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Attachment Quality and Sexual Satisfaction and Sexual Functioning in Romantic Relationships for Combat Veterans

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ATTACHMENT QUALITY AND SEXUAL SATISFACTION AND SEXUAL FUNCTIONING IN ROMANTIC RELATIONSHIPS FOR COMBAT VETERANS

THESIS

A thesis submitted in partial fulfillment of the
requirements for the degree of Master of Science in the
College of Agriculture, Food, and Environment
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By

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ABSTRACT OF THESIS

ATTACHMENT QUALITY AND SEXUAL SATISFACTION AND SEXUAL FUNCTIONING IN ROMANTIC RELATIONSHIPS FOR COMBAT VETERANS

Previous literature has shown that combat veteran posttraumatic stress disorder (PTSD) affects attachment quality, as well as sexual satisfaction and functioning. This study used internet survey methods from 248 male combat veterans in committed relationships to analyze the correlations between PTSD symptoms, attachment quality, sexual satisfaction, and sexual functioning in romantic relationships. The results indicate that PTSD symptoms from combat veterans are correlated with attachment quality, sexual satisfaction, and sexual functioning in romantic relationships. Implications for professionals and future research are explored.

Keywords: Military, posttraumatic stress disorder, attachment, sexual satisfaction, sexual satisfaction, romantic relationships

Ilana Pinsky

May 3, 2016

ATTACHMENT QUALITY AND SEXUAL SATISFACTION AND SEXUAL FUNCTIONING IN ROMANTIC RELATIONSHIPS FOR COMBAT VETERANS

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I would like to dedicate my thesis to the men and women who are currently serving or have served in the U.S. Military. Thank you for your service and the sacrifices you make for this country.

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Chapter One: Introduction

At least 20% of military service members have been diagnosed with posttraumatic stress disorder (PTSD) including those who served in Operation Iraqi Freedom/Operation Enduring Freedom (Badour, Gros, Szafranski, & Acierno, 2014; Campbell & Renshaw, 2013). PTSD has been listed as a trauma and stressor-related disorder that can cause emotional, social, and professional problems (National Center for PTSD, 2014; Safarinejad, Kolahi, & Ghaedi, 2008). Clark and Owens (2012) found that PTSD severity is linked with problematic and/or deteriorating attachment styles in relationships. Furthermore, 80% of veterans with PTSD have reported problems with sexual functioning and satisfaction (Cosgrove et al., 2002; Breyer et al., 2013). There has been extensive research on attachment quality in military-related PTSD, and some research on how military-related PTSD affects sexual functioning and satisfaction. However, additional research is needed to analyze military-related PTSD, attachment, and sexual satisfaction and sexual functioning.

Chapter Two: Literature Review

Theoretical Framework

The theory of traumatic stress reactions (TTSR) is the person-environment interactional framework that elaborates the etiology of posttraumatic stress reactions and adaptation (Wilson, 1989). Traumatic events vary from person to person and one experience to another experience. The TTSR model explains how traumatic stress can alter an individual's personality function in pathological and nonpathological ways. Based on the severity of the traumatic event, multiple stressors are created and fall into different dimensions per individual. Such a dimension could be a threat to an individual's life and the psychological focus behind it, for example, a veteran witnessing someone in his or her unit that was killed in combat. It is also important to remember that cultural differences impact the way a person perceives and interprets a traumatic experience (Wilson, 1989). There are four elements that make up the TTSR model: (1) person variables, (2) the environment and situation of the trauma, (3) individual's response to the trauma, and (4) post-trauma adaptation (Salvatore, 1995; Wilson, 1989).

Person variables. Person variables are the elements that make up a person's psychology/personality which prime, or protect, the individual when exposed to potentially traumatic events. Example constructs that would be considered person variables include genetics, values, abilities, and potentially attachment style. Person variables interact with the remaining variables for the environment and situation of the trauma, and influence subjective responses to the trauma. For example, a religious combat veteran with high morals and beliefs, murders an individual in war, and later feels distressed and guilty about it. This subjective response could lead to a consequence of

pathological symptoms (Wilson, 1989). It is important to note that the person variables not only impact the environment, but the environment can impact the person in return.

The environment and situation of the trauma. This domain of TTSR discusses the surroundings of the traumatic event in greater detail. This domain has four sub-elements pertaining to the context of the traumatic event as well as the post-trauma "milieu" (Wilson, 1989). First is the dimension of the trauma, which could include; bereavement/loss, exposure to death, moral conflict, role in trauma, threat to loss of life, and impact on the community. Second is the experience of the trauma. Was the person alone? With others? Or was it community-based? Third is the way the trauma was structured. The trauma could have a single stressor or multiple stressors. Was the trauma complex or simple? Or was the trauma a natural occurrence or man-made? Last is the post-traumatic milieu. The milieu is based on support that is present, cultural rituals for recovery, societal attitudes towards the event, and the opportunity structure, which is culture being integrated into personal responsibilities or even establishing personal identity. The dimension of the trauma with combat veterans shows that they are entering a life-threatening situation. Combat veterans may or may not experience the trauma alone and/or with others. When combat veterans are in warfare, they face multiple stressors such as being exposed to death and injury. A possible milieu that combat veterans will face is the societal attitudes towards war and their post-war problems, such as PTSD. The environment and situation of the traumatic event significantly affects an individual, however, individuals respond to the trauma in various ways.

Individual's subjective response to trauma. The element of responding to trauma makes up the third component of TTSR. This refers to the individual's initial

response during the traumatic experience (Wilson, 1989). Responses could be emotional, cognitive, motivational, neurophysiological, or coping. Emotional reactions in individuals are affective distress (i.e. feeling emotionally overwhelmed or having anxiety), affective numbing (i.e. difficulties in giving and receiving affection), and affective balance (i.e. reacting emotionally to the trauma). Cognitive reactions can be denial/avoidance, distortion, accurate appraisal, dissociation, and intrusion. Motivational reactions can either be aroused or non-aroused. Neurophysiological reactions involve hyperarousal, depression-avoidance, and balance. Lastly, coping reactions can be instrumental, emotional, positive or negative cognitive re-structure, and resilience (Wilson, 1989). According to the DSM-V, there are four clusters that make up PTSD symptoms (e.g. intrusion/re-experiencing, avoidance, negative alterations in cognitions and mood, and alterations in arousal and reactivity), which demonstrate how an individual responds to traumatic experiences and how these cluster symptoms composed the five different initial responses from trauma. (American Psychological Association, 2013). Emotional reactions could fit into any of the four clusters of PTSD, however, it depends on the element. For an example, a combat veteran with PTSD that experiences emotional numbing, (i.e. falls under avoidance cluster) could possibly detach themselves from their partner, and may not be able to express feelings of love and attachment (Badour, Gros, Szafranski, & Acierno, 2014). Cognitive reactions to trauma could fall under intrusion and avoidance clusters. An intrusive, cognitive reaction in a combat veteran with PTSD could be having a flashback of the trauma and re-living the experience, which is also connected to motivational responses (Wilson, 1989). A motivational response from someone with PTSD could be a defense and safety mechanism (i.e. negative alterations in

cognitions and mood) from a trigger they re-experienced, thus creating a new level of anxiety (Wilson, 1989). Neurophysiological responses fall under alterations in both arousal and reactivity and avoidance (American Psychological Association, 2013; National Center for PTSD, 2014; Wilson, 1989). Combat veterans that experience hyperarousal symptoms (e.g. getting jumpy from hearing fireworks) will experience elevated levels of noradrenalin, serotonin, and dopamine (Wilson, 1989). The individual's subjective response to the trauma event partially sets the foundation for the post-traumatic adaption.

Posttraumatic adaptation. This element discusses how the individual eventually adapts to trauma. These adaptations can either be pathological or nonpathological. Pathological outcomes include: change in personality or behavior, positive alterations in personality, changes in motives, beliefs, attitudes, and values, and changes in ego development. Nonpathological adaptations show little to no change in these areas. PTSD is the most common pathological outcome, and how many combat veterans adapt and cope with their traumatic experiences (Wilson, 1989). Nonpathological outcomes from trauma have shown that positive alterations in personality and ego can form. If a combat veteran's posttraumatic adaption result in a nonpathological outcome, there is a possibility of greater resilience from the trauma (Wilson, 1989). Of particular interest for the current study, pathological outcomes (i.e. PTSD) have been shown to also impact other areas of functioning such as sexual functioning and resultant sexual satisfaction (Antičević & Britvić, 2008; Badour, Gros, & Szafranski, 2014).

Attachment Theory and TTSR

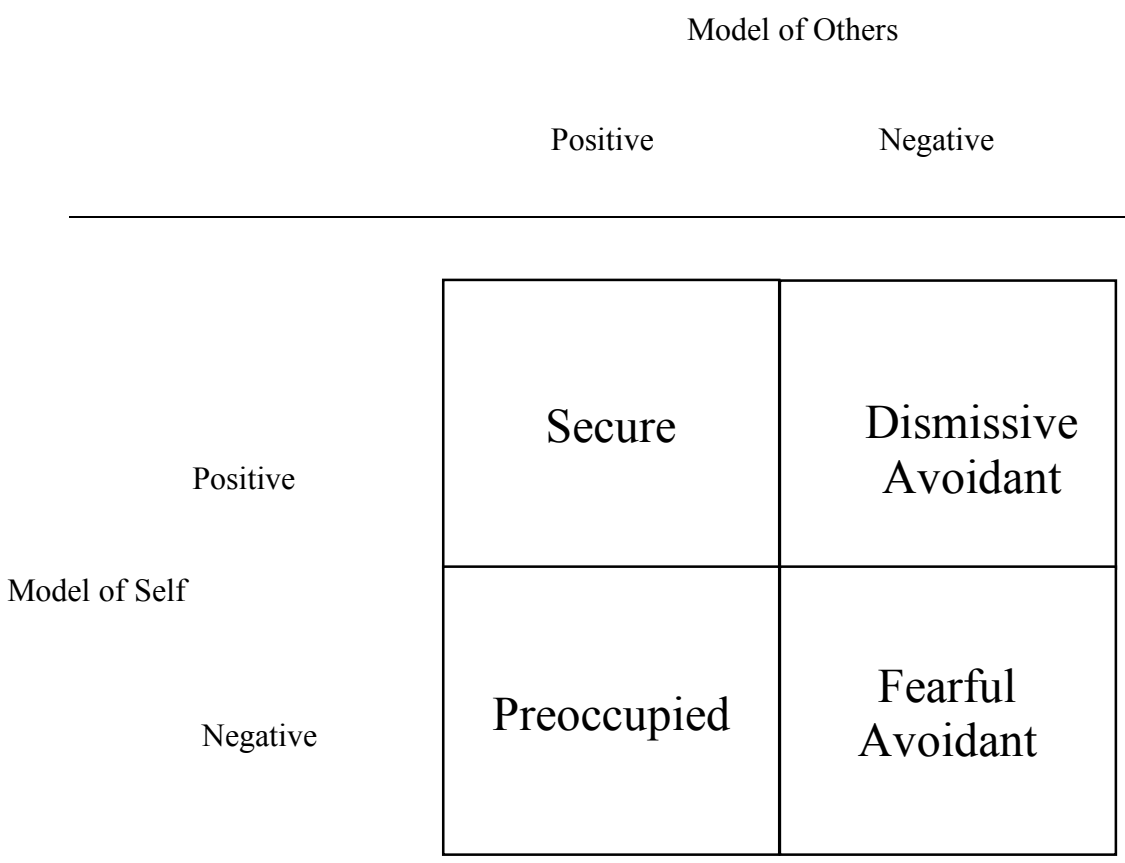
It could be argued that the attachment system, as first articulated by Bowlby (1958/1969) fits into multiple aspects of TTSR within that the attachment system. The attachment system is listed below relates to the aspects of TTSR in the parenthesis: 1) affects the innate perception of threats (person variables) (Bowlby, 1969/1982) 2) influences the response to the perceive threats wherein the individuals approaches/avoids available support figures (environment and situation of the trauma) (Ainsworth, Blehar, Waters, & Wall, 1978**)**, 3) the response of the available support before, during, and after a traumatic event (individual's subjective response to trauma) in turn affects 4) the attachment structure of the individual (post-trauma adaptation) **(**Bowlby, 1969/1982, 1973**).**

Attachment theory was formulated to describe the development of core mental structures through the dynamic between an infant and a caregiver and the subsequent influence of those mental structures on later life and relationships. It is relevant to note that the hypothesized core mental structures and subsequent response patterns (Bowlby, 1969/1982, 1973, 1980) hypothesized (i.e., the attachment system) are especially malleable when the individual is distressed. In other words, the impact on the attachment system is heightened based on the dynamic between the individual and attachment figure. Furthermore, this attachment system is activated when the individual anticipates, perceives, or experiences a threatening situation regardless of age (Bowlby, 1969/1982, 1973, 1980).

Mary Ainsworth built the laboratory foundation for attachment theory and articulated three attachment patterns, or styles, in her study of infant attachment: secure,

anxious-ambivalent, and insecure-avoidant (Ainsworth, Blehar, Waters, & Wall, 1978). Later, Main and Solomon (1990) articulated a fourth attachment style observed in children: disorganized attachment. Bartholomew and Horowitz (1991) also developed four attachment styles for adults (see Figure 1.1). Each attachment style, be it child or adult attachment styles, describes a behavioral/psychological response pattern when the individual is distressed. Since attachment theory and TTSR both articulate pathways in which individuals respond to stressors, it is not surprising that research has found connections between PTSD and attachment.

Figure 1.1 Adult attachment styles modeled from the internal working



Combat Veteran PTSD and Attachment

According to Shura (2013), a higher level of secure attachment does not lessen the severity of PTSD in war veterans. Previous literature found that the survivors who experienced trauma during active service reported higher levels of attachment anxiety associated with higher levels of PTSD symptoms, thus supporting TTSR due to the person variable (i.e. attachment) being impacted from warfare stressors, responding to the trauma, and later developing PTSD as a method of adapting to the trauma (Clark & Owens, 2012). Combat veterans that are anxiously attached and were exposed to on-going traumatic events (i.e. war) were associated with increased levels of PTSD severity symptoms (Besser & Neria, 2012). Clark and Owens (2012) found that veterans with PTSD in intimate relationships had high avoidant attachment and showed significantly higher PTSD symptom severity. Renaud (2008) discovered that avoidantly attached combat veterans showed disinterest in emotional connection. However, the personality factor of conscientiousness was correlated with reduced anxious attachment and reduced the severity of PTSD symptoms in veterans (Clark & Owens, 2012).

PTSD and Sexual Functioning and Sexual Satisfaction

TTSR suggests that pathological post-trauma adaptations can impact multiple areas of an individual's life. Some research has found that problems in sexual functioning among veterans with PTSD are prevalent (Antičević & Britvić, 2008; Letourneau, Schewe, & Frueh, 1997). Cosgrove et al. (2002) stated that veterans with PTSD would most likely report difficulties with sexual disinterest. They found that 80% of veterans with PTSD would experience difficulties in sexual satisfaction and functioning (Cosgrove et al.2002). Orgasmic functioning was a common sexual dysfunction that impaired the

sex lives of veterans with PTSD (Cosgrove et al., 2002). Sexual dysfunction is more common in male veterans than female veterans (Badour, Gros, Szafranski, & Acierno, 2014). Problems in sexual functioning most likely occur from emotional numbing symptoms, which can also impair interpersonal and romantic or sexual relationships with others (Badour et al., 2014). The problems that have arisen in veterans with PTSD include issues with sexual activity, desire, arousal, problems achieving orgasm, and lacking overall satisfaction. However, the two most common sexual difficulties are erectile dysfunction and premature ejaculation (Antičević & Britvić, 2008; Badour et al, 2014).

Premature ejaculation and erectile dysfunction. Premature ejaculation and erectile dysfunction in veterans with PTSD are most likely caused by anxiety that comes with the disorder (Levy, 2012). Erectile dysfunction in veterans with PTSD is most likely caused by anxiety from the disorder or from stressors within their relationship (Levy, 2012). According to Letourneau et al. (1997), nearly 63% of combat veterans suffered from erectile functioning problems while receiving inpatient treatment for their PTSD. They found that 37% of Vietnam veterans with PTSD showed sexual disinterest. It is also possible that veterans with PTSD who are experiencing more sexual problems may not have many sexual partners (Letourneau et al., 1997). However, the literature also indicates that marital status does not make a significant difference (Letourneau et al., 1997). Male partners with erectile dysfunction did not see a difference in sexual desire with their female partners compared to the group without erectile dysfunction (Cosgrove et al., 2002; Levy 2012). However, sexual satisfaction was still negatively affected by the presence of sexual dysfunction (Monson, Taft, & Fredman, 2009). Veterans with PTSD

are also more likely to become intimately aggressive with their partners/spouses, which is associated with the hyperarousal symptom. Re-experiencing symptoms can also lead to intimate aggression in the bedroom and destroy sexual satisfaction (Monson et al., 2009).

Attachment, Sexual Functioning, and Sexual Satisfaction

According to Carrasco (2012), attachment quality and sexual functioning are related to each other and influence one another. When an attachment bond is established, the quality of sexuality can contribute to increasing comfort and closeness (Carrasco, 2012). Dismissive-avoidant attachment is also linked with sexual functioning because it can decrease the desire to have sex in relationships in addition to dismissing the sexual needs of others, nor find enjoyment in sexual pleasure, or experience problems with orgasm (Carrasco, 2012). Research also found that avoidantly attached individuals engaged in sex just to avoid conflict, so their partner would not get angry or upset (Impett, Gordon, & Strachman, 2008). Regardless of gender, avoidant attachment was significant to high aversive sexual feelings and cognitions (Birnbaum et al., 2006). Insecure attachment can lead to sexual aggression and coercion due to potential interpersonal problems. Birnbaum et al. (2006) found that anxiously attached individuals were affected more by daily fluctuations in sexual experiences. When attachment is secured, individuals will most likely show an increase in sexual excitement and improvement in sexual functioning (Carrasco, 2012).

Insecure attachment. When insecure attachment is present in women, it is linked with a greater desire for sex and closeness, which makes them fear they will drive their partner away from having sex (Feeney, 2008). For example, if someone has insecure attachment, then their partner could become more pessimistic when it comes to having

sex. Another possibility is the chance that an individual might not be able to openly express their sexual needs or issues with their partner, which could be discussing what they would like and not like to be done during sexual activity (Khoury & Findlay, 2014). Impett, Gordon, and Strachman (2008) found that men will engage in sex to boost their ego and feel better about themselves, which led to them avoiding showing any signs of distress to their partners. According to Khoury and Findlay (2014), sexual satisfaction influences relationship stability and attachment orientation.

Secure attachment. Securely attached individuals are least likely to have one-night stands or have sexual relations with anyone outside of an existing relationship. There is a greater chance for mutual initiation and enjoyment (Feeney, 2008). When secure attachment is present, both members of the couple show mutual reciprocation, are comfortable enough to openly express their thoughts and feelings to each other, and are mutually dependent on each other (Basham, 2008). This type of attachment will increase positive sexual satisfaction, and partners will be able to clearly express their love and affection in their relationships.

Avoidant attachment. Avoidantly attached individuals were most likely to find sex not enjoyable, uncomfortable, and/or not rewarding, which makes their sexual satisfaction less satisfying (Khoury & Findlay, 2014). Avoidant attachment was not significantly associated with sexual arousal, orgasmic activity, and sexual satisfaction. When avoidant attachment increased, partners believed that sexual activity did not enhance closeness within the relationship (Birnbaum, 2007). Birnbaum (2007) also found that avoidant attachment was not associated with relationship satisfaction. When avoidant attachment was high, individuals reported high doubts about feeling loved and loving

others (Birnbaum et al., 2006). Individuals with avoidant attachment prefer casual sex because it does not involve commitment or any form of emotional closeness (Feeney, 2008).

Anxious Attachment. Anxious attachment is more detrimental to sexual functioning compared to avoidant attachment. Birnbaum and her colleagues (2006/2007) discovered that anxious attachment was significant with aversive aspects of sex. When anxious attachment increased, the relationship and sexual satisfaction, orgasmic activity, and sexual arousal decreased (Birnbaum, 2007). Individuals that have high anxious attachment reported strong doubts about feeling loved. The higher the anxious attachment, the more people relied on sex to fulfill their attachment needs (Birnbaum et al., 2006). According to Impett, Gordon, and Strachman (2008), men specifically, with anxiously attached partners, would not engage in sex as often to please their partners. Some men who had anxiously attached partners felt annoyed or frustrated by their partner's possessive clinginess, and were less likely to engage in sex (Impett, Gordon, and Strachman, 2008).

Sexual Satisfaction and Relationship Satisfaction

Sexual satisfaction is an important factor in romantic relationships. Previous research has conceptualized sexual satisfaction as being content with the sexual factors of a relationship, being satisfied with sexual activity and interaction, and/or experiencing moments of pleasure during sex (Mark & Jozkowski, 2013). According to Lawrance and Byers (1992), sexual satisfaction can also be defined as, "an affective response arising from one's subjective evaluation of the positive and negative dimensions associated with one's sexual relationship (p. 123). There have been positive associations between sexual

satisfaction and relationship satisfaction, and that when there is a change in sexual satisfaction, it will be associated with relationship satisfaction of individuals in long-term relationships. (Byers, 2005).

Relationship satisfaction has been defined in various ways. Two definitions from Byers (2005) involve evaluating the positive and negative aspects in the relationship and how an individual shows an affective orientation to their relationship. Relationship satisfaction can also define how a partner experiences relationship conflict, feelings, emotions, and distance from their partner. Some individuals believe that relationship satisfaction means the relationship lacks dissatisfaction (Mark & Jozkowski, 2013). Research found that poor communication was associated with a decrease in relationship satisfaction, relationship functioning, and overall sexual satisfaction (Byers, 2005).

Sexual Functioning in Men and Relationship Quality

According to the DSM-5, men's sexual functioning involves occurrences of ejaculations, erectile functioning, achieving orgasm, and sexual arousal (Antičević & Britvić, 2008; APA, 2013). This study uses the definition that Rosen and colleagues (1997) used to measure male sexual functioning: erectile functioning, orgasmic functioning, sexual desire, intercourse satisfaction, and overall satisfaction. Erectile functioning consisted of the frequency of erections, firmness of erections, the ability to penetrate, frequency of maintaining an erection, the ability to maintain an erection, and confidence of erection. Orgasmic functioning was measured by how often ejaculation occurred and how often orgasm was achieved. Sexual desire was conceptualized as the frequency of desire and the level of desire. Intercourse satisfaction consisted of the frequency of intercourse, the satisfaction level of intercourse, and the enjoyment of

intercourse. Finally, overall satisfaction consisted of how men felt about their sex lives overall and their relationship satisfaction (Rosen et al., 2007). Costa and Brody (2007) discovered that the frequency of penile-vaginal intercourse and frequency of penile-vaginal orgasms were positively associated with different components of relationship quality: 1) satisfaction, 2) commitment, 3) intimacy, 4) trust, 5) passion, and 6) love.

Rationale of Study

While there is research that supports the relationship between PTSD and attachment, the relationship between PTSD, sexual functioning, and sexual satisfaction, and the relationship between both attachment and sexual satisfaction and functioning. However, there has not been a study that has captured how the multiple variables can affect relationships in various ways. Therefore, the purpose of this study is to analyze the relationship between combat veteran PTSD, attachment quality, sexual satisfaction, and sexual functioning.

This study is designed to answer the following questions: Is there a relationship between attachment quality and sexual satisfaction in combat veterans with PTSD? Is there a relationship between attachment quality and sexual functioning in combat veterans with PTSD? Three hypotheses were used to predict the outcomes of the study.

Hypothesis #1: As avoidant attachment increases, PTSD severity will increase while sexual functioning and sexual dissatisfaction will decrease in combat veterans.

Hypothesis #2: As the severity of PTSD increases, sexual functioning and dissatisfaction will decrease in combat veterans.

Hypothesis #3: As anxious attachment increases, symptoms of PTSD will increase while sexual functioning and sexual dissatisfaction will decrease in combat veterans

Chapter Three: Methodology

Sampling Plan

Participants consisted of male combat veterans over 18 years old (*N*=248). Of the 248 participants, 11.7% were in a committed relationship for at least six months to one year (*N*=29), 22.6% had been in a committed relationship for one to three years (*N*=56), and 65.7% had been in a committed relationship for more than three years (*N*=163).

Of the 248 participants, 0.8% were American Indian/Alaskan Native (*N*=2), 2% were Asian (*N*=5), 2.8% were Black/African American (*N*=7), 5.6% were Hispanic/Latino (*N*=14), 0.4% were Native Hawaiian/Pacific Islander (*N*=1), 84.7% were White/Caucasian (*N*=210), and 3.6% identified as Other (*N*=9).

Of the 248 participants, 6.9% possessed a high school diploma/GED (*N*=17), 36.7% had completed some college courses (*N*=91), 12.5% possessed an Associate's Degree (*N*=31), 32.3% possessed a Bachelor's Degree (*N*=80), 10.9% possessed a Master's Degree (*N*=27), and 0.8% possessed a Doctoral Degree (*N*=2).

It was important to ask the participants if they were taking any medication that affects their sexual functioning because that could have impacted the results of the study. Only 7% of the participants said they were taking medication that affects sexual functioning (*N*=18) and 93% did not (*N*=230).

Of the 248 participants, 39.1% had been deployed once (*N*=97), 29.4% had been deployed twice (*N*=72), 13.7% had been deployed three times (*N*=34), and 17.7% had been deployed more than four times (*N*=44). Based off the 248 participant's length of deployment, 9.3% of the participants had been on deployments that lasted less than six

months (*N*=23), 72.5% had been on deployments lasting seven to twelve months (*N*=180), and 18.1% had been on deployments that lasted more than 12 months (*N*=45).

Of the 248 participants, 58.9% served/currently serving in the U.S. Army (*N*=146), 5.6% served/currently serving in the U.S Navy (*N*=14), 19% served/currently serving in the U.S. Marine Corps (*N*=47), 16.1% served/currently serving in the U.S. Air Force (*N*=40), and 0.4% served/currently serving in the U.S. Coast Guard (*N*=1). Based off the 248 participant's component, 82.7% were Active Duty (*N*=205) and 17.3% were National Guard/Reserves (*N*=43). Based off the 248 participant's rank, 13.3% were commissioned officers (*N*=33), 2.4% were warrant officers (*N*=6), and 84.3% were enlisted (*N*=209).

Measures

In Table 2.1, the descriptive statistics are shown for each measure from data collection.

Demographics. A demographic questionnaire asked participants the following information to make sure they are eligible for the study (e.g. gender, length of relationship, and type of deployment), personal information (e.g. race, level of education, and medication), and military information (e.g. number of deployment(s), length of deployment(s), branch of service, component, and rank) (see Appendix A).

PTSD symptoms and severity. The *PTSD Checklist-Military Version* (PCL-M; Weathers, Litz, Herman, Huska, & Keane, 1993) was given to the respondents and was based on the DSM-IVTR criteria. Participants reported on the extent to which they have experienced PTSD symptoms: B symptoms (re-experiencing symptoms) (items 1-5), C symptoms (avoidance/numbing symptoms) (items 6-12), and D symptoms (hyperarousal symptoms) (items 13-17) (see Appendix B). The measure is 17-items with 5-point Likert-

type response options ranging from *not at all* (1) and *extremely* (5). Example items include "Repeated, disturbing, memories, thoughts, or images of a stressful military experience?" and "Feeling very upset when something reminded you of a stressful military experience?" Therefore, high scores indicate high severity in PTSD symptoms, and low scores indicating low severity in PTSD symptoms. Previous work has shown the internal consistency for the subscales and total scores ranged from: B symptoms, α= .93; C symptoms α= .92; D symptoms α=. 92; and total symptoms α=. 97 (Weathers et al., 1993). The internal consistency for the current sample subscales and total scores ranged from: B symptoms, α= .88; C symptoms α= .87; D symptoms α= .85, and total symptoms α= .94. The average score was 40.3, which means mild to moderate PTSD severity symptoms were present among the participants.

Attachment. The *Experiences in Close Relationships-Revised Questionnaire* (ECR-R; Fraley, Waller, & Brennan, 2000) was designed to measure the levels of anxious and avoidant attachment found in couples that are in romantic relationships (see Appendix C). The participants used the scale to rate how they emotionally felt within their relationship. The measure is 36-items and based off the 7-point Likert scale from *strongly disagree* (1) and *strongly agree* (7). The first 18 questions measure levels of anxious attachment, and questions 19 through 36 measure levels of avoidant attachment. Example items include "I'm afraid that I will lose my partner's love" and "I often worry that my partner doesn't really love me." Previous work has shown good internal consistency for the subscales and total scores range from: Avoidance, α= .93; Anxiety, α= .95 (Fraley et al., 2000). Attachment was measured based on which type of attachment score they receive on a scale. Therefore, high scores indicate poor attachment

and low scores indicating good attachment. Internal consistency for the current sample subscales and total score range from: Avoidance, α=.94; Anxiety, α= .94. Avoidant attachment was more common (*M*=61.2, *SD*=23.5) than anxious attachment (*M*=54.2, *SD*=25.3).

Sexual functioning and satisfaction in males. The *International Index of Erectile Function* (IIEF; Rosen et al., 1997) was designed to measure male sexual functioning and sexual satisfaction: erectile function, orgasmic function, sexual desire, intercourse satisfaction, and overall sexual satisfaction (see Appendix D). Erectile function and orgasmic function measure sexual functioning, while sexual desire, intercourse satisfaction, and overall sexual satisfaction measure sexual satisfaction. The measure is 15-items, and each question has five response options, the anchors of which vary depending on the question. An example of the response options includes *no sexual activity* (0) and *almost always/always* (5) and *did not attempt intercours*e (0) and *almost always/always* (5). An example item includes: "How many times have you attempted sexual intercourse?" Therefore, high scores indicate good sexual satisfaction and functioning, and low scores indicating poor sexual satisfaction and functioning. Previous work has shown acceptable internal consistency for the subscales and total scores range from: erectile function, α= .91; orgasmic function, α= .92; sexual desire, α= .77; intercourse satisfaction, α= .73; and overall satisfaction, α= .74 (Rosen et al., 1997). The internal consistency for the current sample subscales and total score ranges from: erectile function, α= .91; orgasmic function, α= .90; sexual desire, α= .89; intercourse satisfaction, α= .75; and overall satisfaction, α= .90. There was not little to none erectile dysfunction among the participants (*M*=27.0, *SD*=15.5), mild orgasmic dysfunction

(*M*=8.58, *SD*=1.84), mild disturbance in sexual desire (*M*=8.06, *SD*=2.08), mild disturbance in intercourse satisfaction (*M*=12.8, *SD*=2.58), and mild disturbance in overall sexual satisfaction (*M*=7.34, *SD*=2.49).

Relationship satisfaction. *General Measure of Relationship Satisfaction* (GMREL; Lawrance & Byers, 1992) was designed to measure the overall relationship satisfaction (see Appendix E). The measure is five items, and has one question that matches with each item, the anchors of which vary depending on the question. An example of the response option includes *very bad* (1) and *very good* (7) and *very unpleasant* (1) and *very pleasant* (7). An example item is: "Overall, how would you describe your relationships with your partner?" Therefore, high scores indicate good relationship satisfaction, and low scores indicating poor relationship satisfaction. Previous work has shown the internal consistency for the subscales and total scores range from α=. 95 and α=. 96 on relationship satisfaction. The internal consistency for the current sample subscales and total scores range was α= .94.

Overall sexual satisfaction. *General Measure of Sexual Satisfaction* (GMSEX; Lawrance & Byers, 1995) was designed to measure the overall sexual satisfaction (see Appendix F). The measure is five items, and has one question that matches with each item, the anchors of which vary depending on the question. An example of the response option includes *very bad* (1) and *very good* (7) and *very unpleasant* (1) and *very pleasant* (7). An example item is: "Overall, how would you describe your sexual relationship with your partner?" Therefore, high scores indicate good overall sexual satisfaction, and low scores indicating poor overall sexual satisfaction. Previous work has shown the internal consistency for the subscales and total scores range from α=. 96; long-term relationships;

α=. 90 in a student sample; and α=. 96 in a community sample. The internal consistency for the current sample subscale and total score range was α= .93.

Table 1.1 Descriptive Statistics

Measure	Mean	Std. Deviation
Anxiety total score	54.1628	25.27109
Avoidance total score	61.1928	23.48984
Total Symptoms	40.3777	15.47576
Erectile function	27.0429	4.66799
Orgasmic function	8.584	1.84055
Sexual Desire	8.0624	2.07605
Intercourse Satisfaction	12.8116	2.58486
Overall Satisfaction	7.3434	2.48972
GMREL total	29.2695	5.5524
GMSEX	27.4303	6.20374

Note: *N*=248 for every subscale

Procedures

The sampling plan used convenient and snowball sampling. The veteran had to meet four eligibility requirements in order to participate in the study: (1) must be in a committed relationship for at least six months, (2) be at least 18 years old, (3) must be a male, and (4) must have been on a combat-related deployment while serving in a military branch. All potentially eligible participants were recruited from the following locations: University of Kentucky Student Veteran Association, University of Kentucky Student Veteran Resource Center, University of Kentucky Extension for military family programs and camps, Kentucky National Guard, other military organizations around the country, and advertisements posted on social media websites (e.g., Facebook, Reddit, Craigslist).

If the participants were recruited from different locations and resources within the Commonwealth of Kentucky, the researcher spoke to a staff member from the specific organization on how potential participants could access the Qualtrics survey link. The researcher also requested permission to display a flyer on the resource's social media page with the Qualtrics survey link. If the participants were recruited from Craigslist or social networking sites (e.g. Facebook, Twitter, Instagram), they were only redirected to the Qualtrics survey link, since the survey link was advertised online. All procedures were approved by the University of Kentucky's Institution Review Board.

All participants for the study were provided with a Qualtrics survey link. The participants were introduced to the purpose of the research, informed consent for participation, participation is voluntary, all information is anonymous and confidential, understanding the risks for completing the survey, and understanding the potential benefits gained for completing the survey. Participants received the demographic

questionnaire, PTSD Checklist-Military Version questionnaire, the Experiences in Close Relationships-Revised questionnaire, the International Index of Erectile Function questionnaire, the General Measure of Relationship Satisfaction, and the General Measure of Sexual Satisfaction. Additionally, the final survey question asked participants to enter their email address if they wished to be entered for a drawing to win one of four $25 Amazon gift certificates as an incentive for participating in this study. Online surveys can more accessible to individuals. Participants will often feel more comfortable taking an online, especially when they are confidentially disclosing personal information and/or sensitive topics, such as their sexual functioning and sexual satisfaction (Turner et al., 1998). Another benefit to survey research is that Internet data collection is equally compared to traditional methods of data collection in regards to validity and reliability. Thus, making it a more effective way to collect data (Tyron, 2003).

Chapter Four: Results

Due to all questionnaires receiving partial responses, the first step was to look for patterns in missing data. These missing patterns were imputed in SPSS. Once the data was analyzed, 84% of the results had complete data. Of the ten most common patterns in the data set, the largest pattern contained 3.24% of the sample.

Hypothesis #1: As avoidant attachment increases, PTSD severity will increase wile sexual functioning and sexual dissatisfaction will decrease in combat veterans. Correlations were computed for the following variables: PCL-M total score, ECR-R avoidant attachment subscale, and the following IIEF subscales—erectile function, orgasmic function, sexual desire, intercourse satisfaction, and overall satisfaction (See Table 1.1). Small correlations were found between higher avoidant attachment and poor erectile functioning *(*r=-.278, p<0.01) and poor orgasmic functioning (r=-.232, p<0.01). Moderate correlations were found between higher avoidant attachment and less sexual desire (r=-.337, p<0.01), less intercourse satisfaction (r=-.255 p<0.01), and increased PTSD severity symptoms (r=.392, p<0.01). Increased attachment avoidance had a stronger correlation with less overall sexual satisfaction (r=-.517, p<0.01). Each of these findings indicate support for Hypothesis #1.

Hypothesis #2: As the severity of PTSD increases, sexual functioning and dissatisfaction will decrease in combat veterans. Correlations were computed for the following variables: PCL-M total score and the following IIEF subscales—erectile function, orgasmic function, sexual desire, intercourse satisfaction, and overall satisfaction (See Table 1.1). Small correlations were found between high PTSD severity symptoms and poor erectile functioning (r=-.298, p<0.01), poor orgasmic functioning

(r=-.270, p<0.01), less sexual desire (r=-.275, p<0.01), less intercourse satisfaction (r=-.255, p<0.01), and less overall satisfaction (r=-257, p<0.01). Each of these findings indicate support for Hypothesis #2.

Hypothesis #3: As anxious attachment increases, symptoms of PTSD will increase while sexual functioning and sexual dissatisfaction will decrease in combat veterans.

Correlations were computed for the following variables: PCL-M total score, ECR-R anxious attachment subscale, and the following IIEF subscales—erectile function, orgasmic function, sexual desire, intercourse satisfaction, and overall satisfaction (See Table 1.1). Smalls correlations were found between high anxious attachment and poor erectile functioning (r=-.266, p<0.01), poor orgasmic functioning (r=-.228, p<0.01), less sexual desire (r=-.163, p=.01), and less intercourse satisfaction (r=-.189, p<0.01). Moderate correlations were found between high anxious attachment and less overall satisfaction (r=-.368, p<0.01). Large correlations were found between high anxious attachment and increased PTSD severity symptoms (r=.502, p<0.01). Each of these findings indicate support for Hypothesis #3.

Table 2.1 Correlations between the variables of PTSD severity, subscales of the International Index of Erectile Functioning, and the subscales of the Experiences in Close Relationships-Revised

	Measure	1	2	3	4	5	6	7	8	9	10
1.	PCL-M: PTSD Severity Total										
2.	ECR-R: Anxiety total score	.502**									
3.	ECR-R: Avoidant Attachment	.392**	.580**								
4.	IIEF: Erectile Functioning	-.298**	-.266**	-.278**							
5.	IIEF: Orgasmic Functioning	-.270**	-.228**	-.232**	.650**						
6.	IIEF: Sexual Desire	-.275**	-.163*	-.337**	.473**	.432**					
7.	IIEF Intercourse Satisfaction	-.255**	-.189**	-.255**	.708**	.556**	.525**				
8.	IIEF: Overall Satisfaction	-.257**	-.368**	-.517**	.376**	.366**	.317**	.591**			
9.	GMREL total	-.137*	-.479**	-.646**	.221**	.200**	.155*	.315**	.557**		
10.	GMSEX total	-.225**	-.399**	-.539*	.425**	.377**	.249**	.542**	.767**	.610**	

* $p \leq .05$; ** $p \leq .01$

Chapter Five: Discussion

The TTSR framework suggests a reciprocal interaction between a person's internal cognitive and affective experiences and their outside environment. Thus, the environment can impact internal mental structures, such as attachment, just as internal mental structures mitigate the impact of the environment. The TTSR framework, as well as attachment theory suggest that these processes can influence an individual long after they return home, or are away from the traumatic situation.

For the purpose of this study, avoidant or anxious attachment may become present because the veterans may have had a harder time reaching out and/or accepting support from their partner. This demonstrates the veteran's subjective response to the trauma because the attachment system affects not only a general response to what support systems are available before, during, and after combat or threatening experiences, but can have an affect on sexual functioning and satisfaction (Bowlby, 1969; Wilson, 1989).

Attachment and PTSD Severity Symptoms

The current study found a correlation between avoidant attachment and PTSD severity symptoms, which meant as high avoidant attachment (i.e., it was poor) was present, the severity of PTSD symptoms became worse. Clark and Owens (2012) found that when avoidant attachment was high the severity of PTSD symptoms increased. Their finding is also consistent with the present study's finding. Research has found that avoidant attachment is an important factor in relationship to the severity of PTSD symptoms (Renaud, 2008). These results indicate how conscientious the veterans felt in their relationships, and how vulnerable they can be. Such examples could be fear of their partner abandoning them, or feeling like they needed approval from their partner (Clark

& Owens, 2012). It is possible that avoidant attachment and PTSD severity are linked with one another due to the negative alterations and cognitions cluster in mood listed in the DSM-V. Such a symptom under this cluster can be emotional numbing or feeling detached from others (e.g., a partner). Another possible explanation for these findings is the inability for an individual to express loving feelings and affection with their partner (APA, 2013).

The current study found a correlation between anxious attachment and PTSD severity symptoms, which meant as high anxious attachment (i.e., it was poor) was present, the severity of PTSD symptoms became worse. This result was consistent with Clark and Owens' (2012) study and Besser & Neria's study (2012). High anxious attachment and high levels of PTSD develop from the impacts of combat stressors. Anxious attachment can be a response to a traumatic and stressful event, and then when PTSD is developed, it becomes a coping mechanism in order to adapt to a traumatic event (Besser & Neria, 2012; Clark & Owens 2012). A possible explanation for how anxious attachment and PTSD severity are linked with one another may have to do with negative feelings and emotions that develop from PTSD (APA, 2013). Individuals who possess anxious attachment will often worry about their relationship in general, how their partner feels about them, or even the fear their partner may not love them (Fraley, Waller, & Brennan, 2000).

Attachment, Sexual Functioning, and Sexual Satisfaction

The findings showed there was less sexual desire, less intercourse satisfaction, less overall sexual satisfaction when avoidant attachment was high. These findings are consistent with previous literature. Birnbaum et al., (2006) and Birnbaum (2007) found

that highly avoidant attached individuals believed that sex was not the answer to feeling emotionally connected to their partner, and expressed high doubts of loving their partner. One possible explanation to this finding could be linked with combat veterans feeling emotionally detached from their partner, thus leading to the fact that sex was not enjoyable to the veterans. The current study also found that avoidant attachment was significantly correlated with sexual functioning, in this case, erectile and orgasmic functioning. This finding is inconsistent with Birnbaum (2007) who found that avoidant attachment was not significant with sexual functioning such as sexual arousal and orgasmic functioning. Birnbaum hypothesized that sexual functioning is not impacted by avoidant attachment. Her finding and the current study's finding potentially explains how avoidantly attached individuals do not worry about feeling emotional connectedness while having sex. A possible explanation for this may have to do with combat veterans preferring to be in casual, short-term relationships, thus not allowing enough time for a committed relationship to form. If this were the case, this could potentially affect sexual desire for a casual partner, and may not have full sexual attraction to them (Birnbaum., 2007).

The current study found a correlation between anxious attachment, sexual satisfaction, and sexual functioning. The results indicated there was a decline in sexual satisfaction (less sexual desire, less intercourse satisfaction, and less overall sexual satisfaction), and sexual functioning being negatively affected (poor erectile functioning and decrease in orgasmic functioning) when anxious attachment was high. These results were consistent with Birnbaum et al. (2006) and Birnbaum (2007). Previous literature found that anxious attachment will impair sexual functioning more than avoidant

attachment. When higher levels of anxious attachment was present in individuals, their relationship and sexual satisfaction, orgasmic activity, and sexual arousal decreased (Birnbaum, 2007). A possible explanation as to why anxious attachment had more of a significant effect on sexual functioning compared to avoidant attachment was the individual being nervous or insecure. Feelings of anxiety can prevent a male from maintaining an erection because they fear their sexual perform will not be able to please their partner (Barlow, 1986). Higher levels of anxious attachment not only impair sexual functioning, but sexual satisfaction as well. For example, individuals may believe that having sex is another reason for their partner to find them clingy and sexually dependent (Campbell, Simpson, Boldry, & Kashy, 2005).

PTSD Severity, Sexual Dissatisfaction, and Sexual Functioning

Badour and colleagues (2014) found that sexual dysfunction was more common in male veterans than female veterans. The present study's results showed that poor orgasmic functioning was correlated with an increase in PTSD severity. Orgasmic functioning happens to be to the most common form of sexual dysfunction that combat veterans with PTSD face in their sex lives (Cosgrove et al., 2002. Both studies used the same measures (PCL-M and IIEF) to calculate the correlations between the two variables (PTSD severity and sexual functioning). The results from Cosgrove's study was not significant. This may have occurred because Cosgrove's sample size was much smaller (N=90) than the present study (N=253). In contrast to Cosgrove, the current study found a significant correlation between PTSD severity and sexual functioning.

Another common form of sexual functioning that was affected from PTSD symptoms was erectile functioning. The study found that as PTSD severity increased,

erectile functioning declined. This finding is consistent with Letourneau et al. (1997), who found that approximately 80% of the male participants with PTSD experienced problems in sexual functioning (i.e. erectile functioning). An explanation for this finding may be caused by the anxiety that comes with PTSD, possibly stressors from their relationship, or lack of sexual partners (Levy, 2012; Letourneau et al., 1997). Another reason as to why PTSD severity may have affected sexual functioning is that sex could potentially be a distressing situation for a combat veteran (APA, 2013).

Aside from sexual functioning, PTSD severity was also significantly associated with sexual satisfaction. The severity of PTSD symptoms most likely affected sexual satisfaction in romantic relationships, was not only due to sexual dysfunction, but intrusive symptoms, which can lead to intimate aggression (Monson, Taft, & Fredman, 2009).

Practice Implications

Professionals working with veterans need to assess for PTSD, attachment, sexual functioning, and sexual satisfaction (Letourneau, Schewe, & Frueh, 1997). Professionals can assist veterans and their partners to learn how PTSD and attachment styles can affect relationships and sexual functioning (Impett, Gordon, Strachman, 2008). This information could also be useful to partners of veterans, and they will be able to develop a better understanding of how their loved one may act when it comes to affection and sex in order to not internalize the relational impact of PTSD (Hamilton et al., 2009). Couples therapy ideally will go one step further to help partners learn to re-establish secure attachment within their relationship/marriage (Basham, 2008).

Family life education and marriage enrichment programs can also help military relationships/marriages face multiple issues such as communication barriers, lack of problem solving, interpersonal skills and building, socialization, etc. (Orthner & Bowen, 1982). The current research could strengthen programs such as Strong Bonds through the Prevention and Relationship Enhancement Program (PREP, Allen, Stanley, Rhoades, Markman, & Loew, 2011); one of the few military marriage enrichment programs that helps improve military relationships and teaches couples how to manage post-deployment relationship problems

Future Directions

To my current knowledge, this was the first research study to explore how attachment, PTSD, sexual satisfaction, and sexual functioning were affected in combat veterans. However, there are many different directions we can still further explore while studying this topic, and how it can always be improved.

This study only collected data from male combat veterans. However, females can develop PTSD from the military, and can still experience problems in attachment and sex. If females were included in a similar study, the researcher would need to reach out to more organizations (e.g., Women Veterans of America) where there is a high representation of female veterans.

This study did not specify which specific military members could take the survey, meaning it did not say if the survey was only open to U.S. military members or could anyone serving from another country take it? While it seems that most members who took the survey were from the U.S. military, based off the demographics, there is no reason that military members from other countries could not take this survey. A

recommendation for future studies would be to look into how PTSD severity, attachment issues, and sexual problems could potentially be different from members serving other countries and comparing the results.

This study did not ask participants how they found out about the survey, and determine the source of the data collection (i.e., Reddit, Facebook, Kentucky National Guard). A recommendation for future studies is to add a question about which source the participants used to access the survey. Knowing where the participants came from can help us improve recruitment methods and collect a larger sample.

The final weakness of this study was that age of the participants was not collected. This is a weakness because A) age can determine which wars these men experienced, and B) it could also help the researcher determine the possible length of everyone's relationship.

Despite the few limitations, the results from this study provided enough support and evidence that attachment, PTSD severity symptoms, sexual satisfaction, and sexual functioning are all affected by one another. The findings are also consistent with previous research studies on how combat veteran PTSD affects sex and attachment. Thus, making the study's findings reliable.

Further research. Most of the previous literature that focused on veterans with PTSD, were only individually studied. It is important for the next step to include a dyadic analysis, where the veteran and their partner are studied together. Using a dyadic analysis can help us further understand and explore how PTSD in the military impacts attachment and sex within a relationship. There is a need to focus on if there is a bidirectional relationship between a combat veteran's PTSD severity, attachment quality, sexual

satisfaction, sexual functioning and how it affects their partner. The same measures could be used for the study, but there would need to be another copy of the ECR-R, an additional measurement for female sexual satisfaction and functioning, and potentially even the Dyadic Adjustment Scale, which measures relationship adjustment as well as both partner's perceptions of the relationship (Spanier, 1989). A specific research question for this type of study could include, "Will partners of combat veterans be affected by their spouse's PTSD severity symptoms and see a change in their own sexual functioning, sexual satisfaction, and attachment quality?" The Actor-Partner Interdependence Model (Kenny, 1996; Kenny & Cook, 1999) would be used for statistical analysis, and models nonindependence in dyadic studies (Kenny & Cook, 1999). For an example, when two people (e.g.,. a military couple) are having sex, an individual's sexual satisfaction may not be independent of his or her partner's sexual satisfaction (Kenny, 1996).

Aside from conducting a dyadic analysis, another approach to this study is measuring how long the veteran has been back from a combat deployment and examines the four variables post-deployment, which could generate different data. An example to this would be the amount of times a veteran has sex within the last five years since their last deployment versus someone who has only been back for six months. Both results would most likely generate different answers.

Chapter Six: Conclusion

The findings from the present study indicate that avoidant and anxious attachment, sexual satisfaction, and sexual functioning are correlated with PTSD severity symptoms. The severity of PTSD symptoms was correlated with sexual satisfaction and sexual functioning in combat veterans. Anxious attachment, sexual satisfaction, and sexual functioning was correlated with PTSD severity symptoms. When PTSD affects the veteran's attachment, it could be triggered by feelings of self-conscientiousness, vulnerability, or even the trauma/stressors from war. Veterans that face difficulties in attachment and sexual satisfaction will most likely not find sex to be as pleasurable and believed sex will not enhance emotional connectedness. Problems in attachment and sexual functioning influence poor orgasmic functioning, poor erectile functioning, and a decrease in sexual desire and arousal. Other sexual satisfaction and sexual functioning problems that veterans with PTSD can deal with are premature ejaculation and lack of overall sexual satisfaction. This study underscored findings in previous literature and illustrates the many connections between PTSD symptoms, attachment, sexual satisfaction, and sexual functioning.

Appendix A

Demographics Questionnaire

1. Are you at least 18 years old?
____Yes ____No

2. How long have you been in a committed relationship?

a. Less than 6 months
b. 6 months to 1 year
c. 1-3 years
d. More than 3 years

3. Has your partner had a baby within the last 6 months, or currently pregnant?
____Yes _____No

4. Are you male or female?
___Male _____Female

5. Please describe your race/ethnicity.

a. American Indian/Alaskan Native
b. Asian
c. Black/African American
d. Hispanic/Latino
e. Native Hawaiian/Pacific Islander
f. White/Caucasian
g. Other (please describe) _____

6. What is your highest level of education?

a. High school diploma/GED
b. Some college
c. Associate's degree
d. Bachelor's degree
e. Master's degree
f. Doctoral degree

7. Are you currently taking any medication that could affect your sexual functioning?
____Yes ____No

If yes, what medication? _____
How long have you been on this medication?

8. Have you ever been on a combat-related deployment?
____Yes ___ No

9. How many deployments have you been on?

a. 1
b. 2
c. 3
d. 4+

10. How long are your deployments?

a. Less than 6 months
b. 7-12 months
c. More than 12 months

11. What is your branch of service?

a. Army
b. Navy
c. Marine Corps
d. Air Force
e. Coast Guard

12. What is your component?

a. Active Duty
b. Reserve/National Guard

13. What is your rank?

a. Commissioned Officer
b. Warrant Officer
c. Enlisted

Appendix B

PTSD Checklist – Military Version (PCL-M, Weathers, Litz, Herman, Huska, & Keane,1993)

Instructions: Below is a list of problems and complaints that veterans sometimes have in response to a stressful military experience. Please read each one carefully, then choose the option to the right to indicate how much you have been bothered by that problem in the past month.

	Not at all	A little bit	Moderately	Quite a bit	Extremely
1. Repeated, disturbing *memories*, *thoughts or images* of a stressful military experience?					
2. Repeated, *disturbing dreams* of a stressful military experience?					
3. Suddenly *acting or feeling* as if a stressful military experience *were happening again* (as if you were reliving it)?					
4. Feeling *very upset* when *something reminded* you of a stressful military experience?					
5. Having *physical reactions* (e.g., heart pounding, trouble breathing, sweating) when *something reminded* you of a stressful military experience?					
6. Avoiding *thinking about or talking about* a stressful military experience or *avoiding having feelings* related to it?					
7. Avoiding *activities or talking about* a stressful military experience or *avoid having feelings* related to it?					

8. Trouble *remembering important* parts of a stressful military experience?					
9. *Loss of interest* in activities that you used to enjoy?					
10. Feeling *distant or cut off* from other people?					
11. Feeling *emotionally numb* or being unable to have loving feelings for those close to you?					
12. Feeling as if your *future* somehow will be *cut short*?					
13. Trouble falling or staying asleep?					
14. Feeling *irritable* or having *angry outbursts*?					
15. Having *difficulty concentrating*?					
16. Being *"super alert"* or watchful or on guard?					
17. Feeling *jumpy* or easily startled?					

Has anyone indicated that you've changed since the stressful military experience? Yes __ No__

Appendix C

The Experiences in Close Relationships-Revised Questionnaire (ECR-R, Fraley, Waller, & Brennan, 2000)

Instructions: The statements below concern how you feel in emotionally romantic relationships. Using the 1 to 7 scale, choose the number to indicate how much you agree or disagree with the statement.

Question	1	2	3	4	5	6	7
	Strongly Disagree						Strongly Agree
1. I'm afraid that I will lose my partner's love							
2. I often worry that my partner will not want to stay with me.							
3. I often worry that my partner doesn't really love me.							
4. I worry that romantic partners won't care about me as much as I care about them							
5. I often wish that my partner's feelings for me were as strong as my feelings for him or her.							
6. I worry a lot about my relationships.							
7. When my partner is out of sight, I worry that he or she might become interested in someone else.							
8. When I show my feelings for romantic partners, I'm afraid they will not feel the same about me.							
9. I rarely worry about my partner leaving me.							
10. My romantic partner makes me doubt myself.							
11. I do not often worry about being abandoned.							
12. I find that my partner(s) don't want to get as close as I would like.							
13. Sometimes romantic partners change their feelings about me for no apparent reason.							
14. My desire to be very close sometimes scares people away.							
15. I'm afraid that once a romantic partner gets to know me, he or she won't like who I really am.							

16. It makes me mad that I don't get the affection and support I need from my partner.	
17. I worry that I won't measure up to other people	
18. My partner only seems to notice me when I'm angry.	
19. I prefer not to show a partner how I feel deep down.	
20. I feel comfortable sharing my private thoughts and feelings with my partner.	
21. I find it difficult to allow myself to depend on romantic partners.	
22. I am very comfortable being close to romantic partners.	
23. I don't feel comfortable opening up to romantic partners.	
24. I prefer not to be too close to romantic partners.	
25. I get uncomfortable when a romantic partner wants to be very close.	
26. I find it relatively easy to get close to my partner.	
27. It's not difficult for me to get close to my partner.	
28. I usually discuss my problems and concerns with my partner.	
29. It helps to turn to my romantic partner in times of need.	
30. I tell my partner just about everything	
31. I talk things over with my partner	
32. I am nervous when partners get too close to me	
33. I feel comfortable depending on romantic partners.	
34. I find it easy to depend on romantic partners.	
35. It's easy for me to be affectionate with my partner.	
36. My partner really understands me and my needs.	

Appendix D

International Index of Erectile Function (IIEF, Rosen et al., 1997)

Instructions: The questions below concern how you are sexually functioning and being satisfied. Using the 0 or 1 through 5 response options, choose the response option that fits the best with the corresponding question.

Question	Response Options
1. How often were you able to get an erection during sexual activity	0=No sexual activity 1=Almost never/never 2=A few times (much less than half the time) 3= Sometimes (about half the time) 4= Most times (much more than half the time) 5= Almost always/always
2. When you had erections with sexual stimulation, how often were your erections hard enough for penetration?	0=No sexual activity 1=Almost never/never 2=A few times (much less than half the time) 3= Sometimes (about half the time) 4= Most times (much more than half the time) 5= Almost always/always
3. When you attempted sexual intercourse, how often were you able to penetrate (enter) your partner?	0= Did not attempt intercourse 1= Almost never/never 2= A few times (much less than half the time) 3= Sometimes (about half the time) 4= Most times (much more than half the time) 5= Almost always/always
4. During sexual intercourse, how often were you able to maintain your erection after you had penetrated (entered) your partner?	0= Did not attempt intercourse 1= Almost never/never 2= A few times (much less than half the time) 3= Sometimes (about half the time) 4= Most times (much more than half the time) 5= Almost always/always
5. During sexual intercourse, how difficult was it to maintain your erection to completion of intercourse?	0= Did not attempt intercourse 1= Extremely difficult 2= Very difficult 3= Difficult 4= Slightly difficult 5= Not difficult

6. How many times have you attempted sexual intercourse?	0= No attempts 1= One to two attempts 2= Three to four attempts 3= Five to six attempts 4= Seven to ten attempts 5= Eleven + attempts
7. When you attempted sexual intercourse, how often was it satisfactory for you?	0= Did not attempt intercourse 1= Almost never/never 2= A few times (much less than half the time) 3= Sometimes (about half the time) 4= Most times (much more than half the time) 5= Almost always/always
8. How much have you enjoyed sexual intercourse?	0= No intercourse 1= No enjoyment 2= Not very enjoyable 3= Fairly enjoyable 4= Highly enjoyable 5= Very highly enjoyable
9. When you had sexual stimulation or intercourse, how often did you ejaculate?	0= No sexual stimulation/intercourse 1= Almost never/never 2= A few times (much less than half the time) 3= Sometimes (about half the time) 4= Most times (much more than half the time) 5= Almost always/always
10. When you had sexual stimulation or intercourse, how often did you have the feeling of orgasm or climax?	0= No sexual stimulation/intercourse 1= Almost never/never 2= A few times (much less than half the time) 3= Sometimes (about half the time) 4= Most times (much more than half the time) 5= Almost always/always
11. How often have you felt sexual desire?	1= Almost never/never 2= A few times (much less than half the time) 3= Sometimes (about half the time) 4= Most times (much more than half the time) 5= Almost always/always

12. How would you rate your level of sexual desire?	1= Very low/none at all 2= Low 3= Moderate 4. High 5. Very High
13. How satisfied have you been with your overall sex life?	1= Very dissatisfied 2= Moderately dissatisfied 3=About equally satisfied and dissatisfied 4= Moderately satisfied 5= Very satisfied
14. How satisfied have you been with your sexual relationship with your partner?	1= Very dissatisfied 2= Moderately dissatisfied 3=About equally satisfied and dissatisfied 4= Moderately satisfied 5= Very satisfied
15. How do you rate your confidence that could get and keep an erection?	1= Very low 2= Low 3= Moderate 4= High 5= Very High

Appendix E

The General Measure of Relationship Satisfaction (GMREL; Lawrance & Byers, 1992)

Instructions: The question below concerns your overall relationships satisfaction with your current partner. Using the 1 through 7 response options, choose the response option that fits the best with the question.

Overall, how would you describe your relationship with your partner?

Very Bad (1) —— (2) —— (3) —— (4) —— (5) —— (6) —— (7) Very Good
Very Unpleasant (1) —— (2) —— (3) —— (4) —— (5) —— (6) —— (7) Very Pleasant
Very Negative (1) —— (2) —— (3) —— (4) —— (5) —— (6) —— (7) Very Positive
Very Unsatisfying (1) —— (2) —— (3) —— (4) —— (5) —— (6) —— (7) Very Satisfying
Worthless (1) —— (2) —— (3) —— (4) —— (5) —— (6) —— (7) Very Valuable

Appendix F

The General Measure of Sexual Satisfaction (GMSEX, Lawrance & Byers, 1995)

Instructions: The question below concerns your overall sexual satisfaction with your current partner. Using the 1 through 7 response options, choose the response option that fits the best with the question.

Overall, how would you describe your sexual relationship with your partner?

Very Bad (1) —— (2) —— (3) —— (4) —— (5) —— (6) —— (7) Very Good
Very Unpleasant (1) —— (2) —— (3) —— (4) —— (5) —— (6) —— (7) Very Pleasant
Very Negative (1) —— (2) —— (3) —— (4) —— (5) —— (6) —— (7) Very Positive
Very Unsatisfying (1) —— (2) —— (3) —— (4) —— (5) —— (6) —— (7) Very Satisfying
Worthless (1) —— (2) —— (3) —— (4) —— (5) —— (6) —— (7) Very Valuable

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