 27,001 and NEN 7510 certified, and the LISS data archive has obtained the CoreTrustSeal certification. All archived data files related to studies conducted with the LISS panel can be downloaded for free, upon registration (for further information see https://www.lissdata.nl). The VICTIMS-study was approved by an IRB of Centerdata, consisting of independent, internal and external reviewers.

Sample

Data from adult respondents (aged 18+) were aggregated from the first seven annual surveys of the VICTIMS study [26] (2018; response: 82.4% (n=6012), 2019; response: 83.4% (n=5250), 2020; response: 87.9% (n=5773), 2021; response: 86.9% (n=5608), 2022; response: 83.8% (n=5644), 2023; response: 82.4% (n=5281), 2024; response: 80.1% (n=5,800)). Respondents who participated in two subsequent surveys (labeled T1 and T2), and who were exposed to PTEs (violence, accidents, serious threats) in the 12 months between T1 and T2 were selected. If respondents participated in three or more consecutive surveys, only data from the first two consecutive surveys were included in the analysis. Due to the low number of non-disclosers, the following sampling strategy was applied to ensure a sufficient number of PTE victims who did not disclose the event. First, respondents were selected who reported at T2 that they had not disclosed their PTE-exposure between T1 and T2 (non-disclosers). Next, respondents who reported that they disclosed their PTE-exposure were selected. Thus, if respondents reported non-disclosure of PTEs during at least one study year, they were assigned to the non-discloser group. Additionally, respondents who reported that the PTE exposure did not cause them tension or stress were excluded from analysis (166 (11.7%) of 1424 eligible respondents). As a result, a total of 1258 respondents were included in the study, of whom 98 (7.8%) were classified as non-disclosers.

Measures

Sociodemographic variables

Data on sociodemographic variables were extracted at T1 (gender (1=*male*, 2=*female*), age, education level (see Table 1), primary occupation (1=*Paid employment*, 2=*Works or assists in family business*, 3=*Autonomous professional, freelancer, or self-employed*, 4=*Job seeker following job loss*, 5=*First-time job seeker*, 6=*Exempted from job seeking following job loss*, 7=*Attends school or is studying*, 8=*Takes care of the housekeeping*, 9=*Is pensioner ([voluntary] early retirement, old age pension scheme)*, 10=*Has (partial) work disability*, 11=*Performs unpaid work while retaining unemployment benefit*, 12=*Performs voluntary work*, 13=*Does something else*, 14=*Is too young to have*

Table 1 Characteristics of the study sample at T1 and event related variables

	Disclosers ($n=1160$)				Non-Disclosers ($n=98$)			
	high social acknowledgment ($n=278$)	fairly high social acknowledgment ($n=334$)	limited social acknowledgment ($n=302$)	low social acknowledgment ($n=246$)				
	n (%)	n (%)	n (%)	n (%)	n (%)	$\chi 2$	*d.f.*	*p*
Gender						14,368	4	0,006
Male	118 (42,4)	169 (50,6)	131 (43,4)	101 (41,1)	58 (59,2)			
Female	160 (57,6)	165 (49,4)	171 (56,6)	145 (58,9)	40 (40,8)			
Age						14,059	12	0,297
18–34	77 (27,7)	65 (19,5)	73 (24,2)	59 (24,0)	22 (22,4)			
35–49	63 (22,7)	70 (21,0)	71 (23,5)	65 (26,4)	25 (25,5)			
50–64	74 (26,6)	103 (30,8)	74 (24,5)	71 (28,9)	27 (27,6)			
65 or older	64 (23,0)	96 (28,7)	84 (27,8)	51 (20,7)	24 (24,5)			
Education						17,253	8	0,028
Low	48 (17,3)	70 (21,0)	66 (21,9)	68 (27,8)	31 (32,0)			
Medium	108 (38,8)	112 (33,5)	110 (36,4)	91 (37,1)	32 (33,0)			
High	122 (43,9)	152 (45,5)	126 (41,7)	86 (35,1)	34 (35,1)			
Primary occupation						7,755	4	0,101
Employed	198 (71,2)	233 (69,8)	194 (64,2)	159 (64,6)	58 (59,2)			
Not employed	80 (28,8)	101 (30,2)	108 (35,8)	87 (35,4)	40 (40,8)			
Domestic situation						3,095	4	0,542
Single	92 (33,1)	110 (32,9)	110 (36,4)	78 (31,7)	39 (39,8)			
Not single	186 (66,9)	224 (67,1)	192 (63,6)	168 (68,3)	59 (60,2)			
Cultural origin						27,756	4	<,001
Dutch background	228 (82,0)	285 (85,3)	221 (73,2)	175 (71,1)	68 (69,4)			
Non-Dutch background	50 (18,0)	49 (14,7)	81 (26,8)	71 (28,9)	30 (30,6)			
Severe ADS at T1						82,319	4	<,001
No	259 (93,2)	308 (92,2)	268 (88,7)	178 (72,4)	69 (70,4)			
Yes	19 (6,8)	26 (7,8)	34 (11,3)	68 (27,6)	29 (29,6)			
High lack of emotional support at T1						53,678	4	<,001
No	219 (78,8)	222 (66,5)	185 (61,3)	125 (50,8)	50 (51,0)			
Yes	59 (21,2)	112 (33,5)	117 (38,7)	121 (49,2)	48 (49,0)			
PTE type						96,209	8	<,001
Violence	29 (10,4)	44 (13,2)	44 (14,6)	46 (18,7)	39 (39,8)			
Accidents	215 (77,3)	213 (63,8)	176 (58,3)	128 (52,0)	30 (30,6)			
Threats	34 (12,2)	77 (23,1)	82 (27,2)	72 (29,3)	29 (29,6)			
Stress during PTE						61,385	12	<,001
A little bit	72 (25,9)	112 (33,5)	80 (26,5)	37 (15,0)	28 (28,6)			
Moderately	81 (29,1)	90 (26,9)	77 (25,5)	44 (17,9)	31 (31,6)			
Quite a bit	67 (24,1)	81 (24,3)	74 (24,5)	75 (30,5)	22 (22,4)			
Extremely	58 (20,9)	51 (15,3)	71 (23,5)	90 (36,6)	17 (17,3)			
Time since PTE						8,524	4	0,074
Up to 2 months ago	106 (38,1)	133 (39,8)	110 (36,4)	79 (32,1)	47 (48,0)			
3–12 months ago	172 (61,9)	201 (60,2)	192 (63,6)	167 (67,9)	51 (52,0)			

Note. Education levels: Low = primary school, intermediate secondary education, US: junior high school; Medium = higher secondary education/preparatory university education, US: senior high school, intermediate vocational education, US: junior/community college; High = higher vocational education, US: college, university, according to education level categories of Statistics Netherlands (CBS). T1 refers to aggregated data from 2018 to 2024 each in March. ADS = Anxiety depression symptomatology. PTE = Potentially traumatic event.

an occupation), domestic situation (1 = *Single*, 2 = *(Un) married co-habitation*, *without child(ren)*, 3 = *(Un)married co-habitation*, *with child(ren)*, 4 = *Single*, *with child(ren)*, 5 = *Other)*, and cultural origin (1 = *Dutch background*, 2 = *First generation foreign*, *western background*, 3 = *First generation foreign*, *non-western background*, 4 = *Second generation foreign*, *Western background*, 5 = *Second generation foreign*, *non-western background*, 6 = *Origin unknown or part of the information unknown (missing values)*)).

Characteristics of PTEs

The 12-month prevalence of PTEs at T2 was assessed using a list of 21 potentially traumatic or stressful life events (1 = *no*, 2 = *yes*), that is based on previous research of PTEs [for further details see; 26]. The present study follows DSM-5 criteria for PTEs. Therefore, three categories were coded, including events related to violence (in-person sexual violence/abuse, online sexual violence/abuse, robbery, physical violence not by a partner, physical violence by a partner, other violence), accidents (traffic accidents, airplane accidents, company accidents, fires, medical accidents or /errors, other accidents), and serious threats (in-person serious threats, without the use of physical violence, online serious threats, without the use of physical violence, sexual intimidation). If respondents had experienced more than one PTE in the past 12 months, they were asked to identify which PTE was the most drastic or traumatic one. Information on the timing of the most traumatic index event was collected (1 = *1 week ago*; 2 = *2 weeks ago*, 3 = *3 weeks ago*; 4 = *4 weeks ago*; 5 = *1–2 month(s) ago*; 6 = *3–4 months ago*; 7 = *5–6 months ago*; 8 = *7–12 months ago*). Additionally, the level of tension and stress the individual experienced during the index event was measured (Likert scale ranging from 1 = *not at all or barely* to 5 = *extremely*).

Disclosure

Regarding the most traumatic PTE, respondents indicated whether they had spoken to or had contact with any of 19 listed individuals or organizations such as family, friends, the police, lawyers, and therapists (1 = *yes*, 2 = *no*). Respondents who reported no contact with any of the listed sources were classified as non-disclosers.

Anxiety and depression symptoms

Anxiety and depression symptoms were assessed at T1 and T2 using the Mental Health Index-5 [MHI-5; 28]. Example items from the MHI-5 include statements such as "I was very nervous" or "I felt gloomy and depressed". Each of the five items can be answered on a six-point Likert scale (0 = *never* to 5 = *permanently*). After recoding the negatively formulated items, the total score was multiplied by four to achieve a range from 0 to 100. Lower MHI-5 scores reflect higher levels of anxiety and depression symptomatology (Cronbach's α: T1 = 0.896, T2 = 0.890). A cutoff score of ≤44 was used to identify respondents with severe anxiety and depression symptoms [ADS; 29].

Lack of emotional support

Respondents' experienced lack of emotional support before the event (T1) was assessed using the eight-item subscale "lack of emotional support" of the Social Support List-Discrepancy [SSL-D; 30]. Respondents were asked to what extent all people they interact with, for example, "reassure you", "tell you to persevere", or "help you to clarify your problems". Answer categories are based on a four-point Likert scale (1 = *I miss this*, *I would like it to happen more often* to 4 = *It happens too often*, *it would be nice if it happened less often*). In the present study, the total scores of the eight-item subscale "lack of emotional support" were subtracted from the maximum score of 32. Higher scores indicated a greater lack of emotional support (Cronbach's α = 0.891). Following van der Velden et al. [5], a cut-off score of >11 was used to identify respondents with high lack of emotional support.

PTSD symptoms

PTSD symptoms associated with the index event were assessed at T2 using the total score of the eight-item version of the PTSD Checklist for the DSM-5 [PCL-5; 31]. Example items are "Avoiding external reminders of the stressful experience" and "Repeated, disturbing, and unwanted memories of the stressful experience" in the past month. Answer categories are based on a five-point Likert scale (0 = *Not at all* to 4 = *Extremely*). Higher scores indicate greater PTSD symptom levels (Cronbach's α = 0.935). A cut-off score of >12 was used to identify respondents with high PTSD symptom levels (PTSS), excluding the time criterion of one month [32, 33].

Event-related social acknowledgment

Event-related social acknowledgment at T2 was assessed using the total score of two subscales from the Social Acknowledgment Questionnaire: "Recognition as Victim" and "General Disapproval" [SAQ; 34]. Respondents rated each item in relation to their index event on a five-point Likert scale (1 = *totally disagree* to 5 = *totally agree*). Example items include "The reactions of my acquaintances were helpful" and "There is not enough sympathy for what happened to me". Two of the 11 items that imply a specific disclosure recipient (a boss or a public figure), as well as the third SAQ-subscale ("Family Disapproval") were excluded since they were not answered by all respondents. After recoding the negatively formulated items, higher SAQ scores reflect lower levels of event-related social acknowledgment (Cronbach's α = 0.785).

Data analyses

To answer the research question, we first had to divide the subgroup of disclosers based on the levels of event-related social acknowledgment. Therefore, we first distinguished four exclusive subgroups with more or less equal subgroup sizes based on the quartiles of the SAQ total scores (about 25%): disclosers with "high" (scores: 9–16), "fairly high" (scores: 17–21), "limited" (scores: 22–26), and "low" (scores: 27–45) levels of event-related social acknowledgment. These significant differences in SAQ scores between the four discloser sub samples were meaningful. Cohen's D for all six pairs ranged between 2.3 and 5.9, indicating very large effect sizes (see Table 1 in the supplementary material). Differences among the five subgroups in sociodemographic variables and PTE characteristics (type of PTE, stress during PTE, and time since PTE) were assessed using chi-square tests. Differences in PTSS and post-traumatic ADS between non-disclosers and the four discloser subgroups were examined using multivariable logistic regression analyses. At step 1, group membership was entered as predictor. At step 2, pre-event ADS, pre-event lack of emotional support, demographic variables (gender, education, and cultural origin; selection based on $p < 0.10$), and PTE characteristics (type of PTE, stress during PTE, time since PTE) were entered as predictors to control for potential confounding effects. For the multivariable logistic regression analyses, time since the PTE was dichotomized (1 = *up to 2 months ago*, 2 = *3–12 months ago*) as well as primary occupation (1, 2, 3, 7, 8 = *Employed*; 4, 5, 6, 9, 10, 11, 12, 13, 14 = *Not Employed*), domestic situation (1, 4 = *Single*; 2, 3, 5 = *Not Single*), and cultural origin (1 = *Dutch background*; 2, 3, 4, 5, 6 = *Non-Dutch background or origin unknown*). The multivariable logistic regression analyses were conducted with non-disclosers as the reference group, and repeated with the discloser subgroup that received high event-related social acknowledgment as the reference group. Statistical analyses were performed with IBM SPSS Statistics 29.

Results

Characteristics of non-disclosers and disclosers

Table 1 shows that the distributions of gender, education, cultural origin, pre-event ADS, pre-event lack of emotional support, type of PTE, and stress during PTE differ significantly between the five subgroups. No significant differences in age, primary occupation, domestic situation, and time since PTE were observed.

Differences in PTSS and post-event ADS

The results of the bivariate and multivariable logistic regression analyses are presented in Table 2. We focus on the results of the multivariable logistic regression analyses. The upper part shows that non-disclosers suffered from PTSS (35.7%) significantly more often than disclosers who received fairly high (9.6%) and high (4.3%) levels of social acknowledgment. Non-disclosers, however, did not significantly differ in PTSS from disclosers who received limited (24.8%) social acknowledgment. Most notably, non-disclosers were found to be significantly *less* likely to suffer from PTSS than disclosers who received low social acknowledgment (55.3%). Compared to disclosers who received high social acknowledgment, all other sub-samples had significantly higher rates of PTSS.

The lower part of Table 2 shows that non-disclosers suffered from severe post-event ADS (24.5%) significantly more often than disclosers who received fairly high (7.8%) and high (6.5%) levels of event-related social acknowledgment. Non-disclosers did not differ significantly in severe post-event ADS from disclosers that received limited (15.2%) or low (31.3%) social acknowledgment. Compared to disclosers who received high social acknowledgment, disclosers who received limited or low social acknowledgment and non-disclosers showed significantly higher rates of severe post-event ADS.

Robustness of findings

To the best of our knowledge, there are no validated cut-off scores available for the Social Acknowledgment Questionnaire [SAQ; 34], which was used to distinguish subgroups of disclosers with varying levels of event-related social acknowledgment. Categorization of disclosers based on the quartiles of the SAQ scores provides an adequate overview but may result in too much variance being lost. Therefore, we repeated the data analyses using six groups instead of four. Thus, we distinguished six subgroups with more or less equal group sizes (about 16.7%) based on SAQ scores: disclosers with "high" (scores: 9–15), "fairly high" (scores: 16–18), "moderate" (scores: 19–21), "limited" (scores: 22–24), "fairly low" (scores: 25–27), „low" (scores: 28–45) levels of event-related social acknowledgment. Results showed that a finer breakdown of the disclosers into six subgroups had little effect on the key findings (see Table 2 in the supplementary material).

Non-disclosers suffered from PTSS (35.7%) significantly more often than disclosers who received high (3.6%), fairly high (8.1%), moderate (9.6%), or limited (18.9) levels of social acknowledgment. Non-disclosers suffered significantly less often from PTSS compared to disclosers who

Table 2 Prevalence of PTSS and severe ADS at T2

			Reference group			
	PTSS		Non-disclosers		Disclosers, received high social acknowledgment	
	N	n (%)	OR (95% CI)	AOR (95% CI)	OR (95% CI)	AOR (95% CI)
Disclosers						
high social acknowledgment	278	12 (4,3)	0,08 (0,04-0,17)***	0,09 (0,04-0,20)***	1	1
fairly high social acknowledgment	334	32 (9,6)	0,19 (0,11-0,33)***	0,24 (0,12-0,45)***	2,35 (1,19-4,65)*	2,68 (1,30-5,52)**
limited social acknowledgment	302	75 (24,8)	0,59 (0,36-0,97)*	0,66 (0,37-1,18)	7,32 (3,88-13,81)***	7,42 (3,78-14,54)***
low social acknowledgment	246	136 (55,3)	2,23 (1,37-3,61)**	2,05 (1,15-3,65)*	27,41 (14,59-51,49)***	23,12 (11,71-45,64)***
Non-Disclosers	98	35 (35,7)	1	1	12,31(6,05-25,07)***	11,30(5,07-25,19)***
	Severe ADS		Non-disclosers		Disclosers, received high social acknowledgment	
	N	n (%)	OR (95% CI)	AOR (95% CI)	OR (95% CI)	AOR (95% CI)
Disclosers						
high social acknowledgment	278	18 (6,5)	0,21 (0,11-0,41)***	0,36 (0,16-0,81)*	1	1
fairly high social acknowledgment	334	26 (7,8)	0,26 (0,14-0,48)***	0,44 (0,21-0,92)*	1,22 (0,65-2,27)	1,22 (0,61-2,41)
limited social acknowledgment	302	46 (15,2)	0,55 (0,32-0,97)*	0,85 (0,43-1,67)	2,60 (1,47-4,60)**	2,34 (1,25-4,39)**
low social acknowledgment	246	77 (31,3)	1,40 (0,82-2,40)	1,24 (0,64-2,41)	6,58 (3,80-11,39)***	3,41 (1,82-6,38)***
Non-Disclosers	98	24 (24,5)	1	1	4,68 (2,41-9,10)***	2,76 (1,24-6,13)*

Note. OR = Odds ratio. AOR = OR adjusted for gender, education, cultural origin, pre-event severe ADS, pre-existing high lack of emotional support, PTE type, stress during PTE, time since PTE. CI = 95% confidence interval of OR/AOR. *p < .05, **p < .01, ***p < .001. ADS = Anxiety depression symptomatology. PTSS = High PTSD-symptom levels

received low (62.4%) levels of social acknowledgment. Non-disclosers did not significantly differ in PTSS from disclosers who received fairly low (35.9%) social acknowledgment. Non-disclosers suffered from severe post-event ADS (24.5%) significantly more often than disclosers who received high (5.2%) levels of event-related social acknowledgment. However, the differences between non-disclosers and disclosers who received fairly high (7.7%) and moderate (8.6%) levels of event-related social acknowledgment were close to being significant ($p = .052$ and $p = .051$).

Discussion

To the best of our knowledge, this is the first prospective, population-based study among adults recently affected by potentially traumatic events (PTEs) that assesses the extent to which non-disclosers differ from disclosers with varying levels of event-related social acknowledgment in the prevalence of high PTSD symptom levels (PTSS) and severe *post-event* anxiety and depression symptoms (ADS). Importantly, these analyses were statistically controlled for severe *pre-event* ADS and high *pre-event* lack of emotional support as well as other potential confounders.

A key finding of this study is that non-disclosers suffered from PTSS significantly less often than disclosers with low event-related social acknowledgment. However, they exhibited PTSS and severe ADS significantly more often than those with high or fairly high levels of social acknowledgment. No significant differences were observed between non-disclosers and disclosers with limited social acknowledgment when controlling for potential confounders. Therefore, these findings demonstrate the importance of considering variations in event-related social acknowledgment when comparing the effects of trauma non-disclosure and disclosure on post-event psychopathology. Given that trauma disclosure has the potential to elicit either social acknowledgment or social rejection, victims of PTEs may perceive the decision to disclose or not as a high-risk choice that could either prevent or worsen psychological distress. Orchowski and Bhuptani [13] found that non-disclosers of sexual assaults often lacked strong, pre-event social attachments (emotional closeness to others). It seems likely that victims of PTEs are guided by their pre-event experiences with social support: that they have expectations about how people in their social environment will probably react, and act accordingly by disclosing or not disclosing their PTEs. In this perspective, non-disclosure to prevent negative reactions may be considered a healthy coping style.

Among disclosers, the results revealed a continuum along which post-traumatic psychopathology was more prevalent, the less event-related social acknowledgment one received.

Given that the risk of PTSS and ADS was higher among disclosers with limited or low event-related social acknowledgment than in disclosers with high event-related social acknowledgment, our findings align with Tirone et al. [20] and Zalta et al. [6] who reported that general positive social support served as a protective factor against post-traumatic psychopathology.

The finding that non-disclosers did not show significantly more psychopathology than disclosers with limited social acknowledgment and in fact less PTSS than disclosers with low social acknowledgment is relevant for professionals and others working with trauma victims. Non-disclosure should not be considered a malign coping mechanism per se but needs to be put in perspective with probable disclosure outcomes. Therefore, urging trauma victims to share their experiences, for instance, in their private or professional contexts, without thorough evaluation of the quality of their social networks may be premature or even harmful.

Strengths and limitations

Major strengths of this study include its prospective study design with non-retrospectively collected data on pre-event psychopathology and emotional support before the index event, the use of a large sample of adults recently affected by PTEs drawn from a traditional probability sample of the general population, the application of standardized and validated questionnaires, and the strategy for data analysis accounted for relevant confounders in the multivariable logistic regression analyses, minimizing the risk of biased results. In addition, bivariate analyses without covariates revealed comparable associations, so that a major bias due to the inclusion of covariates is therefore unlikely [35].

Nevertheless, some methodological limitations must be considered when interpreting the present findings. Clinical interviews assessing mental health problems were not conducted, which may have enriched our study [36], as may have data based on the full PCL-5 scale. The dichotomization of a set of variables and the resulting loss of variance potentially leads to a loss of granularity and an increased risk of bias. Before the present results can be generalized, they must also be replicated outside the Netherlands. In addition, the dichotomization of cultural origin provides only a reductive homogenous outline for a very heterogeneous cultural matrix that may influence the processing of PTEs. Future research should explore the effects of (non-)disclosure on other relevant mental health outcomes, including substance misuse, concentration difficulties, and sleep disturbances, as well as the impact on children and adolescents (under 18). Additionally, we did not control for potential PTEs experienced in previous years or during childhood. However, severe pre-event ADS was accounted for, which may partially reflect the impact of prior PTEs. Further research is required to investigate potential moderating factors that may influence the current findings, such as victim's attitudes towards disclosure [37], motivations or reasons for (non-)disclosure [e.g. trauma-related shame; 14, 38], and variations in disclosure recipients [19]. In addition, future research is warranted to examine the extent to which specific sources of event-related social acknowledgment are of relevance over and above to the consequences of the overall perceived event-related social acknowledgment. Future research should also examine the effects of timing of disclosure, and therefore could focus on PTSD diagnosis (including the one-month criteria).

Conclusions

The present findings suggest that the generalization of trauma non-disclosure as uniformly harmful and trauma disclosure as inherently therapeutic in adult victims of PTEs appears to be premature. Non-disclosure may serve as a preventative measure, helping to prevent negative or unwanted reactions that may increase levels of post-event psychopathology. Nevertheless, non-disclosure is also linked to a significantly increased likelihood of post-event psychopathology compared to disclosure accompanied by high or fairly high event-related social acknowledgment. Professionals and others working with trauma victims need to be aware of this complex picture before encouraging disclosure.

Supplementary Information The online version contains supplementary material available at https://doi.org/10.1007/s00127-026-03106-3.

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Author contributions Conceptualization: Ideas; formulation or evolution of overarching research goals and aims. o SK, PV, LW • Data curation: Management activities to annotate (produce metadata), scrub data and maintain research data (including software code, where it is necessary for interpreting the data itself) for initial use and later re-use. o SK, PV, LW • Formal analysis: Application of statistical, mathematical, computational, or other formal techniques to analyze or synthesize study data. o SK, PV, LW • Methodology: Development or design of methodology; creation of models. o SK, PV, LW • Software: Programming, software development; designing computer programs; implementation of the computer code and supporting algorithms; testing of existing code components. o SK, PV, LW • Supervision: Oversight and leadership responsibility for the research activity planning and execution, including mentorship external to the core team. o PV, LW • Validation: Verification, whether as a part of the activity or separate, of the overall replication/reproducibility of results/experiments and other research outputs. o SK, PV, LW • Writing—original draft: Preparation,

creation and/or presentation of the published work, specifically writing the initial draft (including substantive translation). o SK, PV, LW • Writing—review and editing: Preparation, creation and/or presentation of the published work by those from the original research group, specifically critical review, commentary or revision: including pre- or post-publication stages. o SK, PV, LW.

Data availability All archived data files related to studies conducted with the LISS panel can be downloaded for free, upon registration (for further information see https://www.lissdata.nl).

Declarations

Competing interests The authors declare no competing interests.

Ethics approval The VICTIMS-study was approved by an IRB of Centerdata, consisting of independent, internal and external reviewers.

Informed consent In accordance with the General Data Protection Regulation (GDPR), all respondents provided explicit digital consent for the use of their data in scientific and policy-relevant research.

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