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 randomized 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 posttraumatic 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

services and have ambivalent relationships with past or current caregivers who may have perpetrated these traumas. These children are often instinctively motivated to attend to the positive aspects of these relationships and are not cognitively or emotionally able to consider a balanced view of their aggressors as individuals who are deserving of punishment. Perhaps this is because of the child's dependency on adults in a stable environment, although these adults might change, and the child then develops an attachment to a new caregiver.

I have treated traumatized adolescents who are able to articulate that their caregivers hurt them and that it was wrong. Most of these youth are still very emotionally and behaviorally affected. I am unsure as to whether asking about thoughts of revenge would be helpful to the therapeutic process.

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Dr. Boylan reports no competing interests.

Dr. Horowitz Replies

TO THE EDITOR: Dr. Boylan is correct in emphasizing the difference between adults and children in the therapy process in working through revenge fantasies that may follow traumatic experiences. No one can accurately distinguish veridical memory from fantasy memory, and children are even less able than they will be as adults at knowing the difference at the time of the experience and knowing the difference on later review. The child is less oriented to review and more oriented to completing a story in a future projecting way that seems to preserve personal safety. That is probably the first priority—to help them do this—in most cases.

As Dr. Boylan states, revenge fantasies, if and when present, are likely to find displaced targets, in play with an agentic self, have more than usual destructiveness, as well as influencing direct negative behavior toward people who are "safer" to attack than the actual aggressor. Unfortunately, the "safer" individual may be the child's own self, which might be manifested through self-harming behaviors such as pulling out hair, picking off skin, or knocking the head.

When a child or adolescent displays play, fantasy, or interpersonal behavioral patterns that appear to enact revenge, it may be beneficial to encourage translation of the somatic actions into verbal statements. This may help to increase self-control and interpersonal regulation. This could be done through conversation with therapists or good caretakers. An example of such would be as follows: "I guess you are still pretty angry that you got beat up. I also might feel scared and then mad until I felt I was okay and safe again." The point is not a catharsis in the old-fashioned sense of emotional venting, but the emphasis on the "okay and safe" concept of completing a reaction to traumatization.

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Dr. Horowitz's disclosure accompanies the original article.

Evolving Treatments for Panic Disorder

TO THE EDITOR: In the Feb. 2007 issue of the *Journal*, Barbara Milrod, M.D., et al. (1) reported a randomized controlled trial in which psychoanalytic psychotherapy was superior to applied relaxation in the treatment of panic disorder. Opponents of psychoanalytic therapies often level the criticism that little (if any) research exists that demonstrates the efficacy and durability of these approaches. We therefore applaud the efforts of Dr. Milrod et al. to manualize psychoanalytic therapy and to test its effects in a randomized controlled trial.

One of the great challenges with psychiatric disorders such as panic, however, is that many different interventions can appear to work at any given time. Therefore, the scientific task is to weed out those procedures that may appear to work from those that can be trusted to work reliably, not only because these trusted procedures have passed muster in controlled trials, but also because we have some directly verified knowledge about the mechanism through which they have produced positive outcomes. Where is the evidence elucidating the mechanism by which understanding unconscious conflicts (if they exist) results in the reduction of panic and agoraphobia?

In the past 30 years, we have seen significant advances in understanding the biological, cognitive, and behavioral mechanisms of panic and agoraphobia. This research has informed (and continues to inform) the development of effective treatments for these conditions, including psychological treatments such as cognitive behavior therapy (CBT) (2, 3). For example, exposure to interoceptive cues, which is an important component of CBT, is based on experimental research showing that individuals with panic disorder are predisposed to appraise changes in physical state as dangerous (4). Moreover, studies of the individual components of CBT in the treatment of panic disorder have demonstrated that exposure produces the greatest effect (5).

We have a scientifically sound model of panic (3) as well as many controlled trials that show the effectiveness of CBT directly derived from this model (6). Thus, any psychodynamic treatment for panic disorder has to meet a rather high standard. This is not to discount psychodynamic therapy altogether, however. Indeed, interpersonal psychotherapy for the treatment of depression was developed long after CBT was an empirically supported treatment for this condition, and it is now a widely accepted treatment for depression (7). Interpersonal psychotherapy, however, is based on a psychodynamic theory in which hypotheses about mechanisms of psychopathology have been empirically tested. We therefore await research substantiating the conceptual basis of the psychoanalytic treatment for panic disorder presented in the article by Dr. Milrod et al., as well as a direct comparison of the short- and long-term effects of psychoanalytic treatment and CBT for this condition.