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Came to Serve, Left Betrayed: Military Sexual Trauma and the Trauma of Betrayal

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I came from a small town in rural Oregon, with my mom and two older brothers. I was a tomboy. My dad died when I was 4 years old and my mom had to work many jobs, which meant she was mostly out of the house. Maybe because of that, my brothers and I were always close, and we moved about town like a pack. They actually brought me up in a lot of ways and looked out for me. Growing up in such a guy-centric environment, when I decided to join the military in high school, it didn't seem like it would be a huge stretch. I imagined that I would fit in with my fellow soldiers just like I had with my brothers and that we'd always have each others' backs. When I was 18, I joined the Army.

My unit and I had been deployed in Afghanistan for approximately 8 months when my platoon leader and fellow soldiers sexually assaulted me. The main

perpetrator was my platoon leader, along with three other men. One night, my platoon leader came to my residence and told me to come with him to his office, which I did because I was ordered to. My entire squad was there in his office. My platoon leader pointed to a glass of liquid on his desk (whiskey and coke) told me to drink it; I didn't know what else to do, so I drank it. It hit me harder than any drink I had had before, probably because there were roofies in it. One of the men then bent me forward over the desk and raped me from behind, which was so painful that I blacked out. When I came to, I had my clothes back on and wanted to kill myself.

Although during my rape there were four men, I place the blame on my platoon leader. He was the only noncommissioned officer present, and had he any integrity or character, he would have stopped the rape. He was my first-line supervisor and also the ringleader in my sexual assault. In retrospect, it seemed as though the other men were giving in to the peer pressure, maybe even following orders, and I also did not resist or say no.

A few days later, my commanding officer approached me in a private location. He told me that he knew what happened and asked me if it was in fact consensual, as he had heard. Because I was terrified to say otherwise, I said yes it was consensual, and that I felt ashamed. I told him that I wanted to talk to a chaplain about what happened. He told me to not tell anyone, especially a chaplain, because if I did, I would get sanctioned, especially because I was drinking. I decided to keep quiet, mostly because I didn't want to get in trouble for drinking or fraternization. I started to receive sexual taunts from other soldiers, though, because word got out about the rape from the people who did it.

About a year after returning from Afghanistan, they told that I would have to face disciplinary actions for indecent sexual behavior. My platoon leader and the three other assailants had to travel together to the hearing. I wasn't offered an advocate or chaperone and was the only female soldier present at the hearing. I was forced to stand in front of the Lieutenant Colonel and my rapists and explain my actions. The comments the Lieutenant Colonel made to me, like telling me that I was an embarrassment to all female soldiers and to the army as a whole, made me feel so ashamed and guilty. I was given an Article 15 punishment, which was put on my permanent record. None of the men received punishments of any kind. In addition to getting the Article 15, I was transferred to another base and received diminished rank. I left service as fast as my obligation was over, much sooner than I had originally anticipated.

A few years passed and I missed being a soldier, so back in Oregon, I joined the National Guard. Things went very well with my new unit and, although it was challenging for many years, I started to date again and met my partner, who is a Navy veteran.

The previous case example illustrates military sexual trauma (MST) as a betrayal trauma. Although this account is fictional, it is based on an amalgamation of several true stories. It illustrates three important elements, which we explore throughout the chapter: individual and institutional betrayal trauma, and reparative individual and institutional experiences.

INTRODUCTION

Anu Bhagwati (executive director, Service Women's Action Network [SWAN], and U.S. Marine Corps officer) highlights the uniqueness of MST in her statement on the 2014 lawsuit against the U.S. Department of Veterans Affairs (VA) by SWAN and Vietnam Veterans of America: "Veterans are experiencing betrayal trauma" (Briggs, 2014). Although we include only an excerpt, the larger statement includes a more detailed description of the various ways in which veterans experience betrayal trauma, all of which boils down to this: MST is a unique type of sexual violence that nearly always includes individual and institutional betrayal trauma. MST survivors receive psychological care from a wide swath of mental health professionals, within the context of both veteran and civilian institutions. As such, we propose that it is important for clinicians who are working with MST survivors to consider how the experiences of betrayal trauma uniquely impact symptomatology, therapeutic relationships, and interactions with veteran organizations. Through this chapter, we will offer our thoughts on understanding and working with survivors of MST from the perspective of betrayal trauma theory (BTT; Freyd, 1996). The therapeutic orientations upon which we will draw, a combination of cognitive, dialectical behavioral, and relational-cultural theories, will influence the way we conceive of MST.

BETRAYAL TRAUMA

Through the lens of BTT, MST and various other forms of sexual violence can be understood in the context of attachment and dependency relationships (Freyd, 1996). To understand the impact of betrayal within

this type of relationship, it is necessary to understand the form and purpose of human attachment. Attachments are first formed most strongly with caregivers in a manner that tends to set the stage for future attachment relationships (Zayas, Mischel, Shoda, & Aber, 2011). Human infants are born in an immature and vulnerable state, requiring near constant caregiving in order to survive. A caregiver having cognitive, emotional, and physiological reactions of love, protectiveness, affiliation, and nurturing toward an infant buffers against the huge responsibility and effort it takes to provide sufficient care (Ainsworth, Blehar, Waters, & Wall, 1978). Human infants have evolved both physical and behavioral repertoires to reinforce caregiving: Big eyes, chubby cheeks, mutual eye contact, facial expressions, coos, and laughter all heavily reinforce attachment relationships (Thompson et al., 2006). In fact, even the most motivated caregivers struggle to care for babies who are less attractive or who are unable to engage in these types of behaviors (Swain, Mayes, & Leckman, 2004). Therefore, we see that the nature of creating and maintaining an attachment relationship is bidirectional: Both parties must contribute. Not all attachment relationships form an ideal exchange of caregiving and receiving. Ainsworth and colleagues first described attachment styles in infants, styles later generalized to adults in romantic relationships, that appeared to explain how attachment may be maintained even in nonideal circumstances: when either caregiver or infant is unpredictable, nonresponsive to attempts to connect, or has overwhelming needs (Ainsworth et al., 1978). Adjustments in behavior (e.g., even very young infants will titrate their exposure to a parent's overwhelming emotional reactions by turning their head or body away from the parent; Ainsworth et al., 1978) appear to develop naturally in these situations in a manner that suggests that the need to trust and depend upon another person is a resilient quality—humans are simply wired to connect.

While a caregiver may set the stage for the dynamics of future attachment relationships (i.e., styles of attachment are typically thought to generalize across relationship types), over the course of a lifetime an individual may form relationships and social contracts with any number of individuals or institutions that draw upon the same dynamics (Fuller, Barnett, Hester, & Relyea, 2003). Both parties must behave in ways that support the relationship: Necessary support must be elicited and reinforced and trust and connection of some sort must be fostered (Swain et al., 2004).

A betrayal trauma is a traumatic violation of trust in a close relationship, one where the victim depends on the perpetrator for survival or important needs. Perpetrators of betrayal traumas can be either individuals (Freyd, 1996) or institutions (Smith & Freyd, 2013). What is remarkable about MST is that it nearly always includes both interpersonal and institutional betrayal.

Soldiers rely on each other for safety and survival, particularly where combat is involved. Soldiers also depend on their commanding officers for orders pertaining to basic survival needs: when to wake, eat, and sleep. As a result of this reliance, soldiers develop relationships that include elements of attachment and dependency, as evidenced by the military commonly being referred to as a "band of brothers." The betrayal of being sexually harassed, assaulted, and/or raped by fellow service members is evident, as in the case example when the female soldier is gang raped by her platoon leader and three fellow soldiers, four people on whom she depends for survival.

Soldiers also rely on the institution of the military as a whole—for employment, identity, values, structure, and purpose. In fact, there is evidence that many young soldiers join the military looking for a "replacement family" that will allow them to escape abusive home environments (Sadler, Booth, Mengeling, & Doebbeling, 2004). Institutional betrayal resembles individual betrayal in that a survivor experiences a violation perpetrated by a trusted or necessary entity (Smith & Freyd, 2013). In this example, the platoon sergeant who questioned the soldier was at once a trusted individual but also a powerful symbol of the larger institutional forces at play in MST. The soldier's fear of the consequences of admitting that she had been raped was immediately reinforced by her platoon sergeant in reminding her of her own vulnerable position. That he discouraged her seeking further support from a chaplain is consistent with the common institutional response of covering up information that may harm its reputation (Smith & Freyd, 2014). The focus on the way in which she had violated military standards (by drinking) is also consistent with institutional responses to abuse within their ranks (Burns, Hyde, & Killet, 2013). Highlighting the ways in which a victim of interpersonal violence does not "belong" in an institution (e.g., breaking rules about drinking) is at once an effective strategy for justifying harm that has befallen this individual, as well as a source of enormous abandonment and self-doubt for the individuals themselves. The irony of this situation is that the very

behavior that she initially undertook in an attempt to demonstrate her compliance with institutional norms (enforced drinking) first facilitated her sexual assault and later ensured her silence.

While it may be challenging to believe that MST survivors receive punishments for the crimes committed against them, this seems to be a common form of institutional betrayal following MST. In the case example, the survivor was admonished by her commanding officer (a spokesperson of the Department of Defense [DoD]) to not report the MST, because she would get "in serious trouble." She also received an "Article 15" punishment (a potentially career-ending punishment) for drinking the alcohol that she was ordered to consume by her perpetrators and for engaging in "indecent sexual behaviors," meaning that she was punished for being forced to drink and then for being raped.

Effects of Interpersonal Betrayal Trauma

Traumas higher in betrayal, in contrast to traumas lower in betrayal, are associated with many negative psychological symptoms (Klest, Freyd, & Foynes, 2013; Martin, Cromer, DePrince, & Freyd, 2013) and physical health problems (Klest, Freyd, Hampson, & Dubanoski, 2013). In their 2013 study, examining the associations between traumatic experiences and symptoms of psychological distress in 273 college-aged students, Martin and colleagues (2013) showed that experiences of higher betrayal trauma most strongly predicted symptoms of psychological distress, such as depression, dissociation, and posttraumatic stress disorder (PTSD), in contrast to experience of traumas with lower degrees of betrayal. Klest, Freyd, and Foynes (2013) surveyed the physiological impact of experiences of betrayal trauma among 833 persons belonging to ethnically diverse groups in Hawaii. The study showed that, in comparison to lower betrayal traumas, higher betrayal traumas were significantly more associated with symptoms of depression, PTSD, dissociation, and anxiety, as well as disordered sleep patterns (Klest, Freyd, & Foynes, 2013). Another study demonstrated that people who experienced traumas with higher betrayal were more likely to have negative self-rated health, in comparison to people who had experienced traumas with lower degrees of betrayal (Klest, Freyd, Hampson, et al., 2013). Additionally, Klest, Freyd, Hampson, et al. (2013) showed that higher betrayal traumas

significantly predicted worse overall health status and health trajectories over a 10-year period of time. This research, a snapshot of what is available for review (see www.dynamic.uoregon.edu), demonstrates the toxic psychological and physical impacts of traumatic experiences with higher degrees of betrayal on survivors.

Effects of Institutional Betrayal Trauma

MST is uniquely harmful, and this fact has been documented by work comparing the effects of civilian sexual assault to MST, the findings of which reveal that MST predicts psychological and physical health difficulties above and beyond equal amounts of sexual violence experienced outside of the military (Suris, Lind, Kashner, & Borton, 2007). Institutional betrayal provides a potential explanation for the added harm of experiencing sexual trauma within an institution such as the military. Smith and Freyd (2013) introduced the Institutional Betrayal Questionnaire, a measure of institutional actions and inactions surrounding traumatic events (e.g., *creating an environment where these events seemed more likely to occur, responding inadequately to reports, punishing individuals who report*), and have since used this measure to document the effects of institutional betrayal directly. In keeping with psychological and physical health outcomes predicted by BTT, experiencing institutional betrayal results in increased dissociation, anxiety, sexual dysfunction, and physical health problems such as pelvic pain and dizziness (Smith & Freyd, 2014; Smith & Freyd, 2013). Critically, each of these outcomes is associated with institutional betrayal, that is, they are correlated to institutional betrayal even after experiences of sexual trauma are statistically controlled for. As we will discuss next, while MST has not yet been researched as an institutional betrayal trauma, empirical research shows that the symptoms of betrayal trauma are similar to those evidenced by MST survivors (e.g., Himmelfarb, Yaeger, & Mintz, 2006; Kimerling, Gima, Smith, Street, & Frayne, 2007). We suspect that as a trauma with a high degree of both interpersonal and institutional betrayal, MST may carry the weight of psychological and physical problems over and above those associated with traumas with lower degrees of betrayal. Research is currently underway on MST as a betrayal trauma (Street et al., 2014).

CLINICAL IMPLICATIONS: UNDERSTANDING THE ROLE OF BETRAYAL IN REPAIRING ISSUES OF MST

Looking through the lens of BTT may aid clinicians in understanding the roles that betrayal and betrayal blindness (a concept discussed later) play in MST. Therapists may be able to gain clinical traction with MST survivors by understanding that MST almost always includes experiences of both individual and institutional betrayal. Moreover, in order to maintain their identity as veterans and their relationship with the military, MST survivors might remain blind to the institutional betrayal. The expected clinical presentation of an MST survivor is detailed in separate chapters of this book. In this section, we add to the clinical picture by discussing factors of the expected presentation of MST from a BTT perspective, further detailing the many ways that betrayal and betrayal blindness might impact both MST survivors and clinicians' case conceptualizations and treatment plans.

Betrayal Blindness and Dissociation

Although acknowledging violations of trust is a highly evolved mechanism (Fodor, 2000), in cases of betrayal, acknowledging trauma carries with it the danger of irrevocably disrupting a necessary attachment relationship, therefore threatening the victim's survival. This presents a conundrum in which the need for self-preservation dictates apparently contradictory actions: to both acknowledge and deny the abuse. In the case example mentioned at the beginning of this chapter, the female soldier needed to maintain the relationships with her fellow soldiers, platoon leader, commanding officer, and the DoD for survival, but these were the same individuals and the institution that had perpetrated sexual violence against her. As her commanding officer warned, acknowledging the trauma might threaten her survival. In response to this very real threat, Freyd (1996) hypothesized that victims of betrayal traumas may engage in betrayal "blindness" as a way to maintain their relationship with the perpetrator. Betrayal blindness is an adaptive coping mechanism that allows the victim to put the trauma out of conscious awareness in order to maintain the needed relationship with the perpetrator—whether that

perpetrator is the actual abuser or the institution that contains the abuse (Freyd, 1996; Freyd & Birrell, 2013). This unawareness may range from a loss of memory—in part or in total—of a traumatic event to difficulty in verbalizing the impact of such an event. In our case example, in order to maintain the relationships with the commanding officer, platoon leader, and fellow soldiers, as well as the institution in the days and week following the assault, the soldier might have needed to put the trauma out of her awareness in order to continue her work.

Dissociation can serve an important function in preserving the relationship between the survivor and perpetrator (Freyd & DePrince, 2001). Relative to the experience of low betrayal traumas, Freyd and colleagues' research has documented stronger associations between experience of high betrayal trauma and symptoms of dissociation among adult civilian sexual trauma survivors (Freyd, Klest, & Allard, 2005). While there is no research yet to evaluate the specific association between experience of MST and dissociation, based on past findings, one might anticipate survivors of MST experiencing high levels of dissociation or unawareness of their experience of MST. When one considers this constellation of trauma symptoms within the context of BTT, one might be able to see the function of unawareness and dissociation in preserving the necessary relationships between the victim and the perpetrators, both individual and institutional. A unique challenge of maintaining awareness of MST and related institutional betrayal is that these traumas coincide with a period of time that is incredibly meaningful to most veterans (i.e., their military service as a whole). This might present clinically through a patient's direct unawareness of the trauma, denial of the institutional role in facilitating or protecting the perpetrator(s), or a partial amnesia toward segments of the traumatic experience. Considering dissociation within the context of BTT, a clinician might be able to have a better understanding of the presence and function of dissociative symptoms among MST survivors.

Healing Betrayal at the Individual and Institutional Level

In considering the role that betrayal plays in the experience of MST, we propose that clinicians focus their therapeutic efforts on helping patients heal relationships fractured because of betrayal both at the individual and institutional level. In our initial case example, the female soldier

decided to reenter service in another branch of the military, and she formed a romantic relationship with a fellow serviceman, both examples of how she bravely forged reparative individual and institutional relationships. We will discuss themes and therapists' ways of being that can support reparative therapeutic relationships and, ultimately, extend this to relationships with other individuals and/or institutions.

Healing Betrayal at the Individual Level

In this section, we explore healing betrayal at the individual level within the context of a therapeutic relationship and the therapeutic elements to bear in mind when working clinically with MST survivors. Given that much of the extant betrayal trauma treatment literature focuses on a healing model influenced by the Stone Center's relational-cultural theory (Birrell & Freyd, 2006), we use that model as a springboard for our suggestions on working with MST survivors. We also wish to emphasize, however, that there are different theoretical frameworks that support the cultivation of healing and safe therapeutic relationships with MST survivors.

Trusting Relationship With the Therapist

Birrell and Freyd (2006) state that the central element of a betrayal trauma is the rupture of trusted human relationships (both with the self and other individuals), and that healing comes from repairing those relational ruptures. In discussing the repair that initially occurs within the context of the therapeutic relationship, Birrell describes therapist behaviors and treatment that focuses on listening, mutuality, and compassion. Regarding listening, Birrell suggests that therapists listen in such a way that they allow themselves to be affected by what the patient says. Through generating mutuality between the therapist and patient, they practice mutual empathy and empowerment. Lastly, Birrell describes therapist compassion. Compassion, "a feeling of connection with others" (Birrell & Freyd, 2006, p. 58), gives way to a deep and healing connection. In emphasizing listening, mutuality, and compassion, the therapist allows the patient to explore (and explores with them) elements of their selves that have previously been silenced and, as a result, fragmented. Through this therapeutic process, both patient and therapist can come to experience the patient not as a manifestation of a label

(e.g., MST survivor or rape victim), but rather as an integrative expression of their past and present experiences and genuine humanness.

These therapeutic principles may be healing for a soldier or veteran who has experienced MST in the following ways: It might be that an MST survivor has been silenced through either an invalidating or disbelieving response to his or her report, direct orders to "deal with" or "forget" the experiences, or a common (though not universal) convention of the military culture to not discuss experiences of MST. Being silenced in this manner, the individual might not have experienced being seen through being heard. If the therapist is able to listen, not only as an observer but also as a listening partner open to being affected by the narrative and emotions of the patient, the patient and therapist might experience a healing connection. The military, by its very nature, is not a culture of mutuality given its hierarchical structure. Moreover, given that sexual violence strips victims of power, the absence of mutuality inherent in the experience of MST is clear. A therapeutic environment where mutual empathy and empowerment are present can provide an antidote to the patient's previous environments, lacking in empathy and rife with disempowerment. Given the negative experiences resulting from reporting abuse and the victim-blaming discourses frequently upheld by society, it might be that an MST survivor has never experienced compassionate responses from any individual in response to the traumatic event. Therefore, if the therapist develops a deep connection with the patient, it is possible to heal previous assumptions of abandonment through this compassionate, therapeutic relationship.

Given the importance of healing relationships ruptured by experiences of betrayal and the evidence supporting the psychological benefits of dependent human relationships (Birrell & Freyd, 2006; Linehan, 1993), we offer these clinical suggestions for working with MST survivors with a great degree of hope for and confidence in their outcomes. If the patient has once experienced the relationship with the therapist as reparative, then the therapist can assist the patient in changing his or her previously impermeable beliefs about individuals as being bad and untrustworthy. The therapist may then help the patient cultivate similar reparative relationships with other individuals in his or her life.

It is not necessary to reinvent the treatment wheel to understand why this type of therapeutic relationship is necessary. Treatments for complex trauma (i.e., trauma that unfolds over a long period of time and/or involves multiple or repeat abuses or abusers) have long

indicated that healing from this type of trauma requires a stable and secure relationship with the therapist (Courtois & Ford, 2009). Given the complex interpersonal and institutional dynamics of MST, devoting sufficient sessions at the outset of treatment to establishing a patient's personal safety, emotional regulation capacities, and connection to the therapist is critical prior to beginning exploration of traumatic material (Courtois & Ford, 2009; Herman, 1992; Linehan, 1993). It is for this reason, perhaps, that many MST treatment centers have begun to include Dialectical Behavioral Therapy (DBT) as part of their treatment milieu at both individual and group levels (Hall & Sedlacek, 2004).

Healing Betrayal at the Institutional Level

Returning to the Institution

Should a survivor of MST, previously estranged from the military institution (e.g., DoD and/or VA), wish to become a patient in the VA Health Administration (VHA), it is not likely to be as simple as picking up the telephone and scheduling an appointment. Other factors that impact a veteran's smooth transition to VA health care utilization may include a deep reluctance to return to any part of an institution that has betrayed him or her. The patient may be unaware of or have difficulty in recognizing the error of conflating the DoD and all facets of the VA. With this, we wish to acknowledge the potential complexities of returning to the institution, while also illuminating the potential therapeutic benefits of doing so.

The generalization of skepticism, anger, and distrust that can occur with black-and-white thinking serves a function for a survivor of MST. Black-and-white thinking describes cognitions that are dichotomous (all bad or all good; e.g., "The military is all bad and betrayed me") and that overly generalize information learned in one context to many others (e.g., "Nothing is safe"; Beck, 2011). One function of such behaviors might be self-protection, which is valid given a survivor's previous experiences and context. However, disentangling the DoD and the VA becomes necessary, as does exploring parts within these systems that are safe and helpful. In this way, the VA is in a unique position to provide evidence to refute black-and-white thinking, should it prove itself to be an institution that can provide the context for a reparative relationship.

Perceiving this contradictory evidence, however, can require a dialectical worldview. This worldview, according to Linehan (1993), is broad

and applies to one's conception of human behavior and an understanding of reality through three primary principles: interrelatedness and wholeness, polarity, and continuous change. Nondialectical thinking is the tendency of the patient to not be able to live in a space where two opposing forces can coexist. For example, if a patient were able to think dialectically, he or she would work to accept clashing understandings or opposing views about the DoD, that is, there exist segments of the organization that hurt and betray, as well as segments that help and are deserving of trust. Thinking nondialectically, however, a patient might vacillate between the DoD as an entirely betraying institution and as an entirely trustworthy institution. In thinking dialectically, it is not the synthesis of the two opposites that we endeavor to assist our patients in obtaining, but rather the recognition and acceptance of the new understanding that results from sitting with the clash between the two opposites (Linehan, 1993). When working with MST survivors, in addition to cultivating a reparative therapeutic relationship as discussed earlier, we recommend that clinicians focus on helping clients modify black–and-white and nondialectical thinking to understand what they may want to preserve of their relationship with the military via the VHA, as a way to begin the healing process of the effects of the betrayal that they endured.

Trusting Relationships Within an Institution

For VA or Military-Affiliated Therapists

Within this environment, both patients and therapists may feel a conflict in discussing institutional betrayal related to MST. After all, the therapist is an employee of the VHA and the veteran is still dependent upon support related to his or her military service. Working with a client who is experiencing active institutional betrayal may be a difficult reminder that the system in which the therapist works may not always *be* trustworthy. A therapist need not disavow his or her role as an employee of the VHA and seek to establish himself or herself as somehow "different" and, thus, more trustworthy. Openly acknowledging this conflict in a dialectical way may be the easiest and most helpful solution. Observations about the risk of seeking services (e.g., "It may take time to figure out whether you can be safe here, given that you experienced abuse where you were supposed to be protected") or about the need to compartmentalize experiences (e.g., "It can be hard to sort out the

ways in which parts of the military have really let you down while still staying connected to the other parts") can demonstrate that discussing institutional betrayal is acceptable.

For Civilian Therapists

Given the statistics that we presented in the earlier section regarding the percentage of veterans who use non-VA health care, we find it likely that civilian therapists will have an MST survivor as a patient at some point in their careers. In order to work with an MST survivor, it is not necessary for civilian clinicians to understand all the intricacies of the DoD or the VA. It is, however, important to consider the ways in which a soldier or veteran might portray the military to a civilian clinician; we propose some suggestions for how clinicians might receive these portrayals. An MST survivor might experience betrayal blindness, the function of which is to protect his or her military identity (and thus, his or her relationship with the DoD). In such a case, the patient might idealize (e.g., passionately and absolutely defend the DoD) the military culture. Following the establishment of a trusting relationship with the therapist, therapists may choose to focus clinical work on thinking dialectically, where the patient acknowledges the MST and its elements of betrayal, while still maintaining a degree of allegiance.

Assessing Institutional Betrayal

Some veterans are aware of institutional betrayal and are able to discuss it as such, as Anu Bhagwati's statement in the opening quote illustrates. For research purposes we do not rely on awareness to measure whether institutional betrayal has occurred, as it often takes time and empowerment to reach this level of understanding. Instead, we use a measure called the Institutional Betrayal Questionnaire, which asks respondents to indicate whether institutions have done concrete things such as covering up a report of sexual violence, made reporting this type of experience difficult, or created an environment where these types of experiences were more likely to occur (Smith & Freyd, 2013). This measure is easily located with an online search and free to use. It may be helpful for therapists to use this measure as part of an assessment battery to gain a better understanding of their patients' experiences or perhaps open a conversation about how larger military

institutions may have contributed to their experiences of MST or may still be causing harm.

Institutional Reparation

It is difficult to overestimate the effect that this type of institutional recognition of betrayal may have on healing the trauma of MST. This type of reparation of institutional betrayal may manifest in direct interactions with institutional actors such as therapists as described previously. It may also arise from more subtle institutional messages and policies—how accessible MST services and facilities are, how many resources are devoted to prevention and response, and how military leaders talk about MST. All of these are potential means of reparation, should they be executed well. Indeed, genuine institutional acknowledgment, validation, and remorse run counter to the secrecy, denial, and blame that many MST survivors first experience when attempting to disclose abuse.

Like most interpersonal traumas, MST disrupts interpersonal connections to others. Yet, unlike other types of sexual abuse, MST often disrupts connections to important social systems that soldiers and veterans have come to heavily rely upon. For this reason, reestablishing connections to other MST survivors via support or psychoeducational groups can be an important aspect of reconnection and healing. It is important that these groups offer a means of connection and shared identity based on strength, healing, or a new skill set rather than the shared experience of MST alone (Hall & Sedlacek, 2004).

The steady influx of MST survivors represents a unique and inescapable challenge for the DoD and VA systems. It can be tempting to turn a blind eye to the magnitude of the problem or the institutional mechanisms that may contribute to MST. This response to traumatic events is a common one for both individuals and institutions (Bloom & Farragher, 2010). As Bloom and her colleagues point out (e.g., Bloom & Farragher, 2010), it can be useful to think of institutions that deal frequently with traumatized patients as being prone to institutional vicarious traumatization—becoming overwhelmed, resorting to coping mechanisms that are effective for immediate distress but harmful as long-term strategies, or even becoming callous to suffering are all potential institutional responses to trauma. If this view is adopted, institutional policies

regarding reasonable workload, self-care, and ethical safeguards shift from preferable to requisite.

CONCLUSION

We understand MST as a betrayal trauma, remarkable in that a soldier nearly always experiences both individual and institutional betrayal through this devastating form of sexual violence and its aftermath. To begin our chapter, we referenced a statement from Anu Bhagwati. In the complete article (Briggs, 2014), Bhagwati names both individual and institutional perpetrators of betrayal trauma. The individual perpetrators she references are the fellow soldier perpetrator(s), and the institutional perpetrators that she references are representatives of the DoD (e.g., commanding officers) who meet disclosures with disbelief, and the VA (specifically, the Veterans Health Administration [VHA]). Experiencing betrayal from one source is toxic enough, and, as we have discussed, experiencing it from another only compounds the negative impact.

Healing from such devastating relational ruptures and betrayals is deeply challenging and is likely to hold both frustration and success for both patient and therapist. We argue here that conceptualizing MST as a betrayal trauma and focusing on the therapeutic relationship as the seat of reparative healing holds promise for survivors. We also propose that the VA (specifically the VHA) is in a unique position to be an institution that provides opportunities for healing and reparative institutional relationships. Given the robust focus, actions, and resources that the VA provides to veteran MST survivors, we are confident that the VA holds a commitment to providing a context for MST survivors to heal.

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