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Andropause/Menopause Disorder

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Part I

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Introduction

Andropause/Menopause Disorder will be included in the Mood Disorders section of the DSM. Many of the symptoms of Andropause/Menopause Disorder are listed under the criteria for Mood Disorders, specifically the Criteria for Major Depressive Episode. The following identifies the symptoms of Andropause/Menopause Disorder, and explains how the disorder differs between genders, cultures, and how it can be viewed as a mental disorder.

Diagnostic Features

A major component of Andropause/Menopause is Depressive Mood Episodes without a history of Major Depressive, Manic, Mixed, or Hypomanic Episodes (Criteria A and C). The patients' depressive episodes are not chemically induced by substance use or substance abuse nor are the episodes due to a General Medical Condition. The episodes are not better explained by Schizophrenia, or Schizophreniform, Schizoaffective, or Delusional Disorders or a Psychotic Disorder Not Otherwise Specified (Criteria B).

The fourth digit in the diagnostic code for Andropause/Menopause Disorder indicates whether the episode is a Single Episode (first) or Recurrent. An episode has ended when it no longer meets the full criteria for at least two months. During this two month period, the symptoms may still exist (Partial Remission), but they do not fulfill the criteria for the disorder, or the symptoms may be in Full Remission.

The fifth digit in the diagnostic code for Andropause/Menopause Disorder indicates the current state of the disorder. If the criteria for Andropause/Menopause Disorder are met, the fifth digit will identify the severity of the current episode as Mild, Moderate, or Severe. If the criteria are not currently met, the fifth digit will identify whether the disorder is in Partial or Full Remission.

Specifiers

There are two special sets of descriptions for Andropause/Menopause Disorder. The first set of descriptors is used to characterize the most recent Andropause/Menopause Episode: Mild, Moderate, Severe, or Onset Due to Surgery. The second set of descriptors describes the overall course of the Andropause/Menopause Disorder: With or Without Full Interepisode Recovery, either the presence of symptoms continues between episodes or the symptoms are completely absent between episodes; or With Rapid Cycling, the patient has four or more episodes within one year.

Recording Procedures

As the DSM-IV allows for the same numbers to be used for multiple disorders, Andropause/Menopause Disorder will have the same first three digits as Major Depressive Disorder, which has some similar symptoms.

1. The first three digits are 296.
2. The fourth digit is either 2, for a single episode, or 3, for recurrent episodes.
3. If the full criteria are currently met for Andropause/Menopause Disorder, the fifth digit indicates the severity: 1-Mild, 2-Moderate, 3-Severe. If the full criteria are not currently met, the

following digits will be used as identifiers: 4-Partial Remission, 5-Full Remission. If the Disorder is the result of surgery, the digit will be 6-Onset Due to Surgery.

Associated Features and Disorders

A few of the symptoms of Andropause/Menopause Disorder are also symptoms of the mood disorders, particularly Major Depressive Disorder and Mood Disorder Due to a General Medical Condition. Patients with Andropause or Menopause Disorder do not exhibit the manic or hypomanic symptoms of other mood disorders and the depressive mood symptoms are not chronic, as in Dysthymic Disorder.

A significant drop in hormone levels, such as testosterone, which is one of the requirements for the diagnosis of Andropause, is also seen in some medical conditions, such as diabetes. Thyroid disorders and medications for hypertension can also result in various levels of depression. Therefore, patients must be evaluated thoroughly and General Medical Conditions eliminated as possible diagnoses before giving the diagnosis of either Andropause or Menopause Disorder. Some patients with depressed mood will also develop Anxiety Disorder or Panic Attacks.

Some men find the changes in their lives, the physical signs of aging, difficult to cope with. Often, this period of their lives becomes a crisis, which is known as a mid-life crisis. This crisis period is a psycho-social adjustment problem. Women too may find it difficult to adjust to this mid-life period of their lives. When the adjustment problem interferes with normal functioning, or results in abnormal behavior for the individual, and the other criteria has been met, a diagnosis of Andropause or Menopause Disorder may be appropriate.

Associated Laboratory Findings

Psychological assessments are necessary to determine the degree of Mood Disorder symptoms. Estrogen, testosterone, and human growth hormone levels need to be tested for a definitive diagnosis of Andropause or Menopause.

Associated Physical Examination Findings and General Medical Conditions

The fluctuating hormones can deplete the body's calcium, resulting in bone loss or osteoporosis. The loss in hormone levels can also cause the patient to be more susceptible to high cholesterol levels, heart disease, diabetes, urinary incontinence, and other health problems.

Specific Culture, Age, and Gender Features

All men and women go through the physical changes associated with Andropause/Menopause. For men, the drop in hormone levels begins at about age 40, often declines gradually, and becomes noticeable by age 60. For women, the decline usually begins in the mid-forties and lasts for about ten years. The final sign of menopause is the ending of the menstrual period. Menopause will be instantaneous for a woman if she has surgery to remove the ovaries.

Psychological attitudes have a role in whether normal Andropause/Menopause becomes a mental disorder. In some cultures, the older generations are looked upon with great respect and as persons of authority. This is a time of life for the persons to relax and enjoy life and spend more time with their families. In the western culture, people often look at this time of their lives as the end of living. They may believe their lives have no meaning. There is often a lack of respect or admiration for this generation. Depression sets in and the result may be Andropause/Menopause Disorder.

Women are more likely to suffer from depression than are men. Therefore, women are also more likely to develop Menopause Disorder.

Prevalence

Nearly 25% of women suffer depression at some point in their lives. Those who suffered depression earlier in life, suffered from severe Premenstrual Syndrome (PMS), or have a family history of depression are at a higher risk of depression during andropause or menopause. There is no actual data for the prevalence of Andropause/Menopause Disorder. The lifetime risk for Andropause/Menopause Disorder is likely similar to that of Major Depressive Disorder: 10-25% for women and 5-12% for men.

Course

Andropause/Menopause Disorder begins with the onset of andropause or menopause symptoms, at about age 40. The course of the disorder varies. Some women may have episodes only during the months they miss their periods. Others may have them for several months and then have a full remission for several months. Men may slowly develop the symptoms and have irregular episodes. Men and women may find their episodes becoming more frequent as they age. Most men and women will go into full remission when the andropause or menopause is complete. Some patients may have a return of episodes following the death of their spouse.

Familial Pattern

Andropause/Menopause Disorder is 1.5-3 times more likely if the person's first-degree biological relatives also had the disorder.

Differential Diagnosis

Andropause/Menopause Disorder must be distinguished from Major Depressive Disorder and from a Mood Disorder Due to a General Medical Condition. The patient may present with similar symptoms to Major Depressive Disorder. The patient may have one of the previously stated medical conditions, such as diabetes, that imitates some of the symptoms of Andropause/Menopause Disorder. A thorough psychological assessment, hormone levels tests, and personal history as well as familial history will be used to determine the correct diagnosis.

The depressive symptoms that are often seen in the psychotic disorders are usually considered to be associated features of the psychotic disorders. The patients with Andropause/Menopause Disorder do not present with the psychotic features of delusions or hallucinations, making Andropause/ Menopause Disorder easy to differentiate from all of the psychotic disorders.

Criteria for Andropause/Menopause Disorder

- In the same two weeks, the patient has had four or more of the following. Either depressed mood or decreased interest must be one of the four. These symptoms cause distress and/or impaired functioning. Abnormally low hormone levels are also required.
 1. Depressed mood, or loss of eagerness and enthusiasm for daily life
 2. Decreased desire or interest for activity (including sexual activity)
 3. Irritability
 4. Weight gain
 5. Decreased energy, fatigue
 6. Insomnia
 7. Difficulty concentrating, decreased mental quickness and sharpness
 8. Abnormally low hormone levels (Required)
- The following Physiological Symptoms may also exist.
 1. Decreased muscle tone
 2. Night sweats and/or hot flashes
 3. Migraine headaches (more often seen in women)

4. Heart palpitations (more often seen in women)

Exclusively seen in women:

- Involuntary urine release and bladder urgency
- Irregular and/or heavy periods
- Vaginal dryness and painful intercourse

Exclusively seen in men:

- Decreased sexual function (impotence) or decreased sensitivity

Men and women both may experience decreased sexual drive. The patient may also develop anxiety and/or panic attacks.

Diagnostic criteria for Andropause/Menopause Disorder, Single Episode, 296.2x

- A. Presence of a single Andropause/Menopause Episode
- B. The Andropause/Menopause Episode is not better accounted for by another mood disorder: Major Depressive Disorder, Schizoaffective Disorder, Schizophrenia, Schizophreniform Disorder, Delusional Disorder, or Psychotic Disorder Not Otherwise Specified.
- C. There has never been a Manic Episode, a Mixed Episode, or a Hypomanic Episode.

If the full criteria are currently met for an Andropause/Menopause Episode, specify its current status: **Mild, Moderate, Severe, or Onset Due to Surgery.**

If the full criteria are not currently met for an Andropause/Menopause Episode, specify the current clinical status: **Partial Remission or Full Remission.**

Diagnostic criteria for Andropause/Menopause Disorder, Recurrent, 296.3x

- A. Presence of two or more Andropause/Menopause Episodes
There must be an interval of at least two consecutive months in which criteria are not met for an Andropause/Menopause Episode.
- B. The Andropause/Menopause Episodes are not better accounted for by another mood disorder: Major Depressive Disorder, Schizoaffective Disorder, Schizophrenia, Schizophreniform Disorder, Delusional Disorder, or Psychotic Disorder Not Otherwise Specified.
- C. There has never been a Manic Episode, a Mixed Episode, or a Hypomanic Episode.

If the full criteria are currently met for an Andropause/Menopause Episode, specify its current status: **Mild, Moderate, Severe, or Onset Due to Surgery.**

If the full criteria are not currently met for an Andropause/Menopause Episode, specify the current clinical status: **Partial Remission or Full Remission.**

Part II

When I first heard the requirements of this project, I knew what my topic would be. I initially thought it would be a “tongue-in-cheek” fun paper. I am currently dealing with the symptoms of menopause myself, and I wondered how the world would be if men too had to suffer with this affliction. After all, why should women have all of the fun?

As I researched the topic, I realized first that the topic of “male menopause” is real and second that it, andropause, and the female menopause can be a serious problem for some people. For some people the symptoms are more a nuisance than a real issue, but for many they can bring about real distress and interfere with life. Andropause is more than a “mid-life crisis.”

The mid-life crisis occurs when a man (less common in women) comes to a new awareness that his life has changed. He has worked his entire life towards the goals of marriage and raising a family, and now feels his life is unfulfilled. This awareness and the physical signs of aging bring this man to the realization that old age, retirement, and eventual death are waiting for him. If this time of life proves difficult to cope with, the result may be a crisis. This mid-life crisis is a psycho-social adjustment problem. It is not andropause, although the symptoms of andropause appear in men who are going through this crisis; both occur during middle age, or mid-life. (Andromeda Andrology Center, 2009)

The symptoms of andropause can be similar to menopause in women and they are sometimes just as overwhelming: hot flashes, night sweats, insomnia, decreased libido, weakness, decreased muscle tone and bone mass, increase in body fat, sexual function problems, and the mood disorder symptoms: lethargy, irritability, mood swings, loss of interest in activities or loss of eagerness and enthusiasm for life, and depression (Renew Man and Andromeda

Andrology Center, 2009). The physiological symptoms alone can be a cause for concern. Decreased muscle tone and loss of bone tissue can easily result in broken bones. Increased body fats often result in high cholesterol levels which can cause heart disease. These patients are also more susceptible to diabetes and other illnesses. (Menopause Signs, 2009) For the purpose of inclusion in the DSM, the psychological symptoms are also a concern.

Putting a real name to the symptoms, specifically the psychological distress, can enable a successful outcome. The patient can realize his/her thoughts and feelings are caused by a legitimate disorder. Legitimizing the disorder helps the patient see that he/she is not simply going crazy and it makes treatment billable for insurance purposes. Legitimizing the disorder also helps to make it more acceptable by society. There is now a real reason for the behaviors of the menopausal persons. Men in general find it difficult to seek psychological help. The knowledge that andropause is normal and is something all men go through, and the acceptance by society that the extreme symptoms are a reality, may help some men feel more comfortable in seeking help. “Treatment can make a big difference in how you feel” (Mayo Clinic, 2007). These are certainly positive reasons for including Andropause/Menopause Disorder in the DSM, but there may be possible drawbacks as well.

Some men and possibly some women too, may feel stigmatized by being given a label. Once a label is given it is very difficult to lose. Andropause/Menopause Disorder does not need to be a lifelong illness. Once labeled, patients might believe they are abnormal, when in reality, all men and women will go through andropause or menopause at some time of their lives. Although for most, it will not develop into a disorder. Another issue is that not everyone is in agreement with the idea of andropause as a real occurrence, certainly not a disorder.

Howard Jacobs in the British Medical Journal argues against andropause, but his reasoning is weak. “The term ‘male menopause’ is inappropriate as it suggests a sudden drop in sex hormones such as occurs in women in the perimenopausal state. It is not an inevitability but may occur mainly in middle aged and elderly men when testosterone production and plasma concentrations fall” (Gould, Petty, Jacobs, 2000). Jacobs’ issue seems to be mainly in the term “male menopause.” In the *For and Against* article, Jacobs admits to the “similarity between most of the symptoms in men and women” and he lists these symptoms (Gould, Petty, Jacobs, 2000). The statement, “it is not an inevitability” is in disagreement with several other sources: “Every man will become andropausal, i.e. no one escapes it” (Renew Man); “Female menopause has been known for centuries, but it has only recently been discovered that males also go through a similar phenomenon with identical symptoms” (Andromeda Andrology Center, 2009); “Hormone changes are a natural part of aging for men” (Mayo Clinic, 2007); and “The concept of male menopause, or andropause, is not new, having first been alluded to in the 16th century Chinese text of Internal Medicine” (Morley, 2001). Lastly, regarding Jacobs’ statement that it “may occur mainly in middle aged and elderly men,” there has been no argument to imply anything different. Andropause and menopause are mid-life changes.

The argument of Jacobs and the unknown number of others that there may be, proves this to be a controversial subject. Such controversy may further inhibit those afflicted with Andropause/Menopause Disorder from seeking help. Inclusion of the Andropause/Menopause Disorder in the DSM may prove to silence the critics or it may rile them up. If the controversy continues, persons suffering with Andropause/Menopause Disorder may be hesitant to seek the help they so badly need. The fear of stigmatization will most likely continue.

Coming to the decision to include a new diagnosis in the DSM must be a long and arduous task. In order for me to develop this new disorder, Andropause/Menopause Disorder, I had to do much research and study this concept thoroughly. There were many aspects to consider. The one aspect that immediately stood out for me was the symptoms of andropause and menopause. They were very similar, nearly identical, and the one major symptom that I immediately identified with other DSM diagnoses was that of depressed mood. I knew then that the category for Andropause/Menopause Disorder had to be Mood Disorders. Identifying Andropause/Menopause as a mood disorder surely would solidify its legitimacy, would it not? But coding this disorder would serve to be another difficult process. I could not find a similar code to the mood disorders; all of the number combinations were already used. I read and re-read the codes repeatedly when suddenly I realized the DSM uses some of the codes for multiple disorders (*APA, Appendix F: Numerical listing*). Now it was onto the next problem.

I carefully read the information on Mood Disorders (Morrison, 2001) and I identified the various categories which needed inclusion in my not so new disorder. I say not so new because the “discovery” of male menopause was first made in the 16th century (Morley, 2001). This aging process has been discussed throughout the years only to be swept under the carpet. Female menopause is a long ago conclusion, but for men to go through menopause contradicts the male ego’s idea of ageless virility (Andromeda Andrology Center, 2009). In giving male menopause a name, thus legitimizing it as a real part of the aging process, men everywhere must be aware of their own immortality. This is the reality that produces the greatest symptom which makes Andropause/Menopause Disorder a reality, depression. Fortunately, only a fraction of the human race suffers this symptom. It is for them that Andropause/Menopause Disorder needs legitimized. Only then can treatment begin and be successful.

Treatment is usually simple for most andropausal and menopausal persons. Often all that is needed is drug therapy. Replacing the lost hormones, testosterone for men and estrogen for women, can reverse some of the symptoms. The insomnia, the difficulty concentrating, night sweats and hot flashes, and the migraines may disappear. Sexual function may return and of course, the hormone levels will return to normal. It is the more serious symptoms, the worrisome ones of depression and its effects that require more serious therapy, that which can be given only by social workers, therapists, or psychiatrists. In order to receive such therapy, Andropause/Menopause Disorder needs to be included in the DSM.

I just have to end with a fun note. This may be something that is understood only by menopausal women and the few men who suffer from night sweats. To the other men who read this, I do not mean to offend any of you, and if I do so, I apologize.

Wind blowing during one of the worst winter storms of the season as couple retires for the night.

He, "Darling, the snow is coming in the window!"

She, "So?"

He, "So, it's getting all over the bed."

She, "So?"

He, "So maybe I should shut the window above the bed?"

She, "Not if you want to live!"

(5 minutes later)

He, "Honey, my head is getting wet and cold."

She, "Put a hat on!"

(5 minutes later)

He, "Could I maybe pull the covers up a little, I'm actually a little cold?"

She, "Cold? It's very @# stuffy in here. I wonder if we have another fan somewhere?"

(5 minutes later)

He, chattering, " Sweet-h-h-heart, the s-s-now is s-s-starting to b-b-build up on my b-b-body."

She, " Jeez, all you do is complain, maybe you should sleep in the spare room?"

(Next morning at the kitchen table)
She, "Where'd you go last night?"
He, "I slept in the spare room."
She, "Don't you love me anymore?"

<http://www.minniepauz.com/male-menopause2.html>.

Now from me, one final question. Have I convinced **you** that Andropause/Menopause is a legitimate disorder that needs to be added to the DSM?

If yes, I have truly got a job well done, for I myself do not see the need for andropause or menopause to be considered a disorder.

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