continuing confusion that exists in the definition of recovery, remission, relapse and recurrence of depression, in spite of the pains that the authors took to use contemporary definitions and guideline recommendations for continuation and maintenance antidepressant treatment.

The definition adopted by the authors was derived from Frank *et al* (1991) where remission begins when a patient does not have any of the Research Diagnostic Criteria (RDC) symptoms of major depression. If remission is maintained for eight weeks, the patient is considered recovered. Return of symptoms of major/minor depression during the eight weeks after losing symptoms heralds a relapse, whereas if this occurs after an eight-week symptom-free interval the individual is considered to have had a recurrence. The pivotal importance given to a two-month symptom-free interval in differentiating a relapse from a recovery is embodied in DSM–IV (American Psychiatric Association, 1994) as well, whereas ICD–10 (World Health Organization, 1992) skirts the issue by using the phrase "several months" rather than commit itself to a definite time frame. However, continuation-phase treatment with antidepressants is usually recommended for four to six months after full recovery. Using the recommendation of four months of continuation treatment (Depression Guideline Panel, 1993), Ramana *et al* (1999) observed that 31 of 77 subjects who 'recovered' from depression had a return of symptoms in the continuation phase of antidepressant treatment. This implies that they had not actually recovered from the underlying pathophysiology of the episode but had only achieved symptomatic recovery. They would be then classified as having had a relapse rather than a recurrence, as would be the case if Frank *et al*'s definition (1991) were followed.

A recent randomised controlled trial by Reimherr *et al* (1998) on the optimal length of continuation therapy in depression addresses this crucial issue in the research and treatment of depressive disorders. Based on their trial, which involved prospective transfer to placebo at multiple points, the authors recommend an additional 26 weeks of fluoxetine after remission to prevent re-emergence of depressive symptoms, thereby proposing that the end of this period defines recovery from the underlying pathophysiology of an episode of depression. This suggests that two months of remission, as proposed by Frank *et al* (1991) and in DSM–IV, is inadequate to define complete recovery from an episode of depression, and warrants fresh attempts to achieve consensus definitions for remission, recovery, relapse and recurrence in major depressive disorder.

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Criteria for traumatic grief and PTSD

Sir: We were interested in Prigerson *et al*'s (1999) consensus criteria for traumatic grief. There were some concepts in the distinction from post-traumatic stress disorder (PTSD) with which we would take issue. Criterion B, in particular, appears to overlap significantly with PTSD. Avoidance of reminders is one of the key criteria in DSM–IV PTSD (American Psychiatric Association, 1994), as well as emotional numbing. In fact, most of Prigerson *et al*'s criterion B can be seen in PTSD. We also feel concerned about the two months of symptoms which the authors have used as a time scale, since clinically this overlaps with normal grief. The distinctness of this diagnosis must, therefore, be questioned. No mention is made of the adjustment reaction and the distinction from this, and in ICD–10 (World Health Organization, 1992) many atypical grief reactions are put in this section.

The authors had a 42% response rate in their study which was predominantly female, of a mean age of 61 years and Caucasian. This undermines the generalisability of the study. Furthermore, in our clinical work on PTSD, avoidance symptoms often delay presentation and this might be significant in the rest of their sample.

Post-traumatic stress disorder is a condition with a 50–95% comorbidity (Green *et al*, 1992) and it is inherently problematic to sort out comorbidity (Yehuda & Mcfarlane, 1995). Further, a recent epidemiological study found a risk of developing PTSD of 31% following unexpected death of a loved one (Breslau *et al*, 1998). A recent paper reinforced the link between grief and PTSD, showing that they appear to share common predictors (Sprang & McNeil, 1998). If this is the case, then perhaps PTSD and traumatic grief syndrome represent a spectrum of severity, or are potential alternatives, or are potentially comorbid. We also wonder whether including this as a sub-specifier in PTSD might be a better place for it, rather than as a distinct diagnosis. The work which the authors have undertaken is preliminary but we feel may assist in the better definition of PTSD and traumatic grief.

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Authors' reply: We appreciate the attention Dr Fox and colleagues have drawn to the distinction between the criteria for PTSD and those we propose for traumatic grief. As stated in our article: "we acknowledge the reaction to be a stress response syndrome

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and note that, as such, many of its symptoms resemble those of post-traumatic stress disorder . . ." (Prigerson *et al*, 1999; p. 67). In fact, we refer to the syndrome as traumatic grief in recognition of the fact that we repeatedly find symptoms of traumatic distress (symptoms in criterion B) to form a unidimensional factor with symptoms of separation distress (grief). If anything, we believe our research has drawn attention to the phenomenological overlap between pathological grief and post-traumatic stress symptomatology.

Nevertheless, we do not consider the overlap to be complete. Criteria for PTSD do not include the core symptoms of separation distress such as yearning, longing, or searching for the deceased, or excessive loneliness resulting from the loss. The unbidden, intrusive thoughts and longings are related to a wish to be reunited with the deceased, and it is the *absence* of the person that is distressing rather than fears that the horrifying event will be re-experienced (Raphael & Martinek, 1997). Re-experiencing the presence of the deceased more typically proves to be a comfort and not a source of distress (Jacobs, 1993; Raphael & Martinek, 1997).

Whereas avoidance is a cardinal feature of PTSD, as our results indicated, the avoidance item had low specificity, an extremely low item–total correlation (r=0.01), and Cronbach's alpha for the criteria set improved with its deletion. The poor performance and low mean levels of the avoidance item were also found in Spooren *et al*'s (1999) study of parents several years after their child's death. Similarly, item response theory analyses we recently conducted on a community sample of 76 widows and widowers revealed the avoidance item to yield the least amount of information for distinguishing between cases and non-cases of traumatic grief. Contrary to Fox's clinical observations, longitudinal data presented by Horowitz *et al* (1997) indicate that the frequency of bereaved subjects in his sample who avoided thoughts of the deceased dropped from 52.9% at 6 months post-loss to 12.9% at 14 months post-loss (when its specificity for predicting complicated grief was only 0.26), suggesting that avoidance phenomena are more likely to dissipate over time than they are to have a delayed presentation. Rather than avoidance, the more salient behaviour is one of searching for reminders of the deceased. In traumatic grief the hypervigilance relates to scanning the environment for cues of the deceased, rather than to fears that the traumatic event will be re-experienced. While PTSD criteria in DSM–IV include sleep disturbances, in an electroencephalographic sleep study, the sleep architecture revealed no evidence of hyperaroused sleep among subjects with syndromal-level traumatic grief (McDermott *et al*, 1997). The evidence appears to be mounting that avoidance *per se* (as opposed to the highly informative dissociative symptoms such as numbness) is not an efficient marker for traumatic grief, and hyperarousal manifests itself in a distinctive way among those with traumatic grief.

In terms of overall diagnostic agreement, in a sample of 76 young adult friends who had been exposed to a friend's suicide, we found that three of the seven (43%) who met SCID criteria (Spitzer *et al*, 1990) for PTSD did not meet our criteria for caseness of traumatic grief, and 12 of the 16 (75%) who met our criteria for traumatic grief did not meet criteria for PTSD (PTSD–traumatic grief kappa=0.27). Thus, although there is substantial overlap between symptoms of traumatic grief and those of PTSD, these disorders do not appear isomorphic, and traumatic grief may prove to be a unique type of stress response syndrome.

Classifying pathological grief responses as adjustment disorders appears an inadequate alternative. Adjustment disorders do not include the specific clinical features of traumatic grief described above. The clinical description of adjustment disorder is imprecise, and would indicate little more than that a widowed person was having difficulty adjusting to the loss. The stipulation in DSM–IV (American Psychiatric Association, 1994) that adjustment disorder "must resolve within 6 months of the termination of the stressor" runs counter to the longer duration Fox *et al* recommend and would exclude the large number of bereaved individuals with symptoms of traumatic grief beyond 6 months. Lastly, criterion D for adjustment disorder explicitly states that the symptoms cannot be a consequence of bereavement. For these reasons, adjustment disorder does not appear to be appropriate or clinically useful for bereaved individuals who suffer from symptoms of traumatic grief, particularly, as it is defined in DSM–IV.

While we and other members of the consensus panel agree that two months post-loss seems premature to make a diagnosis of traumatic grief, we were obliged to report the recommendations of the consensus panel. We await the analysis of longitudinal data collected on the proposed criteria among a more representative sample of widowed elders before drawing firmer conclusions about the preferred timing of the onset/duration of symptoms that should be required for a diagnosis of traumatic grief. We consider this the first step of many towards refining a clinically useful criteria set for this disorder.

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Behavioural changes and psychiatric symptoms in Alzheimer's disease

Sir: In their article on behavioural changes and psychiatric symptoms in Alzheimer's disease, Hope *et al* (1999) state that from their findings "it is worthwhile considering a trial withdrawal of any medication which is prescribed for psychiatric or behavioural changes in dementia". They also state that "if a trial without treatment was instituted . . . then 25% of them would not have the index problem any more". These statements, along with other comments in the paper, suggest that all patients with physical

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