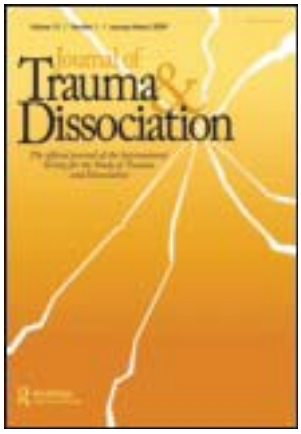

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Childhood Betrayal Trauma and Self-Blame Appraisals Among Survivors of Intimate Partner Abuse

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Childhood Betrayal Trauma and Self-Blame Appraisals Among Survivors of Intimate Partner Abuse

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*Child abuse perpetrated by a close other, such as a parent, is linked to a wide range of detrimental effects, including an increased risk of self-blame. The current study evaluated whether experiences of childhood betrayal trauma were linked to self-blame following victimization in adulthood. A diverse sample of women (*n = *230) from an urban city were recruited based on having experienced an incident of intimate partner abuse (IPA) reported to the local police. Women reported on their trauma histories and levels of self-blame for the target IPA incident. Results showed that a history of childhood betrayal trauma exposure predicted the degree of self-blame for the IPA incident. Women who experienced severe IPA during the target incident also indicated higher levels of self-blame. Findings from this study suggest that it may be important to target self-blame appraisals in interventions with adults exposed to abuse in childhood.*

KEYWORDS *betrayal trauma theory, self-blame, intimate partner abuse*

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Experiences of child abuse that involve betrayal by a trusted person (such as a caregiver) can cause severe distress as well as hinder a child's social, emotional, and behavioral functioning (Cook et al., 2005; Filipas & Ullman, 2006; Freyd et al., 2005). For example, abuse high in betrayal has been linked to serious disruptions in interpersonal functioning in adulthood (Cloitre, Cohen, & Scarvalone, 2002; Cloitre & Rosenberg, 2006; Cloitre, Scarvalone, & Difede, 1997; Gobin & Freyd, 2009; Messman-Moore & Coates, 2007), including a compromised ability to detect harm in relationships (DePrince, 2005; DePrince, Combs, & Shanahan, 2009; Marx, Heidt, & Gold, 2005; Marx & Soler-Baillo, 2005; Messman-Moore & Brown, 2006). Extending this body of work, the current study evaluates whether a history of child abuse by someone on whom the child is dependent is linked to self-blame following intimate partner abuse (IPA) in adulthood. Identifying cognitive processes, such as self-blame, that are linked to histories of child abuse high in betrayal is crucial to developing successful cognitive interventions for those revictimized in adulthood.

Previous research indicated that women exposed to child sexual abuse (CSA) perpetrated by relatives reported engaging in self-blame at the time of the abuse (Ullman, 2007). Self-blame appraisals pose a serious risk to the well-being of abuse survivors. For example, self-blame is linked to increased trauma-related distress (DePrince, Chu, & Pineda, 2011), including greater posttraumatic stress disorder symptoms and poorer recovery from victimization (Najdowski & Ullman, 2009). In addition to unjustly absolving perpetrators of responsibility for the abuse they committed, self-blame may lead survivors to judge adulthood victimizations in the same self-deprecating manner. For example, Arata (1999) found that rape survivors with CSA histories were more likely than survivors without CSA histories to blame themselves for the rape. Furthermore, Filipas and Ullman (2006) found that CSA survivors who were revictimized as adults were more likely to have blamed themselves at the time of the abuse and to blame themselves currently. Extending this work, the current study examined links between child abuse more generally (i.e., not just CSA) and self-blame following adulthood IPA through the lens of betrayal trauma theory (BTT). As reviewed next, BTT points to the importance of the victim–perpetrator relationship in understanding the consequences of child abuse later in life. To our knowledge, this is the first study to assess the role of closeness to the childhood perpetrator in terms of its impact on self-blame appraisals of IPA occurring in adulthood.

BTT: EXTENSIONS TO SELF-BLAME

BTT (Freyd, 1994, 1996) provides a framework for understanding how self-blame could arise from the dynamics of abuse by caregivers. Betrayal trauma

(BT) occurs when people or institutions on which a person depends for survival violate that person's trust or well-being; abuse by someone with whom a child has a close relationship is a primary example of BT (Freyd, 2008). BTT suggests that victims may utilize cognitive strategies to help maintain necessary attachments with abusive caregivers (Freyd, 1994, 1996). For example, memory impairment (Freyd, 1994, 1996; Freyd, DePrince, & Zurbriggen, 2001), dissociation (DePrince & Freyd, 2007; Freyd & DePrince, 2001), altered autonomic emotion processing (Reichmann-Decker, DePrince, & McIntosh, 2009), and emotion appraisals (DePrince et al., 2011) may help victims maintain necessary, though abusive, attachments. Variations in autonomic emotion processing and/or appraisals could provide alternative perceptions of abuse (e.g., as less bad, as not occurring) to facilitate ongoing attachment with the abusive other (e.g., Freyd, 1996). Similarly, self-blame for the abuse may help victims maintain necessary attachments with abusive caregivers by minimizing the perpetrator's responsibility.

Though such strategies may be adaptive in negotiating abusive environments in childhood (Barlow & Freyd, 2009; Freyd, 1994, 1996), they may have important and problematic ramifications for interpersonal functioning later in life (DePrince, 2005; Gobin & Freyd, 2009). For example, revictimization in adulthood following childhood abuse is linked to alterations in relationship schemata such that victims hold expectancies of harm in intimate relationships into adulthood (Cloitre et al., 2002; DePrince et al., 2009). Such expectancies may increase the likelihood that women stay in relationships that become violent and/or feel disempowered to leave such relationships (DePrince et al., 2009). Extending this research as well as the core concepts of BTT (Freyd, 1994, 1996), we predicted that a history of childhood BT would increase women's use of self-blame following IPA in adulthood.

THE CURRENT STUDY

The current study tested the prediction that women with histories of high BT in *childhood* would report greater self-blame following *adult* IPA than women with histories of low or no BT in childhood. Furthermore, we hypothesized that childhood BT would explain unique variance in self-blame following IPA even when IPA incident severity and women's age were controlled. Primary analyses controlled for the severity of the adult IPA incident in case the links between early BT and self-blame could be better explained by the severity of the more recent IPA incident. We also controlled for participant age because of the heterogeneity in women's ages in the sample; older women were, by definition, further out from childhood BT experiences, whereas the childhood event was more recent for younger women.

To test these predictions, we drew on data from a larger project with women exposed to incidents of IPA that were reported to law enforcement.

None of the IPA incidents involved a cross-arrest, which means that responding officers believed the crimes that occurred were perpetrated by male partners (and not the female participants in this study). During the interview procedures, women were asked to report on their histories of childhood trauma exposure, including BT, as well as self-blame for the police-reported IPA.

METHODS

Participants

Women ($N = 236$) were recruited from cases of IPA reported to law enforcement in Denver, Colorado, that involved a heterosexual couple, a male defendant, and no cross-arrest. Women were interviewed shortly after the IPA incident ($Mdn = 26$ days).

Measures

Childhood trauma. The Trauma History Questionnaire (THQ; Green, 1996) is a 24-item self-report questionnaire that measures history of exposure to traumatic events that meet *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition,* posttraumatic stress disorder Criterion A1 (American Psychiatric Association, 1994). The THQ measures the lifetime occurrence of traumatic events in three categories: general disaster (e.g., car accidents, earthquakes), crime-related events (e.g., robberies), and interpersonal events (e.g., physical or sexual abuse). The THQ also gathers information on the number of times each traumatic event occurred and the respondent's approximate age at each event. The THQ has been shown to have moderate to high test–retest reliability and good interrater reliability ($\kappa = 0.76$–1.0), internal consistency, and convergent validity for individuals with severe mental illness (Mueser et al., 2001). In order to collect data on whether participants had witnessed family violence as a child, we added an additional item from the Brief Betrayal Trauma Survey (Goldberg & Freyd, 2006) to the THQ.

Eight items of the THQ were used to classify childhood BT (Goldberg & Freyd, 2006). These items were chosen because they inquire about interpersonal traumas such as physical abuse, sexual abuse, emotional/psychological abuse, and witnessing family violence. To collect data on the perpetrator(s) of each interpersonal trauma, we further modified the THQ to include the inquiry "Who did this to you?" The relationship between the participant and the perpetrator(s) (e.g., father, aunt, teacher) was used to determine levels of closeness to the victim in order to distinguish between levels of BT for each type of abuse. The BT category scheme used was similar to the scheme that was utilized by DePrince et al. (2011) in their study assessing posttrauma

appraisals and trauma-related distress. The scheme was as follows. *High BT* was defined as abuse perpetrated by someone who was very close to the victim, including a caregiver (e.g., father, mother, or legal guardian), immediate family member (e.g., brother, sister, stepparent, or stepsibling), or dating partner (e.g., spouse, significant other). *Low BT* was defined as abuse perpetrated by an extended family member (e.g., aunt, uncle, cousin, grandparent), another individual who was somewhat close to the victim (e.g., friend, friend of parents, neighbor, teacher, babysitter, casual dating partner, coach, business partner), or acquaintance/stranger. Finally, *no BT* was defined as no exposure to interpersonal trauma before age 18.

If the victim indicated that she was abused by more than one person, the perpetrator with whom the victim had the closest relationship was used to classify the level of childhood BT. If the level of betrayal varied across different types of abuse (e.g., high-BT physical abuse but low-BT sexual abuse), the highest level of BT across all eight items was used to classify the overall level of childhood BT. The age of the victim at the time of the abuse was also utilized to determine whether the victim was a child (younger than the age of 18) or an adult at the time of the abusive event or when chronic abuse began. Only events that occurred when the survivor was a child were classified as childhood BT. The following weights were assigned to overall childhood BT levels: high BT = 1, low BT = 0, no BT = −1.

Self-blame appraisals. The Trauma Appraisal Questionnaire (TAQ; DePrince, Zurbriggen, Chu, & Smart, 2010) is a 54-item self-report questionnaire that measures six categories of posttraumatic appraisals: betrayal, self-blame, fear, alienation, anger, and shame. The TAQ was found to have excellent internal consistency (α = .84–.94 throughout four samples) and test–retest reliability (correlations for scales = .73–.88, with self-blame = .82) as well as good convergent, concurrent, and discriminant validity (DePrince et al., 2010). The self-blame subscale of the TAQ collected during the participant's initial interview was used to assess survivors' appraisals of self-blame during an incident of IPA that resulted in a report to law enforcement. Appraisals were evaluated using a Likert scale ranging from 1 = *strongly disagree* to 5 = *strongly agree.* Appraisal items on the self-blame scale are composed of statements such as "I was responsible for what happened," "I deserved what happened to me," and "If I were good enough, then this wouldn't have happened to me." Responses to the self-blame items (Cronbach's α for sample = .89) were summed and divided by the total number of item responses for that scale to produce an overall self-blame mean score for each participant.

IPA incident severity. The Revised Conflict Tactics Scale (CTS; Straus, Hamby, Boney-McCoy, & Sugarman, 1996) is a widely used instrument that assesses conflict in intimate partner relationships. The CTS has been found to have excellent validity and reliability (Straus et al., 1996). The CTS has four scales: psychological aggression, physical aggression, sexual coercion, and

injury. The CTS gathers information on the number of times each aggressive tactic on the four scales is used against the victim by an intimate partner. The CTS was used to assess the severity of the target IPA incident reported to the police. Participants were asked whether each of the items on the four CTS subscales occurred during the target IPA incident. Examples of items include the following: physical aggression subscale: "Did he slap you?" "Did he strangle you?"; sexual coercion subscale: "Did he use threats for sex?" "Did he force you to have sex?"; injury subscale: "Did he cause sprains or bruises?" "Did he knock you unconscious?"; and psychological aggression subscale: "Did he insult you or swear?" "Did he destroy your property?" The items endorsed for each subscale were summed to obtain a tally of events for each subscale, with more endorsed items indicative of higher incident severity. The incident tallies were summed to produce an overall IPA incident severity score: psychological aggression tally + physical aggression tally + sexual coercion tally + injury tally = total IPA incident severity.

Procedure

As part of a larger study, women were contacted to participate in a "Women's Health Study" based on public records of IPA reports in Denver, Colorado (for details about the larger study, see DePrince, Belknap, Labus, Buckingham, & Gover, in press; DePrince, Labus, Belknap, Buckingham, & Gover, 2012). The women who agreed to participate were scheduled for a 3-hr interview at the University of Denver. During the informed consent process women were informed that their names were accessed using public records and that the research was about IPA. Consent information was provided both verbally by research personnel and on written forms. A consent quiz was administered to ensure that all women understood the consent information. Only women who answered 100% of the consent quiz questions correctly were enrolled in the study. Women were asked to complete questionnaire items and answer interview questions that were part of the larger study. Part of this interview included the THQ interpersonal questions, the TAQ, and the CTS. When answering questions on the TAQ, participants were asked to think about the target IPA incident for which they had been recruited into the study. Participants were debriefed and compensated $50 for their time. This study was approved by a university institutional review board.

Data Analysis

Imputation. Of the 236 participants in the study, 201 (85%) had complete data for all variables of interest (i.e., self-blame, childhood BT level, IPA incident severity, and age). Exploratory analyses indicated that data were not missing at random; for example, levels of self-blame were significantly higher

for participants *without* childhood BT data than for those with childhood BT data, $t(223) = 2.51$, $p = .01$. Therefore, based on recommendations by Acock (2005), the Expectation Maximum method was used to conduct a series of single regression imputations for 15% of the data set using SOLAS for Missing Data Analysis© (Statistical Solutions, Saugus, MA) software. First childhood BT was imputed with self-blame as a covariate; next self-blame was imputed with childhood BT as a covariate for all monotone data. Six cases were excluded from the final data set because they were missing data for all of the key variables and we were unable to impute the data, yielding a final total sample of 230. To maintain consistency across imputed and original scores, we converted imputed childhood BT scores into BT level weights (−1 = no BT, 0 = low BT, 1 = high BT) using conventional rounding techniques. Transformations of the imputed data did not alter the beta coefficient for the childhood BT variable. Note that analyses conducted with non-imputed, complete-cases-only data ($n = 201$) yielded the same results.

RESULTS

Demographics

Women ranged in age from 18 to 61, with an average age of 32.6 years ($SD = 10.9$). Women reported their ethnic/racial backgrounds as follows: 43% White/Caucasian, 33% Black or African American, 1% Asian, 1% Pacific Islander, 13% American Indian or Alaska Native, 6% other, and 40% Hispanic or Latina. Women described their current relationship status as follows: 10% married, 11% living with someone, 16% divorced, 12% separated, 3% widowed, 41% single and never married, and 7% other. Women reported the following in terms of highest level of education: 2% first through eighth grade, 28% some high school, 28% high school graduate, 25% some college, 7% associate's degree, 5% 4-year college degree, 3% postgraduate education, and 2% other (e.g., trade school). A majority of women ($n = 186$, 81%) reported having at least one child.

Before beginning analyses, we assessed distributions of all continuous variables for skew, kurtosis, and outliers. Skew and kurtosis were satisfactory for all variables. The results of coding the interpersonal item questions on the THQ showed that 53% of the women reported exposure to high BT during childhood, 19% reported exposure to low childhood BT, and 28% reported no childhood BT.

Comparisons by Childhood BT Levels

Table 1 provides descriptive statistics for self-blame appraisals, IPA incident severity, and the age of the survivor. In addition to providing overall means, Table 1 describes these variables by the level of childhood BT (i.e., high,

TABLE 1 Means (*SD*) for Study Variables by Childhood BT Level

Variable	Overall *M* (*SD*)	No childhood BT[a] ($n = 65$)	Low childhood BT[b] ($n = 43$)	High childhood BT[c] ($n = 122$)	Tukey
Self-blame	2.05 (1.01)	1.71 (.82)	1.88 (.85)	2.29 (1.09)	a,c***; b,c*
IPA incident severity	10.90 (6.98)	10.95 (6.52)	10.79 (6.90)	10.92 (7.29)	
Age	33.15 (10.90)	34.86 (11.89)	32.91 (10.14)	32.33 (10.58)	

Notes: BT = betrayal trauma; IPA = intimate partner abuse.
*$p < .05$.
***$p < .001$.

low, or none). A series of one-way analyses of variance was conducted to compare these study variables by BT group. Results of the one-way analyses of variance showed significant mean differences between self-blame appraisals by childhood BT level, $F(2, 229) = 124.16$, $p < .001$. Table 1 indicates significant differences between pairs as identified by post hoc Tukey tests. For self-blame appraisals, the high-BT group had significantly higher levels of self-blame than both the low-BT and no-BT groups.

Predictors of Self-Blame

Bivariate correlations were performed to explore relationships between all variables included in the multiple regression analysis. These variables included childhood BT level (−1 = none, 0 = low, 1 = high), self-blame, IPA incident severity, and the age of the survivor. Table 2 presents the results of the bivariate correlations.

Table 3 displays results of the simultaneous multiple regression analysis testing childhood BT, IPA incident severity, and the age of the survivor as predictors of self-blame appraisals. The overall regression model was significant in predicting the outcome of self-blame ($R^2 = .10$), $F(3, 226) = 8.43$, $p < .001$. The beta coefficients for childhood BT and IPA incident severity were significant ($p < .001$ and $p < .01$, respectively), and the age of the survivor showed a trend toward significance ($p = .07$).

TABLE 2 Bivariate Correlations Among Variables Used in Regression Analyses

Variable	1	2	3	4
1. Childhood betrayal trauma	—	.26***	−.001	−.10
2. Self-blame		—	.15*	.06
3. IPA incident severity			—	−.18**
4. Age of survivor				—

Notes: IPA = intimate partner abuse.
*$p < .05$.
**$p < .01$.
***$p < .001$.

TABLE 3 Multiple Regression Model Predicting Self-Blame Appraisals of Women IPA Survivors

Measure	Variable	*B*	*SE B*	*B*	R^2
Self-blame appraisals	Childhood betrayal trauma	.31	.07	.27***	.10***
	IPA incident severity	.03	.01	.17**	
	Age of survivor	.01	.01	.12†	

Notes: IPA = intimate partner abuse.
†$p < .10$.
**$p < .01$.
***$p < .001$.

DISCUSSION

Women exposed to childhood trauma high in betrayal reported significantly higher levels of self-blame following an incident of adult IPA relative to women who experienced low or no childhood BT. Our results are similar to those of Arata (1999) and Filipas and Ullman (2006) conducted with CSA survivors in that they demonstrate that survivors of child abuse blame themselves when they are victimized as adults. Our results extend this literature by providing evidence that women who have experienced childhood abuse beyond CSA alone (i.e., physical abuse, emotional abuse, witnessing family violence) also engage in self-blame after experiencing IPA as adults.

These findings highlight the critical link between the victim's relationship to the perpetrator in childhood abuse and appraisals in later abusive adult relationships. Though Ullman (2007) found that survivors of CSA in which the perpetrator was a relative reported engaging in self-blame at the time of the child abuse, the level of closeness to the child abuse perpetrator has not previously been assessed in terms of its link to self-blame appraisals of victimization occurring *later* in life. Our findings show that the closer women were to their perpetrators during childhood (i.e., the higher the levels of childhood BT), the more they blamed themselves for the IPA incident reported to the police, despite the fact that the incident occurred long after the childhood trauma. The relationship between childhood BT and self-blame appraisals is consistent with theoretical predictions derived from BTT. For example, the findings suggest that self-blame may deflect responsibility for the abuse away from the perpetrator, thereby helping victims to maintain attachments to abusive partners. Though self-blame may be adaptive in the initial BT environment by facilitating attachment to an abuser who is necessary for a child's survival, the results of the current study demonstrate that childhood BT may promote women's utilization of these same strategies when they are faced with IPA later in life.

Women who reported more severe forms of IPA during the IPA incident blamed themselves *more* for the abuse than women who reported less severe forms of IPA. These results may be consistent with BTT, in that women

who experienced IPA of greater severity may have needed to utilize higher degrees of self-blame in order to navigate the abusive relationships with their intimate partners. It is striking that links between self-blame and childhood BT as well as IPA severity were present in this sample despite the fact that none of these women were arrested by law enforcement; rather, their partners were identified by law enforcement as culpable. Though the law held their partners responsible, many women still blamed themselves.

These data suggest that the consequences of child abuse on relationship schemata—in this case, self-blame in the face of abuse—persist despite the passage of time. One might assume or hope that the impact of childhood BT would decrease as survivors grow older and the trauma exposure more distant. Unfortunately, this does not appear to be the case. In this sample of women aged 18 to 61, links between childhood BT level and self-blame persevered even when participants' current age was controlled. Furthermore, a trend pointed to the possibility that older women may actually blame themselves more than younger women following IPA. Future research should test whether this trend for age is replicable and, if so, whether age is a proxy for cumulative victimization experiences across the lifespan that increase survivors' likelihood of self-blame. Despite the need for future research, these findings highlight how profound of an impact child abuse has on how women evaluate abuse in their adult interpersonal relationships.

Limitations of the Current Study

Because self-blame data were not collected for the childhood BT events themselves, we could not determine whether women's self-blame following the IPA incident represented a more generalized pattern of self-blame attributions arising from childhood BT experiences. Thus, this study was not able to determine whether women survivors blamed themselves for the childhood BT itself. Despite this fact, the findings are still notable in that assessing whether childhood BT experiences may impact the likelihood that survivors will utilize self-blame in their abusive relationships in *adulthood* is a far more conservative test of the long-term effects of childhood BT. Future studies are needed that assess survivors' appraisals of both the initial child abuse and later adult victimization to better understand the relationship between childhood and adulthood self-blame appraisals. The current study also defined all BT experiences that occurred when women were younger than age 18 as childhood BT. Further research is necessary to determine whether BT experiences that occur during early childhood versus adolescence differentially predict self-blame in adulthood. Because this study utilized cross-sectional data, prospective and longitudinal studies are needed to determine whether a causal relationship exists in which experiences of childhood BT alter appraisal processes leading to self-blame.

Conclusions

This study assessed a diverse community sample of women who had experienced IPA incidents reported to the police in an urban U.S. city. This study advances the field's understanding of appraisal processes among child abuse survivors by demonstrating how a child's relationship to her perpetrator influences the likelihood that she will blame herself for abuse during adulthood, regardless of whether the initial abuse is physical, sexual, or neglectful in nature. Our findings further elucidate the detrimental impact childhood BT experiences have on women's relationship schemata later in life. Survivors appraised interpersonal betrayals in terms of self-blame when they were victimized as adults, ironically more so when the victimization was severe. Moreover, the tendency to utilize self-blame appraisals in the context of IPA showed a positive trend with age. Survivors' tendency to engage in self-blame following IPA may have serious consequences, ranging from low self-esteem to stay/leave decision making in relationships with abusive partners (e.g., Matlow & DePrince, 2011). Though future research is needed to identify links between self-blame and negative outcomes, the current findings point to the importance of considering self-blame appraisals in interventions with IPA victims exposed to BT in childhood. We hope our results will help inform intervention strategies for clinicians working with survivors by highlighting self-blame as an important relationship schema to target in therapy.

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