

into junior high school—a time when neither marijuana nor other psychiatric comorbidity was present—establishing a long history of ADHD symptoms and associated dysfunction (4). The authors' single-survey study of stimulant abusers does not settle the issue of whether concurrent marijuana use is the causative agent in all attentional-based dysfunction and all psychostimulant abuse. For instance, it has been reported that approximately 20% of adults with substance use disorders and 40% of cannabis abusing adolescents have an ADHD diagnosis after detoxification from marijuana (5, 6) (www.CSAT.gov). The authors lack data to support their contention that a diagnosis of ADHD can only be made with confidence after prolonged abstinence from nonmedical drug use. Unlike other comorbid disorders that are difficult to disentangle from substance use disorders, ADHD, by definition, predates substance use (onset ≤ 7 years old) and is a chronic disorder; there are no "attacks" of ADHD. Further, adults with ADHD who have been diagnosed with past and current substance use disorders compared with those diagnosed with no substance use have been shown to have similar characteristics, such as a family history of ADHD, neuropsychological disturbance, and functional impairments associated with ADHD symptoms (4). Moreover, inspection of treatment studies of substance use disorders and ADHD shows a stable persistence in the symptoms of ADHD independent of the fluctuation of substance use throughout the trial (7–10).

In terms of the treatment of substance use disorders, while abstinence is of course preferred, a number of studies that the authors do not mention show that ADHD is not benign when comorbid with substance use. The idea that only absolute abstinence is acceptable prior to initiating other treatment is ideologically based and does not appreciate that ADHD predicts earlier-onset substance use, more severe substance use, a longer course and less remission from substance use, and lower retention rates in the treatment of substance use (11–14). A number of innovative initiatives in this area that have led to newer guideline recommendations to treat ADHD in substance use disorders, after remission or stabilization of the substance use, have been established (14, 15). This practice of treating ADHD in context with "stabilized" substance use has been recently shown to have a positive impact on improving the outcomes of substance use disorders (10) and is being evaluated currently in a large multisite National Institute on Drug Abuse study of adolescents with ADHD and substance use disorders. In this regard, there are a number of new options that could be used to accomplish these goals at different stages of substance use recovery, including effective nonstimulants.

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Dr. Wilens's disclosure accompanies his original article.

Do Nonspecific Factors Influence Psychotherapy Outcome?

TO THE EDITOR: We read with interest the article entitled "Treatment of Acute Posttraumatic Stress Disorder With Brief Cognitive Behavioral Therapy: A Randomized Controlled Trial," by Marit Sijbrandij et al., in the Jan. 2007 issue of the *Journal* (1). The study subjects were randomly assigned to two groups, one of which received brief cognitive behavior therapy (CBT) consisting of four weekly sessions of approximately 120 minutes each, while the comparison group remained on a

waiting list and received no intervention. Assessments were made for both groups at baseline and follow-up at 1 week and 4 months. Nonspecific factors such as therapeutic alliance have long been known to influence the outcome in psychotherapies (2, 3). In our opinion, placing the comparison group on a waiting list did not adequately control for these nonspecific factors and thus did not clearly delineate whether the short-term benefits that were noted in the intervention group were specific to the cognitive strategies that were used.

Although the two groups were comparable at baseline with regard to posttraumatic stress disorder (PTSD) and other comorbid axis I disorders, no screening was conducted for axis II disorders. It is noteworthy that the interface between PTSD and borderline personality disorder has been evaluated in depth, and implications for treatment have been identified (4). We understand that screening for axis II disorders can be highly cumbersome; however, it might be important in studies, such as the one conducted by Sijbrandij et al., in which CBT strategies are used, which may often be ineffective in subjects with cluster B personality traits, especially subjects with borderline personality disorder for whom dialectical behavior therapy may be more effective.

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Drs. Varma and Parashar report no competing interests.

Drs. Sijbrandij and Olff Reply

TO THE EDITOR: Drs. Varma and Parashar comment on our randomized controlled trial in which we compared the administration of four sessions of CBT in patients with acute PTSD with a comparison group on a waiting list. Drs. Varma and Parashar argue that placing the comparison group on a waiting list did not adequately control for nonspecific factors that might have influenced outcome. We assume that they are suggesting that we should have included a treatment group that received only supportive counseling without specific CBT contents. However, we feel that an untreated comparison group on a waiting list is the best comparison group because it is the closest to studying natural recovery. Since it has been repeatedly shown that some early interventions impede natural recovery rather than promote it (1), comparison with an untreated comparison group is essential in trials evaluating the efficacy of early interventions. Moreover, since random-

ized controlled trials comparing early treatment of PTSD relative to a natural recovery comparison group are somewhat scarce (e.g., 2, 3), studies evaluating the potential benefits or risks of any intervention relative to no intervention at all in the immediate aftermath following trauma are still necessary.

Second, the authors comment that we did not perform screening for axis II disorders, specifically for borderline personality disorder. Indeed, performing extensive screening for personality disorder would have meant a significant burden for participants in our trial. We did, however, exclude patients with complex or chronic PTSD and risk for suicide. Therefore, the possibility of inclusion of many patients with borderline personality disorder influencing treatment outcome is implausible. Furthermore, we did not find an interaction effect between prior traumatic experiences—known to be present in many patients with borderline personality disorder—and treatment response in our exploratory subgroup analyses. In conclusion, we feel that any influence of the presence of borderline personality disorder on the efficacy of CBT in our study is highly unlikely.

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The authors' disclosures accompany the original article.

Can Traumatized Children Report Revenge Fantasies?

TO THE EDITOR: I would like to commend Mardi J. Horowitz, M.D., for a stimulating review of an adult patient with post-traumatic stress disorder (PTSD) who had ego-dystonic revenge fantasies and how these fantasies were approached in therapy (1). Dr. Horowitz's article emphasized the importance of working through revenge fantasies as part of psychological recovery from trauma. As a child psychiatrist, I have not been able to access my patients' revenge fantasies, despite being involved in the treatment of PTSD. I suspect that I have seen two variants of revenge fantasies: 1) children acting in an oppositional or conduct-disordered way toward people who are not their aggressors and 2) the transient suicidal and self-harming behaviors of children who appear to identify with their aggressors. In both instances, the children are not thinking or articulating that they would want to harm their aggressors, but their feelings of guilt and helplessness are managed by aberrant behaviors that help to organize these emotions.

Revenge fantasies are likely common in traumatized youth (2). They may be challenging to identify because the majority of traumatized children are under the care of child welfare