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## RESEARCH ARTICLE

# Sexual compulsivity, erectile dysfunction, and suicidality among male survivors of military sexual violence

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## Abstract

Although military sexual trauma (MST) is associated with an increased risk of suicide, suicide attempts, and suicidal ideation among service members and veterans, there is limited knowledge regarding the mechanisms of MST and suicidality among men. The current study examined whether MST was associated with sexual compulsivity and/or erectile dysfunction and if these, in turn, explained elevated suicidal thoughts and the likelihood of engaging in future suicidal behavior after accounting for mental health, military, and demographic characteristics. Service members and veterans who reported their gender as male ( $N = 508$ ) were recruited via social media and completed online self-report measures assessing MST, erectile dysfunction, sexual compulsivity, suicidal ideation frequency, and the likelihood of engaging in future suicidal behavior. Path analysis was used to examine the study hypotheses. In total, 67 participants (13.2%) reported a history of MST; of these individuals, 27 (40.3%) reported suicidal ideation in the past 12 months, and 29 (43.9%) reported an increased likelihood of engaging in future suicidal behavior. MST was associated with increased sexual compulsivity, which, in turn, predicted more frequent suicidal ideation as well as a higher self-reported likelihood of engaging in future suicidal behavior. MST was associated with higher levels of erectile dysfunction, but erectile dysfunction was not associated with suicidal ideation in the adjusted model. Although the data were cross-sectional, precluding determinations of causality, the results support assessing and intervening with regard to sexual compulsivity to mitigate the risk for suicide-related outcomes among men who experience MST.

Suicide is a leading cause of preventable death in U.S. service members and veterans (Maynard et al., 2018). Accordingly, suicide prevention remains a top priority for both the Department of Veterans Affairs (VA) and the Department of Defense (DoD), whose public health approaches seek to understand and target a broad range of individual, interpersonal, and community-level risk factors (Carroll et al., 2020; DoD, 2021). One such risk factor

is sexual assault and/or sexual harassment during military service, termed military sexual trauma (MST) by the VA. According to a meta-analysis, 15.7% of service members and veterans report having experienced MST, including 3.9% of men and 38.4% of women (Wilson, 2018). MST is associated with a heightened risk of suicidal ideation, suicide attempt, and suicide among both men and women (c.f. Monteith, Holliday, Hoyt, & Bahraini,

2019, for a review). Further, some studies suggest that the magnitude of this risk is particularly pronounced among men (Bryan et al., 2015; Monteith, Bahraini, et al., 2016), although this has not been uniformly found across samples or suicide-related outcomes (Gross et al., 2020; Tannahill et al., 2020).

Although numerous studies have investigated the ways in which MST contributes to suicidal thoughts among women (e.g., Blais & Geiser, 2019; Holliday et al., 2021), considerably less is known about explanatory factors in male service members and veterans. Qualitative studies with men who have experienced MST highlight the importance of considering gendered factors and pathways (Monteith et al., 2020). In particular, there are considerable differences in how sexual violence is experienced across genders (Hoyt et al., 2012; Morris et al., 2014; Monteith et al., 2016; Romaniuk & Loue, 2017; Turchik et al., 2012). There are also gender differences in factors known to contribute to suicide risk following sexual violence. Among women, these include heightened negative reactions to disclosure of sexual assault (Dardis et al., 2018; Starzynski et al., 2005), increased alcohol use (Goldberg et al., 2019), and housing and financial concerns (Hoffmire et al., 2021); examples among men include higher gender role stress (Monteith, Holliday, Schneider, et al., 2019). Varying levels of traumatic reactions across MST severities have been significantly associated with suicidal ideation among men and women (Tannahill et al., 2020, 2021; Voller et al., 2015). Importantly, multiple studies have highlighted the role of masculine gender roles in posttraumatic distress following sexual trauma, including men's perceptions of how trauma impacts their sexuality (see Neilson et al., 2020, for a review).

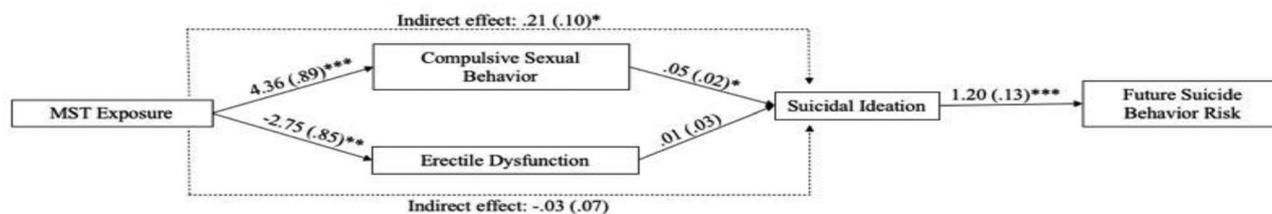
Reflecting these gendered differences in factors that explain the association between MST and suicidal thoughts, several studies have found that for men, the effect of MST on suicide appears to be more severe (Monteith, Bahraini, et al., 2016) and influenced by indirect effects (e.g., Gradus et al., 2013). As such, understanding how MST relates to men's sexual behaviors may offer key insights into why men who experience MST have a higher risk for suicidal thoughts and behaviors. The present study examined sexual compulsivity and erectile function as possible indirect pathways linking MST and suicidal thoughts and behavior among service members and veterans who identify as male.

Sexual compulsivity includes the perceived inability to control one's sexual impulses and thoughts (Grubbs et al., 2020). Compared with their female counterparts, male service members and veterans have been shown to experience higher levels of sexual compulsivity, and it has been associated with heightened suicidal ideation

in service member and veteran samples generally (Kraus et al., 2017). Additionally, sexual compulsivity has been associated with dysregulation of reward processing, particularly among men (Kowalewska et al., 2018). Disruptions of reward processing can exacerbate anhedonia that can follow MST (Vinograd et al., 2021), which can contribute to suicidal ideation (Blais & Geiser, 2019). Other research suggests that sexual compulsivity may reflect broader effects of sexual trauma on ruminative tendencies (Kowalewska et al., 2018), which are also strongly associated with heightened suicidal ideation and suicide attempts (Rogers & Joiner, 2017). Specifically, heightened shame has been identified as a key process linking men's experiences of sexual trauma, rumination, and sexual compulsivity (Reid et al., 2014). Finally, sexually compulsive behavior is negatively reinforced by temporarily reducing or distracting an individual from negative emotions, such as anxiety (Briken, 2020); thus, it is possible that heightened gender role anxiety following MST may prompt compulsive sexual behavior. However, paradoxically, sexual compulsivity may lead to greater suicidality over time by reducing perceived self-efficacy in dealing with difficult emotions (Efrati et al., 2019; Muench et al., 2011; Reid et al., 2014).

Erectile dysfunction refers to the inability to attain or maintain an erection during sexual activity (Armed Forces Health Surveillance Center, 2014). Studies in civilian populations suggest that men's experiences of sexual trauma can lead to erectile dysfunction, particularly among sexual minority men (Bullock & Beckson, 2011; Tewksbury, 2007). There is converging evidence that erectile dysfunction—whether due to age, drug side effects, or treatment availability—may relate to suicidal behavior (Ali et al., 2015; Catalano et al., 2021; Erlangsen et al., 2021). Relatedly, decreased sexual frequency in veteran men is associated with suicidal ideation (Khalifian et al., 2020). Relative to women, men are more likely to rely on sexual activity as a primary source of intimacy (Sherrod, 2018) and can experience difficulty reinforcing their lovability, attachment, and relationship and sexual contentedness when experiencing erectile dysfunction (Connaughton et al., 2016; Johnson et al., 2018; Maestre-Loren et al., 2021; McCabe, 1997; Rosen et al., 2016). Thus, to the extent that MST contributes to erectile dysfunction and decreased sexual frequency, it too may be a mechanism contributing to increased vulnerability to suicidal ideation and suicide.

In sum, we conducted a cross-sectional study to better understand the potential mechanisms of the associations between MST and suicidal ideation and the self-reported likelihood of engaging in future suicidal behavior among male service members and veterans. Specifically, we



**FIGURE 1** Parallel mediator model of compulsive sexual behavior and erectile dysfunction on the association of military sexual trauma (MST) exposure and suicide risk.

Note: \* $p < .05$ ; \*\* $p < .01$ ; \*\*\* $p < .001$ .

examined sexual compulsivity and erectile dysfunction as parallel mediators of the associations between MST and both suicidal ideation and the likelihood of engaging in future suicidal behavior (see Figure 1). We hypothesized that MST would be associated with elevated suicidal ideation frequency and a higher likelihood of engaging in future suicidal behavior and that the mechanisms of these associations would include increased erectile dysfunction and higher degrees of sexual compulsivity.

## METHOD

### Participants

Participants were men ( $N = 508$ ; i.e., identified their gender as male) who reported military service and were recruited to participate in a study examining the association of MST, sexual function, and romantic relationship satisfaction (Blais, 2021). The parent study largely sought to recruit men who identified as partnered or married at the time of participation. The present study represents a secondary analysis of data collected for the parent study.

### Procedure

The Institutional Review Board at Utah State University approved the study. Participants were recruited via Facebook advertisements. Individuals who were interested in participating completed initial screening questions confirming their gender as men, past or current military service (i.e., active duty, National Guard, or Reserve), and age of 18 or older. Potential participants who met the screening criteria were provided with a letter of information and study questions. Individuals who wanted to participate utilized a radio button to indicate that they wished to proceed with the survey. Participants were offered \$15 (USD) compensation for their participation.

## Measures

### Suicidal ideation and the self-reported likelihood of engaging in future suicidal behavior

Two items on the Suicide Behaviors Questionnaire-Revised (SBQ-R; Osman et al., 2001) were used to assess suicidal behaviors. Participants were asked to rate the frequency of suicidal ideation during the past 12 months (Item 2) on a Likert scale ranging from 1 (*never*) to 5 (*5 or more times*). They were also asked to rate the likelihood of engaging in future suicidal behavior (Item 4) on a scale of 0 (*never*) to 6 (*very likely*). The SBQ-R has demonstrated excellent psychometric properties in military samples (Gutierrez et al., 2019) and has been used in several studies of military service members and veterans (Bryan & Anestis, 2011; Gradus et al., 2013; Holland et al., 2014; Sripada et al., 2015). As noted by the scale authors, the measure is adept at measuring risk using the full scale or single items (Osman et al., 2001).

### MST

MST was assessed using the two questions that comprise the VA Military Sexual Trauma Screening Questionnaire. These questions are requisite screening questions that health care providers ask veterans receiving services within the Veteran Health Administration (VHA) and, thus, have been used in a standardized manner with millions of U.S. veterans. The questions include, “When you were in the military, did you receive any uninvited or unwanted sexual attention?” and “When you were in the military, did someone ever use force or threat of force to have sexual contact with you against your will?” Endorsement of either item indicates a positive screen for MST, with “yes” scored as 1 and “no” scored as 0.

## Sexual compulsivity

Sexual compulsivity was measured using the Sexual Compulsivity Scale (SCS; Kalichman & Rompa, 1995). The SCS includes 10 items related to respondents' difficulty controlling sexual thoughts and behaviors (e.g., "I have to struggle to control my sexual thoughts and behavior"). Items are rated on a scale of 1 (*not at all like me*) to 4 (*very much like me*). Scores are summed for a total score ranging from 10 to 40, with higher scores indicating more difficulty with sexual compulsivity. In the current sample, Cronbach's alpha was .89.

## Erectile dysfunction

The five-item Sexual Health Inventory for Men (SHIM; Rosen et al., 1999) was used to assess erectile dysfunction (e.g., "Over the past 6 months, how do you rate your confidence that you could get and keep an erection?"). Participants' responses were scored using a variable-anchor Likert scale (i.e., 0–5 or 1–5), with responses summed for a total score ranging from 1 to 25. Lower scores indicate more erectile dysfunction. In the current sample, Cronbach's alpha was .94.

## Covariates

### *Demographic and military characteristics*

Covariates were selected based on previously identified correlations with MST, suicidal thoughts or behaviors, or sexual health variables, or a majority endorsement of group membership in the present sample. Demographic and military characteristics were assessed via a self-report questionnaire. Covariates included active duty (vs. National Guard/Reserve) service (1 = yes, 0 = no); discharged from service (yes = 1, no = 0); history of VHA care (i.e., "Have you sought health care at the VA?," coded as 1 = yes, 0 = no; Monteith et al., 2021); junior enlisted status (1 = yes, 0 = no); age (Landes et al., 2021); identification as Black, Indigenous, or a person of color (White vs. all others; all others classified as BIPOC; 1 = yes, 0 = no); and identification as gay, bisexual, or queer (vs. heterosexual; 1 = yes, 0 = no; Landes et al., 2021; Schuyler et al., 2020); and depressive symptom severity (Blais & Geiser, 2019; Blais et al., 2018; Blais & Livingston, 2021; Livingston et al., 2020).

### *Depressive symptoms*

Depressive symptom severity was also included as a covariate. The Patient Health Questionnaire–8 (PHQ-8; Kroenke

et al., 2009) was used to assess depressive symptoms during the past two weeks. The PHQ-8 yields scores ranging from 0 to 24, with higher scores indicating more severe symptoms. In the current sample, Cronbach's alpha was .91.

## Data analysis

Sample characteristics and bivariate associations were examined using descriptive statistics, correlations, chi-square tests, and analyses of variance, where appropriate. Path analysis was used to examine associations between MST, sexual compulsivity, and erectile dysfunction and suicidal ideation and the self-reported likelihood of engaging in future suicidal behavior. The latter was regressed onto suicidal ideation. Suicidal ideation was regressed on MST, erectile dysfunction, and sexual compulsivity. Erectile dysfunction and sexual compulsion were regressed onto MST history. Sexual compulsion and erectile dysfunction were allowed to covary. Indirect paths of erectile dysfunction and sexual compulsion were specified. Covariates were included with direct paths to suicidal ideation and self-reported risk of future suicidal behavior and were allowed to correlate with one another. The MLR estimator with Monte Carlo integration was specified given the nonnormal distribution, which was expected given the low base rate of suicidality in nonclinical samples (Gonzalez-Blanks et al., 2020). Akaike information criterion (AIC), Bayesian information criterion (BIC), and adjusted BIC (aBIC) are reported. Missing data were handled using maximum likelihood.

## RESULTS

### Demographic characteristics

Sample characteristics are reported in Table 1. The average participant age was 39.05 years ( $SD = 10.70$ , range: 18–68 years). Half of the sample reported service in the Army. Most participants reported that their highest rank attained was noncommissioned officer (i.e., pay grades E5–E9), officer, or warrant officer, and had been discharged from service. More than half of the participants reported use of VHA health care, which is notable, as 339 individuals were discharged from service. The majority of the sample identified as White ( $n = 422$ , 83.1%) and married or partnered (98.2%). A minority of participants identified as gay, bisexual, or queer (5.9%); notably, 11 of these participants (36.7%) reported they were partnered or married.

**TABLE 1** Demographic characteristics

Variable	<i>M</i>	<i>SD</i>
Age (years)	39.05	10.70
	<i>n</i>	%
Relationship status		
Married or partnered	499	98.2
Single	9	1.8
Service branch		
Army	258	50.8
Air Force	72	14.2
Navy	78	15.4
Marine Corps	27	5.3
More than one branch	20	3.9
Military rank		
Noncommissioned officer, officer, warrant officer	299	58.9
Enlisted	209	41.1
Discharged	339	66.7
Use of VHA health care	290	57.1
Sexual orientation		
Heterosexual	478	94.6
Bisexual/gay/queer/questioning/asexual/other	30	5.9
Race		
Native American/American Indian	4	0.8
Asian American	2	0.40
Black/African American	18	3.5
Hispanic Latinx/Spanish Origin	23	4.5
Native Hawaiian/Pacific Islander	2	0.5
White/European American	422	83.2
More than one race	33	6.5

## Descriptive statistics and bivariate associations

Descriptive and bivariate associations are shown in Table 2. In total, 67 participants (13.2%) reported a history of MST. Of these individuals, most endorsed experiencing sexual harassment during their military service specifically ( $n = 55$ , 82.1%). Regarding suicidal behavior, 167 participants (27.0%) endorsed experiencing past-year suicidal ideation (i.e., a response other than *never* on SBQ-R Item 2), and 157 (30.91%) endorsed an increased likelihood of engaging in future suicidal behavior (i.e., SBQ-R Item 4). Among participants who reported experiencing MST, 27 (40.3%) reported experiencing suicidal ideation in the past 12 months, and 29 (43.3%) reported an increased likelihood of engaging in future suicidal behavior. The average score on the measure of erectile dysfunction within the overall sample was categorized as mild (Rosen et al., 1999). The average PHQ-8 score was 9.13 ( $SD = 6.58$ ), consistent with mild depressive symptoms. At the bivariate level,

higher reported sexual compulsivity and higher degrees of erectile dysfunction were associated with a higher frequency of suicidal ideation and an increased likelihood of future suicidal behavior, with small-to-medium effect sizes. MST was associated with higher levels of sexual compulsivity, erectile dysfunction, suicidal ideation, and a higher likelihood of future suicidal behavior. Participants who identified as gay, bisexual, or queer, as well as those who identified as BIPOC, were more likely to report a history of MST and endorse a higher likelihood of engaging in future suicidal behavior. Intercorrelations among other covariates are reported in Table 2.

## Path analysis

The model specified in Figure 1 had AIC, BIC, and aBIC values of 16,028.27, 16,407.02, and 16,123.35, respectively, with 90 free parameters. After adjusting for covariates, MST was associated with higher erectile dysfunction and sexual compulsivity. Higher sexual compulsivity was associated with a higher frequency of suicidal ideation; in turn, a higher frequency of suicidal ideation was associated with an increased self-reported likelihood of engaging in future suicidal behavior. The indirect effect of sexual compulsivity on the association between MST and a higher frequency of suicidal ideation was significant (see Figure 1). Contrary to our hypotheses, higher levels of erectile dysfunction were not associated with suicidal ideation frequency nor were they observed to be a mechanism of the association between MST and the frequency of suicidal ideation. Finally, identifying as gay, bisexual, or queer (estimate = 1.06,  $SE = 0.44$ ),  $p = .02$ ; being discharged from service (estimate = 1.00,  $SE = 0.36$ ),  $p = .001$ ; and more severe depressive symptoms (estimate = 0.06  $SE = 0.02$ ),  $p = .002$ , were also associated with an increased self-reported likelihood of future suicidal behavior. Only depressive symptom severity was associated with a higher frequency of suicidal ideation (estimate = 0.17,  $SE = 0.02$ ),  $p = .001$ .

## DISCUSSION

In this study, we sought to extend knowledge regarding factors that contribute to the heightened risk of suicide-related outcomes among men who experience MST by examining two potential mediators, sexual compulsivity and erectile function. Whereas previous research with women service members and veterans has demonstrated that MST and poorer sexual function and satisfaction are associated with heightened suicidal ideation (Blais et al., 2018), to our knowledge, this was the first study to examine

TABLE 2 Correlates with significant associations with suicidal ideation or risk of future suicide behavior

	1	2	3	4	5	6	7	8	9	10	11	12	13
1. Suicidal ideation		.68**											
2. Risk of suicide behavior			-.15**	.33**	.51**	-.08	.07	.05	.05	.07	-.004	.18**	.16**
3. Erectile dysfunction			-.24**	.36**	.46**	-.003	-.18**	.15**	.01	.07	.12*	.19**	.19**
4. Sexual compulsivity			-	-.19**	-.34**	-.33**	-.06	-.03	-.02	-.01	-.15**	-.21**	.13
5. Depression					.41**	.02	.14**	.16**	.02	.04	.03	.13**	.25**
6. Age					-	-.02	.04	.15**	.02	.14**	.10	.32**	.23**
7. GBQ identification <sup>a</sup>						-	-.02	-.05	.04	-.27**	.30**	.19**	.08
8. BIPOC <sup>a</sup>							-	.03	-.01	.06	-.05	-.02	.22**
9. Active duty <sup>a</sup>								-	-.02	.10*	-.03	.02	.13**
10. Junior enlisted rank <sup>a</sup>									-	.07	.23**	-.03	.02
11. Discharged from service <sup>a</sup>										-	.14**	.03	.05
12. Use of VHA Care											-	.38**	-.03
13. History of MST												-	.01
<i>M</i>	1.83	0.95	20.22	15.38	0.13	39.05	0.59	0.16	0.72	0.34	0.77	0.58	0.15
<i>SD</i>	1.21	1.26	5.84	5.78	6.58	10.70	0.24	0.37	0.45	0.48	0.42	0.49	0.36

Note: GBQ = gay, bisexual, queer; BIPOC = Black/Indigenous/person of color.

<sup>a</sup>Dichotomously coded as 0 or 1; the variable name included was as coded 1 in all cases.

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

the roles of sexual compulsivity and erectile dysfunction as mechanisms of the association between MST and suicidal ideation in men. As hypothesized, MST was associated with higher levels of sexual compulsivity, which was associated with a higher frequency of suicidal ideation and a higher self-reported likelihood of engaging in future suicidal behavior. Contrary to our hypotheses, however, erectile dysfunction was not a mechanism of the association between MST and suicidal ideation. This may be attributable to the relatively mild scores reported on our measure of erectile dysfunction. Indeed, a number of other interrelated factors may have accounted for previous findings showing a direct association between mental health symptoms and associated erectile dysfunction, including age, cardiovascular symptoms, and physiological changes associated with posttraumatic stress disorder (PTSD; Breyer et al., 2014). Notably, although the rate of MST observed in the current sample was higher than rates observed in the VA, it is not uncommonly high, particularly relative to studies that have assessed MST exposure anonymously (e.g., Blais, 2020; Bovin et al., 2019; Wilson, 2018).

The present findings offer important implications for screening and intervention and highlight areas for future research. From a suicide prevention standpoint, assessing and intervening upon sexual compulsivity may be a critical consideration for clinicians working with men who have experienced MST. A number of relevant constructs are associated with sexual compulsivity that overlap with the sequelae of MST, including shame, guilt, self-criticism, decreased self-efficacy, and perceived unlovability (Brem et al., 2019; Sassover et al., 2021). Processing these cognitive and emotional factors is common in the treatment of PTSD related to MST (Hoyt et al., 2012), suggesting a potential avenue for simultaneously addressing similar concerns regarding sexual compulsivity. Because of shame, however, men with sexual trauma histories may be less likely to spontaneously report concerns about sexually compulsive behavior (Efrati, 2018; Kilimnik & Meston, 2021), pointing to the need for proactive clinical attention to assessing for compulsivity in men who have experienced MST. Although the etiology of sexual compulsivity is not well-understood (Kraus et al., 2018), there is emerging evidence that mindfulness-based approaches are effective in reducing such behaviors (Blycker & Potenza, 2018; Brem et al., 2019). Mindfulness was found to be associated with a lower risk of suicide in a nonclinical military sample (Bravo et al., 2018), suggesting that exploring the utility of mindfulness may be an appropriate intervention point. In addressing sexual compulsions clinically, behavioral treatments also can address the specific nature of the distress caused by these compulsions, such as being contrary to personal values or religious standards; ways in which

these compulsions may be reinforcing or fulfilling other needs, such as connection or affection; and the overlap between this behavior and other risky behavior (see Allen & Hollander, 2006, and Carnes & Adams, 2019, for an overview of this treatment approach). Future research may benefit from specifically examining the overlap between sexual compulsions and other behavior—including substance misuse, gambling, and adrenaline-seeking—as it relates to suicide risk (Derbyshire & Grant, 2015). Although studies have examined MST in relation to risky behaviors, research on MST and sexual behaviors remains relatively understudied (c.f. Forkus et al., 2021).

Contrary to our hypotheses, in the adjusted analyses, erectile dysfunction was not a mechanism of the associations between MST and either suicidal ideation or the likelihood of engaging in future suicidal behavior. Such findings highlight that erectile dysfunction and sexual compulsivity are distinct experiences with differential implications for risk among men who have experienced MST. The average score on the measure of erectile dysfunction indicated mild dysfunction, so it is also possible that our overall sample was not experiencing severe enough symptoms to observe an effect. In other words, it is possible that being partnered or married, as were most participants, may buffer the negative effects of erectile dysfunction on suicidality, precluding our ability to detect an effect. Another related potential explanation is that some men who were experiencing erectile dysfunction had access to adequate treatment, such as medication, so their challenges were mitigated. The use of medication for erectile dysfunction was not well-assessed in the current study, but the availability of medications for erectile dysfunction has been associated with lower suicide incidence (Catalano et al., 2021). Future studies may test this supposition in a sample with a wider range of erectile dysfunction severity. Alternately, other mechanisms not assessed in the current study, including age and various physical conditions, may account for the potential association between erectile dysfunction and suicidal behavior reported in other studies (Ali et al., 2015; Erlangsen et al., 2021).

Previous findings indicate that it is critical to distinguish between types of MST, such as sexual harassment and sexual assault, in studies of both sexual function and suicide risk (Blais & Monteith, 2019; Monteith, Menefee, et al., 2016). For example, more severe types of MST (e.g., sexual assault) are associated with a higher risk of sexual compulsivity in men service members and veterans (Blais, 2021). Unfortunately, the low frequency of military sexual assault within our sample forced us to collapse military sexual harassment and assault into a single variable. As military sexual assault is associated with poorer outcomes and a higher risk of suicidal thoughts (Blais & Geiser, 2019; Blais & Monteith, 2019; Monteith, Menefee, et al., 2016),

the results of the current study may underestimate the magnitude of these associations. This emphasizes the need for research on sexual compulsivity and suicide risk that incorporates varying degrees of MST exposure.

Though not a planned aim of the current study, we found that the reported likelihood of engaging in future suicidal behavior was higher among gay, queer, and bisexual men relative to heterosexual men. These service members and veterans were also more than 3 times as likely to report experiencing MST than their heterosexual counterparts. These findings are consistent with other studies on suicide (Jeffery et al., 2021; McDonald et al., 2020) and MST (Lucas et al., 2018; Sexton et al., 2018). Further, they reiterate prior research that sexual minority service members and veterans with a history of MST are a population at risk for suicide and in which effective suicide prevention initiatives are particularly important. Unfortunately, research on the intersection of MST and suicide in sexual minority individuals is relatively scant, perhaps due to the implementation of “Don’t Ask, Don’t Tell” (Burks, 2011) in the U.S. military, which prohibited sexual minority service members from discussing their sexual orientation. The field could grow meaningfully through the addition of studies that examine the mechanisms of this association within this important population of service members and veterans (e.g., how sexual orientation impacts these mechanisms of sexual shame and stress related to gender roles) and investigate preferences for patient-centered ways of mitigating suicide risk following MST.

The current findings should be considered in light of several limitations. The sample was relatively homogenous in terms of race, ethnicity, sexual orientation, and MST types, as well as partnered or married status. The latter could have had an important influence on our findings, particularly regarding the null effect of erectile function in this sample: Possibly, erectile dysfunction may serve as a larger barrier to intimacy and social support among men without long-term partners and, thus, have a stronger impact on suicidality among single, divorced, and widowed men. In other words, it is possible that being partnered or married, as were most participants in the current sample, may buffer the negative effects of erectile dysfunction on suicidality, precluding our ability to detect an effect.

Additionally, we assessed self-reported gender but not biological sex and, thus, are unable to report on the number of participants who were cisgender and transgender within our sample. Considering previous research demonstrating specific barriers to care for veterans who identify as nonheterosexual when seeking help for MST (Sexton et al., 2018), further research is needed with samples that are more diverse with respect to sexual orientation and gender identity. Such research would

need to address the many factors that disproportionately impact gender and sexual minority men who experience MST, such as marginalization and a lack of access to queer-affirming trauma-informed health care (McKinnish et al., 2019). Similarly, given the interactions between discrimination-related stress and posttraumatic distress among racial and ethnic minority men (Bryant-Davis, 2019), further work is needed to examine these associations in a diverse sample of service members and veterans.

Because MST has been shown to have significant long-term consequences on both physical and mental health (Lutwak & Dill, 2013), the relatively short duration of time since the end of military service within our sample may not have captured the full extent of suicidal behavior that occurs over a longer period following MST. As a complete trauma exposure history was not collected, this precluded our ability to account for other types of traumatic experiences that may impact suicide risk (e.g., childhood abuse; Monteith, Gerber, et al. 2019). Relatedly, more detail about service member characterization of service (e.g., honorable vs. other-than-honorable discharge) and details of separation (e.g., administrative vs. medical discharge) also may provide important information related to distress and risk.

The cross-sectional design also limits our ability to determine causality. Longitudinal studies are critically needed to better inform the field’s understanding of suicide risk. Although MST was a historical event for many participants, it may have been an ongoing trauma for those currently serving in the military, and the measures used to assess sexual variables were current, whereas the measure of suicidal ideation frequency reflected the past 12 months. A longitudinal design would help identify meaningful ebbs and flows in these experiences, including suicidal ideation, which can be dynamic. Other factors that could impact suicide risk or sexual function should also be considered, including relationship satisfaction among partnered men, chronic pain, medical problems that result in sexual health challenges (e.g., neuropathy), and medication use (e.g., antidepressants). Furthermore, whereas the current study used imputation to account for missing data, missing data techniques are imperfect and drive a need for the replication of findings in other samples (Jakobsen et al., 2017). Finally, suicidal ideation, suicide attempt, and suicide are distinct, with different mechanisms (Klonsky & May, 2014); thus, these findings should be further explored in relation to other types of suicidal behavior. Indeed, future studies may benefit from including past suicide attempts as a potential covariate. These limitations notwithstanding, the current study extends previous research regarding the potential mechanisms of risk for suicidal thoughts and behaviors among men who are survivors of military sexual trauma by highlighting the role of sexual compulsivity.

## OPEN PRACTICE STATEMENT

This study was not preregistered. The authors do not have permission to share the data, but can share the syntax and output upon request at [rebecca.blais@asu.edu](mailto:rebecca.blais@asu.edu).

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