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:

Krista Buckley, MD
Suzanne Kennedy, MD
Mark Pasanen, MD
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. Develop enhanced diagnostic and assessment skills to rule in or rule out ADHD in your practice
2. Design standard of care pharmacologic and therapeutic treatment plans for patients with ADHD
3. Discuss the complexity of ADHD and intersecting conditions (i.e., ASD, depression and anxiety

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.

Psychopharmacology in PTSD

March 19, 2025

Suzanne Kennedy, MD

Associate Professor of Psychiatry, UVM

Consultation-Liaison Psychiatrist, Neurology UVMMC

University of Vermont
Larner College of Medicine

Session Objectives

- Awareness of role of medications in PTSD and theories to support their use
- Review FDA approved medications
- Review guidelines for PTSD
- Become familiar with future considerations/research
- Special considerations- comorbidities
- Share online resources

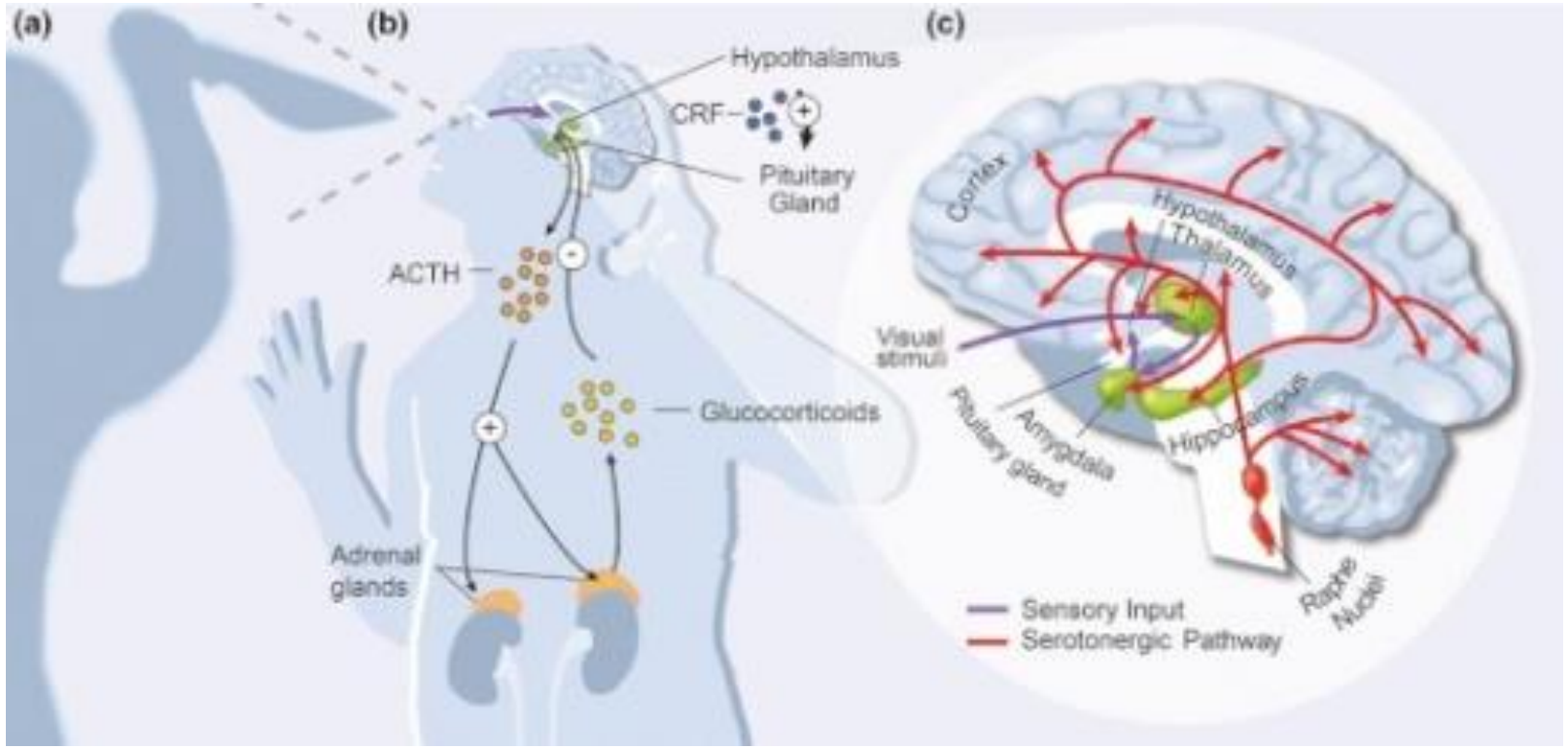
Approach to PTSD

Multimodal approach

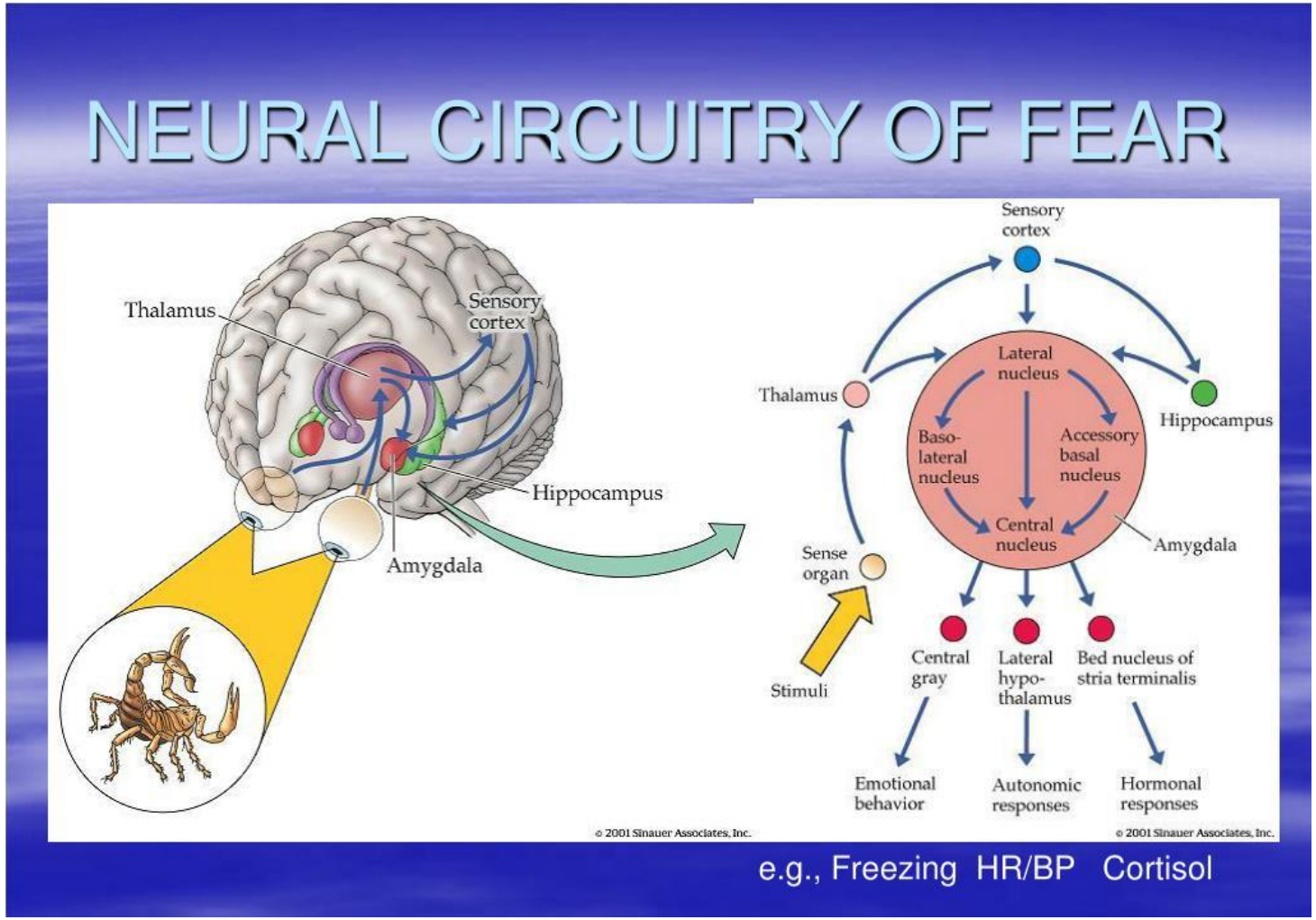
Trauma focused psychotherapy

Medications

Serotonin and anxiety response



Fear and Anxiety Circuitry



PTSD origin theories:

FEAR (amygdala)

- Serotonin
- GABA
- Glutamate
- NE
- Voltage gated ion channels
- CRF/HPA

WORRY (CSTC loop)

- Serotonin
- GABA
- Glutamate
- NE
- Voltage gated ion channels
- DA

Role of medications in PTSD treatment

- Serotonin system
- GABA system
- Glutamate system
- Cannabinoid system (anandamide)
- Adrenergic system
- Others (nicotinic acetylcholine receptors, ion gated channels)

PTSD target symptoms

- Nightmares
  - Medications used for sedating properties
  - Antihistamines
  - Benzodiazepines
- Avoidance
- Hyperarousal*
- Re-experiencing*

*Target adrenergic and serotonergic neurotransmission

Nightmares/Sleep Disruption

- **Prazosin/doxazosin**
  - Alpha 1 antagonist (blocks central receptors-> reduced NE activation)
  - 1-12mg/d. Consider split dosing (short ½ life, trigger timing)
- **Clonidine**
  - non-selective alpha 2 agonist- in brainstem (reduces sympathetic outflow from CNS)
- **Mirtazapine (Remeron)**
  - Presynaptic alpha 2 antagonist-increases release of NE, 5HT
  - Antagonist of 5HT (2a, 2c ,3) and H1 receptors
  - Peripheral alpha 1 antagonist
  - Improves sleep architecture, earlier response
- **Hydroxyzine**
  - Antihistamine- blocks H1 receptors
- **Trazodone**
  - 5HT2a receptor antagonist (potent) + SERT inhibitor (minimal) + blocks alpha 1; H1 receptors
  - *Hypnotic effects*: 25-100mg (due to antagonistic effects 5HT, alpha 1, H1 receptors)
  - Increases slow wave sleep (stage 3-4)
  - *Antidepressant effects*: 150-600mg (more SERT inhibition + 5HT2 antagonism)
- **Others**: ramelteon, trihexyphenidyl, cannabinoids, psychedelics

Serotoninergic medications

SSRIs

SNRIs

TCAs

NDRIs

buspirone

mirtazapine

2nd, 3rd generation antipsychotics

SSRIs

- **Sertraline (Zoloft)***
  - 12wk trials. Broad dose range (25-200mg). Improved all 3 symptom clusters.
- **Paroxetine (Paxil)***
  - 12wk trials. (20 vs 40mg). All 3 clusters improved.
- **Fluoxetine (Prozac)**-*downgraded in VA/Dod guidelines*
  - Variable results (better response in civilians vs combat veterans)
- **Citalopram (Celexa)/escitalopram (Lexapro)**
  - Insufficient evidence- some studies during acute stress disorder- negative
- **Fluvoxamine (Luvox)**
  - Insufficient evidence

SNRIs

- **Venlafaxine (Effexor)**
  - <150mg/d (mainly serotonin reuptake inhibition)
  - >150mg/d (NE reuptake inhibited as well)
  - Most studies. Dose usually <150mg/d.
- **Desvenlafaxine (Pristiq)**
  - Equal serotonin and NE reuptake inhibition
  - Insufficient evidence
- **Duloxetine (Cymbalta)**
  - Equal serotonin and NE reuptake inhibition
  - Insufficient evidence
- **Levomilnacipran (Fetizma)**
  - 10 x higher selectivity for NE relative to serotonin (more equal as dose increases)
  - Insufficient evidence

NDRI

- **Bupropion (Wellbutrin/Zyban)**
  - Inhibits NET and DAT—reducing re-uptake in presynaptic neurons (NE>>DA)
  - Reduces NE activity in LC; increases DA activity in NA
  - May help with comorbid depression & addictions but no evidence for reduction in PTSD symptoms.
  - Some earlier studies (1998)- possibly decreased hyperarousal

Other serotonergic agents

- Serortonin-1A partial agonist/reuptake inhibitor (SPARI)
  - **Vilazodone (Viibryd)**
- Serotonin modulator/stimulator (SMS)
  - **Vortioxetine (Trintellix)**- RTC 2021- no difference after 12 wks
- Noradrenergic/Specific Serotonergic Agent (NaSSA)
  - **Mirtazapine (Remeron)**- some benefit in studies
- Nonselective Cyclics (TCAs)
  - **Amitriptyline, imipramine**
- Serotonin partial agonist (azaspirone class)
  - **Buspirone (Buspar)**
    - Enhances serotonin neurotransmission to amygdala, PFC, thalamus, striatum
    - Affinity for central D2 receptors (antagonist and agonist)
    - Major metabolite-alpha2 receptor antagonist ----enhances NE release

Comorbidities

- Substance use disorder
- TBI
- Chronic pain
- GAD, Panic disorder, Social anxiety disorder
- Sleep disorder
- Psychotic disorder
- Mood disorder (uni vs bipolar disorder)

GABA focused medications

- AED (antiepileptic drugs)
  - *Voltage gated channels; increase GABA concentrations*
  - Divalproic acid-not recommended by VA/DoD (2 negative RTCs)
  - Lamotrigine-small trial (n=15). Possible benefit
  - Topiramate- mixed findings but cognitive s/e risk. Possible benefit in AUD.
  - Tiagabine- not recommended (1 negative RTC)
  - Gabapentin/pregabalin- (alpha2 delta ligand)- *reduce glutamate release*

- Benzodiazepines
  - Positive allosteric modulator (PAM)- enhances GABA action
  - Reserve for “acute” emergencies only
  - Not recommended for daily use
  - May worsen outcome (meta-analysis 2015)

Beta blockers, immune suppressants

- Propranolol
  - Beta blocker
  - crosses BBB
  - Used in performance anxiety
  - Blocked reconsolidation of fear memories in some early studies
  - No consistent benefit in PTSD
- Hydrocortisone, dexamethasone
  - As augmentation
  - May facilitate extinction learning in PTSD

Antipsychotics

- Augmentation
- Many targets (serotonin, dopamine, norepinephrine, histamine)
- Sedation often a result (? is this the “benefit” of augmentaton)
- Brexpiprazole (Rexulti)- added to sertraline (significant improvement with used together)
- VA/DoD:
  - Against use of risperidone (no benefit in large trial when added to SSRI)
  - Neutral on use of quetiapine, olanzapine (weak evidence, s/e risks high)

Research Updates/Future Considerations

Neuromodulation

- ECT (electroconvulsive therapy)
- rTMS (repetitive Transcranial Magnetic Stimulation)
  - Possible benefit if target Right DLPFC (superior to sham)
- tDCS (transcranial Direct Current Stimulation)
- DIFS (Deep Intracranial Frequency Stimulation)- Halo* Clarity
- EEG Neurofeedback (Prism*)
- DBS (deep brain stimulation)
- VNS (vagus nerve stimulation)
- Stellate ganglion blockade
- Hyperbaric Oxygen Therapy (CBS story- Israel)
  - Pure oxygen with 5 min off (perceived lack of oxygen triggering neuronal recovery response)
  - $50K for 60 treatments

Psychodelic Assisted Psychotherapy

- *Goal: reconsolidation of the memory of the trauma*
- MDMA
- Ketamine
- Psilocybin
- Cannabinoids- lack of RTC evidence
- LSD
- Ayahuasca

MDMA assisted psychotherapy

- VA-most research (Lykos Therapeutics)
- Rationale: phenylalanine compound; competes with VMAT-2, reverses action of NERT, SERT, DAT
- Effect: empathogen-entactogen
  - Lead to greater social engagement, openness, empathy, receptiveness to positive affect, and disclosure of emotional content;
  - Facilitate the release of oxytocin, which increases levels of empathy and closeness while also lowering stress responses;
  - Increase self-compassion and prosocial feelings, both of which can assist with perspective taking when recalling a traumatic experience;
  - Reopen the social reward learning critical period, creating cognitive flexibility that may support unlearning of distorted beliefs developed through traumatic experiences and the relearning of more helpful beliefs;
  - Allow people to have higher tolerance when remembering unpleasant memories—a finding corroborated in humans following animal studies that showed that MDMA assists with improving fear extinction learning due to reducing amygdala activity, thus allowing for easier recall of traumatic memories for PTSD patients who may otherwise become overwhelmed by emotions; and
  - Bolster fear extinction through improved hippocampal and ventral/medial prefrontal cortex activity, both of which show deficits in people with PTSD.

Psilocybin Assisted Psychotherapy

- A psychoactive tryptamine
- Effect:
  - sense of unity, transcendence of time/space, loss of self, euphoria
  - Decreases amygdala activity during emotional processing
  - Agonism on receptors. No effect on NET/SERT/DAT- no increase in intrasynaptic serotonin
  - Decrease activity of DMN (default mode network)

Limitations to psychedelic facilitated psychotherapy

- Study bias- how to truly have placebo and blinded clinicians
- Potential drug interactions (SSRI, SNRI may compete with psychedelic-attenuate effects, increase risk of serotonin syndrome)
- How to ensure product is consistent (dose: 75-125mg each session)
- Commitment of time/personnel/space

    12 sessions (90 min) with 6-8 MDMA sessions

    administration sessions last 7.5hrs

    require 2 therapists

    Training Program (Lykos) 100+ hours

FDA approval to date

- SSRIs- only **sertraline, paroxetine**
- No new drug approvals in 20 years.
- FDA denial of Lykos MDMA- August 2024. Recommend another phase 3 trial
- Australia- rescheduled psychedelics (MDMA, psilocybin) for clinical use
- Canada, Switzerland- psychedelics allowance for compassionate use

Guidelines for PTSD medications:

Medication	World Federation of Biological Psych (2022)	Australian Guidelines (2022)	CANMAT (2014)	NICE (2018)	APA guideline watch (2009)
SSRIs		Sertraline Paroxetine Fluoxetine	Sertraline Paroxetine Fluoxetine	Sertraline paroxetine	SSRIs may be better if non combat trauma
SNRIs	venlafaxine	Venlafaxine (conditional)	Venlafaxine XR	Venlafaxine	No head to head trials
Antipsychotics	augmentation			Risperidone (augmentation)	augmentation
Others			2nd- fluvoxamine, mirtazapine, phenelzine Benzo- only acutely Beta blockers- conflicting No gabapentin/pregabalin	Avoid benzodiazepines	Role of prazosin Anticonvulsants- not enough evidence

2023 VA/DoD CLINICAL PRACTICE GUIDELINE: MEDICATION MONOTHERAPY FOR THE PRIMARY TREATMENT OF PTSD BY RECOMMENDATION AND STRENGTH EVIDENCE

Quality of Evidence*	Recommend For	Suggest For	Suggest Against	Recommend Against	Recommend Neither For Nor Against
High	None	None	None	None	None
Moderate	paroxetine^, sertraline^, venlafaxine	None	None	None	None
Low	None	prazosin (only for the treatment of PTSD-associated nightmares)	None	None	None
Very Low	None	None	divalproex, guanfacine, ketamine, risperidone, tiagabine, vortioxetine, prazosin (for the treatment of PTSD)	benzodiazepines, cannabis (or cannabis derivatives)‡	amitriptyline±, bupropion±, buspirone, citalopram±, desvenlafaxine, duloxetine, escitalopram, eszopiclone±, fluoxetine, imipramine±, lamotrigine±, mirtazapine±, nefazodone±, olanzapine±, phenelzine±, pregabalin±, quetiapine±, rivastigmine, topiramate
No Data	None	None	None	None	ayahuasca‡, dimethyltryptamine‡, ibogaine‡, lysergic acid diethylamide (LSD) ‡, psilocybin‡

Key:

* The Work Group determined there was no high-quality evidence regarding medication monotherapy.

^ FDA approved for PTSD.

± Clinicians should strongly consider potential adverse effects.

‡ Studies of these drugs did not meet the inclusion criteria for the systematic evidence review due to poor quality.

2023 VA/DoD CLINICAL PRACTICE GUIDELINE: MEDICATION AUGMENTATION AND COMBINATION* PHARMACOTHERAPY FOR THE TREATMENT OF PTSD BY RECOMMENDATION AND STRENGTH OF EVIDENCE

Quality of Evidence±	Recommend For	Suggest For	Suggest Against	Recommend Against	Recommend Neither For Nor Against
High	None	None	None	None	None
Moderate	None	None	None	None	None
Low	None	None	None	None	3, 4-methylenedioxymethamphetamine (MDMA)
Very Low	None	None	aripiprazole, asenapine, brexpiprazole, cariprazine, iloperidone, lumateperone, lurasidone, olanzapine, paliperidone, quetiapine, risperidone, ziprasidone	None	None
No Data	None	None	None	None	None

Key:

* Combination means 2 or more evidence-based treatments for PTSD are combined to improve outcomes. Augmentation means an intervention that has not demonstrated efficacy for PTSD itself is added to evidence-based treatment to enhance its effect.

± The Work Group determined there was no high- or moderate-quality evidence regarding medication augmentation.

OPTIMIZING PTSD TREATMENT:
A Guide for Mental Health Prescribing Clinicians

There are several effective treatments for PTSD. This quick guide offers tips to implement key recommendations of the VA/DoD Clinical Practice Guideline (CPG) in your work with Veterans.

SCREEN FOR PTSD

PTSD commonly occurs with other mental health problems. Conduct periodic screening of PTSD using the Primary Care PTSD Screen for *DSM-5* (PC-PTSD-5). This 5-item screening measure is designed to identify individuals with probable PTSD.

CONFIRM THE DIAGNOSIS

To diagnose PTSD, the CPG suggests using validated, structured clinician-administered interviews, such as the Clinician-Administered PTSD Scale for *DSM-5* (CAPS-5). See our CAPS-5 Training Curriculum to gain a comprehensive understanding of the assessment and its administration.

MONITOR PTSD

PTSD symptom severity changes over time. To assess changes over time and response to treatment plan changes, use the **PTSD Checklist for DSM-5 (PCL-5)** or another validated instrument.

PRIMARY TREATMENT RECOMMENDATIONS

The CPG recommends 3 specific trauma-focused psychotherapies over other pharmacologic and somatic interventions for the primary treatment of PTSD:

- Prolonged Exposure (PE)
- Cognitive Processing Therapy (CPT)
- Eye Movement Desensitization and Reprocessing (EMDR)

Some patients might prefer to take medication. The medications that are most helpful for treating PTSD with the strongest support are:

- Paroxetine
- Sertraline
- Venlafaxine

University of Vermont
Larner College of Medicine

PHARMACOTHERAPY AND SOMATIC THERAPY RECOMMENDATIONS FOR PTSD

MONOTHERAPY			
Recommend For	- paroxetine	- sertraline	- venlafaxine
Insufficient Evidence to Recommend For or Against	**PHARMACOTHERAPY:** - amitriptyline - bupropion - buspirone - citalopram - desvenlafaxine - duloxetine - escitalopram - eszopiclone - fluoxetine - imipramine	- lamotrigine - mirtazapine - nefazodone - olanzapine - phenelzine - pregabalin - quetiapine - rivastigmine - topiramate	**SOMATIC THERAPY:** - hyperbaric oxygen therapy - neurofeedback - repetitive transcranial - magnetic stimulation - stellate ganglion block - transcranial direct current stimulation
Suggest Against	**PHARMACOTHERAPY:** - divalproex - guanfacine - ketamine - prazosin	- risperidone - tiagabine - vortioxetine	**SOMATIC THERAPY:** - electroconvulsive therapy - vagus nerve stimulation
Recommend Against	- benzodiazepines	- cannabis or cannabis derivatives	
AUGMENTATION			
Insufficient Evidence to Recommend For or Against	- MDMA-assisted psychotherapy		
PHARMACOTHERAPY RECOMMENDATIONS FOR PTSD-ASSOCIATED NIGHTMARES			
Suggest For	- prazosin		

PTSD: National Center for PTSD

- PTSD
  - PTSD Home
  - Understand PTSD
  - Understand PTSD Treatment
  - Get Help
  - For Families and Friends
  - For Providers
  - Disaster Events
  - Apps, Videos and More
  - PTSDpubs
  - PTSD Repository
  - Our Publications
  - En Español
  - About Us
  - More Health Care

QUICK LINKS

Overview | Resources for Providers | Promotional Resources

Contact Us

Ask us a question by calling 866-948-7880 or emailing PTSDconsult@va.gov.

Call Us | Email Us

Overview

PTSD: National Center for PTSD

"Find the medication that works for you."

Craig "Stu" Shipley

U.S. MARINE CORPS, 1964-1968

Medications

Certain medications can be used to treat PTSD symptoms. The 3 recommended medications for PTSD are paroxetine, sertraline, and venlafaxine. If you decide to try a medication, you will work with your provider to check on your response, side effects, and to change your dose, if needed.

Learn more about which medications are most effective for PTSD and those that are not recommended.

- Medications for PTSD
  Medications that have been shown to be helpful in treating PTSD symptoms are some of the same medications also used for symptoms of depression and anxiety.
- MDMA-Assisted Therapy for PTSD
  Learn about research helping us to understand whether psychedelic drugs like MDMA, in combination with talk therapy, might help people with PTSD have a better response to treatment.
- Benzodiazepines for PTSD
  Some medications, including benzodiazepines (or "benzos"), are not recommended for PTSD. Benzodiazepines are medications given by a doctor to improve anxiety and sleep. They do not help with PTSD symptoms and can have serious side effects over time.

Which PTSD Treatment Is Best for You?

No one treatment is right for everyone. Learn about effective treatment options with PTSD Treatment Decision Aid. You can read about different treatments, hear advice from people who have been through these treatments, and watch videos of providers explaining how the treatments work. You can also build a chart to compare the treatments you like the most and print a personalized summary that lists your symptoms, treatment preferences, and questions to share with your provider.

PTSD: National Center for PTSD

Overview | Resources for Providers | Promotional Resources

Contact Us

Ask us a question by calling 866-948-7880 or emailing PTSDconsult@va.gov.

Call Us | Email Us

Overview

PTSD: National Center for PTSD

- PTSD
  - PTSD Home
  - Understand PTSD
  - Understand PTSD Treatment
  - Get Help
  - For Families and Friends
  - For Providers
    - Assessment
    - Trauma, PTSD and Treatment
      - PTSD Essentials
      - Treatment Essentials
      - Types of Trauma
      - Specific Populations
      - Co-Occurring Conditions
      - Trauma-informed Care
    - Continuing Education
    - Consultation Program

Overview | Resources for Providers | Promotional Resources

Contact Us

Ask us a question by calling 866-948-7880 or emailing PTSDconsult@va.gov.

Call Us | Email Us

Overview

Resources

- **VA/DoD Clinical Practice Guidelines- National Center for PTSD**
- CPA- Canadian Psychiatric Association Guidelines
- APA- American Psychiatric Association Guidelines
- Traumatic Stress Institute of Klingberg Family Centers (traumaticstressinstitute.org)
- Tethered To PTSD (tetheredtoptsd.com)- has instructional videos, links to advocacy organizations *Otsuka America Pharmaceutical- maker of brexpiprazole

Articles

- Martin, A.; Naunton, M.; Kosari, S.; Peterson, G.; Thomas, J.; Christenson, J.K. Treatment Guidelines for PTSD: A Systematic Review. J. Clin. Med. 2021, 10, 4175. https://doi.org/10.3390/jcm10184175
- Williams T, Phillips NJ, Stein DJ, Ipser JC. Pharmacotherapy for post traumatic stress disorder (PTSD). Cochrane Database Syst Rev. 2022 Mar 2;3(3):CD002795. doi: 10.1002/14651858.CD002795.pub3. PMID: 35234292; PMCID: PMC8889888.
- Schrader C, Ross A. A Review of PTSD and Current Treatment Strategies. Mo Med. 2021 Nov-Dec;118(6):546-551. PMID: 34924624; PMCID: PMC8672952.
- Sarparast A, Thomas K, Malcolm B, Stauffer CS. Drug-drug interactions between psychiatric medications and MDMA or psilocybin: a systematic review. Psychopharmacology (Berl). 2022 Jun;239(6):1945-1976. doi: 10.1007/s00213-022-06083-y. Epub 2022 Mar 7. PMID: 35253070; PMCID: PMC9177763.
- Hoge CW, Chard KM, Yehuda R. US Veterans Affairs and Department of Defense 2023 Clinical Guideline for PTSD-Devolving Not Evolving. JAMA Psychiatry. 2024 Mar 1;81(3):223-224. doi: 10.1001/jamapsychiatry.2023.4920. PMID: 38198160.
- Mohamed A, Touheed S, Ahmed M, Hor M, Fatima S. The Efficacy of Psychedelic-Assisted Therapy in Managing Post-traumatic Stress Disorder (PTSD): A New Frontier? Cureus. 2022 Oct 31;14(10):e30919. doi: 10.7759/cureus.30919. PMID: 36465766; PMCID: PMC9710723.
- Bajor LA, Balsara C, Osser DN. An evidence-based approach to psychopharmacology for posttraumatic stress disorder (PTSD) - 2022 update. Psychiatry Res. 2022 Nov;317:114840. doi: 10.1016/j.psychres.2022.114840. Epub 2022 Sep 9. PMID: 36162349.
- Bandelow B, Allgulander C, Baldwin DS, Costa DLDC, Denys D, Dilbaz N, Domschke K, Hollander E, Kasper S, Möller HJ, Eriksson E, Fineberg NA, Hättenschwiler J, Kaiya H, Karavaeva T, Katzman MA, Kim YK, Inoue T, Lim L, Masdrakis V, Menchón JM, Miguel EC, Nardi AE, Pallanti S, Perna G, Rujescu D, Starcevic V, Stein DJ, Tsai SJ, Van Ameringen M, Vasileva A, Wang Z, Zohar J. World Federation of Societies of Biological Psychiatry (WFSBP) guidelines for treatment of anxiety, obsessive-compulsive and posttraumatic stress disorders - Version 3. Part II: OCD and PTSD. World J Biol Psychiatry. 2023 Feb;24(2):118-134. doi: 10.1080/15622975.2022.2086296. Epub 2022 Jul 28. PMID: 35900217.
- Phelps AJ, Lethbridge R, Brennan S, Bryant RA, Burns P, Cooper JA, Forbes D, Gardiner J, Gee G, Jones K, Kenardy J, Kulkarni J, McDermott B, McFarlane AC, Newman L, Varker T, Worth C, Silove D. Australian guidelines for the prevention and treatment of posttraumatic stress disorder: Updates in the third edition. Aust N Z J Psychiatry. 2022 Mar;56(3):230-247. doi: 10.1177/00048674211041917. Epub 2021 Aug 27. PMID: 34448406.
- Vigod SN, Frey BN, Clark CT, Grigoriadis S, Barker LC, Brown HK, Charlebois J, Dennis CL, Fairbrother N, Green SM, Letourneau NL, Oberlander TF, Sharma V, Singla DR, Stewart DE, Tomasi P, Ellington BD, Fleury C, Tarasoff LA, Tomfohr-Madsen LM, Da Costa D, Beaulieu S, Brietzke E, Kennedy SH, Lam RW, Milev RV, Parikh SV, Ravindran AV, Samaan Z, Schaffer A, Taylor VH, Tourjman SV, Van M, Yatham LN, Van Lieshout RJ. Canadian Network for Mood and Anxiety Treatments 2024 Clinical Practice Guideline for the Management of Perinatal Mood, Anxiety, and Related Disorders: Guide de pratique 2024 du Canadian Network for Mood and Anxiety Treatments pour le traitement des troubles de l'humeur, des troubles anxieux et des troubles connexes périnatals. Can J Psychiatry. 2025 Feb 12:7067437241303031. doi: 10.1177/07067437241303031. Epub ahead of print. PMID: 39936923.

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