Original Investigation

Belief in sexual myths and sociocultural factors associated with vaginismus: a case-control study in Turkish women

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Abstract

Objective: To investigate the relationship between belief in sexual myths and the presence of vaginismus, and to evaluate the influence of sociodemographic and cultural factors on sexual myth endorsement among Turkish women.

Material and Methods: This case-control study included women diagnosed with vaginismus and an equal number of age-matched women without sexual dysfunction. Participants completed a sociodemographic questionnaire and the sexual myths (SMS). Comparative analyses were conducted to assess differences in total and subscale scores between groups, and multiple regression analysis was performed to evaluate the predictive role of sociodemographic variables on belief in sexual myths.

Results: Women with vaginismus (n=40) had significantly higher total scores on the SMS compared to the control group (n=40; $p<0.001$). Subscale analyses revealed that myths related to sexuality, gender roles, and sexual morality were more strongly endorsed by women with vaginismus. Multiple regression analysis showed that lower education level, conservative family background, and rural upbringing were significant predictors of stronger belief in sexual myths ($p<0.05$).

Conclusion: The findings suggest that belief in sexual myths is more prevalent among women with vaginismus and is influenced by key sociodemographic and cultural factors. Addressing these beliefs through culturally sensitive education and psychosexual interventions may enhance the effectiveness of vaginismus treatment.

Keywords: Vaginismus, sexual myths, sociocultural factors, sexual dysfunction, psychosexual beliefs

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Introduction

Vaginismus [*Diagnostic and Statistical Manual of Mental Disorders* (DSM)-5: genito-pelvic pain/penetration disorder] is a painful condition in which sexual intercourse becomes impossible due to involuntary contractions of the outer third of the vaginal muscles, resulting in pain and/or fear during attempted penetration (1,2). It is not only a physical condition, but also a psychosomatic crisis where both mental and physical symptoms coexist (1,3). Vaginismus is considered a multifactorial disorder and is increasingly recognized as one of the most common sexual problems among women today. In addition, sexual myths are known to contribute to sexual dysfunctions but are often overlooked or poorly addressed.

From a theoretical perspective, sexual myths can be understood within the framework of sexual script theory and sociocultural

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learning paradigms (4,5). According to sexual script theory, individuals internalize culturally transmitted "scripts" that dictate acceptable sexual behaviors and reinforce gendered expectations (6). These culturally learned narratives are further maintained through socialization within family, media, and religious settings (7). Sexual myths are unscientific beliefs and stereotypes about sexuality that are widely accepted within society and often passed down through generations without question (8-11). These myths tend to flourish in traditional cultures where sexuality is viewed as taboo, shameful, or inappropriate to discuss openly (10-12). As a result, these myths may contribute to distorted perceptions of sexuality, unrealistic expectations, and increased anxiety surrounding sexual experiences, particularly among women. Studies have shown that inadequate sexual education, lack of accurate information, and limited communication on sexual matters further reinforce these misconceptions (13). In such contexts, women often have insufficient knowledge about both their own and their partner's sexual functioning, which may lead to low self-esteem, relational problems, and ultimately sexual dysfunctions, including vaginismus (9,14,15).

Despite the growing recognition of vaginismus as a complex and multifactorial condition, the role of sexual myths surrounding its development and persistence remains underexplored. Cross-cultural research demonstrates considerable variation in the reported prevalence and clinical presentation of vaginismus. Population-based studies in Western countries have found prevalence rates between 0.8% and 7%, whereas rates in clinical and community samples from Asia and the Middle East are often substantially higher (16,17). These regional differences are thought to reflect diverse sociocultural norms, levels of sexual education, and openness in discussing sexual issues (7,18). Studies from Arab and Muslim-majority settings further indicate that limited premarital sexual communication, modesty norms, and gendered expectations shape both symptom expression and help-seeking behavior (19). Understanding these cultural nuances is essential for contextualizing the current findings within the global literature.

Therefore, this study was conducted to investigate the relationship between belief in sexual myths and vaginismus by comparing women diagnosed with the condition to a control group without sexual dysfunction. The goal was to explore whether a higher endorsement of sexual myths was associated with the presence of vaginismus. Furthermore, the study aimed to explore how sociodemographic characteristics influence belief in sexual myths within both groups.

Material and Methods

This study was approved by the Ankara Medipol University Non-Interventional Clinical Research Ethics Committee (approval number: 128, date: 18.10.2023) and institutional permission. The participants were recruited through convenience sampling among women who consecutively attended the outpatient gynecology clinic during the study period and met the inclusion criteria.

The participants were divided into two groups: women diagnosed with vaginismus and women without any sexual dysfunction. The diagnosis of vaginismus was made by a gynecologist based on clinical examination and according to the DSM-5 criteria for genito-pelvic pain/penetration disorder. The diagnosis was supported by the presence of recurrent involuntary contraction of the pelvic floor muscles, marked fear or anxiety about vaginal penetration, and consistent avoidance behavior observed during gynecological evaluation. Participants with known psychiatric or neurological disorders, a history of sexual trauma, or any comorbid sexual dysfunctions other than vaginismus (such as dyspareunia, hypoactive sexual desire disorder, or anorgasmia) were excluded. Women currently receiving psychiatric treatment or using psychotropic medication were also not eligible. No additional structured psychometric or self-report instruments were administered.

The control group consisted of women who attended the outpatient clinic for reasons unrelated to sexual dysfunction and were evaluated as not having vaginismus or any sexual intercourse problems based on their clinical history and gynecological examination. These participants reported a history of regular vaginal intercourse without pain, fear, or avoidance behavior, and had no current or past diagnosis of any sexual dysfunction.

Data collection tools

After obtaining informed consent from each participant, data were collected through face-to-face interviews using the introductory information form and the sexual myths scale (SMS). The SMS was developed by Gölbaşı et al. (20) and its validity and reliability were confirmed in Turkish populations. The scale consists of 28 items rated on a 5-point Likert scale ranging from 1 (completely disagree) to 5 (completely agree). Higher scores indicate a greater belief in sexual myths.

The scale includes eight sub-dimensions:

1. **Sexual orientation (items 1–5):** e.g., "Homosexuality is a disease."
2. **Gender roles (items 6–11):** e.g., "Housework is a woman's duty."
3. **Age and sexuality (items 12–15):** e.g., "Sexual life ends with aging."
4. **Sexual behavior (items 16–18):** e.g., "Every stage of sexual intercourse must be under the man's control."
5. **Masturbation (items 19–20):** e.g., "Masturbation causes physical illness."

6. Sexual violence (items 21–24): e.g., "Non-consensual sexual intercourse between spouses cannot be considered rape."

7. Sexual intercourse (items 25–26): e.g., "Sexuality means sexual intercourse."

8. Sexual satisfaction (items 27–28): e.g., "Women can only reach orgasm through intercourse."

The total score of the SMS is calculated by summing the responses to all 28 items, while subscale scores are obtained by summing the relevant items within each sub-dimension. The scale does not include a cut-off point; higher scores indicate a stronger belief in sexual myths (20). The original Cronbach's alpha coefficient for the scale was reported as 0.91 (20). In the present study, internal consistency was found to be excellent, with Cronbach's alpha values of 0.941 in the control group and 0.961 in the vaginismus group.

Due to the sensitive nature of the subject, particular attention was paid to minimizing emotional discomfort and ensuring participant confidentiality and anonymity during data collection. All interviews were conducted in a private counseling room by a female researcher experienced in sexual health communication. Participants were informed that they could refuse to answer any question or withdraw from the study at any time without providing justification. To reduce potential response bias and social desirability effects, neutral, non-judgmental language was used, and participants were assured that there were no "right" or "wrong" answers. No identifying information was recorded on the questionnaires, and data were coded numerically to preserve anonymity. In case of emotional distress during or after the interview, participants were offered immediate psychological support through referral to the hospital's counseling service.

Statistical analysis

The beliefs in sexual myths and related factors were analyzed for both groups. Descriptive statistics are presented as mean, standard deviation, median, and interquartile range (25^{th}–75^{th} percentiles) for continuous variables, and as frequency and percentage for categorical variables. The normality of data distribution was assessed using the Kolmogorov–Smirnov test, histogram plots, skewness–kurtosis coefficients, and Q–Q plots. Comparisons between the vaginismus and control groups were performed using the chi-square test or Fisher's exact test for categorical variables. For continuous variables, the Independent Samples t-test was used when normal distribution was present, and the Mann–Whitney U test was used for abnormal distribution. The total SMS score was normally distributed; thus, comparisons across more than two groups were conducted using the analysis of variance (ANOVA). The homogeneity of variances was evaluated using Levene's test. The one-way ANOVA test was applied when variances were homogeneous, and Welch's ANOVA was used when they were heterogeneous. Post-hoc analyses were performed using Tukey's test following the one-way ANOVA or Tamhane's T2 test following Welch's ANOVA, depending on the assumption of equal variances. Moreover, to control for potential confounding variables, a multiple linear regression analysis was conducted including education level, age, place of residence (urban/rural), and occupational status as covariates to evaluate their independent effects on the total SMS scores.

Results

Sociodemographic characteristics

A total of 80 women were included in the study, with 40 participants in the vaginismus group and 40 in the control group. The mean age was 25.3±2.8 years in the vaginismus group and 26.8±3.8 years in the control group ($p=0.070$). Similarly, there were no differences in terms of age categories (≤25 vs. >25 years), educational level of participants and their husbands, or marital duration ($p>0.05$ for all) between the two groups.

Although not significant, a higher proportion of women in the vaginismus group were housewives or workers, while civil servants were more frequent in the control group ($p=0.171$). The type of family (nuclear vs. extended), place of residence (urban vs. rural), and income level did not differ significantly between the groups, although a higher proportion of women in the vaginismus group resided in rural areas ($p=0.201$) and had medium or good income levels ($p=0.061$).

Overall, no significant differences were found between the groups in terms of sociodemographic characteristics (Table 1).

Beliefs in sexual myths and subscale comparisons

The total SMS score was significantly higher among women with vaginismus (95.3±15.2) compared to those without the condition (73.2±15.6; $p<0.001$). Similarly, all subscale scores of the SMS were significantly higher in the vaginismus group.

In the sexual orientation subscale, the mean score was 19.1±3.9 in the vaginismus group and 17.5±2.5 in the control group ($p=0.030$). The gender subscale showed a substantial difference between groups (15.1±5.3 vs. 10.0±4.0; $p<0.001$), as did the age and sexuality subscale (15.1±3.0 vs. 11.3±3.2; $p<0.001$).

Women with vaginismus also had significantly higher scores in the sexual behavior (11.3±2.3 vs. 7.6±2.6), m masturbation (7.4±1.5 vs. 5.3±1.4), sexual violence (9.1±1.0 vs. 7.2±2.3), sexual intercourse (9.1±1.0 vs. 7.2±2.3), and sexual satisfaction (9.2±1.0 vs. 7.2±2.4) subscales ($p<0.001$ for all).

These findings suggest that women with vaginismus endorse sexual myths more strongly across all dimensions of the SMS (Table 2).

Table 1. Comparison of sociodemographic and related factors of participants vaginismus and control group

		Control group (n=40)*	Vaginismus group (n=40)*	p
Average age (SD)		26.8 (3.8)	25.3 (2.8)	0.070[a]
Age n (%)	≤25	15 (39.5)	23 (60.5)	0.073[b]
	>25	25 (59.5)	17 (40.5)	
Education level n (%)	Middle school	4 (50.0)	4 (50.0)	0.804[b]
	High school	14 (46.7)	16 (53.3)	
	Associate degree	6 (42.9)	8 (57.1)	
	Undergraduate	16 (57.1)	12 (42.9)	
Profession n (%)	Housewife	20 (50.0)	20 (50.0)	0.171[b]
	Civil servant	15 (65.2)	8 (34.8)	
	Worker	3 (30.0)	7 (70.0)	
	Other	2 (28.6)	5 (71.4)	
Education level (husband) n (%)	Middle school	2 (50.0)	2 (50.0)	0.915[b]
	High school	9 (52.9)	8 (47.1)	
	Associate degree	12 (44.4)	15 (55.6)	
	Undergraduate	17 (53.1)	15 (46.9)	
Profession (husband) n (%)	Civil servant	16 (64.0)	9 (36.0)	0.115[b]
	Worker	21 (47.7)	23 (52.3)	
	Other	3 (27.3)	8 (72.7)	
Marriage duration- years average (SD)		2.7 (2.5)	2 (2.1)	0.093[a]
Marriage duration	≤1 year	19 (41.3)	27 (58.7)	0.070[b]
	>1 year	21 (61.8)	13 (38.2)	
Family type	Core	36 (53.7)	31 (46.3)	0.130[b]
	Wide	4 (30.8)	9 (69.2)	
Place of residence	City center	39 (52.7)	35 (47.3)	0.201[c]
	District	1 (16.7)	5 (83.3)	
Income situation	Low	18 (64.3)	10 (35.7)	0.061[b]
	Medium/good	22 (42.3)	30 (57.7)	

*Row percentage is used
[a]Mann-Whitney U test, [b]chi-square test, [c]Fisher's exact test
SD: Standard deviation

Associations between sociodemographic characteristics and sexual myth beliefs

Among women without vaginismus, the total SMS scores varied significantly according to several sociodemographic variables. Participants with lower levels of education had significantly higher SMS scores ($p<0.001$), with the highest scores observed among those with only middle school education (87.4±1.5) and the lowest among university graduates (58.1±10.6). Profession was also associated with SMS scores, with housewives scoring significantly higher (83.3±9.6) than civil servants (58.9±12.7; $p<0.001$). Women with low income had higher SMS scores than those with medium or high income ($p<0.001$). Moreover, participants whose husbands were less educated or worked in manual labor had significantly higher SMS scores ($p<0.001$ for both). Other variables, such as age, marriage duration, family type, and place of residence, did not show significant associations with SMS scores in this group.

In the vaginismus group, similar patterns were observed. The total SMS scores were significantly higher among participants with lower education levels ($p=0.010$), housewives ($p=0.001$), and those whose husbands had lower education levels ($p=0.028$) or were employed as laborers rather than civil servants ($p=0.005$). Moreover, women living in rural areas had significantly higher SMS scores than those residing in city centers (110.8±5.8 vs. 93.1±14.8; $p=0.013$). However, variables such as age group, income level, marriage duration, and family type were not significantly associated with SMS scores within the vaginismus group.

Table 2. Comparison of the scores of those vaginismus and control group participants on SMS and its subscales

SMS and its subscales	Control group		Vaginismus group		p
	Mean (SD)[a]	Median (Q1-Q3)[b]	Mean (SD)[a]	Median (Q1-Q3)[b]	
Sexual orientation	17.5 (2.5)	17.0 (16.0-20.0)	19.1 (3.9)	19.5 (17.0-20.5)	**0.030**[c]
Gender	10.0 (4.0)	8.5 (6.5-12.5)	15.1 (5.3)	15.0 (12.0-18.0)	**<0.001**[d]
Age and sexuality	11.3 (3.2)	11.5 (9.0-13.0)	15.1 (3.0)	16.0 (14.5-16.0)	**<0.001**[d]
Sexual behavior	7.6 (2.6)	8.0 (6.0-9.0)	11.3 (2.3)	12.0 (9.5-12.0)	**<0.001**[d]
Masturbation	5.3 (1.4)	6.0 (5.0-6.0)	7.4 (1.5)	8.0 (6.0-8.0)	**<0.001**[d]
Sexual violence	7.2 (2.3)	8.0 (5.5-8.5)	9.1 (1.0)	10.0 (8.0-10.0)	**<0.001**[d]
Sexual intercourse	7.2 (2.3)	8.0 (5.5-8.5)	9.1 (1.0)	10.0 (8.0-10.0)	**<0.001**[d]
Sexual satisfaction	7.2 (2.4)	8.0 (6.0-8.5)	9.2 (1.0)	10.0 (8.0-10.0)	**<0.001**[d]
Total scale score	73.2 (15.6)	76.5 (64.5-85.0)	95.3 (15.2)	94.0 (87.5-106.0)	**<0.001**[c]

[a]Standard deviation, [b]25-75% first and third quartile values, [c]Independent two-sample t-test, [d]Mann-Whitney U test
SD: Standard deviation, SMS: Sexual myths scale

These findings suggest that lower education and occupational status, both for women and their partners, as well as place of residence, are associated with stronger belief in sexual myths and this trend appears to be stronger in women with vaginismus (Table 3).

Discussion

Sexual function and quality of life (QoL) are key dimensions affected across a broad spectrum of gynecologic and psychosexual disorders. Recent evidence demonstrates that genital pain, even outside the context of vaginismus, is associated with substantial reductions in sexual satisfaction, emotional wellbeing, and mental health (21). In a large population-based study, women reporting genital pain exhibited significantly lower scores on the female sexual function index and on all QoL domains compared with pain-free women, alongside higher levels of anxiety, depression, and sexual distress. Similarly, in women treated for cervical cancer, persistent pain, body image concerns, and hormonal changes have been shown to compromise both sexual functioning and QoL (22). These findings highlight that sexual health is a multidimensional construct influenced by physical, psychological, and cultural determinants. Within this broader context, vaginismus represents a functional condition that, although distinct from oncologic or chronic pain disorders, produces comparable impairments in intimacy, self-esteem, and overall wellbeing. Recognizing such parallels highlights the need for integrated, biopsychosocial models of assessment and treatment that address both the physical and emotional aspects of female sexual dysfunction.

Vaginismus is not merely a physiological condition but a complex phenomenon shaped by sociocultural norms, gender roles, and widely accepted yet inaccurate beliefs about sexuality. Among these, sexual myths, defined as exaggerated and scientifically unfounded beliefs, are frequently cited as contributing factors in the development of sexual dysfunctions, particularly in traditional societies where sexuality is often considered taboo and rarely discussed openly (17,23). In Türkiye, vaginismus is reported as the most common sexual health complaint among women seeking clinical support (23,24). One of the primary predisposing elements underlying this high prevalence appears to be the persistence of sexual myths. Doğan and Saraçoğlu (25) reported that women with vaginismus often lack adequate sexual knowledge and enter arranged marriages, which increases their vulnerability to such myths. Evidence also suggests that women who lack formal sexual knowledge, obtain information primarily from social media, or perceive sexuality negatively due to religious reasons are at higher risk of vaginismus. Thus, sociocultural factors and women's low sexual self-consciousness should be considered holistically in treatment approaches (26).

Psychological factors also play a significant role. Previous studies have identified elevated levels of anxiety, depression, and social phobia among women diagnosed with vaginismus (27-29). Furthermore, stronger belief in sexual myths has been associated with greater emotional distress, lower sexual satisfaction, and resistance to treatment (30-32). There is also evidence that women who fear pain, injury, bleeding, or losing control during penetration are more likely to develop vaginismus (33). Interviews with women who have successfully overcome vaginismus reveal that their experiences are not solely medical or individual in nature but deeply rooted in broader cultural narratives shaped by misinformation and silence surrounding sexuality (34,35). Understanding the role of cultural and religious influences on female sexual pain is particularly important for providing culturally competent care to

Table 3. Comparison of total SMS score of participants vaginismus and control group sociodemographic and related factors

		Control group (n=40)		Vaginismus group (n=40)	
		SMS total score mean (SD)	p	SMS total score mean (SD)	p
Age n (%)	≤25	77.7 (13.6)	0.159*	99.1 (13.0)	0.064*
	>25	70.5 (16.3)		90.2 (16.7)	
Education level n (%)	Middle school	87.4 (1.5)[a]	**<0.001****	104 (8.8)[a]	**0.010*****
	High school	84.5 (10.2)[a,b]		101.3 (13.6)[a]	
	Associate degree	77.3 (4.1)[b]		95.4 (13.5)[a,b]	
	Undergraduate	58.1 (10.6)[c]		84.2 (14.7)[b]	
Profession n (%)	Housewife	83.3 (9.6)[a]	**<0.001*****	104 (10.6)[a]	**<0.001*****
	Civil servant	58.9 (12.7)[b]		81.5 (16.0)[b,c]	
	Worker	79.7 (8.6)[a]		94.9 (13.8)[a,b]	
	Other	70.5 (7.8)[a,b]		83.6 (7.2)[b]	
Education level (husband) n (%)	Middle school	70.5 (26.2)[a-c]	**<0.001*****	103 (15.6)[a,b]	**0.028*****
	High school	86.7 (10.3)[a,b]		100.5 (9.6)[a,b]	
	Associate degree	80.7 (7.3)[b]		100.6 (15.2)[a]	
	Undergraduate	61.2 (12.7)[c]		86.3 (14.3)[b]	
Profession (husband) n (%)	Civil servant	59.3 (12.3)[a]	**<0.001*****	83.6 (16.2)[a]	**0.005*****
	Worker	84.2 (8.6)[b]		101.3 (12.9)[b]	
	Other	71 (5.6)[a,b]		91.3 (11.7)[a,b]	
Marriage duration- years average (SD) marriage duration	≤1 year	74.6 (14.7)	0.608*	93 (16.8)	0.165*
	>1 year	72 (16.6)		100.2 (9.9)	
Family type	Core	72.2 (15.8)	0.214*	93.5 (15.1)	0.164*
	Wide	82.5 (10.4)		101.6 (14.6)	
Place of residence	City center	72.9 (15.6)	0.414*	93.1 (14.8)	**0.013***
	District	86 (0)		110.8 (5.8)	
Income situation	Low	84.3 (9.6)	**<0.001***	97.5 (20.8)	0.607*
	Medium/good	64.2 (13.6)		94.6 (13.1)	

*Independent two-sample t-test. **one-way analysis of variance (post-hoc Tamhane). ***one-way analysis of variance (post-hoc Tukey)
[a-c]: There is no difference between groups with the same letter for each variable
SD: Standard deviation, SMS: Sexual myths scale

Muslim women and for reducing implicit biases in healthcare. Interventions such as psychotherapy, physiotherapy, and sexual education have been found beneficial, but broader cultural change that embraces women's sexual agency is also needed. The cross-cultural literature supports the notion that sociocultural learning and sexual myths are deeply intertwined in shaping women's sexual health across societies. Studies have shown that beliefs concerning female purity, pain, and sexual passivity are sustained through collective cultural narratives rather than individual psychopathology (7). In Muslim-majority and other traditional contexts, limited sexual education, gendered expectations, and modesty norms further reinforce avoidance behaviors and anxiety during sexual activity (7,36). Such myths and sociocultural and religious values are often transmitted intergenerationally, forming part of broader "sexual scripts" that dictate appropriate sexual conduct within a given culture. Recognizing this dynamic is important, as effective treatment requires distinguishing between misinformation that undermines sexual function and satisfaction and moral or religious values that guide cultural identity. Intervention programs incorporating culturally attuned psychoeducation have been shown to improve acceptance and outcomes in the management of vaginismus and related conditions (18,36).

The relationship between sexual myths and sociodemographic variables also influences individuals' access to accurate sexual information and their overall attitudes toward

sexuality (37). Earlier studies have demonstrated that variables, such as education level, marital status, income, and region of residence, are associated with belief in sexual myths. For instance, Yılmaz (32) reported that levels of anxiety and belief in sexual myths varied significantly according to age, education, and income status, while Dalan (30) found higher levels of belief in sexual myths among high school graduates compared to those with other educational backgrounds (30). Similarly, Doğan and Saraçoğlu (25) found a significant relationship between lower education levels and stronger beliefs in sexual myths. These findings support the hypothesis that the lack of formal sexual education together with exposure to traditional belief systems increases the susceptibility of misinformation. This is also consistent with national data from the CETAD survey (2006), which reported higher rates of fear, avoidance, or pain-related barriers to sexual intercourse among women living in rural areas (38). Since biopsychosocial factors strongly influence sexual myths, acknowledging these mediators in sexual education for both women and men is essential (39). The higher prevalence of vaginismus and belief in sexual myths in such regions is often attributed to stronger traditional norms, limited access to sexual health education, and a lower awareness of sexual rights (40). In addition, it is important to distinguish between culturally or religiously grounded sexual values and sexual myths. While values reflect moral or spiritual principles that guide behavior within specific cultural or religious contexts, sexual myths refer to scientifically inaccurate or distorted beliefs about sexuality that can restrict sexual function and satisfaction or perpetuate gender inequality. The present study does not aim to challenge cultural or sociocultural and religious values, but rather to identify misinformed beliefs that may hinder healthy sexual functioning or contribute to conditions such as vaginismus. In this regard, the SMS (20) was specifically designed to assess misconceptions and false beliefs about sexuality, rather than normative or faith-based sexual values, providing a culturally appropriate framework for distinguishing myths from values.

In the present study, women diagnosed with vaginismus exhibited significantly higher beliefs in sexual myths compared to women without sexual dysfunction. This difference was consistent across all subdimensions of the SMS, particularly those related to gender roles, sexual behavior, masturbation, and sexual satisfaction. These results align with previous research showing that distorted beliefs and stereotypical sexual scripts are more prevalent among women with sexual pain disorders (5,6). Such myths, which often emphasize female passivity, male dominance, and the moralization of sexuality, can create cognitive and emotional barriers to sexual expression, thereby reinforcing avoidance and anxiety during sexual activity.

In our sample, patterns mirror findings from other studies conducted in traditional or religious societies, where restricted sexual education and rigid gender expectations perpetuate misinformation and guilt surrounding sexuality (7,36,40). Together, these findings illustrate the multifactorial nature of vaginismus, reflecting an interplay between individual vulnerability, relational dynamics, and sociocultural conditioning.

Our results suggest that addressing these myths will be important for effective prevention and treatment. Culturally sensitive psychoeducation that respects religious and sociocultural and religious values while challenging inaccurate beliefs may help reduce shame, fear, and avoidance behaviors associated with sexual activity. Training healthcare professionals to discuss sexuality in a non-judgmental, culturally aware manner can also improve patient engagement and treatment adherence. Ultimately, these findings emphasize that vaginismus is not merely a psychosexual disorder but a socioculturally mediated condition, requiring interventions that integrate education, empathy, and empowerment (5-7,36,40).

This study has several limitations that should be considered when interpreting the findings. First, the study sample was drawn exclusively from a single private hospital, which may have introduced selection bias. Women seeking care in private settings often represent a more socioeconomically homogeneous group with higher education and income levels than the general population. Therefore, the findings may not fully reflect the attitudes and sexual belief patterns of women from different regions or socioeconomic backgrounds. Moreover, the study sample was obtained from women attending a gynecology outpatient clinic, which may not fully represent the general female population. This clinical recruitment approach, based on convenience sampling, could have introduced selection bias by including individuals who were more likely to seek medical help or to discuss sexual concerns. Consequently, women with milder symptoms or those reluctant to seek care might be underrepresented. Second, the statistical power of the study was restricted due to the relatively small sample size, which prevented the study from potentially detecting more nuanced differences and possible interactions among variables. Although regression analysis was conducted to control for key sociodemographic covariates such as education level, age, and place of residence, unmeasured factors, such as religiosity or exposure to sexual education, may still have influenced the results. Third, the diagnosis of vaginismus was based on clinical evaluation without the use of standardized diagnostic interviews or structured psychometric assessments, which may have introduced variability in diagnostic classification. Furthermore, the cross-sectional design of the study prevented any inference of causality between belief in sexual myths and

the presence of vaginismus. Finally, because the data relied on self-report measures, the possibility of social desirability bias, particularly in reporting sexual beliefs and behaviors, cannot be excluded. The reliance on self-reported data introduces an inherent limitation, particularly in studies addressing sexuality within conservative sociocultural environments, such as is found in Türkiye. Participants may under-report or modify their responses due to feelings of shame, social desirability, or fear of judgment, even when anonymity is guaranteed. This tendency can lead to underestimation of sensitive attitudes or experiences, including belief in sexual myths or fear related to intercourse. Although privacy and neutral questioning techniques were applied to reduce this bias, it cannot be entirely eliminated in sexuality research conducted in traditional societies.

Study limitations

Future research should aim to include more diverse and representative samples by involving participants from multiple regions, healthcare settings, and cultural backgrounds. Larger-scale studies with probabilistic sampling methods could enhance the generalizability of findings and allow for subgroup analyses across different sociodemographic strata. Longitudinal designs are also recommended to better understand the temporal and potentially causal relationship between belief in sexual myths and the development or persistence of vaginismus. In addition, future studies may benefit from incorporating structured diagnostic tools and in-depth qualitative interviews to explore the psychological and relational dimensions of sexual dysfunction in more depth. Moreover, intervention-based studies that integrate sexual education with culturally sensitive approaches, while considering women's sociocultural backgrounds and religious values, could significantly contribute to prevention and treatment efforts.

Conclusion

The findings of this study highlight the importance of addressing sexual myths as a contributing factor in the development and persistence of vaginismus. Healthcare professionals working with women diagnosed with vaginismus should assess not only physiological symptoms but also cultural beliefs and misinformation related to sexuality. Educational interventions that target inaccurate sexual beliefs, particularly among women with limited formal education or those residing in more traditional settings, may be an essential component of comprehensive care. Clinicians are encouraged to incorporate culturally sensitive sexual health education into treatment plans, involve partners when appropriate, and collaborate with mental health professionals to address associated anxiety or phobias. By understanding the sociocultural factors foundation vaginismus, professionals may offer more personalized, effective, and sustainable interventions for affected individuals.

Ethic

Ethics Committee Approval: *This study was approved by the Ankara Medipol University Non-Interventional Clinical Research Ethics Committee (approval number: 128, date: 18.10.2023).*

Informed Consent: *After obtaining informed consent from each participant, data were collected through face-to-face interviews using the introductory information form and the sexual myths scale.*

Footnotes

Author Contributions: *Concept: Y.K, C.K., Design: Y.K., Data Collection or Processing: Y.A., Analysis or Interpretation: Y.K., T.T., Literature Search: Y.K., T.T., Writing: Y.K., T.T., Y.A., C.K.*

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