Male Menopause

A Literature Review

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Abstract

This paper will investigate the validity of male menopause by asking the question, does male menopause or what is commonly referred to as hypogonadism exist? Over the last several decades this has been an issue of concern. Questions have come up in the medical professional field. The research obtained suggests that we begin looking at factors that influence the likelihood of male menopause. This review will look at how drops in testosterone levels, overall health and well-being contribute to the condition of hypogonadism in men. This review discusses common changes associated with particular symptoms associated with behavior, agility and health with this condition. The conclusion identifies symptoms associated with male menopause and different treatments. The discussion will explore other factors that could affect testosterone levels and effective treatments as well as the need for educating men and their providers are the importance of making a correct diagnosis to maintain care and the overall health of the client.

Keywords: Andropause, Hormone Replacement Therapy, Male Climacteric, Hypogonadal men
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To Anita for without you I would not have had a topic to pursue nor would I have understood the need for the importance of understanding in every area physically, spiritually and emotionally men’s health. Because of it I am and will be a better therapist.

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Male Menopause

This paper offers a summary of literature examining male menopause. Menopause is typically known as a condition concerning women. It is a time when a women menstrual cycle ends and hormonal depletion becomes inevitable. It is a place where her hormones drop causing sexual, physical, and emotional changes and difficulties in her life. It is characterized by a plethora of symptoms such as decreased muscle tone, night sweats and/or hot flashes, (Sternbach, 1998; Vermeulen, 1993) migraine headaches heart palpitations, along with involuntary urine release and bladder urgency, irregular and/or heavy periods, vaginal dryness and painful intercourse (Gould, Petty, & Jacobs, 2000). Menopause has been specific to women in the last century however there is evidence to support that that may not be necessarily true.

Over the last century there has been discussion concerning menopause occurring in men. This discussion had brought up queries such as do men also go through a similar cycle in which they develop similar symptoms and changes as they age? Asking the question does male menopause exist can help shed light on the middle aged and ageing male. Furthermore, having a discussion as to what changes that men would go through would help in establishing if there is something similar to menopause for men, this will give us a better understanding of how to meet the needs and give effective treatment if needed.

Speculations over the changes men go through in the middle and later ages has stimulated the conversation for decades asking questions such as what do men go through, and does male menopause happen and if so is it because of drops in hormone levels like women as well. Questions like this provoke us to look deeper into symptoms that supposedly occur. Does male menopause occur and if so does it occur at a certain age, and do men go through the same
symptoms as women? This review will look to see if there is scholarly or professional support that would imply that male menopause is important enough to explore as a serious condition.

This review will begin looking at how drops in testosterone levels, overall health and wellbeing contribute to the condition of hypogonadal men. We will discuss changes in behavior and agility and health in men associated with this condition include symptoms associated with male menopause as well as treatment.

Furthermore we will look at discussions in the past as to whether or not male menopause really exists and if there is any realistic way to tell if it does and if it affects a man at any given age. It will look at additional patterns on how to treat this condition as well as look at testosterone levels in the blood, and how these levels factor in the changes that can occur in men.

First the review will be looking at factors that influence the likelihood of male menopause or androgen. Second it will look at how drops in testosterone levels contribute to the condition of hypogonadal men, and finally how male menopause affects the overall health and well-being of the menopausal male. The review will discuss changes in behavior and agility, and changes in the health men associated with this condition. This discussion will furthermore include symptoms associated with male menopause as well as treatment. The terms hypogonadal, androgen, climacteric men are all terms that will be used in the research to best describe male menopause (Burris et al., 1992).

**Variables and Factors**

In the literature, researchers looked at levels of testosterone, along with health and wellbeing to begin to make their argument concerning male menopause. The testosterone levels would be the core determinant in making a case for male menopause as well as secondary symptoms they would experience both physically and mentally. The researches concluded that
any testosterone levels between 200 and 400 nmol/liter as well as levels less than 200 nmol/liter of testosterone and 8.91 ng/dl of free testosterone from morning samples would be one of the determining factors in answering the menopause question (Araujo, et al., 2003). Researches of one study stated that Testosterone levels decreased by 40% between the ages of 40 and 70 years of age (Barrett-Conner, Von Mullen & Kritz-Silverstein, 1999). Metz put the age between 30 to 60 years for when testosterone begins to drop (Metz & Miner, 1998). In other study the researchers found that insufficient levels of testosterone were found to be the cause of low libido and sexual potency (Burris et al., 1992; Gould & Petty, 2000).

Furthermore the researcher noted that out of 32 different factors/ symptoms there were nine core symptoms broken into three categories as follows: The sexual symptoms: decreased frequency of morning erections, low sexual desire- sexual thoughts, erectile dysfunction. The physical symptoms: inability to engage in vigorous activity, inability or difficulty walking a minimum of 1 mile, inability to bend, stoop or kneel. And finally the psychological symptoms: loss of energy, sadness, and fatigue (Wu et al., 2010; Gould, Petty, & Jacobs, 2000; Malkin et al., 2004). These nine elements were chosen to be that which would be calculated in as determining indicators. These core elements seemed to be repetitive factors from earlier decades of research that test subjects reported on. From these factors they chose nine core factors (Wu, et al. 2010; Wang et al., 2004). These nine were narrowed down by overwhelming reports from subjects in the study going back to the 1930’s (Bhasin et al., 2010; Feldman et al., 2002). Walker stated in his research that both emotional and psychological disturbances tended to manifest in men that were having sexual difficulties (Walker, 1938).

For Sexual health the researchers looked at morning erections, sexual thoughts, and erectile dysfunction. The research focused on the inability to have a morning erection as well as
having decreased sexual thoughts/fantasies and increased erectile dysfunction. Other researches pointed out symptoms of impotence and decrease libido (Metz & Miner, 1998).

Furthermore they looked at the inability to maintain an erection throughout sexual intercourse or (Anderson, Martin, Kung et al., 1999). Anderson also tested the increase or decrease of sexual activity.

For physical side of health the review examined the ability to engage in vigorous activity for a period of time as well as if they were able to maintain stamina while walking without being winded or sore. Furthermore the researchers looked for flexibility in bending, squatting and kneeling.

Finally the researchers looked at the emotional health of the subjects. They looked at loss of energy, sadness, and fatigue basically symptoms associated with depression. Anything that presented itself toward depression was a key factor in completing the model for emotional symptoms of menopause in the subjects.

The researchers concluded that in order to be diagnosed with male menopause or what is termed low androgen or to be considered for any treatments subjects had to have testosterone levels of 200nmol/liter, and have at least three of the signs and symptoms from above, or they had to have a range of 200-400 nmol/liter with at least three signs and symptoms. However the subjects in the study could also have the signs and symptoms of all nine and not yet have been tested. The subjects would at this point have a general diagnosis, but not be treated until testosterone levels can be officially tested and verified testosterone levels dropping as the direct cause.

It was interesting to see that symptoms and variables stayed the same over several decades and that previous researchers from the early 1900’s to 2005 and beyond came to the
same conclusion. The earlier studies also used testosterone levels and the same physical, sexual and mental health components to determine the validity and support the claim for male menopause which was termed male climacteric syndrome previously. One researcher went so far as to say that not only were there symptoms from the nine core but also the enlarged prostate was also a symptom of low testosterone and that treating a patient with testosterone could help the patient reverse the effects of male menopause (Walker, 1938). Another researcher related that women need to be aware that their husbands also go through physical and mental stresses in middle ages like they do (Featherstone & Hepworth, 1985). Paulette stated that the “midlife crisis” was part of male menopause and that the behavior was the result of psychological aspect of male menopause Paulette 2003).

Analysis of Findings & Connection to Research Question

My research did support my question of does male menopause exist? The researchers used different terms based on the how it relates to relating to men such as hypogonadism, male climacteric, andropause or hypotestosteronaemia to explain the decrease in testosterone due to a decline in the Leydig cell mass in the testes and or other issues in the pituitary glands (Gould & Petty, 2000; Olarinoye, Adebisi & Popoola, 2006). If we think about menopause in light of the influx and decrease of sex hormone levels then it is verified as a condition which studies done as early as the 1930’s showed the same symptoms also showed spontaneous erection without direct stimulation were signs of male climacteric and they began treating with synthetic testosterone. It seems that one of the reasons it may have disappeared in the later 20th century may be due to the side effects of the synthetic testosterone (Marshall, 2009; Watkins, 2008). The information did speak to the question concerning the similarities between men and women. It shows a clear
correlation between hormone levels dropping, emotional changes, physical difficulties, and osteoporosis.

The patterns in the literature provide a clear pattern that supports this definition of menopause for men. Researches did find correlation between decreased body fat, and strength with testosterone therapy (Sih, et al., 1997). However there needs to be more research done in a way that will cause physicians to look at all the symptoms and testosterone levels in order to treat the condition.

Furthermore, it would be helpful to have research that would support a bio-identical testosterone that would take out the risks associated with hormone therapy treatments which then would allow men to seek treatments without the fear and doctors to treat without concern for other risks that would jeopardize their patients’ health (Snyder et al., 2000). It would be beneficial to conduct more longitudinal studies with a larger population to gain a better understanding of how the male body functions with the stress of low testosterone levels.

The studies tended to fall short of consistent testing of levels over a long period of time. The researches either only tested testosterone levels upon entry of the research or not at all. The problem with only one blood test is that is can give a mis-reading based on other outside factors and therefore not give an accurate reading. This then does not give adequate results for the participants. Moreover researchers themselves stated that changing and monitoring candidate long-term would have been helpful to the data since would have included a longitudinal study that would have documented for at least 10 plus days of hormone therapy allowing them to see a better outcome. This would of course made it possible to show improvements in the three core areas: their physical health, their sexual health, and their mental health it would be able to show to what degree of the core areas would have improved. Furthermore monitoring the candidates in
the study would be able to show an increase in sexual function, as well as a decrease in body fat, and increase in muscle mass and function, and finally an increase in bone mass (Wang, et al., 2000). Not only in those areas but also in mental stamina as well. It is interesting to find that the overall research supporting male menopause is there but still the medical profession is hesitant to come out and support the research for different reasons. One article did mention that pharmaceutical companies have taken up the cause in the form of penile enhancers, and have overlooked the evidence that has been here along (Boul, 2003). That may be because researchers would rather talk about low levels of testosterone in reference to other medical conditions, however with the research that is out there it would be to their benefit to take the blinders off and go beyond the symptoms.

**Forms of Therapies and Treatments**

Stress and anxiety and depression are some of the biggest factors that come with andropause. A daily regime of exercise and relaxation techniques can be helpful as well as short-term use of medications/drug therapies along with vitamin therapies. Talk therapy can be beneficial and there are several types of psychotherapies to choose from such as cognitive behavioral therapy (CBT). Cognitive behavioral therapy (CBT) is a talking therapy that helps you to manage your problems by changing the way you think and behave. It is commonly used to treat anxiety and depression, but is useful for other mental and physical health problems. CBT does not take the problem away rather it helps deal with ones problems in a more positive way. The concept is, is that your thoughts, feelings, physical sensations and actions are interconnected, and that negative thoughts and feelings can trap you in a vicious cycle (Beck Institute, n.d., Goal of Cognitive Therapy, para 4).
CBT aims to dissolve this cycle by breaking down large problems into smaller problems and shows you how to change these negative patterns into something manageable to aid in improve the way one feels. CBT does not deal with the past but looks at the current problems, and looks for practical ways to improve your state of mind on a daily basis.

Another form of talk therapy would be Adlerian therapy, Adlerian Therapist looks at the whole person moreover it is a cognitive, goal-oriented, social psychology interested in a person’s beliefs and perceptions, as well as the effects that person’s behavior has on others. It is one of the few psychologies interested in democratic processes in the home, school and work place. Individual Psychology promotes social equality, which means granting each other mutual respect and dignity regardless of our inherent differences. It is not a set of techniques but a comprehensive philosophy of living. The three most fundamental principles are: (1) behavior is goal oriented; (2) humans are fundamentally social, with a desire to belong and have a place of value as an equal human being; and (3) the individual is indivisible and functions with unity of personality (Ferguson, 1984). These principles which make Individual Psychology unique from other approaches are described in Adlerian psychology as purposiveness, social interest, and holism. Together, these principles describe the person as moving in unity toward self-chosen goals that reflect a human value for belonging and social contribution.

Another talk therapy is Rational Emotive Behavioral Therapy According to Albert Ellis, "people are not disturbed by things but rather by their view of things" (Hockenbury & Hockenbury, p. 631). The fundamental declaration of Rational Emotive Behavioral Therapy is that the way people feel is largely influenced by how they think. When people hold irrational beliefs about themselves or the world, problems result due to this distortion. The goal of REBT is to help people alter illogical beliefs and negative thinking patterns in order to overcome
psychological problems and mental anguish. Another talk therapy is Client-Centered Therapy.

Two of the key elements of client-centered therapy are:

- **Non-directive**: Therapists allow clients to lead the discussion and do not try to steer the client in a particular direction.

- **Emphasizes unconditional positive regard**: showing complete acceptance and support for the clients. Rogers believe accepting the client for who they are displays support and care no matter what the client is facing or experiencing. Rogers believed people often develop problems because they are used to only receiving conditional support; acceptance that is only offered if the person conforms to certain expectations and by creating a climate of unconditional positive regard, the client is able to express his or her emotions without fear of rejection.

In Client centered therapy the therapist's willingness for the client to be whatever feeling is going on at that moment - confusion, resentment, fear, anger, courage, love, or pride… Rogers stated that ‘The therapist prizes the client in a total rather than a conditional way’ (Cherry 2015; McLoud 2014). The goal of the Client in client-centered therapy is one’s personal growth achieved by the increased awareness and understanding of one’s attitudes, feelings, and behavior.

**Results and Conclusion: the Findings**

What was found was that low testosterone levels did in fact have a negative effect on the subjects in all the core factors, sexually, emotionally, and physically. Furthermore the research went on to show that other symptoms such as breast discomfort, hot flashes, sleep disturbances, mild anemia, etc. (Bhasin, et al., 2006) would be in line with what is described as low androgen or Male Menopause. However after testosterone therapy was given sexual function, mood, and
strength improved (Wang, et al., 2000; Feldman et al., 2002). The researchers however chose not to use the term male menopause because the term menopause is the ceasing of menstruation therefore since men do not have menstrual cycles the proper term would be one of the following: low androgen, Male climacteric, or andropause, which can be used interchangeably.

The connection between the low levels and the nine factors together implied that there is indeed some form of menopause in men. Other factors that were found in earlier research of the twentieth century were headaches, vertigo, and constipation. These variables also supported the changes that were going on with andropause. The information in the research stated that the normal age was between 60 and 80 years of age, but said the average age was 45-60 years old since testosterone level begin dropping off during the early 30’s. Another study said between 35 and 65 and 40 and 55 years of age (Diamond, 1997; Araujo, O’Donnell, Brambilla, Simpson et al., 2003) giving the norm for menopausal symptoms 50 (Vainionpaa & Topo, 2006). Even through the norm was 50 years of age it was common for men to begin experiencing symptoms in their early 40’s. The age and drop of levels plays a large role in treatment because low levels are often considered to be in older men. Younger men are being misdiagnosed or pushed aside, and treated with antidepressants, as well as erectile enhancements when the whole of the problem could be treated with hormone therapy. Not only could this resolve the problematic symptoms, but helping them to have a better life expectancy and increased mental health (Martin, Kung, Everington, Pun., Tan, et al., 1999).

Although men do not go through menopause in the same way women do, the do go through something similar and share some of the same symptoms such as hot flashes, vertigo, headaches, low libido, depression, anxiousness, and osteoporosis. According to the researches most of the studies stated that their findings were inconclusive, but leaned toward the likelihood
of some form of menopause renaming it andropause (Pope et al., 2003). There were few studies that stated against or no male menopause based a few criteria. Based on one they did not have conclusive data to show the testosterone levels were due to consistent drops in levels. Two, the also claimed no menopause because they compared menopause to that which women who have cessation of menstruation go through. These however do not prove an absence of male menopause, but rather show that more studies need to be conducted to give an absolute yea or no concerning male menopause. Researchers from that last century and a half previously conducted research that have hinted that low testosterone level to affect male physical health and emotional wellbeing (Hollander & Samons, 2003; Delhez, Hansenne & Legros, 2003; Seidman, 2006).

Overwhelmingly there seems to be more research on the side of male menopause as documented findings conclude there is a type of menopause that men go through (Metz, Miner 1998; Pope, Cohane, Siegal, & Hudson, 2003). This was backed up by findings in two different articles one stating it was an actual condition, but rare and the other a documentation of one man’s experience through menopause /andropause. The article makes a definite connection between the nine core factors as well as low levels of testosterone.

There is more research to suggest that the rate of andropause will increase to levels of 4,000,000,000 plus in men in the coming years. Another article documented one physician who was treated for male menopause /andropause (Arajuo et al., 2004). He walked the reader through his experience. The physician goes on to claim that he was going through depression as well as dealing with other symptoms. The doctor also without saying stated that the emotional element may of played a role in his divorce. He finished the article by saying he has been taking testosterone treatments for several years and is happily remarried (Smith, & Hilpern, 2010). One journal stated that between 1987 and 997 there were approximately 2.4 million men with
androgen deficiency and that there would be 481,00 new cases per year for the age group 40-69 year of age. They went onto say that androgen deficiency was strongly related to age. Not to mention environmental factor such as educations and economic status and education (Sternback, 1998).

One study interviewed subjects to see if they could pick out their own symptoms. Some of the subjects said they were dealing with menopause while other subjects said they were not dealing menopausal symptoms, but thought they might be going through some sort of emotional dilemma at which point the researchers started asking questions about what they wanted in they future, this caused the subjects to begin evaluating their life purpose and goals. Some of the subjects began to look at the spiritual side of life and from there made changes. The other subjects knew something was wrong but were not sure what the problem was.

**Discussion with Limitation & Assumptions**

The number of research studies has grown in the last three decades concerning male menopause showing the interest in this condition to be of importance. It shows that there is a greater concern for male health as opposes to those in previous decades. It furthermore shows that there is an increase number of men who are asking questions, and wanting answers concerning their own health. Throughout the research process it was clear that there was enough information to argue for the condition of Male Menopause. I would also say that the male menopause terminology would be considered a lay term for andropause. There was however limitation to the noted in search of the idea of male menopause.

Some of the limitations had to do with the fact that some of the studies looked at only blood work which took readings from one sample of blood-serum levels, which made it difficult to document changes for improvement other than by use of a questionnaire. In other words there
was no long term monitoring of those who were given testosterone therapy. Also researchers did not have a good enough sample of subjects nor did they have a large enough group per age group in several studies which didn’t provide for a fair overall population.

Moreover, since many of the researchers did not do a longitudinal study they were not able to go back and test testosterone levels a second time (Isaac, 2003). Researchers noted that diagnosing was difficult because other illness were associated with the same symptoms and doctors may not consider the effects of low testosterone levels problematic when diagnosing an illness and or other factors which could then be overlooked. Other factors that limited the study were an inability to test levels more than more time. This disallowed them to take into consideration any genetic factors and other illnesses. Furthermore, in older men higher PSA (PSA is defined as prostate specific antigen which is a protein produced by the prostate and found in the blood) levels and aging tended to interfere with the testosterone levels. Also, the normal aging process made it difficult to decipher if true andropause was occurring. Other illness such as cancer, mental illness or issues with puberty also played a role in trying to make a clear connection with low andropause (Vaininonpaa & Paivi. 2006). Overall health also played a factor in true readings since obesity can upset the body’s norms for all hormone levels as well as a person’s outlook.

The assumption on the other hand was that based on the current trend of erectile dysfunction ads on television and print there is something that is happening in the male population. However it is not being treated to the best of the medical professions ability since they are only treating partial symptoms those associated with erectile dysfunction.

The assumption for today is that if something is not functioning and causing distress and drug therapy can fix the problem then one should take the drug to fix the symptom. The more
effective approach would be to treat the symptoms by finding the actual problem. In the topic of male menopause the key to appropriate diagnosing would be to begin by checking the hormone levels, having patient answer questions using the earlier mentioned core symptoms from the three categories: sexual, physical and emotional check list, and then by treating the whole person naturally with testosterone therapy as well as psychotherapy, which would be the best approach. Not only would the patients be getting help sexually, but they would be finding appropriate solutions for depression and other physical symptoms. Another limitation was that the population chosen was already being seen medically so they were hyperaware of symptoms which took away from the blind segment of the study.

Authors’ Summary

Looking at the research and the findings the correlation between low testosterone and the core symptoms provide quite an argument for supporting andropause as a condition that affect the male population. The questions one has to ask in the end is what next, and what does the diagnosis really mean? Where do we go with treatment do we continue to give out a little pill like all the media ads treating only the sexual aspect of andropause? To start with we have to respond the needs of the male. Society states the need for men to be masculine and are shamed if they can’t perform physically or sexually. As we saw in the research male menopause/andropause affect both of these areas of the male. From the authors understanding of what the male body goes through the only ways to fully treat him is like women in menopause, use all the tools we have, treating both the hormones and the emotions. We have been telling women in menopause of the things they need to do to stay healthy such as hormone therapy, diet, exercise, and psychotherapy for the emotional components of the condition. We need to support men’s health in the same way.
The researchers all concluded that each of the nine core symptoms are symptoms that play a major role in the diagnosing of andropause along with testosterone therapy. The author has taken all of these factors in to consideration when thinking how to go ahead with treatments. To start with educating the male population about the benefits of testosterone therapy and debunking all the myths tied to print and televisions ads something that was not discussed in the research, as well as helping them to understand that this is not just a sexual issue, but rather a whole body issue is one way of educating men furthermore teaching the terminology and using the research to fully examine whether one is really suffering from andropause or if it is other medical issues.

The researchers linked obesity, diabetes and other health concerns as a culprit. The goal is to rule out the other health conditions so that proper treatment is given. Once andropause is diagnosed, unlike the previous research, monitoring the man being treated is key to regulating the condition. I believe that this is the one thing that was difficult to maintain throughout the studies look at which was part of the reason that Male menopause/ andropause has not fully been accepted in the medical community. This condition has been around since the Middle Ages and yet it is still not widely accepted as a medical condition or concern. It is time to bring andropause into the 21st century, look at causes and the most effective treatments. Even if it is a secondary condition get the right treatment is mandatory to correct the male health and well-being. The best way to do this is by treating the whole man not just the symptoms.
References


