80 - Arousal and Orgasm
BioBalance Podcast — Dr. Kathy Maupin and Brett Newcomb
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Kathy Maupin: Welcome to Biobalance health cast. I'm Dr. Kathy Maupin.

Brett Newcomb: And I'm Brett Newcomb. And today we're going to talk about things sexual. We spend a lot of time talking about replacing hormones and particularly the hormone testosterone. And one of the reasons that we talk about that is the important impact it has on the libido. And if it restores your libido and restores your sexual function and desire and capacity, that's a real blessing if you have lost it. But not everybody gets the same benefit. There are barriers to optimal restoration and today we want to talk about what some of those barriers might be. Because when you make your decision about should I go through this process and try to have my hormones replaced you have to do a cost benefit analysis for these things. And nobody wants to sell you pig and pope we don't want to sell you a bag of good and say this is a panacea and it will solve all problems. It doesn't solve all problems for everybody. And there are some reason why and if we know what those reason are then we can do some things to impact the minimalization. For instance, one of the things that inhibit an optimal response is if you're on anti depressants. Anti depressants, for the most part, there are one or two that don't, inhibit sexual response and libido.

KM: So you're not depressed but you're depressed because you can't achieve an orgasm or you can't have a libido. Because even though you have testosterone replaced, that blunts everything.

BN: Well I spend a lot of time with clients who have these issues in their relationships and I'm explicit ad very clear to them and say to them that if you are on antidepressant, the likelihood will be that the person who is taking antidepressants after they've taken them for several months will lose the desire to have sex. It won't occur to them, they'll wait weeks.

KM: It's off their list.

BN: Yea their partner is walking around for weeks saying when are we going to do this? When are we going to do this? Usually on Saturday mornings we do this and Saturday comes and goes and what happened?

KM: What about me?

BN: Yea exactly, a lot of self reflection there. So we talk to them about, you have to understand that your partner won't feel it and won't want it. But can respond out of their affection for you and out of your initiation. So you have to be the initiating

partner. Because a lot of couples keep track you know I've initiated the last 5 times how come you never do. You laugh, but I'm serious.

KM: I'm laughing because I hear it all the time. And I'm amazed, I want to ask, do you write it down? Do you have it on your laptop?

BN: It's engraved on their forehead.

KM: But it's true, they do have that kind of balance, it's like know, how many times did I set the table this week? Did you do it? Women do that with lists all the time. The lists, how many things have I done, how many things have you done? But men do it too I guess, it's just with sex.

BN: Of course it's with sex.

KM: I mean we have great responses with libido and with re-achieving orgasm. We give people testosterone improves the nuero-transmitters that are necessary for sexual response. But we hit barriers in certain people. And I always tell them it's going to talk longer for me to get you to a place where you're responsive. It's going to take longer for me to adjust things. I mean I might get lucky and be able to adjust things immediately. But in general I can get a good response. It may not be as good as someone who comes in with few medications no antidepressants.

BN: So you may hear bells but not see fireworks.

KM: Right or we may have to adjust dosages so it lasts the whole 4 months for women or 6 months for men. So sometimes there are other issues that w have to combat. And that's one of the barriers, in fact it's the biggest barrier anti depressants is huge, because when you're talking about orgasm and sexual function. The two nuero-trasmistters, you've probably heard of serotonin because that's what increases when you get an antidepressant. But you probably haven't heard that dopamine is the accelerator on the car of sex, and serotonin is the brakes. So you feel better but you don't have a sex drive because your serotonin goes up with an antidepressant. And dopamine if you don't have enough dopamine like in Parkinson's and many other medication change dopamine levels. Then you don't have an accelerator. So if don't have both of those, an anti psychotic will decrease dopamine and antidepressant will increase serotonin so the brakes are on and you're not accelerating you don't have any sex drive, testosterone can't overcome both of those things. In general it can barely make an adjustment.

BN: So it's all about the balance point and trying to find the balance point that is sort of the least invasive as far as changing your body chemistry, but brings you the best result that you can expect because ether are also other factors for people that are depressed and on these medicine or that have psychotic issues and are anti psychotic medicine, will have those issues but there are other problems as well.

KM: And I don't ever advocate taking people off. I never take people off their anti depressants or anti psychotic.

BN: Well it's not your call.

KM: But once they feel better than I ask them to see their psychiatrists or primary care doctors who might change their dosage or might take them off. But I don't advise anyone though to go off antipsychotics or antidepressants because of their sex life. I try to work with them to try to overcome them; it's just not going to be as obvious a change.

BN: Well you know another point along that continuum that you've made to me often is that you have a lot of patients that come in that are on anti cholesterol drugs. And some of the anti cholesterol drugs also inhibit sexual responsiveness.

KM: Most of them do, most of the stantens decrease the element that makes testosterone in your body which is cholesterol in your body. Cholesterol is necessary to repair your brain.

BN: That's what we call good cholesterol.

KM: That's the good cholesterol but it's actually all the cholesterol not just HGL. But all the cholesterol repairs your brain. Your brain is made mostly out of cholesterol unless they're made out of it and cholesterol is also a precursor for testosterone so it's the element we use to made testosterone. If you don't have what you need to make testosterone, you're not going to make it. So it drops testosterone even lower. So generally when I have somebody on low cholesterol medication by giving them testosterone which is the end point, we can leave them on their cholesterol medicine and overcome it with testosterone. So that's a much easier thing to manage than the anti depressants and the anti psychotics. But we have to usually use a higher dose.

BN: But you have work then in tandem with their primary care physician because you're not setting the medication level for the anti cholesterol or the blood pressure medicine.

KM: I'm trying to make them better so they don't need those things anymore.

BN: Right.

KM: Many of my patients go off their anti hypertensive. Anti hypertensive can decrease your libido. It can decrease your response even if you have testosterone. But if you have a normal testosterone, a good healthy dose of it, you may not need the anti hypertensive because your blood pressure will drop and you'll lose weight and your blood pressure will decrease.

BN: You do a lot of what you do with blood tests and you measure elements in the blood so you that you can know what's balancing where and one of the things you talk

about with regards to this whole topic is how much estrone are people manufacturing, because too much estrone will also inhibit the positive gain from the testosterone.

KM: Right we have testosterone levels, we look at those and then we look at total testosterone which is all the testosterone you make but some of that is inactive, in fact most of it is just storage, your body doesn't even see it. Then we look at free testosterone which is what your body actually experiences. And free testosterone is what I'm trying to increase. So if you take medications or do things that increase estrone, estrone is the factor that actually decreases your free testosterone to a very small percentage. So we have to fight estrone. Estrone is one of the hormones from the adrenal gland that when our testosterone drops our estrone goes up and vice versa. But some people make estrone in the fat and some people make estrone when medications go through their liver so they can make it from other places. So I can help some of it, I can't help all of it so we have to look at the whole patient.

BN: So you look at issues of alcohol consumption, obesity, liver disease, high blood sugars.

KM: Right, all of those things increase estrone and decrease the active amount of testosterone. So not only do I want to replaces testosterone, I want to make sure that the active portion of it is high enough to bring a patient back to normalcy. But a lot of these other issues like diabetes and obesity and drinking a lot that can deactivate the testosterone that I give them. It kind of fights me. So we have to go through a whole body redo and I do suggest changes there with weight loss and changing their habits and increasing exercise. All of those things decrease estrone and then give them more of their testosterone to use. That's what they're looking for is actually the effect of testosterone. So if I just give you testosterone and walk away, which is what some people do and they don't look at those other things, then you're not going to feel good very long, you're going to feel good for maybe the first couple weeks and that's it. Because you're going to make a lot of estrone with all your bad habits or you drugs.

BN: And it will eat up all the testosterone you put in their anyway

KM: So it binds it up and you don't feel like you have any even if your total level is high. So you don't have to just look at the testosterone you have to look at drugs, you have to look at diseases, you have to look at habits, and usually you gain weight when we've lost our testosterone. So you have to actually make a concerted effort to lose weight because fat makes estrone, it makes estrogen. That's why you see men in their late 40's and 50's who have the big belly and the man boobs, that's from estrone. I wouldn't go out with that guy if somebody was looking because his testosterone isn't working very well.

BN: They also have that whole type 2 diabetes body structure all that weight around the chest and the abdomen that accumulates fat and that's manufacturing more estrone.

KM: In the end if they don't lose weight they're looking at a type 2 diabetes situation, Which is not good for sex either because type 2 diabetes actually decreases the orgasmic response of both men and women both by affecting blood flow and by affecting nerves that go to the pelvis. So that's another barrier I come upon. People have type 2 diabetes already when they walk in the door and they want their sex lives back. And I can give them their testosterone back and that gives them their desire but then it's very hard for them to come to the point where they can have an orgasm because the estrone that they've made in the fat and plus the fact that they have damaged vessels and nerves they can't get the blood flow to their pelvis.

BN: So do you find them coming back and say "this stuff isn't working for me"?

KM: Well they say it's working for all these things but the one thing I came to you for was my sexual response and sex drive. So I look at their levels and if they have good levels.

BN: But there are two levels of sexual response that we're talking about. One is the arousal state, the ability to have an erection, lubrication and whatever the issues might have been so that you want to have sex and you can have sex. The other is the payoff, the orgasm.

KM: The orgasm which is the payoff.

BN: Right. And there are a whole lot of reasons why people have trouble orgasming that may not have specifically to do with the amount of free testosterone in your body.

KM: That's true you may have great free testosterone and you may still be anorgasmic. Most of the people I work with though are people that used to have great orgasms but in the last 5-01 years have lost them. In general unless they've developed a major illness or had a head injury, than that can be fixed with testosterone alone. But the people who have new diseases or have never had an orgasm, that's a little different. We have to deal with that a differently.

BN: And there are people, I've had a number of female clients come in whom after enough sessions that they feel comfortable with me that they can say it, that they've been married to somebody or in a relationship with somebody for many, many years, had lots of sex with that person and never had an orgasm, and they don't know that they've ever had an orgasm.

KM: Hey don't know what exactly it is until they have them. And I've had patients who always had chronically low testosterone levels and they come in and say "that's it, I had one, it was that's awesome". Now I know what they're talking about, because nobody knows exactly how to describe it. But you know when you have one.

BN: I'm just sitting here wishing I had known you 30 years ago. I remember when I first began to do therapy I had a woman in her 50's come into see me and she had lost

any desire to have sex and any ability to have orgasms. And her physician said, "There's not anything wrong with you. It's all in your head".

KM: So she came to you.

BN: And I didn't know any of this stuff. And I think we wasted her time and her money as well as her sense of self esteem by not really being able to help her achieve that. We worked on strategies for trying to put yourself in the mood and for things to do and try, but the payoff never came.

KM: Well Beverly Whipple who is the biggest researcher on orgasm's she hadn't done all of her research then and I didn't know about that at that time either. But she's been doing research for 30 year and we're discussing thing that have culminated after 30 years of research on orgasms this is the outcomes is that now we know all the different factors to give you the ability to have the ability to have an orgasm. You have to have your neurologic system intact and it's brain and your spine, and you have to have the right stimulation the right trigger points. And you have to also not have certain drugs you have to not have certain medications and disease and you also have to have enough testosterone and those are all things she's found out about orgasm's it kind of has to bethe perfect storm.

BN: But what you don't 'have to have is a partner.

KM: No you don't' have to have a partner to have an orgasm.

BN: Because we're not talking about intimate interactive sex specifically although I think that's the goal for most people.

KM: Yea but it's about sexual release.

BN: But it is possible to physically mechanically, personally to have these things happen in a very satisfying way if all these pieces are in place.

KM: It's good to have an orgasm; it lightens up your entire brain. It brings blood flow to your brain

BN: It's better than an apple a day.

KM: Absolutely. So it is one of the best things you can give yourself and it doesn't require a partner.

BN: So the point of today's conversation is to say that if you have lost your libido if your sexual desire is inhibited if your ability to have orgasms are malfunctioning there are things that can be done. The most elemental thing to be done is replace the testosterone. But you need to know that not everybody gets the same relief from replacing testosterone alone. That's why it's important to have a relations physician who will sit down and talk about to you about and look at the data to say what other

complications factors might there be? And how much is enough? If you're going to do this, how much benefit do you have to receive to be able to say you know it was worth it?

KM: Most people feel like they've been successful if they're back to where they were before they hit 40. I don't know that I can change a lot of people who have had lifelong problems. But some people who have never had an orgasm get them when we give them adequate testosterone. However I think that most people should expect that if they have a lot of medical issues and they have a lot of medications that they require that they may not get the same response as someone who has fewer problems and their only problem is testosterone. So my goal is to have expectations meet what a doctor can deliver.

BN: And ideally the only way they would know that they weren't getting the same response is if their partner was getting hormone replacement too and was recording better results.

KM: Most of the men still have their testosterone and we're 40, if we marry someone who's the same age. They have ten years where they still have testosterone and we don't. So there's an inequity there, well you can talk to God later. But there's an inequity there between timing the loss of libido. So most of my couples are near in age and the men don't come to me for years after their wives are there.

BN: So if they have more questions or interest about this topic, we will do some other podcast. But how can they contact us?

KM: They can write us at podcast@biobalancehealth.com or they can go to our website at biobalancehealth.com or they can call my office at 314-993-0963.

BN: And you can always reach me at Brettnewcomb.com.