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Kadın Cinsel Sağlığı

Relationship between sexual myth and sexual attitudes in Turkish women and associated factors: A correlational study

Türk kadınlarında cinsel mit ve cinsel tutumlar arasındaki ilişki ve ilişkili faktörler: İlişkisel bir çalışma

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ABSTRACT

OBJECTIVE: Sexual myths are exaggerated, false, and unscientific beliefs and thoughts about sexuality. Sexual myths are generally more prevalent in conservative societies. Sexual myths can affect our attitude towards sexuality. This study was conducted to determine the relationship and related factors between sexual myths and sexual attitudes among women in Türkiye.

MATERIAL and METHODS: This research is a relational and descriptive study. The study was conducted with 150 women who applied to the obstetrics and gynecology outpatient clinics in Türkiye between May and July 2022. Data were collected using a personal information form, the Sexual Myth Scale (SMS), and the Brief Sexual Attitude Scale (BSAS). The data were analyzed with IBM Statistical Package for Social Sciences (SPSS) for Windows program version 22. Numbers, percentages, minimum and maximum values, averages, standard deviations, and some statistical analyses were used to analyze the data.

RESULTS: Participants scored 73.90±17.56 points on the SMS and 80.58±7.59 points on the Hendrick Sexual Attitudes Scale. According to the participants' sociodemographic characteristics, the difference between the mean total scores of the SMS was statistically significant ($p<0.05$). Still, the difference between the mean total scores of the Hendrick Sexual Attitude Scale was not statistically significant ($p>0.05$). There was no statistically significant relationship between the SMS and the Hendrick Sexual Attitude Scale ($p<0.05$).

CONCLUSION: Increasing women's knowledge about sexuality and providing continuous education on this subject will help to reduce sexual myths. It is important to address sexual attitudes separately to develop positive sexual attitudes in women.

Keywords: attitude, beliefs, sexuality, Türkiye, women

ÖZ

AMAÇ: Cinsel mitler, cinsellikle ilgili abartılı, yanlış ve bilimsel olmayan inanç ve düşüncelerdir. Cinsel mitler genellikle muhafazakar toplumlarda daha yaygındır. Cinsel mitler cinselliğe yönelik tutumumuzu etkileyebilir. Bu çalışma, Türkiye'deki kadınların cinsel mitleri ile cinsel tutumları arasındaki ilişkiyi ve ilişkili faktörleri belirlemek amacıyla yapılmıştır.

GEREÇ ve YÖNTEMLER: Bu araştırma ilişkisel ve tanımlayıcı bir çalışmadır. Çalışma Mayıs-Temmuz 2022 tarihleri arasında Türkiye'de kadın hastalıkları ve doğum polikliniklerine başvuran 150 kadın ile yürütülmüştür. Veriler kişisel bilgi formu, Cinsel Mit Ölçeği (CMÖ) ve Kısa Cinsel Tutum Ölçeği (KCTÖ) kullanılarak toplanmıştır. Veriler IBM Sosyal Bilimlerde İstatistik Paket Programı (SPSS) sürüm 22 (Windows) paket programı ile analiz edilmiştir. Verilerin analizinde sayılar, yüzdeler, minimum ve maksimum değerler, ortalamalar, standart sapmalar ve bazı istatistiksel analizler kullanılmıştır.

BULGULAR: Katılımcılar CMÖ'den 73,90±17,56 puan, Hendrick Cinsel Tutum Ölçeğinden 80,58±7,59 puan almışlardır. Katılımcıların sosyodemografik özelliklerine göre CMÖ toplam puan ortalamaları arasındaki fark istatistiksel olarak anlamlı bulunmuştur ($p<0,05$) ancak Hendrick Cinsel Tutum Ölçeği toplam puan ortalamaları arasındaki fark istatistiksel olarak anlamlı değildir ($p>0,05$). Cinsel Mit Ölçeği ile Hendrick Cinsel Tutum Ölçeği arasında istatistiksel olarak anlamlı bir ilişki yoktur ($p<0,05$).

SONUÇ: Kadınların cinsellik hakkındaki bilgilerinin artırılması ve bu konuda sürekli eğitim verilmesi cinsel mitlerin azaltılmasına yardımcı olacaktır. Kadınlarda olumlu cinsel tutumların geliştirilmesi için cinsel tutumların ayrıca ele alınması önemlidir.

Anahtar Kelimeler: cinsellik, inançlar, kadınlar, tutum, Türkiye

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INTRODUCTION

Sexuality is essential to each person's personality, a basic human need. However, it also can not be separated from other aspects of life, such as quality of life and life satisfaction.[1] Cultural elements, societal norms, and religious convictions influence sexuality.[2] The subject of sexuality is generally taboo in conservative countries

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like Türkiye.[3] Traditional religious doctrines discourage or delay sexual expression. Individuals internalize these teachings and then adopt them as their own. The management of female sexuality in Turkish culture is provided by externally imposed restrictions and cultural standards such as gender dignity and shame.[4] Men believe that having sex before marriage, engaging in active sexual behavior, having one-night stands, having multiple sexual encounters, taking the initiative in sexual relations, and engaging in sexual intercourse are male rights, not women's.[5] Lack of free discussion and information on sexual issues, the lack of scientific research are some of the important factors contributing to the emergence of sexual myths.[5,6] Sexual myth is information about sexual matters that people insist on being true but have no scientific value, exaggerated or false.[7] The primary reason that sexual myths exist is that sexuality is strongly tied to social value judgments in almost all communities, whether ancient or modern and that sexual topics are not openly discussed or spoken about.[8] Sexual myths affect people's expectations about sexuality negatively, affecting sexual function in individuals causing negative emotions like fear, failure, and incompetence.[9] The formal education system is to fall short of meeting people's demands for sexuality education. This may make it difficult for women to access suitable information sources and internalize information about sexual myths. Sexual myths affect sexual attitudes in women and cause sexual dysfunction. Vaginismus has been observed to be the most common clinically diagnosed female sexual dysfunction in Türkiye. In a study investigating sexual problems in women in a city in Türkiye, it was stated that women have the most (67.3%) vaginismus.[10] There are studies on sexual myths with different sample groups in Türkiye[11,4,6], but the relationship between sexual myths and sexual attitudes has not yet been explored. Thus, the following research questions were developed in order to evaluate the relationship between sexual myth and sexual attitudes in women and associated factors:

- What are sexual myth and sexual attitude scores in women?
- Is there a correlation between sexual myth and sexual attitude in women?
- Is there a relationship between the socio-demographic characteristics of women and their sexual myths and attitudes?
- Is there a relationship between women and their sexual myths and sexual attitudes?

MATERIAL and METHODS

Study Design and Setting

This research is relational, descriptive study. The STROBE Checklist (Strengthening the Reporting of Observational Studies in Epidemiology) was applied in this study as a guideline.[12] This descriptive and relational study was conducted in Kastamonu Training and Research Hospital Gynecology and Obstetrics clinics between May and July 2022.

Participants

It was studied with the age range of 18–65 since there is an increase in chronic diseases at 65 and above, and the age of first marriage is concentrated at 18.[13,14] Inclusion criteria for the study: a) being between the ages of 18 and 65; b) having no psychiatric diagnosis and no communication issues; and c) being volunteer to participate.

Those who met the following criteria were excluded from the study: a) Having a condition that prevents communication; b) Failing to fill in or incompletely filling out data collection forms.

According to the Cohen criteria for effect size, which many social scientists prefer, an effect is considered small if it is less than 0.1, medium if it is between 0.3 and 0.5, and large if it is more than 0.5.[15] Because it comes in at a moderate to significant difference, an effect size of 0.5 is frequently used.[16] The minimum sample size was computed using the G*Power version 3.1.7 (University of Kiel, Germany) program; the minimal sample size was calculated as 112 women, based on a medium effect size (0.3), power of 0.96, and alpha level of 0.005. From 15 May to 15 July 2022, 174 people had their eligibility evaluated. However, 24 women were excluded because they declined to participate (n=18), had a mental diagnosis (n=3), or had communication issues (n=3). A hundred and fifty women were therefore included in the study using a convenience sample. It was used to determine the adequacy of the sample size of the post hoc power analysis. As a result of the power analysis, the power of the study was determined to be 0.084 at the 0.05 significance level and 95% confidence interval (Correlation H1=0.044, lower critical r=-0.160, Upper critical r=0.160, power 0.084).

Data Collection

With a face-to-face interview, the researcher gathered data using the patient information form, SMS, and BSAS. Collected data took approximately 15 minutes for each participant.

Data Collection Procedure

First, after the participants were briefed with information about the aim of the study, written approval was received from the women volunteering to participate in the study.

Data Collection Tools

The Personal Information Form: The Personal information form was developed by researchers based on previous research.[3,8] The form included questions on age, education, marital status, sexual activity, age of first marriage, the status of having a chronic illness, having social security)

Sexual Myths Scale (SMS): The scale was developed for Turkish culture by Gölbasi et al.[17] SMS was developed to measure the respondents' extent of sexual myths. It was confirmed to be reliable and valid. The tool's total Cronbach's alpha coefficient was 0.91. The tool has 28 items and 8 subscales. The scale's lowest and maximum possible scores are 28, and 140, respectively. There is no cutoff point on the scale. The higher the score obtained from the scale the greater the number of sexual myths the person has.

Brief Sexual Attitudes Scale (BSAS): The scale developed by Hendrick et al.[18] was adapted into Turkish, and the validity-reliability study was performed by Karaçam et al.[19] The scale consists of 23 questions and four sub-dimensions. Five-point Likert-type scoring is done (Strongly Agree – Strongly Disagree). High scores from the total of the scale indicate that the individual has an ideal, healthy, and balanced sexual attitude. In contrast, low scores indicate that the individual is in a self-centered sexual life and has a far-from-ideal attitude. The scale contains four subdomains: Permissiveness (items 1–10), Birth Control (items 11–13), Communion (items 14–18), and Instrumentality (items 19–23). The overall score ranges from 23 to 115. The low score obtained from the affirmativeness sub-dimension was related to his random sexual life and his attitude towards this life; the high score obtained from Birth Control indicates the tendency to prefer responsible and tolerant sexuality and the sexual partner to be at the center; The high score obtained from sharing expresses the tendency to ideal sexual attitude acceptable by the society, and the low score obtained from Evaluation as a Tool, the tendency to center oneself in sexual life, biological and Utilitarian sexual attitude. For the total score, the Communion, Permissiveness, Birth Control, and Instrumentality subdomains, respectively, the Turkish version of the scale's Cronbach's alpha values were determined to be 0.85, 0.86, 0.84, 0.69, and 0.69[19] According to the study's goals, the scale's overall score was taken into account in the analyses, and a value of 0.72 was determined for Cronbach's alpha.

Ethical Considerations

The study was approved by the Kastamonu University Clinical Research Ethics Committee (Decision No: 2022 KAEK-28). The researcher first explained the purpose of the study and obtained written consent. The study's participants were permitted to leave at any moment and without giving a reason.

Data Analysis

The data were analyzed with IBM Statistical Package for Social Sciences (SPSS) for Windows program version 22. In addition to numbers, percentages, minimum and maximum values, averages, and standard deviations, the statistical analyses in the table below were used to analyze the data (Table 1). The normality distribution analyses of the data are presented in Table 2, all data are typically distributed.

RESULTS

As a result of the study, the Cronbach α value of the Sexual Myth Scale was found to be 0.895, and the Cronbach α value of the Brief Sexual Attitude Scale was 0.537 (Table 3). According to the demographic characteristics of the women participating in the research, most of them are between the ages of 36–50, their spouses have a high school education and higher education, they are married and sexually active, the first marriage is between the ages of 19–34 and the first menarche is between the ages of 13–16, they apply to the hospital due to gynecological diseases. It was determined that they had 3 children, had no chronic disease, and had social security (Table 4). Participants scored 73.90±17.56 from the SMS and 80.58±7.59 from the Hendrick Sexual Attitudes Scale (HSAS) (Table 5).

Table 1. Statistical tests used in data analysis

	In normally distributed measurements	*In non-normally distributed measurements*
Comparison of paired groups	T-test in independent groups	-
Comparison of multiple groups	Variance analysis (As further analysis, LSD was used in cases where variances were homogeneous, and Dunnet C was used in cases where it was not).	-
Relational inferences	Pearson correlation analysis	-
Internal validity	Cronbach α coefficient	
Normality distribution of data	Kurtosis and skewness coefficients	

LSD: least significant difference.

Table 2. Normal distribution table of continuous variables in the study

		Skewness Number of floors		*Kurtosis Number of floors*	
Continuous variables	*N*	*Statistics*	*Standard error*	*Statistics*	*Standard error*
Sexual myths scale	150	0.136	0.198	-0.102	0.394
Hendrick sexual attitude scale	150	-0.252	0.198	1.341	0.394

Table 3. Internal validity coefficients

Scale	*Cronbach α*
Sexual myths scale	0.895
Hendrick sexual attitude scale	0.537

Table 4. Demographic characteristics of participants

		n	*%*
Age	18–25	51	34.0
	26–35	42	28.0
	36–50	52	34.7
	51–65	5	3.3
Educational status	Primary school	44	29.3
	High school	49	32.7
	University education and above	57	38.0
Marital status	Single	42	28.0
	Married	108	72.0
Sexual activity	Active	98	65.3
	Not active	52	34.7
First marriage age	Not married	37	24.7
	15–18	31	20.7
	19–34	82	54.7
First menstrual age	9–12	42	28.0
	13–16	100	66.7
	16 years and older	8	5.3
Reason for coming to the hospital	Pregnancy	37	24.7
	Gynecological diseases	104	69.3
	Family planning	9	6.0
Number of children	0	55	36.7
	1–3	85	56.7
	4–6	10	6.7
Chronic disease	There is	37	24.7
	None	113	75.3
Social security	There is	118	78.7
	None	32	21.3
Spouse education status	No spouse	40	26.7
	Primary school	33	22.0
	High school	46	30.7
	University education and above	31	20.7

Table 5. Distribution of scores from sexual myths scale and Hendrick sexual attitude scale

Scale and subscales	*n*	*min.*	*max.*	*mean*	*SS.*
Sexual myths scale	150	32.00	123.00	73.90	17.56
Hendrick sexual attitude scale	150	55.00	103.00	80.58	7.59

In Table 6, the difference in the total mean score of the SMS according to age, education status, marital status, sexual activity, age at first marriage, age of first menstruation, number of children, social security, and co-educational quality is statistically significant ($p<0.05$). In the advanced analysis least significant difference (LSD) test, which was carried out to determine from which group the difference according to age originates, the scores of those in the 18–25 age group were lower than those in the 26–35 and 36–50 age groups. This situation can be expressed as a <b, c. Least significant difference test was carried out to determine from which group the education level difference originated; it was determined that the education levels differed. Elementary school graduates had higher scores than high school, university, and higher graduates. In addition, the scores of high school graduates are higher than those of university and higher graduates. This can be expressed as a >b >c.

Those who are married and sexually active have a higher average score. Least significant difference test was carried out to determine from which group the difference was caused by the age at first marriage; it was observed that all groups differed. The scores of those in the 15–18 age group were higher than those in the 19–34 age group and unmarried. The scores of those in the 19–34 age group were also higher than those not married. This can be expressed as: b >c >a. LSD, which was carried out to determine which group caused the difference according to the age of first menstruation, was determined that the scores of those at the age of 9–12 at the first menstruation were higher than the scores of those at the age of 13–16 and 16 years of age at the first menstruation. This can be expressed as a >b >c. Least significant difference test was conducted to determine which group caused the difference according to the number of children. It was determined that the scores of those without children were lower than those with 4–6 and 1–3 children. This can be expressed as a >c, b. The mean score of those with chronic diseases and those without social security was found to be higher. In the further analysis to determine from which group the difference arises according to the level of peer education (Dunnet C), It was determined that the scores of those who did not have a spouse were higher than those whose spouses had primary

school, high school, university or higher education. This can be expressed as a <b, c, d.

Table 6, shows that the difference in the total mean score of the SMS according to the reason for coming to the hospital and the chronic disease status was not statistically significant (p>0.05). As seen in Table 7, the total mean score of the HSAS is statistically related to age, education status, marital status, sexual activity, age at first marriage, age at first menstruation, reason for coming to hospital, child, chronic illness, social security, and spouse's educational status. It was determined that it was not significant (p>0.05). Table 8, shows no statistically significant relationship between the SMS and HSAS (p<0.05). In Table 9, simple regression analysis was applied to reveal the extent to which the HSAS variable, which is thought to be effective on the SMS of the participants, predicted the SMS. As a result of this analysis, it was determined that there was no significant relationship between the HSAS and the SMS (R=0.002, R2 adjusted=-0.007, F (1.148)=0.001; p=0.980).

DISCUSSION

The meaning of sexuality varies from culture to culture. Cultural norms and sexual behaviors are intertwined because individuals learn how to behave and understand the world

Table 6. Comparison of sexual myths scale scores by demographic characteristics

		n	*Sexual myths scale*			
			mean	*SS.*	*test*	*p*
Age	18–25(a)	51	66.96	19.77	F=4.633	**0.004** a < b, c
	26–35(b)	42	75.83	15.90		
	36–50(c)	52	79.04	14.18		
	51–65(d)	5	75.00	21.01		
Educational status	Primary school (a)	44	81.86	14.42	F=9.990	**0.000** a >b >c
	High school (b)	49	74.71	17.62		
	University and above (c)	57	67.05	17.21		
Marital status	Single	42	62.93	16.62	t=-5.168	0.000
	Married	108	78.17	16.05		
Sexual activity	Active	98	77.42	17.72	t=3.494	0.001
	Not active	52	67.27	15.31		
First marriage age	Not married (a)	37	63.00	15.48	F=13.367	**0.000** b >c >a
	15–18 (b)	31	82.84	12.52		
	19–34 (c)	82	75.44	17.75		
First menstrual age	9–12 (a)	42	79.21	19.42	F=3.312	**0.039** a >b >c
	13–16 (b)	100	72.33	16.80		
	16 years and older (c)	8	65.63	8.73		
Reason for coming to the hospital	Pregnancy	37	77.73	16.03	F=1.178	0.311
	Gynecological diseases	104	72.70	18.15		
	Family planning	9	72.00	15.86		
Number of children	0 (a)	55	66.47	18.66	F=10.448	**0.000** a >c, b
	1–3 (b)	85	77.13	14.45		
	4–6 (c)	10	87.30	20.78		
Chronic disease	There is	37	78.22	16.74	t=1.735	0.085
	None	113	72.49	17.66		
Social security	There is	118	72.30	17.01	t=-2.175	0.031
	None	32	79.81	18.53		
Spouse education status	No spouse (a)	40	63.03	16.22	F=9.941	**0.000** a <b, c, d.
	Primary school (b)	33	82.48	13.56		
	High school (c)	46	77.57	19.53		
	University and above (d)	31	73.35	12.69		

Table 7. Comparison of Hendrick sexual attitude scale scores by demographic characteristics

			Hendrick Sexual Attitude Scale			
		n	*mean*	*SS.*	*test*	*p*
Age	18–25	51	78.41	6.55	F=2.359	0.074
	26–35	42	81.95	8.77		
	36–50	52	81.73	7.11		
	51–65	5	79.20	8.84		
Educational status	Primary school	44	80.14	8.63	F=0.112	0.894
	High school	49	80.86	6.26		
	University education and above	57	80.68	7.90		
Marital status	Single	42	78.74	7.97	t=-1.868	0.064
	Married	108	81.30	7.36		
Sexual activity	Active	98	81.16	7.61	t=1.294	0.198
	Not active	52	79.48	7.51		
First marriage age	Not married	37	79.22	7.96	F=1.050	0.353
	15–18	31	80.19	8.01		
	19–34	82	81.34	7.26		
First menstrual age	9–12	42	80.17	5.88	F=0.158	0.854
	13–16	100	80.82	8.32		
	16 years and older	8	79.75	6.61		
Reason for coming to the hospital	Pregnancy	37	82.08	7.10	F=1.192	0.307
	Gynecological diseases	104	80.23	7.92		
	Family planning	9	78.44	4.67		
Number of children	0	55	79.67	7.46	F=0.680	0.508
	1–3	85	81.20	6.91		
	4–6	10	80.30	12.91		
Chronic disease	There is	37	79.95	8.19	t=-0.584	0.560
	None	113	80.79	7.42		
Social security	There is	118	80.93	8.06	t=1.358	0.179
	None	32	79.28	5.45		
Spouse education status	No spouse	40	78.73	8.17	F=1.532	0.209
	Primary school	33	80.55	7.30		
	High school	46	80.89	7.71		
	University education and above	31	82.55	6.70		

Table 8. The relationship between the sexual myths scale and the Hendrick sexual attitude scale

		Sexual myths scale	*Hendrick sexual attitude scale*
Sexual myths scale	r	1	-0.002
	p	-	0.980
	n	150	150
Hendrick sexual attitude scale	r	-0.002	1
	p	0.980	-
	n	150	150

Table 9. Regression analysis between sexual myths scale and Hendrick sexual attitude scale

	Beta	*Standard error*	*Standard beta*	*t*	*p*	*95% confidence interval*	
Constant coefficient	74.278	15.381	-	4.829	0.000	43.884	104.672
Hendrick sexual attitude scale	-0.005	0.190	-0.002	-0.025	0.980	-0.380	0.371

through culture.[20] The participants scored 73.90±17.56 points on the SMS, which can be taken with a maximum score of 140 points, and 80.58±7.59 points on the HSAS, which can be taken with a maximum score of 115. These findings indicate that the participants had moderate levels of sexual myths and had a balanced sexual attitude close to the ideal. In this study, the sexual myth scores of women between 18–25 were lower than other age groups, indicating that this group had less misinformation about sexuality. In the study of Korkmaz & Çetin [21] unlike this study, it was determined that the sexual myth score of women did not change with age. It was concluded that sexual myths increased as the educational level of the women and their husbands, if any, decreased. The mean score of sexual myths was higher in married women, sexually active women and women without social security. As the age at first marriage and menstruation decreased, the mean score of sexual myths increased. It is thought to be due to the belief that a healthy body is the basis of healthy sexuality and the prejudice that decreasing age will negatively affect sexual life and satisfaction. As the number of children increases, the mean score of sexual myths decreases. Sexual health and function can be significantly impacted by a chronic illness and its associated treatment-related side effects.[22] However, this study concluded that the difference in the total mean score of the SMS according to the reason for coming to the hospital and chronic disease status was not statistically significant (p>0.05).

The difference in the mean total score of HSAS according to age, educational status, marital status, sexual activity, age at first marriage, age at first menstruation, the reason for coming to the hospital, number of children, chronic disease, social security, and spouse's educational status was not statistically significant (p>0.05). The reason why attitudes do not change according to these variables is that wrong, unrealistic and unscientific sexual myths are sometimes accepted as accurate in society, which is under the influence of strict religious rules, customs, and traditions. The inability of women to receive information about sexuality due to the lack of institutional sexual education in Türkiye causes sexual myths to rise. Türkiye's national curriculum does not include sexual education. A sex education course is only offered as an elective lesson in a relatively small number of university schools.[23] The sources of sexual information that begin in adolescence are typically friends, television, publications, and the internet.[24] These sites, which are mainly incomplete or, even worse, give inaccurate information, help to spread misconceptions and biases regarding sexuality. However, it can be said that as the age of marriage increases, the increase in access to the right source and the correct information and the freedom of sexuality with marriage effectively decrease the sexual myth score, but the effect of sexual myths continues.

When sexual myth studies including men are examined, it is seen that men have more sexual myths compared to women.[25–27] The reasons for this situation are shown among the reasons for men's more active and dominant character in society, the effort to prove this in men, and their distorted beliefs about sexuality.[28] On the other hand, in a prospective case-control study consisting of 60 trans women as case group and 60 healthy male individuals as a control group, it was found that healthy male individuals had higher levels of belief in sexual myths and lower levels of anxiety and depression than trans women (p=0.000).[29] Studies show that men have more sexual myths than women and trans women.

Unlike our study, In their study with university students, Weeden and Sabini[30] found that sexual attitudes were substantially correlated with the number of sexual partners, the age of early sexual intercourse, and the number of partners. Sexual attitude is critical in shaping sexuality; it is based on life and experiences and has a directing or dynamic effect on the behavior of individuals.[31] This study shows no statistically significant relationship exists between the SMS and HSAS (p<0.05). Simple regression analysis also showed no significant relationship between the HSAS and SMS (R=0.002, R2adjusted=-0.007, F (1,148)=0.001; p=0.980). Someone who has sexual myths may exhibit the opposite attitude. Instead of seeing sexual myths and sexual attitudes as complementary to each other, they should be considered critical issues that need to be addressed separately.

CONCLUSION and RECOMMENDATIONS

As a result, the participants scored 73.90±17.56 points on the SMS and 80.58±7.59 points on the HSAS. The difference in the mean total score of the SMS according to some sociodemographic characteristics was statistically significant (p<0.05). Hendrick sexual attitudes scale total mean score difference is not statistically significant (p>0.05). In other words, no statistically significant relationship exists between the SMS and the HSAS (p<0.05). In order to lay the foundations of a healthy society, it is essential to provide accurate and reliable information to individuals at an early age before they acquire misinformation from different sources and put their health at risk. The inclusion of sexual education issues in the education system of our country and the organization of understandable training on this subject by specialists in the hospital should be supported. Our recommendations include developing policies and ensuring that these policies are sustainable. In this way, unrealistic sexual myths and attitudes of individuals will be replaced by factual information based on scientific sources, and the transfer of information

between generations will continue correctly. Increasing the comprehensiveness of the studies will provide more information by including other studies conducted in various regions of Türkiye with different parameters and men.

Limitations

Although gender plays a vital role in sexuality, only women were included in this study. In addition, the study was performed in a single center, so the findings cannot be applied to the entire Turkish population. Besides its limitations, the sample calculation was made using the G*Power version 3.1.7 (Kiel University, Germany) program. Reaching more than the minimum number of samples formed the vital feature of the study.

Ethics Committee Approval
The study was approved by Kastamonu University Clinical Research Ethics Committee. (date and number of approval: 23.03.2022/2022 KAEK-28).

Peer-review
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Conflict of Interest
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