The Association Between PTSD and Menopause: A Case Report

Trigger Warning: this case discusses abuse

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Background

Literature shows that post-traumatic stress disorder (PTSD) is prevalent during pregnancy and the postpartum period (Yildiz et al., 2017). However, literature is lacking regarding the connection between menopause and exacerbation of PTSD symptoms. Menopause symptoms are common and can affect 50 to 80% of women and include vasomotor symptoms (hot flashes and night sweats), urinary problems, and vaginal issues (Woods & Mitchell, 2005) (Fig 1). Lifetime prevalence of PTSD in American adults is estimated to be about 6.8%, with women more likely to develop PTSD than men (9.7% in women and 3.6% in men) (Kessler et al., 2005).

One recent study shows that current symptoms of PTSD in addition to a lifetime history of intimate partner violence and sexual assault are associated with menopause symptoms including difficulty sleeping, vasomotor symptoms, and vaginal symptoms (Gibson et al., 2019).

In this case report, we present a patient with a history of sexual, physical, and emotional abuse who had worsening PTSD and depressive symptoms in the context of menopause.

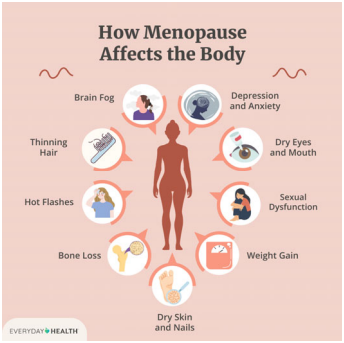

Fig 1. https://www.everydayhealth.com/menopause/perimenopause-symptoms/

Case

A 52-year-old female with a past psychiatric history of depression, anxiety, and eating disorder in remission presented to the menopause clinic for symptoms of hot flashes, night sweats, insomnia, constipation, abdominal distention/discomfort, and weight gain. She also endorsed depression and suicidal ideation (SI) with a plan and was subsequently taken to the emergency room where psychiatry was consulted. Upon interview, she was positive for all symptoms of depression, but she also revealed a significant trauma history dating back to early childhood and extending into recent romantic relationships. For years, she managed to cover her trauma and lead an independent, "normal" life.

Now, she specifically identified constipation, abdominal distension, and hot flashes as being triggers for similar body sensations she felt during past abusive experiences, stating "it's all the same organs." She also described the loss of control of her body going through menopause being a reminder of the loss of control she felt as a victim of abuse. In summary, her active menopausal symptoms precipitated her dormant trauma. Her primary diagnosis was PTSD.

Treatment

Symptomatic treatment: i.e. constipation, sleep
Hormonal: Started Estrogen 0.0375 mg topical twice daily and Progesterone 100 mg nightly
Psychotropic: Increased Sertraline from 100 to 150 mg daily and continued Bupropion XL 150 mg daily
Disposition: Psychiatric hospitalization.

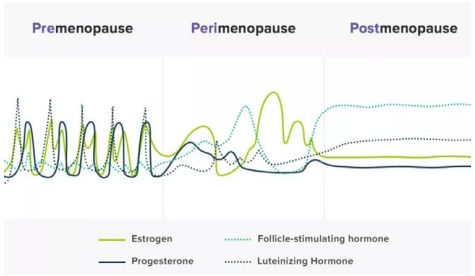

Fig 2. https://au.sfihealth.com/health-insights/menopause/menopause-101/

Discussion

Perimenopausal hormonal changes are similar to postpartum and premenstrual hormonal changes, during which time women are more vulnerable to psychiatric symptoms. PTSD has been associated with the presence of vasomotor and urinary symptoms occurring in menopause (Thomas et al., 2024). Reversely, menopause status has been associated with higher PTSD symptom severity. Michopoulus et al. (2023) showed that perimenopausal women reported significantly worse total PTSD symptoms when compared to premenopausal and postmenopausal women, with increases in hyperarousal and avoidance symptoms. During perimenopause, changes in levels of hormones including estradiol (E2) and follicle-stimulating hormone are associated with risk of developing depression (Fig 2). Low E2 levels are also associated with increased PTSD symptoms which could partially explain increased risk of PTSD exacerbation during menopause (Michopoulos et al., 2023). Apart from the impact on menopause, sexual trauma has also been associated with higher rates of endometriosis, pelvic pain syndromes, and sexual dysfunctions. Finally, an accurate diagnosis of PTSD is crucial and can be therapeutic to the patient itself.

Fig 3. https://www.justiceinspectorates.gov.uk/hmiprobation/research/the-evidence-base-youth-offending-services/general-models-and-principles/other-generic-models-and-principles/

Conclusions

This case highlights many important aspects of consultation liaison psychiatry including the demonstration of collaborative care between gynecology and psychiatry, multimodal treatment approaches, a call for effective screening, and trauma-informed care. Additional research is needed to further study the link between history of trauma, active PTSD, and menopausal symptom burden.

Screening

Current guidelines recommend trauma screening in women of reproductive age, but no such guidelines exist for perimenopausal women (Curry et al., 2018). The link between PTSD and menopause emphasizes the need for appropriate screening in women across the reproductive lifespan and in all settings.

Trauma-Informed Care

Trauma-informed care should be practiced across all clinical settings and includes five core principles (Fig 3). We ensured we maintained trust and safety with our patient (especially given she came to the menopause clinic and didn't expect to see psychiatry). We respected her boundaries and relayed our recommendation of inpatient hospitalization while emphasizing collaboration, which helped her view the hospitalization in a positive light. We empowered the patient to make active choices about her medical care and regain the perceived loss of control commonly seen in patients with trauma.

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