

CHAPTER 4

Betrayal Trauma

Laura A. Kaehler
Rebecca Babcock
Anne P. DePrince
Jennifer J. Freyd

An estimated 6 million children and adolescents in the United States were referred to child protective services (CPS) in 2010 for experiences of maltreatment, including abuse (physical, sexual, and emotional) and/or neglect (U.S. Department of Health and Human Services [USDHHS], 2010). In an estimated 81% of those cases, perpetrators were caregivers. Due to variations in legal and research definitions of child maltreatment as well as false negatives in reporting (Chu, Pineda, DePrince, & Freyd, 2011), the prevalence of caregiver maltreatment is likely underestimated by federal numbers. Moreover, the terms *child maltreatment* and *child sexual abuse* are used in ways that obscure the fact that perpetrators are often relatives or those otherwise in positions of responsibility or known to the child. In the case of sexual abuse, *incest* is the more accurate terminology (Courtois, 2010). Children and adolescents mistreated by those in positions of trust (e.g., caregivers) are at high risk for a range of deleterious outcomes, including depression (Putnam, 2003), dissociation (Putnam, 1997), cognitive deficits (DePrince, Weinzierl, & Combs, 2009), and difficulties in emotional processing (Reichmann-Decker, DePrince, & McIntosh, 2010). For clinicians and researchers seeking to understand the adverse outcomes associated with caregiver maltreatment, betrayal trauma theory (BTT) offers a

potentially useful theoretical framework (Freyd, Klest, & DePrince, 2009, p. 20). At its heart, “BTT is an approach to conceptualizing trauma that points to the importance of social relationships in understanding posttraumatic outcomes, including ‘reduced recall’” (Freyd, DePrince, & Gleaves, 2007, p. 297; see also Freyd, 1994, 1996, 2001).

This chapter first offers a review of relevant issues from attachment theory as they relate to BTT and child maltreatment. Next, we describe BTT research conducted with adult samples and discuss the importance of studying BTT with child and adolescent samples. We then present the BTT research conducted with children and adolescents. Next, the clinical implications of BTT research with children and adults are discussed in terms of the theory’s relevance for revictimization prevention and therapeutic intervention. The chapter concludes with recommendations for future BTT-related clinical and research directions.

Attachment Theory and Maltreatment

Attachment theory, developed by Bowlby (1973, 1988), posits that infants are biologically programmed to develop and maintain an attachment to a caregiver early in life in order to ensure survival. The attachment system supports two major functions: a protective and coping function when the child is faced with dangerous situations (“safe haven”) and an exploratory function by ensuring the availability of the attachment figure (the “secure base”). The attachment system becomes activated under stressful conditions: perceived threats to the availability of an attachment figure, perceived danger in the environment, and perceived challenges when exploring new and challenging situations (Kobak, Cassidy, Lyons-Ruth, & Ziv, 2006). Yet, when the parent is the source of the danger (e.g., in maltreatment or incest), there is a paradox of approach–avoidance needs. The parent’s frightening behavior places the child in an unsolvable situation because the attachment figure acts as both the safe haven and the source of the threat. When frightened, the child will have the urge to move toward the parent (safe haven) as well as away from the source of threat; however, if the child moves away from the source of the threat, he or she then will want to move toward the parent (safe haven). Hesse and Main (1999, 2006) term this paradox the “fright without solution.”

Mary Ainsworth and colleagues (Ainsworth, Blehar, Waters, & Wall, 1978) identified three styles of attachment: securely attached infants (type B) and two insecurely attached groups: anxious–avoidant (type A) and anxious–ambivalent (type C). Main and Solomon (1986) developed a fourth category, disorganized (type D) because the behaviors displayed by many children could not be classified using the three “organized” categories. These children demonstrated contradictory approach–avoidance behaviors and appeared to present an inconsistent behavioral and attentional

strategy. In a literature review based on 13 studies, on average 76% of maltreated infants were classified as being insecurely attached compared to 34% of controls (Morton & Browne, 1998). Maltreated children are more likely than nonmaltreated children to exhibit insecure attachment styles during their preschool (Cicchetti & Barnett, 1991; Crittenden, 1988) and school-age years (Lynch & Cicchetti, 1991). Of great significance is the fact that between half (van IJzendoorn, Schuengel, & Bakermans-Kranenburg, 1999) to more than three quarters (Barnett, Ganiban, & Cicchetti, 1999; Beeghly & Cicchetti, 1994; Carlson, Cicchetti, Barnett, & Braunwald, 1989; Cicchetti & Barnett, 1991) of maltreated children have been found to have disorganized attachment styles.

Betrayal Trauma Theory

Bowlby (1988, p. 121) suggested that the attachment relationship “has a key survival function of its own, namely protection.” Betrayal traumas involve a violation of the trust that children innately have in their protective caregivers, thus constituting a threat to these children’s survival. BTT posits that in order to maintain a necessary attachment to a caregiver, a survivor of parental maltreatment must remain blind to that betrayal—that is, “betrayal blindness” (Freyd, 1996). Ordinarily it would be advantageous to detect betrayal in order to prevent a future violation; however, if detecting that betrayal could damage the security of attachment to an essential caregiver, it may be psychologically necessary to remain unaware of that violation (Freyd, 1996). Awareness of the betrayal caused by abuse may lead to withdrawal from that caregiver; however, by doing so, the child may risk further harm if the parent no longer continues to protect or meet the child’s needs. Therefore, in order to preserve a sense of security and ensure survival, the child may remain unaware of the betrayal. This unawareness allows the child to avoid the “fright without solution” paradox (Hesse & Main, 1999, 2006). One mechanism by which this betrayal blindness may occur is dissociation, which Bernstein and Putnam (1986, p. 727) define as “a lack of normal integration of thoughts, feelings, and experiences into the stream of consciousness and memory.” It is for this reason that research studies derived from a BTT framework have focused on associations between betrayal and dissociation, as well as related alterations in cognition, mental health symptoms, and problems in social and relationship functioning.

Empirical Research on BTT with Adult Samples

Freyd, Martorello, Alvarado, Hayes, and Christman (1998), using a college sample, found that “high dissociators” had difficulty in consciously

controlling attentional focus. In a follow-up study, DePrince and Freyd (1999) again compared high and “low dissociators” and found that high dissociators had more difficulty than low dissociators when trying to ignore information (i.e., selective attention), but less difficulty when trying to remember to pay attention. Furthermore, high dissociators were less able to recall trauma-related than neutral information, whereas low dissociators showed the opposite pattern. These results have been replicated in follow-up research (DePrince & Freyd, 2001; DePrince & Freyd, 2004), which linked high levels of dissociation to more trauma history (Freyd & DePrince, 2001) and more betrayal trauma (DePrince & Freyd, 2004). These results support the BTT premise that interpersonally traumatized individuals may use dissociation as a mechanism for betrayal blindness.

Research conducted by Freyd, DePrince, and Zurbriggen (2001) further explored this tenet by looking at memory for abuse based on the relationship to the perpetrator. They showed that although most participants reported no memory impairment, the impairment occurred more frequently if the perpetrator was a caretaker, even after controlling for the age and duration effects of the abuse. Relatedly, in a sample of adult survivors of childhood sexual abuse, Ullman (2007) found that those who were victimized by relatives were more likely to disbelieve that the documented abuse occurred compared to participants victimized by strangers or acquaintances.

When formulating BTT, Freyd (1996) drew a distinction between two independent aspects of trauma: a terror-inducing or fear dimension associated with immediate life threat, and a social-betrayal dimension associated with threats to security in protective relationships (see Figure 4.1). She later suggested that these two dimensions may account for posttraumatic stress disorder (PTSD) symptom clusters, with the hyperarousal and intrusive symptoms arising from the fear dimension, and the avoidance/numbing symptoms (including dissociation) being evoked by the social-betrayal aspect of the trauma (Freyd, 1999).

Although not focusing specifically on these two dimensions in relation to PTSD, Tang and Freyd (2012), using both a college and a community sample, demonstrated that traumas high in betrayal (i.e., perpetrated by a close other) had the strongest association with symptoms of PTSD (as well as to depression and anxiety) compared to traumas lower in betrayal. Similarly, Ullman (2007) found that those for whom family members were perpetrators (which the authors designate as a betrayal trauma) had more PTSD symptoms than those abused by nonrelatives in an adult sample of child sexual abuse survivors. Looking at general mental health symptoms, Freyd, Klest, and Allard (2005) explored betrayal trauma history and mental health symptoms in a community sample of chronically medically ill patients. Results showed that experiencing traumas high in betrayal predicted anxiety, dissociation, and depression symptoms assessed by the Trauma Symptom Checklist (TSC; Briere,

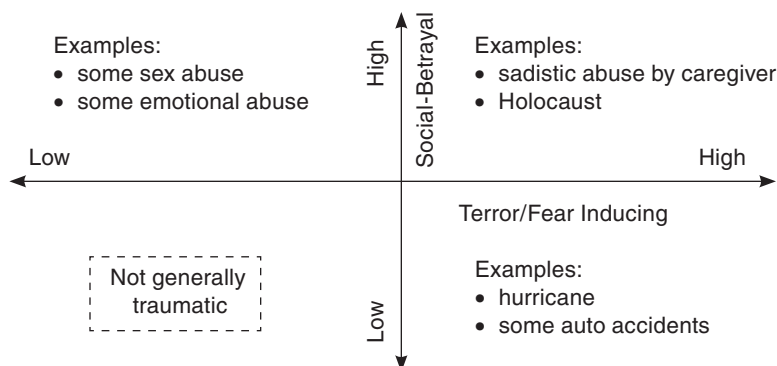


FIGURE 4.1. Two-dimensional model of trauma. Copyright 1996 by Jennifer J. Freyd. Reprinted by permission.

1996). Goldsmith, Freyd, and DePrince (2012) replicated these findings in a nonclinical sample.

In addition to being connected to what DSM-IV (and earlier editions of DSM) referred to as Axis I symptoms, betrayal traumas have also been associated with Axis II symptoms. Kaehler and Freyd (2009) demonstrated that traumas high in betrayal predicted borderline personality disorder characteristics, while traumas low in betrayal did not. In a follow-up study with community participants (Kaehler & Freyd, 2012), a significant gender effect was revealed: Traumas higher in betrayal predicted borderline personality characteristics for both men and women; however, traumas lower in betrayal also predicted these characteristics for men (but not for women). Belford, Kaehler, and Birrell (2012) showed that strong relational health weakened the association between betrayal trauma experiences and borderline personality characteristics. In sum, a history of betrayal trauma has been linked to a broad range of psychopathological symptoms in adults.

BTT (Freyd, 1996) suggests that experiencing traumas high in betrayal may damage trust mechanisms, resulting in either insufficient or excessive trust. Consequently, the survivor may not be able to protect him- or herself when confronted with subsequent betrayals. In their prospective study of college women, Messman-Moore and Brown (2006) found that prior victimization and delayed responses to danger cues increased women's vulnerability to rape and sexual revictimization. Zurbriggen and Freyd (2004) proposed that traumas high in betrayal impair cognitive mechanisms that would typically help an individual make advantageous relationship decisions. This premise has been supported by the work of DePrince (2005), who showed that undergraduates who had been revictimized made significantly more cognitive errors when it came to social or safety issues than students who

had not been revictimized. Furthermore, there were no group differences for more abstract problems, indicating that the cognitive impairments are not attributable to general reasoning differences. Interestingly, pathological dissociation significantly predicted errors in the social and safety rules.

Recent research has explored the impact that a history of high-betrayal trauma (i.e., abuse perpetrated by someone with whom the survivor was “very close”) has on survivors’ interpersonal relationships. Gobin and Freyd (2009) found that high-betrayal trauma survivors reported more everyday betrayals than those who had not experienced a high-betrayal trauma. These survivors also had lower levels of trust, a decreased awareness of betrayals in their intimate relationships, and were more likely to remain in a relationship after a betrayal occurred. Thus, survivors of high-betrayal trauma are more likely to experience betrayals in their intimate relationships and maintain these violating relationships despite having lower levels of trust. The authors suggest that these factors are indicative of a continued pattern of betrayal blindness later in life that may increase survivors’ risk of revictimization. In fact, Gobin and Freyd (2009) found that 69% of participants with a childhood history of high-betrayal traumas were revictimized as adolescents and 49% were revictimized as adults; however, only 9% of participants without this history were victimized as adults. For those with an adolescent history of high-betrayal traumas, 41% later experienced at least one high-betrayal trauma as an adult, whereas only 7% of participants without such histories were victimized as adults.

Owen, Quirk, and Manthos (2012) revealed a positive association between childhood high-betrayal traumas and both avoidance and anxious attachment. Furthermore, participants with this history perceived their romantic partners as less respectful, compared to partners of participants with a history of interpersonal trauma perpetrated by someone not close. Moreover, this association between high-betrayal traumas and perceived partner respect was mediated by psychological well-being and anxious attachment, such that those who had higher well-being or less anxious attachment had more (perceived) respectful partners. Gobin (2012) demonstrated that experiencing a high-betrayal trauma resulted in a devaluation of loyalty in a romantic partner. Being revictimized was associated with less desire for a sincere or trustworthy partner and stronger attraction to verbally aggressive partners. In a community sample of women survivors of intimate partner abuse (IPA), Babcock and DePrince (2012b) showed that IPA survivors with high-betrayal trauma histories were more likely to be revictimized over the course of 6 months after the domestic violence incident by the same intimate partner. Interestingly, IPA survivors who experienced trauma high in betrayal during their childhoods were also more likely to blame themselves for a domestic violence incident reported to the police, compared to women who had not experienced betrayal trauma (Babcock & DePrince, 2012a).

Importance of Studying BTT in Children and Adolescents

Studying BTT with child and adolescent samples is critical in order to better understand the nature and consequences of betrayal trauma experiences and to inform and target interventions toward these younger age groups. Though research studies utilizing adult participants have greatly advanced the field's understanding of childhood betrayal trauma, retrospective accounts of betrayal trauma experiences are subject to potential reporting biases. Thus, studying betrayal trauma and its sequelae in childhood could provide a clearer test of the relationships between it and dissociation and revictimization postulated by BTT.

Previous research (Brewin, Andrews, & Gotlib, 1993; Hardt & Rutter, 2004) demonstrated that when study participants retrospectively report that abuse or neglect has occurred, their reports are most often correct. Despite evidence about the accuracy of retrospective reporting of trauma history, research has shown that children's memories of traumatic experiences can be fragmented or nonlinear, especially if the child dissociated during the traumatic event. As BTT (Freyd, 1996) posits, the closer the child is to the abuser, the more adaptive it may be for the child to dissociate or distance him- or herself psychologically from the abuse in order to maintain a necessary attachment for survival. Dissociation at the time of the traumatic experience can result in partial or full amnesia of the abuse.

Dissociative amnesia limits the data that researchers are able to collect, in that participants can report only on experiences they can recall, and dissociation interferes with memory encoding and recall. In fact, Hardt and Rutter's (2004) review of literature involving abuse revealed that false negative reports of abuse and measurement error were the two most common threats to validity coming from retrospective reports. Even in the cases where abuse and neglect were substantiated through documentation, rates of denying abuse have ranged from approximately 33% (Hardt & Rutter, 2004) to 50% (Fergusson, Horwood, & Woodward, 2000). Other factors such as long-term memory accuracy, infantile amnesia, and mood may also influence retrospective self-reports of abuse (Hardt & Rutter, 2004; Goldsmith & Freyd, 2005).

Given the limitations of retrospective self-reports, prospective research on the impact of childhood betrayal trauma is needed. Asking children and adolescents about their abuse experiences shortly after the abuse occurred may provide more accurate information about the traumatic event, and a clearer account of how the traumatic experience impacted the youth. Moreover, conducting research about betrayal trauma with children and adolescents can inform intervention strategies and hopefully prevent future incidences of abuse. Such studies could also provide invaluable information for the treatment of youth who have experienced betrayal trauma. By providing early interventions to these children and adolescents, the long-term

consequences of betrayal trauma, like increased risk for revictimization and trauma-related psychopathology, may be prevented.

Empirical Research on BTT with Child Samples

Similar to the research with adults, cognitive aspects of BTT have been examined in children as well. Becker-Blease, Freyd, and Pears (2004) found that abused preschool-age children with high levels of dissociation showed poorer memory recognition for emotionally charged, threatening pictures compared to a group of nonabused children with low dissociation in a divided attention state. These results are consistent with the findings from the DePrince and Freyd (1999, 2001, 2004) studies, suggesting that those who have been exposed to betrayal traumas and dissociation may have difficulty processing distressing information.

DePrince et al. (2009) more directly replicated the DePrince and Freyd (1999, 2001, 2004) studies and found that higher levels of dissociation per children's self-report were associated with less interference when trying to remember rather than to ignore information; however, children with lower levels of dissociation showed the opposite pattern. An important limitation of this study, however, is that it did not include trauma or threat-related stimuli.

Research has also investigated detection of rule violations among children who have been maltreated. As mentioned previously, work by DePrince (2005) showed that young adults who reported histories of revictimization made significantly more errors detecting violations of social and safety rules compared to their peers who had not been revictimized, but the groups did not differ in abstract reasoning. Pathological dissociation scores predicted these errors. DePrince, Chu, and Combs (2008) explored dissociation and rule violation errors in school-age children. In this study, unlike the DePrince (2005) experiment, there were no significant differences among groups (no trauma, noninterpersonal, or interpersonal) for any of the rules (abstract, social, or safety). However, as in the DePrince (2005) study, dissociation did predict errors in social and safety rules, even after controlling for estimated IQ, socioeconomic status, and child age. Thus, children as well as adults who dissociate appear to be at risk of insufficiently perceiving social and physical dangers at the time and later.

DePrince et al. (2009) examined executive functioning (EF) in children who had not experienced trauma versus children who had experienced either familial (higher-betrayal) or nonfamilial (lower-betrayal) traumas. Regression analyses revealed an association between familial trauma exposure and an EF composite (consisting of working memory, inhibition, auditory attention, and processing speed). For trauma-exposed participants, an increasing number of familial events significantly predicted worse EF performance; however, the number of nonfamilial events was not significantly associated with EF ability.

Looking specifically at attention-deficit/hyperactivity disorder (ADHD), Becker-Blease and Freyd (2008) showed that abused children (defined as experiencing physical, sexual, or emotional abuse or neglect) had higher levels of impulsivity and inattention, but not hyperactivity, compared to nonabused children. This study had a small sample size, prohibiting further exploration of other potentially relevant variables associated with trauma exposure. However, there does seem to be emerging evidence that exposure to traumas higher in betrayal results in poorer overall cognitive functioning. As with the adult samples, BTT has also been utilized to explain symptoms of psychopathology in children.

Comparing a maltreated, preschool-age, foster care sample to a community, nonmaltreated control group, Hulette et al. (2008) demonstrated that children in a foster care sample had significantly higher levels of dissociation and PTSD symptomatology. Hulette, Freyd, and Fisher (2011), studying the same sample of children when they were school-age, showed that the children who had been in foster care continued to have significantly higher levels of dissociation. Moreover, foster children were more likely to be *pathologically* dissociative than their nonmaltreated peers. Unfortunately, PTSD symptoms were not assessed in that research. Given that the children were placed in foster care, they were more likely to have been exposed to high-betrayal traumas. However, because both of these studies relied on CPS case files for information regarding maltreatment, no definitive conclusions can be made regarding the betrayal aspects of the events. Yet, these are important first steps in understanding how betrayal traumas may be related to psychopathology.

Looking at intergenerational effects, Chu and DePrince (2006) found that a mother's own betrayal trauma history predicted her school-age children's dissociation levels, even when controlling for children's own betrayal trauma exposure. Hulette, Kaehler, and Freyd (2011) showed that there was a significant association between a mother's history of interpersonal trauma and her child's history of interpersonal trauma—that is, more children who experienced interpersonal trauma had a mother who had experienced her own interpersonal trauma. Moreover, more revictimized mothers had children with interpersonal trauma experiences, while nonrevictimized mothers were more likely to have children with no interpersonal trauma experiences. This finding is in line with research on disorganized attachment that has found that the primary caregiver is likely to have had a history of unresolved interpersonal trauma or loss (Lyons-Ruth, Dutra, Schuder, & Bianchi, 2006).

Clinical Implications

Extensive research reveals that experiencing betrayal trauma during childhood places survivors at increased risk of entering relationships in which

they will be additionally victimized. By understanding the mechanisms that lead to the revictimization of betrayal trauma survivors, intervention strategies can be developed that teach specific skills to children and adolescents to prevent them from further experiences of betrayal or abuse in their interpersonal relationships as adults.

Gobin and Freyd (2009) explain that child maltreatment involving betrayal may damage certain social and cognitive mechanisms that are necessary to detect potential harm in interpersonal relationships. For example, a cognitive mechanism impacted by betrayal trauma experiences is the *cheater detector* (Cosmides & Tooby, 1992), which refers to people's ability to detect trustworthiness (or its absence) in other people. Studies have shown that experiencing childhood betrayal trauma is associated with a less well-developed ability to detect cheaters, making it difficult for survivors to determine whether or not someone is trustworthy in their interpersonal relationships (Gobin & Freyd, 2009; Zurbriggen & Freyd, 2004). By not recognizing interpersonal betrayals or identifying whether someone is trustworthy, victims of betrayal trauma become vulnerable to experiencing continued acts of betrayal and abuse by their intimate partners later in life. Not only can the inability to determine whether someone is trustworthy increase a survivor's risk of being revictimized by an untrustworthy partner, it can also prevent the survivor from identifying *trustworthy* people as well—people who could provide him or her with support and help to leave exploitive and abusive relationships (Gobin & Freyd, 2009).

In addition to lack of awareness of interpersonal betrayals and difficulty detecting trustworthiness in people, investigators have found that betrayal trauma survivors have trouble detecting risk in social situations (Soler-Baillo, Marx, & Sloan, 2005). DePrince (2005) found that survivors of child sexual abuse (CSA) had significantly greater difficulty detecting violations in social exchange rules. Furthermore, Cloitre, Scarvalone, and Difede (1997) found that CSA survivors failed to identify threat triggers, and as result, were unable to accurately perceive interpersonal violence as an actual violation when these occurred in their intimate relationships. These difficulties in risk detection are compounded by the tendency of perpetrators of IPA to slowly escalate the severity of the betrayal and abuse (e.g., verbal abuse building to physical abuse) they inflict over time (Platt, Barton, & Freyd, 2009). In order for a survivor to recognize this slow progression of violations, he or she must be able to detect less obvious forms of risk or betrayal. If this ability is not developed, it is likely that survivors will adapt behaviors to preserve the relationship with partners, and will not become aware of their partner's betrayal until the risk of harm is severe.

High-betrayal trauma survivors also report higher levels of dissociation and trauma-related distress (Gobin & Freyd, 2009). Dissociation may render a survivor unaware of betrayal and abuse from his or her intimate partner, thus potentially preserving the relationship in the same manner (with similar emotional and physical costs and dangers) that he or she

did when betrayed as a child. Dissociation has been linked to a decreased capacity of victims to feel fear and anxiety that typically accompany dangerous situations (Noll, Trickett, & Putnam, 2003), which may in turn prevent a survivor from attempting to avoid or flee the situation when IPA is imminent. Higher levels of dissociation and trauma-related distress actually distinguish survivors of betrayal trauma who were revictimized from those who were not revictimized (Gobin & Freyd, 2009). Additionally, Ullman and colleagues found that PTSD numbing symptoms, which Freyd (1999) suggests may arise from the betrayal aspects of the trauma, directly predicted further interpersonal revictimization (Ullman, Najdowski, & Filipas, 2009). These findings underscore the significant role that betrayal blindness and associated PTSD symptoms play in increasing a survivor's risk of being revictimized. Research on how long-term consequences of childhood betrayal trauma increase survivors' risk of revictimization highlights how essential it is to treat young survivors of betrayal trauma to prevent them from experiencing lifelong abuse.

Sociocognitive deficits, dissociation, and trauma-related distress can also thwart survivors' abilities to function adaptively in their social relationships. As a result, survivors are often unable to differentiate between appropriate and inappropriate social behavior, establish healthy boundaries for themselves, or engage in self-protection by avoiding or withdrawing from relationships that are harmful. These difficulties may serve as risk factors for survivors' children as well. Survivors may be unable to (1) differentiate appropriate and inappropriate behavior regarding interactions with their children, (2) establish healthy boundaries around their children, or (3) engage in protective behaviors by ending relationships harmful to their children. Further, survivors' increased risk of experiencing revictimization in their intimate relationships may also, in turn, increase the likelihood that their children will be exposed to, or witness, IPA. Chu and DePrince (2006) showed that children who experienced betrayal traumas had mothers who experienced more betrayal traumas compared to children with no betrayal traumas. Hulette, Kaehler, et al. (2011) expanded this work by demonstrating associations among maternal dissociation, revictimization status, and their child's trauma history. Revictimized mothers had higher levels of dissociation (which may have contributed to their being revictimized) compared to nonrevictimized mothers. Furthermore, the children who experienced interpersonal traumas were more likely to have a revictimized mother. Thus, parental betrayal trauma history and posttraumatic sequelae may increase children's vulnerability of experiencing betrayal as well. Clearly, it is important to assess for potential intergenerational effects of betrayal trauma and to provide appropriate interventions at the parent level to prevent trauma at the child level. This can be done as part of a family therapy model (e.g., child-parent psychotherapy; Lieberman & Van Horn, 2008) or as part of the parent's individual treatment (e.g., see Ford, Steinberg, & Zhang, 2011).

Findings from these studies point to several mechanisms that can be targeted in the treatment of child and adolescent survivors. In addition to treating trauma-related distress in the form of PTSD, depression, and dissociation, interventions that focus on sociocognitive skills training in detecting interpersonal violations, betrayal, and trustworthiness, along with assertiveness, may help young survivors avoid entering unhealthy relationships. Child and adolescent survivors must become aware of and understand the nature of the betrayal they experienced as a child, and be taught methods to identify whether a person is trustworthy or not. Problem-solving and assertiveness skills could be invaluable in teaching young survivors adaptive options of “what to do” in risky or unhealthy interpersonal scenarios in order to protect themselves and avoid harm. If child and adolescent survivors can learn to identify risky situations and recognize what constitutes interpersonal betrayal, they will be better equipped to avoid unhealthy relationships and utilize self-protective strategies if violations do occur. By making prevention of revictimization a priority for survivors of betrayal trauma, we can help to ensure that young survivors will grow up to have healthy interpersonal relationships rather than relationships characterized by more betrayal and abuse.

Conclusion

BTT provides a useful framework for understanding cognitive, emotional, and social consequences of child abuse perpetrated by someone on whom the victim depends. Further, the theory sets the stage for several lines of clinical and research inquiry.

Nonoffending Family Members

As noted by DePrince and colleagues (2012), researchers have focused primarily on victims, particularly when seeking to understand the effects of trauma on memory. However, nonoffending relatives situated in the family system where abuse occurs may also experience pressure to remain unaware, leading to similar psychological consequences as occur in victims. Future research is needed to investigate this possibility. This research could go hand in hand with exploring clinical interventions that target nonoffending parents and children together, such as in trauma-focused cognitive-behavioral therapy (e.g., Cohen, Deblinger, Mannarino, & Steer, 2004) and child–parent psychotherapy (e.g., Lieberman & Van Horn, 2008).

Fear and/or Betrayal?

Following traumas, including child maltreatment, researchers and clinicians have frequently focused on the fear-inducing aspects of these events (for a

review, see DePrince & Freyd, 2002). Fear is important, but it is not the only dimension of danger in trauma. BTT points to the need for researchers and clinicians to consider the social and relational context in which abuse occurs, with important implications for understanding problems such as complex PTSD. The sorts of chronic interpersonal traumas that precede complex PTSD, such as familial sexual abuse/incest or emotional abuse and neglect, also include significant betrayals. As children navigate betrayal in caregiving relationships, their attempts at coping with this untenable situation may give rise to the symptoms of complex PTSD, including problems in affect and impulse regulation, attention and consciousness, self-perception, relations with others, somatic functioning, and systems of meaning (see Dorahy et al., 2009; Ford et al., 1999; Herman, 1992; Taylor, Asmundson, & Carleton, 2006). BTT offers researchers and clinicians a road map for formulating and testing questions about the role that betrayal and attachment play in serious posttraumatic responses, such as complex PTSD.

References

- Ainsworth, M. D. S., Blehar, M. C., Waters, E., & Wall, S. (1978). *Patterns of attachment: A psychological study of the strange situation*. Oxford, UK: Erlbaum.
- Babcock, R., & DePrince, A. P. (2012a). Childhood betrayal trauma and self-blame appraisals among survivors of intimate partner abuse. *Journal of Trauma and Dissociation*, *13*, 526–538.
- Babcock, R., & DePrince, A. P. (2012b, December 24). Factors contributing to ongoing intimate partner abuse: Childhood betrayal trauma and dependence on one's perpetrator. *Journal of Interpersonal Violence*. Advance online publication doi:10.1177/0886260512468248.
- Barnett, D., Ganiban, J., & Cicchetti, D. (1999). Maltreatment, negative expressivity, and the development of type D attachments from 12- to 24-months of age. *Society for Research in Child Development Monograph*, *64*, 97–118.
- Becker-Blease, K. A., & Freyd, J. J. (2008). A preliminary study of ADHD symptoms and correlates: Do abused children differ from non-abused children? *Journal of Aggression, Maltreatment, and Trauma*, *17*, 133–140.
- Becker-Blease, K. A., Freyd, J. J., & Pears, K. C. (2004). Preschoolers' memory for threatening information depends on trauma history and attentional context: Implications for the development of dissociation. *Journal of Trauma and Dissociation*, *5*, 113–131.
- Beeghly, M., & Cicchetti, D. (1994). Child maltreatment, attachment, and the self system: Emergence of an internal state lexicon in toddlers at high social risk. *Development and Psychopathology*, *6*, 5–30.
- Belford, B., Kaehler, L. A., & Birrell, P. (2012). Relational health as a mediator between betrayal trauma and borderline personality disorder. *Journal of Trauma and Dissociation*, *13*, 244–257.
- Bernstein, E. M., & Putnam, F. W. (1986). Development, reliability, and validity of a dissociation scale. *Journal of Nervous and Mental Disease*, *174*, 727–735.
- Bowlby, J. (1973). *Attachment and loss: Vol. 2. Separation: Anxiety and anger*. New York: Basic Books.
- Bowlby, J. (1988). *A secure base: Parent-child attachments and healthy human development*. New York: Basic Books.

- Brewin, C. R., Andrews, B., & Gotlib, I. H. (1993). Psychopathology and early experience: A reappraisal of retrospective reports. *Psychological Bulletin*, *113*, 82–98.
- Briere, J. (1996). Psychometric review of the Trauma Symptom Checklist–40. In B. H. Stamm (Ed.), *Measurement of stress, trauma, and adaptation*. Lutherville, MD: Sidran Press.
- Carlson, V., Cicchetti, D., Barnett, D., & Braunwald, K. (1989). Disorganized/disoriented attachment relationships in maltreated infants. *Developmental Psychology*, *25*, 525–531.
- Chu, A. T., & DePrince, A. P. (2006). Development of dissociation: Examining the relationship between parenting, maternal trauma, and child dissociation. *Journal of Trauma and Dissociation*, *7*, 75–89.
- Chu, A. T., Pineda, A. S., DePrince, A. P., & Freyd, J. J. (2011). Vulnerability and protective factors for child abuse and maltreatment. In J. W. White, M. P. Koss, & A. E. Kazdin (Eds.), *Violence against women and children: Vol. 1. Mapping the terrain* (pp. 55–75). Washington, DC: American Psychological Association.
- Cicchetti, D., & Barnett, D. (1991). Attachment organization in pre-school-aged maltreated children. *Development and Psychopathology*, *3*, 397–411.
- Cloitre, M., Scarvalone, P., & Difede, J. (1997). Posttraumatic stress disorder, self- and interpersonal dysfunction among sexually retraumatized women. *Journal of Traumatic Stress*, *10*, 437–452.
- Cohen, J. A., Deblinger E., Mannarino, A. P., & Steer, R. A. (2004). A multisite randomized control trial for sexually abused children with PTSD symptoms. *Journal of the American Academy of Child and Adolescent Psychiatry*, *43*, 393–402.
- Cosmides, L., & Tooby, J. (1992). Cognitive adaptations for social exchange. In J. H. Barkow, L. Cosmides, & J. Tooby (Eds.), *The adapted mind: Evolutionary psychology and the generation of culture* (pp. 163–228). New York: Oxford University Press.
- Courtois, C. A. (2010). *Healing the incest wound: Adult survivors in therapy* (2nd ed.). New York: Norton.
- Crittenden, P. M. (1988). Relationships at risk. In J. Belsky & T. Nezworski (Eds.), *Clinical implications of attachment theory* (pp. 136–174). Hillsdale, NJ: Erlbaum.
- DePrince, A. P. (2005). Social cognition and revictimization risk. *Journal of Trauma and Dissociation*, *6*, 125–141.
- DePrince, A. P., Brown, L., Cheit, R., Freyd, J. J., Gold, S., Pezdek, K., et al. (2012). Motivated forgetting and misremembering: Perspectives from betrayal trauma theory. In R. F. Belli (Ed.), *True and false recovered memories: Toward a reconciliation of the debate: Vol. 58. Nebraska Symposium on Motivation* (pp. 193–243). New York: Springer.
- DePrince, A. P., Chu, A. T., & Combs, M. D. (2008). Trauma-related predictors of deontic reasoning: A pilot study in a community sample of children. *Child Abuse and Neglect*, *32*, 732–737.
- DePrince, A. P., & Freyd, J. J. (1999). Dissociative tendencies, attention, and memory. *Psychological Science*, *10*, 449–452.
- DePrince, A. P., & Freyd, J. J. (2001). Memory and dissociative tendencies: The roles of attentional context and word meaning in a directed forgetting task. *Journal of Trauma and Dissociation*, *2*, 67–82.
- DePrince, A. P., & Freyd, J. J. (2002). The harm of trauma: Pathological fear, shattered assumptions or betrayal? In J. Kauffman (Ed.), *Loss of the assumptive world* (pp. 71–82). New York: Taylor & Francis.
- DePrince, A. P., & Freyd, J. J. (2004). Forgetting trauma stimuli. *Psychological Science*, *15*, 488–492.
- DePrince, A. P., Weinzierl, K. M., & Combs, M. D. (2009). Executive function performance and trauma exposure in a community sample of children. *Child Abuse and Neglect*, *33*, 353–361.

- Dorahy, M. J., Corry, M., Shannon, M., MacSherry, A., Hamilton, G., McRobert, G., et al. (2009). Complex PTSD, interpersonal trauma and relational consequences: Findings from a treatment-receiving Northern Irish sample. *Journal of Affective Disorders, 112*, 71–80.
- Fergusson, D. M., Horwood, L. J., & Woodward, L. J. (2000). The stability of child abuse reports: A longitudinal study of the reporting behavior of young adults. *Psychological Medicine, 30*, 529–544.
- Ford, J. D., Racusin, R., Daviss, W. B., Ellis, C. G., Thomas, J., Rogers, K., et al. (1999). Trauma exposure among children with oppositional defiant disorder and attention deficit-hyperactivity disorder. *Journal of Consulting and Clinical Psychology, 67*, 786–789.
- Ford, J. D., Steinberg, K. L., & Zhang, W. (2011). A randomized clinical trial comparing affect regulation and social problem-solving psychotherapies for mothers with victimization-related PTSD. *Behavior Therapy, 42*, 560–578.
- Freyd, J. J. (1994). Betrayal trauma: Traumatic amnesia as an adaptive response to childhood abuse. *Ethics and Behavior, 4*, 307–329.
- Freyd, J. J. (1996). *Betrayal trauma: The logic of forgetting childhood abuse*. Cambridge, MA: Harvard University Press.
- Freyd, J. J. (1999). Blind to betrayal: New perspectives on memory for trauma. *Harvard Mental Health Letter, 15*, 4–6.
- Freyd, J. J. (2001). Memory and dimensions of trauma: Terror may be ‘all-too-well remembered’ and betrayal buried. In J. R. Conte (Ed.), *Critical issues in child sexual abuse: Historical, legal, and psychological perspectives* (pp. 139–173). Thousand Oaks, CA: Sage.
- Freyd, J. J., & DePrince, A. P. (2001). Perspectives on memory for trauma and cognitive processes associated with dissociative tendencies. *Journal of Aggression, Maltreatment, and Trauma, 4*, 137–163.
- Freyd, J. J., DePrince, A. P., & Gleaves, D. (2007). The state of betrayal trauma theory: Reply to McNally (2007)—Conceptual issues and future directions. *Memory, 15*, 295–311.
- Freyd, J. J., DePrince, A. P., & Zurbriggen, E. L. (2001). Self-reported memory for abuse depends upon victim–perpetrator relationship. *Journal of Trauma and Dissociation, 2*, 5–16.
- Freyd, J. J., Klest, B., & Allard, C. B. (2005). Betrayal trauma: Relationship to physical health, psychological distress, and a written disclosure intervention. *Journal of Trauma and Dissociation, 6*, 83–104.
- Freyd, J. J., Klest, B., & DePrince, A. P. (2010). Avoiding awareness of betrayal: Comment on Lindblom and Gray (2009). *Applied Cognitive Psychology, 24*, 20–26.
- Freyd, J. J., Martorello, S. R., Alvarado, J. S., Hayes, A. E., & Christman, J. C. (1998). Cognitive environments and dissociative tendencies: Performance on the standard Stroop task for high versus low dissociators. *Applied Cognitive Psychology, 12*, S91–S103.
- Gobin, R. L. (2012). Partner preferences among survivors of betrayal trauma. *Journal of Trauma and Dissociation, 13*, 152–174.
- Gobin, R. L., & Freyd, J. J. (2009). Betrayal and revictimization: Preliminary findings. *Psychological Trauma: Theory, Research, Practice, and Policy, 1*, 242–257.
- Goldsmith, R. E., & Freyd, J. J. (2005). Awareness of emotional abuse. *Journal of Emotional Abuse, 5*, 95–123.
- Goldsmith, R. E., Freyd, J. J., & DePrince, A. P. (2012). Betrayal trauma: Associations with psychological and physical symptoms in young adults. *Journal of Interpersonal Violence, 27*, 547–567.
- Hardt, J., & Rutter, M. (2004). Validity of adult retrospective reports of adverse childhood experiences: Review of the evidence. *Journal of Child Psychology and Psychiatry, 45*, 260–273.

- Herman, J. L. (1992). *Trauma and recovery*. New York: Basic Books.
- Hesse, E., & Main, M. (1999). Second-generation effects of unresolved trauma in non-maltreating parents: Dissociated, frightened, and threatening parental behavior. *Psychoanalytic Inquiry, 19*, 481–540.
- Hesse, E., & Main, M. (2000). Disorganized infant, child and adult attachment: Collapse in behavioral and attentional strategies. *Journal of the American Psychoanalytic Association, 48*, 1097–1127.
- Hesse, E., & Main, M. (2006). Frightened, threatening, and dissociative (FR) parental behavior as related to infant D attachment in low-risk samples: Description, discussion, and interpretations. *Development and Psychopathology, 18*, 309–343.
- Hulette, A. C., Freyd, J. J., & Fisher, P. A. (2011). Dissociation in middle childhood among foster children with early maltreatment experiences. *Child Abuse and Neglect, 35*, 123–126.
- Hulette, A. C., Freyd, J. J., Pears, K. C., Kim, H. K., Fisher, P. A., & Becker-Blease, K. A. (2008). Dissociation and posttraumatic symptoms in maltreated preschool children. *Journal of Child and Adolescent Trauma, 1*, 93–108.
- Hulette, A. C., Kaehler, L. A., & Freyd, J. J. (2011). Intergenerational associations between trauma and dissociation. *Journal of Family Violence, 26*, 217–225.
- Kaehler, L. A., & Freyd, J. J. (2009). Borderline personality characteristics: A betrayal trauma approach. *Psychological Trauma: Theory, Research, Practice, and Policy, 1*, 261–268.
- Kaehler, L. A., & Freyd, J. J. (2012). Betrayal trauma and borderline personality characteristics: Gender differences. *Psychological Trauma: Theory, Research, Practice, and Policy, 4*, 379–385.
- Kobak, R., Cassidy, J., Lyons-Ruth, K., & Ziv, Y. (2006). Attachment, stress, and psychopathology: A developmental pathways model. In D. Cicchetti & D. J. Cohen (Eds.), *Developmental psychopathology: Vol. 1. Theory and method* (2nd ed., pp. 333–369). Hoboken, NJ: Wiley.
- Lieberman, A. F., & Van Horn, P. (2008). *Psychotherapy with infants and young children: Repairing the effects of stress and trauma on early attachment*. New York: Guilford Press.
- Lynch, M., & Cicchetti, D. (1991). Patterns of relatedness in maltreated and nonmaltreated children: Connections among multiple representational models. *Development and Psychopathology, 3*, 207–226.
- Lyons-Ruth, K., Dutra, L., Schuder, M. R., & Bianchi, I. (2006). From infant attachment disorganization to adult dissociation: Relational adaptations or traumatic experiences? *Psychiatric Clinics of North America, 29*, 63–86.
- Main, M., & Hesse, E. D. (1990). Parents' unresolved traumatic experiences are related to infant disorganized attachment status: Is frightened and/or frightening parental behavior the linking mechanism? In M. Greenberg, D. Cicchetti, & M. Cummings (Eds.), *Attachment in the preschool years* (pp. 161–184). Chicago: Chicago University Press.
- Main, M., & Solomon, J. (1986). Discovery of an insecure–disorganized/disoriented attachment pattern. In T. B. Brazelton & M. W. Yogman (Eds.), *Affective development in infancy* (pp. 95–124). Norwood, NJ: Ablex.
- Messman-Moore, T. L., & Brown, A. L. (2006). Risk perception, rape, and sexual revictimization: A prospective study of college women. *Psychology of Women Quarterly, 30*, 159–172.
- Morton, N., & Browne, K. D. (1998). Theory and observation of attachment and its relation to child maltreatment: A review. *Child Abuse and Neglect, 22*, 1093–1104.
- Noll, J. G., Trickett, P. K., & Putnam, F. W. (2003). A prospective investigation of the impact of childhood sexual abuse on the development of sexuality. *Journal of Consulting and Clinical Psychology, 71*, 575–586.

- Owen, J., Quirk, K., & Manthos, M. (2012). I get no respect: The relationship between betrayal trauma and romantic relationship functioning. *Journal of Trauma and Dissociation*, 13, 175–189.
- Platt, M., Barton, J., & Freyd, J. J. (2009). A betrayal trauma perspective on domestic violence. In E. Stark & E. S. Buzawa (Eds.), *Violence against women in families and relationships: Vol. 1* (pp. 185–207). Westport, CT: Greenwood Press.
- Putman, F. (1997). *Dissociation in children and adolescents: A developmental perspective*. New York: Guilford Press.
- Putman, F. (2003). Ten-year research update: Child sexual abuse. *Journal of American Academy of Child and Adolescent Psychiatry*, 42, 269–278.
- Reichmann-Decker, A., DePrince, A. P., & McIntosh, D. N. (2009). Affective responsiveness, betrayal, and childhood abuse. *Journal of Trauma and Dissociation*, 10, 276–296.
- Soler-Baillo, J. M., Marx, B. P., & Sloan, D. M. (2005). The psychophysiological correlates of risk recognition among victims and non-victims of sexual assault. *Behavior Research and Therapy*, 43, 169–181.
- Tang, S. S., & Freyd, J. J. (2012). Betrayal trauma and gender differences in posttraumatic stress. *Psychological Trauma: Theory, Research, Practice, and Policy*, 4, 469–478.
- Taylor, S., Asmundson, G. J., & Carleton, R. N. (2006). Simple versus complex PTSD: A cluster analytic investigation. *Journal of Anxiety Disorders*, 20, 459–472.
- Ullman, S. E. (2007). Relationship to perpetrator, disclosure, social reactions, and PTSD symptoms in child sexual abuse survivors. *Journal of Child Sexual Abuse*, 16, 19–36.
- Ullman, S. E., Najdowski, C. J., & Filipas, H. H. (2009). Child sexual abuse, post-traumatic stress disorder, and substance use: Predictors of revictimization in adult sexual assault survivors. *Journal of Child Sexual Abuse*, 18, 367–385.
- U. S. Department of Health and Human Services. (2010). *Child maltreatment 2010: Reports from the states to the National Child Abuse and Neglect Data System*. Washington, DC: U.S. Government Printing Office.
- van IJzendoorn, M. H. (1995). Adult attachment representations, parental responsiveness, and infant attachment: A meta-analysis on the predictive validity of the Adult Attachment Interview. *Psychological Bulletin*, 117, 387–403.
- van IJzendoorn, M. H., Schuengel, C., & Bakermans-Kranenburg, M. J. (1999). Disorganized attachment in early childhood: Meta-analysis of precursors, concomitant, and sequelae. *Development and Psychopathology*, 11, 225–250.
- Zurbriggen, E. L., & Freyd, J. J. (2004). The link between childhood sexual abuse and risky sexual behavior: The role of dissociative tendencies, information-processing effects, and consensual sex decision mechanisms. In L. J. Koenig, L. S. Doll, A. O'Leary, & W. Pequegnat (Eds.), *From child sexual abuse to adult sexual risk: Trauma, revictimization, and intervention* (pp. 135–157). Washington, DC: American Psychological Association.