# Ep #109: Sex and Menopause: You Are Not Broken with Kelly Casperson


## Full Episode Transcript

**With Your Host**

**Susi Hately**

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**Male Announcer:** You're listening to *From Pain to Possibility* with Susi Hately. You will hear Susi's best ideas on how to reduce or even eradicate your pain and learn how to listen to your body when it whispers so you don't have to hear it scream. And now here's your host, Susi Hately.

Susi: Welcome and welcome back. With this episode I am really excited because I am interviewing Dr. Kelly Casperson and I have wanted to bring a physician on to talk about, of all things, sex on this podcast. Because I have a lot of private clients and my trainees who will sort of say in a hushed voice, "Do you talk with your clients about sex?" And it's usually in that sort of regard.

And whether it's about painful sex or because of the pain they're experiencing there's an impact with sex and an impact with their relationship. And I work with both men and women, so sometimes the conversation can be coming from either group of people. And what this episode is going to be is more directly related to females and people who identify as women and just to get right into it.

And so I want to start off by just opening the gates to Dr. Kelly because she's a urologist. I want her to explain what urology is. Why sex? Why the focus? And just all those things. Let's just get going.

Kelly: Yeah, thanks for having me. So I'm a urologist. Urologists go to medical school and then they do a five- or six-year training on surgery. And surgery is technically genital urinary symptoms or, you know, those organs. So kidney, ureter, bladder, penis, scrotum, testicles. Now more and more the female homologous structures which are labia, clitoris, vagina, vulva, all of that.

So I was going along, I was like seven years into private practice. And you get the seven-year itch of like you get really good at your job and you're kind of bored a little bit. And I had this life changing patient who was crying in my office. I had been working with her for years because we had worked on a cancer thing for her, cured her of that.

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So we had this wonderful relationship and she was crying. Great marriage, no sex, sexless marriage. And she was just feeling so incredibly broken about it. It was a desire problem, the way she viewed her body after having cancer surgery. And I handed her a box of Kleenex because that's what I had in my office.

And like lightning struck my brain. And I was like, all I have is a box of Kleenex. Like is that all anybody has? What do we do? And it was the first time that I started challenging like how are we taking care of women? And the urologists are the ones taking care of the men, the penis owners. Viagra has been around since the late 90s.

I'm like who's taking care of the people who are sleeping with the people we're giving all the Viagra to? We all assume the gynecologists are. But the gynecologists are actually, because when I started asking them like tell me everything you know about low desire and arousal and orgasm and all this stuff. They're like, "Oh, we didn't get taught any of that either."

Number one, medical training is a patriarchal system, right? So if the person above you didn't care, you're not going to learn anything. But number two, the gynecologists, God bless them, are very, very busy. They're delivering babies, curing irregular periods, trying to get people pregnant, dealing with fibroids, dealing with ovarian masses, dealing with birth control. Like they've got, they're full-time already without taking this on.

So I just deep dove into female sexual dysfunction. I learned we actually know a ton but our society doesn't because sex ed in this country is crap, one can argue it's getting worse. And then Hollywood, mass media, the way we market to people, it contradicts the truth of female sexual function.

And then I got into oh, well, the biggest sex organ is actually the brain. And how do I start dealing with that? And then that's where I fell into coach training to work on our thoughts. And what is a desire, right? Is it a

circumstance? Is it a thought? Is it a feeling? Is it an action? What's a desire?

And so really, that's kind of how I came full circle. Interestingly enough, I was a neuroscience undergrad so like I came back to the brain at the midpoint of my career.

Susi: So interesting. Before we got going onto the recording I was letting Kelly know about I feel like in many ways I was a fortunate one because in my 20s I started learning about the pelvic floor as it related to the work I was doing. And I'd had a real time ultrasound. So the ultrasound, for people who are listening, the same you look at kidneys and babies and all that but it was it was really specific around the function of my pelvic floor.

Which then led me to getting more interested and I went to see a pelvic health physiotherapist. And when I spoke, when I actually booked the appointment, the reception said is this for a bowel or a bladder problem? And I'm like, because I'm kind of interested, nothing.

So then when I went in and spoke to the physio there and I said, “So tell me, what brings people to you? Because I don't have a problem, I'm just really curious.” And it was such a, I mean, I still remember the visit.

It was so eye opening and so fascinating in the awareness that I gained about my body. Which gave me a baseline for so much, like when I had my babies and when I fell down my stairs and all that, I could tell, like I knew that having a hypertonic pelvic floor from the fall wasn't because the fall, it was something that I had prior to. So I was able to work with a lot of these things and I just got clearer.

Anyway, she said to me, the reason that women come to her is because now their sex life has been impacted, right? Whatever is going on is now impacting another person. Now, you had said that in fact that's not when they show up. They show up five years, or three years, or many years after.

Kelly: Yeah, that's when I see people. I see people when they're like, “Oh yeah, well, we stopped having sex five years ago.” And I'd say that's common. I don't see people who are like, “Well, three months ago...” I don't see that.

Susi: And what primarily brings people to you?

Kelly: I see a lot of genital urinary syndrome of menopause, called GSM for short. Previously labeled vaginal atrophy, which nobody liked that term. I see tons of that because it really starts kicking in, first of all, just to normalize it 50 to 80% of people after the age of menopause, which is average age of 51 in America. 50 to 80% of them will start having GSM symptoms, on average, eight to 10 years after menopause started.

So I see a lot of people late 50s early 60s, and they come in with symptoms of low estrogen in their pelvis. Now they don't know that that's what it is because we don't get taught a darn thing about menopause. But it's dryness, vaginal dryness, itchiness around the perineum. I have to pee more. I can't hold my pee. I get up more at night to pee. I have more urinary tract infections.

I tell people, you don't have eight things, you have one thing. That one thing is not enough estrogen in your pelvis. In that story I say, “Any pain with sex?” And they say, “Well, I stopped having sex five years ago because of this.” So that's like my very typical story that I see.

Sex becomes very painful, it's more difficult to get aroused. You can have atrophy of your labia minora, atrophy of your clitoris, and it can get tight, you lose your collagen and your blood flow, right? So it can be very uncomfortable and nobody wants to be in pain. We avoid pain, right?

So we avoid the things that cause pain and then that's how I stopped having sex five years ago. Now I'm seeing you for my bladder issue, right? But it's all a low estrogen issue in that circumstance. There are other reasons that you can have pain with sex, but that's a very common one.

Susi: So then, what do you typically do in those scenarios? Like what's the pattern that, where do you go then with those folks?

Kelly: Yeah, well, the first part is just educating them to be like you don't have eight things, you have one thing. This is menopause. And they're like, “This is menopause?” Again, nobody knows this, right? They're like, “I went through menopause.” I'm like, there's no going through menopause, you are in menopause, right?

If you want to get super technical, you're in menopause for one day. It's the 366th day after you stopped having natural periods. Which doesn't help for people who have hysterectomies or IUDs, so it's kind of a crappy definition. But you're always having a low estrogen state forevermore, right?

But we don't get taught that there are consequences to that, whether that's osteoporosis, or increased risk of several different diseases for having low estrogen. But so part of it's just, hey, you didn't get an education. I'm here to tell you this is all what happens when we don't have estrogen. And we just get them on cheap, generic, inexpensive vaginal estrogen product.

And then I have to go through estrogen is safe, especially vaginal estrogen, it does not cause cancer. And we have to go, because everybody's just afraid that estrogen causes cancer because we did that to women about 20 years ago. We scared the crap out of them. So we have to go through that.

So a lot of it's just them having to learn stuff before they can even justify taking care of themselves. Because they don't know why, they don't know the treatment, they're just in the dark. They just thought they peed more and had more UTIs.

Susi: Well, I remember one thing the physio said to me, as I said earlier, I remember that visit very clearly. And she said, “When we think about our grandmothers and great grandmothers, this was something that was just, it was what it was. Like that's just what you dealt with as a woman.”

Kelly: Yeah, well, we used to not be able to see and we have glasses now. We used to not be able to go across town in a day and we have cars now. And only to say we have amazing things that can help us live our absolute best lives, because I see a lot of women be very resistant specifically to this problem.

They're like, “Well, I'm like I'm considered the natural one in my group of friends so I can't be on vaginal estrogen.” And I'm like, “you're wearing glasses. You realize glasses aren't natural? You have shoes on, they’re not natural. You have air conditioning in the summer, that's not natural. You drove a car here, that's not natural.” You can't just pick your natural when you decide you don't have enough, like you’re just afraid of it so you throw the natural thing up as a barrier.

It’s like no, we used to die in childbirth one in eight times, that's natural, right? And so just to open up, because people use natural as like a sales technique, or a way to avoid learning about something, or whatever they use natural for. But I’m always happy to call them on it because I'm like, we sleep in a bed, we used to sleep on the ground. That was natural. Pick your natural.

If you want to help your symptoms, which are caused by low estrogen, the treatment is low estrogen. You can use lube, there's some hyaluronic acid moisturizers, there’s some really great non-hormone products. But even ACOG, which is the American College of Obstetrics and Gynecology has a position paper on currently treated for breast cancer or history of breast cancer, still safe to use vaginal estrogen.

So there's really, you're hard pressed to find somebody except for that very severe case of active breast cancer that you can't be on a vaginal estrogen product. Again, I'm not talking systemic hormones, I'm talking about vaginal estrogen. They shouldn't even be both called estrogen because it's too confusing for people.

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Susi: So why don't we just spend some time there? What's the difference between those two, the systemic and the vaginal?

Kelly: Yeah, so systemic means body, right?

Susi: Yeah.

Kelly: And there's different ways of putting estrogen into the body. You can swallow a pill, you can put on a patch. There's actually a, only to confuse everybody, there's a vaginal ring that's a high enough dose to be systemic.

But then vaginal estrogen is about 1/365 of a dose. And I'll say that because a year of vaginal estrogen is equivalent to one pill of hormone replacement therapy estrogen. Like that's how low dose and different doses it is.

And if we're going to go there with comparisons, systemic estrogen for menopause therapy is about 10 to 25% less of a dose than what birth control is. So it's still way less of hormones. And then way, way less of hormones if you're just going to put it in the pelvic.

I like to call it pelvic estrogen just because it really helps the difference between systemic and vaginal estrogen, especially since there's that one vaginal product that's systemic. But you can be on both.

About 20 to 50% of people on systemic hormones in menopause still need to be on pelvic estrogen because it's still so low dose, right? And your body's prioritizing, like I want this to go to my heart, and my brain, and my bones, and my muscle. The pelvic structures tend to be last trip on the train so a lot of people will use both.

Susi: So if someone was going to go to their regular family physician, what's the conversation that they should have if they are having pain with sex? They are in an age category where menopause is likely or late perimenopause, I mean you don't know you're late perimenopause until, but you're in that sort of section of life.

And having listened to this now they're like, “Huh, well, maybe like A, B, C, D, and E, and F, and G is actually this thing.” What's the best way to engage someone who, as you have said, hasn't had the training? How do you engage their physician in this way?

Kelly: Yeah, I mean, I think just having this information, bringing it in, puts you in such a better spot. If you go in and you say I have pain with sex. Again, I'm stereotyping, not to be mean, but just to be as generic as possible. You go in and you say, I'm having pain with sex, they're going to say you need to relax more, or you should have a glass of wine. Have you tried a little bit more foreplay? Or whatever.

They might just blow you off. Number one, because they haven't had training in how to deal with pain with sex. But number two, they might not just jump to like one of the common reasons for discomfort with sexual intercourse is low estrogen, again, starting at age late 30s, right?

Perimenopause is the 10 years surrounding menopause. So certainly we see hormone, I don't want anybody to say like, I'm 47 so that can't possibly be my problem, right? It's a different age for every woman.

But so if you go in and you say, “Hey, you know what? I'm 43 and I just notice a little bit more dryness down there and it’s really kind of itching and bothering me, and I feel like it's affecting my sex life too. I've heard a generic vaginal estrogen cream can be really effective to people. Do you mind if I just try that?”

And what you've done, you didn't tell your doctor what to do in a forceful manner, right? But you said I have some knowledge. I think there's a low cost easily, you know, I can stop it if it doesn't work. So can I just try it?

And get the Good RX app on your phone, it's dirt cheap now. You should not be paying more than $50 for a vaginal estrogen cream. So there are, again, tricks around that because it used to be very prohibitive, it was so

expensive. But in my town, for example, at my local pharmacy it's 21 bucks. So it's a very cheap thing to just try.

Realize it is going to take, depending upon your condition, six to eight weeks for that because you're literally building healthy skin. You're not just putting a Band-Aid on the problem. So you're literally building healthier skin, again, it takes a little bit to do that.

But the other thing about going to your primary care provider with pain with sex is asking for a referral for pelvic floor PT is never the wrong thing. So like, could I try to vaginal estrogen and get a PT referral? Because when we have pain, you know this, when we have pain, our muscles want to protect that body part, they tend to get tight as a response.

So you can have pain because of tight muscles or you can have tight muscles because you have pain because of GSM. And really, it's either your pelvic floor specialists, me, or an OB who's trained in it, a sex med physician can be helpful, and the physical therapist that can kind of chicken and egg it. It doesn't really matter what came first, we just want you to meet your goals so we're going to address both issues.

Susi: Now up here in Canada, I know that for the most part we can actually go to a pelvic health therapist without a referral, I believe. We pay for it out of pocket, that’s not part of any of our regular care. But I've got listeners all over the world, so different places in the world will have different practices around needing the referral or not needing the referral. But I really like that, it's asking about the estrogen cream or suggesting it. And then if you do need a referral to a pelvic health therapist, then do that.

Now people in Canada, you might be saying, “Well, how do I find a good pelvic health therapist?” And so what I often say is Google it, because in Canada now, from what I understand is that all students in physical therapy school need to have pelvic health training. So they're coming out with a lot more training than used to be.

So it used to be that the orthopedic physical therapists, they were seeing all this stuff and they were seeing the missing link. And so then they learned about the pelvic floor. And now it's starting to shift gears where now people are coming out with a lot more knowledge and application so that the tides are turning.

Some will say that one of the downsides is they don't have all the orthopedic knowledge before they got that pelvic health knowledge, so there's like a gap there. And I think we're just shifting gears in terms of those folks getting up to speed. I think it's a good thing that there's more of that information generally just coming out into the clinic.

Kelly: That's awesome. And the other thing, my PTs in my town, they're amazing, but it's like people with labral tears, hip issues, low back dysfunction, you know, sciatica, what else, sacroiliac dysfunction, all these other “orthopedic issues” can cause pain with sex. And a PT who can manipulate the hip and be like, oh, this might be like a hip issue that's causing the muscles around the vulva, the vagina, to respond inappropriately when you're trying to have sex.

Susi: Oh, and that was absolutely my scenario, because what I discovered is that the hypertonicity of my pelvic floor wasn't even about the pelvic floor. The hypertonicity of my pelvic floor was a response to what was going on in my abdomen.

And so one of the key exercises that she had me do is from the inside of my hip, my ilium, I would just follow up in a diagonal up towards my base of my breastbone. And I would just kind of do these like gentle massage, pressing in and pressing out, breathing down regulating myself and relaxing through my abdomen. And then my whole pelvic bowl, just kind of go, like it would just, I didn't even know that it was that, right?

Because I didn't have pain with sex, I didn't have any of that stuff. But by becoming aware of what I was doing, it was like oh, interesting. So then my running magically improved. I didn't even know that it needed to improve. It

was early enough in my process that I didn't have any symptoms, I was just curious and then saw all this benefit from that, right?

Kelly: That's so cool. That's like you taking your car in for like a 10,000-mile tune-up and they're like, yeah, here's something about your car you didn't know, but like it wasn't broken, right? You did great maintenance.

Susi: Yeah, without even knowing I was doing maintenance. And the thing that's really great is that after I'd fallen down my stairs, I had sprained my coccyx and my pelvic floor went into massive spasm. So I could tell as I was coming out of that space what my normal was. And then when I had trained myself to have a new normal, so I could feel. My body wasn't foreign to me.

Kelly: That's huge.

Susi: Yeah. So then when would someone specifically be asking for a urologist? Because in my own, like whenever I think about urologists, it's true, I usually think about men. I don't think about women.

Kelly: You mean like a woman who is a urologist or women going to urologists?

Susi: Women going to urologists.

Kelly: Fair enough. There aren’t many female neurologists to begin with, in America we’re 9% of practicing neurologists now. Canada is probably similar; I haven't looked at the Canadian data.

It depends, I mean, urology is a specialty, but we all kind of have our own little niche, right? Like I'm much better at handling female sexual dysfunction now because of all this work I've done than if you were to like accidentally have seen me three years into my practice, right? When I just got taught what everybody else got taught was that the penis is what we’re the bosses of, not anything else.

I'd say, you know, pelvic pain very common, painful bladder very common. For the males, a chronic scrotal pain, chronic testicle pain. Again, I see a lot of referred pain. Because the pelvis, our nerves, they're not as specific as like the nerves in our fingers, right? Like I'm pretty sure when my index finger hurts, it's my index finger. But in the pelvis if you're like, “Hey, my labia hurts,” it could be a referred nerve from like a sacral nerve root, a low back issue, stuff like that.

So it's just the nerves aren't as specific down there so you kind of need those specialists to be like, hey, what's going on? The urologists really rule out organ dysfunction. Surgeons are very organ focused. So I'm going to tell you you don't have bladder cancer, I'm going to tell you you don't have GSM, or need hormones.

But as far as like the nerves and the muscles, the PTs are so much better at that than the doctor. The doctor is good to tell you you don't need surgery and it's not cancer. Great information to have, right? But then to get you relief, you're probably going to need to see a PT, pelvic floor PT.

Susi: So this is a great segue now into your upcoming book that's like almost out, right? Like it's coming out next month, isn't it?

Kelly: Yep.

Susi: So yeah, tell us about your book.

Kelly: So my book is called You Are Not Broken, which is the same name as the podcast that I started. And just like side note on that, it like literally, again, the lightning struck the brain because so many women would tell me their stories. And then learning what I learned, I'm like, “Well, you're not broken, most people don't have orgasms by putting something in their vagina.” Right? But we don't know that, right?

Another you're not broken it like a woman being like, I just don't have like spontaneous desire for sex after being married for 10 years and having two

kids and a stressful job. And I'm like, “Well, you're not broken. Most people don't have spontaneous desire for sex in that scenario.” Right?

And just normalizing people's experiences over and over. I'm like, oh, the podcast should be called You Are Not Broken. And I truly believe that nobody is broken, we're all just trying to live our best lives, right?

And so the book is You Are Not Broken, Stop Shoulding All Over Your Sex Life. Because I think the messages we get from our religion, from our partners, from our family, from our friends, from Hollywood, from the top 10 country hits, from, you know, thebestwaytobeamom org. Like everything we get is how your sex life should be.

And there's so many shoulds, like how many times a week should I have sex? How long should sex take? Should it always be spontaneous? Like there's so many shoulds. And again, that's really where I wanted to incorporate the brain. Because it's like I can make your pelvis work great. I just told a woman this like two weeks ago. I'm like, I can give you great vulva and vaginal skin. I can give you the best lube. I can make it so you can put something in your vagina.

But if that's not what you want, that's really good information to have. And I can't tell you the amount of women who come into my office, they're there because they think they want the penis to go in the vagina and it can't because it hurts or whatever it might be. And I say, but what do you actually want?

They have no freaking idea what they actually want. And that is the silent epidemic that we're having with women sex lives, is we were never asked what we want. Like we were never actually told that sex is supposed to be pleasurable, right? And then when it isn't, because we weren't told like how to do that, we think we're broken.

So it's just a fascinating topic and I absolutely love it. And I get stories from like a 71-year-old who emailed me and is like, because of you I laid naked

next to my partner and we cried together and it was like the most intimate that we'd ever been. And it's like that's what intimacy and sex is. It's not just physically putting something in your vagina.

And, of course, you don't just want that because it's never actually been that satisfying to you. It's satisfying to some people; some people love it. But some people it's not what they want. So asking that question like, what are your goals? And just pausing there because a lot of women have no idea what it is.

Long story, but that's what the book is about. Our body and our mind, how to communicate, how to truly realize what we want is intimacy, not just the ability to put something in our vagina.

Susi: When you're working with your patients are you able to have those dialogues with people?

Kelly: It's very hard, right? I'm still a traditional doctor doing traditional insurance-based medicine. And there's so much barriers to getting to that point where I can say, like they just met me. Bonus points if they've listened to my podcast, you know, read the book because they already kind of know. They know so much more when they come in.

But if they just met me and they still think they're there because if I can just get my husband's penis to go in my vagina, our relationship is going to be good. Which is very, that's classic. That's like the classic reason to see me. And it's like for me to be like, okay, underneath that ask, what's actually going on? Oh, we're super distant because stress and our kids have filled up our entire life. We haven't talked to each other about sex in eight years, right?

So it's like you got to dig underneath that ask to be like, "What do you actually want?" And if they think that sex isn't something they desire, the question is, what sex would you desire, right? Sex worth desiring, is that

something we've ever thought about? Versus the sex that Hollywood tells you you should have, which is very unsatisfying for the average woman.

If you look at the orgasm gap, for example, which is fascinating. So much good research on this, but the heterosexual male has the highest “success” of orgasm in any sexual experience at around 98% success. Then we have homosexual males, homosexual females.

The heterosexual female has the lowest amount of orgasm in any partnered sex of anybody, and it comes in around 60% in a long-term relationship. If you put her in a hookup situation, like a college student hookup situation, hook up orgasm for the female is around 7 to 9%, it's abysmal.

And then we could argue like, well, orgasm is just one marker of pleasure and it's maybe not the best marker. And it's like but it’s the best we have to say like are we getting equal kicks from this physical interaction? So women are so underserved in their sexuality. And having their sexuality be there's not just something they do because there's another person in the bedroom or another person in the marriage.

So to me, I'm like this topic will be fascinating until I die. It's so complex with like society, and relationships, and our bodies. And like you do your work with, like you've got to get out of thinking about tomorrow. and yesterday.

You've got to get into your pelvis, learning how to breathe, learning how to know where your clitoris is, learning how to focus on the present moment and touch. All that is a skill that really helps sexually, but we're so disconnected from our bodies, right? So there's so many pieces to this.

Susi: Really interesting. So if you could give, you already listed some, but I just want to circle it back up and lasso it a bit. If you could give five questions that someone could engage with, one of them is like, what do you want? What are four other questions that someone listening to this

could then just start to go into that void that they might not have ever even inquired, but might just be like, “Huh, interesting.”

Kelly: Well, I think so many women, they wonder why they don't desire sex. And to take that question and be like, you know what’s a little bit easier is to think what kind of sex don't you want to have? And that tends to come up a little bit easier for people, right? They’re like I definitely don't want that, I definitely don't want that. But then you can get into like sex where I don't feel seen. Sex where I feel like I'm just being used to satisfy somebody else's need.

Like you kind of get into the sex you don't want to focus on the sex that you might want. Because women have never been asked what kind of sex do you want, right? And that's different for everybody and there's no normal as far as sexuality goes. There's no normal, which is really good to know. So it's like what you do want and what you don't want are probably two questions that will get you different pieces of information.

The third question, so what do we have? We had what kind of sex do you want? What kind of sex do not want? What does sexuality mean to you? Which I think a lot of women have never thought about, right? And when you really get into the research and the people who like embody sexualness and like pleasure, because what you desire is part of that, we’ll make that question four.

And one nice thing about what you desire is like to write down, you know, 5 to 10 things that you desire, and then look at your list and see how many of those things do you actually currently have? Because we forget to desire what we already have, right? We take it for granted or we’re like entitled to it. It's always something we don't have. So desire is a very fun, interesting thing to play with.

And then I would say for the fifth question it would be how do you want to be propositioned for sex, right? Because so many women are like, “He just

comes up and grabs my boob." Or he just says, "Hey, baby, how about now?" And it's not how they want to be proposition for sex, right?

Would they like to just have it scheduled so they don't have to stress about it the other days of the week? Would that be ideal? Would talking on the couch with a cup of tea or a glass of wine and like really feeling emotionally connected, is that the foreplay that they want? Because so many women, they don't like how their propositioned, but they don't really know how they would prefer it because they've never been asked, right?

And so it's like asking ourselves these questions really helps us understand maybe it's not that I don't desire sex. It's that I just don't desire the sex I'm currently having, there's two very different things.

Susi: And if someone is asking those questions of themselves and they get to that point of some clarity, then what are ways to begin to engage with their partner? Because if they haven't been asked, likely they haven't been telling either. So what are ways to inch towards that conversation?

Kelly: Yeah, so tips and tricks for that. First of all, we don't get taught how to talk to our partner about it, right? So it's awkward and it's awkward for a long time. Which leads me into like it's not one conversation. Our bodies change, we have babies, we go through menopause, he has erectile dysfunction issues, there might be a cancer scare, there might be a death in the family.

These are all things that if we haven't learned how to navigate our intimacy and our sex kind of early on when it's easy, kind of like you going to the PT when it's early and easy and nothing's wrong, right? It's like, these are barriers that could make it harder and harder. Or to be like, "Hey, we're in this new phase, I'm not really feeling intimate to you right now. Can we talk about this again? Can we bring it up again?"

Because so many people are like it's the sex talk, right? You talk to your kids once about sex and then you talk to your partner once about sex and

then it's fine. No, no intimacy is built in talking about sex and intimacy. Do it when you're clothed, don't do it after like a failed sex attempt. Like, well, actually, you've never actually done it for me and I've been faking orgasms this entire time. That's not how to do it.

Some people like to know what's coming, so not just spring it on them. Be like, hey, tomorrow when we have breakfast or we have go out on a coffee date, or when we go away this weekend, I'd really like to talk about seeing how I can make sex more interesting for me. And make it about you, not the partner, right? Because if we're blaming and shaming, there's going to be resistance that goes up. So it's really saying I feel.

And you can use me, I always say use me as an excuse. I've been learning a lot about female sexual stuff that I've never was taught before. Did you know that there's a huge orgasm gap in heterosexual couples? Did you know that desire goes down the longer your relationship is? Just those like fun facts of like I was learning about that and I'm curious about X, Y, and Z.

So make it about you, make it curious. And then if your partner chooses to open up and give you feedback, being a good listener and just being available for that person to share and to hold that for them. And to not judge them. Be the best listener you can be because that's what you would ideally want when you are sharing that with somebody. Especially if it's been going on for years, right?

Barry McCarthy in his book, Rekindling Desire, which I highly recommend. He says, I think he says like if it's been sexless for more than six months get help. Because the longer it's been, the more barriers, and shame, and awkwardness, like it's clunky to bring that back into your life.

The other thing I would advise, because especially when we talk about heterosexual heteronormative relationships, is the heterosexual’s view of what sex is is incredibly narrow. It's the penis goes in the vagina, when the penis has an orgasm sex is done. Bonus points if she got an orgasm or not in that time it took for him to have an orgasm.

Realize how incredibly narrow of a window for success that is. And when we have vagina problems, either menopause, or I just had a baby, or I've got cancer, or I just got a hip replaced, whatever it might be. Or we have penis problems, erectile dysfunction, premature ejaculation, whatever, anxiety, depression, side effects from meds, whatever that might be.

When our window of success is so narrow, it's so much easier to fail, right? Versus let's just get naked and like talk. Or let's just do like a naked massage. Or let's just do like, and again I'm just giving suggestions, whatever it might be for you, of like let's just play with hands and mouths today. Let's just focus the orgasm just on you, I don't even want it today, I just want to give you pleasure. Right?

Like you're just starting to look at how expansive sex can be so that you have less room to just fail so hard and fast.

Susi: So great. Thank you so much for this, this has been really, really, really terrific. Remind us where your podcast is.

Kelly: My podcast is on seven platforms now, the most common being Spotify and Apple. It's called *You Are Not Broken*. I'm most active on Instagram, Kelly Casperson MD, and that's my website as well.

Susi: Awesome. Thank you so much, Kelly.

Kelly: Absolutely.