THE RELATIONSHIP BETWEEN VIRGINITY SCRIPTS AND PRECOITAL SEXUAL BEHAVIOUR

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Abstract

THE RELATIONSHIP BETWEEN VIRGINITY SCRIPTS

AND PRECOITAL SEXUAL BEHAVIOUR

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Past research has examined the influence of cultural scripts on our first coital experience, but the impact of virginity scripts on precoital sexual behaviour remains unknown. The purpose of this study sought to examine the link between Carpenter's (2001) cognitive frameworks of virginity and precoital sexual behaviour. Two hundred and forty eight participants (32 men, 215 women, and one unknown) were recruited from a Canadian university, all of whom had experienced precoital behaviour and first sexual intercourse. The findings indicated that past precoital behaviour and coital behaviour with first sexual partner had different relationship patterns with respect to virginity scripts. Virginity scripts were also related to current sexual sensation seeking, motivation for erotic arousal, sexual compatibility, comfort with sexuality, and approach to sexual relationships.

Keywords: virginity loss, precoital sexual behaviour, sexual scripts, virginity frameworks

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Table of Contents

List of Tables

The Relationship between Virginity Scripts and Precoital Sexual Behaviour

Introduction

This study examined the relationship between virginity scripts and precoital sexual behaviour. Although past research has examined the influence of scripts on first sexual intercourse, none have examined the link between virginity scripts and precoital sexual behaviour.

Sexual Script Theory

For many years, researchers have understood the significant influence of society and culture on personal behaviour. Simon and Gagnon (1984) provide a social constructionist perspective on sexual behaviour, arguing that our sexual actions and behaviours are largely a function of a social, rather than biological, process. Scripts play a major role in this perspective. Social scripts, and in particular sexual scripts, are shaped through learning, specifically through operant and classical conditioning (McCormick, 2010). In novel situations, social learning is largely a function of experience. Behaviours or actions that are rewarded are more likely to be repeated, whereas behaviours that are punished are less likely to be repeated. One example of a social reward could be a smile, whereas an example of a social punishment could be a negative response to a sexual interaction. In common situations, scripts are used to create predictability and to lessen anxiety in sexual interactions because there is a commonly understood action or reaction given to particular contexts. The purpose of scripts is to allow people to react automatically without needing to think through the particular custom in every situation. Indeed, scripts are a largely unconscious process. People usually remain unaware of the production and implementation of scripts.

"Scripting" is what guides behaviour within social life (Simon & Gagnon, 1984). It provides instructions for an appropriate response in a social situation. Just like in theatre, the script influences the presence of particular actors, the dialogue, the emotions and the consequences of the actor's behaviour. Social and sexual scripts provide a general structure and basic expectations for how a scene will unfold. Therefore, sexual scripts represent a broad category of scripting that occurs in sexual situations.

According to script theory, scripting operates at three distinct levels: cultural, interpersonal and intrapsychic. Although these categories are generally described separately, they are not distinct, as they mutually influence one another. A change at one level may lead to a shift in another. Sexual scripts involve a complex interplay between the intrapsychic level (your own sexual wants, needs and desires), the interpersonal level (dyadic sexual communication between the "actors") and the cultural level (what is normative in our present day culture).

Scripting is largely an unconscious process that begins in childhood. Children navigate their social environment, learning at a very young age which behaviours are deemed appropriate and which ones are not. For example, since the male sexual organs are located outside the body, boys are taught to handle their genitals (e.g. while urinating or washing) whereas girls are taught not to touch their genitals and to wipe carefully to avoid infection (Wiederman, 2005). Young boys and girls receive very different messages about sexuality, which shape their cultural, interpersonal and intrapsychic scripts.

Cultural scripts, the broadest category of this social process, dictate predictable patterns in our society. These scripts represent the behaviours that are normative and generally accepted in our culture. Gender differences in sexual behaviour can be explained by men and women following opposing, overlapping and complementary scripts (Wiederman, 2005). Female

sexuality is guided by the integration of emotional intimacy and commitment into their sexual scripts (Alksnis, Desmarais & Wood, 1996; Reiss, 1986; Simon & Gangon 1986), whereas male sexuality is guided by the "casual sex" script (Alksnis, Desmarais & Wood, 1996; Marsiglio, 1988; Reed & Weinberg, 1984). These scripts influence the sexual behaviours of men and women and create specific expectations for each gender. The sexual double standard that exists in our society dictates that men initiate sex and women respond or reject these invitations (Beres, 2014). This double standard is a product of cultural scripts. What is sexually acceptable for men, may not necessarily be acceptable for women. For example, if a man has numerous sexual partners, he is considered macho and masculine. In contrast, if a woman has numerous sexual partners, she is viewed negatively and may be subjected to "slut-shaming".

Men and women receive different messages from society about sexuality, which shape their sexual scripts. Cultural scripts are communicated by the mass media and through role models who have adopted the scripts, such as peers or older siblings and parents (Wiederman, 2005). Gender socialization encourages sexual activity for men (Alksnis, Desmarais & Wood, 1996; Gross, 1978; Herek, 1986) and restricts sexual activity for women (Alksnis, Desmarais & Wood, 1996; Fine, 1988; McCormick, 1987). The majority of sexual messages given to women focus on warnings of risk, danger and prevention of pregnancy (Wiederman, 2005; Fisher; 1986). This creates the female role of sexual "gatekeepers", limiting sex in heterosexual relationships which is a true example of a cultural script. In contrast, men are often encouraged by society to express their sexuality (Wiederman, 2005).

Interpersonal scripts are formed between a dyad, using cultural scripts as a guide. This level describes an interaction between two or more "actors". In a heterosexual relationship, the man and the women create their own interpersonal script together. Each person brings their own

cultural scripts and their intrapsychic scripts, which come together to form the interpersonal script. The interpersonal script represents a negotiated script between the partners. Each new sexual partner leads to a newly created interpersonal script (although influenced by past experiences). These scripts are co-created in the moment using the scripts brought to the situation and nuanced adjustments made to those scripts based on the reactions of the partner. Scripts serve to decrease anxiety by creating predictability of a partner's behaviour within a dyad (Wiederman, 2005). Once a couple creates their own interpersonal script, they usually follow this pattern of behaviour in subsequent sexual interactions. Once established, scripts facilitate sexual behaviour by creating a predictable outcome for the couple.

The last level of scripting takes place internally, at the level of the individual, called the intrapsychic level. This includes fantasies, desires, beliefs, thoughts, emotions and other cognitive processes that are specific to the individual. Simon and Gagnon (1984) call this process an "internal rehearsal", where an individual plays out their own behaviour and creates a symbolic reorganization of reality within their psyche. Intrapsychic scripts serve the purpose of establishing and developing the sexual self or personality (Whittier & Simon, 2001; Simon, 1996). People develop sexual preferences, or a "type" of person that they are attracted to. This "type" encompasses biographical, physical and character traits of others that the actor finds sexually desirable (Whittier & Simon, 2001). When the self changes, so too does the "type". The object of one's sexual desire reflects the self. Intrapsychic scripts are an expression of the actor's self-concept.

Some critiques of the theory suggest that it reproduces the status quo of sexual roles in our culture by reinforcing gender differences; however, it is important to note that scripts can change. A dynamic interaction exists between the levels of scripting, and a shift may occur at

any level. A shift in one area may produce changes in another. When a couple is engaging in a sexual interaction, their scripts influence each other. For example, when a person's script does not match that of their partner, they have three choices: choose a new partner, modify their own script or create a new script with the partner. If enough people engage in similar changes, this could potentially shift cultural scripts over time. The cultural script of the traditional gender role of men as the initiator has come into question, with recent research suggesting that shifts in scripts are occurring with women initiating sex some of the time (McCormick, 2010; Beres, 2014).

Scripts used by subcultures within the majority can become more normative, which can transform the majority's cultural script. For example, the gradual acceptance of the Lesbian/ Gay/ Bisexual/ Transexual/ Queer community within society at large has increased over the past decade. Prior to 2005, gay marriage was illegal in Canada (Global News, 2014). This relatively new legalization of gay marriage demonstrates how cultural scripts can shift over time, influencing not only cultural acceptance but also the interpersonal and intrapsychic scripts people enact.

Virginity Loss

Sexual scripting, according to Simon & Gagnon (1984), becomes significant only when it is defined as such by an individual or by society. Behaviour becomes symbolic when there is congruence between the intrapsychic and the cultural level, and between the interpersonal level and our cultural environment. Scripting is a complex interplay between our culture, our relationship with others and our psyche. It represents our definition of the immediate social context. The sexual scripts for virginity loss, for instance, are an important cultural phenomenon that can shape and define our personal and social identity in regards to sexuality. Virginity loss is

such a significant event in sexual development that researchers have sought to identify dominant virginity scripts, which influence subsequent *sexual* scripts and behaviour.

Virginity Frameworks

Carpenter (2001, 2005) sought to find out the various meanings that young Americans attached to their virginity loss and how these meanings shaped their actions and experiences. Is one's virginity loss experience related to earlier and later sexual encounters? The researcher also wanted to understand how individuals define virginity, and why these definitions differ from one person to the next. What factors influence these definitions?

Carpenter conducted semi-structured interviews with 61 young adults living close to the Philadelphia area in 1997. Her interviews began with a discussion on sexuality and virginity loss, and then progressed to the participant's sexual history. Using an inductive approach, she soon realized that a pattern was emerging from these interviews, and that all but a few featured one of three scripts for virginity: a gift, a stigma, or a step in the process of growing up. Carpenter was the first researcher to use these metaphors as a way of theorizing virginity and to recognize their importance in shaping an individual's sexual experiences. People who invoked the same metaphor for virginity loss shared a distinctive set of beliefs, attitudes and behaviour. According to sexual script theory, these common elements of virginity represent cultural scripts that influence subsequent behaviour. (The terms *script*, *framework*, *approach* and *metaphor* will be used interchangeably.)

Individuals holding the *gift* framework view their virginity loss as a unique, non-renewable status symbol. The purpose of losing their virginity is to express their love and commitment, in the context of a romantic relationship, by giving their partner a special part of

themselves. Love and commitment are the primary motivators of sexual activity. Individuals holding the gift script engage in relationship-enhancing behaviour by using an incremental approach to virginity loss. They use sexual behaviour as a way to assess their partner's ability to reciprocate. For example, a partner who responds to less-valuable "gifts", such as kissing and petting, with deepened affection and commitment can be better trusted to reciprocate more valuable ones, including virginity (Carpenter, 2005). By testing the commitment of their partner through precoital behaviour, the individual holding the gift script creates their own interpersonal script with their partner, which is influenced by each person's separate intrapsychic and cultural script.

Choosing the right or perfect partner is of paramount importance to those with the gift script. The partner with whom they lose their virginity is typically someone who they are currently in a relationship with or someone they care about and trust. Emotions of love, affection and commitment are important factors in the equation. They also date their partner longer after their virginity loss, in comparison to the other scripts (Carpenter, 2005; Eriksson & Humphreys, 2013). The emotional and relational considerations of the event are more important than the physical pleasure aspect (Carpenter, 2005).

First sexual intercourse (FSI) is a highly important and monumental event in their life, and they prepare accordingly. Only the most romantic circumstances will suffice for their first time. Given that they typically know their virginity loss partner very well and they prepare for first intercourse, sexual communication is the most open and honest with this script. They are more likely to use a condom and to practice safer sex than the individuals holding the other two scripts (Carpenter, 2005).

Because they attach so much importance to their first time, it could have devastating results if it does not go as planned. Women who view their virginity loss experience as a gift feel disempowered at virginity loss if their male partner does not reciprocate with a gift in kind, such as love or commitment, and these feelings of disempowerment persist in subsequent relationships (Carpenter, 2005). Their distress is magnified by the significance of this virginity loss experience.

It is important to note the gender differences in these virginity frameworks. More women than men identified with the gift script. Indeed, society puts a higher value on female virginity than male virginity. In certain situations, one's virginity script can be flexible. For those of the gift script that did not have a perfect virginity loss experience, they may wish to redefine their sexual identity as virgins- a trend called born-again virgins, or secondary virgins (Carpenter, 2005). For these individuals, virginity loss is intrinsically valuable and, therefore, they may only consider their virginity as "lost" if the experience fulfills their desires and meets their expectations. For a girl, being a virgin may actually enhance their social status (Carpenter, 2005).

People who hold a *stigma* script are so embarrassed of their virginity status that they actively conceal their virgin identity and try to pass as non-virgin (Carpenter, 2005). Some would even lie, bragging about sexual encounters that had not even happened (Carpenter, 2005). This highlights the traditional masculine script that exists in our culture: men are expected to have insatiable sexual appetites, to be sexual initiators and sexual aggressors (Beres, 2014). After they lost their virginity, they could not share this news with their peers, for fear of them finding out they were virgins all along. They might be teased or ridiculed, or even have their sexuality come into question. For men that go against the traditional script by not losing their virginity at a "normal" time (relative to their peers), they might experience significant anxiety and stigma

regarding their virginity status (Carpenter, 2005). Many stigmatized individuals experience discrimination. This highlights the powerlessness of stigmatized people; they lack the power to prevent others from exposing their stigma. For men who hold a stigma script, their virginity status is something to be ashamed of, as it is something that defies their masculinity (Carpenter, 2001, 2005).

Stigmatized individuals view virginity loss as an end in itself and often disconnect sex from love. They hold a very pragmatic approach to choosing their partner for first sexual intercourse. Casual sex partners, friends, acquaintances and even strangers would suffice for their first time (Carpenter, 2005). Love, commitment and trust are less important in partner choice. The progression of sexual intimacy is fast with their first partner. Individuals with a stigma script are not worried about having a perfect experience. Their partner serves the function of ridding them of their stigmatized status and providing them with sexual pleasure. For this reason, if they broke up with their virginity loss partner, they would tend to recover quickly and may have many casual sex partners (Carpenter, 2005).

Because they may not have known their first sexual intercourse partner for a long time, sexual communication is less important for those endorsing the stigma script. Their impatience to lose their virginity often meant that the discussion of protection against sexually transmitted infections or pregnancy did not occur. One participant even believed that demanding safer sex would make him seem inexperienced or expose him as a virgin (Carpenter, 2005). Because of this, people with a stigma script are often inexperienced in foreplay. Most of them had never tried heavy petting because “they had been able to have real sex right away” (Carpenter, 2005, p.105).

An important feature of the stigma script is age. Advancing age can compound the shame experienced; the older they became, the more intense of a stigma they experienced. Some male individuals had a very negative virginity loss experience, in that their more experienced female partner derided them as sexually incompetent. For example, one man ejaculated too quickly, to which the woman reacted with disgust and disappointment. This would further exacerbate the shame in their status, causing them to retreat further into themselves. Sometimes this even caused them to avoid sexual activity long after such a humiliating experience (Carpenter, 2005). These experiences reinforce and strengthen the stigma cultural script within society.

The sexual double standard is present in these frameworks and contributes to certain beliefs that we associate with the virgin/ non-virgin status: virgins can be associated with nerdy, embarrassing and socially inept individuals. In contrast, non-virgins can be associated with a higher social status, cool and popular people, and notions of masculinity or unorthodox femininity. For women with a stigma script, they viewed their virginity as a way to challenge the sexual double standard and to defy traditional femininity norms. The power allocated in gender roles is a function of the virgin's gender and of the peer culture.

Individuals who hold the *process* script were the most neutral about their sexuality, and did not conform to traditional stereotypes. Because of their comfort with sexuality, the process script was less concerned with others' impression of their sexual status. They viewed the transition of virgin to non-virgin as closely linked with other transitions, such as the transition from high school to college, or from adolescent to adult. They were able to construct a sexual identity through their virginity loss by trading in one status for another.

They viewed virginity loss as a step in the process of growing up and a natural stage of development. It was approached as an opportunity to learn about their bodies and their sexuality.

They did not attach too much importance to their first time: they expected it to be clumsy and uncomfortable (Carpenter, 2005). In this sense, they seemed to have more realistic expectations of their virginity loss than both the gift and stigma scripts.

The process script did not necessarily need a "perfect" partner for their virginity loss experience, but they did usually choose a steady romantic partner or a friend who they had known for a long time. They also used an incremental approach to sexual experience, but their motivation was to learn more about sex. More than half of the process-oriented individuals had done "everything but" sex with one casual sex partner. They continued to explore their sexuality with their virginity loss partner and found that, over time, sex became more pleasurable. They were not uncomfortable with the sexual experience of their partner; in fact, the experience was welcomed, as it was perceived as a shared learning experience. They also openly communicated about sex with their partner. Most of the people from the process script used a condom for their first time.

It is important to note that none of the individuals from the process script felt disempowered by their virginity loss experience (Carpenter, 2005). Because learning is an intrinsic and internal process, they were able to maintain agency during and after virginity loss, regardless of their partner's characteristics, their gender or their sexual identity. These scripts shape and dictate our sexual behaviour in important ways, such as the selection of a sexual partner, communication and the use of birth control methods (Carpenter, 2001, 2005). Comparing the three metaphors, the process metaphor is more conducive to physical health, emotional well-being and sexual agency, for both men and women (Carpenter, 2005). The application of this research suggests that if sex educators encouraged adolescents to approach

virginity loss as a step in the process of growing up, it would benefit their sexual health and overall sense of well-being.

Scripts and First Sexual Intercourse Experience

Humphreys (2013) was the first researcher to translate Carpenter's qualitative ideas into a quantitative measure. He sought to investigate the relationship between the virginity scripts and the approach and decisions made during first sexual intercourse. Questionnaires included demographic information (e.g. gender, age, program, year of university, sexual orientation, number of sexual intercourse partners), descriptive information regarding their first sexual intercourse, virginity framework descriptions, levels of communication and planning regarding first sexual experiences, participants' reported affective reactions to their first sexual intercourse at the time that it occurred, and the perceived impact of first sexual intercourse on one's life. For the virginity frameworks, the participants were given a forced-choice measure in which a description of each framework was given. Participants had to indicate which framework they most closely identified with and how confident they were with their choice.

Using a forced-choice format, 54% of participants identified with the process script, 37.7% chose gift and 8.4% chose stigma (Humphreys, 2013). There was a clear gender difference in script choices: men were more likely to classify themselves as stigma-oriented and women were more likely to classify themselves as gift-oriented. Almost one-half of each gender classified themselves as process. In addition, gift-oriented individuals were the most confident with their choice, compared with the two other groups. The age of first intercourse differed significantly between the groups, with the process-oriented individuals engaging in first intercourse earlier than stigma- and gift- oriented individuals (15.99, 16.94 and 16.70,

respectively). Gift individuals had significantly fewer lifetime sexual partners compared to stigma and process individuals (2.31, 7.50 and 5.40, respectively).

After their first sexual intercourse, gift individuals reported more positive affect and felt happier and more "romantic" than process individuals. Stigma individuals reported feeling relieved after their first time and they reported that their first sexual experience had a less positive impact on their lives, compared with gift individuals. Gift-oriented individuals predominantly felt love toward their first partner, process felt *love* or *like*, and stigma were more likely to be *indifferent* or felt *like* towards their partner. Both gift and process individuals were more likely to choose a romantic partner for their first time, whereas stigma individuals were equally likely to choose a romantic partner, a stranger or a friend. Gift individuals had the longest relationships with their partners both before and after first intercourse. Gift-oriented individuals had the highest levels of communication and planning, followed by process and stigma. Lastly, gift-oriented individuals were more likely to report that their first intercourse experience had a greater impact on their life than the other groups.

In summary, Humphreys' (2013) quantitative findings supported many of Carpenter's (2001, 2005) findings. Moreover, his study indicated that there is a relationship between the virginity scripts and first sexual intercourse experience, and that this relationship could be measured quantitatively.

Quantifying the Scripts

Eriksson and Humphreys (2013) were the first to validate the virginity scripts by developing the Virginity Beliefs Scale based on Carpenter's (2001, 2002, 2005) scripts. In a two-part study, the scale items were developed and then a confirmatory factor analysis was conducted

to verify the factor structure. In the first study, Eriksson and Humphreys (2013) performed exploratory factor analysis, where the originally developed 50 virginity belief items measuring elements of the gift, stigma and process scripts, were reduced to 22 items. Different themes were developed for each script: the gift script had themes of romance, partner selection and planning; the stigma script had themes of shame and urgency; and lastly, the process script had themes of development and learning. Demographic information was collected and additional scales, measuring sexual attitudes, endorsement of double standard and affective reactions to first coitus, were used to establish external validity. In the second study, confirmatory factor analysis supported the newly designed 22-item Virginity Beliefs Scale.

The goal of this research was to capture the complex nature of the decision-making process underlying first sexual intercourse by creating a quantitative scale. Fitting people into categories is not always as simple as it seems. Many individuals have a dominant (first) script and then a second. This scale provides a continuous measure of virginity scripts, rather than a categorical measure. The purpose of the scale is to understand the complexities of how individuals view their virginity loss.

There were several statistically significant relationships between the virginity scripts and the other scales. Men scored higher on the stigma subscale than women. Individuals scoring higher on the gift subscale reported fewer lifetime sexual partners and were less sexually permissive. Higher scores on the stigma subscale were related to more traditional gender-role beliefs, more sexual permissiveness, and greater agreement with the sexual double standard. Individuals scoring higher on the process script also reported greater sexual permissiveness.

In terms of positive affective reactions to first sexual intercourse, higher gift scores were positively correlated with satisfaction, romance, happiness, and excitement, and negatively

correlated with feeling sorry. Higher process scores were positively correlated with overall positive emotions and feeling relieved. Higher stigma scores were correlated only with feeling relieved. Gender differences included men reporting more positive affect than women and greater satisfaction, pleasure, relief and excitement.

In terms of gender differences and the affective reactions to first sexual intercourse, the findings of the second study supported the findings of the first study; therefore, the externally validity of the Virginity Beliefs Scale was supported. Other findings in support of external validity were the negative correlations of the gift subscale with number of lifetime sexual partners and the positive correlations between the stigma subscale and traditional gender roles. The three subscales demonstrated good internal reliability across the two samples. The second study provided further support for the Virginity Beliefs Scale as a valid measure of virginity scripts. Thus, the Virginity Beliefs Scale was found to be both reliable and valid.

Research from Humphreys (2013) and Eriksson and Humphreys (2013) suggest that these three virginity scripts are applicable to individuals; people do identify with them. By using the Virginity Beliefs Scale, future researchers will have a deeper understanding of how one's virginity script influences their sexual attitudes, beliefs and behaviour.

Precoital Sexual Behaviour

Research has begun to examine cognitive scripts of virginity, but little is known about how these scripts influence sexual activity *prior* to intercourse. Only recently have researchers been interested in precoital sexual activity, as the focus has primarily been on sexual intercourse. However, research into precoital sexual behaviour is important, because precoital sexual behaviour and first sexual intercourse occur in close proximity to one another (Miller et al.,

1997; Boyce et al., 2003; McKay, 2004; Laumann, Gangon, Michael & Michaels, 1994; Halpern-Felsher, Cornell, Kropp & Tschann, 2005; Herring, Prinstein & Halpern, 2012; Lindberg et al., 2008). Due to the fact that young adolescents are engaging in precoital behaviour before first sexual intercourse, precoital behaviour may have predictive value in determining when first coitus will occur.

If we understand the relationship between precoital behaviour and virginity scripts, we could target groups differently for sexuality education. Sexuality education should be comprehensive, age-appropriate and targeted to specific sub-groups (Public Health Agency of Canada, 2008). For these reasons, sexuality research should recognize the importance of precoital behaviour, not only intercourse. By understanding how these scripts influence precoital behaviour, we can have a better understanding of how to minimize risk and promote sexual health in a positive way.

A review of prevalence rates of precoital behaviour in Canada will help set the stage for understanding the potential link to virginity scripts. McKay (2004) reports that attitudes towards oral sex are changing and that if we put oral sex on a continuum of sexual behaviours, we should expect oral sex to be more common than vaginal sex. Indeed, oral sex seems to occur more frequently than vaginal sex. Data from the *Canadian Youth, Sexual Health and HIV/ AIDS Study* indicates that among grade nine females, 28% have had oral sex and 19% have had intercourse (Boyce et al., 2003; McKay, 2004). Even among adults, oral sex appears to be a normative sexual behaviour, as 84% of men and 73% of women, aged 40-44, had given oral sex and 86% of men and 77% of women (in the same age category) had received it (Laumann, Gangon, Michael & Michaels, 1994; McKay 2004).

Another study indicated that, among grade nine adolescents in California, oral sex is more acceptable than vaginal sex, less of a threat to their values and beliefs and they believed that more of their peers will have oral sex in the near future (Halpern-Felsher, Cornell, Kropp & Tschann, 2005). More students in this sample had (or intended to have) oral sex compared to vaginal sex.

Researchers have identified specific patterns of sexual behaviour in adolescence. One study found that half the respondents were categorized as "Vaginal Initiators/ Multiple Behaviours", meaning that vaginal sex occurred first (with an average age of initiation of 16 years) and oral-genital sex was initiated second, after one year of first sexual intercourse (Haydon, Herring, Prinstein & Halpern, 2012). The second largest category was the "Dual Initiators" who initiated oral-genital and vaginal sex within the same year (Haydon et al., 2012). The remaining participants were lumped into the following categories: "Vaginal Initiators/ Single Behaviour" (only vaginal sex), "Postponers" (delayed sexual activity until 22 years of age), and finally the "Early Initiators" (15 years of age at initiation of sexual activity) (Haydon et al., 2012). Regardless of beginning sexual activity later than their peers, the "Postponers" also followed a fast progression of activity characterized by initiating oral-genital and vaginal sex within the same year (Haydon et al., 2012). The "Early" group reported engaging in first sexual intercourse in combination with initiation of two or more behaviours within the same year (including oral sex and anal sex) (Haydon et al., 2012). This study has important implications for precoital activity because it shows that sexual behaviours are connected and occur in close proximity (Haydon et al., 2012). Understanding more about precoital behaviours can help sex educators develop more comprehensive education programs in order to inform youth of the risks associated with sexual behaviour.

Another study found patterns of sexual behaviour in adolescents aged 14-17 (Miller et al., 1997). Of those who had not engaged in penile-vaginal intercourse, those who reported a 50% or greater likelihood of first penile-vaginal intercourse occurring in the next year (also known as the "Anticipators") had significantly more precoital experience and were more likely to have a current boyfriend or girlfriend than those who reported a less than 50% likelihood of first penile-vaginal intercourse occurring in the next year (also known as the "Delayers") (Miller et al., 1997). It seems that the Anticipators were preparing themselves for first penile-vaginal intercourse both physically and relationally by gaining experience with sexual behaviour and finding the right partner.

Lindberg, Jones and Santelli (2008) found that the initiation of oral sex had occurred within six months of first coital experience in their study population. In regards to anal sex, the greatest predictor was time since initiation of vaginal sex: the likelihood of anal sex increased as time since first coital experience increased (Lindberg, Jones & Santelli, 2008), indicating that anal is a post-coital activity.

These patterns of adolescent sexual behaviours influence factors such as the timing of other sexual behaviours and the selection of a sexual partner. According to sexual script theory, precoital sexual behaviour should also be influenced by our social culture. The peer environment is a large factor in the timing of first sexual intercourse; what is normalized in one high school may be very different than another. Sexual script theory explains how a progression of sexual behaviours becomes normalized throughout adolescence that includes precoital sexual behaviours, such as oral sex, leading up to the loss of virginity. It is possible that there are trends in how different groups of adolescents understand the precoital behaviour they are engaging in and how it is perceived in relation to vaginal intercourse.

This Study

Given that cognitive scripts of virginity influence sexual aspects such as decisions made during first coitus, it is possible that these scripts have a relationship with precoital behaviour as well. This study utilized the quantitative Virginity Beliefs Scale developed by Eriksson and Humphreys (2013), as well as a measure of precoital behaviour developed for this study. Other measures used included the Hurlbert Index of Sexual Compatibility (HISC), the Sexual Sensation Seeking Scale (SSSS), the Affective and Motivational Orientation Related to Erotic Arousal (AMORE), the Multidimensional Sexual Approach Questionnaire (MSAQ), and lastly, the Multidimensional Measure of Comfort with Sexuality (MMCS1, short form). These measures are described in the measures section.

Hypotheses

Precoital Behaviour

Hypothesis 1: I hypothesized that gift- and process-oriented individuals would have a higher frequency of *partnered* precoital sexual behaviours (excluding masturbation) prior to first intercourse than stigma-oriented individuals. The gift group intends to save their virginity by delaying first sexual intercourse. They may have a higher frequency in precoital sexual behaviours, but still score lower on the sexual adventurism than the process or stigma groups, suggesting that there is a disconnect between their self-perceptions and their behaviour. Gift-oriented individuals adopt an incremental approach to sexual intimacy in order to test the commitment of their partners. Also they may have more opportunities to engage in precoital sexual behaviour due to the availability of their partner.

Hypothesis 2: Stigma- and process-oriented individuals will have a higher frequency of reported solo masturbation than gift-oriented individuals. Because the stigma individuals often lack a partner to engage in coitus, they might also lack a partner to engage in precoital behaviour and, thus, engage in more masturbation. Conversely, the gift group may use sexuality for more relational purposes, and less so for sexual pleasure and exploration. Thus, it is suggested that the gift group will have the lowest amount of solo masturbation.

Sexual Partners

Hypothesis 3: Given the gift group is saving their virginity and considers virginity loss to be special and sacred, it is hypothesized that they will have the lowest number of lifetime sexual partners, compared with stigma- and process-oriented individuals. Gift-oriented individuals may believe that sexual activity is only acceptable in monogamous, committed relationships, whereas stigma-oriented individuals would more likely be focused on being sexually active with many partners. Process-oriented individuals would be open to experiment with a new partner should the opportunity present itself and may also have a higher number of lifetime sexual partners than the stigma group.

Sexual Sensation Seeking

Hypothesis 4: Individuals who score higher on the Sexual Sensation Seeking Scale will also report more frequent partnered precoital behaviour. Sexual adventurism, as measured by the Sexual Sensation Seeking Scale, could be related to the frequency of precoital behaviours. Engaging in precoital behaviour is one way a sexually adventurous individual could express this predisposition.

Hypothesis 5: Process- and stigma-oriented individuals will have higher scores on the Sexual Sensation Seeking Scale than gift-oriented individuals. Process-oriented individuals view sexuality as an opportunity for growth and maturation and may feel more open to experiment with their sexuality. The stigma-oriented group may have a tendency for sensation seeking in order to rid themselves of their virgin status.

Motivation for Erotic Arousal

Hypothesis 6: Using the AMORE, the stigma subscale will be positively correlated with "relief from negative emotions" and "enhancing one's power" motivations for engaging in sexual behaviour. Because the stigma framework is inherently negative, stigma-oriented individuals will be motivated to shed this undesirable status and regain power.

Hypothesis 7: Using the AMORE, the gift subscale will be positively correlated with "express value for one's partner" and "provide nurturance and comfort" motivations for engaging in sexual behaviour. Because gift-oriented individuals place such high value on their relationship when considering engaging in sexual activity, it is probable that this group will most likely report relationship-enhancing (or relationship-maintaining) reasons for engaging in sexual behaviour.

Hypothesis 8: Using the AMORE, the process subscale will be positively correlated with "experience pleasure and sensuality" motivations for engaging in sexual behaviour. Process-oriented individuals may not be as concerned with negative judgement from others as stigma- and gift-oriented individuals; therefore, they may be more sexually motivated by the physical and pleasurable sensations of sex.

Comfort with Sexuality

Hypothesis 9: Using the MMSCI, process-oriented individuals will report that they are more comfortable with sexuality than stigma- and gift-oriented individuals. This group may be intrinsically motivated to explore their sexuality and to gain self-knowledge by expressing their sexuality. They feel neither shame nor status empowerment, but simply a curiosity to discover their bodies in a sexual capacity.

Sexual Compatibility

Hypothesis 10: Using the HISC, gift- and process-oriented individuals will have higher sexual compatibility with their first sexual intercourse partner than stigma-oriented individuals. The gift group spends a great deal of time choosing their partner, as well as discussing and planning for their first time. Research has demonstrated that those who report high satisfaction in their relationship are also more likely to report having these discussions with their partner, and that more open communication about sex lends to increased contraceptive use (Widman et al., 2006). The stigma group, on the other hand, are more likely to choose strangers or friends as their first sexual intercourse partner than the gift and process groups (Humphreys, 2013); therefore, they would be less likely to report high sexual compatibility with their first sexual intercourse partner given they may not know them as well.

Approach to Sexual Relationships

Hypothesis 11: Using the MSAQ, the gift subscale will be positively correlated with a "romantic" and "practical" approach to one's current sexual relationship. Their motivation for engaging in sexual activity is to promote bonding and to experience emotional closeness with their partner. Their sexual partners are carefully hand-picked and chosen for the purpose of continuing or maintaining a romantic relationship.

Hypothesis 12: Using the MSAQ, the stigma subscale will be positively correlated with an "exchange" and "game-playing" approach to one's current sexual relationship. Virginity loss is such an important and pivotal event in one's life that it may create patterns of sexual intimacy that continue into adulthood. Stigma-oriented individuals may continue to express these patterns; therefore, they may approach their sexual relationships as conquests rather than use sexual intimacy to promote emotional closeness and attachment such as is the case with the gift group. The stigma group may use sexual activity to rid themselves of insecurity, to empower themselves or to relieve anxiety, for example. They will approach their sexual relationships with a game-playing or an exchange approach- treating their partners as sexual outlets that "owe" them sexual favours and keeping "tabs" on the sexual activities performed on their partner. For example, someone from the stigma category who sought out sexual partners to rid themselves of their status may have learned that certain behaviours will increase the chances of copulating with another individual, leading to this individual caught in a behavioural pattern of playing with another person's emotions to achieve sex.

Method

Participants

Two hundred and forty eight participants were retained for the analysis (32 males, 215 females and 1 participant did not disclose his/ her gender). The majority of the students were in their first year of university (58.9%) and registered in either a Bachelor of Science (36.3%) or a Bachelor of Arts (36.3%). The mean age of the sample was 20 (SD= 5.51, range= 38). *Sexual intercourse* was defined as penile-vaginal intercourse. The average number of lifetime intercourse partners was 4.58 (SD= 6.24, range= 45) and the average number of foreplay partners was 3.5 (SD= 4.24, range= 30). Because the university is predominantly Caucasian, ethnicity data were not collected.

Measures

Each participant received a questionnaire package consisting of demographic questions (gender, age, degree program, year of university, sexual orientation, experience with sexual intercourse, number of foreplay partners prior to having intercourse, and number of sexual intercourse partners, and religious practice), a section for descriptive information regarding their first intercourse experience, and a number of scales, described below.

First intercourse. As part of their demographic questionnaires, participants were asked whether or not they had willingly engaged in sexual intercourse, defined as penile-vaginal intercourse. They were asked to describe their experience in as much detail as possible, including their age at first intercourse, their partner's age, the nature of the relationship (e.g. romantic/lover, friend/companion, etc.), their feelings towards their partner (e.g. love, liking,

dislike, etc.), the length of the relationship prior to first intercourse and the type of birth control methods used.

Virginity Beliefs Scale (VBS) and forced-choice measure. The VBS is used to assess how individuals perceived their virginity loss, which produces a dominant framework based on their responses (Eriksson & Humphreys, 2013). The scale consists of 22 items (10 items for gift, 8 for stigma and 4 for process) with a 7 point Likert scale ranging from 1 (*strongly disagree*) to 7 (*strongly agree*). This scale gives a value for each subscale, with higher values indicating more agreement with the items in that subscale. An example of a gift item is "My virginity was a gift to my first partner". A stigma item is "I regarded my virginity as something negative" and a process item is "I saw my virginity loss as a natural step in my development". Mean subscale scores are calculated by averaging the items within each subscale and range from 1-7, with higher scores in one subscale indicating a higher agreement with that framework. Reliability (alpha) was .89 for gift, .92 for stigma and .80 for process (Eriksson & Humphreys, 2013).

Using the forced-choice format, participants were asked to select one of three options: gift, stigma and process. Including the forced-choice measure produces a categorical measure of Carpenter's (2001, 2005) virginity frameworks. After choosing their framework, participants were asked how confident they were with their response on a scale from 1-10, 10 being most confident. The following descriptions (Humphreys, 2013) were provided to the participants:

> Gift: "I saw my virginity as something special, cherished and guarded. I believed it to be a gift that I would give to someone I loved and someone who would love me back, someone who would appreciate receiving my gift of virginity. I was proud of my virginity."

> Stigma: "I saw my virginity as a label which I was ready to get rid of, something negative and unwanted. I was embarrassed by my virginity status and did not want anyone to know about it, something I felt like hiding and lying about it."
>
> Process: "I thought of my virginity as a stepping stone or rite of passage that everyone must go through; the starting process of sexuality, which was natural and would continue to evolve. I saw virginity as something that would disappear as I grew up and into an adult."

The Precoital Behaviour Scale. The PBS was developed for this study and asks participants about the frequency of precoital activity that they engaged in *prior* to and *during* first sexual intercourse. (Participants filled out the questionnaire twice: once responding about their experience with precoital behaviour *prior* to first sexual intercourse and the second time responding with their experience *during* their first sexual intercourse.) The participant was presented with a list of 20 precoital sexual behaviours and was asked to respond with how often they engaged in each behaviour. Sample items include kissing, manual stimulation, oral sex, anal stimulation and using sex toys. Responses are measured using a 5-point Likert scale ranging from 0 (*Never*) to 5 (*Very frequently*). Responses are totaled to produce a single score for the scale. Scores can range from 0-100, with higher scores indicating more precoital sexual behaviours. Internal reliability was assessed for the Precoital Behaviour Scale. Using only items 1-12, the scale had good internal consistency with an $\alpha = .92$ for precoital behaviours prior to FSI and $\alpha = .88$ for behaviours during FSI. For all 20 items, the scale had an alpha of .89 for precoital behaviours prior to FSI and $\alpha = .87$ for behaviours during FSI. Furthermore, there was a significant correlation between the PSB *prior to* and *during* FSI $r(217) = .50$, $p < .000$, meaning that individuals responded similarly in both surveys. Therefore, the PSB is a reliable measure.

Hurlbert Index of Sexual Compatibility. The HISC is used to evaluate sexual compatibility between intimate partners (Hurlbert, 1993). Directions prompted the participant to respond with their first sexual intercourse partner in mind. This scale consists of 25 items measured using a 5-point Likert scale ranging from 0 (*All of the time*) to 4 (*Never*). Mean responses are calculated (with relevant items reversed scored), with higher scores indicating greater sexual compatibility (α= .86) (Hurlbert, 1993; Fisher et al., 2011). Sample items include "I think my partner understands me sexually" and "I think I sexually satisfy my partner".

Sexual Sensation Seeking Scale. The SSSS assesses the "dispositional need for varied, novel, and complex sexual experiences and the willingness to take personal physical and social risks for the sake of enhancing sexual sensations" (Kalichman, 1994; Fisher et al., 2011). Sensation seeking is derived from the personality trait extraversion, therefore this scale measures extraversion in the context of sexual interaction, including sexual adventurism and sexual risk taking (Fisher et al., 2011). This scale has been used in adolescents and adults, men and women (Fisher et al., 2011). It consists of 10 items, which are rated on a 4-point Likert scale, ranging from 1 (*Not at all Like Me*) to 4 (*Very Much Like Me*). It is scored by taking the mean response (Fisher et al., 2011). High scores on the SSSS correlate significantly with the "perceived pleasure of an array of sexual activities" (Fisher et al., 2011; Kalichman & Rompa, 1995). Sample items include "I enjoy watching X-rated videos" and "I feel like exploring my sexuality". The SSSS has demonstrated excellent internal consistency across several populations, including male and female college populations (α = .83, α = .81, respectively) (Gaither & Sellbom, 2003; Fisher et al., 2001).

Affective and Motivation Orientation Related to Erotic Arousal Questionnaire. The AMORE is used to measure individual differences in eight dispositional sexual motives proposed

within a construct of intrinsic sexual motivation (Hill, 1997). The eight sexual motives compose the 8 subscales, and are as follows: the desire to a) feel valued by one's partner; b) express value for one's partner; c) obtain relief from negative emotional states; d) provide nurturance and comfort to one's partner; e) enhance one's power; f) experience the power of one's partner; g) experience sensuality and physical pleasure; and h) procreate. This scale consists of 62 items and is evaluated based on a 5-point Likert scale, ranging from 1 (*Not at all true*) to 5 (C*ompletely true*). Values for items on each subscale are added together to create 8 total subscale scores, with higher scores related to greater agreement with the statements of that subscale. Sample items include "I frequently want to have sex with my partner when I need him or her to notice or appreciate me" and "I often have a strong need to fantasize about sex or do something sexual when I feel upset or unhappy". Internal consistency coefficients (alphas) for the subscales are typically greater than .85 across a number of samples (Hill, 1997b, 2002; Hill & Preston, 1996; Fisher et al., 2001).

Multidimensional Sexual Approach Questionnaire. The MSAQ is designed to assess several different ways in which people can approach their sexual relationships (Snell, 1992; Fisher et al., 2001). The MSAQ measures eight separate approaches to sexual relations, which comprise the eight subscales: a) a passionate, romantic approach; b) a game-playing approach; c) a companionate, friendship approach; d) a logical, practical and shopping-list approach; e) a dependent, possessive approach; f) an altruistic, selfless, and all-giving approach; g) a communal approach, emphasizing caring and concern for partner's needs and lastly, h) an exchange approach, in which a partner keeps "tabs" on sexual activity and favours performed, expecting to be repaid. The MSAQ consists of 56 items and is measured using a 5-point Likert scale ranging from -2 (*Strongly disagree with this statement*) to 2 (*Strongly agree with this statement*). The

items on each subscale are summed to create subscale scores. Higher scores on a subscale indicate greater agreement with the respective MSAQ statements. Subscale scores can range from -14 to 14. Sample items include "I have a strong sexual understanding of my partner" and "I think people should feel obligated to repay an intimate partner for sexual favours". The subscales on the MSAQ have high internal reliability for both males and females ($\alpha = .80$, $\alpha = .78$, respectively). Past research has found that men and women score similarly on the majority of the subscales; they endorsed a romantic, companionate and communal approach to their sexual relations, while disavowing a game-playing sexual style (Snell, 1992; Fisher et al., 2001).

Multidimensional Measure of Comfort with Sexuality. The MMCS1-S (short form) is composed of four subscales: a) comfort discussing sexuality, b) comfort with one's own sexual life, c) comfort with the sexual activities of others and d) comfort with the taboo sexual activities of others (Tromovitch, 2000; Fisher et al., 2001). The short version of this scale consists of 9 items measured using a 6-point Likert scale ranging from 1 (*Strongly disagree*) to 6 (*Strongly agree*). Sample items include "I am comfortable with my sexual activities, both past and present" and "I can freely discuss sexual topics in a small group of peers". The MMCS1-S is scored by averaging the responses to the items, with higher scores indicating more comfort with sexuality. Internal consistency ($\alpha = .80$), face and construct validity have been established (Fisher et al., 2001).

Procedure

Students accessed the study via Trent University's online research portal. After reading the Consent Form, participants had to select "I Consent" in order to be directed to the questionnaires. The consent form detailed that the study was examining sexual activity prior to first intercourse. In addition, participants were told that they would be asked about their sexual

history, sexual attitudes, motivation for sexual behaviour and comfort with sexuality. The consent form indicated that their responses would remain anonymous and confidential, and that the data would remain on a password-protected computer. Upon completion, the students were directed to the Project Summary page, which detailed counselling services and contact information of the researchers should they wish to learn more about the study. The average time of completion of the questionnaires was 1.25 hours (*SD* = 3.32 hours, *range* = 11.57 minutes-26.93 hours). It is important to note that these times represent how long the students were signed in to Qualtrics online and do not necessarily reflect the actual time taken to complete questionnaires (the students could have been performing other activities or may have left their computer signed in for an extended period of time). Because the study was intended to take 30 minutes, students received 0.5 credit towards their introductory psychology course for participating. This study was approved by the Trent University Research Ethics Board.

Case Removal Summary

Three hundred and thirty two students were recruited from several introductory psychology courses at a Canadian university. Inclusion criteria for the study required that the participants had already experienced consensual, first sexual intercourse and that they identified as heterosexual. Four participants were excluded due to their description of a non-consensual experience for the virginity loss. Another participant reported being age 11 at virginity loss, but since his data were similar to others of his gender, he was not excluded. In addition, four bisexual participants were removed. Although the data of these 4 cases looked similar to other heterosexuals in the sample, the decision was made to exclude these cases to ensure that the sample pool remained as homogenous as possible; therefore, all participants self-identified as heterosexual. Although the order of the SSSS, the AMORE, the MSAQ and the MMCS1 were

randomized to allow even distribution of data collection, 65 participants were removed due to large amounts of missing data (such as incomplete questionnaires) and 11 were removed due to missing or incorrect strike questions. Strike questions are used in psychometric testing to ensure participants are paying attention and reading the questions correctly. For example, a strike question may say “Answer with agree”. If a participant answers with anything other than agree, we can say that they answered the strike question incorrectly and that they were not paying attention to the questionnaire. If a participant got two or more out of three strike questions wrong or left the question unanswered, their data were removed from the study.

Results

Sample Demographics

The sample consisted of heterosexual nonvirgins (N = 248), with women comprising 87% of the total sample (see Table 1). As this study used undergraduate students in introductory psychology classes, the sample was primarily young adults (M = 20 years, SD = 5.51 years, *range* = 17-55 years of age). When asked about their current relationship status, participants indicated that they were in a serious relationship with one person (52.8%), in a casual relationship with one person (10.1%), or single (21%). Most participants were not religious, with 47.8% reporting that they never attended church, and 64.4% reporting that they never engaged in private prayer.

Using the forced-choice virginity frameworks measure, the majority of participants classified themselves as process-oriented (59.8%, n = 147), followed by gift-oriented (31.3%, n = 76) and stigma-oriented (8.9%, n = 22). Of the men in the sample, 65.6% classified themselves as process-oriented (n= 21), 18.8% as gift-oriented (n= 6) and 15.6% as stigma-oriented (n= 5). Almost sixty percent of the women in this sample classified themselves as process-oriented (59.2%, n= 126), 32.9% as gift-oriented (n= 70) and finally 8% as stigma-oriented (n= 17).

Participants reported being very confident with their self-classification in each of these 3 categories (M = 7.70, SD = 1.86, *range* = 2-10), with 10 being the most confident. Analysis of variance revealed a significant effect of forced-choice virginity framework on confidence ratings, $F(2, 230) = 7.13$, $p < .001$. Post hoc analysis using Tukey's HSD indicated that confidence ratings were higher for gift-oriented individuals ($M_{gift} = 8.27$) as compared to stigma-oriented individuals ($M_{stigma} = 6.67$, $p = .003$) and process-oriented individuals ($M_{process} = 7.54$, $p = .014$),

but confidence ratings did not differ significantly between stigma-oriented individuals and process-oriented individuals (p = .138). Therefore, gift-oriented individuals were more confident in their self-classification of the forced-choice virginity descriptions than stigma-oriented and process-oriented individuals.

In terms of sexual partners, the average number of foreplay partners prior to first intercourse was 3.5 (*SD* = 4.24, *range* = 0-30), whereas the average number of lifetime sexual intercourse partners was 4.58 (*SD* = 6.24, *range* = 1-46). Further comparisons between the forced-choice frameworks are discussed in the following section.

First Intercourse Characteristics

The average age of first intercourse was 16.83 years (*SD* = 1.95, *range* = 11-25). Partners' mean age of first intercourse was 17.96 years (*SD* = 2.85, *range* = 13-32). It was also the partners' first intercourse experience for 46.2% of the sample. The majority of the sample (75.1%) characterized the nature of the relationship with their first intercourse partner as "romantic/ lover". Thirty two percent of participants reported that they were involved with their partners for over 7 months prior to their virginity loss, while 28.9% reported being involved with their partner for 1-3 months prior to their virginity loss. Eighty-three percent of participants reported that they desired intercourse with their partner again after the first time. In terms of contraceptive use during first intercourse, 79.4% used condoms, 39.9% used the pill and only 9.3% did not use any contraception. Only 16.2% had been drinking while they lost their virginity, but 46.3% of those individuals believed it had influenced their decision (see Table 2).

Precoital Sexual Behaviour

The most commonly reported sexual behaviours were identified using the Precoital Behaviour Scale. Light kissing (pecking on the lips) was the most frequently reported precoital behaviour *prior* to first intercourse (*M* = 3.56, *SD* = 1.23, *range* = 0-5), followed by making out (kissing with tongue) (*M* = 3.53, *SD* = 1.21, *range* = 0-5) and genital fondling (manual stimulation) (*M* = 2.87, *SD* = 1.49, *range* = 0-5). Increasingly intimate behaviours, such as anal stimulation (by partner) (*M* = .23, *SD* = .81, *range* = 0-5), anal penetration (*M* = .15, *SD* = .54, range= 0-4) and the use of sex toys (by partner) (*M* = .23, *SD* = .77, *range* = 0-4) were the least commonly reported precoital behaviours. Ninety percent of participants had never used a sex toy, and 95% had never engaged in anal penetration *prior* to first sexual intercourse. Thus, only the first 12 items of the scale were examined individually (see Table 4).

The most commonly reported sexual behaviours *during* the first sexual intercourse encounter was making out (kissing with tongue) (*M* = 4.19, *SD* = .98, *range* = 0-5), followed by fondling of female breasts (*M* = 3.69, *SD* = 1.33, *range* = 0-5), kissing without tongue (*M* = 3.65, *SD* = 1.17, *range* = 0-5) and genital fondling by partner (*M* = 3.49, *SD* = 1.4, *range* = 0-5). Oral sex was performed and received occasionally (rarely to orgasm). Similar to the precoital sexual behaviours, anal sex play and the use of sex toys were very rare, therefore, these items were excluded from further analyses examining individual sexual behaviours (see Table 8).

Independent t-tests were conducted in order to determine whether there were statistically significant differences in precoital behaviour as a function of gender. In particular, private masturbation by males prior to intercourse was significantly higher than reports of private masturbation for females, $t(53.13) = 7.37$, $p < .001$ (*df* adjusted for Levene's violation, M_{male} = 3.63, *SD* = 1.07, *range* = 0-5; M_{female} = 2.02, *SD* = 1.57, *range* = 0- 5). In addition, it appears that men were more likely than women to orgasm during manual stimulation with a partner, $t(243) = -$

2.70, $p = .01$, and were more likely to receive oral sex $t(242) = -2.58$, $p < .01$. Men and women did not differ significantly in their sexual or foreplay partners (see Table 12).

Participants scored an average of 30.53 (*SD* = 14.32, *range* = 0-65) on the Precoital Behaviour Scale (PBS) for behaviours *prior* to first sexual intercourse (including masturbation), which was slightly lower than the average for the behaviours *during* their first sexual intercourse (*M* = 31.36, *SD* = 13.76, *range* = 3-100), but this difference was not statistically significant, $t(216) = -1.10$, $p = .27$. Therefore, there was no difference in the precoital behaviours reported prior to and during first sexual intercourse. Furthermore, PBS scores during FSI (including masturbation) did not differ significantly between the genders. Descriptive statistics regarding precoital behaviour during FSI can be found in Table 8 and 10.

Hypothesis 1

H1: Gift- and process-oriented individuals will have a higher frequency of *partnered* precoital sexual behaviours *prior* to first sexual intercourse (excluding masturbation) than stigma-oriented individuals.

The ANOVA performed on partnered precoital behaviour *prior* to first sexual intercourse experience by forced-choice virginity framework did not reach statistical significance, $F(2, 223) = .793$, $p = .454$. ANOVAs were also performed with the forced-choice framework and each specific sexual behaviour individually but the results were nonsignificant.

Pearson's correlation coefficient analysis was performed between the VBS subscales and the individual sexual behaviours (prior and during) and several statistically significant

relationships were found. The gift subscale in particular was strongly associated with the frequency of several precoital behaviours, such as kissing without tongue $r(238) = .24$, $p < .001$, manual stimulation of the genitals (received: $r(238) = .22$, $p = .001$ and performed: $r(238) = .23$, $p < .001$), manual stimulation of the genitals to orgasm (received: $r(236) = .20$, $p = .002$ and performed: $r(237) = .21$, $p = .001$), oral sex (received: $r(235) = .19$, $p = .004$ and performed: $r(237) = .20$, $p = .002$), and lastly oral sex to orgasm (received: $r(235) = .16$, $p = .014$ and performed: $r(237) = .18$, $p = .005$). Therefore, those scoring higher on the gift subscale reported a higher frequency of the aforementioned precoital behaviours.

In contrast, the stigma subscale was *negatively* correlated with kissing without tongue $r(236) = -.16$, $p = .015$ and kissing with tongue $r(235) = -.14$, $p = .036$, and was *positively* correlated with private masturbation $r(236) = .17$, $p = .007$. In other words, those scoring higher on the stigma subscale reported less kissing and more solo masturbation.

The process subscale was positively correlated with masturbating privately $r(242) = .22$, $p < .001$, kissing without tongue $r(242) = .17$, $p = .009$ and caressing a female's breast/ partner caressing your breast $r(242) = .17$, $p = .009$. Therefore, those scoring higher on the process subscale reported a higher frequency of the aforementioned precoital behaviours.

There was a statistically significant positive correlation between the VBS gift subscale and partnered precoital behaviour (excluding masturbation) $r(217) = .26$, $p < .001$. The process subscale $r(222) = .08$, $p = .277$and the stigma subscale $r(215) = -.11$, $p = .090$ were not significantly related to partnered precoital behaviour. In summary, those who scored higher on the gift subscale reported a higher level of partnered precoital behaviour.

Hypothesis 2

H2: Stigma- and process-oriented individuals will have a higher frequency of reported private masturbation than gift-oriented individuals.

The ANOVA conducted on masturbation by forced-choice virginity framework was nonsignificant, $F(2, 243) = 1.054$, $p = .350$. As described in Hypothesis 1, however, those who scored higher on the stigma and the process VBS subscales reported a higher level of private masturbation.

Hypothesis 3

H3: Gift-oriented individuals will have fewer sexual intercourse partners overall than stigma and process-oriented individuals.

An ANOVA demonstrated a significant effect of forced-choice virginity framework for sexual intercourse partners to date, $F(2, 243) = 4.54$, $p = .012$. Post hoc analysis using Tukey's HSD indicated that the number of sexual intercourse partners was higher for process-oriented individuals ($M_{process} = 5.31$) as compared to gift-oriented individuals ($M_{gift} = 2.87$, $p = .015$), but intercourse partners did not statistically differ significantly between stigma-oriented individuals and process-oriented individuals ($M_{stigma} = 5.95$, $p = .892$), and stigma-oriented individuals and gift-oriented individuals ($p = .098$). Bartlett's test of homogeneity of variance was statistically significant $X^2 = 63.183$, $p < .001$, therefore homogeneity of variance was violated.

The ANOVA conducted on number of foreplay partners by forced-choice virginity framework was also significant, $F(2, 243) = 7.08$, $p < .001$. Post hoc comparisons using Tukey's HSD test indicated that a statistically significant difference existed between gift ($M_{gift} = 2.12$) and stigma groups ($M_{stigma} = 5.18$, $p = .007$) and gift and process ($M_{process} = 3.99$, $p = .004$), but not between process and stigma groups ($p = .420$). In summary, gift-oriented individuals had a lower

number of sexual intercourse and foreplay partners than stigma- and process-oriented individuals, and this difference was most pronounced between the gift and process groups.

Pearson's correlation coefficient analysis was performed and there was a statistically significant negative relationship between the VBS gift subscale and overall sexual partners, $r(238) = -.24$, $p < .001$, and foreplay partners $r(238) = -.18$, $p = .004$. There was no statistically significant relationship between the process and stigma subscales regarding sexual partners overall. In other words, those who scored higher on the gift subscale were more likely to report fewer sexual partners overall and precoital foreplay partners.

Hypothesis 4

H4: Individuals who score higher on the Sexual Sensation Seeking Scale will also report more frequent partnered precoital behaviour, excluding masturbation.

A Pearson's correlation coefficient was computed to assess the relationship between SSSS scores and partnered PSB total scores (prior to FSI). There was no statistically significant relationship between SSSS and partnered precoital behaviour scores, $r(219) = 0.10$, $p = .134$.

Hypothesis 5

H5: Process- and stigma-oriented individuals will have higher scores on the Sexual Sensation Seeking Scale than gift-oriented individuals.

An ANOVA was conducted to determine any potential differences between the forced-choice virginity frameworks and sexual sensation seeking. There was a statistically significant effect between the virginity frameworks and sexual sensation seeking, $F(2, 236) = 3.55$, $p = .030$, however, post hoc analyses using Tukey's HSD were nonsignificant ($M_{gift} = 2.21$, $M_{process} = 2.38$,

M_{stigma} = 2.47). In summary, there was a statistically significant effect between the frameworks and sexual sensation seeking, but no statistically significant group differences were observed.

Pearson's correlation coefficient analysis was performed and there was a statistically significant positive correlation between sexual sensation seeking and the VBS stigma subscale, $r(230) = .19$, $p = .005$, and the process subscale $r(235) = .15$, $p = .026$. There was a statistically significant *negative* relationship between the gift subscale and sexual sensation seeking $r(231) = -.14$, $p = .040$. As hypothesized, those who scored higher on the stigma and process subscales also scored higher on the SSSS, but those who scored higher on the gift subscale scored *lower* on the SSSS.

Hypothesis 6

H6: The stigma subscale will be positively correlated with "relief" and "enhancing one's power" motivations for engaging in sexual behaviour.

Pearson's correlation coefficient was computed to assess the relationship between the AMORE scale scores and the VBS subscales. The stigma subscale was positively correlated with both "relieve stress" and "enhance power", $r(227) = .17$, $p = .012$ and $r(219) = .23$, $p = .001$, respectively. The process subscale was also positively correlated with "relieve stress" and "enhance power", $r(234) = .19$, $p = .004$ and $r(223) = .27$, $p < .001$, respectively (see Table 13). Therefore, those scoring higher on the stigma and process subscales of the VBS also scored higher on "relieve stress" and "enhance power" affective and motivational orientation for erotic arousal.

Hypothesis 7

H7: The gift subscale will be positively correlated with "express value for one's partner" and "provide nurturance and comfort" motivations for engaging in sexual behaviour.

Pearson's correlation coefficient was computed to assess the relationship between the AMORE scale scores and the VBS subscales. The gift subscale was positively correlated with "express value" and "provide comfort", $r(225) = .32$, $p < .001$ and $r(231) = .20$, $p = .002$, respectively. The process subscale was also positively correlated with "express value" and "provide comfort" $r(229) = .20$, $p = .003$ and $r(236) = .25$, $p < .001$, respectively. Interestingly, the stigma subscale was *negatively* correlated with "express value" $r(223) = -.20$, $p = .002$. Therefore, those scoring higher on the gift and process subscales of the VBS also scored higher on "express value" and "provide comfort" for partner, whereas those scoring higher on the stigma subscale of the VBS scored *lower* on "express value" subscale of the AMORE (see Table 13).

Hypothesis 8

H8: The process subscale will be positively correlated with "experience pleasure and sensuality" motivations for engaging in sexual behaviour.

Pearson's correlation coefficient analysis was performed and there was a statistically significant positive correlation between the VBS process subscale and the pleasure and sensuality subscale on the AMORE, $r(234) = .32$, $p < .001$. Therefore, those scoring higher on the process subscale of the VBS also scored higher on the "pleasure and sensuality" subscale for the AMORE. It is noteworthy that the other two VBS subscales were not correlated with "pleasure and sensuality".

Hypothesis 9

H9: Process-oriented individuals will report that they are more comfortable with sexuality than stigma- and gift-oriented individuals.

The ANOVA conducted on Multidimensional Measure of Comfort with Sexuality (short form) scores by forced-choice virginity frameworks was statistically significant, $F(2, 240) = 3.432$, $p = .034$. Post hoc analysis using Tukey's HSD revealed no statistically significant differences between the process group and the gift group ($p = .061$), the stigma and the gift group, ($p = .943$) and the stigma and the process group ($p = .195$). Although there was a statistically significant effect of virginity frameworks and comfort with sexuality, no statistically significant group differences were found (see Table 12).

Pearson's correlation coefficient analysis was performed and there was a significant positive correlation between only the VBS process subscale and comfort with sexuality $r(240) = .31$, $p < .001$. The other VBS scales were unrelated to this variable. In summary, those scoring higher on the process subscale scored higher on comfort with sexuality.

Hypothesis 10

H10: Gift- and process-oriented individuals will have higher sexual compatibility with their first sexual intercourse partner than stigma-oriented individuals.

The ANOVA conducted on sexual compatibility by forced-choice framework was statistically significant, $F(2, 221) = 7.884$, $p < .001$. Tukey's HSD post hoc comparisons revealed statistically significant differences between the gift group ($M_{gift} = 3.07$) and the stigma group ($M_{stigma} = 2.46$, $p < .001$), and the stigma and the process group ($M_{process} = 2.91$, $p = .007$), but not between the gift and process group ($p = .168$). Gift-oriented and process-oriented individuals had higher compatibility scores with their first intercourse partner than stigma-oriented individuals.

Pearson's correlation coefficient analysis was performed and there was a statistically significant positive correlation with the VBS gift subscale and compatibility with their first partner, $r(217) = .50$, $p < .001$ and a statistically significant negative correlation with the stigma subscale and sexual compatibility $r(219) = -.26$, $p < .001$. There was no relationship between the process subscale and compatibility. Therefore, those scoring higher on the gift subscale had higher sexual compatibility with their first partner and those scoring higher on the stigma subscale had *lower* sexual compatibility with their first partner.

Hypothesis 11

H11: The gift subscale will be positively correlated with a "romantic" and "practical" approach to one's current sexual relationship.

Pearson's correlation coefficient was computed to assess the relationship between the MSAQ subscale scores and the VBS subscales. The gift subscale was positively correlated with both "romantic" and "practical" approaches $r(229) = .22$, $p < .001$ and $r(231) = .29$, $p < .001$, respectively. Interestingly, the stigma subscale was negatively correlated with a "romantic" approach $r(228) = -.17$, $p = .011$. The process was not related to "romantic" and "practical" approaches (see Table 14). Therefore, participants who scored higher on the gift subscale also scored higher on "romantic" and "practical" approaches to their current relationship and those who scored higher on the stigma subscale scored *lower* on "romantic" and "practical" approaches to their current relationship.

Hypothesis 12

H12: The stigma subscale will be positively correlated with an "exchange" and "game-playing" approach to one's current sexual relationship.

Pearson's correlation coefficient analysis was performed and the stigma subscale was positively correlated with both a "game-playing" and an "exchange" approach to their current relationship, $r(232) = .31$, $p < .001$ and $r(229) = .19$, $p = .004$, respectively. The process subscale was also positively correlated with the "exchange" approach $r(227) = .19$, $p = .003$. By contrast, the gift subscale was negatively correlated with the "game-playing" approach $r(233) = -.40$, $p < .001$. To summarize, those scoring higher on the stigma and process subscales also scored higher on the "exchange" approach, while only those scoring higher on the stigma scored higher on the "game-playing" approach. Individuals scoring higher on the gift subscale scored *lower* on the "game-playing" approach to their current relationship (see Table 14).

Discussion

The focus of this study was to extend Humphreys' (2013) quantitative research on virginity frameworks to precoital behaviours. A large portion of research in human sexuality focuses on sexual intercourse. This is the first study to examine the relationship between virginity scripts and behaviours prior to and during first intercourse. The current study supports past research demonstrating the presence of these cognitive frameworks in the university student sample (Humphreys, 2013). Participants identified with and endorsed the three virginity frameworks, and were very confident in categorizing themselves into one of three groups. The gift-oriented individuals were the most confident in this respect, perhaps because of the importance of their virginity loss in their sexual script, and the extent to which first sexual intercourse (FSI) demonstrates commitment and love in their relationship. This sample was not very religious, which is consistent with research using Canadian undergraduate students (Humphreys, 2013).

Social scripting theory rests on the assumption that people follow internalized scripts when constructing meaning out of behaviour, responses and emotions (Wiederman, 2005). When participants were given the forced-choice virginity measure, about 60% chose process, 30% chose gift, and 10% chose stigma. These percentages and group membership closely resemble past research examining the quantitative measure of the frameworks (Humphreys, 2013). The finding that these virginity scripts are easily identified in the sample of undergraduates suggests that scripts are pervasive and provide guidance for sexual behaviour regarding first intercourse. In addition, the VBS supported many of the hypotheses of the forced-choice measure, reinforcing the VBS as a valid and reliable measure of Carpenter's (2001, 2005) virginity scripts.

The virginity scripts reflect important gender differences. Men were more likely to categorize themselves as stigma-oriented and women were more likely to classify themselves as gift-oriented, which supports previous research (Humphreys 2013). Virginity loss is a pivotal moment in a person's life, which may be experienced differently depending on one's virginity script. First sex is socially part of a much longer process than the incident itself (Holland, Ramazanoglu, Sharpe & Thomson, 2010). When young people have less rigid gender roles and can view virginity loss as a mutually fulfilling experience, it can lend to a more positive and pleasurable experience for both partners (Holland et al., 2010).

When participants were asked how they felt about their first intercourse partner, far more forced choice gift individuals said they felt love towards their partner than stigma-oriented individuals. Furthermore, gift-oriented individuals were more likely to characterize the nature of their relationship as romantic than stigma-oriented individuals. These findings are consistent with previous research (Carpenter, 2001, 2005; Humphreys, 2013), although in this sample, a large portion of process-oriented individuals also had a romantic relationship and felt love towards their first partner.

Research has demonstrated that different patterns of love between partners predict participation in a variety of types of sexual activities. Specifically, mutually high levels of loving between partners are associated with a wide range of sexual activities, including oral sex for both genders and anal sex for males (Kaestle & Halpern, 2007). Furthermore, married and cohabitating couples often have higher odds of having engaged in sexual activities beyond vaginal intercourse, such as oral and anal sex, which speaks to the potentially positive role of sexuality in loving relationships in young adulthood (Kaestle & Halpern, 2007) and the relationship-enhancing nature of partnered sexual behaviour. These findings speak to the

complexities of partnered sexual behaviour and suggest that factors such as feelings towards one's partner and the relationship length and commitment level also influence partnered sexual behaviour.

Stigma-oriented individuals were more likely to feel indifference towards their first partner and also were more likely to know their partners for a shorter period of time. Research shows that partner selection is different for the three groups. For instance, gift-oriented individuals invest more time selecting the "perfect person" to lose their virginity with. Emotions, specifically love, are an important qualifier in choosing their first partner (Carpenter, 2001, 2005; Humphreys, 2013). In this sample, gift-oriented individuals had higher sexual compatibility with their first partner than process- and stigma-oriented individuals. The stigma-oriented individuals, instead, appeared to support the notion of an "opportunity motive" in losing their virginity (Humphreys, 2013), in that they lose their virginity when the opportunity presents itself. Therefore, the stigma group may not value partner selection as much as the gift group, which explains the lower sexual compatibility with their first partner.

For sexual behaviours prior to the first intercourse event, there seem to be some sexual behaviours that were performed more than others in regards to sexual behaviours *prior* to intercourse. Light kissing was the most commonly reported behaviour *prior* to virginity loss, followed by making out and manual stimulation of the genitals. More intimate behaviours, such as anal stimulation, anal penetration and the use of sex toys, were the least commonly reported precoital behaviours. This finding has been observed in other studies, in that kissing and petting is more commonly reported than oral sex and anal stimulation (Shuster, Bell & Kanouse, 1996). Kissing can be viewed as a relationship maintenance and/or relationship enhancing behaviour. Welsh et al. (2005) studied young adult couples who were dating for a minimum of 4 weeks and

found that kissing and desiring a romantic partner correlated positively to relationship satisfaction and commitment (Tolman & McClelland, 2011).

This study has identified a script for behaviours engaged in *during* people's first intercourse. The most commonly reported sexual behaviour *during* first sexual intercourse was deep kissing, followed by fondling of female breasts and genital fondling by partner. The frequencies of precoital behaviours reported by participants suggest that there may be a script for first intercourse. Given the data, the script might include a period of deep kissing which progresses to the male partner caressing the female's breasts, and then manual stimulation of each other's genitals. Although the duration of each activity was not measured in this study, these behaviours were the most commonly reported which suggests that there is a pattern of sexual behaviours that many people follow during their first sexual intercourse.

In this study, the framework that an individual holds was associated with the frequency of precoital behaviour. Specifically, individuals scoring higher on the gift subscale engaged in a higher frequency of partnered precoital behaviour prior to first intercourse, which suggests that they are engaging in precoital behaviour in order to test the commitment of their partner. They are using sexual behaviours as an expression of their love and commitment to the relationship.

In contrast, individuals scoring higher on the stigma subscale scored lower on partnered precoital behaviours, reporting *more* solo masturbation and *less* kissing. Since kissing can be both a product of and a contributing factor to emotional connection, the stigma individuals may not value this aspect of sexual expression. Furthermore, it is possible that stigma-oriented individuals lack a partner to sexually experiment with, causing them to rely on themselves for sexual gratification, leading to the increased frequency of reported masturbation.

Lastly, the process subscale was also associated with masturbation; however, I believe that these participants are masturbating to explore their bodies and sexuality, unlike the stigma-oriented individuals who do so because they lack a willing sexual partner. Process-oriented individuals reported more precoital kissing (without tongue) and more participation in the caressing of female breasts (performing if male, receiving if female). I believe that they are engaging in these behaviours to explore their own bodies and their partner's bodies, and although I cannot extrapolate the timing of these behaviours, I believe that kissing and caressing of female breasts occur in close succession to one another and represent an ordered pattern of partnered sexual behaviour. While process-oriented individuals are motivated by the desire to learn about themselves and their bodies, stigma-oriented individuals use intercourse to ultimately rid themselves of their undesirable status as virgin.

Oral sex was also reported by our sample, which has been previously referred to by researchers as part of an adolescent's "sexual repertoire" (Hensel, Fortenberry & Orr, 2008; Tolman & McClelland, 2011, p. 245). Kaestle and Halpern (2007) found that their sample engaged in more oral sex than anal sex (74% of men experienced fellatio, 75% of women experienced cunnilingus and 16% of each gender had had anal sex).In a study of African American adolescents, Hensel et al. (2008) found that oral sex occurred before, simultaneously or concurrent with intercourse rather than as a substitute (Tolman & McClelland, 2011). It is possible that penile-vaginal intercourse is seen as the focus and goal of sexual behaviour, and that the more intimate behaviours, such as oral sex and anal stimulation, are engaged in when one is comfortable with their partner. Kaestle and Halpern's (2007) study on sexual behaviours in couples reported that older respondents had elevated odds of having participated in oral sex but not anal sex. This suggests that as the amount of time that individuals have been sexually

active grows their level of comfort with a range of sexual activities increases (Kaestle & Halpern, 2007).

Sexual behaviour also varies according to relationship length. Dating relationships of less than one month duration include more frequent fellatio but less frequent cunnilingus than longer term dating relationships (Laumann et al., 1994; Kaestle & Halpern, 2007). In this sample, gift-oriented individuals knew their partners longer and had more precoital experience. Sexual experience with one partner can help to foster trust in that person and their commitment to the relationship, allowing someone with a gift-oriented disposition to feel more comfortable with different sexual behaviours with that partner. This creates a reciprocal relationship whereby time lends to trust which influences sexual behaviour. In this sample, gift-oriented individuals knew their partners longer and had more precoital experience but were still not as comfortable with sexuality in general as the process-oriented (which is what our MMSCI scale measures, not comfort with your FSI partner). I propose that gift-oriented individuals have comfort with sexuality, not in the general sense, but rather only with that specific romantic partner. Therefore, comfort and relationship duration, together, influence precoital and first intercourse sexual behaviours, but only for gift-oriented individuals and only in the context of a romantic relationship. Further research needs to be conducted to confirm this link.

The culturally-perpetuated stereotype that anal sex is being used by *technical virgins* to maintain their virginity status and as a substitute for penile-vaginal intercourse seems to not apply to the current sample (Uecker, Angotti & Regnerus, 2008; Mahoney, 1980; Bruckner and Bearman, 2005), as almost 90% of participants had never engaged in anal penetration *prior* to or during first intercourse. Shuster, Bell and Kanouse (1996) studied sexual practices in adolescent virgins, and found that more than a third had experienced some form of genital sexual activity

(primarily masturbation with a partner but also fellatio with ejaculation and cunnilingus) but *almost none* reported having engaged in heterosexual or homosexual anal intercourse. Anal sex has been reported in other studies of precoital behaviour. Kaestle and Halpern (2007) estimate that 10% of all young adults are in a relationship of more than three months' duration with a partner with whom they have had anal sex. Therefore, duration of the relationship appears to be a major factor for the types of sexual behaviours individuals engage in with their partner.

Precoital behaviours also seem to be gendered. Men engaged in more frequent precoital behaviour than women prior to first intercourse. Specifically men masturbate more than women, a trend that has been observed in other research (Zamboni & Crawford, 2002; Oliver & Hyde, 1993). Men are also more likely to orgasm during manual stimulation and oral sex (Shuster, Bell & Kanouse, 1996). Not only do these patterns reflect gender differences in behavioural patterns, but they also reflect societal norms concerning sexuality. Boys are not criticized when they handle their genitals, whereas girls are judged more harshly if they are found exploring their bodies (Wiederman, 2005). Consequently, boys learn at a much earlier age how to sexually please themselves, compared to girls. Also, women in the current study were more likely to give oral sex than to receive it, which may reflect traditional gender norms regarding oral sex in our culture.

Expectations about sexual behaviour, such as oral sex, tend to differ between the genders, in that fellatio is more of an *expected* behaviour. Kaestle (2009) found that a greater proportion of women versus men from the Add Health study had engaged repeatedly in sexual activities they disliked (12% vs. 3%) and were more likely than men to report participation in these activities, which, for these participants, consisted primarily of fellatio and anal sex (Tolman & McClelland, 2011). Furthermore, fellatio is a quicker and easier behaviour to perform, due to the

fact that the man does not have to remove his pants and simply uses his zipper/ fly, which may also contribute to the gender disparity.

Double standards regarding sexuality and the traditional sexual script have a great influence on our sexual behaviour. Cultural factors may socialize some women to link love and sexual desire more closely than men do (Diamond, 2003; Crockett, Rafffaelli & Moilanen, 2003; Kaestle & Halpern, 2007). Some women may believe that it is not socially acceptable to experiment with their sexuality out of the context of love. Women may be exposed, explicitly or implicitly, to messages that teach them that they are not worthy of receiving pleasure, or that they do not have the right to explore their sexual likes and dislikes. Men are exposed to a very different set of messages regarding sexuality.

Heisler (2014) interviewed mothers regarding the sexual messages they delivered to their children, which they called "memorable messages". According to Knapp et al. (1981), memorable messages are "relatively short communication units that are remembered and perceived by the individual to be influential in one's life" (Heisler, 2014, p. 282). Research shows that these messages shape evaluations of behaviour (Smith et al., 2001) and cause changes to behaviour (Nazione et al., 2011), especially in regard to gendered attitudes (Epstein & Ward, 2011; Heisler, 2014). Heisler (2014) found that a sexual double standard continues to dominate mothers' messages about sexuality to their children. Mothers remembered discussing gatekeeping, sexual activity as the communication of love and intimacy and the negative consequences of sexual activity most frequently with their children; however, the content of the messages was tailored to the child's biological sex. Mothers prepared their daughters to "just say no" when propositioned by a man for sex, and insinuated virginity as a commodity that the daughters possessed. This may provide an explanation for how the gift script develops in young

girls. In contrast, sons were given messages emphasizing sexual experience and knowledge. This sexual double standard reinforces traditional gender roles of masculinity and femininity, and assumes that individuals acting upon non-traditional roles, such as a women with sexual experience, are inappropriate or unsuitable (Heisler, 2014).

Men are lead to believe that their sexuality is a symbol of their masculinity, and that they must "sow their seed" by bedding as many women as possible. Some mothers in Heilser's (2014) study stated that sexual experience for men was positive and/ or expected, stating "boys will be boys" and "I figure he's sowing his oats" (p. 287). Women are taught that sex and love must always go together, while men are applauded for their sexual conquests with casual partners. The traditional sexual script influences our thoughts, beliefs and actions regarding our sexual behaviour. These cultural messages from parents, peers and the media are sometimes subtle and other times obvious, but nonetheless, they influence the way we think about our virginity loss and the behaviours that precede it.

When comparing the number of sexual partners, there were significant differences between the virginity scripts. Gift-oriented individuals had the lowest number of sexual intercourse partners, and this difference was especially pronounced when compared to process-oriented individuals. Process-oriented individuals may not feel as much shame or guilt regarding their sexual exploits and may be more open to sexual experiences, which would translate to more opportunities for experimentation with several partners. On the contrary, gift-oriented individuals may view sex as inappropriate if not in the context of a serious relationship and therefore, may not have intercourse with someone they are not currently dating. They also tend to spend more time ensuring their partner they are with is the one they want. Obviously, the investment of time

with each partner reduces the opportunities to engage with other partners, and subsequently keeps gift-oriented individuals overall number of partners low.

Gift-oriented individuals also had a significantly lower number of foreplay partners, compared to process- or stigma-oriented individuals. This stigma group had the highest number of foreplay partners. One explanation for this finding could be that stigma-oriented individuals are actively trying to lose their virginity, so they attempt to copulate with as many people as possible. Once they have realized that their partner is not willing to have intercourse with them, they move onto someone else and repeat the attempt with a new partner. In summary, the gift group had significantly fewer overall sexual intercourse partners and foreplay partners than the process group and the stigma group, however, this may reflect a gender difference rather than a framework difference since the stigma group is primarily made up of men, and men had more sexual and foreplay partners than women. Future research should use a bigger sample to be able to control for gender to see if observed effect is a framework effect or a gender effect.

Contraceptive use at first intercourse was high in this sample and did not differ between the three frameworks. While I gathered information about contraception with first sexual intercourse partners, it is unknown whether individuals in this sample engaged in safe (i.e. protected) sex with subsequent partners. Future research should examine contraceptive differences between the frameworks in their current sexual experiences. In addition, it would have been interesting to ask whether or not they had planned their first sexual experience, which may have been related to their contraception use at first intercourse.

As expected, process- and stigma-oriented individuals have a higher tendency towards sexual sensation seeking than the gift-oriented individuals. As previously established, the purpose of sex for gift-oriented individuals is to enhance the relationship, whereas the stigma and

process group may be more inclined to use sexuality to be more extroverted or adventurous and be more interested in sexual experimentation. The risks are smaller for gift-oriented individuals because they are likely having sex with a serious dating partner, whom they know and trust, and not solely for the sake of sexual pleasure.

There was a strong relationship between the frameworks and their motivation for erotic arousal. Power and relief from negative emotional states appear to be strong motivators for stigma-oriented individuals to become interested in sex or to experience sexual feelings. The stigma framework is inherently negative, and if those possessing this script can rid themselves of their status, they can regain control of their virginity status or lack thereof. Removing the negative label of virgin can make them feel more powerful and in control. Regaining control could be a powerful motivator for first intercourse and general erotic arousal. A stigma person may pursue sexual intercourse in hopes of regaining control and power, thereby boosting their self-esteem and relieving their negative emotional state.

Furthermore, psychological well-being has been linked to motivations for adolescent sexual behaviour. Female youth with higher impulsivity ratings reported that their motivations were less driven by intimacy/ desire reasons (Dawson et al., 2008; Tolman & McClelland, 2011). Among a sample of African American adolescents, males were more likely to report self-esteem enhancement as a reason for having sex (Robinson, Holmbeck and Paikoff, 2007; Tolman & McClelland, 2011).

Process-oriented individuals also reported obtaining relief from negative states and enhancing their power as motivations for erotic arousal. The motivations of this group are less predictable than the other two groups, as they are less likely to adopt the traditional sexual script. It is unclear why a process-oriented individual would be motivated by relieve negative states or

enhance their power, however, the process group seems to be more fluid and flexible regarding their sexuality and engage in sexual fantasy or behaviour for a wider variety of reasons. The process group had both *other*-centered and *self*-centered motivations for erotic arousal. Since the process subscale correlated with *all* AMORE subscales (feel value, express value, relieve stress, provide comfort, enhance power, experience power and experience pleasure, with the exception of procreate), this suggests that their motivations are more unpredictable and varied than their gift and stigma counterparts.

As anticipated, gift-oriented individuals were sexually motivated by the need to express value and provide comfort to their partner, as they view sex as special, only to be experienced in the context of a loving relationship. The motivation for the gift group is other-centered, rather than self-centered. The process group also had express value and provide comfort to their partner as motivations. The stigma subscale was negatively correlated with "express value" as a motivation for erotic arousal, which suggests that their motivations for engaging in sex appear to be self-centered, rather than other-centered. This supports many of the characteristics that Carpenter (2001) described as linked to each framework.

Ott, Milstein, Ofner and Halpern-Felsher (2006) examined intimacy in adolescent romantic relationships and evaluated it as a possible "positive motivation" for sexual behaviour (Tolman & McClelland, 2011). Specifically, the researchers evaluated goals for intimacy, sexual pleasure and social status within a romantic relationship. Among ninth graders, intimacy was valued the most, then social status, then sexual pleasure. Girls valued intimacy significantly more and pleasure significantly less than boys. Those with more sexual experience valued both intimacy and pleasure more than those who were sexually inexperienced (Ott, Milstein, Ofner & Halpern-Felsher; 2006; Tolman & McClelland, 2011). In this study, the gift-oriented individuals

had more precoital behaviour than the other groups and also had more romantic and caring approaches to their sexual relationships, which demonstrates the notion that sexuality can be used as a romantic expression in a relationship. Therefore, motivations for sex can vary by gender and sexual experience.

Process-oriented individuals were sexually motivated to experience pleasure and sexuality, which was expected due to their neutral or sex-positive attitude towards sexuality. They may not have negative or stereotypical attitudes towards sexuality; therefore, they can enjoy sex for what it is: a means to obtain pleasure and gratification and to learn about oneself and others.

Process-oriented individuals were more comfortable with sexuality than stigma- and gift-oriented individuals. Specifically, they were more comfortable with discussing sexuality, with their own sexual lives and with the sexual activities of others, including taboo sexual activities of others. This difference was especially evident when comparing the process and gift groups. Process-oriented individuals view sexuality as an opportunity to learn about themselves and their partner. Virginity loss is a step in the process of growing up, and sexual experimentation is viewed as contributing to personal growth and maturation. Those with a process virginity framework have a neutral and open-minded view of sexuality. It was expected that this group would be more comfortable with sexuality than the other two groups because the gift-oriented individuals actively try to maintain their virgin status by protecting their virginity/ sexuality. The gift framework is deeply rooted in conservative gender roles, which do not encourage sexual experimentation for women. These beliefs and attitudes could contribute to a discomfort and reluctance to openly experiment with their sexuality, unless in the context of a committed romantic relationship. Gift-oriented individuals had less general comfort in sexuality, but may

have more comfort specifically with their romantic and/ or sexual partner. This warrants further investigation.

Because the gift-oriented individuals take such care in choosing their first sexual intercourse partner and the planning of their virginity loss, it was expected that they would have the greatest sexual compatibility with their first partner. Supporting the research, the gift-oriented individuals in my sample knew their partners longer than the other groups and had the highest sexual compatibility with their first sexual partners, presumably because they discussed and planned their first sexual intercourse. Past research has found that gift-oriented individuals planned their first time thoroughly (Carpenter, 2001, 2005; Humphreys, 2013). This increased level of communication contributes to better compatibility.

In contrast, stigma-oriented individuals did not know their partner for as long and, therefore, had fewer opportunities for developing a rapport or relationship with their first partner, which may explain the lower sexual compatibility with their first intercourse partner. This shorter period of time knowing their partner is related to lower sexual compatibility with that partner.

The gift group had a romantic and caring approach to their current relationship because their approach to their first partner was expected to be romantic and caring also. Past research has demonstrated that young women who reported higher rates of sexual self-concept and greater approach (positive) versus avoidance (negative) motives for engaging in sex reported greater satisfaction with their most recent sexual experience (Impett & Tolman, 2006; Tolman & McClelland, 2011). Therefore, an individual's approach to sexual relationships can influence the quality and satisfaction of their current sexual experiences. If a gift-oriented individual had a pleasurable first intercourse experience with their partner, likely a long-term partner, this may

influence their subsequent sexual relationships. Interestingly, the stigma group did not have a romantic approach to their current partner. Perhaps the stigma-oriented individuals simply see their partner as a sexual outlet, de-emphasizing romance and courtship and emphasizing their own sexual needs. Motives for sex can impact sexual experiences.

Stigma-oriented individuals reported a game-playing and social exchange approach to their current relationship. Stigma-oriented individuals may not be interested in cultivating the relational aspects of the relationship such as an emotional connection with their partner. Instead they may focus on what their partner can and will do for them, sexually. The stigma-oriented individual works towards removing their virginity stigma and, as a consequence, are focused on sex as a game or exchange that gets them to their goal. They are less interested in developing an emotional connection to their first intercourse partner, which explains why they have more acquaintances and strangers as first sex partners.

Process-oriented individuals also had an exchange approach to their current relationship. Past research has demonstrated that both men and women indicate that feeling loved is an important benefit of romantic relationships, but men are more likely to also indicate that sexual gratification is a benefit (Regan, 2003; Kaestle & Halpern, 2007). I believe that process-oriented individuals want to both give and take when it comes to their sexual relationships. Not surprisingly, the gift-oriented individuals were less likely to have a game-playing approach to their current partner. For gift-oriented individuals, the purpose of sexual behaviour is to achieve an emotional connection in their romantic relationships.

In summary, the findings from this study indicate that the virginity frameworks are easily identifiable in a Canadian undergraduate sample and that they are associated with the frequency of specific precoital behaviours, sexual sensation-seeking predispositions, motivation for erotic

arousal, comfort with sexuality, compatibility with their first intercourse partner and approach to current sexual relationships. The virginity scripts provide guidance for precoital behaviour prior to first intercourse and influence characteristics of sexual interaction and motivations for sexual behaviour. The findings that the virginity frameworks are influencing *current* aspects of sexuality (such as motivations for erotic arousal and approach to sexual relationships) suggest that the scripts can create patterns of sexual interaction and behaviour that continue into young adulthood and beyond, long after virginity loss occurs.

Limitations and Future Directions

There are a few limitations of this study that must be addressed. The sample consisted of first year undergraduate students in psychology. Although introductory psychology is a popular course taken by many students in other disciplines, the sample represents a small portion of one university in Ontario, Canada. Students from other universities may not necessarily hold the same beliefs, values and behavioural practices as students from this particular university.

The sample for this study was comprised of young, heterosexual nonvirgins, and therefore cannot be generalizable to other populations, such as members of the Lesbian-Gay-Bisexual-Transgender (LGBT) community or virgins. Research on virginity among the LGBT community indicates that there is a range of virginity definitions, there is little discussion on the topic and that "coming out" is a more important rite of passage than virginity (Averett, Moore & Price, 2014). Therefore, the concept of virginity loss may not be as relevant for LGBT members. Future research should try to incorporate these participants to account for possible differences in precoital behaviour. Because the LGBT community does not engage in the heteronormative sex script, the meanings of precoital behaviour are likely very different, perhaps more meaningful, than heterosexual individuals who may view penile-vaginal intercourse as the goal of sex.

Future research should strive for a more representative male population. If the study included more males, it is likely that the process and stigma group would increase, but not the gift group. In this study, we had a small number of males (13%) and a small number of stigma participants (8.9% for forced choice). This pattern speaks to the gendered nature of the virginity scripts. The unequal group sizes resulted in the ANOVA and t-tests lacking power and, therefore, should be interpreted with caution. Based on Carpenter's (2005) past research, however, the stigma group was expected to be small in number. This group represents a small but important part of the virginity script theory and therefore, could not be excluded to strengthen the statistical analyses. Increasing the sample size could help to alleviate this limitation, although the process group is expected to be the largest of the three groups when examining virginity beliefs of North Americans. Past research has also used ANOVAs as analyses with the forced-choice and t-tests and correlations with the VBS subscales (Humphreys, 2013), therefore, the decision was made to use ANOVA, t-tests and correlations as the analyses.

The questionnaires asked participants about their virginity loss experience, which would be considered retrospective data. Fortunately, the sample consisted mostly of young adults, for whom their first sexual intercourse occurred only about 4-5 years ago. The sample had a mean age of 20 years and the mean age of FSI was 16 years of age, which is a typical age for first intercourse in North America. Results from the National Longitudinal Study of Adolescent Health indicated that the average age of intercourse was also 16 years of age (Haydon, Herring, Prinstein & Halpern, 2012). Therefore, the amount of time that elapsed since their virginity loss and recounting their experience was fairly short considering that virginity loss is such a salient event in a person's life (Holland et al., 2010).

Longitudinal research should be conducted in order to ascertain that these virginity frameworks are stable throughout the lifespan. For example, stigma-oriented individuals feel shame and embarrassment over their virginity status, but once they lose their virginity, they experience relief (Carpenter, 2001). This could explain the larger size of the process group; perhaps many of the previously stigma individuals transition over to the process group after the label of virgin has been removed. It would be interesting to see if the stigma group would maintain their identification with stigma *after* they have their first sexual intercourse. Longitudinal research should be conducted before, around the time of, and after virginity loss to see if the self-identification of participants with these frameworks remains constant.

Future research should examine the process group more in depth, and potentially identify other sub-groups within the process framework. The process group is exemplified by a desire for learning, knowledge and curiosity about sex. There may be more variability in precoital behaviours within the process group that is left to be explored. As our culture moves further away from gender norms, I believe that the stigma and gift groups will become smaller, and the process group will become larger. Crawford and Popp (2003) found that the difference in expectations for female and male sexual behaviour persists but that sexual attitudes have become somewhat more egalitarian (Crawford & Popp, 2003; Kelly, 2010). In addition, the descriptions provided for the three frameworks in the forced-choice options are very gender stereotyped. A more nuanced and less stereotypical description might cause people to be more inclined toward the stigma or gift frameworks.

It is important to note that the Precoital Behaviour Scale does not reflect which precoital behaviours are a part of one's sexual script, sexual routine, or what one would normally do with their regular sexual partner. It only measures behaviours *prior* to and *during* first intercourse, not

the sexual behaviours that participants currently, or recently, have engaged in. Given that this scale has not been previously tested and we have no other population to compare these scores to, these scores may or may not represent what an average undergrad student would normally score. Future research should test the Precoital Behaviour Scale to determine what an average score would be in a given population. It is possible that more intimate behaviours (such as anal sex and the use of sex toys) are practiced more frequently, once one is more comfortable with their partner (Kaestle & Halpern, 2007).

The Precoital Behaviour Scale (PBS) was created for this study and needs to be supported with further validating data. The PBS should be tested on different populations, such as virgins and the LGBT community. Future research should examine the PSB scale more closely.

In addition, the order of the sexual behaviours listed in the PSB scale is unknown. Therefore, other sexual behaviours could have been performed after penetration (e.g. oral sex to orgasm after intercourse). Future research should examine the sequence of events during FSI to potentially identify an *ordered* sexual script.

Conclusion

This study sought to understand the relationship between cognitive virginity scripts and precoital sexual behaviour. It provided an understanding of how different factors can affect precoital behaviour. Furthermore, it extended Carpenter's (2001, 2005) research by demonstrating that the three frameworks differ on constructs such as sexual sensation seeking, motivation for erotic arousal, sexual compatibility, comfort with sexuality and approach to sexual relationships. In short, the findings of this study support that the virginity scripts influence factors relating to sexuality, and both past *and* current sexual behaviour.

Precoital behaviour prior to be virginity loss is normative and should be considered an integral aspect of adolescent identity formation (Tolman & McClelland, 2011). Sexuality should be viewed as a developmental and continuous phenomenon, and adolescent sexual behaviour should be expected rather than viewed as problematic. Viewing virginity loss as an opportunity for growth, learning and development lends to positive and sexually satisfying first sexual experiences for both partners (Carpenter, 2002) and can have an important impact on lifelong sexual development. The implication of these findings suggests that reframing virginity loss as a step in the *process* of growing up is empowering to both genders and encourages healthy sexual exploration.

Learning about precoital activity also has important implications for sexual health research and *comprehensive* sexual education. Sexual educators ought to encourage youth to practice agency in their first sexual experiences. Young adults must possess the language and communication skills to advocate for their own bodies and sexuality, which could contribute to empowering and transformative first sexual experiences. Sexual education in most schools has focused on the negative repercussions of sex in attempts to *scare* teens into abstaining from it.

The social discourse of sexuality as victimization emphasizes the physical, social and emotional risks of intimacy, especially for women (Tsui & Nicoladis, 2004; Fine, 1997). A more helpful approach to sexuality would be the *social discourse of desire* which encourages teens to be independent and make wise decisions regarding their personal boundaries in sexual relationships (Tsui & Nicoladis, 2004; Fine, 1997). Sexual health educators need to be aware that precoital sexual behaviour is common and allow teens to feel comfortable asking questions when needed.

This study helped to shed light on how virginity scripts influence sexual behaviour. Past research often focuses on sexual intercourse and discounts the importance of precoital behaviour on sexual development. Although this study does not address all the factors related to precoital behaviour, it provides possible explanations for patterns in precoital sexual development and provides direction for future sexual education, which should foster the development of the *process* virginity script in youth.

References

Alksnis, C., Desmarais, S., & Wood, E. (1996). Gender differences in scripts for different types of dates. *Sex Roles*, 321-336.

Averett, P., Moore, A., & Price, L. (2014). Virginity definitions and meaning among the LGBT community. *Journal of Gay and Lesbian Social Services*, 259-278. doi: 10.1080/10538720.2014.924802.

Beres, M. (2014). Points of convergence: Introducing sexual scripting theory to discourse approaches to the study of sexuality. *Sexuality & Culture*, 76-88. doi: 10.1007/s12119-013-9176-3.

Bersamin, M. M., Fisher, D. A., Walker, S., Hill, D. L., & Grube, J. W. (2007). Defining virginity and abstinence: Adolescents' interepretations of sexual behaviors. *Journal of Adolescent Health, 41*, 182-188. doi: 10.1016/j.jadohealth.2007.03.011.

Carpenter, L. (2001). The amibuity of "having sex": The subjective experience of virginity loss in the United States. *The Journal of Sex Research*, *38*(2), 127-139.

Carpenter, L. (2002). Gender and the meaning and xxperience of virginity loss in the contemporary United States. *Gender and Society*, 345-365.

Carpenter, L. (2005). *Virginity Lost.* New York: New York University Press .

Eriksson, E., & Humphreys, T. (2013). Development of the Virginity Beliefs Scale. *Journal of Sex Research*, 1-14. doi: 10.1080/ 00224499.2012.724475.

Fisher, T., Davis, C., Yarber, W., & Davis, S. (2010). *Handbook of Sexuality-Related Measures.* Taylor & Francis.

Halpern-Felsher, B., Cornell, J., Kropp, R., & Tschann, J. (2005). Oral versus vaginal sex among adolescents: Perceptions, attitudes, and behaviour. *Pediatrics*, 845-851. doi: 10.1542/ peds.2004-2108. doi: 10.1542/peds.2004-2108.

Haydon, A. A., Herring, A. H., Prinstein, M. J., & Halpern, C. T. (2012). Beyond age at first sex: Patterns of emerging sexual behavior in adolescence and young adulthood. *Journal of Adolescent Health, 50*, 456-463. doi: 10.1016/j.jadohealth.2011.09.006.

Heisler, J. (2014). They need to sow their wild oats: Mothers' recalled memorable messages to their emerging adult children regarding sexuality and dating. *Emerging Adulthood*, 280-293. doi: 10.1177/216.7696814550196.

Hill, C. (1997). The Distinctiveness of sexual motives in relation to sexual desire and desirable partner attributes. *The Journal of Sex Research*, 139-153.

Holland, J., Ramazanoglu, C., Sharpe, S., & Thomson, R. (2010). Deconstructing virginity-young people's accounts of first sex. *Sexual and Relationship Therapy*, 351-362. doi: 10.1080/14681994.2010.496970.

Humphreys, T. P. (2013). Cognitive frameworks of virginity and first intercourse. *Journal of Sex Research*, 1-12. doi: 10.1080/ 00224499.2012.677868.

Kaestle, C., & Halpern, C. (2007). What's love got to do with it? Sexual behaviors of opposite-sex couples through emerging adulthood. *Perspectives on Sexual and Reproductive Health*, 134-139. doi: 10.1363/3913407.

Kalichman, S., & Rompa, D. (1995). Sexual sensation seeking and sexual compulsivity scales: Reliability, validity, and predicting HIV risk behavior. *Journal of Personality Assessment*, 586-601.

Kelly, M. (2010). Virginity loss narratives in "teen drama" television programs. *Journal of Sex Research*, 479-489. doi: 10.1080/00224490903132044.

Lindberg, L. D., Jones, R., & Santelli, J. S. (2008). Noncoital sexual activities among adolescents. *Journal of Adolescent Health, 43*, 231-238. doi: 10.1016/j.jadohealth.2007.12.010.

McCormick, N. (2010). Preface to sexual scripts: social and therapeutic implications. *Sexual and Relationship Therapy* , 91-95. doi: 10.1080/14681990903563707.

McIntire, S., & Miller, L. (2007). *Foundations of Psychological Testing.* California: Sage Publications.

McKay, A. (2004). Oral sex among teenagers: Research, discourse, and education. *The Canadian Journal of Human Sexuality*, 201-203.

Miller, K., Clark, L., Wendell, D., Levin, M., Gray-Ray, P., Velez, C., & Webber, M. (1997). Adolescent heterosexual experience: A new typology. *Journal of Adolescent Health*, 179-186.

O'Sullivan, L., Cheng, M., Harris, K., & Brooks-Gunn, J. (2007). I wanna hold your hand: The progression of social, romantic and sexual events in adolescent relationships. *Perspectives on Sexual and Reproductive Health*, 100-107. doi: 10.1363/3910007.

Schuster, M., Bell, R., & Kanouse, D. (1996). The sexual practices of adolescent virgins: Genital sexual activites of high school students who have never had vaginal intercourse. *American Journal of Public Health*, 1570-1576.

Schwartz, I. M. (1999). Sexual activity prior to coital initiation: A comparison between males and females. *Archives of Sexual Behaviour, 28*(1), 63-69.

Simon, W., & Gagnon, J. (1984). Sexual scripts. *Society*, 53-60.

Spencer, J. M., Zimet, G. D., Aalsma, M. C., & Orr, D. P. (2002). Self-Esteem as a predictor of initiation of coitus in early adolescents. *Pediatrics, 109*(4), 581-584.

Tolman, D., & McClelland, S. (2011). Normative sexuality development in adolescence: A decade in review, 2000-2009. *Journal of Research on Adolescence*, 242-255. doi: 10.1111/j.1532-7795.2010.00726.x.

Tsui, L., & Nicoladis, E. (2004). Losing it: Similarities and differences in first intercourse experinces of men and women. *The Canadian Journal of Human Sexuality, 32*(2), 95-106.

Uecker, J. E., Angotti, N., & Regnerus, M. D. (2008). Going most of the way: "Technical virginity" amoung American adolescents. *Social Science Research, 37*, 1200-1215. doi: 10.1016/j.ssresearch.2007.09.006.

Whittier, D., & Simon, W. (2001). The Fuzzy matrix of "my type" in intrapsychic sexual scripting. *Sexualities*, 139-164.

Widman, L., Welsh, D., McNulty, J., & Little, K. (2006). Sexual communication and contraceptive use in adolescent dating couples. *Journal of Adolescent Health*, 893-899. doi: 10.1080/00224499.2013.843148.

Wiederman, M. (2005). The gendered nature of sexual scripts. *The Family Journal: Counseling and Therapy for Couples and Families*, 496-502. doi: 10.1177/1066480705278729.

Zamboni, B., & Crawford, I. (2002). Using masturbation in sex therapy: Relationships between masturbation, sexual desire and sexual fantasy. *Journal of Psychology and Human Sexuality*, 123-141.

Appendix A

Table 1.

Descriptive Statistics of Sample Demographics

Variable	Total *n*	%	Missing
Gender			1
Women	215	87	
Men	32	13	
Sexual orientation			1
Heterosexual	247	99.6	
Virginity status			
Nonvirgin	248	100	
Degree program			
BA	90	36.3	
BSc	90	36.3	
BBA	9	3.6	
BSN	28	11.3	
Bed	7	2.8	
Other	24	9.7	
Year of University			
1	146	58.9	
2	61	24.6	
3	26	10.5	
4	14	5.6	
5	1	0.4	
Religiosity			
Attendance at church			1
Never	118	47.8	
Once a year	44	17.8	
Few times a year	57	23.1	
Few times a month	14	5.7	
Once a week	12	4.9	
More than once a week	2	0.8	
Private prayer			1
Never	159	64.4	
Few times a year	30	12.1	

	Total (n)	%
Few times a month	19	7.7
Once a week	8	3.2
More than once a week	22	8.9
More than once a day	9	3.6
Current relationship status		
Single	52	21
Casual with >1 person	14	5.6
Casual with 1 person	25	10.1
Serious with 1 person	131	52.8
Engaged or cohabitating	13	5.2
married	13	5.2

Note: N= 248.

Table 2.

Descriptive Statistics of FSI by Gender

	Total		Missing	Men		Women	
Variable	*n*	%		*n*	%	*n*	%
Forced FW			3				
Gift	76	31.3		6	18.8	70	32.9
Stigma	22	8.9		5	15.6	17	8
Process	147	59.8		21	65.6	126	59.2
Partner's first time			1				
Yes	114	46.2		22	68.8	91	42.5
No	129	52.2		9	28.1	120	56.1
Do not know	4	1.6		1	3.1	3	1.4
Nature of Relationship			3				
Romantic/ lover	184	75.1		23	71.9	161	75.6
Friend/ companion	46	18.8		9	28.1	37	17.4
Stranger/ acquaintance	15	6.1		0	0	15	7
Feelings for partner			5				
Love	141	57.8		18	56.3	123	58.3
Like	78	32		12	37.5	65	30.8
Friendship	14	5.7		1	3.1	13	6.2
Indifference	11	4.5		1	3.1	10	4.7
Dislike	0	0		0	0	0	0
Length of relationship before FSI			7				
Hours or days	19	7.9		2	6.3	17	8.1
1-3 weeks	22	9.1		7	21.9	15	9.1
1-3 months	70	28.9		8	25	62	29
4-6 months	53	21.9		3	9.4	49	21.6

	Total		Missing	Men		Women	
	n	%		n	%	n	%
7+ months	78	32.2		12	37.5	66	32.4
Desire intercourse again			8				
Yes	200	83.3		30	96.8	169	81.3
No	40	16.7		1	3.2	39	18.8
Length of relationship after FSI			1				
Hours or days	22	8.9		2	6.3	20	9.3
1-3 weeks	24	9.7		5	15.6	19	8.9
1-3 months	33	13.4		6	18.8	26	12.1
4-6 months	23	9.3		1	3.1	22	10.3
7+ months	72	29.1		10	31.3	62	29
Still together	73	29.6		8	25	65	30.4
Drinking alcohol prior to virginity loss			2				
Yes	40	16.2		1	3.1	39	18.2
No	207	83.3		31	96.9	175	81.8
This influenced my decision			209				
Yes	19	46.3		1	100	18	45
No	20	48.8		0	0	20	50
Form of birth control used (more than one option)							
Condom	196	79.4		27	55.1	169	53.4
Pill	99	39.9		13	26.5	86	27.2
Depo	3	1.2		0	0	3	0.9
IUD	1	0.4		0	0	1	0.03
Diaphragm	0	0		0	0	0	0
Norplant	0	0		0	0	0	0
Spermacide	6	2.4		2	4	4	1.2
Withdrawal	35	14.1		4	8.1	31	9.8
None used	23	9.3		2	4	21	6.6
Other	2	0.8		1	2	1	0.03

Note: N= 248.

Table 3.

Descriptive Statistics of FSI by Framework

	Forced-Choice					
	Gift		Stigma		Process	
Variable	*n*	%	*n*	%	*n*	%
Partner's first time						
Yes	41	53.2	6	68.2	66	53.4
No	35	45.5	15	27.3	78	45.2
Do not know	1	1.3	1	4.5	2	1.4
Nature of Relationship						
Romantic/ lover	69	90.8	9	42.9	104	71.2
Friend/ companion	5	6.6	5	23.8	36	24.7
Stranger/ acquaintance	2	2.6	7	33.3	6	4.1
Feelings for partner						
Love	57	76	4	18.2	79	54.5
Like	15	20	10	45.5	52	35.9
Friendship	2	2.7	2	9.1	10	6.9
Indifference	1	1.3	6	27.3	4	2.8
Dislike	0	0	0	0	0	0
Length of relationship before FSI						
Hours or days	3	4.1	9	40.9	7	4.8
1-3 weeks	2	2.7	7	31.8	13	9
1-3 months	16	21.9	1	4.5	52	35.9
4-6 months	25	34.2	4	18.2	24	16.6
7+ months	27	37	1	4.5	49	33.8
Desire intercourse again						
Yes	69	94.5	16	72.7	113	79
No	4	5.5	6	27.3	30	21
Length of relationship after FSI						
Hours or days	3	3.9	8	36.4	11	7.5
1-3 weeks	5	6.5	2	9.1	17	11.6
1-3 months	6	7.8	1	4.5	26	17.8
4-6 months	6	7.8	0	0	17	11.6
7+ months	25	32.5	3	13.6	44	30.1
Still together	32	41.6	8	36.4	31	21.2

	Gift		Stigma		Process	
	n	%	n	%	n	%
Drinking alcohol prior to virginity loss						
Yes	6	7.8	9	40.9	25	17.1
No	71	92.2	13	59.1	121	82.9
This influenced my decision						
Yes	3	50	5	55.6	11	42.3
No	3	50	4	44.4	13	50
Form of birth control used (more than one option)						
Condom	57	51.4	20	64.5	118	53.4
Pill	31	27.9	6	19.4	61	27.6
Depo	1	0.9	0	0	2	0.9
IUD	0	0	0	0	1	0.4
Diaphragm	0	0	0	0	0	0
Norplant	0	0	0	0	0	0
Spermacide	2	1.8	1	3.2	3	1.3
Withdrawal	10	9	3	9.6	22	9.9
None used	10	9	0	0	13	5.8
Other	0	0	1	3.2	1	0.4

Note: N= 248.

FSI= first sexual intercourse
percentages represent breakdown of groups

Table 4. Part 1 of 5

Descriptive Statistics of Precoital Behaviour prior to FSI- Total Sample

Variable	Total (*n*)	%	Missing	*M*	*SD*
1. Masturbated privately			0	2.23	1.6
Never	65	26.2			
Once	12	4.8			
Rarely	44	17.7			
Occasionally	70	28.2			
Frequently	42	16.9			
Very frequently	15	6			
2. Kissing without tongue			0	3.56	1.23
Never	6	2.4			
Once	10	4			
Rarely	29	11.7			
Occasionally	59	23.8			
Frequently	82	33.1			
Very frequently	62	25			
3. Kissing with tongue			1	3.53	1.21
Never	10	4			
Once	6	2.4			
Rarely	19	7.7			
Occasionally	71	28			
Frequently	89	36			
Very frequently	52	21.1			
4. Caressing a female's breast (performed or received)			1	2.78	1.45
Never	30	12.1			
Once	16	6.5			
Rarely	38	15.4			
Occasionally	81	32.8			
Frequently	58	23.5			
Very frequently	24	9.7			

Note: N = 248.
Precoital Behaviour Scale items used to create statistics
FSI= first sexual intercourse

Table 4. Part 2 of 5

Variable	Total (n)	%	Missing	M	SD
5. Partner manually stimulated my genitals			0	2.83	1.44
Never	31	12.5			
Once	11	4.4			
Rarely	39	15.7			
Occasionally	76	30.6			
Frequently	69	27.8			
Very frequently	22	8.9			
6. Manually stimulated my partner's genitals			0	2.87	1.49
Never	31	12.5			
Once	15	6			
Rarely	34	13.7			
Occasionally	70	28.2			
Frequently	72	29			
Very frequently	26	10.5			
7. Partner manually stimulated my genitals to orgasm			2	1.89	1.69
Never	91	37			
Once	12	4.9			
Rarely	40	16.3			
Occasionally	55	22.4			
Frequently	33	13.4			
Very frequently	15	6.1			
8. Manually stimulated my partner's genitals to orgasm			1	2.48	1.67
Never	60	24.3			
Once	11	4.5			
Rarely	28	11.3			
Occasionally	68	27.5			
Frequently	59	23.9			
Very frequently	21	8.5			

Table 4. Part 3 of 5

Variable	Total (n)	%	Missing	M	SD
9. Performed oral sex			1	2.29	1.65
Never	62	25.1			
Once	17	6.9			
Rarely	41	16.6			
Occasionally	62	25.1			
Frequently	45	18.2			
Very frequently	20	8.1			
10. Received oral sex			3	1.94	1.58
Never	78	31.8			
Once	15	6.1			
Rarely	48	19.6			
Occasionally	59	24.1			
Frequently	37	15.1			
Very frequently	8	3.3			
11. Performed oral sex to orgasm			2	2	1.75
Never	91	37			
Once	9	3.7			
Rarely	32	13			
Occasionally	57	23.2			
Frequently	38	15.4			
Very frequently	19	7.7			
12. Received oral sex to orgasm			3	1.36	1.64
Never	134	54.7			
Once	6	2.4			
Rarely	31	12.7			
Occasionally	41	16.7			
Frequently	24	9.8			
Very frequently	9	3.7			

Table 4. Part 4 of 5

Variable	Total (n)	%	Missing	M	SD
13. Partner manually stimulated my anus			1	0.23	0.81
Never	222	89.9			
Once	10	4			
Rarely	6	2.4			
Occasionally	3	1.2			
Frequently	4	1.6			
Very frequently	2	0.8			
14. Manually stimulated my partner's anus			0	0.17	0.57
Never	226	91			
Once	5	2			
Rarely	14	5.6			
Occasionally	3	1.2			
Frequently	0	0			
Very frequently	0	0			
15. Partner orally stimulated my anus			2	0.1	0.5
Never	235	95.5			
Once	4	1.6			
Rarely	2	0.8			
Occasionally	4	1.6			
Frequently	1	0.4			
Very frequently	0	0			
16. Orally stimulated my partner's anus			2	0.08	0.46
Never	237	96.3			
Once	3	1.2			
Rarely	2	0.8			
Occasionally	3	1.2			
Frequently	1	0.4			
Very frequently	0	0			

Table 4. Part 5 of 5

Variable	Total (n)	%	Missing	M	SD
17. Stimulated my partner's genitals using a sex toy			2	0.17	0.65
Never	227	92.3			
Once	5	2			
Rarely	8	3.3			
Occasionally	3	1.2			
Frequently	3	1.2			
Very frequently	0	0			
18. Partner stimulated my genitals using a sex toy			2	0.23	0.77
Never	223	90.7			
Once	4	1.6			
Rarely	9	3.7			
Occasionally	6	2.4			
Frequently	4	1.6			
Very frequently	0	0			
19. Received/ performed anal penetration			3	0.15	0.54
Never	223	91			
Once	11	4.5			
Rarely	8	3.3			
Occasionally	2	0.8			
Frequently	1	0.4			
Very frequently	0	0			
20. Received/ performed anal penetration to orgasm			1	0.08	0.39
Never	235	95.1			
Once	5	2			
Rarely	6	2.4			
Occasionally	1	0.4			
Frequently	0	0			
Very frequently	0	0			
PSB_A total score				30.53	14.32

Table 5.

Framework Correlations by Precoital Behaviour prior to FSI

	Gift	Stigma	Process
Masturbated privately	-.08	.17**	.22**
Kissing without tongue	.24**	-.16*	.17**
Kissing with tongue	.11	-.14*	.12
Caressing a female's breast	.14*	-.04	.17**
Partner manually stimulated my genitals	.22**	-.13	.10
Manually stimulated my partner's genitals	.23**	-.10	.05
Partner manually stimulated my genitals to orgasm	.20**	-.10	.06
Manually stimulated my partner's genitals to orgasm	.21**	-.10	.02
Performed oral sex	.20**	-.07	.04
Received oral sex	.19**	-.08	.05
Performed oral sex to orgasm	.18**	-.09	.01
Received oral sex to orgasm	.16*	-.04	.05

Note: N = 248.

Given the small number of individuals who endorsed items 13-20, these items were not reported in any subsequent analyses.

FSI = first sexual intercourse

Table 6

Descriptive Statistics of Precoital Behaviour prior to FSI- Gender Comparisons

	Men		Women	
Variable	*M*	*SD*	*M*	*SD*
1. Masturbated privately	3.63	1.01	2.02	1.56
2. Kissing without tongue	3.38	1.26	3.6	1.22
3. Kissing with tongue	3.38	1.26	3.56	1.18
4. Caressing a female's breast (performed or received)	3.2	1.5	2.72	1.44
5. Partner manually stimulated my genitals	3.03	1.47	2.8	1.44
6. Manually stimulated my partner's genitals	3.06	1.54	2.84	1.48
7. Partner manually stimulated my genitals to orgasm	2.63	1.81	1.77	1.64
8. Manually stimulated my partner's genitals to orgasm	2.6	1.74	2.46	1.67
9. Performed oral sex	1.91	1.78	2.34	1.62
10. Received oral sex	2.61	1.67	1.84	1.54
11. Performed oral sex to orgasm	1.69	1.87	2.04	1.74
12. Received oral sex to orgasm	2.23	1.91	1.22	1.56

Note: N = 248.

Given the small number of individuals who endorsed items 13-20, these items were not reported in any subsequent analyses.

FSI = first sexual intercourse

Table 7.

Precoital Behaviour prior to FSI- Gender Comparisons

Variable	*t*	*df*	*p*	Confidence intervals *lower*	*upper*	*Cohen's d*	*Effect size r*
1. Masturbated privately	7.37	53.13	.00**	-1.61	-1.60	1.22	0.52
2. Kissing without tongue	0.95	245	0.35	0.22	0.22	-0.17	-0.09
3. Kissing with tongue	0.81	244	0.42	0.18	0.19	-0.15	-0.07
4. Caressing a female's breast (performed or received)	-1.70	244	0.09	-0.48	-0.47	0.33	0.16
5. Partner manually stimulated my genitals	-0.82	245	0.41	-0.23	-0.22	0.16	0.08
6. Manually stimulated my partner's genitals	-0.80	245	0.43	-0.23	-0.22	0.15	0.07
7. Partner manually stimulated my genitals to orgasm	-2.70	243	0.01*	-0.86	-0.85	0.50	0.24
8. Manually stimulated my partner's genitals to orgasm	-0.43	244	0.67	-0.14	-0.13	0.08	0.04
9. Performed oral sex	1.40	244	0.17	0.43	0.44	-0.25	-0.13
10. Received oral sex	-2.58	242	0.01*	-0.78	-0.77	0.48	0.23
11. Performed oral sex to orgasm	1.05	243	0.29	0.35	0.35	-0.19	-0.10
12. Received oral sex to orgasm	-2.80	36.09	0.01*	-1.01	-1.00	0.58	0.28
PSB_A total score	-1.65	223	0.1	-4.75	-4.68	0.31	0.15

Precoital Behaviour Scale used to create statistics.

*p < .05, ** p < .01

Given the small number of individuals who endorsed items 13-20, these items were not reported in any subsequent analyses.

df adjusted for Levene's violation

Table 8. Part 1 of 5

Descriptive Statistics of Precoital Behaviour during FSI- Total Sample

Variable	Total (*n*)	%	Missing	*M*	*SD*
1. Masturbated privately			1	1.03	1.55
Never	158	64			
Once	14	5.7			
Rarely	21	8.5			
Occasionally	26	10.5			
Frequently	20	8.1			
Very frequently	8	3.2			
2. Kissing without tongue			0	3.65	1.17
Never	5	2			
Once	7	2.8			
Rarely	26	10.5			
Occasionally	59	23.8			
Frequently	86	34.7			
Very frequently	65	26.2			
3. Kissing with tongue			1	4.19	0.98
Never	2	0.8			
Once	3	1.2			
Rarely	9	3.6			
Occasionally	34	13.7			
Frequently	84	33.9			
Very frequently	116	46.8			
4. Caressing a female's breast (performed or received)			0	3.69	1.33
Never	12	4.9			
Once	7	2.8			
Rarely	18	7.3			
Occasionally	51	20.6			
Frequently	80	34.2			
Very frequently	79	32			

Note: N = 248.
Precoital Behaviour Scale items used to create statistics
FSI= first sexual intercourse

Table 8. Part 2 of 5

Variable	Total (n)	%	Missing	M	SD
5. Partner manually stimulated my genitals			1	3.49	1.4
Never	17	6.9			
Once	7	2.8			
Rarely	22	8.9			
Occasionally	57	23.1			
Frequently	80	32.4			
Very frequently	64	25.9			
6. Manually stimulated my partner's genitals			2	3.4	1.5
Never	23	9.3			
Once	8	3.3			
Rarely	19	7.7			
Occasionally	58	23.6			
Frequently	73	29.7			
Very frequently	65	26.4			
7. Partner manually stimulated my genitals to orgasm			3	1.82	1.86
Never	109	44.5			
Once	13	5.3			
Rarely	21	8.6			
Occasionally	39	15.9			
Frequently	40	16.3			
Very frequently	23	9.4			
8. Manually stimulated my partner's genitals to orgasm			0	2.06	1.92
Never	101	40.7			
Once	10	4			
Rarely	15	6			
Occasionally	48	19.4			
Frequently	43	17.3			
Very frequently	31	12.5			

Table 8. Part 3 of 5

Variable	Total (n)	%	Missing	M	SD
9. Performed oral sex	73	29.4	0	2.36	1.84
Never	19	7.7			
Once	18	7.3			
Rarely	56	22.6			
Occasionally	48	19.4			
Frequently	34	13.7			
Very frequently	73	29.4			
10. Received oral sex			1	2.05	1.78
Never	79	32			
Once	32	13			
Rarely	25	10.1			
Occasionally	43	17.4			
Frequently	45	18.2			
Very frequently	23	9.3			
11. Performed oral sex to orgasm			0	1.62	1.85
Never	127	51.2			
Once	12	4.8			
Rarely	11	4.4			
Occasionally	43	17.3			
Frequently	36	14.5			
Very frequently	19	7.7			
12. Received oral sex to orgasm			2	1.21	1.65
Never	147	59.8			
Once	9	3.7			
Rarely	26	10.6			
Occasionally	32	13			
Frequently	19	7.7			
Very frequently	13	5.3			

Table 8. Part 4 of 5

Variable	Total (n)	%	Missing	M	SD
13. Partner manually stimulated my anus			2	0.22	0.82
Never	225	91.5			
Once	4	1.6			
Rarely	7	2.8			
Occasionally	6	2.4			
Frequently	1	0.4			
Very frequently	3	1.2			
14. Manually stimulated my partner's anus			2	0.16	0.67
Never	230	93.5			
Once	3	1.2			
Rarely	7	2.8			
Occasionally	3	1.2			
Frequently	2	0.8			
Very frequently	1	0.4			
15. Partner orally stimulated my anus			1	0.13	0.65
Never	236	95.5			
Once	2	0.8			
Rarely	3	1.2			
Occasionally	3	1.2			
Frequently	1	0.4			
Very frequently	2	0.8			
16. Orally stimulated my partner's anus			1	0.11	0.58
Never	237	96			
Once	3	1.2			
Rarely	1	0.4			
Occasionally	4	1.6			
Frequently	1	0.4			
Very frequently	1	0.4			

Table 8. Part 5 of 5

Variable	Total (n)	%	Missing	M	SD
17. Stimulated my partner's genitals using a sex toy			1	0.12	0.63
Never	236	95.5			
Once	2	0.8			
Rarely	3	1.2			
Occasionally	4	1.6			
Frequently	0	0			
Very frequently	2	0.8			
18. Partner stimulated my genitals using a sex toy			1	0.21	0.8
Never	228	92.3			
Once	4	1.6			
Rarely	5	2			
Occasionally	6	2.4			
Frequently	1	0.4			
Very frequently	3	1.2			
19. Received/ performed anal penetration			0	0.14	0.64
Never	232	93.5			
Once	6	2.4			
Rarely	6	2.4			
Occasionally	1	0.4			
Frequently	1	0.4			
Very frequently	2	0.8			
20. Received/ performed anal penetration to orgasm			1	0.12	0.62
Never	236	95.5			
Once	3	1.2			
Rarely	3	1.2			
Occasionally	2	0.8			
Frequently	1	0.4			
Very frequently	2	0.8			
PSB_B total score				31.36	13.76

Table 9.

Framework Correlations by Precoital Behaviour during FSI

	Gift	Stigma	Process
Masturbated privately	.02	.15*	.08
Kissing without tongue	.21**	-.22**	.03
Kissing with tongue	.13*	-.13*	.16*
Caressing a female's breast	.19**	-.09	.12
Partner manually stimulated my genitals	.17**	-.12	.12
Manually stimulated my partner's genitals	.26**	-.12	.20
Partner manually stimulated my genitals to orgasm	.18**	-.05	.04
Manually stimulated my partner's genitals to orgasm	.17**	-.03	.01
Performed oral sex	.20**	-.10	.04
Received oral sex	.19**	-.06	.05
Performed oral sex to orgasm	.16*	-.06	-.04
Received oral sex to orgasm	.18**	-.05	.01

Note: N = 248.

FSI = first sexual intercourse

Given the small number of individuals who endorsed items 13-20, these items were not reported in any subsequent analyses.

Table 10

Descriptive Statistics of Precoital Behaviour during FSI- Gender Comparisons

	Men		Women	
Variable	*M*	*SD*	*M*	*SD*
1. Masturbated privately	1.94	1.83	0.88	1.46
2. Kissing without tongue	3.44	1.34	3.68	1.15
3. Kissing with tongue	3.66	1.26	4.27	0.9
4. Caressing a female's breast (performed or received)	3.75	1.14	3.68	1.36
5. Partner manually stimulated my genitals	3.34	1.36	3.51	1.41
6. Manually stimulated my partner's genitals	3.47	1.3	3.39	1.53
7. Partner manually stimulated my genitals to orgasm	2.16	1.8	1.77	1.88
8. Manually stimulated my partner's genitals to orgasm	2.13	1.86	2.05	1.94
9. Performed oral sex	2.09	1.87	2.4	1.84
10. Received oral sex	2.69	1.67	1.95	1.78
11. Performed oral sex to orgasm	1.56	1.81	1.62	1.86
12. Received oral sex to orgasm	1.81	1.8	1.11	1.61
PSB_B total score	32.69	12.93	31.01	13.79

Note: N = 248.

FSI = first sexual intercourse

Given the small number of individuals who endorsed items 13-20, these items were not reported in any subsequent analyses.

Table 11.

Precoital Behaviour during FSI- Gender Comparisons

Variable	*t*	*df*	*p*	Confidence intervals *lower*	*upper*	*Cohen's d*	*Effect size r*
1. Masturbated privately	-3.11	37.10	0.00**	-1.97	-0.14	0.64	0.3
2. Kissing without tongue	1.11	245	0.27	-0.33	0.82	-0.19	-0.1
3. Kissing with tongue	2.68	35.90	0.01*	-0.01	1.25	-0.56	-0.27
4. Caressing a female's breast (performed or received)	-0.27	244	0.79	-0.72	0.59	0.06	0.03
5. Partner manually stimulated my genitals	0.64	244	0.52	-0.52	0.86	-0.12	-0.06
6. Manually stimulated my partner's genitals	-0.26	243	0.80	-0.82	0.67	0.06	0.03
7. Partner manually stimulated my genitals to orgasm	-1.10	242	0.28	-1.31	0.53	0.21	0.11
8. Manually stimulated my partner's genitals to orgasm	-0.22	245	0.83	-1.03	0.87	0.04	0.02
9. Performed oral sex	0.87	245	0.39	-0.60	1.21	-0.17	-0.08
10. Received oral sex	-2.21	244	0.03*	-1.61	0.13	0.43	0.21
11. Performed oral sex to orgasm	0.17	245	0.86	-0.85	0.97	-0.03	-0.02
12. Received oral sex to orgasm	-2.25	243	0.03*	-1.51	0.11	0.41	0.2
PSB_B total score	-0.65	231	0.52	-6.805	3.45	0.13	0.06

Precoital Behaviour Scale used to create statistics.

*p < .05, **p < .01

Given the small number of individuals who endorsed items 13-20, these items were not reported in any subsequent analyses.

df adjusted for Levene's violation

Table 12.

Hypotheses Statistics by Framework- SSSS, Comfort + Compatibility

						ForcedFW				Gender			
	Total		Missing	Gift		Stigma		Process		Men		Women	
Variable	*M*	*SD*		*M*	*SD*	*M*	*SD*	*M*	*SD*	*M*	*SD*	*M*	*SD*
Partnered PSB	28.35	14.09	22	29.57	14.42	25.06	15.03	27.85	13.58	30.96	16.31	27.83	13.64
Solo Masturbation	2.23	1.6	0	2.04	1.59	2.5	1.66	2.31	1.6	3.63	1.07	2.02	1.57
Number of sexual partners	4.58	6.24	0	2.87	3.61	5.95	9.92	5.31	6.5	7.44	10.23	4.15	5.32
Number of foreplay partners	3.5	4.24	0	2.12	2.73	5.18	4.59	3.99	4.67	4.06	5.66	3.41	4.01
SSSS score	2.34	0.51	7	2.21	0.56	2.47	0.5	2.38	0.48	2.47	0.86	2.32	0.5
Comfort score	4.55	0.78	3	4.4	0.89	4.33	0.71	4.65	0.71	4.54	0.86	4.56	0.76
Compatibility	3	0.62	22	3.07	0.61	2.46	0.6	2.91	0.6	3.15	0.52	2.9	0.63

Table 13.

Framework Correlations with AMORE

Variable	Gift	Stigma	Process
AMORE subscale			
Feel value	0.18**	0.08	0.30**
Express value	0.32**	-0.20**	0.20**
Relieve stress	0.02	0.17*	0.19**
Provide comfort	0.20**	0.06	0.25**
Enhance power	0.02	0.23**	0.27**
Experience power	0.05	0.10	0.14**
Pleasure	0.04	0.09	0.32**
Procreate	-0.02	0.05	-0.08

Note: N = 248.

VBS subscales were used in the analysis

* p < .05, ** p < .01

Table 14.

Framework Correlations with MSAQ

Variable	Gift	Stigma	Process
MSAQ subscale			
Romantic	0.22**	-0.17*	0.08
Game-playing	-0.40**	0.30**	-0.03
Friendship	0.39**	-0.16*	0.16*
Practical	0.29**	0.00	0.05
Possessive	0.17*	0.07	0.21**
Selfless	0.13	0.09	0.15*
Caring	0.22**	-0.17**	0.24**
Exchange	0.03	0.19**	0.19**

Note: N = 248.

VBS subscales were used in the analysis

* p < .05, ** p < .01

Appendix B

TRENT UNIVERSITY: **PROJECT SUMMARY**

PROJECT: FIRST SEXUAL EXPERIENCES

PRINCIPAL INVESTIGATOR: Clarissa Williams, M.A. candidate

Thank you for taking part in this study. Your participation is greatly appreciated. We would like to take this opportunity to provide you with a more in-depth understanding of the study.

As you are aware, the purpose of this study is examining first consensual sexual experience.

In past research, three types of interpretation of virginity loss have been described. People have perceived it as a *gift* (something precious to give to someone you love), a *stigma* (something negative to get rid of as soon as possible) or a *process* (something that people need to go through to develop as a person) (Carpenter, 2001). The current study hypothesized that how individuals understand their own virginity impacts their precoital experiences. For example, it may influence who they choose as a sexual partner or their attitudes about sexuality. As part of the questionnaire that you filled out today you were asked to categorize your feelings about your virgin status and then fill out numerous measures that assessed your experience with precoital sexual behaviour, sexual risk-taking and sexual history.

If you are interested more specifically in the first sexual intercourse experience and its impact, the following paper may be of interest to you:

Humphreys, T. P. (2012). Cognitive Frameworks of Virginity and First Intercourse.

Journal of Sex Research, 50(7), 664-675.

Please remember that it is normal for some people to experience uncomfortable feelings as a result of filling out questionnaires on highly sensitive issues, such as sexuality. If any of the material that you have experienced in this study has disturbed you on a personal level, to the point that you may wish to discuss it, I recommend contacting the Counselling Centre, here at Trent (705-748-1386) or visiting their website at www. trentu.ca/counseling.

Other counselling resources available in your community are listed below:

Kawartha Sexual Assault Centre	705-741-0262
Sexual Health Clinic	705-748-2021
Canadian Mental Health	705-748-6711
Community Counselling & Resource Centre	705-743-4258
Community Mental Health Crisis Response Program	705-745-6484

Please print a copy of the counseling resource information for your own record.

Thanks again for your participation!

DEPARTMENT OF PSYCHOLOGY

Project Title: FIRST SEXUAL EXPERIENCES

Participant Consent Form

PRINCIPLE INVESTIGATORs: Clarissa Williams, M.A. candidate and Terry Humphreys, PhD

INFORMATION You are invited to participate in a study on sexual activity prior to intercourse. Participation in this study involves filling out online questionnaires concerning intimate sexual experiences and emotions. This study will be asking about your sexual history (including past sexual relationships and first sexual intercourse experience), sexual attitudes, motivation for sexual behaviour, and comfort with sexuality. It is a **prerequisite** of this study that you have already experienced first sexual intercourse. At this point in the research, we are only recruiting those who identify as heterosexual. The questionnaires take approximately 30 minutes to complete.

RISKS & BENEFITS One potential risk or discomfort in this study is that some individuals may feel uncomfortable stating their sexual history and behaviours, however, please note that your responses are completely anonymous and confidential and that your data and any personal identifying information are not linked. You are free to leave any question(s) blank if you prefer not to answer. You may also withdraw from the study without penalty at any time. As a direct benefit, you will receive course credit in PSYC1020H, PSYC1030H, PSYC2016 or PSYC2017. In addition, you will have the opportunity to learn about how researchers design studies regarding psychological issues, thus enhancing your understanding of research methods. You will also be contributing to the psychological literature examining people's understanding of early sexual experiences.

CONFIDENTIALITY Your responses will be kept completely anonymous and confidential. As the study is conducted online, no paper forms will exist. It is expected that the results of this study will be reported in a psychological journal article as well as in presentations at academic conferences. Note, however, that the responses of individual participants will not be identified in any reports of this research; only aggregated data (i.e., averages from many people) will be reported. The completed questionnaires can be accessed only by the primary research (Clarissa Williams) and her supervisor (Dr. Terry Humphreys). All electronic data will be downloaded in a timely fashion, encrypted, and stored on a computer with password protection in a secure

office. All data will be destroyed seven years upon completion of this study, in accordance with the American Psychological Association guidelines.

COMPENSATION For completing today's session, participants will receive .5 research credit toward their PSYC1020H, PSYC1030H, PSYC2016 or PSYC2017 requirements. If students chose to withdraw before completing a single item on the questionnaire, they will not receive any credit. If they complete 50%, they will receive .25 credit, and if over 50%, they receive full credit (i.e. .5%) towards the grade in their respective course.

An alternative way to receive the same amount of credit is to complete a written assignment (guidelines are available through the PSYC1020H, PSYC1030H, PSYC2016 or PSYC2017 instructor).

CONTACT If you have questions about the study or the procedures, you may contact the primary researcher, Clarissa Williams, email: clarissawilliams@trentu.ca. This project has been reviewed and approved by the Research Ethics Committee. If you feel you have not been treated according to the descriptions in this form, or your rights as a participant in research have been violated during the course of this project, you may contact Karen Mauro, Certifications and Regulatory Compliance Officer, email: kmauro@trentu.ca.

CONSENT I have read and understood the preceding description. I give my voluntary **consent** to participate in this study with the understanding that I am **free to withdraw** at any time and/or omit any question(s)/procedure(s) I choose. I understand that my responses will be saved temporarily online and that they will be downloaded by one of the investigators and securely saved as an encrypted file on a password-protected computer. I also understand that withdrawal will not affect my future opportunities for research participation. I understand that I can print this consent form for my records.

Appendix C

QUESTIONNAIRES

Part I: General Demographics

1. SEX: Female Male

2. AGE: _____

3. DEGREE PROGRAM: BA BSc BBA BSN Bed

Other

4: YEAR OF UNIVERSITY: 1st year 2nd year 3rd year 4th year 5th year & beyond

5. RELIGIOSITY:

A. How often do you attend religious services or meetings?

Never Once a year A few times a year

A few times a month Once a week More than once a week

B. How often do you spend time in private religious activities such as prayer, meditation, or Bible study?

Never or rarely A few times a year A few times a month

Once a week More than once a week More than once a day

6. SEXUAL ORIENTATION

Heterosexual (sexually interested in members of the opposite sex)

Gay/ Lesbian (sexually interested in members of the same sex)

Bisexual (sexually interested in members of both women and men)

7. Have you ever willingly engaged in sexual intercourse (by that we mean penile-vaginal intercourse)?

Yes No

8. If yes, with how many partners have you had sexual intercourse (same definition as above)?

_____ partners

9. How many partners have you engaged in foreplay with prior to your first sexual intercourse partner?

_____ partners

PART II: For this questionnaire, first intercourse experience is defined as vaginal/ penile penetration. Before you begin the study, try to recall your first intercourse experience as accurately as possible. Please begin.

1. Please take a few moments to think about your first sexual intercourse experience (vaginal/ penile penetration) and write a few sentences to describe the event in as much detail as possible. For example, describe your partner's characteristics (age, relationship to you), the emotions experienced before, during and after the event, the location, the context, whether or not drugs/ alcohol were involved, etc. What was the sequence or progression of sexual behaviours?

_____

_____

_____

2. How old were you when you first experienced sexual intercourse (vaginal/ penile)? ____ years

3. How old was your partner at the time of your first sexual intercourse? _____ years

4. Was your first intercourse experience your partner's first intercourse as well?

YES NO Don't know

5. What was the nature of your relationship with your first intercourse partner?

Romantic/ Lover Friend/ Companion Stranger/ Acquaintance

6. At the time, what did you feel for your first intercourse partner?

Love Liking Friendship Indifference Dislike

7. How long had you been involved with your partner ***prior*** to having first intercourse?

Hours/ Days 1-3 Weeks 1-3 Months 4-6 Months 7+Months

8. At the time, did you desire to have intercourse with your partner again (after the first time)?

YES NO

9. How long did the relationship last after your first sexual intercourse experience?

Hours/ Days 1-3 Weeks 1-3 Months 4-6 Months 7+Months

Still together

10. What form of birth control and/or protection against sexually transmitted infections (STI) did you use during your first intercourse experience? Please click all that apply.

Condom Oral contraceptives ("the pill") Depo-Provera ("the shot") IUD (intrauterine device)

Diaphragm Norplant Spermicide Withdrawal (pulling out) None used

Other: _____

11. a) I had been drinking alcohol when I lost my virginity.

YES NO

b) If yes: I believe this influenced my decision to lose my virginity.

YES NO

Virginity Beliefs Scale

Instructions: Please think back to the first time you engaged in sexual intercourse. Indicate on the following scale how much you agree with each statement in regard to your first sexual intercourse experience.

1= strongly disagree

2= disagree

3= somewhat disagree

4= neutral

5= somewhat agree

6= agree

7= strongly agree

1. I actively tried to hide my status as a virgin.

2. I chose the person I lost my virginity to with care.

3. I planned my first time carefully.

4. I saw my virginity as a natural step in my development.

5. It was important to me that the circumstances in which I lost my virginity were perfect.

6. I felt my virginity was a burden that I needed to get rid of as soon as possible.

7. It was important to me that my first time was romantic.

8. I felt embarrassed over being a virgin.

9. I considered virginity loss as an inevitable part of growing up.

10. I dated that person I lost my virginity to for a long time before we engaged in intercourse.

11. I was worried about what others might think if they found out I was a virgin.

12. The reason I did not lose my virginity earlier was because I had not found the right partner.

13. I felt that losing my virginity was an important step in becoming a man/ woman.

14. I believed I would stay in a relationship with the person I lost my virginity to for a long time.

15. I lost my virginity later than I would have wanted.

16. I felt in love with the person I lost my virginity to.

17. I regarded my virginity as something negative.

18. My virginity was a gift to my first partner.

19. I was afraid my partner would find out that I was a virgin.

20. I planned my virginity loss with my partner.

21. I was afraid to tell my partner that I was a virgin.

22. I felt losing my virginity was a step in the transition between adolescence and becoming an adult.

Virginity Frameworks

Please indicate which description best suits your framework of virginity: _____

Gift: “I saw my virginity as something special, cherished and guarded. I believed it to be a gift that I would give to someone I loved and someone who would love

me back, someone who would appreciate receiving my gift of virginity. I was proud of my virginity."

Stigma: "I saw my virginity as a label which I was ready to get rid of, something negative and unwanted. I was embarrassed by my virginity status and did not want anyone to know about it, something I felt like hiding and lying about it."

Process: "I thought of my virginity as a stepping stone or rite of passage that everyone must go though; the starting process of sexuality, which was natural and would continue to evolve. I saw virginity as something that would disappear as I grew up and into an adult."

How confident are you with your answer on a scale from 1-10, 10 being most confident? _____

Precoital Behaviour Scale

Please complete this questionnaire twice:

First time: Which behaviours did you engage in **before** the event of your first sexual intercourse experience, i.e., sexual experience days, months, or years, with other partners prior to losing your virginity?

Second time: Which behaviours did you engage in **during** your first sexual intercourse experience, i.e., sexual behaviours minutes or hours before with your first sexual intercourse partner?

Never= 0, once= 1, rarely= 2, occasionally= 3, frequently= 4, very frequently= 5

1) masturbated privately

2) kissing without tongue (pecking on the lips)

3) kissing with tongue (making out)

4) caressing a female's breasts/ partner caressing your breasts

5) partner manually stimulated my genitals

6) manually stimulated my partner's genitals

7) partner manually stimulated my genitals to orgasm

8) manually stimulated my partner's genitals to orgasm

9) performed oral sex

10) received oral sex

11) performed oral sex to orgasm

12) received oral sex to orgasm

13) partner manually stimulated my anus

14) manually stimulated my partner's anus

15) partner orally stimulated my anus

16) orally stimulated my partner's anus

17) stimulated my partner's genitals using a sex toy

18) partner stimulated my genitals using a sex toy

19) received anal penetration/ performed anal penetration

20) received anal penetration/ performed anal penetration to orgasm

Hurlbert Index of Sexual Compatibility

Instructions: Please read the following statements and rate whether or not the statements reflect your own experiences, thoughts or feelings. Indicate the response that best fits your reaction to the statement. **Answer the questions with your first sexual intercourse partner in mind, i.e. the partner with whom you lost your virginity to.**

All of the time→ 0, Most of the time→ 1, Some of the time→ 2, Rarely→ 3, Never→ 4

1. My sexual beliefs are similar to those of my partner.
2. I think my partner understands me sexually.
3. My partner and I share the same sexual likes and dislikes.
4. I think my partner desires too much sex.
5. My partner is unwilling to do certain sexual things for me that I would like to experience.
6. I feel comfortable during sex with my partner.
7. I am sexually attracted to my partner.
8. My partner sexually pleases me.
9. My partner and I argue about the sexual aspects of our relationship.
10. My partner and I share the same level of interest in sex.
11. I would feel uncomfortable engaging in some of the sexual activities my partner desires.
12. When it comes to sex, my ideas and values are different from those of my partner.
13. I do not think I meet my partner's sexual needs.
14. My partner and I enjoy the same sexual activities.
15. When it comes to sex, my partner and I get along well.
16. I think my partner is sexually attracted to me.
17. My partner enjoys doing certain things that I dislike.

18. It is hard for me to accept my partners' views on sex.
19. In our relationship, my partner places too much importance on sex.
20. My partner and I disagree over the frequency in which we should have sex/
21. I have the same sexual values as my partner.
22. My partner and I share similar sexual fantasies.
23. Please answer rarely.
24. When it comes to sex, my partner is unwilling to do certain things that I would like to experience.
25. I think I sexually satisfy my partner.
26. My partner and I share about the same level of sexual desire.

Sexual Sensation Seeking Scale

Directions: Please read the following statements and rate whether or not the statements reflect your own experiences, thoughts or feelings.
Indicate the response that best fits your reaction to the statement:

Not at all like me= 1, Somewhat like me= 2, Often like me= 3, Very much like me= 4

1. I like the "uninhibited" sexual encounters.
2. The physical sensations are the most important thing about having sex.
3. I enjoy the sensation of intercourse without a condom.
4. My sexual partners probably think I'm a "risk taker".
5. When it comes to sex, physical attraction is more important to me than how well I know the person.
6. I enjoy the company of "sensual" people.
7. I enjoy watching "X-rated" videos.
8. I have said things that were not exactly true to get people to have sex with me.
9. I am interested in trying out new sexual experiences.
10. I feel like exploring my sexuality.
11. I like new and exciting sexual experiences and sensations.

Affective and Motivational Orientation Related to Erotic Arousal

Please be extremely honest and think about yourself very carefully when responding to each statement. There are no right or wrong answers.

This questionnaire asks you about reasons you typically experience sexual feelings or that you become interested in sexual issues or behaviours. When you experience these feelings or interests, you may or may not always act on those feelings. "Sex," "having sex," or "sexual activity" can include behaviours with another person (e.g., your partner), as well as sexual behaviour by yourself (e.g., masturbation, viewing or reading erotic materials). **"Partner" can refer to either your spouse or regular romantic partner or any individual with whom you have had sex.** If you have never had sex or are not currently involved sexually with anyone, respond to the statement below like you think you would feel if you were involved in a sexual relationship or were sexually active.

Not all reasons for being interested in sexual issues or sexual behaviour may be listed below. Many of the reasons included may not describe you well at all. If this is the case, please indicate that they are not true for you when rating them.

If a particular statement describes your typical reaction or feelings well, indicate that it is "completely true" by filling in the letter "E" on the computer sheet. If a particular statement does not describe you well or is opposite of the way you feel, indicate that it is "not at all true" by filling in the letter "A" on the computer sheet. Of course, you may choose any letter in between A and E to indicate the degree to which the statement describes you or not.

Please use the rating scale below to indicate how true or descriptive each of the following statements is for you:

A	B	C	D	E
Not at all true		Moderately true		Completely true

1. Often when I need to feel loved, I have the desire to relate to my partner sexually because sexual intimacy really makes me feel warm and cared for.

2. I enjoy having sex most intensely when I know that it will lift my partner's spirits and improve his or her outlook on life.

3. When bad or frustrating things happen to me, many times I feel like engaging in sexual fantasy or doing something sexual to try to feel better.

4. Sex is largely important to me for reproductive reasons.

5. Sexual activities and fantasies are most stimulating when my partner seems extremely self-assured and demanding during sex.

6. I find that I often feel a sense of superiority and power when I am expressing myself sexually.

7. One of the most exciting aspects of sex is the sense of power I feel in controlling the sexual pleasure and stimulation my partner experiences.

8. Often when I am engaging in sex or fantasy, the idea that children might result from sexual behaviour is extremely arousing.

9. Frequently, when I want to feel that I am cared for and that someone is concerned about me, relating to my partner sexually is one of the most satisfying ways to do so.

10. Often the most pleasurable sex I have is when it helps my partner forget about his or her problems and enjoy life a little more.

11. I find sexual behaviour and sexual fantasy most exciting when I can feel forceful and dominant with my partner.

12. Thinking about sex or engaging in sex sometimes seems to help me keep going when things get rough.

13. It is frequently very arousing when my partner gets very forceful and aggressive during sex.

14. I frequently want to have sex with my partner when I need him or her to notice or appreciate me.

15. I especially enjoy sex when my partner and I are trying to have a baby.

16. Often engaging in sex with my partner makes me feel like I have established myself as a force to be reckoned with.

17. A major reason I enjoy having sex with my partner is because I can communicate how much I care and value him or her.

18. The sensations of physical pleasure and release are major reasons that sexual activity and fantasy are so important to me.

19. Sex and sexual fantasies are most exciting when I fell like my partner has totally overpowered me and has taken complete control.

20. When I go through difficult times, I can start feeling better simply by engaging in some type of sexual fantasy or behaviour.

21. The idea of having children is not very significant in my feelings about why my sexual activity is important to me.

22. In many ways, I think engaging in sex and sexual fantasy are some of the most exciting and satisfying activities I can experience.

23. Many times it is extremely thrilling when my partner takes complete charge and begins to tell me what to do during sex.

24. I really value sexual activity as a way of enjoying myself and adding an element of adventure to my life.

25. Often I have a real need to feel dominated and possessed by my partner while we are engaged in sex or sexual fantasy.

26. One of the best ways of feeling like an important part of my partner's life is by relating to him or her sexually.

27. I feel like thinking about or engaging in sexual activity can frequently help me get through unpleasant times in my life.

28. I often feel like fantasizing about sex or expressing myself sexually when life isn't going very well and I want to feel better about myself.

29. Engaging in sexual activity is a very important way for me to experience and appreciate the personal strength and forcefulness that my partner is capable of.

30. I find it extremely exciting to be playful and to have fun when I am expressing myself sexually.

31. Thinking about sex or engaging in sexual behaviour can frequently be a source of relief from stress and pressure for me.

32. I would prefer to have sex primarily when I am interested in having a child.

33. Often when my partner is feeling down on life or unhappy about something, I like to try to make him or her feel better by sharing intimacy together sexually.

34. The experience of sexual tension and energy are in many ways the most thrilling and important aspects of sexual activity and fantasy.

35. I often feel like having sex with my partner when I need to feel understood and when I want to relate to him or her on a one-to-one level.

36. When I need to feel a sense of belongingness and connectedness, having sex with my partner is a really important way of relating to him or her.

37. Doing something sexual often seems to greatly improve my outlook on life when nothing seems to be going right.

38. I frequently feel like expressing my need for emotional closeness and intimacy by engaging in sexual behaviour or fantasy with my sexual partner.

39. Many times when I am feeling unhappy or depressed, thinking about sex or engaging in sexual activity will make me feel better.

40. When things are not going well, thinking about sex or doing something sexual is often very uplifting for me and helps me to forget about my problems for a while.

41. Engaging in sexual activity is very important to me as a means of feeling powerful and charismatic.

42. One of the main reasons I am interested in having sex is for the purpose of having children.

43. The sense of emotional bonding with my partner during sexual intercourse is an important way of feeling close to him or her.

44. One of the most satisfying aspects of engaging in sex is expressing the intensity of my feelings for my partner while we are having sex.

45. I often have a strong need to fantasize about sex or do something sexual when I feel upset or unhappy.

46. I really enjoy having sex as a way of exerting dominance and control over my partner.

47. I often find it a real turn-on when my partner takes charge and becomes authoritative during sexual activity or fantasy.

48. I am often very excited by the sense of power that I feel I have over my partner when I am sexually attractive to him or her.

49. Being able to experience my partner's physical excitement and sexual release is incredibly thrilling and stimulating for me.

50. I find it very exciting when my partner becomes very demanding and urgent during sex and sexual fantasy, as if he or she needs to possess me completely.

51. I frequently become very aroused when I sense that my partner is excited by controlling and directing our sexual activity or fantasy.

52. I frequently want to have sex with my partner because I know how much he or she enjoys it and how good it makes my partner feel as a person.

53. Expressing myself sexually generally makes me feel personally strong and in control of things.

54. I am especially excited by the feeling of domination and being controlled by my partner during sex and sexual fantasy.

55. One of the most satisfying features of sex is when my partner really seems to need the love and tenderness it conveys.

56. Often the sense of power over my partner that I have over my sexual partner can be extremely exhilarating.

57. I find it very rewarding when I can help my partner get through rough times by showing how much I care by being sexually intimate with him or her.

58. I frequently find it quite arousing to be very directive and controlling while having sex with my partner.

59. Sexual intercourse is important in creating a great deal of emotional closeness in my relationship with my partner.

60. Sharing affection and love during sexual intercourse is one of the most intense and rewarding ways of expressing my concern for my partner.

61. The sense of emotional closeness I experience from having sex with my partner is one of the most satisfying ways I know of feelings valued.

62. To me, an extremely rewarding aspect of having sex is that it can make my partner feel good about himself or herself.

The Multidimensional Sexual Approach Questionnaire

INSTRUCTIONS: Listed below are several statements that reflect different attitudes about sex. For each statement fill in the response on the answer sheet that indicates how much you agree or disagree with that statement. Some of the items refer to a specific sexual relationship, while others refer to general attitudes and beliefs about sex. **Answer the questions with your current partner in mind.** If you are not currently dating anyone, answer the questions with your most recent partner in mind. If you have never had a sexual relationship, answer in terms of what you think your responses would most likely be in a future sexual relationship.

For each statement:

A = Strongly agree with the statement.
B = Moderately agree with the statement.
C = Neutral - Neither agree nor disagree.
D = Moderately disagree with the statement.
E = Strongly disagree with the statement.

1. I was sexually attracted to my partner immediately after we first met.

2. I feel a strong sexual "chemistry" toward my partner.

3. I have a very intense and satisfying sexual relationship with my partner.

4. I was sexually meant for my partner.

5. I became sexually involved rather quickly with my partner.

6. I have a strong sexual understanding of my partner.

7. My partner fits my notion of the ideal sexual partner.

8. I try to keep my partner a little uncertain about my sexual commitment to him/her.

9. I believe that what my partner doesn't know about my sexual activity won't hurt him/her.

10. I have not always told my partner about my previous sexual experiences.

11. I could end my sexual relationship with my partner rather easily and quickly.

12. My partner wouldn't like hearing about some of the sexual experiences I've had with others.

13. When my partner becomes too sexually involved with me, I want to back off a little.

14. I like playing around with a number of people, including my partner and others.

15. The sexual relationship between myself and my partner started off rather slowly.

16. I had to "care" for my partner before I could make love to him/her.

17. I expect to always be a friend of my sexual partner.

18. The sex I have with my partner is better because it was preceded by a long friendship.

19. I was a friend of my sexual partner before we became lovers.

20. The sex my partner and I have is based on a deep friendship, not something mystical and mysterious.

21. Sex with my partner is highly satisfying because it developed out of a good friendship.

22. Before I made love with my partner, I spent some time evaluating her/his career potential.

23. I planned my life in a careful manner before I chose my sexual partner.

24. One of the reasons I chose my sexual partner is because of our similar backgrounds.

25. Before I made love with my sexual partner, I considered how s/he would reflect on my family.

26. It was important to me that my sexual partner be a good parent.

27. I thought about the implications for my career before I made love with my sexual partner.

28. I didn't have sex with my partner until after I had considered our hereditary backgrounds.

29. When sex with my partner isn't going right, I become upset.

30. If my sexual relationship with my partner ended, I would become extremely despondent and depressed.

31. Sometimes I am so sexually attracted to my partner that I simply can't sleep.

32. When my partner sexually ignores me, I feel really sick.

33. Since my partner and I started having sex, I have not been able to concentrate on anything else.

34. If my partner became sexually involved with someone else, I wouldn't be able to take it.

35. If my partner doesn't have sex with me for a while, I sometimes do stupid things to get her/his sexual attention.

36. If my partner were having a sexual difficulty, I would definitely try to help as much as I could.

37. I would rather have a sexual problem myself than let my partner suffer though one.

38. I could never be sexually satisfied unless first my partner was sexually satisfied.

39. I am usually willing to forsake my own sexual needs in order to let my partner achieve hers/his own sexual needs.

40. My partner can use me the way s/he chooses in order for him/her to be sexually satisfied.

41. When my partner is sexually dissatisfied with me, I still accept him/her without reservations.

42. I would do practically any sexual activity that my partner wanted.

43. It would bother me if my sexual partner neglected my needs.

44. If I were to make love with a sexual partner, I'd take that person's needs and feelings into account.

45. If a sexual partner were to do something sensual for me, I'd try to do the same for him/her.

46. I expect a sexual partner to be responsive to my sexual needs and feelings.

47. I would be willing to go out of my way to satisfy my sexual partner.

48. If I were feeling sexually needy, I'd ask my sexual partner for help.

49. If a sexual partner were to ignore my sexual needs, I'd feel hurt.

50. Please answer neutral.

51. I think people should feel obligated to repay an intimate partner for sexual favors.

52. I would feel somewhat exploited if an intimate partner failed to repay me for a sexual favor.

53. I would probably keep track of the times a sexual partner asked me for a sensual pleasure.

54. When a person receives sexual pleasures from another, s/he ought to repay that person right away.

55. It's best to make sure things are always kept "even" between two people in a sexual relationship.

56. I would do a special sexual favor for an intimate partner, only if that person did some special sexual favor for me.

57. If my sexual partner performed a sexual request for me, I would probably feel that I'd have to repay him/her later on.

The Multidimensional Measure of Comfort with Sexuality Short Form

Please tell me how much you agree or disagree with these statements.

1 2 3 4 5 6

Strongly agree Strongly disagree

1. I am completely comfortable knowing and interacting with people whose sexual activities significantly differ from my own.

2. I enjoy the opportunity to share my personal views about sexuality.

3. My sexual experiences and exploration are a positive, on-going part of who I am.

4. I am comfortable with my sexual activities, both past and present.

5. I am comfortable talking about my sexual views, my sexual fantasies, and sexual experiences that I have had.

6. Please answer strongly agree.

7. My past sexual experiences and explorations have been worthwhile.

8. It would not bother me to know that a good friend enjoys anal stimulation during masturbation.

9. I can freely discuss sexual topics in a small group of peers.

10. I think it is good for people to experiment with a wide range of sexual practices.