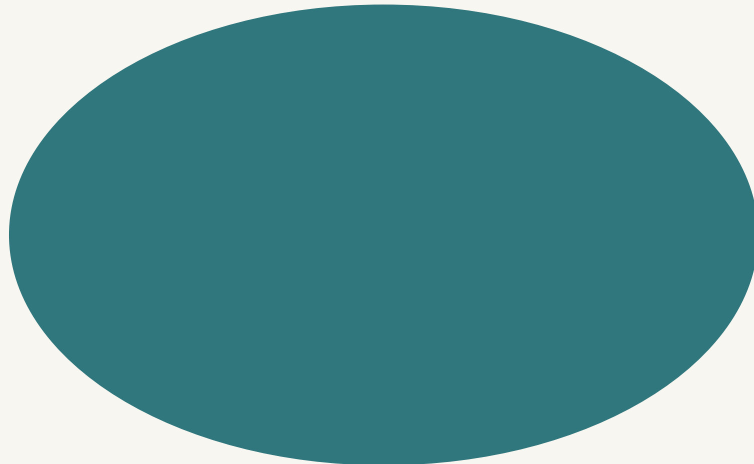
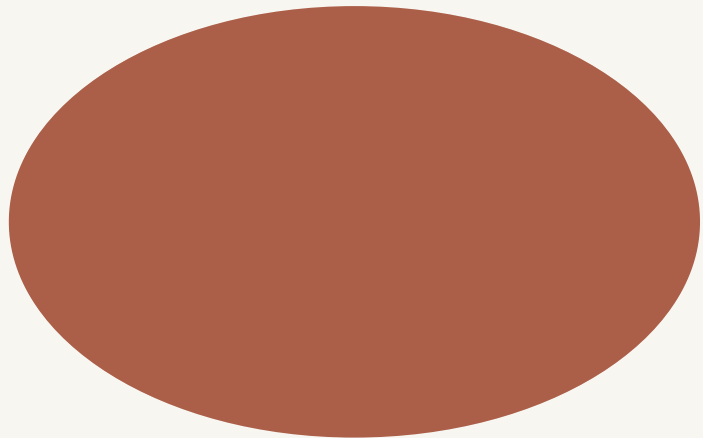
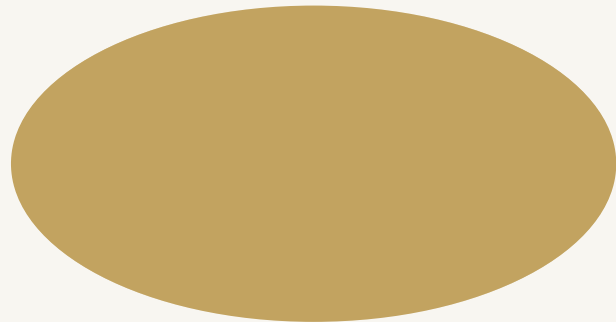
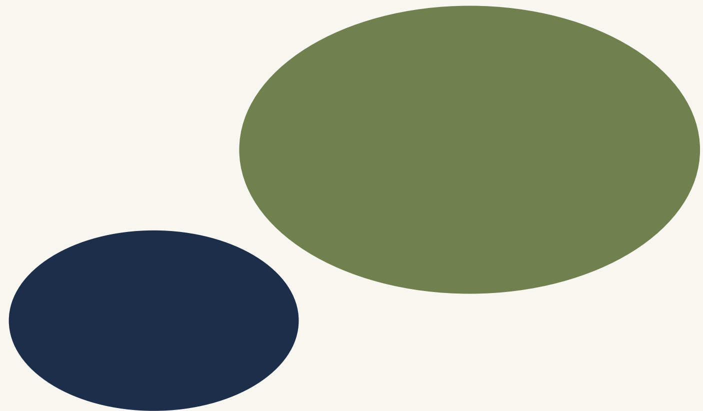



When Trust Becomes Survival

A Unified Model of Betrayal Trauma and Moral Injury

Lisa Long, LPC/MHSP, NCC, CCATP
Shelly Erdman, LPC/MHSP, NCC, BC-TMH, CCPS

TLPCA Summit 2026

Presentation Disclaimer

- This presentation and the content made available in this presentation are for educational purposes only. This presentation may contain copyrighted material which has not been authorized for use by the copyright owner. This material is being shared under the “fair use” allowance under section 107 of the Copyright Act for purposes of criticism, comment, news reporting, teaching, scholarship, and/or research.
- This presentation is not to be used for purposes other than individual education and is not to be distributed or posted online or otherwise. Please consult original sources for more information about using quoted/cited and/or copyrighted materials.
- Nothing written, spoken, or otherwise shared in this presentation constitutes legal advice, clinical supervision, or consultation.

Why this topic matters

Clinical gap

Integrated models remain limited even though many clients show both betrayal trauma and moral injury features across relational and institutional contexts.

Beyond fear-based trauma

Shame, disgust, anger, identity disruption, and loss of trust often exceed a purely fear-centered PTSD lens.

Practice relevance

Counselors often work with clients who remain in betraying relationships or systems because of survival needs, identity, calling, or attachment.

Session contribution

This session offers a unified framework, paired vignettes, and phase-based treatment planning for intimate and institutional betrayal presentations.

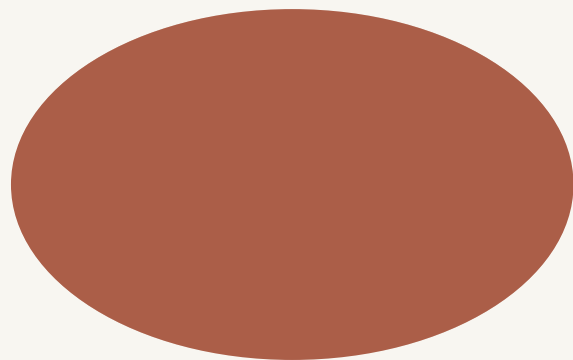
(Litz et al., 2009; Griffin et al., 2019)

Learning objectives

- Identify shared features of betrayal trauma and moral injury across intimate and institutional systems
- Explain betrayal blindness and moral numbing as parallel self-preservation mechanisms
- Apply adapted evidence-based strategies within a phase-based treatment framework
- Clarify the clinician’s role when clients remain in relationships or systems that betrayed them

Format

- Conceptual model
- Clinical markers
- Assessment prompts
- Treatment map
- Paired cases
- Discussion



Core concepts

Betrayal trauma

Harm is perpetrated by a person or system on which the survivor depends for safety, care, attachment, identity, or livelihood. In intimate contexts this may include infidelity, chronic deception, coercive dynamics, or attachment injuries. In institutional contexts it may include cover-up, neglect, retaliation, or misuse of power.

Moral injury

Psychological, relational, and existential distress that follows perpetrating, witnessing, failing to prevent, or being betrayed by authorities in ways that violate deeply held moral beliefs. Themes often include guilt, shame, anger, disgust, spiritual struggle, and loss of meaning.

(Gordon et al., 2004)

Shared constructs and key distinctions

Betrayal trauma

- Dependency on the betrayer
- Attachment and safety disruption
- Hypervigilance and relational dysregulation
- Pressure to preserve the bond

Overlap

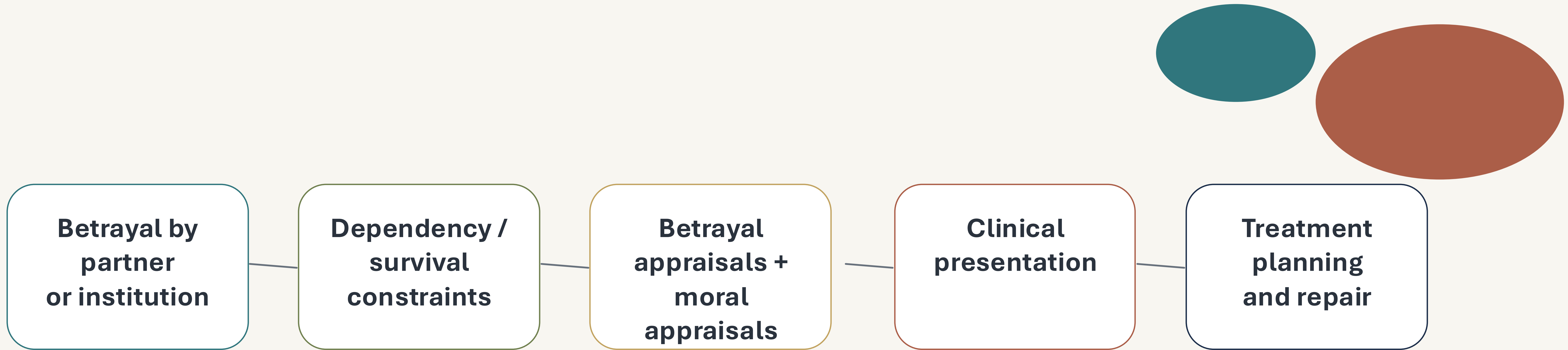
- Assumptive world violations
- Shame, anger, grief, disgust
- Loss of trust and identity disruption
- Complex decisions about staying, leaving, or repairing
- Presentations that exceed a fear-only PTSD lens

Moral injury

- Moral conflict or transgression
- Self-condemnation and guilt
- Betrayal by leaders or institutions
- Meaning, spiritual, and existential injury

(Litz et al., 2009; Griffin et al., 2019)

A unified model across contexts



Clinical takeaway

When dependency and value violation coexist, survivors may minimize, compartmentalize, numb, rationalize, or overfunction in order to preserve attachment, employment, belonging, or identity.

(Litz et al., 2009; Griffin et al., 2019; Purcell et al., 2018)

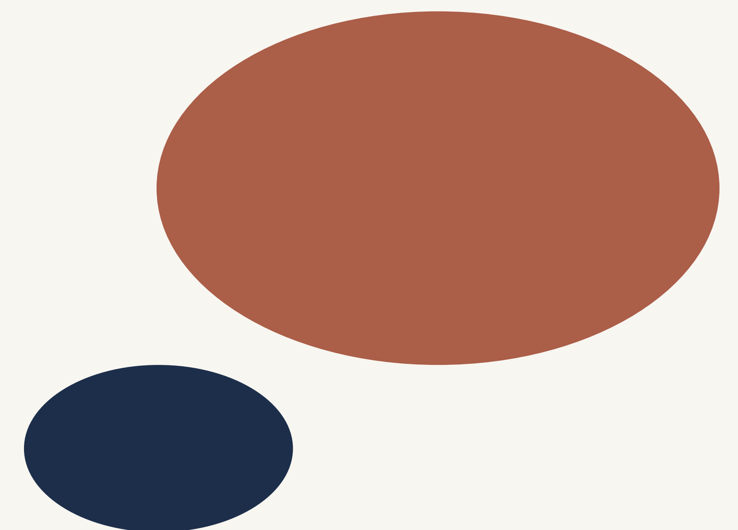
Expanding understanding of concepts

- Moral injury is no longer relevant only to military and veteran populations.
- Children and adolescents may also experience moral injury.
- Those faced with attachment-based trauma in adult relationships may also experience moral injury.
- Risk factors include:
  - (Children & adolescents) Developmentally-appropriate concrete thinking and the development of internal working models
  - High vulnerability to high BT.
  - Low autonomy

(Kidwell & Kerig, 2023; Rokach & Chan, 2023)

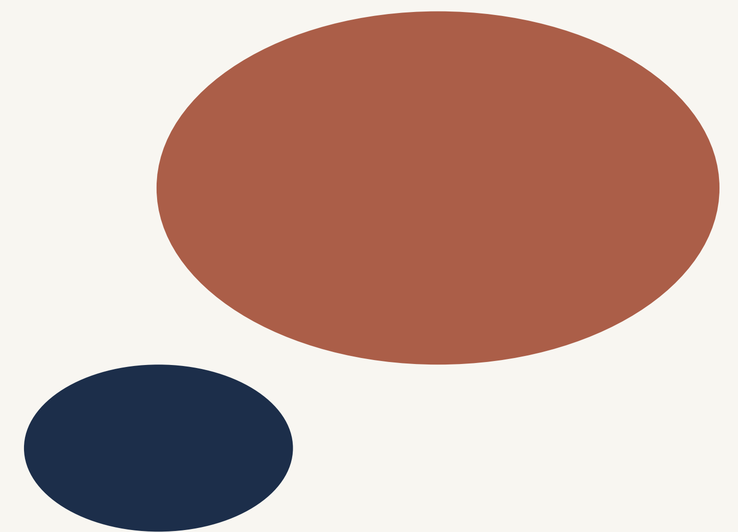
What causes moral injury?

- Potentially Morally Injurious Experiences (PMIEs)
  - Acts of commission or omission committed (or not committed) by self or others that occur in "high stakes situations in which a moral value, belief, or expectation is violated through experiencing, witnessing, or learning about the event" (Kidwell & Kerig, 2023. P. 1)
  - Cognitive dissonance develops as experience and moral expectations clash
  - Symptoms then develop in an attempt to address the dissonance: Rumination, negative appraisals, etc.



What causes betrayal trauma?

- Betrayal Trauma Theory (Freyd, 1996)
  - "Betrayal is the violation of implicit or explicit trust" (p. 9).
  - Psychological response to childhood trauma (in original theory)
  - Survival vs. Escape
  - Forgetting
  - Betrayal blindness



Two common contexts

Intimate-partner betrayal

Examples include infidelity, chronic deception, narcissistic abuse patterns, attachment injury, and repeated violations of transparency. Survivors may show intrusive thoughts, relational hypervigilance, self-doubt, dysregulation, and moral conflict about whether staying or leaving best reflects their values.

Institutional betrayal

Examples include religious cover-up, unethical healthcare practices, workplace retaliation, and training culture harms. Clients and helping professionals may feel trapped by finances, calling, licensure pathways, identity, or community ties while also carrying moral distress and loss of trust.

(Gordon et al., 2004; Purcell et al., 2018)

Survival mechanisms: betrayal blindness and moral numbing

Betrayal blindness

Unawareness, forgetting, minimization, or reinterpretation of betrayal that protects an essential bond when fully acknowledging the betrayal would threaten attachment, safety, stability, or belonging.

Moral numbing

Emotional shutdown, compartmentalization, or constricted moral awareness that helps a person keep functioning when the pain of responsibility, complicity, or institutional wrongdoing feels intolerable.

Shared function

These responses can be understood as survival adaptations under constraint rather than simple denial, weakness, or lack of insight.

(Smith & Freyd, 2014; Griffin et al., 2019)

Recognizing the survival bind

Relational signs

- “I know something is wrong, but maybe I am overreacting.”
- “Leaving would destroy my family, faith community, or identity.”
- Self-blame for not seeing it sooner

Institutional signs

- “I disagree with what is happening, but I cannot afford to leave.”
- Numbing to ethical distress to keep functioning
- Hopelessness about systems and leaders

Nervous-system presentation

- Anxiety/hyper-vigilance/chronic overfunctioning
- Shutdown/collapse/ dissociative distance
- May all signal survival under unresolved betrayal and moral conflict.

(Litz et al., 2009; Griffin et al., 2019)

Assessment: what to listen for

Differentiate from fear-only PTSD

Ask not only “What happened?” and “What symptoms followed?” but also “Who was depended on?” “What values were violated?” and “What does this mean about self, others, and the world?”

Sample questions

Where does the betrayal live—partner, family, church, workplace, healthcare system?
What is difficult to fully acknowledge?
What would it cost to see this clearly?
What values feel injured or compromised?

Attunement and pacing

Track activation, confusion, shutdown, and alliance safety. Assessment itself may need to be paced if fuller recognition threatens regulation, attachment security, or identity coherence.

(Litz et al., 2009; Gordon et al., 2004; Purcell et al., 2018)

Phase-based treatment framework

1. Stabilize

Safety, naming betrayal, grounding, nervous-system regulation, alliance attunement

2. Process

Structured work with traumatic meanings, stuck points, guilt, shame, anger, grief

3. Repair

Meaning-making, values clarification, moral repair, trust decisions

4. Re-engage

Boundaries, relational choice, institutional navigation, committed action

(Litz et al., 2009; Griffin et al., 2019)

Intervention options within the model

CPT-informed work

Useful for betrayal-related and moral-injury stuck points such as "I was foolish for trusting," "I failed my values," or "Everyone in authority will betray me."

EMDR / brainspotting

Can support trauma processing when stabilization is adequate and targets are clearly conceptualized within the larger betrayal and moral meaning structure.

TrIGR / guilt work

Clarify actual responsibility, reduce hindsight bias, identify violated values, and consider reparative action where possible.

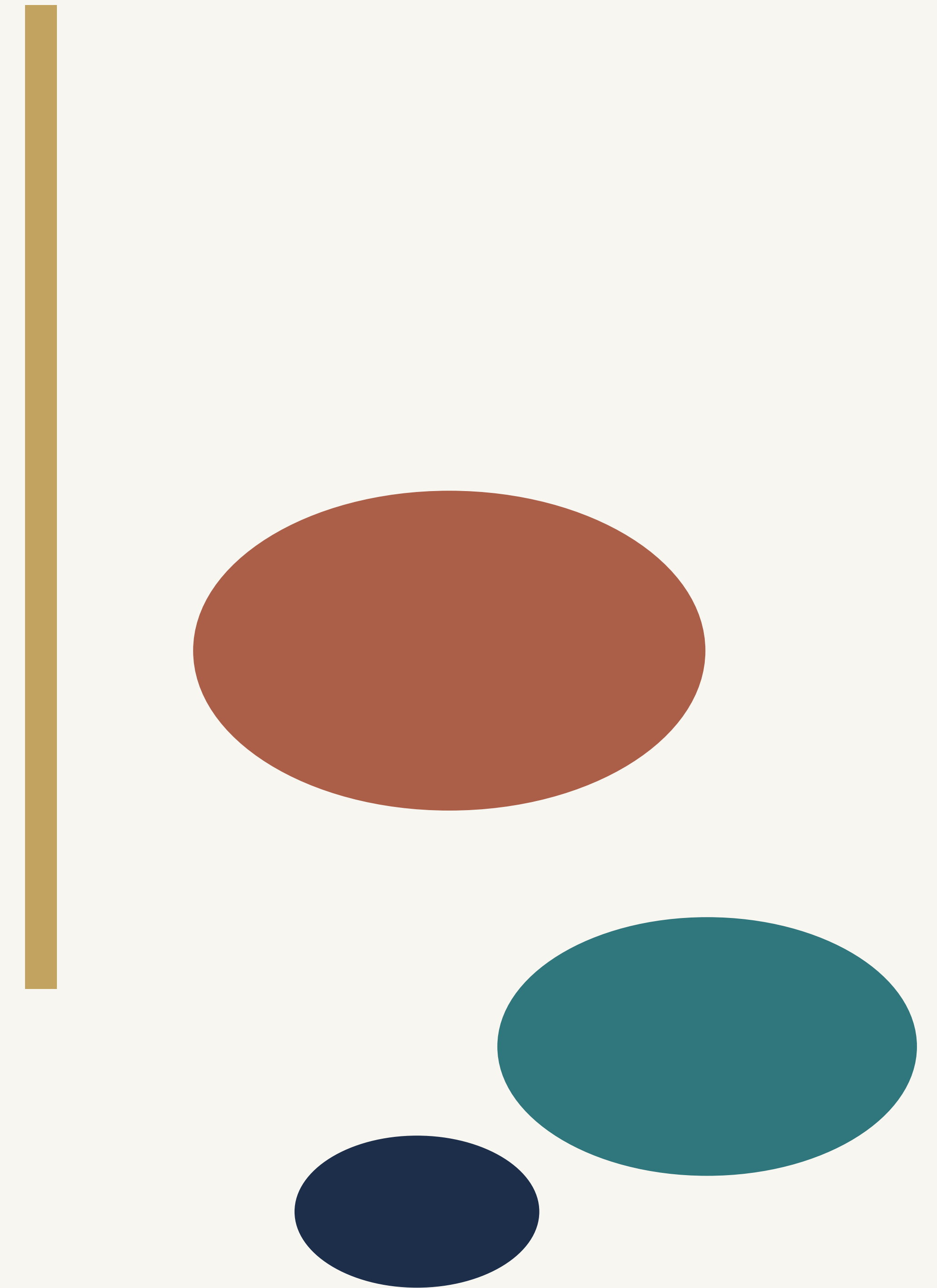
ACT / attunement / regulation

Support willingness, values-guided action, and nervous-system stabilization when leaving is not immediately possible.

(Norman et al., 2014; Griffin et al., 2019; Litz et al., 2009)

Creating Clinical Safety

- Check your bias.
- Do not assume you know what the client should do.
- Do not collude with shame-based statements.
- Maintain a curious stance.
- Avoid the assumption that time heals wounds.
- Remember "… the basic principle of a moral community, that injury to one is an injury to all," (Herman, 2023, p.88).
- "Survivors need truth and repair – acknowledgement, vindication, apology, and amends – from their moral communities," (Herman, 2023, p. 231).



Case application 1: partner after infidelity

Presentation

Partner chooses to remain in the relationship after discovery of infidelity. Symptoms include intrusive thoughts, hypervigilance, emotional flooding, self-blame, and moral conflict related to dignity, spirituality, and family commitments.

Conceptualization

Betrayal trauma appears in attachment rupture and safety disruption. Moral injury appears in appraisals about self-respect, complicity, values, and what staying means about the self. Personality-disorder-adjacent relational patterns may complicate recognition and repair.

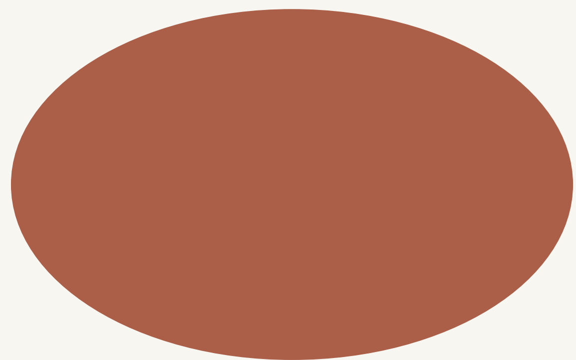
Treatment focus

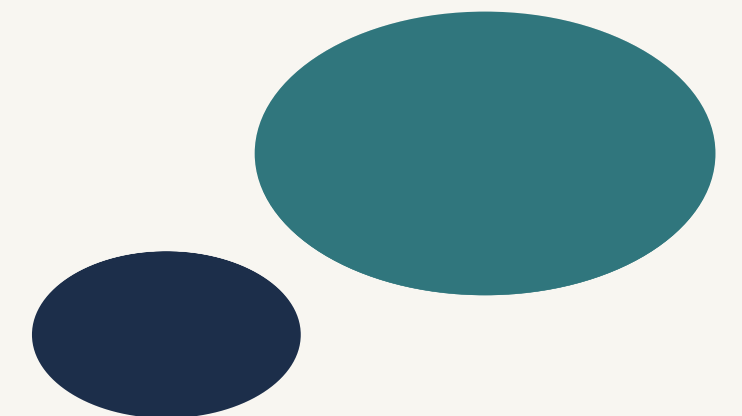
Stabilize, assess safety and consent, identify betrayal and moral stuck points, support values-informed choice, and avoid pressuring either immediate exit or premature forgiveness.

(Gordon et al., 2004; Purcell et al., 2018)

Clinical Targets

- Safety and stabilization (Herman, 1992/2015)
  - Return to baseline functioning
- Problem-solving
  - Identifying obstacles to functioning and treatment
- External voices of shame, judgement, and stigma
- Internal voices of shame, judgement, and stigma
- Ambiguity does not need to be solved in sessions.





Case application 2: clinician in a betraying system

Presentation

A clinician remains employed in a system that pressures ethically troubling choices, minimizes harm, or retaliates against dissent. The clinician reports numbness, anger, shame, exhaustion, and estrangement from professional identity.

Conceptualization

Institutional betrayal centers the system's failures, while moral injury reflects pain over complicity, constrained choice, and violated values. Anxiety, dissociation, and chronic overfunctioning may hide the depth of injury.

Treatment focus

Support accurate naming, reduce self-condemnation, widen choice awareness, regulate overwhelm, clarify values, identify feasible protective action, and process grief over lost trust in the institution.

(Griffin et al., 2019; Smith & Freyd, 2014)

Clinical stance and discussion prompts

Clinical stance

- Name betrayal without overpathologizing survival responses.
- Hold trauma, morality, and context together.
- Use attunement, pacing, and therapeutic presence as interventions in their own right, especially when fuller recognition threatens regulation or attachment security.

Clinical Curiosity

- Where in your setting do you see betrayal dynamics missed by a fear-only trauma lens?
- What signals suggest a client is preserving survival at the cost of awareness?
- How might treatment planning change when leaving is not immediately possible?

(Gordon et al., 2004; Griffin et al., 2019)

Clinical stance and discussion prompts

Treatment Task

1. Psychoeducation & normalization
2. Case conceptualization
3. Reclaiming life (client)
4. Updating trauma memory
5. Addressing meanings of trauma and aftermath
6. Trigger discrimination
7. Location work
8. Maintenance of change in thoughts and behaviors

Moral Injury Application

1. Psychoed on moral injury and trauma. Share other experiences.
2. Discuss role of symptoms
3. Values work, self-care, and identity
4. Reframes, examining the evidence
5. Address issues of shame, guilt, blame, and responsibility
6. Then vs. Now
7. Site visits, imaginal or in-vivo
8. Plan for sustained change

(Murray & Ehlers, 2021)

References

Freyd, J. J. (1996). *Betrayal trauma*. Harvard University Press.

Gordon, K. C., Baucom, D. H., & Snyder, D. K. (2004). An integrative intervention for promoting recovery from extramarital affairs. *Journal of Marital and Family Therapy, 30*(2), 213–231. https://doi.org/10.1111/j.1752-0606.2004.tb01235.x

Griffin, B. J., Purcell, N., Burkman, K., Litz, B. T., Bryan, C. J., Schmitz, M., Villierme, C., Walsh, J., & Maguen, S. (2019). Moral injury: An integrative review. *Journal of Traumatic Stress, 32*(3), 350–362. https://doi.org/10.1002/jts.22362

Herman, J. L. (2015). Trauma and recovery: The aftermath of violence – from domestic violence abuse to political terror. Basic Books. (Original work published 1992).

Herman, J. L. (2023). *Truth and repair: How trauma survivors envision justice*. Hachette Book Group.

Kidwell, M. C., & Kerig, P. K. (2023). To trust is to survive: Toward a developmental model of moral injury. *Journal of Child & Adolescent Trauma, 16*, 459-475. https://doi.org/10.1007/s40653-021-00399-1

Litz, B. T., Stein, N., Delaney, E., Lebowitz, L., Nash, W. P., Silva, C., & Maguen, S. (2009). Moral injury and moral repair in war veterans: A preliminary model and intervention strategy. *Clinical Psychology Review, 29*(8), 695–706. https://doi.org/10.1016/j.cpr.2009.07.003

Murray, H., & Ehlers, A. (2021). Cognitive therapy for moral injury in post-traumatic stress disorder. *The Cognitive Behavior Therapist*, *14*(8), 1-19. https://doi.org/10.1017/S1754470X21000040

References

Norman, S. B., Wilkins, K. C., Myers, U. S., & Allard, C. B. (2014). Trauma informed guilt reduction therapy with combat veterans. *Cognitive and Behavioral Practice, 21*(1), 78–88.

Purcell, N., Griffin, B. J., Burkman, K., & Maguen, S. (2018). “Opening a door to a new life”: The role of forgiveness in healing from moral injury. *Frontiers in Psychiatry, 9*, Article 498. https://doi.org/10.3389/fpsyt.2018.00498

Rokach, A., & Chan, S. H. (2023). Love and infidelity: Causes and consequences. *International Journal of Environmental Research and Public Health, 20*(5), 1-19. https://doi.org/10.3390/ijerph20053904

Smith, C. P., & Freyd, J. J. (2014). Institutional betrayal. *American Psychologist, 69*(6), 575–587. https://doi.org/10.1037/a0037564