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PTSD Criterion A and Betrayal Trauma: A Modest Proposal for a New Look at What Constitutes Danger to Self

Laura S. Brown and Jennifer J. Freyd

Why and how does psychological trauma harm people? The traditional assumption in trauma research has been that extreme fear is at the core of post traumatic responses to events like war and natural disasters. This assumption is at the heart of the PTSD Criterion A definition in the *DSM IV-R*: “witnessed or experienced an event threatening to safety or life.” Is terror the only cause of traumatic distress and harm? Some patterns of events (such as sexual abuse by a parent, acquaintance rape, or government mistreatment of citizens) generate strong symptoms of trauma even absent intense fear, perhaps



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because they involve social betrayal. Betrayal trauma theory (Freyd 1996; 2001; Freyd, DePrince & Gleaves, 2007), drawing on developmental, cognitive, and evolutionary psychology,

posits that (a) there is sometimes a social utility in remaining blind to betrayal and (b) betrayal traumas can be particularly toxic.

In Figure 1 two independent dimensions of trauma are identified as particularly likely to cause psychological harm: the terrorizing and life-threatening aspect of traumatic events and the social betrayal aspects of traumatic events. Recent research has suggested that betrayal may be a particularly potent aspect of trauma when it comes to long lasting harm. For instance, DePrince (2001) discovered that trauma survivors reporting traumatic events high in betrayal were particularly distressed. Freyd, Klest, and Allard (2005) found that a history of betrayal trauma was strongly associated with physical and mental health symptoms in a sample of ill



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individuals. Similarly, in a recent analysis using the Adverse Childhood Experiences (ACE) data set, Edwards et al. (2006), reported finding that high betrayal participants had poorer health and social functioning and poorer mental health than other abused participants.

The Ethics of Diagnosing Trauma-Betrayal as a Factor

Consideration of the effects of betrayal on the experience of trauma raises important questions about how a clinician conceptualizes what constitutes a Criterion A event for an individual. We would like to suggest that the willingness, or failure, to consider the meaning of betrayal may constitute an ethical dilemma for clinicians.

Diagnosis is rarely conceptualized of as an ethical process. Normally, diagnosing someone's distress or dysfunction entails matching symptoms to the lists of criteria in the *DSM-IV*, and naming the problem by how it best fits those criterion sets. People will often be given more than one diagnosis, and even when a prior diagnostic label is eventually determined to have been incorrect, it is rare that any sort of backward corrective process ensues; an erroneous diagnosis can follow someone, along with psychiatric records, for life, coloring how they are perceived and treated by both mental health and medical care providers. Diagnosis is one of the powers of the clinician; like any power, it is subject to abuse, and like any power of an institution of the larger society, at risk of being affected by the politics of that greater context.

Because diagnosis is both an ethical and a political undertaking, diagnosing has the potential either to silence and disempower suffering humans, or to create an experience of visibility, voice, and empowerment. The framework of Betrayal Trauma Theory (BTT) offers an important window through which to analyze how certain categories of adult experience entailing interpersonal betrayal can be understood as types of trauma exposures. In this article we discuss the political and ethical implications of agreeing, or refusing to give a diagnosis that is congruent with a person's lived experiences of distress, and consider the implications of BTT for understanding how an experience might meet Criterion A.

How is diagnosis an issue of ethics? Leaving aside formal ethical considerations regarding competency to diagnose, let's begin by discussing how diagnosis is an authoritarian act on the part of a psychotherapist. As Brown and Ballou (2002) argued, "...we see that the decision to call nonconforming thoughts, values, and actions psychopathology does two things. First, it discounts she or he who is described as such. Second, it blocks our ability to look outside the individual to see forces, dynamics, and structure that influence the development of such thinking, values and actions" (Brown & Ballou, 2002, p. xviii).

Consider the ethics of discounting and misperceiving. If the capacity to be emotionally present is defined as a form of competence in psychotherapy practice, then engaging in a process which is inherently invalidating, as diagnosis can be for many of those receiving such a label, might be considered to ethically problematic, and deserving of scrutiny.

The clinician making the diagnosis generally operates out of a number of non-conscious and usually unchallenged biases about what kind of experience falls within the range of psychopathology, and what constitutes "normal." Assumptions are made by the clinician as to the persistence of a behavior from past times, as to its hypothetical biological basis, as to its prognosis for responding to a particular intervention. Most of this is done from a stance privileging the clinician's standpoint as objective and neutral, and that of the client or patient as skewed by the very distress for which she or he seeks assistance.

Going to the second point raised by Brown and Ballou (2002), and related to this first topic, is the tacit inattention paid by the diagnostic process to the external social realities of people in distress. This is a sort of anti-ethical stance inherent in our current formal diagnostic nosologies; it is a politic of defining distress as an internal, individual experience for which social realities are meaningless. If a person meets criteria for Major Depression, Single Episode, Severe, the contributions of those social realities are not taken into account, or seen simply as one of many Axis IV psychosocial stressors that somehow contribute to the expression of this "real" thing, the Depression. If a person has the symptoms of being traumatized, but lacks an apparent Criterion A event, then they cannot have PTSD, and so their distress will be named in such a way as to obscure the presence of anything experienced as traumatic.

The Trauma of Exploitation and Betrayal

One of the groups of people for whom these ethical ramifications of diagnosing and naming distress as trauma—or not trauma—is particularly salient are people who have experienced betrayal as adults in professional relationships of care. Since the middle 1970s, the growing scholarly literature about people who have had this experience has commented

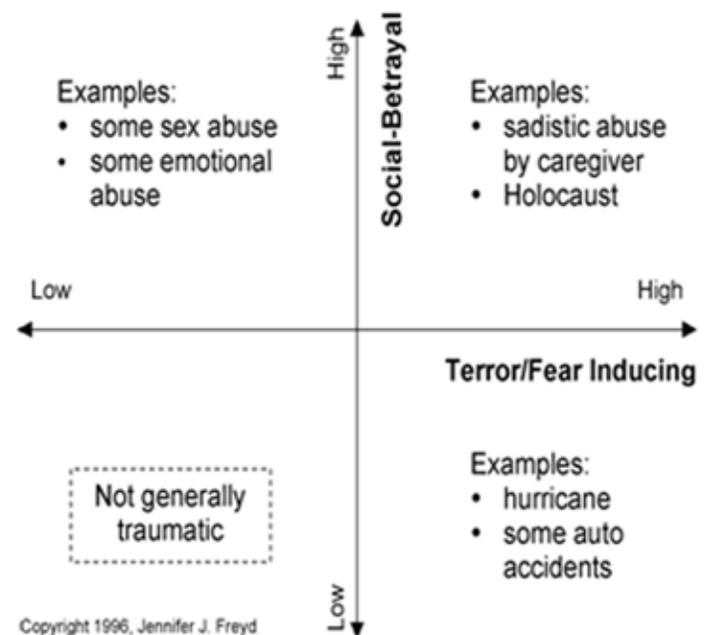


Figure 1. The two-dimensional model of trauma. ©Jennifer J. Freyd, 1996. Reprinted with permission.

on the resemblance of symptoms following sexual exploitation to those following exposure to a Criterion A traumatic stressor (Brown, 1992; Pope, 1994; Schoener, Milgrom, Gonsiore, Leupker, & Conroe, 1989). Persons who, in adulthood, have experienced sexual exploitation by health care providers, psychotherapists, clergy, and others in positions of power, care, and responsibility report intrusive symptoms, emotional numbing, and autonomic hyperarousal in the aftermath of these forms of violation, just as if they had been exposed to a threat to life or personal safety.

However, because most such experiences have not involved threat or force, and are more likely to have taken place within a narrative of love and forbidden romance, the presence of PTSD-like symptoms has been a challenge to clinicians who feel themselves bound by the parameters of the diagnosis as laid out in the *DSM*. This becomes more salient because some unknown percentage of these survivors makes a decision to bring a formal complaint or file a civil lawsuit against the professional who has violated their trust. This, in turn, places the question of what name to call their distress into the legal arena, where an attorney for the professional, or their employer, will call all aspects of the survivor's narrative into account, including the diagnosis given by any subsequent treating clinician.

Attorneys, not trained as psychotherapists, are frequently *DSM* fundamentalists, treating the book as a form of holy writ that cannot be gainsaid. Clinical judgment, the notion that one might consider the meaning of an event to a person's life in determining the appropriate diagnosis, seems to be an incomprehensible idea to many attorneys encountered by the first author in her forensic practice. If the description of Criterion A is "witnessed or experienced an event threatening to safety or life," then that event should be one that is obviously frightening, right? And how was having sex with her priest frightening to this adult woman, the attorney asks the psychologist? In the days of the original iteration of Criterion A, which described trauma as an "event outside the range of usual human experience," it was not unheard of to encounter attorneys who would, after eliciting testimony that sexual abuse of children was not an unusual or uncommon event, would then challenge a PTSD diagnosis given by a mental health professional on the grounds that sexual abuse of a child did not meet Criterion A.

This diagnostic fundamentalism is not entirely confined to attorneys, however. During the memory wars, when every survivor's account of childhood abuse experiences was being treated as false because of the absence of witnesses or corroboration, clinicians working in some settings found themselves frequently being required to change a PTSD diagnosis to something else because no one actually knew whether the trauma had taken place.

Consider the potential ethical issues inherent in this conundrum. A person experiences an event that feels traumatic to them. Force and threat of force were not used; grooming, which resembles romance, manipulation, and abuse of power were all present, however. For a clinician to silence the experience of the survivor of this sort of experience by denying its traumatic realities is an ethical stance; it is a decision to go along with what is officially correct rather than to situate oneself as an ally to the person who has suffered the

violation of trust.

Betrayal Trauma Theory (BTT) offers an empirically-based theoretical model which supports the reality that non-violently exploited individuals have experienced trauma, and calls into consideration how we define a Criterion A event. The BT model posits that betrayal traumas are traumatic emotionally for humans when the extent of the betrayal becomes knowable. Similar to Koss's (1990) conceptualizations of how acquaintance rape is traumatic, wherein the experience becomes overtly perceived as traumatic after the victim reappraises the meaning of the experience from merely unpleasant to one of violation, the BT model tells us, not only why memories for childhood abuse can become elusive or unavailable for many years, as was its original goal, but also why experiences that are confusing or unpleasant, but not an immediate cause of fear, horror, or sense of danger to life, can become traumagenic for people. The betrayals of trust that can occur in contexts where people can reasonably assume that a powerful other is looking out for their interests and welfare are also a form of shattered assumptions; thus, a betrayal trauma does not require a family relationship of care-giving in order to occur so long as there is a reasonable expectation that the other person will have a commitment to one's welfare, safety, and well-being.

Sexual exploitation of adults by psychotherapists, health care providers, attorneys, and clergy represent precisely this sort of scenario. Individuals in each of these professions have made commitments, either explicitly, via the ethical codes of their respective disciplines, or implicitly (as with clergy), within the framework of a particular religious code of morality, to care for the welfare of others with whom they have professional relationships and to place that welfare above the satisfaction of their own desires. Physicians, attorneys, therapists, and clergy are, consequently, given social powers not available to others. Health care professionals may touch their patients' bodies, psychotherapists, clergy, and attorneys elicit secrets about very distressing and shameful life events; all of these are bound, in some manner, to maintain the confidentiality of what has been revealed.

These institutionalized forms of relational power do not require that those holding them actually have feelings of care for the individuals in their keeping, although such care is also implicit in these relationships, and commonly present. However, because of the existence of this implicit expectation of actual caring, many people form symbolic relationships with people in these powerful roles that evoke the parent-child relationship. As the justices of the 9th Circuit Court of Appeals noted in the case of *Simmons v. U.S.*, where a woman sued her psychotherapist who had sexually exploited her, the presence of that symbolic, transference relationship, makes the sexual encounter between a therapist and client (and, for purposes of this paper, between other powerful caregivers and their patients, clients, and congregants), not simply one of adult to adult.

As is true in the relationship between parent and child, the professional in a relationship with an adult client or patient also holds the power to convey information. This is, once again, an ethical stance. One can practice an ethic of

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enhancing client or patient autonomy by sharing maximum information, or an ethic of protectiveness by withholding information deemed by the professional to be potentially harmful. But harmful to whom? In most cases where a professional sexually exploits someone, that professional is very likely to know that their own discipline proscribes this behavior because it is known to do harm. In almost every instance that has been documented in legal cases or scholarly literature, exploiting professionals have withheld that information from the person whom they were grooming for their own sexual use.

Indeed, for many of these exploitative professionals, the abuse of the power of their role included the generation of misinformation as part of the grooming process. Survivors of exploitation have described being told that this relationship, because it was actually love, and thus was special, or was therapeutic in some manner for the client, would not lead to harm. Many of the professionals who perpetrated these violations told their victims that the norms and rules of the profession were not truly about protecting clients, but were actually about blocking their autonomy, or about undermining the potential for genuine mutuality between two kindred souls who had just happened to meet in the context of a professional care-giving relationship. In some cases of abuse of adults by clergy, the rationale given for breaking the rules was that the sexual relationship was an expression of divine love.

BT Theory helps clarify several ways that this scenario is traumatic, and can lead to post-traumatic forms of distress in its survivors. First, as Freyd (1996) has noted, in relationships of dependency and love, one's cheater detectors are frequently ignored in favor of one's attachment needs. It should not be surprising that many of the people exploited by professionals as adults were also sexually abused as children, not, as Kluff (1990) once argued, because they are "sitting ducks" for the next perpetrator (cite), but rather, as BTT would suggest, because they have already over-learned to privilege their attachment needs when those are placed in conflict with needing to know the truth about abuse. Exploitative professionals, consequently, re-invoke earlier betrayal traumas in many of their victims. They may or may not lie explicitly to their clients, patients, and congregants as they groom them, but they almost always withhold the information that what is about to ensue is likely to damage the less powerful party in innumerable and long-lasting ways.

The reappraisal of what has occurred as a violation, buoyed up by a fabric of lies and deception, represents what we would argue constitutes the Criterion A event of a betrayal trauma. This reappraisal happens in many ways, but in each instance, the exploited person comes to realize that what has happened was not love, or caring, or being special, but was in fact an experience of being used, lied to, and betrayed. For many adults who are exploited in this way, the phenomenology of having been betrayed is a conscious one; survivors will use the term explicitly when referring to what happens when they become aware that their therapist, physician, attorney, or clergy person has betrayed, not only the rules of their respective disciplines, but also the implicit relationship of

caring that the exploited person reasonably expected them to offer as part of the professional relationship.

For survivors of sexual exploitation by psychotherapists this experience of betrayal can be experienced as an especially traumatic event. As one survivor put it eloquently to the first author, "I expected my family members to sexually abuse me. They were horrible people, dangerous people. But I expected a therapist to be safe. All of my therapists before him had been safe. Now it feels like there's no safe people, and no safe place." The individual whose just world expectations have been shrunk by childhood trauma and abuse, leaving professionals as the sole people in whom trust can be placed, experiences a shattering of those expectations arising from professional betrayal that is profound and soul-shattering. Such a person has not experienced an event that physically threatened their life. She or he has, nonetheless, experienced an event that phenomenologically was experienced as life-threatening.

A New Way of Conceptualizing Criterion A

BTT allows the clinician to formally define that inner experience of trauma in a way congruent with the survivor's experience. Rethinking Criterion A in this way offers a framework that does not discount the lived realities of the exploited adult whose beliefs about the categories of people who can be trusted, and the trustworthiness of the particular professional who has exploited them, have been blasted by the realization that betrayal has occurred. This, in turn, brings us back to the ethics of diagnosis, and to questions of whether an event such as sexual exploitation of an adult by a professional can lead to the development of PTSD.

We would like to argue that BTT provides an empirically derived additional pathway toward a Criterion A event. When an individual experiences a BTT Criterion A, a cognitive appraisal of having been betrayed in a relationship of trust and care, that individual has experienced trauma. The pervasiveness of PTSD symptoms in the population of people who have been sexually exploited in this way is simply a reflection of a reality; the exploited person has experienced betrayal, and betrayal is experienced as deeply endangering to safety, even when physical realities appear to be free of threat.

To name the distress of the exploited person as trauma-related is, consequently, an ethical stance of aligning the diagnosis with the client's lived, felt experience. It is also a step toward challenging the notion that trauma is simply about fear, and toward the stance that trauma is also about the disruption by betrayal of necessary attachments and dependency relationships. The ethics of founding diagnostic categories in a reality that ignores the importance of attachment to human welfare constitutes another article, but the use of BTT as a paradigm for conceptualizing how the disruption of attachment and dependency by betrayal illuminates the problematic nature of a fear-only basis for understanding what constitutes trauma.

An ethic of empowering the survivors of trauma includes using the diagnostic power of the clinician to make their pain visible and knowable. BTT empirically supports the use of a post-traumatic diagnosis with survivors of adult experiences of sexual exploitation by professionals and care-givers. This paradigm for a Criterion A event enables a clinician to take the ethical stance of allying with the survivor, rather

than conforming concretely to the fear-based constructions regulating the current definition of Criterion A. The task, now, is on-going engagement with those defining trauma, so that the effects of disruptions of attachment and dependency by betrayal, and Betrayal Trauma as a powerful form of traumatic stressor, are included in the diagnostic canon.

Future Questions

Our proposal generates a number of questions that can, and should, be empirically studied so that the potential inherent in the impacts of betrayal as a traumatic stressor for adults can be more completely understood. Is the traumatic harm necessarily associated with appraisal of betrayal, or with the betrayal itself? This is an empirical question worth demanding research. As noted by DePrince and Freyd (2002):

The role of betrayal in betrayal trauma theory was initially considered an implicit but central aspect of some situations. If a child is being mistreated by a caregiver he or she is dependent upon, this is by definition betrayal, whether the child recognizes the betrayal explicitly or not. Indeed, the memory impairment and gaps in awareness that betrayal trauma theory predicted were assumed to serve in part to ward off conscious awareness of mistreatment in order to promote the dependent child's survival goals....While conscious appraisals of betrayal may be inhibited at the time of trauma and for as long as the trauma victim is dependent upon the perpetrator, eventually the trauma survivor may become conscious of strong feelings of betrayal. (pp. 74–75)

We assume here that the appraisal does in fact usher in a psychological crisis that should meet criterion for PTSD. But what about prior to that appraisal—is the event not problematic? Is betrayal blindness and its psychological sequelae an important contributor to the psychological harms experienced by adults who are betrayed? We assume the event that can eventually cause a crisis when fully appraised, is harmful even before then in profound ways, but that harm has a different flavor. Depression, substance abuse, dissociation, and other manifestations of keeping information out of awareness, are very likely present. Is the experience of childhood betrayal trauma a factor contributing to vulnerability to exploitation in adult life?

Should we change Criterion A or advocate a more radical transformation? Kahn (2006) notes “Our clients’ most frequent presenting problems are not the many symptoms of PTSD, but rather their failed or failing relationships” (Briere, 2002). In addition to relationship problems, traumatized clients struggle with depression, anxiety, and substance abuse. Why do we have only one explicit trauma diagnosis in the *DSM*? In addition to incorporating betrayal into PTSD criterion A, we urge an expansion of our conceptualization of post (betrayal) traumatic reactions to other forms of distress, including depression, anxiety, dissociation, personality change.

Our call to reconsider what constitutes a Criterion A event by foregrounding the meaning of relational betrayal in the phenomenology of trauma implies the need for a more general and far-reaching discussion of how trauma is conceptualized, something that we consider an ethical dilemma because it brings into sharp focus the ways in which clinicians and researchers use our power to privilege or silence certain kinds of experience as meaningful in the development of psychic pain. It is clear, both for children and adults abused by caregivers, that the betrayal element of these violations

begins to have negative consequences fairly quickly. However, none of these other symptoms are formally considered traumagenic in nature, and some authors have criticized those who point to trauma as a risk factor for a wide range of forms of distress. We believe that the empirical data about the effects of relational and attachment violations and betrayal warrant such reconsiderations, and re-openings of discussions of the larger contributions of trauma to human difficulties.

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