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Research Article

When Psychological Safety is Violated by Authority: A Multiple Case Study of Power-Based Psychotrauma in Adult Clinical Clients

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Abstract. Psychological trauma has traditionally been conceptualized as a response to discrete, life-threatening events; however, accumulating clinical and theoretical work highlights trauma that arises from violations of expected care, safety, and ethical responsibility by trusted authority figures. This study examines power-based psychotrauma, conceptualized as a psychological injury that emerges when individuals or systems vested with authority or relational power betray fundamental expectations of protection. Using a qualitative multiple case study design, ten anonymized adult clinical cases were drawn from a private psychological clinic in the Philippines, all involving trauma perpetrated by caregivers, family members, intimate partners, or institutional superiors. Archival clinical case reports, including interview material and psychological assessment data, were analyzed using reflexive thematic analysis to identify patterned meanings across cases. Analysis yielded four interrelated themes: (a) Betrayal of Trust and Violation of Safety, reflecting the collapse of role-based protection when authority figures became sources of harm; (b) Complex Psychological Aftermath, characterized by multidimensional trauma sequelae including affect dysregulation, shame, dissociation, relational mistrust, and disturbances consistent with complex trauma presentations; (c) Powerlessness and Identity Disruption, capturing enduring impairments in agency, autonomy, and self-concept rooted in authority-mediated coercion and dependency; and (d) Coping and Meaning-Making in the Healing Journey, illustrating adaptive and maladaptive strategies through which survivors navigated avoidance, help-seeking, narrative reconstruction, and gradual restoration of agency. Interpreted through trauma theory beyond event-based PTSD, betrayal trauma theory, developmental and attachment frameworks, and clinical meaning-making models, the findings demonstrate that trauma perpetrated by trusted authorities produces psychological injuries that extend beyond fear-based symptomatology and are deeply shaped by power asymmetry and relational context. The study underscores the need for trauma-informed clinical interventions that explicitly address betrayal, agency restoration, and identity reconstruction, as well as ethical and institutional accountability in contexts where safety is expected but violated.

Keywords: *Psychotrauma; Complex trauma; Authority abuse; Betrayal trauma; Power dynamics.*

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Traumatic stress research has traditionally emphasized discrete catastrophic events, such as war, disaster, and assault, as prototypical sources of psychological trauma. This emphasis remains evident in the diagnostic formulation of posttraumatic stress disorder (PTSD), which requires exposure to a qualifying traumatic stressor and organizes symptoms around intrusion, avoidance, negative alterations in cognition and mood, and heightened arousal or reactivity (American Psychiatric Association, 2022). At the same time, contemporary trauma research increasingly recognizes that the psychological consequences of prolonged and repeated trauma may extend beyond these core PTSD symptoms, particularly when traumatic experiences occur within interpersonal relationships characterized by dependency, constraint, or limited possibilities for escape. The ICD-11 distinction between PTSD and Complex PTSD (CPTSD) reflects this development by identifying additional disturbances in self-organization involving affect regulation, negative self-concept, and interpersonal functioning (World Health Organization, 2019). Recent systematic review evidence further supports the clinical relevance of these domains and emphasizes the importance of considering developmental and cultural context when assessing complex trauma presentations (Sarr et al., 2024).

Within this broader understanding of trauma, the relational position of the person or system responsible for harm becomes particularly important. Psychological injury may be intensified when the source of threat is also a person or institution expected to provide protection, care, guidance, or ethical responsibility. In these circumstances, the injury involves more than exposure to danger: it may disrupt trust, attachment, agency, self-concept, and assumptions about the reliability of relationships and social systems. Herman's (1992) foundational account of prolonged interpersonal trauma emphasized that experiences occurring under conditions of captivity, coercion, or dependency can reorganize emotional and relational functioning around survival and powerlessness. Building from this relational perspective, the present study uses the term power-based psychotrauma as a conceptual framework for examining psychological injury arising when authority or relational power is used in ways that violate expected safety and care. The term is not proposed as a separate diagnostic category; rather, it directs analytic attention to the role of power asymmetry, dependency, and authority in shaping traumatic experience and its aftermath.

Betrayal Trauma Theory provides an important foundation for understanding this process. Freyd (1996) proposed that trauma perpetrated by a trusted or needed person differs psychologically from impersonal threat because the survivor may remain dependent on the very relationship in which harm occurs. Under such conditions, recognizing, resisting, disclosing, or escaping the betrayal may carry relational, material, or social costs. Strategies such as minimization, emotional disengagement, self-blame, or delayed recognition of harm may therefore function within a context in which preserving attachment or access to necessary resources is psychologically or practically important. Contemporary research continues to demonstrate the relevance of betrayal level to trauma-related outcomes. For example, Gómez (2021), examining an ethnically diverse sample, found associations between high-betrayal sexual trauma and adverse psychological outcomes, including dissociative symptoms, reinforcing the importance of relational closeness and betrayal in understanding traumatic impact. Authority adds another dimension to this process because formal or informal power can further constrain resistance and disclosure. Caregivers, intimate partners, supervisors, educators, clinicians, religious leaders, and other authority figures may control resources, approval, protection, opportunities, or social legitimacy, thereby shaping not only exposure to harm but also the survivor's perceived options for responding to it.

The consequences of authority-based betrayal may also extend beyond an individual relationship when institutions fail to prevent harm or respond adequately after disclosure. Smith and Freyd (2014) conceptualized institutional betrayal as organizational actions or omissions that compound harm among individuals who depend on institutions for protection, support, or justice. Recent evidence demonstrates that this construct remains relevant across institutional settings. A scoping review of 37 peer-reviewed empirical studies found a growing body of research linking institutional betrayal with adverse outcomes and emphasized its implications for institutional policy and practice (Christl et al., 2024). Institutional failure may therefore become a secondary source of psychological injury when survivors encounter silence, minimization, procedural obstruction, retaliation, or inadequate protection after an initial violation. In such situations, mistrust may extend from the individual perpetrator to broader systems that were expected to safeguard the person.

Related processes may also involve moral injury, particularly when actions or failures by trusted authorities violate deeply held expectations concerning duty, justice, protection, or ethical responsibility. Although moral

injury has been studied extensively in military contexts, its underlying emphasis on perceived moral transgression and betrayal by legitimate authority is relevant to understanding how violations of expected care can produce shame, anger, guilt, disillusionment, or disruption of meaning. A systematic review by Hall et al. (2022) found that moral injury-related experiences were associated with a range of mental and behavioral health outcomes, including PTSD symptoms, depression, anxiety, suicidality, substance use, and difficulties in meaning-making. These findings complement betrayal-based perspectives by demonstrating that psychological injury may be organized not only around fear of danger but also around the perceived violation of moral and relational expectations.

Developmental and social psychological perspectives further clarify why authority-mediated harm can have enduring effects. Foundational attachment theory proposes that early caregiving relationships contribute to internal models of safety, self-worth, and expectations of others (Bowlby, 1969/1982; Ainsworth et al., 1978). When a caregiver simultaneously occupies the position of protector and source of threat, the individual must adapt within a relationship in which dependency and danger coexist. Similarly, social power theory conceptualizes authority as the capacity to influence another person's outcomes through legitimate, coercive, reward-based, or other forms of power (French & Raven, 1959). When such power is used coercively, the survivor's perceived ability to refuse, leave, disclose, or seek protection may be restricted. Over time, responses that were adaptive under constrained circumstances—such as compliance, vigilance, emotional numbing, or avoidance—may persist beyond the original context. These processes can also affect meaning-making. Trauma may challenge assumptions concerning safety, justice, personal worth, and the predictability of relationships, requiring survivors to reconcile what occurred with previously held beliefs about themselves and those expected to protect them (Janoff-Bulman, 1992; Park, 2010).

These dynamics warrant particular attention within the Philippine context, where authority and psychological experience are embedded within culturally meaningful systems of relationship and obligation. Filipino psychology has emphasized kapwa, or shared relational identity, as central to interpersonal life, alongside culturally significant concepts such as pakikisama, hiya, and utang na loob (Enriquez, 1992; Pe-Pua & Protacio-Marcelino, 2000). These values can sustain belonging, reciprocity, and social support, but relational obligations and hierarchical expectations may also complicate disclosure when a person responsible for harm is an elder, caregiver, family authority, respected professional, or other socially significant figure. National evidence has documented substantial exposure to violence among Filipino children and young people, including violence occurring within relationships and settings in which safety would ordinarily be expected (Council for the Welfare of Children & UNICEF Philippines, 2016). Barriers to seeking formal psychological support remain relevant as well. Martinez et al. (2020), in a systematic review of Filipino mental health help-seeking, identified stigma, shame, financial and structural barriers, and preferences for informal support from family and close relationships as important influences on whether professional assistance is sought. These relational and cultural conditions make the Philippine setting particularly important for examining how authority, dependency, betrayal, disclosure, and recovery interact.

Collectively, contemporary work on CPTSD, betrayal trauma, institutional betrayal, moral injury, attachment, power, and meaning-making suggests that traumatic harm cannot always be understood adequately by considering the threatening event in isolation. Who caused the harm, what power that person or system held, what protection was reasonably expected, and what constraints existed on resistance or disclosure may all shape the psychological meaning and consequences of the experience. However, these perspectives have often developed within partially separate bodies of literature. Comparatively less attention has been given to clinically grounded, culturally situated examination of how these mechanisms converge across different forms of authority-based trauma, particularly within non-Western settings.

The present multiple case study examines ten anonymized clinical cases in which psychological injury occurred in contexts involving violations of safety by authority figures or other power-holders. Using reflexive thematic analysis, the study examines recurring patterns across diverse relational and institutional contexts while preserving attention to the particular circumstances of each case. Specifically, the study seeks to identify convergent patterns in (1) how authority-based violations are experienced and appraised, (2) the psychological and relational consequences associated with these experiences, and (3) the coping and meaning-making processes that may sustain distress or support recovery. By foregrounding power, dependency, betrayal, and culturally

situated relational expectations, the study aims to contribute a clinically grounded account of psychotrauma as a relational and systemic injury and to inform trauma-responsive approaches that emphasize safety, agency, validation, and accountability.

Methodology

Research Design

The study employed a qualitative multiple case study design (Yin, 2018) to examine power-based psychotrauma across varied relational and institutional contexts. This design was selected because it permits detailed examination of complex psychological experiences within their real-life contexts and supports both within-case and cross-case analysis. Rather than seeking statistical generalization, the study aimed for analytic generalization by identifying recurring patterns across heterogeneous cases that could contribute to conceptual understanding of authority-based psychological injury.

Each case consisted of an individual client's documented trauma history and psychological profile derived from a comprehensive clinical assessment report. Cases were treated as holistic units of analysis, encompassing developmental history, relational context, authority and power dynamics, symptom presentation, and meaning-making processes. The study was situated within a constructivist epistemological paradigm, recognizing trauma narratives as contextually situated accounts shaped by personal history, relational experience, sociocultural context, and clinical interpretation. Consistent with this orientation, reflexive thematic analysis (Braun & Clarke, 2006) was used to identify and interpret patterned meanings across cases.

Cases and Data

Ten cases were selected from the clinical archives of a private psychology clinic in the Philippines. Inclusion criteria were: (a) adult clients, ranging from young adulthood to approximately the mid-fifties; (b) a documented history of trauma involving betrayal or abuse by an authority figure or person in a position of power; and (c) completion of a comprehensive psychological evaluation. The sample comprised eight female and two male clients. Trauma histories included childhood physical and sexual abuse by caregivers or relatives, workplace sexual harassment within hierarchical relationships, chronic domestic abuse and marital betrayal, and combat-related trauma complicated by perceived institutional neglect.

To protect confidentiality, real names, exact ages, locations, dates, and other potentially identifying information were removed, generalized, or replaced with non-identifying case labels. Only information necessary to understand the trauma history, authority relationship, and relevant psychological processes was retained for analysis.

The primary data source for each case was an archival psychological assessment report, typically 15–25 pages in length. Reports contained demographic and psychosocial information, trauma and symptom narratives, interview material, psychological test findings, diagnostic formulations, and clinical recommendations. Where available, collateral information from family members or spouses was also documented and used to contextualize aspects of the case history. No new interviews were conducted for the study; the research involved secondary analysis of existing clinical records. Reports were written in English, although occasional client statements originally expressed in Filipino were translated into English for analysis.

Data Collection

Following ethical clearance and institutional permission, ten archival clinical reports meeting the inclusion criteria were compiled for analysis. Before analysis, all records were de-identified by removing or generalizing names, addresses, specific locations, dates, and other potentially identifying details. Each case was assigned an internal identifier to support systematic organization and cross-case comparison. Each report was read in full and reviewed repeatedly to establish familiarity with the client's developmental history, trauma experiences, presenting symptoms, relational context, and clinical formulation. Analytic attention focused particularly on descriptions of authority relationships, power asymmetry, dependency, coercion, betrayal, perceived violations of safety, and responses to disclosure or non-protection. Clinical observations, diagnostic impressions, and available psychological test findings were used as contextual information; however, the analysis remained qualitative and interpretive rather than score-driven. Diagnostic information served as a clinical anchor rather than as the primary unit of analysis.

Table 1. *Overview of Cases and Authority/Power Context Involved*

Sex	Approx. Age	Authority/ Power Holder Involved	Nature of Power Relationship	Brief Description
Case A	Adult	Former intimate partner	Emotional and relational power	Sexual assault by a trusted romantic partner, followed by traumatic grief and long-term PTSD symptoms
Case B	Young Adult	Extended family member (older cousin)	Familial authority and age-based power	Sexual assault during young adulthood, compounded by resurfacing of earlier childhood sexual abuse
Case C	Adult	Primary caregiver (mother)	Parental authority and dependency	Chronic physical, emotional, and psychological abuse throughout childhood
Case D	Adult	Military and organizational leadership	Institutional and occupational authority	Repeated exposure to life threatening events in conflict zones, compounded by perceived institutional neglect and leadership failures
Case E	Adult	Workplace superior	Hierarchical occupational authority	Sexual harassment and coercive behavior within a structured organizational hierarchy
Case F	Adult	Intimate partner (spouse)	Relational, emotional, and financial power	Prolonged emotional abuse, coercive control, and marital betrayal resulting in trauma related symptoms
Case G	Adult	Family caregivers and later authority figures	Familial dependency and relational power	Intrafamilial sexual abuse in childhood with subsequent patterns of exploitation and relational trauma
Case H	Young Adult	Caregiving adults	Adult authority and	Physical assault, intimidation, and sexual threat within a caregiving environment
Case I	Young Adult	Family members and school-related authority	Familial and institutional authority	Recurrent abuse by relatives and experiences of no protection within educational settings
Case J	Young Adult	Guardians /substitute caregivers	Custodial authority and dependency	Neglect, exposure to violence, and sexual threat under conditions of constrained autonomy

Note: All cases were derived from actual psychological assessment reports from a psychological clinic in the Philippines. Descriptions have been deliberately generalized to preserve confidentiality, while remaining faithful to the documented trauma histories and authority dynamics.

Data Analysis

Data were analyzed using reflexive thematic analysis following Braun and Clarke's (2006) six-phase framework, adapted for multiple-case qualitative synthesis. Coding and theme development incorporated both inductive attention to patterns arising from the case material and deductive attention to concepts relevant to the study's focus on authority, power, betrayal, safety, and meaning-making. During Phase 1, familiarization, each case was read repeatedly, and analytic memos were developed to record preliminary observations, relational dynamics, power asymmetries, and recurring psychological patterns. In Phase 2, initial coding, meaningful segments of text were systematically coded using qualitative data analysis software. Inductive codes reflected patterns expressed within the case material, such as feeling trapped, freezing during abuse, or fear of authority, whereas deductive codes were informed by the study's conceptual framework, including caregiver betrayal, coercive control, institutional non-protection, and meaning disruption. During Phase 3, when generating candidate themes, related codes were compared across cases and grouped by conceptual convergence and divergence. Attention was given to patterns recurring across different relational contexts, including family, intimate relationships, workplaces, and institutional settings. Negative or contrasting cases were also considered to clarify the boundaries and specificity of emerging interpretations. In Phase 4, reviewing and refining themes, candidate themes were evaluated against both coded material and the complete case narratives. The team revised, combined, or removed themes that overlapped, were insufficiently supported, or were overly broad. Themes were retained only when they were meaningfully represented across multiple cases rather than being dependent on an isolated narrative. During Phase 5, defining and naming themes, the central organizing concept of each theme was clarified and related to the study's aims. In Phase 6, producing the analytic account, the final themes were integrated with relevant case material and interpreted in relation to the study's focus on authority, power, betrayal, psychological consequences, coping, and meaning-making.

Reflexivity and Trustworthiness

Reflexivity was maintained throughout the analytic process because the researcher's training in trauma-informed clinical practice could shape attention to and interpretation of the case material. Reflexive memos were used to examine assumptions, document interpretive decisions, and maintain attention to adaptive responses, resilience, and agency in addition to psychological distress. An audit trail of coding decisions, theme development, and analytic revisions was maintained to enhance transparency.

Credibility was further supported through peer debriefing after theme development. An external licensed psychologist with expertise in trauma and no involvement in the study reviewed anonymized thematic summaries and selected case excerpts. The reviewer evaluated the coherence and clinical plausibility of the thematic structure, providing an independent check on the researcher's interpretations.

Ethical Considerations

Ethical approval for the study was obtained from the appropriate institutional ethics body, or the study was classified as ethically exempt in accordance with local and national research guidelines governing the use of fully de-identified archival clinical records. Despite exemption or expedited review status, the study adhered to stringent ethical standards consistent with the APA Ethical Principles of Psychologists and Code of Conduct.

Informed Consent. All clients whose case reports were included in the study had previously provided written informed consent during their clinical engagement, explicitly authorizing the use of anonymized clinical data for research and professional dissemination. Where feasible, the clinic made reasonable efforts to inform former clients of the present study; however, given the retrospective nature of the data, some clients were no longer reachable. In such cases, original consent documentation authorizing research use remained on file and was deemed sufficient.

Confidentiality and Anonymity. Strict confidentiality safeguards were implemented. All case materials were de-identified prior to analysis, and no real names of clients, family members, perpetrators, clinicians, institutions, or locations were used. Demographic details were generalized, and specific dates or unique circumstances were modified or omitted when not essential to thematic interpretation. To further reduce the risk of identification, the study reported results using composite or paraphrased excerpts rather than verbatim quotations.

Risk of Re-traumatization. As the study involved secondary analysis of existing records and did not include direct contact with clients, the risk of re-traumatization was minimal. Nevertheless, the researcher approached the data with care and respect, ensuring that the presentation of findings avoided sensationalism or graphic detail. The analytic and reporting process prioritized survivors' dignity and emphasized psychological meaning over descriptive excess.

Dual-Role and Conflict of Interest Management. Because the data source was a clinical setting in which professional relationships existed, potential dual-role conflicts were explicitly managed. The researcher did not analyze or interpret any cases for which they had been the treating clinician, thereby minimizing risks of bias or ethical ambiguity. Reflexive documentation further supported transparency in managing professional proximity to the data.

Results and Discussion

Reflexive thematic analysis of the ten clinical cases yielded four interrelated themes that characterize the experience of power-based psychotrauma across participants. These themes represent patterned meanings evident across cases rather than discrete categories, and they were derived through iterative within-case and cross-case analysis. Although presented separately for analytic clarity, the themes are conceptually and experientially interconnected. In particular, violations of safety and trust formed the foundational context from which complex psychological sequelae and enduring disruptions in agency and identity emerged, subsequently shaping coping strategies and meaning-making processes.

Themes

Betrayal of Trust and Violation of Safety

Across all cases, traumatic injury emerged within relationships or systems in which safety, care, or ethical responsibility was reasonably expected. Authority figures—whether caregivers, family members, intimate partners, or institutional superiors—became sources of harm rather than protection. This inversion of the expected safe haven was consistently described as profoundly disorienting and psychologically destabilizing. Participants did not frame the trauma solely in terms of physical danger or emotional injury; rather, they emphasized the shock of role violation, wherein individuals or systems entrusted with protection actively inflicted harm or failed to intervene. This betrayal was experienced as extending beyond the abusive acts themselves, fundamentally altering participants' assumptions about safety, trust, and relational predictability.

In cases involving childhood maltreatment (Cases C, G, H, I, and J), betrayal occurred within caregiving systems characterized by dependency, hierarchy, and limited avenues for escape. Participants described early internalized beliefs that adults—particularly parents and caregivers— were meant to provide safety, guidance, and containment. When these figures instead became perpetrators or passive bystanders, survivors reported confusion and disbelief alongside fear. Case C, which involved chronic physical and emotional abuse by a primary caregiver, illustrated this rupture clearly. In adulthood, the client reflected that "home never really felt safe," describing an early realization that protection within the family was conditional or illusory. This perception persisted long after the abuse ended, shaping the client's later difficulty trusting close relationships.

Similarly, Cases G and I involved intrafamilial sexual abuse compounded by family silence or minimization. In both cases, survivors described not only the violation itself but the psychological impact of non-response from other adults in the family system. One participant (Case G) noted that disclosure attempts were implicitly discouraged, conveying the message that "nothing would be done" and that maintaining family stability took precedence over personal safety. Case I described a similar experience, where abuse by relatives occurred alongside an absence of meaningful protection from other authority figures, reinforcing the belief that seeking help was futile. Across these cases, betrayal was experienced not only as interpersonal harm but as a systemic failure of care, wherein those responsible for safeguarding actively or passively withdrew protection.

Participants exposed to trauma in adolescence under custodial or substitute caregiving arrangements (Cases H and J) described heightened vulnerability due to constrained autonomy. These cases emphasized how authority-based betrayal was intensified by limited choice and dependence. One participant (Case H) described feeling unable to resist or leave an abusive environment, explaining that "there was nowhere else to go." This lack of alternatives magnified the sense of entrapment and reinforced the internalized belief that safety could not be assumed even in spaces designated for care.

Betrayal was not confined to childhood. In adult intimate relationships (Cases A and F), violations of trust occurred through sexual assault, coercive control, emotional abuse, and relational deception. In these cases, authority operated through relational, emotional, and sometimes economic power, rather than formal hierarchy. Participants described trauma not only as violation of bodily or emotional boundaries but as the collapse of fundamental assumptions regarding mutual care, honesty, and protection within intimate partnerships. Case A, for example, described a clear psychological demarcation between life before and after the assault, noting that intimacy was no longer experienced as safe or predictable. Case F similarly articulated a shift from perceiving the partner as a source of support to recognizing a pattern of control and emotional harm, which retrospectively reframed the relationship as unsafe.

Across these adult cases, participants emphasized a "before-and-after" rupture in relational meaning. Trust, once assumed as inherent to intimacy, became conditional and fragile. As one participant (Case F) reflected, closeness was now accompanied by vigilance, with kindness perceived as potentially deceptive. These narratives highlight that betrayal in adult relationships functions not merely as loss or grief but as trauma to relational schemas, reshaping how safety and attachment are conceptualized moving forward.

Authority-based betrayal also emerged within institutional and occupational settings (Cases D and E), where formal hierarchies constrained resistance and disclosure. Case E involved sexual harassment by a workplace superior, with professional authority and career dependence creating an environment of fear and silence. The participant described reluctance to report the behavior due to concerns about retaliation and credibility, indicating that authority functioned as a structural barrier to safety. The trauma, in this case, was not limited to the harassment itself but extended to the experience of navigating a system perceived as prioritizing hierarchy and reputation over individual well-being.

Case D, while involving exposure to external threat, was marked by perceived institutional failures and leadership neglect. The participant described a sense of moral injury arising from the belief that those in command failed to uphold their responsibility to protect, resulting in enduring anger, disillusionment, and loss of trust in institutional authority. The injury here was framed less in terms of fear and more in terms of ethical betrayal, wherein leadership's inaction or indifference violated deeply held expectations of duty and care.

Across institutional contexts, betrayal was amplified when systems tasked with protection appeared to privilege control, continuity, or reputation over safety and accountability. Participants consistently interpreted such responses as confirmation that authority could not be relied upon, reinforcing patterns of silence, self-doubt, and disengagement from formal support systems.

Complex Psychological Aftermath

Across all cases, authority-based trauma was followed by a multidimensional constellation of psychological sequelae that extended beyond circumscribed posttraumatic fear responses. While symptom profiles varied in severity and expression, participants consistently exhibited complex posttraumatic reactions affecting emotional regulation, self-concept, relational functioning, and meaning-making. These patterns were not reducible to isolated symptoms but reflected enduring reorganizations of psychological functioning shaped by betrayal, dependency, and power asymmetry.

Most participants demonstrated core trauma symptoms, including intrusive memories, physiological reactivity to reminders, avoidance of trauma-associated cues, and persistent hyperarousal. However, the triggers for these symptoms were frequently relational rather than situational. Rather than responding primarily to environmental danger cues, participants described intense reactions to interpersonal signals that resembled authority dynamics, such as changes in tone of voice, facial expressions, proximity, or perceived disapproval.

For example, Case B reported dissociative episodes triggered by routine intergenerational family interactions, particularly when older relatives engaged with younger family members. The participant described feeling "suddenly not present" during these interactions, accompanied by somatic freezing and emotional detachment. Similarly, Case E described pronounced physiological anxiety in response to authority-linked sensory cues within professional environments, noting that the presence of a superior figure or even sensory reminders associated with the workplace (e.g., particular sounds or spatial arrangements) elicited rapid heart rate, muscle tension, and difficulty concentrating. These reactions illustrate how trauma reminders became embedded in interpersonal and hierarchical contexts, reflecting the relational nature of the original violations.

Hypervigilance across cases was therefore interpersonally oriented. Participants described continuously monitoring others for signs of threat, particularly those occupying positions of power. One participant (Case F) noted being "constantly alert to shifts in mood or voice," interpreting minor expressions of irritation as potential precursors to harm. This pattern suggests that trauma-related arousal was organized around anticipatory threat detection within relationships, rather than generalized fear of the environment.

Beyond core trauma symptoms, participants exhibited marked disturbances in affect regulation, consistent with complex trauma presentations. Emotional experiences were often described as unstable, overwhelming, or blunted. Several cases (notably Cases B, C, and G) included histories of suicidal ideation or self-harm, typically emerging during periods of heightened shame, perceived abandonment, or relational rupture. These behaviors were often framed by participants as attempts to escape intolerable internal states rather than explicit desires to die.

Participants frequently described oscillations between emotional flooding and emotional numbing. Case C, for instance, reported episodes of intense anger and despair alternating with periods of emotional detachment, during which feelings were described as "shut off" or inaccessible. Case G similarly described using emotional numbing as a means of maintaining daily functioning, stating that feeling "nothing" was preferable to the pain associated with remembering or anticipating relational harm.

Anger was present across cases but was often unexpressed or redirected inward. Participants described difficulty articulating anger toward perpetrators or authority figures, instead experiencing irritability, guilt, or self-directed hostility. In several cases, anger manifested as chronic tension, short temper, or somatic complaints rather than outward expression. One participant (Case A) described becoming "easily irritated with people who did nothing wrong," later recognizing this as displaced anger that felt unsafe to express directly.

Shame and self-blame emerged as pervasive and organizing affects across cases, particularly among individuals

exposed to trauma during childhood or adolescence. Participants frequently questioned their own role in the abuse or interpreted the harm as evidence of personal defect, weakness, or failure. This internalization was especially pronounced in cases involving prolonged caregiver betrayal, such as Case C, where negative self-evaluations had become deeply entrenched. The participant described long-standing beliefs of being "fundamentally flawed," which persisted even in the absence of ongoing abuse.

Self-blame often intensified following unsuccessful disclosure attempts. When participants were met with disbelief, minimization, or silence, shame became further embedded in their self-concepts. Case G described feeling that speaking about the abuse had "only made things worse," leading to the conclusion that silence was safer and that the harm must have been deserved or exaggerated. In such cases, the absence of external validation reinforced internalized blame, transforming relational betrayal into a core identity feature.

These patterns reflect how authority-based trauma not only generates distress but actively reshapes how survivors evaluate themselves. Shame functioned not merely as an emotional reaction but as a cognitive– affective lens through which subsequent experiences were interpreted, influencing self-esteem, relational engagement, and help-seeking behavior.

Participants also demonstrated enduring cognitive and existential disturbances following authority-based trauma. Many endorsed persistent negative beliefs about themselves, including perceptions of incompetence, worthlessness, or inability to make sound judgments. Beliefs about others were similarly altered, with participants expressing chronic distrust of authority figures and expectations of harm within close relationships. Case F articulated a belief that "closeness always comes with risk," resulting in guardedness even in supportive relationships.

In several cases (notably Cases B and I), spiritual and moral beliefs were disrupted following perceived institutional or community non-protection. Participants described losing faith in religious, familial, or societal structures that were expected to uphold moral order and protect vulnerable individuals. Case B, for instance, described distancing from previously held spiritual beliefs after abuse occurred within a community context that failed to intervene. This loss of faith was experienced as deeply unsettling, contributing to a broader sense of existential disorientation and mistrust in social systems.

Powerlessness and Identity Disruption

A third theme reflected enduring disruptions in agency, autonomy, and identity, rooted in the original power asymmetries that characterized participants' traumatic experiences. Across cases, authority-based harm was not experienced as an isolated violation but as a condition of constrained choice, in which resistance, escape, or refusal were perceived as impossible or dangerous. Participants consistently described feelings of helplessness during the trauma itself, often characterized by freezing, compliance, or dissociation in response to coercion by authority figures. These responses were later reinterpreted by participants as evidence of weakness, despite being adaptive survival reactions at the time.

In cases involving childhood abuse and early dependency (notably Cases C, G, H, and I), the inability to resist or escape authority figures became internalized as a broader and more enduring sense of powerlessness. Participants described learning, often implicitly, that asserting needs or boundaries was ineffective or punished. This learning generalized beyond the original trauma context and persisted into adulthood.

For example, Case C, who experienced chronic abuse by a primary caregiver, later described an entrenched belief that "speaking up never changes anything," which manifested as passivity in adult relationships and difficulty making independent decisions. Similarly, Case G reflected that early experiences of being ignored or silenced during abuse led to a pattern of enduring harmful situations without protest, stating that "it feels safer to endure than to challenge." These narratives illustrate how traumatic power asymmetries became encoded as relational expectations, shaping later behavior even in contexts where objective power differentials were no longer present.

In adulthood, this internalized powerlessness frequently manifested as difficulty with assertiveness, boundary-setting, and self-advocacy, particularly in relationships involving perceived authority. Case F, for instance, described significant impairment in functioning independently following prolonged relational domination by an

intimate partner. Even after the relationship ended, the participant reported panic when faced with routine decisions and expressed a persistent belief that competence depended on another person's approval. Rebuilding a sense of personal efficacy required sustained therapeutic intervention, underscoring the depth of agency disruption produced by relational power abuse.

Identity development was notably disrupted among participants exposed to trauma during formative developmental periods. Several cases reflected identity diffusion or trauma-defined self-concepts, in which participants described themselves primarily through the lens of the abuse. Self-descriptors such as "damaged," "broken," or "always the one at fault" appeared across narratives, suggesting that trauma had become a central organizing feature of identity rather than an experience that occurred to an otherwise intact self.

Case C articulated feeling "stuck" in the role of the powerless child even in adulthood, describing difficulty accessing a sense of self separate from the family dynamics in which the abuse occurred. Case I similarly reported uncertainty about personal preferences, values, and future aspirations, noting that survival-oriented adaptation had taken precedence over identity exploration. These accounts align with clinical descriptions of developmental arrest or identity foreclosure following chronic interpersonal trauma.

Several participants also described a fragmented or divided sense of self, with trauma-related parts perceived as frozen at the age or emotional state of the abuse, while functional adult roles were performed in parallel. One participant (Case G) described experiencing a "younger part" that remained fearful and submissive, alongside an adult self-responsible for work and caregiving. This internal division contributed to feelings of unreality, inconsistency, and confusion about personal identity, reflecting the dissociative organization often observed in complex trauma.

Participants' relationships to power following trauma varied, reflecting different adaptive strategies aimed at preventing re-victimization. Some participants became averse to positions of authority, associating power with harm, corruption, or moral danger. For example, Case F declined leadership opportunities, expressing fear that occupying authority would either expose them to harm or risk replicating abusive dynamics. This avoidance was framed not as lack of ambition but as a protective stance shaped by prior experiences of power misuse.

Other participants adopted hyper-vigilant or oppositional orientations toward authority. Case E, for instance, described heightened sensitivity to hierarchical dynamics and a readiness to challenge perceived unfairness or control, noting that "it feels dangerous to assume authority will be safe." While this stance provided a sense of protection and moral clarity, it also contributed to interpersonal strain and occupational stress.

A smaller subset demonstrated compensatory over-control behaviors, such as perfectionism, rigid self-discipline, or excessive responsibility-taking, as efforts to reclaim a sense of agency. These behaviors were often described as necessary to maintain safety and predictability but were also recognized as exhausting or self-punitive. Case H, for example, described developing strict routines and high personal standards as a way of preventing chaos, later recognizing this as an attempt to counteract early experiences of unpredictability and helplessness.

Coping and Meaning-Making in the Healing Journey

The final theme captured the diverse, evolving, and often nonlinear strategies participants used to cope with authority-based trauma and to construct meaning in its aftermath. Coping responses ranged from avoidance and emotional numbing to active engagement in psychotherapy, advocacy, and identity reconstruction. Across cases, coping was not static; rather, it reflected stage-dependent adaptations shaped by perceived safety, availability of support, and the individual's readiness to confront traumatic material.

Avoidance and suppression emerged as common early coping strategies, particularly in contexts where disclosure was perceived as unsafe or futile. Several participants described prolonged periods of emotional compartmentalization, during which attention was redirected toward productivity, caregiving, or spiritual practices as a means of maintaining daily functioning. These strategies were often described as necessary for survival rather than deliberate avoidance.

For instance, Case A described immersing herself in work and parenting responsibilities, noting that staying

constantly occupied helped keep intrusive memories "at bay." Similarly, Case E initially minimized workplace harassment, framing it as something to be endured rather than addressed, in part due to fears of professional retaliation. In other cases, spiritual reliance functioned as a coping resource; Case C described prayer as a way to "hand over" distress when speaking about the abuse felt impossible. While these strategies provided short-term stability, participants frequently reported that they lost effectiveness over time, particularly as life transitions or cumulative stressors reduced the capacity for emotional suppression.

Across cases, avoidance was associated with delayed help-seeking and symptom escalation. Participants described reaching a point at which previously effective strategies no longer contained distress, prompting emotional crises or functional impairment that led them to seek professional support. This pattern suggests that avoidance served an initially adaptive role but ultimately necessitated transition toward more integrative coping approaches.

In several cases, participants engaged in maladaptive coping behaviors, including substance use and self-harm, particularly during periods of heightened emotional overwhelm. These behaviors were interpreted within the analysis as attempts to regulate intolerable affect or reclaim bodily control, rather than indicators of moral weakness or character pathology.

Case A reported using alcohol nightly in early adulthood to dampen nightmares and hyperarousal, describing it as "the only way to sleep." Case C engaged in self-harm during adolescence, framing it as a means of externalizing emotional pain and exerting control over bodily sensation in the context of pervasive powerlessness. These behaviors often emerged in the absence of relational support and diminished as participants accessed trauma-informed care and developed alternative emotion regulation strategies.

Importantly, participants demonstrated insight into the functional role these behaviors played in survival. Several described recognizing, in retrospect, that such coping strategies were attempts to manage emotions that had previously felt unmanageable. This reframing was itself part of the meaning-making process, allowing participants to view past behaviors with greater self-compassion rather than shame.

Social support functioned as a critical moderating factor in coping trajectories across cases. Participants who encountered belief, validation, or active protection following disclosure consistently described these experiences as turning points in their recovery. Even a single supportive relationship appeared sufficient to disrupt entrenched patterns of silence and self-blame.

For example, Case B described a significant shift after a caregiver acknowledged the abuse and facilitated access to therapy, stating that being believed made it possible to imagine survival beyond the trauma. In contrast, participants whose disclosures were met with minimization or silence reported prolonged distress, intensified shame, and delayed recovery. Case G described withdrawing further after family members discouraged discussion of the abuse, concluding that "keeping quiet was safer than being dismissed."

These contrasting trajectories underscore the role of relational validation in trauma recovery. Supportive responses did not eliminate symptoms immediately but created conditions in which adaptive coping and meaning-making could begin.

Meaning-making processes evolved gradually and were marked by substantial variability across participants. Early narratives were often characterized by self-blame, confusion, or minimization, reflecting attempts to reconcile the trauma with existing beliefs about authority, family, or self-worth. Over time, some participants began to reframe responsibility, recognizing authority abuse as a violation of duty rather than evidence of personal failure.

Case A articulated a shift from self-condemnation ("I caused this by trusting") to a clearer attribution of responsibility ("the harm resulted from abuse of power"). Case C described coming to understand caregiver abuse as rooted in dysfunction rather than personal defect, which reduced entrenched shame. These narrative shifts did not occur abruptly; participants described oscillating between old and new interpretations, particularly during periods of stress.

In later stages of recovery, several participants identified emerging sources of purpose or agency. This included advocacy (Case E), caregiving roles informed by heightened sensitivity to others' vulnerability (Case F), or professional aspirations connected to lived experience (e.g., interest in mental health or social services). Such developments were not universal and did not imply resolution of all symptoms; rather, they reflected expanded identity possibilities beyond trauma-defined self-concepts.

Engagement in psychotherapy was consistently described as a central context for coping and meaning reconstruction. Therapeutic relationships provided corrective relational experiences in which participants' perceptions were validated, and power dynamics were made explicit and collaborative. Participants emphasized the importance of being able to narrate their experiences without judgment or dismissal.

Several cases described psychotherapy as the first setting in which trauma-related language—such as "abuse," "betrayal," or "coercive control"—became available, allowing previously diffuse distress to be named and organized. Case C noted that learning terminology for trauma responses reduced self-pathologizing and fostered self-compassion. Even among participants with persistent symptoms, increased insight, emotional literacy, and self-acceptance were described as meaningful indicators of progress.

Discussion

The present multiple case study examined psychotrauma associated with violations of care, safety, and ethical responsibility by authority figures and other power-holders. Across the ten clinical cases, psychological injury was repeatedly organized around betrayal within relationships or systems in which protection was reasonably expected. The findings therefore draw attention not only to the traumatic experience itself but also to the relational position of the person or institution involved, the degree of dependency or power asymmetry, and the survivor's perceived capacity to resist, leave, disclose, or obtain protection. These patterns are consistent with contemporary trauma scholarship emphasizing that chronic interpersonal trauma can affect emotional regulation, self-concept, relationships, agency, and meaning in ways that extend beyond fear-based responses alone.

Trauma Beyond Event-Based Models

The findings are consistent with contemporary approaches that distinguish between the core symptoms of PTSD and the broader disturbances that may occur following prolonged or repeated interpersonal trauma. PTSD remains defined through exposure to qualifying traumatic events (American Psychiatric Association, 2022), while ICD-11 additionally recognizes Complex PTSD (CPTSD), characterized by core PTSD symptoms together with disturbances in self-organization involving affect dysregulation, negative self-concept, and relational difficulties (World Health Organization, 2019). Recent clinical scholarship continues to support the relevance of this distinction. Maercker et al. (2022) describe CPTSD as particularly associated with sustained or multiple traumatic exposures, including childhood abuse and domestic or community violence, while Sarr et al. (2024), in a systematic review of 36 studies, found that CPTSD is associated with greater symptom severity, impairment, and difficulties across several domains compared with PTSD.

The present cases demonstrated patterns resembling these disturbances in self-organization, including chronic shame, impaired affect regulation, relational mistrust, negative self-evaluation, and disruptions in identity. These similarities should not be interpreted as establishing CPTSD diagnoses across the sample; rather, they indicate convergence between the qualitative themes identified in this study and contemporary descriptions of complex posttraumatic adaptation. Importantly, the cases further suggest that chronicity alone may not fully explain these patterns. Within this sample, the relational meaning of the trauma—particularly whether harm involved betrayal by a trusted or needed authority—appeared important in shaping disruptions of trust, identity, and agency. This interpretation extends the discussion beyond the duration or intensity of traumatic exposure toward the relational conditions under which trauma occurs.

Betrayal Trauma and the Centrality of Authority

The findings are strongly consistent with Betrayal Trauma Theory (Freyd, 1996), which proposes that traumatic experiences involving a trusted or needed person may have distinctive psychological consequences because the survivor remains dependent on the relationship in which harm occurs. Across the present cases, dissociation, minimization, self-blame, delayed recognition of harm, and difficulty disclosing were particularly evident when

the person responsible for the harm occupied a caregiving, intimate, occupational, or institutional position of power. Such responses are consistent with the concept of betrayal blindness, in which awareness or acknowledgment of betrayal may be constrained when maintaining the relationship is important for attachment, safety, material security, or social belonging (Freyd, 1994, 1996).

More recent empirical work provides additional support for the relevance of betrayal to posttraumatic outcomes. Gómez (2021), examining an ethnically diverse sample of college students, found that high-betrayal sexual trauma was associated with dissociative symptoms and PTSD-related outcomes. Although the population and trauma type differ from those represented in the present study, these findings support the broader importance of relational closeness and betrayal in understanding traumatic impact. The current cases extend this perspective qualitatively by illustrating how authority may operate as an additional structural constraint: survivors may depend not only on an interpersonal relationship but also on the resources, approval, protection, employment, family position, or institutional legitimacy controlled by the person or system involved.

The findings therefore suggest that authority is not merely a characteristic of the perpetrator but part of the context through which trauma is interpreted and managed. Within this sample, power asymmetry influenced perceived options for resistance, escape, disclosure, and help-seeking. This may help explain why some participants normalized harmful experiences, remained silent, or questioned their own interpretations of events. The findings support greater attention to the question of who held power and what consequences resistance carried, alongside conventional assessment of what traumatic event occurred.

Power, Agency, and Developmental Timing

A further contribution of the findings concerns the relationship between power asymmetry and enduring disruptions in agency. Participants exposed to authority-based harm frequently described helplessness, freezing, compliance, or an inability to challenge the individual responsible for the harm. In some cases, these responses appeared to persist beyond the original traumatic context as difficulty asserting boundaries, making independent decisions, trusting personal judgments, or advocating for oneself. This pattern is consistent with longstanding accounts of powerlessness in prolonged trauma (Herman, 1992) and with attachment-based perspectives emphasizing the psychological consequences of threat occurring within relationships on which safety and development depend (Bowlby, 1969/1982; Main & Solomon, 1990).

The present findings also suggest that developmental timing may influence the breadth of these consequences. Participants whose trauma occurred within childhood caregiving relationships showed particularly pervasive disturbances involving identity, self-worth, trust, and relational expectations. Contemporary evidence supports the relevance of attachment processes to complex trauma. In a clinical sample of trauma-exposed adults, Karatzias et al. (2022) found that attachment orientation was significantly associated with disturbances in self-organization characteristic of CPTSD, particularly in relation to negative self-concept and interpersonal functioning. These findings provide contemporary empirical support for the present study's observation that disruptions originating within caregiving or dependency relationships may become incorporated into later understandings of self and relationships.

At the same time, the present cases demonstrate that profound authority-related injury is not restricted to childhood. Adult intimate-partner betrayal, workplace harassment, coercive relationships, and institutional failures were also associated with disruptions in agency, trust, and self-concept. Developmental vulnerability therefore should not be interpreted deterministically. Rather, the findings support a lifespan perspective in which earlier relational experiences, current dependency, cumulative exposure, and the meaning assigned to authority may interact in shaping posttraumatic responses.

Clinical Implications and Treatment Considerations

The findings have several implications for trauma-informed clinical formulation. Participants' narratives suggest that clinical attention limited to fear, avoidance, and intrusive recollection may not fully capture the difficulties associated with authority-based betrayal. Problems involving shame, mistrust, diminished agency, negative self-concept, interpersonal boundaries, and disrupted meaning were prominent across the cases. Assessment may therefore benefit from examining the relational context of trauma, including the survivor's dependency on the person or institution involved, perceived options for resistance or disclosure, subsequent responses from others,

and the meaning attributed to the betrayal.

Contemporary treatment evidence supports psychological intervention for complex posttraumatic presentations, while also indicating that treatment needs may vary according to trauma history and symptom profile. Hu et al. (2025), in a meta-analysis of randomized controlled trials involving adults exposed to complex trauma, found significant post-treatment improvements in PTSD symptoms, depression, anxiety, and dissociation following psychological interventions, with benefits for several outcomes maintained at follow-up. At the same time, treatment response varied, and the authors emphasized the need for further optimization and individual tailoring. The present qualitative findings do not establish the superiority of any particular treatment model, but they suggest that clinical formulation in authority-based trauma should explicitly consider agency, relational safety, attachment, shame, and meaning alongside conventional posttraumatic symptoms.

The therapeutic relationship may be particularly important in this context because therapy itself involves an asymmetry of professional authority. Survivors who have experienced harmful uses of authority may approach clinicians with mistrust, excessive compliance, reluctance to disagree, or fear of negative consequences for disclosure. Trauma-informed principles emphasizing transparency, collaboration, choice, empowerment, and respect therefore remain especially relevant (Substance Abuse and Mental Health Services Administration, 2014). These principles may help reduce the risk that therapeutic interactions unintentionally reproduce dynamics of silencing, dependency, or loss of control.

Meaning-making may also be important where authority violations are experienced as moral as well as interpersonal injuries. Hall et al. (2022), in a systematic review of 57 publications representing 49 samples, found that moral injury-related experiences were associated with PTSD, depression, anxiety, suicidality, substance use, and other adverse outcomes, with negative cognitions, social support, and meaning-making identified among potential explanatory mechanisms. Although much of that literature derives from military populations, it supports the present study's observation that some authority-based injuries involve not only fear but also anger, shame, disillusionment, and violation of expectations concerning duty, fairness, and protection.

Institutional Betrayal and Ethical Responsibility

The findings also converge with literature on institutional betrayal, in which organizations compound interpersonal harm through failure to prevent abuse, inadequate responses to disclosure, minimization, procedural obstruction, or other failures of protection (Smith & Freyd, 2013, 2014). Several participants in the present study described institutional or systemic responses as psychologically significant in their own right. Where individuals encountered silence, disbelief, non-protection, or perceived prioritization of institutional interests, these responses appeared to reinforce mistrust, helplessness, and the belief that seeking assistance was ineffective or unsafe.

Recent scholarship confirms that institutional betrayal remains an active and expanding area of trauma research. Christl et al. (2024), in a scoping review of 37 peer-reviewed empirical studies, documented a growing body of evidence concerning the individual costs associated with institutional betrayal and its implications for institutional policy and practice. This contemporary literature supports the present study's interpretation that psychological harm may be amplified when systems expected to provide protection or redress instead reproduce the power imbalance underlying the original violation.

From this perspective, recovery from authority-based trauma cannot be understood solely as an individual clinical process. Institutions and authority figures may contribute either to continued injury or to conditions that support recovery. Responses characterized by accountability, validation, procedural transparency, meaningful protection, and respect for survivor autonomy may help counter the dynamics of powerlessness and betrayal identified across these cases. Conversely, institutional silence, minimization, or self-protective responses may reinforce the original message that authority cannot be relied upon when protection is needed. The findings therefore underscore both a clinical and ethical responsibility to recognize how the exercise of power—and the institutional response when that power is misused—can shape the course of traumatic injury and recovery.

Conclusion

This multiple case study contributes to contemporary trauma scholarship by showing that psychotrauma may be

shaped not only by the nature of a harmful event, but also by the relational and structural conditions in which that harm occurs. Across ten clinical cases, experiences involving betrayal, dependency, and misuse of authority were associated with enduring disruptions in trust, agency, identity, emotional regulation, and meaning-making. These findings reinforce the importance of understanding trauma within relational, developmental, and systemic contexts, particularly when the person or institution responsible for harm also occupies a position expected to provide protection, care, guidance, or ethical responsibility.

A central insight of the study is that power asymmetry appears to influence how traumatic experiences are understood, endured, disclosed, and integrated. When survivors depend on authority figures or institutions for safety, belonging, resources, approval, or legitimacy, their capacity to resist, leave, disclose, or seek protection may be constrained. In this sense, the findings extend existing trauma perspectives by foregrounding authority and power as important contextual features in the formation and persistence of psychological injury. The study therefore supports a broader trauma formulation that considers not only what happened, but also who held power, what expectations of protection were violated, and what options were realistically available to the survivor.

The findings also have implications for clinical practice. Trauma assessment may benefit from explicitly exploring experiences of betrayal, coercion, dependency, institutional response, and loss of agency alongside conventional posttraumatic symptoms. Therapeutic work with survivors of authority-based trauma may likewise require particular attention to relational safety, collaboration, validation, boundary restoration, self-trust, and the rebuilding of agency. Because previous misuse of authority may shape how survivors respond to clinicians and other professionals, trauma-informed care should remain sensitive to power within the therapeutic relationship itself.

At the same time, the study highlights that recovery is not solely an individual psychological process. Participants demonstrated adaptive capacities through help-seeking, boundary formation, meaning reconstruction, and gradual restoration of agency, but these processes were strengthened when relational and institutional contexts provided safety, validation, and accountability. Conversely, silence, minimization, or institutional self-protection may reproduce the power dynamics associated with the original harm. The findings therefore underscore an ethical and systemic responsibility for institutions to respond to disclosures with transparency, protection, accountability, and respect for survivor autonomy.

Future research should examine whether these patterns are transferable across broader and more diverse populations and institutional settings. Studies involving public mental health services, schools, workplaces, faith-based organizations, and community settings may clarify how authority-based trauma manifests across different social structures. Cross-cultural research is also warranted to examine how hierarchy, collectivism, family obligation, and culturally shaped expectations of authority influence betrayal, disclosure, help-seeking, and recovery. Prospective, longitudinal, mixed-methods, and quantitative studies could further examine authority- and betrayal-related constructs in relation to symptom severity, dissociation, identity disruption, relational functioning, and recovery over time.

Intervention research may also help determine whether standard trauma-focused approaches sufficiently address the needs of individuals affected by authority-based betrayal or whether additional emphasis on attachment, shame, agency restoration, trust, and meaning-making improves outcomes. Similarly, research on institutional response and repair could clarify how validation, accountability, protection, or continued silence influence long-term recovery.

Contributions of Authors

Author: conceptualization, proposal writing, data gathering, data analysis, writing of the manuscript

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