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

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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 (35-40 min)
  - Q&A
- Case presentation?
  - Discussion
- Closing Announcements
  - 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

Series Objectives

Learning objectives for this ECHO series include the ability to:

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

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:
My Take-Home Points

Mark E Pasanen, MD

Associate Professor, Larner College of Medicine at UVM

April 16, 2025

University of Vermont
Larner College of Medicine

Project ECHO®

Session Objectives

Learning objectives for this ECHO session include the ability to:

1. Incorporate PTSD and trauma screening into practice
2. Improved diagnose of PTSD and complex PTSD
3. Develop treatment plans for patients with trauma-related disorders, including non-pharmacologic and pharmacologic care
4. Incorporate the principles of trauma-informed care into daily practice, including first steps

Trauma

DSM-V defines a traumatic event as:

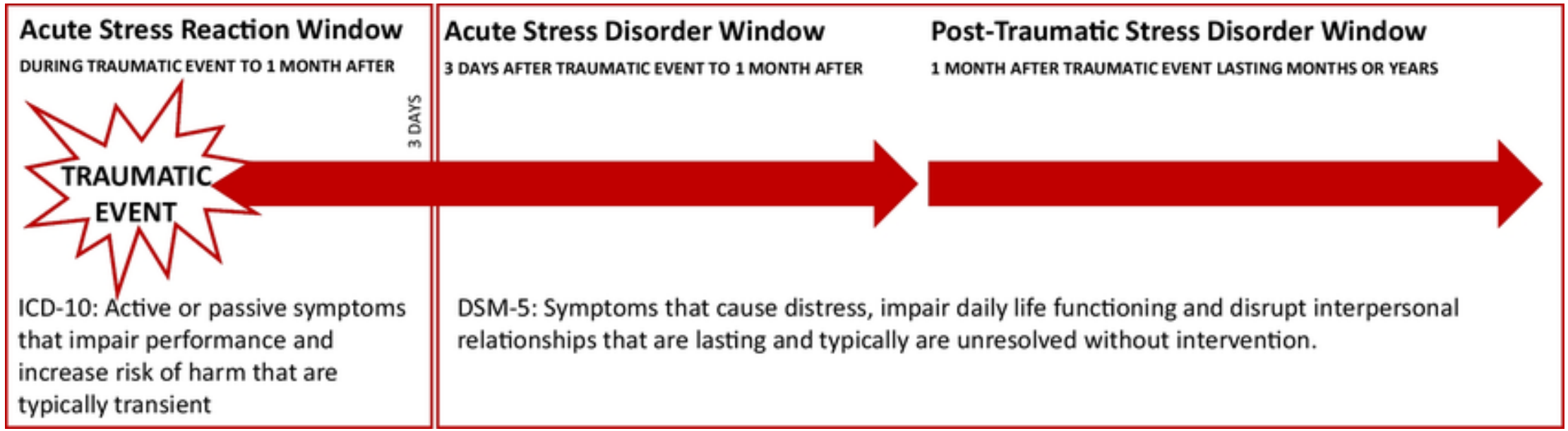
The person was exposed to: death, threatened death, actual or threatened serious injury, or actual or threatened sexual violence, in the following way(s):

- 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)

Acute Stress Disorder and PTSD

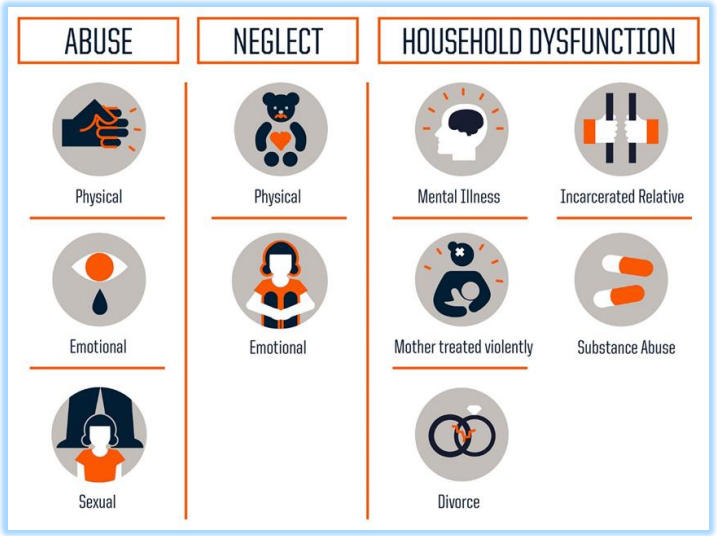
Acute Stress Disorder = 3 days -1 month

PTSD = > 1 month



How common is Trauma/PTSD

- About 70% of adults have experienced a traumatic event
- PTSD:
  - 6-8% lifetime prevalence in adult population
  - More common after rape, physical or sexual assault
  - Higher risk for many groups:
    - Women, Black, Hispanic, LGBTQ+, prior trauma, underlying anxiety, etc
    - Military > Civilians



Asking about Trauma

"Do you have a history of trauma (in childhood), whether that's emotional, physical, sexual or all the above?"

If yes, …

"That sounds really difficult. Thank you for sharing that with me."

Diagnosing PTSD

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	

Traumatic Event(s)

Violence

Rape

Abuse

Invasions

Serious illness

Re-experiencing/Intrusion

Unwanted memories

Nightmares

Flashbacks

Emotional distress or physical reactivity after trauma reminders

Avoidance

Trauma-related thoughts/feelings

Trauma-related reminders

Avoid people, places and situations

Changes in Mood & Cognition

Inability to recall key features of the trauma

Negative thoughts/assumptions about self or world

Exaggerated blame of self/others for causing the trauma

Decreased interest in activities

Feeling isolated

Negative affect/Difficulty experiencing positive affect

Arousal and Reactivity

Irritability or aggression

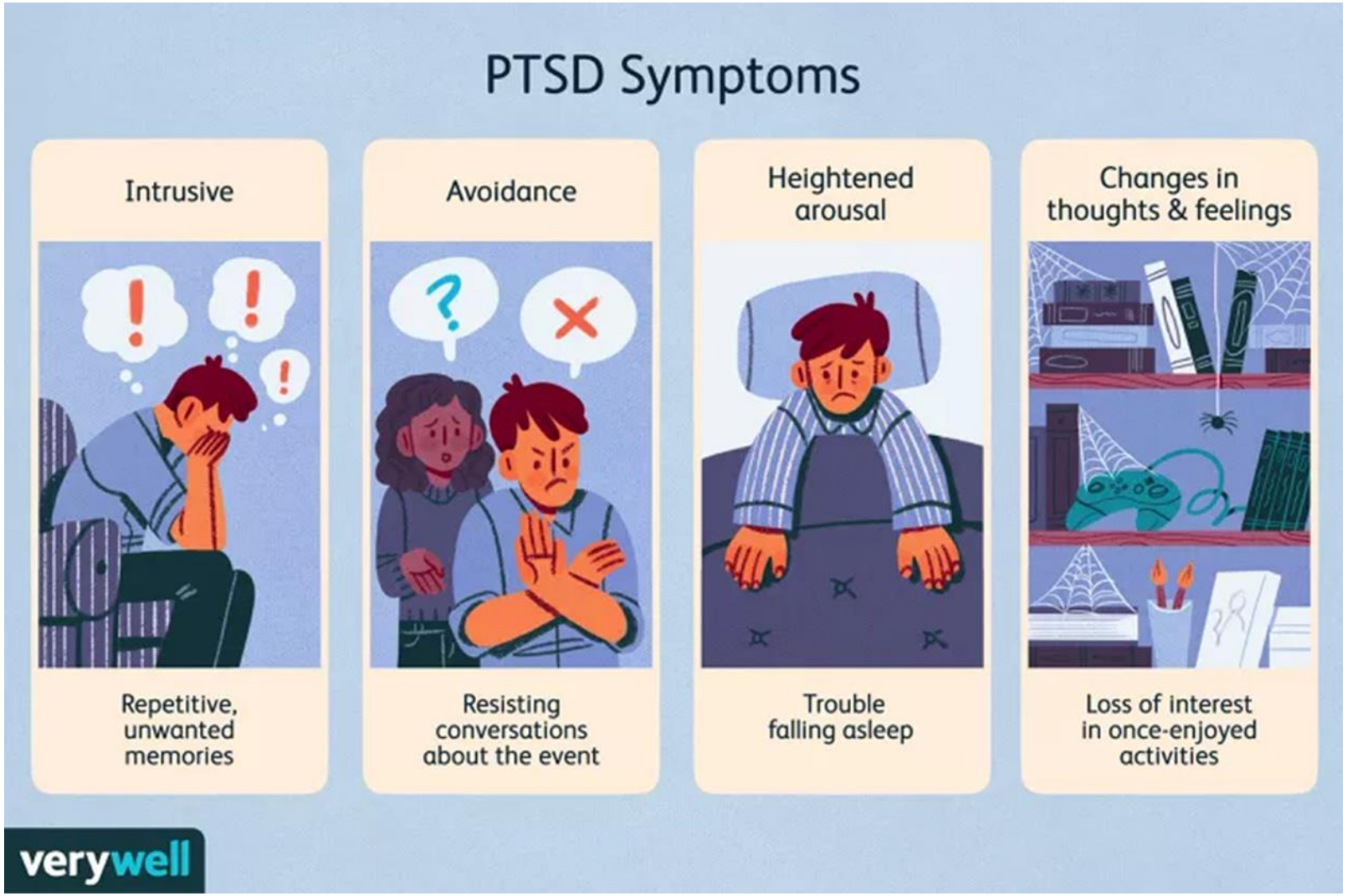
Risky or destructive behavior

Hypervigilance

Heightened startle reaction

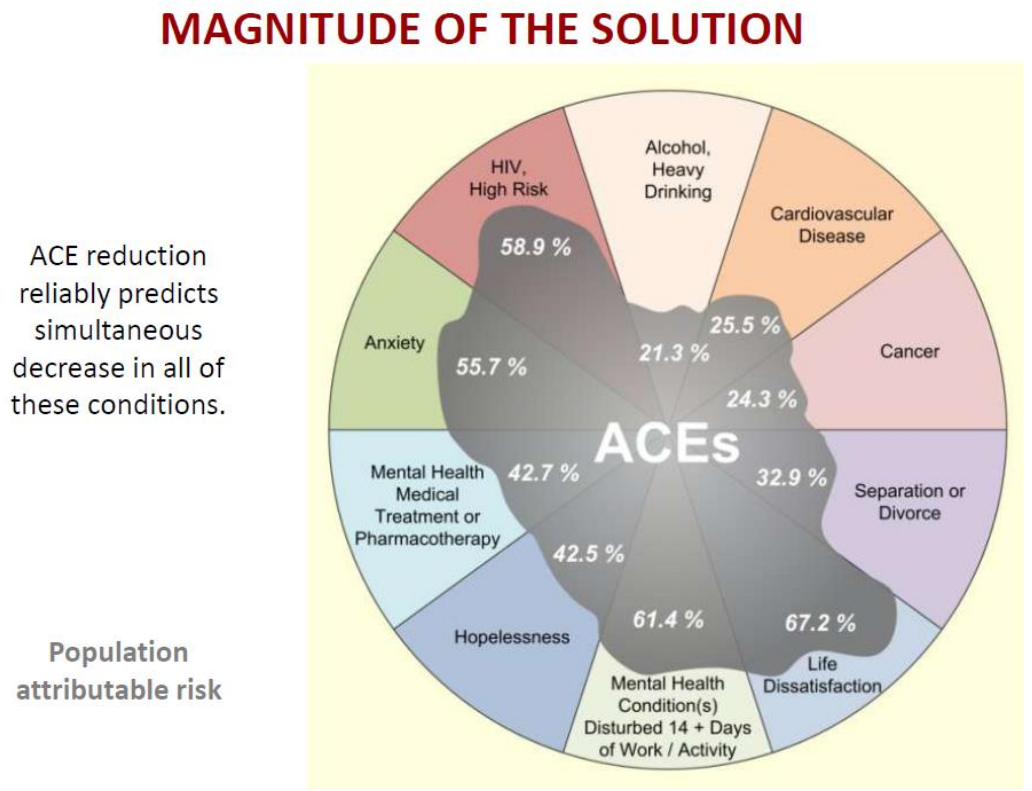
Difficulty concentrating

Difficulty sleeping


PTSD Symptoms
Intrusive
Repetitive, unwanted memories
Avoidance
Resisting conversations about the event
Heightened arousal
Trouble falling asleep
Changes in thoughts & feelings
Loss of interest in once-enjoyed activities
verywell

Considerations in Screening for Trauma

- Integrating **trauma screenings** into routine care such as the **Adverse Childhood Experiences (ACEs) questionnaire** or a **Trauma History Screen (PSL-5)** during initial assessments or during follow-up visits.
- These screenings should be done with care, **ensuring patients know they can decline to answer any questions** and titrate their disclosures.
- This acknowledges trauma and helps to identify patients who might benefit from further trauma-informed interventions.
- The PC PTSD-5 which is the PTSD screening instrument used at the VA: **"Sometimes things happen to people that are unusually or especially frightening, horrible or traumatic, for example…" And then it goes through a list.** And if the patient says no, then they're not screened further for PTSD.



Reference: [ACEs - The Magnitude of the Solution]

Text Box 1. The Primary Care PTSD Screen for DSM-5 (PC-PTSD-5)

Sometimes things happen to people that are unusually or especially frightening, horrible, or traumatic. For example: YES/NO

- *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?

If 'No,' screen total = 0; if 'Yes,' continue with screening.

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 of others for the event(s) or any problems the events may have caused?	YES	NO
Total score is sum of "YES" responses in items 1-5.	**TOTAL SCORE**	

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

Reexperiencing (1)

Avoidance (1)

Changes in Mood & Cognition (2)

Arousal & Reactivity (2)

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

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.

Complex PTSD Definition

- "Exposure to an event or series of events of an extremely threatening or horrific nature, most commonly prolonged or repetitive events from which **escape is difficult** or impossible (e.g. torture, slavery, genocide campaigns, prolonged domestic violence, repeated childhood sexual or physical abuse)"
- All diagnostic requirements for PTSD must be met in addition to "disturbances in self-organization," defined as difficulties in:
  - Affect regulation
  - Self-concept
  - Relationship functioning
- Startle reaction may be diminished rather than enhanced

Risk Factors for C-PTSD

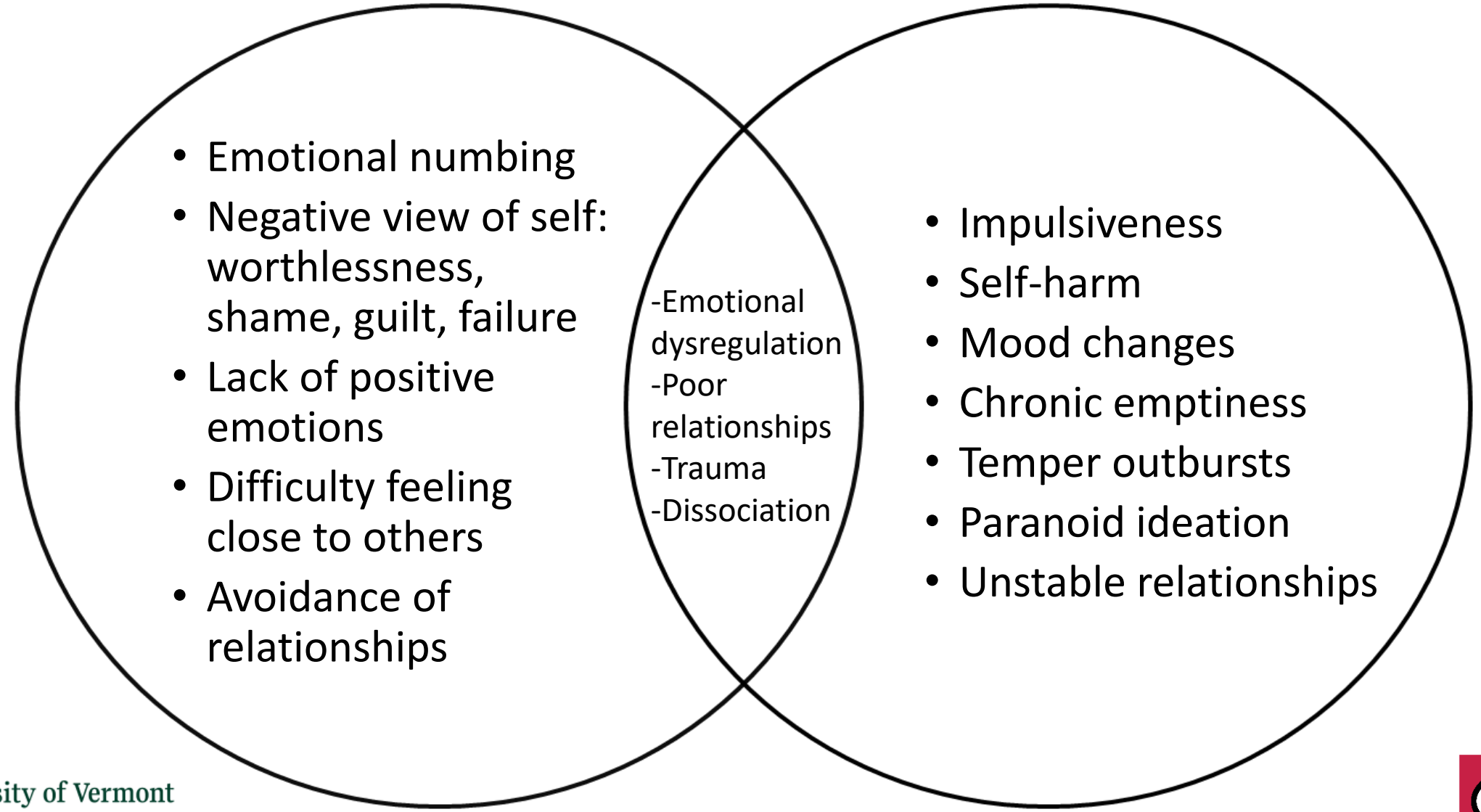
- Younger age
- Chronic, repetitive trauma
- Trauma inflicted by caregivers or trusted figures
- Feeling trapped or powerless
- Intensity of trauma
- Lack of social support
- Re-victimization
- Discrimination faced by marginalized groups

C-PTSD Presentation in Primary Care

- Somatic symptoms without clear medical cause: chronic pain, GI issues, cardiovascular symptoms, sleep disturbances, fatigue
- Stress-related conditions: hypertension & cardiovascular disease, diabetes & metabolic syndrome, autoimmune conditions, chronic pain syndromes
- Psychiatric symptoms: anxiety, depression & suicidal ideation, emotional dysregulation, dissociation, poor concentration, negative self-identity
- Behaviors: substance use, self-harm, eating disorders, overuse of pain medications
- Difficulty with medical appointments

Complex PTSD

Borderline Personality



Approach to Treating PTSD

Multimodal approach

Trauma focused psychotherapy

Medications

Treatment Goals

- Maintain the safety of the patient and others
  - assessments of suicidality/homicidality
- Reduce symptoms of distress related to intrusive re-experiencing
  - Unwanted intrusive memories of the traumatic event vary widely from occasional unwanted thoughts to frequent nightmares or flashbacks
- Reduce hyperarousal
  - Can include symptoms such as insomnia, anger, irritability, and trouble concentrating and can be very distressing
- Reduce avoidant behaviors
  - Avoidance of stimuli associated with the traumatic event may lead to behavior changes that affect psychosocial functioning
- Lessen the risk of relapse of symptoms and diminish anxiety related to fear of recurrence.
- Address related comorbidities
  - For example, substance use disorder (SUD) or mood dysregulation
- Improve adaptive and psychosocial functioning through psychotherapy often combined with pharmacologic management

Trauma-Focused Psychotherapy

- Cognitive Behavioral Therapy/Cognitive Processing Therapy
- Prolonged Exposure Therapy
- Eye Movement Desensitization and Reprocessing (EMDR)

CBT/Cognitive Processing Therapy

- **Cognitive Processing Therapy (CPT)**

  After a trauma, it's common to have negative thoughts — like thinking what happened is your fault or that the world is very dangerous. CPT helps you learn to identify and change these thoughts. Changing how you think about the trauma can help change how you feel.

  What happens during CPT? You'll talk with your therapist and fill out worksheets about the negative thoughts and beliefs that are upsetting you. Then your therapist will help you challenge those thoughts and think about your trauma in a way that's less upsetting.

https://www.ptsd.va.gov/publications/print/understandingptsd_booklet.pdf

Prolonged Exposure Therapy

- **Prolonged Exposure Therapy (PE)**
  People with PTSD often try to avoid things that remind them of the trauma. This can help you feel better in the moment, but in the long term it can keep you from recovering from PTSD.

  In PE, you expose yourself to the thoughts, feelings, and situations that you've been avoiding. It sounds scary, but facing things you're afraid of in a safe way can help you learn that you don't need to avoid reminders of the trauma.

  What happens during PE? Your therapist will ask you to talk about your trauma over and over. This will help you get more control of your thoughts and feelings about the trauma so you don't need to be afraid of your memories.

  They will also help you work up to doing the things you've been avoiding. For example, let's say you avoid driving because it reminds you of an accident. At first, you might just sit in the car and practice staying calm with breathing exercises. Gradually, you'll work towards driving without being upset by memories of your trauma.

EMDR

Eye Movement Desensitization and Reprocessing (EMDR)

People with PTSD react negatively to the memory of their traumas. EMDR can help you process these upsetting memories, thoughts, and feelings. You'll focus on specific sounds or movements while you talk about the trauma. This helps your brain work through the traumatic memories. Over time, you can change how you react to memories of your trauma.

What happens during EMDR? Your therapist will ask you to choose a memory from the trauma and identify the negative thoughts, emotions, and feelings in your body that go with it.

You'll think about this memory while you pay attention to a sound (like a beeping tone) or a movement (like your therapist's finger moving back and forth). Once the memory becomes less upsetting, you'll work on adding a positive thought.

What is dialectical behavior therapy (DBT)?

Dialectical behavior therapy (DBT) is a type of talk therapy (psychotherapy). It's based on cognitive behavioral therapy (CBT), but it's specially adapted for people who experience emotions very intensely.

Cognitive behavioral therapy (CBT) is a type of talk therapy that helps people understand how thoughts affect emotions and behaviors.

"Dialectical" means combining opposite ideas. DBT focuses on helping people accept the reality of their lives and their behaviors, as well as helping them learn to change their lives, including their unhelpful behaviors.

- **Mindfulness** enables individuals to accept and be present in the current moment by noting the fleeting nature of emotions, which diminishes the power of emotions to direct their actions.
- DBT also inculcates **distress tolerance,** the ability to tolerate negative emotion rather than needing to escape from it or acting in ways that make difficult situations worse.
- **Emotion regulation** strategies give individuals the power to manage and change intense emotions that are causing problems in their life.
- Last but not least, DBT teaches techniques of **interpersonal effectiveness,** allowing a person to communicate with others in a way that is assertive, maintains self-respect, and strengthens relationships; a core principle is that learning how to ask directly for what you want diminishes resentment and hurt feelings.

From Cleveland Clinic and Psychology Today

Pharmacologic Treatment

- SSRI: Most data for sertraline/paroxetine
- SNRI: Venlafaxine
- Prazsosin for sleep disturbance/nightmares
  - 1 mg 30-60 min before bedtime
  - Gradually increase to max of 15 mg
- Role for other meds less clear

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	For augmentation			Risperidone (for augmentation)	For 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.

JAMA Psychiatry

RCT: Brexpiprazole and Sertraline Combination Treatment in Posttraumatic Stress Disorder

POPULATION

106 Men, 310 Women

Adult outpatient participants with posttraumatic stress disorder (PTSD)

Mean (SD), 37.4 (11.9) y

INTERVENTION

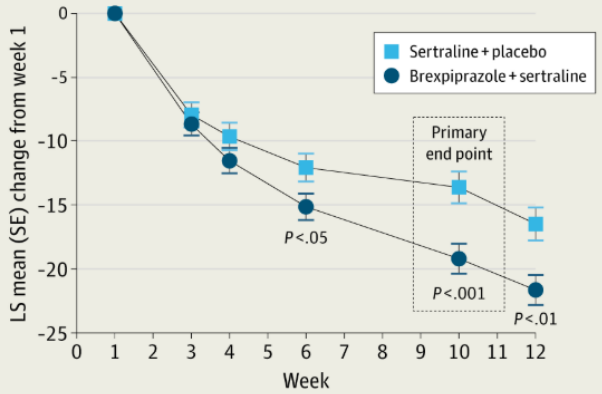
416 Participants randomized

214 Brexpiprazole+sertraline
Oral brexpiprazole, 2-3 mg/d (flexible dose), and sertraline, 150 mg/d

202 Sertraline+placebo
Oral sertraline, 150 mg/d, and placebo

FINDINGS

Brexpiprazole + sertraline demonstrated significantly greater improvement than sertraline+placebo in change in CAPS-5 total score from randomization (week 1) to week 10



Least-squares (LS) mean (SE) change,
brexpiprazole + sertraline, −19.2 (1.2) points
LS mean (SE) change,
sertraline + placebo, −13.6 (1.2) points
Between-group difference,
−5.59 points (95% CI, −8.79 to −2.38); *P* <.001

SETTINGS / LOCATIONS

86 Trial sites in the US

PRIMARY OUTCOME

Change in Clinician-Administered PTSD Scale for *DSM-5* (CAPS-5) total score (range: 0 [absent] to 80 [extreme or incapacitating]) from randomization (week 1) to week 10 for brexpiprazole+sertraline vs sertraline+placebo

Davis LL, Behl S, Lee D, et al. Brexpiprazole and sertraline combination treatment in posttraumatic stress disorder: a phase 3 randomized clinical trial. *JAMA Psychiatry*. Published online December 11, 2024. doi:10.1001/jamapsychiatry.2024.3996

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

TREATMENT COMPARISON CHART

Add Treatment

	PSYCHOTHERAPY			MEDICATION
	Cognitive Processing Therapy	Eye Movement Desensitization & Reprocessing	Prolonged Exposure	SSRI/SNRI
What type of treatment is this?	Psychotherapy (a type of trauma-focused CBT)	Psychotherapy	Psychotherapy (a type of trauma-focused CBT)	Antidepressant medications: • SSRI: Prozac, Paxil & Zoloft • SNRI: Effexor
How does it work?	Teaches you to reframe negative thoughts about the trauma	Helps you process and make sense of your trauma	Teaches you how to gain control by facing your fears	Restores the balance of naturally occurring chemicals in your brain
What will I do?	• Talk about your thoughts • Writing assignments and worksheets	Call the trauma to mind while focusing on an external motion or sound	• Talk about the trauma • Start doing safe things you have been avoiding	Take a pill at regular time(s) each day
Is it effective?	Yes, **53** out of every **100** people who receive a trauma-focused therapy (such as Cognitive Processing Therapy) will no longer have PTSD	Yes, **53** out of every **100** people who receive a trauma-focused therapy (such as Eye Movement Desensitization and Reprocessing) will no longer have PTSD	Yes, **53** out of every **100** people who receive a trauma-focused therapy (such as Prolonged Exposure) will no longer have PTSD	Yes, **42** out of every **100** people who receive this treatment will no longer have PTSD
How long does treatment last?	Weekly sessions for around 3 months	Weekly sessions for around 2-3 months	Weekly sessions for around 3 months	Variable (symptoms may return if you stop taking the medication)
What are the risks?	Temporary discomfort when talking or writing about the trauma	Temporary discomfort when thinking about the trauma	Temporary discomfort when talking about and confronting reminders of the trauma	Potential side effects, such as: headache, sleep problems, dry mouth, upset stomach, weight gain & sexual side effects
Group or individual?	Group or individual	Individual	Individual	Individual
Will I need to talk about my trauma?	Depends on type of CPT	Optional	Yes	No
Will I have homework?	Writing assignments and worksheets	No	• Listen to session recordings • Do safe activities you have avoided	No
How available is this in VA?	Moderate	Low	Moderate	High
Does VA have an app for that?	CPT Coach	No	PE Coach	No
	Treatment Overview	Treatment Overview	Treatment Overview	Treatment Overview

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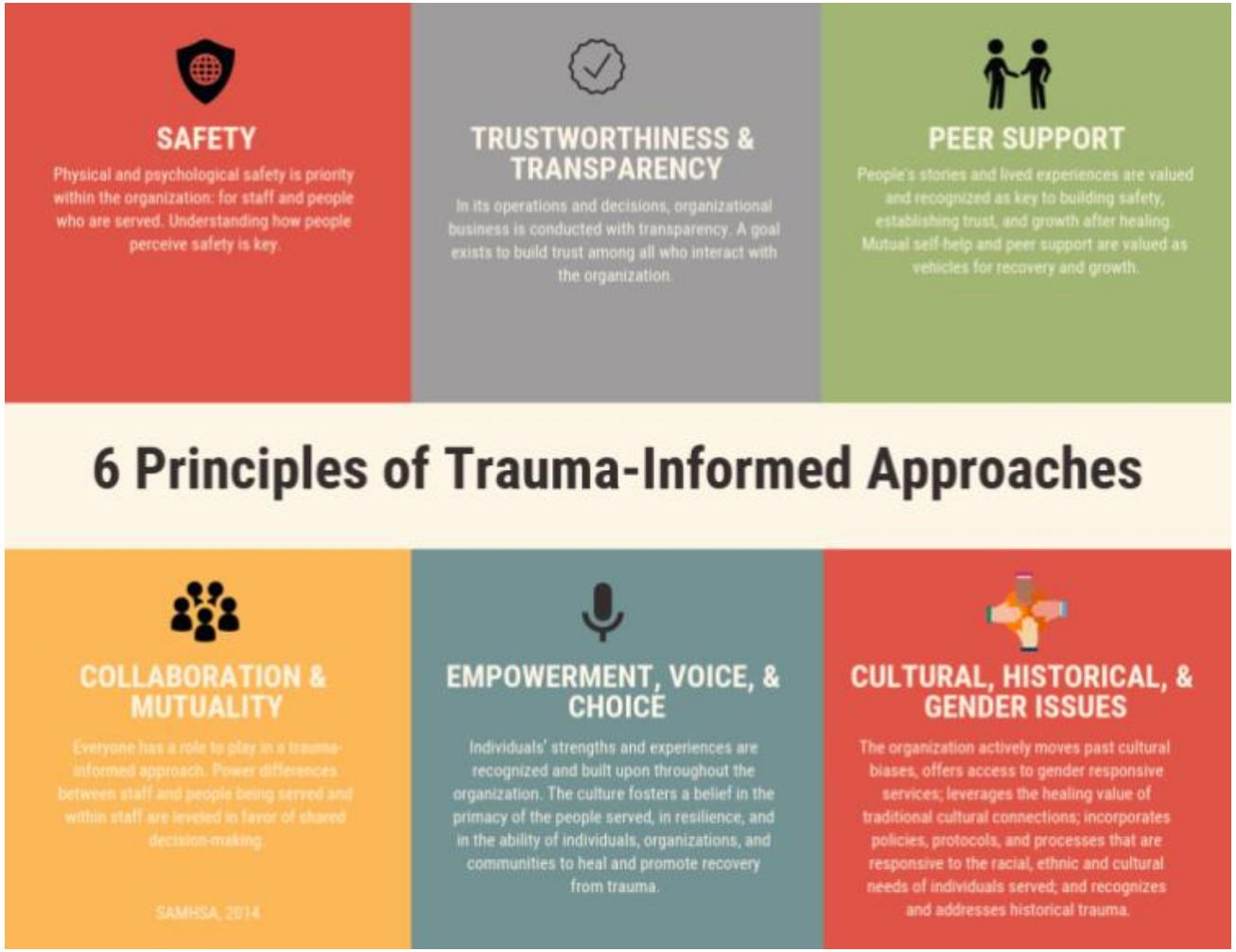
https://www.ptsd.va.gov/apps/decisionaid/compare.aspx

Project ECHO

What is trauma-informed care?

- **Definition**: A treatment approach that acknowledges the widespread impact of trauma and recognizes varying signs and symptoms in patients.
- **Key Goal**: To provide services that avoid re-traumatization and promote safety, trust, and healing.
- **Key Point:** Process VERSUS Event (Grief)

SAMHSA's Guiding Principles - Trauma-Informed Care



Trauma Informed Communication Pearls

- **Use Sensitive Language**: For instance, instead of saying, "Did you experience abuse?" say, "Some people have experienced difficult or painful situations that can affect their health. Is this something you'd like to discuss today?" This allows patients to share at their own comfort level.
- **Avoid Assumptions**: Always provide the opportunity for patients to disclose if they wish. Asking **open-ended questions** can invite conversation in a gentle way.
  - Example: "Sometimes, people with chronic health issues have experienced traumatic events in their past. Does that resonate with you?"
- **Reassurance**: Emphasize the patient's autonomy by reassuring them they are in control of the conversation. For example, "You can share as much or as little as you feel comfortable with."

Eight Tips for Mitigating Re-traumatization

1

AVOID SCHEDULING EXTENSIVE INTERVIEWS

Asking questions may take several hours, but once an interviewee has felt re-traumatized, they need time to recover and heal before proceeding. Try scheduling shorter conversations that take place over several days.

2

ESTABLISH ROUTINE

For recurring conversations about the same topic or in the same physical space, create a routine to provide safety and familiarity.

3

IDENTIFY POTENTIAL TRIGGERS

Have the other person describe or write out things that make them feel safe and unsafe.

4

PRIORITIZE CONSENT

When possible, let the other person know they don't have to answer questions that make them feel uncomfortable or upset.

5

KEEP AN OPEN MIND

Avoid making assumptions or skipping through questions you may think you know the answer to. Understand that this may be the first time the other person is sharing their story.

6

MAKE SPACE TO RELAX

Try using breathing or mindfulness exercises to calm symptoms of trauma when they arise. Let others know how to use these exercises on their own when they feel unsafe at other times in their lives.

7

BE TRANSPARENT

Some evaluations require physical examinations or contact between both parties. Ask for permission before touching another person and explain every action before performing it.

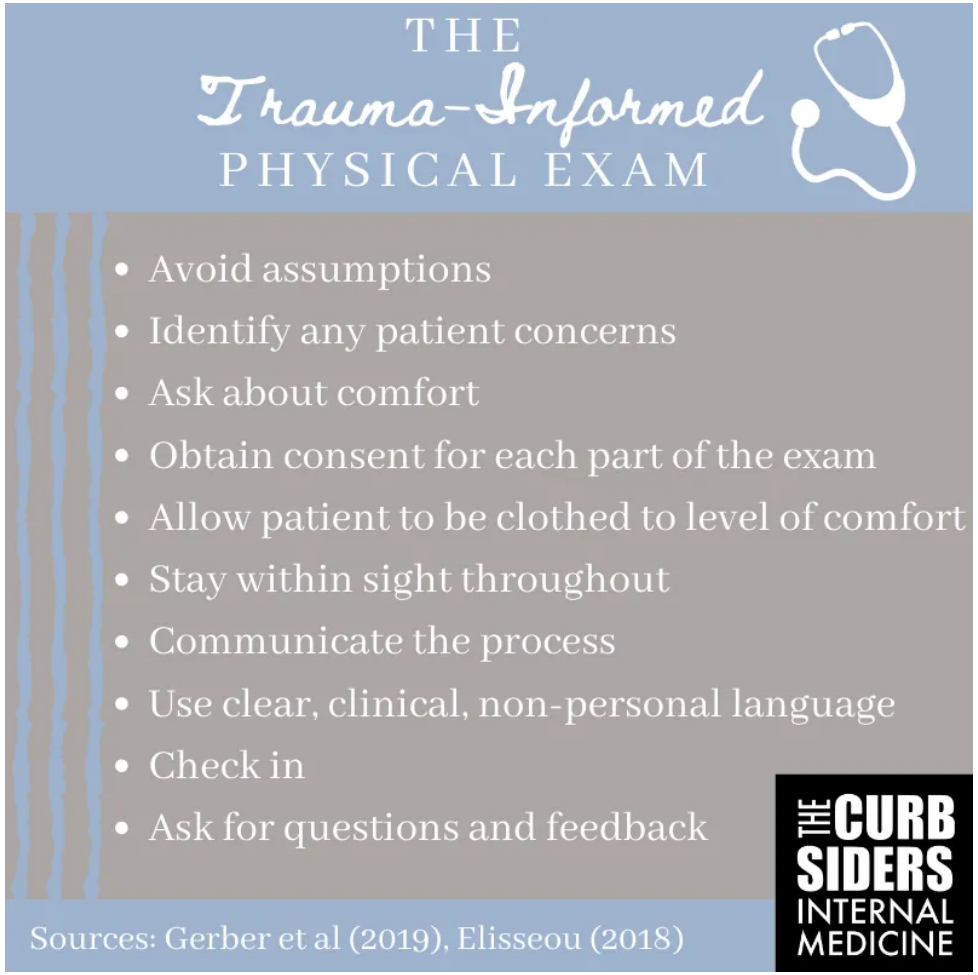
8

HAVE RESOURCES AVAILABLE

Be familiar with hotlines or text lines that trauma survivors can easily contact, such as the Crisis Text Line. Find out what organizations exist within your community, or see below for a list of national and international groups.

Trauma-Informed Communication Pearls

- **Informed Consent** builds trust and reduces fear of being overpowered or re-traumatized.
  - Ensuring that patients fully understand what will happen during an examination or procedure
  - Explaining step-by-step
  - Checking in frequently to ask if they are comfortable.



Collaboration in Treatment Planning

- **Example**: Trauma-informed providers empower their patients by offering them a central role in decision-making about their treatment.
  - For instance, instead of directing the treatment plan, you might say: "What strategies do you think might help you feel more in control of your anxiety, or what have you found helpful in the past?"
- This collaborative approach promotes **patient autonomy** which is key in trauma recovery.
  - A trauma survivor often feels powerless due to their past experiences, so providing choices within the treatment process helps to restore a sense of agency.

Further Education for Providers

Staying informed about trauma and TIC practices with ongoing education:

SAMHSA's Concept of Trauma and Guidance for a Trauma-Informed Approach. *U.S. Department of Health and Human Services*. Retrieved from https://store.samhsa.gov/sites/default/files/pep23-06-05-005.pdf

How to Be Mindful of Re-Traumatization. *Online MSW Programs*. Retrieved from https://www.onlinemswprograms.com/resources/how-to-be-mindful-re-traumatization/

Becoming Trauma-Informed: Dr. Millstein article

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

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*

Closing Announcements – and THANKS!

- 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 and series evaluation – including evaluation 3 months from now
- 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