UVM Project ECHO
Mental Health Advanced Series:
Trauma and Related Disorders

Course Directors: Sara Pawlowski, MD & Mark Pasanen, MD
ECHO Director: Patti Smith Urie

Series Faculty:

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Sara Pawlowski, MD
Corinne Roberts, MD

Didactic presentation is recorded. Registered participants will receive the link.

University of Vermont
Larner College of Medicine

Project ECHO

Session Agenda

- Welcome
- Objectives
- Didactic Presentation (30-35 min)
  - Q&A
- Case presentation(s)
  - Clarifying questions
  - Discussion
- Closing Announcements
  - Topic and cases for next session
  - Feedback and evaluation

ECHO Model: All Teach, All Learn

Cohort-based learning on ZOOM

- Have your camera on as much as possible, especially when joining the meeting and during discussions
- Questions and comments are welcome – use the “raise hand” feature or put them in the chat
- This is not a webinar! Participation is key

Case-based learning

- 1-2 participant cases each session using provided template
- Contact Mark Pasanen to present a case

Series Objectives

Learning objectives for this ECHO series include the ability to:

1. Recognize PTSD and trauma-related disorders
2. Incorporate the principles of trauma-informed care into daily practice
3. Implement evidence-based non-pharmacologic and pharmacologic treatment plans for patients with trauma-related disorders

CMIE Disclosures

The Robert Larner College of Medicine at The University of Vermont is accredited by the American Nurses Credentialing Center (ANCC), the Accreditation Council for Pharmacy Education (ACPE), and the Accreditation Council for Continuing Medical Education (ACCME), to provide continuing medical education for the healthcare team.

The University of Vermont has approved your application and designates each session a maximum of **1.5 *AMA PRA Category 1 credit(s)***™.

This program has been reviewed and is acceptable for up to **1.5 Nursing Contact Hours**.

The Robert Larner College of Medicine University of Vermont has been authorized by the American Academy of PAs (AAPA) to award AAPA Category 1 CME credit for activities planned in accordance with AAPA CME Criteria. This activity is designated for **1.5 AAPA Category 1 CME credits**.

As a Jointly Accredited Organization, The Robert Larner College of Medicine at the University of Vermont is approved to offer social work continuing education by the Association of Social Work Boards (ASWB) Approved Continuing Education (ACE) program. Organizations, not individual courses, are approved under this program. State and provincial regulatory boards have the final authority to determine whether an individual course may be accepted for continuing education credit. The University of Vermont maintains responsibility for this course. Social workers completing this course receive 1.5 continuing education credits.

Successful completion of this CME activity, which includes participation in the evaluation component, enables the participant to earn up to **1.5 MOC points** in the American Board of Internal Medicine's (ABIM) Maintenance of Certification (MOC) program; It is the CME activity provider's responsibility to submit participant completion information to ACCME for the purpose of granting ABIM or ABP MOC credit.

This activity was planned by and for the healthcare team, and learners will receive 1.5 Interprofessional Continuing Education (IPCE) credit for learning and change.

Participants should claim only the credit commensurate with the extent of their participation in the activity.

CMIE Disclosures

Interest Disclosures: As an organization accredited by the ACCME to sponsor continuing medical education activities, UVMCMIE is required to disclose any real or apparent conflicts of interest (COI) that any speakers may have related to the content of their presentations.

Meeting Disclaimer: Regarding materials and information received during this educational event, the views, statements, and recommendations expressed during this activity represent those of the authors and speakers and do not necessarily represent the views of the University of Vermont.

PTSD and Trauma-Related Disorders:

Assessment and Symptom Constellation in Primary Care

Krista Buckley, M.D.

Attending Psychiatrist & Assistant Professor, UVMMC

February 19th, 2025

University of Vermont
Larner College of Medicine

Project ECHO

Session Objectives

Learning objectives for this ECHO session include the ability to:

1. Discuss DSM-V trauma related disorders
2. Review epidemiology of PTSD
3. Review symptoms and diagnostic criteria for PTSD
4. Cover screening techniques

Trauma

DSM-V defines a traumatic event as:

"The person was exposed to: death, threatened death, actual or threatened serious injury, or actual or threatened sexual violence, in the following way(s):

- Direct exposure
- Witnessing the trauma
- Learning that the trauma happened to a close relative or close friend
- Indirect exposure to aversive details of the trauma, usually in the course of professional duties (e.g., first responders, medics)"

How common is trauma?

According to the Sidran Institute, trauma is pervasive in the United States:

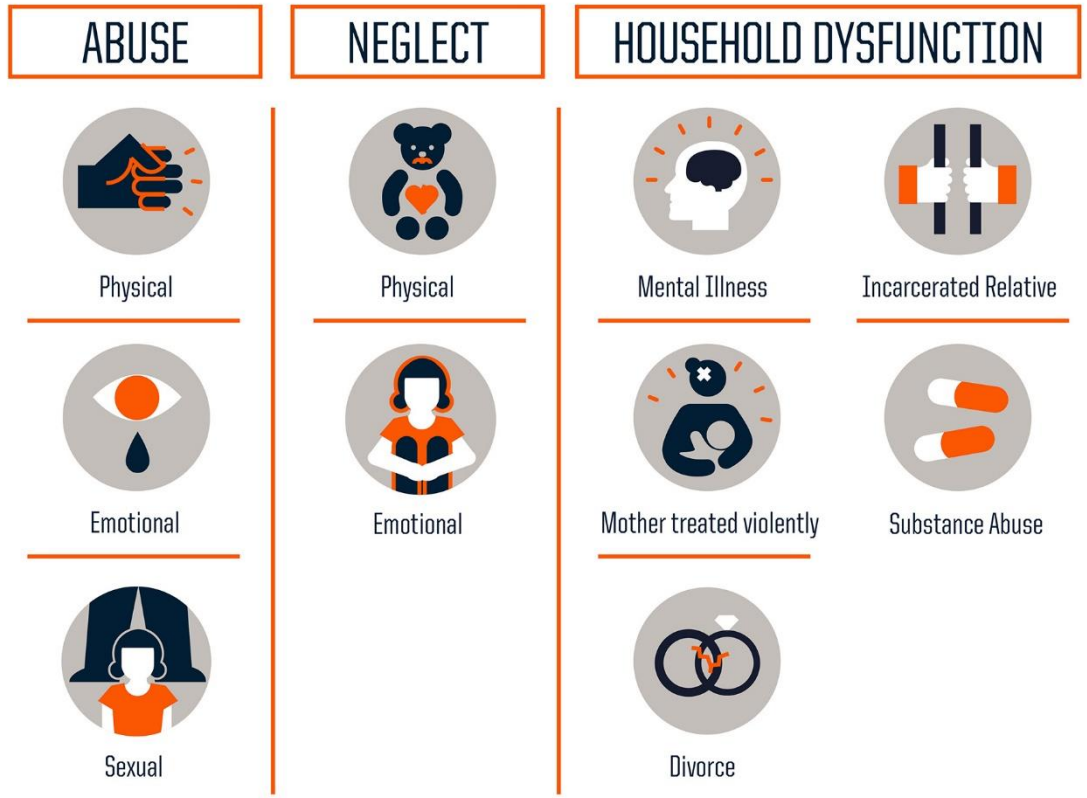
- Roughly 70% of U.S. adults have experienced a traumatic event at least once
- Not everyone who experiences trauma will develop PTSD

According to the WHO World Mental Health Survey:

- Over 70% of respondents from 26 countries report a traumatic event
- 30.5% were exposed to 4 or more traumatic events

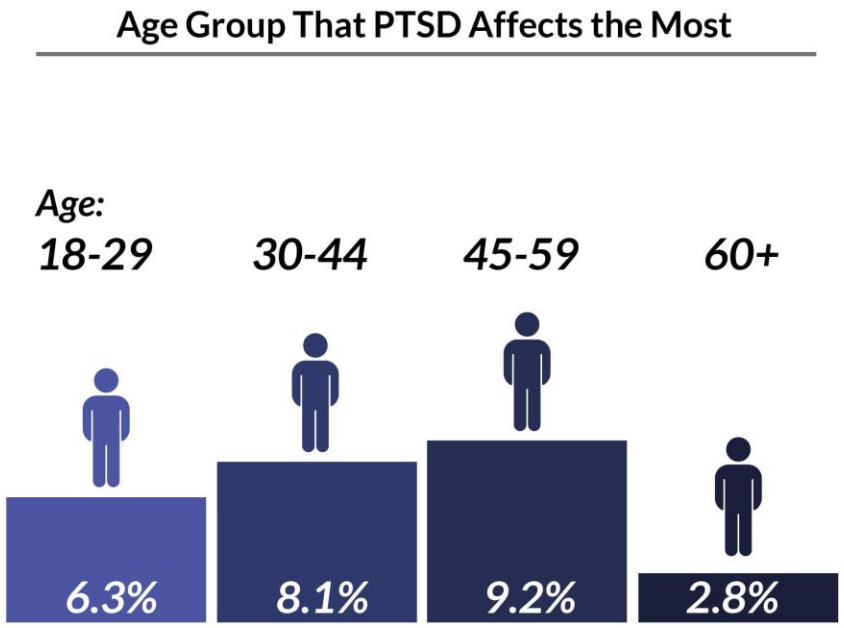
How common is trauma?

- According to the CDC, adverse childhood experiences (ACEs) — potentially traumatic events that occur in childhood — are common:
- 61% of adults surveyed across 25 states reported experiencing at least one ACE, such as violence, abuse, neglect, or substance use issues in the home
- Nearly 1 in 6 reported experiencing ≥ 4 or ACEs
- Women and some ethnic minority groups had a greater risk of experiencing four or more ACEs



Who is at risk for developing PTSD?

- Lifetime prevalence of PTSD: 6.1%
- In the USA in 2020, that was ~13 million people
- The risk of developing PTSD varies based on the trauma:
  - Risk is especially high after rape (49%), physical assault (~32%), and other sexual assault (~24%)
- Higher rates in women (~8%) than men (~4%)
- Military has higher rates than civilians



Who is at risk for developing PTSD?

Sayed et al 2015 study looked at pre-trauma, peri-trauma, and post-trauma risk factors for developing PTSD.

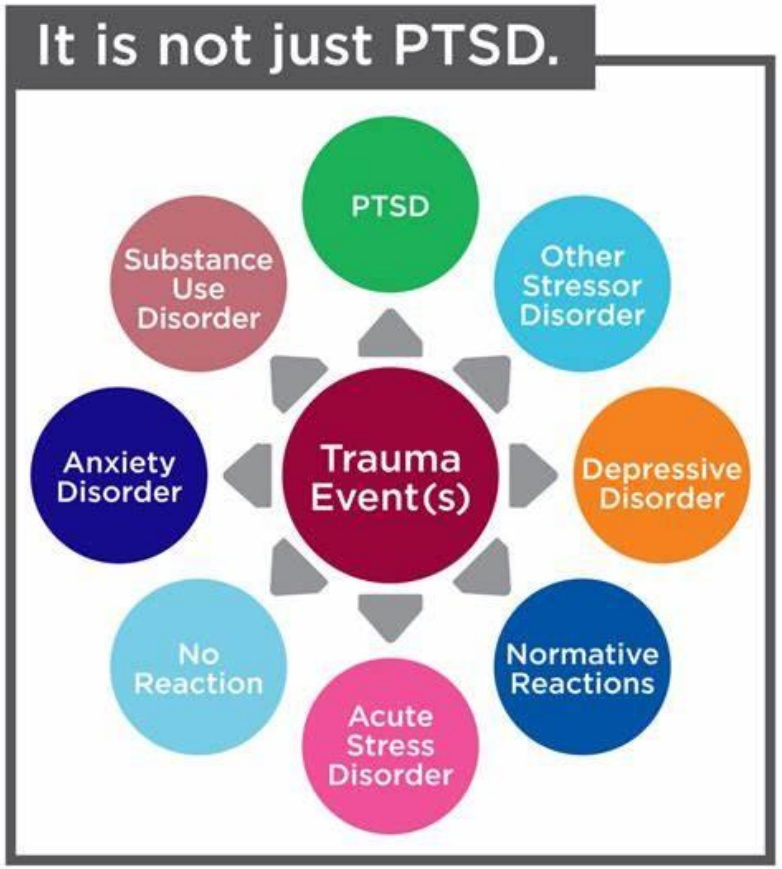
PRE-TRAUMATIC
- Female
- Age (45-59 years old)
- Low IQ
- Black or Hispanic
- LGBTQ+
- Preexisting anxiety or externalizing behaviors
- Prior Trauma
- Family Psych History
- Genetic/neurobiology

PERI-TRAUMATIC
- Sexual or physical assault
- Perception of the trauma (risk of loss of life)
- Continued perception of threat

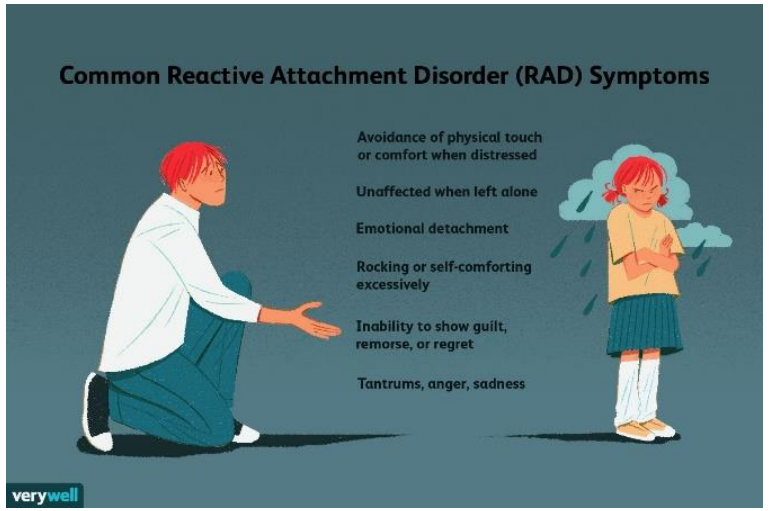
POST-TRAUMATIC
- Social support
- Cognitive Flexibility
- Physical Activity
- Embracing a moral compass

Trauma and Stressor-Related Disorders

- Reactive Attachment Disorder (children)
- Disinhibited Social Engagement Disorder (children)
- Posttraumatic Stress Disorder
- Acute Stress Disorder
- Adjustment Disorders



Reactive Attachment Disorder



A. A consistent pattern of **inhibited, emotionally withdrawn behavior** toward adult caregivers, manifested by both of the following:
   - The child rarely or minimally seeks comfort when distressed
   - The child rarely or minimally responds to comfort when distressed

B. **A persistent social or emotional disturbance** characterized by at least two of the following:
   - Minimal social and emotional responsiveness to others
   - Limited positive affect
   - Episodes of unexplained irritability, sadness, or fearfulness that are evident even during nonthreatening interactions with adult caregivers

C. The child has experienced a **pattern of extremes of insufficient care** as evidenced by at least one of the following:
   - Social neglect or deprivation in the form of persistent lack of having basic emotional needs for comfort, stimulation, and affection met by caring adults
   - Repeated changes of primary caregivers that limit opportunities to form stable attachments (e.g., frequent changes in foster care)
   - Rearing in unusual settings that severely limit opportunities to form selective attachments (e.g., institutions with high child to caregiver ratios)

D. The care in Criterion C is presumed to be responsible for the disturbed behavior in Criterion A (e.g., the disturbances in Criterion A began following the lack of adequate care in Criterion C)

E. The criteria are not met for autism spectrum disorder

F. The disturbance is evident before age 5 years

G. The child has a developmental age of at least nine months

Disinhibited Social Engagement Disorder

A. A pattern of behavior in which a **child actively approaches and interacts with unfamiliar adults** and exhibits at least two of the following:
   - Reduced or absent reticence in approaching and interacting with unfamiliar adults
   - Overly familiar verbal or physical behavior (that is not consistent with culturally sanctioned and with age-appropriate social boundaries)
   - Diminished or absent checking back with adult caregiver after venturing away, even in unfamiliar settings
   - Willingness to go off with an unfamiliar adult with little or no hesitation

B. The behaviors in Criterion A are not limited to impulsivity but include socially disinhibited behavior.

C. The child has exhibited a pattern of extremes of insufficient care as evidenced by at least one of the following:
   - Social neglect or deprivation in the form of persistent lack of having basic emotional needs for comfort, stimulation and affection met by caregiving adults
   - Repeated changes of primary caregivers that limit ability to form stable attachments (e.g., frequent changes in foster care)
   - Rearing in unusual settings that severely limit opportunities to form selective attachments (e.g., institutions with high child to caregiver ratios)

Adjustment Disorder

DSM 5

Diagnostic Criteria

A. The development of emotional or behavioral symptoms in response to an identifiable stressor(s) occurring within 3 months of the onset of the stressor(s).

B. These symptoms or behaviors are clinically significant, as evidenced by one or both of the following:

1. Marked distress that is out of proportion to the severity or intensity of the stressor, taking into account the external context and the cultural factors that might influence symptom severity and presentation.
2. Significant impairment in social, occupational, or other important areas of functioning.

C. The stress-related disturbance does not meet the criteria for another mental disorder and is not merely an exacerbation of a preexisting mental disorder.

D. The symptoms do not represent normal bereavement.

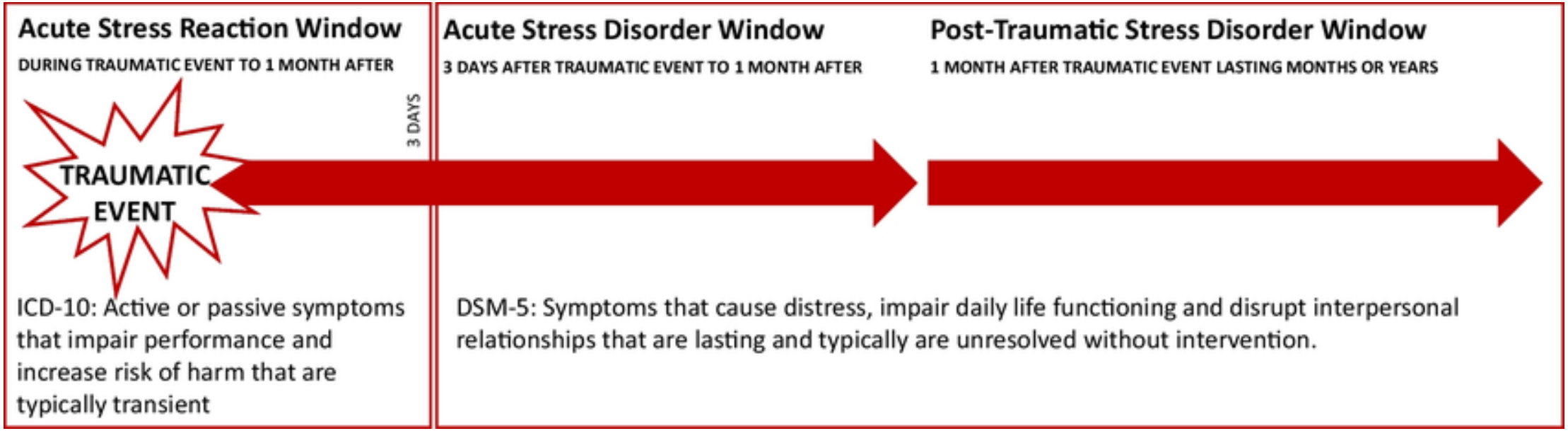
E. Once the stressor or its consequences have terminated, the symptoms do not persist for more than an additional 6 months.

Specify:

- With depressed mood
- With anxiety
- With mixed anxiety and depressed mood
- With disturbance of conduct
- With mixed disturbance of emotions and conduct
- Unspecified: For maladaptive reactions that are not classifiable as one of the specific subtypes of adjustment disorder

Acute Stress Disorder and PTSD

Acute Stress Disorder = 3 days -1 month
PTSD = greater than 1 month



PTSD Criteria

PTSD (DSM-5, 2013)	PTSD (ICD-11, 2018)
A. Exposure to actual or threatened death, serious injury, or sexual violence	• Exposure to an extremely threatening or horrific event or series of events
B. Intrusions	• Re-experiencing
C. Avoidance	• Avoidance
D. Changes in cognitions and mood	
E. Arousal & reactivity	• Persistent perceptions of heightened current threat
F. Duration more than 1 month	• Must last for at least several weeks
G. Clinically significant distress or impairment of function	• Significant impairment in personal, family, social, educational, occupational, or other important areas of functioning
H. Due to event, not due to physiological effects of a substance or medical condition	

PTSD Criterion A: TRAUMATIC EVENT

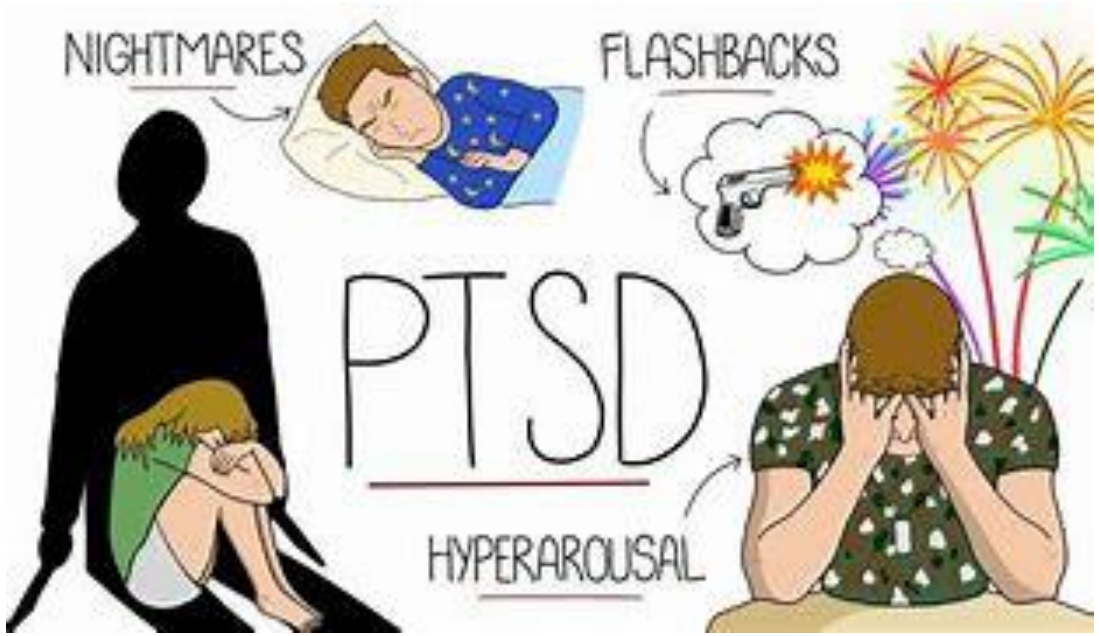
Criterion A (1 required): The person was exposed to: death, threatened death, actual or threatened serious injury, or actual or threatened sexual violence, in the following way(s):

- Direct exposure
- Witnessing the trauma
- Learning that the trauma happened to a close relative or close friend
- Indirect exposure to aversive details of the trauma, usually in the course of professional duties (e.g., first responders, medics)

PTSD Criterion B: RE-EXPERIENCING

Criterion B (1 required): The traumatic event is persistently re-experienced, in the following way(s):

- Unwanted upsetting memories
- Nightmares
- Flashbacks
- Emotional distress after exposure to traumatic reminders
- Physical reactivity after exposure to traumatic reminders



PTSD Criterion C: AVOIDANCE

Criterion C (1 required): Avoidance of trauma-related stimuli after the trauma, in the following way(s):

- Trauma-related thoughts or feelings
- Trauma-related reminders

PTSD Criterion D: CHANGES IN MOOD & COGNITION

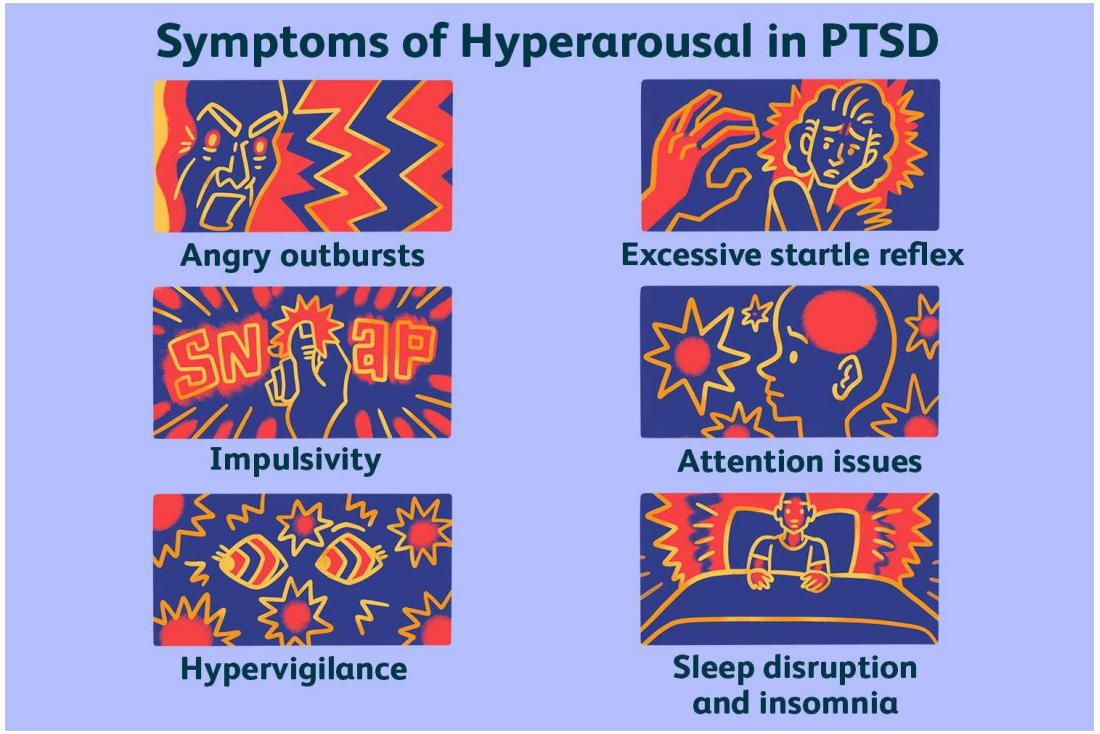
Criterion D (2 required): Negative thoughts or feelings that began or worsened after the trauma, in the following way(s):

- Inability to recall key features of the trauma
- Overly negative thoughts and assumptions about oneself or the world
- Exaggerated blame of self or others for causing the trauma
- Negative affect
- Decreased interest in activities
- Feeling isolated
- Difficulty experiencing positive affect

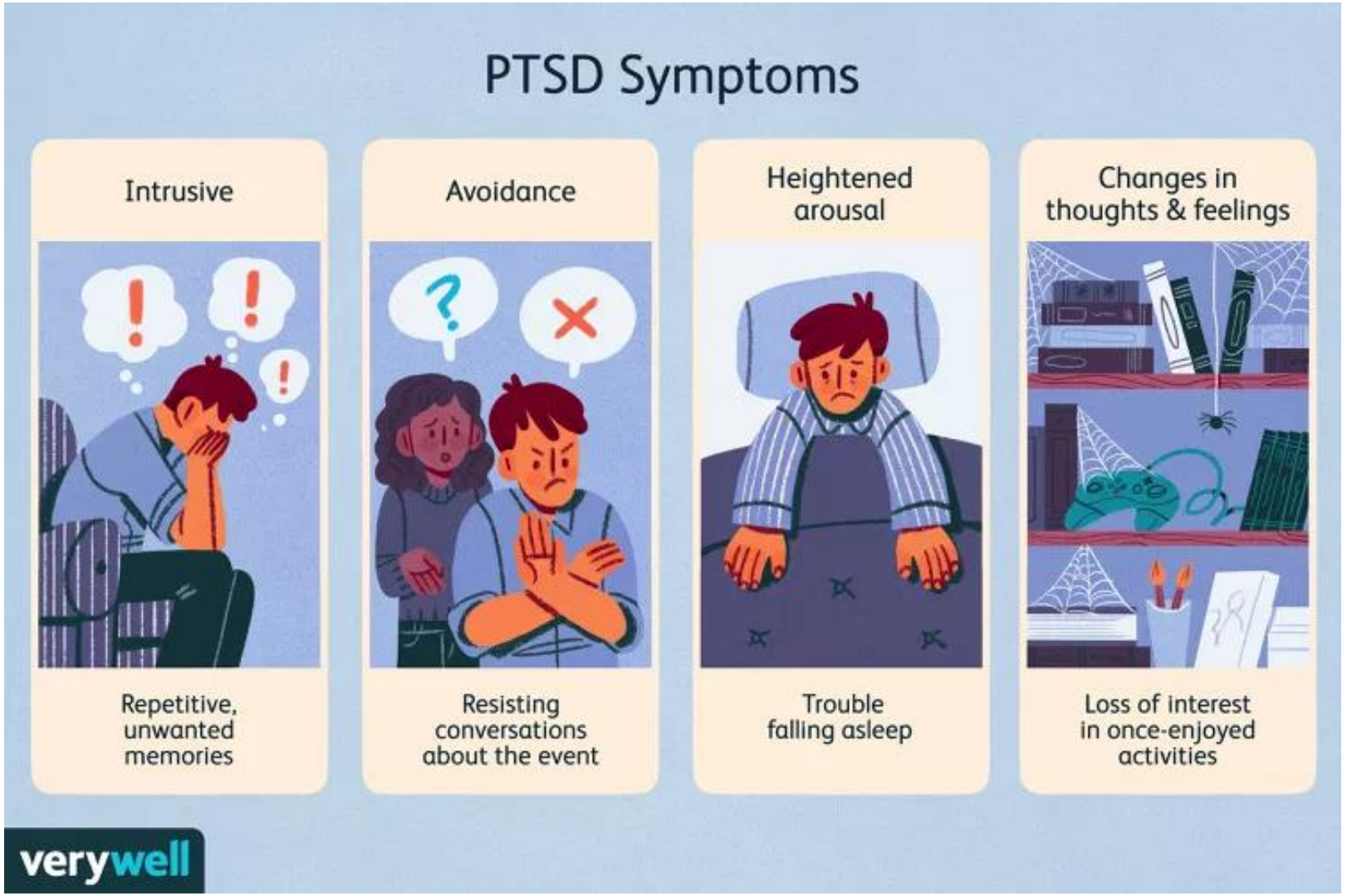
PTSD Criterion E: AROUSAL & REACTIVITY

Criterion E (2 required): Trauma-related arousal and reactivity that began or worsened after the trauma, in the following way(s):

- Irritability or aggression
- Risky or destructive behavior
- Hypervigilance
- Heightened startle reaction
- Difficulty concentrating
- Difficulty sleeping

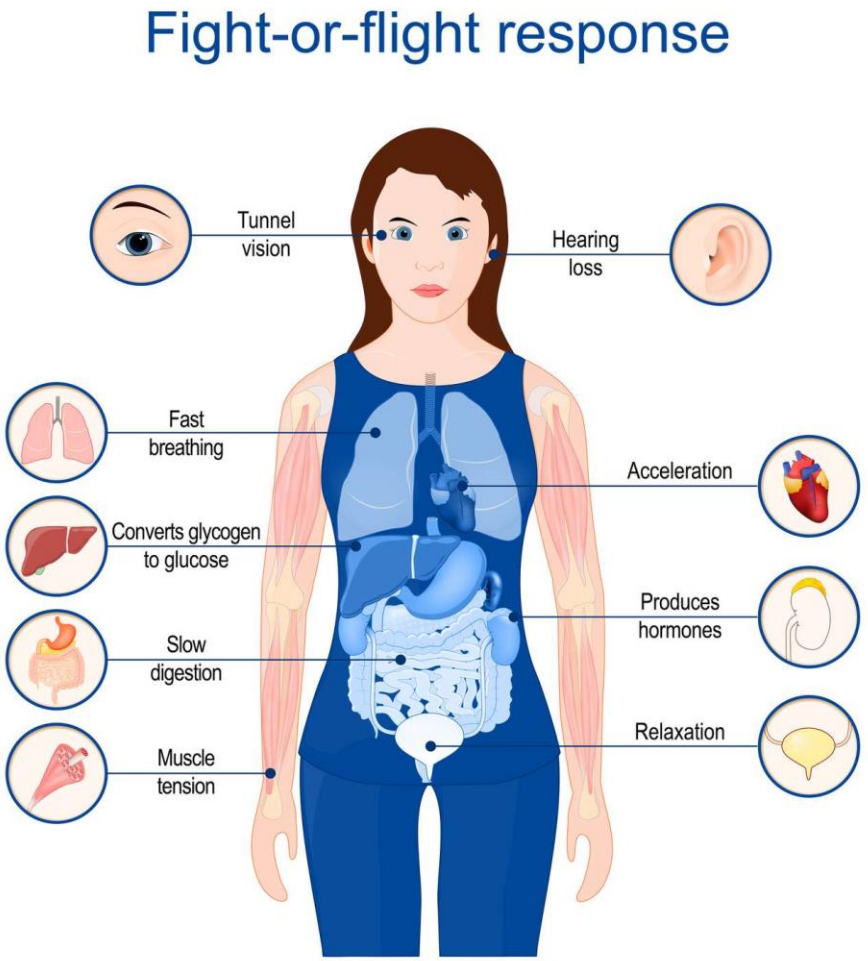


PTSD SYMPTOMS



Common Chief Complaints

- “Not sleeping”
- “No appetite”
- “I can’t leave my house”
- “Depression”
- “Anxiety”
- “IBS”
- “Anger”
- “Alcohol use”
- “Can’t keep a job”
- “Suicidal Ideation”



How do we screen?

- **ASK ABOUT TRAUMA**
- **ASK ABOUT CURRENT SAFETY**

"Do you currently feel safe from trauma in your life?"

"I ask all my patients about traumatic experiences because we know now how they can impact health. Have you experienced any trauma?"

"Difficult life experiences, like growing up in a family where you were hurt, or where there was mental illness or drug/alcohol issues, or witnessing violence, can affect our health. Do you feel like any of your past experiences affect your physical or emotional health?"

"Do you feel that trauma affects your participation in medical care? How can we best support you?"

"I am sorry this happened to you. Thank you for sharing this with me. This information can help me understand how best to care for you. Trauma can continue to affect our lives and health. Do you feel like this experience affects your health or well-being?"

- **Primary Care PTSD Screen for DSM 5 (PC-PTSD-5)**
- **PTSD Checklist for DSM-5 (PCL-5)**
- **Clinician-Administered PTSD Scale for DSM-5 (CAPS-5)(Gold Standard)**

PC-PTSD-5

Sometimes things happen to people that are unusually or especially frightening, horrible, or traumatic. For example:

- a serious accident or fire
- a physical or sexual assault or abuse
- an earthquake or flood
- a war
- seeing someone be killed or seriously injured
- having a loved one die through homicide or suicide.

Have you ever experienced this kind of event?
YES / NO

If no, screen total = 0. Please stop here.

If yes, please answer the questions below.

PC-PTSD-5

Male Cutoff = 4

Female Cutoff = 4 gives many false negatives

In the past month, have you...

1. Had nightmares about the event(s) or thought about the event(s) when you did not want to?
   YES / NO
2. Tried hard not to think about the event(s) or went out of your way to avoid situations that reminded you of the event(s)?
   YES / NO
3. Been constantly on guard, watchful, or easily startled?
   YES / NO
4. Felt numb or detached from people, activities, or your surroundings?
   YES / NO
5. Felt guilty or unable to stop blaming yourself or others for the event(s) or any problems the event(s) may have caused?
   YES / NO

PCL-5

- 20 question self-report scale
- Need to screen for Criterion A (Trauma)
- Two methods for scoring:
  - Total score
  - Symptom cluster scores

Table A

PCL-5

Instructions: Below is a list of problems that people sometimes have in response to a very stressful experience. Please read each problem carefully and then circle one of the numbers to the right to indicate how much you have been bothered by that problem in the past month.

In the past month, how much were you bothered by:	*Not at all*	*A little bit*	*Moderately*	*Quite a bit*	*Extremely*
1. Repeated, disturbing, and unwanted memories of the stressful experience?	0	1	2	3	4
2. Repeated, disturbing dreams of the stressful experience?	0	1	2	3	4
3. Suddenly feeling or acting as if the stressful experience were actually happening again *(as if you were actually back there reliving it)*?	0	1	2	3	4
4. Feeling very upset when something reminded you of the stressful experience?	0	1	2	3	4
5. Having strong physical reactions when something reminded you of the stressful experience *(for example, heart pounding, trouble breathing, sweating)*?	0	1	2	3	4
6. Avoiding memories, thoughts, or feelings related to the stressful experience?	0	1	2	3	4
7. Avoiding external reminders of the stressful experience *(for example, people, places, conversations, activities, objects, or situations)*?	0	1	2	3	4
8. Trouble remembering important parts of the stressful experience?	0	1	2	3	4
9. Having strong negative beliefs about yourself, other people, or the world *(for example, having thoughts such as: I am bad, there is something seriously wrong with me, no one can be trusted, the world is completely dangerous)*?	0	1	2	3	4
10. Blaming yourself or someone else for the stressful experience or what happened after it?	0	1	2	3	4
11. Having strong negative feelings such as fear, horror, anger, guilt, or shame?	0	1	2	3	4
12. Loss of interest in activities that you used to enjoy?	0	1	2	3	4
13. Feeling distant or cut off from other people?	0	1	2	3	4
14. Trouble experiencing positive feelings *(for example, being unable to feel happiness or have loving feelings for people close to you)*?	0	1	2	3	4
15. Irritable behavior, angry outbursts, or acting aggressively?	0	1	2	3	4
16. Taking too many risks or doing things that could cause you harm?	0	1	2	3	4
17. Being "superalert" or watchful or on guard?	0	1	2	3	4
18. Feeling jumpy or easily startled?	0	1	2	3	4
19. Having difficulty concentrating?	0	1	2	3	4
20. Trouble falling or staying asleep?	0	1	2	3	4

PCL-5 (8/14/2013) Weathers, Litz, Keane, Palmieri, Marx, & Schnurr – National Center for PTSD

- For total score: initial research shows a cut off score of 31-33/80.
- For symptom cluster scores need score of 2 (moderately) or higher on:
  - 1 B item (questions 1-5),
  - 1 C item (questions 6-7),
  - 2 D items (questions 8-14),
  - 2 E items (questions 15-20).

PCL-5

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Reexperiencing (1)

Avoidance (1)

Changes in Mood & Cognition (2)

Arousal & Reactivity (2)

Differential Diagnosis

- 80% of patients with PTSD also have another psychiatric comorbidity

PTSD comorbid with	No. (%)[b]
Major depressive disorder	77 (30.9)
Alcohol dependence + alcohol abuse	40 (16.1)
Dysthymic disorder	37 (14.9)
Personality disorder	27 (10.8)
Psychosomatic disorder	17 (6.8)
Psychotic disorder	17 (6.8)
General anxiety disorder	13 (5.2)
Drug dependence + drug abuse	8 (3.2)
Panic disorder	7 (2.8)
Social phobia	6 (2.4)
Total	249 (100.0)

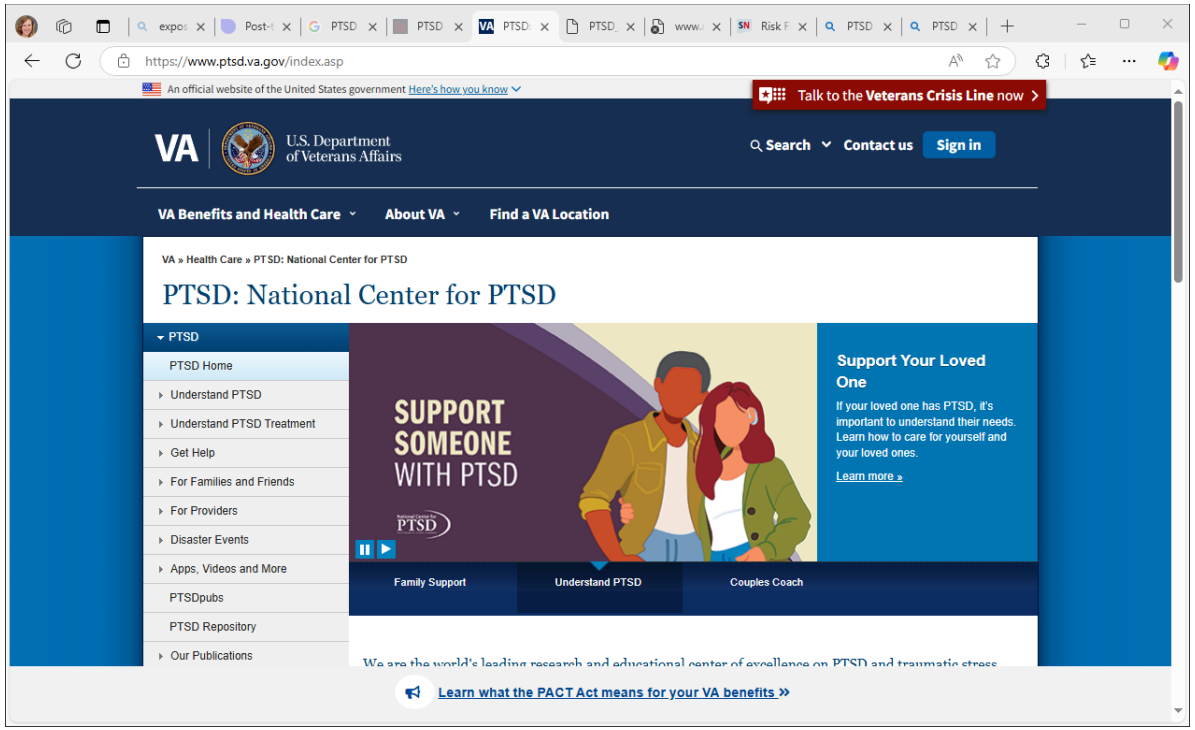
[a]A total of 402 war veterans with diagnosed PTSD underwent expert evaluation for compensation claims related to war suffering; out of these 249 had different psychiatric-psychological diagnoses comorbid with PTSD.
[b]The percentages do not add up because of rounding.

Differential Diagnosis

Mania or PTSD?	• PTSD exacerbations can look very manic (not sleeping, not eating, restless)
Treatment resistant depression or PTSD?	• PTSD treatment is trauma-based therapy with medication as supportive therapy
OCD or PTSD?	• Checking behaviors around safety are common in PTSD
Psychosis or PTSD?	• Seeing shadows out of the corner of your eye • Hearing name called from another room

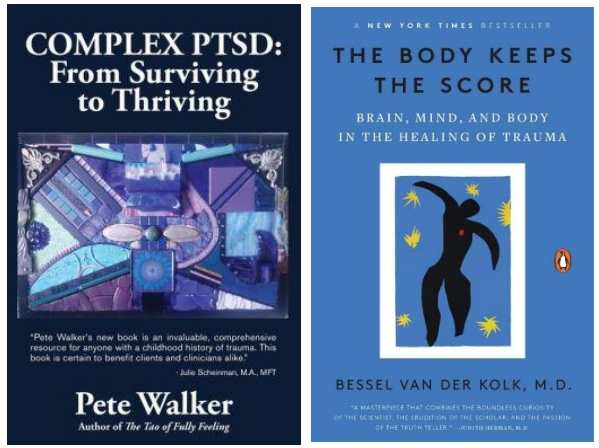
Discussing with patient

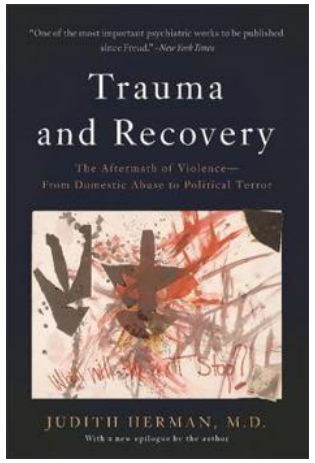
- Refer to psychiatry if needing diagnostic clarification
- Provide education and resources
- Refer for PTSD therapy:
  - Trauma-focused CBT
  - EMDR
  - Cognitive Processing Therapy

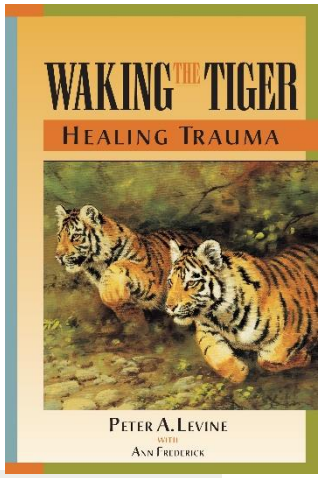


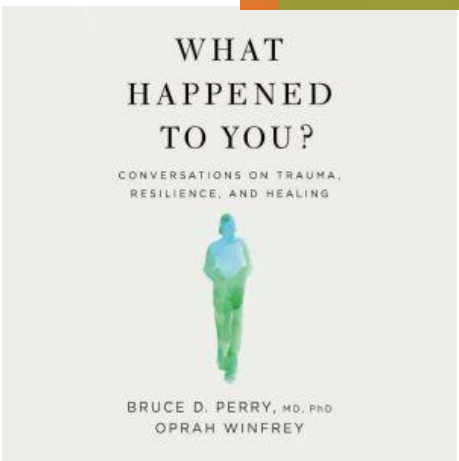
Books

- "Complex PTSD: From Surviving to Thriving" by Pete Walker
- "The Body Keeps The Score: Brain, Mind, and Body in the Healing of Trauma" by Bessel van der Kolk
- "Trauma and Recovery" by Dr. Judith Herman
- "Waking the Tiger: Healing Trauma" by Peter A. Levine and Ann Frederick
- "What Happened to You?: Conversations on Trauma, Resilience, and Healing" by Bruce D. Perry and Oprah Winfrey









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- Sayed, S., Iacoviello, B.M. & Charney, D.S. Risk Factors for the Development of Psychopathology Following Trauma. *Curr Psychiatry Rep* 17, 70 (2015). https://doi.org/10.1007/s11920-015-0612-y
- National Center for PTSD www.ptsd.va.gov
- National Counsel for Behavioral Health script-templates-for-trauma-informed-inquiry.pdf

Questions?

Case Presentation

Bringing Knowledge to Action through interactive, case-based discussions

Participant presents the case and poses the question(s) for the group

↓

Clarifying questions about the case from group to case presenter

↓

Ideas, suggestions, recommendations from participants

↓

Ideas, suggestions, recommendations from ECHO faculty team

↓

Full group discussion

↓

Summary and wrap-up by facilitator

Case Presentation

DO <u>NOT</u> INCLUDE:

Names, Address, DOB, Phone/Fax #, Email address, Social Security #, Medical Record #

Consider the level of detail necessary. Go with less when possible.

The discussion and materials included in this conference are confidential and privileged pursuant to 26VSA Section 1441-1443. This material is intended for use in improving patient care. It is privileged and strictly confidential and is to be used only for the evaluation and improvement of patient care.

UVM Office of Primary Care and AHEC Program

University of Vermont Project ECHO

Mental Health Advanced Series: Trauma and Related Disorders

2025 SPRING SERIES – Wednesdays from 12:00 to 1:30PM

WHO SHOULD ATTEND?
Individuals or practice teams throughout Vermont providing adult primary care, including Family Medicine and Internal Medicine, Gynecology, as well as pediatricians serving young adults in transition from pediatric to adult mental health care.

SCHEDULE	
Feb 19	PTSD and Trauma-Related Disorders: Assessment and Symptom Constellation in Primary Care, *Krista Buckley, MD*
Mar 5	Complex and Chronic PTSD, *Corinne Roberts, MD*
Mar 19	Psychopharmacology in PTSD, *Suzanne Kennedy, MD*
April 2	Trauma-Informed Basics, *Sara Pawlowski, MD*
April 16	Wrap-Up and Review/Participant Identified Topics, *Mark Pasanen, MD*

University of Vermont
Larner College of Medicine

Project ECHO

Closing Announcements

- Slides are posted at www.vtahec.org
- Recording of didactic portion will be sent by email to the full cohort
  - **All recordings are for the use of registered participants only**
- Please complete the evaluation survey
- CMIE information and session QR code auto-send after evaluation
- Please contact us with any questions, concerns, or suggestions:
  - Mark.Pasanen@uvm.edu
  - Patti.Smith-Urie@uvm.edu