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LIGHT

RESEARCH ARCHIVES

Canadian Consensus Guidelines for the Treatment of Seasonal Affective Disorder

Excerpts Regarding Bipolar Disorders

Canadian Consensus Guidelines for the Treatment of Seasonal Affective Disorder:

(Excerpts regarding bipolar disorders)

Diagnosis and Epidemiology

How is a "seasonal pattern" of depression defined?
Seasonal affective disorder (SAD), first described in 1984, is also referred to as seasonal depression, winter depression or major depression with a seasonal pattern. Each of these terms refers to a subtype of major depressive disorder. SAD is characterized by the following four central features:

Recurrent major depressive episodes that start around the same time each year (e.g., September-October) and end around the same time each year (e.g., March-April).

Full remission of symptoms during the unaffected period of the year (e.g., May-August).

Over the lifetime course of the illness there are relatively more seasonal depressive episodes than non-seasonal episodes.

Seasonal depressive episodes occur in at least 2 consecutive years.

The DSM IV criteria for SAD are shown below. There is some argument about the definition for "the same time each year", but most investigators and clinicians allow for a 60-90 day "window" for the timing episode onset and timing of remission. In general, the patient should have an "absence of symptoms" for at least two months to be considered in remission from the seasonal episode. The most common type of SAD is winter depression. "Summer" SAD is uncommon in northern latitudes and much less is known about it.

DSM IV Criteria for "Seasonal Pattern" Specifier (SAD)
With Seasonal Pattern can be applied to the pattern of Major Depressive Episodes in Bipolar I Disorder, Bipolar II Disorder, or Major Depressive Disorder, Recurrent.

There has been a regular temporal relationship between the onset of major depressive episodes in bipolar I or bipolar II disorder or major depressive disorder, recurrent, and a particular time of the year (e.g, regular appearance of the major depressive episode in the fall or winter). Note: Do not include cases in which there is an obvious effect of seasonal related psychosocial stressors (e.g., regularly being unemployed every winter).

Full remissions (or a change from depression to mania or hypomania) also occur at a characteristic time of the year (e.g., depression disappears in the spring).

In the last 2 years, two major depressive episodes have occurred that demonstrate the temporal seasonal relationships defined in Criteria A and B, and no nonseasonal major depressive episodes have occurred during that same period.

Seasonal major depressive episodes (as described above) substantially outnumber the non-seasonal major depressive episodes that may have occurred over the individual's lifetime.

Summary Diagnostic Criteria For Seasonal Affective Disorder
Recurrent major depressive episodes that start around the same time each year (e.g., September-October) and end around the same time each year (e.g., March-April)

Full remission of symptoms during the unaffected period of the year (e.g., May-August)

Over the lifetime course of the illness, there are relatively more seasonal depressive episodes than non-seasonal episodes

Seasonal depressive episodes occur in at least 2 consecutive years

What are the symptoms of depression in SAD?

SAD patients have the usual symptoms of depression, including low mood, reduced interest, decreased concentration, low energy and fatigue. SAD patients also tend to have a specific symptom cluster consisting of the so-called "reverse" or "atypical" vegetative symptoms of depression. These symptoms include increased sleep (70-90% of SAD patients), increased appetite (70-80% of SAD patients), unacceptable weight gain (70-80% and carbohydrate/sweets craving (80-90%).

Do SAD patients frequently have bipolar illnesses?

The majority of patients with SAD have unipolar depression, but as many as 20% may have or go on to develop a bipolar course. Typically the manic or hypomanic episodes occur in the spring and summer, and these must be carefully distinguished from the improved mood that is associated with recovery from the winter depression. There are important treatment differences for patients with bipolar as compared with unipolar illness.

Are there other diagnoses to consider in a patient presenting with winter difficulties?

Many people will complain of seasonal difficulties, but clinicians need to consider a variety of conditions in the differential diagnosis of SAD. Seasonally recurrent psychosocial stressors (e.g., fall/winter unemployment, anniversary grief reactions during the fall-winter) may produce some of the symptoms of depression. Some people experience marked changes in sleep, appetite, weight and energy during the winter but do not meet criteria for a major depressive episode - such patients are generally considered to have "subsyndromal" SAD. Preliminary studies suggest that such patients may also have a good response to light therapy. Finally, a number of reports indicate that conditions other than major mood disorders may be subject to significant seasonal influences. These conditions include eating disorders, premenstrual syndromes and anxiety disorders (panic disorder, obsessive-compulsive disorder).

What is the prevalence of SAD?

There have been more than 15 studies that have examined the prevalence of SAD in various population groups. Community-based surveys in North America have reported the prevalence of SAD between 0.8% and 9.7%. European community-based studies have estimated the prevalence of SAD between 1.3% and 3% of the population and studies in Asia report rates of 0 to 0.9%. The discrepancy in these findings may be attributed to a variety of methodologic differences between the studies. However, the most important factor that appears to account for the relatively wide range of prevalence estimates is the diagnostic instrument that was employed in each study. Most studies use the SPAQ (see section on diagnosis), which tends to over-estimate the prevalence. Studies that have used a more accurate structured diagnostic interview and standard diagnostic criteria suggest that the prevalence of SAD in Canada is between 2% to 3%, and that the rate in the US is less than 1%. By comparison, bipolar disorder or manic depression occurs in just over 1% of the population.