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ARTICLE



Sexual vs. Non-sexual trauma, sexual satisfaction and function, and mental health in female veterans

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ABSTRACT

Trauma in general, and sexual assault in particular, is associated with serious mental health and functional problems. The quality of sexual satisfaction/function may be particularly impacted by sexual assault, and such sexual problems may account for some of the broader mental health and functioning impairments in sexual assault survivors. Accordingly, we examined self-reports of sexual health and mental health in a sample of 255 female veterans in committed, monogamous relationships who provided data regarding sexual assault ($n = 153$) or nonsexual trauma ($n = 102$). Trauma type was not associated with differences in sexual function, but sexual trauma was associated with significantly lower sexual satisfaction, greater posttraumatic stress disorder (PTSD) and depressive symptoms, and higher suicidal ideation. Furthermore, the indirect effect of trauma type on all mental health outcomes was significant via sexual satisfaction but not via sexual function. Finally, trauma type moderated the association of sexual function with suicidality, such that the association was significantly positive in those with a history of sexual assault but nonsignificant in those with nonsexual trauma. These results suggest that (1) female veterans' experience of sexual assault is related to sexual satisfaction, which in turn is related to mental health outcomes, and (2) a history of sexual assault may increase the importance of sexual functioning with regard to suicidality.

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Trauma in general, and sexual assault in particular, is associated with serious mental health and functional problems (e.g., Beck, Grant, Clapp, & Palyso, 2009). Sexual assault is associated with a wide range of mental health concerns, including posttraumatic stress disorder (PTSD), depression, suicidality, anxiety, disordered eating, and substance abuse (e.g., Basile et al., 2006; Fischer, Stojek, & Hartzell, 2010; Kilpatrick, Arcierno, Resnick, Saunders, & Best, 1997; Zinzow et al., 2012). Military sexual trauma (MST) is sexual assault or repeated, threatening sexual harassment that occurs during military service. MST is reported by nearly 40% of female veterans (Campbell &

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Raja, 2005; Haskell et al., 2010; Kelly, Skelton, Patel, & Bradley, 2011), and is currently a high-priority Veterans Health Initiative (Department of Veterans Affairs, 2004). In female veterans, MST is consistently associated with both PTSD (e.g., Murdoch, Polusny, Hodges, & Cowper, 2006) and depression (e.g., Hankin et al., 1999; Suris, Lind, Kashner, & Borman, 2007), as well as particularly high levels of suicidal ideation (Monteith et al., 2016). Female veterans with a history of MST also consistently report poor quality of life and limited abilities to perform activities of daily living (e.g., Nunnink et al., 2010; Suris et al., 2007). In fact, female veterans who have experienced MST are more likely than those who have not to receive mental health diagnoses and to struggle with substance abuse (Kimerling et al., 2010).

Quality of romantic and sexual function/satisfaction may be particularly impacted by sexual assault, given the interpersonal nature of sexual assault and the potential for intimacy-related triggers. The most common sexual problems experienced by sexual assault survivors include fear of sexual stimuli and dysfunction of arousal and desire, both of which may persist for years post-assault and both of which have been shown to contribute to decreased participation, pleasure, and satisfaction in sexual activities across multiple studies with varied methodologies (e.g., meta-analysis by van Berlo & Ensink, 2000). Two preliminary studies of Veterans Affairs users have similarly found that MST in particular is also associated with decreased sexual satisfaction and function in female veterans, albeit with only a single-item measure (McCall-Hosenfeld, Liebschutz, Spiro, & Seaver, 2009; Turchik et al., 2012).

Sexual satisfaction and functioning, in turn, are integral to relationship satisfaction and functioning (e.g., Heiman et al., 2011; McCarthy, 2003). Relationship functioning is critical to treatment seeking (Meis, Barry, Kehle, Erbes, & Polusny, 2010), treatment response (Evans, Cowlshaw, Forbes, Parslow, & Lewis, 2010; Price, Gros, Strachan, Ruggiero, & Acierno, 2011), and overall trauma recovery (meta-analyses by Brewin, Andrews, & Valentine, 2000; Ozer, Best, Lipsey, & Weiss, 2003). For survivors of sexual assault in romantic relationships, potential triggers of their PTSD and related symptomatology (e.g., physical intimacy) are a fundamental aspect of the romantic relationship itself (e.g., Byrne & Riggs, 2002; Tolin & Foa, 2006). Therefore, survivors may evidence a strong relationship between relationship satisfaction/function, sexual variables, and mental health outcomes, as a function of the pervasiveness of salient triggers and presence of fear of sexuality. Furthermore, the persistence of decreased sexual satisfaction and participation for years post-assault (e.g., van Berlo & Ensink, 2000) is likely to erode relationship satisfaction/function overtime. Thus, sexual dissatisfaction and dysfunction may account for some of the broader mental health and functioning impairments in those who experience sexual assault. However, little research has addressed this possibility.

To further our understanding of these issues, we examined self-reports of sexual behavior and mental health in a sample of 255 female veterans in committed, monogamous relationships who reported a history of sexual or nonsexual trauma (e.g., combat). First, we examined whether type of trauma (sexual vs. nonsexual) was associated with differences in sexual satisfaction/function and in mental health outcomes. Second, we examined whether type of trauma mediated the association of sexual satisfaction/function with mental health outcomes. Finally, we conducted exploratory evaluations of type of trauma as a moderator of the association of sexual satisfaction/function with mental health outcomes, to determine if the experience of sexual assault heightens the association of sexual relationships with these outcomes.

Method

Participants

Participants were 255 women who self-identified as veterans of the United States military who had experienced some type of trauma while in the military. All participants were in committed, monogamous romantic relationships and provided data regarding “a very stressful military experience,” with 153 (60%) reporting sexual trauma and 102 (40%) reporting nonsexual trauma (e.g., combat). The sample was primarily married (72.2%) and Caucasian (82.0%). Participants reported a mean age of 32.63 years ($SD = 7.25$), and a mean relationship length of 5.95 years ($SD = 5.48$). The majority of participants was Active Duty (79.6%), and identified the Army as their current/former branch (65.5%). All participants had graduated high school or achieved their General Equivalency Diploma (GED).

Measures

Sexual satisfaction

Sexual satisfaction was measured using the Sexual Satisfaction Scale for Women (SSS-W; Meston & Trapnell, 2005). This 30-item self-report measure assesses the following domains on a 5-point Likert scale: contentment, communication, compatibility, relational concern, and personal concern. The SSS-W is summed to create a total score, with higher total scores indicating greater sexual satisfaction. It demonstrates reliability, internal consistency, and discriminant validity (e.g., Meston & Trapnell, 2005). In the present sample, reliability of this measure was acceptable (Cronbach's $\alpha = .83$).

Sexual function

Sexual function was measured using the Female Sexual Function Index (FSFI; Rosen et al., 2000). This 19-item self-report measure assesses sexual activity,

sexual intercourse, and sexual activity during the past 4 weeks, using a 5-point Likert scale. The FSFI is summed to create a total score, with lower total scores indicating greater sexual dysfunction. It FSFI demonstrates excellent internal consistency (e.g., Rosen et al., 2000). In the present sample, reliability of this measure was acceptable (Cronbach's $\alpha = .86$).

Posttraumatic stress disorder

PTSD symptoms were measured using the PTSD Checklist for DSM-5 (PCL-5; Weathers et al., 2013). This 20-item self-report measure assesses the presence of PTSD symptoms on a 5-point Likert scale. The PCL-5 is summed to create a total score, with higher scores indicating the presence of greater PTSD symptoms. It demonstrates satisfactory internal consistency, test-retest reliability, and convergent validity (e.g., Sveen, Bondjers, & Willebrand, 2016). In the present sample, reliability of this measure was acceptable (Cronbach's $\alpha = .96$).

Trauma

Participants were asked to identify the nature of their “most stressful military trauma” in a single, open-response item. These responses were subsequently coded as sexual or nonsexual trauma.

Depression and suicidality

The 9-item Patient Health Questionnaire (PHQ-9; Kroenke, Spitzer, & Williams, 2001) was used to assess depressive symptoms during the past 2 weeks, using a 4-point Likert scale. The ninth item (“How often have you been bothered by... [t]houghts that you would be better off dead, or of hurting yourself in some way?”) assesses the presence of suicidal ideation. The PHQ-9 is summed to create a total score, with higher scores indicating the presence of greater depressive symptoms. It is a well-validated measure, and demonstrates strong diagnostic validity (e.g., Hammash et al., 2013; Kroenke et al., 2001). In the present sample, reliability of this measure was acceptable (Cronbach's $\alpha = .92$).

Procedures

Facebook advertisements were targeted to English-speaking women aged 18–65 who identified as partnered (key terms: domestic partnership, engaged, in a relationship, married) and working in a government agency (key terms: government employee, military, veterans). The advertisement links forwarded potential participants to an anonymous and confidential online survey (not affiliated with the military or Veterans Affairs), where they completed screening and all study-related measures. To be eligible for the current study, participants had to endorse some form of military

trauma, and provide responses to questions about MST. Self-report screening items obtained status on female sex, service in the United States military, and current involvement in a romantic relationship. Individuals who did not meet screening criteria were not allowed to advance in the survey. Upon study completion, participants were directed to a separate confidential website where they were given the option to enter identifying information to receive a \$15 check for their participation. This study was approved by the Institutional Review Board of Utah State University.

Data analysis

To examine whether type of trauma (sexual vs. nonsexual) was associated with differences in sexual satisfaction/function or mental health outcomes, we used multivariate analyses of variance (MANOVAs) with sexual function, sexual satisfaction, PTSD symptoms, depressive symptoms, and suicidality as dependent variables.

To examine whether type of trauma mediated the association of sexual satisfaction/function with mental health outcomes (PTSD symptoms, depressive symptoms, and suicidality), we conducted six independent mediation analyses using Hayes (2013) PROCESS SPSS macros. This macro bootstraps the sampling distribution, avoiding the often-violated assumption that the sampling distribution be normal (Bollen & Stine, 1990). In each of the six models, trauma type (MST vs. other) was entered as the independent variable; sexual satisfaction or sexual function was entered as the mediating variable; and one of the three mental health outcome variables was entered as the outcome variable.

To examine whether type of trauma moderated the association of sexual satisfaction or sexual function with mental health outcomes (PTSD symptoms, depressive symptoms, and suicidality), we used six independent linear regressions. In each regression, the independent variables were: (1) trauma type, (2) one of the three mental health outcome variables, and (3) the interaction of trauma type with the target mental health outcome variable for that regression. The dichotomous trauma type variable was coded as 0 (nonsexual trauma) or 1 (sexual trauma). The sexual functioning and sexual satisfaction variables were centered, and the two interaction terms were created by multiplying each of these centered variables by the dichotomous trauma type variable. All significant interactions were probed to evaluate conditional effects by recoding the trauma type variable as 0 (sexual trauma) and 1 (nonsexual trauma), following recommendations of Aiken and West (1991). Regressions were checked for problems with multicollinearity (using variance inflation factor) and normality of residuals, with no problems identified.

Results

The two groups (sexual assault survivors vs. survivors of nonsexual trauma) did not differ significantly in terms of age [$t(252) = .172, p = .86$], race ($\chi^2 = 8.64, p = .195$), relationship status ($\chi^2 = 5.29, p = .152$), relationship length [$t(253) = .157, p = .88$], service branch ($\chi^2 = 5.11, p = .164$), or service component ($\chi^2 = 5.86, p = .053$). Complete sample demographics for both groups are reported in Table 1.

Descriptive statistics and intercorrelations for all variables of interest are reported in Table 2. For all participants, reports of sexual satisfaction were moderately correlated with PTSD symptoms, depressive symptoms, and suicidality. Participants' reports of sexual function were also somewhat correlated with their PTSD symptoms and depressive symptoms, but not their level of suicidality. Sexual function and sexual satisfaction demonstrated a small inverse correlation.

Table 1. Sample demographics.

	Sexual trauma <i>n</i> = 153	Nonsexual trauma <i>n</i> = 102
Age (<i>M</i> [<i>SD</i>])	32.57 (7.24)	32.73 (7.29)
Years in Relationship (<i>M</i> [<i>SD</i>])	2.05 (1.75)	2.09 (1.84)
Relationship Status (<i>n</i> [%])		
Married	110 (72.0%)	74 (72.5%)
Divorced	4 (2.6%)	2 (2.0%)
Partnered	38 (24.8%)	21 (20.6%)
Other	1 (0.6%)	5 (4.9%)
Race		
White/Caucasian	130 (85.0%)	94 (92.2%)
Black/African-American	10 (6.5%)	2 (1.9%)
Asian/Asian-American	0 (0.0%)	1 (1.0%)
American Indian/Alaskan Native	3 (1.9%)	3 (2.9%)
Biracial	8 (5.2%)	1 (1.0%)
Other	2 (1.4%)	1 (1.0%)
Service Branch		
Army	91 (59.4%)	75 (73.5%)
Air Force	24 (15.7%)	10 (9.8%)
Navy	24 (15.7%)	11 (10.8%)
Marine Corps	14 (9.2%)	6 (5.9%)
Service Component		
Active Duty	121 (79.1%)	67 (65.7%)
National Guard	19 (12.4%)	21 (20.6%)
Reserve	13 (8.5%)	14 (13.7%)

Table 2. Means, standard deviations, and intercorrelations for all variables.

	Mean (SD)	1	2	3	4
1. PTSD Symptoms	34.47 (22.10)				
2. Depressive Symptoms	12.12 (7.73)	.74***			
3. Suicidality	0.47 (0.90)	.48***	.61***		
4. Sexual Function	18.86 (6.04)	.14*	.18**	.10	
5. Sexual Satisfaction	81.74 (22.19)	.43***	-.49***	-.31***	-.28***

PTSD: posttraumatic stress disorder.

* $p < .05$. ** $p < .01$. *** $p < .001$.

Trauma type (sexual vs. nonsexual) was not associated with differences in sexual function ($F[1,253] = 1.04, p = .31$). However, relative to participants reporting only nonsexual trauma, those reporting sexual trauma endorsed significantly lower sexual satisfaction ($F[1, 238] = 7.48, p < .01$), greater PTSD symptoms ($F[1,227] = 4.73, p < .05$), greater depressive symptoms ($F[1,227] = 4.08, p < .05$), and higher suicidality ($F[1,227] = 4.74, p < .05$).

In the bootstrapped analyses of trauma type and sexual satisfaction, models were significant in the prediction of all three mental health outcomes: PTSD ($F[2, 232] = 25.90, p < .001; R^2 = .18$), depression ($F[2, 215] = 34.75, p < .001; R^2 = .24$), and suicidality ($F[2, 219] = 12.34, p < .001; R^2 = .10$). Moreover, the indirect effect of trauma type via sexual satisfaction was significant for all three mental health outcomes (Table 3). In contrast, although all three models with trauma type and sexual functioning were significant (PTSD: $F[2, 246] = 4.00, p = .020; R^2 = .03$; depression: $F[2, 227] = 5.82, p = .003; R^2 = .05$; suicidality: $F[2, 232] = 3.27, p = .027; R^2 = .03$), none of the indirect effects of trauma type via sexual function were significant (Table 4).

The results of the moderation analyses are reported in Tables 5 and 6. No significant moderation of the association of sexual satisfaction with outcomes was detected. One significant interaction involving sexual function was detected, in the model predicting suicidality. A probe of this interaction revealed that the association of sexual function with suicidality was significant ($\beta = .19, p = .02$) in those with a history of sexual assault, but nonsignificant ($\beta = -.08, p = .485$) in those with nonsexual trauma.

Discussion

The results of the present study expand the literature on the association of sexual dissatisfaction and dysfunction with broader mental health and

Table 3. Direct and indirect effects (via sexual satisfaction) of Trauma type on mental health outcomes.

	Direct effects			Indirect effects via sexual satisfaction		
	B	SE	t	B	SE	95% CI
<i>PTSD as Dependent Variable</i>						
Trauma Type	1.96	2.72	0.72	3.41	1.30	(1.05, 6.24) ^a
Sexual Satisfaction	-0.41	0.06	-6.91***	-	-	-
<i>Depression as Dependent Variable</i>						
Trauma Type	0.74	0.96	0.76	1.29	0.54	(0.32, 2.47) ^a
Sexual Satisfaction	-0.17	0.02	-8.06***	-	-	-
<i>Suicidality as Dependent Variable</i>						
Trauma Type	0.18	0.12	1.44	0.09	0.04	(0.02, 0.20) ^a
Sexual Satisfaction	-0.01	0.00	-4.44***	-	-	-

PTSD: Posttraumatic stress disorder; CI: confidence interval.

*** $p < .001$.

^a95% CI does not contain 0, indicating that the indirect effect is significant at $p < .05$.

Table 4. Direct and indirect effects (via sexual functioning) of Trauma type on mental health outcomes.

	Direct effects			Indirect effects via sexual functioning		
	B	SE	t	B	SE	95% CI
<i>PTSD as Dependent Variable</i>						
Trauma Type	5.50	2.84	1.78	0.40	0.47	(-0.20, 1.83)
Sexual Functioning	0.17	0.08	2.07*	-	-	-
<i>Depression as Dependent Variable</i>						
Trauma Type	1.98	1.02	1.93	0.16	0.21	(-0.15, 0.72)
Sexual Functioning	0.08	0.03	2.69**	-	-	-
<i>Suicidality as Dependent Variable</i>						
Trauma Type	0.26	0.12	2.22*	0.01	0.02	(-0.01, 0.06)
Sexual Functioning	0.00	0.00	1.45	-	-	-

PTSD: Posttraumatic stress disorder; CI: confidence interval.

* $p < .05$. ** $p < .01$.

*95% CI does not contain 0, indicating that the indirect effect is significant at $p < .05$.

Table 5. Coefficients from regressions of mental health outcomes onto Trauma type, sexual satisfaction, and their interaction.

	B	SE	β
<i>PTSD Symptoms as Outcome</i>			
Trauma Type	1.43	2.73	0.03
Sexual Satisfaction	9.28	2.26	0.43***
Trauma Type * Sexual Satisfaction	0.13	2.77	0.01
<i>Depressive Symptoms as Outcome</i>			
Trauma Type	0.66	0.99	0.04
Sexual Satisfaction	3.66	0.82	0.48***
Trauma Type * Sexual Satisfaction	-0.14	1.00	-0.02
<i>Suicidality as Outcome</i>			
Trauma Type	0.18	0.13	0.10
Sexual Satisfaction	0.23	0.10	0.26*
Trauma Type * Sexual Satisfaction	-0.01	0.13	-0.01

PTSD: Posttraumatic stress disorder.

* $p < .05$. *** $p < .001$.

Table 6. Coefficients from regressions of mental health outcomes onto Trauma type, sexual functioning, and their interaction.

	B	SE	β
<i>PTSD Symptoms as Outcome</i>			
Trauma Type	4.97	2.84	0.11
Sexual Functioning	0.52	2.30	0.02
Trauma Type * Sexual Functioning	3.61	2.87	0.13
<i>Depressive Symptoms as Outcome</i>			
Trauma Type	1.94	1.02	0.12
Sexual Functioning	0.38	0.82	0.05
Trauma Type * Sexual Functioning	1.46	1.02	0.16
<i>Suicidality as Outcome</i>			
Trauma Type	0.26	0.12	0.14
Sexual Functioning	-0.07	0.10	-0.08
Trauma Type * Sexual Functioning	0.23	0.12	0.21

PTSD: Posttraumatic stress disorder.

* indicates that the two variables have been multiplied to form an interaction term.

functioning impairments in those who experience sexual assault. Specifically, these results suggest that female veterans' experience of MST is related to level of sexual satisfaction, and sexual satisfaction, in turn, is related to mental health outcomes in this population. Further, they suggest that a history of MST may increase the importance of sexual function with regard to suicidality. This novel finding may be reflective of the fact that sexual assault is not simply a single violation, but can have lasting effects on survivors' ability to adequately engage in a critical aspect of romantic relationships (e.g., van Berlo & Ensink, 2000), thereby increasing feelings of defectiveness and isolation, both of which are risk factors for suicide (e.g., Dutra, Callahan, Forman, Mendelsohn, & Herman, 2008; Trout, 1980). It also suggests that suicide risk assessments should be completed regularly for female veterans reporting sexual dysfunction secondary to MST, and that treatment of sexual dysfunction should be prioritized in such cases. Future research is needed to determine whether the current findings replicate and, if so, to determine what specific sexual issues (e.g., dysfunction of arousal, inorgasmia, pain) may be particularly predictive of suicidality.

Additionally, the differential associations of sexual dissatisfaction and sexual dysfunction with trauma type and mental health outcomes are notable and worthy of further discussion and examination. Indeed, recent research suggests that different factors (e.g., experiential avoidance, relationship violence, relationship satisfaction, anger, psychological distress) may account for impairments in sexual satisfaction versus impairments in sexual function in sexual assault survivors, and that sexual function and satisfaction may not consistently be correlated (Leonard, Iverson, & Follette, 2008). Indeed, in the present sample, these variables demonstrated only a small, inverse correlation. These findings suggest that sexual satisfaction and function are distinct variables that should continue to be examined both in relation to each other, as well as independently, in future research.

Although this study had notable strengths, including a substantial sample size, it is not without limitations. First, all assessment relied on self-report scales, which are subject to bias. Additionally, the data were cross-sectional, which prohibits any causal inferences. This latter limitation is particularly noteworthy, given that research has shown that the association between interpersonal support/functioning and mental health outcomes such as PTSD are bidirectional (meta-analyses by Brewin et al., 2000; Ozer et al., 2003). Furthermore, participants in the present study were asked to report on their "a very stressful military experience," and were categorized based on whether their identified trauma was either sexual or nonsexual. However, it is possible that participants may have also experienced both types of trauma, and/or multiple traumas of either or both types. Additionally, data on sexual orientation were not collected for this sample. The inclusion of such information in future research will help to further illuminate interpersonal

processes following MST. Finally, sexual dissatisfaction and dysfunction occurring secondary to sexual assault may be associated with additional mental health and functional outcomes beyond PTSD, depression, and suicidality. Future research can address this limitation by examining the potential impact of sexual satisfaction/function deficits on alcohol and substance, eating disorders, and physical health in this population. Future research would also benefit from investigating the association of sexual dissatisfaction and dysfunction with broader mental health and functioning impairments in male survivors of sexual assault in both the civilian and military populations.

The present findings have potentially important clinical implications, as they suggest that individual- and couple-level therapies that address sexual satisfaction/function for sexual assault survivors and their partners may be particularly beneficial for that population. Notably, this interpretation is consistent with previous calls to address sexual health and well-being as essential components of both mental and physical health care for both civilian women (e.g., Davidson, Bell, LaChina, Holden, & Davis, 2009) and female veterans (e.g., Yano et al., 2010). Addressing sexual satisfaction/function in the mental health treatment of female survivors of sexual assault may best be achieved by integrating modules and therapeutic approaches from the existing sexual health literature. For example, cognitive-behavioral therapy (CBT) techniques have been found to be helpful in reducing PTSD and depressive symptoms for both civilian women (e.g., Najavits, Weiss, & Liese, 1996) and female veterans seeking treatment through the Veterans Affairs system (e.g., Schnurr et al., 2007). CBT treatment including (1) enhancement of communication and sexual skills, and (2) reduction of sexual and performance anxiety, has also been shown to be effective for women with hypoactive sexual desire (McCabe, 2001; Trudel et al., 2001). Specifically, such treatment may result in significant improvement in quality of sexual and marital life, sexual satisfaction, perception of sexual arousal, sexual self-esteem, and reduced depression and anxiety (e.g., Trudel et al., 2001). Adjunctive interventions addressing body image concerns and negative sexual attitudes may also be helpful in addressing aspects of both sexual dysfunction (Heiman & Meston, 1997; Segraves & Althof, 1998) and other concerns that frequently co-occur following sexual assault (e.g., Wenninger & Heiman, 1998).

Research addressing both female sexual dysfunctions broadly and female orgasmic disorder specifically stresses the importance of couples' treatment in addition to individual therapy in resolving these problems (e.g., Kilmann et al., 1987). As aforementioned, the empirically supported associations between post-trauma mental health symptoms and various elements of interpersonal relationships highlight the importance of social relationships – and intimate relationships in particular – for those who have experienced trauma, including sexual assault. As such, addressing relationships in treatments for psychological

distress related to sexual assault may help to improve individual psychopathology in this population. Moreover, even when individual psychotherapies for PTSD produce overall improvements in psychosocial functioning, these improvements do not consistently extend to individuals' intimate relationship functioning (Schnurr, Hayes, Lunney, McFall, & Uddo, 2006).

Thus, therapy that includes attention to such relationships, including couples-based therapy (e.g., Monson et al., 2012), may help improve reduction in posttrauma mental health symptoms and improvements in relationship satisfaction in this population. Specifically, couples could benefit from cognitive-behavioral interventions designed to enhance communication skills and increase sexual skills, as well as from engaging in nondemand touching exercises (Kilmann et al., 1987). Sex education and psychoeducation about the impact of sexual assault – and about the unique factors associated with military sexual trauma for female veterans and their partners – will also help to provide normalization, foster understanding, reduce distress, and inform necessary therapeutic discussions. Indeed, teaching couples that changes in sexual satisfaction and function following sexual assault are normative and related to other aspects of posttrauma psychopathology, and empowering them to improve both their individual and couples functioning is likely to result in the best outcome for all involved. Notably, such treatment adjuncts are consistent with the Department of Veterans Affairs' priority of improving evidence-based health care for female veterans (e.g., Yano et al., 2006) and its emphasis on the integration of mental, physical, and interpersonal health for this population (e.g., Kelly et al., 2011).

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