Short communication

Social characteristics of seasonal affective disorder patients: comparison with suicide attempters with non-seasonal major depression and other mood disorder patients

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Abstract

Although it is evident from numerous studies that patients with mood disorders generally have a deficient social functioning and a weak social network, little is known about these aspects of seasonal affective disorder (SAD) patients. We studied the social situation, the social network and the social functioning of SAD (n = 20) patients in comparison with matched suicide attempters (SA) with non-seasonal major depression, and with findings from other major depressive disorder (MDD) studies and community samples. The social situation and the clinical background of both the SAD and the SA groups were almost similar and the social networks were equally disadvantageous and weaker than those observed in some community/healthy populations. Furthermore, the data on global functioning and social adjustment of the SAD group were well comparable to those of other MDD patients and significantly worse than that of a community sample. Thus, the results indicate a considerable social impairment in SAD.

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1. Introduction

Since 1984, when the diagnostic criteria for seasonal affective disorder (SAD) were first described, a number of scientific articles have been published describing various aspects of SAD. However, the social functioning of SAD patients has not yet specifically been studied, despite the fact that patients with mood disorders in general have a poor psychosocial functioning and deficiencies in social adjustment [11] as well as a weak social network [2]. Suicide attempters and suicide victims, many of whom suffer from a mood disorder [6] have also been shown to have impaired social functioning and a disadvantageous social network [12].

The aim of the present study was to investigate the social situation, the social network and the social functioning of SAD out-patients.

2. Materials and methods

The study was conducted in 1995–1996 at the Department of Psychiatry, Lund University Hospital, Sweden. The approval by the University Medical Ethics Committee and the informed consents from all of the participating subjects were duly obtained. The SAD patients (n = 20, 18 females and two males) with ongoing major depressive disorder (MDD) were recruited from our Light Therapy Unit and the age and gender matched suicide attempters (SA) with non-seasonal MDD (n = 20) were recruited from an in-patient ward, specialised in mood disorders and suicidal behaviour. The recruitment procedure has been described previously [18].

The details of family history, life history, somatic and psychiatric history as well as of the present social situation were obtained from all the patients through semi-structured interviews. Axis I and II diagnoses were made according to the DSM-III-R [3]. The psychopathology and the social functioning were measured by the Montgomery–Åsberg depression rating scale (MADRS) [16] and the interview schedule for social interaction (ISSI) [19] the global assessment of...
functioning (GAF) and the social adjustment scale-self-rating version (SAS-SR).

Data from the SAD and the SA groups were compared by the cross-tabulation (categorical scales) or the Mann–Whitney U-tests (continuous scales) and the paired samples t-test. To adjust for the potential confounders, the total score and each subscale of ISSI were separately analysed in a general linear model.

In order to evaluate the severity of the social functioning in the SAD group, the GAF and the SAS-SR data from four studies were retrieved from the published literature. These selected studies had used a similar diagnostic frame as the present study and had clear statements of the group means, the standard deviation (S.D.) and the number of participants, enabling us to compare the data by the Student’s t-test.

3. Results

No significant differences were found between the SAD and the SA groups regarding the sociodemographic factors i.e. marital status, total number of children and number of children younger than 18, educational level, vocational-, housing- and economical-status, and most of the clinical background factors i.e. family history of mood/substance use disorder, early separation from at least one parent by the age of 12, traumatic experiences such as physical/sexual abuse, and any physical illness. Not surprisingly, the SA had significantly more often made previous suicide attempts ($P < 0.001$) and had also significantly more often been treated as in-patients ($P < 0.02$). The duration of the current depressive episode was as expected short among SAD patients: 2.1 ± 2.4 months (mean ± S.D.) as compared to 8.3 ± 8.2 months (mean ± S.D.) in the SA patients ($P < 0.003$).

Age, scores on the MADRS and the ISSI for both the SAD and the SA groups are presented in Table 1. There were no significant differences between the groups in the MADRS total scores or in suicidal ideation item. Both groups had low scores on all the subscales of the ISSI and there were no significant differences between the groups. The results remained the same when the scores on each subscale of ISSI were adjusted separately for potential confounders (marital, educational and vocational status, the clinical background factors and the MADRS scores) in a general linear model.

GAF ratings of the SAD group over the previous 1 year in comparison with GAF ratings from seven MDD samples are presented in Table 2. GAF ratings of the SAD group were comparatively low reflecting moderate malfunctioning.

The SAS-SR scores of the SAD group were comparatively high, reflecting maladjustment. In comparison to MDD samples, the social adjustment of the SAD patients was equally impaired in several role areas, though, with a few significant differences. Compared to the community sample, the SAD patients were functioning poorly in all eight domains and the differences were statistically significant in overall adjustment and in all functional roles except the “extended family” and the “parent” roles.

4. Discussion

This is probably the first study where the social characteristics of SAD patients were specifically studied in comparison with SA, and with some of the published data from clinical MDD samples and from community samples. Our main findings were that the clinical background, the social situation and the social network of the SAD patients were similar to that of matched SA in-patients, and furthermore, the social impairments of the SAD patients were as severe as found in studies with MDD patients.

This subsample of SAD was found to be representative for all the SAD patients evaluated in our Light Therapy Unit from its start in October 1992 until April 1996 concerning gender, marital status, educational level, seasonality and severity of depression. The study sample was younger as compared to the total sample (35 vs. 46 years), but age was taken into account in the matching procedure. We believe that the sample sizes were appropriate; the statistical power for detecting a difference of 1 S.D. in the ISSI scores between SAD and SA was 88.5%. Nevertheless, the results of this study, particularly from the comparison of the social situation of...
SAD and SA, would have to be taken with caution and ought to be replicated.

We found no significant differences between the SAD and the SA groups concerning social network, as measured by ISSI, total score and subscales. ISSI is a self-rating instrument, and as such prone to be affected by a patient's mood status [12]. However, we found no significant differences between the groups in severity of depressive symptoms, or in suicidal ideation. Furthermore, the differences in ISSI scores remained non-significant when corrected for possible confounders such as traumatising events in the past, comorbid personality and substance use disorder, long-lasting physical or psychiatric symptoms and the severity of the present depression. Moreover, the ISSI scores were definitely lower than scores seen in some community/healthy populations [5,17] and were also as low as observed in some other clinical samples [4,12,17]. The psychosocial functioning of SAD in this study as measured by the GAF was remarkably low. The samples with episodic major depression, chronic major depression and depression had lower GAF ratings than our SAD sample. The ratings in these studies were made to reflect the present state and probably covered only the previous 2 weeks [3] while we had rated over the previous 1 year which had included an euthymic period of several months, possibly explaining the higher ratings for the SAD group. The social adjustment of SAD patients, measured by the SAS-SR during an episode of depression, was almost equally disturbed as that found in other samples with MDD. In our comparative calculations, we were not able to adjust for different clinical factors, which might influence a patient's functioning in several role areas [15]. However, the GAF ratings together with the ISSI scores indicate that SAD patients could have a long-lasting social impairment of a considerable magnitude, and that they could be socially mal-functioning while depressed as shown by the SAS-SR ratings. These results plead for early recognition and inclusion of measures to ensure the needful social support and strategies to enhance the social functioning in the management of this recurring malady. An early recognition could facilitate adequate treatment, which might prevent a further deterioration of the social impairment and could possibly lead to an amelioration as seen in other mood disorders [1,10]. This need for early detection is further stressed by the fact that SAD patients very often do not receive correct diagnosis, despite several contacts with the medical profession [13].

5. Conclusion

The scores on the scales assessing social function of the SAD out-patients were surprisingly low and similar to hospitalised SA and other clinical MDD groups and were also worse than those observed in community/healthy samples. Therefore, it is our conclusion that SAD patients have a considerable social impairment.

References


