
SLTBR NEWSLETTER

Society for Light Treatment and Biological Rhythms

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Alfred J. Lewy, M.D., Ph.D., *President*, Department of Psychiatry, Oregon Health Sciences University, Portland OR 97207. Tel 503-279-7746; MCI Mail 359-1279; Fax 503-279-5738 attn 7746. **Norman E. Rosenthal, M.D.,** *President-Elect*, Clinical Psychobiology Branch, National Institute of Mental Health, Building 10 / 4S-239, Bethesda MD 20892. Tel 301-496-2141; MCI Mail 359-4687; Fax 301-480-8348 attn. 496-2141. **Anna Wirz-Justice, Ph.D.,** *Vice President*, Psychiatrische Universitaetsklinik Basel, Wilhelm Klein-Strasse 27, 4025 Basel, Switzerland. Tel 4161-58-54-73; MCI Mail 316-0437; BITNET WIRZ@URZ.UNIBAS.CH; Fax 4161-58-52-58 attn 5473. **Michael Terman, Ph.D.,** *Secretary, Newsletter Editor*, New York State Psychiatric Institute, Box 50, 722 West 168th Street, New York NY 10032. Tel 212-960-5712; MCI Mail 308-7099; BITNET TERMAN@NYSPI; Fax 212-960-2584. **Carla J. Hellekson, M.D.,** *Treasurer*, Fairbanks Psychiatric and Neurologic Clinic, 1919 Lathrop, Drawer 30, Fairbanks AK 99701. Tel 907-452-1739; MCI Mail 320-9655; BITNET FFCJH@ALASKA; Fax 907-474-7204 attn Bus. Off. IAB.

ANNUAL MEETING SET FOR NIH/BETHESDA ON SUMMER SOLSTICE

SLTBR will meet for a day of research presentations and committee forums on 21 June 1989 at the National Institutes of Health, Bethesda MD. The morning session will feature members' research. The afternoon session will focus on SLTBR program development in such areas as Federal/Industrial Relations, DSM-IV Criteria, and Insurance Reimbursement.

Program Chair is *Dr. Daniel Kripke, Veterans Administration Medical Center V116A, 3350 La Jolla Village Drive, San Diego CA 92161. Tel 619-453-7500 ext 3436; Fax: 619-453-7500 ext 3531 attn 3436.* He solicits your abstracts (deadline: 22 April 1989), which will be reviewed by the Program Committee in early May, for quick feedback. In order to assemble the Abstract Booklet, please prepare your submissions in camera-ready format, following these guidelines: a) all text and figures must fit one 8.5 x 11" sheet with 1" margins; b) use elite type or larger; c) center title and author information at the top--title, authors, institution, mailing address.

Each member of SLTBR may submit one abstract, or co-author multiple abstracts for a total of one submission per member. (*See Call for Members, below.*)

Non-members may appear as junior authors. All topics of interest to SLTBR are welcome, but the emphasis must be on new data not previously presented elsewhere. For further details, see our next issue.

The meeting date is sandwiched between meetings of the International Society for Chronobiology and the Association of Professional Sleep Societies. SLTBR members may wish to make advance lodging arrangements through those groups.

SAD AND LIGHT THERAPY IN 1989

This overview of light therapy in SAD patients summarizes an enormous and enthusiastic research effort over the last five years, that was stimulated by the pioneering studies of Alfred Lewy and Norman Rosenthal. An initial consensus has been obtained at many centers around the world: a) certain *individual* depressive patients, independent of classic diagnostic categories such as unipolar or bipolar, endogenous or neurotic, show a *periodic, yearly* recurrence of their affective illness; b) in those patients whose depressive phase has occurred for *at least two consecutive years in autumn or winter*, light therapy is the treatment of choice; c) this

close linkage with autumn or winter is the *primary predictor* for clinical improvement with light; *d) atypical symptoms* of increased sleep need, carbohydrate craving and weight gain may accompany the depressive phase, but are not obligatory for diagnosis of SAD; *e) the prevalence* of SAD may range from 3-10% in temperate zones. However many people complain of SAD-like symptoms in winter, without having a major depressive disorder (ca 25%). Thus seasonality of mood, sleep and appetite can be considered a dimension ranging from the major affective disorder of SAD through the winter doldrums ("sub-syndromal SAD"); *f) the mechanisms* that underlie the therapeutic response to light are still unknown. Different groups have differences in their diagnostic criteria, patient sample, and light treatment results. The following summary of the present status of SAD and phototherapy research is a personal judgment of the available data.

CLINICAL EXPERIENCE WITH SAD

Patient population. Winter SAD patients have been predominantly women, mostly of middle age, but with onset of the illness in their twenties, with a major depressive disorder but not otherwise diagnostically specific. They are notable for a family history of depression (ca 60%), SAD (ca 15%), suicide (ca 15%) and alcoholism (ca 30%), and prior treatment with antidepressants (ca 50%), though few have been hospitalized. There have been no differences found between patient groups recruited via the media, via doctors' practices or via outpatient clinics. The DSM-III-R criteria are working criteria, and have not yet been validated. Of greatest importance appears to be the occurrence of at least two consecutive depressive phases at a similar time of year. Anamnestic data are required to establish whether the 60-day window is appropriate or too narrow. It is not known whether this strict 60-day window should be applied only to the onset of a depressive episode, to its cessation, or to both. Winter SAD patients are often, but not necessarily always, characterized by atypical symptoms of increased sleep need and morning fatigue, increased appetite, weight gain, and carbohydrate craving.

Newspaper questionnaires. Potkin was the first to publish a symptom checklist for SAD-like symptoms in a national newspaper (*USA Today*, March 1985). High seasonality scores were correlated with latitude and hours of sunshine, ranging from 1.0/1000 circulation (48°N) to 0.1/1000 (28°N). In Norway (Hjemmet, February 1986) twice as many persons had high seasonality scores above the Arctic circle (2.19/1000 circulation, >66.5°N) as below it (0.97/1000). In Switzerland (47°N; four main German-language newspapers, September 1984), an average response of 0.67/1000 circulation was

observed. In the Southern Hemisphere, 58% of those who completed a questionnaire in response to a journal article had seasonal problems: 20% of these were linked with winter and 20% linked with summer (Boyce, 1988). Since Australia has milder winters, longer photoperiods and the social factor of Christmas not associated with the shortest day, these descriptions support the ubiquity of seasonal phenomena.

Random sample studies of SAD-like symptoms. A Gallup Poll on seasonal symptoms in Norway (1986) indicated that 24% suffered in winter; Terman (1986) used the Seasonal Pattern Assessment Questionnaire (SPAQ, Rosenthal) in New York City and found 35% with winter symptoms without problems, 25% "winter complainers" and 2-3% with clinically relevant SAD symptoms. Additionally, he reanalyzed a random sample study in Manhattan screening normal populations for psychopathology (that used a non-seasonally oriented questionnaire, the Psychiatric Epidemiology Research Interview). This independently revealed that certain sub-scales related to SAD symptoms showed seasonal rhythms with a maximum in winter -- Sadness, Anxiety, Demoralization, and Poor Self-Esteem. Kasper (1987) also found a 27% incidence of problematic winter symptoms using the SPAQ in Montgomery County MD: he labelled these "subsyndromal SAD". The SPAQ has now been applied in New Hampshire, New York, Washington, and Florida (Rosen, 1988), with the expected cline in incidence of winter SAD-like symptoms of 26%, 24%, 22%, and 13.5%. Recently, Depue has developed and validated an "Inventory of Seasonal Variation" (1989) suitable for large-scale studies.

A recent editorial in a major psychiatric journal has strongly dismissed SAD as epidemiologically unfounded, clinically spurious, and based on circular argumentation (definition of the illness by the treatment; Eastwood and Peter, 1988). Although classical epidemiological studies of the incidence of depression often have a minor autumn peak in addition to the main peak in spring, they do not distinguish patients with regular seasonal periodicity from those without. An early study (1947, Basel) notes in this respect: "In particular, it is those patients with less severe, periodically recurring depressive phases who typically show a regular onset of depression coupled to time of year. . . ."

LIGHT THERAPY

Clinical trial design and criteria for improvement. Clinical trials of a new treatment demand certain standards to establish evidence of efficacy, such as a common definition of clinical response to avoid spurious or small fluctuations in clinical state atten-

attendant on situational factors or time course. A crossover design, though providing the clearest demonstration of response differential, is subject to order effects. Yet, as in drug trials, the problem of individual differences in sensitivity to a given dosage is otherwise difficult to address.

Bright light vs. placebo. The difficulty of an appropriate "blind" protocol for light therapy is legion. A number of ingenious "placebo" treatments have been based on the theoretical assumption that a certain intensity-duration threshold needs to be surpassed for light to affect the biological clock. Dim white, yellow, or red light; bright light at a distance; eyes vs. skin; an "environmental" placebo; hypnotic suggestion of bright light: all have induced some response and this has not always been significantly different from bright light. Expectation ratings, when registered before treatment, have been high, but similar for "theoretically active" and "placebo" treatments, which is important to note when bright light and placebo do show differential results. Since the initial finding by Lewy that bright light of at least 2500 lux is required to suppress human melatonin secretion, a number of studies have measured lower thresholds (ca 500-1000 lux), with individual differences in sensitivity as well as dependency on timing of the light pulse. Thus many light interventions considered "dim placebo" may indeed have been above the individual threshold.

Light Source. The original studies of light therapy all used full-spectrum Vita-Lite fluorescent lamps; Color-Gard (full-spectrum without UV), cool white fluorescent bulbs, and incandescent light sources appear equally effective.

Timing of light application. Although first studies began with extension of the photoperiod at dawn and dusk, a single pulse of light (that also extends the photoperiod, albeit asymmetrically) is similarly efficacious. A cross center comparison (Terman et al., 1989) has surveyed this crucial theoretical issue of timing in a large cohort that used 2 or more hours of bright light, with the following treatment results: morning alone = morning plus evening > evening alone = midday = brief light pulse > dim light. A number of individual studies with acceptable sample sizes do, however, find no difference between a.m., p.m., and/or midday light. In crossover designs, most patients respond to morning light, and the order effect appears to favor response with the second treatment (an argument against placebo). In some patients, maintenance doses have been reduced, suggesting that light does not induce tolerance.

Dose-response relationships. Most studies have used

light of 2500 lux with durations up to 6-8 hours per day. For light therapy to be a practical treatment, daily sessions need to be reduced to a minimal effective dose. We have found this to be one hour's duration. The dose relationship of clinical response in our SAD sample is shown in the table below:

N	Duration	Intensity	Remission Rate*
13	0.5 h	2500 lux	31%
39	1.0 h	2500 lux	50%
16	2.0 h	2500 lux	63%

A dose relationship with intensity exceeding 2500 lux has also been documented by Terman's group:

N	Duration	Intensity	Remission Rate*
15	0.5 h	3000 lux	40%
15	0.5 h	10000 lux	93%

*Pre- to posttreatment reduction of Hamilton depression score of at least 50%, to a level <8.

Note that there are individual differences in sensitivity to light, as ca 30-40% do respond to 0.5h light at 2500-3000 lux.

Onset of improvement, duration of treatment, and relapse rate. A rapid improvement which begins 2-4 days after commencing light therapy is common to all studies. Duration of treatment has been usually limited to a single week. This is not necessarily the optimum design: two or even three weeks may provide total remission rather than preliminary clinical response, and additionally may stabilize improvement. The question of relapse rate is important for long-term treatment strategies. It has not been systematically addressed. There are discrepancies between groups as to the number of light responders who relapse after the first week of withdrawal, which may be related to sample differences (predominantly bipolar vs. unipolar, for example). There are no long-term catamnestic studies of SAD patients after light therapy (e.g., modification of depressive phase in timing, intensity, duration).

Side effects. Phototherapy has no major side effects, apart from possible hypomania in bipolar patients. Initial nausea, headache, and irritability have been noted. Exhaustive ophthalmological tests before and after light of 2500 and 10,000 lux have revealed no pathology. Long-term light treatment effects on the retina, however, have not yet been studied. There is little information as to interaction with drugs: although it is not clear whether response is modified by tricyclics, lithium appears to retard it substantially, possibly through its action of

dampening light transmission in the retina (Remé et al., 1987).

Mechanisms. The "phase-shift" hypothesis of Lewy states that winter depression is due to an abnormal phase angle between their circadian rhythms and sleep. Most, but not all SAD patients appear to have a phase delay type of disturbance. If the human phase response curve resembles that of other mammals, morning light should advance, and evening light delay, circadian rhythms. This is the case for the melatonin rhythm. Although SAD patients preferentially respond to morning light, a therapeutic effect is also seen in the evening and even at midday ("photon-count" hypothesis of Rosenthal). Czeisler has shown that repeated light exposure suppresses circadian amplitude; in SAD patients, we have seen that diurnal variation of mood is abolished after light treatment. The concept of a "medial hypothalamic syndrome" relates known neurobiological mechanisms to seasonality and atypical symptoms in SAD, which are strongly coupled to depressive mood and improve with light and in summer (Kraeuchi and Wirz-Justice, 1988). Serotonin is a probable neurotransmitter candidate: d-fenfluramine improves depression and selectively reduces carbohydrate intake in SAD similarly to light (O'Rourke, 1988). Dopamine function has also been implicated in SAD in studies by Depue (1989), as reflected by low prolactin secretion and high blink rates.

Controversial issues. There are two controversial issues in this field, which have raised problems with credibility in the psychiatric community at large. First, the extraordinary publicity that has been attendant on this novel, non-pharmacological, "natural" therapy, can be misunderstood (and misused) as promotion of a facile treatment for a serious disorder. To combat false expectations on the side of patients and commercial misuse on the side of therapists and manufacturers is one of the reasons why SLTBR was founded. Second, the more groups that have applied light therapy, the more difficult it has become to disentangle hypotheses from pragmatic advice. Although we in the field do not agree with each other (at the moment) as to mechanisms of action of light, we share a common acceptance of light as therapeutic. This conflict needs to be explicitly recognised in our public discussions. What do we know of the precise mechanism of action of antidepressants and lithium, after 20 years' research? Yet what psychiatrist does not judiciously use these drugs in clinical practice?

Conclusion. In the critic's own words in another paper: "Affective symptoms, principally mood, are continuously distributed variables with a periodic component. That is, individuals with affective disorders and healthy control subjects both have cycles.

. . . The significant difference between disorder and normality in the analysis of these periodicities is in amplitude" (Eastwood et al., 1985). SAD patients have large amplitude seasonal swings compared with normal subjects. Their predictable periodicity, characteristic symptoms, and response to light alone without other medication, can be looked upon as a boon to researchers. In the early 1970's untreated endogenous depressive patients on the ward were sufficient in number for neurobiological investigation; in the late 80's the patients on the ward are all therapy resistant chronic depressives whose neurobiological characteristics reflect more their multiple treatment history than the illness itself. The description and treatment of SAD has given us a theoretical challenge and a clinical model equivalent in scope and potential to the original amine hypothesis.

A. W.-J.

BRIGHT LIGHT TREATMENT FOR SHIFT WORKERS

Evidence is accumulating that the natural light-dark (LD) cycle is a powerful zeitgeber (time cue) for human circadian rhythms, as for the rhythms of other animals and plants. The bad news is that this may contribute to the difficulty shift workers have adjusting to the night shift: while their sleep and work times are shifted, the natural LD cycle remains constant. The LD cycle may exert control over the phase of the internal circadian rhythms, opposing the shifting necessary for physiological adaptation. The good news is that artificial bright lights can be used to shift human circadian rhythms, and might form a useful component of shift worker strategies. Research in this area is so new that we only have a rough idea of when to apply bright light to produce a desired shift, extrapolated from the phase response curve (PRC) of animal experiments. So far the largest phase shifts, more than about 2 hrs/day, have been produced in temporal isolation units, where all other potential zeitgebers are blocked out. More work is necessary to determine the optimum parameters of light (timing, intensity, duration, number of repetitions or days of light exposure, etc.) to produce a desired phase shift.

We have designed light-work-sleep schedules to improve sleep and reduce fatigue in rotating shift workers (e.g., Eastman, 1987). The basic strategy is to use the sleep-wake schedule and LD cycle (of bright light) as zeitgebers to shift circadian rhythms before the change to each new shift. If the circadian rhythms are shifted and do not remain locked to the 24-hr zeitgebers, then sleep and work will

occur at more appropriate phases of the circadian cycle, preventing the biologically-based deleterious consequences of shift work. The work shifts must change in the delaying direction (from days to evenings to nights). Sleep is gradually delayed by about 2 hrs/day (a 26-hr schedule) around the transitions between work shifts. For rotations between the day and night shift, 3 or 4 days off are needed before the night shift. During the delaying sleep-wake schedule, bright light is applied before bed, and sunlight is blocked out after waking through the use of welder's goggles (worn when the worker is outdoors). Technically, it is more difficult to block out than to apply bright light. Field work with normal subjects has shown that the circadian rhythm of body temperature can be entrained to a 26-hr light and sleep schedule in some subjects, but in others the 24-hr zeitgebers seem to maintain control. Better control over the natural LD cycle or other 24-hr zeitgebers may be necessary to make these strategies feasible for a greater proportion of shift workers.

Charmane Eastman, Ph.D., Biological Rhythms Research Laboratory, Rush-Presbyterian-St. Luke's Medical Center, 1653 West Congress Pkwy., Chicago IL 60612-3864. Tel 312-942-4472; MCI Mail 363-7775; Fax 312-942-2387 attn 2-8328.

SIGH-SAD: RELIABLE? VALID?

As the Structured Interview Guide for the Hamilton Depression Rating Scale, Seasonal Affective Disorder Version (SIGH-SAD; Williams et al., 1988) comes into widespread use in evaluation of patients' symptoms of SAD, determination of its validity and reliability becomes increasingly important. The Light Therapy Unit and the Biometrics Research Department at New York State Psychiatric Institute are formulating evaluation procedures. We seek participation of researchers in other centers. There are several aims of such an undertaking.

First, item analysis will determine which items are essential to evaluation of SAD, allowing elimination (or compartmentalizing) of items which do not contribute to total score in assessing severity of the disorder and efficacy of treatment. Determining the validity of individual items in the questionnaire will require analysis of ratings of subjects while depressed but before treatment, after receiving treatment, and while in a euthymic state, to see to what extent the items are sensitive to change in the subject's condition.

We also plan to prepare a set of videotaped SIGH-SAD interviews with both non-seasonally depressed and SAD patients. These will be used in addressing

the issue of cross-center reliability. Such concurrent procedures err in favor of greater reliability because variation in administration of the questionnaire is eliminated, but they do permit direct comparison of the scorers' ratings. The tapes would also be a valuable training tool providing a standard of assessment throughout the field, as has been amply shown for DSM-III SCID training tapes. Having new interviewers achieve a specified level of agreement will increase workers' confidence in the comparability of scores.

Within-center reliability will be assessed by having pairs of interviewers independently administer the instrument to a series of subjects. (This is referred to as "test-retest reliability.") Memory of responses to earlier administration of the instrument, and intervening events both influence the results of this manner of comparison, making timing of the two interviews important. We suggest a minimum of an hour before the second interview, but no more than three days, and no intervening change in the patient's treatment. Both interviews are conducted in person. While logistics of scheduling inevitably limit opportunities for such paired interviews, the combined efforts of various research groups should provide a large enough set of ratings to evaluate reliability in this way. Ratings results should state the time elapsed between the two interviews.

Similar assessment of reliability of the companion Hypomania Interview Guide (including Hyperthymia) for Seasonal Affective Disorder (HIGH-SAD; Williams et al., 1988) will be undertaken as well. We look forward to hearing from researchers studying SAD to ascertain the interest in joining this collaboration. We also welcome inquiries about specifics of conducting the interviews and reports of any difficulties encountered, in order to help hone the instruments.

Janet B.W. Williams, D.S.W. (Box 74), Martha Link, B.S. (Box 50), Michael Terman, Ph.D. (Box 50), New York State Psychiatric Institute, 722 West 168th Street, New York NY 10032. Tel 212-960-5524; MCI Mail 308-7099; BITNET TERMAN@NYSPI; Fax 212-960-2584.

INSURANCE REIMBURSEMENT OF LIGHT BOX CLAIMS

The SLTBR Insurance Liaison Committee plans a nationwide survey of the status of insurance claims for light boxes purchased by SAD patients. We already have initial indications of highly variable success rates.

With approximately 40 claims honored, Dr. Norman Rosenthal's group at NIMH gave the most encouraging news by far. Claims are supplemented by letters describing SAD and citing light therapy as the accepted treatment. Undoubtedly, recognition of SAD in the DSM-III-R has been an important factor. Neal Owens, of the SunBox Company, has heard from 40-50 purchasers who received reimbursement. He notes that Blue Cross/Blue Shield in the Northeast US has been particularly responsive (though, ironically, not in his home state of Maryland).

Dr. Carla Hellekson reported no such success among her patients in Alaska. The same was true for Dr. Barbara Parry in San Diego. In Philadelphia, all initial claims by Dr. Steven James' patients were refused, but several cases are being appealed. In New York, Dr. Michael Terman's experience and mine have been much the same, with several appeals pending, and a few reimbursements from private insurers (who requested documentation that the treatment was not "experimental.") In New Hampshire, Betty Welch reported no success for apparatus reimbursement, but clinical fees have been covered for "Assessment of Atypical Depression" and follow-up visits, given a SAD diagnosis. Dr. George Brainard reported similar experience in Philadelphia; he recommends including reprints of appropriate articles with materials submitted. Dr. Breck Lebeque's group in Utah has fared no better, but notes that recent apparatus purchases by Health Maintenance Organizations and community health centers augurs well for more widespread acceptance.

Our committee asks that all clinicians who have endorsed insurance claims for light apparatus join us in contacting their past patients with a standardized SLTBR questionnaire (on facing page, ready for you to photocopy). *We ask that you write a personal cover letter, enclosing the questionnaire, asking each individual to mail me his or her response directly.* Survey research strongly suggests that if you provide a stamped, pre-addressed return envelope, the response rate will be significantly enhanced. I will tally this information, by geographic area, carrier, etc., and summarize the data for future Newsletter reports and discussion by the committee. Within the year we hope to determine an effective approach to insurance companies, and we will consider offering official SLTBR back-up when claims are challenged.

Leslie Powers, M.D., 15 West 75th Street, New York NY 10023. Tel 212-722-5222; MCI Mail 373-0801.

THE DSM-IV DEBATE

The DSM-IV Committee has delayed its deadline for accepting opinion concerning DSM-IV SAD criteria to May 1989. The deadline for accepting data has been also delayed, to May 1990. Therefore, we have more time (and another winter) to collect data relevant to changing the SAD criteria. Dr. David Dunner, who is in charge of the Seasonal Affective Disorder Subcommittee, will be submitting a preliminary report recommending no change in the DSM-III-R criteria based on the data he has received so far. This letter will also be sent to several experts in the field and may be published in a SLTBR Newsletter. Dr. Dunner also indicated there may be funds available from the MacArthur Foundation to pay for analysis of data already gathered.

A session focusing on DSM-IV criteria will be held at the SLTBR annual meeting. At that time we will have an opportunity to hear your opinions and consider relevant data. I am now soliciting requests from SLTBR members who wish to speak at this session. Drs. Robert Spitzer and David Dunner will be invited to that meeting.

The main issues which have been discussed so far are: *a)* the 60-day windows for the spontaneous onset and remission of SAD; *b)* the lack of specificity regarding the season of the year; *c)* whether "Depression NOS" (or "subsyndromal SAD") should be included; and *d)* whether "responsiveness to light" should be incorporated into the criteria.

Data are necessary to change these criteria. If it can be shown that many SAD patients are either unable to remember or do not fulfill the strict window criteria of DSM-III-R and yet respond to light therapy, for example, such data would support a change.

Although we have been given somewhat of a reprieve, May 1990 will come very quickly.

David Avery, M.D., Dept. of Psychiatry, Harborview Medical Center, 325 Ninth Avenue, Seattle WA 98104. Tel 206-223-3425; Fax 206-223-3289 attn 3425.

SAD PATIENT SUPPORT GROUPS

Washington, DC area patients have taken initiative in forming a self-help support group, the *National Organization for Seasonal Affective Disorder (NOSAD)*, and we think other communities could benefit by such activities as well. What is the purpose of such a group, and how can you help to start one in your area?

Society for Light Treatment and Biological Rhythms

INSURANCE LIAISON COMMITTEE

Leslie Powers, M.D., *Chair*
15 West 75th Street, Suite 4B
New York, NY 10023
Tel (212) 724-5222



Dear Friend:

This letter is being sent to you by your clinician, researcher, or light treatment apparatus supplier in cooperation with a national survey of insurance reimbursement claims being conducted by the Society for Light Treatment and Biological Rhythms, a not-for-profit professional organization concerned with the advancement of this new clinical technology.

Among SLTBR's goals is to educate insurers about the utility of light treatment for Seasonal Affective Disorder, and motivate reimbursements in pending and future cases. We need to assemble as comprehensive a data base as possible in order to report accurately on current claim success rates. Please oblige us with a prompt response (mail to address above). All responses will remain confidential. You need not identify yourself by name, but if you wish to receive a summary report, please include a stamped, self-addressed envelope. Finally, if you receive more than one copy of this request, please do not submit duplicate responses.

Thank you very much for your cooperation.

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1. When did you purchase your light box? _____
 2. Manufacturer, model, price _____
 3. Who sold you the box (e.g., manufacturer, doctor)? _____
 4. Did you file an insurance claim for the box? ☐ yes ☐ no

If yes: ☐ Resolved satisfactorily (reimbursed \$ _____)
☐ Denied: please describe the reasons given by the insurance company for the refusal, and describe any subsequent action taken by you or your doctor (e.g., appeal, resubmission). Use reverse side of page.

5. Name of Policy or Insurance Company _____
6. In which State is policy issued (e.g., Montana)? _____
7. Did the insurer require (or did your prescribing physician submit) any back-up information with your claim, e.g., research papers, letter of explanation? If yes, please describe:

8. If known, diagnosis listed on claim: _____

Like other mutual-aid groups, SAD support groups aim to provide emotional support and practical help to people who face a common problem. They offer an important supplement to professional mental health services by decreasing the sufferer's sense of isolation, providing social support, experiential knowledge, normalizing experiences, shared coping skills, and positive role models. An additional function of some mutual-aid groups is to provide support and education to family members. In fact, a recent survey of one national mutual-help group for persons with mood disorders found that family members, in particular, described valuable benefits from participation.

Research conducted by the New Jersey Self-Help Clearinghouse indicates that approximately one out of every three mutual-aid groups is started with the help of a professional who functions as a catalyst and a consultant. As Clearinghouse director Edward Madara notes, "The professional is often in a very favorable position to identify, encourage and link persons who have the potential to start a mutual-help group." He suggests forming a core group committed to *starting* a mutual-aid group, not just those who express interest in *joining* such a group. Also, he cautions, it is important to think in terms of "mutual aid" from the start, with all core group members expected to share the work and the responsibilities of organization. Survival of the group is at risk when one person "does it all."

Whether you are a mental health professional or a lay person, if you are interested in forming a mutual-aid group for persons with SAD you can obtain a wealth of practical information from the Clearinghouse by writing or phoning *New Jersey Self-Help Clearinghouse, Saint Clare's - Riverside Medical Center, Pocono Road, Deniville NJ 17384; 201-625-7101.*

Currently NOSAD holds monthly work group meetings. Format consists of a brief presentation by a professional on some aspect of SAD such as "SAD and the Family" or "Medication in the Treatment of SAD." Our goal is to establish a network of local support groups across the country, and we are developing guidelines for the establishment of such groups. We welcome inquiries from professionals and patients interested in organizing support groups at the local level. People in other communities who join NOSAD (\$15 membership fee) will receive its Newsletter.

Barbara Ingersoll, Ph.D., 4838 Park Avenue, Bethesda, MD 20816. Tel 201-229-9497.

FEDERAL/INDUSTRIAL RELATIONS

In our last issue we asked for responses from colleagues who have contacts within governmental and industrial agencies that may be interested in SLTBR concerns. We also asked who might be interested in forming a committee which would focus on the interactions between our developing field and federal/industrial agencies. Several individuals have provided relevant information and expressed interest in this endeavor, and three initiatives are currently underway:

The Center for Devices and Radiological Health (CDRH) of the Food and Drug Administration (FDA) has expressed interest in learning more about the field of SAD research. Dr. Morris Waxler of the FDA is helping to arrange a set of presentations at CDRH in order to summarize the current status of our field. These lectures are tentatively scheduled for April 1989.

The U.S. Congress has requested its Office of Technology Assessment (OTA) to develop a report on Biological Rhythms and Shift Work. Dr. Gary Ellis of OTA has notified us that an advisory panel will meet on 10 February 1989 to review this field. SLTBR will be represented by our president, Dr. Alfred Lewy. In addition, I will attend as an observer. If you wish further information on this work, contact Dr. Gary Ellis, Senior Analyst, Congress of the United States, Office of Technology Assessment, Washington DC 20510-8025.

The Commission Internationale de l'Eclairage (CIE, or International Commission on Illumination) has 36 member countries and provides forums on the science and art of lighting. Division 6 is specifically concerned with the photobiological consequences of lighting. It is chaired by Lucia Ronchi, Ph.D., Istituto Nazionale di Ottica, 6 Largo Fermi, 50125 Florence, Italy. CIE's US National Committee (USNC) is interested in recruiting researchers in SAD, light therapy, biological rhythms, and systemic effects of light. I serve as USNC Corresponding Secretary; a meeting will be held in July 1989.

Please contact me if you have information relevant to SLTBR federal/industrial liaison, or would like to participate on the committee.

George C. Brainard, Ph.D., Department of Neurology, Jefferson Medical College, 1025 Walnut Street, Philadelphia PA 19107. Tel 215-928-7644; MCI Mail 357-6719; Fax 215-928-5044 attn 7644.

BOOK REVIEW: THE HIBERNATION RESPONSE

This new book (Whybrow and Bahr, 1988) is intended for the general public and describes seasonal rhythms and how to adjust to them. The authors propose a multidimensional approach to ameliorate such symptoms as depression, weight gain, lethargy and loss of libido that comprise "the hibernation response." Included in the group of people with the response are patients with SAD.

Unfortunately, the book is seriously flawed. Some information is presented as *proven* when underlying material is speculative at best. This applies both to the descriptions of physiology as well as to most of the therapeutic program. For example, the authors assert that: *a)* humans have a mating season in the fall leading to a preferred season for births; *b)* nightly melatonin "prepares us for sleep;" *c)* circannual rhythms exist in the ability to perform cognitive tasks; *d)* indoor light is insufficient to synchronize circadian rhythms to a 24 hour day; *e)* thyroid hormone secretion occurs within minutes to generate heat in acclimatized people exposed to cold; and *f)* cold temperatures are as important as light in inducing seasonal changes in people. None of these assertions is supported by research.

The authors frequently extrapolated from animal data directly to humans without informing the reader. In addition, the list of references was inadequate. Even though this is a lay book, if work was cited by the researcher's name, it should have been listed in the reference section for interested readers.

I had serious reservations about their clinical advice. The use of bright, full spectrum light was advocated for everyone with symptoms. Readers were provided with information on constructing or purchasing a light box, and then on how to use it. At this point in our knowledge of SAD and related problems, I believe that people who have the syndrome should be supervised by a health professional. Self-diagnosis and treatment could conceivably be dangerous. There are anecdotal reports of switches into mania in bipolar patients treated with light. Since there is little evidence of the efficacy of light in non-seasonal major depressive disorder, it is possible that such patients could become more depressed when the self-treatment fails.

The therapeutic program contains components that have not been accepted as treatment by health professionals who see patients with SAD and subsyndromal symptoms. These components are: *a)* acclimatizing to cold (based on the theory that some people become symptomatic as a result of colder temperatures); *b)* creating a "Spring Room" in one's home

complete with full spectrum lighting, appropriate wall colors, spring fragrance and spring sounds; *c)* eating a diet of "mood foods", comprised of frequent small meals high in protein until dinner, and then high in carbohydrate (based on the premise that symptoms resulting from a relative deficiency in protein resemble the hibernation response, and that high carbohydrate meals facilitate increased serotonin production and thereby drowsiness); and *d)* taking a trip toward the equator at self-selected times in order to "ease [the person] into the temperature of the coming season so that [he/she] can acclimatize more rapidly and fully." At least, these portions of the self-treatment regimen are probably harmless, although quite costly for procedures without proven efficacy.

The section on sleep and insomnia was woefully inadequate. Only one rare type, Delayed Sleep Phase Syndrome, is described as being the underlying cause of insomnia. The authors suggest using bright lights to shift a person's phase of sleepiness. The clinical sleep community has not yet accepted this treatment strategy for insomnia, although some promising research is underway. Further, twice in the book the authors advocated the use of alcohol before sleep. This shows a lack of understanding of the negative role of alcohol in sleep disorders.

In summary, medical books for the lay public are important for educational purposes. However, researchers and clinicians have a responsibility to be accurate and to present speculative information as such. This book, the first of its kind on this topic, does not meet these criteria.

Margaret L. Moline, Ph.D., Institute of Chronobiology, New York Hospital - Cornell Westchester Medical Center, White Plains NY 10605. Tel 914-997-5863; fax 914-997-5958.

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