**ABSTRACT**

The DSM-5 defines post-traumatic stress disorder (PTSD) as primary or secondary exposure to trauma accompanied by intrusive symptoms such as recurrent memories and disturbing dreams; dissociative reactions (flashbacks); avoidance of people, places, conversations, situations, and other “triggers;” cognitive and mood dysfunction; and reactivity and arousal dysfunction. In children, PTSD may be characterized by diminished interest in play, aggressive play, reenacting trauma, temper tantrums, reduced affect, ADHD-like symptoms, or somatic disorders.

Trauma may induce loss of left-side brain functions, increases or decreases in cortisol levels, decreases in muscle mass and bone density, and various inflammatory or autoimmune disorders. In the brain, PTSD may impact the salience, default mode, and central executive networks, which mediate attention, sensory integration, social interaction, self-awareness, memory, judgment, and cognition. Psychosocial factors are also impacted by PTSD. Trauma survivors may struggle with identifying feelings and emotions, as well as differentiating feelings from thoughts or actions. Trauma may induce learned helplessness, substance use, identity disturbance, obsessions and compulsions, anxiety disorders, and/or self-destructive behaviors.

Diagnostic and screening tools for PTSD consist of inventories (such as BAI, BDI, and PCL-5) and clinical interviews (such as CAPS and SCID). Of these, PCL-5 (Psychometrics Post-Traumatic Checklist) was originally designed for use in the Veteran’s Administration hospital system but is extensively used in civilian practice to evaluate PTSD severity.

Pharmacological treatments of PTSD include selective serotonin reuptake inhibitors sertraline, paroxetine, and fluoxetine, as well as the serotonin-norepinephrine reuptake inhibitor venlafaxine. Nonpharmacological treatments include Eye Movement Desensitization and Reprocessing Therapy (EMDR), Trauma-Focused Cognitive Behavioral Therapy (TF-CBT), traumatic resiliency, trauma informed care, DROS3 metrics, and mindfulness therapy.

EMDR is a structured therapeutic modality in which clients focus on a traumatic memory while experiencing bilateral eye movements with the purpose to reduce the vividness of traumatic memories, build coping skills, and mitigate cognitive distortions. EMDR is based on the Adaptive Information Processing (AIP) model, which asserts that information is stored and received through complex neural networks that are integrated across multiple brain areas.

TF-CBT is a phase-based therapeutic modality for children and adolescents, which helps develop coping skills, process a trauma narrative, and provide closure. TF-CBT is beneficial even to children in foster care or those without participating parents or guardians. TF-CBT has been effectively adapted to different languages, cultures, and countries. Positive treatment outcomes include reduced intrusive thoughts, improved interpersonal relationships, and enhanced personal safety skills.

Traumatic resiliency aims to widen one’s zone of resiliency by implementing techniques such as tracking bodily sensations, remembering positive experiences, connecting to the present place or moment, performing calming gestures, recognizing out-of-zone states, and shifting focus from unpleasant stimuli.

Trauma-informed care, while not a particular therapy, refers to a set of principles that can be integrated in various practices. Principles include awareness of clients’ traumas, creation of safe spaces, and sensitivity to cultural experiences. DROS3 (develop, record, observe, stories, stats, and sense-making) is a method for practitioners to develop holistic practices and address patients’ spiritual needs. Mindfulness therapy, which often encourages clients to focus on one particular object and notice its attributes, has been associated with decreased anxiety and improved coping skills in youth as well as older adults.