TAKE-HOME NOTES:

# Seasonal affective disorder (SAD): Part 1 – history, epidemiology, aetiology and diagnosis

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The idea that our mood fluctuates with the seasons has been around for many centuries. However it was not until the 1980s when Rosenthal and colleagues performed a series of bright light therapy trials and coined the term 'seasonal affective disorder' (SAD) that a new interest in the condition was generated.

**Symptomatology**

Symptoms of winter depression begin during the autumn/winter seasons. There is a cluster of '***atypical depressive symptoms***' that are characteristic of the condition and are as follows:

- increased sleep, with associated daytime somnolence
- increased appetite; in particular carbohydrate and chocolate cravings
- weight gain.

As well as the above atypical symptoms, many of the symptoms characteristically seen in non-seasonal depression can occur, e.g. loss of interest in normal activities, decreased energy, decreased motivation, impaired concentration and irritability. Indeed the most common and obvious differential diagnosis is non-seasonal depression and this distinction is important, particularly when considering whether to advise light therapy treatment.

Symptoms typically resolve during the spring/summer. Moreover, many sufferers will experience some degree of symptoms of elevated mood in the summer time and as many as one third will develop hypomania (although full blown mania is rare).

**Diagnosing SAD**

The diagnosis is made primarily on clinical grounds and SAD should be considered in all people with recurrent affective disorders. In addition to a full history, there are several questionnaires that have been designed to aid diagnosis. The Seasonal Pattern Assessment Questionnaire (SPAQ) is brief and is the most widely used.

**Epidemiology**

The severity of SAD lies on a spectrum. Any cut-off between 'normal' seasonal changes and bona fide SAD can be deemed arbitrary. However, two large community prevalence studies in the UK estimated 3.5% (in Aberdeen) and 2.4% (in North Wales) of adults to be affected to a level of clear clinical significance.

SAD is most common in females of reproductive age. It is relatively rare in children. In the older adult population the ratio between males and females tends to equalise.

Recent evidence has shown that it is not simply the higher the latitude the higher the prevalence of SAD as was first thought. Rather, it may be more geographically mobile populations moving away from the equator that are at higher risk. Furthermore, geographically stable populations at high latitude are likely to be resistant to SAD (e.g. Icelanders).

**Reflection**

(2.1) Do you think that people suffering from the symptoms of SAD at temperate latitudes are in the minority or majority compared with the general population? What would you estimate to be the prevalence of SAD in Scotland and Wales?

(2.2) What kind of difference in the prevalence of SAD might you expect between a) different age groups and b) men and women?

(2.9) Which symptoms do you think might indicate a relationship between SAD and phase shifts?

(3.5) Can you think of any symptoms of non-seasonal depression that might be shared by sufferers of SAD?

(3.9) Thinking back over this section, try to list the main hallmarks of SAD.

### Tables and figures

(2.3) Epidemiology: age and gender

(3.12) DSM-IV classification

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