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Attitudes and Beliefs of Midwifery Students on Sexuality and Evaluation of Sexuality: A Mixed-Method Study

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Abstract

Background: *The sexual attitudes and beliefs of midwifery students, who play an important role in improving sexual health, can affect both the students themselves and people with disabilities to whom they provide education and counselling. This study aimed to determine the attitudes and beliefs of midwifery students on sexuality and the evaluation of sexuality.*

Methods: *This research is a mixed-method study that includes two stages: qualitative and quantitative. In the first stage, data was collected from 334 students using a socio-demographic data form and the sexual attitude and belief scale. The second stage involved conducting phenomenological interviews with 21 students.*

Results: *The students who believed they had adequate knowledge about sexuality and reproductive health, as well as those who had previously engaged in scientific activities related to sexuality, held more positive attitudes and beliefs towards sexual care. The qualitative section of the study identified four main themes, each containing 13 sub-themes, which provided further insights into the students' perspectives on the subject.*

Conclusions: *The students acknowledged that their society had strict sexual taboos, but their attitudes toward sexuality changed after studying sexual health and women's health at university. The study highlighted the challenges faced by midwifery students in assessing sexual health. By addressing these difficulties, trained midwives can better evaluate the sexual health of patients in clinical settings, leading to early detection of sexual problems.*

Keywords: Sexuality, Sexual health, Sex education.
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Introduction

Sexuality is a fundamental aspect of human life that is influenced by various factors such as biology, psychology, society, culture, and religion[1]. Addressing sexual health issues is important in healthcare, including for midwifery students who are training to become future health professionals. However, societal attitudes, religious beliefs, cultural norms, and personal discomfort can create barriers to discussing sexual health[2]. Midwifery students must recognize these influences, reflect on their own biases, and create an environment that is open and non-judgmental for individuals to express their sexual health concerns. By incorporating sexual health in their practice, midwifery students can contribute to the overall well-being and satisfaction of individuals and promote healthy sexual relationships[3,4]. The sexual attitudes of midwifery students, who have an important role in improving the sexual health of individuals, families, and societies, can negatively affect both themselves and the individuals they counsel and care for[5]. Indeed, some studies show that the sexual health of the sick person is frequently neglected or pushed to the side due to negative attitudes and behaviors[6]. However, the evaluation of sexual health, the detection of possible health problems, and the management of these problems by professional caregivers are considered prerequisites of the holistic approach[7]. For midwifery students who will be future members of the health team to be able to evaluate sexual health and provide sexual health care with a holistic approach, it is very important and necessary to know their beliefs and attitudes affecting midwifery care and to determine the difficulties they experience in evaluating sexual health[4,8]. There are many descriptive studies in the literature aimed at determining the beliefs and attitudes of students regarding the sexual health of patients. However, studies specifically focusing on midwifery students are very limited. Furthermore, there are no studies where students are examined in-depth, difficulties faced by students when communicating with individuals/patients in the clinic are identified, and students' suggestions for eliminating these difficulties are addressed. For this reason, the present study was performed with a concurrent nested design in which quantitative and qualitative data were used together to determine the attitudes and beliefs of midwifery students towards sexuality and to evaluate sexuality. For this general purpose, answers to the following questions were sought:

1. What are the beliefs and attitudes of midwifery students regarding the sexual care of individuals/patients?
2. What are the difficulties that midwifery students face when evaluating sexual health?
3. What are the solutions for students in order to evaluate sexual health more easily?

Materials and Methods

This mixed-method study was designed as descriptive and qualitative research. The combination of findings obtained in this way reveals more comprehensive results than either of

these approaches can do alone[9]. In this study, after determining the sexual attitudes and beliefs of midwifery students by quantitative methods, qualitative interviews were conducted to reveal in detail the attitudes and beliefs of the students about sexual health and their evaluation of patients' sexual health. The Good Reporting of a Mixed Methods Study (GRAMMS) guidelines as provided by the Enhancing the Quality and Transparency of Health Research (EQUATOR) network were followed.

The study population consisted of students continuing their education at the midwifery department of a university in northern Turkey between January and March 2022. A sample selection was not made, and 334 students who continued education at the midwifery department and volunteered to participate in the data collection process were included in the study. Research data was collected by the Personal Information Form and the Sexual Attitudes and Beliefs Scale. Interviews lasted an average of 10–15 minutes. The IBM SPSS Statistics 26 Package program was used to analyze the data. Categorical variables were presented as frequency and numerical variables were presented as mean and standard deviation. The Student's t-test, One-way analysis of variance test, and Posthoc Tukey test were used to check the intergroup differences. In all analyses, Pvalue<0.05 was accepted as statistically significant.

Personal Information Form: Research data was collected through face-to-face interviews using the Personal Information Questionnaire developed by the researchers in line with the literature[10,11]. It consisted of 22 questions about sociodemographic characteristics and experiences in providing sexual health care to the students.

Sexual Attitudes and Beliefs Scale (SABS): The scale was developed by Magnan and Reynolds in 2006[12]. The validation and reliability studies in Turkey were performed by Ayhan et al[13]. The SABS includes 12 items. Participants mark answers on a six-point Likert scale. For each statement in the scale, participants mark the answer closest to their opinions on a scale between 1 and 6 (1=I absolutely disagree, 6=I absolutely agree). The overall score that can be obtained from the scale varies between 12 and 72. Both for the overall score and for each item score, high scores indicate negative beliefs and attitudes regarding sexual evaluation and counseling of the patient and suggest that there are more barriers to assessing and advising on sexual problems. Cronbach's alpha reliability coefficient of the survey and re-test text correlation value was found to be respectively 0.75 and 0.82 and in the Turkish version 0.73 and 0.90 again[12,13]. Cronbach's alpha was measured as 0.66 in this study.

The descriptive phenomenology method was used in the qualitative phase of the research. In this research, the number of participants was determined based on the principle of data saturation. The data collection process was terminated after the data became repetitive and no new information could be obtained after the statements of the 21st participant. In-depth individual interviews were conducted using the Semi-Structured Interview Form, which included eight open-ended questions prepared by the researchers[11,14]. The interviews were recorded with a digital audio recorder. Interviews lasted an average of 20 minutes. During data analysis, the audio recordings were transcribed, and raw data was created by combining them with observation notes. To ensure a holistic approach, the raw data was read at least twice by all the researchers, and the nonverbal communication cues of the participants were interpreted. Using content analysis, data was encoded at three levels[15]. The expressions and statements of the participants that were deemed important were encoded. The researchers compared and classified the codes according to their differences and similarities, and four main themes consisting of 13 sub-themes were created. These themes included students' thoughts and judgments about sexuality; difficulties in evaluating the sexuality of individuals or patients; groups posing difficulties when evaluating sexuality according to life stages; and solutions to easily evaluate the sexuality of the individual or patient. The main themes were examined and compiled in the findings and discussion section.

Ethical approval was obtained from the Ondokuz Mayis University Social and Humanities Research Ethics Committee (number: 2021-1053, date: December 31, 2021). Institutional permission was also obtained from the university where the research was conducted. The students were informed of the aim and method of the study, and their written informed consent was obtained. The study was conducted in accordance with the Helsinki Declaration principles.[†]

Results

Since a mixed method was used in this study, the findings were examined separately, quantitatively, and qualitatively. The mean age of the students was 20.48±1.86 (17-30) years. 97% of the students stated that they did not have a sexual partner and did not have any sexual experience (95.2%). 62.3% of the students stated that they had enough knowledge about sexuality and reproductive health (and had not participated in any previous scientific activities related to sexuality (congress, panel, and symposium, among others) (74.3%). The most common sources of information on sexual issues were family (48.2%), school (41.9%), internet-TV (41%), friends (33.8%), and healthcare providers (11.7%) (Table 1).

The vast majority of the students who participated in the study stated that an evaluation of sexuality should be made in the care given during pregnancy and the postpartum period (94.3%). Students' experiences and their thoughts on providing care for sexual health are shown in Table 2.

The mean SABS score of the students who participated in the study was 34.39±7.17. Item scores ranged between a minimum of 2.00±1.14 and a maximum of 3.62±1.19 (Table 3). No significant difference was found in the SABS total score of the participants concerning marital, economic income, mother's and father's educational status, family type, and place of residence (Pvalue>0.05) (Table 4). A statistically significant difference was found in the SABS total score of the students according to age (t=3.88, Pvalue=0.000). Accordingly, the attitudes and beliefs of students aged 17–21 (35.17±7.02) years regarding sexual care were found to be more negative than

[†] **Presented as an oral presentation at the 6th International 7th National Midwifery Congress, 25-27.09.2023 in Ankara.**

those of student's aged ≥22 (31.52±7.04) years. Similarly, a significant difference was found in SABS total score concerning the student's classes (F=20.28, Pvalue=0.000). Posthoc Tukey test revealed that the sexual attitudes and beliefs of 1st-year students were more negative compared to the 2nd, 3rd, and 4th-year students (Pvalue<0.05). In addition, the sexual attitudes and beliefs of 2nd-year students were more negative compared to 4th-year students (Pvalue<0.05) (Table 4).

No significant difference was found in SABS total scores concerning family structures of students (F=2.55, Pvalue=0.055), family approach to sexual issues (F=2.54, Pvalue=0.056), sexual experience (t=0.83, Pvalue=0.40), and having a sexual partner (t=1.02, Pvalue=0.30) (Pvalue>0.05). However, a significant difference was found in SABS total scores concerning thinking that you have enough knowledge about sexuality and reproductive health (t=−6.05, Pvalue=0.00) and attending a previous scientific activity related to sexuality (t=−2.15, Pvalue=0.03) variables (Pvalue<0.05). Accordingly, students who did not think they had enough knowledge about sexuality and reproductive health had more negative sexual attitudes and beliefs compared to students who thought otherwise (32.63±6.56). Those who did not participate in any previous scientific activity related to sexuality (34.89±7.01) also had more negative attitudes and beliefs towards sexual care compared to students who participated in such a scientific activity (32.96±7.49) (Pvalue<0.05).

Table 1: Distribution of characteristics of students on sexual issues (n=334)

Variable	n	%
First source of information on sexual issues*		
Family	161	48.2
School	140	41.9
Internet - TV	137	41
Friend	113	33.8
Health care provider	39	11.7
I didn't get any information.	5	3.0
Sexual experience		
Yes	16	4.8
No	318	95.2
Current sexual partner		
Yes	10	3.0
No	324	97
Do you think you have enough knowledge about sexuality and reproductive health?		
Yes, I do.	208	62.3
No, I don't think so.	126	37.7
Participation in a previous scientific activity related to the subject of sexuality		
Yes	86	25.7
No	248	74.3

* Multiple options are selected.

Table 2: Thoughts and experiences of students on providing care for sexual health (n=334)

Variable	n	%
Should there be an evaluation of sexuality in the care given during pregnancy and postpartum period?		
Yes	315	94.3
No	19	5.7
Do you talk about sexuality with the patient/pregnant woman you care for?		
Yes	221	66.2
No	113	33.8
What roles do you think nurses and midwives have in assessing sexuality?		
Educator role	255	76.3
Counsellor role	244	73.1
Care provider role	174	52.1
Therapeutic role	102	30.5
I don't think they have any role	10	3.0
How do you feel when the person you care for asks you about sexuality?		
I feel comfortable.	207	62.0
I feel partially comfortable.	115	34.4
I feel uncomfortable.	12	3.6
Which option best defines you when talking to the patient/woman you care for about sexual matters?*		
I do not have any barriers/problems with sexuality.	177	53.0
I feel uncomfortable when a third person is present in the environment when I'm talking about sexual issues.	162	48.5
I find my knowledge of sexual issues inadequate.	97	29.0
I'm afraid to talk about sexual issues.	41	12.3
I don't have time to talk about sexual issues.	11	3.3

* Multiple options are selected.

Table 3: Sexual Attitude and Beliefs Scale Item Scores of Students (n=334)

Variable	Mean±SD	Agree (%)	Disagree (%)
1. Discussing sexuality is necessary for the health of the patient.	2.00±1.14	87.7	12.3
2. I understand how my patients' illnesses and treatments can affect their sexuality.	2.68±1.17	72.2	27.8
3. I'm uncomfortable talking about sexual issues.	2.02±1.19	12.9	87.1
4. I'm more comfortable talking to my patients about sexual issues than most of the nurses I work with.	3.58±1.27	35.4	64.6
5. I think most of the hospitalised patients are too sick to deal with sexuality.	2.73±1.24	21.5	78.5
6. I give my patients time to discuss their sexual problems.	3.28±1.27	54.0	46.0
7. When my patients ask me about sexuality, I suggest they talk to their doctor about it.	2.79±1.23	24.3	75.7
8. I'm confident in my ability to diagnose the patient's sexual problems.	3.62±1.19	44.0	56.0
9. Sexuality is a very private matter for discussing with patients.	3.21±1.69	41.1	58.9
10. It is a nursing responsibility to allow the patient to talk about their sexual problems.	2.58±1.51	73.6	26.4
11. Sexuality should only be discussed if brought up by the patient.	2.29±1.26	16.8	83.2
12. Patients expect nurses to ask about their sexual problems.	3.57±1.32	44.4	55.6
Sexual Attitude and Beliefs Scale Total Score	**34.39±7.17 (16–59)**		

Table 4: Comparison of some variables with respect to students' sexual attitude and beliefs scale scores (n=334)

Variable	X± SD	Test value	Pvalue
Age			
17–21 years	35.17±7.02	t=3.88	**0.000**
≥22 years	31.52±7.04		
Class			
1st year	37.96±7.13		**0.000**
2nd year	35.32±6.18	F=20.28	Post Hoc Test /Tukey
3rd year	32.70±5.90		1st year > 2nd, 3rd, 4th year
4th year	30.61±7.02		2nd year > 4th year
Marital status			
Married	41.50±4.94	t=1.40	**0.161**
Single	34.35±7.17		
Income status			
Income less than expense	33.55±7.97		
Income equal to expense	34.66±6.58	F=1.89	**0.152**
Income more than expense	36.68±7.73		
Place of residence			
Dormitory	34.32±7.22		
Family house	33.90±6.91	F=0.55	**0.64**
Roommate	35.15±6.85		
Relatives	36.66±9.84		
Mother's educational status			
Illiterate	34.00±6.61		
Primary education	34.15±7.30	F=0.32	**0.80**
High school	34.79±7.31		
University and above	35.21±6.81		
Father's educational status			
Illiterate	36.80±5.01		
Primary education	33.97±7.38	F=1.25	**0.28**
High school	35.44±7.26		
University and above	33.72±6.49		
Family type			
Nuclear family	34.24±7.11		
Extended family	34.33±7.02	F=0.69	**0.49**
Divorced/separated family	36.13±8.49		

t: Student's-t test, F=One-way ANOVA

Content analysis conducted in the qualitative section of the study, which examined the views of midwifery students regarding sexuality and approaching female/patient sexuality, revealed four main themes consisting of 13 sub-themes. 21 midwifery students (all female) with an average age of 21.5±2.5 (19-24) years participated in the qualitative section.

Theme 1. Thoughts/Judgements about Sexuality

The majority of students mentioned that discussing sexuality within their families is considered taboo due to cultural and societal beliefs. They disapprove of premarital or extramarital sexual relationships and value virginity, wanting their first sexual partner to be their future spouse. However, their views on sexuality have evolved after studying midwifery at university. They now recognize sexuality as a basic human need and believe it should be openly discussed in society. They have become more comfortable talking about sexuality and, while they personally do not approve of premarital sexual relationships, they express respect for individuals who engage in them.

Not being able to talk about sexuality

"Our collective family structure is repressive on these issues. We are reluctant to talk about these issues, but I think

mothers should give the girls and boys an initial basic education in this regard." (p20)

"Sexuality was shameful, something that was ignored. You felt ashamed talking about it." But that is not the case right now. After our education, we can talk freely about sexuality." (p19)

Approach to premarital/extramarital relationships

I'm one of those people who say "not without getting married" (p12)

"In our family, this turns into a crisis" (p11)

Gender discrimination

"In our society, men can do it before marriage, but women can never do it. I don't think either side should do it. For example, if I had a partner, I wouldn't want him to do it" (p2)

"While virginity is more important in women, it doesn't matter in men (p8)

Sexual biases change with education

"I was very judgemental before I entered college, but from what I've seen in the lectures, my thinking has changed. I'm not judging people right now, I respect everyone's decisions" (p5)

"After I got into college, a lot of things changed in my head. I used to be constantly embarrassed when sexual issues came up. I was saying to myself 'what is this, oh not this issue, but now I can really talk about it as a normal health-related topic, I can even have conversations" (p7)

Theme 2. Difficulties in evaluating the sexuality of individuals/patients

It was observed that students, particularly in their first year, faced challenges in communicating while taking anamnesis from male patients in the presence of others in the patient's room. However, as the students progressed in their education, they became more comfortable in their communication with patients. When it comes to evaluating sexuality, the students initially focused on family planning methods and were somewhat hesitant to address sexual health issues in depth. Additionally, three students mentioned experiencing difficulty in evaluating sexuality in individuals with cancer or other challenging diseases.

Not being able to evaluate sexuality in the 1st year

"When I was a freshman, I couldn't evaluate sexuality, like the patients would get mad at me, but now I'm taking patient anamnesis and then I'm moving on to sexuality (p17)

"I was very shy at first, but now I think I can at least ask more easily" (p4)

Not being able to communicate with male patients

"I was at the urology clinic, I think there was a male patient, an adult, we had to ask the patient about this stuff, our forms at the time were detailed. I had a very difficult time asking him questions" (p18)

Patient companions

"There are at least two patients or two companions in the rooms, and we can't interview patients comfortably because of noise even though there is a screen. I can't get the clear answers I'm looking for. They answer evasively" (p14)

Individuals with gynaecological cancer/serious disease

"My patient had cervical cancer and underwent hysterectomy, she was very young and had no children. I didn't know how to approach that woman, what to say. I couldn't talk about sexuality" (p13)

"If I go and ask someone in a neurosurgery clinic what your sexual relationship is like, the patient will answer back: what does that have to do with anything?*" (p4)*

Patients with taboos

"I'm afraid to ask those questions when approaching people with different opinions and different cultures" (p2)

"Makes communication difficult in adults with false hearsay information" (p20)

Theme 3. Groups posing difficulties when evaluating sexuality

It was discovered that students had difficulty communicating with children or people over the age of 50 but were more comfortable communicating with people their age. Only one student stated that she had difficulty with adolescents.

"Adolescents have a fixed belief that you can't change, I can't change it anyway" (p17)

"She was 60 and had a hysterectomy. She angrily said to me, "Why are you asking me now?" Do I have to answer this? She was so mad at me" (p7)

Theme 4. Solutions for easier evaluation of individual/patient sexual health

Most students believe that to more easily evaluate sexuality, sexuality should become a more common topic in society, which can only happen through education. Furthermore, students suggested that the rooms should be planned for one person or that there should be no relatives during the interview. One student said that midwives and nurses working at the clinic should be role models for them, while another student said that forms could be distributed and filled out by patients instead of verbal communication.

Society must change.

"I'd be more comfortable if people's perspectives on this changed slightly. Still, even the word "sexuality" is considered "very rude." (p21)

"Society needs to be more aware..." If they were, things would be easier. (p14)

I want to be alone with my patient.

"I'm more comfortable having a one-on-one discussion with the patient." (p20)

"There are single rooms where I can have a better interview with the patient." (s16)

Role Models

"There must be a role model. Nurses/midwives at the hospital are also ignoring sexuality (p13)

"We don't have any issues with sexual health education, but if we had taken applied training on this subject, if our instructor showed us how to approach patients with role play, it would be more useful." (p18)

Sexuality evaluation form

We can give the patient a short form about sexuality and ask her to fill it out, after which we can assess sexuality. Those who are ashamed to talk may be able to fill out the form (p1)

Discussion

In this study, the SABS mean score shows that midwifery students do not have a negative attitude toward sexuality. Other studies in the literature using the same scale reported higher scores[16,17], whereas others reported lower scores[18,19]. However, our results were consistent with other studies conducted in

Turkey[10,14]. Considering that many factors affect sexual attitudes and behaviors, such differences are expected. One of the most important of these variables is culture. As a matter of fact, unlike in western cultures, in Turkey, individuals cannot comfortably talk about sexuality due to situations such as embarrassment, shyness, and conservatism, as in eastern cultures similar to China and Japan[14,20,21]. The study's qualitative and quantitative data also show that students grew up learning that sexuality cannot be discussed and that this topic was not discussed in the family. Individuals who grow up knowing that sexuality should not be addressed hesitate to discuss these issues[20]. Another factor affecting sexual attitudes and behaviors is education. It was found that students who thought they had enough knowledge about sexuality and reproductive health and those who participated in a previous scientific activity on the subject of sexuality had more positive attitudes and beliefs about sexual care. Furthermore, qualitative interviews with the students showed that the taboos about sexuality began to crumble with the education students received. They began to talk freely about sexuality with their friends/patients. The sexual attitudes and beliefs of first-year students who have not yet taken sexual health courses were more damaging compared to those of more senior students who had taken sexual health courses, which shows that education can indeed help break down taboos created by society. Studies in the literature show that taking courses on sexual health and participating in scientific activities makes fewer barriers to evaluating sexuality and positively affects attitudes and behaviors[1,22].

Qualitative results of this study showed that the students had difficulty talking about sexuality when taking anamnesis from male patients, cancer patients, or patients with severe diseases; when there were other individuals in the patient's room; and when evaluating the sexual health of elderly individuals who were afraid to talk about sexuality or those with sexual taboos. In a study conducted on Turkish nursing students, similar results were obtained that showed that the students avoided asking questions and collecting data on sexual subjects due to unsuitable physical environment, lack of sufficient knowledge about sexuality, embarrassment, feeling uncomfortable, and negative behaviors of patients/relatives[23]. In another qualitative study conducted with nursing students, it was found that male students had difficulty evaluating the urogenital system and collecting data on the sexual health of female patients and vice versa[24]. In a qualitative study, nurses stated that they did not think that elderly patients or patients with serious diseases had sexual needs[25]. The perception that elderly patients or patients with serious illnesses do not have sexual needs is present in many societies. It may cause the sexuality of these individuals to be often overlooked or become a secondary issue, making it difficult for students to prioritize sexuality in their practices[26,27]. In qualitative interviews, the students stated that sexuality should become a more open topic in society to evaluate sexuality easily, and this would only happen through education. The students also recommended that practical applications and midwives or nurses should support education should be role models in the clinic. In an experimental study with midwifery students, the results showed that education including interactive workshops was more effective than only theoretical education, and the students' clinical skills improved more in terms of sexual health counseling after interactive education[28]. Similarly, according to the results of an experimental study conducted on nursing students, education, including interactive methods (brainstorming, role-playing, and group work were used in the lessons), reduced the negative attitudes, beliefs, and behaviors of students toward sexuality[22]. Therefore, adding interactive training to nursing and midwifery curricula may be beneficial. By doing so, midwifery students can more easily evaluate the sexual health of patients while working in the field or clinic after graduation, detect problems early, and become role models for students and interns. In the in-depth interviews, most students stated that the patient's physical environment (people in the room, sound, noise, etc.) is essential in evaluating sexual health, as is also stated in the literature. For this reason, the exclusion of other people in the patient rooms during interviews and making the physical environment suitable may contribute to the easier assessment of sexual health by the students and effective communication with the patients[29].

According to the study, the sexual beliefs and attitudes of midwifery students were not predominantly negative. However, the society in which these students grew up had strong sexual taboos. The courses they took at university, specifically those related to sexual health and women's health, played a significant role in helping them overcome these negative attitudes. As a result, the students became more comfortable discussing sexual health. Nevertheless, they still faced challenges when communicating with older age groups, individuals with strong sexual taboos, male patients, individuals with serious diseases, and patients who had a relative or someone else present in the room.

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Conflict of Interest

The authors report there are no competing interests to declare. The manuscript has been read and approved by all the authors.

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