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Sexual Myths During Pregnancy and Affecting Factors

Gebelikte Cinsel Mitler ve Etkileyen Faktörler

Şükran Başgöl[1], Saliha Yurtçiçek Eren[2]

[1]Department of Midwifery, Faculty of Health Sciences, Ondokuz Mayis University, Samsun, Turkey
[2]Department of Midwifery, Faculty of Health Sciences, Muş Alparslan University, Muş, Turkey

ABSTRACT

Introduction: Sexual myths during pregnancy are significant social constructs based on misinformation and beliefs, shaping individuals' perceptions of this period. Investigating these myths is crucial for promoting accurate knowledge about sexuality during pregnancy and improving healthcare services.
Objective: In this study, we aimed to examine sexual myths during pregnancy and the factors that influence them.
Method: The study was descriptive and cross-sectional. Snowball sampling method was used and 431 pregnant women who completed the online questionnaires were included in the study. Data were collected using a personal information form and the Scale of Attitudes and Beliefs about Sexuality during Pregnancy. Independent samples t-test, ANOVA test, and regression analysis were used for data analysis.
Results: The mean score of the Attitudes and Beliefs Scale about Sexuality During Pregnancy (ABSSP) was 61.64 (SD 15.83). It was found that there is a significant difference in the number of pregnancies, number of children, educational status, spouse's educational status, presence of a risky condition in the fetus, planned and voluntary pregnancy, receiving sexual health education, continuing sexuality during pregnancy, comfortable talking about sexuality with spouse, and marriage type variables between the mean score ABSSP scale ($p<0.05$).
Conclusion: Health professionals should provide opportunities for couples to discuss sexuality in pregnancy and to express their attitudes about sexuality before pregnancy and during pregnancy follow-up. The risk factors identified in this study will contribute to the structuring of educational content and the literature.

Keywords: Pregnancy, Sexuality, Myths, Attitudes.

ÖZET

Giriş: Gebelikte cinselliğe ilişkin mitler, yanlış bilgi ve inanışlara dayanan, bireylerin bu döneme dair algılarını şekillendiren önemli toplumsal olgulardır. Bu mitlerin araştırılması, gebelikte cinsellikle ilgili doğru bilginin yaygınlaştırılması ve sağlık hizmetlerinin iyileştirilmesi açısından oldukça önemlidir.
Amaç: Bu çalışmada, gebelikte cinselliğe ilişkin mitlerin ve bu mitleri etkileyen faktörlerin incelenmesi amaçlanmıştır.
Yöntem: Çalışma tanımlayıcı ve kesitsel tasarımda yürütülmüştür. Veriler, kartopu örnekleme yöntemiyle toplanmış ve çevrimiçi anketleri tamamlayan 431 gebe çalışmaya dahil edilmiştir. Veriler, kişisel bilgi formu ve Gebelikte Cinselliğe Yönelik Tutum ve İnançlar Ölçeği kullanılarak toplanmıştır. Verilerin analizinde bağımsız örneklem t-testi, ANOVA testi ve regresyon analizi kullanılmıştır.
Bulgular: Gebelikte Cinselliğe Yönelik Tutum ve İnançlar Ölçeği (GCYTİÖ) toplam puan ortalaması 61.64 (SS 15.83) olarak bulunmuştur. Gebelik sayısı, çocuk sayısı, eğitim durumu, eşin eğitim durumu, fetüste riskli durum varlığı, planlı ve isteyerek gebelik, cinsel sağlık eğitimi alma durumu, gebelikte cinselliği sürdürme, eşle cinsellik hakkında rahat konuşabilme durumu ve evlilik türü değişkenleri ile GCYTİÖ puan ortalamaları arasında anlamlı fark bulunmuştur ($p<0.05$).
Sonuç: Sağlık profesyonelleri, gebelik öncesinde ve gebelik takiplerinde çiftlere cinsellik hakkında konuşma fırsatları sunmalı ve bu konudaki tutumlarını ifade etmelerine destek olmalıdır. Bu çalışmadan elde edilen risk faktörleri, eğitim içeriklerinin yapılandırılmasına ve literatüre katkı sağlayacaktır.

Anahtar Kelimeler: Gebelik, Cinsellik, Mitler, Tutumlar.

INTRODUCTION

Pregnancy is an important time when many physiological, psychological, and social changes occur together. It is reported to be one of the times when sexuality is most affected (1,2). Sexuality is a concept that begins at birth. Sexual needs are at the bottom of Maslow's hierarchy of basic needs and are included in physical needs. In fact, sexuality is not only a physical need, but also a fundamental part of human life (3). However, sexuality is also influenced by many physiological, psychological, social, economic,

Corresponding Author: Şükran Başgöl, e-mail: sukran.basgol@omu.edu.tr
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political, cultural, religious, and spiritual factors. In particular, various misconceptions and attitudes about sexuality during pregnancy can negatively affect couples' sexual behavior and relationships (4).

False beliefs and attitudes about sexuality, also known as sexual myths, are inaccurate, incomplete, or exaggerated information shaped by society's imagination and passed down from generation to generation (5-7). The most important reason for sexual myths is explained as the fact that sexuality is closely related to the value judgments of society, and issues related to sexuality are not openly discussed, debated, passed over, and condemned (1,8). Discussing sexuality is often stigmatized and may be considered sinful in some Muslim-majority countries (8). In fact, superstitions, false beliefs, and behaviors may become widespread because of the inability of health care personnel to provide adequate counseling about sexuality during pregnancy or to create an environment in which pregnant women feel comfortable expressing their thoughts about sexuality. Superstitions, false beliefs, and behaviors may become widespread because of the inability of health care providers to provide adequate counseling about sexuality during pregnancy or to create an environment in which pregnant women feel comfortable expressing their thoughts about sexuality. As a result of inadequate sexual health education in societies, sexual myths spread as individuals view social media, social environment, and the culture in which they live, where uncontrolled information is available, as a source of education (9). A systematic review of 13 studies (3,122 participants) reported that negative beliefs such as sexuality can harm the fetus (can cause injury, miscarriage, or fetal infection) and endanger pregnancy or maternal health (can cause rupture of membranes, bleeding, preterm delivery, and maternal infection) were common (92.3%) (2).

Sexual myths during pregnancy negatively affect individual/couple health in particular and public health in general. Therefore, increasing sexuality education and awareness is very important to improve the well-being of individuals, couples, and communities. It is also important for health professionals providing sexual and reproductive health education and services to be aware of sexual myths and related factors during pregnancy to develop educational content (10). Although there are studies in the literature that evaluate sexual myths in general, the lack of studies that evaluate beliefs about sexuality in pregnancy was highlighted in a systematic review study (2). This study aims to identify sexual myths and influencing factors during pregnancy. The results will be useful to inform health professionals and couples about sexual myths and related factors during pregnancy. This study may help people identify and correct misconceptions and thus help couples have enjoyable and healthy sexual experiences during pregnancy.

Research Questions

1. What is the level of sexual myths of pregnant women?

2. What are the factors that influence the sexual myths of pregnant women?

METHOD

Study design

This cross-sectional study was conducted between July 5, 2022, and December 31, 2023, among pregnant women aged 18 years and older living in a city in the eastern Anatolian region of Turkey.

Sample

The study population consisted of all pregnant women aged 18 years and older living in the Eastern Anatolia region of Turkey. To obtain a sufficient number of pregnant women to represent the population, the formula for unknown sample size was used and the minimum number of pregnant women to be included in the sample was determined to be 384 with a 95% confidence level and 5% sampling error (11). Between July 5, 2022, and December 31, 2023, 431 pregnant women who volunteered to participate in the study and met the research criteria were enrolled in the study.

Pregnant women, those under the age of 18, without visual impairment, with at least primary education, who could speak and understand Turkish, who were open to communication and cooperation, and with no diagnosed mental problems were included in the study. These criteria were based on the information provided by the participants.

Data collection

This cross-sectional study was conducted between July 5, 2022 and December 31, 2023 on pregnant women who volunteered to participate in the study by sharing on social media (Facebook, Instagram, Twitter, Telegram, etc.) forum pages via the web. In the first page of the e-survey, information about the study and the purpose of the study were explained to women, and when they confirmed that they wanted to participate through e-approval, they started the survey questions in the second page. It took approximately 15 minutes for the patients who agreed to participate in the study to fill out the questionnaire form.

Data collection tools

"Personal Information Form" and "Attitudes and Beliefs Scale about Sexuality During Pregnancy" were used as data collection tools in the study.

Personal information form

This form, which was prepared by the researchers in line with the literature (2, 10), consisted of a total of 25 questions that aimed to determine sociodemographic (age, education level, employment status, etc.) and obstetric (gestational week, risk status of the pregnant woman and her baby, etc.) data of the participants and the factors that could potentially influence attitudes and beliefs about sexuality during pregnancy.

Attitudes and Beliefs Scale about Sexuality During Pregnancy (ABSSP)

“The scale developed by Salcan and Gökyildiz (2020) consists of 25 substances, its total score ranges from 25 to 125 and is of type 5 Likert. High scores indicate an increase in sexual myths during pregnancy. There is no inverse substance on the scale. 5-degree; “I totally agree = 5, I agree = 4, I am undecided = 3, I disagree = 2, I strongly disagree = 1″. The scale consists of 4 subdivisions: “Pregnancy and Sexuality” (5 expression), “Concern about the Baby” (7 expression), “Gender/Attraction” (5 expression), and “Concern about Pregnancy” (8 expression). There are no inverse substances on the scale. Increasing the scale score is interpreted as increasing sexual myths about pregnancy” (12). Cronbach’s alpha value of the scale was reported as 0.916 in orginal article (12) and it was calculated as 0.93 in our study.

Data analysis

The data obtained were analysed with Statistical Package for the Social Sciences 25.0 programme. Descriptive features such as number, percentage, mean, standard deviation were used in the analysis of the data. Since the data showed normal distribution, the scale scores parametric test in paired groups in the comparison of variables with "Independent Group T Test", and "One-Way Analysis of Variance (ANOVA)" was applied for the comparison of more than two groups. In order to determine which groups were the source of the change, Tukey test, one of the post-hoc tests, was applied. Statistical significance level was accepted as $p < 0.05$.

Ethical considerations

This study was performed in line with the principles of the Declaration of Helsinki. Approval was granted by the Ethics Committee of University Muş Alparslan (Date: 07/04/2022, No: 55498). Pregnant women participating in the study were informed about the purpose of the study, the method, the time required, that participation would not cause any harm, and that participation was voluntary, and informed consent was obtained. The study was conducted in accordance with the ethical standards specified in the tenets of the Declaration of Helsinki of 1964 and its subsequent amendments.

RESULTS

The comparison of the descriptive characteristics of the pregnant women with their attitudes and beliefs about sexuality is shown in Table 1. The mean age of the pregnant women who participated in the study was 28.49±5.23 years, the mean age at marriage was 22.75±3.32 years, and the mean duration of marriage was 2.35±1.06 years. 52% of the pregnancies were multigravida and 49.7% had 1-4 children.

Table 1. Comparison of women's personal information and ABSSP scores

Variables	n	%	ABSSP	t/ F	p-value
			Mean ± SD		
Trimester of pregnancy					
First trimester (0- 14 weeks)	134	31.1	63.09 ±15.44	F= 1.081	0.340
Second trimester (15-27 weeks)	166	38.5	60.39 ±15.85		
Third trimester (28-39 weeks)	131	30.4	61.74 ±16.19		
Number of pregnancies					
Primigravida[a]	207	48.0	59.76 ±15.55	t= -2.378	**0.018***
Multigravida[b]	224	52.0	63.37 ±15.92		b>a
Number of children					
Primipar[a]	207	48.0	60.03 ±15.48	t= -2.208	**0.028***
Multipar[b]	224	52.0	63.39 ±16.06		b>a
Educational level of the pregnant					
Primary/Secondary School [a]	139	32.3	66.09 ±16.38	F= 10.137	**0.000***
High School[b]	131	30.4	61.38 ±14.81		a>b
University and over[c]	161	37.4	58.01 ±15.28		a>c
Education level of partner					
Primary/Secondary School [a]	105	24.4	67.57 ±14.62	F= 14.477	**0.000***
High School[b]	127	29.5	62.80 ±15.83		a>b,c
University and over[c]	199	46.2	57.77 ±15.43		b>c
Work Status					
Working	103	23.9	60.44 ±14.92	t= -0.880	0.379
Not-working	328	76.1	62.02 ±16.11		
Perceived income					
Poor	75	17.4	65.09 ±16.71	F= 2.168	0.116
Moderate	295	68.4	60.94 ±15.62		
Good	61	14.2	60.77 ±15.42		
Family type					
Nuclear family	361	83.8	61.26 ±15.74	t= -1.121	0.263
Extended family	70	16.2	63.58 ±16.26		
Longest living place					
City Center	275	63.8	61.03 ±15.52	F= 0.734	0.481
District	96	22.3	62.14 ±16.65		
Village	60	13.9	63.65 ±15.99		
Chronic Disease Status					
Yes	47	10.9	63.76 ±16.59	t= 0.973	0.331
No	384	89.1	61.38 ±15.74		

ABSSP: Attitudes and Beliefs Scale About Sexuality During Pregnancy; T: İndependent Sample T-Test; SD: Standard Deviation; F: One-Way Analysis Of Variance; * Analysis Of Variance (Advanced Analysis Tukey HSD,) In Bold: $p < 0.05$ is Statistically Significant.

The educational level of 37.4% of the pregnant women and 46.2% of their husbands was university or higher. Pregnant women were mostly unemployed (76.1%), while their husbands were mostly employed (94.0%). Of the pregnant women, 83.8% had nuclear families and 68.4% reported their income as medium. Of the pregnant women, 63.8% lived in the city center and 89.1% had no chronic diseases. We found that 85.2% of the pregnant women were not at risk and 86.1% reported that their baby was not at risk. Most pregnant women (63.8%) were married for love. Eighty-one percent of the pregnancies were planned and voluntary. It was found that 84.2% were comfortable discussing sexuality with their spouses, 78.2% did not receive any sexual health education, and 64% maintained their sexual life during pregnancy (Table 1).

It was found that women with 2 or more pregnancies (multiparous) had more sexual myths about pregnancy than those who conceived for the first time (primiparous) ($p<0.05$, Table 1). Women with 1-4 children also had more sexual myths about pregnancy than women with no children ($p<0.05$, Table 1). Pregnant women and their spouses with primary education had higher levels of sexual myths about pregnancy than pregnant women with high school, university, or postgraduate education ($p<0.05$, Table 1). Pregnant women with fetal risk status had more sexual myths than those without, women with unplanned and unwanted pregnancies had more sexual myths than those with planned and wanted pregnancies, and pregnant women who did not receive sexual health education had more sexual myths than those who received sexual health education ($p<0.05$, Table 2). It was found that pregnant women

who were not sexually active during pregnancy had more sexual myths than those who were sexually active, pregnant women who could not talk comfortably about sexuality with their husbands had more sexual myths than those who could, and those who had an arranged marriage had more sexual myths than those who had a love marriage (p<0.05, Table 2).

Table 2. Comparison of attitudes and beliefs about sexuality during pregnancy and other factors

Variables	n	%	ABSSP	t/ F	p-value
			Mean ± SD		
Risky condition during pregnancy					
Yes	64	14.8	63.34±13.99	t= 0.930	0.353
No	367	85.2	61.34±16.13		
Risky situation in the fetus					
Yes[a]	60	13.9	65.86 ±13.48	t= 2.236	**0.026***
No[b]	371	86.1	60.96 ±16.09		a>b
Planned and voluntary pregnancy					
Yes[a]	349	81.0	60.78 ±15.41	t= -2.338	**0.020***
No[b]	82	19.0	65.30 ±17.12		b>a
Receiving sexual health education					
Yes[a]	94	21.8	58.24 ±14.54	t= -2.367	**0.018***
No[b]	337	78.2	62.59 ±16.07		b>a
Continuation of sexuality during pregnancy					
Yes[a]	276	64.0	56.40 ±13.62	t= -10.206	**0.000***
No[b]	155	36.0	70.97 ±15.23		b>a
Talking about sexuality comfortably with your partner					
Yes[a]	363	84.2	60.40 ±15.46	t= -3.806	**0.000***
No[b]	68	15.08	68.25 ±16.27		b>a
Marriage form					
Arranged[a]	156	36.2	64.02 ±16.90	t= 2.363	**0.019***
Lovely[b]	275	63.8	60.29 ±15.06		a>b

ABSSP: Attitudes And Beliefs Scale About Sexuality During Pregnancy; T: İndependent Sample T-Test; SD: Standard Deviation; F: One-Way Analysis Of Variance; * In Bold: p < 0.05 is Statistically Significant

The mean score of the Attitudes and Beliefs Scale about Sexuality During Pregnancy (ABSSP) was 61.64 (SD 15.83). Linear regression analysis was performed for the factors found to have a significant relationship. The factors with a significant relationship in the linear regression analysis were analyzed with the stepwise method and a statistically significant relationship was found between three factors (number of children, spouse's educational status, continuation of sexuality during pregnancy) and mean ABSSP scores (F = 13.989; p = 0.000). With the created model, 23.2% of the change in ABSSP was explained (Table 3).

Table 3. Linear regression analysis examining the factors affecting the attitudes and beliefs about sexuality during pregnancy

Variables	B (%95 CI)	Beta	t	*p*	Zero-order	Partial
Constant				**0.000**		
Number of pregnancies	-2.594 (-5.597–0.409)	-0.140	-1.698	0.090	0.117	-0.083
Number of children	5.259 (-0.408–10.109)	0.166	2.131	**0.034**	0.128	0.103
Educational level of the pregnant	-1.064 (-4.646 – -0.311)	0.056	2.966	0.351	– 0.212	-0.045
Educational level of the partner	-2.478 (-3.306 – 1.178)	-0.127	-2.247	**0.025**	– 0.252	-0.109
Risky situation in the fetus	– 0.923 (-4.841 to – 2.995)	– 0.317	– 0.463	0.643	– 0.107	– 0.023
Planned and voluntary pregnancy	1.626 (– 1.869 to – 5.121)	0.040	0.914	0.361	0.112	0.045
Receiving sexual health education	2.297 (– 1.011 to – 5.606)	0.060	1.365	0.137	0.114	0.066
Continuation of sexuality during pregnancy	13.304 (10.480 to – 16.128)	0.404	9.260	**0.000**	0.442	0.412
Talking about sexuality comfortably with your partner	3.125 (-0.761 to – 7.011)	0.072	1.581	0.115	0.181	0.077
Marriage form	1.106 (-2.064 to – 4.275)	0.034	0.686	0.493	-0.113	0.033

DISCUSSION

Sexual myths are false beliefs that are stereotyped by society but have no scientific basis. These beliefs have been shaped by society's imagination and have survived to this day by word of mouth. In this study, in which the levels of Attitudes and Beliefs Regarding Sexuality (sexual myths) of pregnant women and related factors were determined, it was found that the sexual myths of pregnant women were at a moderate level, while a significant difference was found between the number of pregnancies, number of children, educational status, educational status of spouse, presence of risky conditions in the fetus, planned and willing pregnancy, receiving sexual health education, continuation of sexuality during pregnancy, comfortable talking about sexuality with spouse and type of marriage variables and the mean scale score. Therefore, we believe that the results will make an important contribution to the pregnancy literature.

Educational level is an important sociodemographic characteristic that influences sexual myths among pregnant women. It has been reported that an individual's basic knowledge and awareness of anatomy and physiology increases as the level of education increases (2). In this study, it was found that pregnant women and their spouses with primary education had higher sexual myths than pregnant women and their spouses with high school, university, or postgraduate education. Similarly, other studies in the literature have found that educational level is an important factor in influencing misconceptions about sexuality and that sexual myths decrease with more education (14-16). In fact, our other result that supports this finding is that sexual myths were lower among pregnant women who received sexual health education. There are similar findings in the literature. For example, the attitudes toward sexuality of pregnant women who received prenatal education were found to be more positive than those who did not receive education (14-17). This result also shows that correct information given in prenatal education is effective in reducing false beliefs and myths about sexuality during pregnancy. In this study, the regression analysis showed that the educational level of the spouses was a very important risk factor for sexual myths during pregnancy. A spouse with a high level of education who does not have sexual myths during pregnancy may also influence the pregnant woman and enable her to develop a positive attitude towards sexuality.

Number of pregnancies and number of children are among the obstetric characteristics that influence sexual myths of pregnant women. In this study, women with 2 or more pregnancies had more sexual myths about pregnancy than those who conceived for the first time, and women with 1-4 children had more sexual myths about pregnancy than those who had no children. In the literature, it has been explained that primigravidae pregnant women need more education, are inexperienced and therefore have more sexual myths (15). In a similar study conducted by Pamuk (2021) with pregnant women, pregnant women who had children had more sexual myths than those who had never had children (18). Therefore, this result of our study is also consistent with the literature.

It was found that women in arranged marriages had more sexual myths than women in love marriages. In the country where the study was conducted, arranged marriage is a way of identifying potential brides, especially in rural areas, where families who want to marry off their sons go in search of girls, visit the homes of suitable families who have daughters, and determine the bride candidates by looking at the girl's respectability, her carelessness, cleanliness, and the socio-economic characteristics of the family (19). According to the study by Uyar et al. (2017), the level of belief in sexual myths was found to be higher among women in arranged marriages (20). In this study, sexual myths were found to be higher among those who had arranged marriages. This situation may be because people who get married by meeting through love feel closer to each other, can communicate better, and can talk about sexuality. In the studies conducted, it has been found that women in arranged marriages have a lower level of education and cannot talk comfortably about sexuality with their husbands (19, 20). Again, this situation supports the results of our study.

Sexual myths have been reported to cause women to feel guilty and inadequate and to avoid sexual intercourse (21). It has been explained that spouses tend to reduce the frequency of sexual intercourse with myths (22). In fact, in this study, it was found that sexual myths were higher among pregnant women who did not continue sexuality, and it was found to be an important variable in the regression analysis. It is very important for health professionals to be aware of these variables that affect pregnant

women's attitudes and beliefs about sexuality in terms of women's health in particular and public health in general.

Strengths and limitations

The study was conducted in the eastern Anatolian region of the country and cannot be generalized to the entire country due to regional and cultural differences. In addition, the study includes only women. Unfortunately, no gender comparison was made.

CONCLUSION

Spouse's level of education, number of children, and continuation of sexuality during pregnancy were found to be important associated risk factors affecting pregnant women's attitudes and beliefs about sexuality. It was also found that multiparity, the woman's level of education, the presence of a risky condition in the fetus, type of marriage, being able to discuss sexuality comfortably with the spouse, planned pregnancy, and receiving sexual health education also had significant effects on sexual myths. Health professionals should provide opportunities for couples to discuss sexuality in pregnancy and to express their attitudes towards sexuality before and during pregnancy. In this process, health professionals should provide sexual health education to couples so that existing misinformation about sexuality can be replaced with the truth. Similarly, couples should be encouraged to attend prenatal education classes. Couples should be adequately informed about sexual health protection and promotion. Thus, we believe that reducing pregnant women's negative attitudes and beliefs about sexuality will be useful in improving their sexual health. The risk factors obtained from this study will contribute to the literature and it is recommended that mixed methods and qualitative studies involving couples should be conducted to determine different risk factors.

DESCRIPTIONS

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