

The ANUWELL Guide to Hormones After 40

How changing hormone levels can influence sleep, cognition, body composition, energy and sexual health.

The ANUWELL Editorial Team · 8 min read · Updated September 2026

KEY TAKEAWAYS

Key takeaways

The short version, if you read nothing else.

THE NETWORK

Hormones are part of the body's signaling network. Even relatively small shifts can affect sleep, cognition, body composition, energy, mood, and sexual health.

TWO ARCS

Hormones change differently across midlife. For men, the shift is often more gradual. For women, the transition through perimenopause can be much more variable and unpredictable.

CONTEXT

Hormones do not operate in isolation. Sleep, stress, muscle mass, nutrition, and blood sugar can all influence how you feel and how your body responds.

GOOD CARE

Good hormone care starts with context. Baseline labs, symptoms, health history, and goals help shape the initial plan, with follow-up used to monitor response and adjust treatment over time.

BY THE NUMBERS

Hormones after 40, in four figures

~1% / yr

the average rate testosterone declines in men from the 30s onward. ^[1]

10 to 15%

how much daytime testosterone dropped in healthy young men after one week of five-hour nights. ^[2]

3 to 8%

the muscle mass adults lose per decade after 30 without training. ^[3]

~52

the average age of the final period in the US. ^[4]

THE SYSTEM

The network behind how you feel

Start with the fact that surprises almost everyone. The hormone most people call male is the most abundant biologically active sex hormone in a woman's body across most of her life. ^[5] And men depend on estrogen: in a landmark experiment, lowering estradiol in men drove fat gain and eroded sexual function independently of testosterone. ^[6] There are no male hormones and female hormones. There is one signaling network, running in every body, at different volumes.

That network is a set of ongoing conversations. The brain signals the pituitary, the pituitary instructs the glands, the glands answer with hormones, and those hormones report back to the brain, which adjusts

the signal. Sex hormones, thyroid, cortisol, and insulin all run on versions of this loop, and they influence each other constantly. Which is why hormones never feel like chemistry from the inside. They feel like sleep quality, word recall, waistline, drive, and desire.

After 40, the signal in these loops starts to change. Not all at once, and not the same way for everyone. But predictably enough that understanding the pattern puts you ahead of most of the appointments you will ever sit through.

TWO ARCS

The taper and the transition

Midlife hormone change follows two different shapes, and knowing which curve you are on changes how to read your own experience.

MEN: THE TAPER

For men, it is a taper. Testosterone declines around one percent per year from the 30s onward, on average, while the protein that binds it rises, so the free, usable fraction falls somewhat faster. ^[1] The change is gradual, which is exactly why it hides: there is no single month where everything shifts, just a slow drift in recovery, drive, and body composition that is easy to misfile under stress or age. And here is the part worth knowing before the internet tells you otherwise: the taper is not destiny. In a large European study of men aged 40 to 79, only about two percent met the full criteria for age-related low testosterone, low levels and symptoms together. ^[7] Many men maintain healthy levels for decades. The point of testing is to find out which story is yours.

WOMEN: THE TRANSITION

For women, it is a transition. Hormones do not taper so much as swing, sometimes higher than in your 30s, sometimes sharply lower, before settling after the final period at an average age of about 52. ^[4, 8] The volatility itself drives many of the symptoms, which is why the experience can be loud even while a single lab draw looks normal. The full arc, from first signals to guided care, has its own cornerstone guide in this library.

	Men: the taper	Women: the transition
Shape	Gradual decline, roughly 1% per year from the 30s ^[1]	Fluctuation for years, then a defined transition ^[8]
Tempo	Slow drift, easy to misattribute	Variable, sometimes month to month
Key signals	Recovery, drive, body composition, morning energy	Cycles, sleep, mood, temperature, cognition
Testing logic	Confirmed morning levels plus symptoms, on more than one draw ^[9]	Clinical picture first; single draws swing too much to diagnose ^[8]

WHERE YOU FEEL IT

Five domains, one network

Sleep

Hormones and sleep run a two-way street. Progesterone and estrogen changes fragment sleep in the transition, cortisol rhythm shapes when you wake, and the traffic runs backward too: one week of short nights measurably lowered testosterone in healthy young men. ^[2] Poor sleep is not just a symptom of hormone change. It is the cause of more of it.

Cognition

Word-finding pauses and a fog over focus track hormone shifts in both sexes. Estrogen receptors sit throughout the brain, thyroid hormone sets the tempo of nearly everything, and studies that follow women through the transition find the fog is real, measurable, and for most people temporary. ^[10] Slow thinking in midlife is worth investigating, not accepting.

Body composition

Sex hormones help decide where fat is stored and how easily muscle is kept. As they shift, storage moves toward the midsection and muscle becomes harder to hold, in both men and women. ^[6, 11] Since muscle is also the body's largest disposal site for blood sugar, this is where hormones and metabolism become one conversation.

Energy

Persistent fatigue is the least specific signal and the most common one. Sex hormones, thyroid, cortisol rhythm, iron, sleep debt, and blood sugar swings can all produce it, alone or together. ^[12] That is precisely why energy complaints deserve a system read rather than a single-hormone guess.

Sexual health

Desire, arousal, comfort, and performance all have hormonal inputs in every body: testosterone and estradiol in men, and testosterone, estrogen, and tissue changes in women. ^[5, 6] These changes are physical, common, and treatable, and they belong in the same clinical conversation as everything above, stated just as plainly.

THE INTERPLAY

It is rarely just one hormone

The most common mistake in hormone health is chasing one number. Thyroid dysfunction can look exactly like low testosterone or perimenopause: fatigue, weight change, mood change, mental fog. ^[12] Chronically elevated stress load pushes on the same systems. Insulin resistance develops quietly alongside all of it and makes every other problem harder. ^[13] And several of these can be true at once.

This is why hormone testing worth doing reads across systems rather than checking a single level: sex hormones alongside thyroid, metabolic markers, and inflammation, so the pattern is visible and the mimics get caught. It is also why results need a physician rather than a search bar. A number out of context is a guess with confidence.

"Fatigue has a dozen credible suspects. Testing across systems is how you stop interrogating the wrong one."

CARE

What good hormone care looks like

01 Start with a baseline

Initial labs help your physician understand where you are starting, alongside your symptoms, health history, stage of life, and treatment goals. In certain situations, a physician may repeat a specific result if it is borderline or requires confirmation before making a diagnosis.

02 Build the plan, then monitor

When treatment is appropriate, your physician can develop an initial protocol based on the full clinical picture. Follow-up labs are typically recommended after treatment has had time to take effect so your care team can see how you are responding, monitor relevant safety markers, and adjust the plan when needed.

03 Monitor what you treat

Hormone treatment is not set-and-forget. Follow-up labs help your physician assess your response, monitor key safety markers, and make adjustments when needed. A plan that evolves over time is not a sign that treatment is uncertain. It is what thoughtful, responsive hormone care should look like.

THE PLAYBOOK

Five moves, whichever arc you are on

01 Test, don't guess

A systems-level baseline: sex hormones with their binding proteins, thyroid, metabolic markers, inflammation. Morning draw, fasted where required. You cannot personalize what you have not measured.

02 Lift

Two to three challenging resistance sessions weekly. Muscle is the tissue midlife erodes fastest and the one that pays back most, in strength, blood sugar handling, and body composition. ^[3, 15]

03 Anchor protein

A substantial protein serving at every meal, front-loaded into the day. The body gets less efficient at turning protein into muscle with age, so the target rises exactly when habits drift. ^[16]

04 Treat sleep like a hormone intervention

Because it is one: a single week of short nights lowered testosterone measurably, and sleep debt degrades insulin sensitivity and stress tolerance. ^[2, 17] Consistent wake time, morning light, cool dark room, earlier caffeine cutoff, alcohol counted honestly.

05 Retest and trend

Your own baseline is the reference range that matters most. Recheck flagged markers on the cadence your physician sets and read the trend, not the single draw.

START HERE

Your next two weeks

WEEK 1

- Write down what has actually changed in the last year: sleep, recovery, mood, drive, body composition. Specifics beat impressions.
- Book a morning lab draw for a systems-level panel, fasted per instructions.
- Add a protein anchor to breakfast and set a consistent wake time.

WEEK 2

- Complete two to three resistance-training sessions. You don't need a gym or heavy weights. Bodyweight exercises and resistance bands can provide an effective workout.
- Hold the wake time. Move caffeine earlier and count drinks honestly for one week.
- When results arrive, review them with a physician against your list from week one, not in isolation.

Two weeks does not change your hormones. It produces the record, the baseline, and the habits that make everything after it work better.

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Testosterone therapy, hormone therapy, and the other treatments discussed here are prescription medical care and are not appropriate for everyone. Personal and family medical history, including prostate or breast cancer, blood clots, stroke, cardiovascular or liver disease, elevated red blood cell counts, untreated sleep apnea, and plans for fertility, meaningfully changes whether treatment is appropriate, which is why it is prescribed only where clinically appropriate following review by a licensed physician; completing an assessment does not guarantee a prescription. Treatment requires ongoing laboratory monitoring. Report unusual bleeding, and seek immediate medical care for possible signs of a blood clot, heart attack, or stroke, such as chest pain, shortness of breath, leg pain or swelling, sudden severe headache, or sudden changes in vision or speech.

FAQS

Common questions

Do men go through a version of menopause?

Not really, and the difference matters. Women experience a defined transition ending in a clear event. Men experience a gradual average decline of about one percent per year, with wide individual variation, and most men never develop true hormone deficiency. ^[1, 7] "Andropause" makes a slow, variable taper sound like a universal cliff, which is why physicians avoid the word.

Can lifestyle actually change my hormone levels?

Meaningfully, yes, at the margins that matter. Sleep restriction measurably lowers testosterone, and restoring sleep restores it. ^[2] Resistance training, adequate protein, and improved body composition all support the network. ^[15, 16] What lifestyle cannot reliably do is fix a confirmed clinical deficiency, which is what evaluation and treatment are for.

How do I know whether it is my hormones or something else?

You often cannot tell from symptoms alone, because thyroid, iron, sleep debt, stress load, and blood sugar produce overlapping pictures. ^[12, 13] That is the argument for a systems-level panel read by a physician: it either confirms the hormone story or catches the mimic before you spend a year treating the wrong thing.

My labs came back normal. Is that the end of it?

No. Normal is a statistical range, single draws are snapshots, and hormone levels in particular swing by time of day and, for women in the transition, by week. ^[8, 9] Persistent symptoms with normal labs deserve a repeat draw, a trend, and a physician reading the whole picture, not a shrug.

Is hormone treatment something I would be on forever?

Not necessarily, but hormone therapy does not automatically end when menopause does. Some women continue treatment well beyond menopause because hormones influence more than hot flashes or cycle-related symptoms. They also play a role in bone health, vaginal and urinary health, sexual function, sleep, mood, and overall quality of life.

There is no single age or timeline when every woman should stop. Your physician will periodically review your symptoms, health history, labs when appropriate, treatment goals, and individual risks to determine whether continuing, adjusting, or stopping therapy makes sense. For some women, treatment is temporary. For others, ongoing therapy may remain beneficial later in life.

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