

## How distinct is ‘distinct quality’ of mood?

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### ABSTRACT

**Background.** The DSM-IV criteria for melancholia include the clinical feature ‘distinct quality’, defined as a mood state differing from that experienced in bereavement. Both propositions – its specificity to melancholia and its definition – remain problematical.

**Methods.** We examine both propositions by analysing an adjective checklist completed by melancholic and non-melancholic depressed subjects, as well as by a bereaved sample. The checklist was refined by a principal components analysis to four scales – one assessing a general ‘mood’ severity or dysphoric dimension, and the other three assessing dimensions of ‘fatigue’, ‘numbness’ and ‘guilt’.

**Results.** If the concept of ‘distinct quality’ has validity, we would require specificity of the refined qualitative constructs to melancholic depression. The ‘numbness’ component met that requirement, but only to a degree. While bereaved subjects did differ from those with melancholic depression on a number of our refined qualitative mood domains, such differences appeared more related to lower levels of depression in the bereaved sample.

**Conclusions.** We argue for deleting the ‘distinct quality’ criterion from diagnostic checklists of melancholia until its definition has been improved, its utility demonstrated and its specificity to any depressive subtype established as having clinical significance.

Others imply that they know what it is like to be depressed because they have gone through a divorce, lost a job, or broken up with someone. But these experiences carry feelings. Depression, instead, is flat, hollow, and unendurable. (Jamison, 1995.)

The purest form of depression is when you can give absolutely no reason why you’re depressed. As B says, in EITHER/OR, “A person in sorrow or distress knows why he sorrows or is distressed. If you ask a melancholic what it is that weighs down on him, he will reply, ‘I don’t know what it is, I can’t explain it’. Therein lies melancholy’s infinitude.” (Lodge, 1995.)

### INTRODUCTION

The DSM-III (APA, 1980) criteria for the melancholic subtype of major depression included ‘distinct quality’, a feature that has resisted clear definition. While deleted from the

DSM-III-R (APA, 1987) criteria set, if returned as one of a small set of melancholia criteria in DSM-IV (APA, 1994), being defined as a mood ‘experienced as distinctly different from the kind of feeling experienced after the death of a loved one’. The definition, therefore, indicates what it is not, rather than providing any positive defining characteristics, a process akin to defining baseball as ‘not cricket’.

‘Distinct quality’ has been previously criticized, with Carroll (1984) considering it to be one of the most difficult to measure reliably. Rubinson *et al.* (1988) stated that both its status (as a DSM criterion for melancholia) and its definition were unknown to a high percentage of clinicians, being variably conceptualized as: (i) a mood state incomprehensible to the patient; (ii) somehow different from normal sadness; or even (iii) the experience of severe dysphoria.

Its history is interesting. Roth (personal communication, 1995) noted that, while ‘vital feelings’ had been described by Wernicke (1906)

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in reference to the somatic concomitants of psychotic depression, his description of the term was less vivid and explicit than Schneider's later descriptions. Roth (1995) noted that the term 'distinct quality' was actually derived from Schneider's concept of 'vital depression'. Schneider (1920) held that vital depression had a somatic focus, with the feature '...near physical, often sharply localized [in the head, chest or stomach], and...qualitatively different from the spontaneous psychic moods of normal... people'. Roth (1995) added that Schneider 'attached considerable diagnostic significance to these vital symptoms and in some of his writings equated them in their specificity for psychotic-endogenous depression to the "first rank" symptoms of schizophrenia'.

Roth (1995) commented that the actual term 'distinct quality' was 'first used in Newcastle... It appeared a more clear and direct description than "vital depression" of the subjective experience of endogenous patients that their mood disturbance was distinct from normal sadness'. In an earlier paper (Roth, 1959), he described 'a quality of affect which many intelligent and discerning patients are able to attest is different in kind from normal despondency, which relatives will insist is outside the range of their ordinary affective response', and referred to papers by Gillespie (1929) and Partridge (1949). Gillespie held that in 'autonomous' (compared to 'reactive') depression, the depression was 'subjectively a much more extraneous-seeing thing...much more of a "foreign body"'. Partridge held that 'endogenous and reactive... illnesses seemed different in quality, though to convey the difference in words would tax the abilities even of a professional writer'. In essence, he viewed endogenous illnesses as being less 'personal to the patient', and not having 'the same stamp... of having struck the patient from without and of being alien to their normal states'. Roth (1995) indicated that the first written use of the term was by Kiloh & Garside (1967), whose definition was: 'Patients may describe their depression as similar to "normal" sadness or gloom, differing only in degree: others describe their experience as something beyond normal experience, having a quality distinct from "normal" depression'. Carney *et al.* (1965) then included 'distinct quality', as one of the ten features contributing to the Newcastle

Index distinguishing endogenous and neurotic depression. Those authors stated that some depressions may differ from normal sadness or gloom by degree, or by having a 'quality quite distinct from the depression with which they normally react to adversity'.

In the late 70s, an NIMH collaborative project led to the development of the Research Diagnostic Criteria (RDC). The RDC set (Spitzer *et al.* 1978) for 'endogenous major depressive disorder' included 'Distinct quality to depressed mood, i.e. depressed mood is perceived as distinctly different from the kind of feeling he would have or has had following the death of a loved one' as the first criterion, changing the comparison from other types of depression to bereavement. Reflecting the significant contribution of RDC criteria to the subsequent DSM system (Spitzer, personal communication, 1996), 'distinct quality' emerged in DSM-III (APA, 1980), with the mood state being defined (for major depressive episode, with melancholia) as being different 'from the kind of feeling experienced following the death of a loved one', and so akin to the current DSM-IV definition.

Thus, the concept of distinct quality has moved away from an initial focus on 'a characteristic form of bodily pain' (Roth, 1995) or 'corporization' (i.e. feeling physically ill) as defined by Schneider (1920), to defining a mood disturbance that: (i) differs from both grief and reactive depression; and (ii) has some specificity to the melancholic (endogenous) depressive subtype. We now report two studies, designed to determine whether 'distinct quality' can be defined on the basis of positive features and whether the DSM definition has utility.

If 'distinct quality' is a valid construct, then we would expect it to have some specificity or 'distinctiveness' in melancholic patients, both subtyped according to DSM and our own clinical criteria, when compared to: (i) non-melancholic depressed subjects, and (ii) those exposed to a bereavement.

## METHOD

### Development of a qualitative measure

As 'distinct quality' is currently defined in DSM-IV as being a distinctly different 'experience', we elected to assess it as a symptom rather than as a behavioural sign.

Table 1. Summary data for comparison study subgroups

Study subgroup	Number of patients	Hamilton score Mean $\pm$ s.d.	Beck score Mean $\pm$ s.d.	Age Mean $\pm$ s.d.	Female %
EDs	27	23.7 $\pm$ 6.5	26.2 $\pm$ 10.9	46.8 $\pm$ 15.2	67
NON-EDs	60	20.6 $\pm$ 6.4	30.2 $\pm$ 10.8	40.4 $\pm$ 10.4	67
MELs	38	23.1 $\pm$ 6.5	27.3 $\pm$ 9.7	46.0 $\pm$ 14.2	71
NON-MELs	49	20.4 $\pm$ 6.4	30.6 $\pm$ 11.6	39.6 $\pm$ 10.1	63
DSM 'distinct quality' positive	50	21.6 $\pm$ 6.1	27.9 $\pm$ 10.8	43.3 $\pm$ 13.6	68
Bereaved subjects	30		13.1 $\pm$ 5.1	48.7 $\pm$ 16.2	77

EDs = MDU-defined endogenous depression; NON-EDs = MDU non-endogenous; MELs = DSM-IV-defined melancholia; NON-MELs = DSM-IV non-melancholia.

We assembled a 42-item adjective check list (see Table 1), with adjectives selected from mood state measures, reports by our depressed patients, as well as from other sources. As an example, Styron (1989) argued for a 'truly arresting designation' to describe the 'malady *in extremis*' of clinical depression and nominated 'brainstorm', an item therefore included. The checklist instruction requested subjects to 'rate the extent to which each term describes your mood state when you are at your worst', with rating options being 'not at all', 'somewhat true', 'reasonably true' and 'absolutely true'.

### Samples

#### *Study A: contrasting those with melancholic and non-melancholic depression*

Subjects were a subsample of depressed patients meeting DSM-IV major depressive episode criteria and recruited from our Prince Henry Hospital Mood Disorders Unit, complemented by in-patients managed at the Prince of Wales psychiatric unit by the first author, with the majority in receipt of psychotropic medication. A structured interview was undertaken to obtain details on clinical features generating DSM depressive diagnoses. We excluded psychotic subjects as recent DSM systems have restricted the distinct quality feature to melancholia. One of the five assessing senior psychiatrists completed a check list of DSM-IV diagnostic criteria for melancholia, and was specifically required to state whether 'distinct quality' was present or not – with the DSM-IV definition provided. The majority of the sample (i.e. those assessed at the MDU) were scored on the 17-item Hamilton (1960) and the 21-item BDI (Beck *et al.* 1961) depression measures.

One hundred and two patients completed the adjective check list, with 15 subsequently

excluded because they had psychotic features (i.e. delusions and/or hallucinations), generating a sample of 87 (51% in-patient) subjects (for whom we had Hamilton and BDI data for 71), and with 84% rated as at 'episode nadir'. Twenty-five had experienced a bereavement involving a family member or close friend in the year before, or subsequent to depression onset. Fifty-eight per cent of the sample were rated as positive on the DSM-IV 'distinct quality' item. Our Mood Disorder Unit (MDU) 'clinical diagnoses' (Parker *et al.* 1994) resulted in 27 (31%) being assigned as having 'endogenous depression' (ED), while 38 (44%) met DSM-IV criteria for melancholia (MEL). The overall agreement between those receiving both DSM MEL and MDU ED diagnoses was reasonable ( $\kappa = 0.49$ ) with 22 positive and 44 negative by both systems, and 21 discordant. Clinician-rated 'distinct quality' was present in 31% of the EDs, 44% of the MELs and 25% of those rated as meeting both ED and MEL criteria. Table 1 provides relevant sociodemographic and depression severity data.

Those rated as MEL or NON-MEL scored similarly on the Hamilton (23.1 *v.* 20.4,  $t = 1.73$ , NS) and BDI (30.2 *v.* 26.2,  $t = 1.20$ , NS). Similar trends were evident for the MDU subgroups with the EDs scoring similarly on the Hamilton (23.7 *v.* 20.6,  $t = 1.78$  NS) and Beck (30.2 *v.* 26.2,  $t = 1.20$ , NS) scales compared to the NON-EDs.

#### *Study B: contrasting bereaved subjects with clinically depressed subjects*

Our depressed subjects were obtained from Study A. To obtain a bereaved sample, we approached the NSW Branch of the National Association for Loss and Grief, and that organization gave permission for us to approach 19 of their group convenors. The convenors

invited the voluntary participation of members, and distributed the adjective check list derived for Study A, the BDI and a semi-structured questionnaire seeking anonymous details on participants. Forty-six members returned data sheets. As Beck *et al.* (1961) suggested that BDI scores of 21–30 were indicative of moderate depression, as against 31–40 for severe and more than 40 for extreme depression, we elected to exclude those who had BDI scores of 21 or more ( $N = 16$ ), as significantly depressed bereaved subjects might confound analyses by their comorbid status (i.e. being both depressed and bereaved). Sociodemographic and Beck data for our bereaved sample are provided in Table 1. All had experienced the death of a close family member (40% the spouse; 37% a parent; 13% a child; and 10% a sibling), either following a sudden and accident event (30%), an acute illness (30%), a chronic illness (30%) or more rare circumstances (e.g. one suicide and one a consequence of birth complications). The salient death had occurred at a mean of 9.3 (s.d. 10.0; range 3–52) months preceding our assessment, but with only 20% judging themselves as still at the nadir of their grief.

## RESULTS

### Study A

#### *Item analyses*

Comparison of those meeting DSM-IV MEL with the residual major depression (NON-MEL) group revealed higher scores on 76% of the 42 checklist items, but significant (i.e.  $P < 0.05$ ) for only seven items: wretched, anguished, paralysed, frozen, desolate, agony and washed out. Summed raw scores for all 42 items produced similar mean scores for the MEL and NON-MEL subgroups (79.7 and 71.6 respectively;  $t = 1.48$ , NS). Similar comparisons of the MDU-diagnosed EDs (compared to the NON-EDs) revealed higher scores on 59% of the items, but significant for only two: paralysed and wretched. Summed raw scores for all 42 items were similar for the EDs and NON-EDs (i.e. 77.0 *v.* 74.3,  $t = 0.46$ , NS).

Comparison of those meeting the DSM-IV definition for 'distinct quality' revealed higher scores on 86% of the items, being significant for eight items, namely, wretched, sense of dread, colourless, sluggish, bleak, agony, tortured and

Table 2. *Four-factor PCA, reporting factor loadings on the five highest loading items for each labelled factor*

Item	Factor and derived scale			
	I 'Mood'	II 'Fatigue'	III 'Numbness'	IV 'Guilt'
Gloomy	0.80			
Flat	0.77			
Bleak	0.74			
Dispirited	0.66			
Listless	0.51			
Fatigued		0.90		
Tired		0.87		
Exhausted		0.83		
Drained		0.56		
Frail		0.29		
Numb			0.71	
Frozen			0.70	
Heavy			0.61	
Paralysed			0.60	
Colourless			0.59	
Guilt				0.82
Self-critical				0.78
Shame				0.73
Burdened				0.66
Tormented				0.64

Items excluded from the final scales: bothered, sad, sluggish, sense of doom, sense of dread, mental pain, empty, alone, wretched, hopeless, anguished, washed out, depressed, fragile, clumsy, brain-storm, helpless, tortured, despair, agony, desolate, trapped.

washed out. Summed raw scores for those rated positive for 'distinct quality' were higher than those rated negative (i.e. 79.3 and 68.2,  $t = 1.98$ ,  $P = 0.05$ ).

#### *Scale development and analyses*

Next, analyses were undertaken to identify dimensions underlying the adjective check list. A screening PCA considered all 42 items, and imposed three-factor, four-factor and five-factor solutions. Eighteen items (including 'wretched', which had been the only item identified in each of the three previous sets of contrast analyses) were culled as these did not clearly load on those factors. The definitive PCA then considered the restricted 24-item set, and tested 3–6 factor solutions, with the four-factor solution appearing the most coherent. The first unipolar factor accounted for 32% of the variance with 21 of the 23 items having loadings in excess of 0.40, with the remaining bipolar factors accounting for 11, 7 and 7% of the variance. Table 2 identifies (via the pattern matrix of an oblique

Table 3. Scale scores for those meeting or not meeting (I) and MDU endogenous depression diagnosis, (II) a DSM-IV melancholia diagnosis, (III) both MDU and DSM-IV 'melancholia' criteria and (IV) the DSM-IV distinct quality criterion

Criterion	Factor scale			
	Mood	Fatigue	Numbness	Guilt
MDU endogenous depression				
Yes ( <i>N</i> = 27)	10.3	9.9	6.9	8.6
No ( <i>N</i> = 60)	9.5	10.8	5.4	9.4
<i>t</i> test	0.85	0.98	1.59	0.89
DSM-IV melancholia				
Yes ( <i>N</i> = 38)	10.6	10.4	6.9	9.3
No ( <i>N</i> = 49)	9.1	10.6	5.2	9.1
<i>t</i> test	1.70	0.30	2.10*	0.22
DSM-IV and MDU melancholia				
Yes ( <i>N</i> = 22)	10.1	9.9	6.9	8.7
No ( <i>N</i> = 65)	9.6	10.7	5.6	9.4
<i>t</i> test	0.47	0.87	1.41	0.70
DSM-IV distinct quality				
Yes ( <i>N</i> = 50)	10.8	10.7	6.3	9.5
No ( <i>N</i> = 34)	8.2	10.5	5.2	8.7
<i>t</i> test	2.93**	0.26	1.39	0.83

\*  $P < 0.05$ ; \*\*  $P < 0.01$ .

Table 4. Comparison of scale scores for bereaved group and clinically depressed subgroups

Group	Factor scale			
	Mood	Fatigue	Numbness	Guilt
A Bereaved	7.7	8.2	5.0	6.1
B MDU ED	10.3	9.9	6.9	8.6
C MDU NON-ED	9.5	10.8	5.5	9.5
D DSM-IV MEL	10.6	10.4	6.9	9.3
E DSM-IV NON-MEL	9.1	10.6	5.2	9.1
F DQ positive	10.7	10.6	6.3	9.5
Contrasts		<i>t</i> tests		
A v. B	2.4*	1.7	1.8	2.9**
A v. C	2.0*	3.2*	0.6	3.9**
A v. D	3.0**	2.3*	2.0	3.7**
A v. E	1.5	3.0**	0.2	3.5**
A v. F	3.5**	2.8**	1.5	4.2**

ED = MDU endogenous; NON-ED = MDU non-endogenous; MEL = DSM-IV melancholia; NON-MEL = DSM-IV non-melancholia; DQ = DSM-IV distinct quality.

\*  $P < 0.05$ ; \*\*  $P < 0.025$ .

rotation) the five highest loading items for each of the four factors. Factor I appeared to describe a flat and gloomy mood (so that the factor was labelled 'mood'); factor II described a sense of tiredness and exhaustion ('fatigue'); factor III described a washed out and frozen dimension ('numbness'); and IV defined a guilt/self-critical ('guilt') dimension. Factor IV correlated 0.38 with Factor I, while the remaining factors had inter-correlations of 0.17 to 0.26.

Four scale scores were then created by summing the relevant five items. Table 3 examines scale scores in relation to several assigned categories. Those positive for DSM-IV defined 'distinct quality' returned higher 'mood' scale scores. Those assigned as DSM-IV MELs scored significantly higher (i.e. 33%) on the 'numbness' scale, with a similar but formally non-significant trend (i.e. 28% higher) evident for those assigned to the MDU ED class. As

each of our measures of 'melancholia' had provided differing rates within the overall sample (i.e. 44% as MELs; 31% as EDs), we undertook a third comparison – of those who met both MEL and ED criteria for 'melancholia' (i.e. 22 or 25% of the sample). Table 3 demonstrates that the comparison groups did not differ on any of the scales, although there is again a trend for 'numbness' scores to be higher (23%) in the composite 'melancholic' class.

Logistic regression analyses were undertaken to examine the extent to which the four scale scores predicted assignment to the variably defined 'melancholic' and 'non-melancholic' classes, as well as the presence or absence of DSM-IV defined 'distinct quality'. In relation to DSM-IV MEL prediction, while the 'numbness' scale score was an individual significant predictor (beta = 0.14,  $P = 0.04$ ), the remaining scales were non-significant, while the overall prediction allowed by the combination of the four scale scores failed to predict assignment ( $\chi^2 = 9.0$ ,  $P = 0.06$ ), and with the overall correct classification of 63% being unimpressive. In terms of predicting MDU ED status, a high 'numbness' scale score was the only individual predictor (beta = 0.16,  $P = 0.04$ ), while the overall prediction offered by all four scales was of marginal significance ( $\chi^2 = 9.4$ ,  $P = 0.05$ ), with 68% of cases classified accurately.

In relation to predicting the presence of 'distinct quality', the 'mood' scale score was an individual significant predictor (beta = 0.2,  $P = 0.01$ ), while the remaining scales were non-significant. The overall prediction allowed by the four scale scores just achieved significance ( $\chi^2 = 10.1$ ,  $P = 0.04$ ), with the overall correct classification (at 67%) being relatively unimpressive.

### Study B

Respecting the status and definition of 'distinct quality' in both the DSM-III and DSM-IV systems, our principal focus is the extent to which melancholic depression is 'experienced' as different from bereavement. We, therefore, compared scores from our Study B bereaved sample on a range of mood descriptor items with the variably defined 'melancholic' depressed subjects from Study A. When scores on the 42 items were summed, the bereaved subjects returned a mean score (i.e. 55.3) significantly

lower ( $P < 0.01$ ) than those in Study A assigned as MEL (79.7) or ED (74.3), with  $t$ s of 3.55 and 2.82 respectively. In addition, they scored significantly lower ( $P < 0.01$ ) than the NON-MELs (mean = 71.6,  $t = 2.63$ ), the NON-EDs (mean = 74.3,  $t = 3.20$ ), as well as those with DSM-IV defined 'distinct quality' (mean = 79.4,  $t = 4.04$ ). Item analyses established that the bereaved sample returned lower scores than those with: (i) ED on 88% of the items (significant for 43%); (ii) MEL on 93% of the items (significant for 52%); and (iii) those in Study A with distinct quality on 93% (significant for 57% of the items).

The contrast analyses were repeated using scale scores and are summarized in Table 4. Apart from the 'numbness' scale, where all comparisons were non-significant, the grief subjects scored lower than all four principal comparison groups (i.e. EDs, NON-EDs, MELs, NON-MELs) as well as those positive on the DSM-IV 'distinct quality' item). We interpret the analyses as indicating that the bereaved differed from all comparison groups principally by being less depressed.

### DISCUSSION

Groups of clinically depressed (both melancholic and non-melancholic depression being represented) as well as bereaved subjects completed a comprehensive adjective checklist of mood descriptors, designed to identify any qualitative 'distinct quality'. The sum of the total scores showed similar scores for the 'melancholic' groups (whether defined by DSM or MDU clinical systems) and their non-melancholic comparison groups, indicating comparable severity of overall mood state, and confirmed by similar Hamilton and BDI scores for those contrast groups. If, instead, the 'melancholic' subjects had returned significantly higher total scores, our capacity to define a 'distinct' or over-represented domain might well have been confounded by the greater mood severity in the melancholic subgroup. DSM-defined 'distinct quality' was present in 31% of the EDs and 44% of the MELs, prevalences sufficiently substantive to allow any intrinsic differentiation to be identified.

Our large number of item comparisons argued for a data reduction strategy and we therefore

undertook a principal components analysis (PCA) of the 42 adjectives. That solution identified four constructs (i.e. 'mood', 'fatigue', 'numbness' and 'guilt'). If 'distinct quality' is specific to a depressive subtype, then subject to it being represented in our adjective checklist, we would anticipate that one of the factors (other than the general factor of 'mood') would be significantly over-represented and specific to the melancholic subjects, both when compared to those with non-melancholic depression and those experiencing a bereavement. Conversely, if 'distinct quality' is validly defined by the DSM-IV descriptor, then those so assigned should score higher on any identified 'distinct quality' factor. Our findings in relation to each of those postulates will be considered.

First, comparisons of melancholic and non-melancholic depressives. In Study A, we did find some evidence of differentiation and specificity, in that the DSM-IV-defined MELs did score significantly higher (34%) than the NON-MELs on the 'numbness' scale, in the absence of any significant differentiation across the 'mood', 'fatigue' and 'guilt' scales, and with such findings confirmed in the logistic regression analyses. Replication was not achieved when: (i) the MDU-defined EDs, and (ii) a composite sample of those meeting MEL and ED status were contrasted with remaining subjects, although similar trends were evident.

Secondly, comparisons involving the presence or absence of 'distinct quality' after noting a caveat – that our study might have benefited from assessing levels of agreement between raters in assessing 'distinct quality'. Those meeting the DSM-IV 'distinct quality' criterion did not differentiate on 'numbness' scale scores, and scored higher on the 'mood' scale only, which suggests that they differed more by greater dysphoria than by having any distinct mood quality (such as numbness).

While inconclusive, and restricted to the 'bottom up' analyses rather than the latter 'top down' analyses, our analyses suggest that a dimension of 'numbness' may be somewhat over-represented in melancholia, but its specificity (at least as measured here) is not impressive when both melancholic and non-melancholic depressive returned substantive scores on that dimension. While this could reflect a limited capacity for variable subtyping

measures to diagnose 'melancholia' validly, it is unlikely to be a robust explanation when our two measures of melancholia showed considerable agreement.

It is easy to find support for the proposition that a 'numbness' dimension (here underpinned by the experience of feeling numb, frozen, heavy, paralysed and colourless) might define 'distinct quality'. Leonhard (1979) held that the cardinal feature of melancholia was not retardation as argued by Kraepelin (1921), or 'corporization' as proposed by Schneider (1920), but 'apathetic indifference'. Healy (1993) reported results from another adjective checklist study (designed to define 'depressive dysphoria'), and noted that words such as 'dispirited, sluggish, empty, and washed out' suggested 'a somewhat different state from the normal experience of sadness'. Again, the personal report of Styron (1989) is useful: 'I had begun to respond indifferently to the island's pleasures. I felt a kind of numbness, an enervation (p. 215)...the slowed-down responses, near paralysis, psychic energy throttled back close to zero (p. 278)...I would lie as long as six hours, stuporous and virtually paralyzed (p. 280)'. The construct of 'numbness' certainly has some superficial similarity to 'loss of vitality'. The limitation to any such argument, however, is that it would be possible to find similar support for many other experiential constructs – including the other three identified in our analyses.

Next, we consider a second component of the DSM-IV definition – that the mood state should be 'experienced as distinctly different from the kind of feeling experienced after the death of a loved one'. We need to note a study caveat. There are clearly multiple stages of grief, with Parkes (1973) identifying alarm, numbness, pining, depression and recovery. Each stage might generate variable contrasting findings with a depressed group, and our bereaved sample with a mean process duration of 9 months, were clearly unlikely to be in any immediate post-bereavement phase. While our melancholic depressed subjects (whether MELs or EDs) did score significantly higher than the bereaved on three of the four scales and on approximately half of the contributing items, the high rate of significant differences allows a general conclusion – that there was a distinct lack of specificity. On reflection, this should not be

surprising. Parkes (1973) has argued that bereavement is more a state of separation anxiety rather than a depressive condition. If valid, we would not expect bereaved subjects to affirm depressive cognitions. Additionally, in order to examine the DSM-IV proposition, we excluded bereaved subjects with significant depression scores on the BDI, and the mean BDI scores for our bereaved subjects were clearly less than the mean scores for our MDU depressed sample (i.e. 13.1 v. 29.2). Thus, we suggest a parsimonious explanation for our several findings – that the bereaved subjects were merely less depressed or less likely to be depressed, so contributing to the different scale scores for the ‘melancholic’ and the bereaved. And yet, there was a paradox. The bereaved as well as all the variably defined ‘melancholic’ and ‘non-melancholic’ groups in Study A returned similar scores on the ‘numbness’ scale – the one suggested in Study A as possibly defining ‘distinct quality’, and thus the one where the greatest differences would be anticipated if the DSM-IV definition of ‘distinct quality’ has validity in relation to the second component.

While we have confirmed that the mood state in melancholia is different from that in bereavement, such a finding is pseudo-profound, in that the distinction does not appear specific to the melancholic type of depression. It appears more to reflect a simple reality that depression and bereavement are distinctly differing processes, and that the principal differences between the two states are driven by the greater dysphoria inherent to depressive disorders.

The DSM-IV definition could be explored using a converse strategy of first administering a mood state checklist to bereaved subjects and determining the underlying dimensions. There are, however, intrinsic limitations to any such approach. For example, which bereavement phase should then be appropriately compared to the experience of melancholia, when each phase might variably approximate to or differ from the mood state of melancholia?

If there is ‘distinct quality’ to the depressed mood of the melancholic, and if it relates to a construct of ‘numbness’, what might this mean? While the concept of ‘vital depression’ is, like ‘distinct quality’, variably defined, its weighting to a melancholic depressive subtype is long evident in theorizing and research work. Kupfer

& Frank (1984) used ‘vital depression’ as a synonym for melancholia in their paper. Maes *et al.* (1992) identified a ‘vital depression’ cluster characterized by psychomotor disturbance, anergia, cognitive distortions, distinct quality, early morning wakening and non-reactive mood (which they called the ‘vital symptoms’), and demonstrated associations with greater severity and older age, as well as stronger evidence of biological disturbance.

Our findings generate two important conclusions. First, that it may be extremely difficult to refine an experiential measure of ‘distinct quality’, as well as shaping one possessing sufficient specificity to allow diagnostic subtyping of the major depressive disorders at the practical level. It may be that our negative results reflect failure to capture ‘distinct quality’ within our adjective checklist, making our final scale inadequate for the task. If, as put in DSM-III and DSM-IV, it is a qualitative mood state, we believe that it is unlikely that we would not have captured it within our comprehensive set of items. If, however, it is a somatic feature (as originally conceptualized) then our adjective checklist would clearly have failed to identify it – while the DSM definition would also be challenged. Future research should then range far beyond the DSM definitions if this currently ineffable concept is sufficiently distinct to allow definition. Secondly, our findings suggest that there are clear limitations to the continued use of ‘distinct quality’ as a criterion measure of any endogenous or melancholic subtype (as incorporated by the Newcastle Index and DSM-IV respectively). On theoretical grounds we have concerns about its current DSM-IV definition – in that no positive defining characteristics are provided, and we are informed only that ‘distinct quality’ differs from the mood state experienced during bereavement. While the mood state in bereavement must differ cross-sectionally to the mood of melancholia in different ways at different stages, to the extent that it differs merely as a consequence of any depression being less severe or having a lower prevalence in the bereaved group, then the resulting contrived ‘distinctness’ has no real meaning. A diagnosis of ‘melancholia’ has important clinical implications, in suggesting (Rush & Weissenburger, 1994) the greater utility of physical treatments, such as antidepressant drugs and ECT, in



addition to any research implications. For DSM-IV melancholia assignment, only a small number of criteria are required in addition to the base of major depressive disorder. If any criterion is invalid or resistive to definition, false positive assignment to the melancholic class is a risk.

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