cognitively impaired, socially isolated, unemployed, and marginalized. Because all of these impairments are a direct consequence of the disease and its correlates, it would be unfair to say the illness is in remission. Indeed, both the individual and the family might be puzzled as well as frustrated in their daily struggle with the impact of the illness to hear that the medical profession has declared the same patient to be in remission. Remission could also be misinterpreted by insurance companies and payers working on the premise that symptomatic and functional improvement go hand in hand.

We have been presented with clear criteria that define remission in certain important symptom domains; perhaps a label of "symptomatic remission" or some analog thereof may be more appropriate. Labels are powerful symbols; all we ask for is some deliberation on this point before the field adopts them.

Reference

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Dr. Andreasen Replies

Thank you, Drs. Remington and Kapur, for your thoughtful discussion about our choice of words. You are perhaps correct that the term "remission" may be misinterpreted and that "symptomatic remission" might have been a better choice.

I certainly concur that a definition that includes measures of quality of life and psychosocial function is preferable. As we stated in the article, we were somewhat handicapped by the lack of widespread consensus on appropriate rating methods for these aspects of schizophrenia. The field will progress, however, and a new and more complete definition of remission will be presented eventually. In fact, here at Iowa, we have been working on a "local" definition that we are already using that incorporates measures of psychosocial function.

I would disagree with you about only one small issue. There is tremendous pressure from patients and family members to have psychiatrists think and speak about schizophrenia in a less pessimistic and more upbeat manner. As you are no doubt aware, there is considerable emphasis on the concept of "recovery." Many families wish we would discuss that possibility more often. In this context, use of the term "remission" is definitely a more modest approach.

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Why the Hamilton Depression Rating Scale Endures

TO THE EDITOR: As stated by R. Michael Bagby, Ph.D., et al. (1), the Hamilton Depression Rating Scale was designed to measure depression severity and clinical changes in depressed patients during treatment with antidepressants (2). The validity of the Hamilton depression scale was demonstrated in this patient population (3, 4).

The review by Dr. Bagby and colleagues relevantly underlined the extended use of this scale: only 13 (18.5%) of the 70 studies published since 1979 that examined the psychometric properties of the Hamilton depression scale were carried out in depressed patients.

We suggest that this use, as shown by Dr. Bagby et al., extended the original aim of the scale and that the relevance of the Hamilton depression scale should be discussed in terms of experimental design and specific objectives (3, 4). Concerning experimental design, nondepressed patients should not be taken into account when we study the validity of the Hamilton depression scale because it has been shown that the scale is not valid in nondepressed patients (3, 4). Concerning its specific objectives, the scale should not be compared to DSM-IV criteria because the two measures have different objectives; i.e., the Hamilton depression scale assesses depression severity in depressed patients, and the DSM-IV defines a diagnosis of major depression.

Finally, we do not agree with the conclusion of Dr. Bagby et al. about the lack of validity of the Hamilton depression scale, and we suggest that the scale is a victim of its success and of inappropriate extended use. Unless significant improvement of depression assessment emerges from objective biological and morphological techniques, we do not believe it is possible to create a new instrument that would be able to assess depression from a diagnostic point of view (such as DSM-IV) and a severity point of view (such as the Hamilton depression scale) in all circumstances and in all subjects.

References

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TO THE EDITOR: The review of the psychometric properties of the Hamilton depression scale by Dr. Bagby et al. included the most relevant studies published from January 1980 to May 2003 that examine both interrater reliability and validity. It clearly demonstrated that the 17-item version, which in this period has been the gold standard as the outcome measure in trials with antidepressive therapies, is a multidimensional scale.

One potential evolutionary solution for a one-dimensional gold standard, as suggested by the authors, would be to use the six core items of the dimension of depression comprising depressed mood, guilt, work and interests, psychomotor retardation, psychic anxiety, and general somatic symptoms—the 6-item Hamilton depression scale—when we measure the outcome of antidepressive interventions because this subscale has been proven to be more effective than the 17-item