even if it cannot be attained in all cases. Although marked symptom reduction, as achieved by the commonly used definitions of response, is highly laudable, it is not sufficient as an end point of treatment. Clinical criteria for remission need to be identified for both unipolar and bipolar disorder. Treatment studies should be designed to evaluate treatment options and their outcomes and should use definitions of remission in addition to those of response. The limited literature examining this issue in patients with unipolar depression largely compares antidepressants of one class to those of another. The data on bipolar disorder are also extremely limited — and the design of these studies presents unique methodologic challenges. The cyclic, recurrent nature of bipolar disorder, the occurrence of both manic and depressive episodes, the invariable use of multiple concurrent pharmacological strategies and the clinical and ethical issues related to medication-free periods make them particularly challenging.

Clinical lore and published research would suggest that subsyndromal symptomatology, even in the absence of acute episodes, in bipolar disorder contributes substantially to morbidity and impaired social and work function. Current mood stabilizers, including lithium and the anticonvulsants, should be evaluated to determine not only whether they have efficacy for acute mania, acute depression and prophylaxis against acute episodes, but also whether they can induce and sustain remission and prevent long-term minor and subsyndromal depressive and manic symptoms.

Mood disorders, bipolar and unipolar, are common and cause an enormous burden of suffering. Treatment of acute episodes and, more particularly, incomplete treatment of acute episodes, address only one component of the long-term suffering of our patients. A more holistic approach is required to understand and treat the full range of clinical symptoms that contribute to the burden of suffering with these disorders. A treatment approach that aims for complete resolution of the mood disorder will serve our patients best by reducing not only their current symptoms, but also their future likelihood of recurrence.

References

1. Judd LL, Akiskal HS, Schettler PJ, Endicott J, Maser J, Soloman DA, et al. The long-term natural history of the weekly symptomatic status of bipolar I disorder. *Arch Gen Psychiatry* 2002;59:530-7.
2. Judd LL, Akiskal HS, Maser JD, Zeller PJ, Endicott J, Coryell W, et al. A prospective 12-year study of subsyndromal and syndromal depressive symptoms in unipolar major depressive disorders. *Arch Gen Psychiatry* 1998;55:694-700.

Canadian College of Neuropsychopharmacology
Collège canadien de neuropsychopharmacologie

2002 Jock Cleghorn Prize

Ms. Richelle Booker is the recipient of the 2002 Canadian College of Neuropsychopharmacology (CCNP) Jock Cleghorn Prize. Ms. Booker is doing research training in the Department of Psychiatry, University of Alberta in Edmonton. This award is designed to recognize the best poster presentation by a research trainee at the Annual Meeting of the CCNP. The award, donated by the CCNP, consists of $500. Congratulations to Ms. Booker!

Presentation: Inhibition of ^{3}H-GABA uptake in rat brain cortical prisms by *Hypericum perforatum*, several of its constituents and a range of commercially available preparations