

How to battle the blues



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Dr. Mark Walter jots down a few notes in his office at Sheridan Psychiatry on Thursday afternoon. Walter offers solutions to Sheridan-area residents suffering from Seasonal Affective Disorder, a seasonal pattern to depressive episodes, during the dark winter months.

• Exercise, light therapy may be helpful in treating SAD

It is at this time of year, during the uncomfortable transition to winter, that I am often asked about the phenomenon of Seasonal Affective Disorder (SAD). Like many things in medicine, authors on the subject tend to prefer a show of words to describe a relatively simple concept. Fortunately, the corresponding acronym SAD is both simple and easy to remember. Discussion about SAD has been ongoing since it was first described in the mid 1980s; although the concept has stuck around, there has been no consensus about whether SAD represents a distinct mood disorder diagnosis. In fact, Seasonal Affective Disorder is not listed as a diagnosable “illness” in the DSM-IV-TR, the most current edition of the diagnostic manual used in psychiatry; instead, the idea of a seasonally-influenced depression is described as being “with seasonal pattern.”



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So what is it?

The acronym SAD proposes to describe a seasonal pattern to depressive episodes, with fairly predictable mood deterioration at one point in the year and a fairly predictable mood improvement at another time in the year. In most cases, this would involve onset of depression in the winter months and alleviation of depression in the spring. It is important to point out that the formal definition of SAD does not allow for depressive episodes which do not follow seasonal patterns. In reality, depression is not so well behaved, and many people who experience seasonal major depression also experience non-seasonal major depression.

For the practical purpose of treating real depression in real people, I believe that it is simply enough to identify a seasonally-influenced depression and to treat it accordingly. Although the topic of light therapy inevitably arises in discussions of seasonal depression, it is not the primary treatment for any major depressive episode. Medication and psychotherapy do not lose their place as the principal treatments for major depression, just because a depression follows a seasonal pattern. Light therapy, however, can be a helpful add-on treatment for seasonal depression.

How do you treat it?

The treatment approach to winter depression depends upon the nature of the mood problem and its severity. Winter doldrums or blues, episodes of dysphoric or “blue” mood which are brief (lasting only a few days) and not accompanied by major depression indicators such as suicidal thinking or inability to carry out one’s duties, may not require a specific treatment. It may also be appropriate to address doldrums with exercise or with light therapy. For more severe mood disturbances, however, light therapy should not be used as a standalone treatment; in those cases, medication and/or psychotherapy should be the first treatment options considered. The specific medication treatment depends upon the nature of the mood problem, other medical conditions that may be present, and

the medication history.

What about the light?

While most studies have demonstrated the benefit of short-term light therapy in treating seasonal depression, other studies have suggested long-term light therapy benefit in both seasonal and non-seasonal depression. In most cases, light therapy is freely recommendable as an add-on treatment approach; however, in a few conditions, it is generally not recommended. These conditions which recommend against the use of light therapy include: 1) phototoxicity (e.g., in retinal disease), 2) a history of bipolar disorder, 3) skin conditions which make a person susceptible to light (e.g., lupus) and 4) use of medications which sensitize a person to light.

A newer, 10,000 lux light box with a UV filter is recommended at an exposure of 30 minutes each morning (the earlier, the better) for at least 2-4 days, for a sustained response.

The antidepressant effect is mediated by white light – not ultraviolet light – reaching the eyes; however, it is not required or recommended that a person stare at the light screen. The antidepressant effect is not carried out through the skin. There is also no observed antidepressant response to the ultraviolet light of tanning beds, which can damage both the skin and the eyes. There is also reason to believe that larger light boxes (studies have used light boxes that were a minimum of 12 inches by 18 inches in area) are preferable over miniature light boxes in antidepressant effect. White light has been shown to be superior to blue, green and red light, while there is no demonstrable advantage in “full-spectrum” bulbs over fluorescent bulbs. At least one study has looked for clinical predictors of favorable response to light therapy; of those investigated, hypersomnia (excessive sleeping) was revealed to be a particularly strong indicator.

So what should I do?

The decision to purchase a light box is governed by cost, convenience and by the severity of mood symptoms. At no time should light box therapy be considered a standalone treatment for severe depression. If you have experienced depression complicated by high severity, suicidal thinking, recurrence or failed response to medications, then a professional assessment to evaluate for multiple causes of mood disturbance should be undertaken.

Simple, winter doldrums can be fended off with light therapy, but also with physical exercise and outdoor activities. If, however, your doldrums endure for more than a few days or are accompanied by social isolation, failing work or school performance, or absenteeism, then consider the possibility of a more severe mood problem and talk with your doctor.

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