not give up her potential fatal choice, which she kept as part of her attachment to her father. By bringing Dr. Uhlmann into her family, she attained a healthier family constellation while treating him as she would her closest relatives. A positive outcome with seriously disturbed patients, in which the therapist is a somewhat distant but real and reliable "relative" is not unusual and quite understandable to the family-oriented therapist. Bolstered by such an understanding, Dr. Uhlmann might have tolerated his patient's negativism and suicidality with less pessimism and puzzlement.

In the physician suicide case, excessive deference to a medical colleague certainly contributed to the regrettable outcome. But we can be more specific. Dr. A's depression was reactive to his wife's infidelity. Two years of treatment with medication and ECT did little, and 2 years of treatment began with another psychiatrist, Dr. P, who reluctantly agreed to the patient's request that the wife attend all sessions. Marital issues, however, were hardly addressed, as Ms. A was allowed to simply observe. This resulted in a therapy that was neither individual nor marital. We can speculate that Dr. A wanted to punish his wife by "dragging" her to therapy, and perhaps she did penance in participating. But we don't even know if the affair ended and whether anger, remorse, justification, a contributory marital history, and ultimate reconciliation were addressed. Evidently not. This is analogous to treating a patient exposed to toxins without ruling specific agents in or out.

It is not a simple matter to decide how much to explore when an affair comes to light. The details sought by an offended spouse and offered by a guilty one may not prove therapeutic. The psychiatrist working on the case must exercise damage control while exploring marital issues and finding ways to help the spouses rebuild their relationship or exit constructively. If Dr. P felt unprepared to perform marital therapy himself, he could have negotiated with Dr. A, who seemed devoted to him, to involve a consultant family therapist with Dr. P in attendance.

Training in family therapy is still the exception rather than the rule in psychiatry residency programs. Such training may seem to impose on already overscheduled programs, but developing specific skills to work with families makes clinical work more interesting and rewarding. Most residents and medical students like this training, which is experiential and includes "live" supervision. Family-inclusive psychiatry adds to the attractiveness of our specialty in an era when technological approaches threaten to overwhelm its humanistic side. We should not leave this area to our colleagues in nonmedical disciplines, but a recent APA document suggested that by default, as it devoted almost three pages to somatic therapies, half a page to psychotherapies, and no specific mention to family therapy (2). By learning to "think family"—always viewing the patient in that context—we are more likely to provide the best psychiatric treatment.

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Dr. Hendin and Colleagues Reply

TO THE EDITOR: We welcome the comments about our case conference and join Dr. Plutzer's acknowledgment of the treating psychiatrist, whose willingness to share his experience made this presentation possible. Each writer comments that the wife's extramarital affair precipitated the patient's depression, a conclusion that we made in our published report. Clearly, opening up and exploring the patient's intense unexpressed feelings about the affair was an essential but neglected therapeutic task. The treating psychiatrist had come to the same conclusion.

Dr. Gudeman identifies a number of possible lines of inquiry for therapeutic exploration. To these, we might add the question: What had the patient been like before his wife's affair? This would have been useful to explore from the wife's as well as the patient's perspective. Drs. Lieberman and Wolin suggest that family therapy was needed. Such treatment would have been premature, in our view, and not indicated before the patient could acknowledge how he felt about his wife's unfaithfulness, which this particular patient was more likely to be able to do without the presence of his wife.

Although we concur with the general thrust of the comments on our report, we wish to make a point about the tone in which some of the comments were conveyed. From the beginning of our Suicide Data Bank project, we were keenly aware that the literature about therapists' experiences with patients who had died by suicide while under their care is meager, at best. Through our in-depth study of 36 such patients to date, we have come to understand how ill-considered remarks by supervisors and colleagues invite sealing over the singularly painful experience of losing a patient to suicide.

Some colleagues hasten to reassure the therapist that the suicide was inevitable, that nothing could have been done to prevent the patient's death. However well-intended, such assurances serve to stop further discussion, preventing the therapist from voicing and coming to terms with feelings about treatment decisions and about the suicide. On the opposite side of the spectrum is the more harmful tendency to blame the therapist. Although we trust that this was not his intention, several of the comments made by Dr. Plutzer are illustrative of this reaction, which our studies show has been the source of considerable additional pain for many therapists who have experienced a patient's suicide.

Rather than judgment, colleagues who are willing to openly discuss treatment cases that have ended so tragically deserve our support in examining their responses to the patient and exploring strategies and interventions that *might* have made a difference. Scrutinizing cases of completed suicide can tell us much about what did not work in the patient's treatment. In every case of suicide we have examined, problematic interventions or noninterventions can be identified. It is quite a different matter, however, to conclude that the suicide could have been prevented had the therapist done something different. Such certainty is simply not warranted.

Our experiences working with therapists who have lost a patient to suicide has convinced us of the critical need for forums that invite talking through experiences and learning from mistakes without fear of blame and recrimination. We are gratified that our project has provided one such forum

and are deeply grateful for the enormous amount that these therapists have taught us about suicidal patients and their treatment.

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Interferon for Hepatitis C Patients With Psychiatric Disorders

TO THE EDITOR: We read with great interest the recent clinical case conference by Chiadi U. Onyike, M.D., M.H.S., et al. (1). Practicing psychiatrists are increasingly asked to assist gastroenterologists in making risk-benefit assessments regarding interferon alpha (IFN-α) treatment of patients with chronic hepatitis C virus infection. Reluctance to treat patients with hepatitis C virus and psychiatric illnesses with IFN-α is certainly understandable because of concerns of precipitating or worsening psychiatric comorbidity. However, the exclusion of patients with comorbid hepatitis C virus infection and psychiatric illnesses is not justifiable without a comprehensive risk-benefit analysis.

Although Mr. C came to the psychiatry service after the decision to treat him with a second course of IFN-α had been made, Dr. Onyike et al. appropriately raised the question of whether he should be offered yet another trial of IFN-α in the future despite neuropsychiatric toxicity associated with his first two courses of IFN-α. The authors suggested that the answer was yes. We contend that critical information regarding this determination is missing from the case discussion. Specifically, Mr. C's hepatitis C virus genotype and viral load bore directly on this risk-benefit analysis.

It is estimated that 70% of the U.S. population with hepatitis C virus is infected with genotype 1, and the remaining 20%–30% are infected with genotypes 2 or 3 (2). Pegylated IFN-α with ribavirin achieves sustained virological response (i.e., complete eradication of hepatitis C virus; absent hepatitis C virus viral load 6 months after IFN-α treatment is completed) in 50%–59% of the patients with genotype 1 and 80%–90% of the patients with genotypes 2 and 3 (2, 3). These sustained response rates, however, were derived from large clinical trials (3–5) and may not be applicable to the hepatitis C virus-infected population with psychiatric illness because these trials excluded all patients with a history of psychiatric illness and substance abuse. The following factors have all been associated with reduced sustained virological response rates: male gender, African American race, high body mass index, advanced age (>40 years), high hepatitis C viral load, and hepatitis C virus genotype 1 (6).

Similarly, several risk factors are thought to increase the probability of emergent psychiatric comorbidity during IFN-α treatment (7–9). Those factors include the following: a previous history of any psychiatric illness, a history of substance abuse, a family history of psychiatric illnesses, and a history of suicidal ideation (8). Although these factors are not well validated, they were used as exclusion criteria in several large hepatitis C virus clinical trials (3–5). The patient described by Dr. Onyike et al. would have had an estimated 50%–60% chance of achieving sustained virological response if infected with genotypes 2 or 3 but only a 10%–20% chance of achieving sustained virological response if infected with genotype 1. These predictions factor in the lower remission rates for an African American man and for patients with a higher body mass index (6). Furthermore, this patient would have had a greater likelihood of developing psychiatric complications because of his previous and family psychiatric histories (7, 9). The high probability of IFN-α-induced psychiatric comorbidity coupled with a hepatitis C virus genotype 1 and a high viral load would make the case for a future course of IFN-α difficult to justify.

The practice of excluding patients with hepatitis C virus and psychiatric illnesses from IFN-α treatment is stigmatizing (8) and will result in substantial morbidity and mortality for a vulnerable population no less deserving of treatment than patients with hepatitis C virus without psychiatric illnesses. Nonetheless, evidence-based patient selection is paramount when endeavoring to treat patients with comorbid psychiatric illnesses and hepatitis C virus to minimize the morbidity and mortality associated with IFN-α treatment. Despite the absence of a consensus regarding when IFN-α treatment should be withheld (either because of the low estimated likelihood of sustained virological response and/or the high probability of psychiatric morbidity), clinicians must still make an individualized and balanced risk-benefit analysis incorporating hepatitis C virus disease-specific factors as well the potential for psychiatric complications before offering IFN-α treatment.

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