Asia-Oceania Federation of Sexology

AOFS NEWSLETTER

February 2015

Issue 13

AOFS ORGANIZATION STRUCTURE

One of the major decisions made during the Brisbane AGM held in October 2014 was that the registration of AOFS would be changed from Hong Kong, where it has been registered since its inception, to another country within the AOFS membership.

It was also decided that this was an opportunity to review the constitution. A sub-committee has been set up to work on this and the final format will be presented at the next AOFS AGM to be held in Korea in 2016.

Any member with expertise or interest in being part of this sub-committee is invited to contact Dr Margaret Redelman.

2016 AOFS CONFERENCE – SOUTH KOREA

The organizing committee headed by Professor Nam Cheol Park is welcoming all members to put this event into their diaries.

The 14th AOFS Conference is provisionally planned for March 31 - April 3, 2016 at the Kintex in Goyang, South Korea.

Information will be loaded onto the AOFS website as it becomes available.

2015 WAS CONGRESS

We encourage all AOFS members to submit research and other works for inclusion at this, our international conference.

Editor:

Dr Margaret Redelman

Inside this issue

SOME SINGAPORE ACTIVITIES TO BE ENJOYED DURING THE CONFERENCE


Peranakan Museum


Sri Mariamman Temple

Singapore Discovery Centre


Armenian Church


ArtScience Museum


Kusu Island


Old Ford Motor Factory


Singapore Flyer

Jurong Bird Park


Buddha Tooth and Relic Temple

PRESENTATION FROM THE 13TH AOFS CONFERENCE IN BRISBANE 2014

OBESITY, SMOKING AND ED IN SEXUAL HEALTH MEDICINE

Prof Dr FX Arif Adimoelja
Naval Teaching Hospital Dr. Ramelan,
School of Medicine, Hang Tuah University, Indonesia


Arif Adimoelja, Prof., Dr.

SUMMARY

Obesity and Cigarette Smoking are risk factors related to the fast manifestation of many degenerative diseases causing acceleration of precocious aging process. These conditions are due to the occurrence of Oxidative Stress which is a precursor for many changes in the body. The cellular inflammatory process impacts gene material causing erosion and shortening of the telomere arm length. Current studies report that telomere arm shortening promotes and accelerates the occurrence of diverse degenerative diseases.

Sexual function disorders can be seen as the "Gate-way" to more serious morbidities; Critical limb ischemia, Hypertension, Dyslipidemia, Stroke, Cardio-Vascular-Diseases, Kidney Failures, Diabetes Mellitus, Hypogonadism.

Sexual Dysfunction is a neuro-vascular condition moderated by hormonal conditioning.

Hypogonadism is indicative for the process of Precocious Aging. The ADAM questionnaire can be used. Laboratorial blood examination in this case will be indicative.

Impact of obesity and smoking cigarettes on ED
Brief interview: 38 men

Group 1 men:	23	obese and smokers
	23	100% experience ED
	4	17% experience CVD
	23	100% hypogonadal
Group 2 men :	15	non obese, non smokers
	2	13% ED
	0	0% CVD
	15	100% eugonadal

Preliminary research on 239 men - smokers and ED

Group A - placebo treated group - 21 men
→ 1 man recovered ED (4%: EHS = 2)

Group B - treated with low dose PDE5i, 5 mg/daily - 116 men
→63 men recovered ED (54.3%; EHS= 3)

Group B - treated with low dose PDE5i, 5 mg/daily - 116 men
→ 63 men recovered ED (54.3%; EHS= 3)
Group C - treated with PDE5i 5 mg/daily plus Phyto-DHEA 259 mg/daily - 102 men
→ 58 men recovered ED (58.9%: EHS = 4)

METHOD 1

ORAL INTERVIEW

Subjects: 38 married men average age 52 yrs (range 16 – 66 years) randomly recruited and interviewed. Divided into two groups - Group A consisted of 23 men and Group B of 15 men. Interviews were performed between 10 August 2012 and 12 August 2014.

Group A: 23 obese men who admitted being smoke
average waist circumference = 106 cm (range 102 – 118 cm)

Group B: 15 non obese men who claimed never to have smoked cigarettes.
average waist circumference = 88 cm (range 85 - 90 cm)

RESULTS

Group A: 23 (100%) men experienced ED (mild, moderate & severe)
18 (78.3%) men were hypogonadal (T serum blood level < 11 nmg/ml)
4 (17%) men reported CVD, other cardiac diseases, hypercholesterolemia, high triglycerides, hypertension, stroke and prostate disease

METHOD 2

Subjects: volunteers aged 34 – 55 years. All smokers with decreased T blood serum level (400 mg/L or less). Severe ED excluded (EHS 0-1)

Erection hardness measured by the Erection Hardness Score (EHS Pfizer) method.

The 393 Volunteers were divided in 3 groups:
1 Control Group - placebo - 21
2 Refrain from smoking Group (PDE5i low dose daily) - 116
3 Refrain from smoking Group (PDE5i low dose daily+ Phyto-DHEA 250 mg daily – 102

All subjects needed to refrain from smoking during the 3 months of the trial + 1 week before commencing trials.

RESULTS

Group A - Placebo group

4.8% subjects recovered some erection capability after 3 months
EHS 2 → enlarge (tumescent only) but not hard enough for vaginal penetration
No increase T blood serum levels as compared before trial ($p > 0.005$)

Group B - refrain from smoking + low dose PDE5i 5 mg daily for 3 months

46 (39.7%) subjects recovered erection capability after 2 months
EHS 2- 3 → enlarge but not hard enough for vaginal penetration

63 (54.3%) subjects recovered erection after 3 months
EHS 3 → hard but not rigid enough, difficult to penetrate vagina
increase T blood serum levels ($p < 0.001$)

Group C - absolute refrain from smoking + PDE5i 5 mg + Phyto-DHEA 250 mg daily for 3 months

54 (52.9%) subjects recover erection after 2 months
EHS 3 → hard but not totally rigid, possible to penetrate vagina
58 (56.9%) subjects recovered erection after 3 months
EHS 4 → fully rigid and easy to penetrate vagina
increase of T blood serum levels ($p < 0.001$)

CONCLUDING REMARKS and DISCUSSION

The result of this preliminary trial supports the hypothesis on the mechanism of penile erection involving at least 3 functions; vascular, neurological and hormonal. Erectile function depends on a good functioning of the endothelial cells of the blood sinuses, nitrous oxide production through nerves endings and adequate hormonal/testosterone blood serum levels.

Shortening of telomeres is among the defining characteristics of the most serious morbidities associated with obesity and smoking cigarettes. Current research has shown that constitutionally short telomeres might be associated with an increased risk of vascular endothelial cells and bladder cancer.

Endothelial Progenitor Cells **(**EPCs) are produced in the bone marrow and can be detected in blood vessels. EPCs can refresh and regenerate endothelial cells that may also rejuvenate blood vessels. EPC's have been noted to have beneficial actions in cardio-vascular diseases, in wound healing and endometriosis. Current studies show that EPCs production can be enhanced by the consuming of daily low dose oral PDF5i medication.

This preliminary trial has shown that phyto-DHEA (extract of Protodioscin from Tribulus Terrirs L plant) supports the action of PDE5i by accelerating the vasculogenic process.

REFERENCES

Adaikan PG (2002) - ED treatments: Current and Future .7th Asian Congress of Sexology, Raffles City Convention Centre, Singapore. November, 14 – 17.
Adimoelja A (2014) - Effect of aging on sexual function. 4th.IAS National Congress, Bumi Hotel, Surabaya, Indonesia, Sept. 26-28.
Adimoelja A. (2013) - Obesity, smoking in regenerative medicine. International. Symposium II on regenerative medicine, CME and WS X on Men's health, sex and aging, JW Marriott hotel, Surabaya, Indonesia, Sept, 27-29.
Adimoelja A (2012) - What obesity means to men's health. The Greatwall International Andrology and Urology Forum, Hainan International Convention Centre, China, March, 8-12
Adimoelja A (2000) - Phytochemicals and the breakthrough of traditional herbs in the management of sexual dysfunction. Int. J. Andrology Volume 23 ; Supplement 2; 83-84
Donal P.F. (2014) - Smoking and obesity increase chances of erectile dysfunction – http;//www.healthcentral.com/erectile-dysfunction/news-3011-143.html
Gauthaman A , Adaikan PG, Prasad RN.V. and NG S.C. (1999b) Proerectile Pharmaco-logical effect of Tribulus terretrs L extract on yhe rabit corpus cavernosum , NUH in Press
Martin T. (2014) - Obesity and smoking, a deathly combination. - http://www.smoking.com/od/tobaccorelateddiseases/a/smokingobbesity/html
McGrath M., Wong J.Y.Y, Michaud D., Hunter D.J., De Vivo I. (2007) - Telomere length, cigarette smoking and bladder cancer risk in men and women. Cancer Epidemiol. Biomarkers Pre. April; 16 : 815
Valdes AM, Andrew T, Gardner JP, Kimura M., Oelsner E., Cherkas, Aviv A.,D. Spector TD. (2005) - Obesity, cigarette smoking and telomere length in

WAS SINGAPORE CONFERENCE CALL FOR SYMPOSIA

The WAS Conference Organising Committee has asked if AOFS would like to host a symposium at the conference in Singapore. If anyone has an idea for a symposium that could be hosted by AOFS could you please contact Dr Margaret Redelman ASAP so the idea can be explored by the AOFS executive committee.

TESTOSTERONE FOR WOMEN

Testosterone for women has long been a contentious arena whether for medical politics or gender based bias. Australia has one brand of testosterone preparation available for women. Lawley Pharmaceurticals has a 1% testosterone cream (AndroFemme 1%) which is available by prescription but only in Western Australia. The company is currently expanding its male range and it is hoped will seek approval of its female preparation throughout Australia very soon.

If you have an opinion on the use of Testosterone in women please send in your comments.

MEMBER'S REFLECTIONS ON HER PRACTICE

PROFESSIONAL ROLE AS A REHABILITATION COUNSELLOR / SEXOLOGIST

Elaine Harvey B H Sc (Rehab Clng) M H Sc (Sexual Health), USyd, MRCAA - of Positive Sexology Pty Ltd

Introduction

Being sexual is a normal aspect of human life. Sexuality incorporates: who we are, body image and self worth, the act of sex, our values and attitudes, the ability to give and receive pleasure and our quality of life.

Often people are told by health professionals to "not worry about those concerns now but to concentrate on getting better first" when often it is these sensitive concerns that they are worried about most! Acknowledging the whole person, which includes their sexual health, allows for opportunities to provide education and treatment. Due to a variety of aspects such as attitudes; lack of knowledge and training; cultural and religious values; embarrassment and personal beliefs it can be very confronting for health professionals to deal with clients presenting intimate concerns.

It is my intention to discuss what my role as a Rehabilitation Counsellor *and* a Sexologist is like for me in private practice.

Being a Rehabilitation Counsellor and a Sexologist I am a member of both the Rehabilitation Counselling Association Australasia (RCAA) and the Society of Australian Sexologists Ltd (SAS Ltd). Both these professional bodies provide the Codes of Ethics and governing Constitutions which allow for quality allied health practice and support.

Professional Role and Practice

In the provision of best care and services for clients who experience chronic illness, congenital and/or acquired disability and sexuality issues, the professional role is to understand the physical and psychological aspects of sexuality. So, in a rehabilitation practice it is necessary to apply a positive and respectful approach which must be substantially broad as Sexuality is influenced by the interaction of "biological, psychological, social, economic, political, cultural, ethical, legal, historical and religious and spiritual factors" [1].

The provision of absolute confidentiality and privacy: assessment for Informed Consent; and explanation regarding Mandatory Reporting are all paramount in specialised counselling. This allows the client to feel free to discuss intimate aspects of their health: shows they can understand the process of counselling and are able to make decisions for themselves; and are aware of the legal connotations for the practitioner and themselves if concerns are raised in counselling that warrant reporting.

Open effective communication and the understanding of sexual theory and practices, along with knowledge of the evaluation and treatment process are required skills. A supportive and safe environment enables strategies to be developed in the rehabilitation setting to actively help increase sexual function [2].

Why is understanding sexual factors recommended for rehabilitation counsellors?

The World Health Organisation states "the role of the rehabilitation professional in addressing sexuality has been a growing topic ..." [3]. The client may be too shy/inhibited to broach the topic.

It is the rehabilitation professional's responsibility to be willing to respectfully inquire about the client's sexual health.

Why it is important for a rehab counsellor who is not a sexologist to address these issues?

Too often Health Professionals concentrate only on the injury or illness. Pain, fatigue, body image, depression, lack of mobility, communication issues, lack of information, effects of medication, changes in sensation and alterations in sexual functioning can all combine to impact sexual health. A work related injury may be a connecting factor influencing several issues. An opportunity to discuss sexual concerns means consideration of the whole person has been undertaken. Having a good understanding of how medical conditions and medications affect a client's sexual health, will hopefully encourage the rehabilitation specialist to assess the client and/or the client's partner. There is evidence based research to indicate that if the sexual health of a person has changed (eg erectile dysfunction) then consideration to other aspects of their health such as heart disease or diabetes should be checked for by their GP.

It is important to be open-minded and non-judgmental if an effective professional relationship with rapport, is to be developed. It is also very important to understand one's own values and belief's regarding sexuality so that the boundary between patient and self is maintained.

Knowing one's personal and professional limitations and knowledge of the appropriate assessments for sexual dysfunctions are essential for the rehabilitation professional. Professional education and continuing development are crucial. Transference and counter-transference must be understood and utilisation of the Code of Ethics is important to protect the client and the professional from inappropriate interactions.

Supervision with an accredited supervisor is very important. Documentation of supervision is required for accreditation.
As with other aspects of rehabilitation counselling, the rehab counsellor / sexologist uses talk therapy. There is no physical intimacy or any touch whatsoever. The client remains fully clothed at all times and there is no physical contact with the sexologist.

In Australia the practice of sexology is un-regulated. There are steps being taken to raise the bar by making provision for accreditation and regulation through the national professional organisation - the Society of Australian Sexologists Ltd.

Counselling Method
The process starts with a comprehensive sexual history. The four stage P-LI-SS-IT method is helpful [4].
PLISSIT stands for:

P Permission granting (To discuss any issue without fear)
Li Limited Information (Provision of educational material)
SS Specific Suggestions (Homework)
IT Intensive Therapy (Detailed treatment aspects).

Role of the Rehabilitation Counsellor/Sexologist
The role of the rehab counsellor/sexologist is to conduct the assessment; to provide specific educational material or limited information; and if required, to develop an agreed-to homework/treatment plan. The aim is to engage agreement and increase interest to bring about positive change.
In my private practice, I choose not to conduct long term counselling. If this is required then I refer to for example, a clinical psychologist. Referral to a GP may be required for medical investigation and this may need to be explained.
I do a review at the 6th session with an enquiry as to why they are still attending. Usually 1 - 8 counselling sessions are necessary. It is common for clients to conclude after 5 sessions with a positive outcome. Follow up can be offered to the client.
Reports can be provided to referring health professionals with the client's permission and consideration of the Health Information and Privacy Act 2002 guidelines. Strict confidentiality should be maintained in a multi-disciplinary team response.

Services I provide for people with acquired disability include:
Opportunities to talk with a trained sexologist about those intimate issues that affect life that are often very hard to speak about. Provision of sexuality assessments and identification of sexual and relational needs. Individualised and couple's sex therapy based on needs from a rehabilitation perspective. Education sessions (individual or group) for people with acquired disabilities, partners, parents and carers. Design and delivery of sexuality educational programs for professional and community organisations.

Summary
In my private practice, I am often faced with misunderstandings, bias, negativity and silence which I endeavour to change through opportunities of education and communication within the health industry. It is pleasing to see the interest professionals are showing in seeing their clients as whole human beings. But even more importantly, it is interesting to see the relief Health Professionals display when they realise that there is an allied Health Professional to whom they can refer a client with sexual difficulties.

Because I am not embarrassed, I can offer the client a liberating opportunity to discuss and redefine themselves around sexuality. Helping people to mourn the loss of what was once possible, and then helping them find another approach that allows for a healthy positive sexual outcome, is a truly rewarding experience!

References

1. World Association for Sexual Health (WAS) (2007) Definitions of Professional Specialties, Definitions accepted by the WAS General Assembly, April 17th, 2007, Sydney Australia.
2. Esmail, S, Knox, H, & Scott, H. (2010) Sexuality and the Role of the Rehabilitation Professional, International Encyclopedia of Rehabilitation, pp1-17.
3. World Health Organisation (WHO) (2006) Defining Sexual Health: Report of a technical consultation on sexual health. Geneva.

AUSTRALIAN POPULATION STUDY

MASTURBATION, PAYING FOR SEX AND OTHER SEXUAL ACTIVITIES: THE SECOND AUSTRALIAN STUDY OF HEALTH AND RELATIONSHIPS

Juliet Richters, Richard O. De Visser, Paul B. Badcock et al

Sexual Health, 2014, 11, 461-471

Abstract

Background: This study describes the prevalence of (solo) masturbation, paying for sex and a range of other sexual practices among Australians.

Methods: A representative sample of 20 094 men and women aged 16–69 years (participation rate among eligible people, 66.2%) were recruited by landline and mobile phone random-digit dialling and computer-assisted telephone interviews in 2012–13.

Results: Many respondents (men, 72%; women, 42%) had masturbated in the past year. Half (51%) of the men and 24% of women had masturbated in the past 4 weeks. In the past year, more than two-fifths of respondents (men, 63%; women, 20%) had looked at pornography in any medium. Approximately 15% of men and 21% of women had used a sex toy. Digital -anal stimulation with a partner was practised by 19% of men and 15% of women, and oral-anal stimulation by 7% of men and 4% of women. Sexual role playing or dressing up were engaged in by 7–8%. Online sex, swinging, group sex, BDSM (bondage and discipline, 'sadomasochism' or dominance and submission) and fisting (rectal or vaginal) were each engaged in by less than 3% of the sample. Seventeen per cent of men said they had ever paid for sex; 2% had done so in the past year.

Conclusion: Most of the solo practices studied were engaged in by more men than women, but women were more likely to have used a sex toy. Autoerotic activities are both substitutes for partnered sex and additional sources of pleasure for people with sexual partners.

Additional keywords: anilingus, brachioproctic eroticism, dildo, erotica, fetishism (psychiatric), Internet, rimming, sexual behaviour, vibrator.

Masturbation often generates discomfort and this large population study is able to give a snapshot of what is really happening in this Western multi-cultural community.

Here are some points from the article regarding masturbation:

Men are significantly more likely to masturbate than women (almost 50% more likely).

Men masturbate more frequently than women (mean frequency 3.4 compared to 0.8 per month).

Men who masturbated more frequently tended to be more educated, more affluent, non-heterosexual, accessing pornography, had a broader sexual repertoire and more sexual partners.

Age patterns differed for men and women. Men under 30 years were most likely to masturbate, with the rate falling in each 10-year age group thereafter. Among women, the highest rates were for 20 to 50 years; younger and older women were less likely to masturbate.

Points raised in the article's discussion:

Solo masturbation is a common but not universal behaviour.

Gender differences in prevalence and frequency are a robust finding across many cultures.

Sociocultural influence making masturbation more acceptable or less taboo among better-educated and wealthier people.

Disappointing that masturbation is less frequent among younger women given that it is generally agreed to have benefits for learning about one's body and negotiating for a more rewarding sexual practice with a partner.

Younger women seem to be more uncomfortable speaking about masturbation than younger men.

In men, masturbation is linked to lack of live-in partner and may be seen as an 'outlet' or 'second best activity' which ought not to be necessary.

If you have an opinion or information about masturbation in your country please send in for posting in the next edition.

SYDNEY UNIVERSITY ANNOUNCES A NEW REVAMPED SEXUAL HEALTH PROGRAM

Western Sydney Sexual Health (WSSH), within the Sydney Medical School, University of Sydney, announces the launch of their revised postgraduate program in HIV, STIs and Sexual Health. The changes compliment the successful program which offers a wide range of coursework and research options for professionals and students interested or working in the field of sexual health. Among the changes include the introduction of an Advanced Masters course for students wishing to study a discipline in more detail, and for students wanting a shorter experience (or just starting out) the department now offers a Graduate Certificate, which can be completed within 6 months. The revised program also allows greater capacity for distance and blended learning for international students and local students not living in Sydney.

In the program, students can focus their studies on a variety of pathways, including sexual health counselling (sex therapy), public health, laboratory, nursing or clinical medicine aspects of sexual health. Western Sydney Sexual Health teaching team draws on multi-disciplinary, experienced practitioner-academics. The courses are taught from an interdisciplinary perspective which provides students with a breadth of knowledge in working in sexual health. The new postgraduate program includes nested qualifications from Graduate Certificate to Advanced Masters, including Graduate Diploma and Masters.

The pathway system secures the WHSSH program as globally unique among education providers as providing excellent interdisciplinary education in sexual health. Associate Professor Richard Hillman, Academic Lead of the program, remarked “students come to us from a variety of backgrounds. One of the great strengths of the department is that we provide a multidisciplinary environment so students get an opportunity not only to study their own area of expertise but also to interact with other specialists helping to deliver services in the (sexual health) area.” Excitingly, the introduction of the Advanced Masters allows students in the Sexual Health Counselling pathway to complete enough professional placement hours to fulfill accreditation requirements with the Society of Australian Sexologists.

When asked about the future of the program, Senior Lecturer Shailendra Sawleshwarkar remarked that it is the “possibility of engaging with new technology to provide flexible and blended interprofessional education” that is the most exciting continual focus of the program. Online learning has been gradually incorporated into the program since the early 2000’s allowing flexibility for international and local students to attend and as a consequence WSSH is now at the forefront of the art of online learning and has a truly international spread of alumni. This combination of online education, together with short, intensive periods of face to face teaching ensures that the student body includes busy professionals, people from outside Sydney, and those from overseas.

The student-centered approach of staff at WSSH is the real strength of the program. Student learning is at the core of the program. “The ethos of the course has been encouragement to academic excellence as well as developing students to be a better person for themselves and their community,” according to Dr Patricia Weerakoon, Honorary Senior Lecturer. Patricia Weerakoon was recently nominated as a favourite teacher among Sydney University Alumni. With alumni of the program making waves in the private and the public spheres is a testament to the program’s ability to impact the community.

The program brings together globally recognized academics and specialists in the area of Sexual Health and the new changes are a welcome addition to a history of the department, which aims to be responsive to the community’s changing needs.

The coursework programs are available at the Graduate Certificate, Graduate Diploma, Masters and Advanced Masters levels. Research based programs can be completed through a Master of Philosophy or a PhD.

Further information can be found at
http://sydney.edu.au/medicine/wsshc/education/index.php
or contact WSSH at
MHSSHenquiries@sydney.edu.au

Staff of WSSH (L-R):
Dr Christopher Fox, Associate Professor Richard Hillman, Ms Janice Le, Dr. Julian Langton-Lockton, Dr. Rick Varma, Dr. Shailendra Sawleshwarkar, Ms. Monica Marshall

Invitation to contribute

We ask that all members of AOFS contribute to this newsletter by submitting their country's Sexology Conference and educational meetings information, information on special education/professional development programs, outcomes of sexological or education programs, acknowledgement awards given to members of AOFS, fun activities held by members and anything else that you feel would be of interest to other members of AOFS. Photos are welcome.

Please send contributions to the Newsletter to Margaret Redelman at: aofsasia@gmail.com

Regional conferences

WAS 25-28 July 2015, Singapore

World STI & HIV Congress 13-16 September and Australasian HIV & AIDS Conference 16-18 September 2015, Brisbane, Australia

Congress of the
WORLD ASSOCIATION FOR SEXUAL HEALTH
SINGAPORE, JULY 25–28, 2015
Suntec Singapore Convention & Exhibition Centre

World STI & HIV Congress 13-16 September and Australasian HIV & AIDS Conference 16-18 September 2015, Brisbane, Australia

For the first time in its 40 year history the International Society for STD Research (ISSTDR) is holding its biennial meeting in Australia. The meeting is being held in conjunction with the International Union against STIs (IUSTI). ISSTDR and IUSTI are the eminent global bodies dedicated to research into STIs, HIV and sexual health, from basic science through to population health.

In 2015, the Congress will incorporate The Australasian Sexual Health Conference and be hosted by the Australasian Sexual Health Alliance (ASHA) and the Australasian Society for HIV Medicine (ASHM). The meeting will be held back-to-back with the Annual Australasian HIV & AIDS Conference, 16-18 September.

The theme of the 2015 Congress will be "Up and Coming". It will highlight research from the Asia Pacific region and promote research into the sexual health of vulnerable populations; including Indigenous people, ethnic minorities, and sexual/gender minorities.