The Human Brain's Role in Libido and Sexual Relationships After 40
BioBalance Podcast — Dr. Kathy Maupin interviewed Brett Newcomb
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In a recent interview with Therapist Brett Newcomb, we discussed the human brain's role in libido and sexual relationships after 40. I get asked a lot by my patients where the libido went, and why it is gone, and what controls libido? Brett's expertise with treatment of sexual relationship issues comes from the perspective of a therapist exploring the interaction of the brain and the biology of sex.

In popular literature you find statements to the effect that the brain is your most important sexual organ. I think we need to think about it in that certain way, to talk about it as a sexual organ. Thinking about it in that way is what scientists call a "Heuristic" concept, which is a way to discuss something that does not exist in a concrete, laboratory sense "reality". It is like when you were in Kindergarten and your teacher would say, "Put your thinking cap on." And everybody would put an imaginary cap on their head and fasten it. There is not a real thinking cap. If we dissected your brain, we would not find a part that we could say, "Here is your thinking cap." The same thing is true in terms of the brain as a sexual organ. There are "tentacles" that are physiological, psychological, emotional, cultural, all simultaneously regulated by the brain; not in a hierarchical "1, 2, 3" way, but interwoven. That is where we get to the issue of the libido. It is part of that whole interwoven matrix of messages from all of the component parts of the brain. There, we then identify our experience as what we call a "sexual experience."

When patients ask me where their libido went, my answer is "You probably have lost your testosterone. Let me check and see if we can replace the testosterone, and see if libido returns." It is much more complicated than that. But, testosterone is necessary for a healthy libido and a healthy sexual response.

Let's talk a little about the neurotransmitters. According to Brett, we want to make a distinction between primary level dysfunctions and secondary level dysfunctions. Primary being defined as those physiological issues where an individual reports they never really had orgasm or a full sexual experience that was satisfying for them. They may go through the motions, but they have not ever had the satisfying experience. The secondary level we are talking about are those couples that have had high-quality relationships and then for any of a number of possible reasons, lost the handle. We want to talk about the mechanisms of recovery for those who have had it, and need to try to get it back. When we talk about arousal, we talk about desire, we talk about the physical processes and experiences, we talk about orgasm, we talk about the after math; the "whole ball of wax". If we break out any component of that, it is like a tentacle that we want to focus on. We may need to focus on specific tentacles but we do not ever want to lose sight of the whole ball of wax. Because, that experience is what people are actually looking for.

In regards to this, my simplistic "We need to get your hormones back," still holds true. Because, often testosterone is one of the required components to get the relationship back in all the other ways. One of these tentacles is testosterone.

As Brett confirms, that is where the heuristic concept comes in. Because, the brain works through the use of chemical messengers and testosterone is one of those chemical messengers. We are working to build the whole perceptual experience of a good sexual encounter. That is where the whole is greater than the sum of the parts. But, we have to use the specific parts to get the sum. So, you have to talk about the hormones and neurotransmitters. That is why people have problems when they are on anti-depressants, and some types of blood-pressure medicines. All of those things are factors that can reduce sexual performance, and the sexual experience. Whether they reduce the desire; if someone has reduced the testosterone, then they are not going to feel the desire. And, what happens with a lot of couples is they get habituated in their sexual behaviors. They fall into a routine of, "every Wednesday night, and every other Saturday morning is 'our time.'" Not spontaneous anymore, and not open for other opportunities, they do not look for those moments and do not recognize them when they present themselves. So, if you suddenly get an afternoon where the kids are all "outshopped" somewhere, and you are home, it does not occur to you that, "now is the time to have creative, new sex." It occurs to you, "now, I can shampoo the carpet" because it is not Wednesday night or Saturday morning. The habituation effect causes us to lose spontaneity, because we are habituated to thinking, "Wednesday and Saturday." When age begins to be a contributing factor, or when testosterone loss begins to be a contributing factor, sometimes on Wednesday or Saturday, we become anxious about our performance. And maybe rationalize our anxiety with thoughts like, "I recognize I'm supposed to do this today. But it's just too much trouble. I'll find a creative, indirect opportunity that interferes, so I don't have to perform." Then, you get performance anxiety. Couples do not easily communicate about that. Very often, they do not have the ability to sit down and say, "You know, I am finding that Wednesdays I am avoiding sex. I am aware of it, but I am building an anxiety load on Wednesday afternoon, because I know the expectation is there. Then I have performance anxiety." And for men, particularly men beyond 40, performance anxieties are deadly. You get all of that working, and the question is, "how do we reverse that?"

And, often women do not even care if it does not get working again. Because, without the testosterone in their brain, their acknowledgment of even being sexual is decreased. Lack of testosterone removes all parts of sexuality. They do not think about sex at all, they do not consider having sex with their spouse. Even if they are not really avoiding it, they just do not have it on their list.

Brett asked if the the women that I talk to make a distinction between sex and romance? Do they still have romance fantasies, but, see them as innocently nonsexual? "Can't we just be emotionally warm and go out to dinner and have a nice time but without all of that other stuff?"

Romance is built into how we are trained as females. Generally it is part of our upbringing. It is more of a habit to want and expect romance, even though most of us rarely have that in our relationships. The expectation of romance was there before hormones because of our exposure to things like Walt Disney fantasies at an early age. I think in general, women still desire that, that is how they know that they are valued.

Brett observed these as markers of being loved that are hard wired, early on. But, everything else has come with hormonal emergence in our teens. Women in their 20's and 30's develop more of a sexual persona, related to their hormonal levels, as well has how they were taught and what their relationships are like. Some women have more testosterone than others. Some women have higher sexuality than others. That usually continues unabated until our 40‘s, some people earlier than that. (If the ovaries are removed, there is a drastic change.) When that happens, I notice women saying either, "My husband wanted me to come, because he says we that we are not having good sex”, or “we are not having sex often enough”, or “I don't want him, he feels unloved," that kind of thing. They come to me because their marriage is on the rocks and they are not sure why. They think it might have something to do with sex, but they do not talk about it. In this generation, in this age group, women do not talk about sex to their partners. It gets worse as we get older. As we get to people who are in their sixties, “nice women do not talk about sex”. As a result, having a conversation about sex is not a normal thing. Then it is all about body language, and feelings and catching the moods from your husband. And, all of that has to do with hormones and pheromones, which come from hormones.

And, Brett explained the imbalance sometimes occurs because couples develop signaling or cueing strategies over the course of their relationship. It is that dance of cueing that we do. And, when the testosterone diminishes and the hormonal imbalance occurs in the presence of that cueing, the receptor sights do not work. The husband might be sending all of the signals that they have mutually agreed on without talking about them, and the wife’s chemistry is off-balance, then her receiver's not turned on and she’s not getting those signals anyway. He does not understand that chemical change in her, and that makes him angry, hurt, jealous. We have that conversation when people are taking anti-depressants, because many anti-depressants suppress both arousal and climax. When I have couples that I know are on anti-depressants, one of the things that I am very careful to talk to them about is to say what they should expect over the next several months; the partner who is on the anti-depressant will lose the stimulatory arousal mechanisms. They may be able to participate if the other partner starts it, but it is not going to occur to them to initiate sex, because it will not come naturally. And, then even if they are participating responsibly, and get themselves engaged, all of a sudden, in the middle of it, sexual desire just turns off like it had never started. The other partner has to understand that it is not personal, it is that their body chemistry just shut off because of the drug. Some of the issues with testosterone loss are similar.

The medical community tends to put women who do not feel well in their 40‘s on anti-depressants, which compounds their sexual impairment. They are no longer feeling the depression, but they are angry and they are stressed. And their husbands are not

happy, which makes everything worse. What we try to do is replace what is missing; not just give people serotonin, which is what the anti-depressants do. Oftentimes testosterone is a mood-elevator. When we give people back their testosterone, their mood elevates and they find they do not need the anti-depressants. So, we do two things; we give them back a sex drive, we overcome the anti-depressant by increase dosing. Then, we can get them off the anti-depressant and can decrease our dosing a little bit.

But, as Brett pointed out, this treatment is not accepted in the general medical community. It is a specialized knowledge based on extensive research.

Endocrinologists and anti-aging physicians know about this because they read about it in medical and endocrine journals. And, I have articles that state this. However, in general, this therapy is not picked because it encompasses a lot of social knowledge, or knowledge about sex. And, generally, physicians are kind of impaired because we are not very social in general; they do not want to talk about it. A physician does not really want to address these sexual and social issues, so, they do the next best thing; "Here, take this pill."

We were talking about the brain as the most important sexual organ and the chemical messengers of the brain being out of whack. And if they are out of whack long enough for a different kind of habituation to occur, then we restore the balance, Brett described his understanding of this as being similar to what we tell people that are on ADHD medicines; you still have to develop compensatory strategies. Once the medicine can normalize the chemical structure of the brain, you still have to have performance strategies to make use of that opportunity. Then we come back to the brain developing performance strategies for seduction, arousal, for creating the “whole is greater than the sum of the parts”. How do we facilitate that whole desire for sexual experience component from just the physical release component of the chemistry?

Happily, I rarely have to deal with that. When people come in with that issue, we discuss how testosterone might change that. And, they basically snap back within six weeks. They are back to their old brain pattern, their old sexuality, their old desire. In general, if this was chemical to begin with, they do not have to relearn those aspects.

Sometimes I get people who have perfect levels, everything else gets better but that. Then I know that they have to come see Brett or see someone to counsel them on how to get back into their old sexuality, or maybe they were always like that. It may be that that was their normal, and they expect something more. It is such an expectation-laden issue, that I have to say that most of the time it will bring people who are functional back. People that do not want to have a sex drive generally do not show up in my office. Because they know testosterone replacement does cause that. If they just have a psychological block, or if they are pressured to show up in the office because somebody else has the leverage to say, "if this doesn't get any better then we're done", they do not show up seeking treatment.

Not wanting to be fixed is more common in women's brains than in men's. Men tend to have more external, obvious signs that their testosterone is low and they want to be fixed.

Brett asked if I thought this is more of a physiological issue or a cultural issue in terms of that whole, catholic message of, "sex is for procreation, and once you're not going to procreate, then sex is not a big deal anymore, and it is okay to let it go."? My answer was that, once again, the women who show up in my office are there about sex.

They are not coming in because their spouse wants them to. Those women would rather lose their marriage than get back into a sexual relationship. Some of them say to me, "I'm so glad it's over. that's just one thing off my list." This is difficult for me to understand, but that is something they have felt their whole lives; they put up with it. And, now that they do not have to put up with it, they are relieved. That is not chemical. We can give them testosterone, but they are not going to get sexual desire back because they do not want to.

There is a lot of higher thought brain work here. And there is a lot of lower thought brain work that is just the natural instinct that all people have that draws them to having sex. Just like any other mammal, we are drawn to have sex if we are in tact mentally and hormonally and emotionally. That is one of the things that is natural to being human.

And that leads to a whole range of other discussions that we will be having in the future. Whether it is the cultural messages of sex, or the communication strategies of sex, or the physiological aspects that need to be considered.