TREATMENT: Once a trauma has occurred, early detection, immediate assessment, and aggressive treatment may prevent or attenuate the development of malignant memories. A clear treatment plan, based on careful assessment of developmental factors, differential diagnosis, and benefits and risks, should be developed. Following a one blow trauma, the post-traumatic period may be divided into the first hours and days, the first month, and the long-term.

During the immediate post-trauma phase, the youngster may be unresponsive, avoidant, mute, or withdrawn, and day dream or stare off in a glazed look, or appear robot-like. Such states, often mistaken for oppositional defiant behavior because the child may not respond to directives and instructions, may lead to escalating threats and power struggles. Aggressive behavior and tantrums may be other manifestation of the child's attempt at fight or flight or regain a sense of control. Transient regressive behaviors may appear, including clinging, sleeping in the parental bed, and loss of recent developmental gains. While alarming, such symptoms usually represent transient normal emergency attempts to cope, restore organization and control, or reestablish the stimulus barrier. Such efforts to adapt by attenuating arousal and over-stimulation through control over the environment and modification of inner experience and should be allowed and power struggles avoided. Additionally, animal studies, showing that there may be a critical period before which a fear memory is transferred from temporary storage in the hippocampus to permanent storage (34), suggest that aggressive intervention during the early hours and days may be especially effective. Such treatment would consist of restoring a sense of control and reassurance of safety, affection, and protection. Restoration of family, group, and community nurturance and protection is vital and lays the groundwork for necessary treatment alliance with parents. Psychopharmacological treatment, such as a course of benzodiazepines, propranolol or clonidine (14, 17, 55), could attenuate autonomic hyper-arousal manifested by tachycardia, elevated blood pressure, hyperactivity, distractibility, and nightmares. These immediate and aggressive attempts to modify the entire experience of the trauma may partially neutralize the effect of the event and prevent formation of malignant memories.

Following the early post-trauma hours and days, most youngsters

and families usually require and seek continuing assistance for the next two weeks. During this period, symptoms usually begin to subside except for episodes of reexperiencing triggered by external or internal cues. After the first few days, a predictable and normal daily pattern should be restored, and children made aware of what to expect each day. Youngsters should be allowed to continue their attempts at active mastery and interact with caregivers by talking, playing out, role playing, and art. However, they should be redirected when these activities become overstimulating, appear to trigger unmanageable reexperiencing, are endless and do not seem to promote resolution, or are transmitted to non-traumatized youngsters by "contagion" (85). Throughout, cognitive reframing by patient and nurturing caretakers should continue, allowing for the youngster's proneness to misconceptions based on concreteness, egocentricity, and magical causality.

Assistance beyond the acute period is often sought less actively or even resisted by some parents. However, clinical access to youngsters may improve through educational efforts directed at caretakers that alerts them to the natural history of the trauma response (13). Aside from citing statistics and weighing risk factors, it is ultimately impossible to predict long term outcome accurately. Although youngsters may need reassurance that a rare traumatic event will definitely not recur and that they will feel better soon, reassurance that they are safe and protected and recognition of their own competence to survive and heal should be underscored.

Individual treatment of acute and chronic trauma often includes multimodal approaches dictated by clinical needs and age (57, 91, 13). Once a treatment alliance has been established, therapists must remain alert for how malignant memories are reexperienced in the therapeutic relationship (i.e. distrust, need for control, fears of dependency and passivity). Individual and group treatments may be offered at the school (62). Individual treatment modalities include psychoanalytic, art (83) play (43, 86, 80, 92) cognitive behavioral (11) and flooding and desensitization (68, 72). Psychoeducational groups have been described using drawings and role playing (19). The whole gamut of psychotropic medications used with children and adolescents can be considered symptomatically.

Adolescents are generally more likely to be exposed to rape,

automobile accidents and other high risk behaviors, school and street violence, and peer suicide. Additionally, trauma during adolescence may unmask earlier childhood trauma. Survivors may require specialized treatment for substance abuse, eating, behavior, personality, or affective disorders. Adolescent developmental tasks of identity formation, sexuality, and differentiating from the family are special areas of concern. Angry and striving for autonomy and individuation, adolescents may utilize family support or holding environments poorly and resist therapeutic alliances. They may respond to milieu and group therapies with other survivors better than younger children, although some may require more privacy initially. However, resiliency deriving from more developed psychosocial and cognitive skills may enable considerable therapeutic gains with adolescents.

Treatment of survivors of all ages suffering severe disorders that accompany the emergence of hidden trauma can be quite demanding. It includes establishment of a safe holding environment in a patient long-term therapeutic relationship, medications to subdue depression, arousal, aggression and rage, and careful attempts to weave the traumatic experiences and walled off memories into the personal narrative. Because psychic trauma, especially in younger children, might be rooted in enduring neurodevelopmental changes, this process may remain incomplete and care may require a lifetime. Even when given control over the pace at which these efforts are made, the haunted survivor may remain mistrustful, frightened, and difficult to engage as malignant memories are resurrected in the transference. Sometimes, a survivor's adaptation is best served by understanding the need for strengthening fragile defenses until ego development or the treatment alliance buttress capacities to tolerate the anxiety that accompanies remembering and reexperiencing. Ultimately, one hopes for the acceptance of vulnerability and mortality tempered by love and healing as a beginning of wisdom. This attainment is beyond the developmental capacity of youth.

Mental health professionals are beginning to recognize how violence -- be it in the home, media, street, school, genocide, or war -- can leave indelible signature on the human psyche, on brain function and structure. Mental health professionals have important roles to play in preventing malignant memories and subduing their pernicious effects, as well as studying the dramatic cascade of

interactions among environment, brain, and behavior initiated by trauma.