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