Original Article

Relationship between Sexual Myths and Sexual Function of Women

Nulufer Erbil, RN, PhD
Professor, Department of Obstetrics and Gynecology Nursing, Faculty of Health Sciences, Ordu University, Ordu, Turkey

Correspondence: Nulufer Erbil, RN, PhD, Professor, Department of Obstetrics and Gynecology Nursing, Faculty of Health Sciences, Ordu University, Cumhuriyet Campus, 52200, Ordu, Turkey
E-mail: nerbil@odu.edu.tr nulufererbil@gmail.com

Abstract

Background: Sexual ignorance or misinformation on sexual issues may lead to the formation of erroneous cognitive schemes such as extreme anxiety, feelings of guilt, unrealistic expectations, or fear of failure.
Aim: The study was conducted to investigate the relationship between sexual myth beliefs and sexual function of Turkish women.
Material and methods: The sample of this descriptive and cross-sectional study were included 402 women. Measures were collected using questionnaire form, the Female Sexual Function Index (FSFI) and Sexual Myths Form.
Results: The mean of the total FSFI score of women was 25.01 (SD 7.06). Themean of the sexual myths of women was 22.59 (SD 8.73). Twenty-five sexual myths of 48 sexual myths were answered as "right", higher rate than 50% by women. It was determined that FSFI and subscales including orgasm, satisfaction did not correlate with sexual myths score, while desire, arousal, lubrication, pain and total FSFI score did negatively correlate with the sexual myths score of women. It was found that 53.2 % of women had a sexual dysfunction. The sexual myths score of women with sexual dsyfunction was higher than women with normal sexual function, and difference was statistically significant ($p<0.001$).Women's age, education level, occupation, mother's education, husband's education, husband's occupation, residence, family type, marriage type, opinion about virginity and information about sexuality affected their sexual myth scores. Women with lower duration of marriage and higher number of children had higher sexual myths scores. Correlation between FSFI scores and sexual myths scores of women was found.
Conclusions: The study exposed that correlated of sexual function and sexual myths of women. It is recommended that it is necessary to start education from childhood to eliminate sexual myths from the society. Healthcare providers undertake interventional studies in this regard in order to correct sexual myths.

Key words: Sexual function; Sexual myth; Sexual belief; Women sexuality.

Introduction

Although sexuality plays an important part in most people's lives, it remains a topic which is often difficult to discuss and which is engulfed in misinformation. Majority of behaviors, attitudes and concepts about sexuality are socially constructed (Askun & Ataca, 2007). Sexual attitudes may include personal decisions about when sex is permisible, general beliefs about the norms of culture, and the perceived appropriateness of certain sexual behaviors (Marks & Fraley, 2005).

Furthermore, common beliefs and attitudes about sexuality vary among cultures. There may even be regional differences within the same culture on sexuality. Even the beliefs and attitudes about sexual issues vary from individual to individual, with age, gender, education, and family structure (Vicdan, 1995). A person's sexuality and how it is expressed are influenced by the interaction of biological, psychological, cultural, spiritual, economic, political, social, legal, historical and religious factors (World Health Organization, 2017).

Sexual ignorance or misinformation on sexual issues may lead to the formation of erroneous cognitive schemes such as extreme anxiety, feelings of guilt, unrealistic expectations, or fear of failure (Ozmen, 1999). These are factors in the occurrence and duration of sexual dysfunctions (Kukulu et al., 2009). The most common type of false information is sexual myths (Ozmen, 1999; Kukulu et al. 2009).

Sexual myths are false beliefs about sexuality which are not related to proven scientific evidence. They are spread through the transmission of false and exaggerated informationand are shaped and fueled by the imagination of the community (Sungur & Tarcan, 2007). These myths are usually transmitted to young people by friends, older siblings, newspapers, magazines, books, and the internet. Unfortunately, this information about sexuality is often incomplete, unreliable, and out-of-date, thus spreading misinformation, myths, and misunderstandings (Ozmen, 1999).

Although studies have shown that sexual myths are common, it is quite clear that education and accurate information on this topic are needed for our young population and society at large (Yasan & Gurgen, 2004).The development of a sexual dysfunction is not directly dependent on the existence of specific sexual beliefs, but indiviudals with a negative-based belief system may develop negative cognitive self-schemas as they experience and interpret certain sexual situations (Ozmen, 1999).In terms of sexual behaviours,

Turkey manifests a very complex picture, because the Turkish cultural mosaic is made up of many different value systems (Tekeli, 1995).

The rural and urban populations of this country display significant differences in attitudes towards sexuality and sexuality has not yet been accepted as natural and integral part of human life in most part of Turkey (Golbası & Kelleci, 2011).

The studies investigating the relationship between sexual myths and sexual dysfunction of women in Turkey are limited. This study was conducted to investigate the relationship between sexual dysfunction and the sexual myth beliefs held by Turkish women.

Material and Methods

The descriptive and cross-sectional study was conducted at in maternity and gynecology hospital in Blacksea region in northern of Turkey. The study was recruited 402 women using the convenience sampling method were included in this study. Inclusion criteria for including to the study of women were married, not pregnant, admitted to the gynecologic policlinics and being volunteer.

Data of this study was collected via Turkish version of the Female Sexual Function Index (FSFI), sexual myths form and questionnaire form. Permission to use the FSFI Turkish version in this study was obtained from Aygin & Eti Aslan who had conducted validity and reliability test of the FSFI (Aygin & Aslan, 2005). Face to face interview technique was used in the research. The questionnaire form, FSFI and sexual myth form were were given women to be completed by themselves.

The questionnaire form, FSFI and sexual myth form took approximately 15 to 20 min to complete.

Measurements

The Questionnaire Form

The questionnaire form included woman's age, marriage age, duration of marriage, occupation, education level, children of number, education level of mother of women, husband's education level, husband's age, husband's occupation, outcome perception, place of residence, growing up family type, current family type, raising attitude of their family, marriage type, opinion about virginity, information about sexual life, and having problem about sexual life.

Female Sexual Function Index

The Female Sexul Function Index (FSFI) are 19 items and the six domains including desire, arousal, lubrication, orgasm, satisfaction, and pain. Total FSFI score scale ranged from 2 to 36.[13] Total FSFI score of $\leq$26.55 is defined as sexual dysfunction.[14] The Turkish version of the FSFI was used.[12] In the Turkish version, Cronbach Alpha values of its subscales and total FSFI was between 0.74 and 0.94. In the current study, the Cronbach Alpha internal consistency coefficient of its subscales and total FSFI was found between 0.74 and 0.94.

Sexual Myths Form

Sexual myths form according to the literature (Ozmen, 1999; Gulec et al. 2007; Ozdener et al., 2007; Bostancı et al., 2007; Torun et al., 2001). Sexual myth form occured from 48 sexual myths items replied as "right" or "wrong". Every "right" sexual myth were given "one" point. Sexual myth score were between "0" and "48" points. Higher scores showed that women believed more sexual myth.

Ethics approval

The aim and procedures of the study were explained to participants and were asked whether they want to participate in the study. The researcher gave assurance to women that the information will remain confidential. Before the implementation of the research was granted written permission from Institutional Review Board. The study conformed to the principles of the Decleration of Helsinki.

Data Analysis

Analysis of data were used descriptive statistics including mean, standard deviation, range, frequency, percent, minimum, maximum. The FSFI and sexual myth scores according to characteristics of women were compared via t test and Mann Whitney-U test. The Pearson correlation analysis test was used to determine the relation between FSFI and its subscales' scores and sexual myths scores, and other continuous variables. A level of *p* value <0.05 was considered as statistically significant.

Results

A total of 402 women entered in this study, their mean age was 31.46±7.52 years (range 18-52 age), the marriage age mean was 20.70±3.50 years (range 14-39 age), the duration of marriage was 10.65±7.55 (range 1-38 years), the number of child was 1.91±0.89 (1-7 children),and husband's age mean was 35.59±7.80 years (range 20-75).

It was determined that 52% of women was 30 ages and lower, 76.9% of them were housewives and 51.5% of them graduated secondary school and lower education 91.5 % of mother of women was primary school andd lower. 54% of husbands graduated high school and higher education, and 12.2% of their husbands were officer person, 96.3% of them perceived as "good and middle level income".

It was found that 75.9% of the women lived province, 56.2% of women grew up in nuclear families and 75.9% of them currently had nuclear families. Raising attitude of family of 49.3% of them was sppressing. Marriage type of %61.9 of them were voluntary, 86.3% of them stated that must be protected until marriage of virginity, 13.9 % of them had sexual life problems, and 55% of them had information about sexual life *(see Table 3,4).*

The mean of the total FSFI score of women was 25.01 (SD 7.06) *(Table 1).* The mean of sexual myths of women was 22.59 (SD 8.73, range 0-46). Twenty-five sexual myths of 48 sexual myths were answered as "right" higher rate than 50% by women. FSFI subscales; orgasm (r = -.065, p=.192), satisfaction (r = .012, p=.809) did not correlate with sexual myhts score, while desire (r = -.136, p=.006), arousal (r = -.115, p=.021), lubrication (r = -.114, p=.023), pain (r = -.135, p=.007) and total FSFI score (r=-108, p=.030) did negatively correlate with sexual myhts score *(see Table 1).* It was determined that 53.2 % of women had a sexual dysfunction and their the FSFI mean score was 19.85±6.60.

The sexual myths mean scores of women with sexual dsyfunction was 24.42±8.60, and was higher than women with normal sexual function (20.62±8.46), and difference was statistically significant (p=0.000), *(see Table 2).*

Table 1. Correlations between sexual myths and FSFI and its subscales scores

	Means of its subscales and FSFI			Correlations between FSFI and sexual myths scores	
Subscales of FSFI	**Subscale mean±SD**	**Subscale total mean±SD**	**Range**	**r**	**p**
Desire	1.61±0.53	3.23±1.07	1.20-6.00	-.136	**0 .006**
Arousal	0.99±0.33	3.99±1.34	0-6	-.115	**0 .021**
Lubrication	1.11±0.35	4.44±1.43	0-6	-.114	**0.023**
Orgasm	1.43±0.50	4.29±1.51	0-6	-.065	0.192
Satisfaction	1.52±0.51	4.56±1.53	0-6	.012	0.809
Pain	1.49±0.54	4.47±1.64	0-6	-.135	**0.007**
Total FSFI	1.31±0.37	25.01±7.06	1.20-36	-.108	**0.030**

SD: Standard deviation

Table 2. Comparison of sexual myths scores according to having sexual function or dysfunction of women

Sexual function	**n**	**%**	**Sexual myths mean±SD**	**FSFI mean±SD**
Normal (0 >26.56 and ↑)	188	46.8	20.63±8.33	30.24±2.38
Dysfunction (0 ≤26.55 ve ↓)	214	53.2	24.43±8.55	19.85±6.60
Total	402	100.0	22.59±8.73	25.01±7.06
Test and p value			t=-4.497 p=0.000	t=21.461 p=0.000

SD: Standard deviation

Table 3.Comparison of FSFI scores and numbers of sexual myths according to socio-demographic characteristics of women (n=402)

Women's socio-demographic characteristics	n	%	Sexual myths score±SD	FSFI score±SD
Age groups (age)				
30 age and lower	209	52.0	23.50±8.65	24.56±7.44
31 age and higher	193	48.0	21.75±8.59	24.87±7.08
Test and P value			**t=-2.034, p=.043**	t=.422, p=.673
Occupation				
Housewife	309	76.9	23.58±8.43	24.39±7.08
Working	93	23.1	19.60±8.72	25.76±7.76
Test and P value			**t=--3.958, p=.000**	t=1.589, p=.113
Education level				
Secondary school and lower	207	51.5	26.26±8.24	23.54±6.94
High school and more	195	48.5	18.84±7.36	25.95±7.41
Test and P value			**t=9.274, p=.001**	**t=3.369, p=.001**
Education of the woman's mother				
Primary school and lower	368	91.5	23.02±8.55	24.64±7.11
Secondary school and more	34	8.5	18.70±8.89	25.49±8.81
Test and P value			**t=-2.809, p=.005**	t=-.658, p=.511
Education of husband				
Secondary school and lower	185	46.0	25.08±8.39	22.95±7.82
High school and more	217	54.0	20.59±8.35	26.21±6.40
Test and P value			**t=-5.532, p=.000**	**t=-4.515, p=.000**
Occupation of husband				
Office person	49	12.2	18.06±8.45	24.48±8.19
Others(self-employed, farmer, laborer)	353	87.8	23.30±8.50	24.74±7.13
Test and P value			**t=-4.045, p=.000**	t=.282, p=.819
Outcome perception				
High and middle level	387	96.3	22.61±8.67	28.87±7.19
Low level	15	3.7	23.93±8.43	20.40±7.98
Test and P value			MW-U= 24.94 p=.355	**MW-U= 1887.00**, **p=.021**

SD: Standard deviation

Table 4.Comparison of FSFI and sexual myths scores according to some characteristics of women(n=402)

Women's some characteristics	n	%	Sexual myths score±SD	FSFI score±SD
Place of residence				
Village and town	97	24.1	21.57±8.51	23.57±7.48
Province	305	75.9	26.09±8.21	25.07±7.16
Test and P value			**t=-4.592, p=.000**	t=1.783, p=.075
Grown up family type				
Small family	226	56.2	21.98±8.63	24.54±7.89
Large family	176	43.8	23.52±8.63	24.92±6.37
Test and P value			t=-1.776, p=.076	t=-.510, p=.611
Current family type				
Small family	305	75.9	21.77±8.37	24.87±7.24
Large family	97	24.1	25.46±8.96	24.19±7.34
Test and P value			**t=-3.718, p=.000**	t=.809, p=.419
Raising attitude of their family				
Free	204	50.7	22.77±8.95	24.98±7.46
Supressing	198	49.3	25.55±8.35	24.38±7.14
Test and P value			t=.150, p=.881	t=1.381, p=.168
Marriage type				
Voluntary marriage	249	61.9	21.70±8.34	25.58±6.91
Arranged marriage	153	38.1	24.22±8.94	23.29±7.61
Test and P value			**t=-2.858, p=.004**	**t=-3.106, p=.002**
Opinion about virginity				
No problem, ambivalent	55	13.7	20.36±9.65	22.60±8.19
Must be protected until marriage	347	86.3	23.02±8.44	25.04±7.06
Test and P value			**t=-2.128, p=.034**	**t=-2.328, p=.020**
Having sexual problem				
Yes	56	13.9	23.76±6.93	19.03±8.20
No	346	86.1	22.48±8.89	25.63±6.67
Test and P value			t=-1.031, p=.303	**t=6.630, p=.000**
Having information about sexual life				
Yes	221	55.0	21.77±8.50	25.35±7.08
No	181	45.0	23.74±8.73	23.92±7.41
Test and P value			**t=-2.273, p=.024**	**t=1.980, p=.048**

SD: Standard deviation

Table 5. Means and standard deviations of some characteristics of women, and correlations between its subscales with FSFI and sexual myths scores of women

Women's characteristics	Mean±SD	Sexual myth score		FSFI score	
		r	p	r	p
Marriage age (year)	20.70±3.50	-.157	**.002***	.069	.170
Marriage duration (year)	10.65±7.55	.046	.357	-.016	.749
Number of children	1.91± 0.89	.148	**.004***	-.093	.075
Husband age (year)	35.59±7.80	-.040	.419	-.010	.841

**p<.01 , SD: Standard deviation*

In this study, FSFI scores of women who have lower education levels (p=.001), lower educated husbands (p=.000), arranged married (p=.002), believing needs to be protected until marriage of virginity(p=.020), problem with sexual life (p=.000) and knowledge about sexual life (p=.048) were lower than other women, and differences between groups were statistically significant *(see Table 3,4).*

The results of this study indicated that sexual myth scores of women who have younger (p=.003), housewife (p=.001), seconder school and lower educated (p=.001), had a mother with less-educated (p=.009), husband with less-educated (p=.000), a husband who is tradesman (p=.000), village and town living, living in nuclear family (p=.000), arranged married (p=.007), believing needs to be protected until marriage of virginity (p=.030), do not have information about sexual life (p=.024) were higher than other women, and differences between groups were statistically significant.

Also, it was found that the group differences of sexual myths scores were not statistically significant according to the income perception (p=.210), family type they grow up (p=.076) and they grew up and the family upbringing attitude (p=.881), *(see Table 3,4).* There were negatively correlation between marriage age (r= -.157, p=.002), and positively correlation between marriage age (r=.148, p=.004) and sexual myth scores. There were not correlation between duration of marriage (r= .046, p=.357), husband age (r= -.040, p=.419) andsexual myth scores *(see Table 5).*

Discussion

Sexual myths become ingrained into communitiesand influence the emergence of sexual roles in the process of socialization (Kora & Kayır, 1996). Sexual ignorance or misinformation and incorrect beliefs commonly accepted in society can lead to the formation of a system of faulty thinking. The belief in sexual myths can lead to consequences that may negatively affect both the sexual and the general health of the individual (Torun et al., 2011).

This study investigated therelationship between sexual myths and sexual dysfunction of women. The sexual myths scores of women were 22.59. Forty-eight sexual myths were presented to the women. They identified 25 as "right", a rate higher than 50%. This result shows that women widely believe certain sexual myths. Kora & Kayır (1996) found that more than half of senior-level medical students believed in sexual myths which were accepted by their culture and society. There was no significant difference according to gender and no items were found to be completely false. Yasan & Gurgan (2004) found that 53.7% of nurses with a sexual partner held beliefs in certain sexual myths, while the rate of belief in sexual myths was 65.1% for nurses without a sexual partner (Yasan & Gurgen, 2004). The results of this study are similar to other studies (Yasan & Gurgen, 2004; Kora & Kayır, 1996)

Results of this study indicated that 53.2 % of women had a female sexual dysfunction, and the mean score for sexual myths of women with sexual dsyfunction was 24.42±8.60. This scorewas higher than forwomen with normal sexual function (20.62±8.46), and thedifference was statistically significant (p=0.000).

Previous studies have indicated that sexual mythsand inaccurate information about sexuality can lead to sexual dysfunctions in men and women. Such misinformation often creates exaggerated and unrealistic expectations, guilt and feelings of inadequacy, anxiety and fear of failure (Ozmen, 1999; Kayır, 1998; Set et al., 2006). In the study of Nobre and Pinto-Gouveia (2006), women statedthat sexual beliefs and attitudesplay a role as vulnerability factors for sexual dysfunction.

In Turkey, prevalent factors for sexual dysfunctions in womeninclude a lack of formal sex education, myths about sexuality, lack of sexual experience, growing up in a conservative setting and an emphasis on the importance of virginity, all of these factors negatively affect women's sexuality and sexual life (Ozmen, 1999; Incesu, 2004). These findings are consistent with the literature.

This current study also found that the subscales of the FSFI including orgasm (r = -.065) and satisfaction (r = .012) did not correlate with sexual myths score of women, while desire (r = -.136), arousal (r = -.115), lubrication (r = -.114), pain (r = -.135) and total FSFI score (r=-108) did negatively correlate with the sexual myths score of women *(see Table 1).* In other words, as the number of sexual myths held by women increased, sexual desire, arousal, lubrication, pain and general sexual function became worse.

The most common sexual function problem among women is the lack of sexual desire. In Turkish society, it is widely believed that women will not be viewed as "good" when they show interest in sexuality, initiate, enjoy, actively participate insexual intercourse, and experiencesexual intercourse with orgasm (Incesu, 2004). Consequently, many Turkish women suffer from a lack of sexual desire, and few of them are willing to bring this issue of concern to a doctor's attention.

These study results revealed that the FSFI scores were lower for women with lesseducation and for thosewith less-educatedhusbands. Lower scores were also seen in women whose marriage had been arranged, who believed that virginity needed to be protected until marriage, who had sexual problems, and who had little knowledge about the topic of sex. The differences between thegroups were statistically significant (see Table 3,4). Yasan (2009) indicated that majority of patients who had applied to the psychiatry outpatient clinics due to sexual problems had arranged married couples. Women with vaginismus reported arranged married as marriage type, frequently (Dogan & Saracoglu, 2009). These findings reflect those of the literature (Ege et al., 2010; Erbil, 2011). There are many variables which determine individuals' sexual attitudes and behaviors: family-of-originand current family environments, and social structure, traditions, religious beliefs and ethical attitudes. In many cases, only sociocultural factors play a major role in the emergence of sexual dysfunction (Incesu, 2004).

This study also found that the sexual myth scores of participants were higher than those of other women if they were younger, a housewife, had lower education, had a mother with less education, had a husband with less education, had a husband who was a tradesman, lived in a village or town, lived in a nuclear family, had an arranged married, believed that virginity needed to be protected until marriage, and were ill-informed about sexuality. We found thedifferences between the groups were statistically significant (see Table 3,4). There was also a correlation between marriage age (r= -.157, p<.01), number of children (r=.148, p<.01) and sexual myth scores (*see Table 5*).

Nobre and Pinto-Gouveia (2006) noted the importance of sexual beliefs as vulnerability factors for the development of sexual dysfunctions. Women expressed their beliefs in age-related myths about sexuality. These included the belief that women lose their sexual desireafter menopause and that as women age, the pleasure they get from sex decreases. They also held on to certain body image beliefs (Nobre & Pinto-Gouveia, 2006). Erbil (2013) found that women's positive body image also had a positive effect on their sexual function. Another study reportedthat university students who had lived a long time in rural areas and whosemother had only a primary school education were more likely to believe in sexual myths (Evcili & Golbası, 2016). Interestingly, these students who had received sufficient information on the topic

of sex education were found to believe in more sexual myths, and the students seemed unable to objectivelyevaluate their knowledge (Evcili & Golbası, 2016).

In conclusion, sexual myths can exert a negative effect on women's sexual function. They cancreate guilt and feelings of inadequacy and may be the basis for sexual function disorders. Without correct and up-to-date information about sex and sexual function, beliefs in sexual myths will continue to proliferate (Sungur, 1999).

For those seeking help with sexual difficulties, it may be very helpful to first investigate a person's sexual knowledge and determine the sources of theirconflicting feelings and negative cognitive schemes. Often, this information becomes important in identifying the origins of the patient's complaints in order to offer concrete steps towards developing more positive attitudes on the topic of sexuality (Ozmen, 1999).

Limitations

There are some limitations of the study. Firstly, the study included only married women. Unfortunately, it did not include gender comparison. Secondly, sexual dsyfunction was evaluated as self-reported with scale, was not medically examined. Thirdly, sexual myth question form was a form based on literature.

Conclusions

This study determined that women with sexual dysfunction believed in sexual myths more than women without sexual dysfunction.

Our results also found that the higher the number of sexual myths held by women, the worse their sexual desire, arousal, lubrication, pain and general sexual function became.

Women's age, education level, occupation, mother's education, husband's education, husband's occupation, residence, family type, marriage type, opinion about virginity and information about sexuality affected their sexual myth scores.

Our recommendations are that sex education should be included as part of the curriculum of students' formal education to promote healthy attitudes towards sexual behavior. Equally important, sex education should be a lifelong learning process for everyone. The only way to address and correct false beliefs about sexuality is to provide accurate and up-to-date information and counseling and other treatments for those who seek help with this important life issue.

For the future, more intervention studies are needed to counter the spread of false and incomplete information about sexuality and sexual myths. In addition, access to current information about sex and community and health resources should be made available to anyone seeking to learn more about sexuality.

These steps could be taken to begin changing attitudes and developing healthier attitudes towards sexuality and its function in each person's life.

Acknowledgements

The author thank all women who so willingly participated in this study and the English specialist PM Knauer.

References

Askun, D., Ataca, B. (2007). Sexuality related attitudes and behaviors of Turkish university students. *Archives Sexual Behavior* 36, 741-752.

Aygin, D., Aslan F. 2005. The Turkish adaptation of the Female Sexual Function Index. *Turkiye Klinikleri Journal of Medical Sciences* 25, 393–99.

Bostancı, N., Buzlu, S., Tufek, F., Kalaycıoglu, D., Yıldırım, N., Yılmaz, S. (2007). Sexual myths by gender in university students: Preliminary evaluation results. Andrology Bulletin 31, 362-364.

Dogan, S., Saracoglu, G.V. (2009). The assesment of sexual knowledge, marital characteristics, sexual function and satisfaction. *Journal of Trakya University Faculty of Medicine* 26, 151-158.

Ege, E., Akın, B., Yaralı Arslan, S., Bilgili. N. (2010). Prevalence and risk factors of female sexual dysfunction among healthy women. Turkish Science Research Foundation *TUBAV Science Journal 3, 137-144.*

Erbil, N. (2011). Prevalence and risk factors for female sexual dysfunction among Turkish women attenting a maternity and gynecology outpatient clinic. *Sexuality and Disability* 29, 377-386.

Erbil, N. (2013). The relationships between sexual function, body image, and body mass index among women. *Sexuality and Disability* 31, 63-70.

Evcili, F., Golbası, Z. (2016). Determination of sexual myths, sexual health knowledge levels and affecting factors of university students. Sexuality and Sexual Treatments XI. National Congress, Speech and Abstract Book, Istanbul Bilgi University, October 14-16, Istanbul.

Golbası, Z., Kelleci, M. (2011). Sexual experience and risky sexual behaviours of Turkish University

Students. *Archives of Gynecology and Obstetrics* 283, 531-537.

Gulec, G., Kılıc, Y., Bilgic, S. (2007). Comparison of sexual myths in first and sixth grade students of ESOGU Faculty of Medicine. Osmangazi University Journal of Medicine 29, 136-145.

Incesu, C. (2004). Sexual Functions and Sexual Dysfunctions. Clinical Psychiatry 3, 3-13.

Kora, K., Kayir, A. (1996). Sexual roles and sexual myths, Dusunen Adam 9, 55-58.

Kayir, A. (1998). The concept of sexuality and sexual myths, Turkish Psychiatric Index, Sexual Dysfunctions Monograph Series 1, 30-35.

Kukulu, K., Gursoy, E., Ak Sozer, G. (2009). Turkish university students' beliefs in sexual myths. *Sexuality and Disability* 27, 49-59.

Marks, M.J., Fraley, R.C. (2005). The sexual double standard: Fact or fiction? *Sex Roles* 52, 175-186.

Nobre, P.J., Pinto-Gouveia, J. (2006). Dysfunctional Sexual Beliefs as Vulnerability Factors for Sexual Dysfunction. *The Journal of Sex Research* 43, 68-75.

Ozdener, N., Yoldascan, E., Sutoluk, Z., Ozdener, O.E., Akbaba, M. (2007). Sexual myths of married men in a rural town in Anatolia. 5th International Reproductive Health Congress Abstract Book,278-279.

Ozmen, H.E. (1999). Sexual myths and sexual dysfunctions. Psychiatric World 3,49-53.

Rosen, R.C., Brown, C., Heiman, J., Leiblum, S., Meston, C., Shabsigh, R. (2000). The Female Sexual Function Index (FSFI): A multidimensional self-report instrument for the assessment of femalesexual function. *Journal of Sex & Marital Therapy* 26, 191–208.

Set, T., Dagdeviren, N., Akturk, Z. (2006). Sexuality in adolescents. Journal of General Medicine 16, 137-141.

Sungur, M.Z. (1999). Cultural factors in sex therapy: the Turkish experience. *Journal of Sex & Marital Therapy* 14, 165–171.

Sungur, M.Z., Tarcan, T. (2007). Male Sexuality. Sexual Education Treatment and Research Association Publications, 10-18.

Tekeli, S. (1995).. Introduction: women in Turkey in the 1980s. In: Tekeli S (ed.) Women in Modern Turkish Society: A Reader. Zed Books, London.

Torun, F., Torun, S.D., Ozaydın, N.A. (2011). Men's belief in sexual myths and factors effecting these myths. *Dusunen Adam The Journal of Psychiatry and Neurological Sciences* 24, 24-31.

Wiegel, M., Meston, C., Rosen, R. (2005).The Female Sexual Function Index (FSFI): Cross-validation and developmentof clinical cutoff scores. *Journal of Sex & Marital Therapy* 31,1–20.

World Health Organisation. Sexual and reproductive health; Gender and human rights http://www.who.int/reproductivehealth/topics/gender_rights/sexual_health/en/ Accessed: 12.02.2017.

Yasan, A. (2009). The role of traditional culture on sex therapy. *Anatolian Journal of Psychiatry* 10, 72-73.

Yasan, A., Gurgen, F. (2004). The ways to get sexual knowledge and the comparison of the rate of sexual myths in nurses who have sexual partners and who do not have. *Yeni Symposium* 42, 72-76.