

presentation of sudden decompensation in an adolescent or adult should lead us to suspect that malignant memories have been triggered. Overwhelming shame, guilt, depression, disorganization, and suicidal behavior often accompany such presentations.

Intervention must sometimes be quite massive and include establishment of a safe holding environment in a long-term therapeutic relationship, medication to subdue arousal or rage, and careful attempts to reappraise the traumatic experiences, integrating avoided and walled-off memories. The patient must be given control over the pace at which efforts to uncover are made. Because psychic trauma might induce structural brain changes, especially in younger children, it may ultimately not be possible to achieve a cure.

Trauma before and/or during adolescence can affect the developmental process, and intervention with adolescents can be especially rewarding because so much of the personal narrative is reworked, reformed, and integrated with the group narrative during this period. Yet adolescents present difficult challenges because of their, as yet, immature cognitive capacities. Additionally, striving for autonomy and individuation, adolescents resist therapeutic alliances, and many utilize holding environments poorly. Sometimes we may best serve an adolescent's adaptation by strengthening defenses and assisting efforts at avoidance, rather than exposing memories.

Treatment of the adolescent often demands interpreting his or her experience to family members and enlisting their cooperation, if not offering them treatment as well. Yet it is in the family that so much trauma may have occurred. Additionally, malignant memories of parents deriving from their own traumatic adolescence may be triggered during the adolescence of their offspring, leading to complicated family problems and difficulties in accessing the parent or adolescent. Avoidance symptomatology may result in reluctance in both the adolescent and the family to utilize mental health services (Schwarz and Kowalski, 1992b).

It is hoped that the concept of "malignant memories" will serve to organize thinking about the complex multidimensional human response to violence and lead to interventions preventing their formation, as well as detoxifying them, restructuring their configurations, or uncoupling relationships among reexperiencing, arousal, and avoidance. For example, animal studies show that there may be a critical period before which a fear memory is transferred from temporary storage in the

hippocampus to permanent storage (Kim and Fanselow 1992). Therefore, in the immediate aftermath of trauma, would aggressive provision of intensely reassuring, nurturing, and safe experiences undermine their formation? Would dampening neurophysiological arousal with pharmacotherapeutic agents during or in the immediate aftermath of a trauma lessen the likelihood of formation of such memories?

Memory is formed by and also informs experience. Its importance cannot be overstated. Once an event is over, psychological effects derive only from memories of the event. Memories form the tapestry of our personal narratives that make us human and are woven into the collective narrative that forms our group identities. It is in our memories that our developmental achievements are stored.

As mental health professionals, we are beginning to recognize how violence—be it in the home, media, street, genocide, or war—leaves sometimes indelible signatures on the human psyche, on brain function and possibly structure as well as mind and soul. We have important roles to play in the deterrence of violence, in the prevention of malignant memories, in subduing their pernicious effects on our patients' lives, and in studying the biopsychosocial mechanisms that link exposure to stress with enduring changes in brain structure and function, experience, behavior, and development.

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