Betrayal Trauma: Relational Models of Harm and Healing

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ABSTRACT. We examine a model that emphasizes the importance of relationships as the context of trauma and healing. First, we present an overview of the effects of betrayal trauma and oppression on psychological functioning. Then, we propose a relational model of healing, using elements of the Stone Center's Relational-Cultural theory. Finally, we discuss healing in the wider context of community and an ethic of compassion and mutuality. doi:10.1300/J189v05n01_04 *[Article copies available for a fee from The Haworth Document Delivery Service: 1-800-HAWORTH. E-mail address: <docdelivery@haworthpress.com> Website: <http://www.HaworthPress.com>*

KEYWORDS. Trauma, betrayal trauma, relational, healing

INTRODUCTION

Much has been said about the effects of trauma, especially about fear, anxiety, and terror induced by overwhelming events. Less has been said about the effects of the violation of human bonds and the effects of loss of important human connections. This paper presents first of all, an

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The authors thank Amy Reiss for her suggestions.

The manuscript preparation was supported in part by the Trauma and Oppression Research Fund at the University of Oregon Foundation.

Journal of Trauma Practice, Vol. 5(1) 2006
Available online at http://jtp.haworthpress.com

doi:10.1300/J189v05n01_04

overview of the effects of this betrayal trauma on memory, mental health, and psychological functioning. After that, we address healing from relational trauma and betrayal in a therapeutic context. Finally, we discuss healing in the wider context of community and social world.

We are clinicians specializing in treating trauma (P.J.B) and researchers on the cognitive and emotional effects of trauma (J.J.F). We have collaborated over the years in research projects and teaching on topics related to trauma. In doing this work together, we have become convinced of the centrality of ethics to all research and treatment, and this is reflected in our presentation of the topic. In preparing this paper we have chosen to keep our individual voices distinct in the next two sections. We join together in the concluding section of the paper.

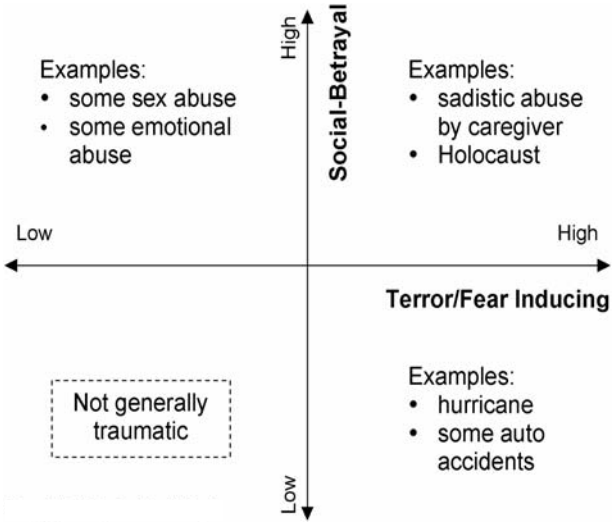
PART 1 (J.J.F.): EFFECTS OF TRAUMA

All types of violence, abuse, and oppression can have traumatic effects. However, traumas that occur in the context of interpersonal relationships can be particularly detrimental because of the betrayal involved in the violation of basic assumptions of interpersonal and social relationships (Freyd, 1994, 1996).

According to betrayal trauma theory (Freyd, 1999, 2001), traumas leading to psychic disorders arise from two distinct dimensions of harm: life-threat, or fear and social betrayal (see Figure 1). From this viewpoint, the symptom cluster known as post-traumatic stress disorder may better be understood as arising from two conceptually independent dimensions of trauma. The dimension of life-threat may be most salient for symptoms of anxiety, hyperarousal, and intrusive memories. The dimension of social betrayal may be primary for symptoms of dissociation, numbness, and constricted, or abusive relationships. Supporting this viewpoint, Freyd, DePrince, and Zurbriggen (2001) found that physical and emotional abuse perpetrated by a caregiver was related to higher levels of self-reported memory impairment for the events compared with non-caregiver abuse. High levels of both life-threat and social betrayal characterize many of the most severe traumas; with both dimensions present we expect both classes of symptoms.

Betrayal trauma theory emphasizes the nature of the relationship between the victim and perpetrator. Freyd, Klest, and Allard (2005) have found that relational traumas–traumatic events that occur in the context of an ongoing relationship, and which involve the betrayal of important

FIGURE 1. A Two-Dimensional Model of Trauma



bonds, such as incest, spousal battering, or psychological abuse, are more highly correlated with symptoms of depression, anxiety, and other symptoms of emotional distress than are non-relational traumas. Indeed, the range of severe consequences of betrayal traumas is almost difficult to grasp: For example, research has demonstrated a connection between childhood sexual abuse victimization and adult sexual behaviors that are associated with greater risk for HIV infection and AIDS (Zurbriggen & Freyd, 2004). Studies have shown that adults who are sexually abused as children have a higher incidence of adult criminal behavior and perpetration of abuse (Widom, 1989) as well as a host of other health and living difficulties (Freyd et al., 2005). All sectors of society are affected by some forms of violence and trauma, such as domestic violence (AMA, 2002). However, children are more vulnerable to all forms of abuse; racial, ethnic, and other minorities experience greater social oppression in this culture (Root, 1992). Despite the extensive and profound effects of this problem, we have lacked adequate theory to account for the etiology and consequences of trauma at a societal level, and our lack of theoretical understanding has hampered our ability to stop offenders and to help victims experiencing traumatic sequellae.

The central organizing construct of this model is the importance of relationships as the context of trauma and healing. Understanding the impact of both trauma and oppression necessarily involves understanding the betrayal involved in violation of basic assumptions of interpersonal and social relationships (Freyd, 1996); and healing necessarily involves establishing growth-fostering relationships (Miller & Stiver, 1997) and processing trauma in context of such relationships. Second, the relational perspective aims to include the relationship of oppression as well as violence to traumatic outcomes. Although oppression is often institutionalized at societal levels, it is necessarily enacted in the context of interpersonal relationships. Thus, oppression fits within a relational/betrayal model of trauma.

PART 2 (P.J.B.): HEALING FROM BETRAYAL: LISTENING, MUTUALITY, AND COMPASSION

> Trauma is the shock to the psyche that leads to dissociation: our ability to separate ourselves from parts of ourselves, to create a split within ourselves so that we can know and also not know what we know, feel and yet not feel our feelings. It is our ability, as Freud put it in Studies on Hysteria, to hold parts of our experience not as a secret from others but as a "foreign body" within ourselves. (Gilligan, 2002, p. 6)

Most standard treatments for psychological distress implicitly and explicitly involve the reduction of symptoms. For example, evaluation of cognitive-behavioral treatment for depression relies on lowering of scores on inventories measuring levels of depression; pharmaceutical intervention for psychosis attempts to lower levels of hallucinations and delusions. Those who are sufferers of the consequences of betrayal and relational trauma, on the other hand, experience dissociation, fragmentation and silencing. Judith Herman (1992) puts it this way: "Thus, under conditions of chronic childhood abuse, fragmentation becomes the central principle of personality organization. Fragmentation in consciousness prevents the ordinary integration of knowledge, memory, emotional states, and bodily experience. Fragmentation in the inner representations of the self prevents the integrations of identity. Fragmentation in the inner representations of others prevents the development of a reliable sense of independence within connection" (p. 107). Grand and

Alpert (1993) describe the core trauma of incest as damage to the experience of being connected to others, and to the elemental sense of physical-sensory continuity, or secure sense of existence. In other words, those traumas that involve betrayal cut us off from connection with others and even a basic sense of "being" within ourselves.

Effective treatment must above all address this fragmentation. Sufferers must be given the safety to know and experience parts of themselves and their experience that had been silenced in order to maintain survival in oppressive and abusive environments. They must be given the space to know what has been silenced in themselves, to regain "silenced knowings." Lorenz and Watkins (2001) describe these silenced knowings that result from a history of oppression:

> Many silenced knowings can exist within apparently ordinary lives and communities, the lives of others and our own lives. By silenced knowings we mean understandings that we each carry that take refuge in silence, as it feels dangerous to speak them to ourselves and to others. The sanctions against them in the family, community or wider culture render them mute and increasingly inaccessible. Once silenced, these knowings are no longer available to inform our lives, to strengthen our moral discernment. Once pushed to the side, these knowings require our energy to sustain their dissociation, and our numbing to evade their pain.

The fragmentation and silencing that occurs as a result of relational trauma is not confined to the individual psyche. The violation of deep human bonds results in what has been called a state of condemned isolation: "The most terrifying and destructive feeling that a person can experience is isolation. This is not the same as 'being alone' in the more straightforward sense. It is feeling locked out of the possibility of human connection" (Miller, 1988, p. 1). In a similar vein, Ebner (in Friedman, 1976) sees insanity as the results of the complete closedness of the I to the Thou, a condition in which neither word nor love is any longer able to reach the individual. As a result, the isolated psyche turns inward on itself, loses real connection with concrete others and gropes in a maze in which it loses itself in a deeper and deeper way (Buber, 1958).

The focus of the treatment, then, for those who have suffered betrayal is reconnection-reconnection within themselves and reconnection with the wider community. What has been fragmented and silenced must be allowed to re-emerge. Bonds which have been violated must be allowed to mend. This involves nothing short of bold and careful listening, deep

empathy, true compassion and mutual relationship–all of which result in transformation of those "silenced knowings" on the part of client and therapist alike. It is unfashionable, in this age of managed care and risk management, to advocate a treatment that not only takes time, but also involves the possibility, on the part of the therapist, of coming to new understandings of that forgotten realm of what Buber (1957) calls the "interhuman," but a treatment that does not address this level of experiencing risks objectifying the already wounded and creating a superficial adjustment to society which involves the risk of further abuse.

Listening

> Whatever else we may be saying each time we address another, we are beseeching them, 'Listen to me. Please, listen.' Our very lives depend on that listening. This plea is not merely one of the things we utter in our speech, it is what we utter with the whole of our speech. We never speak except to be heard. When we are not heard we have not truly spoken. And when we cannot speak we have increasingly less to say, therefore less to ask for, and the lights of our being steadily darken. (Carse, 1985, p. 29)

How, then, do we listen? Stories of trauma, by necessity, begin in fragmented and sometimes implausible ways. They evoke strong reactions in listeners, from compassion to outright rejection. They scare us, they anger us, and they never leave us untouched. It is easy to distance ourselves or become vicariously traumatized by them (Perlman, 1995). Therefore, it is tempting to settle for a technique of "active listening" that helps the teller of the narrative create a clearer and more factual narrative, but one that sacrifices emotional depth and truth for surface particulars. It is harder to hold on to the uncertainty necessary as an individual struggles for the emotional truth embedded in traumatic events (Anderson & Goolishian, 1992).

The challenge here is in allowing ourselves as listeners to get outside of our own expectations and theoretical frame. If we are not sufficiently open to listening in ways that challenge our own thinking, nothing is left us but the boredom of remaining in the same abstract frame-a state that Fiumara (1990) calls benumbment, or epistemic torpor (see also DePrince & Freyd, 2002). This is reminiscent of remaining stuck in what Elbow (1986) has called the "doubting game," an epistemological stance that relies exclusively on critical thinking and judging to the expense of "believing" what is told to us. Elbow insists that optimal thinking

involves equal parts of the "doubting game" and the "believing game," and the fact that good thinking involves two processes that conflict with each other explains why the activity is "complex and rare" (p. 255).

Clinchy (1996) has argued persuasively that engaging in the "believing game" which results in what she calls "connected knowing" is not mere subjectivism or naïve credulity, but requires active work involving the attempt to embrace new ideas, and looking for what is "right" even in ideas or narratives which initially seem ridiculous or objectionable. The application of this kind of "believing" to listening to trauma narratives is clear. Instead of doubting, rejecting, *or* credulously believing fragmented and perhaps uncertain events as they begin to be retrieved, we can become emboldened to reach below the surface to the level of experience and being. As Elbow (1986, p. 261) says, we can ask, "You are having an experience I don't have: help me to have it."

An effective listener must have the capacity to care enough to be involved and be affected by what they hear. Douglas Steere (1964, p.13) gives us this warning: "For the listener who knows what he or she is about, there is a realization that there is no withdrawal halfway. There is every prospect that he or she will not return unscathed. . . . A friend of mine who has spent many years in listening admits that in the course of it, he has learned something of the 'descent into Hell' and is quite frank in confessing that for him each act of listening that is not purely mechanical is a personal ordeal. Listening is never cheap."

Listening in this way involves not only risking "personal ordeal," but also the risk of changing how we see and experience the world. It requires a mature empathy which involves trying to imagine the reality of the other (Kohn, 1990), without which empathy is ultimately self-oriented. In other words, to imagine how I might feel in the other person's situation is primarily self-centered. It cannot be considered mature empathy until I try to imagine how the other person feels and thinks about his or her experience. The other person is not considered an instance of a category (e.g., a "survivor," or a "borderline"), but an individual with a unique and deep subjectivity. Only then can I, as Buber said, not feel "a general discomfort or state of suffering, but this particular pain as the pain of the other" (Buber, in Kohn, 1990, pp.132-133).

> It is always the case that when someone listens to you with genuine openness you will find a voice to say what you have never been able to say before, and did not know you could have said. This is not simply having new words to say; it is rather an expanding, an opening toward oneself, an awakening of the heart. This could be

> put in even stronger terms. It is not that sensitive listening will lead you to discover a new depth to yourself; it will create a new depth. This is why listening, why speaking expectantly, is creative. I am heard therefore I am. I am who I am only because I have been heard. (Carse, 1985, p. 30)

Mutuality

> . . . affecting the other and being affected by the other; one extends oneself out to the other and is also receptive to the impact of the other. There is openness to influence, emotional availability, and a constantly changing pattern of responding to and affecting the other's state. There is both receptivity and active initiative toward the other. (Jordan, 1986, p. 82)

As we enter the world of the other more deeply, listening courageously and daring to try to understand from the other's perspective rather than our own, as we begin to experience the other as fellow subject rather than object, we are of course entering the world of Buber's (1958) I-Thou relationship. According to Buber (1958), the I-It relationship occurs when we allow a particular characteristic or attribute to stand for the totality of the other person. As Buber says, "I can take out from him the color of his hair, or of his speech, or of his goodness. I must continually do this. But each time I do it he ceases to be a Thou" (p. 9). So if we talk about, or think about the people we work with as "survivors," "borderlines," or "people with PTSD" (Becker, 2000), even though this may be necessary, there is the danger of this being what the person becomes and it becomes more difficult to see them and treat them in their particularity.

By contrast, Buber's (1958) I-Thou is a relation of whole and dynamic beings. We allow ourselves to truly experience the other as subject, not an instance of a category. Buber (1958) insists that in such a relationship, the other person is not to be treated as an object of investigation, but allowed to exist in his or her own inner unity, and invited into dialogue by real and unprotected self of the therapist. Buber says that we must remember that "the relation of the soul to its organic life depends on the degree of wholeness and unity attained by the soul." He talks about the "dissociated soul" that responds to the healing appearance of "a whole, unified soul, which lays hold of the shattered soul, agitates it on all sides, and hastens the event of its crystallization" (cited in Friedman, 1976, p. 91).

Writers from the Stone Center have done much work to help us, as therapists, understand and operationalize the I-Thou relationship. They speak of mutual relationships which are based on mutual empathy and mutual empowerment. These relationships represent

> A joining together based on the authentic thoughts and feelings of all the participants in the relationship. . . . Because each person can receive and then respond to the feelings and thoughts of the other, each is able to enlarge both her own feelings and thoughts and the feelings and thoughts of the other person. Simultaneously, each person enlarges the relationship. (Miller & Stiver, 1997, p. 29)

In these relationship, "one feels heard, seen, understood, and known . . . listening, seeing, understanding, and being emotionally available, are vitally important" (Jordan, 1986, p. 86). They emphasize the authenticity of the therapist (the unprotected self of Buber) and the willingness to engage in mutual empathy. "Mutual empathy occurs when two people relate to one another in a context of interest in the other, emotional availability and responsiveness; cognitive appreciation of the wholeness of the others; the intent to understand" (Jordan, 1986, p. 3).

Annie Rogers (1994, p. 319) describes the I-Thou relationship in psychotherapy this way: "The psychotherapy relationship is two-sided, whether we acknowledge it or not. Each person brings to that relationship whatever is unrecognized, unknown, and unapproachable in her or his life, and a wish for knowledge of truths and wholeness. Since one cannot thrive on memories, on a relationship with projections, what keeps alive the hope of wholeness is an interchange of love, longing, frustration, and anger in the vicissitudes of a real relationship." This real relationship is the only way to healing for those who have suffered betrayal. The fragmentation caused by the violation of human bonds can only be healed by new and healing human bonds.

Since these new and healing human bonds cannot be based solely on technique and symptom reduction, they must be based on therapeutic presence, authenticity, and mutuality. We, as a species, are sensitive to "cheaters" and those who would betray us (Freyd, 1996). There is no reason to expect that this does not extend to the therapeutic situation. And those who have a history of betrayal will be exquisitely sensitive to any action on the part of the therapist that is damaging to the relationship. As a result, it is important to remain as open, vulnerable, and authentic as possible so that what has been fragmented and silenced can be allowed to return and to speak its truth.

Compassion, Ethics and Community

Within this real relationship, if we allow ourselves, we come to what Buber calls the realm of the interhuman: "If we want to do today's work, and prepare tomorrow's with clear sight, then we must develop in ourselves . . . 'imagining the real,' for in its essential being this gift is not a looking at the other, but a bold swinging, demanding the most intensive stirring of one's being, into the life of the other. . . . Let it be said again that all this can only take place in a living partnership. . . . If mutuality stirs, then the interhuman blossoms into genuine dialogue" (Buber, 1957, p. 110).

The object relations theorist Donald Winnicott has spoken of what he calls "potential space"–a place of possibilities (Winnicott, 1971). And the post-colonial writer Homi Bhabha (1990) has called it a "third space," a difficult location where what we already know and are sure of may come into question and be revised, and where what has been silenced within and among us can find voice. It is in this difficult space that we can begin to sense the stirrings of the passionate power that Audre Lorde refers to in "Sister Outsider" (1984). This passionate power is not sexual or pornographic, she maintains, but that life force and creative energy long suppressed by a system that "defines the good in terms of profit rather than in terms of human need" (p. 55). She sees this power as the nurturer of all our deepest knowledge and the source of our passion which demands that we go beyond what is seen as conventionally accepted and merely safe.

Ryan Haule (1996) says that in this space, the *I* and the *It* can become the "*We,*" and that we can transform our experience of ourselves. In this space of we-ness, we can go from two separate entities engaged in a contractual enterprise to becoming a part of a third and larger energy that connects us and shows us new "lived meanings." "A momentous future lurks in the we, awaiting realization through our cooperative activity. For, although we are already living in our mutuality, we are doing so only partially" (Haule, 1996, p. 61).

In this space of we-ness, which we have attained by courageous listening, bold authenticity, and the willingness to think and experience in new ways, we can arrive at a place of true compassion–for those with whom we work for ourselves. In translation from the Tibetan, compassion denotes a feeling of connection with others. The Dalai Lama (1999) sees compassion as the most precious of our human qualities arising from "the inability to bear the sight of another's suffering" (p. 73). According to the Dalai Lama, our sense of compassion can be consciously enhanced and

"the more we develop compassion, the more genuinely ethical our conduct will be." In fact, he claims that "as far as ethics is concerned, where love of one's neighbor, affection, kindness, and compassion live, we find that ethical conduct is automatic. Ethically wholesome actions arise naturally in the context of compassion" (p. 131).

Roberts (2001) sees as one of our major blocks to feeling and actualizing compassion what she calls the null curriculum: "The null curriculum is all the relevant and important information that has not been included in our educations. It is striking to call attention to the fact that what we do not know has as much, and probably more, influence on how we see society, ourselves and others than that which we have been taught" (underlining original). As a result, she says, this raises the possibility that perceptions and perspectives are the result of incomplete information. For example, if we look at cultures of fear around the world, we can see that they use trauma systematically to silence people through suffering (Kleinman, 1995). Stories of violence are used by health professionals "to rewrite social experience in medical terms" (p. 176). The person who has been tortured becomes first a victim, and then a patient with Posttraumatic stress disorder. Trauma becomes a medical pathology rather than a religious, moral, or ethical happening.

Ethics must be the core of our work as psychotherapists. We have too often been taught that ethics are merely an abstract set of rules that tell us what to do in difficult situations. But every moment is the ethical moment an ethical position is the way we position ourselves with the other. Ethics is part of how we think and act in all aspects of our lives: We cannot artificially separate the ethics of our professional and personal lives (Brown, 1997). So to be truly ethical, we must not use ethics as a means to just safeguard what exists, but in order to be truly therapeutic, we must be willing to step outside old ways of thinking, to find new ways of acting and being. We must be willing to examine our assumptions about healing and helping. For example, we must question the assumption that healing means getting rid of pain. More truthfully, healing involves moving through and not always beyond our pain into meaningful connection with others. Survivors' pain must be taken to the larger world or they will be stuck in their pain and isolation (Heyward & Jordan, 1992). Ellen Goodman (2002) asks the question, in response to the possible development of a drug that can reduce symptoms like intrusive memory: "I don't romanticize mental illness. But at the same time, I wonder what will happen if we are able to lighten the load of memory. Would we end up with a drug to make loss "lite," to speed up "closure," to make horror

"manageable"? At some point reducing human suffering is editing human experience. For better or for worse" (p. A19).

PART 3 (P.B.J. AND J.J.F.): SEEING BEYOND THE INDIVIDUAL SUFFERING

At this point, we can begin to see that "treatment of trauma" from a relational perspective cannot remain confined to the consulting room or even to the psychological and medical perspective. An ethic of compassion and mutuality requires that we look at the wider social, cultural and economic systems of oppression and violence. As Jordan says, (1992), "We can no longer look only at factors within the individual which facilitate adjustment; we must examine the relational dynamics which encourage the capacity for connection" (p. 1). In addition, we must question a system that pathologizes suffering individuals while refusing to look beyond, to the system that sees nothing wrong with objectifying others in the name of help, that rewards power dynamics that, if not properly recognized, have the power to cause great harm (Walker, 2002), and that privileges individualism and rights over the bonds of human communities.

We, as psychologists, have inherited a science that perceives the world as a connection of discrete things (individuals) and sees what happens between these discrete things as less real. You can't see, weigh, or touch human bonds, so they were not seen as important as the human "pathology" ascribed to the individual. Western psychology has been accused of failing to transcend the cultural conditioning of industrial capitalism and liberal political philosophy (Sloan, 2001), and not examining culture-bound notions of mind and person as autonomous, self-contained, socially isolated, and disconnected from history. The outcome of this unexamined individualism is that the individual is seen as the container of the problem, leaving the culture and the context unexamined. As Kurt Lewin (in Marrow, 1969, pp. 225-226) described:

> The American cultural ideal of the self-made man, of everyone standing on his own feet, is as tragic a picture as the initiative destroying dependence on a benevolent despot. We all need each other. This type of interdependence is the greatest challenge to the maturity of individual and group functioning.

When we conceive of ourselves only in terms of autonomous individuals and see the strong and independent self as the healthy one, this pushes interdependency and reliance on others into the light of pathology (Lorenz & Watkins, 2001).

Our research needs to move in the direction of studying relationships in addition to individual suffering, and to be willing to examine the context that surrounds the individual pathologizing that we do. Liang et al. (2001) have provided a beginning model for such an endeavor. Although much more needs to be done, we can see with this model that examining the relationships in which people live their lives can be an indicator for mental health. Initial findings support the idea that relational health is associated with mental health and adjustment for college-aged women. Relationships are important for the mental health of individuals and perhaps for us as a nation, if we are willing to look.

The ethic of compassion challenges us, as therapists and as researchers, to be open to discovering our own silenced knowings with open listening, impeccable ethics, and a willingness to enter into a mutually empowering relationship (Miller & Stiver, 1997). It challenges us to dare to live in a community in which human beings have "to do with one another, but in such a way that the personal life of all is enhanced and nourished, not diminished" (Berry, 1985, p. 72).

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RECEIVED: 06/01/04
REVISED: 12/15/04, 06/15/05
ACCEPTED: 07/01/05

doi:10.1300/J189v05n01_04