How Aging Affects Orgasm
BioBalance Podcast — Dr. Kathy Maupin and Brett Newcomb
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Dr. Kathy Maupin: Hi this is Dr. Kathy Maupin and I'm the founder and medical director of Bio Balance Health. We are here for podcast number 25. Bret Newcomb is my advisor and the moderator of these discussions. He is an expert on teaching everyone how to deal with difficult situations, handle life, and handle their business. You can look him up at Brettnewcomb.com is that right?

Brett Newcomb: Brettnewcomb.com, yes.

KM: If you need somebody to talk to your office or your business.

BN: Central communication strategies, dealing with difficult situations, conflict resolutions strategies.

KM: I had you come to my office to talk about dealing with difficult people because every office has to deal with that.

BN: Both within and without.

KM: Yes, within and without. And [my staff] were better with customer service. It was awesome.

BN: It's a huge customer service component. And a lot of people don't think about it that way. But it is beneficial when they do.

KM: That's right, you're an excellent teacher.

BN: Thank you.

KM: So, we're here today to talk about how aging effects orgasm.

BN: Which is a continuation of a couple of other podcasts that we've done. If our listeners want to go back and check, podcast number 21 and podcast number 22 are the podcast where we've talked about the orgasm process and functionality. We also have a podcast on erectile dysfunction that we talked about. But much of the information that we referenced is anecdotal from my experience of 30 years as a family clinician, and your experience as a physician. But some of it comes from an excellent research book called The Science of Orgasm.

KM: It's by Dr. Barry Komisaruk, Carlos Beyer-Flores and Beverly Whipple. It's usually a medical book for physicians.

BN: It's pretty technical.

KM: It is pretty technical, but that's where we're kind of interpreting that for the regular listeners. You don't have to have a medical degree to understand what we're talking about.

BN: Right.

KM: So, one of the things I deal with every day is how aging affects orgasms. Now we're talking about orgasms for both men and women. The idea is that as we age, our orgasms become less frequent or non-existent and our sexual dysfunction increases. That is a normal change after 50 for pretty much everybody.

BN: Mainly because of changes in hormones. Not because people just reach a certain point and sex turns off. That's the descriptive effect but the real effect is that it turns off because of changes that we now know are reversible.

KM: Right, so my patients aren't necessarily saying "this is a problem". There are other things that go into sexual function and orgasm. We've talked about those before. But we're talking about impotence without hormones what happens and then impotence with hormones and what happens.

BN: Well, this certainly is the focus of what you do because you can help them with replacing hormones. A lot of what I've done through the years is dealing with couples who are aging and finding that their intimacy and sexuality are changing and they change for a lot of psycho-social reasons that may or may not be causally related to the hormone changes. But part of what we discuss is if we can reinstitute the hormones and get that vigor back into their individual lives, does that automatically result in increased vigor in their intimacy levels and in their sexual lives? And my response to that is not typically, no. They have to do some work. I mean there are some issues that also evolve from long periods of time together; the adaptation effect. You get bored, you get comfortable, you get automated. You know it's kind of putting a label on your partner when you first get together with them and then you put that on a box and put that on a shelf and then you relate to them for 20 years like they're still that person but they change. I remember one of my clients was talking about when he first got married to his wife and they were young and he didn't like pizza. But over the years he learned to like pizza and one day they had been married for 30 years and she said something to him about how "you don't like pizza". And he said, "I've been eating pizza for 30 years haven't you noticed? And I do like it." And she said "no, I just remember you don't like pizza."

KM: The good news is that when we look at our spouse they still look like they did when we met them.

BN: Yeas.

KM: That's the good part about that. I understand that's the issue. Often times a patient comes to me after counseling and they've been told that this isn't really a couple issue. You still care about each other. You still love each other. But you don't have the physical love the physical response. Or one of the partners isn't interested. That has a lot to do with chemistry and hormonal, hormones that are gone. And it can happen from women [who have had] a hysterectomy. It can happen from just getting over the age of 40 and testosterone goes away. So that type of things gets better. And I can tell when they need to go see somebody for counseling. Because, their hormones will come back and they'll typically say, (it's almost a given), they'll say 'you know I feel a whole lot more sexual and I feel like my old self. But I don't necessarily like my husband any more than I did'.

BN: Right or they'll say I'm starting to notice the mail man and getting a twinge. Or the boy down at the grocery store.

KM: Yes, well that is not the goal at my practice.

BN: No I know it's not. But that's where you have to give the message; go and look at the whole thing. It's back to the balance part.

KM: Because I don't want them to look at the mailman. I want them to look at their husbands.

BN: Yes, and re-energize that if that's possible to do.

KM: I don't want anyone to get the wrong impression of what I'm trying to do. I just want to bring them back to normal. Whatever they were at 35-40 I'd like to bring whatever age they are back there so that they can then have enough energy and enough sexual introspection to know if their relationship is worth fighting for.

BN: And one of the things that hopefully will drive people to your office is that men begin to have potency issues and erection issues typically in their 50's and later 50's. So they're not getting good erections, they're not feeling the level of desire, they're not having satisfying orgasms. So they go and get an ED drug, they get a drug like Cialis which is advertised heavily and mass marketed. And that helps with the erection but then 52% of them quit taking the drug within a few months because it doesn't improve their sex life. And that goes back to arousal and intimacy.

KM: That goes both ways. It also has to do with their wives. But often time I see the wives first. They come in and I fix the wives and then they say 'you've got to see my husband' a year later or a few months later. You know 'I just I don't think it's working out for him'. Often, then, I'll see their husbands and then everyone's happy. That's usually the sequence in my office.

BN: I would think, and I don't know that we've talked about this, but I would think that men especially in their younger years tend to be more orgasmically focused and

they're focused on having sex and having an orgasm and they're not intimacy focused. And women are more typically intimacy focused. You know it's wham, bam, thank you man, and then I feel empty and I feel violated or I feel alone or he wants to have sex but he doesn't want to touch me or kiss me. So I don't feel aroused I don't feel the desire. So it's easier to just let him do what he wants and just get it over with. And it becomes a chore. And so part of the challenge is to improve the body so that the bodies work at maximum level, but also improve the communication and the awareness and help the guys move towards the whole intimacy concept where sex is more about intimacy and connection and resolution and satisfaction but not primarily about resolution and satisfaction.

KM: We can have that discussion about young people too. Because you know, once you get married that's the sort of issue you can deal with early on. Some of those issues sort out by the time people get to 40 and are still married to the same person and then the wheels fall off.

BN: Yes, but there are multiple reasons that if people know about they can try to compensate for. For instance, as men get older they will regularly complain or their wives will complain about them or they'll feel guilty because it takes longer, it takes more time for them to become aroused and erected. It may take more direct stimulation. They can't just fantasize about something or see a picture. There has to be a connective process. And that may not have been the way they were. They may in their past have just been ready constantly if not instantaneously. And now it takes a little bit of work and it's awkward to have that discussion. You know to say 'I'm not responding the way I historically have so does that mean I don't love you or does that mean I don't want you or does that mean I'm changing'.

KM: I know all my patients would much rather talk to the gal that do their hair or their nails than their husbands about these issues. So what is it? Why would we rather talk to a stranger about this?

BN: Oh my gosh. Yes, I talk to other people because it's less threatening. If you are my intimate partner and I take the risk, because the definition of intimacy is that I will take masks off with you that I won't take off with other people, can tell a casual person or a casual acquaintance something like that and we can all laugh about it or talk about it and it doesn't really affect my own ego. But if I tell you and you reject me or you laugh at me or you're disgusted by knowing what I'm talking about or what I want or what I fantasize about, then I am truly wounded. And that's a risk that many of us are not willing to take and it comes from the rest of the pattern of the relationship. If I find generally in my relationship with you that I can count on you to be sensitive or supportive or empathic then I'm more willing to offer that to you. But if I find you're taking shots at me or you're jabbing me or you're ignoring me or you don't enjoy me. I had a client in last week that said my wife says she loves me but I don't like me. And I come home and there's tension, and hostility and avoidance, and animosity but she

still says loud and clear oh I love you and we're happy. And he says "I'm not happy". I want to come home to bright eyes, and somebody that laughs at my jokes even if they're the same old jokes from 30 years I just want someone to be glad I'm home. And you know we've just gotten to a point where it's all mechanical. And I said to him as you suggested "have you had this conversation with her?" and he said "no, because it doesn't go anywhere?" They don't know how to do it. So sometimes they need help in learning how to do it. But they also need encouragement in trying. Whether it's about sex, young couples or old couples, when we talk about having sex I ask them "do you talk to each other, do you laugh, do you make jokes, do you share fantasies do you have fantasies that you're willing to explore and so many couples don't have that conversation with their partner ever. And it's really sad.

KM: I find that's true. I have patients who, women who have never had an orgasm but their husbands don't know. Ever. And then we give them testosterone.

BN: And either they're really good at faking it or their husbands don't pay enough attention to care.

KM: Right and I'm not sure what that is because that's not my job, that's not my job to ask that.

BN: No but that's the kind of stuff that I deal with.

KM: But generally they'll start talking about it. They probably have a low testosterone, just basic low testosterone, genetically, or they were on the pill and that decreased their testosterone but then often they'll come back after testosterone therapy, the pellet therapy, and they'll come back and say "I had my first one, It was great". And I'm like, "did you tell your husband?" "well no, because he . . ."

BN: "He wasn't there." I mean emotionally of course.

KM: No. They're afraid to tell them that they've never had it, never had one before, because he thinks everything is cool. I think it's probably a matter of faking it because they just didn't know what they were missing. Once they know, I don't think they would ever make that mistake before. They'll fix it If it's broken.

BN: Well, it's kind of like describing sight to a blind person who's never been sighted. If you've never had it and you thought sex was good and now it's exponentially better. What's making that happen, and can I talk about it?

KM: I think as people get older we get less expressive, we take more things for granted with each other, we just don't talk about things like this because we think 'oh I'm old I shouldn't be talking about sex'. And since I talk about sex all day long I figure I should be talking about sex, most of the time, but not for everyone.

BN: Well you know in the book, The Science of Orgasm, they quote some research by Timmers, Sinclair and James. It talks about two different ways to conceptualize orgasm and one of the ways to conceptualize it is linear and goal oriented. Which is classically male pattern. Reach orgasm, count orgasm, be aware of how quickly you can do it again. And so you have score cards. And the other way to conceptualize is called the circle concept in which each element of the process in the circle is an end and a goal to be experienced in and of itself. So it's not just the end of the road but it's the process which is another way to say the level of intimacy the level of attending and engagement. It isn't always about having an orgasm. You learn that you can have great sexual experiences and contacts with petting, with kissing, with lying together before and after. A lot of women complain that as soon as it's over the man wants to either fall asleep or he wants to get up and play golf. So he doesn't want to stay there with her and be in that space for any length of time. And yet that's such an important and satisfying experience for her when she can have it. But if it's 'how do I raise the issue, how do I make the request without him feeling attacked, without him feeling disappointed or angry? I just want a little more. Can you do that?' It's the same conversation when the woman says "Oh you're driving too close to that car, and I'm scared." And he says "Don't tell me how to drive." And she says "I'm not trying to tell you how to drive. I'm trying to tell you I'm scared." The message here is "I'm afraid" and he's hearing the message as critique, criticism, power.

KM: Hmm, I had somebody talk to me about whether hormones would help correct her back seat driving last week.

BN: It won't help her be less of a back seat driver. But it may help if their testosterone and estrogen levels change and their sexual responsiveness becomes better. For them it may help the overall level of intimacy so that it becomes a non-issue.

KM: Right.

BN: And that's really the key. It isn't a specific behavior. I tell clients all the time that when you argue about the facts you've already lost the battle because it's about feelings. And so if I feel better with you or about then I am less threatened by the little pieces that may not be my preference or may not be comfortable for me. But they're okay because we're okay.

KM: Testosterone in women; no one really discusses this in the medical community because there really isn't a good way to just give you a pill and walk out of the room and say take this and it'll be better. Because testosterone shouldn't be given orally. It just doesn't do the same thing as when we do pellets. But when we use non-oral testosterone preferentially as a pellet you get a much nicer woman. You know everybody's got this bad rep about testosterone they all ask me if it's going to make me a woman who is aggressive and nasty and angry. I've had one woman in 9.5 years that felt that way. And that's it. I've seen thousands and thousands of patients. I've never had somebody get more angry. The hormone that makes people angry and

aggressive is dihydrotestosterone. Generally women don't make that much out of their testosterone. Especially not out of the pellets. It's a little different when they take oral. Oral they make tons of it. And so that might make them a little angry. It's all about how you take it and if it's pure or synthetic. But in general, my therapy. thank goodness, makes people calmer, nicer, happier. Men as well.

BN: Two summary comments that I want to make before we close this down. And I want to talk about psycho-social issues that get involved in sexual compatibility and intimacy as people age. Whether they've had hormone replacements or not. Changes in roles and finances after retirement. When men stop being the aggressive go getter charger and just become retired. Then they have identity issues. Who am I? And if the money changes, or if she's working still and making more money than he's bringing in. If those dynamics change that often plays out in the sexual relationship.

KM: That's true. That is true. I hear that a lot. And mostly I hear from women, "when is he just going to get out of the house." Because those are women that have always stayed home, the house was their haven. They were able to do other things.

BN: And he's invaded that space.

KM: And he's telling her what to do. Cause he did at work .

BN: Because he's managed the company and now he's going to manage her.

KM: Right, right, so I hear that end of it.

BN: Changes in roles.

KM: Yes. That can affect it.

BN: Changes in finances affect it and couples need to learn to talk about those things. Anticipate them and project them. Try to resolve them. Anxiety and depression related to age associated losses and transitions. Like the old joke; I'm not as good as I once was and I'm no longer as good once as I ever was. But hopefully that'll change.

KM: No they say, never mind, but you know the song.

BN: They do say that, but their lying. Yea, exactly. And there are personal, religious and moral values perceptions that we're taught culturally about old people and sex that have to change because there are more old people who are even older and still feeling sexual. And so how do I fit my reality against my cultural training? So that cultural training needs to evolve.

KM: That's true.

BN: And then finally I want to mention women across the spectrum who are surveyed about sex and intimacy. Young women and old women say there are three primary

things that they associate to satisfying sex. That is feeling closeness to the partner before sex, feeling receptive, feeling connected, feeling aware. Emotional closeness after sex. Don't roll over and go to sleep, don't get up and go play golf. Lay here for some period of time. And then just generally the frame of feeling loved. Not feeling objectified, not feeling used, not feeling demanded. But feeling loved and cherished so if men can know that, then they can work on communicating that message. And if they do, it pays huge dividends.

KM: So, on the other side, what do men want?

BN: Uh, I think men want to be desired. I think they don't want to feel as if it's a functional chore for you to pay attention to me. I think they want to feel important. I think they regularly feel that especially when there are children involved that they're at the end of the line. When the lunches are made, when the kids' homework is done, when the house is clean, when the laundry is done, when the phone call to mom is done, then maybe I'll have time for you if I'm not too tired and don't fall asleep. And so I get those messages from men all the time. And what often happens with young children in a household is it gets scheduled. You know every Wednesday morning we have sex or every Saturday afternoon we have sex, between 2 and 3. And then it becomes for both, more of a chore, more of a checklist activity. There's not spontaneity, there's no playfulness, there's no instant intimacy.

KM: There's no privacy.

BN: There's no privacy. Those are very real problems.

KM: We've been taught in our generation to leave the door open, let the kids sleep with you. All that stuff. And so there is no couple intimacy.

BN: I actually don't recommend either of those.

KM: I know you don't. I know psychologists and counselors don't but the general public think oh, you should be able to do that. And some children do need that. But your marriage needs to have certain times where the children are not invited in.

BN: Absolutely, I tell parents teach your kids mom and dad need private time, this our time. For the next hour.

KM: I tell them to get a slide lock that's on the inside of their door. Because that's the only thing that's going to keep most kids out.

BN: Absolutely. You need privacy for that. But you need intentionality. I am intending to spend time paying attention to you in our relationship. Because it's the key thing that makes all the rest of this work.

KM: And do that throughout your whole marriage. The biggest predictor to whether you're going to have sex life after menopause is whether you had a good sex life before menopause.

BN: Is if you had sex life before. Hello.

KM: So you think when we get older and the kids are out of the house and we are free to have sex. You aren't practicing now so it's not going to work very well later. I mean you have to go through a whole new practice session and retraining. And I hear about that a lot and it works.

BN: Retraining and reorientation. Well we talk about those things in future podcasts. Because there is so much more to talk about in terms of satisfying sexual relationships and good healthy aging processes.

KM: That's right, even though I'm trying to reverse aging.

BN: I know.

KM: Thank you Brett Newcomb. And if you need somebody to teach your employees or your family how to conduct themselves and how to be healthy emotionally, then Brett's your guy. This is Dr. Kathy Maupin. If you want to come talk to us you can dial 314-993-0963 or you can go to my website at biobalancehealth.com. I also have a blog at drkathymaupin.com. And it will have some of this information listed in the blog.

BN: OK, thank you.

KM: Thank you very much.