DMR*Dynamics* David M. Reiss, M.D.

Psychiatry

Adult Psychiatry
Borderline Disorders
Medical-Legal Evaluations
Qualified Medical Examiner
Agreed Medical Evaluations

With Offices in ***California*** *in:*
San Diego, Fresno, Oxnard, Huntington Beach, Palm Springs, San Clemente, Bakersfield
Licensed in: ***California, New York, Massachusetts, Vermont, Connecticut, Pennsylvania, WV and ND***

Direct Phone: 262.477.9242
(262 4PSYCH2)
San Diego Office:
619.280.3422
Fax: 619.280.3406

DMREISS@GMAIL.COM

www.DMRDynamics.com

Mailing Address:
P.O. Box 9684
Rancho Santa Fe, CA
92067-4684

Street Delivery Address:
12707 High Bluff Drive, #200
San Diego, CA 92130

Interim Medical Director
Providence Behavioral Health Hospital
Holyoke, MA (11/01/2011 – 02/29/2012)

Staff Psychiatrist, Rotating
The Brattleboro Retreat
Brattleboro, VT (3/2014 – 12/2014)

)

SEASONAL AFFECTIVE DISORDER

What is S.A.D.? What causes it?

All depression and affective or "mood" disorders are multi-determined, having many causes and contributory factors. Even the most "biologically" based affective disorders, such as classical Bi-Polar "manic-depressive disorder" can be impacted by psychological factors and issues and situational events and stressors; even clearly situational emotional reactions are "colored" by underlying biology, personality characteristics, etc.

Current theory holds that S.A.D. probably is a separate "disorder." This does not mean that the symptoms are any different from depression arising from any other causes, but that the *cause* of the depression is specific. There are no laboratory tests or other "markers" for S.A.D., other than that S.A.D. tends to respond to light therapy (exposure to artificial sunlight) whereas other forms of depression do not. The diagnosis is made simply upon the pattern of occurrences of depressive episodes and the absence of clear indications of other types of depression (such as bipolar disorder or psychotic depression).

In my personal clinical practice, I have seen many people who have more mood fluctuations in the winter, but I cannot say I recall a single patient who had no mood symptoms at other times but only on a seasonal basis. Essentially with all the persons I have treated it appears that the season, weather, etc. has an impact (sometime significant, sometimes minor) on underlying affective vulnerabilities rather than having a "stand alone" S.A.D. However, that is not a controlled study and that may reflect the nature of my practice and my referral base. In either event, whether seen as a "stand alone" disorder or a subtype of depression, treatment is empirical (based upon symptoms, with use of light therapy along with whatever other typical treatments for depression are necessary), and the question of whether S.A.D. is a separate disorder or

one of many factors that contribute to depression is more an issue of semantics than substance.

Even taking a "cynical" view that S.A.D. is not a stand-alone disorder, there are many reasons, both psychological and physiological/biochemical why certain persons may be more prone to mood fluctuations in different seasons (typically, the winter). Psychological reasons pertain to changes general levels of activity, opportunity for vacation, relaxation, recreation, interpersonal interactions, etc. - as well as personal issues such as experiences of or memories of "happy care-free summers" versus "school work."

Physiologically, the availability of exercise may be a factor for some people and the current thinking is that S.A.D. is most directly related to exposure to sunlight – which is why light therapy is used. Sunlight impacts diurnal (daily) rhythms of production of multiple hormonal and other chemical within the body, through the retina's connection to the pineal gland. Absorption of sunlight by the skin directly stimulates the manufacture of melanin and D vitamins by the skin, perhaps most importantly, D3. There are strong correlations between low vitamin D3 levels and depression (see the below article) but what is not yet clear is how many non-depressed people may also have low vitamin D3 levels. There is controversy regarding how much supplement and what form of supplement is best. Some persons appear to respond to supplemental Vitamin D with improved mood, others do not.

There is dome data that indicates that supplementing D3 is not as effective in S.A.D. patients as light therapy or anti-depressants. This implies that most likely, the issue is much more complicated than just one factor – probably involving multiple vitamin/hormonal factors as well as activity / diurnal cycle factors and psychological factors.

What are the symptoms?

Depression caused by S.A.D. is no different from depression that arises from any other cause. S.A.D. only describes the triggering mechanism for the depression; it does not imply any specific symptomatology. There can be any of the symptoms related to anxiety and depression - nervousness, sadness, moodiness, irritability, lack of energy, insomnia or hypersomnia, change in appetite, difficulty concentrating or focusing, social withdrawal, loss of motivation, loss of libido (sexual drive) - and in severe cases, despair, desperation or even suicidal ideation.

How could S.A.D. affect performance?

Again, the depression caused by S.A.D. is no different in character or symptomatology

from any other depression, and may vary from minor moodiness, of little consequence, to severe disruption of functioning. An person who is depressed may have difficulties staying motivated to perform, practice or complete/perform; difficulties with concentrate or memory; a lack of energy preventing optimal performance; irritability that can compromise teamwork; poor judgment that may affect diet, other habits, impulsive behaviors, inaccurate estimates of one's own performance in either direction ("I've done enough, I don't need to do more" vs. excessive self-criticism, which in a vicious cycle increases depression and decreases motivation), etc.

Do you think active people are more or less prone to S.A.D.?

How levels of activity impact the vulnerability to S.A.D. may be different depending upon the type of activity. Theoretically, someone is more active outdoors, getting more sunlight – even in the winter – may be less prone to S.A.D. Indoor activity, through the general anti-depressant effects of exercise and interpersonal connection, should help decrease depression, but would not provide the direct exposure to light that is most likely responsible for S.A.D. People who tend to decrease their level of activity during the winter – or change their diet, exercise routine, etc. – are going to be more vulnerable to emotional changes, whether it is diagnosed as S.A.D. or not.

From a psychological perspective, beyond the effect of light or the physiological effect of exercise, a person who enjoys activity and feels deprived, bored and/or lonely during winter months is going to be more prone to moodiness or depression. That may take the same form as S.A.D. – a pattern of depression related to weather; although theoretically, that may not qualify as S.A.D. if one uses the strict biochemical criteria of depression caused by lack of exposure to light. Since there is no "test" other than D3 levels – which is not of itself diagnostic; either chemical or psychological causes may contribute to the pattern of mood changes generally described as S.A.D..

Thus, while from a physiological point of view active people may be less prone to S.A.D. due to increased activity, sunlight exposure, etc. – they may be more prone to S.A.D. if their routine activity level drops in the winter. In any given individual, either factor may be stronger.

What factors in a person's life do you think contribute to S.A.D.? (Personality, home life, diet, etc.)

Any and all factors that vary with season may contribute to S.A.D., since S.A.D. is only an observation of a pattern of depressive episodes. If one's personality traits leads one to enjoy cold weather, or being indoors, having more family contact and less contact with friends – they may feel better in the winter. If personality traits lead a person to enjoy being outdoors, having more social activities available, being less restricted by

weather, that person would be more like to develop a pattern of moodiness that could contribute to or mimic S.A.D.. If family activities/home life is affected by the season (amounts of time spent at home, vacations, other family activities or interactions) that may have an impact in playing into this pattern. Diet may impact mood at any time of year, and if diet generally changes during the winter, that will be a factor. Perhaps most significant would be lack of vitamin D3 taken in via food or supplement when there is less exposure to sunlight. However, other dietary changes can affect mood, energy level, concentration (use of sugar, "energy drinks", fast food, etc.) may all play some role, different in each individual depending upon their unique body chemistry – as well as psychologically, their enjoyment of different seasonal foods. Of course, another psychological factor is the occurrence of the major winter holidays. For some persons, this is a very happy time of year, with activating, connection with friends and family, etc.; for other people, the holidays bring up negative family issues, issues of loss, general stress of "required" activities and interactions.

How is someone dealing with S.A.D. perceived by others?

Again, this is no different from the change in interpersonal interactions and perceptions that will impact any person with depression, regardless of the cause of the depression. If a person becomes less motivated, less energetic, more irritable, forgetful, overly critical of self and/or others – it can negatively impact both personal performance and performance in a group/team effort.

How is S.A.D. distinguishable from depression?

S.A.D. is diagnosed only by the pattern of occurrence of depression. The symptomatology itself is not different or distinguishable from depression arising from any other cause (other than a classical bipolar/manic presentation or depression arising from an underlying schizophrenia or psychotic illness).

How do you suggest our readers reach out for help?

Education, de-stigmatization, and availability of support are key, as well as encouragement from concerned and/or knowledgeable peers. Not all moodiness is depression or needs treatment. Over-diagnosis and over-treatment can be as dangerous and damaging to self-esteem as under-diagnosis. The key is having the self-awareness and/or turning to someone whom you trust to monitor your moods and your level of functioning; and if the problem is disruptive, to seek advice from a professional to determine if formal mental health treatment of some type is indicated. . This is not as easy as it sounds. On one extreme, there can be denial (by self and friends) that leads to problematic under-treatment (not getting any help); on the other

side, a person may consciously or unconsciously seek an "excuse" or "externalize blame" for problematic performance or behavior by jumping to a diagnosis. It is very important to have supportive contacts who will not stigmatize you for seeing a professional to "check out" whether there or not there is a clinically significant problem.

How many concurrent symptoms would result in the diagnosis of S.A.D.? Meaning, if someone is feeling a little down, you probably would not call it S.A.D., but if they have x, y and z simultaneously and there are additional factors, you might. This also goes along with the next question: When should someone be concerned about himself or herself, or about someone else?

There is really no definitive answer as to the number of symptoms or a specific combination of symptoms. For research purposes, sometimes "checklists" or "menus" of symptoms are used, but practically, they can be misleading. The key factor in determining if there is problem is disruption of normal and safe functioning. Everyone has changes in mood, good days and bad days. If there are persistent changes in mood, concentration, irritability and/or motivation that impact functioning at a normal level (not that one should expect exactly the same level of functioning every day, but a normal pattern of mild ups and downs), there is reason to seek consultation. Of course, any development of dangerous behaviors – use of drugs or alcohol; impulsive risk-taking behaviors, sexually or otherwise; violent or self-destructive feelings – then professional intervention is definitely needed. Only a full and comprehensive evaluation can definitively distinguish between normal mood fluctuations, S.A.D. and other mental health issues or illnesses.

How is S.A.D. treated?

Other than for the use of light therapy (which requires specific types of light, best used at specific types of day), the treatment of S.A.D. is no different from the treatment of anxiety or depression from any other cause (counseling, psychotherapy, use of anti-depressant medication if necessary). As to self-treatment for mild mood fluctuations – get enough exercise and sleep; keep a good diet; don't isolate; and if you're not feeling "yourself" and restoring a normal routine/diet doesn't help, seek professional advice.

How can one prevent S.A.D.?
Are there certain foods, vitamins, activities, etc. that can help prevent S.A.D.?
Are there certain foods, vitamins, activities, etc. that should be avoided?

The answers here are really no different than for general well-being – eat well, sleep well, get exercise, be active, maintain healthy relationships, avoid fast-foods, avoid "energy drinks", of course avoid illicit drugs or overuse of alcohol (and if you start feeling

depressed, avoid any alcohol use, since alcohol is a chemical depressant and even small “normal” amounts can aggravate depression that is already present, or trigger depression in susceptible individuals). Over-attention or obsessional concern about S.A.D. can in itself be counterproductive, a “self-fulfilling” hypochondria in response to normal mood fluctuations. If you are experiencing specific concerns, get an evaluation so that you can put your mind at ease or obtain treatment if necessary.

Again, if any vitamin or supplement is specific, it is D3. There is not yet a good overall consensus among experts as to what is the “best” type and dosage of supplementation – consult a trusted doctor or nutritionist. Be aware that over-use of vitamins and supplements can cause toxicity – don’t “take everything” or follow every suggestion you hear; rely upon knowledgeable advice, with the understanding that even experts do not have one definitive answer.

If you experience S.A.D. one year, does it mean you're prone to experience it every year after that?

By definition, S.A.D. is only diagnosed if there is a recurrent pattern, not just becoming somewhat depressed one winter. If there is a pattern, then one should take appropriate steps to anticipate it will probably continue if not treated. However, experiencing some mild moodiness during winter – even over a couple of winters; and especially for adolescents when being in school vs. being on vacation is a significant issue – does not indicate that you have S.A.D. or should expect the pattern to continue (professional evaluation can help to make that determination).

How can one help/support a peer who has S.A.D.?

No differently than I would suggest regarding helping any person with depression: Be supportive, honest, do not stigmatize, take action if there is evidence of danger or disruptive functioning that the person is ignoring; do not “play psychiatrist” – if you have concerns, discuss it with the person in a calm, non-accusatory manner and support them in seeking an appropriate evaluation.

Is there anything important you'd like to add about S.A.D.?

Actually, my best advice would be not to worry – or even think about – S.A.D. *specifically*. Doing so can run the risk of “talking yourself into” a problem. What is important is to honestly keep track of your functioning – mood, activity, motivation, energy, sleep, appetite, relationships – and if you or your friends detect a disruption, seek appropriate help, and let a professional decide on what diagnosis or treatment is appropriate.

J Psychopharmacol. 2010 Sep 7. [Epub ahead of print]

Lower vitamin D levels are associated with depression among community-dwelling European men.

Lee DM, Tajar A, O'Neill TW, O'Connor DB, Bartfai G, Boonen S, Bouillon R, Casanueva FF, Finn JD, Forti G, Giwercman A, Han TS, Huhtaniemi IT, Kula K, Lean ME, Punab M, Silman AJ, Vanderschueren D, Wu FC, Pendleton N.

Arthritis Research UK Epidemiology Unit, University of Manchester, UK.

Abstract

Low serum 25-hydroxyvitamin D (25(OH)D) and elevated parathyroid hormone (PTH) levels have been linked with depressive symptoms among adults in various clinical settings. Data in generally healthy, community-dwelling individuals remain inconclusive.