Orgasm Facts and Functionality

BioBalance Podcast — Dr. Kathy Maupin and Brett Newcomb
Recorded on January 26, 2011
Podcast published to the internet on February 12, 2011
Published on drkathymaupin.com and biobalancehealth.com on February 18, 2011.

Dr. Kathy Maupin: This is the BioBalance Health podcast episode 21. I'm Dr. Kathy Maupin, founder and medical director of BioBalance Health. With me today is Brett Newcomb. He is a presenter and trainer and a marriage and family counselor. Today we are talking about orgasm.

Brett Newcomb: Functionality and facts.

KM: Just the facts about it. Because no one talks about it. This is one of those things that no one talks to their doctor about because there is not time. It is a long discussion. Or they don't want to go to a psychiatrist about this.

BN: Well they talk sometimes if they have defined issues. Like if they have premature ejaculation issues or if they are anorgasmic and that concerns them. But generally in the general population there's not a lot of talk about orgasm. There is a lot of talk about sex. Sexual encounters, frequency, desire, what have you. But all of those conversations, at some level, involve the understanding of the functionality of the orgasmic response which can be different in men and women. There is a lot of literature that breaks it down scientifically but if you are not a scientist it is kind of hard to read through that information and get the critical information, or usable information. Which is why [people] sometimes come to you or to me or someone like us to have those conversations. But we have to find a way to open the door to that conversation.

KM: True.

BN: So one of the ways potentially to open the door to a conversation about orgasm is to talk about the evolving understanding or the evolving definition of orgasm. What it actually is; is it a physiological event, is it a psychological event, is it a sociological event? Or, how does it mix, what are the disparate elements that come together.

KM: And why do we have them? I always want to know why.

BN: That's the scientist in you.

KM: Yeah, that's the scientist in me. I always want to know what was the purpose of this?

BN: It's kind of like what the guy said about art - 'I don't know what's art, but I know what I like.'

KM: That's perfect for the description of this. One of the books we have used to cite something, and not just use our own experience which is vast in this subject in terms of talking with our patients. . .

BN: In terms of working with people who have these issues, not in terms of the amount of orgasms.

KM: No.

BN: Just checking.

KM: In talking to patients about their lives. And, 25 years of that on my end, and 30 years of that on your end, has a lot of stories and a lot of history that we have learned from our patients.

BN: A lot of pain. A lot of people are suffering around these issues because they are not educated or informed, or they are culturally bound, or they are physically limited and medicine has not had a solution for them until recently. Psychology hasn't really had a solution for them until recently.

KM: It has only been 5 years since American College asked OB/GYNs to get a sexual history as part of [a patient's] history. One of the things we ask is 'is your sex life adequate?' But most women aren't going to talk about that. And, most doctors don't want them to because doctors, in general, MD, DO, we aren't picked because we are social human beings, we are picked because we are smart and if we are social human beings that's a plus. But it is hard for most MDs and DOs to actually broach the subject. They were nerds, we were all nerds. We didn't have much of a sex life like everybody else because we had a delayed adolescence but we didn't take advantage of it.

BN: It is also difficult to have an open and honest conversation in those settings if the husband and wife are both there, or both partners are there, at least initially. Some of this information you have to get individually then you bring them back together and talk about it.

KM: That takes multiple visits and everyone is busy. In any case, one of the sources if you are interested is a book called "The Science of Orgasm". It is one of my favorite books because I was waiting for this book to come out by somebody. It is by Komisaruk, he is a PhD. He and several other authors came together to describe the medical physiology, how it works, the history of it, and things that cause problems in function, and other medical things that kind of interfere. We are going to talk about those but not necessarily all today.

BN: I would say it is a book primarily for scientists, physicians, academicians.

KM: Right. If you could read it, I would just say 'read this book and we'll stop talking.' It is really a book for doctors to understand this and I have to say most doctors don't.

When I was in the operating room, I would operate and leave the cervix in because one of the three orgasms comes from movement of the cervix. So when I did hysterectomies, I always left the cervix in unless there was cervical cancer. I have been doing this forever. I would have a male doctor, usually a urologist or another surgeon walk in and say 'tell the residents why you leave the cervix in' and then they would laugh and walk out or laugh and listen because they didn't believe me. They thought it was ridiculous.

BN: But this book talks about that research.

KM: And I bought 12 copies and I sent them to every surgeon who ever made fun of me in the operating room because this actually delineates the nervous system, and you have to leave the cervix in.

BN: It is a feedback loop to the brain stem.

KM: Right. That is absolutely correct.

BN: Without that there, the full experience is not possible because they don't get the feedback that is required.

KM: I was watching Oprah in 2000, and I saw someone who had lost her orgasms because of a hysterectomy, and I thought 'I never want to be that doctor.' Ever. This woman was furious. But it turns out that they had taken her cervix and they had not given her hormones back; that's two things. However, that was her only type of orgasm. She didn't have one of the other two, she didn't have clitoral stimulation orgasms or G-spot orgasms, so that was it. And when the cervix was gone, it was gone. I just never wanted to be that doctor.

BN: Let's talk about the evolution of our understanding or orgasms. Most people know about the Kinsey research. You know there are a lot of jokes out there about it, although I don't know that very many people have actually read it. It's just been around for a long time.

KM: That was in the 50's.

BN: 1953, Kinsey, et. al., defined orgasm as the explosive discharge of neuromuscular tension at the peak of sexual response. Part of coming up with a definition, is you're trying to hit a moving target. An orgasm is a "moving target." It is not a certifiably discriminate or discreet marker that you can check a box and say, 'well, that's done.'

KM: Especially until you have had one. Before you have had one, it is really hard to tell if you have had one. Most of the patients that come in to see me say "I never had one, and now I've had one. Now I know what they are all talking about!"

BN: Yes, especially if they have a history of being inorgasmic. So they don't know. It's kind of like asking a blind person to describe the elephant; what do you see? You will get totally different answers every time.

KM: Everyone has a different experiences with orgasms, too.

BN: Then in 1966, Masters & Johnson, here in St. Louis, were famous for their research and the things that they developed. They described orgasm as a brief episode of physical release from the vasocongestion and myotonic implement developed in response to sexual stimuli.

KM: I am a doctor and I don't even know what that means.

BN: Nobody does.

KM: I went to the Masters and Johnson week long course back in the 80's. It was awesome. But they didn't describe it that way.

BN: Let me give you one more scientific definition. This is *Kothari & Patel, 1991*, 1991, "an explosive cerebrally encoded neuromuscular response at the peak of sexual arousal elicited by psychobiological stimuli, the pleasurable sensations of which are experienced in association with the dispensable pelvic physiological concomitant."

KM: That's really hard for even a wordsmith like you to take apart and understand. I think it is just so complicated in terms of personal experience in trying to describe it that everybody has a different definition. Interestingly enough, (this is scary), the American College of OB/GYN, which is the ruler of OB/GYN practice for the United States, up until about 10 years ago, or maybe a little bit less, 8-10 years ago we had a president of ACOG write in his editorial page of our journal that all sexual response by women was secondary to male stimulation. So he did not believe that women had a sexuality.

BN: So they are sexually neutral?

KM: They didn't have a sexuality without their spouse, supposedly. He didn't take into account lesbians, which he should have, and he should have taken in to response women who are never with a partner, but still masturbate and still have a sexual response. They are still sexual beings; they still have fantasies, they still have all kinds of other sexuality in their lives even if they don't have a partner. It was just ridiculous. It just showed how archaic our organization is in terms of that kind of sexual counseling.

BN: And the literature looks at that issue and it talks about the fact that there are men and women who can achieve orgasm, or what they understand as orgasm, without sexual stimulation and without a partner. They don't have to touch themselves, they don't have to use some device; they can fantasize and imagine and reach that point. That is more common in women than it is in men, but it can happen to both.

KM: I think probably the best definition of an orgasm would be a pleasurable emotional response, but it is also a physiological response. It involves blood flowing to your pelvis and a release of tension. That's about all I could say would be universal for orgasms. Honestly, I'm not sure that we need to define it because when you have one, you know it.

BN: Again, when you talk about common wisdom, common knowledge, common issues around the topic of orgasm, and in my experience with men and women, couples, coming into my office to talk about these issues, they ask questions about what's normal - 'am I normal, am I abnormal'. What's normal in terms of size, what's normal in terms of frequency, what's normal in terms of firmness of the erection, what's normal in terms of the orgasm count, are you multiplely orgasmic, what if you don't have orgasm, etc.? And anecdotally, what I have said before is that it is my observation from talking to these individuals, is that as a man matures, he becomes more available for intimacy and less orgasmically focused. Young men are all about the score, all about the resolution and they will brag about how many women they have had, or how many times they have done it, or how often they reload, or whatever the marker may be.

KM: Because they can.

BN: Because they can, yeah. But as they diminish in their ability to do that, they have to replace that with something else. And that is actually a beautiful opportunity because when they do that, they start to pay more attention to their female partner and her responses and her needs and her desires than they do to their resolution experience. What happens then is an opportunity for increased intimacy and a different level of sexual satisfaction than maybe either of them have ever experienced before. One of the strongest components of a healthy sexual life is paying attention to your partner, to the experience. Getting your mind involved; your mind is your most sexual organ. Not just because it releases the hormones and the neurotransmitters, but because the psychosocial byplay that comes from the fantasy, the conversation, from the attunement to the responsiveness of your partner.

KM: That would be ideal. That would be awesome. I deal with patients who are testosterone deprived. Generally [as a process of] aging, my patients at BioBalance have lost their testosterone and in general they have lost their ability to have orgasms. They are not always forthcoming with that being their primary problem. I am not a psychologist so they don't want to tell me all their intimate details. They often don't feel comfortable enough, until they have seen me a couple of times, to tell me that they are having orgasmic problems. They will tell me they are having trouble with their sex life.

BN: And they are going to have corollary anxiety and depression issues because a lot of men have defined themselves by their sexual prowess.

KM: And women define themselves by their husbands, often. Not always, but by their partner and if their partner is not happy. . .

BN: So if I am diminishing. . .

KM: And if your wife is diminishing then we have problems at home because nobody is happy. Women are more process and experiential, enjoying the experience. Men are more goal oriented in general. As soon as men are so upset about the goal that they aren't involved in the experience at all. . .

BN: And the goal is often two-fold. The goal is the wonderful erection I can have and the orgasm.

KM: Three-fold - and making your wife have an orgasm. Because that is often what I hear.

BN: Yes, although a lot of men are less concerned about that than they are measuring their own functionality. One simple solution, according to the advertising media, is to take an ED drug. They make those commercials look like everybody in town has this issue, but if you just take one of these little pills, then the trees bloom, and the water spills, and the house explodes.

KM: Which is why it is called advertising. It is not a medical reality or a life reality.

BN: Right. And so they try to get these drugs and not necessarily understand or evaluate, or have an evaluation, for a full-blown physical. The fascinating piece of it for me is these drugs evolved serendipitously from research on blood pressure medicine because they work by controlling the blood flow and regulating the blood flow and focusing it.

KM: Dilating the blood vessels in the pelvis.

BN: But guys with erectile dysfunction issues, that is often a marker of blood pressure problems; they are waiting to have a stroke, or they are waiting to have a heart attack.

KM: Or blood vessel problems. They have clogging of the arteries, basically, and they can't get enough blood flow down there. But I want to talk about ED in another podcast because we haven't completely exhausted this at all. I get asked a lot 'what happens in an orgasm, exactly what's happening?' The fact is that stimulation is all about oxytocin and testosterone. Generally, if you don't have testosterone, you are not making oxytocin.

BN: That's male or female.

KM: Male or female. My patients, once they get testosterone, feel so much better because their oxytocin goes up. (We talked about oxytocin a few weeks ago. It is the "cuddle" hormone.) [Oxytocin] works directly on the brain to increase responsiveness to touch and stimulation. Then stimulation causes more oxytocin, so it is kind of a positive feedback system. My patients, when they become intact again, we don't generally have

to go through too much stuff like this unless there is some other problem. However, they ask me about this. You have to have testosterone in your brain and in your body. And you have to oxytocin from the testosterone, or when we get too old to have the testosterone cause oxytocin to go up, we have to have that replaced as well.

BN: Let me make sure I understand what you are saying. The oxytocin that comes with the testosterone is a requirement for an orgasm or is a benefit of an orgasm, or both?

KM: Both. The system is testosterone lays the groundwork in the brain for oxytocin to be produced, in people under 70, generally. Then when the patient is stimulated, they think about something, they start the ball rolling. Because of the testosterone being present, the oxytocin goes up, then touch or breast stimulation or any kind of stimulation to the body is going to cause the oxytocin to increase. Then it is a positive feedback system. It increases dopamine, dopamine goes to the nerves that go to the pelvis, dilating vessels, and bringing blood flow there.

BN: So would that be one of the reasons that the literature says that as men age they need more direct stimulation physically in order to get a good erection?

KM: Yes.

BN: So it is the oxytocin diminishment.

KM: Right, but in general as men age, their testosterone drops. They are talking about men without any testosterone support. So testosterone drops, then oxytocin drops, so what they are talking about is, if you go upstream which is what I always like to do, what is the first thing that happened? The first thing that happened is testosterone dropped. If we go back to that step, then we don't have to deal with all these other things, in general, because we treat the testosterone drop. But, because they go through this and they want the steps going on, you know, it is a neurologic function that is stimulated by these hormones. So you have to have your hormones in tact, you have to have your nerves in tact. It is a young person's game basically. But we are going to live a long time and it is such a pleasurable experience, we don't want to give that up as we get older. I think that is the driving force for patients to come in and see me. One of the cool facts about this whole process is in the neurologic process, you can tell when your partner is having an orgasm. If you can't tell another way, you can tell by pupil dilation. That's one of the neurologic things. Kind of one of those little "pearls".

BN: You can tell if you are paying attention.

KM: Right. You have to actually look at their eyes, which is not always possible. The other thing that I thought was very interesting, we have already talked about the different types of orgasms, but no one really talks about that. Everybody talks about clitoral orgasms - yes that's the most common. The G-spot; my most frequent question on that is 'where is it?' My answer is it is about an inch behind the opening of the vagina on the top part, the part that lies right under the bladder.

BN: The interior vaginal wall?

KM: Right. That's what I was trying not to say. Interior vaginal wall, about an inch in and it feels a little bit like a lump of tissue, like a ridge. It has a lot of neurons in it. That is the G-spot. Of course, most people know where the clitoris is. And most people know where the cervix is. Those types of orgasms, you can have them all together depending on stimulation. You can actually stimulate all three. Some people get the G-spot through anal stimulation, however that is not typical. Or no one tells me about it.

BN: But those contractions of those particular muscles are a part of the orgasmic release for males and females. So that stimulation at that time of contraction can be identified as an anal orgasm.

KM: Yes.

BN: But you have shifted now to talking about women's orgasms, and we are running out of time. I would suggest that maybe we should continue our conversation in our next podcast. And as we always do, we would like to say that anybody that has any questions about these issues or others that they would like for us to discuss or respond to, to get in touch with you and you can tell them how to do that.

KM: If you have any questions or comments about our show or about bio-identical hormones and testosterone, please e-mail them to podcast@biobalancehealth.com We also invite you to visit our website at biobalancehealth.com and learn about our services, our supplements and actually what we do about supplying testosterone to our patients. You can call my office, that's another option, 314.993.0963. Or, you can read my blog: DrKathyMaupin.com. It includes transcripts of this podcast as well as excerpts from the book that I am writing.