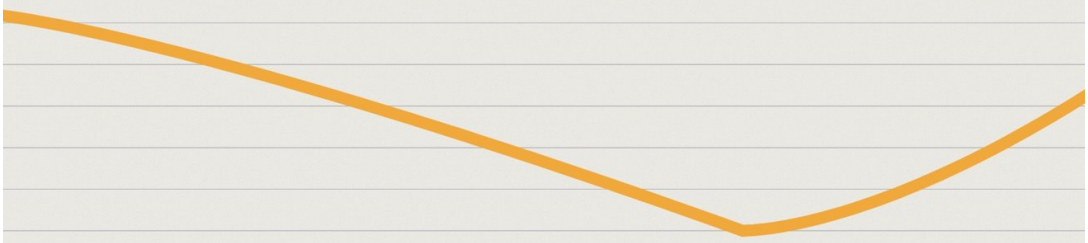
SUSAN McDOWELL

Thinking School

ANDRO-PAUSE EXPOSED



The Hidden Male Menopause, Low Testosterone, and the Secret to Reclaiming Energy, Strength, and Confidence

30 DAY PLAN
STEP BY STEP, INSIDE

AN EVIDENCE-BASED PRACTICAL GUIDE

ANDROPAUSE EXPOSED

The Hidden Male Menopause, Low Testosterone, and the Secret to Reclaiming Energy, Strength, and Confidence

SUSAN McDOWELL

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Andropause Exposed / Susan McDowell — 1st Edition

ISBN 9798298795098

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The stories in this book are illustrative composites based on experiences commonly described by men and their families. Names and identifying details are invented.

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A Few Words

Every stage of life brings with it unique challenges and profound opportunities. As men move through midlife, many experience shifts in energy, mood, strength, and even identity that can feel confusing or difficult to speak about. Too often, these changes are brushed aside as "just aging" or left unspoken because of stigma and taboo. But silence doesn't serve our health—and it certainly doesn't serve our sense of wholeness.

Andropause, often referred to as the "male menopause," is one of those realities that deserves our full attention. It is not a weakness, nor is it something to be ashamed of. It is part of the natural rhythm of life, a reflection of our physiology and the cycles that shape who we are as human beings. Just as women move through menopause with its hormonal transitions, men too experience shifts—most notably in testosterone—that can influence both body and mind.

Andropause, or late-onset hypogonadism, is a universal process in male physiology. It unfolds differently for each man, and not every man will develop symptoms, but the gradual decline in testosterone is woven into the natural rhythm of aging. This shift is not a disease in itself, but a biological stage, a marker of the body's evolution through life. The universality of andropause is often overlooked, partly because the

symptoms can be subtle at first, and partly because society has not yet given men the same open space to discuss their changes as women now have with menopause. Yet across cultures, professions, and lifestyles, men in midlife and beyond share common threads: changes in energy, strength, mood, and drive that remind us of the intimate connection between hormones and vitality. Recognizing andropause as a universal passage helps to dissolve the stigma—it is not a personal failure, nor a weakness, but a shared human experience that unites men across backgrounds and geographies. By normalizing the conversation, we allow men to see themselves not as isolated or "less than," but as part of a broader cycle of life that carries both challenges and opportunities for growth. Understanding this universality also opens the door to compassion: for oneself, for other men walking the same path, and for the families and communities who walk alongside them.

Talking with men going through this transition, and reading the research behind it, one thing stands out: how differently andropause reveals itself. In one man it appears as persistent fatigue and irritability; in another, as a loss of confidence, muscle mass, or sexual drive. For many, it is not only a physical hurdle but also an emotional and psychological one, stirring questions of identity, purpose, and aging. Looking at the whole person—not just hormone levels or lab results—shows how deeply interconnected the physical, mental, and emotional layers of andropause truly are. And with the right understanding and care, men can rediscover their strength, clarity, and vitality.

A word about how this book was put together. I am not a physician; my background is in research and investigative journalism, and the habits of that work run through every chapter. I read the original study rather than the headline about it, I check who paid for the research, and I look for what a confident claim leaves out. Where the evidence is strong, I say so plainly. Where it is thin—as it is for many supplements and some popular fixes—I say that too, because a tired man at the end of a long day deserves to know which advice is solid ground and which is still a guess.

Understanding andropause is not just about learning a medical definition; it is about reclaiming ownership of your health and your story. When we accept that our bodies are constantly evolving, we open the door to deeper self-knowledge and greater well-being. When we acknowledge these changes without judgment, we gain the power to respond—wisely, compassionately, and proactively.

For decades, the conversation around midlife hormonal change has been dominated by menopause. And rightfully so—women's health has long been underserved, and greater awareness of menopause has empowered countless women to seek support, break taboos, and reclaim their vitality. Today, there are thousands of books, articles, and programs devoted to understanding and navigating the female menopause.

By contrast, andropause—the so-called "male menopause"—has remained largely in the shadows. Far fewer resources exist to help men understand what is happening in their bodies, even though the hormonal and emotional changes they experience can be just as profound. This imbalance in the literature has left many men without the language, tools, or guidance to make sense of their symptoms. Instead, they are often told to "push through," "man up," or accept fatigue, irritability, and declining vitality as inevitable signs of aging.

This lack of balance has real consequences. Without adequate awareness or education, men may go years without recognizing that low testosterone and the physiological shifts of andropause are at the root of their struggles. Physical symptoms like loss of muscle mass, weight gain, or reduced sexual drive are often compounded by mental and emotional challenges such as depression, anxiety, and a diminished sense of confidence. The silence around andropause has created a gap—not only in medical literature but in men's ability to care for themselves with compassion and clarity.

It is time to bring balance to the conversation. Just as women benefit from openly acknowledging the realities of menopause, men too deserve a voice, a framework, and a guide. By shining light on andropause, we give

men the opportunity to better understand their own cycles, to normalize their experiences, and to embrace this chapter of life with strength and self-awareness rather than confusion or shame.

While general knowledge about andropause is empowering, it is essential to remember that no two men experience this stage of life in the same way. The shifts in hormones, metabolism, mood, and energy are influenced by many factors—genetics, lifestyle, stress levels, sleep quality, medical history, and even cultural expectations of masculinity. That is why seeking professional advice tailored specifically to you is so important. A skilled healthcare provider can look beyond the surface symptoms, assess your hormone levels, explore underlying conditions, and consider the bigger picture of your health and well-being. But equally valuable, a compassionate clinician will listen to your personal story: how you feel, what you fear, and what you hope for in this next chapter of life. This individualized approach ensures that any plan—whether it involves medical treatments, nutritional support, exercise strategies, stress management, or holistic practices—is aligned with your unique needs and goals. Too often, men feel they must "tough it out" or rely on generic solutions found online, but real healing and transformation come when we honor the individuality of each person. Seeking professional guidance is not a sign of weakness—it is an act of self-respect, a conscious choice to invest in your health, and a commitment to living with clarity, strength, and vitality.

This book is an invitation to step beyond taboo, to see andropause not as an ending, but as a passage. It is an opportunity for men to reconnect with their vitality, to honor their needs, and to discover new ways of living with strength, confidence, and purpose. My goal is to walk with you through the science, the strategies, and the holistic practices that will help you not only understand this stage of life but thrive within it.

Because knowing yourself—your physiology, your cycles, your needs—is not a limitation. It is freedom.

CHAPTER 1

Introduction to Andropause

Andropause is one of the most impactful—and least understood—chapters in a man's life. It often remains shrouded in ambiguity and misunderstanding, and my aim in this book is to illuminate this experience with clarity, empathy, and a blend of clinical insight and holistic perspective, empowering men and their loved ones with knowledge.

The concept of male hormonal changes with age has evolved through various terms, each reflecting a growing, though sometimes contentious, understanding of this natural process.

Our understanding of male hormonal aging has undergone significant evolution. The first descriptions of a "male climacteric" in the 1940s—by Werner and by Heller and Myers—laid the groundwork, drawing parallels to female menopause. These early observations focused on a constellation of symptoms ranging from nervousness and reduced potency to irritability, fatigue, depression, memory issues, and even hot flushes.

Over time, continuous research allowed opinions about these complaints to evolve from a general clinical syndrome identified by questionnaires to a more precisely defined clinical and biochemical syndrome. A pivotal moment came with the International Society for the Study of the Aging

Male (ISSAM) publishing its first recommendations for the diagnosis and treatment of LOH in 2002, which were subsequently updated. This marked a shift towards requiring both low testosterone levels and clinical symptoms for a diagnosis, moving away from relying solely on patient questionnaires.

Large-scale studies like the European Male Ageing Study (EMAS), involving thousands of men aged 40 to 79, have provided crucial insights. The EMAS data, published in 2010, rigorously evaluated numerous potential symptoms of androgen deficiency and found that only a select few were consistently linked to total or free testosterone levels. Specifically, **three sexual symptoms** (decreased frequency of morning erection, decreased frequency of sexual thoughts, and erectile dysfunction), **three physical symptoms** (inability to engage in vigorous activity, inability to walk more than 1 km, and inability to bend, kneel, or stoop), and **three psychological symptoms** (loss of energy, sadness, and fatigue) were confirmed as being related to testosterone levels. The EMAS concluded that LOH, when defined by strict criteria (at least three sexual symptoms combined with specific low testosterone levels), affects a notably smaller percentage of men (around 2%) than previously estimated. This rigorous approach emphasized the need for a biochemical correlation to symptoms for accurate diagnosis, building upon earlier empirical observations.

Defining Andropause and Related Terms

The **"male menopause"** is perhaps the most widely recognized, albeit controversial, term for age-related hormonal changes in men. Popularized in 1944 by Heller and Myers, it was used to describe various complaints in aging men that somewhat mirrored the climacteric symptoms experienced by women. The use of "male menopause" was further supported by observations that symptoms like sudden and excessive sweating are not gender-dependent, and "climacteric symptoms" affect both sexes, differing only in their incidence rates.

However, the term is often considered a misnomer in medical and scientific circles because, unlike female menopause, which is a definitive cessation of menstruation and reproductive capability, male hormonal changes are typically insidious in onset, gradual in progression, and do not lead to a complete shutdown of reproductive function. While women experience a dramatic decline in hormones and become infertile, men's testosterone levels decline slowly, and they can often still father children into their later years. This fundamental difference is a key point of ongoing debate regarding the appropriateness of the term "male menopause."

Late-Onset Hypogonadism (LOH) is currently the most widely accepted and medically preferred terminology to describe the condition. LOH is defined as a "clinical and biochemical syndrome in men with advancing age" that is associated with low testosterone levels, age-related comorbidities, and a deterioration in overall health. The diagnosis of LOH is formally established when both low testosterone levels and corresponding clinical symptoms are present. This integrated diagnostic approach, emphasized by organizations like the International Society for the Study of the Aging Male (ISSAM), moved away from initiating treatment based solely on symptom questionnaires. Research like the European Male Ageing Study (EMAS) has been crucial in refining the definition and incidence of LOH, suggesting its prevalence might be lower than initially thought when strict criteria are applied. LOH is also recognized as a type of secondary male hypogonadism that arises from the normal aging process.

There is also the acronym **ADAM**, which stands for Androgen Deficiency in the Aging Male. This term was adopted as a more medically precise descriptor for the condition. It refers to a decline in androgenic hormones, primarily testosterone, in aging men. To help identify individuals who might be experiencing ADAM, specific questionnaires like the Ageing Males' Symptoms (AMS) scale and the Androgen Deficiency in Ageing Males (ADAM) scale were developed. While these questionnaires were initially used as independent diagnostic tools, and in

the case of ADAM, often assumed a decisive role for sexual symptoms, their utility as sole diagnostic tools has since been questioned due to their low specificity.

Andropause is closely linked to **testosterone deficiency (TD)**, also called **Testosterone Deficiency Syndrome (TDS)**, as we will explore throughout this book. These terms are used interchangeably with LOH and represent a broader scientific understanding of androgen deficiency. The American Urological Association (AUA) has specifically adopted the term Testosterone Deficiency (TD) to encompass the full clinical picture, referring to the signs and symptoms associated with low total testosterone in addition to the state of low testosterone production itself. For a patient to be a candidate for Testosterone Therapy (TT) under this definition, they must meet both criteria: abnormal laboratory measurements and relevant clinical signs and symptoms. The AUA currently identifies low blood testosterone as less than 300 nanograms per deciliter (ng/dL).

KEY CONCEPT

Terms You'll Meet in This Book

- **Andropause / "male menopause":** the popular names for age-related hormonal change in men.
- **Late-Onset Hypogonadism (LOH):** the medically preferred term—a clinical and biochemical syndrome that requires both symptoms and low testosterone.
- **ADAM:** Androgen Deficiency in the Aging Male; also the name of a screening questionnaire.
- **TD / TDS:** Testosterone Deficiency (Syndrome), the term favored by the American Urological Association.
- **TRT / TT:** Testosterone Replacement Therapy, or Testosterone Therapy.

Despite advancements, andropause remains a subject of considerable debate and controversy within the medical community and public discourse. The lack of a universally agreed-upon definition and terminology is a major challenge. While "male menopause" is widely understood by the public, its biological inaccuracy fuels contention. The constant evolution of terms like ADAM, LOH, and TD, along with varying diagnostic criteria and cut-off values for testosterone, contributes to confusion among clinicians and patients alike. Estimates of how common low testosterone is vary significantly across studies due to differing diagnostic criteria and testosterone cut-off points. For instance, while some data suggest about 2% of men overall may have low testosterone, other studies estimate it affects over 8% of men aged 50–79 years, and as many as 50% of men over 80 years old. The EMAS study, using its strict criteria, reported a prevalence of only 2.1%.

A central debate revolves around whether andropause is a distinct medical condition requiring intervention or simply a natural, expected

part of the aging process that varies individually. Unlike the abrupt and universal nature of female menopause, the decline in male testosterone is typically slow, gradual (around 1–2% per year after age 30–40), and often does not result in a complete loss of reproductive capacity. This subtle, non-abrupt nature means symptoms can be vague and easily mistaken for normal aging, chronic diseases, or side effects of medications. Some researchers argue that a man's robustness at 20 is simply not the same as at 80, and that this decline may be a natural evolutionary process.

The non-specific nature of many symptoms, such as fatigue, mood changes, and decreased energy, makes diagnosis challenging as they can overlap with numerous other conditions like depression, hypothyroidism, chronic illnesses (e.g., diabetes, obesity, cardiovascular disease), and even certain medications (e.g., opioids, steroids). Moreover, symptom questionnaires alone are deemed to have low specificity and are not sufficient for diagnosis without corroborating lab tests. The variability in individual testosterone levels and the lack of universally established age-dependent reference ranges further complicate accurate diagnosis.

The therapeutic use of testosterone is arguably the most contentious aspect. While it can bring benefits such as improved libido, muscle mass, bone density, cognition, and energy levels, significant debate exists regarding its long-term safety and efficacy. Concerns persist about potential risks such as prostate issues (including prostate cancer), cardiovascular events (heart attack, stroke, blood clots), and erythrocytosis (increased red blood cell count). Some medical professionals express caution, suggesting that reasons for TRT are often non-medical, driven by aggressive marketing, especially in the United States. This emphasizes the critical importance of an individualized, evidence-based approach, where benefits and risks are thoroughly discussed with the patient, and continuous monitoring is performed.

A significant hurdle is the low social awareness surrounding male hormonal changes and men's reluctance to discuss their health issues,

particularly sexual dysfunctions, with their doctors or social circles. Symptoms are often internalized or dismissed as simply "getting older," leading to underdiagnosis and undertreatment of what could be a treatable condition impacting quality of life.

While the existence of a clinical and biochemical syndrome involving declining testosterone in aging men is largely accepted, the journey to a unified understanding of "andropause" continues. It underscores the profound need for compassionate, informed dialogue, meticulous diagnostic evaluation, and a balanced consideration of treatment options to truly empower men in navigating this phase of life and enhancing their overall well-being.

Prevalence and Incidence of Low Testosterone in Men

Understanding how common low testosterone is—and how often new cases appear—can help men recognize potential changes in their own health and seek support. It is a step toward holistic well-being, acknowledging that men, too, experience significant hormonal shifts with age.

The journey to precisely define and measure the prevalence of low testosterone (often discussed under terms like "andropause" or "late-onset hypogonadism") has been complex and, at times, controversial. However, various studies and medical consensus have provided valuable insights.

It's well-established that testosterone levels in men typically begin to decline around the age of 30 or 40, at an approximate rate of 1% to 2% per year. Some studies suggest this decline can be 2% to 3% per year starting in the 20s or 30s. This is a key difference from female menopause, which is characterized by a more abrupt and definitive cessation of reproductive function. By his 50s, a man may have lost roughly 15% to 30% of the testosterone he had at his peak, although individual variation

is wide. One of the primary challenges in determining how common low testosterone is lies in the lack of a universally agreed-upon definition and diagnostic cut-off values. The American Urological Association (AUA) generally identifies low blood testosterone as less than 300 nanograms per deciliter (ng/dL). However, some experts suggest levels below 250 ng/dL are low, and many clinicians consider symptoms alongside lab results for diagnosis. The European Male Ageing Study (EMAS), which applied strict criteria (at least three sexual symptoms combined with specific low testosterone levels), reported that late-onset hypogonadism (LOH) affects a notably smaller percentage of men, around 2% to 2.1%.

Despite the varying definitions, data broadly suggest that about 2% of men overall may have low testosterone. The US Hypogonadism in Males (HIM) study estimated that 13.8 million American men aged 45 and older who visit a primary care doctor may have low testosterone. In the Massachusetts Male Aging Study, about 12 new cases of androgen deficiency appeared each year for every 1,000 men. The prevalence of low testosterone unmistakably increases with advancing age. Studies show that over 8% of men aged 50 to 79 years may have low testosterone. The prevalence of symptomatic androgen deficiency in men aged 30–79 is about 5.6%, which substantially increases with age. Roughly 20% of men in their 60s show biochemical evidence of androgen deficiency. This percentage rises significantly, with as many as 50% of men in their 80s potentially experiencing low testosterone levels.

It's crucial to note that not all men with low testosterone levels experience significant symptoms. For instance, one study found that nearly half (47.6%) of men aged 50 and above with low testosterone were asymptomatic. Similarly, some studies suggest that while testosterone gradually declines, about 90% of men may never experience overt symptoms, with only 5% to 10% showing classic signs. This underscores that low testosterone isn't always a "problem" unless it impacts well-being.

Low testosterone is more common in men who have certain health conditions or lifestyle factors. Men with a BMI over 30 kg/m^2 tend to

have testosterone levels that are, on average, 30% lower than men with a healthy BMI. Studies have shown that 20% to 64% of obese men have low total or free testosterone, and 30% of overweight men have low testosterone compared to only 6% of those with normal weight. Low testosterone is prevalent in men with type 2 diabetes, with estimates ranging from 25% to 50% of those affected. Conditions such as obstructive sleep apnea, chronic kidney dysfunction, liver cirrhosis, and HIV/AIDS are also associated with a higher likelihood of low testosterone.

Certain medications, including chronic opioid use, can significantly lower testosterone levels.

Understanding these numbers helps us recognize that while a decline in testosterone is a natural part of aging for most men, the severity and symptomatic impact can vary greatly. This knowledge empowers us to approach our health proactively, focusing not just on numbers, but on how we feel and function daily. If you're experiencing symptoms that resonate with these descriptions, please know that you're not alone, and open, honest conversation with a healthcare provider is the best path forward for personalized guidance and support.

Age is not the whole story. When researchers in the Massachusetts Male Aging Study compared men of the same age measured in the late 1980s and in the early 2000s, average testosterone had fallen by roughly 1% a year across the period, over and above the effect of aging itself. Changes in obesity and smoking explained only part of this population-wide drift, and the rest is not fully understood—but it is one more reason why the habits described in Chapters 8 and 9 matter.

Andropause vs. Female Menopause

Both andropause (also known as late-onset hypogonadism or testosterone deficiency syndrome) and female menopause represent significant hormonal shifts that occur as individuals age, impacting

various aspects of their physical and emotional health. It is a testament to the human body's constant evolution.

For a long time, both menopause and andropause faced skepticism and were often dismissed as "just aging," "midlife crises," or even psychological issues, rather than valid physiological conditions. This historical lack of acceptance highlights a shared challenge in validating these experiences. However, growing awareness and research are helping to shift this perception. The symptoms associated with both andropause and menopause can significantly impair an individual's overall quality of life, affecting personal relationships, professional performance, and general satisfaction. This underscores the critical importance of addressing these changes holistically.

The Nature of Andropause

Andropause, or late-onset hypogonadism (LOH), describes a clinical and biochemical syndrome in aging men associated with declining testosterone levels, age-related health conditions, and a general deterioration in health. Unlike the more definitive female menopause, andropause is characterized by an insidious onset and a slow, gradual progression. Testosterone, the main male hormone, typically begins to decline around the age of 30 or 40, at a rate of approximately 1% to 2% per year. Some studies even indicate a 2% to 3% decline per year starting in a man's 20s or 30s. Over the decades, these small annual losses add up.

In contrast, female menopause is a well-characterized and universal process that signifies an abrupt cessation of reproductive function and menstruation, along with a more sudden and dramatic drop in estrogen and progesterone levels. For women, the lack of a menstrual period for 12 consecutive months is a clear diagnostic marker.

Compelling Similarities in the Journey

Despite their differences, men and women navigating these life stages often encounter common ground in their experiences.

While the exact timing and presentation vary, both andropause and female menopause typically begin to manifest symptoms around middle age, often in the 40s and 50s. This overlapping period often brings about similar reflections on life and health. At their core, both conditions are driven by a significant decline in primary sex hormones—testosterone in men and estrogen and progesterone in women. These hormonal changes underpin a wide array of potential physical, emotional, and psychological symptoms. Many of the complaints experienced during andropause remarkably mirror those seen in female menopause, emphasizing the systemic role of sex hormones in overall health. These can include mood changes such as irritability, nervousness, sadness, depression, and loss of motivation or confidence. Individuals may also experience fatigue and decreased energy levels, a sense of exhaustion and lack of drive. Sleep disturbances, including insomnia, are also frequently reported. A reduced sex drive or libido is a hallmark symptom for both sexes, often accompanied by sexual dysfunction. Changes in body composition, such as an increase in central body fat and a decrease in lean muscle mass, are also common. Interestingly, symptoms like sudden and excessive sweating or hot flashes are not exclusive to women and can affect both sexes.

Key Differences

While the shared experiences foster understanding, acknowledging the key differences is equally empowering for personalized care.

The most significant distinction is the **gradual decline vs. abrupt cessation**. Female menopause involves a relatively sudden and complete cessation of ovarian function and menstrual periods, marking a clear biological landmark. In contrast, testosterone levels in men decline much more gradually over several decades, with testicular function largely preserved, though at a lower capacity. There is no definitive “stop” for male hormone production in the same way there is for female menstruation.

A defining feature of female menopause is the complete loss of reproductive ability; women can no longer conceive naturally after menopause. For men, while sperm quality and quantity may decrease with age, the ability to produce sperm generally does not cease entirely, and men can father children well into their later years, even beyond 80. All women who live to a certain age will go through menopause. However, andropause is not considered an obligatory event for all men. While testosterone levels do decline with age, not all men will experience a significant enough drop or develop noticeable symptoms to warrant a diagnosis of symptomatic hypogonadism. Some men, even in their 60s, 70s, or 80s, can maintain testosterone levels within the normal range for younger men and remain largely asymptomatic.

The diagnosis of female menopause is straightforward, marked by the absence of menstruation for 12 months. Diagnosing low testosterone in men, however, is more complex due to the vague nature of symptoms, individual variations in optimal testosterone levels, and a lack of universal consensus on precise diagnostic cut-off values for different age groups. Clinicians must consider both symptoms and laboratory findings, often requiring multiple blood tests.

Historically, and still to some extent, female menopause has been more openly discussed and acknowledged in society, particularly in recent generations. In contrast, discussions around male hormonal aging have lagged, with many men reluctant to seek medical help for symptoms they may attribute simply to “getting older” or view as a personal weakness. This cultural barrier can unfortunately delay diagnosis and treatment.

AT A GLANCE

Andropause and Menopause at a Glance

	Andropause (men)	Menopause (women)
Onset	Gradual, over decades	Relatively abrupt
Hormones	Testosterone falls about 1–2% per year	Estrogen and progesterone drop sharply
Fertility	Reduced, but usually preserved	Ends
Who is affected	Not all men develop symptoms	All women who reach midlife
Diagnosis	Symptoms plus repeated blood tests	12 months without a period
Public awareness	Still limited	Widely discussed