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01. DETERMINANTS OF FEMALE SEXUAL ORGASMS IN FINLAND
Osmo Kontula

Introduction: The physiological and psychological processes that are produced by sexual desire and arousal are aimed in our minds at sexual gratification and ultimately, orgasms. The pursuit of sexual pleasure is the key motivating factor in sexual activity. Experiencing pleasure as well as orgasms is not a given, and many things can stand in the way of sexual enjoyment, particularly among women. These are essential issues and questions of sexual wellbeing. It is valuable to know more about the trends and determinants of the orgasms. Especially female orgasms are a great challenge in sexual health promotion.

Methods: In Finland four national sex surveys based on random samples from central population register have been conducted: 1971, 1992, 1999, and 2007. They are representative of the total population within the age range of 18-54 years in 1971 (N=2152) and 18-74 years in 1992 (N=2250), 1999 (N=1496), and 2007 (N=2590). Measures include age at first orgasm through masturbation and sexual intercourse, frequency of orgasm in intercourse, and orgasm during the latest sexual intercourse.

Results: Of young and middle-aged women, more than 80 percent had experienced orgasms through masturbation. A third of girls had their first masturbatory orgasm before upper-primary school, before the age of 13. One in two women had experienced orgasms for at least two years before having sexual intercourse for the first time. The figure for young women was nearly two-thirds.

Of women, 55 percent had an orgasm the last time they had intercourse. Twelve percent of women reported having multiple orgasms the last time they had sexual intercourse. In 2007, nine percent of women reported never having had an orgasm from intercourse.

Women who reported considering sex crucial for relationship happiness and who found it easy to discuss sex with their partner were approximately twice as likely to have orgasms than women who responded differently to those two questions. Additional positive factors included experiencing a feeling of love, considering one's relationship very happy, as well as the feeling that sex was getting better and better, the longer one had known one's partner. A relationship that felt good and worked well emotionally, and where sex was approached openly and appreciatively, promoted orgasms.

Conclusion: The findings indicate that women differ from one another greatly in terms of their tendency or capacity to experience orgasms. A significant portion of women experienced persistent problems having orgasms from intercourse, whereas many found it easy to have multiple orgasms. The inequality in sexual enjoyment among women was drastically greater than among men.

02. SEXUAL ACTIVITIES AMONG AGING POPULATION IN FINLAND
Osmo Kontula

Introduction: Sexuality is an essential fea-
ture of human life throughout the life course. Most people are living longer than preceding generations, and more are remaining sexually active later life. Sexual issues are becoming more prominent also in the old age care and services. Gerontologists and other medical experts generally agree that continued sexual interest and activity can be therapeutic for older men and women. This paper presents how sexual activities change in aging men and women and what are their determinants.

Methods: Three national sex surveys were conducted in Finland in 1992, 1999, and 2007. Each survey’s sample was drawn from the Central Population Register, so that all Finns had an equal opportunity to be selected into the sample. Of these three population surveys, respondents in the age group 55 – 74 years were included in these analyses. Their numbers were 532 (1992), 384 (1999), and 901 (2007). The number of respondents was altogether 1,817, of which 1,019 were women and 798 men.

Results: Among the aged population women over the age of 60 have a permanent sexual partner less often than do men. At age 70 and older, less than half of the women in Finland have a husband or another type of steady partner. Among the males, more than four-fifths of those 70 and older lived in a couple relationships. The implication of this observation is that men have a much better chance than women to keep up their sexual activities through the aging process. Frequency of intercourse was lower in the oldest age groups, who reported a mean frequency of intercourse every other week compared to every week in the younger age groups. Even a long duration of relationship is not a determinant of decreasing sexual activities if couples are able to stay healthy and sexually functioning.

In addition to age, the most important predictors of sexual activities among aging men were: a loving relationship, positive sexual self-esteem, easy sexual performance (erection), and a history of multiple partners. For women, important predictors included high sexual desire (own and partner’s), and a high value given to sexual happiness in the relationship. For men, other health-related factors that had a positive outcome on sexual activities included: not smoking, drinking heavily at least sometimes, and low body mass index (slimness).
en with complete SCI at selected levels to
differentiate the role of pudendal, pelvic and
hypogastric nerves in mediating the analge-
sia. Unexpectedly, the women with complete
SCI at or above Thoracic level 10 could feel
the vaginal and cervical stimulation, and the
stimulation produced analgesia measured at
the fingers. This led to my hypothesis that
the vagus nerve must therefore convey vagi-
nal and cervical sensation to the brain, by-
passing the spinal cord. We tested and con-
firmed the hypothesis by showing, with the
use of functional MRI (fMRI), that the vagus
projection nucleus (solitary nucleus [NTS]
in the medulla oblongata) was activated in
those women by vaginal or cervical self-
stimulation. Some of the women experi-
enced orgasms from the stimulation. This
finding enabled us to publish the first evi-
dence worldwide of sites where orgasm is
represented in the brain in women. Then,
using fMRI, we mapped the differential pro-
jection of the clitoris, vagina and cervix to
the sensory cortex (paracentral lobule) in
women. In that study we also reported the
unexpected finding that the nipple projec-
tion is not only to the thoracic region but
more significantly, overlaps with the genital
projection zone. We have currently exten-
ed those fMRI studies to able-
bodied men,
mapping the projection sites to the parace-
tral lobule of penile skin
– different from
deep penile stimulation (apparently it is not
commonly recognized that two different
nerves convey penile sensibility), testicles,
rectum, nipples, and prostate, and how they
combine to generate orgasm. We provide
evidence that the prostate projection is dif-
f erent from the rectal projection, both to
slightly different regions of the paracentral
lobule. We are now analyzing these projec-
tions in men with complete spinal cord inju-
ry to ascertain whether the vagus nerve conveys prostate sensory activity to the
brain, homologous with the role of the vagus
nerve in women, and to ascertain whether
nipple self-stimulation has an additive or
synergistic effect. In addition, our recent
fMRI evidence that electrical stimulation of
the external ear stimulates (presumably via
the auricular branch of the vagus) the clas-
tical vagus projections in the brain, includ-
ing the paracentral lobule, suggests that all
three types of stimulation – prostate, nipple,
and ear – may all summate at the paracen-
tral lobule (i.e., the “genital sensory cortex”)
to enhance sensual pleasure in able-bodied
men with complete SCI, perhaps attenu-
ate chronic pain, and perhaps induce and
enhance orgasm.

04.NEW RESEARCH FINDINGS AND CON-
CEPTS IN MALE/FEMALE SEXUAL RE-
SPONSE: FOUR NERVE CONCEPTUALIZA-
TION
Barry R. Komisaruk
Our research on nerve pathways involved in
sexual response, orgasm and pain blockage
in women has led us to analyze and concep-
tualize the roles of the different genital sen-
sory nerves in women and men. First, it is
evident that the claim by Kinsey et al (1952)
that the vagina and cervix are insensate are
totally wrong, not only by their own evi-
dence in the very same book but by wom-
en’s reports and our own research. We have
found that the clitoris, vagina, and cervix
project to the genital sensory cortex in distinc-
tly different regions from each other,
indicating that they receive sensory inner-
vation by three different nerves – most like-
ly the pudendal, pelvic, and hypogastric,
respectively. This is consistent with wom-
en’s reports that stimulation of each of these
three genital regions produces different
sensory qualities and that each of these re-
gions contributes differentially to orgasm.
We have also found evidence that a fourth
nerve, the vagus nerve, conveys vaginal and
cervical (but not clitoral) stimulation, on the
basis that complete spinal cord injury, which interrupts all sensory pathways
through the spinal cord, nevertheless does
not block vaginal and cervical sensibility.
This led me to hypothesize that the vagus
nerve conveys the vaginal and cervical sens-
sibility, which we confirmed by showing
that, using fMRI, the vagal sensory nucleus
in the medulla of the brainstem is activated
by vaginal or cervical self-stimulation in
these women, and some of those women experienced orgasm from the stimulation. More recently, we have found that electrical stimulation of the vagus nerve in women and men, accessed via its “auricular branch”, which carries sensory activity from the external ear, also activates the genital sensory cortex. This provides further evidence that the vagus nerve is a fourth genital sensory nerve. Our further studies of the genital sensory nerves have provided evidence that a specific pathology, “Tarlov cysts” may be responsible for genital sensory pathologies, e.g., Persistent Genital Arousal Disorder (PGAD) and perhaps other pelvic pain syndromes, even in men. Furthermore, our recent findings in men provide evidence that the prostate sends sensory activity to the genital sensory cortex, and that the penis sends sensory activity to the genital sensory cortex not only via the pudendal nerve (i.e., dorsal nerve of the penis), but also via the pelvic nerve (afferents of the parasympathetic cavernosal nerve), the latter of which may have the greater influence on orgasm in men.

Rationale: The internet has revolutionized both sex education and sex therapy.
Introduction: Two these changes are being presented: Distance education by MOOCS and therapy by Skype.
Methods: A live demonstration on a large screen.
Results: In the future, sex education and sex therapy will reach ever larger groups of students and clients.
Conclusion: Everyone active in the area of sexual health should become familiar with the new means of electronic communication.

05. SEX EDUCATION AND SEX THERAPY IN THE ELECTRONIC AGE
Erwin Haeberle

06. HYPERSEXUALITY: WHAT ARE WE PATHOLOGIZING?
Charles Moser
Introduction: Various proposals to define Hypersexuality (and similar concepts) as a sexual disorder have been proposed. This presentation will analyze those proposals and the assumptions inherent in the concept.
Methods: Linguistic and logical analysis.
Results: The assumption of a “normal” sex-
ual frequency and the concept of “normal” sex interests will be shown to be spurious concepts. The ethical issues inherent in treating a disorder that has not been accepted as a real disorder will be discussed. Conclusion: Hypersexuality is morality masquerading as evidence based scientific concept and a psychiatric diagnosis.

07. PARAPHILIC DISORDERS AND DSM-5: LOGICAL INCONSISTENCIES
Charles Moser
Introduction: Simple Paraphilias are no longer mental disorders in DSM-5, replaced with a new term “Paraphilic Disorders.” The present paper will analyze the diagnostic criteria, language, and logical consistency of this new disorder.

Methods: Linguistic and logical analysis

Results: The Paraphilic Disorders named in DSM-5 do not meet the new definition of a Paraphilia. The definition of a Paraphilic Disorder does not meet the new DSM-5 definition of Mental Disorder. Other inconsistencies will be highlighted. The lack of rationale for this diagnostic category will be highlighted.

Conclusion: The Paraphilic Disorders described in DSM-5 are not evidenced based, not clinically useful, and do not help clinicians make consistent diagnoses.

08. SOMNAMBULISTIC VOYEURISM AND SEXUAL HYPNAGOGIC HALLUCINATIONS WITH OUT-OF-BODY EXPERIENCE
Carlos H. Schenck

In a preceding abstract, a classification of sleep-related abnormal sexual behaviors and experiences was presented. In this abstract, two striking cases are presented that illustrate the extreme nature of abnormal sexual behaviors and experiences that can occur during some cases of pathological sleep (complex sleepwalking [SW]; narcolepsy). The first case involves somnambulistic voyeurism (Schenck CH. Paradox Lost: Midnight In The Battleground Of Sleep And Dreams. Extreme-Nights, LLC: Minneapolis, Minnesota, USA, 2005 [ISBN 0-9763734-0-8], pages 370-1). A 21 year-old man with childhood-onset, persistent SW had been arrested several times late at night by the police because of indecent exposure and lewd behavior (masturbation) in public. He would be standing in front of a dark window (with the curtain or shade pulled down) of a home in his neighborhood while fondling his genitals, with his penis exposed, and usually masturbating. He appeared glassy-eyed and confused while mumbling that he was looking into an open window and seeing a female who was either naked or else in the process of undressing herself, which aroused him sexually. He was convinced that the curtain or shade was pulled up, the lights in the bedroom were on, and he could clearly see inside. However, in contrast to what he perceived, the police reported that each time they found him, he was staring at a closed and shaded window that he could not see through, and there was no light turned on inside the room. On a number of other occasions (without police involvement), he awakened on his own during similar episodes, realized he had been SW, put his penis back into his pants, zipped them up and returned home. So he was clearly sleepwalking and having sexual hallucinations in his sleep. He had no history of daytime sexual perversion (paraphilia). The second case involves narcolepsy (Coelho FMS, et al. Sexual hypnagogic hallucinations and narcolepsy with cataplexy: a case re-
port. *Sleep Science* 2011;4(3):110-2. A 46 year-old man reported a history of sexual hypnagogic hallucinations (HH--emerging during wake-sleep transitions at bedtime) that were triggered by the start of sex with his wife (mainly in the evenings). While floating up in air, he had an out-of-body experience (OBE) in which he was seeing the sex he was having with his wife in bed at that moment—but he had stopped the actual sexual activity with his wife in bed. Therefore, he was hallucinating the sex with his wife, and not actually seeing the sex (since it had stopped when he started hallucinating). The OBE & sexual HH had been present for 6 years (along with other typical narcoleptic symptoms). His wife often complained, since the sexual activity with her husband would be interrupted when he started to have sexual HH and OBE. For the husband, the sexual activity with his wife in bed continued without interruption since he had a rapid transition from actual sex to combined sexual HH/OBE, as an abnormal narcoleptic brain-mind response to having sex. Therefore, in this repeating scenario, the husband had continual sexual pleasure, in contrast to his wife who only experienced sexual pleasure during the initiation of foreplay. This case illustrates how narcolepsy is not only associated with HH (along with cataplexy and sleep paralysis, i.e. paralysis in sleep-wake and wake-sleep transitional states--the classic "narcoleptic tetrad" together with sleep attacks), but also with abnormal sexual experiences and other forms of extreme dissociated states, such as OBE.

**09. SLEEP DISORDERS AND SEXUALITY—SEXSOMNIA**

**Carlos H. Schenck**

The first classification of sleep-related abnormal sexual behaviors and experiences was published in 2007 (Schenck CH, et al. *Sleep* 2007;30:683-702). Many categories of sleep-related disorders were represented: parasomnias (confusional arousals/sleepwalking from Non-REM sleep, with/without obstructive sleep apnea [OSA]; REM sleep behavior disorder, viz. dream-enactment disorder from rapid-eye-movement [REM] sleep; sleep-related seizures; sleep related dissociative disorders; nocturnal psychotic disorders; Kleine-Levin syndrome (periodic hypersomnia); severe chronic insomnia; restless legs syndrome (and its variant, restless vagina syndrome); narcolepsy; sleep exacerbation of persistent sexual arousal syndrome; sleep related painful erections. Synonyms for sexual parasomnias include sexsomnia, sleep-sex, and sleep related abnormal sexual behaviors. Sexsomnia is a young-adult male predominant disorder, and usually emerges in the context of either i) a longstanding, multidimensional, complex history of Non-REM sleep parasomnias (2-5 separate parasomnias in reported cases), or ii) or OSA, with the onset of sexsomnia emerging in tandem with snoring and other hallmark symptoms of OSA. A full range of sleep related sexual behaviors with self and/or bed partners or others have been reported, including masturbation, sexual verbalizations/ vocalizations, fondling, sexual intercourse with climax, sexual assault/rape, ictal sexual hyperarousal, ictal orgasm, and ictal automatism. Adverse physical and/or psychosocial effects from the sleep-sex were present in all parasomnia and sleep related seizure cases, but pleasurable effects were reported by 5 bed partners and by 3 patients with sleep related seizures. Forensic consequences were common, including all reported cases involving minors. No reported case involved daytime paraphilia, or sexual deprivation. All parasomnias cases reported amnesia for the sleep-sex. Polysomnography (sleep laboratory multi-channel physiological monitoring of sleep) documented a Non-REM sleep parasomnia or OSA in most cases, and in 3 cases there was sexual moaning from slow wave sleep and sexual intercourse during stage 1 sleep/wakefulness in one case (with sex provoked by the bed partner). Bedtime clonazepam therapy was effective in most cases of parasomnias, nasal continuous positive airway pressure therapy was effective in controlling comorbid OSA in all treated cases, and all reported treated pa-
patients with sleep related sexual seizures responded to anticonvulsant therapy. Therefore, sexsomniia is a treatable appetitive parasomnia (along with sleep-related eating disorder). The literature on sexsomnina has expanded since 2007, but further research on this intriguing condition needs to be conducted, leading to additional cases and case series being reported from around the world, thereby enhancing awareness of this condition that is associated with major psychosocial and legal consequences.

010. NATURE OF VAGINAL ORGASMS
Roy Levin
During penile vaginal intercourse (PVI) a number of genital sites are stimulated by the pressure and friction of the thrusting penis. These include the clitoral glans, the perirethral glans (the triangular area of the vestibule surrounding the urethral meatus from the clitoral glans to the vaginal introitius), the internal clitoris (crura), the labia minora, the anterior vaginal wall, the ‘G-spot’, the urethra, Halban’s fascia (urethrovaginal septum), vestibular (vaginal) bulbs. Rarely is the cervix or distal (deep) part of the anterior vaginal wall involved as during high sexual arousal the former is withdrawn up and away from axis of the penile thrusting (vaginal tenting) and has poor sensory innervation while the vaginal ballooning removes the latter from the penile glans. The perirethral glans has erotic sensitivity and is stimulated by being pushed into and then pulled out of the vagina by the penile shaft. In those women who have highly sensitive or well innervated perirethral glans, orgasms may arise from its stimulation just by PVI alone. There are still no empirical studies in relation to the erotic function of the vestibular bulbs or the crura, they may or may not be innervated for inducing erotic arousal. The so-called ‘vaginal orgasm’ is thus induced by a possible multiple activity of erotic sites. To try and isolate particular ones yielding the most stimulation and activity for the creation of the orgasm will vary with the individual woman, with the particularities of the sexual practice(s) employed and even perhaps the stage of the menstrual cycle. Because of this known stimulus complexity some authors, myself included, are of the opinion that to name the attribution of orgasm by PVI alone to just the vagina is now outdated and any such orgasm should really be designated simply as a ‘genital orgasm’.

011. VAGINAL ORGASMS VS CLITORAL ORGASMS
Roy Levin
Freud (1905) differentiated the sexual arousal induced by clitoral stimulation and that induced from penile vaginal intercourse (PVI) alone. He claimed, without empirical support, that the former was less mature than the latter and that to achieve his concept of ‘normal femininity’ the clitoris had to be deroticized and the vagina eroticized, a difficult but most important transfer for women. If they did not do this they could become ‘anesthetic at the vaginal orifice’. This belief was held by him and his followers for many years but became converted by others into the concept of a clitoral orgasm and a vaginal orgasm, the latter had to be created by PVI alone. The clitoris was claimed to ‘undermine healthy femininity’ (Hitschman & Bergler 1936) and was a barrier to the development of adult genitality. The rise of biologic psychiatry and feminism made these Freudian notions fall into disregard. Lately, a coterie of psychologists have resurrected this ‘undermining concept’ using questionnaires that investigated whether the woman obtained her orgasm from PVI alone or from clitoral stimulation and correlated their responses with psychological tests. They reported that the clitoral stimulation/orgasm was not beneficial to their physical, psychological, interpersonal or behavioral health and created ‘noxious consequences’. A postulated mechanism for this was that as PVI is the only activity that promotes the propagation of genes, evolution rewards it but ‘punishes’ any other activator of sexual arousal. However, because the generation of arousal/orgasm by PVI is a multisite stimulus, women cannot with...
surely specify where their arousal is generated from (the ambiguity problem) and subjects who try to interpret unclear/vague signals as clear and distinct employ paresidia a behavior most often seen when subjects see images in clouds, rock faces. In this situation it is ascribing arousal to a specific site. The present review critically examines and rejects that the clitoris should become a vestigial organ by women undertaking a psychological clitoridectomy and that women who cannot have orgasms by PVI alone are sexually dysfunctional or that their male partners are sexually inadequate because they cannot induce such activity by their penis alone.

**012.BEYOND THE G SPOT: RESEARCH CONCERNING SEXUAL RESPONSES IN WOMEN**

**Beverly Whipple**

**Introduction:** Dr. Whipple’s research program has focused on validating women’s reports of sensual and sexual pleasure.

**Methods and Results:** This talk will review Dr. Whipple’s interdisciplinary research concerning the re-discovering and naming of the Grafenberg spot (G spot) and the phenomenon of female ejaculation. The adaptive significance of the G spot will be discussed, that is the strong pain blocking effect produced by anterior vaginal wall stimulation as well as during labor and childbirth. The variety of women’s sexual responses will be reviewed that have been documented in her human physiology laboratory from vaginal, cervical, and imagery-induced orgasm to studies concerning orgasms in women with complete spinal cord injury. The various sensory pathways that are involved in female sexual responses, including fMRI of the brain studies of orgasm will be discussed.

**Conclusion:** Ways these research findings can be used in sexual health as well as future directions of this research program will be discussed.

**013.THE BENEFITS OF SEXUAL EXPRESSION ON HEALTH**

**Beverly Whipple**

**Introduction:** In 2003 and 2007 the Planned Parenthood Federation of America (PPFA), in cooperation with the Society for the Scientific Study of Sexuality, published a white paper on the Health Benefits of Sexual Expression. Dr. Whipple was a senior author on this paper. Although most reports focus on potential negative outcomes of sexual expression, this presentation based on PPFA paper and more recent research, will focus on the positive benefits of sexual expression on health.

**Methods and Results:** An analysis of published data demonstrate a positive effect of sexual expression on decreased mortality, lower frequency of fatal coronary events, and decreased risk of breast cancer in men and women. The effects of sexual expression on general well-being, pain management, and quality of life will also be addressed.

**Conclusion:** This discussion will address the health benefits of sensual and sexual expressions not just benefits of sexual intercourse. There is a need for more research in the area of the positive health benefits of pleasure, sensual, and sexual expression.

**014.PRACTICAL INTRODUCTION INTO SEXOCORPOREL COUNSELING**

**Karoline Bischof**

**Aim:** This workshop is a practical illustration of the theoretical framework of Sexocorporel. It addresses persons wishing to increase their competencies in sexual counseling. It also encourages the enrichment of personal erotic abilities.

**Background:** From childhood on, through learning processes, most people adopt particular habits to elicit and increase their sexual arousal (sexual arousal modes) involving precise rituals of genital stimulation, body movement, and muscle tension. High tonic muscle tension is often present during elevated sexual arousal. Coupled with shallow or arrested breathing and reduced amplitude of motion, it physiologically limits the experience of sexual pleasure and can directly cause a number of sexual dysfunc-
tions in both women and men, such as anhedonic orgasm, coital anorgasmia, low sexual desire, erectile problems, early ejaculation, and dyspareunia. A therapy employing exercises that focus on variations in movement and muscle tone, deep abdominal breathing, and sensory awareness can effectively promote sexual functioning and the sensory, emotional and relational experience of sexual pleasure.

**Methods:** Based on the theoretical framework of Sexocorporel presented in my keynote lecture, in various simple (clothes-on) exercises, participants can experience the body-brain unity, sample therapeutic interventions and acquire new therapeutic skills.

**015.SEXOCORPOREL: BODY AND MIND IN SEXUAL PLEASURE**
**Karoline Bischof**

Sexocorporel was developed by Prof. Jean-Yves Desjardins at the University of Quebec, Montreal, Canada. Constantly updated with latest scientific findings, it is increasingly taught and applied in sex therapy in Europe and in Canada. It is a practically oriented, comprehensive model of all physiological, emotional, cognitive and relational components directly interacting in human sexuality. At its core is the constant inseparable neurophysiological interaction between the brain (mind) and the body. Modifications on the level of the body (motion, muscle tension, breathing) modify our sexual functioning, our emotions, fantasies, how we experience our sexuality and how we think about it.

From childhood on, through learning processes, most people adopt particular habits to elicit and increase their sexual arousal (sexual arousal modes): through direct or indirect stimulation of their genitals while moving their bodies in varying degrees, with varying muscle tension. Neurophysiological findings and clinical observation evidence that high muscle tension, shallow or arrested breathing, and reduced amplitude of motion are less conducive to sexual pleasure than deep breathing, varying movement and muscle tone. Some therapeutic approaches focus on indirect psychosocial causes of sexual problems. Others, to the contrary, strictly medicalize them. Sexocorporel considers all cognitive, emotional and relational components in the context of the genital and neurophysiological reality of a person. Most sexual concerns originate directly from limits in sexual learning, and in particular, from a sexual arousal mode that cuts down on the experience of sexual pleasure, thus restricting the development of sexual desire, and impairing the perception of oneself as an erotic man or woman. Sexocorporel allows a concise evaluation of strengths and limitations in the arousal mode and other components directly affecting a person's sexuality. It offers an effective therapy by way of individually adapted learning steps inducing new patterns of stimulation, movement, breathing, awareness, emotion regulation, and thought. It thereby promotes both sexual functioning and the sensory, emotional and interpersonal experience of sexual pleasure.

**016. COITAL ORGASM – CAN IT BE LEARNED? SUMMARY AND A SAD STORY WITH A HAPPY ENDING**
**Karoline Bischof**

**Rationale:** Coital anorgasmia is a common complaint among women consulting for sexual problems, often promoting low sexual desire. A genetic predisposition has been proposed, but “environmental factors” not further defined are deemed to be the main agents. In this panel, we discuss the role of neurophysiological, emotional and cognitive factors and the person’s learning history. This final presentation will summarize the core points and illustrate them with an oncological case report.

**Case:** 53y old woman with secondary anorgasmia of two years who had been orgasmic through clitoral stimulation prior to an extensive clitoridectomy and vulvectomy for Bowen’s disease.

Sexocorporel therapeutic interventions included instructions for digital vaginal stimulation and mobilisation of the pelvis through iliopsoas and pelvic floor muscle contrac-
tions with abdominal breathing.

**Outcome:** After three months’ training, the patient achieved satisfying orgasms through vaginal stimulation and pelvic movement.

**Discussion:** As research among women with genital mutilation (FGM) demonstrates, the clitoris is not inevitable for orgasm. Indeed, the rate of orgasm through penile-vaginal stimulation is higher among FGM women than among women with an intact clitoris. We propose that orgasmic response and the favored location of stimulation depends not just on genetics, but on the physical learning history. Clitoral response can be achieved comparatively easily, but may keep a woman from exploring and developing her vaginal sensitivity. The more remote vagina and surrounding pelvic floor muscles require repetitive pressure and extension to develop responsiveness. Awareness of the vagina as an erogenous organ is enhanced through pelvic movement and deep abdominal breathing. Through corresponding training, as suggested in sexocorporeal therapy, vaginal sexual response can be accessible to women even after destructive surgery.

**Recommendations:** Women consulting for coital anorgasmia can be encouraged to develop vaginal sexual response through repetitive vaginal stimulation and play with pelvic muscles. It is important to give this information to women with extensive vulval surgery.

### 017.THE ELEMENTS OF RECOVERY ACCORDING TO SURVIVORS OF SEXUAL ABUSE AND VIOLENCE

**Maaret Kallio**

**Introduction:** Many people have experienced sexual abuse and violence. According to the Finnish School Health Promotion Study (2013), 20% of girls and 9% of boys in the 9th grade of comprehensive school had experienced sexual violence at some point or repeatedly. Among upper secondary school students, 23% of girls and 6% of boys had experienced sexual violence; among vocational school students, the corresponding figure was 33% of girls and 11% of boys.

**Methods:** The survey I conducted addressed recovery from sexual abuse and violence. It was administered to Finnish respondents who had experienced sexual abuse and violence. The survey was conducted in the form of an anonymous online questionnaire and comprised 319 respondents. The questions asked about respondents’ personal skills and methods in advancing their recovery as well as the support they had received from both professional support providers and intimates. Additionally the survey compiled the thoughts, ideas and tools that respondents had a desire to share, peer to peer, with those who have similar experiences. Most respondents had experienced sexual violence or abuse in childhood or adolescence at the hands of an adult perpetrator.

**Results:** Respondents described a number of coping mechanisms that served as the first steps toward recovery. Personal, individual mechanisms in the early stages of recovery included music, nature, writing and the regularity of daily life, all of them serving to reinforce a feeling of hope and the ability to see good while in the midst of a particularly difficult life situation. Some respondents had also discovered characteristics within themselves that had helped to further their recovery.

**Discussion:** Social support in recovering from sexual trauma has been previously acknowledged as particularly important. The issue was also strongly manifested in the responses to survey questions: the support of both intimates and professional support providers was seen as key. Conversely, respondents also described factors that had hindered their recovery when they had sought the support of intimates or professionals. Many respondents described being left on their own and their painful experiences being rejected by both those closest to them and by professionals.

**Conclusion:** We need more discussion about sexual violence and recovery in order to provide needed support and to recognize
violence as early as possible. Many professionals in the support services field and many victims themselves believe that it is not possible to overcome such experiences or to move forward. This belief is not always correct and can itself be an obstacle to recovery.

Methods: Statistical data from University Student Health Survey 2012. Selected data collected from September 2013 till April 2015 in internet-based counseling services: Case examples and descriptive statistics.

Results: Erectile dysfunction, female genital pain and fear of any sexual activities were among the common reasons for attending in internet-based sexual health counseling. Students also needed to know, what is normal in sexuality and in sexual behavior. Most students reported the contact was enough for them to get information and encouragement to ease their concerns. In more difficult sexuality problems with a comorbidity of mental or physical symptoms and diseases the internet-based contact served mainly as a facilitator to seek out the proper face-to-face health care in local health services.

Conclusion: The secure internet-based sexual counseling services are an excellent alternative and addition to traditional appointments and services especially with a cases of mild problems and in need of support or evaluation of the mind-related reasons for sexual concerns.

019.GENITO-PELVIC PAIN/ PENETRATION DISORDER VS SEXUAL PAIN: NEW NAME OR NEW CONCEPTUALIZATION?
Yitzchak M. Binik
The diagnostic definitions of dyspareunia and vaginismus originated in the 19th century and have not been significantly modified or questioned until recently. In 2014, the DSM-5 introduced the new diagnostic label of Genito-Pelvic Pain/Penetration Disorder to replace the terms dyspareunia and vaginismus. This change constitutes more than a simple name switch but reflects a fundamental reconceptualization of these diagnoses from mutually exclusive categories to a relatively continuous spectrum of problems ranging from mild vulvar pain with penetration difficulties to the absence of successful penile vaginal penetration accompanied by intense vulvar pain. The theory and empirical research underlying this change will be presented and critically re-
viewed. In addition, the implications of this change for research and clinical work will be discussed.

020.SEX THERAPY EDUCATION IN THE NORDIC COUNTRIES
Elsa Mari Almas

From 2002 the Nordic countries (Denmark, Estonia, Finland, Iceland, Norway and Sweden) have had common authorization of sexological practitioners. The Nordic Association for Clinical Sexology (NACS) has been authorizing Specialists in Sexological Counselling (NACS) and Specialist in Clinical Sexology (NACS).

In this presentation the Nordic model for authorization and education will be described. Based on a comparison of the Nordic model with other educational models in Europe, future development of the model will be proposed.

Sexological treatment must be practiced on different levels and in different settings in accordance with the PLISSIT-model. This requires programs that can be adapted to these needs:

Basic sexology (P), sexological counselling (LI), sex therapy (SS), psychotherapy/specialized medical treatment (IT).

There is a paradigmatic challenge in sexology stemming from the realization that human sexuality is not only a physiological function of procreation; it is also a cultural system of meanings, in interaction with individual experiences, stories, wishes and needs. The understanding of the paradigmatic change that is going on, implies that sexological practice, and therefore also education, must integrate understandings of how cultural changes affect the role of sexuality in society. Sexological practitioners must be aware of their role in the cultural process of co-creation and interpretation of human sexuality.

This presentation will discuss the implications of these ideas for development of sexological training and practice. The special need for SAR (personal work) and practical training in sexological education will also be discussed.

021.GENDER EUPHORIA
Elsa Mari Almås and Esben Esther Pirelli Benestad

Gender carries a meaning to most of us, but what might be the meaning of gender? In this performance lecture, a married couple: Professor Elsa Almås and professor Esben Esther Pirelli Benestad guide us through some diverse and colourful landscapes of gender. Female and male genders are seen as the major ones, in addition five more are added.

In addition an introduction is given on how to address gender variant children. This is a journey both into this couple's personal lives and experiences, and into multiple experiences accumulated by others. One basic question is whether or not gender variant individuals are disturbed as is still advanced by psychiatric manuals. Could it be that the disturbance rests elsewhere?

One of the presenters, Esben Esther, is certainly someone who does disturb. Who then needs therapy; Esben Esther or those that are being disturbed by hir?

022.WHY IS LGBT NOT A PSYCHIATRIC DISORDER?
Esben Esther Pirelli Benestad

In the 1960's the French philosopher Michel Foucault (15 October 1926 – 25 June 1984) introduced the analogy between religion and therapy. Human actions that had previously been labeled "sinful" by different priesthoods were "taken over" by professional therapists and labeled mental disturbances rather than actions or emotions of sin.

This was a lifesaving procedure since religious ways of treating sins within the realm of LGBT had been cruel punishments and death sentences. (As is still the case in some societies).

Many wise therapists and scientists like Richard von Krafft-Ebing, Albert Moll and Sigmund Freud supported the notion of homosexuality as a disease or disturbance, but interestingly enough, and this goes for a
large number of researchers in addition to the ones mentioned, all have moved more and more away from applying pathological labels to the love and self-conception of LGBT people.

One major contributor to this move from diagnose to human diversity was the many encounters the researcher had with differently talented people.

The clean bill of health arises in interactions with the people in question. This lecture will focus on the uncommon common sense that demonstrates the awkwardness in holding on to LGBT as psychiatric disorders.

023. HOW ARE WISHES AND NEEDS OF THE TRANSGIFTED MET IN SOCIETY
Esben Esther Pirelli Benestad

Even though a consensus as to how to meet and treat trans-gifted individuals has been worked out and renewed by the World Professional Association for Transgender Health (WPATH), these recommendations are often not followed. Offers given by health-care systems around the world are lacking on many levels of care and on professionalism.

Trans-gendered people are met with large amounts of counter transference by straight and also by queer therapists. Health care systems can but rarely be better than the experts working within them. Thus have therapists’ biases had the power to counteract the wishes and needs so clearly expressed by the trans gifted themselves.

One great bias has been the psychiatric dominance in the field of transgender care. Psychiatrists are trained to focus on “things that have gone wrong in peoples’ heads”, still psychiatry has clung to conditions that are successfully treated with hormones and/or surgery. Procedures that adjust the body not the mind.

One argument for clinging has been that one must differ those who are genuinely transgender from those who have gender incongruence as part of a dilution. This is a persisting argument, even though stories of dilution are totally different form the narratives met among the trans gifted. This lecture will offer a way to meet those of us who are trans gifted based not on seeing them as mentally disturbed, but as people with some sets of wishes and needs that need to be met.

024. ASSESSMENT, DIAGNOSIS AND TREATMENT OF FEMALE SEXUAL DISORDERS
Sheryl A. Kingsberg

Women have had a long slow struggle against cultural taboos to reclaim their right to a satisfying sexual life. In 2014, the concept of healthy sexuality has, in theory, become an accepted entitlement of women and sexual problems have become more widely discussed. Further, epidemiologic research has now confirmed a high prevalence (12%) of female sexual disorders. Yet, for a myriad of reasons, such as lack of time, patient or provider embarrassment, lack of FDA/other international health authorities approved treatments, physicians continue to evade the topic in clinical visits which results in a significant void in comprehensive healthcare. The World Health Organization considers the maintenance of sexual health to be the responsibility of the medical provider. In 2001, the U.S. Surgeon General, David Satcher, in his Call to Action to promote sexual health as one of the goals of Healthy People 2010, described the role of health care professionals and the need for better education and preparation in the field of sexual health. Health care professionals must first understand what constitutes functional sexuality in order for this to be addressed in the clinical setting. Unfortunately, as is true for research, sexual medicine as a whole has not been given high priority in medical education. This leaves many providers unprepared and even uncomfortable, and this discomfort is, ultimately, an obstacle to competency and fitness.

Although varying models for understanding healthy female sexual response have been proposed, all generally include the elements of desire, arousal, orgasm, and resolution.
and current research also emphasizes the importance of evaluating pain as a source of sexual problems. Current models reflect the biopsychosocial and multifactorial nature of the female sexual response. Basson’s model of female sexual function acknowledges the importance of emotional intimacy, psychological factors, and sexual stimuli and posits that in women arousal often precedes desire. This description updates the traditional linear models of Masters and Johnson as well as Kaplan, in which desire precedes arousal. Levine suggests that desire has 3 distinct but interrelated components—drive (spontaneous biologically driven sexual interest), cognitive factors (expectations, beliefs, and values about sex), and motivation (emotional and interpersonal factors)—further emphasizing the complexity of female sexuality.

This lecture will provide an overview of the female sexual disorders, how to assess and diagnose female sexual disorders, and current treatment options.

Learning Objectives
1. Define the Female Sexual Disorders
2. Outline techniques for assessment and diagnosis of sexual disorders
3. Identify treatment options for each of the sexual disorders

025. ENDOCRINOLOGY AND TESTOSTERONE USE IN WOMEN
Susan Davis
Androgens are vital hormones in women, circulating in concentrations ranging from nanomolar to micromolar. Not only are androgens the precursor hormones for estrogen biosynthesis in the ovaries and extraglandular tissues, but androgens act directly via androgen receptors throughout the body. Androgen levels decline with age in women with the greatest fall in total and free testosterone occurring before the menopause.

Large randomised placebo-controlled trials (RCTs) involving naturally and surgically postmenopausal women presenting with hypoactive sexual desire disorder (HSDD) demonstrate that testosterone therapy, with/without concurrent estrogen therapy, improves the quality of the sexual experience. In addition, other studies demonstrate testosterone therapy improves sexual well-being in premenopausal women with HSDD. Recently we have shown transdermal testosterone improves sexual function in women with SSRI/SNRI-associated sexual dysfunction in a RCT. These effects appear not to be mediated by aromatization of testosterone to estrogen. The other potential benefits of testosterone in women include favorable effects on bone density, muscle mass, vascular endothelial function and cognitive function. Transdermal testosterone has been found to improve verbal learning and memory in postmenopausal women who are users of estrogen and non-users of estrogen.

Contrasting the favorable effects of testosterone demonstrated in RCTs, systemic DHEA therapy does not improve sexual function, mood or wellbeing in women. Testosterone has not been approved, other than for surgically menopausal women on estrogen therapy in Europe. Despite this, the use of testosterone by women is widespread, with vast numbers of women using testosterone preparations developed and marketed for men, testosterone preparations compounded on individual prescriptions as oral lozenges and creams, and testosterone implants. Hence there is a clear need for a testosterone therapy delivering an appropriate female dose to be approved, so that women have the option of using a product formulated for women.
026. SEXUAL PSYCHOTHERAPY: INTO NEW TRENDS TO DEAL WITH SEXUALITY
Oswaldo M. Rodrigues, Jr

Psychotherapy applied to sexuality has different approaches since its more scientific proposals in the 1950’s. Techniques over processes gained more attention driving health professionals away from psychotherapy forms.

The need of dealing with different forms of techniques from other health professionals and incorporating new techniques and working with those other professionals is helping to create a new understanding of a process of the psychotherapy.

Physical therapy helping psychotherapy

Physical therapists have been focusing sexual issues and in several countries are presenting ways of helping patients to understand body and sexual functioning through techniques applied directly in the patients bodies. There are some ethical considerations according the country and how to apply it to psychotherapy.

New technique helping to treat premature ejaculation

In the past years, an Argentinian psychologist, Julio Obst, proposed the use of an interesting technique. The Valsalva maneuver is performed by attempting to forcibly exhale while keeping the mouth and nose closed. Applied to male patients with premature ejaculation is helping them to overcome sexual complains.

Couple’s therapy as base of sexual treatments

Since the 1960’s treat sexual dysfunctions within the couple has been the focus of a major group of psychotherapists. Although there are patients that do not want to treat their difficulties with the presence of a sexual partner, the use of couple’s psychotherapy helps more patients to overcome sexual difficulties, and also include couple’s issues that may under lay the same sexual issues. All over Latin America it has been the preferred underlying technique in psychotherapy of sexual issues.

Evaluation psychosexual using interview and sexual inventories and other sexual scales according to main problem.

Sexual inventories are used since the 1950’s, although forms and types depends upon the country and historical moment.

In the past few decades, in the Instituto Paulista de Sexualidade, in Brazil, we designed an special form of psychosexual diagnosis in order to involve patients to better understand their sexual problems and to evaluate the psychotherapy process.

Increasing cooperation between organic and psychological treatments

Sexual problems may have concomitant organic and psychological issues, and both approaches must be coordinated in order to help patients.

Past decades shows best results among studies caring to deal with both trends at the same time.

027. THE NEW PSYCHOSEXUAL THERAPY AND MEN WITH LOW TESTOSTERONE
Oswaldo M. Rodrigues, Jr

While considering sexual health as a main guide to a psychotherapist help a person to overcome a sexual complain, there should be much more to work in this person’s sexual behavior and attitude than just the ability to perform coitus.
When we read that gonadotropin-deficient hypopituitary men were cycled through periods of treatment with testosterone and gonadotropin in a research and “Two thirds of the sample had no socio-sexual experience” (Clopper and cols, 1993), we should be able to see the need of developing sexual behaviors!

When we also read about men that need to be treated with testosterone:

- “higher-than-expected dropout rate in the men receiving testosterone.” = 30% (Alan et all, 2007)
- “The drop-out rate among the subjects was significant.” (Sih et all, 1997)

And yet, those men with organic factors associated to low testosterone may might be also diagnosed with some sort of depression states or anxieties, or even couples relationship issues.

This lead us, psychotherapists to an approach according to this diagnosis and help to develop:

- social skills, assertiveness
- new cognitive schemas
- overcome cognitive distortions
- couple’s communication
- sexual techniques, sexual behaviors
- well-being!

The objective is to describe and guide psychotherapists through psychological techniques in order to help organic issues such as low testosterone in male patients.

028.MASTURBATORY HABITS AS A LEADING HINT TO EVALUATE AND TREAT SEXUAL PROBLEMS

Gila Bronner

Introduction: Masturbation is a common sexual behavior, reported by men and women of all ages. Masturbation is often neglected in the diagnostic inquiry of people with sexual problems, consequently missing essential components of a comprehensive sexual history. This presentation aims to increase the awareness of clinicians to the importance of assessing masturbatory habits and understanding the role of masturbation in the process of sexual treatment and intervention.

Methods: An analysis of various masturbatory habits among men and women who were referred to the sex therapy clinic.

Results: Based on the various manifestations of masturbation, specific set of questions as well as a diagnostic and therapeutic flowchart were developed. Physicians and sex therapist may use these tools to proactively address masturbatory habits that may result in SD, thus overcoming the discomfort involving this issue.

Conclusion: Understanding the role of masturbation in the framework of sexual behavior and sexual function of individuals as well as couples, who complain on SD, may assist in diagnosis and treatment. Sex education of patients, masturbation retraining and relearning may serve as important modes of intervention.

029.MEDICAL AND PSYCHIATRIC ASPECTS OF MASTURBATION

Itzhak Z. Ben-Zion

Masturbation has been judged as immoral and a religious sin by the main religions (Christianity, Judaism and Islam). In addition, masturbation was blamed for homosexuality, insanity, sterility, and a variety of other mental and physical disorders. The attitude toward this sexual behavior became gradually more tolerant throughout the 20th century, and it is no longer perceived as a behavioral aberration. Some authorities even consider autoeroticism as a mode to reduce the risk of sexually transmitted diseases. Studies found that masturbation was highly prevalent in the general population, even among the elderly.

However, sometimes masturbatory practices may present medical or psychological problems. In other cases masturbation may lead to sexual dysfunction. Masturbation among psychiatric patients may be part of obsessions or compulsions, dysphoria, dysthymia or mania. Physical discomfort or genital itching in diabetes, among demented or mentally retarded people may result in a behavior that is considered as masturbation.
In some cases masturbation is associated with self-harm, injuries or edema. In other cases, the association between masturbation and religious or social sanctions is presented by reports of emotional trauma, feeling filthy and contaminated. This presentation will demonstrate the various relationships found between medical and psychiatric aspects and masturbation.

**030. UNUSUAL MASTURBATORY PRACTICES: CASES AND DISCUSSION**

*Itzhak Z. Ben-Zion and Gila Bronner*

**Introduction:** "Unusual masturbatory practice" was previously described as "idiosyncratic masturbatory style". These two terms refer to masturbating by using a distinctive technique that could not easily be replaced by their partner’s hand, mouth, or vagina. These habits may create an obstacle for arousal and pleasure, when the individual tries to participate in sexual relationship.

**Methods:** We describe cases of “unusual masturbatory practice” among men and women, demonstrating the use of a specific diagnostic flow-chart, designed for evaluation and intervention.

**Results:** These described masturbatory behaviors were associated with various SD, e.g. delayed ejaculation, low sexual desire and erectile dysfunction among men, and disorders of arousal and orgasm in women. When patients understand how their masturbation affects the sexual function and pleasure, a relearning training was personally tailored for each patient.

**Conclusion:** The presented cases demonstrate that discussing masturbation as integral part of the sexual history taking, and assessing exact masturbatory practices, sometimes lead to better diagnosis and successful interventions.

**031. TREATMENT OF ORGASM PROBLEMS IN WOMEN – THREE CASE STUDIES**

*Dania Schiftan and Karoline Bischof*

**Introduction:** Various forms of orgasm problems can successfully be treated through the sexocorporeal method. This shall be illustrated by means of three case studies. The most frequent concerns of women in consultation are about the inability to reach orgasmic discharge, the inability to enjoy orgasm pleasurably, and, most frequently, the desire for orgasm during intercourse. Basically, every woman can learn to reach orgasm. The capacity for sexual arousal is innate. Women can learn and continue to develop throughout their lives the ability to trigger, increase and eventually enjoy arousal. This development can be limited by the individual learning history, which can be impeded by physical, cognitive and emotional factors. Accordingly, treatment seeks to prompt learning processes that are individually adapted to the strengths and limits of the respective patient as determined by a concise evaluation.

**Methods:** The treatment of three women with orgasm complaints will be presented. It consists of learning steps individually adapted to the client’s relevant strengths and limitations, combined with imparting knowledge about the biology of the arousal function, getting to know their own sex through various perception exercises, development and strengthening of arousal – playing with the three laws of the body (tension, rhythm and amplitude of movement). For the wish for orgasm during intercourse (coital orgasm) vaginal exploration is also important, since the perception of vaginal stimulation can be improved through sensory training. A special focus is placed on increasing pleasure – thus turning an orgasmic discharge (reflexive muscle contractions) into an orgasm (connected to a strong emotional experience). Lastly, the ability to orgasm is improved by means of genital release through pelvic movement as well as emotional release through mobility in the chest area.

**Results:** In all three cases the clients were able to reach the goal they aimed for within a period of 15-20 sessions.

**Conclusion:** The three case studies demonstrate the effectiveness of the sexocorporeal method for the treatment of orgasm problems. Women who are willing to actively practice these techniques will experience
both a heightened perception and an increase of pleasurable sensations. It can thus be shown that women are able to reach orgasm, if they undergo the relevant learning steps.

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033. BODY AND PELVIC MOVEMENT DURING AROUSAL PREDICTS COITAL ORGASM IN HETEROSEXUAL WOMEN
Peter Hilpert, Karoline Bischof and Guy Bodenmann

Introduction: Female coital orgasmic infrequency is a common problem often presented in sexual therapy. It is frequently associated with a low level of sexual arousal and lack of desire for intercourse. Research has thus far rarely looked into what happens during vaginal intercourse – more specifically, what women actually do with their bodies to maintain and raise arousal, and how this influences their ability to experience coital orgasms. Clinical observations in Sexocorporeal sexual therapy indicate that women utilize several different patterns of attaining arousal which are more or less conducive to achieving coital orgasms. Movement of the body and in particular, the pelvis, has been identified to be the most conducive, while holding still and focusing on precise stimulation of a specific genital area appears to be the least conducive.

Methods: 1237 women filled out an online-survey. They were asked about their preference of body and pelvic movement and of precise stimulation of a specific genital area during arousal with a partner. The frequency of orgasm during three different sexual
stimulation situations was elicited: sexual intercourse with additional stimulation of the vulva, sexual intercourse without additional stimulation of the vulva, and stimulation of the vulva without vaginal penetration.

**Results:** The results show several highly significant associations: Preference of body and pelvic movement during arousal with a partner was clearly associated with more frequent orgasms during intercourse both with and without additional stimulation of the vulva, but not with the frequency of orgasms during stimulation of the vulva alone. Preference of precise stimulation of a specific area was highly associated with orgasms during vulva stimulation without penetration, and highly negatively associated with coital orgasms without additional stimulation of the vulva.

**Conclusion:** This study corroborates clinical observations that the ability of women to achieve coital orgasm is highly dependent on their preferred pattern of raising arousal. In particular, the preference for body and pelvic movement is conducive to coital orgasms. This has important clinical implications for the treatment of coital anorgasmia.

**035.EXPLORE THE COURSE OF THE RELATIONSHIP IN THE FAMILY OUT OF THE CLOSET GAY COUPLES**

*Lin Yen-Chin*

**Introduction:** This study aims to understand (a) factors interact with family history of the closet gay couples personal perceptions and ideas (b) the relationship between gay couples (c) interactive course gay couples and families (d) partnership interaction.

**Methods:** This study used qualitative research orientation interpretation phenomenological method, with four out of the closet for gay couple’s families for the study, collecting data through two companion studies paired depth semi-structured interviews and phenomenological analysis method description and inductive analysis.

**Results:** The main findings are divided into four parts: (1).Gay couples personal perception and ideas,(2).The interaction between gay couples,(3).Interaction of gay couples and family. (4). Factors interactive partnership.

**Conclusion:** The interaction relationship between the gay couples and individuals parents react differently and showed different patterns in personality traits.
However, little was discussed on homosexual daily life. Strong relationship between gay and AIDS was still perceived in Taiwan community. Although gay must face AIDS stigma and fear of death, which were the major pressure sources, partner other than family members and friends would provide more support about emotion, material and information and strengthen power against AIDS.

**Methods:** Five more than 20 years old male homosexual with AIDS-diagnosed were recruited from some regional medical center. Interview was conducted. Participants described their own life from four aspects: (1) basic dates (2) high risk behavior model (3) family supportive system (4) Lust, intimate relations and sexual interaction experiences.

**Results:** Male homosexuals with AIDS did not change their desire for intimate relationship and were still active in sexual activity. But they rarely tell their sexual partner the truth. If their medical condition was stable and not discomfort, they would continue their sexual activities without using condom even that they knew this was high-risk behavior. Thus, 1) Family’s support would drive individual to control their AIDS. 2) After AIDS was diagnosed, male homosexuals still expect intimate relationship to love. 3) Under stable condition, male homosexuals still had active sexual life and multiple sexual partners. Whether condom or not was dependent on guys self-perceived the concentration and transmission risk of HIV.

**Conclusion:** From this study, the expectancy to intimate relationship and sexual behavior model of male homosexuals were more understood.

037. ALTERED STATES OF CONSCIOUSNESS (ASC) INDUCED BY A NEW METHOD OF REPEATED CLITORAL STIMULATION AND CLITORAL ORGASM

Ümit Sayın (Sayın-1), Justine Dawson and Nicole Daedone

**Rationale (Optional):** Nicole Daedone, the author of the bestselling book “SLOW SEX” has developed a technique of clitoral stimulation, coined as “OMING Meditation-Orgasm Technique” (Daedone, 2011). There have been claims that this method induced altered states of consciousness (ASC) in some women after a certain period of time, we have performed a descriptive study through a survey among the women, who participated an event of “One Taste Company” in California-USA in March-2014.

**Introduction:** It is reported that prolonged orgasms induced ASC in some women (Taylor, 2001; Sayın, 2012). Similar findings have been reported by other researchers. Recently, it has been reported that ASC was observable in some women who practiced “OMING Meditation Technique” developed by Nicole Daedone, as mentioned in her book “SLOW SEX”.

**Methods:** A very short survey questionnaire which consisted of 3 questions was delivered to the women who participated an event performed by “One Taste Company”. 25 women, who have been practicing “OMING Meditation-Orgasm Technique” for at least 3 months regularly, were taken into the study. They also signed a form of written statement of consent before the survey. The technique consisted of the stimulation of glans clitoris using a lubricant by the help of a partner for at least 15 minutes. It was determined that the women participating the study used this technique with an average of 5.1 times a week. In the third question 85 different forms of ASCs, which were assumed to be possible to occur during the OMING orgasms, were asked to be checked in a table, as described by other researchers (Taylor, 2002; Sayın, 2011, 2012; King, 2010).

**Results:** Pulsating feeling (0,92); throbbing (0,8); warmth (0,84); exciting feeling (0,80); pleasurable (0,84); quivering (0,76); elevation of mood (0,84); happiness and contentness (0,80) were the most common feelings over 80 % of the participants of the study. Least experienced consciousness states below a frequency of 25 % of the women practicing OMing Orgasm Technique were as
follows: flying (0.28); astral voyage (0.24); death feeling (0.08); near death experience (0.04); losing the soul (0.04); traveling to different lands (0.24); voyage to unknown places (0.20).

**Conclusion:** Using many different techniques of sexual stimulation including expanded sexual response (ESR) and “Oming Orgasm Meditation Technique”, practiced in a regular basis, various ASC patterns may occur in a statistically significant number of women. This phenomenon needs to be investigated thoroughly by means of further surveys and/or laboratory research to establish as a contributing technique to enhance the pleasure and orgasms of women.

**038. OPINIONS OF GYNECOLOGIC PATIENTS ABOUT IMPACT OF PLANNED HYSTERECTOMY ON THEIR REPRODUCTIVE FUNCTION**

Nellija Lietuviete

**Rationale:** Objective of this study was to summarize opinions and concerns of women on the day before planned hysterectomy.

**Introduction:** Conclusion about scheduled hysterectomy usually brings women to many questions about operation and postoperative changes in their bodies. After hysterectomy woman may be influenced by both physiological and psychological factors. Losing the uterus can make women worry about feeling less womanly after operation, or losing their sexual attractiveness. There is still no single view about real impact of hysterectomy on sexuality, data are discrepant.

**Methods:** 54 patients of wide spectrum Gynecology clinic were recruited to participate. Inclusion criteria were: age 18-50 years, scheduled to undergo planned hysterectomy without ovarectomy due to benign indication, voluntary agreed to participate. Inquiry form was used to collect answers. Study was approved by the Committee of Ethics.

**Results:** All patients had been thinking about impact of hysterectomy on their future life. 75.93% had worried that hysterectomy can have a negative effect on their future, 59.26% asked other women with hysterectomy experience about changes after operation, 51.85% searched information from Internet sources, 87.04% wanted to receive more information from gynecologist. 51.85% thought they will feel less feminine without uterus, 59.26% worried that partners will find them less feminine. 31.48% thought that their sexual life will become worse, 27.78% thought it will not change, 22.22% thought it will improve. 68.52% had regular sexual partners, 56.76% of them had only partly told their partner about operation, 24.32% had not told at all, 18.92% had told everything. 14.81% had concerns about ‘cleaning’ of the body without regular bleeding, 20.37% thought they will have earlier and more heavy menopausal symptoms, 29.63% thought they will need to use HRT after operation, 5.56% were not sure if they can discontinue birth control method after hysterectomy.

**Conclusion:** Impact of hysterectomy on their lives is very important for the patients. They are afraid of negative effects and are not ready to talk honestly to their partners. Myths and doubts are still present on the day before hysterectomy. Gynecologists should actively discuss more about planned operation with patients instead of waiting for them to ask questions.

**039. RESEARCH ON THE SEXUAL EXPERIENCES AND SATISFACTION LEVELS OF TURKISH CYPRIOYOUNG ADULT MALES**

Mehmet Beyazsachi

**Rationale (Optional):** The purpose of this research is to identify the sexual activity phenomenon and observe the sexual satisfaction levels.

**Introduction:** The sexual desires are said to be unstable and discontinuous by Fromm (1981:50); if not supported by strong emotional connections such as sympathy and love, they will be short lived even in their densest state. Also according to Fromm, sexual discontinuity cases can be seen more frequently with males which make this research about this phenomenon on the Turk-
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ish Cypriots even more significant.

**Methods:** The combination of the qualitative and quantitative analysis methods of the phenomenal meaning makes this study a two part research. This phenomenal meaning makes the known, but not deeply analyzed and understood, phenomenon more clear (Yıldırım and Şimşek, 2011:72). The first stage of this research was done by observing the sexual activity phenomenon, using qualitative analysis and then the second part was illustrated by observing whether there are meaningful differences within the quantitative analysis data about sexual satisfaction.

The qualitative part of the research was done by collecting data using open questions on certain subjects such as the experiences before, during and after intercourse. For the second, quantitative, stage of the analysis, Arizona Sexual Experiences Scale (ASE) made suitable for Turkish examples by Soykan (2004) was used to determine the sexual satisfaction levels. ASE Cronbach Alfa Level level was told to be 0.88. The reality correlation number is 0.53 and the end point was set to be 11, which has selective properties and enables the reality scale.

120 Nicosia Turkish Municipality (NTM) employees construct the universe of the analysis. 80 suitable and appropriate and candidates were selected. NTM was chosen specifically because the employees are from the all parts across the island.

Data analysis at the qualitative stage was done using descriptive analysis. When the outline of the research was constructed, data was collected using semi-structured questions, coded under concepts and related to their frequency. SPSS was used to analyze the quantitative data. The differences within the analysis were determined by using ANOVA. The meaningful differences within the groups were determined with Sheffe test. For dual compositions t-test was used. Also the averages of the arithmetic data and standard deviation values are given. Meaning level at quantitative dimensions is assumed to be 0.05.

**Results:** According to the research observations, the level of sexual satisfaction differs based on frequency of intercourse, orgasm and foreplay periods, pleasure points of the partner, contact style and protection (p<0.05). When the findings were evaluated in the accordance of the quantitative data, it can be seen that level of sexual satisfaction at the end of sexual activity differs with sleeping together and oral sex.

**Conclusion:** To conclude, the need of academic programmes was suggested about protection methods, sexual experiences and activities that affect the sexual satisfaction.

**040. THE LACK OF INFORMATION OF VENERIAL DISEASES IN THE EDUCATION SYSTEM: A SURVEY ON STUDENTS**

Asiye Kocatürk

**Poster**

**Introduction:** A survey on the information and general knowledge of the students of an educational school on general sexuality and Venereal Disease (VD) was investigated. 469 students (328 females, 69.9 % and 141 males, 30.1 %) filled the forms of a specific questionnaire of 38 items. Average age was 24.

**Methods and Results:** 469 students (328 females, 69.9 % and 141 males, 30.1 %) filled the forms of a specific questionnaire of 38 items. Average age was 24. 35 to 40 % of the students did not have any accurate and correct information on the basic issues on sexuality, VDs, treatment of VDs and protection from VDs as they gave vague and inaccurate answers to various questions. The most common knowledge source was the internet (64.2 %).

**Conclusion:** A structured and detailed education on human sexuality and preventive medicine, VDs should be given at the high school and university levels, since there is no informative education system on sexuality in Turkey.
041. CHEATING ON OF TURKISH WOMEN AND TURKISH MEN?
Berk Karaoğlu
Abstract of the Lecture:
People's mind might have a few certain reasons for infidelity, but actually it is a very complex situation that changes depending on culture, economic conditions, psychological and genetic structure. Depending on my clinical observations, current research, popular topics and scientific data, I will try to explain why Turkish women and Turkish men cheat or which reasons cause Turkish people to cheat. In this aspect, Turkish woman's psychology, their emotion, their family and their way to evaluate sexuality are important, the Turkish man's relationship patterns and their sexual attitudes are also important. We will explain why Turkish women and Turkish men cheat by evaluating some important landmarks such as sexuality, sexual urges, sexual satisfaction, sexual infidelity, romance, personality traits, sexual demands, emotions and sexual expressions.

Introduction: The goal is the shortening of the treatment time of vaginismus, which usually takes 10 to 12 sessions with cognitive-behavioral therapy alone, by adding the hypnotherapy sessions in the treatment process.

Methods: Cognitive-Behavioral Therapy and Hypnotherapy. It started with 4 sessions of Cognitive-Behavioral Therapy and followed with 2 sessions of Hypnotherapy in same day.

Results: After the successful application of 4 sessions of Cognitive-Behavioral Therapy by psychologist, the patient reached the point where the patient overcame the feeling “anything which doesn't belong to me, can't be inserted in me” with the help of her partner who is doing insertion exercises with his little finger into her vagina. After reaching that point, hypnotherapist applied 2 hypnotherapy sessions in the same day. After these 2 hypnotherapy, the couple successfully managed sexual intercourse. As a result, normal treatment of vaginismus takes 10-12 sessions of Cognitive-Behavioral Therapy, but adding Hypnotherapy decreased the number of sessions to 6. Because of the same day application of hypnotherapy, it also decreases the treatment period.

Conclusion: Using both cognitive and subliminal development, under the Cognitive-Behavioral Therapy and Hypnotherapy, has shown to successfully treat vaginismus. To further shorten this treatment period, decreasing the number of Cognitive-Behavioral Therapy sessions and emphasizing on subliminal objects is advised.

042. SHORTENING OF VAGINISMUS TREATMENT TIME BY USING COGNITIVE-BEHAVIORAL THERAPY AND HYPNOTHERAPY TOGETHER.
Berk Karaoğlu
ORAL PRESENTATION
0.43 ANALYSIS OF 450 VAGINISMUS CASES RETROSPECTIVELY
Murat Ulusoy
1- 73 % University graduates, teachers; “English, Class”
2- 23 % High School graduates, “Accountant, housewife”
3- 4 % Primary School graduates
4- Average Ages
77 % between 20- 30
19 % between 30- 40
4 % ages < 20 and > 40
5- Average marriage durations: 4 years; ranging from 1 month to 19 years.
6- Clients, coming to our therapy come as the third choice. Before contacting us; they’ve consulted psychologists, psychiatrists and gynecologists. 13 % come to us as the first choice.
7- 17 % are the smallest or the only child of their family (the effect of being coddled).
8- 12 % have the problem of urinary retention since adolescence.
9- 84 of them have “auditory-tactile –visual” positive, 3 % of them are normative, don’t give control to the others, have negative “auditory-tactile –visual”; In 13 % of them either or both are positive.
10-75 % Cognitive
6 % Behaviorist
15 % Dynamic

4 % Existentialist
11- 83 % Providing genital friendship after suggestion and exercising on their own (74 % can’t let an object in before,., 26 % can let something in), 17 % needs to exercise after suggestion (volitional incapability).
12- Reasons of failure: Leaving the therapy because of avoiding genital examination; decision of divorce, Not loving and taking care of the partner.
13- Average period of success:
1 day...............12- 24 hrs. 87 %
1,5 days.............24- 36 hrs. 9 %
2,3 days.............36- 48 hrs. 2 %
Follow up from the Internet.......2 % 20 days to 30 days because of impatience to the pressure in the vagina, being coddled by the family, urinary retention.
14- Success rate 96 %, Rate of Failure 4 % (the ones, leaving the therapy because of 12 th item are included in this percentage).
15- Cities where most of the clients come from are: İstanbul, İzmir, Ankara, Manisa, Bursa, İzmit Turkish people from the European Countries.
16- 10 % of the group can work over the problem with simple proposals (the number of people given support via the Internet between the years 2005- 2006 was; 1440; the number of successors was 140.

044. ULUSOY TECHNIQUE IN VAGINISMUS TREATMENT
Dr. Ulusoy’s Hypnosis Induction Technique and Preparation to Hypnotherapy Murat Ulusoy
1-Emphasizes mind- body relaxation.
2- Focuses on auditory- tactile-visual structures.
3- Includes eye fixation, respiration, passes, changes in perception and imagination.
4- It is not obtrusive.
5- A pre- evaluation; consisting of 1 or 2 minutes is for preparation and for living the experience.
Preparation of the Patient
1- Formulation (cognitive, behavioral, I dynamic, existentialist).
2- Sampling and modelling.
3- Spiritual instrument and working principle in hypnotherapy (conscious- subconscious mechanisms of resistance).
4- Testing of auditory, tactile, visual qualities as the personality construction.
In Dr Ulusoy HIT:
1- There is heated acting
2- What is important will be the mind- body relaxation (can I enter into hypnosis? There are people who can’t enter into a hypnotic state, but everyone can experience the mind- body relaxation).
3- Mind will be conscious from the beginning till the end (There may be a thought of either “am I in a hypnotic state or not?” but everything should be accepted as it is).
4- A lot of thoughts may come into conscious mind (these are not important and can be welcomed).
5- A different perceptual state will be experienced on the other hand.
6- We will work on a problem focused basis.
Dr. Ulusoy's HIT processes:
Auditory:
1- The patient sits at the corner of the seat, hands are situated on the knees.
2- She is told to fix her eyes to the opposite wall; to the corner where the ceiling and the wall intersects.
3- Three deep breathing is produced with the movement of the hand; each breath is reinforced with a positive statement.
4- At the end of the third breath, she is told to close her eyelids volitionally.
5- Eyes are closed with the right hand to make a silhouette and a pass (melatonin).
6- A relaxation suggestion is given; beginning from the head to neck, shoulders, arms, hands, from neck to the spinal column, back muscles, hip muscles, thighs and legs, through the feet and toes.
7- A suggestion about the pulling of the body backwards with the metaphor of a magnet/needle is given.
8- “When your head and your back leans on the seat, a deep relaxation will reach through the entire body” is given as a suggestion.
9- The body leans on the seat in a short while.

If it doesn’t lean on the seat (volitional resistance) she is told to lean her back to the seat with her own volition.

Tactile (Perceptual)
1- The suggestion about the left hand’s relaxation, lightening is given.
2- “The left hand, on the other hand; getting heavier like a stone, bar, iron” is given as a suggestion.
3- She is asked to answer the question as Yes or No and direct the therapist.
4- She is asked if she is sensing a perceptual difference between the arms (Yes or No). If she doesn't feel any difference, visual process is applied.

Visual
1- I want you to imagine a valley between the two mountains, where there are trees, flowers, colorful butterflies. There's a purling creek running on the ground. This is the valley of happiness; You will experience, feel and live according to this valley of happiness. Now, I want you to look around, in this valley and tell me what you see, feel and experience.
2- You’re here to solve your existing problems. Each time you sit on this seat, you'll feel a deeper relaxation than the former, take the suggestions that I give you more comfortably, do the task that I give you more easily, make identification with success as you watch the films that I present at more ease and overcome your problem in a short time.

If there’s no visualization, there’s a serious resistance; this may be because of excitement, fear of what will happen, lack of sufficient heated acting, or patient's lack of perception about heated acting, fear of losing the self, an obsessive personality, or the desire to control everything. In these cases, a break is given.

• The fact that either one or few of these systems are eminent in every person is told to the patient, adding that the fear she experiences is because of the anxiety and her lack of releasing himself. She is told that in the second session, when she sits on the seat, direct suggestions will be given and she is required to release her body as if she
is sitting on a comfortable armchair at her home.
• Some people can’t produce imaginations, but can focus on thoughts. Therefore, patient is told to listen to what the therapist tells as if she is listening to a play on the radio.
• In the second session an improvement is observed in relaxation and suggestibility (imagination and tactility improves. Occasionally, a focus on thought when eyes are closed is improved.
...Patient takes 3 deep breathes and opens her eyes. She is evaluated on audial (+, -), tactile (+, -) and visual (+, -) basis.

Major factors affecting the course of treatment in vaginismus
1- Bodily symptoms, originating from the mind (hypnotherapy).
2- Sensitivity to the vaginal tissue (cognitive-behavioral approach).
3- Sensitivity in the lower abdominal area when an object enters into the vagina (cognitive-behavioral approach).
4- Fear and anxiety of the examination of the vaginal area (hypnotherapy, cognitive approach, persuasion).
5- Problem of erection, different sexual desire and impulses in man; e.g. fetishism (medical approach, hypnotherapy, sexual education).
6- Arguments and quarrels between the couple (short term family therapy).
7- Thinking of failure (providing a positive belief system).
8- Deformation of membrane, bleeding and associated pain (medical).
9- Different and negative treatments in the past (providing a belief of success and persuasion).
10- The effect of dominating over the man through vagina (Dr. Ulusoy, 2009); viewing the vaginal intercourse as having a domination over man, using the effect of rewarding and punishing man and associating the other wishes and expectancies from man with the intercourse and relationship (existentialist approach- hypnotherapy).
11- Obsessive Compulsive disorder, Panic attacks, conversive fainting, refraining from the intercourse, refraining from fear and panic (cognitive approach-hypnotherapy).
12- Sexual abuse and rape in the past (hypnotherapy).
13- Sexual pressure from the family (hypnotherapy).
14- Cognitive distortions (hypnotherapy).
15- Improving the feasibility of the tasks (hypnotherapy).
16- Giving competence to the partner in penile experience and behavioral approach (cognitive-hypnotherapy-indirect suggestions).
17- Penis size (behavioral).
18- The effect of tolerant partner: The real tolerant man not only perceives that this is an illness and something must be done as a treatment, but also proves this in the course of the treatment and supports his partner. On the other hand, man’s accompanying his wife’s fear by remaining silent in the course of the examination or his saying “ok honey, don’t worry, let’s go” makes the course of the therapy harder in terms of behavioral approach.
19- Cultural code: avoiding being examined by a male doctor. The physician’s sufficiency and success in therapy is far more important than his gender.
20- The Tree Theory: The major factor for vaginismus to occur is in fact not cognitive, behavioral, dynamic or existentialist. These are the branches and leaves of a tree. The main factor, causing the problem is the body and roots of the tree. Consider two women from the same family, one might easily have a sexual intercourse, whereas the other might have the problem of vaginismus.

When we consider the overall qualities of women with vaginismus, we see that they view every aspect of life in a negative way. Though their belief system sees the truth and experiences it, they quickly drop like a rock and focus on failures. Even during the exercises, they focus on not positive but negative sides. A father, who is a designer, is drawing the posture of the genital area when his daughter becomes an adolescent but this daughter can be coming to us as a
vaginismus patient. Thus the real problem in vaginismus is the lack of giving self-esteem when we rise up our daughters. This can be called the fear of stepping forward in every aspect of life. Another factor is the lack of offering an individual the ability and capability of problem solving (persuasion, reorganization of the belief system-behavioral approach, hypnotherapy).

21- The story of the man who trips himself up: I'm afraid so much; I've succeeded it now, but will I be able to do it again when I go home? Can I do it after the menstruation period?

22- Reducing the patient who has undergone several treatments; telling her to forget everything she has learned in the past and listen to whatever I say.

23-Uneducated patient who sees herself as well informed; she reproaches everything as if she has already known these, this makes the learning process of the new information harder, she ignores the cues and cues of knowledge you convey.

24-Not facing the truth in behavioral approach: Cognitive technique and confrontation.

25-Princess effect (the effect of being cuddled). Being the smallest- the only daughter of the family (Dr. Ulusoy, 2009).

26-Seesaw effect (Dr. Ulusoy, 2005) The withdrawal and interaction of the man whereas the woman solves the problem. (Medical, hypnotherapy).

27-Simulation Technique (Dr. Ulusoy, 2005) through the progressive techniques during the treatment sessions; or through the process of intercourse imaginary suggestions for joy after the treatment (processes of enjoyment, desire, temptation and orgasm).

28-Integration of Lozanov Technique (Dr. Ulusoy, 2008) Communicating the plans and progresses in the hypnotic state (seeing, hearing, practicing, addressing to all the senses, relaxation; all makes learning easy and improves the capacity of perceiving. Learning without stress provides a compatible working of body-mind functions).

29-In cases of vaginismus, woman feels herself relatively comfortable as she knows that there won't be an intercourse after the foreplay. We name this as relative calming—Dr. Ulusoy

**Dr. Ulusoy’s Technique in Vaginismus**

Dr. Ulusoy’s technique in vaginismus helps the problem to be overcome in an average of 1 to 3 days by a step by step progress. Cognitive, behavioral and metaphoric and imaginative hypnotherapy techniques specific to vaginismus are used. In case of facing with a problem due to personality characteristics, this period can extend up to 3 days. If more serious problems due to the personal qualities are observed and if we don’t get through time, we maintain a supportive treatment through behavioral therapy.

In our treatment:

We use a technique appropriate to the cultural structure of the Turkish women, which is called Dr. Ulusoy’s technique.

1-Listening and formulating the problem (with a view of cognitive, behavioral, dynamic and existentialist approach)

Cognitive: It will hurt, it will bleed a lot, my vagina is tight—penis is big, it will tear into pieces, the penis will stuck into it.

Behavioral: incest, abuse, rape histories in the past, negative experiences about first intercourse, first intercourse under examination, intercourse under anesthesia, seeing or hearing the parents’ intercourse as a little child, a process of thinking that mother is suffering from the intercourse, hating from the father.

Dynamic: the protective quality of elder people in the family (mother, father, elder brother, grandmother).

Existentialist: Woman's viewing herself as an object, thinking that she'll be worthless after the intercourse, and/or her competence to have a dominance over man through vagina.

2-Modelling.

3-Education.

4-Dr. Ulusoy HIT and mind-Imagination focused on body relaxation and a metaphoric approach hypno-drama, Albrecht’s ideomotor response.

5-Using the behavioral approach as a feed-
back. (Dilator penetration to the vaginal area for three or rarely four times)
It is an integrated and complete approach.

Classification of vaginismus patients:
1-The ones, who can’t touch the big and small vaginal lips and the area between them (outer genital area).
2-The ones who can touch the outer genital area but not the inner part.
3-The ones who can touch the outer and inner parts of the vagina and who can direct the finger but can’t have a penis experience.
4-The ones belonging to either one of these three groups and have no spasms, but who can’t let the penis in. (The ones who can’t provide a control over their hips, thighs and breath)
5-The ones belonging to either one of these three groups; have ranging spasms from insignificant to the deepest; but who still can’t let the penis in.

As is seen, there are different categories in vaginismus. These different categories are affected by:
1-Women’s own personality patterns (e.g.: panic attacks, obsessive compulsive disorders and a perfectionist character…etc.)
2- Lack of sexual education and information.
3- The occurrence of cognitive, behavioral, dynamic and existentialist factors and their effects on women on different basis.
Vaginismus is shaped as ivy. Therefore, in the treatment of vaginismus, all of these details must be taken into consideration.

THE EVALUATION OF PROCESS AND THE PATIENTS REFERRED BETWEEN JANUARY-JULY 2011
75 patients have consulted and after a month follow up, it’s confirmed that their problem is overcame.

RESULTS OF THE INQUIRY
How many places did I consult to form vaginismus problem?
The number of people attending the inquiry: 4849
I haven’t had a treatment...... 3201 (65 %)
I had a treatment but couldn’t overcome it......... 829 (17 %)
I have consulted to at least 3 places but I couldn’t overcome it 327 (7 %)
I have consulted to at least 5 places but couldn’t overcome it 170 (4 %)
I have consulted to aductor and had overcome it ..........149 (3 %)
I have consulted to more than one doctors and had overcome it 91 (2 %).

I CAN’T HAVE AN INTERCOURSE WITH MY PARTNER BECAUSE:
The number of people attending the inquiry 194
I have such fears as it will hurt, it will bleed, it will tear into pieces, the penis is too big....141 (73 %).
I had a sexual abuse in the past..............4 (2 %).
My partner doesn’t love and care for me....5 (3 %).
I don’t like sexuality and don’t get a clitoral joy ... 13 (7 %).
I have grown up with sexual prohibitions and protection..... 31 (15 %).

FOR MY VAGINISMUS PROBLEM:
The number of people attending the inquiry...... 933
I go to a gynecologist........................................ 138 (15 %).
I go to an anesthesiologist.................................8 (1 %).
I go to a psychiast.................................92 (10 %).
I go to a psychologist............................69 ( %).
I go to the one who can solve it in a session...86 (9 %).
I consider the gender factor in choosing a doctor and go to a female doctor..31(3 %).
I go to a preacher because of spell and magic ...43 (5 %).
I go to an experienced and trustworthy doctor who works on vaginismus...466 (50 %).

045.OPINIONS OF GYNECOLOGIC PATIENTS ABOUT IMPACT OF PLANNED HYSTERECTOMY ON THEIR REPRODUCTIVE FUNCTION
Ieva Briedite
Gunta Ancane
Nellija Lietuviete

Rationale: Objective of this study was to summarize opinions and concerns of women on the day before planned hysterectomy.

Introduction: Conclusion about scheduled hysterectomy usually brings women to many questions about operation and postoperative changes in their bodies. After hysterectomy woman may be influenced by both physiological and psychological factors. Losing the uterus can make women worry about feeling less womanly after operation, or losing their sexual attractiveness. There is still no single view about real impact of hysterectomy on sexuality, data are discrepant.

Methods: 54 patients of wide spectrum Gynecology clinic were recruited to participate. Inclusion criteria were: age 18-50 years, scheduled to undergo planned hysterectomy without ovariectomy due to benign indication, voluntary agreed to participate. Inquiry form was used to collect answers. Study was approved by the Committee of Ethics.

Results: All patients had been thinking about impact of hysterectomy on their future life. 75.93% had worried that hysterectomy can have a negative effect on their future, 59.26% asked other women with hysterectomy experience about changes after operation, 51.85% searched information from Internet sources, 87.04% wanted to receive more information from gynecologist. 51.85% thought they will feel less feminine without uterus, 59.26% worried that partners will find them less feminine. 31.48% thought that their sexual life will become worse, 27.78% thought it will not change, 22.22% thought it will improve. 68.52% had regular sexual partners, 56.76% of them had only partly told their partner about operation, 24.32% had not told at all, 18.92% had told everything. 14.81% had concerns about ‘cleaning’ of the body without regular bleeding, 20.37% thought they will have earlier and more heavy menopausal symptoms, 29.63% thought they will need to use HRT after operation, 5.56% were not sure if they can discontinue birth control method after hysterectomy.

Conclusion: Impact of hysterectomy on their lives is very important for the patients. They are afraid of negative effects and are not ready to talk honestly to their partners. Myths and doubts are still present on the day before hysterectomy. Gynecologists should actively discuss more about planned operation with patients instead of waiting for them to ask questions.

046. TOGETHER OR APART?
A STUDY OF THE ROLE OF INTIMACY IN CONFLICTS AND REASONS FOR SEPARATING AMONG COUPLES
Osmo Kontula

Lecture Abstract

Background: This study examined the strengths and conflicts among Finnish married and cohabiting couples, and the reasons why couples separate and divorce. It includes information of their intimate relationship. A relationship that ends is like a multi-stage process leading to separation. The aim was to survey this process and the role of intimacy in it.

Method: The subjects were selected from among those who, according to the Population Register Centre’s records, had formed a marriage or cohabitation agreement in 2005. More than 3,000 middle-aged women and men responded to the postal survey.
Approximately half were still in the relationship they had begun in 2005, while the rest had separated from their spouse.

**Results:** The most common conflicts among those living together had to do with the sharing of housework and the rearing of children. In addition to everyday household issues, other important sources of conflict included the ways of expressing intimacy and emotion, and sex—in other words, the couple’s sense of togetherness and intimate relationship. Among the divorced, the most common sources of conflict had been differences in values and lifestyles, the way they discussed things, use of free time, and expressions of intimacy and emotion. The relationships that had ended in divorce usually suffered from various shortcomings in the spouses’ partnership and ability to convey intimacy and understanding to one another.

**Conclusions:** Apart from the good functioning of the partnership aspect, relationships can be assessed by considering a couple’s mutual sense of togetherness, their intimate relationship, the compatibility of their personalities, and the various influences originating from the outside world. An interesting characteristic associated with strong relationships was that those in a happy union believed their own relationship to be markedly better than that of other couples. Strengthening this perception served as a factor that helped prevent divorce.

**047.ESR: EXPANDED SEXUAL RESPONSE: BASIC DEFINITIONS AND PARAMETERS**

H. Ümit Sayın (Sayın-2)

**PLENARY LECTURE AND POSTER**

**Rationale and Methods:** In the literature, lately, a new term is coined and cited as expanded sexual response (ESR). To investigate the main parameters of a possible ESR, we have contacted some women who claimed to have enhanced sexual response through internet and/or making surveys by means of gathering the filled SAYIN-ESR Scale, or by making face to face interviews and by other means. Our aim was to establish the main scientific basis of the definitions and parameters of ESR, if ever it existed, and to establish an objective ESR scale out of our preliminary findings. Until 2015 we were able to pinpoint nearly 60 ESR women with a comparison of 250 normal women (NESR, none-ESR women).

**Results:** It is concluded that some aspects of the sexual response of women with ESR were different than the women without ESR (NESR): 1) The ESR women experienced vaginal, clitoral and blended orgasms, as described by Whipple et al. 2) The ESR women experienced multiple orgasms in most of their sexual activities. 3) The ESR
women were able to attain long lasting and/or prolonged and/or multiple and/or sustained orgasms and/or status orgasmus that lasted longer than the classical single orgasm and/multiple orgasm patterns defined in the literature. 4) The ESR women claimed to have strong pelvic floor muscles (PFM) compared to NESR women. 5) The libido of ESR women was very high compared to NESR women. 6) ESR women described a phenomenon called G-Spot orgasms. 7) ESR women described sensitive erogenous zones in their genitalia other than clitoris. 8) ESR women masturbated frequently. 9) ESR women had erotic fantasies more frequently than the NESR women. 10) ESR women admitted to have a form of altered states of consciousness during some of their prolonged orgasms and/or status orgasmus. The difference between the parametric or none-parametric measures between the ESR and NESR women was statistically different (see also: Sayin, H.Ü. Doors of female orgasmic consciousness: new theories on the peak experience and mechanisms of female orgasm and expanded sexual response, SexuS Journal and NeuroQuantology Journal, also available from the congress web site www.twincongress2015.com or www.drumitsayin.com )

Conclusion: ESR is a novel phenomenon in the human female which was defined recently; however, Tantric literature and Eastern history showed many samples of ESR in women. Our survey data, which is still continuing, revealed that more detailed scientific research should be carried out on the possible existence of such a phenomenon. The psychometric ESR-Scale is available from the author.

048.THE MECHANISMS OF VAGINAL ORGASMS
H. Ümit Sayin (Sayin-3)

Introduction: There has long been a furious debate on the "Vaginal vs. Clitoral Orgasm" since the times of Freud. Some feminists opposed vaginal orgasm declaring and supporting the hypothesis that "there is only clitoral orgasm, but no phenomenon called vaginal orgasm and women do not need men and sexual intercourse to attain an orgasm". Hite Report, which was a feminist report and was surveyed among feminist women in 1974, also defended similar hypothesis. However, both Hite Report (1974) and Cosmo Report (1982) reported that one third of women (30% and 34%, respectively) described a phenomenon called "vaginal or coital orgasm". However, many physicians, sex therapists, psychologists, and psychiatrists oppose the existence of "vaginal-coital orgasms" and they also add that no such thing as "G-Spot" exists in Turkey and on the globe. This presentation is aimed to prove that both "G-Spot and Vaginal-Coital Orgasms" exist.

Findings: Some data of ours and other researchers have proven the fact that a phenomenon as "vaginal-coital orgasms" must exist.

1) The clitoral hood cannot move directly enough to stimulate the glans during coitus. If some deep erectile structures of clitoris, such as bulbus or crus, are stimulated as well, this sensory input will not be carried by pudendal nerve, because most of the deep structures of clitoral complex are innervated by pelvic nerve, which may cause another type of "clitoris-pelvic orgasm", which is not exactly the same as "glans-pudendal nerve orgasm".

2) Most of the descriptions of each type of orgasms in the literature are very different in terms of their physiological, neuropharmacological and psychological. For instance; orgasms triggered by coitus induce 4 times fold prolactin release in the female brain compared to manual clitoral orgasms, which is proposed to be a measure of satiety.

3) It has been reported that the women who are aware of their G-Spots and who have been responding-pleasurable G-Spots, are more likely to attain coital vaginal orgasms.

4) There appears to be other deep vaginal erogenous zones (DVZs) in some sexually
hyperactive and responsive women, other than clitoris and G-Spot, as reported recently. Those zones are more prominent in women with ESR and high sexual responsiveness, compared to none-ESR (NESR) women or average women. Nearly 99% of ESR women were able to attain vaginal-coital orgasms. Those areas are innervated by pelvic nerve and partially by hypogastric nerve, similar to G-Spot, which induce a separate orgasm reflex arch pathway; thus a very different physiological orgasmic response builds up.

5) Our preliminary studies by means of the electrical and vibration stimulation of DVZ seem to trigger orgasm patterns alone, without the stimulation of glans clitoris (unpublished data). Similar interesting data comes out of the research group of Komisaruk; stimulation of cervix alone induced orgasmic behavior in women who were hemiplegic, having no connection of nervous input from glans via pudendal nerve and from vagina via pelvic nerve; this is also a proof that orgasm reflexes can be triggered from the brain without the existence of input through glans clitoris.

6) In some women, undergone clitoridectomy, some coital orgasms have been reported, which shows that without the existence of glans clitoris, orgasms may build up by some other mechanisms, while inner clitoral complex may have some contributions to those kind of orgasms, however they are unlikely to trigger an orgasm by the stimulation of bulbus or crus of clitoris alone; there should be other triggering neural pathways and mechanisms that play major roles in the development of "orgasms without clitoris".

7) After the definition of novel “four nerve and six pathway theory of female orgasm” (see below), it was realized that at least six different pathway-mediated orgasm reflex arches, some of which may contribute to build up "vaginal orgasms" originating from direct stimulation of DVZ, may exist!

8) Some other survey in USA, United Kingdom and Europe as well as our preliminary research and other accumulating data showed that vaginal walls are not senseless, but some women experience pleasure and orgasm through the stimulation of various parts of vaginal walls.

9) Some of our and other researcher’s preliminary data also showed that some specifically designed electronic dildo shaped vibrators that have a rotational and vibrating property at the tip may induce orgasms of vaginal origin (unpublished data), which may also show that stimulation of PC-muscles, O-Spot, A-Spot and Cervix may trigger vaginal orgasms in some women. Near to these findings, electrical stimulation of cervix and DVZs by a TENS unit (transcutaneous-electrical-nerve-stimulation unit) may induce similar vaginal orgasms (unpublished data).

10) Recently it is reported that the female orgasm can be triggered through the stimulation of glans clitoris, inner clitoris, Grafenberg’s spot, PC-Muscle, Anterior Fornix (A-Spot), Cervix, Nipples, Ear lobes, and even by only fantasizing and foreplay (Komisaruk et al. Science of Orgasm. 2006)

11) Recently, "Brain Orgasms" without the stimulation of any genital erogenous zones have been reported. If brain orgasms can exist, than we should investigate many other pathway systems and mechanisms, such as the "oxytocin pathway", other than focusing only on the 'glans clitoris'!

12) ZISS group from Switzerland has also devised a technique called "Sexo-corporal Sex Therapy" in part of which, they also teach women how to attain vaginal-coital orgasms through various workshops and trainings.

Conclusions: There are many ongoing researches on the subject. Although, today we even have enough evidence, data and findings, as well as scientific publications and literature that both "G-Spot and DVZ" and...
“vaginal-coital orgasms” EXIST, it is so weird that some people still argue against all these academic and scientific publications and literature. We believe that their concern is more ideological, rather than being scientific.

049. LOVE HORMONE OXYTOCIN: ACUTE BEHAVIORAL EFFECTS OF OXYTOCIN, IN A DOSE DEPENDENT MANNER
H. Ümit Sayın (Sayin-4)

PANEL LECTURE AND POSTER

Introduction: The hormone and neurotransmitter OXYTOCIN (OXY) has been proposed to take part in many behavioral patterns of female behavior, including sexual arousal, orgasm, LOVE, attachment to the partner, birth and motherhood. It is hypothesized to be used in sex therapy to treat vaginismus, anorgasmia, arousal problems and others in future. We revised our former study and added 10 more data in two different intranasal doses of OXY (10 IU, N=36; 30 IU, N=10)

Methods: As a continuing study, we administered 10 IU OXY intranasally to 36 women and 30 IU OXY intranasally to 10 women to assess the main acute effects of OXY on female behavior. A special psychometric scale containing 24 questions to assess the possible acute effects of euphoria, elevation of mind, anxiolysis, empathy, sexual arousal, analgesia, altered states of consciousness (ASC), happiness feeling, and effects on general psychology, SUBJECTIVELY was used within 10 minutes after the administration. Along with OXY, a placebo spray was used intranasally before or after OXY administration in a double blind research design, to compare the effects of OXY with placebo. There was a time lapse of two hours between the two administrations.

Results: The acute effects of OXY were controversial and altered from women to women.

1) 10 IU OXY Acute Effects (N=36):
24 women described an effect of euphoria (66.6 %); 13 women reported an effect of clouding consciousness (36.1%); 15 women described a mild ASC (41.6 %); 18 women mentioned about an acute effect of sexual arousal (50 %), while 14 women had a feeling of rush and increase of heat at genitals (38.8 %); 18 women had increased empathy (50 %); 24 women described a feeling of calmness and happiness (66.6 %); 14 women reported a feeling of analgesia (38.8 %); 15 women told about a feeling of anxiolysis (41.6 %). The main effects which were described by most of the women were calmness, euphoria, empathy, happiness feeling, relaxation, drowsiness and sexual arousal.

2) 30 IU OXY Acute Effects (N=10):
9 women described an effect of euphoria (90 %); 4 women reported an effect of clouding consciousness (40%); 6 women described a mild ASC (60 %); 18 women mentioned about an acute effect of sexual arousal (50 %), while 7 women had a feeling of rush and increase of heat at genitals (70 %); 9 women had increased empathy (90 %); 10 women described a feeling of calmness and happiness (100 %); 8 women reported a feeling of analgesia (80 %); 7 women told about a feeling of anxiolysis (70 %).

OXY prominently induced calmness, euphoria, empathy, happiness feeling, relaxation, ASC and sexual arousal in a dose dependent manner.

Conclusion: Intranasal OXY spray DOES have some acute effects on the female behavior and consciousness at the doses of 10 and 30 IU in a dose dependent manner. In future intranasal OXY sprays can be used both in sex therapy and psychiatry successfully, since its effect is very sharp and acute within seconds. However, OXY degrades in the brain very fast, thus the administration should be repeated.
PROBLEMS IN SEXUAL EDUCATION AND SEX THERAPY IN TURKEY
H. Ümit Sayin (Sayin-5)
WORKSHOP LECTURE and POSTER
Introduction: In Turkey there is no sex education at the levels of high schools and universities. Maybe that is why sexual problems and sexual function disorders (SFD) are increasing day by day. For healthy sexuality and sexual behavior, structured and healthy education on human sexuality is essential. During the last decades, some SFD’s such as vaginismus, anorgasmia, erectile dysfunction (ED), premature ejaculation and lack of sexual desire increased a great deal. There are neither structured nor detailed sex therapy education systems for the health professionals, or MSc and PhD programmes of Sex Therapy at the universities.

Findings and Description: According to our latest surveys, vaginismus increased to around 12-15%; anorgasmia has increased to more than 25-30% among educated & middle class women in the Turkish population. Lack of sexual interest in men and women also peaked during the last decades. Among women, lack of sexual interest is around 35-40%, even at younger ages. One of the reasons of this social transformation is that the women are not getting education about their bodies and sexuality since Turkish society has become very religious, dogmatic and conservative during the last 2 or 3 decades. Another reason is the increasing taboos and myths of the society, besides “the fear of sexuality” and political precautions against sex education.

Discussion and Conclusion: The sexual behavior, attitudes, taboos and trends of Turkish women and men are changing, and diverting from the European sexual behavioral system and life styles. Structured Sexual Education for the public, as well as, the health professionals, should be started as soon as possible and the associations, such as ASEHERT, which have been established to give education mainly to the public, should be supported and funded by international and national funds.

NEW TRENDS IN SEX THERAPY: PLEASURE AND ORGASM ORIENTED TREATMENT OF VAGINISMUS AND ANORGASMIA
H. Ümit Sayin (Sayin-6)
WORKSHOP LECTURE and POSTER
Introduction: Vaginismus is an increasing sexual function disorder (SFD) in the Turk-
ish female population, as well as anorgasmia. Since there is a chaos about the treatment of vaginismus and anorgasmia among the Turkish Sex Therapists and health professionals, most of the classical behavioral and cognitive therapy models are not used. For the behavioral therapy, dilators are not mainly available in Turkey. Near to this, “masturbation and techniques for reaching orgasms” are not taught properly to the patients, since masturbation and orgasm is a kind of growing taboo. Most of the time vaginismus is overcome by “the legal rape” of the husband in some countries like, Turkey.

**Method and Technique:** In this treatment method, a 15 step vaginismus self-treatment is taught using masturbation techniques and also bullet vibrators, vibrating dilators and specifically designed normal silicone dilators at various sizes (7 different sizes are recommended). This technique is called “pleasure and orgasm oriented vaginismus treatment”.

**Discussion and Conclusion:** Before passing to the intercourse session with the partner, the vaginismus patient should be trained to get pleasure from sex and should learn how to reach a clitoral orgasm. This training may take a long time, as long as 2-3 months. Before, the patient experiences pleasure and orgasm from sexual intimacy, foreplay-pleasure, fantasy, masturbation, mutual masturbation with the partner and achieves to attain a clitoral orgasm, no treatment of intrusion (penile or dilators) or intercourse should be started. Today, in Turkey, such an approach is not applied and effective in many therapy clinics.

**STEP-1: SEXUAL MIND:** Creating a sexual mind
**STEP-2: DISCOVERY:** Discovering your body. Gaining information by reading, watching, talking.
**STEP-3: Masturbation-1:** Learning clitoral orgasm manually.
**STEP-4: Masturbation-2:** Learning clitoral orgasm using vibes.
**STEP-5: PC-MUSCLES:** Improving PC Muscles. Learning to control PC muscles.

**STEP-6: PLEASURE & ORGASM Oriented Vaginismus Therapy:** Learning orgasm oriented treatment.
**STEP-7: DEFLOWERING:** Surgical or other methods.
**STEP-8:** Learning to use vibrating dilators.
**STEP-9:** Vibration-Pleasure-Orgasm-Dilator Transfer.
**STEP-10:** VIBRATING DILATORS: First vibrating dilator and bullet vibe
**STEP-11:** Second dilator and bullet vibe and masturbation.
**STEP-12:** Third dilator and orgasm without bullet vibe.
**STEP-13:** Fourth and fifth dilators.
**STEP-14:** Last dilators, sex toys
**STEP-15:** INTERCOURSE: First trials for intercourse with the partner.

**052. GLOBAL NEUROPHARMACOLOGICAL CASTRATION OF HUMAN SEXUALITY SSRI’S AND ANTI-PsYCHOTICS**

Psychopharmacology of Psychiatric Medications and Sexual Function Disorders Due to Psychiatric Drugs
H. Ümit Sayin (Sayan-7)

**WORKSHOP and POSTER**

**Introduction:** Most of the psychiatric drugs used in the treatment of depression, anxiety and bipolar disorder, mania and psychosis influence sexual behavior, libido and the potency to get pleasure and to attain orgasm. Because of lack of proper control in Turkey, many anti-depressive SSRI’s and agents impairing dopaminergic system, dopamine receptors and pathways are widely used without warning the side effects of this psychiatric medication.

**Findings and Scope:** SSRIs can cause various types of sexual dysfunction such as anorgasmia, erectile dysfunction, diminished libido, genital numbness, and sexual anhedonia *(pleasureless orgasm)* (Bahrick, Audrey (2008). "Persistence of Sexual Dysfunction Side Effects after Discontinuation of Antidepressant Medications: Emerging Evidence". The Open Psychology Journal 1: 42–50. doi: 10.2174/1874350100801010042) Initial studies found the incidence of sexual
Sexual dysfunction occasionally persists after discontinuing SSRIs. The frequency with which this happens is unknown.

SSRIs: It is well known that many antidepressant drugs and SSRIs (e.g. Fluoxetine-Prozac; Citalopram-Cipram, Celexa, Seropram etc.; Paroxetine-Paxils Seroxat, Loxamine etc.; Fluvoxamine-Luvox, Fevarin Facvoxil etc.; Sertraline-Zolof, Lustral, Asentra etc.; and others) and increase of serotonin in the brain totally blocks pleasure and orgasm in most of the females (Komisaruk et al. The Science of Orgasm. 2006).

Anxiolytics: A widely used anxiolytic, such as alprazolam (Xanax) also blocks pleasure, reaching to orgasm and decreases the quality sexual satisfaction.

Anti-Psychotics: Some anti-psychotic medications which interfere with the dopamine receptors, dopaminergic pathways also decrease pleasure and block orgasm in females.

Discussion and Conclusion: Around the globe and also in Turkey, above drugs are used widely; however, most of the time the patient is not acknowledged about the negative side effects of these drugs. By using SSRIs, depressive mood can be treated; however, sexual potential of the patients may be impaired, and this is a long term effect, which even persists after quitting the treatment; the long term outcome is unknown. It is well documented that above psychiatric medications may totally block orgasm, sexual pleasure and induce anhedonia. The physicians should be careful before prescribing anti-depressants, anxiolytics and anti-psychotics; because, the long term side effects of these drugs are not investigated well enough, and they may induce an iatrogenic (drug induced) depression, by means of interfering sexual functions and inducing anorgasmia. Today, sexual function disorders due to the psychiatric medications are very widespread around the globe and also in Turkey.

053.THE USE OF SEX TOYS AND VIBRATORS IN SEX THERAPY
H. Ümit SAYIN (Sayın-8)
LECTURE, PANEL TALK AND POSTER
Introduction: Sex Toys (STs) and vibrators (VBs) have been used in Europe and Americas successfully in sex therapy, since the dawn of direct-current electric motor, around 1880s. The famous comedy-history film “HISTERIA” summarizes how the VBs were started to be used by physicians and sex therapist by the end of 19th Century in USA. However, although the STs and VBs have been used for more than 120 years in the West by either individuals independently and/or by sex therapists, the frequency of using VBs by women in Turkey is less than 1 % (Kadınca Report-KR, 1993 and Hülya Report-HR, 2003) compared to the frequency of 52.5 % in USA (Reference: Articles of Herbenick and Rosenberger). There is strong resistance to use STs and VBs in the Turkish population as well as among the physicians, psychologists, psychiatrists and sex therapists because of many cultural reasons.

Background and Findings: Our surveys both on women (KR-1993; HR-2003; İstanbul Report-IR-2013) and also some short surveys on the study of VB usage by some Turkish women volunteers have shown the fact that STs and VBs are both very effective in inducing orgasm and giving pleasure to the Turkish females. Our surveys on women and other interview results have revealed that only around 1 % of the female population in Turkey is willing to use and/or continue using STs and Vs. It is also observed that more than 50 % of Turkish women were wondering about the effects of STs and VBs; however, they were too shy and intimidated to try them on themselves or use them with their partners. Some
women buy these devices discreetly from the internet by ordering some unknown devices from the erotic shops. Our survey with 32 women, using and assessing VBs and filling in a questionnaire and our face to face interviews with around 50 women also revealed the fact that, VBs improved  

> a) Their orgasm consistency  
> b) Induced orgasms  
> c) Improved their sexual lives with and/or without a partner  
> d) Improved the pleasure during masturbation with VBs or without VBs  
> e) Enhanced the pleasure they were taking from sexual encounters, foreplay, sexual contentness and pleasure & orgasm during masturbation.

**Discussion and Conclusions:** Since the reaction and resistance of Turkish male partners and also the sex therapists & psychologists-psychiatrists is very harsh and reactive against STs and VBs; the Turkish society should be trained on the effects of VBs. In Turkey the frequency of anorgasmia cases varies from social strata to strata, in 1990s and in the beginning of 2000s, the anorgasmia frequency was 15-19 % in the educated and middle class women; in 2015, this ratio increased to 30 to 35 % in the same age and social group. In the whole society and among the uneducated women, anorgasmia ratio may be even higher. Turkish society (public and health professionals) needs some structured education systems both on SFDs, sexual physiology and also STs & VBs. In a society where anorgasmia frequency can be expected as high as from 25 to 40 % of the female population, it should be noted that VBs can be very successful in improving sexual life styles and orgasm consistencies of Turkish women.

**054. THE EVALUATION OF SEX TOYS AND VIBRATORS BY TURKISH FEMALE USERS: HOW TO IMPROVE THEM**

H. Ümit Sayin (Sayin-9)

**POSTER**

**Introduction:** Sex Toys (STs) and vibrators (VBs) have been used in Europe and Americas successfully in sex therapy. The frequency of using VBs by women in Turkey is less than 1 % (Kadinca Report-KR, 1993 and Hülya Report-HR, 2003) compared to the frequency of 52.5 % in USA (Reference: Articles of Herbenick and Rosenberger). There is strong resistance to use STs and VBs in the Turkish population as well as among the physicians, psychologists, psychiatrists and sex therapists because of many cultural reasons.

**Methods and Results:** Our survey (which still continues) with 32 women, using and assessing VBs and filling in a questionnaire and our face to face interviews with around 50 women supplied the main data (N=82). The survey questionnaire had 50 questions (multiple choice or fill in the blanks, or chose using a likert-scale). The problems and the assessments of STs and VBs that were sold in Turkey were asked. The questions and the top ten evaluations were:

A- What is your opinion about the problems and bad designs of current VBs and STs? How to evaluate their effects?

1-Their vibration frequency is sometimes too low. (Highest response)
2-Their vibration frequency should have been modulated and they should be in a larger vibration span. (Highest response)
3-Vibration frequencies should have had more options and more adjustments. (Highest response)
4-The devices should not have been activated by batteries, but charges and city electricity, such that no power problem, after a while, should have been faced. (Highest response)
5-Those toys do not seem to be a manufacture of thorough and detailed research and engineering or investigation. (High response)
6-The devices are not suitable for the women’s body and are not designed as ergonomic.
7-These devices have not been tried on women properly and in controlled experiments; poor design and poor engineering. (High re-
8. The toys sold in Turkey are very cheap and junk Chinese devices. (Moderate response)
9. Their packages, marketing and way of commercializing is very poor and bad. (Moderate response)
10. There is no information about how to use them and no detailed information on the web sites of erotic shops. They are not well defined. (Moderate response)

B- When you look at the STs and VBs sold in Turkey what would be your suggestions to improve them to function more properly and effectively?

1. Their shapes and designs should be better. (Highest response)
2. Driven by batteries is a bad characteristic, they should be manufactured with charges which plugged in. (Highest response)
3. The vibration frequencies should be increased. (Highest response)
4. The engineers and designers who manufactured them have never asked women the effects of these devices, they should be designed on the demands of women. (Highest response)
5. They should be designed after long research by the doctors and physicians after structured and long experiments. (Highest response)
6. Vibration frequencies should go from the lower to the very high with gradually increasing many steps. (High response)
7. The adjustment buttons and other functions and vibration programs should be more and they should be adjusted. (High response)
8. They should be designed as ergonomic. (High response)
9. They should be redesigned according to the physiology of females. (High response)
10. They should be marketed with more detailed information. (High response)

Discussion and Conclusions: Women who use STs and VBs know what they need better than men. The current designs and engineering of the VBs are too bad and clumsy. They should be redesigned according to the demands of women and structured scientific research and detailed experimentation according to the directions of women.

055.ELECTROPHYSIOLOGICAL EFFECTS OF CHILDHOOD EPILEPSIES AND TRAUMA ON THE ADULT HIPPOCAMPUS; ELECTROPHYSIOLOGICAL EVIDENCE OF NEO-FREUDIEN THEORIES
H. Ümit Sayin (Sayin-10)
POSTER

Introduction: Author’s research which lasted nearly for 12 years on the long term effects of childhood epilepsies and traumas on the electrophysiology of the adult hippocampus and learning (Sayin, Epilepsia, 45 (12) 1539-1548, 2004) clearly showed that a kind of strong trauma or childhood epilepsy (febrile seizures or others) may have long term electrophysiological effects and alters the GABAergic circuitry of the child-traumatized hippocampus at the stage of being adults, making them more prone to develop anxiety, have altered personality traits, impaired learning, susceptible to seizures. These reports are one of the few publications on this topic. As Sigmund Freud had pointed out 100 years ago, there may be some specific "critical periods" during the developmental stages (Oral, Anal, Phallic, Genital etc.)

Methods and Results: Electrophysiological investigation of the rat hippocampus of the pups who had strong traumas (or epileptic seizures, e.g. in febrile seizures, PTZ, kainic acid and kindling models) revealed the fact that, there are long term electrophysiological and plastic changes in the adult rats' hippocampus, parahippocampal gyrus, and
temporal lobe, such as impaired GABAergic inhibition which results in the decrease of inhibitory circuits and induces hyper-excitation states of the brain. Especially the traumas or childhood epilepsies at the developmental stage of 20-30 postnatal days in the pups after birth (which corresponds to the first 3-7 years in the human beings) there is a critical period of the nervous system, which makes the cerebrum more susceptible to many changes. The abstract of a 2015-Neuroscience Journal article summarizes the condition as:

AGE-DEPENDENT LONG-TERM STRUCTURAL AND FUNCTIONAL EFFECTS OF EARLY-LIFE SEIZURES: EVIDENCE FOR A HIPPOCAMPAL CRITICAL PERIOD INFLUENCING PLASTICITY IN ADULTHOOD


Neural activity promotes circuit formation in developing systems and during critical periods permanently modifies circuit organization and functional properties. These observations suggest that excessive neural activity, as occurs during seizures, might influence developing neural circuitry with long-term outcomes that depend on age at the time of seizures. We systematically examined long-term structural and functional consequences of seizures induced in rats by kainic acid, pentylentetrazol, and hyperthermia across postnatal ages from birth through postnatal day 90 in adulthood (P90). Magnetic resonance imaging (MRI), diffusion tensor imaging (DTI), and electrophysiological methods at PP95 following seizures induced from P1 to P90 demonstrated consistent patterns of gross atrophy, micro-structural abnormalities in the corpus callosum (CC) and hippocampus, and functional alterations in hippocampal circuitry at PP95 that were independent of the method of seizure induction and varied systematically as a function of age at the time of seizures. Three distinct epochs were observed in which seizures resulted in distinct long-term structural and functional outcomes at PP95. Seizures prior to P20 resulted in DTI abnormalities in CC and hippocampus in the absence of gross cerebral atrophy, and increased paired-pulse inhibition (PPI) in the dentate gyrus (DG) at PP95. Seizures after P30 induced a different pattern of DTI abnormalities in the fimbria and hippocampus accompanied by gross cerebral atrophy with increases in lateral ventricular volume, as well as increased PPI in the DG at PP95. In contrast, seizures between P20 and P30 did not result in cerebral atrophy or significant imaging abnormalities in the hippocampus or white matter, but irreversibly decreased PPI in the DG compared to normal adult controls. These age-specific long-term structural and functional outcomes identify P20–30 as a potential critical period in hippocampal development defined by distinctive long-term structural and functional properties in adult hippocampal circuitry, including loss of capacity for seizure-induced plasticity in adulthood that could influence epileptogenesis and other hippocampal-dependent behaviors and functional properties. 2015 IBRO. Published by Elsevier Ltd.

Discussion and Conclusions: These are the first electrophysiological evidence which proves that at the critical certain ages of the postnatal development, a strong trauma or epileptiform discharges may result in long term changes in the excitatory and inhibitory circuitry of the hippocampus, impaired learning and memory, hence some possible psychological changes, as well. More structured and detailed electrophysiology studies should be carried on the reveal other details.

056.EFFECTS OF VIBRATORS ON THE ORGASM PATTERNS & SEXUAL LIFE STYLES OF TURKISH WOMEN: DIFFERENT CLASSIFICATIONS

POSTER
H. Ümit Sayin (Sayin-11)
Asiye Kocatürk and Taner Arisal

Background and Introduction: The use of vibrators (VBs) is not very widespread among women in Turkey. A survey was made after the use of VBs (bullet vibes) among Turkish women to understand the reactions against VBs and the effects of VBs in female sexual response.

Methods: We have recently made a survey on 32 women, part of which has been realized in the women who had never used a VB before (N= 9). The survey and study is still continuing. These women were all given bullet VBs (3000 RPM, frequencies at different potentiometer grades of 2, 2.5 and 3 volts, frequency levels: 40 Hz, 50 Hz and 60 Hz) and the survey questions were collected 3 months after delivering the bullet vibes. The bullets (and other vibrators) were supplied by CENSAN Company Ltd. The questionnaire consisted of 50 questions about the sexual behavior of women and the effects of various vibrators, including bullet vibes to the participants. The determination of the classification of women was realized by some preliminary studies. **Group-1:** Women who can achieve clitoral orgasms by means of very low stimulation frequency (25-40 Hz). **Group-2:** They can attain clitoral orgasms by higher frequencies such as 40-60 Hz. **Group-3:** They can attain clitoral orgasms by 50-80 Hz moderate stimulations. **Group-4:** They can be stimulated and attain orgasms by a wider range of stimulation frequencies (40-100 Hz). **Group-5:** They need very powerful vibrations such as massage vibrators, which are around 80-100 Hz. 0-6 likert scale included the choices of effects on their clitoral orgasms and sexual behavior: 0-very badly; 1-badly; 2- No effect; 3-little positively; 4-moderately; 5-much in a positive way; 6- very much in a positive way.

Results: 1-The distribution of the subjective evaluation of women according to their responses to the bullet vibrators and/or other vibrators which they have used before for the study were (N= 32); **Group 1** (Moon women) = 15 %; **Group 2** (Sun women) = 26 %; **Group 3** (Earth women) = 43 %; **Group 4** (Sky women) = 15 %; **Group 5** (Venus women) = 1 %.

2- “Did bullet vibrators or other vibes affect your sexual response and capability to attain clitoral orgasm?”

0 (very badly)= 0.0 %; 1 (badly)= 0.0 %; 2 (No effect)= 14 %; 3 (Little effect)= 0.0 %; 4 (moderate effect)= 14 %; 5 (much effect)= 32 %; 6 (very much effect)= 42 %.

3- “Did bullet vibrators or other vibes affect your general sexual response positively?”

0 (very badly)= 0.0 %; 1 (badly)= 0.0 %; 2 (No effect)= 11 %; 3 (Little effect)= 0.0 %; 4 (moderate effect)= 4 %; 5 (much effect)= 45 %; 6 (very much effect)= 40 %.

4- “By Using bullet vibe or other vibrators did you attain a clitoral orgasm?”

69 %= Yes, every time; 18 %= Yes, usually; 7 %= Yes, sometimes; 3 %= Yes, very rarely; 3 %= No, never.

5- “By Using bullet vibe or other vibrators how was your libido affected?”

0 (very badly)= 0.0 %; 1 (badly)= 0.0 %; 2 (No effect)= 8 %; 3 (Little positive effect)= 0.0 %; 3 (moderate positive effect)= 8 %; 5 (much positive effect)= 46 %; 6 (very much positive effect)= 38 %.

Discussion and Conclusions: This study group could attain orgasms by low frequency bullet vibrators and **reached to clitoral orgasms easier (87 %)**; their sexual life styles were improved by bullet vibes positively (85 %); also bullet vibes **improved their libido (79 %)**. Despite the fact that there is resistance against the use of VBs in the Turkish society by both the public and the professional therapists and doctors, VBs can be used in the treatment of anorgasmia and other sexual function disorders in Turkey.
057. İSTANBUL REPORT: PRELIMINARY FINDINGS; THE DECLINE OF THE FANTASY PATTERNS AND THE FREQUENCY OF MASTURBATION IN TURKISH WOMEN DURING THE LAST DECADES
H. Ümit Sayin (Sayin-12) and Asiya Kocaörk
POSTER
Introduction: Our surveys on the sexual behavior of Turkish women on both young Female University Students (FUS, ages of 17 to 23) and all ages (17 to 60) have showed a pattern that the sexual behavior of Turkish women have altered a great deal during the last decades. Our surveys Kadınca Report (KR, 1993, N=1536), Hülya Report (HR, 2003, N=709) and preliminary findings in Istanbul Report (IR-2013-2015, N=1139), which is still continuing, have shown such tendency. In this report we present the latest findings on the decline of female fantasy patterns and masturbation frequencies during last 20 years.

Methods: The data of 1139 forms of İstanbul Report (939 FUS in 2013-2015 at the age interval of 17-23 and 200 new data form at the age intervals of 23 to 60) and our former reports of KR (1993, N=1536) & HR (2003, N=709; total N=2245 women) were compared in the SPSS program. Appropriate analysis and statistical comparison is made by using SPSS and Sigma-stat statistics programs. The surveys were realized in some different women’s magazines and also using the internet and face to face interviews. The target group was educated, secular, liberated, middle class women, (ages: 17 to 60).

Results: a) In our former surveys, 10 and 20 years ago, the ratio of having sexual fantasies was: 81.7% (combined KR-1993 and HR-2003, N=2241 women, at the ages of 17 to 60), and having no fantasy was 18.1% in the whole combined group. In 2013-2015, “imagining a sexual fantasy” dropped to 53% and “having no fantasy” increased to 44.3% (IR-pilot-preliminary, 2013-2015; N=1139). Among the educated and middle class women the tendency of fantasizing dropped statistically significantly during last decade.

b) Between 10 to 20 years ago, the ratio of the women who never masturbated was 35.1% (combined KR-1993 and HR-2003, N=2241 women, at the ages of 17 to 60); in 2013-2015, this ratio increased to 63.3% (IR-pilot-preliminary, 2013-2015; N=1139). In 20 years, an increase of the number of none-masturbating women was multiplied by 1.8 times.

c) Conclusion: In Turkey, 20 years ago, among 1000 middle class and educated Turkish women, 817 women were having sexual fantasies and 649 women were experiencing masturbation. In Turkey, in 2015; among 1000 middle class and educated Turkish women, only 530 women are having sexual fantasies, and only 367 women are masturbating. Both masturbation and fantasy behavior declined significantly.

Discussion: Sexual fantasy and masturbation are the basic, natural and healthy sexual behaviors. Also, sexual education and sex therapy starts with teaching the healthy masturbation techniques to the patients. Fantasy patterns are also indispensable counterpart of masturbation and sexual behavior. Our various surveys have shown that the frequency of sexual fantasy, masturbation and orgasm patterns decreased and declined during the last 20 years among educated and middle class women in Turkey. The reason of this decline is the transformation of the Turkish society during the last decades into a conservative and very religious social system, and banning many attitudes as well as books, media, cultural rights etc. in the society. As well as political means, another factor is the lack of sexual
education on sexuality at any education level, including universities and post-doctoral education.

058. İstanbul Report: Preliminary Findings
The Decline of the Orgasmic Behaviour in Turkish Women During the Last Decades
H. Ümit Sayın (Sayın-13)
Asiye Kocatürk and Hacer Canatan

Poster
Introduction: Our surveys on the orgasmic behavior of Turkish women on both young Female University Students (FUS; ages of 17 to 23; N=939) and all ages (17 to 60; N=200; total N=1139) have showed a pattern that orgasmic frequency and consistency of Turkish women have altered and declined a great deal during the last decades. Our surveys Kadınca Report (KR, 1993, N= 1536), Hülya Report (HR, 2003, N=709; combined total KR+HR, N= 2245) and preliminary findings in İstanbul Report (IR-2013-2015, N=1139), which is still continuing, have shown such a decline. In this report we present the latest findings on the decline of orgasmic frequency, multiple orgasms and other orgasmic attitudes of Turkish women during the last 20 years.

Methods: Comparison of the data of 1139 forms of İstanbul Report (939 FUS in 2013-2015 at the age interval of 17-23 and 200 new data form at the age intervals of 23 to 60) and our former reports of KR (1993, N=1536) & HR (2003, N=709) is made in the SPSS program. Appropriate analysis and statistical comparison is carried out by using SPSS and Sigma-stat statistics programs. The surveys were realized in some different women’s magazines and also using the internet and face to face interviews. The target group was educated, secular, liberated, middle class women, (ages: 17 to 60). Content from sexual life; orgasmic behavior & consistency, orgasmic frequency & number, multiple orgasms were asked.

Results:

<table>
<thead>
<tr>
<th>Are you content of your current sexual life?</th>
<th>Very Content</th>
<th>Sometimes, less content</th>
<th>Not Content</th>
<th>Not interested</th>
</tr>
</thead>
<tbody>
<tr>
<td>KR-HR-1993-2003 N=2245 women</td>
<td>41 %</td>
<td>21 %</td>
<td>23 %</td>
<td>Rest</td>
</tr>
<tr>
<td>IR-2013 N=1139 women</td>
<td>26 %</td>
<td>22 %</td>
<td>47 %</td>
<td>Rest</td>
</tr>
</tbody>
</table>

Discussion and Conclusions: Reaching to orgasm, experiencing multiple orgasms and being content of present sexual life was declined a great deal, significantly. Experiencing vaginal-coital orgasm ratio stayed at the similar ratio of 16-19 % in both of the study groups. The possible reasons of the findings can be summarized as follows:
- The Turkish society became more conservative and religious during the last 20 years.
- The inhibitions and taboos increased during the last 20 years.
- Education and training on sexuality dropped during the last 20 years.
- Political system and social conditioning.
- The social insecurities, instabilities and political system’s social impact.
- Increased use of SSRI anti-depressants in the whole society.
- A possible effect of widely used GMO food.
- Too much exposure to electromagnetic radiation due to high magnetic effects of smart cellular phones.
059. İSTANBUL REPORT: Preliminary Results of a Survey on the 398 Postpartum Women in Istanbul:
SEXUAL SATISFACTION, SEXUAL FUNCTION DISORDERS, VERBAL AND PHYSICAL VIOLENCE IN THE TURKISH FAMILY STRUCTURE
Asiye Kocatürk and H. Ümit Sayin (Sayin-14)

Introduction: The authors started a series of surveys, named as Istanbul Report (IR) on Female Sexuality. This study was a subgroup of the survey series of IR. The correlation of domestic violence towards the spouse and children were investigated among post-partum women.

Methods: The survey was realized among the post-partum women after their giving births in various hospitals in Istanbul. There were 58 questions. 398 responses were collected and analyzed in SPSS. The education distribution in the group was: Elementary: 29 %; High School: 53.4 %; University: 16.6 %; MSc & PhD: 0.8 %. The group was divided into two according to their responses: sexually content, satisfied and happy (A, N=295); sexually non-content, not satisfied and having sexual problems with their husbands (B, N=103). Verbal and physical violence by the husbands towards the women and the children, at different degrees, were investigated. This data was compared with Kadınca Report (KR-1993; N=2245), Hülya Report (HR-2003; N=1139), Istanbul Report (IR-2013; N=1139).

Results:
1- There is verbal and physical violence to some degree in the Turkish family structure.
2-Among the 398 post-partum women, the SPD frequency encountered at least once (or more) in their entire lives was 42.3 %, while the most common specific SPDs were as: Vaginismus: 10.3 %; Dyspareunia: 12.8 %; Anorgasmia: 14.2 %; Lack of sexual interest: 6.8 %; Lubrication problems during intercourse: 2.5 %.
3-In group A (where the women had a good sexual relationship with the spouse) verbal violence towards the women was 16.8 %, physical violence was, 7.5 %; verbal violence towards children was 7.1 %, while physical violence was 3.4 %.
4-In group B (where the women had unhappy and unsatisfactory sexual relationship with the spouse); verbal violence towards the women was 27.7 %, physical violence was, 14.7 %; verbal violence towards children was 13.2 %, while physical violence was 7.8 %. When both groups are compared there is a significant difference in terms of the attitude of the fathers. Violence attitude is nearly doubled.

5-66 % of the group stated that they experienced orgasms, always or generally or sometimes in their sexual relations with their husbands. 68.2 % of them experienced clitoral orgasms always or generally or sometimes; while coital-vaginal orgasm frequency was 17.9 % (always) and 11.3 % (generally). 47.8 % stated that they never or rarely or sometimes experienced coital-vaginal orgasms. 32.3 % of the group experienced only ONE orgasm at each love making, while 47.9 % said they experienced orgasms between 2-10. Compared to the other data of the Istanbul Report, these ratios were consistent with other frequencies in the other data of women of IR-2013 (N=1130). The general vaginal-coital orgasm consistency was not changed as it was in Turkish population (between 16 % and 17 %, data obtained during last 20 years). Anorgasmic women doubled in both of the 2013-IR groups compared to KR and HR.

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<tbody>
<tr>
<td>Yes, frequently</td>
<td>49 %</td>
<td>26 % *</td>
<td>32.3 % *</td>
</tr>
<tr>
<td>Sometimes/ Seldom</td>
<td>32 %</td>
<td>39 %</td>
<td>33.7%</td>
</tr>
<tr>
<td>NO Orgasm Anorgasmia</td>
<td>19 %</td>
<td>35 % *</td>
<td>34 % *</td>
</tr>
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</table>

6-Overall data stated that a good sexual relationship and attaining an orgasm decreased the verbal or physical violence of the husband to the spouse and the children. Or in problematic and sexually none satisfactory relationships with violence, the orgasm and sexual satisfaction ratios dropped significantly.
Conclusion: In the Turkish family structure, sexual function disorders, sexual dissatisfaction, anorgasmia and verbal-physical violence is one of the important factors that contribute to the happiness of the marriage. The less violence, the more sexual satisfaction is observed; or sexually suitable and satisfactory relationships decrease the verbal or physical violence. This study obviously reveals that there is a sexual relationship problem in the Turkish family structure. To overcome this problem, the families or the wives or husbands should be both given a structured education about relationships, conflict resolution, their bodies and sexuality, starting from high school and universities.

060.EFFECTS OF GENETICALLY MODIFIED ORGANISMS (GMOs) ON HUMAN SEXUAL REPRODUCTION AND FERTILITY POSTER-Review
Levent Kartal
Introduction: Genetically modified organisms (GMOs) have been widely used in many countries during last decades. The long term biological effects of GMOs are not well investigated and documented. After 2000s, it has been debated in some academic and scientific circles that GMOs have some long term hazardous biological effects on human sexuality and fertility.

Background and Findings: There are some reports that GMOs influence the human sexuality. In 2001, a California biotech company, EPICYTE, engineered a GM corn genetically. It has been reported that males eating this EPICYTE GMO (GM-corn) develop antibodies to their own sperms and become IRREVERSIBLY infertile. The females who eat this EPICYTE gene loaded corn develop antibodies to either their own ovum or to the foreign spermatozoa. EPICYTE-gene is only one example of the possible long term irreversible hazardous effects of GMOs. Also it is reported that GMO-soy beans induce a decrease in libido and impaired sexual drive; research shows that the consumption of GMO-soy beans induced low levels of testosterone with increased levels of DHEA (precursor of testosterone). Such incidences may result in decrease in libido, sexual appetite and fertility.

-62. Hypogonadism and erectile dysfunction associated with soy product consumption.
Siepmann T1, Roofeh J, Kiefer FW, Edelson DG.
Abstract: Previous research has focused on the beneficial effects of soy and its active ingredients, isoflavones. For instance, soy consumption has been associated with lower cardiovascular and breast cancer risks. However, the number of reports demonstrating adverse effects of isoflavones due to their estrogenic properties has increased. We present the case of a 19-y-old type 1 diabetic but otherwise healthy man with sudden onset of loss of libido and erectile dysfunction after the ingestion of large quantities of soy-based products in a vegan-style diet. Blood levels of free and total testosterone and dehydroepiandrosterone (DHEA) were taken at the initial presentation for examination and continuously monitored up to 2 y after discontinuation of the vegan diet. Blood concentrations of free and total testosterone were initially decreased, whereas DHEA was increased. These parameters normalized within 1 y after cessation of the vegan diet. Blood levels of free and total testosterone were paralleled by a constant improvement of symptoms; full sexual function was regained 1 y after cessation of the vegan diet. This case indicates that soy product consumption is related to hypogonadism and erectile dysfunction. To the best of our knowledge, this is the first report of a combination of decreased free testosterone and increased DHEA blood concentrations after consuming a soy-rich diet. Hence, this case emphasizes the impact of isoflavones in the regulation of sex hormones and associated physical alterations.

Discussion and Conclusion: In this poster presentation, GM-corn and GM-soy bean are only two examples, about which the devastating effects of GMOs have been proven.
There is much other GM food which is served on our dinner tables all over the globe. In Turkey, during the last decade, "original and natural heirloom" seeds of many plants that are used as food products have been banned to sell commercially and it was compulsory to use patented hybrid seeds that the government decides on. Also in some food, GM-plants are also used. In Turkey, infertility cases tripled during the last 2 decades; sexual function disorders (SFDs) such as lack of sexual desire, decrease of libido, anhedonia, anorgasmia increased a great deal. A long term investigation of the comparison of GMOs and SFDs should be carefully carried out with cohort long term surveys on the Turkish population, to investigate whether the increment in SFDs and infertility cases have any correlation with the consumption of GM-food of any kind (corn, soy and others).

061. ACUTE EFFECTS OF 15 MAIN BASIC NOTE PARFUME FRAGRANCES ON MOOD, SEXUAL AROUSAL, LIBIDO AND SUB-CONSCIOUSNESS IN WOMEN
Ümit Sayın (Sayın-15), Hacer Canatan, Aydan Taşkınlar and Burcu Karavelioğlu

Introduction: It is reported that perfumes and fragrances have effects on mood, consciousness, childhood memories, recent or distant memories, anxiety, sexual arousal, and libido. It is also hypothesized that fragrances and perfumes have direct effect on the limbic system, temporal lobe and also subconsciousness & collective unconsciousness, association of memories and flashing of some geometric shapes and entoptic images. A preliminary double blind study on the effects of basic 15 notes of fragrances on mood, sexual arousal, libido, memory and consciousness in women was designed.

Methods: Different pleasant and attractive solutions of the fragrances of honeysuckle, sandalwood, lemon, patchouli, violet, amber, garden rose, tobacco, orange, crème caramel, musc, vanilla, lavender, jasmin, and mint were prepared. In the similar set and settings with a relaxing classical music (Vivaldi, Seasons), the solutions of fragrances were sprayed on gauges and smelled for 3 minutes through a surgical mask, when eyes were blindfolded. Before and after the experiment, a scale and a questionnaire were asked to be filled by the women. Their statement of written consent was also taken. The preliminary data from 20 women (ages from 18 to 50) were collected and analyzed. The study is continuing.

Results and Conclusion: The main psychological effects of most of the basic note fragrances were: relaxing; soothing; anxiolysis; feeling calm; sexual arousal; increase in libido; remembering childhood, past or recent memories; feeling; brief and mild altered states of consciousness; happiness; feelings of peace; elevation of mind. Also, when eyes were blindfolded and they smelled the fragrances, almost all of the women perceived some geometric shapes such as concentric circles, solid circles, ellipses, square, triangle, round shapes, rectangles, honeycombs, spirals. The scale also consisted of the prints and tables of entoptic images; 80 % of the women stated that when smelling some of the fragrances they perceived some entoptic images when their eyes were blindfolded. Sandalwood, patchouli, tobacco, orange, crème caramel, musc, vanilla and jasmin were most sexually arousing fragrances in this study group. The effects of the 15 basic note fragrances are summarized in the table. More detailed studies on the effects of perfumes and fragrances should be made. It is also concluded that they directly stimulate memory functions of the brain, as well as the sub-consciousness and collective unconsciousness (entoptic images).
Some of the presentations and posters in the Anatolian Congress were as follows.

The contributors and authors of these posters were:

DR. ÜMIT SAYIN
DR. ASİYE KOCATÜRK
DR. HACER CANATAN
LEVENT KARTAL
TANER ARISAL
AYDAN TASKINLAR
BURCU KARABELIOGLU
ISTANBUL REPORT: Preliminary Results of A Survey on the 398 Postpartum Women in Istanbul:
SEXUAL SATISFACTION, SEXUAL FUNCTION DISORDERS, VERBAL AND PHYSICAL VIOLENCE IN THE TURKISH FAMILY STRUCTURE

Asiye Kocatürk¹,² and H. Umit Sayın¹,³
1: ASEHERT-CİSEATED, İstanbul-Turkey www.ciseated.org 2: Faculty of Health Sciences, Midwife Department, MEDİPOL University, İstanbul-Turkey 3: Institute of Forensic Sciences, İstanbul University, Cerrahpaşa, Istanbul-Turkey

Introduction:
The authors started a series of surveys, named as istanbul Report (IR) on Female Sexuality in 2013. This study was a subgroup of the survey series of IR. The correlation of domestic violence towards the spouse and children were investigated among post-partum women.

Methods:
The survey was realized among the post-partum women after their giving births in various hospitals in Istanbul. There were 58 questions. 398 responses were collected and analyzed in SPSS. The education distribution in the group was: Elementary: 29 %; High School: 53.4 %; University: 16.6 %; MSc & PhD: 0.8 %. The group was divided into two according to their responses: sexually content, satisfied and happy (A, N=295); sexually non-content, not satisfied and having sexual problems with their husbands (B, N=103). Verbal and physical violence by the husbands towards the women and the children, at different degrees, were investigated. This data was compared with Kadınca Report (KH-1993; N=2245), Hulya Report (HR-2003; N=1139), Istanbul Report (IR-2013; N=1139).

Conclusions:
In the Turkish family structure sexual function disorders, sexual dissatisfaction, anorgasmia and verbal-physical violence is one of the important factors that contribute to the happiness of the marriage. The less violence, the more sexual satisfaction is observed; or sexually suitable and satisfactory relationships decrease the verbal or physical violence. This study obviously reveals that there is a sexual relationship problem in the Turkish family structure. To overcome this problem, the families or the wives or husbands should be both given a structured education about relationships, conflict resolution, their bodies and sexuality, starting from high school and universities.

<table>
<thead>
<tr>
<th>Comparison of IR-HR and IR-Postpartum Data</th>
<th>Do you attain orgasms?</th>
</tr>
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<tbody>
<tr>
<td>Yes, frequently</td>
<td>49 %</td>
</tr>
<tr>
<td>Sometimes</td>
<td>32 %</td>
</tr>
<tr>
<td>No Orgasm</td>
<td>19 %</td>
</tr>
</tbody>
</table>

Results:
1- There is verbal and physical violence to some degree in the Turkish family structure.
2- Among the 398 post-partum women, the SFD frequency encountered at least once (or more) in their entire lives was 42.3 %, while the most common specific SFDs were as: Vaginismus: 10.3 %; Dyspareunia: 12.8 %; Anorgasmia: 14.2 %; Lack of sexual interest: 6.8 %; Lubrication problems during intercourse: 2.5 %.
3- In group A (where the women had a good sexual relationship with the spouse) verbal violence towards the women was 16.8 %; physical violence was 7.5 %; verbal violence towards children was 7.1 %, while physical violence was 3.4 %.
4- In group B (where the women had unhappy and unsatisfactory sexual relationship with the spouse) verbal violence towards the women was 27.7 %; physical violence was, 14.7 %; verbal violence towards children was 13.2 %, while physical violence was 7.8 %. When both groups are compared there is a significant difference in terms of the attitude of the fathers. Violence attitude is nearly doubled.
5- 66 % of the group stated that they experienced orgasms, always or generally or sometimes in their sexual relations with their husbands. 68.2 % of them experienced clitoral orgasms always or generally or sometimes; while coital-vaginal orgasm frequency was 17.9 % (always) and 11.3 % (generally). 47.8 % stated that they never or rarely or sometimes experienced coital-vaginal orgasms. 32.3 % of the group experienced only ONE orgasm at each love making, while 47.9 % said they experienced orgasms between 2-10. Compared to the other data of the Istanbul Report, these ratios were consistent with other frequencies in the other data of women of IR-2013 (N=1139). The general vaginal-coital orgasm consistency was not changed as it was in Turkish population (between 16 % and 17 %, data obtained during last 20 years). Anorgasmic women doubled in both of the 2013-IR groups compared to KH and HR.
ALTERED STATES OF CONSCIOUSNESS (ASC) INDUCED BY A NEW METHOD OF REPEATED CLITORAL STIMULATION AND CLITORAL ORGASM

H. Ümit Sayın¹,², Justine Dawson³ and Nicole Daedone

1: ASEHERT-CISED, Istanbul-Turkey www.cised.org • 2: Institute of Forensic Sciences, Istanbul University, Cerrahpaşa, Istanbul-Turkey • 3: ONE TASTE Co.

Rationale (Optional):
Nicolette Daedone, the author of the bestselling book “SLOW SEX” has developed a technique of clitoral stimulation, coined as “OMING Meditation-Orgasm Technique” (Daedone, 2011). There have been claims that this method induced altered states of consciousness (ASC) in some women after a certain period of time, we have performed a descriptive study through a survey among the women, who participated an event of “One Taste Company” in California-USA in March-2014.

Introduction:
It is reported that prolonged orgasms induced ASC in some women (Taylor, 2001; Sayın, 2012). Similar findings have been reported by other researchers. It has been reported that ASC was observable in some women who practiced “OMING Meditation Technique” developed by Nicolette Daedone, as mentioned in her book “SLOW SEX”.

Methods:
A very short survey questionnaire which consisted of 3 questions was delivered to the women who participated an event performed by “One Taste Company”. 25 women, who have been practicing “OMING Meditation-Orgasm Technique” for at least 3 months regularly, were taken into the study. They also signed a form of written statement of consent before the survey. The technique consisted of the stimulation of glans clitoris using a lubricant by the help of a partner for at least 15 minutes. It was determined that the women participating the study used this technique with an average of 5.1 times a week. In the third question 83 different forms of ASCs, which were assumed to be possible to occur during the OMING orgasms, were asked to be checked in a table, as described by other researchers (Taylor, 2002; Sayın, 2011, 2012; King, 2010).

Results:
Pulsating feeling (0,92); throbbing (0,8); warmth (0,84); exciting feeling (0,80); pleasurable (0,84); quivering (0,76); elevation of mood (0,84); happiness and contentness (0,80) were the most common feelings over 80% of the participants of the study. Least experienced consciousness states below a frequency of 25% of the women practicing Oming Orgasm Technique were as follows: flying (0,28); astral voyage (0,24); death feeling (0,08); near death experience (0,04); losing the soul (0,04); traveling to different lands (0,24); voyage to unknown places (0,20).

Conclusion:
Using many different techniques of sexual stimulation including expanded sexual response (ESR) and “OMing Orgasm Meditation Technique”, practiced in a regular basis, various ASC patterns may occur in a statistically significant number of women. This phenomenon needs to be investigated thoroughly by means of further surveys and/or laboratory research to establish as a contributing technique to enhance the pleasure and orgasms of women.

References:
ESR: EXPANDED SEXUAL RESPONSE
BASIC DEFINITIONS AND PARAMETERS

Ümit SAYIN, M.D., PhD.
Institute of Forensic Sciences, Istanbul University, Istanbul-Turkey

Rationale and Methods:
In the literature, lately, a new term is coined and cited as expanded sexual response (ESR). To investigate the main parameters of a possible ESR, we have contacted some women who claimed to have enhanced sexual response through internet and/or making surveys by means of gathering the filled SAYIN-ESR Scale, or by making face to face interviews and by other means. Our aim was to establish the main scientific basis of the definitions and parameters of ESR, if ever it existed, and to establish an objective ESR scale out of our preliminary findings. Until 2015 we were able to pin-point nearly 60 ESR women with a comparison of 250 normal women (NESR, none-ESR women).

Results:
It is concluded that some aspects of the sexual response of women with ESR were different than the women without ESR (NESR):
1. The ESR women experienced vaginal, clitoral and blended orgasms, as described by Whipple et al.
2. The ESR women experienced multiple orgasms in most of their sexual activities.
3. The ESR women were able to attain long lasting and/or prolonged and/or multiple and/or sustained orgasms and/or status orgasms that lasted longer than the classical single orgasm and/multiple orgasm patterns described in the literature.
4. The ESR women claimed to have strong pelvic floor muscles (PFM) compared to NESR women.
5. The libido of ESR women was very high compared to NESR women.
6. ESR women described a phenomenon called G-Spot orgasms.
7. ESR women described sensitive erogenous zones in their genitalia other than clitoris.
8. ESR women masturbated frequently.
9. ESR women had erotic fantasies more frequently than the NESR women.
10. ESR women admitted to have a form of altered states of consciousness during some of their prolonged orgasms and/or status orgasms. The difference between the parametric or non-parametric measures between the ESR and NESR women was statistically significant.

Conclusion:
ESR is a novel phenomenon in the human female which was defined recently; however, Tantric literature and Eastern history showed many samples of ESR in women. Our survey data, which is still continuing, revealed that ESR PHENOMENON EXISTS.
THE MECHANISMS OF VAGINAL-COITAL ORGASMS IN WOMEN

Ümit SAYIN, M.D., PhD.
Institute of Forensic Sciences, Istanbul University, Istanbul-Turkey
humitsayin@gmail.com www.ciseated.org www.drumitsayin.com

Introduction:
There has long been a furious debate on the “Vaginal vs. Clitoral Orgasm” since the times of Freud. Some feminists opposed vaginal orgasm declaring and supporting the hypothesis that “there is only clitoral orgasm, but no phenomenon called vaginal orgasm and women do not need men and sexual intercourse to attain an orgasm”. Hite Report, which was a feminist report and was surveyed among feminist women in 1974, also defended similar hypothesis. However, both Hite Report (1974) and Cosmo Report (1981) reported that one third of women (30% and 34%, respectively) described a phenomenon called as “vaginal or coital orgasms”. However, many physicians, sex therapists, psychologists, and psychiatrists oppose the existence of “vaginal-coital orgasms” and they also add that no such thing as “G-Spot” exists in Turkey and on the globe. This presentation is aimed to prove that both “G-Spot and Vaginal-Coital Orgasms” exist.

Findings:
Some data of ours and other researchers have proven the fact that a phenomenon as “vaginal-coital orgasms” must exist.

- The clitoral hood cannot move directly enough to stimulate the glans during coitus. If some deep erectile structures of clitoris, such as bulbus or crus, are stimulated as well, this sensory input will not be carried by pudendal nerve, because most of the deep structures of clitoral complex are innervated by pelvic nerve, which may cause another type of “clitoris-pelvic organ”, which is not exactly the same as “glans-pudendal nerve organ”.
- Most of the descriptions of each type of orgasms in the literature are very different in terms of their physiological, neurophysiological and
- It has been reported that the women who are aware of their G-Spots and who have been responding-pleasurable G-Spots, are more likely to attain coital vaginal orgasms.
- There appears to be other deep vaginal erogenous zones (DVZs) in some sexually hyper active and responsive women, other than clitoris and G-Spot, as reported recently.
- Our preliminary studies by means of the electrical and vibration stimulation of DVZ seem to trigger orgasm patterns alone, without the stimulation of glans clitoris (unpublished data)
- In some women, undergone clitoridectomy, some coital orgasms have been reported, which shows that without the existence of glans clitoris, orgasms may build up by some other mechanisms, while inner clitoral complex may have some contributions to those kind of orgasms, however they are unlikely to trigger an orgasm by the stimulation of bulbus or crus of clitoris alone; there should be other triggering neural pathways and mechanisms that play major roles in the development of “orgasms without clitoris”.

- After the definition of novel “four nerve and six pathway theory of female orgasm” (see below), it was realized that at least six different pathway-mediated orgasm reflex arcs, some of which may contribute to build up “vaginal orgasms” originating from direct stimulation of DVZ, may exist!
- Some other survey in USA, United Kingdom and Europe as well as our preliminary research and other accumulating data showed that vaginal walls are not senseless, but some women experience pleasure and orgasm through the stimulation of various parts of vaginal walls.
- Recently it is reported that the female orgasm can be triggered through the stimulation of glans clitoris, inner clitoris, Grafenberg’s spot, PC-Muscle, Anterior Fornix (A-Spot), Cervix, Nipples, Ear lobes, and even by only fantasizing and foreplay (Komisaruk et al. Science of Orgasm. 2006).
- ZFSS group from Switzerland has also devised a technique called “Sexcorporal Sex Therapy” in part of which, they also teach women how to attain vaginal-coital orgasms through various workshops and trainings.

Conclusions:
There are many ongoing researches on the subject. Although, today we even have enough evidence, data and findings, as well as scientific publications and literature that both “G-Spot and DVZ” and “vaginal-coital orgasms” EXIST, it is so weird that some people still argue against all these academic and scientific publications and literature. We believe that their concern is more ideological, rather than being scientific.
ABSTRACTS OF INTERNATIONAL ANATOLIAN CONGRESS ON NEUROSCIENCE AND SEXUAL HEALTH

LOVE HORMONE OXYTOCIN: ACUTE BEHAVIORAL EFFECTS OF OXYTOCIN IN A DOSE DEPENDENT MANNER

Ümit SAYIN, M.D., PhD.
Institute of Forensic Sciences, İstanbul University, İstanbul-Turkey
humitsayin@gmail.com www.ciseated.org www.drumitsayin.com

Introduction:
The hormone and neurotransmitter OXYTOCIN (OXY) has been proposed to take part in many behavioral patterns of female behavior, including sexual arousal, orgasm, LOVE, attachment to the partner, birth and motherhood. It is hypothesized to be used in sex therapy to treat vaginismus, anorgasmia, arousal problems and others in future. We revised our former study and added 10 more data in two different intranasal doses of OXY (10 IU, N=36; 30 IU, N=10).

Methods:
As a continuing study, we administered 10 IU OXY intranasally to 36 women and 30 IU OXY intranasally to 10 women to assess the main acute effects of OXY on female behavior. A special psychometric scale containing 24 questions to assess the possible acute effects of euphoria, elevation of mind, anxiety, empathy, sexual arousal, anorgasia, altered states of consciousness (ASC), happiness feeling, and effects on general psychology, SUBJECTIVELY was used within 10 minutes after the administration. Along with OXY, a placebo spray was used intranasally before or after OXY administration in a double blind research design, to compare the effects of OXY with placebo. There was a time lapse of two hours between the two administrations.

Results:
The acute effects of OXY were controversial and altered from women to women.

10 IU OXY Acute Effects (N=36):
24 women described an effect of euphoria (66.6 %); 13 women reported an effect of clouding consciousness (36.1 %); 15 women described a mild ASC (41.6 %); 18 women mentioned about an acute effect of sexual arousal (50 %), while 14 women had a feeling of rush and increase of heat at genitals (38.8 %); 18 women had increased empathy (50 %); 24 women described a feeling of calmness and happiness (66.6 %); 14 women reported a feeling of analgesia (38.8 %); 15 women told about a feeling of anxiolysis (41.6 %).

30 IU OXY Acute Effects (N=10):
9 women described an effect of euphoria (90 %); 4 women reported an effect of clouding consciousness (40 %); 6 women described a mild ASC (60 %); 18 women mentioned about an acute effect of sexual arousal (50 %), while 7 women had a feeling of rush and increase of heat at genitals (70 %); 9 women had increased empathy (90 %); 10 women described a feeling of calmness and happiness (100 %); 8 women reported a feeling of analgesia (80 %); 7 women told about a feeling of anxiolysis (70 %).

OXY prominently induced calmness, euphoria, empathy, happiness feeling, relaxation, ASC and sexual arousal in a dose dependent manner.

Conclusion:
Intranasal OXY spray DOES have some acute effects on the female behavior and consciousness at the doses of 10 and 30 IU in a dose dependent manner. In future intranasal OXY sprays can be used both in sex therapy and psychiatry successfully, since its effect is very sharp and acute within seconds. However, OXY degrades in the brain very fast, thus the administration should be repeated.
PROBLEMS IN SEXUAL EDUCATION AND SEX THERAPY IN TURKEY

H. Ümit SAYIN, M.D., PhD.
Institute of Forensic Sciences, Istanbul University, Istanbul-Turkey

Introduction:
In Turkey there is no sex education at the levels of high schools and universities. Maybe that is why sexual problems and sexual function disorders (SFD) are increasing day by day. For healthy sexuality and sexual behavior, structured and healthy education on human sexuality is essential. During the last decades, some SFD’s such as vaginismus, anorgasmia, erectile dysfunction (ED), premature ejaculation and lack of sexual desire increased a great deal. There are neither structured nor detailed sex therapy education systems for the health professionals, or MSc and PhD programmes of Sex Therapy at the universities.

Findings and Description:
According to our latest surveys, vaginismus increased to around 12-15% anorgasmia has increased to more than 25-30% among educated & middle class women in the Turkish population. Lack of sexual interest in men and women also peaked during the last decades. Among women, lack of sexual interest is around 35-40%, even at younger ages. One of the reasons of this social transformation is that the women are not getting education about their bodies and sexuality since Turkish society has become very religious, dogmatic and conservative during the last 2 or 3 decades. Another reason is the increasing taboos and myths of the society, besides “the fear of sexuality” and political precautions against sex education.

Discussion and Conclusion:
The sexual behavior, attitudes, taboos and trends of Turkish women and men are changing, and diverting from the European sexual behavioral system and life styles. Structured Sexual Education for the public, as well as, the health professionals, should be started as soon as possible and the associations, such as ASEHERT, which have been established to give education mainly to the public, should be supported and funded by international and national funds.
NEW TRENDS IN SEX THERAPY: PLEASURE AND ORGASM ORIENTED TREATMENT OF VAGINISMS

H. Ümit SAYIN, M.D., PhD.
Institute of Forensic Sciences, Istanbul University, Istanbul-Turkey

Introduction:
Vaginismus is an increasing sexual function disorder (SFD) in the Turkish female population, as well as anorgasmia. Since there is a chaos about the treatment of vaginismus and anorgasmia among the Turkish Sex Therapists and health professionals, most of the classical behavioral and cognitive therapy models are not used. For the behavioral therapy, dilators are not mainly available in Turkey. Near to this, “masturbation and techniques for reaching orgasms” are not taught properly to the patients, since masturbation and orgasm is a kind of growing taboo. Most of the time vaginisms is overcome by “the legal rape” of the husband in some countries like, Turkey.

Method and Technique:
In this treatment method, a 15 step vaginismus self-treatment is taught using masturbation techniques and also bullet vibrators, vibrating dilators and specifically designed normal silicone dilators at various sizes (7 different sizes are recommended). This technique is called “pleasure and orgasm oriented vaginismus treatment”.

**STEP-1: SEXUAL MIND:** Creating a sexual mind
**STEP-2: DISCOVERY:** Discovering your body. Gaining information by reading, watching, talking.
**STEP-3: Masturbation-1:** Learning clitoral orgasm manually.
**STEP-4: Masturbation-2:** Learning clitoral orgasm using vibes.
**STEP-5: PC-MUSCLES:** Improving PC Muscles. Learning to control PC muscles.
**STEP-6: PLEASURE & ORGASM Oriented Vaginismus Therapy:** Learning orgasm oriented treatment.
**STEP-7: deflowering**-Surgical or other methods.
**STEP-8:** Learning to use vibrating dilators.
**STEP-9:** Vibration-Pleasure-Orgasm-Dilator Transfer.
**STEP-10:** VIBRATING DILATORS: First vibrating dilator and bullet vibe
**STEP-11:** Second dilator and bullet vibe and masturbation.
**STEP-12:** Third dilator and orgasm without bullet vibe.
**STEP-13:** Fourth and fifth dilators.
**STEP-14:** Last dilators, sex toys, vibrators
**STEP-15: INTERCOURSE:** First trials for intercourse with the partner.

Discussion and Conclusion:
Before passing to the intercourse session with the partner, the vaginismus patient should be trained to get pleasure from sex and should learn how to reach a clitoral orgasm. This training may take a long time, as long as 2-3 months. Before, the patient experiences pleasure and orgasm from sexual intimacy, foreplay-pleasure, fantasy, masturbation, mutual masturbation with the partner and achieves to attain a clitoral orgasm, no treatment of intrusion (penile or dilators) or intercourse should be started. Today, in Turkey, such an approach is not applied and is not applied or effective in many therapy clinics.
GLOBAL NEUROPHARMACOLOGICAL CASTRATION OF HUMAN SEXUALITY: SSRI’S AND ANTI-Psychotics

Psychopharmacology of Psychiatric Medications and Sexual Function Disorders Due to Psychiatric Drugs

H. Ümit SAYIN, M.D., PhD.
Institute of Forensic Sciences, Istanbul University, Istanbul-Turkey

Introduction:
Most of the psychiatric drugs used in the treatment of depression, anxiety and bipolar disorder, mania and psychosis influence sexual behavior, libido and the potency to get pleasure and to attain orgasm. Because of lack of proper control in Turkey, many anti-depressive SSRI’s and agents impairing dopaminergic system, dopamine receptors and pathways are widely used without warning the side effects of this psychiatric medication.

Findings and Scope:
SSRIs can cause various types of sexual dysfunction such as anorgasmia, erectile dysfunction, diminished libido, genital numbness, and sexual anhedonia (pleasureless orgasm) (Bahrick, Audrey (2008)). Initial studies found the incidence of sexual side effects from SSRIs not significantly different from placebo, but since these studies relied on unprompted reporting, the frequency was underestimated. In more recent studies, doctors have specifically asked about sexual difficulties, and found that they are present in most patients.

Sexual dysfunction occasionally persists after discontinuing SSRIs. The frequency with which this happens is unknown.

SSRI’s: It is well known that many anti-depressant drugs and SSRIs (e.g. Fluoxetine-Prozac; Citalopram-Cipram, Celexa, Seropram etc.; Paroxetine-Paxil Seroxat; Loroxine etc.; Fluvoxamine-Luxa; Fevarin-Facvoor etc.; Sertraline-Zoloft, Lustral, Asentra etc.; and others) and increase of serotonin in the brain totally blocks pleasure and orgasm in most of the females (Kомисарук в.а. The Science of Orgasm. 2006).

Anxiolytics: A widely used anxiolytic, such as alprazolam (Xanax) also blocks pleasure, reaching to orgasm and decreases the quality sexual satisfaction.

Anti-Psychotics: Some anti-psychotic medications which interfere with the dopamine receptors, dopaminergic pathways also decrease pleasure and block orgasm in females.

Discussion and Conclusion:
Around the globe and also in Turkey, above drugs are used widely; however, most of the time the patient is not acknowledged about the negative side effects of these drugs. By using SSRIs, depressive mood can be treated; however, sexual potential of the patients may be impaired, and this is a long term effect, which even persists after quitting the treatment; the long term outcome is unknown. It is well documented that above psychiatric medications may totally block orgasm, sexual pleasure and induce anhedonia. The physicians should be careful before prescribing anti-depressants, anxiolytics and anti-psychotics; because, the long term side effects of these drugs are not investigated well enough, and they may induce an iatrogenic (drug induced) depression, by means of interfering sexual functions and inducing anorgasmia. Today, sexual function disorders due to the psychiatric medications are very widespread around the globe and also in Turkey.
USE OF SEX TOYS AND VIBRATORS IN SEX THERAPY

H. Ümit SAYIN, M.D., PhD.
Institute of Forensic Sciences, Istanbul University, Istanbul-Turkey

Introduction:
Sex Toys (STs) and vibrators (VBs) have been used in Europe and America successfully in sex therapy, since the dawn of direct-current electric motors, around 1880s. The famous comedy-history film “HISTERRA” summarizes how the VBs were started to be used by physicians and sex therapist by the end of 19th Century in USA. However, although the STs and VBs have been used for more than 120 years in the West by either individuals independently and/or by sex therapists, the frequency of using VBs by women in Turkey is less than 1% (Kadinca Report-1993 and Hülya Report-1993) compared to the frequency of 53.5% in USA (Reference: Articles of Herbenick and Rosenberger). There is strong resistance to use STs and VBs in the Turkish population as well as the physicians, psychologists, psychiatrists and sex therapists because of many cultural reasons.

Background and Findings:
Our surveys both on women (KR-1993; HR-2003; Istanbul Report-IR-2013) and also some short surveys on the study of VB usage by some Turkish women volunteers have shown the fact that STs and VBs are both very effective in inducing orgasm and giving pleasure to the Turkish females. Our surveys on women and other interview results have revealed that only around 1% of the female population in Turkey is willing to use and/or continue using STs and VBs. It is also observed that more than 50% of Turkish women were wondering about the effects of STs and VBs; however, they were too shy and intimidated to try them on themselves or use them with their partners. Some women buy these devices discreetly from the internet by ordering some unknown devices from the erotic shops. Our survey with 32 women, using and assessing VBS and filling in a questionnaire and our face to face interviews with around 50 women also revealed the fact that, VBS improved
a) Their orgasm consistency
b) Induced orgasms
i) Improved their sexual lives with and/or without a partner
d) Improved the pleasure during masturbation with VBS or without VBS

Discussion and Conclusions:
Since the reaction and resistance of Turkish male partners and also the sex therapists & psychologists-psychiatrists is very harsh and reactive against STs and VBS; the Turkish society should be trained on the effects of VBS. In Turkey the frequency of anorgasmia cases varies from social strata to strata. In 1990s and in the beginning of 2000s, the anorgasmia frequency was 15-19% in the educated and middle class women; in 2015, this ratio increased to 30 to 35% in the same age and social group. In the whole society and among the uneducated women, anorgasmia ratio may be even higher. Turkish society (public and health professionals) needs some structured education systems both on SFDs, sexual physiology and also STs & VBS. In a society where anorgasmia frequency can be expected as high as from 25% to 40% of the female population, it should be noted that VBS can be very successful in improving sexual life styles and orgasm consistencies of Turkish women.

IN SEX THERAPY WHICH VIBE CAN BE USED TO DEVELOP WHICH REFLEX

Learning and developing clitoral orgasm
- Bullet-vibe: massage gadgets: clitoral part of rabbit vibe: butterfly: butterflies that can be harnessed by specially designed underwear or belts

G-Spot discovery and stimulation, learning and developing G-Spot orgasm reflex
- Specially designed anterior furore stimulators: SYRIAN

Stimulation of inner clitoris, DVZ and learning and developing vaginal orgasm reflex
- New generation vibes with special design: rabbit clitoris-type vibes with rotating tip and clitoral stimulator head: variety of vibes with or without vibration: SYRIAN

Learning vaginal orgasm reflex
- New generation Rabbit-dolphin clitoris vibes with two functions and a rotating tip: cashmires with powerful vibrations: syrian with special vibrations and reactions: SYRIAN

Developing and stimulating PC-muscles

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Volume 13: Issue 2
THE EVALUATION OF SEX TOYS AND VIBRATORS BY TURKISH FEMALE USERS: HOW TO IMPROVE THEM

H. Ümit SAYIN, M.D., PhD.
Institute of Forensic Sciences, İstanbul University, İstanbul-Turkey

Introduction:
Sex Toys (STs) and vibrators (VBs) have been used in Europe and America successfully in sex therapy. The frequency of using VBs by women in Turkey is less than 1% (Kedemc Report-XB, 1993 and Hülya Report-HR, 2003) compared to the frequency of 52.5% in USA (Reference: Articles of Herbenick and Rosenberger). There is strong resistance to use STs and VBs in the Turkish population as well as among the physicians, psychologists, psychiatrists and sex therapists because of many cultural reasons.

Methods and Results:
Our survey (which still continues) with 32 women, using and assessing VBs and filling in a questionnaire and our face to face interviews with around 50 women supplied the main data (N=82). The survey questionnaire had 50 questions (multiple choice or fill in the blanks, or chose using a likert-scale). The problems and the assessments of STs and VBs that were sold in Turkey were asked. The questions and the top ten evaluations were:

What is your opinion about the problems and bad designs of current VBs and STs? How to you evaluate their effects?
1- Their vibration frequency is sometimes too low. (Highest response)
2- Their vibration frequency should have been modulated and they should be in a larger vibration span. (Highest response)
3- Vibration frequencies should have had more options and more adjustments. (Highest response)
4- The devices should not have been activated by batteries, but charges and city electricity, such that no power problem after a while, should have been faced. (Highest response)
5- Those toys do not seem to be a manufacture of thorough and detailed research and engineering or investigation. (High response)
6- The devices are not suitable for the women’s body and are not designed as ergonomic. (High response)
7- These devices have not been tried on women properly and in controlled experiments; poor design and poor engineering. (High response)
8- The toys sold in Turkey are very cheap and junk Chinese devices. (Moderate response)
9- Their packages, marketing and way of commercializing is very poor and bad. (Moderate response)
10- There is no information about how to use them and no detailed information on the web sites of erotic shops. They are not well defined. (Moderate response)

When you look at the STs and VBs sold in Turkey what would be your suggestions to improve them to function more properly and effectively?
1- Their shapes and designs should be better. (Highest response)
2- Driven by batteries is a bad characteristic, they should be manufactured with charges which plugged in. (Highest response)
3- The vibration frequencies should be increased. (Highest response)
4- The engineers and designers who manufactured them have never asked women the effects of these devices, they should be designed on the demands of women. (Highest response)
5- They should be designed after long research by the doctors and physicians after structured and long experiments. (Highest response)
6- Vibration frequencies should go from the lower to the very high with gradually increasing many steps. (High response)
7- The adjustment buttons and other functions and vibration programs should be more and they should be adjusted. (High response)
8- They should be designed as ergonomic. (High response)
9- They should be redesigned according to the physiology of females. (High response)
10- They should be marketed with more detailed information. (High response)

Discussion and Conclusions:
Women who use STs and VBs know what they need better than men. The current designs and engineering of the VBs are too bad and clumsy. They should be redesigned according to the demands of women and structured scientific research and detailed experimentation according to the directions of women.
EFFECTS OF VIBRATORS ON THE ORGASM PATTERNS & SEXUAL LIFE STYLES OF TURKISH WOMEN: DIFFERENT CLASSIFICATIONS

H. Ümit Sayın1,2, Asiya Kocatürk1,3, Taner Arısal1

1: AŞEHER-CISEATED (Association of Sexual Health Education Research & Treatment), Istanbul-Turkey www.ciseated.org
2: Institute of Forensic Sciences, Istanbul University, Cerrahpasa, Istanbul-Turkey
3: Faculty of Health Sciences, Midwife Department, MEDIPOL University, Istanbul-Turkey

Background and Introduction:
The use of vibrators (VBS) is not very widespread among women in Turkey. A survey was made after the use of VBS (bullet vibes) among Turkish women to understand the reactions against VBS and the effects of VBS in female sexual response.

Methods:
We have recently made a survey on 32 women, part of which has been realized in the women who had never used a VB before (N= 9). The survey and study is still continuing. These women were all given bullet VBS (3000 RPM, frequencies at different potentiometer grades of 2, 2.5 and 3 volts, frequency levels: 40 Hz, 50 Hz and 60 Hz) and the survey questions were collected 3 months after delivering the bullet vibes. The bullets (and other vibrators) were supplied by CENSA Company Ltd. The questionnaire consisted of 50 questions about the sexual behavior of women and the effects of various vibrators, including bullet vibes to the participants. The determination of the classification of women was realized by some preliminary studies.

Group 1: Women who can achieve clitoral orgasms by means of very low stimulation frequency (25-40 Hz).
Group 2: They can attain clitoral orgasms by higher frequencies such as 40-60 Hz.
Group 3: They can attain clitoral orgasms by 50-80 Hz moderate stimulations.
Group 4: They can be stimulated and attain orgasms by a wider range of stimulation frequencies (40-100 Hz).

Group 2: They need very powerful vibrations such as massage vibrators, which are around 80-100 Hz. 0-6 likert scale included the choices of effects on their clitoral orgasms and sexual behavior: Very bad); 1: badly; 2: No effect; 3: Little positively; 4: Moderately, 5: Much in a positive way; 6: Very much in a positive way.

Results:
The distribution of the subjective evaluation of women according to their responses to the bullet vibrators and/or other vibrators which they have used before for the study were [N=32]: Group 1 (Men women) = 15; Group 2 (men women) = 26; Group 3 (female women) = 43; Group 4 (Men women) = 13; Group 5 (women women) = 1%

Discussion and Conclusions:
This study group could attain orgasms by low frequency bullet vibrators and reached to clitoral orgasms easier (87 %); their sexual life styles were improved by bullet vibes positively (85 %); also bullet vibes improved their libido (79 %). Despite the fact that there is resistance against the use of VBS in the Turkish society by both the public and the professional therapists and doctors, VBS can be used in the treatment of anorgasms and other sexual function disorders in Turkey.
ISTANBUL REPORT: PRELIMINARY FINDINGS
THE DECLINE OF THE ORGASMIC BEHAVIOUR IN TURKISH WOMEN DURING THE LAST DECADES

H. Ümit Sayın1,2, Asiye Kocatürk1,3, Hacer Canatan4
1: ASEHRT-CİSEATED, İstanbul-Turkey www.ciseated.org
2: Institute of Forensic Sciences, İstanbul University, Cerrahpaşa, İstanbul-Turkey
3: Faculty of Health Sciences, Midwife Department, MEDIPOL University, İstanbul-Turkey
4: Health Science Faculty, OKAN University, TÜZLA-İstanbul

Introduction:
Our surveys on the orgasmic behavior of Turkish women on both young Female University Students (FUS; ages of 17 to 23; N=939) and all ages (17 to 60; N=200; total N=1139) have showed a pattern that orgasmic frequency and consistency of Turkish women have altered and declined a great deal during the last decades.

Methods and Results:
Comparison of the data of 1139 forms of Istanbul Report (894 FUS in 2013-2015 at the age interval of 17-23 and 200 new data form at the age intervals of 23 to 60) and our former reports of KR (1993, N=1536) & HR (2003, N=709) is made in the SPSS program. The surveys were realized in some different women's magazines and also using the internet and face to face interviews. The target group was educated, secular, liberated, middle class women, (ages: 17 to 60). Content from sexual life; orgasmic behavior & consistency, orgasmic frequency & number, multiple orgasms were asked.

Discussion and Conclusion:
Reaching to orgasm, experiencing multiple orgasms and being content of present sexual life was declined a great deal, significantly. Experiencing vaginal-coital orgasm ratio stayed at the similar ratio of 16-19 % in both of the study groups: Mainly this can be due to the recent political system and the women becoming more conservative and inhibited with less education in sexuality.
ACUTE EFFECTS OF 15 MAIN BASIC NOTE PERFUME FRAGRANCES ON MOOD, AROUSAL, LIBIDO AND SUBCONSCIOUSNESS IN WOMEN

H. Ümit Sayin, Hacer Canatan, Aydan Taşkinlar and Burcu Karavelioglu

1: ASEHERT-CISEATED, Istanbul-Turkey  www.cisated.org  2: Institute of Forensic Sciences, Istanbul University, Cerrahpaşa, Istanbul-Turkey  3: OKAN University

Introduction:
It is reported that perfumes and fragrances have effects on mood, consciousness, childhood memories, recent or distant memories, anxiety, sexual arousal, and libido. It is also hypothesized that fragrances and perfumes have direct effect on the limbic system, temporal lobe and also sub-consciousness & collective unconsciousness, association of memories and flushing of some geometric shapes and entoptic images. A preliminary double blind study on the effects of 15 basic notes of fragrances on mood, sexual arousal, libido, memory and consciousness in women was designed.

Methods:
Different pleasant and attractive solutions of the fragrances of honeysuckle, sandalwood, lemon, patchouli, violet, amber, garden rose, tobacco, orange, créme caramel, musk, vanilla, lavender, jasmin, and mint were prepared. In the similar set and settings with a relaxing classical music (Vivaldi, Seasons), the solutions of fragrances were sprayed on gauges and smelled for 3 minutes through a surgical mask, when eyes were blindfolded. Before and after the experiment, a scale and a questionnaire were asked to be filled by the women. Their statement of written consent was also taken. The preliminary data from 20 women (ages from 18 to 50) were collected and analyzed. The study is continuing.

Results and Conclusion:
The main psychological effects of most of the basic note fragrances were: relaxing; soothing; anxiolytic; feeling calm; sexual arousal; increase in libido; remembering childhood, past or recent memories; feeling; brief and mild altered states of consciousness; happiness; feelings of peace; elevation of mind. Also, when eyes were blindfolded and they smelled the fragrances, almost all of the women perceived some geometric shapes such as concentric circles, solid circles, ellipses, square, triangle, round shapes, rectangles, honeycombs, spirals. The scale also consisted of the prints and tables of entoptic images: 80 % of the women stated that when smelling some of the fragrances they perceived some entoptic images when their eyes were blindfolded. Sandalwood, patchouli, tobacco, orange, créme caramel, musk, vanilla and jasmin were most sexually arousing fragrances in this study group. The effects of the 15 basic note fragrances are summarized in the table. More detailed studies on the effects of perfumes and fragrances should be made. It is also concluded that they directly stimulate memory functions of the brain, as well as the sub-consciousness and collective unconsciousness (entoptic images).

<table>
<thead>
<tr>
<th>Basic Note Perfume</th>
<th>Preliminary data from 20 women</th>
<th>Relaxing</th>
<th>Soothing</th>
<th>Anxiolytic Effect</th>
<th>Sexual Arousal Effects</th>
<th>Possible Effects on Libido</th>
<th>Remembering Childhood Memories</th>
<th>Remembering Past Memories</th>
<th>Seeing Geometric Shapes and Entoptic Images</th>
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EFFECTS OF GENETICALLY MODIFIED ORGANISMS (GMOs) ON HUMAN SEXUAL REPRODUCTION AND FERTILITY

Levent Kartal
CISEATED-ASEHERT, Association of Sexual Health Education Research & Treatment

Introduction:
Genetically modified organisms (GMOs) have been widely used in many countries during the last decades. The long-term biological effects of GMOs are not well investigated and documented. After 2000s, it has been debated in some academic and scientific circles that GMOs have some long-term hazardous biological effects on human sexuality and fertility.

Background and Findings:
There are some reports that GMOs influence the human sexuality. In 2001, a California biotech company, EPICYTE, engineered a GM corn genetically. It has been reported that males eating this EPICYTE GMO (GM-corn) develop anti-bodies to their own spermars and become IRREVERSIBLY infertile. The females who eat this EPICYTE gene loaded corn develop anti-bodies to either their own ovum or to the foreign spermatozoa. EPICYTE-gene is only one example of the possible long term irreversible hazardous effects of GMOs. Also it is reported that GMO-soy beans induce a decrease in libido and impaired sexual drive; research shows that the consumption of GMO-soy beans induced low levels of testosterone with increased levels of DHEA (precursor of testosterone). Such incidences may result in decrease in libido, sexual appetite and fertility.

Discussion and Conclusion:
In this poster presentation, GM-corn and GM-soy bean are only two examples, about which the devastating effects of GMOs have been proven. There is much other GM food which is served on our dinner tables all over the globe. In Turkey, during the last decade, “original and natural heirloom” seeds of many plants that are used as food products have been banned to sell commercially and it was compulsory to use patented hybrid seeds that the government decides on. Also in some food, GM-plants are also used. In Turkey, infertility cases tripled during the last 2 decades; sexual function disorders (SFDs) such as lack of sexual desire, decrease of libido, anhedonia, anorgasmia increased a great deal. A long-term investigation of the comparison of GMOs and SFDs should be carefully carried out with cohort long term surveys on the Turkish population, to investigate whether the increment in SFDs and infertility cases have any correlation with the consumption of GM-food of any kind (corn, soy and others).