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Frequency of absence of vaginal bleeding during first sexual intercourse and its psychological, sociological, and physical correlates among women in Turkey

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Abstract

Introduction and Objective. Myths equating virginity with first-coital vaginal bleeding conflict with biomedical evidence. The aim of the study is to assess the prevalence of absent first-coital bleeding among women in Turkey and its physical and psychosocial correlates.

Materials and Method. In a retrospective cross-sectional study, 533 women were classified as bleeding-negative (n=155, 29.1%) or bleeding-positive (n=378, 70.9%) based on first intercourse history. Retrospective (T0) and current (T1) variables were compared.

Results. The groups were homogenous regarding age at T1, age at T0, and the calculated time elapsed between T0 and T1. Significant differences emerged at T1; Group 1 exhibited higher rates of university/master's education (p=0.008), and lower-level economic status was higher in Group 2 (p<0.05). Crucially, at T1, the divorce rate was substantially higher in Group 1 (12.9% vs. 2.6%; p=0.002), and the lifetime number of marriages was significantly elevated (p<0.05). Regarding T0, Group 2 reported significantly higher subjective fear (69.6% vs. 54.8%), physical arousal (76.5% vs. 64.5%), higher VAS pain scores (5.08 ±2.67 vs. 4.55 ±2.82; p=0.041), and required more penetration attempts (2.64 ±3.37 vs. 2.13 ±1.57; p=0.020). Importantly, 41.9% of women in the bleeding-negative group (Group 1) explicitly reported exposure to domestic, verbal, or physical violence at T1, specifically triggered by the absence of bleeding on the wedding night.

Conclusions. Absence of first-coital bleeding is a common physiological variation (29.1%) but remains a trigger for domestic violence and relationship instability in settings where virginity myths persist. Routine violence screening and psychosexual counselling should be integrated into gynaecological care.

Key words

sexual intercourse, virginity, vaginal bleeding, psychological effects, hymen.

INTRODUCTION

Sexuality is a multifaceted and broad concept encompassing not only biological components but also deeply intertwined psychological, social, and cultural dimensions. Within many traditional frameworks, the female body and female sexuality are highly regulated through social, religious, and cultural constructs [1]. A prominent example of such constructs is 'virginity', which holds no objective medical definition but functions strictly as a socio-cultural and religious value judgment used to evaluate and control women's sexual histories [2].

In structurally patriarchal societies, these socio-cultural meanings are often reductionistically mapped onto the female anatomy, specifically the structural integrity of the hymen [3]. Culturally, the tearing of this tissue and subsequent vaginal bleeding during the first sexual intercourse (coitus) are widely accepted as definitive, physical proof of virginity [4, 5]. However, this social myth deeply contradicts bio-medical and histological evidence. The hymen is a highly dynamic anatomical structure with extensive individual variations in terms of thickness, compliance (elasticity), vascularization, and morphology [6]. In individuals with highly elastic or minimally vascularized hymenal tissue, the absence of tearing or bleeding during first coitus is a completely normal physiological phenomenon [7, 8]. Therefore, anatomical variations dictate that the presence or absence of bleeding cannot serve as an objective or scientifically reliable indicator of a woman's sexual history [8].

The socio-cultural specificities of Turkey present a compelling context for examining this phenomenon. While contemporary Turkey exhibits a dual social structure where younger, urban generations increasingly adopt more liberal perspectives on gender and relationships, deeply rooted traditional and conservative norms regarding female sexuality, and strict expectations of premarital virginity still heavily persist, particularly in rural or semi-urban areas [9]. In these traditional subcultures, the historical expectation of a blood-stained sheet on the wedding night remains a powerful social mechanism [9, 10]. Consequently,

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open communication within intimate relationships regarding past sexual experiences or physical anatomy is often treated as a profound taboo [11]. This lack of relational trust and constructive communication forces couples to rely on outdated anatomical myths rather than mutual understanding, creating an environment ripe for intense marital and psycho-sexual tension [9, 10, 11].

When biological reality is ignored in favour of these rigid cultural constructs, the absence of bleeding during first intercourse is frequently interpreted as a betrayal of trust or a violation of family honour [7, 8]. This misinterpretation subjects women to intense psychological stress, emotional alienation, and physical vulnerability [12, 13]. The chronic psychosocial burden and anxiety surrounding the fear of not bleeding lay the groundwork for severe traumatic clinical outcomes, including depression, profound guilt, social isolation, and sexual dysfunction [12, 13]. In extreme traditional settings, where patriarchal ideology equates a woman's body with familial honour, this can escalate into systemic domestic abuse, honour-based violence, or even serious crimes traditionally categorized as 'honour killings' [14–18]. These traditional practices are heavily influenced by local cultural practices, educational levels, and geographical backgrounds rather than true theological foundations [16, 17, 18]. Addressing this critical gap between medical science and socio-cultural expectations requires a multi-disciplinary framework spanning gynaecology, psychiatry, and sociology to effectively de-objectify women as subjects of bio-political control [7, 8].

OBJECTIVE

The aim of the study is to determine the frequency of the absence of vaginal bleeding during the first sexual intercourse among women presenting to a tertiary centre in Turkey, and to analyze its psychological, sociological, and physical correlates. It is hypothesized that the absence of bleeding does not correlate with structural socio-economic differences, but is significantly linked to adverse relational outcomes, including domestic conflict and higher rates of relationship dissolution.

MATERIALS AND METHOD

Study design and participants. A retrospective, cross-sectional study was conducted with participants who presented to the Gynaecology Clinic at the Training and Research Hospital in Antalya, Turkey, between 1 January – 31 December 2021. The participants were evaluated based on their experiences during their first sexual intercourse (retrospective timepoint, T0) and their current status at the time of questionnaire completion (present timepoint, T1). Based on their clinical history regarding their first sexual experience, participants were stratified into two distinct groups: those who did not experience vaginal bleeding during their first sexual intercourse (Group 1, n=155) and those who did experience vaginal bleeding (Group 2, n=378).

The primary outcome variable of the study was to evaluate the frequency of the absence of vaginal bleeding during the first sexual intercourse (T0). The secondary outcome variables included comparing current psycho-sexual parameters (T1), physical pain scores, and structural relational outcomes (such as history of domestic conflict or marital status) between the two groups.

Inclusion criteria.

1) Presenting to the hospital's gynaecology clinic between 1 January – 31 December 2021 (T1);
2) agreeing to participate in the study and providing written informed consent (T1);
3) completing the questionnaire assessment fully without missing data (T1).

Exclusion criteria.

1) history of hymenal surgery or genital reconstruction prior to the first sexual intercourse (T0);
2) active menstruation during the first sexual intercourse (T0);
3) regular use of tampons during menstruation prior to sexual initiation (T0);
4) history of non-sexual pelvic or genital trauma prior to first intercourse (T0);
5) presence of severe systemic diseases, including diabetes, major cardiovascular, renal, hepatic, autoimmune, or endocrine disorders at T1;
6) confirmed history of bleeding diathesis or coagulation disorders;
7) cognitive impairment, advanced neurological disorders, or memory deficits that could distort retrospective recall (T1);
8) use of prescription medications, illicit substances, or alcohol capable of affecting cognitive recollection at T1, or use of hormonal therapies capable of causing withdrawal bleeding at T0.

Data collection and assessment tools. Data were gathered using a comprehensive, structured clinical questionnaire designed by the authors, administered in a private setting to ensure confidentiality. The questionnaire was structured into five specific thematic blocks, distinguishing between retrospective experiences (T0) and current variables (T1):

Socio-demographic and socio-economic profile (T1). Age, body mass index (BMI, kg/m^2), current marital status, total number of lifetime marriages, location of residence during the first sexual intercourse, current education level, parental education levels, and family income level.

Medical and pharmacological history. Assessment of systemic diseases, coagulation history, and medication profiles.

Characteristics of the first sexual intercourse (T0). Age of the sexual partner at T0, the exact number of attempts required to achieve successful penile-vaginal penetration, and the subjective presentation of fear, physical pain, and vaginal spasm (vaginismus-like symptoms) during the initial experience.

Sexual and relational functioning. The presence of physical sexual arousal and subjective orgasm success during the first experience (T0). Additionally, current requirements for professional psychiatric or psychosexual support due to long-term sexual anxiety were recorded at T1.

Relational safety and violence assessment (T1)s. Exposure to physical, verbal, or severe psychological violence perpetrated by the partner, the partner's family, or the participant's own family, specifically triggered by the absence or reported absence of vaginal bleeding. Violence was screened using direct, standard behaviour-based disclosure questions regarding post-marital conflict related to virginity expectations.

Pain assessment. Subjective physical pain perception during the first sexual intercourse (T0) was measured retrospectively using the Visual Analog Scale (VAS). The scale consists of a 10-cm horizontal line anchored by word descriptors, ranging from 0 (indicating "no physical pain at all") to 10 (indicating 'the worst possible physical pain imaginable').

Statistical analysis. Data were analyzed using SPSS 25.0 software for Windows. The Kolmogorov-Smirnov test was utilized to evaluate the normality of the distribution for continuous variables. Continuous variables exhibiting a normal distribution were analyzed using the independent samples t-test, whereas non-normally distributed continuous variables were evaluated via the Mann-Whitney U test. Continuous data are presented as mean ± standard deviation (M ± SD). Categorical and nominal variables were evaluated using Pearson's Chi-square test or Fisher's exact test where appropriate, and are expressed as absolute frequencies and percentages [n (%)]. A p-value of less than 0.05 was defined as statistically significant for all analyses.

Ethical approval. Ethical clearance for this study was officially granted by the Institutional Ethics Committee of the University of Health Sciences, Antalya Training and Research Hospital (Protocol Ref. No: 58/10). All participants provided written informed consent prior to data enrollment, and all procedures were conducted in strict compliance with the principles of the Declaration of Helsinki to secure participant confidentiality.

RESULTS

Study cohort and flow. A total of 646 participants were initially assessed for eligibility, of whom 113 were excluded based on strict exclusion criteria, including incomplete questionnaire, refusal to participate, drug/substance/alcohol use, active menstruation, or prior genital trauma and surgeries (Fig. 1). The final analysis was completed with 533 participants. Based on their retrospective clinical history, 155 participants (29.08%) reported the absence of vaginal bleeding during their first sexual intercourse (Group 1, Bleeding Negative), while 378 participants (70.92%) experienced vaginal bleeding (Group 2, Bleeding Positive) (Tab. 2).

Socio-demographic and socio-economic characteristics. Comparative analysis of socio-demographic features at the time of questionnaire evaluation (T1) and initial intercourse (T0) is detailed in Table 1. The mean age of the participants at T1 was almost identical between the groups: 33.46 ± 7.80 years (range: 18–59 years) for Group 1 and 33.48 ± 8.78 years (range: 18–63 years) for Group 2 (p=0.976). Similarly, no statistically significant differences were observed regarding BMI at T1

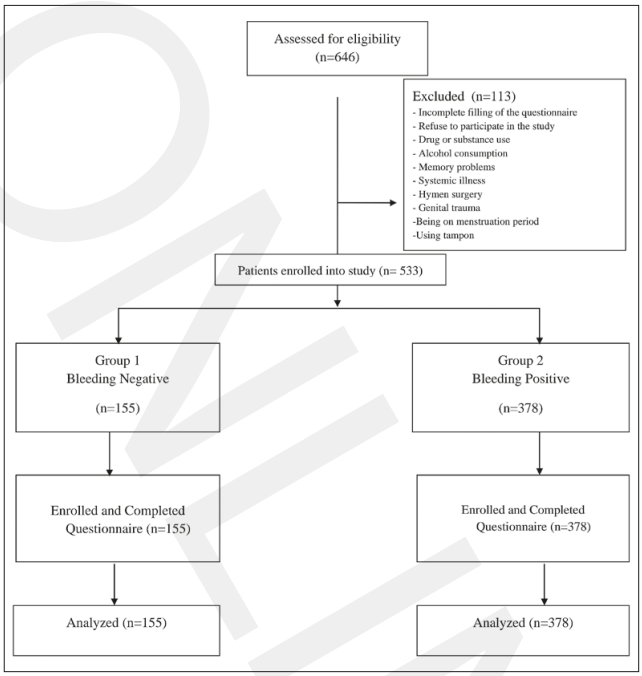

Figure 1. Flowchart of the enrollment and assessment of the study participants

(p=0.190), maternal education level (p=0.450), father's education level (p=0.281), or residential area at T0 (p=0.131). The mean age at first sexual intercourse (T0) was 20.68 ± 2.76 years (range: 14–31 years) in the bleeding-negative group and 21.15 ± 3.29 years (range: 15–35 years) in the bleeding-positive group (p=0.114). To evaluate potential cohort effects and timeline variations, the secondary variable representing the time elapsed between T0 and T1 was analyzed. The mean time elapsed since the first sexual experience was 12.78 ± 7.92 years (range: 0–41 years) for Group 1 and 12.33 ± 8.41 years (range: 0–45 years) for Group 2, showing a highly homogenous temporal distribution between the two study populations (p=0.561).

In contrast, structural differences emerged regarding education and economic status at T1. Higher education levels (university and master's degrees) were significantly more prevalent in Group 1 (p=0.008). Conversely, lower-level economic status was predominantly represented among women who experienced bleeding during their first intercourse (64.6% in Group 2 vs. 38.7% in Group 1; p<0.05). Notably, current marital status at T1 differed significantly (p=0.002); the rate of divorce was substantially higher among women who did not experience bleeding compared to those who did (12.9% vs. 2.6%). Reflecting this relational instability, the average lifetime number of marriages was significantly elevated in Group 1 (1.16 ± 0.51 vs. 0.99 ± 0.34; p<0.05).

Psycho-sexual parameters, pain, and domestic violence outcomes. The physiological and psychosocial experiences surrounding the first sexual intercourse (T0) revealed distinct clinical patterns between the cohorts (Tab. 2). Participants in the bleeding-positive group (Group 2) reported significantly higher rates of subjective fear (69.6% vs. 54.8%; p<0.05) and physical arousal (76.5% vs. 64.5%; p=0.007) during first coitus. Retrospective physical pain perception measured via VAS scores was also significantly higher in Group 2 (5.08 ± 2.67) than in Group 1 (4.55 ± 2.82; p=0.041). Corroborating these physical outcomes,

Table 1. Participants' socio-demographic characteristics

		Bleeding Negative (Group 1) (n=155) (29.08%)	Bleeding Positive (Group 2) (n=378) (70.92%)	p
Age (years) (T1) [Mean ± SD (Min–Max)]		33.46 ± 7.80 (18–59)	33.48 ± 8.78 (18–63)	0.976
BMI (kg/m²) (T1) [Mean ± SD]		25.19 ± 3.50	24.55 ± 5.66	0.190
Age at first intercourse (years) (T0) [Mean ± SD (Min–Max)]		20.68 ± 2.76 (14–31)	21.15 ± 3.29 (15–35)	0.114
Partner's age at first intercourse (years) (T0) [Mean ± SD]		24.29 ± 3.75	24.79 ± 3.57	0.148
Time elapsed between T0 and T1 (years) [Mean ± SD (Min–Max)]		12.78 ± 7.92 (0–41)	12.33 ± 8.41 (0–45)	0.561
Education level (T1) [n (%)]	Primary education	14 (9.0%)	74 (19.6%)	**0.008***
	High school	53 (34.2%)	130 (34.4%)	
	University	77 (49.7%)	159 (42.1%)	
	Master's degree	11 (7.1%)	15 (4.0%)	
Economic status (T1) [n (%)]	Lower level	60 (38.7%)	244 (64.6%)	**<0.001***
	Intermediate level	85 (54.8%)	40 (29.1%)	
	High level	10 (6.5%)	24 (6.3%)	
Residential area at T0 [n (%)]	City	120 (77.4%)	243 (64.3%)	0.131
	Town	20 (12.9%)	115 (30.4%)	
	Village	15 (9.7%)	20 (5.3%)	
Marital status (T1) [n (%)]	Single	10 (6.5%)	25 (6.6%)	**0.002***
	Married	125 (80.6%)	343 (90.7%)	
	Divorced	20 (12.9%)	10 (2.6%)	
Number of marriages (T1) [Mean ± SD]		1.16 ± 0.51	0.99 ± 0.34	**<0.001***
Education level of mother [n (%)]	Primary education	92 (59.4%)	207 (54.8%)	0.450
	High school	35 (22.6%)	79 (20.9%)	
	University	13 (8.4%)	47 (12.4%)	
	Master's degree	15 (9.7%)	45 (11.9%)	
Education level of father [n (%)]	Primary education	75 (48.4%)	225 (59.5%)	0.281
	High school	45 (29.0%)	69 (18.3%)	
	University	30 (19.4%)	64 (16.9%)	
	Master's degree	5 (3.2%)	20 (5.3%)	

BMI – Body Mass Index; T0 – time of first sexual intercourse; T1 – time of study questionnaire.
*p < 0.05

Table 2. Sexual functions, exposure to violence, and pain outcomes of the participants

		Bleeding Negative (Group 1) (n=155) (29.08%)	Bleeding Positive (Group 2)(n=378) (70.92%)	p
Fear in intercourse (T0) [n (%)]	No	70 (45.2%)	115 (30.4%)	0.001*
	Yes	85 (54.8%)	263 (69.6%)	
Vaginal spasm during intercourse (T0) [n (%)]	No	75 (48.4%)	175 (46.3%)	0.703
	Yes	80 (51.7%)	203 (53.7%)	
Arousal during intercourse (T0) [n (%)]	No	55 (35.5%)	89 (23.5%)	0.007*
	Yes	100 (64.5%)	289 (76.5%)	
Orgasm during intercourse (T0) [n (%)]	No	115 (74.2%)	259 (68.5%)	0.212
	Yes	40 (25.8%)	119 (31.5%)	
Psychiatric support requirements (T1) [n (%)]	No	150 (96.8%)	373 (98.7%)	0.164
	Yes	5 (3.2%)	5 (1.3%)	
Violence in the absence of bleeding (T1) [n (%)]	No	90 (58.1%)	-	Not Applicable
	Yes	65 (41.9%)	-	
Pain during intercourse (T0) [VAS score, Mean ± SD]		4.55±2.82	5.08±2.67	0.041*
Number of attempts to achieve) successful intercourse (T0) [Mean ± SD]		2.13±1.57	2.64±3.37	**0.020***

VAS – Visual Analog Scale; T0 – Time of first sexual intercourse; T1 – Time of study questionnaire.
*p < 0.05 indicates statistically significant differences between the two groups.

achieving successful penile-vaginal penetration required a significantly higher number of behavioural attempts in the bleeding-positive cohort (2.64 ± 3.37 attempts) compared to the bleeding-negative cohort (2.13 ± 1.57 attempts; p=0.020). No significant differences were detected between the groups regarding retrospective vaginal spasm (p=0.703), subjective orgasm experiences at T0 (p=0.212), or current psychiatric support requirements at T1 (p=0.164). Crucially, within the bleeding-negative cohort (Group 1), 41.9% of the women explicitly reported being subjected to domestic, verbal, or physical violence perpetrated by their partners or families, specifically triggered by the absence of vaginal bleeding on the wedding night.

DISCUSSION

Physiological reality and the perception of virginity. The finding that 29.08% of women did not experience bleeding during their first sexual intercourse demonstrates that the common societal equation of 'virginity equals bleeding' does not align with biological realities. This rate is consistent with studies by Rashidi et al. (2020) and similar research by Nazaralieva et al. (2024), which indicate that nearly a half of women do not experience bleeding during their first intercourse [7, 8]. As emphasized by medical and forensic literature, the elastic nature of the hymen may prevent tearing despite penetration, thereby precluding bleeding [19]. Furthermore, the occurrence of bleeding in subsequent rather than the first sexual encounter (5.3%) can also be explained by this anatomical elasticity. The results obtained in the current study provide evidence that the absence of bleeding during first intercourse is a medically normal and prevalent anatomical variation; therefore, vaginal bleeding cannot be accepted as a reliable criterion for virginity.

The hymen, a part of the external genitalia, is an anatomical structure that structurally resembles the vagina and exhibits significant inter-individual variation. As observed in this study, the non-rupture of the hymen during coitus can be explained by its elasticity or specific structural properties. Additionally, non-sexual factors, such as tampon use, medical examinations, or physical exercise, may affect the integrity of the hymen. These data scientifically support the fact that the state of the hymen cannot be an absolute indicator of virginity [6, 19]. It is not possible to reliably determine sexual history by observing the hymen; terms such as 'intact' or 'torn' are considered medically misleading [20].

Sociological impacts and the spiral of violence. One of the most striking findings of the current study is that 41.9% of women who did not experience vaginal bleeding during their first sexual intercourse were subjected to psychological or physical violence by their partners or family members. This data parallels findings from a large-scale study by Nazaralieva et al. (2024) involving 6,370 women, which reported that 43.2% of participants did not experience bleeding during their first intercourse [7], and were subjected to systematic accusations, partner alienation, and emotional and physical violence. Cultural traditions, such as the expectation of a 'blood-stained sheet', turn vaginal bleeding – which is not biologically mandatory – into an absolute tool of proof, thereby paving the way for bullying, domestic violence, and honour killings. As highlighted in the literature, cultural norms based on honor and virginity keep female sexuality under strict control and legitimize violence under the guise of protecting family honour [8, 21]. Consequently, the findings of the current study indicate that the societal perception of virginity, which is incompatible with medical reality, constitutes a severe element of structural violence against women's health and safety.

The significant variations in education, economic status, and long-term marital outcomes observed between the two cohorts in the current study further underline how socio-economic resources and socio-cultural environments shape a woman's capacity to navigate traditional expectations. Higher educational attainment may grant women better access to accurate anatomical information, potentially modifying their pre-coital expectations and lowering immediate psychological barriers. However, as documented by contemporary sociological research, deeply-rooted traditional and conservative norms regarding female sexuality create severe communication blockages within intimate relations [22, 23]. Within these traditional subcultures, sexuality and anatomical functions are treated as profound taboos, preventing any constructive, open premarital dialogue between partners [10, 24]. This absolute deficiency in relational trust and mutual communication forces couples to rely heavily on rigid socio-cultural myths rather than medical parameters [24, 25]. Consequently, an environment ripe for intense marital tension is generated, triggering subsequent relationship dissolution, and explaining the significantly higher divorce rates and lifetime numbers of marriages documented within the bleeding-negative cohort in the presented study.

Clinical and sexual functional findings. In the study it was found that the fear and pain (VAS) scores were higher in the group that experienced bleeding during their first sexual intercourse (Group 2). This may be explained by the fact that the tearing of a thicker hymenal structure during penetration complicates the physical experience, increases pain, and necessitates more attempts. Conversely, the psychological anxiety felt by women who do not bleed due to the fear that something is wrong, negatively affects their arousal levels and orgasm success (although not statistically significant).

When evaluating the complex correlation between these acute physical symptoms and subsequent relational outcomes, a comprehensive multi-dimensional interpretive framework must be prioritized. The clinical presentation of sexual difficulties, heightened fear, or elevated pain scores during sexual initiation, cannot be reductionistically assigned to a single anatomical or isolated biological cause; instead, it reflects a complex multifactorial etiology where acute psychological anxiety, rigid socio-cultural virginity expectations, distinct anatomical variations of the hymen, and interpersonal partner dynamics continuously converge [26, 27].

These data align with similar psychosexual studies in the literature. For instance, a study of 336 women by Briedīte and Brokane (2018) noted that 52% of participants experienced bleeding during their first intercourse; while no direct correlation was found between bleeding and pain levels. It was also reported that negative experiences during the first intercourse increased rates of anorgasmia and sexual dissatisfaction [28]. In conclusion, the findings of the current study show that both anatomical difficulties during first

intercourse (thick hymen/pain) and psychological anxieties stemming from societal pressures (absence of bleeding/guilt) play a decisive role in women's long-term sexual health and satisfaction [29, 30].

In this study, higher divorce rates were observed in the group without bleeding, indicating that the absence of bleeding during the first intercourse has long-term destructive consequences on family integrity. This reflects the pressure of societal expectations of virginity and religious/legal norms on the institution of marriage. Indeed, Eskandari et al. (2025) state that the Civil Code based on Shiite jurisprudence accepts anatomical conditions such as vaginal narrowing/obstruction as legal grounds for the annulment of marriage [31]. Furthermore, the absence of bleeding during first intercourse can lead to unfounded allegations of lack of virginity in women and acute erectile dysfunction in men. This creates a basis for unjust accusations, contentious divorces, excessive compensation demands, and even honour-based murder trials [32]. This reveals that the absence of bleeding, a medically normal anatomical variation, can be transformed into an official ground for separation, divorce, and life-threatening danger against women due to rigid cultural and legal frameworks.

Vaginal bleeding is not an absolute or indisputable proof of virginity. The findings of this study should be shared in all societies where virginity is perceived as a social burden. Every step taken to break the spiral of honour killings and violence against women by increasing societal awareness will be a significant victory for human rights and women's right to life.

Clinical implications. In clinical practice, it must be clearly communicated to patients that the absence of vaginal bleeding during first sexual intercourse is a natural biological and histological variation. Given the significant societal pressure stemming from virginity myths, integrating routine screening for domestic and intimate partner violence into standard gynaecological examinations is essential. For patients at risk of honour-based violence due to these socio-cultural expectations, healthcare providers must ensure a private, trauma-informed, and secure clinical environment. Consequently, gynaecological care for such patients should be structured through a holistic, multidisciplinary approach that integrates psychiatric and social support services to safeguard the patient's psychosocial integrity and overall well-being.

Limitations of the study. The primary limitation of the study may be recall bias; however, the fact that the first sexual intercourse experience is a highly memorable event for women reduces this risk. Furthermore, due to the socio-cultural taboo surrounding sexual experiences, the risk of participants providing reports that differ from the actual situation due to social desirability bias cannot be ignored. This may have led to a deviation in the reporting rates, particularly regarding exposure to violence and the details of sexual experiences. To minimize this issue, participant identities were kept strictly confidential. The fact that the group without bleeding had a higher education and income level may be associated with the ability of these women to express themselves more freely, which raises the possibility that the actual frequency of 'absence of bleeding' might be even higher than the data suggests.

CONCLUSIONS

The study reveals that the absence of vaginal bleeding during first sexual intercourse occurs at a rate of 29.08%, proving that this is a natural, biological variation resulting from the anatomical diversity of the hymenal tissue. The absence of bleeding, which is considered a proof of virginity in societal myths, is used as a tool of pressure for stigmatization, feelings of guilt, and patriarchal control over women. The findings obtained demonstrate that the rate of exposure to violence among women who do not experience bleeding is at a critical level of 41.9%, highlighting the devastating impact of this taboo on women's health and their right to life. To prevent this tragedy, the following strategic steps are imperative:

- **Dissemination of scientific awareness.** Hymenal variations and virginity myths must be integrated into societal consciousness through educational programmes, sexual health literacy initiatives, and the media.
- **Legal and ethical regulations.** The medically unethical practice of 'virginity certification' must be completely prohibited; furthermore, the 'absence of bleeding' must not serve as any legal mitigating factor or justification in judicial proceedings concerning honour-based violence.
- **Clinical and acute trauma management.** Scientific facts regarding these anatomical variations should be conveyed to couples during premarital counselling. During clinical crises where acute societal pressure escalates, routine violence screening should become a standard procedure in gynaecology clinics and emergency departments. All processes must be conducted with a focus on privacy and integrated with trauma management.

In conclusion, by debunking a deep-rooted social taboo and replacing it with scientific data, this study aimed to provide a strategic contribution to the prevention of honor-based violence and the promotion of gender equality.

Conflict of interest. The authors declare that the research was conducted in the absence of any commercial or financial relationships that could be construed as a potential conflict of interest.

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