How Do Women Survivors of Childhood Sexual Abuse Experience 'Good Sex' Later in Life?

A Mixed-Methods Investigation

by

Lianne A. Rosen
M.Sc., University of Victoria, 2012
B.A., University of Ottawa, 2010

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Abstract

There is a significant volume of research evidence documenting the sexual problems experienced by women survivors of childhood sexual abuse (CSA). Accordingly, existing treatment paradigms for sexual problems in this population tend to equate the absence of symptoms with adequate sexual functionality, implying that CSA survivors can aspire to sexual functionality at best. However, this false dichotomy reinforces a medicalized, genital-focused view of women's sexuality, and provides no information about what connotes a positive sexual experience for CSA survivors. The current mixed-methods study is centered on the research question, “how do women survivors of CSA experience 'good sex'?” Semi-structured interviews were conducted with 15 women who self-identified as CSA survivors and self-reported having experienced good sex. Participants were also asked to complete standardized quantitative measures of women's sexual functioning, sexual satisfaction, and sexual self-schema. Using interpretative phenomenological analysis (IPA), four themes emerged from the qualitative portion of the study. The women expressed a clear definition of good sex (theme one), identified factors that contributed to their experience of good sex (theme two), conceptualized good sex within a developmental context (theme three), and discussed similarities in the experience of good sex between survivors and non-survivors, though noted that the pathways to this experience were different for survivors (theme four). Participants' scores on the quantitative portion of the study varied widely from each other and were inconsistent across individual scores of sexual functioning and sexual satisfaction. These findings demonstrate that women survivors of CSA can and do experience good sex, and this experience of good sex may not be captured accurately by constructs of sexual functioning, sexual satisfaction, and sexual self-schema as depicted in

commonly-used questionnaires. Implications for health practitioners, clinicians and researchers are discussed.

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Dedication

To all survivors of sexual abuse and assault.

what is stronger
than the human heart
which shatters over and over
and still lives

- rupi kaur (2017)

Introduction

The problem of childhood sexual abuse (CSA) has received growing awareness and attention over the past thirty years. Research has indicated that individuals who experience CSA are more likely to experience a range of physical, psychological, and/or interpersonal problems later in life (e.g., Chen et al., 2010). Prevalence data also suggest that women are disproportionately more likely than men to experience CSA (Stoltenborgh, van IJzendoorn, & Bakermans-Kranenburg, 2011). A substantial body of research has been devoted to exploring the association between CSA and later sexual problems in adulthood, due to the explicitly sexual nature of the trauma. However, while experiencing CSA seems to increase the likelihood of sexual difficulties, studies attempting to conceptualize associated features such as sexual satisfaction find mixed or contradictory results (e.g., Leonard, Iverson, & Follette, 2008). This problem may be reflective of issues in the broader study of human sexuality, as sexual functioning tends to be classified according to a system of behavioural categories (e.g., functional or dysfunctional) rather than a continuum. While some studies have attempted to remedy this conceptualization by studying the heights of human sexual experiences, there is little research that specifically seeks to describe the positive sexual experiences of women survivors of CSA. The current mixed-methods study explores how women survivors of CSA define and interpret their own good sexual experiences later in life.

Defining Childhood Sexual Abuse

There is no consistent, universal definition of what comprises CSA. Earliest definitions simply cited any activity that was deemed sexual that occurred with a child (Haugaard, 2000); however, questions rapidly arise over how to characterize both “sexual activity” and “child”. Cultural norms can play a significant role in how these terms are defined, as seen in the evolution

of concepts such as marriage and adulthood over time. In addition, as CSA is widely classified as a criminal act, definitions vary between legal and research contexts, and also differ depending on the jurisdiction. This lack of consistency creates difficulty in establishing accurate incidence and prevalence rates of CSA.

One key consideration is defining what age range constitutes a child. Formally, the age of majority in most Canadian provinces is 18; however, the age of consent (i.e., the age at which individuals are deemed legally able to consent to sexual activity) is 16 (Department of Justice Canada, 2015). The age of consent in the United States differs by state and ranges from 16 to 18 (Glosser, Gardiner, & Fishman, 2004). Context further affects how the age of consent is defined. In Canada, there are 'close in age' or 'peer group' exemptions stipulated in the Criminal Code (Department of Justice Canada, 2015). An individual who is 14 or 15 years of age can consent to sexual activity if their partner is less than five years older, while an individual who is 12 or 13 years of age can legally consent if their partner is less than two years older. Lastly, laws in Canada also stipulate that youth from ages 12 to 17 cannot legally consent to sexual activity if the other individual is in a position of trust, authority, or dependency (Department of Justice Canada, 2015). Operational definitions in research contexts have also varied considerably. For example, a meta-analysis of CSA outcomes found that the upper-age criteria used in research ranged from 12 to 18 years (Irish, Kobayashi, & Delahanty, 2010). Studies also differ in whether they incorporate a specified age differential between perpetrator and victim into their criteria (Hulme, 2004).

Regardless of age restrictions, nonconsensual sexual activity with children or adolescents is considered sexual abuse. In Canada, laws apply to all forms of sexual touching, from kissing to sexual intercourse (Department of Justice Canada, 2015). However, research contexts identify

additional forms of sexual activity, such as noncontact sexual exposure (e.g., being exposed to the sex organs of another without consent; Leserman, 2005), that may constitute CSA. Operational definitions in research contexts also seek to quantify the degree of coercion (e.g., unwanted or forced). These additional criteria are often employed to operationalize the severity of the abuse experience; clearly, a one-time unwanted sexual exposure is not of the same severity as repeated forced intercourse. However, issues arise in determining comparative levels of severity. For example, it is not possible to identify whether repeated instances of forced oral sex are more or less severe than several instances of unwanted sexual intercourse.

Accordingly, it is difficult to determine how many individuals experience CSA. Studies tend to evaluate the number of verified cases of CSA reported to child welfare agencies in a given year (i.e., incidence), or employ retrospective reports of how many adults experienced CSA as children (i.e., prevalence; Martin & Silverstone, 2013). The most recent Canadian incidence data collected in 2008 show that CSA is substantiated in 0.43 per 1,000 children (Trocmé et al., 2010); similar American data collected in 2005-2006 suggest incidence rates of1.8-2.4 per 1,000 children (Sedlak et al., 2010). However, incidence estimates are widely believed to underestimate rates of CSA. A large proportion of incidents are not reported to the authorities; MacMillan and colleagues (2013) found that less than ten percent of individuals who reported CSA had had contact with child protective services. As well, incidents that are reported to child protective services or to police yet are not substantiated are also not included in these calculations (Fallon et al., 2010). Prevalence data offers a different perspective in examining frequency of CSA occurrence. In a meta-analysis of 217 CSA prevalence studies, Stoltenborgh and colleagues (2011) calculated a global prevalence estimate of 11.8%, or 118 per 1,000 children. Importantly, prevalence differed significantly by gender; in the same study, worldwide

prevalence of CSA among girls was estimated at 18.0%, while for boys the prevalence rate was 7.6%. These estimates are similar to rates reported in a second meta-analysis of CSA prevalence by Barth and colleagues (15% and 8%, respectively; 2012). While some studies suggest that boys may under-report CSA due to gender role socialization (e.g., O'Leary & Barber, 2008), CSA remains an issue that is disproportionately gendered. Given the scope of the problem, it is essential to study associated impacts of CSA in order to best support the needs of survivors.

Long-Term Effects of CSA among Women

Unfortunately, women survivors of CSA are more likely to experience a number of psychological, physical, and relational concerns as adults compared to women without a CSA history (e.g., Leserman, 2005). CSA has been shown to be a significant risk factor for development of a range of mental health problems later in life. A meta-analysis of 37 longitudinal studies showed that CSA was associated with the lifetime diagnosis of anxiety, depression, eating disorders, post-traumatic stress disorder, and sleep disorders (Chen et al., 2010). CSA has also been linked to higher incidence of personality disorders (Moran et al., 2011), schizophrenia and other psychotic disorders (Cutajar et al., 2010b), suicide attempts and completed suicide (Devries et al., 2014; McCarthy-Jones & McCarthy-Jones, 2014), as well as elevated rates of problematic alcohol and drug use (Plant, Miller, & Plant, 2004; Simpson & Miller, 2002). CSA may also affect the course of psychopathology; in one study, women with a history of CSA who had been diagnosed with depression were more likely to have attempted suicide or engaged in self-harm compared to non-abused women with depression (Gladstone et al., 2004). Furthermore, this group of women were more likely to report an earlier age of depression onset as well as comorbid anxiety disorder. Lastly, service usage among survivors of CSA appears significantly elevated; in a prospective study, nearly one quarter of individuals with

a history of CSA sought public mental health services, more than three times higher than the control group (Cutajar et al., 2010a). However, some studies offer contradictory evidence; for instance, a study of a clinical sample of CSA survivors found no association between abuse characteristics and the severity of mental disorders (Bak-Klimek et al., 2014). It may be that CSA represents a nonspecific risk factor for psychopathology rather than a causal event; a review of meta-analyses by Hillberg, Hamilton-Giachritsis, and Dixon (2011) found that the overall effect size for CSA was small to moderate, and differed based on the study methodology and operational definitions of abuse. The association between CSA and mental health may instead be mediated by other intervening factors, such as neuroticism, impulsivity, emotion regulation, body dissatisfaction, and hypothalamic-pituitary axis overactivation (for a review, see Castellini, Maggi, & Ricca, 2014).

CSA in women has also been linked to elevated rates of physical health concerns (e.g., Rosen, Runtz, Eadie, & Mirotchnick, 2017). A meta-analysis of 31 studies by Irish and colleagues (2010) found that CSA was significantly related to a host of physical health problems, including gastrointestinal, pain, and cardiopulmonary symptoms. Another population-based study showed that CSA was independently associated with headache/migraines, asthma, diabetes, cardiovascular symptoms and chronic fatigue even when controlling for other forms of abuse (Romans, Belaise, Martin, Morris, & Raffi, 2002). In particular, chronic pain symptoms and syndromes (e.g., fibromyalgia, migraines, chronic fatigue syndrome) have been linked to a history of CSA (see Nelson, Baldwin, & Taylor, 2012 for a review). Some chronic pain symptoms have been studied under the umbrella of 'medically unexplained symptoms', which also includes non-epileptic or psychogenic seizures; research has shown that individuals with non-epileptic seizures who reported a history of CSA had more severe psychogenic seizures than

those without a history of abuse (Selkirk, Duncan, Oto, & Pelosi, 2008). Research also suggests that survivors of CSA experience a greater likelihood of adult obesity, though severity of the abuse is a significant factor (Hemmingsson, Johansson, & Reynisdottir, 2014; Rohde et al., 2008). McCarthy and McCarthy (2014) reported that body mass index served as a mediator between CSA and later physical health problems such as cardiovascular disease and diabetes. Survivors of CSA also appear to have significantly greater functional impairment associated with physical health symptoms and are more likely to describe their health as poor (Coles, Lee, Taft, Mazza, & Loxton, 2015; Leserman, 2005). Strikingly, Talbot and colleagues (2009) reported that the effects of severe CSA on the burden of illness were comparable to an additional 8 years of age, while the same effects on bodily pain and ability to carry out the tasks of daily living were similar to adding 20 years of age. Lastly, CSA survivors report more health care utilization, including more primary care visits, surgeries, and hospitalizations (Hulme, 2000; Kamiya, Timonen, & Kenny, 2016).

Beyond the psychological and physical effects associated with CSA, research has shown that survivors also experience negative consequences in their interpersonal functioning and relationships (e.g., DiLillo, 2001). A review of the literature by Davis and Petretic-Jackson (2000) noted that survivors of CSA are more likely to experience difficulty with trust and intimacy within interpersonal relationships. Similarly, Callahan, Price and Hilsenroth (2003) reported that survivors of CSA rated their interpersonal functioning as significantly lower, particularly in terms of shyness, uneasiness, and self-consciousness in interpersonal settings. Preliminary evidence suggests that survivors of CSA experience more difficulty in couple relationships, friendships, relationships with parents, and in parenting their children, though methodological problems are evident in existing studies and further research is needed to explore

these associations (see DiLillo, 2001 and Rumstein-McKean & Hunsley, 2001 for reviews).

Interpersonal sequelae among CSA survivors are studied most frequently in their intimate relationships. Broadly, survivors of CSA tend to report less satisfaction in their romantic relationships than non-survivors (DiLillo & Long, 1999; Testa, VanZile-Tamsen, & Livingston, 2005). A prospective cohort study found that survivors of CSA were more likely to report higher rates of relationship disruption (e.g., divorce), even when controlling for family background variables; women were also less likely to view their romantic partners as supportive or caring (Colman & Widom, 2004). Larson and LaMont (2005) found that women survivors of CSA were more likely to have negative attitudes and feelings about marriage after controlling for age. In addition to challenges with interpersonal trust and intimacy, findings from Mullen and colleagues (1994) suggest that difficulty with communication may also affect survivors' intimate relationships. In their study, women survivors of CSA reported that they had significantly more difficulty confiding in their partners and discussing personal concerns; nearly one quarter of survivors in their sample also reported that they had "no meaningful communication" with their partners. Adult attachment style, where childhood learning of relational styles acts as a blueprint for later adult relationships, may typify the relational problems experienced by CSA survivors, with research suggesting that survivors of CSA endorse more insecure attachment styles than non-survivors (e.g., Aspelmeier, Elliott, & Smith, 2007). It is clear that CSA has a significant impact on the intrapersonal and interpersonal experiences of survivors.

CSA and Sexual Problems

The most substantial body of research on the interpersonal impact of CSA focuses on the link between sexual abuse in childhood and sexual problems in adulthood. The literature is largely split into studies of two separate domains: sexual risk/impulsive sexual behaviours and

sexual dysfunctions, which have been characterized as either hypersexual or hyposexual responses to abusive experiences (Aaron, 2012; Vaillancourt-Morel, Godbout, Sabourin, Briere, Lussier, & Runtz, 2016). In terms of sexual risk behaviours, CSA has been linked to elevated rates of unprotected sexual intercourse, earlier age of first intercourse, and greater numbers of sexual partners (Arriola, Louden, Doldren, & Fortenberry, 2005). These findings have been replicated across both clinical and community samples, including the general population of women, ethnic minority women, college student samples, adolescents, and at-risk populations of women (Senn, Carey, & Vanable, 2008). For example, a 30-year longitudinal study of a birth cohort found that young adult women who experienced CSA reported having significantly more sexual partners, more unintended or unwanted pregnancies, and more sexually transmitted infections, though these effects were nonsignificant for older women (van Roode, Dickson, Herbison, & Paul, 2009). In a sample of participants recruited from a sexually transmitted infections clinic, more than half of female participants reported a history of CSA; abuse survivors in this sample were also more likely to have engaged in sex work (Senn, Carey, Vanable, Coury-Doniger, & Urban, 2006). Possible mediating factors for the association between CSA and later sexual impulsivity include substance use, dissociation, emotion dysregulation, and post-traumatic symptoms (Messman-Moore, Walsh, & DiLillo, 2010; Mosack et al., 2010; Rodriguez-Srednicki, 2002; Walsh, Latzman, & Latzman, 2014).

By contrast, research has also suggested that CSA is associated with elevated rates of sexual dysfunctions. Multiple studies report that survivors of CSA experience significantly more problems with sexual desire, arousal, and orgasm (Leonard, Iverson, & Follette, 2008; Leonard & Iverson, 2002; Loeb et al., 2002; Najman et al., 2005). Some research suggests that CSA survivors are also more likely to experience gynecological problems, notably chronic pelvic pain,

and other sexual pain disorders such as vaginismus (Lacelle, Hébert, Lavoie, Vitaro, & Tremblay, 2012; Paras et al., 2009; Randolph & Reddy, 2006; Reissing, Binik, Khalifé, Cohen, & Amsel, 2003). Among couples seeking sex therapy, Berthelot and colleagues (2014) found that more than half of women in their sample reported a history of CSA. At a physiological level, a series of studies have found that survivors of CSA show reduced responsiveness to sexual stimuli, as observed in terms of reduced vaginal blood flow (often linked to sexual arousal) and increases in the stress hormone cortisol (Rellini, Elinson, Janssen, & Meston, 2012; Rellini, Hamilton, Delville, & Meston, 2009; Rellini & Meston, 2006). In particular, CSA survivors who also report sexual problems show the least amount of vaginal response in these studies. Furthermore, a study by Lorenz, Hart, and Meston (2015) showed that women survivors of CSA exhibited an elevated sympathetic nervous system response (i.e., decreased heart rate variability) in response to sexual stimuli, suggesting anxiety- and fear-based responses to sexual cues. In a review, Rellini (2014) suggests that survivors of CSA may have different physiological sexual responses, particularly for sexual arousal, as compared to non-abused women with sexual dysfunctions. Rellini posits that early negative sexual experiences in the context of abuse may promote a stronger implicit association between sexual cues and negative or avoidance responses.

A number of theoretical models have been proposed to explain the simultaneous relationship between CSA and impulsive sexual behaviours as well as sexual dysfunctions. One of the most frequently-cited models is Finkelhor and Browne's (1985) theory of traumagenic dynamics (e.g., Easton, Coohey, O'leary, Zhang, & Hua, 2011). This model postulates that four dynamics constitute the developmental harm done by CSA; the most relevant dynamic here is termed traumatic sexualization, a process where a child's developing sexuality is shaped in developmentally and interpersonally inappropriate ways. In particular, children who are

rewarded by perpetrators for sexual behaviour may learn to exchange sexual interactions to satisfy their needs. Alternatively, children may develop misconceptions about sexual memories and behaviours, and learn to associate fear with sexual activity. Finkelhor and Browne (1985) cite a number of possible factors that can affect traumatic sexualization, including the child's degree of understanding or the use of force. It is logical how impulsive sexual behaviour could stem from experiences where survivors had their needs met by engaging in sexual activity, whereas sexual difficulties could originate from fearful or shameful associations with sex. Subsequent research has identified specific characteristics of the abuse that could increase the likelihood of sexual problems later in life, including the relationship between child and perpetrator, the severity of the abuse, the force and duration of the abuse, and the response to the abuse from individuals in the child's environment (see Aaron, 2012 for a review).

More recently, Zwickl and Merriman (2011) suggested an alternative model of how CSA relates to sexual difficulties among adult women. Their model defines CSA as the primary stressor and incorporates physical consequences of the abuse (e.g., genital trauma), as well as cognitive/affective consequences and 'third variables' (e.g., family cohesion/support, other forms of childhood maltreatment). In their model, the use of either avoidant or self-destructive coping strategies leads to sexual dysfunctions or risky sexual behaviours, respectively. There is also a feedback component, whereby coping strategies may influence the 'third variables' or cognitive/affective consequences of CSA. For example, self-destructive coping strategies could influence the affective consequences of CSA by reinforcing feelings of shame or guilt after an impulsive sexual encounter (Zwickl & Merriman, 2011). This model provides some rationale for how women in young adulthood may engage in self-destructive coping strategies but may shift to avoidant coping strategies as they age (e.g., Najman et al., 2005). For instance, a qualitative

study of female CSA survivors in mid-life (Træen & Sørensen, 2008) found that survivors' narratives about sexuality held themes of shame related to sex, as well as shame for how their previously self-destructive feelings and actions related to sex had affected their intimate relationships in the past. This model offers a more ecologically valid portrait of the factors that can affect sexuality for CSA survivors, yet is more difficult to operationalize and test given the host of factors that could fall under the category of 'third variable'.

However, not all studies have found a significant association between CSA and sexual dysfunction (e.g., Meston, Rellini, & Heiman, 2006). Rind and Tromovitch (2007), in a response to Najman and colleagues (2005), argue that study analyses are rarely causal, problems exist with consistent definitions of CSA and sexual dysfunctions, and potential third variables (e.g., dysfunctional family environment) can be confounded in studies of CSA and adult sexuality. Furthermore, the definition of sexual dysfunction seems especially problematic. Rates of sexual dysfunctions have been found to be very high in the general population; a frequently-cited study by Laumann and colleagues (1999) found that 43% of American women in their probability sample reported experiencing sexual dysfunction, defined as either low sexual desire, arousal problems, or sexual pain. Other population-based studies found prevalence rates of sexual dysfunctions among women ranging from 26% (Kadri, Alami, & Tahiri, 2002) to nearly 60% (Swaby & Morgan, 2009). Such large prevalence rates suggest that the way in which sexual dysfunction is conceptualized may be pathologizing normative variations in women’s sexual functioning. More recent estimates (e.g., Burri & Spector, 2011) emphasize the inclusion of personal distress as a diagnostic criterion; these authors report a lifetime prevalence rate of sexual dysfunction of 15.5% among their sample of UK women. Regardless, it is striking that the way in which sexual dysfunction is operationally defined may not correspond to women's

subjective experiences of their sexual functioning. The use of the term 'sexual dysfunction' has itself been critiqued as an overtly biomedical construct that neglects sociohistorical and cultural influences in the construction of women's sexual functioning (e.g., Angel, 2010; Cacchioni, 2007; Tiefer, 2002, 1988). In order to explore how sexual dysfunctions are understood, it is essential to review what is considered normative for women's sexuality.

Models of Women's Sexuality

Traditional understanding of normative sexual responses comes from the ground-breaking work of Masters and Johnson (1966), whose four-phase model of the Human Sexual Response Cycle became the gold standard definition of sexual functioning. The four physiological phases they described (excitement, plateau, orgasm, and resolution) are still reflected in current classifications of sexual dysfunction; while the most recent version of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5; APA, 2013) does not cite Masters and Johnson explicitly, most of the listed sexual dysfunctions that are specific to women are classified according to these four stages (e.g., female sexual interest/arousal disorder, female orgasmic disorder). However, reliance on the Masters and Johnson model over the years has resulted in a prioritization of the observable behaviours associated with sexuality. While such behaviours are undoubtedly easier to measure and operationalize, they exclude the wider context in which sexual interactions take place. This focus on genital functioning over and above any other factors (e.g., interpersonal, intrapersonal, cultural) has been criticized as reflecting a medicalized and mechanical view of human sexuality (Schnarch, 1991; Tiefer, 2004).

Recognition of these limitations has led researchers to postulate alternative models of women's sexuality. Based on her clinical experiences, Kaplan (1979) added desire as an initial stage in the Masters and Johnson model. However, her model was also criticized for its

exclusion of relational factors and the requirement of a strict progression through phases of the model (Whipple, 2002). More recently, Basson (2000) argued that there were fundamental variations in women's sexuality that necessitated a different model. She stated that women have a “lower biological urge to be sexual for release of sexual tension” (p.52), and that women's motivation to be sexual may be more strongly motivated by additional factors, such as relational closeness. There is some empirical evidence to support this assertion; for example, Meston and Buss (2007) found that women chose to engage sexually for emotional reasons more so than men. Basson also argued that women's subjective awareness of their sexual arousal is separate from their genital and physiological responses, and that the experience of orgasm is not a necessary component of women's sexual response. Accordingly, her model of women's sexual responses is cyclical, specifying that women receive feedback on their decisions to be sexual by experiencing positive or negative change in external factors (e.g., increased expressions of love and commitment), which can in turn influence future decision-making. Perhaps most significantly, Basson theorized that women's sexual desire is responsive, predicated on the “opportunity to be sexual, the partner’s neediness, or an awareness of one or more potential benefits or rewards that are very important to them (but not necessarily sexual)” (p. 53). That is, women's sexual desire does not exist in a vacuum; rather, women's desire is dependent on a number of additional features. With the incorporation of non-physiological factors such as desire into theoretical models of women’s sexuality, researchers have since studied how to construe and operationalize these external variables (e.g., Meston & Trapnell, 2005).

Accordingly, a host of related constructs have emerged in the literature on women's sexuality. In particular, sexual satisfaction and sexual self-schema or self-concept are among the most frequently studied sexual constructs among survivors of CSA (e.g., Rellini & Meston,

2011). Sexual satisfaction generally refers to the subjective experience of contentment or discontent with one's sexual life; Philippsohn and Hartmann (2009) note that this assessment of satisfaction is largely independent from sexual activity or behaviour. Thus, while sexual satisfaction is generally believed to capture enjoyment derived from sex, women may in fact report satisfaction with their sexual lives despite engaging in little or no sexual activity. Historically, sexual satisfaction has been operationalized in terms of the presence or absence of sexual dysfunction (e.g., Rust & Golombok, 1985). Occasionally, researchers examine sexual satisfaction by asking the question 'are you sexually satisfied' and asking participants to reply with either 'yes' or 'no' (e.g., Heiman et al., 2011). By contrast, studies have suggested that women's sexual satisfaction is closely linked to their relationship satisfaction, in accordance with Basson's (2000) model (e.g., Haning et al., 2007). For example, Lawrance and Byers (1995) developed a model of sexual satisfaction that focuses on the contextual rewards and costs of engaging in a sexual relationship; of note, their work emphasizes that sexual satisfaction is not the same as the absence of dissatisfaction. Currently, a number of empirically-validated measures seek to capture the hypothesized multi-factorial nature of women's sexual satisfaction. One of the most frequently-used measures is the Sexual Satisfaction Inventory for Women (SSS-W; Meston & Trapnell, 2005), which interestingly also has subscales for sexual distress, in accordance with historical tradition. Sexual satisfaction domains in this measure include relational (communication and compatibility) and personal (contentment) subscales.

Another related construct is the idea of sexual self-schema, which refers to the ways in which individuals conceptualize themselves as sexual beings. Andersen and Cyranowski (1994) state that women's sexual self-schema is influenced by both past and current sexual experiences, and in turn plays a role in how sexually-related information is processed. Essentially, cognitive

representations of sexual themes in relation to the self play a role in how sexuality is experienced. Thus, sexual self-schema would seem particularly apt for survivors of CSA given that their past abusive experiences would likely influence how they see themselves as sexual beings. Andersen and Cyranowski (1994) developed a measure of women's sexual self-schema that involves trait ratings; their measure has two positive factors (e.g., tendency to experience passionate/romantic feelings, behavioural openness) as well as one negative factor (embarrassment or conservatism; Cyranowski, Aarestad, & Andersen, 1999). Studies have suggested that women's sexual self-schemas are related to their sexual behaviours, sexual functioning, and romantic relationships (Andersen & Cyranowski, 1994; Cyranowski & Andersen, 1998). Rellini and Meston (2011) found that the sexual self-schemas of their participants, mediated by negative affect, predicted scores on a measure of sexual satisfaction. This study suggests that sexual self-schemas are linked to the subjective emotional and physical experiences associated with sexual interaction.

While a large body of literature has attempted to examine the connections between sexual functioning, sexual satisfaction, and sexual self-schema, results remain quite contradictory, particularly among studies of CSA survivors. Frequently, sexual functioning and sexual satisfaction have been found to be uncorrelated, particularly for survivors of CSA (e.g., Leonard, Iverson, & Follette, 2008; Najman, Dunne, Purdie, Boyle, & Coxeter, 2005; Rellini & Meston, 2006). This is not surprising given that sexual satisfaction for women may not be predicated on their sexual responsivity or physiological responses, as suggested by Philipssohn and Hartman (2009). Indeed, Rellini and Meston (2011) found that their sample of CSA survivors did not demonstrate significantly different physiological responsivity, in terms of changes in vaginal blood flow in response to sexual stimuli, than their control group. Furthermore, sexual self-

schemas are not always associated with a history of CSA. For instance, Rellini and Meston (2011) found that there were no significant differences in negative sexual self-schema (e.g., embarrassed/conservative) between CSA and non-CSA survivors. Results are also inconsistent when researchers attempt to account for the severity of the abuse, which is often employed as a predictor of more negative outcomes; for example, a study by Lacelle and colleagues (2012) found non-significant results in comparing the sexual self-schemas of CSA survivors to controls, while Lemieux and Byers (2008) found that women who had experienced penetrative CSA had significantly more positive sexual self-schemas compared to both CSA survivors who had experienced unwanted touching, as well as non-survivors.

Furthermore, the constructs of sexual satisfaction and sexual self-schema have been framed as indicators of more positive aspects of women's sexual experience. Lemieux and Byers (2008), in a study of the sexual well-being of CSA survivors, examined cognitive-affective appraisals of sexual stimuli, sexual self-esteem, sexual self-schema, and sexual satisfaction, among other variables. Their findings showed that survivors of penetrative CSA reported mixed sexual appraisals of themselves (i.e., comparatively lower sexual self-esteem while also reporting more positive sexual self-schema), in addition to greater rates of sexual risk-taking behaviours such as unprotected sex. By contrast, Van Bruggen and colleagues (2006) found that while CSA survivors in their sample tended to have lower sexual self-esteem, this was not associated with an increase in sexual risk behaviours. These studies highlight the importance of conceptualizing positive aspects of sexual experience like satisfaction separately from sexual problems, instead of classifying a lack of problems as a positive outcome. However, the net result of these findings is that survivors of CSA tend to have less positive sexual attributions and experiences than non-survivors. Accordingly, these findings do not offer insight into what does constitute a positive

sexual experience for CSA survivors.

In general, these models of women's sexuality differentiate between several binary outcomes: functional or dysfunctional, comparatively more or less satisfied, and positive or negative self-schemas. While the majority of research focuses largely on negative outcomes for CSA survivors, some insight into possible positive outcomes can be found by reviewing treatment approaches.

CSA and Sexual Recovery

While there are some evidence-based treatment approaches that incorporate trauma-focused work and couples therapy (e.g., emotionally-focused couples therapy for trauma survivors; MacIntosh & Johnson, 2008), there are no evidence-based, manualized treatment approaches for sexual problems among CSA survivors. Accordingly, treatments are based on general theories of psychotherapy as well as clinical experience. Treatment approaches for sexual problems among CSA survivors center on four main theoretical perspectives: trauma-focused work, pharmacotherapy, sex therapy, or mindfulness (e.g., Brotto, Seal, & Rellini, 2012; Hall, 2008; Maltz, 2012a, 2012b).

While trauma-focused models do not tend to address sexual problems explicitly, Hall (2008) suggests that these approaches to treatment emphasize resolution of post-traumatic stress-related symptoms such as guilt or shame, with the assumption that 'normal' sexual functioning will follow. However, Hall (2008) argues that the assumption of 'normal' sexual functioning relates solely to genital functionality and is unlikely to result in sexual satisfaction for survivors of CSA. Similarly, pharmaceutical treatments also implicitly endorse the medicalized approach to sexuality and assume that treatment of the specific physiological dysfunction will result in positive outcomes (Hall, 2008). Chivers and Rosen (2010), reviewing the use of

phosphodiesterase type 5 inhibitors (PDE5, i.e., Viagra) in treating arousal problems in women, offer the reminder that women's subjective experiences of arousal tend to be distinct from their genital responses and state that treatment solely using pharmaceuticals is unlikely to be successful. A significant body of work has also argued against the appropriation of women's sexuality by pharmaceutical companies in order to attain financial profits (e.g., Moynihan, 2003). For instance, there has been significant debate over the recent FDA approval of flibanserin (initially developed as an antidepressant) in the United States, a drug marketed heavily to treat hypoactive sexual desire disorder in women, despite questionable research evidence (e.g., Cacchioni, 2015; Moynihan & Mintzes, 2010) and the fact that this diagnosis was removed from the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders (APA, 2013). Beyond these challenges, survivors of CSA are largely excluded from drug trials and efficacy studies, making the use of medication to address sexual problems with this population experimental at best (Hall, 2008).

By contrast, treatment approaches in the field of sex therapy with CSA survivors have largely been pioneered by Maltz (2012a). She endorses a combination of trauma-focused work specific to the sexual problem and modified sex therapy techniques to create safe, relaxed experiences of touch. In particular, Maltz (2012a) emphasizes the exploration of how the experience of abuse continues to affect the individual sexually, as well as discussing and normalizing how these problems were likely to have been adaptive at some point in the client's life. For example, experiences of dissociation during unwanted sex were likely protective during an abusive experience though they may become distressing later in life when wanting to engage sexually with a trusted partner. Maltz advocates treating couples rather than an individual, particularly emphasizing how sexual concerns are dyadic rather than the 'problem' of one person.

Maltz (2012b) also offers a number of safe, progressive touch exercises ranging from "playful non-sexual touch to sensual, pleasuring touch" (p. 277). A key concern is whether the therapy mimics the environment of the sexual abuse, in terms of an experienced authority figure prescribing sexual activities (Hall, 2008). Maltz (2012b) is keenly aware of this possible dynamic and states that the therapist must "do the opposite of what happened in the abuse" (p. 272). She emphasizes empowering the client and ensuring that the client sets the pace, direction and content of sessions, while the therapist offers guidance and suggestions. However, no empirical data related to the efficacy of her approach are available.

Also within the domain of sex therapy-type interventions, Meston, Lorenz, and Stephenson (2013) conducted a randomized clinical trial on the effectiveness of expressive writing interventions for women with histories of CSA. These authors identify women's sexual self-schemas as their target for intervention and employ an expressive writing exercise, where individuals are encouraged to express their deepest thoughts and feelings while writing for a set amount of time about a structured topic related to their sexual self-schema. Meston and colleagues hypothesized that expressive writing could facilitate the cognitive processing of beliefs and self-schemas about sexuality among CSA survivors, and subsequently improve their sexual functioning. The intervention was conducted over five treatment sessions, consisting of 30 minutes of expressive writing as well as time to discuss their writing with a study therapist if participants chose to do so. Participants were randomized to the sexual schema-focused expressive writing condition or to the control condition, which involved trauma-focused expressive writing. Results from the study showed that participants who engaged in sexual schema-focused expressive writing were more likely to no longer meet diagnostic criteria for hypoactive sexual desire disorder and female sexual arousal disorder at 1-month and 6-month

follow-up (Meston, Lorenz, & Stephenson, 2013). The authors also note improvement in symptoms of depression and post-traumatic stress disorder across both groups.

Lastly, Brotto and colleagues (2012) tested a mindfulness-based intervention for women with histories of CSA as well as current sexual distress. These authors suggested that mindfulness approaches, emphasizing awareness of what is occurring in the present as well as a non-judgemental therapeutic stance, may be effective in helping CSA survivors to connect and attend to the psychological and physiological experiences of sexual behaviour. General treatment strategies in this intervention included psychoeducation about women's sexual responding and relevant contributing factors, as well as mindfulness-based strategies such as body scans and mindful breathing. The intervention was conducted over two sessions, with the second session largely serving to troubleshoot and encourage participants to continue practicing mindfulness exercises. The researchers reported that participants who received the mindfulness-based intervention showed greater concordance between their ratings of subjective sexual arousal and the physiological measurements of sexual arousal (Brotto, Seal & Rellini, 2012). These preliminary findings suggest that mindfulness-based interventions may be helpful in the sexual recovery of CSA survivors, though further research is needed.

What is striking across these treatment approaches is that there is little discussion of what constitutes the desired outcome. While Brotto and colleagues (2012) measured concordance of ratings of arousal as their outcome measure, these data were obtained in a laboratory setting and it is unknown whether these changes are similar in other, more naturalistic environments. Data are also mixed regarding whether improved concordance of arousal ratings contribute to improved sexual functioning or satisfaction. Meston and colleagues (2013) employ diagnostic criteria for sexual dysfunctions as the outcome measure in their expressive writing study, which

may not accurately capture participants' positive experiences or sexual satisfaction. Other approaches offer suggestions for treatment, presumably aiming for subjective ratings of improvement on the part of the survivor. However, Hall (2008) argues that these approaches reinforce a normative standard of what is 'expected' as part of sexual behaviour (e.g., a particular sequence of behaviours culminating in penile-vaginal intercourse and orgasm). It may be that the sexuality of women survivors of CSA is not well captured by a system of comparative, binary categories (e.g., functional or dysfunctional, more or less sexually satisfied). Studies that depart from a categorical understanding of sexuality, and shift instead towards exploring a continuum of human sexual experience may offer additional insight.

Beyond Sexual Functionality: Exploring the Concept of Great Sex

In recent years, several researchers have asked the question of whether there is more to sexuality than adequate functionality or satisfaction. This line of inquiry has been partially prompted by the recognition that popular conceptualizations of sexuality generally emphasize sexual functioning and satisfaction that is superlative rather than merely functional. Magazines and self-help books promote pleasurable sexual activity as an essential component to health and well-being, and largely cite novelty as the solution – albeit within rigid gender norms for sexual interactions (e.g., Gupta & Cacchioni, 2013; Ménard & Kleinplatz, 2008; Tyler, 2008). Accordingly, researchers have applied empirical methods to the study of sexual experiences that effectively provide contrasting evidence to these popular assumptions (Ménard et al., 2015).

Authors such as Sprinkle (2005) and Schnarch (1991, 2009) have postulated theories of what comprises "spectacular" and/or "profound sexual experiences", respectively, based on their clinical insights. Ogden (2007) studied "sexual ecstasy" using qualitative interviews with women who self-described "loving" sex, and she argues for the need to redefine sex "from a

woman's point of view" (p. 18). Participants her in research described sexual desire and lust as stemming from physical, emotional, and relational connectedness. Ogden writes how participants described sexual satisfaction as a "flowing continuum of pleasure, orgasm and ecstasy" (p. 20) rather than a sequential progression; she also notes that sexual satisfaction can stem from stimulating one's partner in a "dance of give and take" (p. 22). Similarly, Kleinplatz and colleagues have published a series of studies based on qualitative interviews with participants who self-reported experiencing "great sex". Their research has focused on identifying the components of great sex (Kleinplatz et al., 2009), the factors that facilitate it (e.g., Kleinplatz, Ménard, & Campbell, 2014), and how individuals who are often marginalized or stereotyped in sexuality research may have key insights regarding great sex (e.g., Ménard et al., 2015). Specifically, study participants emphasized that great sex involved being present, intimate, connected, communicative, and authentic (Kleinplatz et al., 2013). In this study, the researchers highlighted that contrary to popular stereotypes, there were no differences observed in participants' responses based on demographic characteristics (i.e., age, gender). The phenomenon of heightened sexual experiencing discussed by these researchers is not captured by conventional constructs of sexual functioning, satisfaction, or self-schema. Instead, qualitative studies ask participants to discuss their experiences and interpretations without imposing preconceived hypotheses that may be informed by sociocultural or researcher bias.

Overall, the challenges present in the study of women's sexuality in general are compounded when studying the sexuality of female CSA survivors. Historically, research on sexuality has focused on negative outcomes rather than positive processes; accordingly, findings suggest that CSA survivors experience a disproportionate number of sexuality-related challenges. Treatment strategies are largely based on physiological norms for sexual functioning,

emphasizing the unspoken assumption that women survivors of CSA should learn to tolerate a particular sequence of sexual activities (Kleinplatz, 2012). Similar to how the studies discussed above challenge assumptions of what constitutes the range of sexual experiences, conducting research on the positive sexual experiences of women CSA survivors may provide concrete data on what these experiences can be like.

One study to date has focused on positive sexual experiences among CSA survivors. Hitter and colleagues (2017) conducted a qualitative study with eight women survivors of CSA to explore positive sexual self-schema and sexual satisfaction within a developmental context of post-traumatic growth. The researchers described four themes related to positive sexual self-schemas among CSA survivors: The Context for Sexual Development, Sexual Exploration, Coping Strategies, and Embracing the Sexual Self as a Whole. These themes depict developmental or healing processes by which participants constructed positive views of themselves as sexual beings and experienced sexual satisfaction. For instance, the Sexual Exploration theme encompassed participants' experiences of positive intimate and sexual relationships, sexual risk-taking, and development of sexual agency. The authors reported that their findings highlighted the importance of relational and interpersonal experiences in healing and post-traumatic growth. However, the researchers identified that additional study of the characteristics of sexual experiences, partners, and relationships that facilitate healing among CSA survivors is warranted. Furthermore, given the focus on subjective sexual satisfaction in this study, there is little discussion of what constitutes a positive experience for these women.

Limitations of Existing Research

The limitations inherent in the research literature have been discussed throughout this review and will be summarized in this section. First, there are definitional and methodological

problems in studying both CSA and sexual functioning. There is no gold standard definition of either of these constructs; particularly for sexual functioning, a historical emphasis on solely observable behaviour has severely restricted the range of what is considered 'normal'. Studies based on newer models of women's sexual responses show inconsistency in measuring constructs related to women's sexual functioning, such as sexual satisfaction and sexual self-schema. These inconsistencies are particularly apparent in studies of female CSA survivors. Treatment strategies aiming to improve the sexual functioning of women survivors of CSA are largely contingent on techniques that fit within a narrow definition of women's sexuality. In general, women's sexuality is reduced to a strict categorization of normal or abnormal; for women survivors of CSA, the vast majority of research studies how their sexual experiences fall into the 'abnormal' category. Studies of more positive constructs related to sexual experience, such as sexual satisfaction, tend to show that overall, CSA survivors have less positive experiences or perceptions than non-survivors. While qualitative studies aimed at exploring a broader continuum of human sexual experience offer an alternative to the traditional binary conceptualization of sexual functioning, there has been little research conducting this type of investigation with CSA survivors. Furthermore, asking survivors of CSA to define what comprises a good sexual experience for them may serve to place agency and control in the hands of the participants, instead of suggesting preconceived hypotheses of what their experiences are like from a position of authority.

Current Study

It is clear from the empirical evidence reviewed above that there is minimal information regarding CSA survivors' positive sexual experiences. Merely articulating this gap in the research literature represents a significant departure from traditional views of women's sexuality

and sexuality following sexual trauma. In addition, employing a qualitative methodology enables a dimensional rather than categorical conceptualization of sexuality. Ensuring that participants who are CSA survivors experience agency, control and empowerment throughout the research process is essential to exploring a sensitive topic with this potentially vulnerable population. Lastly, incorporating quantitative measures into the qualitative framework (i.e., mixed-methods research) allows for comparison of how survivors' own conceptualizations of their sexual functioning and satisfaction are similar to and/or differ from assessments based on measures that are frequently used in research on women's sexuality.

The central research question of this study is, "how do women survivors of CSA experience 'good sex'?" This qualitative study is exploration- rather than hypothesis-driven; thus, no specific hypotheses are presented. Instead, the goal of the investigation is to query women survivors of CSA who report having experienced good sex. This study asks participants to discuss what good sex is for them, how it is brought about, and what elements comprise such experiences (see Appendix D for specific question prompts).

Method

Theoretical Framework for Mixed-Methods Analysis of Qualitative and Quantitative Data

The research question seeks to explore in detail a specific, understudied phenomenon from the perspectives of those who have lived these experiences. The ideal method to approach this question is interpretative phenomenological analysis (IPA; Smith, Flowers, & Larkin, 2009). IPA explores how individuals make sense of specific life experiences and reflect on the significance of these experiences. IPA is a phenomenological approach, which emphasizes capturing the essential qualities of an experience and prioritizes "go[ing] back to the things themselves" (Husserl, 2001/1901, p. 168). IPA is also hermeneutic, attending to how the

phenomenon is interpreted through the lens of the individual's context. Importantly, data are interpreted through the meaning-making processes of both the participant and the researcher (a "double hermeneutic"; Smith & Osborn, 2015, p.26). Lastly, IPA is an idiographic approach, emphasizing detailed individual accounts rather than generalizations to a group. IPA is particularly suited to research in sexuality because it can challenge existing assumptions around what is 'normal' versus 'pathological', given the focus on individualized, context-dependent description and interpretation (Smith et al., 2009).

In addition, IPA as used in this study is rooted in an explicitly feminist framework. Feminist approaches often emphasize providing a voice to those who are marginalized or unheard (e.g., Gilligan, 1982). Accordingly, the explicit goal of this research is to bring to light the positive sexual experiences of women survivors of CSA, who have long been expected to merely tolerate sex at best (Kleinplatz, 2012). Feminist paradigms also seek to equalize the inherent power differential between researcher and participant, to localize data explicitly in the sociocultural and historical context of individuals, and to challenge the idea of academic distance or neutrality (Morrow, 2011). Feminist research aims to empower participants and provide them with a felt sense of agency, participation, and control in the research process. This emphasis is particularly essential for survivors of CSA, whose experiences are often rooted in stigma, shame and secrecy. Accordingly, participants in this study were able to choose their preferred method of completing the study, either over the telephone or by on-line video chat (e.g., Skype; see 'Procedures'). During data analysis, the researcher explicitly attended to issues of context and bias by keeping a diary of personal reactions to the analytic process and discussing the analytic process with members of her research lab to check assumptions. Transparency and agency for participants was attended to via the iterative process of analysis, in that each step of the analysis

requires returning to interview transcripts to ensure that participants' words are accurately captured. Participants were also encouraged to provide feedback and suggestions about the study methodology during the interview.

Lastly, this study employs a mixed-methods design (i.e., using both qualitative and quantitative research methods; Yardley & Bishop, 2015) by incorporating quantitative data into the IPA framework. This research aims to contextualize the quantitative measures that are frequently used in research and clinical settings with CSA survivors, by comparing and contrasting findings from both qualitative and quantitative data. This approach is rationalized through the adoption of pragmatism as a theoretical guideline; specifically, rather than dividing research approaches into polarized questions of breadth versus depth, pragmatism recognizes that all research with humans requires both empirical grounding as well as imagination and creativity (Yardley & Bishop, 2008). Accordingly, the qualitative methodology serves as the overall theoretical framework, while the quantitative portion is intended to provide comparative empirical data, in depicting how participants in the current study compare to normative questionnaire data on a case-by-case basis. Unlike purely quantitative studies, the quantitative analyses in this study are not intended to depict findings from a representative sample. The quantitative results are employed as a preliminary indicator of what is captured (or not) within sexuality questionnaires. In the current study, qualitative and quantitative data are integrated in the interpretation and discussion of the findings (Yardley & Bishop, 2015).

Participants

Participants for this study needed to be able to shed light on the phenomenon in question; that is, in contrast to random sampling approaches, they were included specifically based on their self-reported experiences of sexual abuse. Individuals with first-hand knowledge of the

phenomenon under study are termed 'key informants' in phenomenological research paradigms (Moustakas, 1994). Thus, key informants for this research were women who self-identified as survivors of CSA, and who also reported having had good sexual experiences. Additional inclusion criteria included being over the age of majority (i.e., over age 19) and being comfortable using spoken and written English.

Participants were recruited through advertisements in three on-line community and support forums for survivors of CSA: *Pandora's Aquarium*, *HAVOCA* (*Help for Adult Victims of Child Abuse*), and *After Silence*. *Pandora's Aquarium* and *After Silence* are based in the United States while *HAVOCA* is based in the UK, though users can access these forums from anywhere in the world. Moderators for these forums were contacted in advance in order to approve the recruitment notice (see Appendix A). Of note, the recruitment notice employed the relatively value-neutral term of 'good sex' to avoid preconceived biases inherent within other terms (e.g., 'satisfactory', 'functional').

Fifteen women participated in the study, which is a large sample size for IPA (Smith & Osborn, 2015). Detailed demographic characteristics of the sample are presented in Table 1. Participants had a mean age of 36.7 years (*SD* = 13.2, median = 35.0), and ranged between 19 and 60 years. The majority of the sample (*n* = 12; identified as Caucasian, with the remaining participants endorsing Black, Hispanic, or mixed ethnicity. Nine participants lived in the United States, with the remaining participants living in Canada, the UK, or Italy. The majority of participants (*n* = 13) were currently in a romantic relationship, and had been in those relationships for a mean of 12.6 years (*SD* = 12.0, median = 8.0). Nine participants reported that they were heterosexual, and the remaining participants identified as asexual, bisexual, queer, or unknown. More than half of participants reported an annual family income of $30,000 CAD or

less; however, three participants earned $85,000 CAD or more annually. Regarding their highest level of educational attainment, five participants reported having attended or completed college, and five participants reported earning a Bachelor's degree. Nearly half (46.7%; *n* = 7) of participants self-identified as having some form of disability.

Table 1. *Selected Demographic Characteristics*

Variable	*N*	*n*	%
Ethnicity	15		
Caucasian		12	80.0
Hispanic		1	6.7
Black		1	6.7
Mixed		1	6.7
Country of Residence	15		
USA		9	60.0
UK		3	20.0
Canada		2	13.3
Italy		1	6.7
Annual Family Income ($CAD)	15		
Less than $30,000		7	62.6
$30,000 - $100,000		4	26.7
Greater than $100,000		3	20.0
No answer		1	6.7
Relationship Status	15		
Single		2	13.3
In a relationship		13	86.7
Sexual Orientation	15		
Heterosexual		9	60.0
Bisexual		2	13.3
Asexual		2	13.3
Unknown		1	6.7
Queer		1	6.7

Procedures

The methodology for this study received approval from the Human Research Ethics Board at the University of Victoria (file number 16-089). Potential participants who were interested in the study were directed to an on-line informed consent form (see Appendix B) prior to being interviewed, in order to ensure their understanding of the study rationale, the multi-step study protocol, and the confidential nature of the project. Participants who agreed to participate submitted an electronic form to the researcher that contained their preferred method of communication (telephone or video chat) as well as three possible times where they were available to hold the interview. The researcher then emailed the participant to schedule an interview time.

Prior to commencing the interview, the researcher provided a verbal review of the informed consent and reiterated that participants could withdraw their consent or decline to answer questions at any point. The interview began with 'closed' questions regarding participants' demographic characteristics and continued to semi-structured questions regarding their positive sexual experiences. Question prompts were open-ended and flexible, to allow for consistency between respondents yet openness for individualized responses (see Appendix D for the interview outline). In particular, the researcher sought to encourage reciprocal dialogue during the interview (e.g., Smith & Osborn, 2015). Participants were encouraged to suggest revisions to questions or additional questions during the interview. At the conclusion of the interview, participants were provided with a three-digit identification code and directed to the on-line portion of the study. Women were asked to remain either on the telephone or connected via video chat to the researcher while they completed the questionnaire, in order to answer any questions that arose. All 15 participants fully completed the measures.

The on-line questionnaire asked participants to complete several commonly-used sexuality-related measures; specific measures are discussed below. Responses were stored solely using the identification code provided to participants during the interview. At the conclusion of the on-line portion of the study, participants received an electronic debriefing form that reiterated the goals of the study (see Appendix C). In addition, given the sensitive nature of the questions, information regarding available psychological support and resources was provided. Lastly, participants debriefed by telephone or video chat with the researcher. This follow-up interview aimed to explore participants' experiences with the closed-ended questionnaires, answer any questions they may have had about the study, solicit feedback about the study, and provide closure (see Appendix D). The total time to complete the interview and questionnaires ranged between half an hour to two hours. As an honorarium for participating in the study, participants received a $5 US gift card to Starbucks, delivered via email.

Upon completion of the data collection, interviews were transcribed verbatim by the researcher and any potentially identifying information was removed. Transcripts were labelled solely with the three-digit code that had been assigned during the interview. Qualitative data analyses were conducted using the IPA approach outlined by Smith, Flowers and Larkin (2009). To begin, the researcher read and re-read one interview transcript in order to immerse herself in the data. Next, the researcher explicitly notated summaries of the content, semantics, and/or preliminary interpretations that arose from her reading of discrete sections of the interview transcript. From these exploratory comments, the researcher developed a list of emergent themes throughout the transcript. This process was repeated for each of the fifteen transcripts. The emergent themes across the fifteen transcripts were subsequently compiled into one list. This list was similarly read and re-read by the researcher, and themes were grouped by similarity and

frequency. Lastly, overarching themes were developed to capture these groups of subthemes. As discussed, the researcher monitored sources of bias by journaling and reflecting on her own reactions to the interviews and the analyses. A further validity test of the proposed themes was performed by members of the research team, who independently identified themes in transcripts excerpts and compared these with the themes previously developed by the researcher.

Measures

Sexual Satisfaction Scale for Women (SSS-W). The SSS-W (Meston & Trapnell, 2005) is a 30-item self-report measure that assesses sexual satisfaction and distress specifically among women (see Appendix E). Items are grouped into five domains: communication, compatibility, contentment, relational concern and personal concern. Participants are asked to rate how much they agree or disagree with statements relating to their sexual lives (e.g., "I feel content with the way my present sex life is"), along a five-point Likert-type scale ranging from 'strongly agree' to 'strongly disagree'. In the validation study, total mean scores for the measure were 123.2 (SEM = 2.30) among the control group and 88.8 (SEM = 2.06) among the sample of women with a sexual dysfunction (Meston & Trapnell, 2005).

The SSS-W has been employed in a number of studies regarding the sexual lives of CSA survivors (e.g., Rellini & Meston, 2007; Seehuus, Clifton, & Rellini, 2014; Stephenson, Hughan, & Meston, 2012). Stephenson, Pulverman, and Meston (2014) found a total mean score of 72.9 (SD = 8.6) on the SSS-W with a sample of CSA survivors. The measure consistently demonstrates acceptable internal consistency (Cronbach's $\alpha \geq 0.74$) and test-retest reliability (r = .58–.79), as well as convergent validity with the Female Sexual Function Index (FSFI) and divergent validity from marital satisfaction (Meston & Trapnell, 2005). The measure has also been shown to differentiate between women with and without DSM-IV-TR diagnoses of sexual

dysfunctions. Furthermore, the factor structure of the SSS-W has been validated among women with histories of CSA (Stephenson et al., 2014). Means and standard deviations for the SSS-W and other quantitative measures employed in the current study appear in Table 2.

Female Sexual Function Index (FSFI). The FSFI (Rosen et al., 2000) is a 19-item self-report measure of women's sexual functioning (see Appendix F). Items are clustered into six subscales (desire, arousal, lubrication, orgasm, satisfaction, and pain) and inquire about frequency, ease/difficulty, and confidence regarding various sexual behaviours (e.g., "Over the past four weeks, how often did you feel sexual desire or interest?"). This factor structure has been validated within a general population of women as well as among survivors of CSA (Stephenson et al., 2014). The measure's instructions also include operational definitions for sexual activity, sexual intercourse, sexual stimulation, and sexual desire. For the purposes of the current study, some of these definitions were modified to make the language more gender-neutral (e.g., altering the definition of sexual intercourse from "penile-vaginal penetration" to "penetration of sexual parts of the body"). Responses are rated on a Likert-type scale from zero to five, with higher total scores indicating increased sexual functioning (i.e., increased sexual frequency, ease, confidence in bodily responses). Mean total scores for the measure in the validation study were 30.5 (SD = 5.29) in the control sample and 19.2 (SD = 6.63) in a sample of women diagnosed with female sexual arousal disorder (Rosen et al., 2000). The measure has shown good internal consistency (Cronbach's α = 0.82–0.92) and test-retest reliability (r = .79–.88; Rosen et al., 2000; Meston, 2003); furthermore, a cut-off score of 26.55 has been shown to optimally identify women who meet diagnostic criteria for sexual dysfunction (Wiegel, Meston, & Rosen, 2005). In addition, a cut-off score of 5 or less on the sexual desire subscale has been suggested to effectively identify women who meet diagnostic criteria for hypoactive sexual

desire disorder (Gerstenberger et al., 2010). However, this cut-off score has been criticized for overpathologizing differences in women's sexual desire; Forbes (2014) suggests that usage of this cut-off score indicates that women are sexually dysfunctional if they think about sex for less than half of their waking hours. Furthermore, the diagnosis of hypoactive sexual desire disorder no longer exists in the DSM-5, as discussed previously (APA, 2013). Accordingly, this cut-off score is not employed in the current study. Several translations of the FSFI have been developed (e.g., Ryding & Blom, 2015), and the measure has been employed in over 1,500 research studies.

Sexual Self-Schema Scale – Women's Version (SSSS). The SSSS (Andersen & Cyranowski, 1994) is a measure of women's cognitive representations of their sexual selves (see Appendix G). The scale consists of 50 trait adjectives (26 scored and 24 fillers) such as "passionate" and "polite." Participants are asked to rate how well the adjectives fit for them using a 7-point Likert-type scale, ranging from 'not at all descriptive of me' to 'very much descriptive of me'. Subfactors within the scale include Passionate/Romantic, Directness/Openness, and Embarrassment/Conservatism. From the validation study, internal consistency for the total scale was good (Cronbach's $\alpha = .82$) and test-retest reliability was strong at 2-week and 9-week intervals ($r = .89$ and $r = .88$). In a sample of college-aged women, the mean total score for the measure was 60.47 (SD = 14.15; Anderson & Cyranowski, 1994). Convergent validity has been demonstrated as scores on the SSSS, particularly Romantic/Passionate subscale scores, have been associated with a variety of sexual cognitions and behaviours including sexual pain, sexual dysfunction, and sexual aversion (e.g., Andersen et al., 1997; Meston, Rellini, & Heiman, 2006; Reissing, Laliberté, & Davis, 2005). Findings have also shown that women survivors of CSA have significantly lower Romantic/Passionate subscale scores (Meston, Rellini & Heiman, 2006).

Results

The results section addresses the following topics: (1) qualitative findings from the interview portion of the study, (2) quantitative results from the questionnaire portion of the study, and (3) findings related to the comparison of the interview and the questionnaire results. Quantitative analyses were conducted using SPSS version 22.0, and graphs were created using Microsoft Excel.

Qualitative Findings: CSA Survivors' Experiences of Good Sex

Four overarching themes were identified from the interpretative phenomenological analysis (IPA) of interview transcripts (for a description of the qualitative methodology, see the 'Method' section above). Figure 1 provides a visual depiction of the themes and subthemes. The researcher named the first theme 'Good Sex as Defined by CSA Survivors', which comprises eight subthemes related to how participants defined and experienced good sex. The second theme was named 'Factors that Contribute to CSA Survivors' Experiences of Good Sex' and involves four subthemes that facilitated the experience of good sex for participants. The third theme, termed 'Good Sex in a Developmental Context', comprises five subthemes related to participants' changing experiences with good sex over time. The final theme, named 'Good Sex is Similar, Pathways are Different', details participants' understanding of the similarities and differences in good sex for survivors of CSA as compared to non-survivors.

Theme one: Good sex as defined by CSA survivors. This theme captures survivors' conceptions of what elements or characteristics comprise good sex for them. Participants detailed eight subthemes that connote good sex, including safety, good feelings, being present, being vulnerable, personal agency and control, communication, and understanding sex in the context of a relationship.

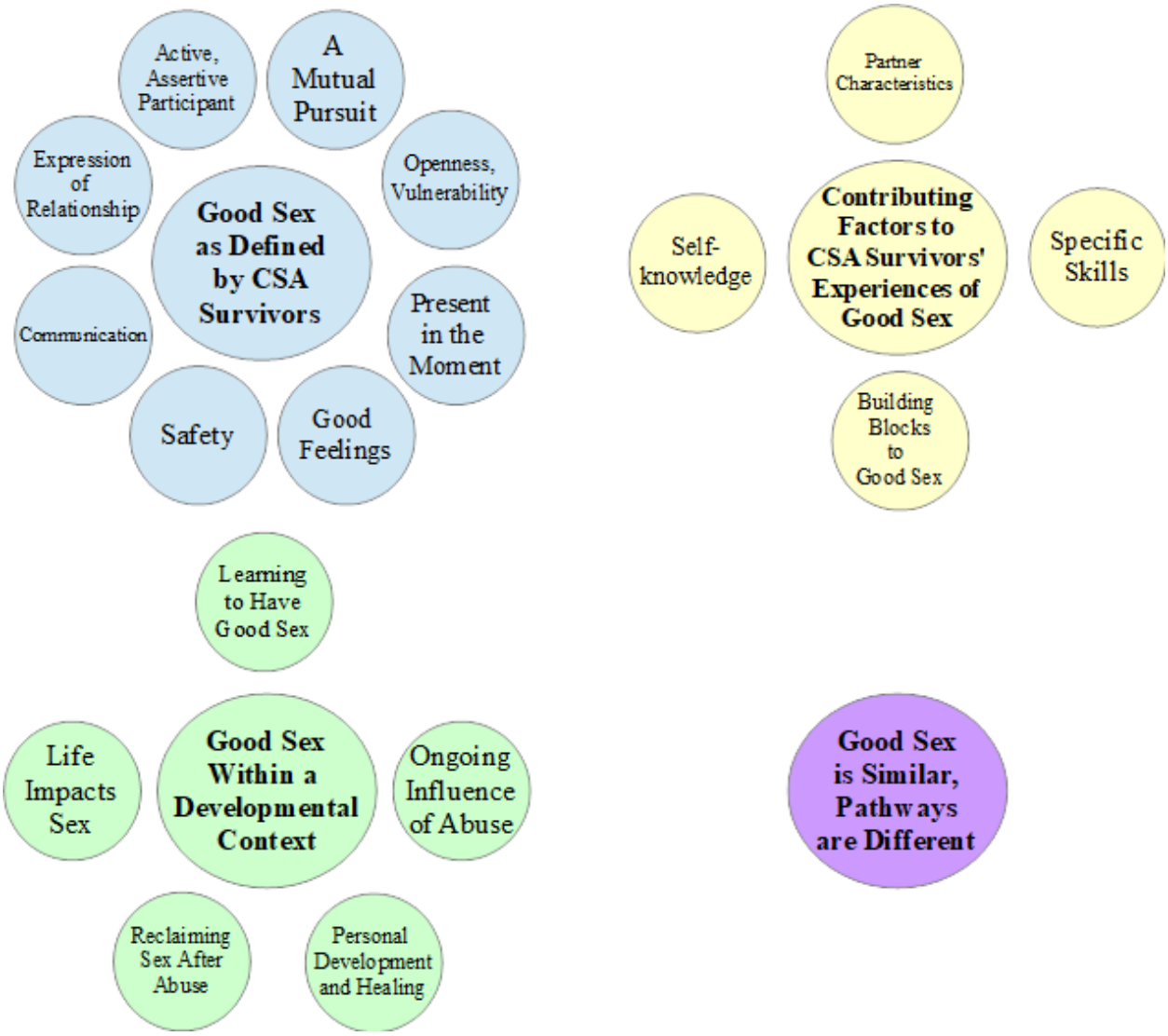

Figure 1. Themes and subthemes derived from IPA analysis of interview transcripts.

Safety. Safety during sex was of prime importance to participants. Firstly, all participants stated that good sex is consensual, and several emphasized that consent is an ongoing process throughout a sexual interaction. Participant 402 described consent for both herself and her partner in the context of safety, noting that it was important "…to keep checking in and make sure the other person is still consenting to everything. …making sure it's safe is most important for me". For this participant, consent is not a blanket statement for all sexual

activity; rather, it is a process to be monitored and engaged in continuously. Participants also emphasized physical safety in the context of their environment. Many participants considered what would help their environment to both be and feel safe. Privacy and physical security were important for participants, particularly in the context of controlling access to their space. For example, participant 401 noted, "I know, um, some people live in apartments where their landlords have, can access for laundry and whatnot, and like, that would not fly". Others took specific steps in order to create safety in their environment, such as locking doors, turning lights on or off, ensuring pets or children were elsewhere, and/or managing the temperature of the room. Participant 407 described how she created a sense of physical safety in her bedroom:

> My bedrooms are always adorable. My sheets are awesome, my bedding is awesome, my rugs, everything is just ridiculously, everything that I want. So I can't, I can't wait to go to bed at night, because I used to be able to not sleep. So my room is like, awesome. (chuckling) … So that's my little safe place area.

This participant made a deliberate effort to create a sense of safety in her bedroom by creating spaces that were visually pleasing and tailored to her taste. By exerting personal control over her environment, she created a space that she experienced as emotionally and physically safe. In addition, some participants discussed physical health as a component of safety during good sex. In particular, a few participants in casual sexual relationships noted the importance of condom use as well as having themselves and their partners screened for sexually transmitted infections.

Another component of safety for participants was establishing personal boundaries and having them respected. Participants stated that it was important to express their sexual wants and needs, as well as the limits to what they felt comfortable engaging in sexually. Participant 415 described boundaries as, "… [W]hat you're willing to do, what you're not willing to do ever, and don't ever bring that shit up because hell no. What you are willing to do but it may trigger you as far as PTSD context goes". This participant distinguishes between strict boundaries related to

sexual activity and sharing the awareness with her potential partner about what may affect her in terms of her past abuse experiences. Establishing boundaries helps to delineate the framework within which participants felt safe being sexual. Boundary discussions were also related to consent to sexual activity. Participant 406 shared a frank discussion about boundaries that had taken places with a prospective casual sexual partner:

> I was talking with him through messages. He said, "Oh, what are you doing tonight?" I said, "Oh, I have eaten garlic!" He said, "Oh, we don't kiss, don't worry!" And I said, "No kiss, no sex". (laughing) So he replied back, "Don't worry, I'll kiss you".

This participant explicitly stated that kissing was a necessary ingredient for her to consent to sex, and she made this clear to her prospective partner. In addition to expressing their boundaries, participants emphasized the importance of having these boundaries respected. For instance, participant 408 expressed her need for nonsexual touch as well as the importance of having her husband respect that need, stating "…there are times where I just want to be held and know that I don't have to say, 'Uh, buddy, take your hands away'". Participants felt safe in the knowledge that they did not have to police or enforce their boundaries, as their boundaries would be respected by their partners.

A fourth component of safety for participants was having safety and security within the context of their relationships. Several participants stated that they could only have good sex within the context of committed romantic relationships and/or marriage. The knowledge that their partners were "in it for the long haul" allowed participants to feel safe in engaging sexually. Some participants noted that the declarative nature of marriage allowed them to feel safe in their commitment to their romantic partners. In particular, participants stated that they knew that their partners were invested in the relationship to the same extent that they were. Participant 410 explained the importance of committed relationships to good sex:

> I don't think I'd have good sex with someone who I wasn't in some kind of committed relationship with. And that might be, just a very committed friendship, or you know, like a real, invested, you know, relationship that is usually platonic. But it would have to be someone who I'm really committed to and invested in. And them in me as well.

By contrast, some participants reported that they had good sex within casual sexual encounters; however, the context of this type of relationship remained critical to creating safety. Specifically, the fact that both parties were explicit in expressing their needs and focusing on physical experiencing allowed participants to feel safe. Participant 406 stated, "I like occasional [sexual partners] because we have sex once or twice and we don't have time to explore other things". This participant felt safe by limiting the depth of emotional connection with her sexual partners. Interestingly, this participant noted that she would like to carry over the same kind of freedom and safety within longer-term committed relationships in the future, but she did not feel that she was ready to do so. Overall, participants felt safe in their relationships by explicitly conveying the terms of these relationships and feeling confident that their partners approached the relationship in the same fashion that they did.

In addition, participants described safety in the context of feeling safe to inhabit their bodies during sex. Some participants described histories of dissociating during sex, particularly in abusive or non-consensual experiences, as a way to protect themselves. Participant 402 stated:

> When I was a small kid and it was abusive, I was completely separate from my body. And my body went through it and then I, you know, came back later or whatever. And I still separate a lot from my body, um, but I'm able to start the process of, sort of, being more connected from like my brain or my mind or whatever to my body. …The more safe I feel, the more it's okay to be present and in my body, I think.

Participants are able to identify that they are safe by being able to connect their minds and bodies, and be present during sexual activity. Lastly, participants described safety in their intentions around having sex. Some participants described checking in with themselves prior to

sexual activity regarding their motivations for engaging in sex in that moment. In essence, participants monitored their motivations in order to ensure that they were in line with their needs, desires, and/or values. For example, participant 410 stated, "I need to have a very safe intention around sex…like, my intention needs to be about having fun and having a good time". Participants create a sense of safety for themselves by ensuring that their motivations for sex are in their best interest.

Good feelings. Participants defined good sex as an enjoyable experience, both physically and emotionally. Good sex involves physical pleasure and enjoyable sensations, as described by participant 410: "I think we just kind of need that thing of bringing our bodies close and having that physicality". Participant 412 described the importance of enjoyable physical contact that was not necessarily sexual: "I don't like to be held so much but I like to hold somebody, my partner. To feel that comfort, a real level of comfort that way. And that's more important to me than the actual sex". Regardless of whether the physical contact is explicitly sexual in nature, good sex involves enjoyable physical experiences overall. A few participants noted that they defined good sex in terms of having an orgasm, though other participants reported that orgasm was not necessary for an enjoyable physical experience. Furthermore, most women emphasized the importance of sexual activities aside from penetrative intercourse. In general, participants agreed that good sex felt good physically, though the definition of an enjoyable physical experience differed for each individual.

Participants also defined good sex in terms of positive emotional experiences and having needs for connection met. As participant 405 explained, "…sex isn't just sex, it's about being with a person who you love. It's more than just a penis in a vagina!". Good sex is an emotional experience beyond the physical mechanics; rather, it involves connection and emotional

closeness with one's partner. Participant 406 explained the importance of emotional connection in the context of a casual sexual encounter:

> … Good sex is when I feel loved. Uh, I'm not, um, I'm not talking about sexual pleasure, I can offer that to myself, uh, very well. … So I don't, I really don't need a man in order to have this. I mean it's not – what I take from men, is something else, not physical pleasure. …It has to be, uh, the emotional connection. If not, I'm not interested.

For this participant, physical enjoyment is a necessary but not sufficient element to good sex. Regardless of the casual nature of the relationships, it is still important for her to connect emotionally with her short-term partners. In addition, some participants reflected that the emotional connection heightened the enjoyment of their physical experience. As participant 408 stated, "…anyone can hop into bed and have, you know, an orgasm. But to make it where it explodes, it's when you honour each other. …it opens the door to let you fly". Overall, participants reported that good sex involved feelings of emotional closeness and connection with their partner.

In addition, many participants defined good sex as an enjoyable and fun experience. Participant 405 described good sex as a "genuinely enjoyable thing", stating that "I can enjoy sex and that's okay". Multiple participants reported that they knew that sex was good when they were enjoying themselves and having fun in the process. Participant 409 stated that good sex "… has to be enjoyable but probably the most important criteria is, not so much during, that's one thing, but after, that I don't feel, … wrong, or hmm, dirty". For this participant, her reflections after sex significantly affect her interpretation of what occurred. In order to have good sex, this participant stated that she needs to feel good about what occurred instead of her "brain taking over" and questioning her motivations. In essence, good sexual experiences are enjoyable and fun both during and after sex.

Present in the moment. Participants emphasized being present during sexual activity is a key component of positive sexual experiences. Several participants discussed the idea of being present in the moment in a cognitive sense. For instance, participant 410 described being present in the moment by distinguishing between experiencing and enacting: "…I just enjoyed it, I wasn't performing, I wasn't like having fantasies – I was in the room. So for me, that's the definition [of good sex][1]: I was in the room". For this participant, being present involves experiencing rather than doing. Rather than focusing on what her partner might be thinking and performing to that, or using fantasy as a way to cognitively distance herself, she simply describes being present. Participant 401 described being present in terms of being able to identify good sexual experiences: "I don't [recognize good sex] until after the fact, I think. Because the whole point of it is, like, that I'm actually in the moment, so...I kind of don't, can't recognize it because I'm not thinking about it. As soon as I think about it, then it fails". For this participant, being present in the moment means experiencing rather than interpreting or judging her experience. Similarly, participant 402 contrasted being present and experiencing sex with having preconceived goals for a sexual encounter: "It's important for me not to have a goal, like 'both people must orgasm' or 'one person must orgasm' or like 'it has to go for this long', or something. Just sort of...not expecting anything, really. Just like letting it happen". Participants highlighted the importance of being present as experiencing what transpires in the moment, instead of being drawn into thoughts, goals, or interpretations of the experience.

As discussed above, being present also involves experiencing the physical sensations in one's body. Participants contrasted their experiences of dissociating from their bodies with

[1] Note that words in square brackets were added by the researcher for clarity.

positive sexual experiences, where they stayed present and experienced physical sensations. Participant 404 emphasized that being present involves ongoing effort:

> Over time I realized that, uh, I was dissociating and there was times where I wouldn't and...so I kind of, I guess, learned what I liked and what I didn't like. I mean, that was, I figured out when I was present which aspects were keeping me from it.

The experience of being present in her body during sex allowed this participant to begin piecing together how she could stay present. Similarly, participant 410 stated that in positive sexual experiences, she is able "to sit in my own body and not be afraid of my physicality". Being present and experiencing physical sensations in one's body is an important aspect of good sexual experiences for many participants.

Lastly, many participants identified being present as incorporating both of the physical and mental aspects discussed above. These participants described a kind of balancing act in maintaining self-awareness and presence in the moment without either dissociating or becoming caught up in thoughts. As participant 414 explained,

> …you kind of have to let go a bit. If you're too much in your head, or completely the opposite, if you're not aware of what you're doing, both those things can make it a bad experience. Whereas if you can let go of yourself a bit, really let yourself be in the situation… it feels right, that you don't have to be too much in your head or too far gone from your head.

A positive sexual experience is one where participants are present in their minds and in their bodies, and are able to experience what unfolds moment by moment. As participant 410 stated, "…good sex is sex where I can feel kind of as much myself…as possible".

Vulnerability and openness to experience. The fourth subtheme in the definition of good sex for survivors of sexual abuse is the experience of being vulnerable. Several participants reflected that the experience of engaging sexually is innately vulnerable, and described needing to lower their walls or "put my guard down", as participant 404 put it, in order to feel

comfortable and be able to connect with their partners. Participant 413 framed this as, “being vulnerable with a person in order to be all in”, explaining that being vulnerable and letting yourself be seen by your partner allows for a good sexual experience. Some participants stated that one aspect of being vulnerable during good sex was openness to experience. These participants reported that allowing themselves to be safely vulnerable with their partners enabled them to feel confident in trying new things. As participant 409 stated, “[good sex is] not so much about skill but just willing to explore things together”. Participant 406 described a new kind of sexual experience with a casual sexual partner:

> One of these guys I went out with, he told me he likes to dominate. And, uh, I told him, I've never, uh, I have never experienced this but I would like...I mean, if it goes, uh, until my comfort zone, I'm fine. He said, don't worry, I know how to, I won't go out of your comfort zone. So he did dominate me … and I have to say, I enjoyed it so much.

By identifying and expressing her boundaries to her partner, this participant was able to explore new things and be vulnerable sexually. She was able to be open to new experiences due to her confidence in her safety and in her partner’s respect for her boundaries.

For some participants, comfort with being vulnerable during sex also involves ongoing exploration with one’s partner. Participant 415 described the importance of exploration in the context of learning about other sexual activities:

> A lot of things sound weird. The first time that someone said oral sex was a thing, both on a female and on a male, I kind of thought about and was like, you’re kidding. So, having the openness and the willingness to explore.

This participant described openness to exploration in the context of moving beyond her initial reaction and being vulnerable by trying something new. Many participants emphasized that a slow pace to this exploration was essential. Participant 408 described this as, “we were exploring and learning each other…we just went slowly and enjoyed each other”. In particular, this

participant emphasized exploration beyond specific sexual activities; rather, she described exploration as an ongoing, mutual process focused on enjoyment and learning. Some participants reported that pacing exploration slowly allowed them to feel safe in being vulnerable with their partners. Lastly, several participants identified that initiating sexual activity with their partners involved an element of risk-taking as an aspect of being vulnerable during good sexual experiences. Participant 404 explained this dynamic in detail:

> Initiating…releases some fear in me. Of rejection and…not being able to stop it during. But, you know, on the other hand, when I am able to and realize that he's allowing me to control it and initiate it, uh, I get a good feeling about it, you know? It kind of helps me out.

This participant takes a risk with her partner when she initiates sexually, and she identifies feeling the fear of rejection as well as some lasting fears related to her experience of sexual trauma. However, the benefit of initiating sex and taking this risk allows her to feel good, counter the influence of her previous abuse, and connect with her partner. By contrast, several participants stated that initiating sexual activity was quite challenging and they did not do so. Being vulnerable with their sexual partners, whether while exploring sexually, being open to new experiences, or taking some risks and initiating sexually, was one aspect of good sex identified by participants.

Sex as a mutual pursuit. Most participants emphasized that good sex for them is a joint activity and a mutual pursuit that they engage in with their partners. This mutuality expresses itself in the other factors discussed in this section – for instance, participants described the importance of mutual engagement, mutual good feelings, and mutual enjoyment. As participant 406 explained, “you both know that you're making the other one...feel good”. Many participants defined good sex in in relation to both themselves and their partners, and used words such as “both” or “we” in describing their experiences. Participant 410 explained, “I think sometimes

people have that idea, that you have to wear all the right underwear and, you know, have the right stuff – but I don't think it is. I think good sex is actually just you bringing yourself and someone bringing their self, and you're both on board". This participant counters the stereotypical expectation that good sex requires props or superficial embellishments to create continued excitement. Instead, she states that both partners bringing their authentic selves and committing to a shared experience is what creates good sex.

Furthermore, good sexual experiences are different depending on what the individuals involved bring to the experience. As participant 409 stated, "[Good sex] has to do with you exploring, together, what you as a couple – not as individuals – as a couple enjoy together. And that's different for every couple". This participant specifies that good sex cannot be broken down into the component parts brought by each individual. Instead, good sex is defined as a joint pursuit, which signifies that positive experiences will be different with each partner.

Many participants also spoke of the importance of reciprocity, balance, and shifting attention in good sexual experiences. Participant 406 put this simply as, "I give you pleasure, you have to give me pleasure back. I give it back, you have to give it back". This focus on mutual enjoyment is essential for good sex. Participants described a number of different ways of achieving this balance of attention and focus. For example, participant 408 stated, "I need him to put me first in the sexual relationship. But on the reverse, I need to put him first in the sexual relationship. So our focus is more on the other person than on ourselves". When each individual is attending and attuned to the other, then the focus becomes shared enjoyment. By contrast, participant 402 described a different approach:

> One of the things is to make sure that I'm thinking about myself and not just the other person. Because I tend to go towards just thinking about the other person, since that was what it was like when I was a kid was that it had to all be all about

> pleasuring the other person in order to survive the experience. So I have to be sure that, like, I think about myself too.

This participant recognizes behavioural patterns in herself that are influenced by her past abuse experiences. In order to compensate for these reflexive behaviours, she ensures that she is attending to herself to maintain balance and a truly mutual focus. Broadly, most participants emphasized that good sex is a shared activity and involves balance between attending to themselves and attending to their partners.

Personal agency and control. All participants reported that actively engaging with their partners and taking control in their sexual activities was key to having a good experience. In discussing the importance of personal agency, several participants tended to cite their past abusive experiences as examples of having their personal agency taken from them, or having been passive in order to survive the experience. Accordingly, positive experiences for participants are those where they are actively participating, consenting, and exerting control over what is happening. As participant 412 explained, "…not feeling, um, pressured or, um, like, obligated… or forced in any way…just having the freedom to, I mean, getting to be with the person that I want to be with". Having the freedom and personal agency to decide whether to be sexual and with whom is essential for participants. In addition, most participants discussed the importance of actively engaging and participating in sexual activity. Participant 405 explained, "I just honestly thought, after the abuse, that good sex was just, you lay back and thought of England kind of thing, you let it happen. And I've learned to be involved in sex, that I need to be involved". Similarly, participant 410 described previous sexual experiences as "something that would be done to me rather than something I was a part of. Now I'm a much more equal partner". These participants note that actively participating and engaging in sexual activity is a way of exerting their personal agency over the experience, which in turn creates a positive

experience. In addition, being an active participant in sexual activity provides reassurance to survivors that the sexual activity is consensual, on their terms, and different from their experiences of trauma.

Some participants also described exerting personal agency in the context of giving and taking control over sexual activity. For example, participant 404 stated, “if we're in the act of...making love, that, uh, if it changes for me and I no longer can be in it and enjoying it, then, uh, I need to know that I can stop it”. Participants need to know that their partners will respect their wishes and give them control should they need to change the activity. Several participants described taking control as evidence to themselves of being an active participant, while giving control to their partners as a deliberate action based on trust. Participant 409 discussed the give and take of control in detail:

> I think that is very important so that you can take control if you need. And you can let go of control when you need to. When you have somebody that you can trust…you can give up control or you can take control when you need and that person is going to go with it, no matter which you decide, and you can change that midway…you can take control or give, freely, control. And that's the biggest, that's the biggest thing. Give freely (emphatically) that control. ... And that's a big difference…we [survivors] don't always know that we need to, but we do. Um...that we have to give control, willingly. And that it has to be a conscious decision.

This participant contrasts passivity with active decision-making to give control to one’s partner. She also notes that trust of one’s partner is an essential component to this balance of control. The give and take of control is an ever-evolving component of a sexual interaction, and doing so deliberately allows participants to exert their agency and assertiveness in choosing to be sexual on their own terms.

Expression of relationship. Most participants were clear that good sex occurred in the context of an overarching relationship. Whether that relationship was a committed long-term

romantic relationship, a friendship, or a casual sexual encounter, participants saw sex as one of many aspects of those relationships. Participant 402 emphasized the importance of this connection:

> I like to know that the person that I'm having sex with, we also have a lot more to our relationship personally. Maybe because it keeps me from feeling like they're only having sex with me to have sex with me…I need, like the element of like friendship and partnership and that kind of thing.

For this participant, having a relationship with multiple dimensions provides concrete evidence that she is not being taken advantage of sexually. Similarly, most participants discussed the role of sex as a normal, important component of their relationships. Many participants also conveyed that good sex represents love, caring, and romance in their relationships – in essence, sex becomes the physical enactment of these qualities in their relationships.

Most participants also emphasized that good relationships make good sex. To that end, participants discussed the importance of maintaining their relationships and putting effort into strengthening their emotional connection with their partners, which in turn creates a positive sexual experience. For example, when participant 405 was queried about what activities are necessary for good sex, she replied, "…if [my partner] hasn't been here all week 'cause he's been working at home for once…I need dinner and I need him to run me a bath. I need...that's my routine, yeah, food and a bath. Then I'm okay!" The activities that help this participant feel loved and cared for in the context of her relationship create the connection required for a positive sexual experience. Lastly, some participants emphasized the need for depth in their relationships as a component of good sex. Being in a relationship that is long-term allowed for deepening trust, connection, and commitment, which in turn created more positive experiences. Participant 409 discussed the depth of her relationship when recounting the disclosure of her abuse history to her husband:

> It took that level of trust, that level of communication, that level of...love. And concern and care and all of those things. For me to trust him enough, and our relationship, to let him in to my dark world, that I've kept him out of for so long. And then for that, then to translate...into awesomeness. (laughing)

For this participant, having depth to her relationship was key to authenticity with her husband and enjoyable sexual experiences. Overall, participants uniformly defined good sex within the broader context of their relationships and saw sexual activity as an important component of their relationships.

Communication. The final subtheme related to CSA survivors' definitions of good sex is communication. Given that many participants conceptualized good sex as a mutual activity and as one that occurs within a broader relationship context, it is logical that communicating effectively with one's partner would create a positive experience. Most participants affirmed the importance of both expressive and receptive communication. Participant 414 described this as, "…both just have to be able to listen to their partner and take cues from their partner, and just, you know, really engage with each other". Active communication, both in conveying information to one's partner and also being receptive to the partner's communication, is important. Many participants also noted the importance of honest, clear communication, as well as ongoing communication throughout sexual activity. With regards to expressing themselves, most participants discussed the necessity of explicitly conveying their sexual likes, dislikes, wishes, and boundaries to their partners. As participant 408 stated, "with my husband, there are certain things I will do and certain things I won't do…because of past experiences. And he's comfortable with that. But I let him know verbally". Explicit, verbal communication regarding boundaries is a necessary ingredient of good sex for most participants.

In addition, several participants highlighted the importance of nonverbal as well as verbal communication. Being able to read their partners' nonverbal signals or cues, as well as their

partners being able to do the same, facilitated communication around potentially difficult topics. Participant 408 described a sequence of nonverbal cues exchanged by her and her husband regarding initiation of sexual activity:

> …when he comes up to me and puts his arms around me, especially when he puts his hands on my breasts, I'm going, "Ookay, I think I know where this is heading!" And I have a choice, like I can either snuggle back into him or I can lovingly put his hands on my waist. And, and that is, you know, a nonverbal for a green light or a red light.

This participant is receptive to her husband's nonverbal communication and interprets his meaning accurately due to her familiarity with him and his cues. In turn, she can make a decision about whether she wishes to be sexual and convey her response using the same nonverbal language. By using nonverbal cues to respond, she has the choice of turning down his sexual overture without the difficult task of finding the right words to do so. Effective communication involving expressive, receptive, verbal, and nonverbal communication is a key component of good sex for most study participants.

Theme two: Factors that Contribute to CSA Survivors' Experiences of Good Sex.

This theme comprises factors identified by participants that help to facilitate or enable good sexual experiences. The four subthemes include self-knowledge, partner characteristics, specific skills, and building blocks to good sex.

Self-knowledge. While virtually all participants were clear that having and expressing personal boundaries were critical to safety, a vital precursor to this was developing the knowledge of their own likes, dislikes, and boundaries. Participant 401 explained this process as, "internally in terms of like, being able to figure out "Yeah, I like that" or "No, I don't like that". Many participants indicated that their self-knowledge increased over time and with each sexual experience. As participant 405 stated, "I know what feels right for me and what's good for me,

but for me I'm still quite early in my experiences with good sex". Here, she anticipates that her likes and dislikes will continue to evolve with time and positive sexual experiences. In addition, some participants identified that it was important for them to be aware of what was likely to contribute to negative feelings related to their abuse experiences, so they could prepare themselves and their partners. Lastly, many participants discussed the importance of knowing their sexual wants and desires. Participant 410 highlighted the difficulties in identifying and acknowledging her own sexual desire:

> I … had a lot of…that kind of generational shame about being a woman, and then, and not kind of owning being a sexual being or having sexual desires. So I think I would have been very much, um, when I was younger, very, very much led by my partner, their needs and wants. And I wouldn't have ever admitted to having, like having a sex drive. It would have felt really, really wrong. And I still struggle with that now but…I'm getting better and better at recognizing that in myself and being more open about that.

This participant cites social influences as the inhibiting factor in her awareness of her own sexual desire, and highlights that this lack of awareness led to her own passivity. She notes that she continues to find it challenging to identify desire in herself and to accept having sexual desire. Other participants noted that their experiences of abuse stifled the idea of having their own sexual desire. By developing awareness and acceptance of their sexual desires, participants are able to convey this information to their partners and thus facilitate good sexual experiences.

Partner characteristics. Many participants were emphatic that their experiences with their current or previous partners significantly contributed to the emergence of their positive sexual experiences. Accordingly, there were several significant partner characteristics identified by participants that they felt facilitated good sex. First, many women described their partners as patient, nonjudgmental, accepting, and respectful of them and their boundaries. These participants particularly emphasized that their partners did not pressure them for sex and were

clear that the relationships meant more to them than physical gratification. As participant 408 stated, “[My husband] said, ‘I love you regardless and I will never leave you. If we never have sex again, I'm okay with that’. That is the ultimate gift of love that you can give”. Similarly, many participants emphasized that their partners demonstrated their unconditional love, caring, emotional connection, and affection. These qualities allowed participants to experience many of the components discussed in the definition of good sex – safety, being present, having good feelings, and expressing personal agency in their decision-making around sex. Most women also identified that their partners were observant, attuned to them, and receptive to their cues. Participant 406 contrasted her previous negative experiences in long-term relationships with the sensitivity and awareness of her casual sexual partners:

> If my hand did like this (slight motion), then they would stop without me saying “no”, without me saying “it hurts”, without me... I mean, just the movement of my body, they just would stop and say, “oh, are you okay?”, everything, it's okay. So, …this made me think that, um, it can be possible that someone really cares about you (laughing), you know?

It was a new experience for this participant to have her partners be so attuned to her nonverbal signals, and it gave her hope for the future.

Another important partner characteristic was the partner’s reaction to the disclosure of participants’ past sexual abuse. Participants varied with the amount of detail that they told their partners, as well as in their relative comfort with discussing their history of abuse. For example, participant 409 stated, “...your partner knows what's going on, at least to some point. You know, they don't have to know every single detail, but to know that at some point you might have to stop, you know, whether you want to or not, or you might have to change things or do things differently, and they're okay with that”. For this participant, her partner’s response to her disclosure of abuse results in the partner’s flexibility and openness to modifying the experience if

needed. By contrast, participant 415 was very open with the details of her trauma history, and in response, her partner "…cared about my well-being. So he made sure to go as slow as I wanted, or to stop and take breaks, and do basically all those things that you hear people in their 30s talk about, and be like 'what, you can do that?!'" Regardless of the amount of detail conveyed, partners who facilitate enjoyable sexual experiences for participants are flexible and supportive in response to learning about participants' abuse histories. Some women noted that their partners were able to meet their needs in the context of their abuse disclosure by fulfilling specific roles. For example, participant 405 stated:

> For me and my partner to have good sex, I, actually, conversely seem to need...almost domination in a way. (chuckling) … I'm still empowered in that I can still say no to it. I definitely struggle with initiating it so I kind of need him to take control and be a bit more dominant and then...but be gentle at the same time with me and not hurt me. So it's a really fine line that we walk sometimes.

For this participant, when her partner takes the lead and initiates sexually, the overall experience is good for both of them. In this case, her partner is able to fill a role and be more dominant, which in turn helps her to feel safe and in control.

In addition, some participants reported that it was helpful for them when their partners had previous experience with sex or relationships, and were able to normalize sex for them. When their partners were comfortable with sex and could provide a context for engaging sexually in a safe and enjoyable way, many women found this facilitated enjoyable sexual experiences. For example, participant 411 stated that it was helpful that her partner had had several previous relationships, as he was able to reassure her effectively that enjoying sex was normal. Lastly, a few participants discussed the importance of their partner matching them in terms of sexual desire, physical fitness, and/or sexual compatibility. For instance, participant 415 stated that it was important for a sexual partner to be able to keep up with her physically and

stated, “Look, you can’t be doing pre-algebra if I’m on calc. You need to get into the same space”. Partners who have similar sexual wants and needs facilitate a positive sexual experience for participants.

Specific skills. Some participants identified several skills or abilities that helped to facilitate good sexual experiences for them. While communication is a key component of good sex, some participants noted that communication itself is a skill. Participant 415 explained, “…communication is a skillset. Like talking is a skillset, right? That is definitely a skill set, that’s not something I woke up one day and was like, let’s talk openly and candidly, whether it hurts your feelings or not”. In addition, some participants discussed skills related to preparation for having sex in a good, safe way. Several participants noted that they paused to reflect beforehand to ensure that they were feeling ‘good enough’ to result in a positive experience. Specifically, several women reported that they needed to ‘check in’ with themselves regarding their motivations for having sex, in order to ensure they were acting on their own desires rather than a sense of obligation or duty. Participant 402 described her process for checking in with herself:

> I just sort of like to scan myself, like mentally, and just see if um, there's any places of anxiety or fear or anything like that. And I like to make sure that I'm not pressuring myself into feeling like I have to take the next step. Because there's a lot of complicated, like, thought processes that I can get into where I can feel like I need to for x, y, and z reason – just due to past experiences. Um, so I make sure that I really want to be doing this and I make sure that I'm like, okay on the inside.

For this participant, deliberately pausing in order to reflect on her emotions and thought processes allows her to affirm to herself her personal agency and choice in deciding to engage sexually.

In addition, a few participants identified that the practice of mindfulness had helped them to stay present and embodied. Participant 410 reported that she had taken several mindfulness courses, and explained how this had been helpful to her:

> Mindfulness has… helped me be less afraid of being in my own body or in, just in myself. It's kind of allowed me to tolerate the physical sensations that come up for me or the physical experiences that come up for me – not just during sex but like, if I have body memories or something like that? It's made me more resilient and I'm more open to tolerate it, to sit in my own body and not be afraid of my physicality.

This participant notes that mindfulness has been helpful to her generally, and that she has been more able to experience her own body during sex as a result.

In contrast to popular sources of information that suggest specific sexual activities or skills in order to improve the quality of sexual experiences (e.g., Ménard & Kleinplatz, 2007), no participants in the current study identified specific skills related to sexual activity as facilitating enjoyable sexual experiences for them. A few participants noted that it had been helpful to learn what their partner enjoyed sexually, or vice versa, though they emphasized that this was a function of individual preferences and evolving context. Some participants stated that they worried about whether they were 'good' at sex, though this also seemed to be specific to ensuring their partner's enjoyment. Regardless, participants did not report that specific sexual activities or skillsets were required. Indeed, several participants noted that it was important not to have a particular sequence of sexual activities or goals in mind, as this would deter them from being present and fully embodied. As participant 409 stated, "...it's not about finding one thing that works. It's not, it's absolutely not. If we'd found one thing, like just one thing all the time, I would dread that in my head and it would be terrible forever after".

Building blocks to good sex. This subtheme reflects participants' depictions of how the elements of good sex developed and unfolded over time. Throughout the interviews, it was

notable that participants would frequently cite how one aspect of good sex facilitated or created the other. For example, some participants stated that communication enabled them to feel comfort and safety. Other participants reported that safety allowed them to be vulnerable with their partners. Each of these statements were compiled and upon analysis, a system of building blocks related to good sex emerged. These building blocks are illustrated in Figure 2. Broadly, participants identified safety, trust, and connection with their partner as the foundational elements. Participants reported that these elements facilitated communication and reciprocal nature of control. Positive feedback from these experiences led to increased comfort and relaxation while engaging sexually with their partners. In turn, this comfort affected participants' ability to be present in the moment, which subsequently facilitated openness and vulnerability. Importantly, participants described these elements as an iterative process, where each positive experience with specific elements reinforced the foundations of safety, trust, and connection. Each element also reinforced additional elements in the trajectory; for instance, each experience of feeling more comfortable and relaxed while engaging sexually contributed to increase ease and comfort with verbal and nonverbal communication. Participants also endorsed varying levels of progression within this model – for example, some women reported experiencing good sex without emphasizing openness or vulnerability. In summary, this is not a list of the requirements for good sex among participants. Instead, this model serves solely to capture the voices of participants as they described a process of gradually improving sexual experiences, unfolding over time.

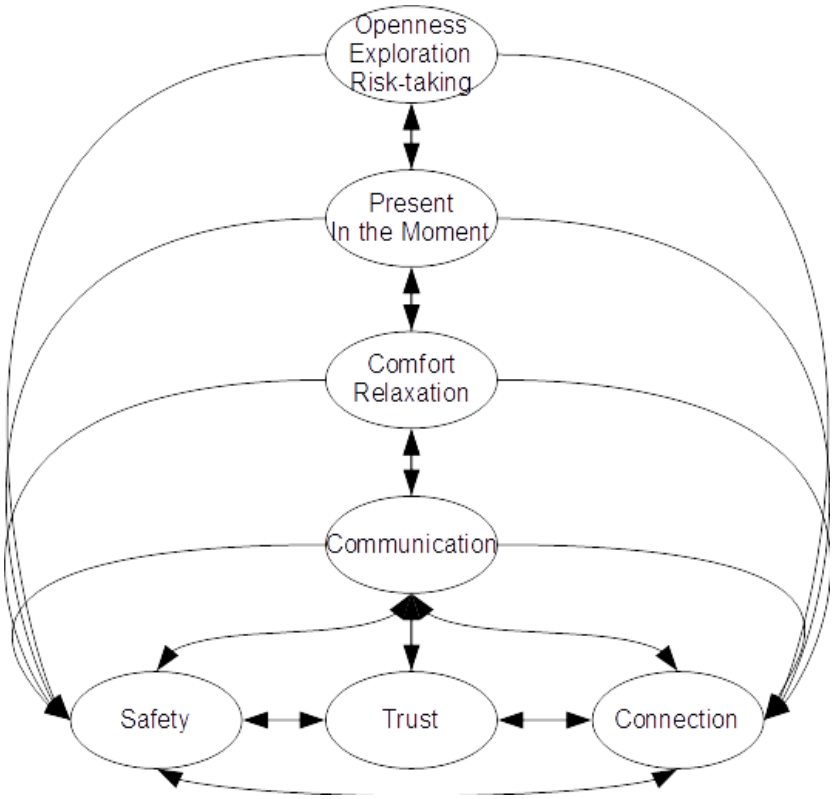

Figure 2. The subtheme 'Building Blocks to Good Sex'. This figure illustrates participants' depictions of how the components of good sex facilitate each other and develop over time.

Theme three: Good sex within a developmental context. This overarching theme captures participants' depictions of how good sex evolved and continues to evolve for them over time. The five subthemes in this section are named reclaiming sex after abuse, learning to have good sex, personal development and healing, ongoing influence of abuse, and life impacts sex.

Reclaiming sex after abuse. Many women in the study described the importance of reclaiming or taking back sex for themselves after their experience of abuse. This reclaiming served as one way to counter the experience of abuse and exert their personal agency. Some participants accomplished this by separating their abusive experiences from their understanding of sex in general. For example, participant 407 described a turning point in her conceptualization of herself as a sexual being:

> …when I was 14, somebody asked me if I was a virgin in front of a bunch of people. And I was gonna say no, and...when I thought about saying no, I thought, "No, that's not right". You know, I didn't do that to myself, I didn't choose it, and I so I got kind of angry? Um, and I said, I finally said, "Yeah, I'm a virgin". And from that point on, you know I'm a little bit stubborn about it, you know what I mean? I am going to have this for me and you are not going to take it away.

By defining herself as a virgin, this participant reconceptualised her experience of trauma as unrelated to her sexual life. She based this definition on her lack of choice and personal agency during the traumatic experience. This quote also illustrates the role of stubbornness and tenacity in reclaiming sex. Later in the interview, this same participant stated, "I was very stubborn about it, and of all the things that were taken from me, sex was not gonna be one of 'em. You know? That's a part of adult you, that is a part of life, that is a part of having a family". This participant channeled her frustration and anger about the influence of the abuse on her life into stubbornness about wanting to reclaim sex for herself. She defined sex as a normal part of life and adult identity. Accordingly, participants who cited this stubbornness were able to use these feelings to reclaim sex for themselves.

Several participants also described the importance of optimism, hope, and curiosity in prompting them to explore sexuality as a positive experience and to reclaim it for themselves. Participant 405 drew on her hope for better sexual experiences as motivation to keep trying, stating "I just got this little piece of hope, and no matter how low it got, I just held onto it. I always believed that things would get better eventually". Similarly, participant 402 discussed her curiosity about the possibility of enjoyable sexual experiences: "…my friends would talk about like, having sex and their relationships and I sort of realized that I'd pushed that part of myself away. So I was curious, I guess?" For this participant, the contradiction between her own negative experiences in the context of trauma and her friends' depictions of enjoyable sexual experiences prompted her to be curious about what she was missing. Several participants

reported that maintaining hope and curiosity in the face of challenge is one aspect that helped them to keep working towards improving their sexual lives.

When participants did have positive sexual experiences, they reported that such experiences were empowering and validating. All participants reported that they were happy, grateful, and lucky to be able to have good sex. As participant 411 put it, “I’m really glad…that I can get something that I never thought I would get out of life. It's almost like, I hit, I don't know, like you hit, when you play lottery tickets and you don't ever expect to win, and then one day you do (chuckling)”. This participant described feeling minimal hope about having good sex, yet she kept trying and now is almost surprised and grateful for her enjoyable sexual experiences. Participant 407 characterized her positive sexual experiences as an act of victory: “[My partner] is enjoying it and I'm enjoying it. It's kind of a little bit bigger victory than a normal person, who's just like “‘Oh I can have better sex, I'm good at having sex now’. It does have a little, you know, victory to it.” This participant describes how having good sex as a survivor of childhood sexual abuse is itself an act of empowerment and both a symbolic and literal victory. Interestingly, several participants highlighted how reclaiming their sex lives factored into their decision to participate in the study. Some participants noted that freely choosing to discuss their positive sexual experiences left them feeling pleased, empowered, and content by the end of the interview.

Learning to have good sex. When queried about whether they learned how to have good sex, the majority of participants reported that they learned what good sex was and how to have it in a variety of different ways. One of the preliminary aspects of learning to have good sex was gaining concrete knowledge about sex as well as information about healthy relationships. The women in the study cited a number of sources that they used to find out information about sex,

including their friends, medical professionals, books and other resources, pornography, and online communities. Participant 402 explained why she was prompted to seek more information:

> I definitely read a lot about sex and about, um, masturbation and stuff like that, to try and like figure it all out. Because I was coming from a place where all the information I had was ...not good, so I needed to find information that was more...safe and accurate and, um, I don't know, just better information.

This participant used books and other resources to find accurate information about sex, in order to counter her existing knowledge which was based solely on her experiences of abuse. The participants who reported that they looked to pornography to find knowledge stated that they were largely looking for information about how other women act during sex. The use of online communities ranged from support groups for survivors of sexual abuse to online forums for individuals interested in alternative sexual practices (i.e., bondage/discipline, dominance/submission, sadism/masochism [BDSM]). Participants reported that these forums allowed them to hear from others about their experiences and gain a wider range of knowledge. In terms of knowledge-seeking about healthy relationships, participants reported that they again spoke to friends and also gained information from psychotherapists. Participant 405 explained, “I think the skills that I've learned in counselling, I really have needed them. I've needed to know…what's safe. I guess, like, how to touch and what to touch and that it's okay to touch…sort of, how to identify safe and healthy sex, really”. In the context of therapy, this participant gained concrete information about what is safe and healthy in relationships and during sex.

In addition, participants emphasized that they learned about sex from their partners. Specifically, participants reported that their partners acted like a kind of scaffolding, providing a model for healthy skill development and supporting them in building those skills. For example,

participant 414 discussed how her partner's awareness and attunement to her helped her begin exploring her sexual preferences:

> If for any reason I wasn't feeling it…he would pick up on that. He was just really attentive about it and picked up on the signals, even though I wasn't even 100% aware, and he would stop and say, "What's wrong? Like, you're not into it." And I was like, "Yes, yes, yes, let's continue." And he was like, "No, seriously, you're not." And then, he made me aware that I wasn't…. so that, then I suddenly started thinking about, what do I actually like?

Even though the participant herself is not aware of her feelings in this moment, her partner checks in with her regarding his perception that she is not enjoying sex, and expresses his desire that she enjoy the activity, which in turn, normalizes that sex is an activity that can and potentially should be enjoyed. As a result, this participant stated that she began to tune into her own experience more and reflect on what she might enjoy sexually. Other participants reported that their partners cued them to check in with themselves about their motivations to engage sexually, that their partners explicitly taught them what they liked sexually, and/or their partners helped them to counter feelings of shame or guilt about sex. Lastly, some women reported that their partners helped them to counter negative beliefs or expectations that they had about themselves. For example, participant 411 stated, "…basically he's telling me that I'm normal. It's normal. I'm not a freak, I'm not, you know, ruined by what happened to me… that feeling that you're, like, you're unlovable or something, you know? I always kind of felt that way and it's so nice to realize that it's not true". By her partner telling her that he loves her, desires her, wants to be with her and doesn't consider her broken or ruined, this participant is able to counter some of her own negative appraisals of herself effectively.

Some participants described additional strategies for learning how to have good sex. Several women reported that a trial and error approach was helpful in learning what good sex was. In essence, participants built on sexual experiences that were successively 'less bad' in

helping them to learn what they liked and didn't like sexually. Over time, this resulted in a shift towards good or positive sexual experiences. A few participants also noted that they used alcohol to manage negative emotions before having sex. In discussing her difficulty with initiating sex, participant 404 stated, "I kind of use some assistance from unhealthy means. I tend to use alcohol to relax a little bit". However, other participants noted that using substances such as alcohol resulted in them being less present in the moment during sex and more likely to return to old behavioural patterns (e.g., not focusing on their own experience). While alcohol may aid some participants in reducing fear and negative emotions, alcohol also seems to dampen sensation, which accordingly affects participants' overall sexual experiences.

Lastly, some participants described a turning point or key moment in their learning about good sex. These moments tended to occur during an interaction where participants took some kind of interpersonal risk, and received a response that either surprised them or countered their negative expectations of what would occur. As a result, these experiences seemed to facilitate a significant change in the quality of participants' sexual experiences. Participant 409 gave a detailed example of her experience of a turning point, which occurred when she disclosed her history of CSA to her husband after seven years of marriage:

> …he was really upset because he could tell that I was upset and I wouldn't tell him anything. … I was totally freaking out when I told him because I thought like, uh, is he going to be, like, second-guessing things ... It's already hard enough, like, and now I've got to worry about what he's thinking, and I was like all freaked out. And yeah, no, he was fine (chuckling). … the biggest thing for me is why I didn't want to tell him. It's because I didn't want to screw up what we already had. But the biggest surprise for me? Was that, by telling him, it made it so much better.

This participant described how her fear of affecting her husband's perception of her kept her from disclosing her history of abuse. However, much to her surprise, her husband was accepting and supportive of her disclosure, and this significant conversation improved the quality of their

sexual experiences dramatically. These key moments tended to occur during abuse disclosures, but they also occurred in the context of participants reclaiming sex for themselves and reframing sex as something positive.

Personal development and healing. Most participants reflected that their overall personal development and recovery from CSA contributed to their positive sexual experiences. These women described healing from trauma and increasing their self-knowledge through a variety of methods, including attending psychotherapy, journaling, and connecting with other survivors either in person or through online forums. Participant 402 stated that, "going to therapy and stuff helps because you just work through more stuff and then you're generally a stronger person". For this participant, increasing her resiliency and personal strength provided her with the personal resources to work on developing the core components of good sex. In whichever fashion that participants chose to process and work on their traumatic experiences and increase their personal insight, these processes translated into similar improvements in their sexual lives. For example, participants who understood their triggers for trauma-related symptoms and/or flashbacks were able to use these same insights in identifying and managing triggers that occurred while they were being sexual with their partners. However, the process of personal development was far from simple, and participants emphasized that there was no one path to healing. As participant 409 stated, "I think getting to know ourselves, um, is not...linear. It's not linear. You know, you can't just follow a step book. It's not AA, there's not 12 steps (chuckling)".

Many participants also reflected that good sex for them tended to be a function of age, development, and maturity. These women cited increased comfort, increased openness to learning new things, and greater time for healing since the occurrence of abuse, as reasons why

age tended to positively affect sexual experiences. Participant 408 explained how her sexual experiences have continued to be enjoyable as her and her partner have aged:

> …when you get older, you have to be like, okay, instead of making this, okay, we're gonna do this the way we've always done it, and maybe have set-up a situation for failure, we find different ways that can create...a more satisfying experience in other ways that can, uh, help an older person enjoy our sex together.

With increased comfort and willingness to explore together, as a function of maturity and depth to their relationship, this participant has increased her enjoyment of being sexual with her partner.

Importantly, many participants noted that their experiences of good sex continued to develop and evolve over time. These participants explained how their definitions of good sex had shifted and changed as they aged, and several stated that they expected the definition to continue to change. For example, participant 410 explained how she would like to characterize good sex in the future:

> I don't associate sex with love particularly, or emotional connection. …I mean, it is with someone I love. …maybe that's something that I would like to bring, as I continue to redefine, then maybe that's something that I would like to mean, that good sex also has an emotional connection.

This participant illustrates the developing and changing nature of good sex over time. She noted that she is having good sex at present with someone she cares for and identified how she would like this to be a part of her sexual activity. Participants also emphasized that the quality of their sexual experiences waxed and waned over time, though trended generally towards gradual improvement. When queried about current proportions of good sexual experiences, participants' responses ranged from all the time, to 75% of the time, to rarely or not currently being sexual whatsoever. The majority of participants reported that their sexual experiences were positive most, but not all, of the time. In essence, experiencing good sex in their lives did not guarantee

that participants would continue to have positive sexual experiences. Instead, participants learned over time what elements were more likely to contribute to better sex.

Lastly, the women in the study expressed their personal development and healing by discussing their desire to share their knowledge and help other survivors. Most participants cited their desire to help as the reason why they chose to participate in the study, and others reported that they mentored other survivors informally or posted suggestions to the online community support forums that they frequented. These participants strongly wished to share the insights they had gained and the strategies that had been helpful for them. Several participants reported that they also viewed participating in the study as itself an opportunity for personal development and growth. Participant 409 described gaining new insight over the course of the interview:

> … you actually solve more as you're doing it too, than even before you came in, because, you know, you're thinking about it actively. You're bringing past things and past experiences all together in one neat little box and you're like, "Oh, that makes sense", "Hmm, there's that" (laughing)

By reflecting on her experiences and discussing them over the course of the interview, this participant gained a better understanding of herself as a whole being. Actively reflecting on their experiences in the course of the interview was one small way in which participants continued their personal development.

Ongoing influence of abuse. Participants reported that while they had all experienced good sex at some point in their lives, their experience of CSA continued to play a role in their current sexual lives. Participants described varying levels of having processed and worked through their traumatic experiences, particularly in relation to triggers (i.e., a cue that is linked to past experiences of trauma and prompts negative emotional or physical states, such as traumatic flashbacks; van der Kolk, 1998). Some participants described a balance of working on coping with these triggers when not being sexual and avoiding triggers as much as possible while being

sexual. Some women also noted that sex could continue to feel unsafe due to the influence of triggers, even though participants knew they were physically safe. Participant 402 explained this dynamic:

> Obviously, sex can be triggering and it can, you know, have other effects. No matter how hard you try to make it good and safe it can have other effects. So I think about half the time, um, I'm getting triggered and then it feels like it wasn't a good experience. Not that anything bad happened, but just because...it brings up other stuff and about half the time I manage to like, enjoy it.

For this participant, sex is itself triggering and she has varying success with coping with this and focusing on the present experience, rather than being cued and brought back to her history of trauma.

Several participants also described questioning themselves about their sexual likes and dislikes, and wondering whether their experience of CSA was influencing them in terms of what they preferred sexually. Essentially, these participants wondered whether their sexual preferences (and by extension, themselves) were 'normal'. For example, participant 405 stated that she watched pornography and compared the behaviours of the women performers to herself, solely to determine whether she was normal. These women stated that this questioning could make it difficult to separate the influence of their past abuse from their current sexual desires, and cause them to feel negatively about their desire. Participant 409 described her difficulties in trying to sort through this problem:

> …you sometimes go, "Well...why do I like that. Do I like that because I just, that's who I am and that's what I like? And that's okay, I can handle that, that's fine. Or...do I like that because that's what happened to me? Do I, you know, do I want this particular thing to happen because that's what happened to me? Is that what I like? Is that what I like because I like it or because..." It's just crazy. (chuckling) But that's the spiral, you know, that you always do, right? And it's like, and it drives you absolutely mad.

In wishing to exert their personal agency and choice over their sexual lives, participants can struggle with identifying whether their experience of trauma is contributing to their sexual desires. This participant went on to state that the solution for her was to normalize her sexual preferences, whether by comparing what she wanted to her husband and his 'normal' background, or by seeking support on the online community forums for survivors of CSA. Some participants acknowledged that they occasionally struggled in separating their history of abuse from their current perceptions of themselves as sexual beings.

Lastly, several participants described how their experiences of past abuse concretely affected their sexual lives at present. These women described behavioural patterns linked to the experience of abuse that they continued to engage in, if they were not aware and deliberate with their sexual decision-making. For example, a few participants described that their sexual experiences were not good when they were more passive, which they attributed to the need for passivity during their experiences of trauma in order to survive the experience. Participant 410 noted that she had a pattern of pulling herself away during sex and fantasizing, which she related to her abuse history: "I have this like, fantasy place in my head and I completely go off into that. That's not very nice, that's not good sex because I'm not, it's not me, I'm not in the room and the things I bring to mind are not nice, healthy things. They're not positive". For this participant, having what she deems as unhealthy fantasies are linked to her experience of abuse and distance her from current sexual experience. A few participants also noted that their current partners were a different gender than their abuser, and stated that they did not believe that they would be able to have good sex with a partner who was the same gender as their abuser. With all of their efforts towards having good, healthy, and enjoyable sexual experiences, several participants noted that their experiences of CSA continued to affect their sexual lives at present in some way.

Life impacts sex. Most participants acknowledged that elements of their day-to-day lives also affected their positive sexual experiences. Overall, good sex for participants required the availability of personal resources and energy, as a precursor for engaging actively in sex and creating the components of a positive sexual experience. Life stressors can reduce the availability of personal resources and decrease the incidence of good sex for participants, as it does for women in general. For example, participant 411 explained how sources of stress in her life diminish her sexual desire:

> I need to have in life, where I'm not overworked or too tired. I can get to where, you know, I can get in the mood. If I get a job schedule where I'm really busy, that kind of kills things for me. If I'm under a lot of stress, ‘cause I'm a caregiver for a family member and that's, that's hard. So that can kind of kill, that's something in the environment that doesn't work well. It's, it's a lack of stress, to be able to look forward to when I can be with him.

This participant explained that her sexual desire is affected by her levels of stress and available energy, and that she needed to be able to anticipate enjoyable sexual experiences with her partner in order to want to be sexual. Many participants also noted that the quality of their relationship with their partners affected good sex. Most women noted that they needed to feel emotionally connected to their partners in general, and needed to have conflict resolved and sources of tension in their relationship managed before being sexual. Lastly, participants stated that their mental health status affected their available personal resources to engage sexually. While mental health problems were not prohibitive of good sex, participants explained that the quality of their sex could fluctuate with their mental health status. For example, participant 412 acknowledged her history of anorexia and depression, and stated, “it's hard for me to want to be sexual if I don't feel good about my body”. Her mental health status significantly affected her sexual desire as well as her comfort with being present in her body. However, women also took steps to manage their mental health. Some participants, including the participant quoted above, spoke explicitly to

their partners about the reasons for their lack of sexual desire, in order to maintain their emotional connection, gain mutual reassurance, and strengthen their relationship overall. Others sought external support; for example, participant 415 described including her partner in her psychotherapy sessions:

> …[My partner] did two sessions with my therapist with me, to talk about what to do when I'm triggered, what to do when I'm in a crisis…. So, had a couple sessions talking about that and how to deal with like triggers in that moment, and stuff like that. …It wasn't like, luck that we had a really good experience. No, there was, like, work that was put in…

This participant, together with her therapist, helped her partner to learn how he could support her effectively in moments of crisis. While the participant noted that these sessions and strategies were effortful, the result was that their sexual experiences were very positive. The stresses and strains of daily life can affect the availability of personal resources for participants, much as stress affects sexual quality for non-survivors; however, with planning and attention to managing these barriers, these participants continue to enjoy positive sexual experiences.

Theme four: Good sex is similar, pathways are different. The final theme captures participants' thoughts regarding whether good sex for them was similar or different to how individuals without a history of CSA experience good sex. The majority of participants responded that they believed the experience of good sex (i.e., the definition of good sex, as described in the first theme) was similar for other individuals. A few participants felt that these similarities were more applicable to other women than to men. However, most participants stated that the pathways to good sex (i.e., the contributing factors and developmental context, as described in the second and third themes), as well as the relative importance of specific components, were different. Most participants stated that they believed good sex for survivors of CSA required a greater emphasis on safety, consent, and control. In addition, several noted that

facilitating these elements required greater effort, more planning, and deliberate attention. For instance, participant 405 stated that she believed other individuals were more sexually spontaneous than she, since her sexual decision-making was very deliberate and required reflection. Participant 407 described effortful, deliberate planning of how to disclose her history of abuse to a potential partner, as an example of how she differed from others without a history of abuse. Broadly, participants stated that good sex required much more effort for them than for individuals without a history of trauma. However, what is necessary for good sex for CSA survivors may also be beneficial for non-survivors. As participant 409 stated,

> I don't think that not knowing yourself is going to lead to better sex whether or not you've been abused. Right? Like I think it's harder for us, because if we don't know ourselves, we can't, in my opinion. But, or, I do think that ultimately, the things that we have to do, if everyone did, they'd probably have better sex too.

This participant suggests that non-survivors could experience improvements in the quality of their sexual experiences, if they engaged in the same types of effort as CSA survivors who experienced good sex.

Quantitative Findings

Participants' scores on the questionnaires were compared to control group means as well as mean scores from other population samples (i.e., other CSA survivors, women with diagnosed sexual dysfunctions). These data were obtained from the validation studies for the respective questionnaires as well as other recent quantitative studies with CSA survivors. Essentially, participants' scores were analyzed ideographically (i.e., how does each woman's score compare to norms?). Cut-off scores for the measures were used when available. Results from each measure are discussed separately, and descriptive statistics for each measure are shown in Table 2.

Table 2. *Descriptive Statistics for Quantitative Measures (Total Scores)*

Measure	*M*	*SD*	Range
Sexual Satisfaction Scale for Women	92.4	20.1	59.5 - 128
Female Sexual Function Index	23.1	11.0	4.4 – 34
Sexual Self-Schema Scale – Women's Version	54.7	14.7	27 - 82

Female Sexual Function Index (FSFI). Overall, 46.7% (*n* = 7) of participants scored below the cut-off score of 26.55 on the FSFI (Wiegel, Meston, & Rosen, 2005). However, participants 410, 413, and 415 reported no partnered sexual activity over the prior month; given that the FSFI is predicated on the assumption that participants have been sexually active with a partner in the specified time period, these participants' scores on this measure may not be valid. Of the remaining participants with interpretable data, 33.3% (*n* = 4) participants scored below the cut-off score, suggesting that these individuals met criteria for current sexual dysfunction. The set of data points on the bottom half of Figure 3 depicts participant total scores on this measure, compared to sample means from the validation study (Rosen et al., 2000). Means for both a control group as well as a sample of women with diagnosed female sexual arousal disorder (FSAD) are illustrated. A sizeable proportion of participants in the current study had total FSFI scores close to or above the mean of the control group in the validation study, while a number of participants had total FSFI scores close to or below the mean of the FSAD group from the validation study.

Sexual Satisfaction Scale for Women (SSS-W). The set of data points on the top half of Figure 3 depicts participants' total scores on the SSS-W, contrasted with sample means from the validation study (Meston & Trapnell, 2005). Means for a control group as well as a sample of

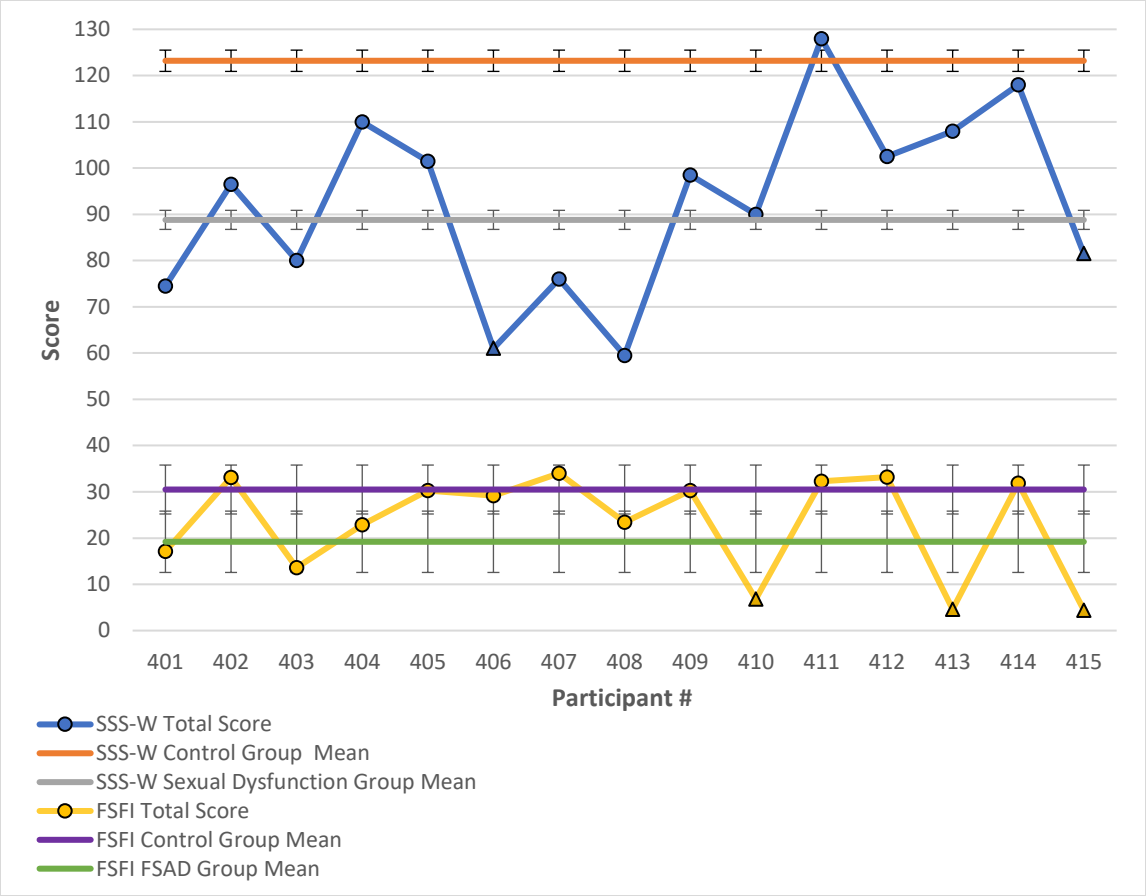

Figure 3. Sexual Satisfaction Scale for Women (SSS-W) and Female Sexual Function Index (FSFI) total scores for each participant. Data are contrasted with mean group scores from the respective validation studies (Meston & Trapnell, 2005; Rosen et al., 2000). Note that standard deviations of the mean scores are depicted by thin black lines, and the results of participants whose scores may not be interpretable are denoted with a triangle.

women meeting criteria for DSM-IV-TR sexual dysfunction (e.g., dyspareunia, vaginismus, hypoactive sexual desire disorder, female sexual arousal disorder) are illustrated.

Similar to scores on the FSFI, participants in this study had total SSS-W scores that ranged from close to the control group mean from the validation study to well below the sexual dysfunction group mean. Two participants reported that they were not currently in a romantic relationship; given that items on the SSS-W are frequently linked to partners and relational experiences, the scores of these participants may not be interpretable and are identified in the

figure. While no correlations can be calculated due to the small sample size, there are several instances where inconsistent directionality can be observed between participants' scores on the SSS-W and the FSFI. Participants 402, 407, and 412 had total scores on the SSS-W close to or below the mean of the sexual dysfunction group, yet had total scores on the FSFI that are closer to the mean of the control group. These participants are scored as sexually dissatisfied yet sexually functional. By contrast, participants 404, 409 and 413 had total SSS-W scores close to the mean of the control group, yet had FSFI total scores that were either closer to the mean of the FSAD group or invalid due to reports of no sexual activity over the prior month. In other words, these individuals are scored as sexually satisfied yet sexually dysfunctional or sexually inactive.Participant data from each of the subscales of the SSS-W were also compared to sample means from Stephenson, Pulverman, and Meston (2014), who reported subscale means for a group of CSA survivors (n = 134) as well as a non-abused group (n = 104). These data are illustrated in Figure 4. Note that the Contentment subscale is intended to measure personal sexual satisfaction, Communication and Compatibility subscales are intended to measure satisfaction with these aspects in a relational context, and the Relational Concern and Personal Concern subscales are intended to measure relative personal distress regarding the effects of sexual problems on one's partner as well as oneself (Meston & Trapnell, 2005).

Of note, 46.7% (n = 7) of participants scored more than one standard deviation above both group means on the Communication subscale. Similarly, 53.3% (n = 8) of participants scored more than one standard deviation above both group means on the Compatibility subscale. These results suggest that these participants were highly satisfied with their communication as well as their sexual compatibility or 'fit' with their partners, which is consistent with their reports from the interview portion of the study.

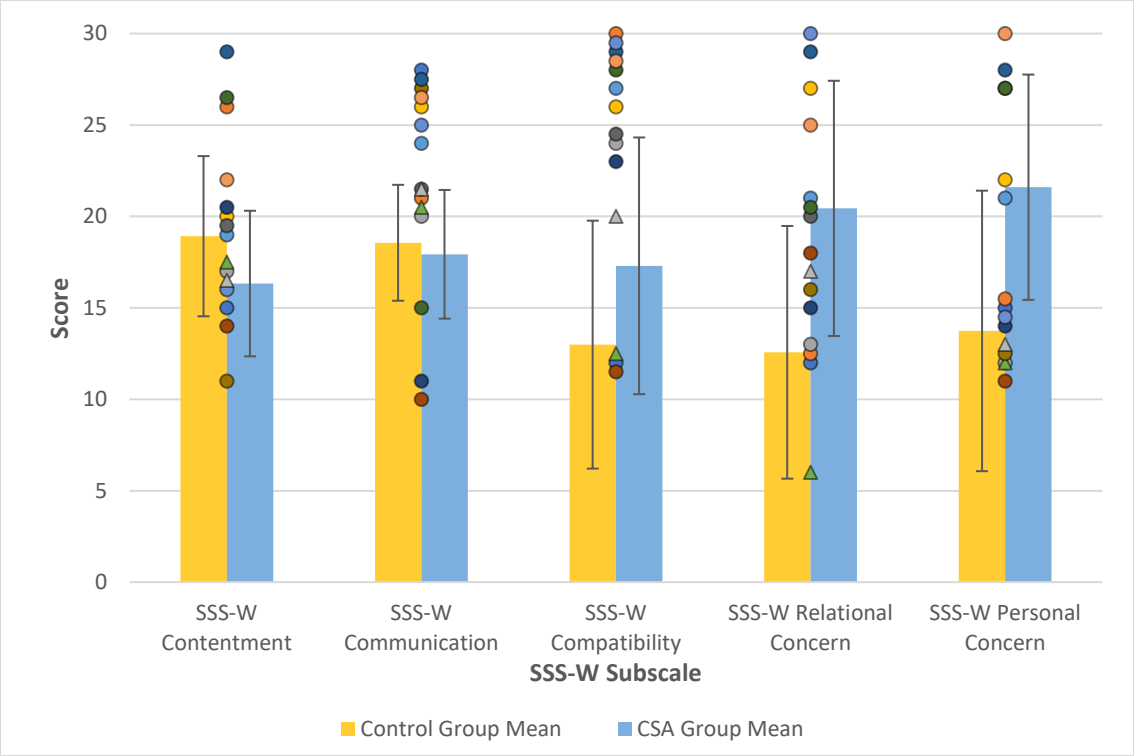

Figure 4. SSS-W subfactor scores by participant, contrasted with mean group scores (Stephenson, Pulverman, & Meston, 2014). Note that each coloured circle represents one participant's subscale score, and the standard deviations of the mean group scores are denoted by thin black lines. Coloured triangles indicate that this participant's score may not be interpretable, as they reported that they were not currently in a romantic relationship.

Sexual Self-Schema Scale – Women's Version (SSSS). Participant total scores on the SSSS, depicting the extent to which they held a positive view of themselves as sexual beings, were contrasted with mean scores from a sample of college age women (N = 387) in the original validation study (Andersen & Cyranowski, 1994). These data are depicted in Figure 5. The majority of participants' scores fell within one standard deviation of the mean group score, suggesting that many participants held similarly positive sexual self-schemas as the original control group. The five participants who scored more than one standard deviation below the control group total score had comparatively low scores on the Passionate/Romantic subscale of

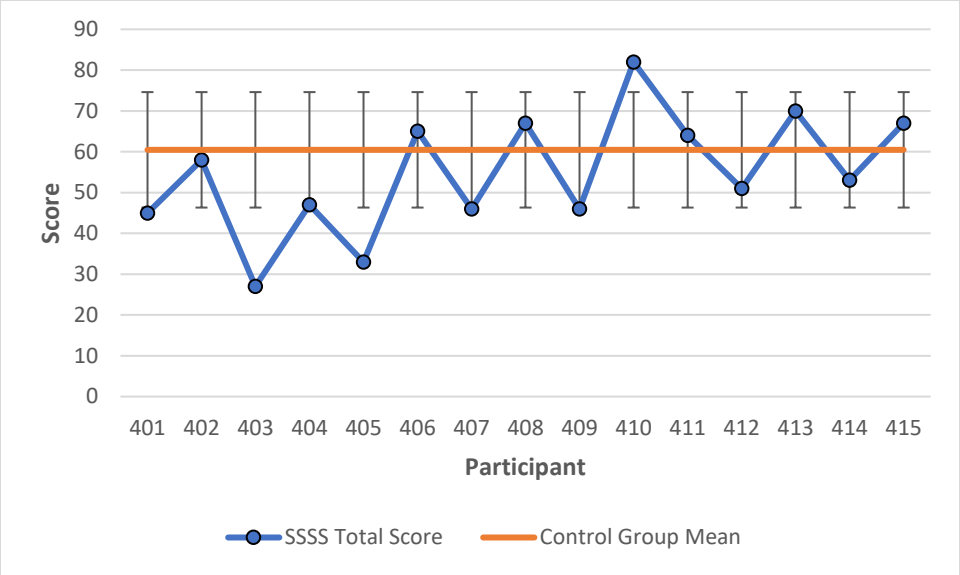

Figure 5. Sexual Self-Schema Scale – Women's Version (SSSS) total scores by participant. Data are contrasted with the control group mean from the validation study (Andersen & Cyranowski, 1994). Note that the standard deviation of the mean score is depicted by thin black lines.

the SSSS, suggesting that these individuals saw themselves as more unromantic or emotionally detached. However, three of these five women had scores within one standard deviation of the validation mean score on the Directness/Openness and Embarrassment/Conservatism subscales, suggesting that these individuals perceived themselves as similarly open to sexual experiences and less negative about sexual topics.

Participant Impressions of the Interview and the Questionnaires

To conclude the study, participants were asked to reflect on their experience of participating in the study and provide feedback about their impressions of both the interview and the measures. Overall, 60.0% (n = 9) of participants stated that they preferred the interview rather than the questionnaires, stating that they felt it was easier to tell a story or provide details rather than trying to fit their experiences into the available item responses. Some participants noted that they had anticipated the interview to be more challenging, and were surprised by their increasing comfort and the insights they gained. By contrast, one participant stated that she

preferred the questionnaires, as she found answering the open-ended questions of the interview to be difficult. The remaining participants had no preference, noting that they could see value in the different types of data gained from both the interview and the questionnaires. Many participants also identified that the experience of the interview was itself valuable, in that they were able to openly discuss sexual topics, synthesize their thoughts on these issues, and reflect on the progress they had made.

Several participants identified challenges with the interview, such as worrying about whether they would be asked specific questions about sexual functioning. Women also described some initial discomfort or awkwardness with discussing such a sensitive topic. However, they reflected that the nature of the open-ended questions allowed them to discuss what they felt comfortable discussing. A few participants became tearful during the interview when reflecting on areas of difficulty or their history of trauma. These moments of emotionality were managed by the researcher by checking in with the participant and collaboratively deciding to redirect the interview. In these instances, the women were also reminded that they could withdraw from the study or choose not to answer any question.

Participants also identified specific issues with the questionnaires. Several participants felt that their experiences were not well-captured by the questionnaire wording. For example, participants who were not currently in a long-term romantic relationship found it challenging to answer SSS-W items related to partners. Participant 415 stated that she felt the measure wording assumed that "…if I'm doing a sex study, I must be in a relationship right now", which she found frustrating. Several participants also identified differences between their responses to the questionnaires and the interview, given that the questionnaires specified a temporal context while the interview was open-ended. In these instances, participants stated that they did not believe the

questionnaire responses accurately reflected their perceptions of their experience, and caused them to feel negatively about their sexual functioning and/or satisfaction. When queried about suggestions to improve the experience of the questionnaires, one participant suggested incorporating items that would help to clarify the overall context and/or the potential influence of their trauma history. Several participants also stated that it was helpful to have the researcher available while they completed the questionnaires, so that they could ask questions and receive immediate clarification. Broadly, participants identified benefits and drawbacks to both the interview and the questionnaires that provide important information about the data collection methodology as well as interpretation of findings.

Of note, the women who participated in this study were a relatively diverse group in terms of age, country of residence, socioeconomic status, disability status, and sexual orientation (see the 'Participants' section for a more detailed description of the demographic characteristics of participants). There were some aspects of relative homogeneity, as most participants self-described as Caucasian and were currently in long-term romantic relationships. Even with the breadth of cultural identities and experiences reported by participants, their responses during the interview were strikingly similar. Most participants did not highlight other aspects of their cultural identities during the interview. If one compiled separate participant quotes from multiple transcripts, it would be difficult to identify the contributions of specific participants aside from details about partner characteristics or abuse history. However, a few salient points related to identity emerged. Older participants who had been in long-term committed relationships tended to emphasize the continued evolution of their sexual lives and romantic relationships as they grew older. These ideas are reflected in the 'Personal Development and Healing' subtheme. Participants who reported experiencing mental health problems tended to discuss how their

mental health status specifically affected the quality of their sexual experiences, which is highlighted in the 'Life Affects Sex' subtheme. It may be that the intersections of identity as a woman and as a survivor of CSA, shared by all participants, were the most salient cultural identities for the women in the current study.

Discussion

In summary, this study sought to explore the research question, "how do women survivors of CSA experience 'good sex'?" Data from semi-structured interviews with fifteen CSA survivors, who self-reported having experienced good sex, were analyzed using interpretative phenomenological analysis (IPA). Four overarching themes emerged, entitled 'Good Sex as Defined by CSA Survivors', 'Factors that Contribute to Good Sex among CSA Survivors' 'Good Sex within a Developmental Context', and 'Good Sex is Similar, Pathways are Different'. Participants' responses on the quantitative portion of the study depicted varying levels of sexual functioning, sexual satisfaction, and sexual self-schemas as quantified by their respective standardized measures. Most (but not all) participants' sexual self-schemas were positive, while sexual functioning and satisfaction scores varied considerably by individual. In comparing the interview and the questionnaires, participants emphasized the importance of context, personal choice, and item wording.

Results from the current study provide empirical evidence to counter existing stereotypes and beliefs about CSA survivors' experiences of consensual sex. First, it is clear that good sex for study participants is not simply the absence of sexual dysfunction, abuse, or dissatisfaction (e.g., Kleinplatz, 2012). Instead, good sex is a qualitatively distinct experience involving the varying contributions of the specific subthemes. Furthermore, in contrast to medicalized models of sexual functioning that depict a hierarchy of desirable physiological responses and distinguish between types of women's orgasms (e.g., Brody & Costa, 2017), few participants in the current

study discussed orgasm whatsoever. Instead, CSA survivors tended to emphasize good feelings, physical enjoyment, and positive emotions associated with good sex. Lastly, a simple yet critical finding is that participants for this study exist at all. That is, CSA survivors can and do have positive sexual experiences as adults, and participants emphasized that sharing their experiences and helping other survivors was a key motivator in choosing to participate in the current study.

Contextualizing Good Sex as Defined by CSA Survivors

Participants' definition of good sex comprised eight subthemes including safety, good feelings, being present, being open, being an active and assertive participant, mutuality, communication, and expression of relationship. These findings are markedly different from early research that defined 'normal' sexuality for women solely in terms of observable behaviour and physical responses (e.g., Masters & Johnson, 1966). Indeed, there is comparatively little research detailing what constitutes good sex in general, much less among women survivors of CSA, as sexuality research continues to focus largely on identified dysfunctions or negative correlates of sexual behaviour (Arakawa, Flanders, Hatfield, & Heck, 2013). However, results from the current study can be compared to other qualitative findings and theoretical models in the sexuality literature that provide definitions of 'healthy' or 'satisfying' sex. For example, Pascoal and colleagues (2014) identified two main themes in a thematic analysis of definitions of sexual satisfaction: positive aspects of individual experience such as physical pleasure, and relational elements such as mutuality and expression of feelings. While Pascoal et al. conducted their study with both men and women from the general population, these same dimensions can be observed in the findings from the current sample of 15 CSA survivors. Similarly, Fahs, and Plante (2017) analyzed women's definitions of good, happy, and joyous sex, and described four themes including physical pleasure, emotional connection, comfort, and control over sexual scripts.

Again, there are clear parallels to the ideas reported by participants in the current study (i.e., good feelings, safety, assertiveness/agency). However, the women survivors of CSA in the current study emphasized safety and consent to a much greater degree.

By contrast, Maltz and Holman (1980) introduced the CERTS model of healthy sexuality as a tool for psychoeducation with abuse survivors, based on clinical experience. This model defines healthy sex in terms of consent, equality, respect, trust, and safety. The emphasis on safety and consent is similar in the current study, while equality is reminiscent of the subtheme of personal agency, reflecting the importance of individuals taking active steps to be equally involved in sexual activity. Mutual respect and trust are also captured within the subthemes of safety and mutual pursuit; in other words, these themes illustrate the importance of good or healthy sex as a joint activity where partners are safe and trust each other. The CERTS model does seem to capture the foundational elements of safety, trust, and connection illustrated in the subtheme 'Building Blocks to Good Sex', as detailed by the women in the current study (see Figure 2). Broadly, the current study provides some empirical evidence to support the CERTS model, which is a novel contribution to a psychotherapeutic approach widely employed with abuse survivors. However, the CERTS model does not discuss other aspects identified by participants in the current study such as enjoyment, positive feelings, or openness.

Comparison can also be made with the components of optimal sexuality identified by Kleinplatz and colleagues (2009). This phenomenological research identified eight components of great sex, including being present, connection, deep intimacy, extraordinary communication, interpersonal risk-taking, authenticity, vulnerability, and transcendence. There are clear commonalities between the components reported by Kleinplatz et al. and the current findings, notably in the emphasis on communication, being present, openness, and the expression of

relationship through physical intimacy. However, there are differences in the relative intensity of the identified themes. For example, while safety and consent are discussed by Kleinplatz and colleagues as necessary prerequisites to optimal sexual experiences, the participants in the current study described the importance of physical and emotional safety in great detail, and viewed safety as a core element of good sex. By contrast, Kleinplatz et al.'s components of optimal sexuality include extraordinary communication and transcendent experiences. While participants in the current study also emphasized good feelings and the importance of communication, they used wording that implied a lesser intensity to these components (e.g., feeling good rather than transcendent; communicating well rather than extraordinarily). Overall, CSA survivors' definition of good sex in the current study emphasizes safety and consent more so than similar research with community samples and samples of individuals who reported having experienced great sex, yet emphasizes good feelings and enjoyment more so than the CERTS model (Maltz et al., 1980) specific to abuse survivors.

It is important to note that the identified subthemes in the women's definition of good sex are not a prescriptive list of activities for having better sex, nor are they intended to reinforce a performative or goal-oriented approach to sexual activity. That is, not all participants discussed every subtheme, and yet all participants self-reported having experienced good sex. Instead, these subthemes are intended to depict how some women define and experience good sex. To illustrate this point, bread-making may serve as an apt analogy. Four basic ingredients are required: flour, salt, water, and yeast. However, the proportions of each may vary, the recipes and processes may differ, and other ingredients may be added. Individuals have preferences for which types of bread they like and what they consider good. Thus, this list of subthemes can be

interpreted as one ‘recipe’, where there are likely similarities across recipes but no one ideal approach.

Exploring Contributing Factors to Good Sex among CSA Survivors

Four subthemes comprised the theme of ‘Contributing Factors to Good Sex among CSA Survivors’. These subthemes included self-knowledge, partner characteristics, specific skills, and building blocks to good sex. For women in general, countering the historic narrative of passivity and shame associated with women’s sexuality has been a topic of social discourse as well as clinical attention. The advent of 1960s sexual liberation politics in North America, the subsequent morality backlash, and the ‘personal is political’ feminist movement of the 1980s and 1990s has kept women’s sexuality and sex positivity at the forefront of Western political and social discourse. In a seminal chapter, Rubin (1992) localizes sex negativity in a historical context of morality and social control, argues that sexuality is politicized similarly to gender, and applauds a ‘pro-sex feminism’ that supports sexual pleasure and activities that challenge restrictive, heterosexist norms. From a clinical perspective, Barbach (2000) conducted group therapy with women she termed ‘preorgasmic’ and sought to emphasize the normality of sexual desire for women. She provided psychoeducation about women’s bodies and diversity of sexual desires, and suggested exercises for increasing bodily awareness and comfort. Research evidence suggests that women survivors of CSA are more likely to have lower sexual self-esteem (e.g., Lemieux & Byers, 2008; Van Bruggen, Runtz, & Kadlec, 2006). Accordingly, the process of developing self-knowledge, conceptualizing sexual desire positively, and exploring one’s sexual likes and dislikes may constitute a significant positive step for abuse survivors. The women in the current study acknowledged that participating in the study itself aided them in continuing to explore their thoughts about sex and sexual desire. Maltz (2012b) and Haines (2007), in their

respective texts focus on sexual healing for abuse survivors, and provide psychoeducation and normalization about healthy sexual desire. Findings from the current study support how important it is for women who have experienced CSA to engage in normalizing and developing a positive view of self as a sexual being

Participants in the current study also cited specific skills that contributed to a positive sexual experience for them, including communication, self-awareness, and mindfulness. Communication skills, both related to sex and generally within a relationship context, have been shown to predict both relationship satisfaction and sexual satisfaction (Byers, 2005; Mark & Jozkowski, 2013). Byers (2011) suggests that conveying sexual likes and dislikes to one's partner increases the likelihood of having mutual needs met and can also increase the felt sense of intimacy and closeness between partners. A few participants highlighted the role of mindfulness skills in helping them to be more present and to feel more comfortable in their bodies. Mindfulness-based interventions, which teach individuals to be intentionally present in the moment and to observe their sensations and thoughts without judgement, have been shown to have moderate effect sizes in preliminary treatment efficacy studies for women with sexual dysfunctions (Stephenson & Kerth, 2017). For example, Brotto, Seal, and Rellini (2012) conducted a pilot study of a two-session mindfulness-based intervention with female CSA survivors who reported sexual distress. These authors conceptualized sexual difficulties in this population as partially stemming from a disconnection between physiological and subjective sexual responses; for example, an episode of dissociation could be considered as an extreme form of this disconnection. These researchers noted that participants in their study had greater concordance between genital and subjective ratings of physiological arousal after the intervention, as well as reduced sexual distress. While mindfulness-based interventions seem to

be an important avenue for further research, being solely in the moment and observing one's thoughts and sensations may not be sufficient. As participants in the current study reported, good sex involved being present in both the mind and the body, by balancing experiences and sensations while also being consciously aware of cognitive processes and actively engaging in decision-making about sexual activity. Of note, participants in the current study did not describe any specifically sexual skills as contributing to good sex. While popular sources of information cite specific or novel sexual techniques as a key ingredient for better sex (e.g., Ménard & Kleinplatz, 2007), findings from this research suggest that good sex does not require individuals to be 'good at sex'. Findings from the current study suggest that CSA survivors' acceptance and comfort with their own sexuality, as well as the acceptance and patience of a partner in partnered sex, are far more relevant in creating a positive sexual experience.

Lastly, participants in the current study reported that certain characteristics of their sexual partners facilitated positive sexual experiences. Participants described their partners as accepting, respectful, loving, observant, attuned to them, reassuring, and responsive, among other qualities. These findings are mirrored in results reported in a qualitative study of positive sexual self-schemas among women CSA survivors by Hitter and colleagues (2017). Their study involved the thematic analysis of semi-structured interviews with eight women, and hypothesized that relational healing was a significant factor in resilience and post-traumatic recovery. Participants in their study described the importance of partners who were kind, supportive, and caring, which facilitated sexual experiences that were healing. In the current study, these partner characteristics were evident in descriptions of both long-term romantic partners as well as casual sexual partners. By contrast, other research has found that female CSA survivors perceive their male partners as generally more emotionally distant, less well-adjusted, and less supportive (e.g.,

DiLillo, 2001). Participants in the current study tended to cite sexual experiences with specific partners as key moments or turning points in their sexual lives, and several stated that they did not believe they would have good sex with another partner. Plainly, CSA survivors' positive sexual experiences of seem to be closely tied to their partners' support and positive attributes.

Evolution of Good Sex over Time

The theme, 'Good Sex Within a Developmental Context' comprised five subthemes including reclaiming sex after abuse, learning to have good sex, personal development and healing, ongoing influence of abuse, and life impacts sex. Women in this study reported that learning about sex and relationships was a key developmental process, and they sought out information from friends, health care practitioners, psychotherapists, online communities, sexual partners, and resources like books and the Internet. These findings are reminiscent of research related to how young adults obtain information about sex mainly from educational websites and friends (Charest, Kleinplatz, & Lund, 2016). However, there is little research specific to abuse survivors regarding how they seek out information about healthy sex or healthy intimate relationships. Wright, Crawford, and Sebastian (2007) suggest that some women survivors of CSA are prompted to seek out information about healthy sex and relationships following the recognition that their past traumatic experiences constituted sexual abuse. Participants in the current study gained significant information about healthy sex and relationships from partners, psychotherapists, and on-line communities, and this may be an important avenue for further research. In particular, assessing the quality and accuracy of the sexual information accessed by CSA survivors, and learning more about the types of sexual information required, could structure the development of new informational resources such as websites.

Participants reflected that their overall personal development and healing contributed to the improved quality of their sexual experiences. In particular, participants emphasized that personal development was an ongoing process, as their level of healing and adjustment fluctuated, their relationships with their sexual partners continued to deepen over time, and their definitions of good sex shifted and changed. These findings suggest that personal development and effort over time contribute to good sex; similar findings were reported by Ménard and colleagues (2015), who found that older individuals who had experienced great sex had needed to overcome early sex-negative learning and make active choices to prioritize improving the quality of their sexual relationships. Population-based studies have tended to report that sexual quality and satisfaction decrease with age; however, a recent study (Forbes, Eaton, & Krueger, 2017) found that while age initially predicted a lower quality of sexual life, after controlling for the degree of thought and effort that individuals invested in their sexual lives, age instead predicted a higher quality of sexual life. Forbes and colleagues theorized that older adults gained sexual wisdom over time, which they defined as increased comfort, openness, and flexibility regarding sexual schemas as well as knowledge of themselves and their partners. Contrary to popular stereotypes that either depict older adults as nonsexual or conceptualize penetrative sexual intercourse as a requirement for healthy ageing (Gott, 2006), results from the current study emphasize that good sex as defined by CSA survivors instead develops over time and may improve as a function of age, experience, deliberate effort, and relational depth. This finding is likely applicable to non-survivors as well (e.g., Kleinplatz et al., 2013) and suggests that improved sexual quality is linked more so to the pleasurable, emotional and relational experience of sex rather than genital functionality. In other words, good sex can occur regardless of physical health status, age, or medical conditions.

Participants cited stubbornness and determination to reclaim sex for themselves as a significant aspect of learning to have good sex. These themes are similar to constructs of survival and resiliency found in research on coping and healing from abuse (Clare, Hamilton-Giachritsis, & Harrop, 2014). For instance, Morrow and Smith (1995) identified themes of resistance and rebellion as a survival tactic to manage the felt sense of powerlessness and lack of control associated with the experience of abuse. Other findings suggest that positive cognitive self-talk and perspective-shifting regarding negative views of the self are predictors of resiliency and recovery from abuse (Bogar & Hulse-Killacky, 2006). Participants in the current study re-conceptualized sexuality for themselves as separate from their history of abuse, or maintained the hope and belief that they were able to have positive sexual experiences. As one participant stated, "I am going to have this for me and you are not going to take it away". By working to reclaim sex for themselves, good sex became an act of resistance and empowerment for the women.

Importantly, participants highlighted that they experienced good sex simultaneously with ongoing negative symptoms related to their experience of abuse. Participants described healing and personal development, as well as the experience of good sex, at the same time as they experienced trauma-related symptoms such as flashbacks or questioning their normalcy. These findings highlight that the evolution of good sex over time is not a linear association with the reduction of abuse-related symptoms. The women in the current study shared their successes and their ongoing frustrations in working to improve the quality of their sexual lives, and openly acknowledged how their sexual experiences fluctuated over time with the severity of their trauma-related symptoms. However, these findings also illustrate that ongoing trauma-related symptoms do not preclude the experience of good sex, and the other contributing factors to good

sex identified in this research (i.e., partner characteristics, self-knowledge) may become more salient in such contexts.

Evaluating Quantitative Results

Overall, 33.3% of participants scored above the cut-off score on the FSFI, which the authors of the measure suggest indicates current symptoms likely meeting criteria for a DSM-IV-TR diagnosis of sexual dysfunction. This figure does not include the women whose scores on the FSFI were uninterpretable due to their lack of reported sexual activity with a partner within the specified time period. While it is difficult to obtain prevalence data on the rates of female sexual dysfunction in the general population due to methodological problems in conducting research on sexual dysfunction in general (see McCabe et al., 2016 for a review), Lutfey and colleagues (2008) reported a 38.4% prevalence rate of sexual problems (i.e., problems with arousal, lubrication, orgasm, desire) in a large community sample of American women, using a modified version of the FSFI. However, these authors report a 13.7% prevalence rate of women in their sample who reported both sexual problems and sexually-related personal distress, a key diagnostic criterion. Prevalence data on rates of female sexual dysfunction among CSA survivors are perhaps even more fraught with methodological challenges; Leonard and Follete (2002) summarized existing findings with clinical, community, and college student samples, and reviewed a host of estimates of the prevalence of various sexual problems ranging from 32.3% to over 90%. These authors caution the interpretation of the prevalence estimates due to lack of methodological consistency on definitions of both CSA and female sexual dysfunction. Thus, findings from the current sample suggest that while a significant proportion of participants report sexual functioning that is clinically interpretable as problematic, few participants reported personal distress associated with their sexual functioning in the interview. Accordingly, these

participants would be unlikely to meet current diagnostic criteria for sexual dysfunction. This finding suggests that while the FSFI may capture discrete information about specific domains of sexual functioning, there may not be agreement between these data and individuals' own experience of their sexual lives.

Scores on the SSS-W also varied considerably by participant. In addition, there was inconsistent directionality when comparing scores on the SSS-W and FSFI, with some participants scoring lower on the measure of sexual satisfaction and higher on the measure of sexual functioning, and others scoring the reverse. These differences are consistent with other studies of CSA survivors (e.g., Leonard, Iverson, & Follette, 2008; Najman, Dunne, Purdie, Boyle, & Coxeter, 2005; Rellini & Meston, 2006), highlighting the differences between subjective reports of sexual satisfaction and sexual functioning. Approximately half the participants in the current study also scored one standard deviation higher on SSS-W Communication and Compatibility subscales compared to mean scores from samples of both CSA survivors and non-survivors, indicating a relative lack of problems in those respective domains. These scores may reflect the importance of partner characteristics and communication in facilitating good sex, as reported by participants in the interview portion of the study. Lastly, participants' scores on the SSSS tended to be close to mean scores from a general sample of college-age women in the validation study, suggesting that the women in the current study held relatively positive views of themselves as sexual beings. This result may reflect the subthemes of personal development and healing, learning to have good sex, and reclaiming sex as discussed by participants in the interview – participants who had experienced good sex may have built more positive views of themselves as sexual beings over the course of these developmental processes.

Methodological Comparison

The current study sought to explore CSA survivors' experiences of good sex using a mixed-methods research design. Mixed-methods research is particularly suitable for exploring how the perceptions of individuals who have experienced a phenomenon compare to the conceptualizations and operational definitions of these phenomena as employed in research. Qualitative and quantitative results in the current study portray the participants quite differently; the qualitative results convey nuance, complexity, and richness in the data, while quantitative results are inconsistent and tend to conceptualize participants' experiences negatively. Plainly, CSA survivors' experiences of good sex are not well captured by existing quantitative measures, as these measures are simply not designed to explore positive constructs. These findings highlight the need for careful consideration of data collection methodology.

When queried, participants tended to prefer the interview to the questionnaires, though participants also reported on the utility of having questionnaire data to quantify and compare experiences. However, participants identified problems with the questionnaires themselves. Primarily, some participants described a sense of disconnection between what they detailed during the interview and their responses on the questionnaires. Participants who did not report recent sexual activity or who described recent sexual changes found that their responses on the questionnaires did not match with their perceptions of themselves and their sexual lives. Accordingly, these participants described feeling frustrated, irritated, self-critical, and/or saddened after completing the questionnaire measures. The debriefing interview held after participants completed the questionnaires allowed these three women to express their negative reactions to the researcher, which they reported had been helpful.

Participants' comments on the questionnaire part of the study can be partially attributed to problems with inherent biases within the measures themselves. Investigation of specific item wording can reveal assumptions about norms for sexual activity. For example, the FSFI was specifically developed for a population of women with a male partner, and this heterosexual bias is reflected in the item wording as well as the definitions of sexual activities provided in the measure (e.g., defining sexual intercourse as penile-vaginal intercourse). For the purposes of the current study, these definitions were modified to be more inclusive (e.g., defining sexual intercourse as penetration of sexual parts of the body); regardless, bias remains in emphasizing penetrative sexual intercourse as a necessary component of sexual functioning. In addition, the FSFI is not valid among individuals who have not been sexually active with a partner in the past four weeks, as individuals receive scores of 0 on specific items for not having been sexually active and thus are scored as though they are severely dysfunctional (Meyer-Bahlburg & Dolezal, 2007). However, conceptualizing sexual functioning solely as sexual activity with a partner assumes the primacy of these types of sexual activities, over and above solo sexual activities such as masturbation, and affirms an implied hierarchy of desirable or expected sexual activity. In a review of sexual functioning measures, Giraldi et al. (2011) concluded that the FSFI is useful in clinical contexts due to its strong psychometric properties and large volume of research data, albeit not among non-heterosexual women and women who have not been sexually active with a partner in the specified time period. They also note that the measure cannot be used for diagnosis without the addition of a measure of sexual distress. Clearly, valid usage of the FSFI is predicated on predetermined assumptions about the woman completing the measure, which may or may not be accurate. Accordingly, only ten of the 15 FSFI scores in the current study are interpretable and valid.

Similarly, 22 of 30 items on the SSS-W, described as a measure of sexual satisfaction, are worded to capture degrees of difficulty or distress within specific domains. For example, participants are asked to rate their worry about their sexual difficulties affecting their partner, and individuals who report minimal worry are scored as more sexually satisfied. This type of wording equates the lack of sexual dissatisfaction with sexual satisfaction, a false equivalency that reflects a medicalized view of human sexuality (i.e., if there are no problems, you are healthy; Tiefer, 2004). In addition, 17 of 30 items on the SSS-W also assume partnered sexual activity, and participants reported frustration there was no item response to indicate that these items were not applicable to them. Similar methodological critiques of the ways in which sexual satisfaction is conceptualized in the literature have been published (e.g., Rosen & Bachmann, 2008). Mark and colleagues (2014) suggest that measures of sexual satisfaction have been plagued by criterion-predictor overlap, where constructs associated with sexual satisfaction (in this instance, sexual distress) are measured and interpreted as a proxy for sexual satisfaction. While measures of sexual satisfaction addressing these critiques have been published (e.g., New Sexual Satisfaction Scale; Štulhofer, Buško, & Brouillard, 2010), these measures have tended to be gender-neutral. Accordingly, these measures are used far less often in studies of women's sexuality and even more rarely among studies of female survivors of CSA, which results in diminished availability of reliability and validity data specific to these populations. Broadly, the women in the current study had variable scores on measures of sexual functioning and satisfaction, and generally more positive scores for sexual self-schema; however, implicit biases within the measure design and item wording may account for some of participants' feedback regarding the measures.

Limitations and Future Directions

In addition to the questionnaire limitations discussed above, this study also has sample and methodological limitations. First, while the sample size of fifteen participants is large for IPA, the sample is not generalizable or representative. There is insufficient statistical power for more complex quantitative analyses due to the small sample size. Furthermore, the fact that participants were recruited on the basis of specific experiences rather than randomly sampled signifies that the normality assumption inherent within most multivariate statistical analyses is likely to be violated (Tabachnick & Fidell, 2007). However, these results were not intended to be generalized to the population of all women CSA survivors who have experienced good sex. Instead, quantitative analyses were conducted from an ideographic, pragmatic perspective, and results are intended to serve as an in-depth investigation of some individuals' experiences of the phenomenon in question.

In addition, participants were not asked to quantify or specifically discuss their experiences of CSA. In most quantitative research with CSA survivors, data are collected regarding the details of the traumatic experiences, including the age at which the experience occurred, the perpetrator characteristics, the type of victimization that occurred, and other details that allow the researchers to operationalize a working definition of CSA and to allow for comparison across research studies (e.g., Leserman, 2005). In the current study, no analyses of participants' traumatic experiences in relation to their later experience of good sex can be performed. It may be that all participants in the current study experienced relatively mild severity of CSA experiences, or have engaged in healing processes such as psychotherapy that would mitigate their trauma-related distress. However, given that recruitment notices for participants were posted in support forums for adult survivors of CSA, any potential participants would have

had to seek out online support in order to have seen the study advertisement. While research is limited, some previous findings suggest that survivors of sexual victimization employ on-line forums in order to gain and share information, obtain companionship and support, and to help themselves in the process of recovery, which implies that individuals who access these forums have identified themselves as a survivor of assault and are seeking help for their distress (e.g., Yeager, 2012). During the study, participants also described a range of healing processes, as well as the ongoing influence of their past experiences of trauma. More importantly, the decision was made to allow participants to self-define their experience of CSA in accordance with the feminist theoretical paradigm underlying this study. Thus, self-defining as a survivor of CSA prioritized participant agency and ensured they were treated as the experts on their own experience, in addition to minimizing researcher bias and diminishing the risk of negative emotional reactions among participants.

Researcher reflexivity. An important methodological consideration in IPA is the influence of the researcher on the obtained results. One of the strengths of IPA is the explicit emphasis on researcher awareness of their own impact on data interpretation. Smith, Flowers, and Larkin note that, "the reader [of an IPA study] should be aware that they are positioned as attempting to make sense of the researcher attempting to make sense of the participant's experience" (2012, p. 182-183). In the interest of context and transparency (as suggested by Yardley, 2000), the researcher acknowledges the influence of her own cultural identities as a white, cis-female, heterosexual, Jewish, and economically and educationally privileged individual. The researcher also cites past experience conducting qualitative, phenomenological research in the field of human sexuality as likely colouring her interpretations in the current study. In particular, the researcher notes that she has been a collaborator with Kleinplatz and

colleagues (e.g., Kleinplatz et al., 2017) since 2009, and has been participating in quantitative research on the long-term effects of childhood maltreatment since 2010 (e.g., Rosen, Runtz, Eadie, & Mirotchnick, 2017). In addition, the researcher acknowledges that her clinical background likely biases her interpretations, as she has clinical training and experience providing couples and sex therapy, as well as working with trauma survivors. Lastly, the researcher defines herself as having a feminist orientation to both her research and clinical practice, which may also colour her phenomenological analyses.

Several aspects of conducting the current study affected the researcher on a personal level. The researcher noted internal reactions to some of the content discussed in the interviews – for example, when one woman reported that she sought out pornography as a source of sexual information, the researcher identified feeling frustrated by the likely inaccuracies portrayed by mainstream pornography and the desire to educate the participant. In the rare instances where participants discussed details of their traumatic histories, the researcher noted that she experienced some sadness and anger directed towards the perpetrators. In response, the researcher employed strategies from her clinical training to help ground herself and stay present with the participants during the interview, and also engaged in self-care activities afterwards. These strategies aided the researcher in managing her reactions during the interview, and kept the researcher from influencing participants with her own views. Lastly, the researcher acknowledged feeling pleased and grateful in instances where participants reflected that the experience of participating in the study had been an opportunity for healing and self-reflection.

The researcher attended to these sources of bias through journaling and self-reflection throughout the data collection and analyses, as well as discussing her reactions with her dissertation supervisor (Dr. M. Runtz). One benefit to the researcher's clinical background is that

she is comfortable with self-reflection and is practiced in identifying her biases and the subsequent impact on her work. The researcher also sought to gain cross-validation of her results by sharing quotes from participant interviews with members of her research group, comparing their observed themes with her own results, and incorporating this feedback into the analyses. Lastly, the idea of the 'independent audit' (Yin, 2014) has been proposed as a strategy for evaluating the validity of qualitative research; accordingly, the researcher maintained a chain of documentation from the initial research question through raw transcripts, tables of themes and subthemes, self-reflective processes, and drafts of the dissertation. From this documentation, one could trace exactly how the researcher evaluated the data and drew conclusions. While it is impossible to separate the influence of the researcher from the results in IPA studies, the transparency and attention to analytic validity provide concrete evidence as to the methodological rigour of the current study.

Study strengths and future research directions. The current study has a number of strengths. First, the usage of IPA allows for extensive detail and depth regarding an understudied phenomenon that is plagued by assumptions and bias. Both IPA and the explicitly feminist paradigm of this research challenge the idea of academic neutrality and charge the researcher to attend to the influence of their own sociocultural context, as well as preconceived ideas regarding the phenomenon in question. Through research that is exploration- rather than hypothesis-driven, findings from the current study provide concrete, rich data from individuals who have lived the phenomenon in question. As a result, this information can be used to counter harmful or inaccurate stereotypes about the sexuality of CSA survivors in clinical practice, in research contexts, and among the general public. Another strength of the study is the usage of online data collection to capture the experiences of a diverse group of women in terms of age,

country of residence, education, relationship experiences, socioeconomic background, and sexual orientation. The combination of qualitative and quantitative methodologies allows for a unique comparison of data obtained from these approaches, as well as direct feedback from participants regarding the methodology. Lastly, this study prioritized participant agency, control, and empowerment, and viewed participants as the authorities of their own experience. Accordingly, participants reported positive experiences as well as personal benefit from participating in the study.

Future research directions include exploring the construct of good sex among other populations of interest, such as male survivors of CSA or survivors of adult sexual assault, and evaluating areas of convergence and divergence. Findings could also be employed as the basis of measure development to promote quantitative investigation of the constructs identified in this study. With such measures, broader sampling could provide evidence regarding the generalizability of the findings. Research could be conducted specifically on how women survivors of CSA learn to have good sex, seek out sources of sexual information, and evaluate the accuracy of the information, which would have additional clinical and research implications. The subtheme ‘Building Blocks to Good Sex’ and the associated model could also be a similarly fruitful subject for additional research exploring a specific developmental trajectory related to good sex. Findings could also be used to develop new treatment strategies and psychoeducational approaches for clinical work with survivors of CSA (discussed further below), which could in turn be evaluated for effectiveness. Importantly, future research should continue to acknowledge broader systemic and contextual factors in conducting sexuality research with women survivors of CSA, particularly in recognizing the inherent systemic power differential between researcher

and participant, and work to promote researcher reflexivity and awareness of bias within research design.

Clinical Implications

Findings from the current study have significant clinical implications for existing treatment approaches as well as implications for new clinical strategies. Several women explicitly described how psychotherapy had been essential to their healing from abuse, while others noted that they employed journaling and connecting with other survivors as forms of self-treatment. As reviewed in the introduction, existing treatment strategies for sexual problems among CSA survivors involve four main theoretical perspectives: trauma-focused work, pharmacotherapy, sex therapy, and mindfulness. Findings from the current study suggest that trauma-focused work and pharmacotherapy are likely to be insufficient at addressing sexual problems for women with a history of CSA. The women emphasized specific attention to reclaiming their sexual lives in addition to coping with trauma-related symptoms, and also minimized the importance of physiological functioning (such as arousal and lubrication) in good sex. While some participants described the importance of mindfulness skills in helping them to stay present and experience their bodily sensations, participants also noted that in order to create safety, they needed moment-by-moment awareness of their decision-making as well as deliberate action and involvement in response to their thoughts or feelings. Mindfulness approaches can be interpreted as experiencing thoughts and sensations without reacting or engaging, which may potentially be deleterious for abuse survivors in reinforcing a different kind of passivity and ignoring the broader context. For example, abuse survivors could feel pressured by partners or social expectations to engage in penetrative sexual intercourse, and could employ mindfulness techniques to cope with discomfort or reluctance that may be instead be an entirely appropriate

response. Barker (2013) cautions that misappropriation of mindfulness techniques could "…[attempt] to get people to have sex which they found painful and distressing through techniques which enabled them to 'be with' the experience of pain and distress during sex, rather than attending to what the pain and distress might be telling them about their (social) assumptions about the kinds of sex that they 'should' be having." (pp.150). While mindfulness approaches offer a promising avenue to facilitate presence and bodily awareness, findings from the current study indicate that survivors may benefit most from having a variety of tools and knowledge at their disposal.

This study provides novel empirical evidence for the strategies presented by Maltz (2012b). Psychoeducation about healthy sex and relationships, normalizing and reclaiming sexual desire and personal agency, and exercises facilitating bodily awareness and safety with and without a partner are all supported by the definition and facilitating factors for good sex identified by participants. In particular, Maltz emphasizes that individuals can choose how they define and experience themselves as sexual beings, and this developmental process is echoed by the words of the women in the current study. Maltz also emphasizes the importance of partner involvement in treatment paradigms, which corresponds to participants' depictions of the importance of partner characteristics. Couples therapy approaches may allow both partners to jointly define and approach sexual problems in a dyadic context, rather than specifying the survivor of CSA as the identified 'patient' (Sobia, Cobansky, & Ingram, 2004). Involving the survivor's partner in psychotherapy may also allow the therapist to 'coach' the partner in supporting the survivor effectively through traumatic re-experiencing such as flashbacks, as detailed by one woman in the current study. However, couples therapy should not be the only treatment modality under consideration, as this emphasis on partner contributions may alienate

survivors who are not currently in relationships or who are exploring casual sexual partnerships and wish to improve their sexual lives.

Perhaps more importantly than specific treatment paradigms, this study's findings emphasize the importance of allowing survivors to exert control over the therapy process and decide on their own goals for treatment. Given that research is limited regarding what constitutes good sex in general, clinicians should be wary about explicitly or implicitly identifying specific behavioural goals for their clients (e.g., tolerating penile-vaginal intercourse), as any specific behaviour may not connote good sex for that individual. Clinicians may also wish to be mindful of their own biases and expectations about what constitutes good sex, and reflect on how these assumptions influence their clinical practice. For example, holding the belief that orgasm is necessary for good sex may influence practitioners to explicitly or implicitly emphasize the importance of orgasm to their clients and cause clients to feel discouraged or frustrated. One formalized opportunity for developing such awareness is the Sexuality Attitude Reassessment required for licensure as a sex therapist by the American Association of Sexuality Educators, Counselors and Therapists (AASECT), which requires therapists to participate in ten hours of process-oriented exploration in a group setting regarding their own sexual beliefs and values (AASECT, n.d.). Ensuring that survivors direct the course of therapy involves exploring what their perception of sex is generally, what their perception of good sex is, and how they would like their sexual lives to be.

Psychotherapists and other health care providers working with survivors of CSA have an important role as a resource for accurate information about sex. In the current study, survivors described seeking knowledge about healthy relationships and 'normal' sexuality from a variety of sources, including friends, partners, health care professionals, the Internet, and pornography.

For example, one woman vividly detailed how her gynecologist explained female reproductive anatomy to her. Accordingly, health care providers should be able to summarize accurate information for survivors and also be able to direct survivors to reputable, sex-positive information resources. For example, a good general source of information for most sexuality-related questions is *The Guide to Getting It On* (Joannides & Gross, 2015), and several of the texts cited previously (Barbach, 2000; Maltz, 2012b) provide psychoeducation and normalization specifically for women and survivors of CSA, respectively. More explicit or evocative depictions of healthy sex may be found in poetry; for instance, Maltz (2003, 2006) compiled several anthologies of poetry which vividly express themes of sexual intimacy, connection and pleasure. Health care providers also hold significant influence regarding what is viewed as normal, and they may serve as the first point of contact for survivors as they begin to discuss sexual concerns (e.g., Havig, 2008). For instance, one woman in the current study reported that she was not easily orgasmic in the way that her therapist had described the experience of orgasm to her, and stated that there must be something wrong with her even though she stated that she was happy with her sexual life. Thus, health care providers should also be aware of how their beliefs about sexuality are conveyed, implicitly and explicitly. Health care providers should be prepared to counteract prevailing negative stereotypes and misinformation about women's sexuality (e.g., sexual desire is not shameful; most women do not have orgasms from penetrative intercourse; Barbach, 2000), and can model openness and comfort for survivors in discussing sexual topics. These strategies may be beneficial whenever the topic of sexual concerns arises, as many survivors of CSA do not disclose their past experiences to their health care providers and many health care providers do not routinely screen for a history of trauma (McGregor, Gautam, Glover, & Jülich, 2013). Furthermore, individuals who are non-heterosexual or members of sexual minority groups such

as BDSM practitioners may face additional barriers and fears of stigma about 'coming out' to their health care providers (Johnson, Mimiaga, & Bradford, 2008; Waldura, Arora, Randall, Farala, & Sprott, 2016).

Findings from the current study also prompt reflection into the implications of clinical data collection. Participants in the current study preferred the interview format though acknowledged the utility and practicality of completing questionnaires. Practitioners may wish to reflect on the appropriateness of the method of collecting information (i.e., clinical interview vs. questionnaires) based on the context of their study. For instance, the interviews in the current study took place in a quiet, private setting, with no time constraints, and with a researcher-clinician who is knowledgeable about trauma and sexuality, and trained in empathic responding. For settings in which privacy is limited, time is of the essence, or for screening purposes, a questionnaire rather than a rushed, invalidating or triggering interview may result in a more positive experience for survivors (though individual preference may vary). Health care providers should also reflect on the questionnaires they employ in relation to the population or individual, as well as the clinical utility and purpose of the information gathered by the questionnaire. In particular, health care providers should be aware of the biases inherent within the questionnaires they employ, how these assumptions influence the obtained results, and should determine whether specific questionnaires are appropriate for the individual in question. Havig (2008) calls attention to the power differential between survivor and health care provider, noting that since survivors of CSA were stripped of power during their traumatic experiences, health care providers should be mindful of the power given to them by the health care system. As a result, health care providers should seek to involve survivors as collaborators and build trust in the client-provider relationship. Beyond all considerations, survivors should give informed consent

regarding the privacy and confidentiality of their data, and also have the agency to provide information in whichever format they would prefer.

Summary

This study sought to explore the research question, “how do women survivors of CSA experience 'good sex'?” Findings provide concrete data as to how the fifteen women who participated in the study defined good sex, involving safety, good feelings, being present in the moment, being an active, assertive participant, communication, openness and vulnerability, experiencing sex as a mutual pursuit, and conceptualizing sex as part of a broader relationship context. Study results identified factors that contributed to the experience of good sex for participants, such as specific skills, self-knowledge, partner characteristics, and building blocks. The findings also revealed themes that detail the developmental and comparative context of women’s good sexual experiences. Quantitative findings related to sexual functioning, sexual satisfaction, and sexual self-schema were inconsistent, as participants scored quite differently from each other as well as differently across the three measures. However, most women appeared to have significantly more positive sexual self-schema compared to sample means from other studies. Participants reflected that both the interview and questionnaire formats held clinical utility, though provided more negative feedback for the questionnaires due to perceived lack of fit between the measure items and their subjective experiences.

This study provides empirical evidence supporting existing theories and findings on the sexuality of women CSA survivors, particularly for other qualitative studies and Maltz’s (2012b) theoretical paradigm for sex therapy treatment. Results from the study also contradict common expectations about the sexual lives of CSA survivors. While CSA is an undoubtedly traumatic and deleterious experience that has negative effects persisting throughout the lives of survivors,

participants in the current study show that having a positive and enjoyable sexual life as an adult is possible. Women survivors in this study were motivated to share their experiences in order to help other, similar women, and gained personal benefit from discussing and reflecting on their experiences of good sex. Researchers and clinicians alike need to ensure that survivors are equal collaborators and active decision-makers in their work and in their own healing. Practitioners and researchers also need to be wary of assuming that the lack of sexual problems is the only possible positive outcome with this population. Findings from the current study hold significant implications for care, treatment, and future research with female survivors of CSA. Most importantly, this research documents how women CSA survivors have positive, pleasurable, and meaningful sexual experiences, and provides hope for all survivors that they too can reclaim their own sexual lives.

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Appendix A: Recruitment Notice

How do survivors of sexual abuse experience 'good sex'?

My name is Lianne Rosen and I am a Ph.D. student in Clinical Psychology at the University of Victoria in British Columbia, Canada. Together with my supervisor, Dr. Marsha Runtz, Associate Professor in the Department of Psychology, I am interested in studying how women survivors of childhood sexual abuse experience good sex later in life. I am hoping to move beyond most studies that focus on sexual problems and instead try to understand what good sex looks like for survivors as part of the healing process.

I am interested in interviewing women over the age of 19 who are survivors of childhood sexual abuse and who have experienced what they view as good sex at some point in their lives. It doesn't matter if it was once or many times, long ago or currently. You also need to be comfortable with spoken and written English. The study will consist of an interview, either over the phone or by video calling (e.g., Skype), followed by several on-line questionnaires. Your information will remain confidential and anonymous.

If you think you might like to participate, and are interested in learning more about this study, please click on the link below to read about what is involved and how you can participate.

(link)

If you have any questions, please don't hesitate to contact me. Thank you very much!

Lianne Rosen, M.Sc.

Appendix B: Letter of Information for Implied Consent

You are invited to participate in a study entitled 'How do Survivors of Childhood Sexual Abuse Experience Good Sex?'. This study is being conducted by Lianne Rosen, M.Sc. (Ph.D. student in Clinical Psychology) and Dr. Marsha Runtz (Associate Professor in the Department of Psychology), both at the University of Victoria in British Columbia, Canada. You may contact Ms. Rosen if you have any questions about this research at (email). You may also contact Dr. Runtz at (email).

Purpose and Importance of the Study: The purpose of this study is to explore the meaning and understanding of "good sex" for women survivors of childhood sexual abuse. This is important as we have very little research in this area; most studies tend to look at sexual problems rather than the possibility of positive sexuality among survivors and thus offer little insight into sexual recovery following sexual abuse. Understanding what good sex is like for survivors can be useful for promoting more research in this area and can also broadly encourage a more positive view of adult survivors' sexuality. Findings may be helpful in developing new clinical approaches for enhancing positive sexual experiences.

Your participation in this study will involve an interview of approximately 30 to 60 minutes with Ms. Rosen, followed by approximately 20 minutes to complete a set of on-line questionnaires. After the questionnaires, participants will be interviewed again by Ms. Rosen for approximately 5 to 10 minutes. The total time requirement for the study is approximately 1 to 1.5 hours. You have the choice of conducting the interviews either over the phone or by video calling (e.g., Skype). **With your consent, the interviews will be audiotaped**, to facilitate analysis by the researchers.

Voluntary Participation: Your participation in this study must be completely voluntary. **You may refuse to answer any question(s) without having to explain your reasons for doing so and without consequences**. You may also withdraw from the study at any time, for any reason. You will still receive a $5 gift card for Starbucks in order to thank you for your participation. **Should you wish to withdraw your data after participation, please contact us and provide the identification code that you had been assigned when you completed the study.** We will then match the code to the audiotape or interview transcript and delete your data. However, please note that once data are published it will be logically impossible to withdraw.

Anonymity: **The information obtained from your participation will be kept anonymous and confidential**. Your interview transcript will be assigned a code number, which will not be linked with your name or e-mail address. **We are limiting participation in this study to individuals aged 19 or older**.

Confidentiality: The confidentiality of your data will be further protected by keeping your responses, all data files and other research records secure (e.g., in password-protected, encrypted files in a securely-stored external hard drive). Only the researchers will have access to the data. Computerized anonymous data will be kept for at least 10 years beyond the date of the last publication of the findings from this study; any identifying information (e.g., document linking

your information with the identification code) will be deleted once data are published.

Sensitive Topics: If you decide to participate in the study, you will be asked to discuss sensitive topics such as your sexual experiences. However, please note that you will not be asked to discuss your experience of childhood sexual abuse.

Eligibility: **You are eligible to participate in the study if you are a survivor of childhood sexual abuse and have also experienced good sex at some time in your life**. You must also be female, over the age of 19 and comfortable with spoken and written English.

Inconvenience and Risk: Participation in this study may cause some inconveniences to you, including the time it will take to complete the study (approximately 60 to 90 minutes). A potential risk of participating in this study is that some people may feel emotional discomfort when discussing sensitive topics such as their sexuality. To manage these risks, we want you to know that you can decline to answer any question or withdraw from the study at any time. You may contact Ms. Rosen or Dr. Runtz if you have any concerns that have arisen as a result of participating in this research. If you become fatigued during the interview, you may ask Ms. Rosen to reschedule the interview for a later date.

Benefits: As thanks for participating in the study, **you will receive a $5 eGift Card to Starbucks**, delivered by e-mail. Additional benefits to your participation include helping us, the researchers, understand good sex for survivors of childhood sexual abuse. You may also be indirectly helping other survivors of childhood sexual abuse by sharing your experiences, as information gained from the study could inform future research and treatment approaches.

Results from the Study: After you complete the study, you will have access to an on-line debriefing form that discusses the basic purpose of the research. You may also choose to receive a copy of your transcribed interview by e-mail to verify the accuracy and add additional comments if you wish; your comments will be included in the data analyses. If you would like a summary of the findings after the study is completed, you can contact Ms. Rosen directly or check Dr. Runtz's website (http://web.uvic.ca/~runtzweb/) for summaries of papers prepared from this project. It is anticipated that the results of this study will be shared with others in the following ways: in presentations to other graduate students and faculty, in conference presentations, on the website, and in published peer-reviewed articles. Results from the study will be presented both in group form and individually (e.g., quotes from the interview); however, there will be no identifying information attached to the results.

Ethical Approval: In addition to being able to contact the researchers, you may verify the ethical approval of this study, or raise any concerns you might have by contacting the Associate Vice President, Research at the University of Victoria at (250) 472-4545 or ethics@uvic.ca.

THANK YOU FOR YOUR INTEREST IN THIS STUDY.

Appendix C: Debriefing Form

Thank you for your interest and your participation in this study! You are almost finished. Your responses have been greatly appreciated; we realize that these are personal questions that can be difficult to answer. Please be assured your responses will remain anonymous and confidential.

Purpose of the Interview: The interview portion of this study asked a number of questions about how you have interpreted and understood your own positive sexual experiences. Transcripts of the interviews will be analyzed for ideas and themes about how you have experienced positive sexual interactions, which will be combined with information from a number of interviews from other participants. These overall themes will illustrate how women survivors of sexual abuse experience good sex as adults.

Purpose of the Questionnaires: The questionnaires you have just answered are commonly used in sexuality-related research. They are questionnaires designed specifically for women and look at women's sexual satisfaction, functioning, and ways in which they see themselves as sexual beings. We are hoping to explore how your responses on the questionnaire are similar to or different from other women's responses. Having the information from both the interview and the questionnaires provides us with multiple sources of information to help illustrate women's positive sexual experiences.

The final step of the study is to speak briefly with Ms. Rosen, to ensure that any possible questions you have about the research are answered. We would also like to hear about your experiences in completing the questionnaires. This final interview should take no more than 5 to 10 minutes.

If any of the questions in this study made you uncomfortable in any way, or if participating in this study brought up any issues that are distressing for you, some resources that might be of assistance are provided below:

- National referral service for counselling: 1-800-THERAPIST
- To find a Psychologist in Canada: http://www.cpa.ca/public/findingapsychologist/
- Women's resources in Canada: http://www.cwhn.ca/en
- To find a Psychologist in Canada or the US: http://locator.apa.org
- Canadian Suicide & Crisis Hotlines: http://suicideprevention.ca/thinking-about-suicide/find-a-crisis-centre/ (Free)
- National Suicide Prevention Hotline (US): 1-800-273-TALK (8255) (Free)
- For outside North America: http://www.bps.org.uk/bpslegacy/dcp
- Mental Health Information: http://www.cmha.ca/
- Download the MindShift app for help coping with anxiety: http://www.anxietybc.com/mobile-app (Free)

To print a copy of this form, please use CTRL + P or follow the usual methods for printing from your web browser.

Appendix D: Semi-Structured Interview Schedule

1. Review informed consent. Ask participants to assent verbally.

Turn on audio recorder with consent.

2. Let's begin with some questions about demographic information.
   - How old were you (in years) as of your last birthday?
   - What is your country of residence?
   - Do you identify with a particular ethnic or racial group?
   - What is your sexual orientation?
   - Are you currently in a romantic relationship?
   - (if applicable) How many years have you been with your current partner(s)?
   - What is your approximate yearly income? (indicate if in US or CDA $)
   - What is the highest level of education that you have achieved?
   - Do you identify as having any form of disability?
   - Where did you find out about this study?

Now that we have discussed your demographic information, I would like to proceed with questions related to your perspective on good sexual experiences. Are you ready to continue? Any questions for me before we continue?

3. What is good sex for you?
   - Has your definition of what good sex is changed over time?

4. At what point in your life did sex become good?
   - Did you learn how to have good sex? How do you think you learned to have good sex?

5. What are the elements or characteristics of good sex?
   - How would you recognize good sex if you saw it?

6. What proportion of your sexual experiences are good?
   - How do you feel about that?

7. Have you taken any particular steps towards increasing the proportion of good sexual experiences? If so, what have you done?
   - How successful do you feel you have been with this?

8. How have your sexual experiences changed over time?
   - How do you feel about your sexual life overall?

9. What do you need in order to have good sex?
   - partner, relationship, environment, skills, activities?

10. Do you think that good sex for you is similar or different to how other people might experience good sex?

- How so?

Thank you, this concludes the interview portion of the study. Is there anything else you'd like to add about your perspectives or experience of “good sex”?

Direct participants to the on-line questionnaire and affirm that we will stay connected by phone or video chat while they complete the questionnaire. Provide three-digit identification code specific to participant. Offer to answer any questions as they arise.

After the questionnaire:

Good to speak with you again. You're almost finished! First, I wanted to ask if you had any questions about the questionnaires you just completed.

11. How did you find completing the questionnaires?
    - How did the questions compare to what we were discussing earlier?

12. How did you feel while completing the questionnaire? During the earlier interview?
    - Did you have a preference?

13. Could you tell me about how participating in this study has been for you?
    - Is there anything else you'd like to say about your experience during this study?

Thank participant.

Appendix E: Sexual Satisfaction Scale for Women (SSS-W)

Please rate the extent to which you agree or disagree with the following statements. Your responses will be kept completely confidential; please answer as honestly as possible.

1. I feel content with the way my present sex life is.

Strongly disagree	Disagree a little	Neither agree or disagree	Agree a little	Strongly agree

2. I often feel something is missing from my present sex life.
3. I often feel I don't have enough emotional closeness in my sex life.
4. I feel content with how often I presently have sexual intimacy (kissing, intercourse, etc.) in my life.
5. I don't have *any* important problems or concerns about sex (arousal, orgasm, frequency, compatibility, communication, etc.).
6. Overall, how satisfactory or unsatisfactory is your present sex life?
7. My partner often gets defensive when I try discussing sex.
8. My partner and I do not discuss sex openly enough with each other, or do not discuss sex often enough.
9. I usually feel completely comfortable discussing sex whenever my partner wants to.
10. My partner usually feels completely comfortable discussing sex whenever I want to.
11. I have no difficulty talking about my deepest feelings and emotions when my partner wants me to.
12. My partner has no difficulty talking about their deepest feelings and emotions when I want him or her to.
13. I often feel my partner isn't sensitive or aware enough about my sexual likes and desires.
14. I often feel that my partner and I are not sexually compatible enough.
15. I often feel that my partner's beliefs and attitudes about sex are too different from mine.
16. I sometimes think my partner and I are mismatched in needs and desires concerning sexual intimacy.

17. I sometimes feel that my partner and I might not be physically attracted to each other enough.

18. I sometimes think my partner and I are mismatched in our sexual styles and preferences.

19. I'm worried that my partner will become frustrated with my sexual difficulties.

20. I'm worried that my sexual difficulties will adversely affect my relationship.

21. I'm worried that my partner may have an affair because of my sexual difficulties.

22. I'm worried that my partner is sexually unfulfilled.

23. I'm worried that my partner views me as less of a woman because of my sexual difficulties.

24. I feel like I've disappointed my partner by having sexual difficulties.

25. My sexual difficulties are frustrating to me.

26. My sexual difficulties make me feel sexually unfulfilled.

27. I'm worried that my sexual difficulties might cause me to seek sexual fulfillment outside my relationship.

28. I'm so distressed about my sexual difficulties that it affects the way I feel about myself.

29. I'm so distressed about my sexual difficulties that it affects my own well-being.

30. My sexual difficulties annoy and anger me.

Appendix F: Female Sexual Function Inventory (FSFI)[2]

INSTRUCTIONS: These questions ask about your sexual feelings and responses during the past 4 weeks. Please answer the following questions as honestly and clearly as possible. Your responses will be kept completely confidential. In answering these questions the following definitions apply:

Sexual activity can include caressing, foreplay, masturbation and sexual intercourse.
Sexual stimulation includes situations like foreplay with a partner, self-stimulation (masturbation), or sexual fantasy.

CHECK ONLY ONE BOX PER QUESTION.

Sexual desire or interest is a feeling that includes wanting to have a sexual experience, feeling receptive to a partner's sexual initiation, and thinking or fantasizing about having sex.

1. Over the past four weeks, how **often** did you feel sexual desire or interest?	Almost always or always Most times (more than half the time) Sometimes (about half the time) A few times (less than half the time) Almost never or never
2. Over the past 4 weeks, how would you rate your **level** (degree) of sexual desire or interest?	Very high High Moderate Low Very low or none at all

Sexual arousal is a feeling that includes both physical and mental aspects of sexual excitement. It may include feelings of warmth or tingling in the genitals, lubrication (wetness), or muscle contractions.

3. Over the past 4 weeks, how **often** did you feel sexually aroused ("turned on") during sexual activity?	No sexual activity Almost always or always Most times (more than half the time) Sometimes (about half the time) A few times (less than half the time) Almost never or never
4. Over the past 4 weeks, how would you rate your **level** of sexual arousal ("turn on") during sexual activity?	No sexual activity Very high High Moderate Low Very low or none at all
5. Over the past 4 weeks, how **confident** were you about becoming sexually aroused during sexual	No sexual activity Very high confidence

[2] Note that the wording of some instructions and items has been modified from the original FSFI to minimize heterosexual bias.

activity?	High confidence Moderate confidence Low confidence Very low or no confidence
6. Over the past 4 weeks, how **often** have you been satisfied with your arousal (excitement) during sexual activity?	No sexual activity Almost always or always Most times (more than half the time) Sometimes (about half the time) A few times (less than half the time) Almost never or never
7. Over the past 4 weeks, how **often** did you become lubricated ("wet") during sexual activity?	No sexual activity Almost always or always Most times (more than half the time) Sometimes (about half the time) A few times (less than half the time) Almost never or never
8. Over the past 4 weeks, how **difficult** was it to become lubricated ("wet") during sexual activity?	No sexual activity Extremely difficult or impossible Very difficult Difficult Slightly difficult Not difficult
9. Over the past 4 weeks, how **often** did you maintain your lubrication ("wetness") until completion of sexual activity?	No sexual activity Almost always or always Most times (more than half the time) Sometimes (about half the time) A few times (less than half the time) Almost never or never
10. Over the past 4 weeks, how **difficult** was it to maintain your lubrication ("wetness") until completion of sexual activity?	No sexual activity Extremely difficult or impossible Very difficult Difficult Slightly difficult Not difficult
11. Over the past 4 weeks, when you had sexual stimulation, how **often** did you reach orgasm (climax)?	No sexual activity Almost always or always Most times (more than half the time) Sometimes (about half the time) A few times (less than half the time) Almost never or never
12. Over the past 4 weeks, when you had sexual stimulation, how **difficult** was it for you to reach orgasm (climax)?	No sexual activity Extremely difficult or impossible Very difficult

	Difficult Slightly difficult Not difficult
13. Over the past 4 weeks, how **satisfied** were you with your ability to reach orgasm (climax) during sexual activity?	No sexual activity Very satisfied Moderately satisfied About equally satisfied and dissatisfied Moderately dissatisfied Very dissatisfied
14. Over the past 4 weeks, how **satisfied** have you been with the amount of emotional closeness during sexual activity between you and your partner?	No sexual activity Very satisfied Moderately satisfied About equally satisfied and dissatisfied Moderately dissatisfied Very dissatisfied
15. Over the past 4 weeks, how **satisfied** have you been with your sexual relationship with your partner?	Very satisfied Moderately satisfied About equally satisfied and dissatisfied Moderately dissatisfied Very dissatisfied
16. Over the past 4 weeks, how **satisfied** have you been with your overall sexual life?	Very satisfied Moderately satisfied About equally satisfied and dissatisfied Moderately dissatisfied Very dissatisfied
17. Over the past 4 weeks, how **often** did you experience discomfort or pain during penetration of sexual parts of the body?	Did not attempt sexual penetration Almost always or always Most times (more than half the time) Sometimes (about half the time) A few times (less than half the time) Almost never or never
18. Over the past 4 weeks, how **often** did you experience discomfort or pain following penetration of sexual parts of the body?	Did not attempt sexual penetration Almost always or always Most times (more than half the time) Sometimes (about half the time) A few times (less than half the time) Almost never or never
19.Over the past 4 weeks, how would you rate your **level** (degree) of discomfort or pain during or following penetration of sexual parts of the body?	Did not attempt sexual penetration Very high High Moderate Low Very low or none at all

Appendix G: Sexual Self-Schema Scale – Women's Version (SSSS)

Directions: Below is a listing of 50 trait adjectives. For each word, consider whether or not the term describes you. Each adjective is to be rated on a 7-point scale, ranging from 0 = *not at all descriptive of me* to 6 = *very much descriptive of me*. For each item, fill in the appropriate circle. Please be thoughtful and honest.

Question: To what extent does the term _____ describe me?

Rating Scale:

Not at all descriptive of me	0	1	2	3	4	5	6	Very much descriptive of me

1. generous
2. uninhibited
3. cautious
4. helpful
5. loving
6. open-minded
7. shallow
8. timid
9. frank
10. clean-cut
11. stimulating
12. unpleasant
13. experienced
14. short-tempered
15. irresponsible
16. direct
17. logical
18. broad-minded
19. kind
20. arousable
21. practical
22. self-conscious
23. dull
24. straightforward
25. causal
26. disagreeable
27. serious
28. prudent
29. humorous
30. sensible
31. embarrassed
32. outspoken
33. level-headed
34. responsible
35. romantic
36. polite
37. sympathetic
38. conservative
39. passionate
40. wise
41. inexperienced
42. stingy
43. superficial
44. warm
45. unromantic
46. good-natured
47. rude
48. revealing
49. bossy
50. feeling