

FAMILY FACTORS: Envirosocial factors provide an essential context for the development of malignant memories. Further differentiating them from adults, dependency on others for security and safety provides a crucial envirosocial context for defining what might become a traumatic stressor for youngsters. For example, children's PTSD and behavior symptoms were associated with parent PTSD symptoms (77) and with parent and family factors (44, 23). Moreover, youngsters are physically more vulnerable to family violence or betrayal by family members who neglect or abuse them. A traumatic event affecting the child can also induce traumatic responses in family members, which in turn may alter the family environment (33). Moreover, genetic factors (94) that mediate arousal states and learning mechanisms may predispose some children and parents to form malignant memories. Thus, a symptomatic child-parent system may function as an oscillator that maintains malignant memory activity through reinforcing feedback loops. Components of such a system may synergistically trigger each other and escalate arousal, reexperiencing, and avoidance symptoms in vicious cycles. Characteristics such as intensity or stability of any particular system would depend on individual, pre-event, or post-event factors.

SYMPTOM ACCUMULATION WITH DEVELOPMENT: Beginning in infancy and early childhood, trauma to either the child or principal caretaker that severely disrupts good-enough-mothering may interfere with essential early developmental processes that modify the genetic endowment and organize the core of the personality. These processes are variously conceptualized as psychological birth, attachment, formation of basic trust and self structures, state and affect regulation, and symbiosis. Exquisitely sensitive to caretakers' emotional states and behavior more than to cognitively-mediated assessment of danger, infants may respond with symptomatic disturbances of global functioning, excessive crying, eating, sleeping, psychophysiological lability, overstimulated states, or apathy and failure to thrive.

Toddlers add to their repertoire of responses disruptions of rapprochement and separation-individuation and changes in autonomy, motor activity, and aggressivity. Preschoolers add somatization, repetitive play, avoidance, fears, sadness,

dissociative states, clinginess, regressive behaviors, and feelings of shame regarding their vulnerability. They may show delays in cognition, including language development (39), or present as withdrawn and mute (12). Their aggressiveness and vengefulness may be erroneously labeled as a behavior disorder. Yet these youngsters may also exhibit increasingly effective coping with their developing language, cognitive, and social skills, such as helpfulness.

In addition, school-age children may be anxious, depressed, or inhibited, and may report guilt, hypervigilance, change in play, loss or change in interests, return of old or onset of new fears, sleep disorder, and impaired concentration, functioning and initiative. School age children are increasingly reactive to extra-familial traumatic events and their effects on caretakers and the community (76). They may also manifest disorders in school performance and learning (73).

Adolescents may add identity, eating, and personality (including multiple personality) disorders, and pseudo-seizures. They may act out with suicidality, hypersexuality, substance abuse, delinquency and truancy. In an effort to relieve intensely uncomfortable stress-induced states of subjective affective emptiness and numbing that can include hypo-responsivity to physical pain, some adolescents report urges to self-mutilate. Yet, school age youngsters and adolescents may also actively and creatively cope through more effective feeling, thinking and acting and can exhibit surprising resilience and drive for mastery (49).