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Lack of association between seasonality and psychopathology in psychiatric outpatients

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Abstract

There exists an extensive literature documenting the impact of seasonality on rates of depression, atypical depression, bulimia, and suicide. In the present report drawn from the Rhode Island Methods to Improve Diagnostic Assessment and Services (MIDAS) project, we reviewed the results of 1500 diagnostic evaluations of patients who presented to our psychiatric outpatient practice between 1995 and 2001. We sought to determine whether seasonal fluctuations in psychopathology were discernible at the level of how patients present for psychiatric treatment. Contrary to our hypotheses, we did not find (1) higher rates of onset of major depressive disorder in the spring and fall, (2) higher rates of depressive symptoms or rates of atypical depression in the winter, (3) higher rates of bulimia in the winter, or (4) higher rates of suicidal ideation in the spring. We conclude from these results that the association between seasonality and psychopathology may not be discernible at the level of presentations to an outpatient psychiatric practice.

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1. Introduction

The relationship between psychopathology and seasonality has long been recognized (Jackson, 1986; Wehr and Rosenthal, 1989). In seasonal affective disorder (SAD), the cyclic recurrence of depressive episodes according to the seasons is the hallmark of the disorder. Prospective studies that have followed patients diagnosed with SAD at

baseline have confirmed that a significant percentage of such patients have a clear seasonal component to their illness (Leonhardt et al., 1994; Sakamoto et al., 1995; Schwartz et al., 1996). Fall and winter appear to be the most common seasons for SAD episodes to occur, though a minority of SAD patients experience their recurrences in the spring or summer (Boyce and Parker, 1988; Kasper et al., 1989; Rosen et al., 1990). Explanations for the increased depressive incidence in the fall and wintertime include a neurophysiological reaction to decreased light exposure, shorter and colder days leading to decreased outdoor activity and

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isolation, and a psychological response to the holiday season (Rosenthal et al., 1984).

Estimates of the prevalence of SAD in the community have ranged from 1.2–4.3%, with variations across latitude (Faedda et al., 1993; Kasper et al., 1989; Rosen et al., 1990). Among psychiatric outpatients, as many as 10% of all depressed patients and 16% of patients with a recurrent mood disorder may suffer from SAD (Thase, 1989; Faedda et al., 1993; Hardin et al., 1991; Kasper et al., 1989; Rosen et al., 1990).

Seasonal fluctuations are not unique to SAD. A large community survey found that depressed subjects who do not meet criteria for SAD nevertheless experience higher rates of symptomatology in the winter months (Kasper et al., 1989), a finding that has been replicated by others (Kasper and Kamo, 1990; Müller et al., 1991; Pande et al., 1992; Rosen et al., 1990). Not only are rates of depressive illness higher in these months, but the presentation appears to be distinct. Depressed patients in winter months more commonly present with increased appetite, hypersomnia and lethargy (Garvey et al., 1988; Hardin et al., 1991; Kasper et al., 1989; Rosenthal et al., 1984; Sakamoto et al., 1995; Thompson and Isaacs, 1988; Wirz-Justice et al., 1986)—symptoms that are all associated with the atypical features subtype. Mania may also demonstrate a seasonal pattern, with some studies (Symonds and Williams, 1976; Walter, 1977), but not others (Silverstone et al., 1995; Whitney et al., 1999), demonstrating a peak in summer months.

In addition to reports indicating that mood disorders fluctuate during the course of the year, there is evidence suggesting that the prevalence of bulimia is higher in the wintertime as well (Blouin et al., 1992; Hardin et al., 1991; Lam et al., 1991; Lam and Goldner, 1998). It has also long been thought that rates of suicide peak in late spring and early summer, though two studies have not been able to confirm this (Parker and Walter, 1982; Zung and Green, 1973). We are not aware of any reports that have suggested that anxiety disorders fluctuate throughout the course of the year, and one study examining rates of admissions to a psychiatric hospital over the course of 6 years found no seasonal fluctuation in admissions for

non-affective illnesses (Eastwood and Stiasny, 1978).

While these reports provide strong evidence suggesting an association between seasonality and psychopathology, there are several caveats to this literature that should be noted. First, the method of recruitment in many studies was through advertisement or referrals for individuals with specific symptom profiles; these types of studies are susceptible to the ‘self-fulfilling prophecy’ bias. Second, the majority of these studies relied on retrospective reports. Third, studies that have found a seasonal component to psychiatric illness have not consistently replicated which months of the year or seasons patients are at greatest risk.

In the present study, we sought to determine whether seasonal fluctuations in psychopathology were discernible at the level of an outpatient psychiatric practice. That is, can clinicians expect to see differences in rates of psychopathology depending on what month of the year it is? To examine this question, we reviewed the diagnostic evaluations of 1500 consecutive patients who presented to our outpatient psychiatric practice during 1995–2001 and who participated in the Rhode Island Methods to Improve Diagnostic Assessment and Services (MIDAS) project. Although we did not assess SAD *per se*, if the symptomatology and prevalence rates of mood disorders, suicidality and bulimia fluctuate in a predictable manner through the course of the year, then we would expect that the types of patients presenting for treatment might reflect this. Thus, based upon the results of the 1500 diagnostic evaluations, we hypothesized that as a function of month of presentation (1) major depression would be a more common presentation in the winter (December through February), (2) the onset of the major depressive episodes for which patients present to our practice would be highest in the spring (March through May) and fall (September through November), (3) depressed patients presenting for treatment in the wintertime (December through February) as opposed to other times of the year would more commonly present with atypical features, (4) bulimia would more commonly present in the winter (December through February), and (5) rates of suicidal ideation would be highest in April and May.

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