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MIDWIFERY STUDENTS' SEXUAL MYTHS AND ASSOCIATED FACTORS

Ebelik Öğrencilerinin Cinsel Mitleri ve İlişkili Faktörler

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ABSTRACT

This study was carried out to determine sexual myths of midwifery students and associated factors. The study was performed descriptively with 301 students studying in the midwifery department of a university in Turkey. Data were collected by information form and Sexual Myths Scale (SMS). A high score from SMS refers to a high ratio of sexual myths. In this study, it was found that mean total score of SMS among first year midwifery students (60.57±15.93) was found to be significantly higher than the second (52.39±14.77), third (53.86±18.97) and fourth year students (47.41±16.13) ($p<0.001$). Mean total SMS scores of the students who did not take a course on sexuality and sexual health were found to be significantly higher than the ones who did ($p<0.05$). Mean total SMS score of the students, who did not consider their knowledge on sexual health as sufficient, was reported to be significantly higher than the ones who considered as sufficient ($p<0.05$). In this study, it was found that sexual myths showed a continuous decrease from the first year of midwifery education. Taking courses on sexuality and sexual health reduces sexual myths. It may be recommended to provide education on sexual myths and sexual health.

Keywords: Sexuality, sexual myths, midwifery student

ÖZET

Bu çalışma ebelik öğrencilerinin cinsel mitleri ve ilişkili faktörleri değerlendirmek amacı ile yapılmıştır. Araştırma, Türkiye'de bir üniversitesinin ebelik bölümünün 301 öğrencisi ile tanımlayıcı olarak yapılmıştır. Veriler bilgi formu ve CMÖ ile toplanmıştır. CMÖ' den yüksek puan alınması cinsel mitlerin de yüksek olduğunu göstermektedir. Bu çalışmada birinci sınıf ebelik öğrencilerinin CMÖ toplam puan ortalamasının (60.57±15.93), ikinci (52.39±14.77), üçüncü (53.86±18.97) ve dördüncü (47.41±16.13) sınıfların puan ortalamalarından anlamlı düzeyde yüksek olduğu bulunmuştur ($p<0.001$). Cinsellik ve cinsel sağlık ile ilgili ders almayan öğrencilerin CMÖ toplam puan ortalamaları ders alanlardan anlamlı düzeyde yüksek bulunmuştur ($p<0.05$). Ayrıca cinsel sağlık ile ilgili bilgilerini yeterli bulmayan öğrencilerin CMÖ toplam puan ortalamaları bilgilerini yeterli bulanlardan anlamlı düzeyde yüksek bulunmuştur ($p<0.05$). Bu çalışmada ebelik eğitimi boyunca birinci sınıftan itibaren cinsel mitlerin sürekli bir şekilde azalma gösterdiği bulunmuştur. Ayrıca cinsellik ve cinsel sağlık ile ilgili ders almak cinsel mitleri azaltmaktadır. Cinsel sağlık ve üreme sağlığı ile ilgili eğitimlerin tüm yaş gruplarında sistematik olarak verilmesi önerilebilir.

Anahtar Kelimeler: Cinsellik, cinsel mitler, ebelik öğrencileri

1. INTRODUCTION

Sexuality is one of the issues that have been much wondered and most banned during history. This fact has provided a basis for the generation of misinformation, expectations and sexual myths in time. Sexual myths are the ideas on sexuality which are exaggerated, false and unscientific but people believe to be true. These false beliefs affect sexual attitudes and behaviors of the individuals; and thus, may cause situations that may influence their sexual health and general health (Torun, Torun and Özaydın, 2011, Sungur 2013). It has been indicated that sexual behaviours and sexual myths of the individuals are closely associated with their information sources. School and family are the main sources of information in sexual health education that are most reliable and acceptable. However, families and schools are passive in sexual education during adolescence period in Turkey; and they are not effective (Evcili and Gölbaşı, 2019). Sexual health issues that are not addressed during adolescence period lead to various problems at advanced ages. Moreover,

conservative and patriarchal family structure in Turkey makes it difficult to communicate for family members about sexuality-related issues. Although it is on the agenda, sexual health education is not yet given in the schools (Evcili and Gölbaşı, 2019). Due to all these reasons, adolescents can not have an efficient sexual health education before university. Inability to get an adequate education on sexual health confronts sexual myths as predisposing, triggering and maintaining factors in the emergence of sexual health problems (Güneş et al. 2016). Especially lack of sexual education and knowledge and false beliefs on sexuality have been known to cause sexual dysfunction, and even sexual violence events (Evcili and Gölbaşı 2016,Yancı and Polat 2019). In this context, training of the society in the field of sexual health and development of a social awareness on sexual myths will contribute to the resolution of sexual problems as well as it will be an important step for the struggle with sexual violence (Evcili and Gölbaşı 2016, Eker and Erdener 2011, Aygin et al. 2017, Ünal Toprak and Turan 2020).

Previous studies have shown that healthcare professionals also have sexual myths like society. In the study by Uji et al., it was stated that nurses were the ones who admitted rape myths and who performed first aid or first interview to rape victims (Uji et al. 2007). Similarly, doctors were found to deal mostly with physical damage in sexual violence events and did not care real victimization experienced. However, it is essential and important that a healthcare professional should be devoid of sexual myths as possible in order to prevent sexual health problems and sexual violence events, to raise the awareness of public in this subject or to evaluate the condition without prejudice and bias. This study was carried out to evaluate sexual myths of student midwives who will provide health care service in the future.

2.MATERIAL AND METHOD

This descriptive study was performed with the students of a midwery department in a state university in Ankara in January 2019.

2.1. Sample and participants

This study was conducted with 301 students who were studying in the midwifery department of a university in Ankara, Turkey during 2018-2019 fall semester. Total number of students studying in the department was 497. The study was carried out with the students who were present at school during the dates of data collection and who approved to participate in the study. 80.08% of the universe constituted the sample in the study.

2.2.Data collection instruments

Data of the study were collected by an information form and Sexual Myths Scale which was developed by Golbasi et al. in 2016 (Golbası et al. 2016).

Information form

There were four questions regarding age, sex, marital status and family type of the students in the information form. Besides, there were also five questions in the form determining their characteristics related to sexual health.

Sexual Myths Scale (SMS)

Sexual Myths Scale, which was developed by Golbasi et al. in 2016, consists of 8 subscales and a total of 29 items. The scale is 5-point Likert type; and the questions can be scored from totally disagree (1 point) to totally agree (5 points). In the scale, subscales of sexual orientation includes item 1-5, gender includes items 6-11, age and sexuality includes items 12-15, sexual behaviour includes items 16-18, masturbation includes items 19-20, sexual violence includes items 21-24, sexual intercourse includes items 25-26 and sexual satisfaction includes items 27-28. The scores given to each item are added up; and thus, total score of the scale is obtained. Besides, the scores of subscales can be retrieved by adding up the score of each item in the subscales. The scale does not have a cut-off point; and a high score obtained from the scale indicates a high ratio of sexual myths (Golbası et al. 2016). In the study, cronbach's alpha coefficient of SMS was found to be 0.927.

2.3. Statistical Analysis

Data were analyzed by using SPSS 21.0 (Statistical Package for Social Sciences) package program. Normality of data was evaluated by Shapiro-Wilk test. Descriptive statistics, independent samples t test and one way anova test were used to assess data. Tukey and Games-Howell post-hoc tests were used to determine which group created the difference at the end of variance analysis. $P<0.05$ was considered as statistically significant.

2.4. Ethical considerations

The study was based on the ethical principles of Helsinki Declaration. A written permission was taken from the institution where the study was conducted; and students provided verbal consent to participate in the study.

3.RESULTS

In this study, mean age of the students was 20.2±1.5 years old (min: 18.00. max: 32.00); 66.1% were within 18-20 year old age group; 93.3% were females; 97.3% were single; 85.7% had a core family and 30.9% were third year students (Table1).

Table 1. Sociodemographic characteristics of the students

Sociodemographic characteristics	**n**	**%**
Age group		
18-20 years	199	66.1
21 years and older	102	33.9
Sex		
Female	296	98.3
Male	5	1.7
Marital status		
Single	293	97.3
Married or having a partner	8	2.7
Family type		
Core	258	85.7
Large	32	10.6
Broken	11	3.7

It was determined that 59.5% of the students considered their knowledge on sexual health as sufficient, 46.5% acquired their first information regarding sexual health from school and 64.8% had taken a course on sexuality and sexual health. In addition, 42.2% had a partner and 67.8% evaluated their general sexual health as good (Table 2).

Table 2. Sexual health-related characteristics of the students

Sexual health-related characteristics	**n**	**%**
Considering their knowledge on sexual health as sufficient		
Yes	179	59.5
No	122	40.5
Way of acquiring first information on sexual health *		
School	140	46.5
Family	106	36.2
Friends	109	36.2
TV	85	28.2
Books	85	28.2
Porn	3	1.0
I did not acquire any information	5	1.7
Taking any courses on sexuality and sexual health		
Yes	195	64.8
No	106	35.2
State of having a partner		
Yes	127	42.2
No	174	57.8
Level of assessing sexual health in general		
Good	154	67.8
Moderate	69	22.9
Bad	28	9.3

*answers are more than one.

The mean scores of SMS and its subscales were given in Table 3. Mean total SMS score was found to be 53.92±17.26; and the highest mean score was found as 13.10±5.07 by sexual orientation subscales.

Table 3. Mean scores of SMS and its subscales

SMS Subscales	M±SD*	Minimum	Maximum
Sexual orientation	13.10±5.07	5.00	25.00
Gender	9.23±4.25	6.00	30.00
Age and sexuality	7.31±3.46	4.00	20.00
Sexual behaviour	4.43±2.29	3.00	15.00
Masturbation	4.81±2.24	2.00	10.00
Sexual violence	6.21±2.94	4.00	20.00
Sexual intercourse	4.41±2.02	2.00	10.00
Sexual satisfaction	4.37±1.93	2.00	10.00
SMS Total	53.92±17.26	28.00	124.00

*Mean± Standard Deviation

Mean score of the females from age and sexuality subscale of SMS was 7.3±3.4 and mean score of the males was found to be 4.6±0.8. The difference between both groups for sex was found to be statistically significant ($p<0.001$). It was also found that sex of the students did not create a significant difference on mean SMS and subscale scores ($p>0.05$).

Mean score of the first year students from sexual orientation subscale of SMS (15.0±5.0) was found to be significantly higher than second (12.6±5.0), third (12.9±4.5) and fourth (11.5±5.3) year students ($p<0.001$). Moreover, mean score of first year students from age and sex subscale of SMS (9.1±3.5) was statistically significantly higher than second (7.1±2.9), third (7.0±3.7) and fourth year students (5.6±2.2) ($p<0.001$). In addition, mean scores of second and third year students were significantly lower than first year students but higher than fourth year students ($p<0.001$).

Mean score of fourth year students from masturbation subscale of SMS (3.7±1.9) was found to be significantly lower than first (5.5±2.0), second (5.1±2.5) and third (4.7±2.0) year students ($p<0.001$). The groups creating difference in terms of sexual violence subscale of SMS were first and second year students; and mean score of first year students (6.9±3.2) were found to be significantly higher compared to second year students (5.5±2.1) ($p<0.05$).

In sexual intercourse subscale of SMS, mean scores of first (5.0±1.7) and second (4.8±1.8) year students were determined to be significantly higher than third (3.9±2.0) and fourth (3.8±2.1) year students ($p<0.001$). Besides, mean scores of first (4.6±1.8) and third year students (4.5±2.0) from sexual satisfaction subscale were found to be higher than fourth year students (3.6±1.7) at a statistically significant level ($p<0.05$). For total mean score of SMS, mean score of first year students (60.57±15.93) was significantly higher compared to the scores of second (52.39±14.77), third (53.86±18.97) and fourth year students (47.41±16.13) ($p<0.001$). It was found that the class in which the students were educated did not make a significant difference on mean scores of the subscales including gender and sexual behaviour ($p>0.05$).

When total SMS and subscale scores were compared based on family type, mean scores of the students having a large family from sexual orientation (15.1±4.7), age and sexuality (15.1±4.7) and sexual intercourse (5.3±2.2) subscales and total SMS (61.8±20.2) were found to be significantly higher than the ones who had a core family (12.9±4.9, 7.1±3.2, 4.31±1.9 and 53.05±16.70, respectively) ($p<0.05$). It was also found that there were not statistically significant differences in gender, sexual behaviour, masturbation, sexual violence and sexual satisfaction subscales based on family type ($p>0.05$).

In this study, mean scores of total SMS and subscales of sexual orientation, age and sexuality, masturbation, sexual violence and sexual intercourse were found to be significantly higher among the students who did not have a partner compared to the ones who did ($p<0.05$). Mean scores of the students, who did not take a course on sexuality and sexual health, from total SMS and subscales of sexual orientation, age and sexuality, masturbation and sexual intercourse were found to be higher than the participants who had taken the course at a statistically significant level ($p<0.05$). Furthermore, mean scores of the ones who did not consider their knowledge on sexual health as sufficient from total SMS and the subscales including sexual orientation, age and sexuality, masturbation, sexual intercourse and sexual satisfaction were significantly higher than the ones who did not consider as sufficient ($p<0.05$) (Table 4).

Table 4. Distribution of some sexual health-related characteristics of the students based on total SMS and subscale scores

SMS Subscales	Taking any course on sexual health M±SD		p[a]	Having sufficient knowledge of sexual health M±SD		p[a]
	Yes	No		Yes	No	
Sexual orientation	12.6±5.0	14.0±5.0	**0.025**	12.3±4.8	14.2±5.1	**0.001**
Gender	9.2±4.5	9.2±3.5	0.880	9.2±4.6	9.1±3.6	0.818
Age and sexuality	6.6±3.3	8.4±3.4	**<0.001**	6.8±3.4	8.0±3.4	**0.003**
Sexual behaviour	4.3±2.2	4.5±2.3	0.435	4.3±2.2	4.5±2.4	0.577
Masturbation	4.5±2.1	5.3±2.4	**0.004**	4.5±2.2	5.1±2.2	**0.015**
Sexual violence	5.9±2.7	6.6±3.1	0.055	6.0±2.9	6.4±2.8	0.376
Sexual intercourse	4.0±1.9	5.1±1.9	**<0.001**	4.1±2.0	4.8±1.9	**0.001**
Sexual satisfaction	4.2±1.9	4.6±1.8	0.060	4.1±1.8	4.6±2.0	**0.038**
SMS Total	51.6±17.2	58.1±16.6	**0.002**	51.7±17.4	57.1±16.5	**0.008**

M±SD: Mean± Standard Deviation, [a] Based on Oneway ANOVA test

Again in this study, mean scores of 18-20 year old students (n=199) from sexual orientation (13.7±4.9), age and sexuality (7.9±3.7), masturbation (5.1±2.2), sexual intercourse (4.6±1.9) and total SMS (56.1±17.2) were found to be significantly higher compared to the ones who were 21 years and older (n=102) (11.9±5.0, 6.1±2.4, 4.1±2.1, 3.9±2.0 and 49.6±16.5, respectively) ($p<0.005$). Moreover, it was seen that there were no significant differences in gender, sexual behaviour, sexual violence and sexual satisfaction subscales based on age group of the students ($p>0.05$). Also, no statistically significant differences were found between total SMS and subscale scores based on students' level of assessing their sexual health and their marital states ($p>0.05$).

4. DISCUSSION

Individuals require education and information at any age in order to have a healthy sexual life. However, there is not any standardized sexual health education program carrying out in Turkey. Inadequacies in sexual education, lack of knowledge, inability to express sexuality-related issues openly and inability to benefit from scientific resources are the most important factors paving the way for sexual myths (Evcili and Golbasi 2019, Karabulutlu and Yılmaz 2018, CETAD 2006).

In this study, it was determined that mean total SMS score of the students was relatively low compared to the literature (Vefikulucay et al. 2017, Özdemir 2018, Evcili and Demirel,Vefikulaçay et al. 2020). The reason of this can be explained by the fact that almost half of them had acquired their first information on sexual health at school. This outcome shows that sexual health education, that is given systematically and regularly, decreases sexual myths. Thus, in this study, it was observed that mean total SMS score was higher among first year midwifery students compared to the others and a significant decrease began from the second year and continued in the later years. Moreover, it was found that mean scores of SMS and subscales of sexual orientation, age and sexuality, masturbation and sexual intercourse were observed to be significantly higher among the students who did not take a course on sexuality and sexual health compared to the ones who did. This may be explained by the fact that the number of courses on sexual health has been increased within the curriculum of midwifery students and their science-based knowledge has been enhanced day by day due to these courses. As a result of their study, Ozsoy and Bulut detected that nursing students who had taken similar sexual health courses believed on less number of sexual myths (Özsoy ve Bulut 2017). In the study by Davul and Yazici which they conducted with 1st and 4th year university students, time spent during university education had a positive effect on sexual myths and attitudes (Davul ve Yazıcı 2019). Based on the results of all these studies, it can be stated that havinga midwifery or nursing education during university decreases the number of sexual myths. In addition to this, having a university education at different departments may have different influences on sexual myths. In their study with university students, Apay et al. reported more sexual myths among 4th year university students (Apay,Akpınar and Aslan 2013). Moreover, in their study on the sexual myths which were believed by the students studying at several departments, Kukulu et al. (2009) found no difference between the departments although medical students have learned more about sexuality issues (Kukulu,Gürsoy an Sözer 2009). The idea that perception of sexuality and sexual myths, which begin to shape from infancy, can not be completely changed by the formal education given at 20s may be shown as a reason of this. Also, Gunes et al. emphasized the importance of giving sexual education by proper sources at a suitable age for the extinction of sexual myths common in the society and for a healthy sexual life (Güneş et al. 2016).

One of the most commonly encountered outcomes of acquiring false or insufficient information on sexuality from inappropriate sources is sexual myths. According to the research by CETAD (2006), information sources of the individuals on sexuality were found to be their friends, environment, newspapers, magazines, movies and pornographic materials. Again according to the same study, environment and friends were indicated to be the most important information sources by all age groups. Even 42% of the women reported their first sexual information source as their "spouses" (CETAD). In the study by Apay et al., 58.8% of the university studentsreported their information sources on sexuality as the courses at school as similar to our study (Apay and Akpınar and Aslan 2013). In addition, Karabulutlu et al. found in their study that nursing students acquired sexual information mostly from written/visual media (45.9%) (Karabulutlu and Yılmaz 2018).

Although sexuality is a subject that concerns both sexes, it seems as concerning mostly males due to gender-based perceptions. At the end of a study by CETAD, the ratio of males believing in sexual myths was found to be higher (CETAD 2006). In relevant studies, it was indicated that male healthcare professionals (Özdemir 2018) and male university students had more sexual myths (Karabulutlu and Yılmaz 2018, Davul and Yazıcı 2019). Besides, the facts that men have sexual experiences at earlier ages than women and have more experiences may cause the development of their sexual patterns at an earlier age. Unlike the literature, mean total SMS score of female students was found to be higher than male students but this difference was not found to be significantly different based on sex in our study. In addition, only statistically significant difference was found between sexes in terms of age and sexuality subscale.

In our study, mean total SMS score of the students having a large family was found to be significantly higher than the other family types. In the study by Ozdemir, mean total SMS score of the ones who were living in a large family was determined to be higher (Özdemir 2018). Since living in a large family with elder parents will make it more difficult to talk about intimate issues, it is an expected circumstance to see that students, who were raised within such a family, have higher mean SMS scores. Cultural features have a significant effect in the shaping of sexual myths. For that reason, some similarities or differences may vary between the cultures. At the end of a study comparing Polish and Turkish students for sexual myths, it was found that both students believed in and approved a similar number of sexual legends (Apay et al. 2013). In another study comparing Polish and German students, it was found that Polish students' sexual myths were more and more religious (Martyniuk et al. 2015).

Mean scores of the students, who did not have a partner, were found to be significantly higher than the ones who had in terms of sexual orientation, age and sexuality, masturbation, sexual violence, sexual intercourse and total SMS ($p<0.05$). In our country, relationships with the opposite sex are not welcome. Therefore, statistically significant higher score of the students, who did not have a girl/boyfriend, from total SMS and subscales is an expected result. In terms of sexual orientation, ager and sexuality, masturbation, sexual intercourse, sexual satisfaction and total SMS, mean scores of the students who did not consider their knowledge on sexual health as insufficient were found to be significantly higher compared to the ones who did. Also in the literature, it was emphasized that feeling to have a sufficient level of knowledge on sexuality increased their self confidence (Zeren ve Gürsoy 2018). Our result supports the literature in this sense.

Moreover, the results of our study showed no statistically significant differences between mean SMS scores of the students based on marital status, place of birth, place of residency, education level of the father and occupations of the mother and father. Also, Ozdemir found in their study with healthcare staff that there were no significant differences between mean total SMS scores based on place of residency, education level of the father, education level of the mother, geographical region and income states (Özdemir 2018).

5. CONCLUSIONS

It was concluded that midwifery students, who are healthcare professionals of the future, had significantly more sexual myths in the first year of their entrance to university and these myths started to decrease from the second year and continued to decrease. Thus, it can be stated that four-year university education made students to reach accurate and scientific information and helped them to get rid of false information that they had about sexuality in time. For that reason, it may be suggested to enrich educational curricula of all healthcare professionals for sexual and reproductive health courses including all midwifery schools and to update them after reviewing for the myths. Furthermore, it is essential to generate courses on sexual and

reproductive health which are prepared by the field experts for all ages throughout educational life and to include them in the curricula. Apart from these, it may be recommended to create educational programs which are prepared and presented by experts and to increase their numbers in order toeducate families and parents.

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