INTRODUCTION
Every day communities and individuals are exposed to traumatic incidents; whether they are inflicted by humans or naturally occurring. Resilience is generally the expected response, but for some, posttraumatic stress disorder may be an occurrence. It is important that these individuals’ brain models receive a more intimate understanding in the phenomenology of the disorder. Among several models, importantly, is the perspective that PTSD is considered a “forgetting” disorder. Other elements in the onset and triggers of PTSD can identify further models to examine at the bench.

TREATMENT
- Trauma focused cognitive-behavioral therapy is commonly used to treat PTSD.
- Another option is family therapy due to the fact that PTSD affects both the person and their family.
- Medication is sometimes prescribed to allow people with PTSD to lessen secondary symptoms such as depression or anxiety (Bisson, A. 2007).
- A newer treatment is known as EMDR (Eye Movement Desensitization and Resensitization).
- Eye movements and other bilateral types of stimulation are believed to work by “unfreezing” the brain’s information processing system, which is interrupted in moments of severe stress (Cantor, C. 2005).
- There is no “quick fix” for PTSD, and can in fact months, to years, to a lifetime. It is important for people suffering from PTSD to remember that their lives will not always be filled with hard times, suffering, and pain.

LITERATURE REVIEW
PTSD was originally associated with veterans of the Vietnam War, but is now being associated with various trauma inducing experiences such as rape, abuse, environmental disasters, accidents, and torture (Ursano & Blumenfeld 2008). Current studies have demonstrated that around 30% of veterans, 45% of battered women, 50% of sexually abused children, and 35% of adult rape victims are most likely to experience PTSD at some point in their lifetime (Ursano & Blumenfeld 2008).

Most studies and reviews focus on military veterans, but there is increasing interest in other groups who are susceptible – health workers, police, and fire fighters. Researchers in the UK found a prevalence rate of 13% for PTSD symptoms amongst suburban police officers (Ursano & Friedman 2006). Rates in urban police officers and officers in armed situations may be higher. Prevalence rates for PTSD in the community are probably about 2–3% (Ursano & Friedman 2006). Rates of PTSD in police forces are therefore likely to be four to six times higher than in the general public. Rates of PTSD symptoms in professional fire fighters may be as high as 18% (Ursano & Friedman 2006).

CONCLUSIONS
As with any assessment or supposition, there will always be possible problems, which are why it is important to address such things early on. This is in hopes that further research and theories may be generated and inspired from this piece. It has become widely known that mentally ill female veterans obtain a less significant amount of their care from Department of Veterans Affairs (VA) facilities than the mentally ill male veterans do. This may be because women are less likely than men to be service connected for psychiatric disabilities (Kessler et al, 1995). Veterans have documented, compensatory circumstances associated to or aggravated by military service. They receive priority for enrollment into the VA healthcare system. It is this along with this and other gender differences associated with PTSD that it is important to examine this subject.

FURTHER RESEARCH
Currently, pharmacological and psychosocial treatments for this disorder target the neurocircuitry of fear-related learning, memory formation, and extinction (Watson, P, Shalev, A. 2005). Modern pharmacologic medicines can enhance response to psychosocial interventions by accelerating the process of extinction learning (Watson, P, Shalev, A. 2005). Animal models of resilience to traumatic exposure are continually surfacing, so they may show clarification of the genetics prevailing resilience in traumatic exposure to the identification of genetic biomarkers for this disorder and new ideas for therapeutic intervention (Bisson, A. 2007).