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When Trauma Remains Unspoken: Brief Psychodynamic Psychotherapy in Delayed Disclosure of Workplace Sexual Trauma

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ABSTRACT

Post-traumatic stress disorder (PTSD) and major depressive disorder (MDD) commonly follow sexual trauma. However, some patients present with complex features such as internalised shame, self-blame, and difficulty disclosing trauma, which may hinder engagement with structured treatments. Delayed disclosure is especially relevant in sociocultural contexts where stigma, power dynamics, and concerns about family reputation influence help-seeking. We report the case of a 30-year-old woman who developed PTSD and comorbid MDD following workplace sexual trauma, with a background of childhood abuse. Her presentation was characterised by persistent low mood, intrusive memories, hyperarousal, avoidance, somatic symptoms, and significant functional impairment. A key feature was delayed disclosure of trauma, influenced by internalised shame and sociocultural factors. She showed improvement following treatment with pharmacotherapy and a 12-session course of brief psychodynamic psychotherapy (BPP). BPP focused on linking current symptoms to earlier relational trauma, addressing maladaptive defence mechanisms, and facilitating emotional expression within a safe therapeutic relationship. The patient demonstrated significant improvement in trauma-related symptoms, including reduced intrusions, avoidance, and emotional distress, alongside improved affect regulation and insight, particularly after being able to verbalise previously unspoken traumatic experiences. This case highlights the value of brief psychodynamic psychotherapy in managing complex trauma presentations characterised by shame, relational difficulties, and delayed disclosure. It underscores the importance of culturally sensitive, relational approaches in contexts such as Malaysia, where disclosure may be inhibited. We provide the psychodynamic formulation and the principles of BPP applied in the sessions to highlight how this form of therapy may serve as a useful adjunct in trauma-informed care, particularly for patients who struggle to engage with standard trauma-focused interventions.

Keywords: brief psychodynamic psychotherapy, post-traumatic stress disorder, sexual trauma

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INTRODUCTION

Post-traumatic stress disorder (PTSD) and major depressive disorder (MDD) are well-recognised consequences of sexual trauma. While trauma-focused therapies are widely recommended, some patients present with complex clinical profiles characterised by pervasive shame, self-blame, and difficulty engaging in structured interventions (McCann et al., 2023). In such cases, psychopathology may be driven not only by fear-based mechanisms but also by maladaptive relational patterns rooted in earlier developmental trauma (Cruz-Fuentes *et al*., 2022).

Brief Psychodynamic Psychotherapy (BPP) is a time-limited psychodynamic intervention that focuses on identifying unconscious conflicts, maladaptive relational patterns, affective avoidance, and internalised self-representations that contribute to psychological distress. The approach is mainly grounded in psychoanalytic and psychodynamic theory, which holds that unconscious thoughts, feelings, and unresolved conflicts influence present behaviour and distress (Levenson, 2017). BPP is usually performed under 6 months, highly focused on one central conflict or relationship pattern, and involves a more structured, active therapist stance. Traditional psychodynamic therapy is open-ended, explores multiple themes more broadly over a longer period, and relies more on a neutral, less directive stance to facilitate deeper personality change (Porcelan & Scribner, 2022). Essentially, unlike traditional open-ended psychodynamic psychotherapy, BPP is structured around a specific therapeutic focus and aims to achieve change within a

limited number of sessions. BPP has been used in depression, anxiety disorders, personality pathology, and trauma-related conditions, particularly where interpersonal difficulties, shame, and emotional suppression are prominent (Caselli *et al*., 2023).

Delayed disclosure of trauma refers to disclosure occurring months or years after the traumatic event. Previous studies have reported delays ranging from several months to decades, particularly in sexual trauma where shame, fear of blame, and concerns about social consequences inhibit help-seeking (Lanthier et al, 2018). In many Eastern population settings, including Malaysia, cultural values emphasising modesty, respect to authority, and safeguarding of family reputation may inhibit disclosure, especially when the perpetrator occupies a position of power (Abdul Latiff et al., 2024).

This case describes a woman with PTSD and comorbid MDD following workplace sexual trauma, whose presentation was shaped by disclosure that only occurred after more than five years, reactivation of childhood abuse, and internalised shame. It highlights how BPP can facilitate gradual disclosure, address shame-based beliefs, and support integration of trauma within a culturally sensitive framework, underscoring its value in complex trauma presentations where standard approaches may be insufficient.

CASE REPORT

Clinical presentation

A 30-year-old married woman, employed in the public sector, presented with a two-year history of depressive symptoms and trauma-related anxiety following a workplace sexual assault perpetrated by her superior. The onset of symptoms was temporally associated with the traumatic event, although her presentation was influenced by a background of childhood sexual abuse and emotional neglect.

She reported persistent low mood, anhedonia, fatigue, impaired concentration, sleep disturbance, and reduced motivation, resulting in significant occupational and interpersonal dysfunction. Despite attempts to maintain routine functioning, she experienced marked psychological distress when approaching her workplace, leading to avoidance behaviours, frequent medical leave, and declining work performance. She described pervasive feelings of guilt, worthlessness, and inadequacy, particularly in relation to her roles within the family.

In addition, she exhibited core symptoms of post-traumatic stress, including recurrent intrusive memories, distressing nightmares, psychological distress on exposure to trauma-related cues, and active avoidance of reminders. Hyperarousal symptoms were evident, including hypervigilance, exaggerated startle response, and situational panic attacks characterised by palpitations, breathlessness, tremors, and nausea. These episodes were consistently triggered by workplace-related stimuli.

The clinical course was characterised by fluctuation. Partial remission occurred during a period when the perpetrator was absent from the workplace, with improvement in mood, sleep, and functioning. However, symptoms relapsed upon re-exposure and were further exacerbated by subsequent interpersonal stressors, including victim-blaming remarks from a colleague. A colleague suggested that she had exaggerated the incident and should simply move on, which intensified feelings of guilt and shame. This led to increased avoidance, emotional withdrawal, and further functional decline.

She also presented with recurrent somatic complaints, particularly abdominal pain, resulting in repeated healthcare visits and investigations. These symptoms appeared to be related to her psychological distress, which was consistent with features of somatisation following traumatic experiences.

Historically, the patient reported childhood sexual abuse by a trusted relative during her teenage years. Disclosure at the time was met with a lack of emotional support. She also described chronic emotional neglect and invalidation within the family, where her emotional needs were frequently dismissed. These experiences contributed to longstanding beliefs of being unworthy, unsafe, and unable to rely on others for protection.

Psychosocially, her condition was compounded by limited support from her spouse, from whom she had kept the experience a secret. Nevertheless, she retained some protective factors, including a supportive sibling relationship and reliance on spiritual coping. There was no history of suicidal ideation, psychotic symptoms, manic or hypomanic episodes, or substance use.

Mental State Examination

The patient was well-groomed and cooperative. Her speech was coherent, relevant, and of low tone, with occasional tearfulness when discussing distressing material. Mood was subjectively anxious, with congruent affect. Thought processes were logical and goal-directed. Thought content was consistent with trauma-related preoccupation and themes of guilt and worthlessness, without delusions or suicidal ideation. There were no perceptual abnormalities. Cognitive functions, insight, and judgment were intact.

Investigations

Routine blood investigations, including full blood count, renal profile, liver function tests, thyroid function tests, and fasting blood glucose, were within normal limits, except for mildly elevated liver enzymes. Psychometric assessment using the Beck

Depression Inventory indicated severe depressive symptoms.

Diagnosis

A diagnosis of post-traumatic stress disorder (PTSD) with comorbid major depressive disorder (moderate to severe, without psychotic features) was made, based on DSM-5 criteria (American Psychiatric Association, 2022). Differential diagnoses considered included generalised anxiety disorder, persistent depressive disorder, and borderline personality disorder, but these were less consistent with the trauma-specific symptom profile and clinical course.

Treatment

The patient was treated with Sertraline 150 mg once daily, an antidepressant medication, which resulted in partial improvement in mood, sleep, and anxiety symptoms. However, adherence was inconsistent due to psychosocial factors. She was engaged in psychotherapy focusing on trauma processing and emotional regulation. A brief psychodynamic approach was adopted, conducted over 12 sessions. During the initial sessions (Sessions 1–3), the focus was on building a therapeutic alliance, providing a safe space for disclosure, and exploring the patient's traumatic experiences. In the middle phase (Sessions 4–8), therapy focused on identifying feelings of shame and self-blame and helping the patient understand how her childhood experiences influenced her current reactions to the workplace trauma. In the final phase (Sessions 9–12), the focus shifted towards encouraging emotional expression, improving assertiveness, enhancing self-understanding and emotional regulation, and consolidating therapeutic gains before termination of therapy. Supportive interventions included medical leave, psychoeducation, and reinforcement of adaptive coping strategies.

Outcome

The patient demonstrated significant improvement in her trauma-related symptoms following brief psychodynamic psychotherapy, particularly after being provided with a safe therapeutic space to explore and verbalise previously unspoken traumatic experiences. She reported a reduction in intrusive memories, emotional distress, and avoidance behaviours, alongside improved affect regulation and psychological clarity. Her previous somatic symptoms, such as abdominal pain, had subsided and no longer impaired her daily functioning. This progress was most notable after she began linking her current symptoms to earlier unresolved trauma, facilitating greater emotional integration.

However, her course remained vulnerable to relapse in the context of re-exposure to workplace stressors, inconsistent treatment adherence, and limited psychosocial support. Despite these challenges, she remained engaged with services and demonstrated increasing insight and motivation for recovery. Ongoing management focuses on sustained pharmacological treatment, continued trauma-focused psychotherapy, and strengthening psychosocial support systems.

DISCUSSION

Psychodynamic Formulation

From a psychodynamic perspective, the patient's presentation can be understood as the reactivation of unresolved early relational trauma in the context of a recent workplace sexual assault. Early experiences of emotional neglect and childhood sexual abuse, along with repeated invalidation by caregivers, shaped a shame-based sense of self marked by feelings of defectiveness, worthlessness, and difficulty trusting others. These internalised relational patterns shaped her tendency towards self-silencing, over-compliance, and difficulty seeking help, reflecting an insecure attachment style (Bowlby, 1988; Fonagy *et al*., 2002). The workplace trauma functioned as a precipitating event that reactivated these earlier internal conflicts, leading to a convergence of past and present experiences of helplessness, betrayal, and lack of protection.

Her persistent self-blame and reluctance to disclose the assault can be understood as manifestations of introjection of critical and invalidating figures, alongside the use of defences such as suppression, intellectualisation, and dissociation, which serve to contain overwhelming affect while limiting emotional processing (Cabaniss et al., 2011). Somatic symptoms may represent the conversion of unresolved psychological distress into bodily expression, consistent with trauma-related somatisation (van der Kolk, 2014). Interpersonally, there is evidence of repetition of early relational dynamics, with expectations of disbelief, and emotional unavailability extending into her marital and occupational relationships, reflecting patterns of repetition compulsion and maladaptive internal working models (Gabbard, 2014) (see Figure 1 and Table 1).

Delayed disclosure was a key feature of this case. It is often associated with shame and fear of blame (Marriott et al., 2016), and may be further influenced by cultural factors. In Malaysia and similar contexts, stigma, respect for authority, and concerns about family reputation may inhibit disclosure, especially when the perpetrator is in a position of power (Abdul Latiff et al., 2024). In this patient, these factors contributed to prolonged suppression of trauma, with subsequent emotional and physical symptoms. As highlighted by Krupnick (2002), BPP was particularly

helpful as it allowed gradual exploration of distress in a safe therapeutic relationship without requiring immediate detailed disclosure.

Brief Psychodynamic Psychotherapy (BPP)

Brief psychodynamic psychotherapy (BPP) is a useful complementary approach in trauma care, particularly for addressing meaning-making, emotional regulation, and relational difficulties that may not be fully targeted by exposure-based therapies (Krupnick, 2002). Unlike trauma-focused therapies such as trauma-focused cognitive behavioural therapy (TF-CBT), eye movement desensitisation reprocessing therapy (EMDR), and prolonged exposure therapy, which primarily focus on processing traumatic memories and reducing PTSD symptoms, brief psychodynamic psychotherapy (BPP) emphasises the exploration of unconscious conflicts, emotional experiences, and interpersonal patterns that underlie psychological distress. BPP may be particularly beneficial for patients with complex trauma presentations involving shame, self-blame, relational difficulties, and delayed disclosure. In this case, BPP provided a framework for understanding how earlier traumatic experiences influenced her current symptoms and relationships, facilitating emotional expression and psychological integration (Almeida *et al*., 2024). This approach was particularly suitable for this case because it provided a time-limited yet effective intervention that addressed trauma, relational difficulties, and shame-related struggles in a patient with limited support.

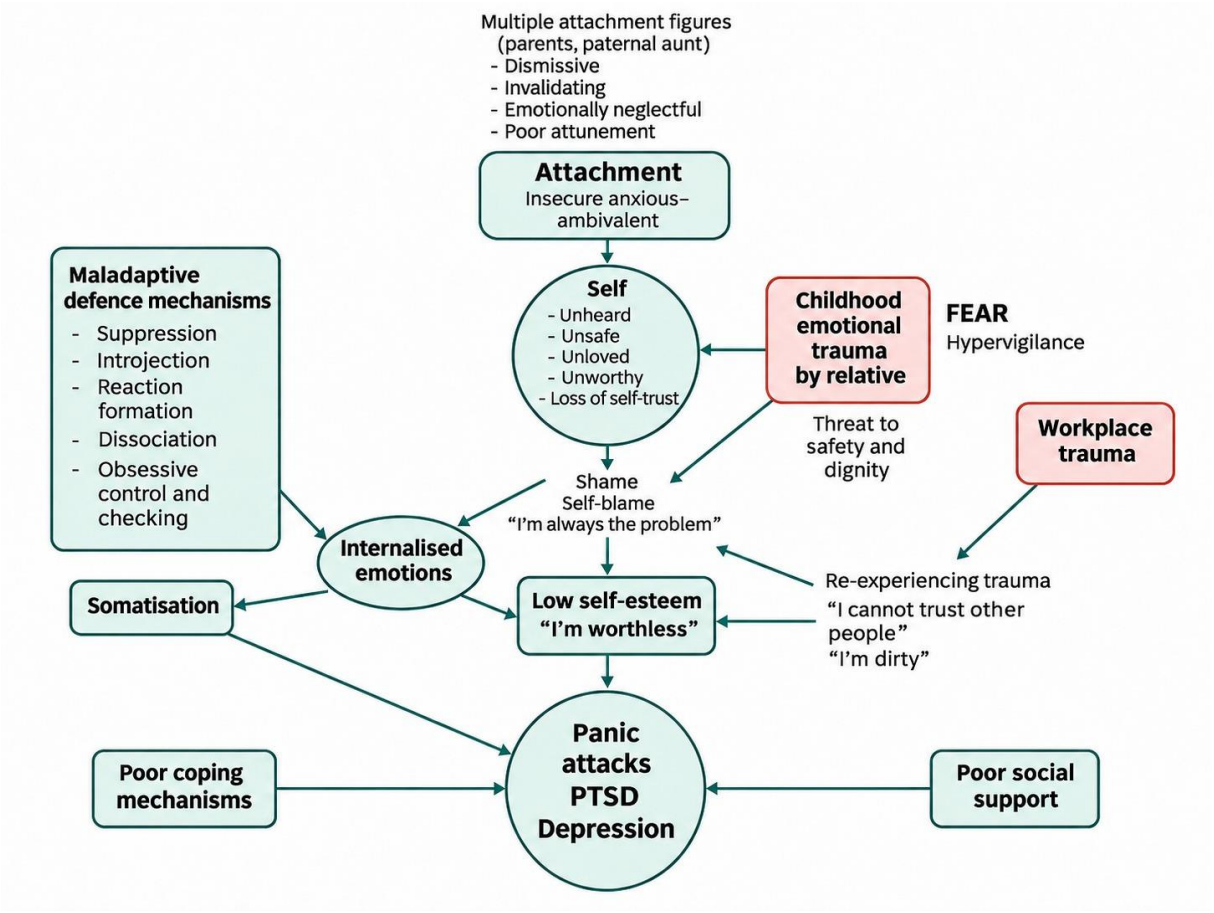


Figure 1. Visual summary of the psychodynamic formulation of the case highlighting the underlying issues that contribute to the development of presenting symptoms.

Table 1. Summary of psychodynamic issues addressed during therapy and the principles applied. Adapted from Center for Substance Abuse Treatment (CSAT, 1999).

Psychodynamic Issue	Example from Case	Core BPP principle applied
1. Internalised shame and negative self-representation	Persistent self-blame ("I am unworthy/disgusting") following childhood and workplace sexual trauma	Interpretation of unconscious meanings by linking shame to internalised critical figures; restructuring maladaptive self-representations
2. Repetition of trauma and maladaptive relational patterns	Workplace assault and invalidation mirrored earlier childhood abuse and lack of protection	Linking past and present (repetition compulsion) by increasing awareness of recurring relational dynamics and developing new patterns
3. Emotional suppression and difficulty asserting needs	Withheld disclosure of trauma from husband and others; prioritised harmony over emotional expression	Facilitating emotional expression by supporting emergence of authentic affect and development of assertiveness
4. Maladaptive defence mechanisms (intellectualisation, dissociation, somatisation)	Detached, analytical recounting of trauma; emotional numbing; somatic complaints (abdominal pain) during distress	Clarification and confrontation of defences by shifting from cognitive avoidance to affective processing; linking mind–body experience
5. Insecure attachment and fear of rejection	Fear of being judged or burdening others; limited help-seeking and relational withdrawal	Corrective emotional experience in therapy by providing consistent, validating therapeutic relationship to revise attachment expectations
6. Impaired affect regulation	Difficulty identifying and processing emotions; hypervigilance and panic triggered by trauma reminders	Enhancing reflective functioning (mentalisation) by improving capacity to understand and regulate internal emotional states
7. Transference and relational expectations in therapy	Initial guardedness, fear of invalidation, and expectation of emotional unavailability from therapist	Working with transference by interpreting relational patterns within therapy to promote insight and relational change

The therapeutic relationship played a central role. The patient initially showed fear of judgement and rejection, reflecting past relational experiences. Through a consistent and supportive approach, therapy provided a corrective emotional experience, helping her develop trust and process emotions more openly. This transition from a detached narrative style to deeper emotional engagement enhanced her capacity for affect regulation (Fonagy & Bateman, 2006).

This report describes a single case, and findings may not be generalisable. Improvement cannot be attributed solely to BPP due to concurrent pharmacotherapy and psychosocial interventions. Formal post-treatment psychometric measures were not obtained. Nevertheless, the case provides clinically relevant insights into the role of BPP in complex trauma presentations characterised by delayed disclosure and internalised shame.

CONCLUSION

This case highlights the value of brief psychodynamic psychotherapy in managing trauma-related disorders characterised by internalised shame, relational difficulties, and delayed disclosure. It demonstrates how addressing underlying self-representations and interpersonal patterns can facilitate emotional integration beyond symptom reduction. In sociocultural contexts such as Malaysia, where stigma

and power dynamics may inhibit disclosure, a relational and culturally sensitive approach is particularly important in supporting recovery. Given these benefits, there is a need to encourage clinicians to develop competencies in psychodynamic techniques and to incorporate them into trauma-informed care. Greater emphasis on training and supervision in brief psychodynamic psychotherapy may enhance clinicians' ability to effectively manage complex trauma, particularly in patients who struggle with shame, relational difficulties, and delayed disclosure.

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