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.

References


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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 reaction to traumatization. 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 vent-
Without the equivalent of a pharmaceutical industry to provide financial backing, psychotherapy researchers must battle one another for ever-shrinking federal funds. A step forward for psychodynamic psychotherapy should not be a defeat for CBT. This has become as much of a “guild war” as any. In both cases, it is in our patients’ best interest that the field remains open to and accepting of a range of treatment approaches.

References


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Author disclosures accompany the original article.

BK_Ca Channel in Autism and Mental Retardation

To the Editor: We read with great interest the article by Frederic Laumonnier, Ph.D., et al. (1) in the Sept. 2006 issue of the Journal, as it potentially contributes to knowledge of the etiobiology of autism and may identify a novel treatment target. With the exception of two prior reports (2, 3), channel mutations have not been commonly observed in autism. Therefore, the study by Dr. Laumonnier et al. may represent one of the first on definitive mutations in a channel associated with autism. Yet, several complexities to the relationship between channel mutations, autism, and epilepsy are introduced by the data presented.

The most compelling finding of the article was the discovery and characterization of balanced translocation, which appeared to interrupt one allele of the KCNMA1 gene in the first intron in a patient with autistic disorder. The patients’ parents do not carry the balanced translocation, and therefore, the fact that this translocation is de novo supports the notion that it may be pathogenic. Using semiquantitative reverse transcriptase-polymerase chain reaction, Dr. Laumonnier et al. showed that BK gene expression was decreased by approximately 50% in lymphoblastoid cell lines from the patient, which is consistent with the mutation leading to haploinsufficiency.

In Figure 2 of the article, the authors showed that the BK toxin, iberiotoxin (IbTx), blocked whole-cell current from the autistic patient significantly more than it did in the comparison subject, which suggests decreased activity of this receptor, presumably because of the haploinsufficiency of the genetic mutation. However, this analysis represents a somewhat ambiguous assessment of such a change, since the authors did not provide information regarding the amplitude of the