Treatment in Psychiatry begins with a hypothetical case illustrating a problem in current clinical practice. The authors review current data on prevalence, diagnosis, pathophysiology, and treatment. The article concludes with the authors' treatment recommendations for cases like the one presented.

Understanding and Ameliorating Revenge Fantasies in Psychotherapy

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Ellen had revenge fantasies toward her husband, Max, because she held him responsible for the accidental death of their 10-year-old son, Morgan. Instead of taking Morgan to ski on an intermediate slope as planned, Max had impulsively selected an advanced slope. Morgan hit a tree and later died of a head injury.

Ellen had been diagnosed as having major depressive disorder and had received several different antidepressant medications and a course of cognitive behavior therapy. The combined treatment was largely successful, and her depression was in remission. She sought additional psychotherapy 2 years after Morgan's death because of persisting intrusive revenge fantasies and destructive acts directed at Max. She experienced depersonalization and derealization about three times a week for about an hour. The result of these symptoms was a diminished sense of self-control, confidence, and safety, although she was caring well for her 8-year-old daughter and keeping her career afloat.

Nature of the Problem

In evaluating and treating stress response syndromes, including posttraumatic stress disorder (PTSD), clinicians may encounter intrusive and persistent thoughts of vengeance associated with feelings of rage at perpetrators (1–3). The inciting stressors can be injuries, rape, mugging, rejection, divorce, physical abuse, insulting criticism, deliberate neglect, or betrayal of promises. Symptomatic revenge fantasies go beyond normal bitter thoughts; they are unwanted, uncontrollable, dangerous, or intensely evocative of shame or guilt. Revenge fantasies also may permeate the thinking of people with paranoid traits when they feel under stress.

Revenge fantasies are common but not specific to PTSD, complicated grief, or other stress response syndromes. The patient may expect to be judged critically for such hostility and may not divulge the fantasies. Direct questions may open the door to disclosure. Revenge fantasies may even include rage at the self and lead to suicidality.

Revenge fantasies have been discussed in the literature on PTSD (1, 4, 5) and in the psychoanalytic literature (6–11). They are not adequately addressed in the literature for general psychiatrists, however.

Prevalence of Revenge Fantasies

The prevalence of revenge fantasies is unclear and probably varies across populations and subgroups. In a study of 174 victims of violent crime (2), feelings of revenge were found to be common among subjects who developed PTSD. Such feelings were correlated with intrusive symptoms and hyperarousal but not with self-reported avoidant symptoms.

In another study (4), some 1,300 Kosovar Albanians were surveyed on their trauma experiences during the Kosovo war. A few months after the war ended, half of the men and 43% of the women reported feelings of revenge against perpetrators; a year later, these high frequencies had not significantly declined. Among respondents who reported revenge feelings, 64% of the men and 49% of the women said they might act on their fantasies; a year later, the proportion declined to 45% among men and remained the same among women. Respondents with a higher incidence of general psychiatric morbidity were more likely to report revenge feelings. Those who met diagnostic criteria for PTSD were more likely than those without PTSD to harbor revenge fantasies. In the context of war, the notion of revenge is more socially sanctioned than in the context of peacetime civilian trauma, which probably contributes to the high frequency of reports of revenge feelings in this population. In societies that promote an attitude of forgiveness and rely on due process of law, revenge fantasies are less likely to be acknowledged but are still common.

Phases of Response

Revenge fantasies tend to persist in late phases of psychological response to trauma. In the immediate shock that leads to an outcry phase, the person feels overwhelmed and may reach quick dysfunctional conclusions, such as Ellen's thinking, "I cannot live now!" on learning of Morgan's death. Subsequently, there may be denial and in-

trusion phases of response. For Ellen, a denial phase included emotional numbing and a frozen sense of derealization, as well as ideas of Max dying instead of Morgan, magically restoring her son to life. In her intrusive phase, she experienced unbidden images of Morgan being loaded into an ambulance, which were associated with unbearable pangs of horror and sorrow. Gradually, in a working-through phase assisted by her first therapist, Ellen began to accept the reality of Morgan's death and was able to resume her caretaking responsibilities and career tasks.

Her clinical depression lifted, but her revenge fantasies remained. She knew that these intrusive fantasies would soon end her marriage to Max, and this recognition motivated her to seek additional psychotherapy.

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Emotional Content of Revenge Fantasies

Hate toward perpetrators burns at the core of revenge fantasies, but often a medley of emotions is present. These include anger at perpetrators, fear that no rescuer can be trusted, despair over the harshness of the world, and a general disgust with the injustices of the world. Self-disgust over allowing vulnerability is often present, as is anxiety over the future possibility of entering undermodulated states of mind.

Revenge fantasies are persistent because they also provide additional positive emotional effects. The victim can feel good about gaining a sense of power and control by planning vengeance and may experience pleasure at imagining the suffering of the target and pride at being on the side of some spiritual primal justice. If that self-righteous feeling is surrendered, revenge fantasies may activate shame or guilt. Simply calling this medley of emotions "anger" in therapy can be unempathic.

The Identity Strengthening Function of Revenge Fantasies

Self-righteous indignation feels like energy or fuel for the self (12, 13). The burning of this fuel helps people feel solid and coherent rather than frail or empty. It is important to address this function of the symptom as a self organizer. With the recognition that one can regain identity coherence without revenge preoccupations, the patient can stop obsessive thinking about getting even with the perpetrator. A revenge scenario features a weak-to-strong conversion that reinforces repetition of the symptom because it functions as a defense against being overwhelmed by sadness, helplessness, and hopelessness. A goal in treatment is stabilizing an intact sense of self, which can contain intense feelings of anger, grief, and remorse.

Revenge Fantasies and Psychotherapy Techniques

It is helpful to ask our patients to reconstruct their sense of helpless victimization and how it led to the restorative preoccupation with revenge scenarios. Some useful gambits include questions along the lines of the following: Why did the perpetrator act? Who was harmed, and in what way? What was the context? How much suffering of the aggressor would be enough? What would be the likely consequences of the imagined retaliation? How would the patient feel about these consequences? What are the patient's values concerning justice, payback, compassion, and forgiveness? Under what circumstances might revenge fantasies lose their emotional power? Is that a desirable goal? What are alternative ways to gain a sense of purpose and meaning?

There are different self and other schematizations to organize the process of appraising the multiple meanings of any serious events. There will be multiple versions of what the trauma means. A gradual sorting out of realistic and exaggerated beliefs about self-roles, other roles, and interactive scripts is useful. Interactive scripts are schematized scenarios of expected actions, responses, and reactions, including expectations of praise or scorn from critics of actions. Making these scenarios clear for contemplation by both therapist and patient promotes differentiation between reality and fantasy. The patient may realize that new appraisals are more realistic than earlier ones. Repeating a choice to select and focus on realistic appraisals can modify both expectations and intentions and can lead to a sense of increasing coherence and self-regard.

In examination of self-other scripts, one can contrast the extreme versions, such as beliefs about the demonized and idealized other and the idealized and demonized self. Reality can be found in between these two. The goal is seeking central appraisals that can complete the train of thought and attenuate revenge fantasies.

Some people may have a personality style and prior experiences that make resolution of a posttraumatic revenge fantasy more difficult. The adult trauma may link associatively to a childhood one and prime a latent potential for primal rage, a sense of grievance (9), and an enduring role-relationship model of a justified self destroying a monster (6, 13).

How can the patient work on such associative linkages? Although it takes time, looking back on childhood experiences from the perspective of an adult can help counteract deeply held dysfunctional beliefs about the meanings of childhood events, such as a feeling of parental betrayal. For example, when looking back on memories of being abused by a parent, reinterpretation of parental limitations, seen through adult appraisals, are different from typical childhood extremes, such as the notion that either "I, the child was totally at fault" or "my parent was an evil monster."

From a child's perspective, a parental action is usually regarded as if it were done on purpose and for a simple reason. As an adult, the patient can revise the story and the explanations of how and why episodes of abuse and neglect occurred (14–16). For example, one patient had revenge fantasies about his wife, whose rages tortured him. His reactions were influenced by schemas embedded in childhood when his drug-addicted mother flew into unpredictable rages and beat him. Now, as an adult, he could realize that his mother had a disorder, and this realization could help counteract ideas that his mother was out to torture him either because he was terrible or because she was a monster. His wife's rages were also not in her control, and his reactions had to be those to a human being, not a monster.

Realistic appraisal may lead from angry reminiscences of parental deficits to realistically poignant sorrow and mourning for a desired childhood that can never occur. The mourning process for an irretrievable ideal of childhood leads to regained personal strength and attenuates bitterness (17, 18). The patient who completes this kind of work can feel ready to seek satisfactions that the here and now might provide and look to the future for what is realistically possible in the give-and-take of relationships. An important part of this work is to learn to forgive others; equally important is to forgive the self.

Working Through Ellen's Revenge Fantasies

Ellen's persistent revenge fantasies toward her husband led her to commit impulsive destructive acts, such as throwing away his papers, mail, and telephone messages. She felt unreal after such episodes. She regretted this behavior but could not stop. She hated Max for his reckless and self-centered choice at the top of the ski run. She had daydreams of a more extreme revenge but was able to govern such impulses.

Her conscious reflections included an inward critical voice that said she ought to forgive Max. Another, different critical voice ordered, "Never forgive him! He should pay for his crimes!" In psychotherapy these conflicting attitudes were clarified as a first step. One attitude said in effect: "Max should pay for his self-centeredness, and nothing is payment enough for the terrible damage done to me and my Morgan. I would be bad if I failed in my moral obligation to punish him. It is good that I punish Max because he very much deserves it." Another attitude contained opposite concepts, which can be paraphrased as: "I should care about Max. He is my husband. What is done cannot be undone. He feels terrible about what happened. We need each other's support, yet I am preventing that. I must suppress my rage for the greater good of our marriage and the well-being of our daughter."

She wanted to erase one of these attitudes—either one would do—to give a unified sense of her goals and values. Her therapist pointed out that this could not be done. Instead, the eventual focus of the therapy, established by joint agreement between Ellen and her therapist, was to balance out and harmonize her ambivalence. This discussion led Ellen to set a goal for herself: living well with Max would take priority over punishing him. Ellen wanted to soften blaming Max with a wish to restore their previously warm, close, and caring relationship.

Although Ellen reported a good therapeutic alliance with her primary care physician and her first therapist, she seemed remote as this second psychotherapy began. But gradually she was increasingly able to accept clarifications. As this occurred, though, Ellen did not show a positive response to the listening and compassion that her therapist was providing. Instead, she felt a transference resentment that seemed irrational to her. To the therapist, at the gut level of countertransference, her seeming ingratitude for empathic support seemed a bit insulting. Why was she more irritable? The therapist recognized this reflex response and knew that an angry response to offered support is typical in persons who have experienced traumatic events. It becomes safe to begin to express part of the rage when someone else is there to increase safety and to bear witness (19).

In Ellen's case, the therapist knew that the support he offered could come nowhere near providing what her injured soul wanted, which was restoration of Morgan's life and of her life before the tragedy. Her hostile response was clarified and paraphrased back to her as: "Is this little bit of human warmth and understanding all I get for what I have gone through!? Why couldn't you have just spared me my pain! Why do you not suffer as much as I? It's not fair! Give everything back!"

The therapist had to decide how much to focus on each of Ellen's grievances, which he likened to the four angles of a rectangle around the central focus of her grievance: anger at Max, anger at the therapist, childhood anger at her parents (for their perceived selfishness), and anger at herself (for marrying a self-centered man and letting her son go skiing with him). The therapist elected to focus mainly on the current trauma and Ellen's anger at Max, paying enough attention to transference and countertransference to build a safe alliance. Within this alliance, issues of forgiveness that once seemed weak, stupid, unjust, and impossible were reconsidered as a strong and rational way to move ahead.

Because Ellen was a high-functioning person before her terrible loss, her resentful transference reactions were amenable to reality reappraisal. In a patient with a disorganized personality, however, this might not have been the case, and more attention to distortions might be indicated, as well as more disclosure by the therapist to correct irrational attributions of being uncaring. This would require slower and repeated work to clarify who was angry at whom, how blame was being attributed, and who had what intentions behind their behavior.

In Ellen's therapy, a tactful level of work on all four corners of the rectangle was less necessary than it would have been with a more disordered patient. Once the safety of therapy made it possible, she could express her rage at Max and her own shame, guilt, and sadness as aspects of

herself rather than as dissociated or even disembodied feelings. She was able to tolerate her resentment without depersonalization. In her communications, Ellen was able to examine and reexamine her beliefs about her loss and about the rest of her world as well as her place as an individual who could resume an acceptable place in the world. That process enabled her to revise her expectations, intentions, goals, and plans for the near future. The revenge fantasies attenuated, her marriage stabilized, and her sense of identity reconsolidated. A period of planned termination was set to allow more work on reacting to another without loss of self-cohesion.

Summary and Recommendations

Revenge fantasies can give a sense of restored purpose and control in an otherwise shattered life. It is important to help patients recognize the futility of this apparent utility. Helpful psychotherapy techniques include interpretations and reappraisals with careful differentiation of rational and irrational beliefs (20). The function of revenge fantasies as giving an illusion of strength can then be interpreted.

The result of therapy may be attenuation of the symptom. Revenge fantasies are well-established trains of thought. It is helpful to let patients know that revenge fantasies are likely to return with triggers such as seeing a movie, being slighted, or entering an irritated mood from fatigue. Next, help the patient plan a response, which can involve reviewing a preestablished set of ideas, such as "There it is again. I have already explained it to myself. I am done with that and have decided I am going to let it go."

Addressing revenge fantasies solely as reactive anger or urging forgiveness without analysis of the compensatory functions of the fantasies may constitute incomplete treatment. The goal is to help the patient gain a sense of restored control, self-esteem, and self-coherence without resorting to the "strong-me" properties of a revenge fantasy.

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