



Sexual attitudes and sexual functions during pregnancy: A comparative study

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ARTICLE INFO

Keywords:

Sexuality
Attitudes
Myths
Turkish pregnant women
Syrian pregnant women

ABSTRACT

Background: Sexuality is a multidimensional, not shallow, concept that involves the biological make-up and desires of women and men. It is a complex process that is shaped by the culture to which the individual belongs and the social conditions in which he/she lives.

Aims: This descriptive and cross-sectional study aims to determine the sexual function status and sexual attitudes of Turkish and Syrian pregnant women who admitted to birth clinics in Turkey to investigate the relationship between pregnancy processes and some variables.

Methods: This descriptive and cross-sectional study population (n:200) consisted of Turkish and Syrian pregnant women who met the research inclusion criteria, agreed to participate in the research and admitted to the Y City Education and Research Hospital in Turkey.

Findings: In the study, the mean "Female Sexual Function Index (FSFI)" score of Turkish pregnant women was found to be (20.83 ± 9.28) , whereas the FSFI score of Syrian pregnant women was (16.28 ± 11.45) , Considering the Attitude Scale Towards Sexuality (ASTS), Turkish women score was found to be (123.77 ± 45.35) , in contrast the ASTS score of Syrian pregnant women was (94.74 ± 43.69) .

Clinical implications: Since sexual myths can have a negative impact on pregnant women's sexual functions, clinicians should be knowledgeable about sexuality and sexual myths.

Strengths & limitations: Regarding the limitations, first, the sample size was small. Second study results can only be generalized to this group. Last limitation, spouses of the women who participated in the study did not participate in the study

Conclusion: The study found that there is a difference in the sexual dysfunction and sexual attitudes of the women, depending on to be the refugee and socio-cultural structure.

1. Introduction

Sexuality is a multidimensional, not shallow, concept that involves the biological make-up and desires of women and men [1]. It is a complex process that is shaped by the culture to which the individual belongs and the social conditions in which he/she lives [2]. In particular, attitudes toward sexuality during pregnancy vary from culture to culture [3].

In some cultures, it is believed that frequent sexual intercourse causes twin pregnancy and facilitates childbirth by widening the vaginal canal and that partners should have frequent sexual intercourse, especially in the early stages of pregnancy, for the fetus to develop better [4]. On the other hand, in some cultures, it is forbidden for pregnant women

to have sexual intercourse, and pregnancy is seen as a sign of sexual competency [4]. According to Islamic belief, it is thought that sex during pregnancy is a sin and sexuality should be avoided because the baby will be born with blemishes on the skin due to the misperception of the vernix caseosa as sperm [5]. Pregnant women in Iran believe that sexual intercourse during pregnancy is a sin [6]. In Israel, it is believed that continuing sexual intercourse will harm the mother and baby [7]. Since motherhood represents innocence and sex is linked to pleasures that are associated with guilt and sin, a complex situation arises regarding femininity and motherhood during pregnancy [8]. These false beliefs, namely sexual myths and attitudes, can lead to sexual dysfunction by causing exaggerated and unrealistic expectations about sexuality, feelings of guilt and regret, and anxiety and fears about sexuality [5, 7, 9]. In

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<https://doi.org/10.1016/j.eurox.2023.100215>

Received 20 May 2023; Received in revised form 21 June 2023; Accepted 4 July 2023

Available online 7 July 2023

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addition, couples may be vulnerable to a decrease in sexual activity in the long term due to myths and attitudes that affect sexuality during pregnancy [10]. Despite this information, the literature does not adequately describe the sexual myths and attitudes that affect the sexual lives of pregnant women. For this reason, there is a need for research to identify cultural differences by revealing the barriers to sexuality during pregnancy.

This study was carried out as descriptive-comparative research to determine whether there was an intercultural difference in terms of sexual attitudes and sexual functions of Turkish and Syrian pregnant women.

2. Methods

2.1. Study design

A cross-sectional-descriptive and comparative design was used.

2.2. Setting and sample

The study was conducted with pregnant women in the SBU Adana City Training and Research Hospital between July and December 2022. In the study, the sample size was calculated by using the sampling of the unknown population formula on the Raosoft software. Thus, the minimum sample size that was based on a type 1 error of 0.05 and test power (power analysis) of 0.80 ($\alpha = 0.05$, $1-\beta = 0.80$) was found to be 164 participants. Assuming there could be some attrition with a 1.2 pattern effect, the number of people to be recruited was found as 197. Accordingly, pregnant women matching the criteria of the study for inclusion were included.

2.3. Inclusion criteria of the study

The study comprised women who were aged between 20 and 40 years, could communicate in Turkish or answer questions in the company of an interpreter who knew Turkish and Arabic, lived with her husband or partner, had a singleton pregnancy, were in the 1st, 2nd, or 3rd trimester, were primiparous or multiparous, and signed the voluntary consent form.

2.4. Exclusion criteria of the study

According to the exclusion criteria, women who were unwilling to continue the study, had a problem that prevented communication, had been receiving psychiatric treatment, had a serious complication or condition that could endanger the pregnancy, had a chronic disease, or had a known diagnosis of sexual dysfunction were excluded from the study.

2.5. Measures and instruments

2.5.1. Descriptive information form

The authors created this questionnaire considering similar studies in the literature. It comprises twenty-four questions about the socio-demographic, fertility, and pregnancy characteristics of women [3, 11, 12].

2.5.2. The Attitude Scale Toward Sexuality (ASTS)

Yılmaz Sezer and Şentürk Erenel (2021) developed this scale to evaluate the attitudes of pregnant women and men who have a pregnant partner toward sexuality during pregnancy and conducted its validity and reliability study [12]. It consists of 34 items and three sub-dimensions, namely "anxiety about sexual intercourse during pregnancy," "dysfunctional beliefs and values about sexuality during pregnancy," and "approving sexuality during pregnancy." Total scores on the scale vary from 34 to 170. The cut-off point of the ASTS is 111.5.

Individuals who score ≥ 111.5 on the ASTS are considered to have positive attitudes toward sexuality during pregnancy. Cronbach's alpha coefficients of the scale was 0.90 for the overall scale. In this study, this coefficient was found 0.99 for the overall scale.

2.5.3. The Female Sexual Function Index (FSFI)

This scale to assess women's sexual functions [13]. The validity and reliability study of the scale in our country was conducted by Aygin and Aslan (2005) [14]. It is a multidimensional scale with six sub-dimensions and 19 items. The sub-dimensions of the scale are "desire," "arousal," "lubrication (wetting)," "orgasm," "satisfaction," and "pain." Scores on the scale are between 4 and 95. The cut-off score was calculated as 26.55. Low scores on the scale indicate an increase in sexual dysfunction. The scale has a Cronbach's alpha of 0.98. In our study, the alpha value was calculated as 0.99.

2.6. Data collection and procedure

First, the descriptive information form was used to select the pregnant women who met the research criteria. Then, ASTS and FSFI were given to the pregnant women who met these criteria in an envelope. Considering privacy and ethical principles, the participants were taken to a suitable room in the institution alone and they were given enough time to fill out the scales. Participants who needed help while answering the statements on the scales were assisted by the researcher. The participant, who completed filling out the forms, was asked to place them in the envelope and put the envelope in the box prepared beforehand. It took each participant approximately 30 min to fill out the forms.

2.7. Ethical aspects of study

This study was approved by the Research Ethics Committee of X University (No: 122; Date: 13.05.2022) before the data collection phase was initiated. Before the study was conducted, written permission was obtained from Y City Education and Research Hospital (E-96172664-050.06.04; Date: June 28, 2022), which was the study setting. The aim of the research was explained to the participants, and then they submitted written informed consent. The procedures of the current research were performed following the principles about research comprising human participants and the principles of 1964 Helsinki Declaration. The subjects were informed they could quit the research at any stage and their personal data would be kept confidentially.

2.8. Statistical analyses

Statistical analyses were performed on the SPSS 26 software. The findings were analyzed by using descriptive statistics and frequency tables. Mann-Whitney U test was used for measurement values with a non-normal distribution, and the correlations between two qualitative variables were analyzed by using "Pearson- χ^2 " cross tables. "Binary Logistic Regression - Backward: LR method" was used to determine the factors affecting the risk of sexual dysfunction. Statistical significance was set at $p < 0.05$.

3. Results

Table 1 shows the distribution of pregnant women's socio-demographic characteristics. In the study, the mean age of Turkish and Syrian pregnant women was 29.48 ± 5.41 and 28.35 ± 5.33 , respectively. While no statistically significant relationship was found between the participants' gestational week, education level, education level of the spouse, family type, income level, employment status, whether the pregnancy was desired, and sexual dysfunction ($p > .05$), there was a statistical difference between the groups in terms of the number of pregnancies ($p < .05$, Table 1). No statistically significant

Table 1
Distribution of introductory and obstetric characteristics of Turkish and Syrian women.

Variables	Turkish (n = 100)		Syrian (n = 100)		p
	$ \bar{X} \pm S.S.$	Median	$ \bar{X} \pm S.S.$	Median	
Age (y)	29.48 ± 5.41	30.0	28.35 ± 5.33	28.5	.155**
Husband' age (y)	32.18 ± 6.40	33.0	32.44 ± 5.78	32.5	.725**
Numberof pregnancies	2.03 ± 0.94	2.00	3.18 ± 1.44	3.00	.000**
Gestational week	23.58 ± 8.27	23.50	23.47 ± 7.00	24.00	.894**
Female education level	n	%	n	%	.444*
Not literate	6	6.0	10	10.0	
Literate	8	8.0	13	13.0	
Primary school	25	25.0	24	24.0	
Middle school	40	40.0	30	30.0	
University and above	21	21.0	23	23.0	
Male education level					.532*
Not literate	3	3.0	5	5.0	
Literate	8	8.0	13	13.0	
Primary school	25	25.0	29	29.0	
Middle school	36	36.0	28	28.0	
University and above	28	28.0	25	25.0	
Family type					.108*
Immediate family	57	57.0	68	68.0	
Extend family	43	43.0	32	32.0	
Income status					.115*
High	58	58.0	72	72.0	
Middle	38	38.0	25	25.0	
Low	4	4.0	3	3.0	
Work status					.774*
Yes	40	40.0	42	42.0	
No	60	60.0	58	58.0	
Desired pregnancy					.871*
Yes	74	74.0	75	75.0	
No	26	26.0	25	25.0	
Sexual dysfunction					.144*
No	30	30.0	21	21.0	
Yes	70	70.0	79	79.0	

* Pearson- χ^2 .

** Mann-Whitney U

difference was found between the groups in terms of the ages of the participants and their spouses ($p > 0.05$, Table 1).

A statistically significant difference was found between the mean desire, arousal, lubrication, orgasm, satisfaction, and total ASTS score and the mean score on the FSFI according to the groups ($p < .05$, Table 2). It was determined that Turkish participants' mean scores on the desire, arousal, lubrication, orgasm, and satisfaction sub-dimensions and the total scale were significantly higher than the mean scores of Syrian participants ($p < .05$, Table 2). Also, Turkish participants' mean scores on the anxiety about sexual intercourse during pregnancy, beliefs about sexuality during pregnancy, and approval of sexuality during pregnancy sub-dimensions and the total scale were significantly higher than the mean scores of Syrian participants (Table 2). According to the Spearman correlation analysis, a weak and statistically significant positive relationship was found between the mean FSFI and ASTS scores of Turkish and Syrian participants ($r = .449$; $p = .000$).

As a result of the Backward: LR logistic regression analysis performed by using all the parameters in the study, the family type was found to be an important parameter affecting sexual dysfunction ($p < .05$, Table 3). Participants with an extended family type had a 5.545 times higher risk

Table 2
FSFI and ASTS total and sub-dimensions and comparison between Turkish and Syrian women.

Variables	Turkish (n = 100)		Syrian (n = 100)		p*
	$ \bar{X} \pm S.S.$	Medyan	$ \bar{X} \pm S.S.$	Medyan	
FSFI					
Desire	3.11 ± 1.07	3.6	2.72 ± 1.31	3.0	0.032
Aruosal	3.26 ± 1.59	3.6	2.48 ± 1.91	3.0	0.005
Secretion	3.55 ± 1.69	3.8	2.77 ± 2.09	3.6	0.013
Orgasm	3.56 ± 1.79	4.0	2.69 ± 2.09	3.4	0.003
Sexual success	3.75 ± 1.83	4.4	2.76 ± 2.17	3.6	0.001
Pain	3.60 ± 1.94	3.6	2.86 ± 2.30	3.6	0.051
Total score-FSFI	20.83 ± 9.28	22.9	16.28 ± 11.45	20.9	0.005
ASTS					
Anxiety about Sexual Intercourse during Pregnancy	33.50 ± 12.19	43.0	25.34 ± 11.98	26.0	0.000
Dysfunctional Beliefs and Values about Sexuality during Pregnancy	36.94 ± 14.63	48.0	28.10 ± 13.19	28.0	0.000
Approving Sexuality during Pregnanc	53.33 ± 18.86	62.0	41.30 ± 18.72	39.0	0.000
Total score-ASTS	123.77 ± 45.35	153.5	94.74 ± 43.69	93.0	0.000

* Mann-Whitney U

for sexual dysfunction than those with a nuclear family type ($OR=5.545$). Another parameter affecting sexual dysfunction was the total ASTS score ($p < .05$, Table 3). A one-unit increase in total ASTS score decreased the risk for sexual dysfunction by 1.2% ($OR=.988$, Table 3).

4. Discussion

Although medical developments reduce false beliefs and myths about pregnancy in today's society, it is seen that they continue to exist, especially in eastern societies. This situation negatively affects pregnant women's sexual health [3,15]. In this study, during-pregnancy sexual attitudes and sexual dysfunctions of Syrian refugee pregnant women who lived in Turkey and Turkish pregnant women were determined and the results were discussed in light of the findings in the literature in this section.

The research was carried out with 200 pregnant women in X province of Turkey. It is important for the reliability of the research that the groups in the study are similar in terms of socio-demographic characteristics. It was determined that there was a difference between the Syrian and Turkish pregnant groups in terms of their mean scores on the total ASTS and FSFI and their sub-dimensions. It was also determined that extended family structure and sexual attitudes were important parameters affecting sexual dysfunction. In the model established by considering the correlations between the variables, it was found that participants with an extended family type had 5.5 times more sexual dysfunction and a one-unit increase in ASTS scores decreased the rate of having sexual dysfunction by 1.2 units.

Although it is stated in the literature that myths about sexuality cause sexual dysfunction [16], no studies showing the effects of sexual attitudes on sexual dysfunction during pregnancy have been found. However, some studies in the literature have shown that sexual activity during pregnancy is taboo and avoided in some cultures [17]. While motherhood is accepted as a symbol of purity in different cultures and communities, sexuality is mostly associated with pleasures involving the

Table 3
Logistic Regression model based on sexual dysfunction disorder.

Variable	B	S.H.	Wald	sd	p	OR	95% (OR)	
							Lower	Top
Family type*	1.713	.473	13.108	1	.000	5.545	2.194	14.017
ASTS- Total	-0.012	.004	9.175	1	.002	0.988	0.980	0.996
Stable	2.083	.546	14.526	1	.000	8.026		

* Reference category: Immediate family CCR= 75.0% $\chi^2_{(8)}= 10.416$; p = .237

body, sin, and guilt [18]. This understanding leads to a complexity regarding femininity and motherhood in pregnancy [19]. The negative attitudes of pregnant women toward sexuality resulting from these contradictory thoughts may cause sexual dysfunctions. In the study, it was determined that Turkish pregnant women's attitudes toward sexuality (123.77 ± 45.35) were more positive than those of Syrian pregnant women (94.74 ± 43.69). Today, approximately 3.5 million Syrian citizens who migrated due to the civil war in Syria live in Turkey [20]. It can be said that Syrian individuals living in Turkey as refugees have more negative attitudes toward sexuality due to their living conditions, struggle to live in a different country, and not knowing the norms and cultural characteristics of the country they live in and that as a result of these negative factors, sexual dysfunction is more common.

In the study, it was determined that Turkish pregnant women (70%, total FSFI score: 20.83 ± 9.28) had less sexual dysfunction than Syrian pregnant women (79%, total FSFI score: 16.28 ± 11.45). In a descriptive study (508 participants) with Turkish pregnant women and their spouses on sexual dysfunction in Turkey, Gumusay et al. (2021) found that 76.4% of women lost interest in sexual intercourse during pregnancy and that the mean score on the total FSFI was 17.82 ± 11.81 [21]. In the study conducted with 252 healthy Turkish pregnant women by Angin et al. (2020), the participants' mean FSFI score was 18.4 ± 9.8 [22]. In a cross-sectional study conducted with 472 Turkish pregnant women by Aksoy Derya et al. (2020), it was found that 54.7% of the women had sexual dysfunction and that the mean FSFI score was 18.97 ± 8.11 [23]. Confusion regarding the roles of "parent" or "partner" during pregnancy due to sexual attitudes and sexual myths in society can be considered the cause of this sexual dysfunction [24]. This situation clearly reveals the cultural differences between countries. When pregnant women's mean scores on the sub-dimensions of the FSFI were compared, it was seen that the mean sub-dimension score of Turkish pregnant women was > 3.00 . For a threshold value to be taken into account in the international domain, the norm values of the society must be known. However, the threshold value for FSFI varies in different study groups [25–27].

It was observed that the majority of couples had sexual intercourse until the seventh month of pregnancy [28]. The mean scores of Syrian pregnant women on the "arousal" and "orgasm" sub-dimensions of the FSFI were quite low compared to those of Turkish pregnant women. We think that the reason for this difference in arousal phase between countries may be due to the number of pregnancies that the participants had. It can be said that this is because the labia majora are similar in shape before pregnancy in primiparas, they are extremely large and edematous in multiparas, and this situation continues throughout the 1st and 2nd trimesters of pregnancy [29].

5. Conclusions

This study revealed the sexual attitudes and sexual dysfunction of refugee and local women during pregnancy. According to the comparison of the mean FSFI scores of the women in the study group, it is clear that sexual dysfunction is a common health problem in all societies covered by the study and can affect women's quality of life. In conclusion, the sexual dysfunction of women and accordingly their sexual attitudes during pregnancy should be investigated and they should be provided with counseling during routine health check-ups during pregnancy. It is important to know the norms and values of individuals

from different ethnic origins living in society to increase the quality of life of pregnant women and have a problem-free sexual life. For this reason, all health personnel, especially midwives, should consider the socio-cultural characteristics of women and develop effective coping methods within the framework of a holistic approach before evaluating their attitudes toward sexual life and sexuality. It is thought that health services can be effective as a result of such approaches. It is of great importance that health professionals use intercultural care models so that they can access the cultural data of the individuals living in the society that they serve in a more systematic and standard way.

6. Limitations

This research has several limitations. First, since pregnant women's spouses were not included in the study, only women's views on sexual attitudes and sexual dysfunction during pregnancy were evaluated. The second limitation is that the participants' feelings, thoughts, and concerns could not be evaluated because the research was not qualitative. The last limitation is that the findings of the study cannot be generalized to other Syrian refugee pregnant women and Turkish pregnant women living in Turkey since the study was conducted with Syrian refugees and Turkish participants in a single region of Turkey.

Declaration of Competing Interest

The authors declare that they have no known competing financial interests or personal relationships that could have appeared to influence the work reported in this article.

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