ties, except for a chronic mild sleep disturbance and oversolicitous behaviors toward younger siblings. She presented as a compliant and eager-to-please child who exhibited great difficulty when speaking about herself. She persisted in denying memories of her earlier home life and past abuse but appeared guilty and ashamed whenever the subject was brought up.

Although treatment at the age of eight was successful in helping Miss A adapt to her new home and maintain good grades, winning several awards of recognition, she remained on the fringes of her peer group, typically serving as a peacemaker and caretaker. She preferred the company of adults, from whom she sought praise and attention, and of younger children, whom she mothered.

As early adolescence approached, Miss A exhibited little interest in dressing or acting like her peers and preserved a younger appearance. However, by thirteen, physical changes attracted comments from boys, to which she responded angrily. Refusing to acknowledge her development, she demanded not to be called a "teenager."

In this case, Miss A's malignant memories of early neglect and abuse were triggered by her own emerging sexuality and the potential for abuse again. Except for a mild sleep disorder, her defensive avoidance, repression, denial, and reaction formation allowed for relative equilibrium through latency. Triggered by an overstimulating experience at the onset of her adolescent sexuality, malignant memories flooded her with intense affect and arousal, strongly coloring her interpretation of current experience.

Case B: Trauma in Adolescence

At fourteen, Miss B (see table 3) suddenly began to have severe headaches and up to ten daily "blackout spells" of twenty-five to thirty seconds, characterized by unresponsiveness and staring. Typically, she experienced a prodrome of dizziness, tingling, and weakness in the upper extremities and a gradual and rapid dimming of vision, "like I was looking through a screen," progressing to a brief loss of consciousness. A thorough neurological investigation, including direct observations and EEGs during these episodes, revealed no abnormalities.

History revealed development as normal, and she was pleasant, easy, compliant, and a well-behaved "mother's helper." Current symptoms began after a short visit to a relative's home in Texas.

TABLE 3
TRAUMA IN ADOLESCENCE

Traumatic event
Rape/physical assault, terror

Malignant memory
Cognition: cognitive constriction, amnesia, inattention, confusion, flashbacks
Perception: derealization, depersonalization, hallucinations
Affect: dysphoria, lability, irritability, shame, guilt
Arousal: pseudoseizures, anxiety, flashbacks, intrusive imagery, tachycardia with amitriptyline, response to benzodiazepines
Behavior: suicidality, school avoidance
Somatic: headaches, visual changes, blackouts
Regressed states: dissociation, hallucinatory states, idealizing transference

Triggers/cues
Heterosexual contact
Confinement in close quarters
Proximity to site of trauma

Although she initially denied violence, Miss B soon remembered fragments of molestation by a nineteen-year-old stepcousin in Texas during the visit. Terrified of his retribution, she was frightened of angering her family and worried that no one would believe her. When recalling the events, she became dysphoric, irritable, tearful, and confused. Intense anxiety was accompanied by dissociative symptoms of depersonalization and derealization and a feeling of having "lost time" with long periods of time passing without her conscious awareness.

She experienced flashbacks of repetitive, intrusive visual images of the cousin laughing at her and often developed headaches afterward. She felt guilty and worthless, and difficulty in concentrating interfered with her schoolwork. She was angry at her mother for allowing her to visit a potentially dangerous setting yet feared setting off a depression in mother.

An attempt to treat her headaches with amitriptyline was unsuccessful because of tachycardia, which persisted after discontinuation. After intensive individual and group psychotherapy in the hospital, and with one milligram of alprazolam per day, symptoms remitted, and Miss B returned to home and school. Unfortunately, she soon relapsed, this time also having auditory hallucinations of her cousin's laughter and intense suicidal ideation, after she was taken to Texas against medical

advice. Again hospitalized, she recalled other aspects of the trauma, which included being raped several times.

After six months of additional outpatient psycho- and pharmacotherapy, she felt ready to visit benevolent grandparents in Texas. On returning, she felt triumphant that she was no longer being "punished" by the memories of the abuse. Miss B is still wary of being alone with teenage boys and fears that she will not be able to date successfully.

Miss B illustrates many issues related to PTSD and malignant memories in adolescents. It is important to have a high level of suspicion, no matter what the presenting problem, whether somatic, cognitive, affective, or behavioral. Goodwin, Simm, and Bergman (1979) and Gross (1979) described hysterical seizures following incest. Malignant memories of the rape were organized and expressed initially through such symptoms, regressed states, avoidance, and perceptual distortions. There were physiological as well as psychosocial components to this presentation. Use of alprazolam was successful, while amitriptyline probably exacerbated an autonomic system dysregulated by trauma.

Without an intensive holding environment providing nurturance and safety, dampening of arousal with alprazolam, and opportunity for cognitive reappraisal, Miss B could have become developmentally arrested and left with persistent malignant memories.

Case C: Trauma in Childhood Not Clinically Detected in Adolescence but Surfacing in Adulthood

At thirty-six, Mr. C (see table 4) was a bright, articulate, talented, and successful executive and devoted father. Suddenly, on the breakup of his third marriage, he became tormented by intense nightmares and sought treatment. Initially, he was totally amnesic for the first ten years of his life. Reporting an adolescence marked by family conflict, Mr. C reported social, athletic, and academic success and seemed to suffer little. However, he did not experiment sexually and eventually married a high school sweetheart.

Associations to nightmares began triggering piecemeal recall of two traumatic constellations. The first, during toddlerhood and early childhood, consisted of severe eczema for which he was tied down supine

TABLE 4
TRAUMA IN CHILDHOOD NOT DETECTED IN ADOLESCENCE

Traumatic events
Eczema, tied down supine—toddlerhood, early childhood
Beatings (victim, witness)—middle/late childhood

Malignant memories
Cognition: amnesia, concrete "black and white" thinking, confusion, distractability
Perception: skin sensations
Affect: rage, anxiety, depression, numbness, guilt
Arousal: insomnia, nightmares, agitation, response to medication
Behavior: suicidality, agitation, avoidance
Somatic: skin burning/cold, hives, alopecia
Regressed states: object hunger, splitting, idealizing transference

Triggers/cues
Divorce
Toddlerhood of son
Empathic disruptions
Contact with family of origin

in the crib for long periods in order to prevent scratching. The second set of memories was of vicious "cold-blooded" beatings by a sadistic father that made him feel as "garbage," coupled with neglectful intrusions and emotional neglect by an obsessive, perfectionistic, and possibly episodically depressed mother.

Mr. C quickly became flooded with intense rage, becoming increasingly agitated, disorganized, and suicidal. He developed dermatological symptoms of alopecia and "burning skin," or would feel numb and have "cold skin" with specific memories. He required intensive psychotherapy and medication, including neuroleptics, anxiolytics, and lithium carbonate and a brief hospitalization for suicidality.

We discovered that his success in business and his choices of spouses were expressions of a grandiose self that survives, plays "perfect son," and mediates family conflict—the "superman" corporate man. Eventually, Mr. C reintegrated around an idealizing transference and holding environment of intensive therapy and used his considerable intellect to cognitively reappraise the violence of his childhood. To avoid reexperiencing malignant memories, Mr C broke off all contact with his entire family. His grandiosity, drivenness, and exaggerated expectations of himself and others lessened. He terminated the first treatment episode calmer and hopeful in a new marriage and a renewed sense of self.

However, as in rapprochement, Mr. C would "touch base" for an office visit or two several times a year for four years when triggers such as empathic failures by his wife or intrusive calls from his father reactivated brief relapses from which he quickly recovered.

Mr. C had a relapse when his new son entered toddlerhood. He felt the intense dilemma of being trapped in a business and marriage that were denying his intense needs for narcissistic mirroring. He reexperienced pain, rage, and "hot skin" alternating with emptiness, numbing, and "cold skin." Thinking again became concrete and "black and white." He felt as "garbage" again. Often, the only solution appeared to be suicide. Obtaining considerable relief in interacting with his son, with whom he felt intense joy and loving, Mr. C could not maintain these states when separated from him. Intensive psychotherapy to provide an empathic center for rapprochement and restoration of self-soothing representations, together with lithium carbonate, fluoxetine, and alprazolam to attenuate his affective intensity and lability, again stabilized him. With a stronger therapeutic alliance, rooted in a more stable holding environment and transference, enabling identification with the male therapist, Mr. C continues to attempt to integrate split off parts of the self. Small slights by his wife, or even just her presence, still trigger injury, rage, numbness, somatic symptoms, and avoidance, which he recognized as irrational but which precluded intimacy with her. These symptoms remitted temporarily with the addition of clonidine.

In summary, during adolescence, we can hypothesize that, although heterosexual intimacy eluded him, Mr. C adaptively refined the grandiose "perfect son," identifying with and sublimating his father's aggression and perfectionistic demandingness of an obsessional unempathic mother. He utilized considerable cognitive and social abilities to form a rigid psychic structure while splitting off the injured, enraged aspects of his self. This developmental period, albeit partially arrested, may have enabled his adaptation. Only specific triggers in adulthood reactivated the malignant memories.

Conclusions

We have observed case vignettes of trauma during childhood reactivated in adolescence, trauma during adolescence, and malignant memories from childhood activated only in adulthood. These illustrate that