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A Double Betrayal: The Implications of Institutional Betrayal for Trauma-Related Symptoms in Intimate Partner Violence Survivors

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Intimate partner violence (IPV) is a global health concern that is known to result in a plethora of detrimental outcomes, among them trauma-related symptoms. According to the betrayal trauma theory, these outcomes may be rooted not only in the abusive partner's betrayal but also in institutional betrayal, namely institutions' failure to fulfill their obligations to provide safety, resources, and protection to IPV victims/survivors. Yet, thus far, research on institutional betrayal has been focused on survivors of abuse that occurred within an institutional context. This study aimed to explore the implications of institutional betrayal for trauma-related symptoms among survivors of IPV, while broadening the scope of institutional betrayal and exploring institutional betrayal in relation to varied contexts. An online survey was conducted among Israeli female adults using self-report measures. The sample consisted of 117 IPV survivors, $M_{age} = 39.35$ ($SD = 7.9$), who reported involvement of various institutions around their IPV. Regression models indicated that institutional betrayal had a unique effect in explaining all four clusters of trauma-related symptoms. The risk for clinically significant trauma-related symptoms increased by 3% ($OR = 1.03$) for each increase in institutional betrayal, after controlling for income, having children with the abusive partner, degree of IPV exposure, and being abused by multiple partners. The present results suggest that institutional betrayal can be a retraumatizing experience, amplifying trauma-related distress in IPV survivors.

Public Policy Relevance Statement

Institutional betrayal is an often-overlooked phenomenon among intimate partner violence victims/survivors. The present findings shed light on its outcomes and inform how to provide proper treatment and assistance after it has occurred. Further, it can assist in training of service providers and embracing trauma-informed policy in institutions in order to prevent institutional betrayal from occurring in the first place.

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Intimate partner violence (IPV), defined as physical, verbal, psychological, or sexual abuse perpetrated by a romantic partner (Saltzman et al., 1999), is a worldwide health concern that negatively impacts the well-being of millions of people around the world. Although both men and women may be victims of IPV, violence toward women tends to be more severe and more likely to result in physical harm (Archer, 2002). Moreover, according to evidence, IPV is the most frequent type of violence against women (World Health Organization, 2021), and its prevalence worldwide is estimated at 30%, although it is even higher in some regions

(Aftab & Khan, 2011; Garcia-Moreno et al., 2006; García-Moreno et al., 2013; Meekers et al., 2013). For victims, IPV may result in deleterious, even deadly outcomes, as in cases of violent attacks ending in femicide or suicide (World Health Organization, 2021). Additionally, research has found IPV to have diverse negative implications for survivors' physical and mental health, such as higher frequencies of chronic pain and sleeping difficulties, as well as elevated depression, anxiety, guilt, dissociation, and trauma-related symptomatology (Beydoun et al., 2012; Campbell, 2002; Dekel et al., 2019; Devries et al., 2013; Lahav et al., 2018, 2019, 2020; Siegel et al., 2022; Taft et al., 2011).

Trauma-related symptomatology consisting of intrusion (e.g., intrusive memories, nightmares, flashbacks), avoidance (e.g., efforts to avoid trauma-related thoughts or external reminders), hyperarousal (e.g., hypervigilance, irritability), and negative alterations in mood and cognitions (e.g., negative thoughts about oneself and others; American Psychiatric Association, 2013) is the most studied sequelae in the aftermath of IPV (Campbell, 2002; DeJonghe et al., 2008; Dutton, 2009; Golding, 1999; Jones et al., 2001). These symptoms, which are usually attributed to the posttraumatic phase, namely after the trauma ends (i.e., posttraumatic stress disorder symptoms), may also develop during trauma exposure when individuals are subjected to repeated attacks, as is often the case with an ongoing stressor such as IPV. Accordingly, trauma-related symptoms have been documented among individuals who reported being subjected to IPV presently or in the past (Dutton, 2009; Jones et al., 2001; Lahav, 2021).

The betrayal trauma theory developed by Freyd (1996, 1997) offers an important prism through which one may understand trauma-related symptomatology in the aftermath of IPV. According to this theory, being subjected to abuse within a close relationship, such as in the case of IPV, consists of an inherent interpersonal betrayal, as the perpetrator, who is often an attachment figure, not only fails to provide support and safety but also becomes the very source of threat and danger. This might lead to a state of *betrayal blindness*, wherein the abuse is unacknowledgeable to the victim, as it would jeopardize the relationship with the abuser (Freyd, 1997). Under these harsh conditions, the victim often tends to dissociate from the painful and traumatic experience as a way to preserve the essential attachment relationship, at the same time undergoing the harsh effects of the abuse (Freyd, 1996, 1997). This leads to various detrimental outcomes, with trauma-related symptomatology being one of them (Freyd, 1996, 1997). Research has lent support to this theoretical view, indicating higher prevalence of dissociation (Briere & Spinazzola, 2005) as well as of medical (Beck et al., 2009; Ross, 2005) and mental (Kaehler & Freyd, 2009; Trippany et al., 2006) difficulties in survivors of interpersonal trauma.

Yet, whereas interpersonal betrayal is inherent to IPV, another type of betrayal, which arises from the nature of the interactions between victims and institutions, may also occur and contribute to elevated trauma-related distress. According to the betrayal trauma theory (Smith & Freyd, 2013), individuals exhibit trust or dependence upon large institutions as they do in close relationships. In this vein, institutions can be considered a source of attachment, looked upon for providing safety and security (Lahav & Ben-Ezra, 2024; Mayseless & Popper, 2007). Furthermore, a sense of trust in institutions is considered a basic tenet in society and has been shown to underlie trust that individuals have among each other (Spadaro et al., 2020). It therefore mirrors the dependence and sense of trust that an IPV victim might have with significant individuals in her life. Thus, when these institutions fail to fulfill their obligations and to provide safety, resources, and protection, it poses a form of institutional betrayal that takes another toll on trauma victims' well-being and further exacerbates their distress (Smith & Freyd, 2013). Institutional betrayal may occur when institutions conduct deliberate acts (e.g., an institution commits a transgression or violation) or acts of omission (e.g., an institution does not enact suitable policies or does not respond to the victim's needs adequately). Examples of institutional betrayal are cases where institutions create an environment that legitimizes or facilitates abuse, or when institutions do not provide validation, support, resources, or even use sanctions and punishment toward victims (Smith & Freyd, 2013).

Several paths may explain the detrimental effect of institutional betrayal. According to the conservation of resources theory (Hobfoll, 1989), resource loss begets further losses in a negative spiral that is often set off by traumatic or stressful events. Institutional betrayal can be perceived as such a loss of resources (lack of backup or assistance in one's time of need from a figure or an institution that is otherwise considered a source of support), resulting in a sense of depletion of resources and increased vulnerability to posttraumatic distress (Hobfoll et al., 2016). Other mechanisms that might explain these negative outcomes of institutional betrayal relate to cognitive perceptions following stress or trauma. When faced with certain adversity, mental perceptions of actual or potential threats to one's integrity and safety (termed the hostile-world scenario; Shmotkin, 2005) can be hypersensitized, leading to an emphasis on threat and a perceived loss of competence (Shmotkin & Bluvstein, 2024). Victims might perceive cases of institutional betrayal as an occurrence that reinforces such negative engagement with the hostile-world scenario, chafing one's ability to cope.

Research, which has been mainly focused on sexual assault, has supported the betrayal trauma theory and revealed the detrimental outcomes of institutional betrayal on victims' well-being. Institutional betrayal was found to be related to elevated dissociation, anxiety, sexual dysfunction, trauma-related outcomes (Smith & Freyd, 2013), health problems (Smith & Freyd, 2017), depressive symptoms (Smith et al., 2016), and attempted suicide (Monteith et al., 2016). Research on institutional betrayal in the context of IPV, though, has been sparse. Although previous studies have revealed the harmful effect of negative interaction with institutions such as the law system (e.g., Laing, 2017; Roberts et al., 2015) or the police (e.g., Srinivas & DePrince, 2015) on the well-being of IPV victims, the vast majority of research has not explored both deliberate acts and acts of omission at the hands of institutions and thus could not fully capture the effects of institutional betrayal. In fact, to the best of our knowledge, only one study thus far has assessed betrayal trauma in the context of IPV. Results of this study, conducted among a sample of undergraduate students, indicated the same trend so that institutional betrayal was related to elevated distress manifested in depressive symptoms, posttraumatic stress symptoms, and anxiety symptoms, above and beyond the effects of physical violence, sexual violence, and psychological aggression inflicted by the partner (Lee et al., 2021). This study contributes to extant research on institutional betrayal by extending its findings to IPV victims and revealing that the extent of the negative outcomes related to the betrayal goes beyond the interpersonal trauma of IPV (Lee et al., 2021).

Although the aforementioned studies were of substantial importance as they validated the concept of institutional betrayal and have brought awareness to its implications for trauma-related distress, they suffer from a substantial limitation. Most studies have exclusively focused on victims of interpersonal trauma that *occurred within institutional contexts*, among people who are a part of the institution. For example, previous studies were conducted among individuals who were sexually assaulted on university campuses and in the U.S. Armed Forces (Monteith et al., 2016; Smith et al., 2016; Smith & Freyd, 2013). Similarly, the study by Lee et al. (2021) assessed the associations between institutional betrayal and psychological distress in the face of IPV on college campuses. Thus, these studies cannot reveal the victims' experience of institutional betrayal that may be rooted in their interactions with institutions to which they do not necessarily belong. Nor can these studies indicate whether victims' *overall* experience of institutional betrayal, which may result from their interactions with various institutions, contributes to their trauma-related distress.

This issue is imperative given the high prevalence of interpersonal trauma that takes place outside institutional contexts as well as the multiple institutions that victims may approach. In the case of IPV, specifically, many women may be abused by their partners outside any institutional context and may reach out to varied institutions (e.g., the police, the judicial system, welfare services, or health care providers) in order to get help. Failure of institutions to fulfill their obligations, such as minimizing or doubting the information given by victims, blaming victims, or withholding adequate protection measures, treatment, and resources, may form an institutional betrayal, which may be further traumatizing (Platt et al., 2009). The present study therefore aimed to fill this gap and explore the implications of institutional betrayal for trauma-related symptoms among women who reported lifetime exposure to IPV, while broadening the scope of institutional betrayal. To expand and diversify existing studies, we examined the overall experience of institutional betrayal in relation to various contexts. Therefore, institutional betrayal was explored with regard to formal institutions (or their representatives) that are likely to deliver help to women exposed to IPV: law enforcement institutions (e.g., police, courts of law), health institutions (e.g., physical and mental health systems, physicians, and psychotherapists), welfare services, and religious organizations. In order to study the unique contribution of institutional betrayal in explaining trauma-related symptomatology, its effects were assessed after controlling for sociodemographic variables and IPV features (i.e., income, sharing children with the abusive partner, degree of IPV exposure, and being abused by multiple partners vs. a single partner), which have been found to be linked with trauma-related symptoms (Bogat et al., 2003; Houskamp & Foy, 1991; Jones et al., 2001).

Based on the betrayal trauma theory, the two main hypotheses of the present study were as follows:

1. Institutional betrayal would be associated with elevated trauma-related symptoms.
2. Institutional betrayal would have a unique contribution in explaining trauma-related symptoms, above and beyond income, having shared children with the abusive partner, degree of IPV exposure, and having been abused by multiple partners.

Method

Participants and Procedure

The current research is part of a larger longitudinal study that focuses on the implications of IPV for women's well-being and is based on the first measurement of that study. This research employed a convenience sample of Israeli female adults using an online survey distributed on social media platforms (e.g., Facebook) and through the research participation of undergraduate psychology students in exchange for credit, via the Ruppin Academic Center website. Inclusion criteria were (a) being a woman, (b) being 18 years of age or older, and (c) having been in one or more romantic relationships during her lifetime. IPV lifetime exposure was identified based on the Revised Conflict-Tactics Scale (CTS-2; Straus et al., 1996). The survey, which was administered using the Qualtrics software (QualtricsLabs, Inc., Provo, Utah, United States), was distributed between February 6, 2023, and March 15, 2023, with a completion time of about 15–30 min. The Tel Aviv University and the Ruppin Academic Center institutional review boards approved all procedures and instruments (Approval Number 23-146). Clicking on the link to the survey guided potential respondents to a page that provided information about the purpose of the study, the nature of the questions, and a consent form. Participants were also provided with contact information of the research team and of several Israeli organizations that provide support/treatment for IPV. To avoid duplicative entries to the survey, a built-in option of the Qualtrics platform ("Prevent Ballot Box Stuffing") was used, and to uncover potential fraudulent entries by bots, records attached to IP addresses that were duplicated in the data set were discarded. Participants recruited via social media were invited to take part in a raffle for four $100 gift vouchers, and those recruited via the Ruppin Academic Center website received course credit.

A total of 1,708 women, of whom 1,645 (96.3%) were recruited via social media platforms and 63 (3.7%) were recruited via research participation of undergraduate psychology students, entered the survey but filled out only a portion of the study's questionnaires. Of them, only 558 (32.7%) were both classified as having lifetime exposure to IPV and provided data about whether there had been any involvement of institutions regarding their IPV exposure. Among this subgroup of participants, the majority ($n = 441, 79.1\%$) reported a lack of any institutions' involvement regarding their IPV exposure and thus were not included in the present study. The remaining 117 participants (20.9%), who reported the involvement of institutions regarding their IPV exposure, constituted the present sample. All participants in the present sample were recruited via social media platforms. Table 1 presents the demographic characteristics of the present sample. The vast majority of the sample were Jewish ($N = 107$, 91.5%), were secular ($N = 87$, 70.1%), and had average or above-average incomes ($N = 68$, 58.1%). The mean years of education in the sample was 14.9 years ($SD = 3.4$), the equivalent of an undergraduate degree in Israel. Participants reported various types of violence inflicted upon them by partners during their lifetime: All participants reported psychological violence (100%), 78.6% reported physical violence, and 69.2% reported sexual violence. Thus, the vast majority of the sample ($n = 108, 92.3\%$) was classified as having undergone at least two types of violence. The majority of the sample reported being inflicted with IPV at the hands

Table 1
Demographic Characteristics of the Study Sample

Characteristic	*M* (*SD*) or *n* (%)
Age	39.35 (7.9)
Level of IPV exposure	
Psychological abuse	5.77 (1.9)
Physical abuse	4.28 (3.7)
Sexual abuse	2.16 (2.2)
Injury	1.61 (1.7)
Total	12.09 (7.12)
Relationship status	
In a relationship	40 (34.2%)
Not in a relationship	77 (61.8%)
Education	
High school diploma or less	20 (17.1)
Vocational or other training	32 (27.3)
Undergraduate degree	34 (29.1)
Graduate degree and above	31 (26.5)
Religiosity	
Secular	83 (70.1)
Religious/conservative	32 (27.3)
Other	2 (1.7)
Income	
Below average	49 (41.8)
Average or above-average income	68 (58.1)
Having shared children with the abusive partner	
Yes	66 (56.4%)
No	51 (43.6%)
Number of abusive partners	
Was abused by a single partner	76 (65.0%)
Was abused by a multiple partner	41 (35.0%)
Duration of abusive relationship (years)	8.24 (7.84)

Note. $N = 117$. IPV = intimate partner violence.

of a single partner (65.0%) and having shared children with the abusive partner (56.4%). Additionally, 58.1% of the sample reported incidents of injury due to IPV. The average length of abusive relationships one had been in was 8.24 years ($SD = 7.84$).

Measures

Background Variables. Participants completed a Brief Demographic Questionnaire that assessed age, education, relationship status, religiosity, and income.

IPV Lifetime Exposure and Features of IPV. The degree of IPV exposure was assessed via 33 items from the CTS-2 (Straus et al., 1996) forming four subscales: physical violence (eight items), psychological violence (12 items), sexual violence (seven items), and injury resulting from IPV (six items). Participants were asked whether they had experienced the violent acts during their lifetime (no = 0/yes = 1). Scores for each subscale were calculated by summing up positive answers of relevant items. The total degree of lifetime IPV exposure was calculated by summing up positive answers for all 33 items. In addition, participants were asked to indicate (a) whether they have children with the abusive partners (no = 0, yes = 1) and (b) whether they were abused by a single partner or multiple partners (single partner = 0, multiple partners = 1). The CTS-2 has previously demonstrated good validity and reliability (Straus et al., 1996). This scale revealed good internal consistency for the total score in the present study (Kuder–Richardson Formula 20 = 0.92).

Trauma-Related Symptomatology in the Aftermath of IPV. Trauma-related symptoms were measured via a modified version of the Posttraumatic Stress Disorder (PTSD) Checklist–5 (Weathers et al., 2013). In this 20-item self-report measure, participants are asked to indicate the extent to which they experienced each symptom in the past month, on a 5-point Likert scale ranging from 0 (*not at all*) to 4 (*extremely*). The original version was adapted so that the index event was IPV exposure. Research has suggested that a cutoff score of 33 is a useful threshold for indicating clinical symptomatology (Bovin et al., 2016). The PTSD Checklist–5 has demonstrated high internal consistency and test–retest reliability (Bovin et al., 2016). This scale had good internal consistency in the present study for intrusion, avoidance, negative alterations in mood and cognitions, and hyperarousal clusters, as well as the total score ($\alpha = .92, .87, .92, .88, .96$, respectively).

Institutional Betrayal. Perceived institutional betrayal was measured via an adapted version of a new questionnaire developed by Bachem et al. (2020), which was partially based on the Institutional Betrayal Questionnaire–Health (Smith, 2017). First, participants were given examples for different institutions that they may have interacted with (police, welfare, judicial system, and health systems), and were asked whether there had been any involvement of institutions surrounding their IPV. Participants who indicated such involvement were asked to indicate the institutions that had been involved (e.g., police, welfare, judicial system, and health systems). Next, participants were presented with 16 items describing successes or failures on the part of institutions in fulfilling their obligations (e.g., "The institutions acted transparently"; "The institutions betrayed my trust in them"; "Their actions reflect interests other than enhancing my safety and wellbeing"; "The institutions covered up events of malpractice"; "The institutions did not take proactive steps to prevent the reoccurrence of abuse"). Participants rated their agreement with each of the 16 items on a 5-point Likert scale, ranging between 1 (*completely disagree*) and 5 (*completely agree*). The total score was calculated by summing up responses to all of the items. This scale revealed good internal consistency for the total score in the present study ($\alpha = .93$).

Analytic Strategy

The analyses were performed using R software. Given that sociodemographic variables and IPV features of income, having shared children with the abusive partner, degree of IPV exposure, and being abused by multiple partners (vs. single partner) have been found to be related trauma-related symptoms (Bogat et al., 2003; Houskamp & Foy, 1991; Jones et al., 2001), these variables were treated as covariates in the present analyses. Of the total sample size of 117 participants, none of the data were missing, and no imputation procedures were needed to fit the data in our study. We applied the Mahalanobis distance measure for our raw data to detect and omit multivariate outliers (Leys et al., 2018). No outliers were detected in our data. To explore the relationship between the study variables and trauma-related symptoms, association analyses were conducted. Pearson's correlations were conducted to assess continuous-by-continuous relationships, Pearson's point biserial correlation coefficient for continuous-by-nominal ones, and the χ^2's ϕ measure of association for nominal-by-nominal ones (Hollander & Wolfe, 1999).

All continuous data were tested for univariate and multivariate normality.

To explore the unique contribution of institutional betrayal above and beyond income, having shared children with the abusive partner, degree of IPV exposure, and being abused by multiple partners in explaining trauma-related symptoms, hierarchical linear regression models were conducted. The models consisted of three blocks: The first included income, the second included the features of abusive relationship (having shared children with the abusive partner, degree of IPV exposure, and being abused by multiple partners), and the third included the level of institutional betrayal. We applied the Anderson–Darling test for the normality of residuals on our estimation models (Razali & Wah, 2011). In cases where the data met the normality assumptions, an ordinary least squares model was fitted to the data. In cases where the data departed from normality, a bootstrapped model was fitted. Since this work is based on observational data, using a convenience sample, we applied the conservative case-based bootstrapping procedure. In such cases, the model's explanatory power was calculated using Nakagawa et al.'s (2017) bootstrapped R^2 measure. All models were tested for multicollinearity, and their residuals were also tested for the independence assumption. No multicollinearity or autocorrelation was found. To explore the contribution of institutional betrayal above and beyond income, having shared children with the abusive partner, degree of IPV exposure, and being abused by multiple partners in explaining the presence of clinically significant trauma-related symptoms (yes/no), a hierarchical logistic model was fitted to the data. Accordingly, model diagnostics included the commonly used Cragg and Uhler's (Nagelkerke) pseudo-R^2 value, the Hosmer and Lemeshow goodness of fit test, and the Omnibus test of model coefficients for the improvement of the nested model.

Power Analysis

A post hoc power analysis to compute achieved power for the given sample size ($N = 117$) was conducted using G*power. For hierarchical linear regression purposes, we applied Cohen's (1977) recommended effect size thresholds for a medium effect size ($f^2 = 0.15$). Results suggested that our sample was adequate for detecting all of the aforementioned effects, that is, providing a power of .99. For the hierarchical logistic regression purpose, the sample provided a power of .76, which is marginally below the required threshold of .80, and may call for some caution in the interpretation of these results. We note that the decision to perform a logistic regression is based on the satisfactory results of the linear regression, where the dependent binary variable is the cutoff value for the PTSD Checklist–5, used as dependent variables in the linear regression.

Results

Institutional Betrayal and Trauma-Related Symptoms in the Aftermath of IPV

Participants reported the involvement of several institutions regarding their IPV exposure: the police (70.9%), welfare system (51.8%), judicial system (46.2%), mental health systems (36.8%), physical health systems (15.4%), and religious authorities (6.0%). Thus, the majority of participants reported the involvement of two institutions or more ($n = 79$, 67.5%). The average of institutional betrayal was 51.71 ($SD = 18.46$), and the vast majority of the sample ($n = 97$, 82.9%) reported at least one manifestation of institutional betrayal. Of the total sample, 94.9% ($n = 111$) reported at least one intrusion symptom, 89.7% ($n = 105$) reported at least one avoidance symptom, 96.6% ($n = 113$) reported at least one symptom reflecting negative alterations in mood and cognitions, and 97.4% ($n = 114$) reported at least one hyperarousal symptom. The majority of the sample (59.8%, $n = 70$) had trauma-related symptoms above the cutoff indicating clinically significant symptomatology.

Associations Between Institutional Betrayal and Trauma-Related Symptoms

As can be seen in Table 2, the levels of institutional betrayal were positively and significantly correlated with trauma-related symptoms (all clusters as well as the total score): The greater the perceived institutional betrayal, the higher the levels of trauma-related symptoms. In addition, the total degree of IPV exposure, income level, and being abused by multiple partners were correlated with trauma-related symptoms (all clusters as well as the total score). Conversely, the correlations between having

Table 2
Correlations Between Study Variables and Trauma-Related Symptoms

Variable	1	2	3	4	5	6	7	8	9	10
1. Having shared children with the abusive partner (yes)	—									
2. Income (lower than average)	0	—								
3. Having been abused by multiple partners (yes)	.06	0	—							
4. Total degree of IPV exposure	.14	.19*	.11	—						
5. Institutional betrayal	.01	.22*	.05	.14	—					
6. Intrusion symptoms	.04	.24**	.27**	.29**	.36***	—				
7. Avoidance symptoms	.05	.19*	.22*	.27**	.31***	.80***	—			
8. Negative alterations in mood and cognitions	.04	.24**	.27**	.19*	.33***	.70***	.72***	—		
9. Hyperarousal symptoms	−.02	.24**	.27**	.22*	.36***	.72***	.66***	.83***	—	
10. Trauma-related symptom total score	.03	.26**	.30**	.26**	.38***	.88***	.84***	.93***	.92***	—
M (*N*)	66	49	41	12.09	51.72	9.06	4.18	13.98	11.80	39.03
SD (%)	56.4	41.8	35	7.12	18.46	5.74	2.44	7.58	6.09	19.75

Note. $n = 117$. Pearson's point biserial coefficient and ϕ measure of association serve as measures of association, where Pearson correlation is inapplicable. IPV = intimate partner violence.
* $p < .05$. ** $p < .01$. *** $p < .001$.

shared children with the abusive partner and trauma-related symptoms were nonsignificant.

The Unique Contribution of Institutional Betrayal in Explaining Trauma-Related Symptoms

Results of the linear regression models are presented in Table 3. The effect of income decreased in the nested models and became statistically insignificant in the last step of the analysis. The effect of the total degree of IPV exposure in explaining trauma-related symptoms was positive and significant, yet somewhat weak for some clusters, when introduced into the model. The addition of the institutional betrayal variable into the model further weakened this effect and canceled it altogether for the negative alterations in mood and cognitions, hyperarousal, and avoidance clusters. The effect of being abused by multiple partners remained positive and statistically significant for all four trauma-related symptom clusters. The effect of the institutional betrayal variable was positive and significant for all trauma-related symptoms clusters. Results of the likelihood ratio test indicated a good fit of this explanatory variable to the model and a significant increase in the model's overall coefficient of determination ($\Delta R^2 > 0.06$ with $p < .001$ for all four trauma-related clusters).

Results of the logistic regression model for explaining clinically significant trauma-related symptoms are presented in Table 4. Model fit indices indicated a good fit of the model to the data, $\chi^2(8, N = 117) = 5.65, p = .69$, and satisfactory improvement over the null model, $R^2 = 0.32, \chi^2(5, N = 117) = 31.8, p < .001$. The effects of the respondent's income, being abused by multiple partners, and the total degree of IPV exposure were all statistically significant in their initial contribution to the model, $R^2 = 0.25, \chi^2(3, N = 117) = 12.97, p < .001$. However, the effect of the total degree of IPV exposure was canceled when the institutional betrayal variable was introduced into the model. As in the linear regression models, the effect of sharing children with the abuser had no statistically significant effect in all stages of the estimation. The effect of the institutional betrayal variable was positive and significant, wherein a marginal increase of the betrayal score increased the risk for clinically significant trauma-related symptoms by 3% ($OR = 1.03$, 95% CI [1.01, 1.06]). The introduction of this variable to the model significantly contributed to the incremental explanatory power of the model, $\Delta R^2 = 0.07$, $\chi^2(1, N = 117) = 7.38, p = .007$.

Discussion

The present study is, to our knowledge, the first to explore the implications of the overall experience of institutional betrayal, which is not restricted to a specific institution, for trauma-related symptoms among survivors of IPV. The present findings suggest that the repercussions of institutional betrayal are not limited to cases where victims belong to the institution (Lee et al., 2021; Monteith et al., 2016; Smith et al., 2016; Smith & Freyd, 2013), but are also applicable to victims who experience failure of various institutions to fulfill their obligations to them. Results indicated that institutional betrayal had a unique effect in explaining all four clusters of trauma-related symptoms, above and beyond sociodemographic variables and IPV features. Additionally, the risk for clinically significant trauma-related symptoms increased by 3% ($OR = 1.03$) for each increase in institutional betrayal, after controlling for income, having children with the abusive partner, degree of IPV exposure, and being abused by multiple partners. We next review these results and suggest possible interpretations.

The connection between individuals and institutions resembles close relationships, wherein the institutions are expected to provide help and support to individuals in times of need (Smith & Freyd, 2013). Moreover, the asymmetry in power that characterizes the

Table 3
Regression Standardized Coefficients for Trauma-Related Symptoms

	Trauma-related symptom											
	Intrusion			Negative alteration in mood and cognitions			Hyperarousal			Avoidance		
Variable	β	R^2	ΔR^2	β	R^2	ΔR^2	β	R^2	ΔR^2	β[a]	R^{2b}	ΔR^2
Step 1												
Income (low than average)	2.82**	0.06	0.06**	3.75**	0.06	0.06**	3.01**	0.06	0.06**	0.94*	0.04	0.04*
Step 2												
Income (low than average)	2.37*			3.49*			2.68*			0.76		
Having shared children with the abusive partner (yes)	0.34			0.75			−0.17			0.21		
Having been abused by multiple partners (yes)	3.07**			4.20**			3.28**			1.03*		
Total degree of IPV exposure	0.17*	0.18	0.12**	0.11	0.15	0.09*	0.13	0.16	0.10**	0.07*	0.13	0.09**
Step 3												
Income (low than average)	1.66			2.65			1.92			0.50		
Having shared children with the abusive partner (yes)	0.32			0.72			−0.19			0.20		
Having been abused by multiple partners (yes)	2.91**			4.01**			3.11**			0.98*		
Total degree of IPV exposure	2.91**			0.09			0.10			0.06*		
Institutional betrayal	0.09***	0.26	0.08***	0.11**	0.22	0.07**	0.10***	0.24	0.08***	0.03**	0.19	0.06**

Note. $n = 117$. IPV = intimate partner violence.
[a] Case-based bootstrapped estimates. The p values were calculated through confidence interval inversion. [b] Bootstrapped R^2 measure.
* $p < .05$. ** $p < .01$. *** $p < .001$.

Table 4
Estimates of the Contribution of Study Variables to the Probability of Clinically Significant Trauma-Related Symptoms

Variable	β	*OR*	95% CI for *OR*	R^2	Improvement over last model (χ^2)
Step 1					
Income (low than average)	1.36**	3.88	[1.71, 8.84]	0.13	11.42***
Step 2					
Income (low than average)	1.39**	4.04	[1.66, 9.83]		
Having shared children with the abusive partner (yes)	0.32	1.38	[0.60, 3.23]		
Having been abused by multiple partners (yes)	1.20*	3.34	[1.32, 8.47]		
Total degree of IPV exposure	0.06*	1.07	[1.002, 1.13]	0.25	12.97***
Step 3					
Income (low than average)	1.21**	3.34	[1.34, 8.32]		
Having shared children with the abusive partner (yes)	0.30	1.34	[0.56, 3.23]		
Having been abused by multiple partners (yes)	1.23*	3.41	[1.30, 8.93]		
Total degree of IPV exposure	0.06	1.06	[1.00, 1.13]		
Institutional betrayal	0.03**	1.03	[1.01, 1.06]	0.32	7.38**

Note. $n = 117$. *OR* = odds ratio; CI = confidence interval; IPV = intimate partner violence.
* $p < .05$. ** $p < .01$. *** $p < .001$.

interactions between individuals and institutions places these individuals in a position of dependency, wherein their agency cannot be taken for granted (Platt et al., 2009). Thus, the failure on the part of institutions to meet their obligations and to provide assistance and protection does not only hinder IPV victims/survivors from receiving necessitated resources but also produces a traumatizing experience of betrayal, in addition to the one inflicted by their abusive partners (Platt et al., 2009; Smith & Freyd, 2013). In the context of IPV, this can be particularly debilitating for victims. According to Herman (1992) who suggested viewing IPV as a form of domestic captivity, the abusive partner uses tactics that aim not only to shatter the victim's self but also to annihilate the victim's internalized positive bonds with others, as a way to gain control over the victim and to deepen the power imbalance. Drawing upon this view, institutional betrayal appears to play into the hands of perpetrators on both practical and psychological levels. Deliberate inadequate service or acts of omission on the part of institutions may hamper survivors' ability to acknowledge the abuse and to extricate themselves from the violent relationships in a safe manner (Platt et al., 2009). Additionally, institutions' responses such as minimizing or doubting the information given by victims, blaming victims, or preventing them from appropriate protection, treatment, and resources may intensify survivors' feelings of distrust, isolation, guilt, and helplessness and may further reinforce the internalized victim–perpetrator dynamics wherein survivors' needs and emotions are downplayed, their perceptions and views are doubted or distorted (Lahav, 2021; Siegel et al., 2022), and their trust and dependency upon others are exploited (Platt et al., 2009). Institutional betrayal may, therefore, be experienced as an additional trauma that amplifies survivors' distress, and as the current finding demonstrates, its implications for trauma-related symptomatology may go above and beyond survivors' background characteristics as well as characteristics of actual IPV.

Important limitations of the study should be noted. First, its cross-sectional design limited the ability to determine the directionality of the associations. Second, the present study relied on convenience sampling and self-report measures, which may be subject to response bias and shared-method variance. Third, we did not control for previous potentially traumatic events other than previous IPV. Indeed, previous trauma, particularly interpersonal trauma, might converge with the effects of IPV. Although these might increase one's vulnerability to current traumas, we believe that current and past IPVs, which we did account for, still explain a significant proportion of the variance in our outcomes. Furthermore, we did not measure other concomitants of trauma-related symptoms such as severity and frequency of abuse by the same partner and time elapsed since the abuse. The latter, in particular, has been shown to predict negative outcomes of IPV (Fernández-Fillol et al., 2021). It is therefore important to include these in future studies. Fourth, although the exploration of institutional betrayal in relation to various institutions was a strength of the present study as it enabled encompassing IPV victims' experience of institutional betrayal, we did not measure levels of institutional betrayal for each of the relevant institutions. This may pose a limitation as it did not allow detecting institutions that are rated highest on institutional betrayal nor providing specific direction for intervention efforts. Thus, we highly recommend that future studies measure levels of institutional betrayal both overall and specifically for each institution. Finally, the present sample consisted of mostly Jewish, Israeli female survivors of IPV, thus limiting its generalizability. In order to elucidate the relations between institutional betrayal and trauma-related symptoms, future studies should explore these variables over time via self-report measures and clinical assessments among IPV survivors with diverse cultural backgrounds.

A methodological note that may be added to the limitations of our study is the statistical power of the logistic regression. Since this study is part of a longitudinal study, where respondents are recruited based on multiple criteria, response collection proves to be quite a complicated task. The fact that our study included 117 respondents may somewhat limit the robustness of the results, but cautionary methodological measures were taken throughout the analysis. These measures call for more conservative estimation methods, which produce higher probability values for our finding. A larger sample pool may have been able to increase the significance level of our findings and discover stronger effects for the measured statistical associations and dependencies.

Implications for Practice

Despite these limitations, this study has provided the first indication of empirical evidence concerning the implications of institutional betrayal for trauma-related symptoms among survivors of IPV that occurred outside the institutional context. Our findings indicate that institutions' failure to fulfill their obligations may be a form of retraumatizing for IPV survivors. Thus, it is imperative that institutions, which are often involved in providing services to IPV survivors, become more aware of the implications of their responses for survivors' well-being and strive to provide a safe, validating, and supportive environment that promotes survivors' safety and recovery. Specifically, compulsory training of service providers concerning the dynamic and obstacles that characterize complex interpersonal trauma, such as IPV, and embracing trauma-informed policy while interacting with survivors of IPV may be greatly beneficial. Such training should, for example, underscore the negative effect of institutional betrayal above and beyond other characteristics of IPV. This would educate service providers regarding its negative effects—thus helping to reduce or prevent institutional betrayal, but also assist IPV victims to recognize it and cope with it after it has occurred.

The present findings have clinical implications as well, which are applicable not only for clinicians who work in institutional settings but also for those who work in private settings as well. Our findings indicate that clinicians' awareness and evaluations of their clients' institutional betrayal experience are highly important and may contribute to early detection and inform treatment provision to vulnerable survivors who suffer from elevated symptomatology due to this additional trauma. Furthermore, service providers who work with IPV survivors should consider working collaboratively with institutions when cases of betrayal arise—provided survivors consent to this. Similar to psychologists working with school-age children who meet with teachers of their clients, this could assist to inform and educate members of those institutions regarding the incident of the betrayal, helping the survivor and the institution to carve a more collaborative path forward. In such cases, survivors could be empowered in advocating for themselves when interacting with institutional representatives.

Although actual face-to-face meetings can be advisable in some settings, given the discretion of the therapist and the survivor, there are other avenues for facilitating the coping process with institutional betrayal. One can, within the therapy session, assist the survivor to understand and come to terms with the institutional betrayal and help to make sense of what could help one to cope in that context. This exploration process must include a psychoeducational component, by the care provider, explaining that there are varied contexts in which institutional betrayal can potentially occur, including ones that seem unrelated to the original IPV. This can validate the experiences of many IPV survivors, who might feel subjected to the further stress of institutional betrayal in other contexts, without being aware of it as such. In the same vein, it is recommended that such adjustments be evaluated empirically. Thus, it is important to assess whether closer collaborations between institutions and mental health providers who work with IPV survivors, as well as implementing psychoeducation in therapeutic contexts regarding institutional betrayal, have a positive impact in lowering occurrences of institutional betrayal and helping to cope with it once it does occur.

Keywords: intimate partner violence, domestic abuse, institutional betrayal, trauma-related symptoms, posttraumatic stress symptoms

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