strategies of these syndromes. However, in our view, the current pathophysiological knowledge of catatonia should be considered when establishing the diagnostic validity of the syndrome. In a description of a final common pathway of catatonia, one should consider, for instance, the work of Northoff (5). This author assumed that there is a "bottom-up" deregulation of the motor circuit in neuroleptic malignant syndrome as a result of the antipsychotic blockade of striatal dopamine D_2 receptors, which is in contrast to the "top-down" modulation as a result of a cortical γ-aminobutyric acid (GABA)-ergic alternation in catatonia.

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Drs. Taylor and Fink Reply

TO THE EDITOR: We appreciate Drs. Van Den Eede and Sabbe's support for a separate DSM category for catatonia. Their modification of our suggested catatonia subtyping into malignant and nonmalignant forms, each with the specifier "retarded" and "excited," is consistent with our view that subtyping should reflect lethality to guide treatment.

Their folding the term "delirious mania" into the malignant excited form, while congruent with our classification, might continue the notion that catatonic excitement differs from severe mania with catatonic features. Bleuler and Kraepelin's original descriptions of catatonic excitement (1) are consistent with the view that the excitement in catatonia represents breakthrough mania.

Drs. Van Den Eebe and Sabbe minimize the dangers of using atypical antipsychotics in the treatment of catatonic patients. Every atypical agent, however, has been reported to induce the malignant form of catatonia, i.e., the neuroleptic malignant syndrome. But this literature is sparse, and a systematic review of the published cases would serve us well.

Whether catatonia associated with schizophrenia responds less well to benzodiazepines than does catatonia from other sources also requires further study. From their remarks, however, we conclude that Drs. Van Den Eebe and Sabbe agree that benzodiazepine therapy is the initial treatment of choice for catatonia, regardless of etiology.

Finally, Drs. Van Den Eebe and Sabbe consider malignant catatonia induced by antipsychotics (neuroleptic malignant syndrome) to result from striatal D_2 blockade (2), while we and others have suggested that it results from a GABA A/B imbalance because the syndrome can be induced by non-D_2-blocking agents and can be treated by $GABA_A$ agonists. The salient point of this discussion, however, is that the early recognition of catatonia encourages effective treatment that has been developed in clinical experiments that are independent of hypotheses of mechanisms.

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Family Therapy and a Physician's Suicide

TO THE EDITOR: "A Physician's Suicide," a clinical case conference by Herbert Hendin, M.D., et al. (1), is an excellent case study and opportunity to learn from one's prior experience. It takes courage to present unsuccessful attempts to save a life. Many residents in training and psychiatrists beginning their careers have not had sufficient experience or conviction that psychodynamic psychotherapy, in combination with medication, is frequently the most effective and, in this case, potentially lifesaving treatment. While it is true that not all suicides are preventable, in my opinion, this one might have been.

The good news was that the patient sought help, his depression was recognized, and he stayed in treatment for 4 years. The astonishing tragedy was he did not get the help he needed. All the classic warning signs for suicide were present. He had a plan, he bought a gun, and he told his family he felt hopeless; he became increasingly agitated, he began self-medicating with benzodiazepines, and the treatment given was ineffective against his unremitting depression. He suffered two major losses and humiliation because of his wife's affair and his inability to work. He improved just enough to have the energy to kill himself. Finally, he was an anesthesiologist who had access to and knowledge about lethal medications.

From a psychodynamic point of view, the greatest tragedy was his psychiatrist's failure to deal with two factors: first, the patient's resistance to exploring his anger and humiliation regarding his wife's affair and, second, the psychiatrist's countertransference. The surgical metaphor at the end of the discussion is a good one: "The patient may choose whether or not to have the operation but does not decide how the procedure is conducted, and the family is not invited into the operating room" (p. 2096). When this patient refused his doctor's recommendation that meaningful psychotherapy was necessary, his refusal should have been explored and interpreted as resistance. This is a basic effective technique. Patients should not dictate treatment. Permitting his wife to sit in as a "consultant/caregiver" was a form of acting out (or "acting in") the therapy. It further demeaned him as if he were a child. Exploring the meaning of this and not permitting it to continue was essential. As long as it persisted, effective therapy was seriously compromised.

Countertransference errors further compounded the problem. That the patient was a physician probably contributed to his doctor's countertransference "V.I.P." treatment. Prescribing another round of 18 ECT treatments after the initial

course was unsuccessful not only reflected poor clinical judgment but may also have reflected the psychiatrist's sense of hopelessness. When used appropriately, ECT can be lifesaving. In this case, it contributed to further hopelessness by the patient and the doctor. Finally, the psychiatrist's collusion with his patient in failing to recognize the significance of his wife's affair represented a major blind spot. This failure to address the patient's intense unexpressed anger and humiliation reinforced the patient's earlier feelings of inadequacy: "Dr. A normally showed little affect in discussing these topics" (p. 2094).

It is easy to be a Monday morning quarterback and criticize an event with an unsuccessful outcome. Instead, I commend the authors and the treating psychiatrist for presenting this case. The psychiatrist's own comments after the suicide reflect his pain and self-doubt, but in reporting this case, he helped us learn a great deal.

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TO THE EDITOR: In their recent case conference, Dr. Hendin and colleagues discussed the suicide of Dr. A, a 51-year-old married staff anesthesiologist. The authors made several important points regarding the difficulty a physician, in this case a psychiatrist, has in providing treatment to other physicians. They observed that the treating psychiatrist might have seen the patient in individual treatment rather than in couples therapy, might have explored marital difficulties, and might have placed emphasis on psychotherapy rather than on pharmacotherapy.

All of these points made by the authors make sense, but in a clinical pathological conference, it seems that the authors shied away from discussing the central issue. The anesthesiologist's depression was precipitated when he learned that his wife was having an extramarital affair. Although the affair allegedly ended, the core issue and last straw for the patient was his wife's affair. The authors could have used this precipitant as the starting point for a discussion of therapy. One wonders what this extramarital affair meant to the patient.

The job of the psychiatrist should have been to explore, most likely in individual therapy, such issues as whether the anesthesiologist felt he was a failure in his loving relationship with his wife, whether he was sexually satisfied, whether the affair threatened his masculinity, whether he was able to share intimate feeling with his wife, and whether he thought his wife was unhappy with the marriage and, if so, why. A detailed exploration of the precipitant would have allowed the patient to acknowledge what was most painful. It would have permitted an alliance to be formed between the patient and therapist and allowed release of forbidden thoughts, wishes, and fantasies.

Once the patient began to acknowledge his feelings, the psychiatrist could have helped him put the feelings in some perspective. This might have involved the patient's looking at his strengths and limitations and at his relationships with others. Long-standing personality issues would become salient. The therapeutic goal would be to help the patient come to terms with both his needs and those of his wife and others.

A clinical pathological conference is an opportunity to look at what might have been done differently. The goal of individual work would have been to help the patient acknowledge, bear, and put in perspective what was most painful. This would have involved the psychiatrist being capable of tolerating these affects. If this work had been attempted as couples therapy, it would have been necessary for the wife to agree to therapy not just to serve as a helper. This would have meant that both members of the couple would have had to share intimate and painful details, a difficult but rewarding task. The precipitants would have needed to be discussed with both present.

Although the authors made good points about the patient's history, work experience, etc., in my opinion, they failed to begin with the precipitant and work toward understanding the nature of the pathology. If one begins with the precipitating event, a patient often will see that there are alternatives and hope. Patients will begin to trust and feel acceptable and accepted.

These comments are not meant to say that suicide could have been prevented but rather how one could have looked at alternative approaches and considered how a different approach just might have changed the outcome. A dynamic treatment perspective in this case might have opened up the possibility for the patient to change his mind.

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TO THE EDITOR: Two recent articles on the treatment of suicidal patients—the case conference by Hendin et al. and the Introspection by R. Peter Uhlmann, M.D. (1)—highlight the potential but neglected role of family therapy in these challenging cases. The articles are written by two psychiatrists struggling to understand disparate outcomes with their respective patients: a suicidal woman who denigrated therapy, eventually living a fulfilling life, and a physician invested in therapy who killed himself when he seemed to have much to live for. With hindsight, both psychiatrists wished they had intervened differently—Dr. Uhlmann with more individual psychotherapy and "Dr. P" with more, perhaps better, drugs. In our opinion, a key unrecognized issue is family therapy. We believe that it was their difficulty in appreciating the family system that compromised the psychiatrists' ability to understand their own roles and the outcomes, good and bad.

Dr. Uhlmann's contact with his patient's family was both formal and informal in a community where he was the sole psychiatrist. His patient kept appointments but demeaned the process. Her attendance, however, signaled her need and, ultimately, her ability to make good use of the relationship. His dedication to a relationship that left him perplexed set a good example, as did his meaningful connection with her family. We believe his chronically suicidal patient included him as a central figure in her life, probably as a replacement for her father who had killed himself; she held onto this absent father in a melancholic identification with her psychiatrist. As with many chronically suicidal patients, she would