

Medicine, Masculinity, and the Disappearance of Male Menopause in the 1950s

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Summary. In an earlier article, I described how the topic of male menopause lived on in the popular press from the mid-1950s through the mid-1990s in spite of its contemporary absence from the medical literature. The present article addresses the question of *why* male menopause vanished from medical discourse in the 1950s. This disappearance offers an interesting case study of how and why diagnoses and therapies fall in and out of favour. For this particular set of symptoms, psychiatry replaced endocrinology as the explanatory framework, and tranquilisers replaced hormones as the preferred therapy. But medical fashion was not the only factor determining diagnosis and treatment. In the 1950s, when the dominant model of masculinity clearly differentiated men from women, male patients and their male physicians alike balked at the idea that men could suffer from what seemed like a woman's problem, namely, menopause. The diagnosis of a stress-induced condition fitted better with the image of the hardworking breadwinning male, especially among middle-aged men who might also have worried about becoming superannuated. Cultural conceptions of masculinity and ageing figured significantly in the framing of this condition.

Keywords: male menopause; andropause; climacteric; testosterone; hormone replacement therapy; anxiety; stress; tranquilisers; masculinity; ageing

If you Google the term 'andropause', the search engine retrieves about 475,000 results. Not bad for a word that did not exist—according to the second edition of the *Oxford English Dictionary*—in 1989. Although the term first appeared in a French medical journal in 1952, it did not achieve currency until some four decades later. Of the 267 biomedical journal articles with the keyword 'andropause' indexed by PubMed, the National Library of Medicine's index of articles in biomedical journals, only 13 were published before 1990. In June 2006, as part of its progress toward the publication of a third edition, the venerable *OED* added a draft entry on-line for andropause, defined as 'A collection of symptoms, including fatigue and a decrease in libido, affecting some men in middle or old age and attributed to a gradual decline in androgen levels; the stage of a man's life when this occurs. Cf. *male menopause*'.¹

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¹Google search and PubMed search performed on 27 August 2007. PubMed identifies the earliest mention of andropause in Creyx *et al.* 1952. The first article to address the condition of andropause itself appeared in a Spanish medical journal five years later: Fernandez Cruz 1957. The *OED* entry can be found at http://dictionary.oed.com/cgi/entry/20000584?query_type=word&queryword=andropause&first=1&max_to_show=10&single=1&sort_type=alpha

One of those 475,000 web pages on andropause was launched in 2002 by the Dutch pharmaceutical company Organon to inform consumers about the symptoms of this condition and the availability of a drug treatment. The site, a seamless and shameless blend of education and advertisement, offered a handy quiz to help men diagnose themselves by answering the following ten questions:

- 1 Do you have a decrease in strength and/or endurance?
- 2 Do you have a lack of energy?
- 3 Do you have a decrease in your sex drive (libido)?
- 4 Are you more sad and/or grumpy than usual?
- 5 Have you lost height?
- 6 Have you noticed a decreased enjoyment in life?
- 7 Have you noticed a recent deterioration in your ability to play sports?
- 8 Has there been a recent deterioration in your work performance?
- 9 Are your erections less strong?
- 10 Are you falling asleep after dinner?²

Given the neologism and its newfound attention from the worlds of science, commerce and popular culture, a twenty-first-century observer might mistake andropause as a recently discovered phenomenon. But the symptoms it comprises have been identified by both physicians and patients for the better part of a century.³ Indeed, the signs identified by the questionnaire above, with the exception of No. 5, mirror precisely the characteristics of a man at 'the critical age' described by a French physician in 1934. In the words of L. Moinson, writing in the *Journal de Medicine de Paris*:

It is generally manifest by a serious weakening of sexual potency, more and more difficulty completing daily tasks, a lack of enthusiasm, an absence of optimism, a less pronounced taste for the good things in life that he used to appreciate, a greater predisposition to always consider the bad side of events and to envisage the worst. Add to that a lack of agility, greater difficulty doing certain exercises, playing usual sports, greater susceptibility to fatigue. . .⁴

While the symptoms remained relatively constant, their diagnosis and treatment varied greatly over time.

The declining production of sex hormones had been the suspected cause of debilitation in ageing men since the late nineteenth century, when the French scientist and physician Charles-Edouard Brown-Séguard reported that injections of extracts of dog and guinea

²<http://www.andropause.com/diagnosis/quiz.asp>. Accessed 27 August 2007

³Sengoopta 2006, pp. 178–81. Stolberg 2007 finds evidence for even older historical roots in his recent article.

⁴L. Moinson, *Journal de Medicine de Paris*, 16 (1934), 345, quoted in Donald 1938, p. 325 [original in French, translation by the author].

pig testicles had rejuvenated his 72 year-old body. Once the chemical structure of testosterone was derived in the 1930s, synthetic forms of the hormone were soon made available for doctors to administer to patients suspected of hypogonadism. From the late 1930s to the mid-1950s, physicians debated the suitability of testosterone replacement during the male climacteric, as well as the diagnosis and very existence of the male climacteric itself.

After 1955, the debate suddenly ended, as evidenced by an almost complete absence of articles on the subject in medical journals. Individual physicians may have continued to inject their flagging middle-aged patients with testosterone, but the literature of the profession shelved discussion of male menopause and testosterone replacement for the next 40 years. I have already described, in a previous article, how the media continued to pay attention to the male climacteric, or male menopause as it was called after about 1960, in spite of the waning interest among health care researchers and professionals.⁵ The popular press, I argued, promoted a pathologised model of middle age in men which fostered a lay-driven medicalisation of male menopause in the years from the 1950s to the 1990s. What that article left unanswered was the question of *why* male menopause vanished from the medical literature in the 1950s. It is to this topic that I return in the present essay.

The disappearance of male menopause (as male climacteric) from medical discourse in the 1950s and its reappearance (as andropause) in the 1990s offer an interesting case study of how and why diagnoses and therapies fall in and out of favour. How a set of symptoms is interpreted by physicians and patients depends on both medical and cultural factors that shape the framework in which the clinical phenomenon is understood, diagnosed and treated. In the case of the physical, sexual, emotional and cognitive symptoms expressed by middle-aged men, the prevailing diagnosis seemed to shift from the organic to the functional and back to the organic over the course of the twentieth century. Since the rise of andropause in the late 1990s has been discussed extensively elsewhere, this article will focus on the transition that took place in the 1950s.⁶

Initially diagnosed as the expression of an endocrine disorder, the symptoms were treated accordingly with testosterone replacement therapy starting in the late 1930s. But, for reasons which shall become apparent below, this organic diagnosis was superseded in the late 1950s by a functional explanation. The same set of symptoms became the manifestation of psychoneurosis, now to be treated with psychotropic drugs. Psychiatry replaced endocrinology as the explanatory framework, and tranquilisers replaced hormones as the preferred therapy. When the gonads were absolved, the condition was no longer compared to the menopause; instead, the nervousness, irritability, fatigue, depression, decreased concentration and decreased libido were swept into the catch-all category of anxiety produced by the stresses of modern life.

Medical fashion was not the only factor determining the diagnosis and treatment of this particular constellation of complaints. The contemporary cultural climate was equally important. In the 1950s, the dominant model of masculinity clearly differentiated men from women. The diagnosis of a mid-life hormonal crisis for men was much too close to menopause for comfort. Male patients and their male physicians alike balked

⁵Watkins 2007.

⁶See Marshall 2006, 2007; Szymczak and Conrad in Rosenfeld and Faircloth (eds) 2006.

at the idea that men could suffer from what seemed like a woman's problem. The diagnosis of a stress-induced condition was a better fit with the image of the hardworking breadwinning male, especially among middle-aged men who might also have worried about becoming superannuated. Cultural conceptions of masculinity and ageing figured significantly in the framing of this particular affliction.

I have borrowed the metaphor of 'framing' from Charles Rosenberg, who uses it 'to describe the fashioning of explanatory schemes for particular diseases'.⁷ The symptoms discussed in this article, although they remained consistent over time, were differently interpreted and treated within different historical frames. These frames reflect the social and cultural constraints under which medicine operates; physicians, as much as their patients, live within the context of their times and are equally subject to contemporary mores, values and attitudes. Rosenberg also acknowledges the critical role of laypeople in shaping the illness experience, as well as the role of diagnosis in shaping the framework in which individuals think about themselves. As middle age became increasingly medicalised and pathologised, mid-life men could see themselves as patients. If their symptoms were diagnosed as male menopause, they might feel feminised; a diagnosis of anxiety made an alternate interpretive framework available. And if no diagnosis or treatment was given, then the individual wrestled with the experience of unpleasant and perhaps debilitating symptoms that went unnamed and unrecognised by medicine. As Rosenberg astutely observes, 'disease does not exist until we have agreed that it does'.⁸ And once symptoms have been recognised, they can be re-evaluated and re-integrated into newly evolved explanatory frameworks, which will produce different diagnoses and different therapies. This article answers Rosenberg's call for scholarly attention to these processes of definition and redefinition, by examining the shifting frames in which medicine construed, diagnosed and treated the malaise of middle-aged men.

The Debate over Male Climacteric

In 1938, a British physician published his 'Observations on the Male Climacteric' in the *Clinical Journal*.⁹ He began by noting that medical references to a male climacteric dated back to the seventeenth century, but that he had located just three English-language articles on the topic published in recent decades. He attributed this paucity of attention to the medical profession's 'cautious scepticism' about the legitimacy of such a condition, then went on to defend both the existence of hormone deficiency in middle-aged men and the success of treatment with testosterone injections. His definition of the climacteric as 'an ill-defined state of potential nervous instability' characterised by a complex of both psychological and physical manifestations gained increasing currency in the medical literature over the next several years. The trend to diagnose these symptoms as climacteric and endocrine in origin probably had something to do with the availability of synthetic testosterone, recently brought on to the market by pharmaceutical manufacturers after the hormone was isolated by scientists in 1935.

⁷Rosenberg 1989, p. 3.

⁸Rosenberg 1989, p. 2.

⁹Donald 1938.

Physicians reported their efforts to treat a variety of male complaints with testosterone injections in the 1940s. Impotence was a popular target for hormone therapy, with decidedly mixed results. Researchers commented on the importance of psychic influences and debated the ability of hormone injections to overcome the psychological component in achieving erections.¹⁰ They had more luck in prescribing testosterone for their patients who suffered from fatigue, problems concentrating, loss of memory, restlessness, insomnia and irritability; in one study, 88–100 per cent of the subjects with these symptoms reported improvement as a result of testosterone treatment.¹¹ In 1944, an editorial in the *Journal of the American Medical Association* concluded that the success of testosterone replacement therapy in relieving middle-aged men's symptoms demonstrated the 'increasing probability that the male climacteric is just as truly a syndrome based on endocrine disturbances as is the menopause syndrome in women'.¹²

Others, however, were not so sure. An article in the *Cleveland Clinic Quarterly* reported almost the opposite results: out of a group of 60 men who were given several weeks of testosterone injections for nervousness, emotional instability, mental depression, fatigue and decreased libido and potency, 84 per cent showed little or no improvement. 'For this reason', the author concluded, 'it appears that the method of diagnosis requires improvement, and further critical evaluation of the subject is necessary before a dependable conclusion can be reached as to the position in which the term, male climacteric, should be placed in clinical medicine'.¹³ One correspondent who wrote to the editor of the *Journal of the American Medical Association* rejected outright the notion of a male climacteric: 'There is not sufficient foundation for calling the whole gamut of neurasthenic complaints occurring in men between 45 and 60 climacteric, just because a mental depression may be associated with sexual impotence'.¹⁴

At issue was whether the symptoms in question were caused by endocrine deficiency (decreased testosterone production) or arose from psychoneurosis. Most authors recognised that the outward symptoms of the male climacteric were indistinguishable from those of a neurotic disorder, but by the late 1940s a temporary consensus had formed around the notion that androgen insufficiency *could* be responsible for the lassitude and tension experienced by some middle-aged men. Perhaps the leading proponent for the notion of a climacteric in men comparable to the menopause in women, August A. Werner, an internist at St Louis University School of Medicine, believed that 'practically as many men as women experience some degree of glandular disturbance with characteristic symptoms, if the condition were recognised and provided that correct information were available'.¹⁵

Obtaining that 'correct information' was the problem, since it was difficult to obtain reliable measurements of testosterone levels. Some investigators contended that measurements of urinary hormone levels could be correlated to blood testosterone levels. But not all doctors had access to laboratories in which to assay urinary hormone

¹⁰Rennie *et al.* 1939; Carmichael *et al.* 1941. See also Oudshoorn 1994, p. 101.

¹¹McGavack 1947, p. 18.

¹²Anon. 1944, p. 300.

¹³McCullagh 1946, p. 176.

¹⁴Bauer 1944, p. 914.

¹⁵Werner 1948, p. 108.

excretions, so a clinical alternative was proposed. A patient would be given testosterone injections for several weeks, followed by placebo injections. If he experienced relief from his symptoms while on testosterone, but relapsed on the placebo, then his condition could be diagnosed as endocrine in origin.¹⁶ The practitioner was urged to rule out other aetiologies first, namely, 'a. Infection, b. Overwork; worry, c. Mental states—melancholia', although the last category might only be eliminated after seeing the results of the therapeutic test.¹⁷

Opponents of testosterone replacement therapy rejected the therapeutic test as dangerous, because the administration of androgens might promote cancerous growth in the prostate in older men. They considered it more likely that the 'vague syndrome of the male climacteric' could be better explained by social and economic factors:

The years beyond 50 are critical years for many men, for it is at this age that various social phenomena and the stress and strain of our economy have their greatest impact. A man in the business world has usually at this age attained an executive position of responsibility. Buffeted by the forces of a highly competitive industrial age, the demands on his nervous energy may be extreme. His children have reached college age and the added cost prods him to further productive effort. Wives' tongues often become more caustic at this age, disrupting the harmony of the household. Thus, unquestionably, the middle-aged man often suffers a change of life but the symptoms usually arise from extraneous factors rather than a lack of androgens.¹⁸

This unflattering portrait of the menopausal woman, with her 'caustic tongue', indicated the authors' aversion to equating a man's clinical picture with that of his wife. Others had no problem drawing parallels between men and women at middle age. The chapter on 'The Male Climacteric' in the 1953 textbook, *Endocrine Treatment in General Practice*, began with a side-by-side listing of the 17 most common symptoms in males and females. The symptoms were identical; the only difference lay in their relative order of frequency.¹⁹ It was then a short step to parallel treatment: oestrogen for women and testosterone for men.

A spirited debate over the male climacteric played out in the pages of medical journals in the mid-1950s. Were the symptoms akin to those of women or not? Was their cause primarily endocrine or psychological? Should the patient receive hormones or counselling? Was 'male climacteric' an appropriate designation or a harmful misnomer? An article in an issue of the *British Medical Journal* for 12 June 1954 argued in defence of the male climacteric as a legitimate and definite clinical entity. Two months later, an editorial in the *Journal of the American Medical Association* grudgingly conceded that 'the so-called male climacteric is a rare condition' but warned against the 'promiscuous use of male hormone'.²⁰ The following year, articles in the two major geriatrics journals came

¹⁶Heller and Myers 1944.

¹⁷McGavack 1955, p. 640.

¹⁸W. Fagerstrom, quoted in Hess *et al.* 1955, p. 171.

¹⁹Goldzieher and Goldzieher 1953, p. 280.

²⁰Spence 1954; Anon. 1954, p. 1427.

out on opposite sides of the testosterone therapy debate, with one regarding it as 'a major disservice' and the other as a valid way to 'relieve human suffering'.²¹

After 1955, the controversy abruptly ended, with no apparent resolution. The topic of male climacteric and the use of testosterone replacement therapy virtually disappeared from the medical literature. A search of PubMed for the keywords male climacteric, male climacterium, male menopause and andropause found just ten articles, all in overseas journals, from 1956 to 1969, 21 in the 1970s (9 of which were not in English), 22 in the 1980s (7 foreign language), and 51 in the 1990s. Only after 2000 was interest fully resumed, as noted above, in what was now primarily known as andropause.

While the keywords male menopause and climacteric went missing, scattered references to the depression, irritability, nervousness, fatigue and sexual impotence that afflicted middle-aged men appeared in articles with titles such as 'Emotional Problems of the Middle-Aged Man'. But even these faded away by the end of the 1950s. We must take care not to assume that the absence of evidence of male menopause in medical journals is itself evidence of the absence of interest in this syndrome amongst medical practitioners. It is highly unlikely that men no longer suffered from these symptoms or stopped going to their doctors for help. Rather, we must look elsewhere to find information about the revised diagnosis and treatment of these complaints, to help explain the disappearance of male menopause from the medical literature.

From Testosterone to Tranquilisers

Hints about this shift in medical thought and practice had already appeared in articles on the male climacteric, which acknowledged the similarity between the symptoms of androgen deficiency and the symptoms of a psychoneurotic condition. An editorial in the *British Medical Journal* on the controversy over the existence of a male climacteric observed that 'The symptoms of the presumed syndrome, briefly, are depression, irritability, lack of concentration, palpitation, weakness, and sexual impotence. All of these are present in the neuroses and in involutional depressive states...'.²² Perhaps not surprisingly, psychiatrists were the ones who tended to advance the hypothesis that the symptoms developed 'because of a combination of stress and a predisposed personality make-up', not as the result of decreased testosterone production.²³ However, other specialists and generalists also held this view; the author of the long quote above about the years beyond 50 being critical for men was an urologist. These medical authorities looked without instead of within the patient for the source of his woes. Whereas the advocates of a hormonal explanation isolated the testes as the cause of men's complaints, psychiatrists and others insisted that maladjustment to the changing conditions of mid-life could bring about psychological and even somatic symptoms.

If the stresses of life, not testosterone deficiency, triggered this symptom group, then an alternative treatment to hormone injections had to be found. Testosterone had never really taken off as a popular therapy for mid-life men. First of all, as noted above, it was not particularly effective in treating impotence, which was often the main symptom that

²¹Hess *et al.* 1955, p. 173; McGavack 1955, p. 653.

²²Anon. 1953, p. 1039.

²³Braceland 1954, p. 2. See also Billig and Adams 1954.

drove men to seek help from their doctors. Second, it was expensive: in the 1940s, a month's worth of treatments cost almost \$900 in today's dollars.²⁴ Third, the most effective method of delivery was via injection, which meant that a patient had to return to his doctor's office two or three times a week to get his shot. Given that men prefer not to go to the doctor, twice- or thrice-weekly visits might not have seemed worth the effort. As historians Sheila M. Rothman and David J. Rothman have noted, weak demand kept testosterone from becoming a blockbuster drug at mid-century.²⁵

The turn from testes to psyche as root cause of middle-aged men's malaise meant that clinicians looked to psychiatry for solutions. Reports on the use of electric shock treatments (ECT, for electroconvulsive therapy) were not good. Although ECT apparently worked in cases of major depression, it produced serious adverse side effects in men seeking relief from their symptoms.²⁶ It is possible that some men underwent psychoanalysis, which was at the peak of its popularity in America between the late 1940s and the late 1960s, although this treatment was both expensive and time-consuming.²⁷ More likely, patients received less intensive forms of psychotherapy, either at the hands of general practitioners or upon referral to psychiatrists. Even more likely, they left their doctors' offices with a prescription for tranquilisers, which flooded the drug market in the 1950s and 1960s.

The first minor tranquiliser, meprobamate, won FDA approval in 1955 for the treatment of anxiety and tension. Sold as Miltown by Wallace Laboratories and as Equanil by Wyeth, it became the best-selling drug in America within 14 months.²⁸ In the early 1960s, the next generation of minor tranquilisers, the benzodiazepines, burst on to the market as Librium and Valium, to even greater success. According to historian Andrea Tone, 'Valium was the most widely prescribed drug of any kind in the Western world between 1968 and 1981'.²⁹ The minor tranquilisers (so called to distinguish them from the more powerful major tranquilisers, such as chlorpromazine, prescribed for schizophrenia) offered what seemed to be a safer alternative to barbiturates, whose powerful effects of sedation and muscle relaxation were mitigated by their addictiveness and potential lethality if taken in too large a dose.³⁰ They appeared to be another link in the recent and growing chain of pharmaceutical miracles, joining contemporary wonder drugs such as antibiotics, antihistamines, and the recently approved polio vaccine.

Tranquilisers appealed to consumers and providers alike. They greatly expanded the province of the general practitioner by enabling him to treat psychological symptoms with a stroke of his pen. Initially, psychiatrists gradually incorporated tranquilisers into their practices, usually as adjuvants to psychotherapy. In the case of the middle-aged man, one pair of psychiatrists cautioned, 'Tranquilizing drugs . . . will be only of symptomatic help. If they are needed at all, additional psychotherapy will be essential to clear the

²⁴Rothman and Rothman 2003, p. 162.

²⁵*Ibid.*

²⁶Billig and Adams 1954, pp. 450–1. See also Shorter 1997, p. 223.

²⁷Shorter 1997, p. 170.

²⁸Tone in Tone and Watkins (eds) 2007, p. 161.

²⁹Tone in Tone and Watkins (eds) 2007, p. 169.

³⁰The minor tranquilisers were eventually found to be habit-forming. Speaker 1997, p. 343.

causative emotional conflicts'.³¹ GPs and internists, on the other hand, were quick to appreciate the potential of these drugs and to incorporate them into their practices without too much concern about getting to the bottom of patients' problems. Indeed, it was non-specialists who wrote the large majority of the prescriptions for tranquilizers.³² And they wrote those prescriptions more frequently for people between the ages of 40 and 59—the menopause and climacteric years—than for any other age group.³³

A study of the nature and extent of psychotropic drug use in the United States in the 1960s found that most recipients of a prescription for tranquilisers had not been diagnosed with a specific psychiatric disorder; that is, doctors prescribed tranquilisers to achieve a desired effect (e.g. sedation) rather than to treat a defined mental condition. The investigators concluded that 'physicians' prescribing reflects the treatment of these symptoms in patients who are not primarily mentally ill'.³⁴ A related study a few years later came to the same conclusion: 'New therapy with psychotherapeutic drugs is quite specific with respect to symptoms being treated but much less so with respect to diagnoses'.³⁵

Manufacturers spent millions of dollars to advertise the new tranquilisers to doctors. Advertisements in medical journals from the 1950s and 1960s reveal the broad spectrum of symptoms in the wide range of patients that tranquilisers promised to relieve. One of the markets that manufacturers sought to capture was that of menopausal women and climacteric men who might previously have been prescribed hormone replacement therapy. This effort clearly met with success, as evidenced by the data cited above showing that tranquilisers were most often prescribed to the 40–59 age group. Wallace not only promoted Miltown to 'relieve tensions of the menopause', it also marketed a combination product of Miltown and conjugated equine estrogens called Milprem.

Described as 'an important advance in menopausal therapy because it replaces *half* control with *full* control, because it treats the *whole* menopausal syndrome, because *one* prescription manages *both* the psychic and somatic symptoms', Milprem covered all of the therapeutic bases.³⁶ While male climacteric was not referenced explicitly, the wording and images in some ads made it clear that middle-aged men would benefit from tranquiliser therapy. 'Recognize this patient?', asked an ad for Deprol, a combination meprobamate product. It showed a distressed-looking 50-something-year-old man saying to his physician, 'Trouble is I don't see any way out. I'm at a dead end in this job and with the kids and all I can't start over now learning another'. The facing page of the advertisement told readers, 'When you recognise depression and anxiety traceable to an emotionally charged situation with no somatic disorder—start the patient on "Deprol"'.³⁷ Pfizer's two-page spread for Vistaril touted it as 'effective

³¹Billig and Adams 1957, p. 541.

³²General practitioners, internists, and surgeons wrote over 70 per cent of the prescriptions for psychotropic drugs in the 1960s, according to Balter and Levine 1969, p. 10. See also Tone in Tone and Watkins (eds) 2007, p. 164, who states that 75 per cent of prescriptions for minor tranquilisers were being written by non-psychiatrists by 1975.

³³Balter and Levine 1969, p. 9. See also Manheimer *et al.* 1968, p. 449.

³⁴Balter and Levine 1969, p. 11.

³⁵Parry *et al.* 1973, p. 774.

³⁶Milprem advertisement 1957. This advertisement ran frequently through the 1960s.

³⁷Deprol advertisement 1964. Deprol was the trade name for meprobamate and benactyzine.

anxiety control with a wide margin of safety through all seven ages of man'. The text elaborated on the 'frantic forties': 'For many patients in their "frantic forties", the pace never slackens—may even accelerate—while tensions multiply and physical resources dwindle. Out of this seedbed of stresses and anxieties grow much of the alcoholism, psychosomatic illness, and sympathetic overactivity in the middle years'. It went on to avow that Vistaril successfully relieved 'anxiety, tension, nervousness and insomnia', the very same set of symptoms previously attributed to testosterone deficiency.³⁸

Other psychotropic drugs sought to cash in on middle-aged malaise. Ciba's Ritalin, the stimulant that would later gain notoriety for its widespread prescription to school-aged boys, was initially advertised to 'boost the spirits, relieve physical fatigue and mental depression' in middle-aged men.³⁹ The antidepressant Nardil, from Warner Chilcott, promised to treat 'the common problem basically unresponsive to tranquilizers'; in men, this problem was described as 'impaired appetite, insomnia, irritability, loss of attention and concentration, tendency to worry and marked irritability'.⁴⁰ Upjohn promoted its antidepressant, Monase, 'for the 4 out of 10 patients with no demonstrable pathology'. The ad featured a dejected-looking man seated on a couch. The lengthy paragraph of text began:

Chief Complaint: Chronic Fatigue. Sometimes it's an unhappy marriage. Or perhaps a job problem, as in the case of Mr X. But always these myriad symptoms: anxiety, chronic fatigue, apathy, inability to concentrate, moodiness, disinterest in everyday activities.⁴¹

These advertisements for tranquilisers and other psychotropic drugs were almost identical to those that ran a decade earlier for testosterone. In 1947, Roche-Organon promoted its Neo-Hombreol brand of testosterone injections as 'Restoring Self-Confidence to Climacteric Men'. The advertisement copy continued to explain: 'Men going through the climacteric all too often experience "a loss of self-confidence and a feeling of futility... intense subjective nervousness or a feeling of tension ... decrease in memory and mental concentration ..."'.⁴² Starting in the late 1950s, doctors no longer had to diagnose male patients complaining of these symptoms as climacteric and testosterone deficient. Instead, they could avoid diagnosis altogether by simply ascribing the symptoms to the stress and strain of daily living. The tranquilisers and other psychopharmaceuticals now at their disposal meant that symptoms could be treated without definitively determining their root cause. Although we may suspect, from the therapy of choice, that the symptoms were thought to be functional in nature as opposed to purely organic, the functionalist explanation was never formalised into a diagnosis of a recognised mental disorder. 'Everyday life' seemed reason enough for what one tranquiliser advertisement called the 'garden variety' anxieties.⁴³

³⁸Vistaril advertisement 1962. Vistaril was the trade name for hydroxyzine.

³⁹Ritalin advertisement 1956. On the prescription of Ritalin to 'problem boys', see Singh in Tone and Watkins (eds) 2007. Ritalin was the trade name for methyl-phenidylacetate.

⁴⁰Nardil advertisement 1960. Nardil was the trade name for phenylethylhydrazine.

⁴¹Monase advertisement 1962. Monase was the trade name for etryptamine acetate.

⁴²Neo-Hombreol advertisement 1947.

⁴³Mellaril advertisement 1962. Mellaril was the trade name for thioridazine.

The Masculine Mystique

The rapid and widespread adoption of tranquilisers in general practice does not, on its own, solve the mystery of the disappearance of male menopause from the medical vocabulary in the late 1950s. Pharmaceutical innovation cannot be held solely responsible for shifting the frame in which medicine diagnosed and treated the symptoms presented by middle-aged men. Indeed, an overly determinist account that looks only at medical fashion neglects the significant contribution made by cultural factors to the conceptualisation of middle age in men. Specifically, we must take into consideration how contemporary views of masculinity shaped the expectations and roles for men—especially older men—in American society at mid-century.

In 1957, a physician writing in *Today's Health*, the general audience magazine published by the American Medical Association, cautioned readers about 'The Suicidal Cult of Manliness', in which 'even keen executives and able professional men . . . drive themselves to the point of exhaustion in work, play, social activities or a combination of these'.⁴⁴ The following year, an article in *Look* magazine explained why men worked so hard: 'in our patriarchal American society, men feel the need to assert themselves and prove their masculinity by accomplishing things'.⁴⁵ In 1963, in a special issue on men, *Ladies' Home Journal* asked 'What Makes a Man Masculine?' The answer: money. 'The epitome of maleness today,' the author reported, 'according to a recent public opinion poll, is "the executive hero", a suave man of the world and aggressive money-maker'.⁴⁶

These writers embraced what R. W. Connell has called 'hegemonic masculinity', the culturally dominant archetype of how a man should behave.⁴⁷ Gender theorists recognise that there exists a multiplicity of masculinities that men construct and demonstrate gender in many different ways. However, one of those patterns usually predominates within the mainstream culture; that pattern describes expected norms and customs, even if a large proportion of men do not adhere to it in actual practice. Hegemonic masculinity, then, represents 'the idealized form of masculinity at a given time and place'.⁴⁸ In American society at mid-century, the model male was heterosexual, white, educated, and middle to upper class.⁴⁹

He was also in the prime of his life, which left middle-aged and older men to worry about their status in society. In both popular magazines and medical journals, middle-aged men were depicted as fearful of growing old, of being superannuated, of losing their masculinity. Yet while older men, gay men, men of colour and working-class men may have been

⁴⁴McGee 1957, p. 28.

⁴⁵Attwood 1958, p. 58.

⁴⁶Hoffman 1963, p. 96.

⁴⁷Connell 1995, p. 77. For an interesting discussion of hegemonic and non-hegemonic masculinities in a different context, namely that of male contraception, see Oudshoorn 2003.

⁴⁸Courtenay 2000, p. 1388.

⁴⁹*Ibid.* See also Emslie *et al.* 2006, p. 2247, and Gilbert 2005, p. 33. Gilbert argues against the notion of a single predominant norm of masculinity in the 1950s (p. 8). I do not dispute his claim that there were multiple models of masculinity present in that decade, nor that there was a gap between cultural definitions of 'ideal masculine behaviour' and the actual realities of men's lives at home and at work (p. 31). I do contend that a form of hegemonic masculinity did hold sway within the advice literature and popular culture, which influenced the ways in which men (and women) believed they *ought* to act.

marginalised by the dominant culture, they still shared the quality of not being women.⁵⁰ Will H. Courtenay has observed that ‘there is very high agreement in our society [America in the late 1990s] about what are considered to be typically feminine and typically masculine characteristics’.⁵¹ This truism held even more strongly in the 1950s.

Sociologists of health have identified one aspect of typically masculine behaviour to be the denial of disease, which may be manifest in various ways, for example, by demonstrating toughness in the face of pain or by avoiding the doctor. A survey of older men (over the age of 49) in 1991 found that almost half of those who admitted to experiencing depression had not discussed it with anyone.⁵² Another study, conducted in 1999–2001, found that men with mental health problems much preferred to label them as stress-induced rather than admit to a diagnosis of depression, which was construed as ‘unmanly’.⁵³ Such attitudes and behaviours were no less prevalent in the 1950s. *Today’s Health* reported in 1958 on the increasing trend of ‘executive health programmes’ to encourage corporate men to visit the doctor. The article told the story of a 42-year-old sales executive who kept putting off his check-up because he was afraid that cancer was behind his recurrent stomach aches. ‘When doctors diagnosed tension as the cause of his attacks he returned to work a much relieved man, and a much better worker’.⁵⁴

This anecdote reveals an important clue to the revised diagnosis of the symptoms previously classified as climacteric, namely, the relationship between tension and masculine identity. In the 1950s—and continuing to the present day—it was acceptable, even expected, of men to be stressed. The author of the article, ‘The Suicidal Cult of Manliness’, explained the aetiology of stress to his readers:

Our bodies and emotional integrations must pay some tax for the privilege of living and working in these exciting times. Annoyances and frustrations, alarming headlines, confused politics, philosophies and ideas, consciousness of responsibilities, disappointments in ourselves and others all add up to something we call stress.⁵⁵

This physician encouraged men to relax and take it easy, but he acknowledged that the pace of modern life made his advice difficult to heed. Other writers, both lay and medical, echoed his concerns. ‘What is bad about the all-American rat race’, concluded one, ‘is the price in stress that Americans are paying for their material abundance’.⁵⁶ ‘Today’s social structure seems to be particularly conducive to the development of tensions’, wrote another.⁵⁷ A third forecast no cease to the stress as individuals grew older: ‘for the middle-aged man [as compared to his wife], the pressure increases’.⁵⁸

Pressure, tension, and stress all contributed to the diagnosis of anxiety and the prescription of tranquilisers. In the 1950s and early 1960s, tranquilisers had not yet earned the

⁵⁰Courtenay 2000, p. 1389; Emslie *et al.* 2006, p. 2247; Kimmel in Brod and Kaufman (eds) 1994, p. 126.

⁵¹Courtenay 2000, p. 1387.

⁵²Courtenay 2000, pp. 1396–7. See also Oudshoorn 1997, p. 143.

⁵³O’Brien *et al.* 2005, p. 515.

⁵⁴Vicker 1958, pp. 27, 38.

⁵⁵McGee 1957, p. 28.

⁵⁶Attwood 1958, p. 58.

⁵⁷Billig and Adams 1957, p. 538.

⁵⁸Lagemann 1957, p. 75.

epithet 'mother's little helpers', because the diagnosis and treatment of anxiety had not yet been feminised. As Andrea Tone has pointed out, men were just as likely to be diagnosed as anxious; indeed, so many businessmen were taking tranquilisers that the drugs were often called 'Executive Excedrin'.⁵⁹ The dominant model of masculinity called for men to work, and play, hard. A prescription for tranquilisers was almost a badge of merit: evidence that one was working to the limits of one's capacity.

Stress, then, became a legitimate explanation for the symptoms exhibited by middle-aged men. By contrast, the climacteric diagnosis seemed emasculating, because it came too close to the female condition of menopause. Whatever men were, they were not women, and therefore they could not and should not be menopausal. Since the male climacteric was often defined in terms of menopause, the two, whether analogous or not, were inextricably linked in the minds of men and their doctors, who were also men and equally subject to the sway of hegemonic masculinity. Better to attribute the symptoms of nervousness, irritability, fatigue, depression, decreased concentration and decreased libido to the more masculine cause of overwork than to conclude that the man was going through the 'change of life' like a woman. Just as the late twentieth-century men in the sociological study above chose to discuss their emotional problems in terms of stress rather than depression, their forebears at mid-century preferred stress over male menopause as an explanation for their psychological and physical complaints. In this way, both groups believed they could preserve their masculine identities in the face of illness.

Conclusion

With middle-aged men's malaise now recast as the manifestation of a stressful modern life, the fusty diagnosis of male climacteric became a thing of the past. Absent from the medical lexicon for some 40 years, male menopause was re-born as andropause in the 1990s about the same time that impotence was re-named erectile dysfunction. With the advent of Viagra in 1998, the problem of erectile dysfunction got its own solution and was dropped from the list of symptoms.⁶⁰ Recall that one of the reasons testosterone had fallen out of favour in the 1950s was its ineffectiveness in treating impotence. With that complaint off the examining table, testosterone re-emerged as a potential therapy for the remaining symptoms. Prescriptions of testosterone got an additional boost when the Food and Drug Administration (FDA) approved two new delivery systems to replace the hassle of injections: a skin patch in 1995 and a topical gel in 2000.

But just as medicine and pharmaceutical technology did not tell the whole story of the disappearance of male menopause in the 1950s, they cannot provide a complete explanation for its reappearance in the 1990s. As in the earlier period, contemporary ideas about masculinity and ageing played a significant role. As Barbara Marshall has shown, ageing came to be understood as a kind of de-masculinisation, which in turn brought about the re-medicalisation of male menopause in an effort to rescue the masculinity of older men. This process involved the re-casting of the relationship between masculinity and ageing in more explicitly sexual terms, as opposed to the 1950s focus on work and

⁵⁹Tone in Tone and Watkins (eds) 2007, p. 165.

⁶⁰For more on Viagra, see Fishman in Tone and Watkins (eds) 2007 and Loe 2004.

financial success. With a newly scripted cultural narrative about ageing, gender and sexuality, physicians and pharmaceutical companies professed their interest in conceptualising (and commercialising) middle age in men as a condition of testosterone deficiency.⁶¹ Thus, cultural and economic factors contributed to the swing of the medical pendulum back toward an organic, and specifically endocrine, aetiology for the symptoms of middle-aged males.

The history of male menopause demonstrates that our understanding of illness is best characterised as mutable. Diagnoses and therapies went in and out of style, depending on a host of interconnected medical, technological, cultural and economic factors. The physical and psychological experience of the symptoms, as articulated by generations of patients, remained fairly constant. What changed were the explanations given and the manners in which they were treated. Physicians did not march ever forward toward identification, classification, and definitive knowledge of this condition. Instead, they have viewed this stable set of symptoms through a series of different lenses, coloured by medical fashion and the contemporary cultural climate.

In addition to the see-sawing of medical thought between organic or functional causes and shifting cultural ideas about masculinity, there is a third factor to take into account: the patient experience. Certainly, both patients and doctors were influenced by the medical and cultural climate, but ultimately they stuck with or gave up prescribed medications depending on whether they perceived the drugs to work or not. With no randomised controlled trials of tranquilisers or testosterone for this particular condition, doctors and patients relied on their own empirical evidence to judge pharmaceutical success or failure. It is important not to lose sight of the role of this highly subjective and individual interpretation of symptoms and treatments. In the absence of a lasting consensus on diagnosis and treatment, a dynamic matrix of personal experiences, conceptions of masculinity and medical therapeutics shaped, and continues to shape, the history of male menopause.

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⁶¹Marshall 2007.

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