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The relationship between pregnant women and their spouses' belief in sexual myths during pregnancy, relationship satisfaction and sexual satisfaction

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ABSTRACT

Aim: Pregnancy, birth and post-partum period is an important process in which many physiological, psychological and social changes are experienced by mothers and fathers. Pregnancy is also one of the periods when sexuality is most affected, and sexual dysfunctions are common during this period. The aim of this study is to investigate the sexuality and sexual myths of pregnant women and their partners.

Material and Method: This research was conducted in an university hospital in Turkey with a total of 128 participants, 77 pregnant women and 51 spouses who agreed to participate.

Results: There was a statistically significant relationship in terms of working status, having a history of miscarriage in the family, and sexual knowledge adequacy before marriage. Men's employment rate and pre-marital sexual knowledge adequacy status were higher than women. A statistically significant difference has been achieved in the "Sexuality/Attractivess" sub-dimension in Sexual Myths During Pregnancy Scale (SMDPS) and the "Avoidance" and "Communication" sub-dimensions in Glombock - Rust sexual satisfaction Scale (GRSSS). An inverse low correlation between sexual myths during pregnancy and GRSSS in men and low-level lineer relationship between GRSSS and Relationship Satisfaction Scale(RSSS) scores in women are detected.

Conclusions: Exaggerated, false beliefs that are considered true but not actually related to sexuality, sexual myths negatively affect the relationship of couples. The prevalence of sexual myths during pregnancy will decrease and the impact on the quality of sexual life during pregnancy will be minimized by obtaining consultancy services.

Keywords: Pregnancy, sexuality, sexual satisfaction, myth, relationship satisfaction

INTRODUCTION

Pregnancy, birth and post-partum period is an important process in which many physiological, psychological and social changes are experienced by mothers and fathers (1). Pregnancy is also one of the periods when sexuality is most affected, and sexual dysfunctions are common during this period (2).

Despite the age of information and technology, common causes of sexual dysfunction in women include sexual inexperience or lack of knowledge, growing up in a conservative society, deficiencies in sexual education, and false beliefs and myths about sexuality (3). These factors affect the sexual attitudes and behaviors of couples during a sensitive period such as pregnancy, causing negativity in the sexual life of couples (4).

Sexual myths are mythical beliefs that have not been scientifically clarified in terms of sexuality and have no evidence for individuals. Sexual myths are among the factors that can affect general public health, as they affect the sexual process and quality of sexual life. In addition, common beliefs and attitudes may differ both between cultures and regionally. These differences are based on individuals, age, gender, education, family type varies between (5).

It was stated that false beliefs of pregnant women negatively affect sexual function, and it was determined that less sexual intercourse, less desire and less arousal occurred in pregnant women with false beliefs in this process (6). Fear of harming the fetus or pregnancy is among the reasons

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for this decrease (7). Although sexual intercourse has been proven to be safe in all trimesters, the widespread fear of harming the fetus/pregnancy is explained by the prevalence of sexual myths and lack of sexual knowledge (8). As can be seen, sexual myths still maintain their prevalence today, and with the continuing lack of sexual knowledge, sexual myths affect the quality of sexual life.

Almost all of the sexual myths consist of negative attitudes that sexual intercourse during pregnancy will be harmful, and these attitudes also negatively affect the quality of sexual life. Pregnant women avoid sexual intercourse due to the fear of harming the fetus during pregnancy and the thought that sexual intercourse will cause miscarriage and bleeding, and this situation negatively affects the quality of sexual life (9,10).

For this reason, it is important to reveal the attitudes and knowledge levels of pregnant women and spouses towards sexual myths (11). Although there were studies examining sexual myths in previous literature, no article investigating the sexuality and sexual myths of pregnant women and their partners have been published. Regarding this purpose we assume that our research will be an important step in determining the myths about sexuality of pregnant women and their pregnant spouses and identifying possible sexual problems they experienced.

The aim of this study was to elucidate false information, attitudes and beliefs of pregnant women and their partners about sexual life during pregnancy. Additionally, determinining the myths on the relationship between relationship satisfaction and sexual functions and providing training and consultancy in order to contribute to a healthy sexual life and healthy family structure would be positioned as an important asset.

MATERIAL AND METHOD

The study was carried out with the permission of Balıkesir University Health Sciences Non-Interventional Researches Ethics Committee (Date: 22.03.2022, Decision No: 2022/34). All procedures followed were in accordance with the ethical standards of the responsible committee on human experimentation (institutional and national) and with the Helsinki Declaration of 1975, as revised in 2008. This research has been conducted as a survey within 128 individuals who have applied to our institution in Turkey.

77 pregnant women and 51 spouses over 18 years old and at least graduated from primary school has been enrolled within the scope of this study. Patients diagnosed with mental retardation and psychotic disorder, individuals with primary or acquired neurological diseases that may affect cognitive abilities (stroke, dementia, head trauma, cranial operation) and those with ongoing alcohol or substance abuse were excluded. An informed consent form was obtained from the participants who agreed to participate in the study. Sexual Myths During Pregnancy Scale(SMDPS), Glombock - Rust sexual satisfaction Scale(GRSSS), Relationship Satisfaction Scale(RSSS) were applied.

Patient data collected within the scope of the study were analyzed with the IBM Statistical Package for the Social Sciences (SPSS) for Windows 23.0 (IBM Corp., Armonk, NY) package program. Frequency and percentage were given for categorical data, and median, minimum and maximum descriptive values for continuous data. "Mann Whitney U Test" was used for comparisons between groups, and "Chi-square or Fisher's Exact Test" was used for comparison of categorical variables. "Spearman Correlation Analysis" was used to evaluate the relationship between continuous variables. The results were considered statistically significant when the p value was less than 0.05.

RESULTS

Within the scope of the study, a total of 128 individuals, 51 (39.8%) male and 77 (60.2%) female, were included in the evaluation. The distribution of the socio-demographic characteristics of the participants according to their gender was given in **Table 1**. When the table was examined, it was seen that there was a statistically significant relationship in terms of working status, having a history of miscarriage in the family and sexual knowledge adequacy before marriage ($p<0.05$). It was seen that men's employment rate and pre-marital sexual knowledge adequacy status were higher than women.

The distribution of sexual myths during pregnancy, Glombock - Rust sexual satisfaction and relationship satisfaction scale scores by gender of the participants were elaborated in **Table 2**. When the table was examined, it was seen that there was a statistically significant difference between the two groups in the "Sexuality/ Attractivess" sub-dimension and the "Avoidance" and "Communication" sub-dimensions ($p<0.05$). The median scale score of women was higher than men in significant parameters.

Sexual myths during pregnancy, Glombock - Rust sexual satisfaction and relationship satisfaction scale scores have been analyzed via Spearman correlation analysis (**Table 3**). When the table was examined, it was seen that there was an invers low correlation between sexual myths during pregnancy and Glombock - Rust sexual satisfaction scores in men, and a lineer low-level relationship between Glombock - Rust sexual satisfaction and relationship satisfaction scale scores in women ($p<0.05$).

Table 1. Distribution of socio-demographical characteristics of individuals by gender

Characteristics	Total (N=128)	Male (n=51)	Female (n=77)	p-value
	n (%) or Median (Min-Max)	n (%) or Median (Min-Max)	n (%) or Median (Min-Max)	
Age, years	29 (18-46)	30 (24-46)	29 (18-42)	
Residential area				0.617
City	82 (64.1)	34 (66.7)	48 (62.3)	
Village – town	46 (35.9)	17 (33.3)	29 (37.7)	
Working status	79 (61.7)	48 (94.1)	31 (40.3)	<0.001
Marriage age				0.134
≤18 years	1 (0.8)	0 (0)	1 (1.3)	
18 – 25 years	66 (51.6)	20 (39.2)	46 (59.7)	
26 – 30 years	44 (34.4)	21 (41.2)	23 (29.9)	
31 – 35 years	13 (10.2)	8 (15.7)	5 (6.5)	
≥36 Years	4 (3.1)	2 (3.9)	2 (2.6)	
Duration of marriage				0.817
0 – 1 years	29 (22.7)	12 (23.5)	17 (22.1)	
1 – 3 years	45 (35.2)	20 (39.2)	25 (32.5)	
3 – 5 years	12 (9.4)	4 (7.8)	8 (10.4)	
5 years or above	42 (32.8)	15 (29.4)	27 (35.1)	
Way of conceving				0.585
Natural	113 (88.3)	44 (86.3)	69 (89.6)	
With treatment	15 (11.7)	7 (13.7)	8 (10.4)	
Previous miscarriage	28 (21.9)	6 (11.8)	22 (28.6)	0.042
Sexual knowledge adequacy before marriage	104 (81.3)	47 (92.2)	57 (74)	0.019
Sexual guilt during pregnancy	7 (5.5)	2 (3.9)	5 (6.5)	0.702
Frequency of sexual intercourse during pregnancy				0.176
≤ 3/months	80 (62.5)	36 (70.6)	44 (57.1)	
≥ 4 /months	48 (37.5)	15 (29.4)	33 (42.9)	
Sexual knowledge adequacy during pregnancy	97 (75.8)	36 (70.6)	61 (79.2)	0.365
Previous sexual disorder	5 (3.9)	0 (0)	5 (6.5)	0.156

Table 2. Distribution of survey scores by gender of individuals

Chractersitics	Total (N=128)	Male (n=51)	Female (n=77)	p value
	n (%) or Median (Min-Max)	n (%) or Median (Min-Max)	n (%) or Median (Min-Max)	
Sexual myths during pregnancy				
Pregnancy & sexual life	14 (5-21)	14 (6-21)	14 (5-21)	0.578
Concern for baby	10.5 (7-33)	9 (7-28)	11 (7-33)	0.555
Sexuality/attractivess	8 (5-20)	7 (5-20)	9 (5-20)	0.008
Concern for pregnancy	16 (8-32)	16 (8-32)	16 (8-32)	0.606
Glombock - Rust sexual satisfaction scale				
Touching	2 (0-14)	1 (0-12)	3 (0-14)	0.062
Avoiding	1 (0-12)	1 (0-9)	2 (0-12)	0.024
Satisfaction	3 (0-12)	3 (0-12)	3 (0-12)	0.381
Frequency	3 (0-7)	3 (0-6)	3 (1-7)	0.387
Communication	3 (0-8)	2 (0-8)	3 (0-8)	0.008
Relationship satisfaction scale	40,5 (19-42)	41 (25-42)	40 (19-42)	0,408

Table 3. Distribution of the relationship between the survey scores of the individuals by gender

Spearman's RHO			SMDPS	GRSSS	RSSS
Male	SMDPS	Correlation coefficient	1.000	-0.406	-0.106
		p-value	-	0.003	0.460
		N	51	51	51
Female	GRRSS	Correlation coefficient	0.153	1.000	0.417
		p-value	0.184	-	<0.001
		N	77	77	77

SMDPS:Sexual Myths During Pregnancy Scale, GRSSS:Glombock - Rust Sexual Satisfaction Scale, RSSS:Relationship Satisfaction Scale

DISCUSSION

Sexual attitudes and behaviors are shaped by environmental factors such as social value judgments, laws, history, lifestyle, traditions, religious belief, culture and moral attitudes, gender roles, and social status (12). In a study, it was stated that the sexuality perception of couples, cultural norms, parenting thoughts, lack of knowledge, and negative thoughts about sexual life had a negative effect on sexuality during pregnancy (13).

Physiological situations such as nausea and vomiting, weakness and tiredness experienced during pregnancy are among the factors affecting sexuality in pregnant women. Most pregnant women think that their sexual functions are decreased in this period. Due to these problems, it is inevitable to experience some difficulties between spouses in the field of sexuality as well as in all areas of life (14).

Changes in the body image of the pregnant also negatively affect the sexual life during pregnancy. Especially in the later stages of pregnancy, pregnant women may be worried due to weight gain, enlargement of the abdomen and breasts, thickening of the waist, and darkening of the vagina color due to pigmentation (15). Women also experience the fear of losing their sexual attractiveness, love and interest of their spouses during pregnancy (16). This situation was also supported by previous studies, and women stated that the sexual intercourse they experienced during pregnancy was initiated by their husbands, they had sex to prevent their husbands' infidelity and they could not have an orgasm (17 – 19). In our study, the sexual myths during pregnancy parameters and Glombock - Rust sexual satisfaction and relationship satisfaction scale scores by gender of the participants were statistically significantly different between the two groups in the "Gender/Attraction" sub-dimension and the "Avoidance" and "Communication" sub-dimensions.

Although there are no biological differences in men during pregnancy, it is known that they also show some psychological reactions in adapting to the new role (20). Therefore, pregnancy is considered as an event that affects the psychological state of men. Acceptance of pregnancy in men includes not only the acceptance of the baby but also the changing state of the mother. In this case, men try to adapt to pregnancy by being more emotionally involved with their wives, keeping their wives in the foreground, and searching for pregnancy-specific information, and they feel happy and proud about being a father (21,22).

In the second half of pregnancy, father candidates become more aware of the pregnancy and begin to accept the baby thoroughly. Couples do not change their routine sexual lives due to the fact that sexuality is not affected much in the second trimester, thus increasing their interdependence (23). However, men who feel the fetus fully due to the enlargement of the uterus in the future, bargain with their feelings and emotions about having sex not only with their spouse, but also with the woman who will be the mother of their baby. Some men, on the other hand, believe that touching a pregnant woman, even if they want sexual intercourse with their wives, is defiling something sacred. Others believe that it is immoral to have sex with a pregnant woman and therefore avoid sexual intercourse. On the other hand, most men think that touching their wives during pregnancy increases happiness and peace (22). During this period, couples should maintain a healthy relationship in order to develop mutual emotional bonds and close physical attraction, as well as to share sexual satisfaction and meet each other's sexual needs (24).

Despite this, the results of some studies show that sexual intercourse can be most comfortable in the first trimester. Pauleta et al. (25) found in their study with pregnant women that they had sexual intercourse most frequently in the first trimester and that their sexual desire and satisfaction in this trimester did not change compared to the pre-pregnancy period. On the contrary, Zahumensky et al. (26) stated that the least sexual involvement among the three trimesters was the first trimester, however, as the pregnancy progressed, sexual dysfunctions increased and coitus accompanied by orgasm decreased.

Libido is affected by physical and mental changes during pregnancy. Increases and decreases in libido can be seen at various stages of pregnancy. While the variability in libido is quite evident in the mother-to-be, it is milder or not observed in the father-to-be (27). Frequency of sexual intercourse is an important parameter that informs us about the level of libido. The common view in many studies on this issue is that the frequency of sexual intercourse decreases significantly during pregnancy when compared to the pre-pregnancy period (28).

In a meta-analysis of 59 studies dealing with pregnancy and the postpartum period, it was concluded that the frequency of sexual intercourse slightly decreased or even did not change in the first trimester, it was very variable in the second trimester, and decreased significantly in the third trimester (29).

When libido is examined in terms of initiating sexual activity, it is seen that this activity is usually initiated by the male partner before and during pregnancy. Naim and Bhutto (30) stated that mostly men initiate sexual intercourse during pregnancy and rarely women in an early publication. In the study of Gökyıldız and Beji (19) on 150 Turkish pregnant women, it was shown that the initiator of sexual intercourse during pregnancy was generally answered as male. It is understood that the male

partner is significantly dominant in initiating sexuality before and during pregnancy. The reason for this may be the cultural structure of the society and the biological structure of the woman (22).

Sexual intercourse resulting in orgasm has been examined in many studies and it has been determined that it decreases significantly before pregnancy compared to the gestational period (28). In this study we have found an inverse low correlation between sexual myths during pregnancy and Glombock - Rust sexual satisfaction scores in men, and a lineer low-level relationship between Glombock - Rust sexual satisfaction and relationship satisfaction scale scores in women.

From this point of view, it is possible to say that the quality of sexual life is among the factors affecting the quality of life. Scientific explanation of sexual myths during pregnancy and including sexual myths during pregnancy among the topics to be emphasized while providing consultancy services will enable individuals to access accurate information, and thus, the rapidly spreading sexual myths during pregnancy will leave their place to scientifically based information (22). In our study it was determined that men's employment rate and pre-marital sexual knowledge adequacy status were higher than women, which was an expected finding of our geography.

The prevalence of sexual myths during pregnancy will decrease and the impact on the quality of sexual life during pregnancy will be minimized by obtaining consultancy services on how sexual life will take place during pregnancy and obtaining information from the right sources. At this stage nurses should give priority to issues related to sexuality during pregnancy, because throughout history, the relationship between pregnancy and sexuality has been influenced by the existence of cultural stereotypes, misperceptions, myths and taboos (22).

The strength of this research could be attributed to the idea that although there were studies examining sexual myths in the literature, this was the first study that comparatively investigated the sexuality and sexual myths of pregnant women and their partners.

CONCLUSION

The meaning attributed to the concepts of sexuality and sexual health is significantly influenced by religious rules, taboos and traditions. It is thought that sesxual myths about pregnancy may have an effect on sexual satisfaction and relationship satisfaction. Providing counseling services will reduce the prevalence of sexual myths during pregnancy and increase the quality of sexual life.

ETHICAL DECLARATIONS

Ethics Committee Approval: The study was carried out with the permission of Balıkesir University Health Sciences Non-Interventional Researches Ethics Committee (Date: 22.03.2022, Decision No: 2022/34).

Informed Consent: All patients signed the free and informed consent form.

Referee Evaluation Process: Externally peer-reviewed.

Conflict of Interest Statement: The authors have no conflicts of interest to declare.

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