2010

Seasonal Affective Disorder: A Phenomenological Inquiry

Frances Civilette Downs

SEASONAL AFFECTIVE DISORDER:
A PHENOMENOLOGICAL INQUIRY

DISSERTATION

Presented in Partial Fulfillment of the
Requirements for the Degree of
Doctor of Philosophy in Nursing

Barry University

Frances Civilette Downs

2010

SEASONAL AFFECTIVE DISORDER:
A PHENOMENOLOGICAL INQUIRY

DISSERTATION

By

Frances Civilette Downs

2010

APPROVED BY:

Sandra Walsh

Sandra Walsh, PhD, RN, FAAN
Chairperson Dissertation Committee

Carolyn L Page

Carolyn LePage, PhD, ARNP
Member, Dissertation Committee

Mary M. Wyckoff, PhD, ACNP
Member, Dissertation Committee

Claudette Spalding

Claudette Spalding, PhD, ARNP, CNAA
Chair, Division of Nursing

Pegge Bell

Pegge Bell, PhD, APN
Dean, College of Health Sciences

Abstract

Background: Seasonal affective disorder (SAD) is a form of major depression affecting up to 10.5% of people living in areas where sunshine is limited. The most common form of SAD occurs in the short, dark days of winter. The cause of SAD is attributed to the lack of light. By describing the human experience of persons living with SAD, the study addressed an identified gap in literature.

Purpose: The purpose of this study was to explore and document the lived experience of SAD.

Theoretical Framework: This hermeneutic-phenomenological study was conducted using the theoretical underpinnings set forth by Max van Manen.

Research Method: Twelve adults with SAD ranging in age from 23 to 72 engaged in individual recorded conversations with the researcher. Guided by the phenomenological method described by van Manen, recordings were transcribed, reviewed, and confirmed with the participants, and then analyzed for meaning. Themes were uncovered, described, and explored utilizing the words of the participants, along with insight cultivators such as literature, poetry, and music.

Results: Analysis of the transcribed interviews resulted in the emergence of three major themes: light seeking, autumn apprehension, and longing for validation of SAD as a legitimate disorder. Two secondary themes of social withdrawal and disruption of energy were also found to impact the lifeworlds of the participants. Coping mechanisms described by the individual participants indicate that the resilience theory may be an appropriate framework to identify and to explore creative ways of dealing with SAD.

Conclusions: This hermeneutic-phenomenological approach offers the insider's view of SAD and gives participants and nursing professionals the opportunity to become more empathetically engaged. The findings provided a glimpse into the lifeworld of those who suffer with SAD and gave them a voice. Nurses may use the information gained in this study to cocreate and to provide appropriate, compassionate, and holistic care for those with SAD. In addition to identifying the themes that are relevant to SAD, the study identified several areas for potential future investigations of issues surrounding the disorder.

ACKNOWLEDGMENTS

As we express out gratitude, we must never forget that the highest appreciation is not to utter words, but to live by them.

John Fitzgerald Kennedy

I sincerely and gratefully acknowledge my chairperson, Dr. Sandra Walsh, for her scholarly guidance, mentorship, patience, and friendship. She has been my guru along every step of this journey. Dr. Walsh continues to be my inspiration. I hope to show my appreciation by living up to the professional standards she models.

I also acknowledge Dr. Max van Manen for providing scientists with a tool that allows human beings to understand and to relate to one another. I thank Dr. van Manen for his personal assistance and expert counsel. It was a great advantage to be able to call upon his authoritative expertise. Thank you to my committee, Dr.Le Page and Dr. Wyckoff, for their hard work and dedication to this project.

Lastly, I thank Dr. Jesse Colin and Dr. Claudette Spalding, both of whom assured me I was “doctoral material” long before I believed it myself. I also acknowledge support from Sigma Theta Tau, Lambda Chi, and Beta Tau chapters as well as the Florida Nurses Foundation Undine Sams and Friends Award for funding this research.

DEDICATION

I wish to dedicate this dissertation to Doctor Darrell Downs, my husband, my friend, and my love. My two greatest accomplishments in life, this dissertation, and the creation of our son Evan, could not have been possible without you.

TABLE OF CONTENTS

LIST OF FIGURES

CHAPTER ONE

Introduction

Background of the Study

Recurrent major depression with regular seasonal patterns is commonly referred to as seasonal affective disorder (SAD). The most recognized form of SAD, winter depression, is generally seen in dark, short wintry days at northern latitudes (Hansen, Skre, & Lund, 2008). The lack of sunlight in winter is the prevailing accepted etiology of SAD (Lam & Levitan, 2000; Rosenthal, 2006). The American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders* (4th ed.; DSM-IV) criteria for the diagnosis of SAD require the sufferer to have experienced at least two seasonally related episodes of clinical depression, with seasonal (summer) remission between episodes (American Psychiatric Association, 1994).

Symptoms associated with SAD diminish with the application of light therapy (Lam & Levitan, 2000; Lee, 2003; Rosenthal, 2006). Light therapy has become an accepted treatment for SAD. Repeated scientific studies have shown light therapy to be at least as efficacious as antidepressant pharmaceuticals (Rosenthal, 2006). Light therapy is a powerful intervention that falls into the realm of holistic nursing practice (Zahourak, 2000).

The constellation of recurrent depressive symptoms was first named SAD and was scientifically described in contemporary literature in the mid-1980s by Rosenthal and colleagues (Rosenthal, Sack, Gillin, Lewy, Goodwin, & Davenport, 1984). Magusson and Partonen (2005) reported that the typical onset of SAD occurs between ages 20 to 30, and females are more likely to report symptoms associated with SAD than males. Sufferers of SAD often do not seek medical assistance for some years. Individuals generally endure symptoms, not recognizing SAD as a treatable disorder. Magusson and Partonen discovered that SAD patients may seek care from medical providers as opposed to specialty psychiatric care. They also reported that patients generally present with complaints of excessive sleep, extreme fatigue, or general feelings of lethargy. Individuals with SAD are often subjected to batteries of medical tests and are frequently misdiagnosed. Lurie and colleagues (2006) reported that SAD continues to be unrecognized and underdiagnosed, especially in the primary-care area. They reported that SAD patients often suffer for years before the actual diagnosis is made. This is largely due to the lack of awareness of SAD.

Hermeneutic phenomenology as described by van Manen (1990, 2002) offers a philosophical stance from which to explore the essence of living with SAD. As with all qualitative research, the researcher functions as the tool for collecting, synthesizing, and reporting findings. Acknowledging this role, the researcher is called upon to reflect upon and disclose personal assumptions and bias. In his approach to hermeneutic phenomenology, van Manen wrote that he does not believe that it is appropriate or possible for the researcher to claim to suspend all preconceptions. Rather, the researcher cocreates reality along with the study participants in a hermeneutic interpretive exchange (van Manen, 1990, 2002). Phenomenology as a research method offers a vehicle to acknowledge and value the human lifeworld, the lived world as experienced in everyday situations and relations (van Manen, 1990).

Statement of the Problem

In his more recent work, Rosenthal (2006) contended that much of the general public still did not view SAD as a “legitimate affliction” (p. 247). Elaborating, he wrote that many people still did not grasp the magnitude of the symptoms of those who suffer from SAD. This lack of understanding represented a knowledge gap evident in nursing professionals as well as the public. This lack of knowledge continues to contribute to the underreporting and undertreating of individuals who suffer from SAD (Lurie, Gawinski, Pierce, & Rousseau, 2006). As a result, many SAD patients endure years of suffering as their symptoms are misdiagnosed, unrecognized, or undertreated. The experience of living with SAD remains poorly understood by others.

Purpose

The purpose of this study was to explore and document the lived experience of individuals with SAD. A hermeneutic-phenomenological nursing inquiry gives voice to those who suffer and helps address the identified gap in literature related to SAD. A rich, thick description was generated, painting a picture of the impact SAD has on the lived experience of the individuals. A qualitative hermeneutic-phenomenological approach offers the insider’s view, giving participants and nursing professionals the opportunity to become more compassionately engaged. Qualitative studies such as this provide nurses with information to incorporate into professional holistic approaches to persons with SAD (Benner, 1994).

Research Question

The research question was, “What is the lived experience of the individual with seasonal affective disorder?”

Significance of the Study

A phenomenological inquiry provides a description from the perspective of individuals who endure the symptoms of SAD (van Manen, 1990). The prevalence of SAD has been estimated to be as high as 10.5% of the population who live in susceptible areas (McConville, McQuaid, McCartney, & Gilmore, 2002). This large number makes it likely that nurses will encounter SAD sufferers in their practice. Nurses interacting with patients across practice settings are in a unique position to have effective communication with patients (Finch, 2005). As the health-care provider in whom the patient is likely to confide, the nurse may be the first professional to hear patient concerns regarding SAD symptoms. This study contributes to nursing literature, providing a basis for recognition of the lived experience, and may contribute to insightful and effective nursing interventions for these patients. Cogent understanding of what it means to live with SAD may encourage clinical nurses neither to trivialize nor to overlook the seriousness of this disorder.

Phenomenology in Nursing

Phenomenological research correlates with Carper’s theoretical framework of ways of knowing in nursing (Holtslander, 2008). Numerous phenomenological studies have contributed to nursing science (Benner, 1994). The expansion of knowing through nursing scholarship ideally includes all aspects of the human experience. Hermeneutic-phenomenological research provides a vehicle to bridge understanding between human beings. This understanding within the context of the nurse-patient relationship promotes empathic cocreation of care. Holistic nursing practice calls for provision that recognizes the totality of the human being. A phenomenological approach respects the interconnectedness of body, mind, emotion, and spirit, as well as the social, cultural, relational, contextual, and environmental aspects of humanness (American Holistic Nurses Association, 2007). Acknowledging these elements of the lifeworld brings respect for the multidimensional complexities of life.

Significance for Nursing

The significance of this study lies within the value of the descriptive narrative outcome. A graphic image of the lived experience with SAD provides an understanding of the lifeworld as seen through the unique perspective of the participants. An emic view provides clues as to how to recognize, legitimize, and provide nursing care for those who suffer (Benner, 1994). Dr. Janice Morse wrote that nurses have always known that by understanding the experience of illness and being cared for, we become better nurses, better able to provide appropriate care (Madjar & Walton, 1999).

Qualitative studies generally do not have clearly predictable paths, and specific findings may not be foreseeable (Polit & Beck, 2004). The contribution that this study makes to the base of nursing knowledge lies in the rich, thick descriptions of the essence of the meaning of the lived experience of those with SAD (Burns & Grove, 2001). The verbal pictures painted by the participants in this study should be recognizable by other SAD sufferers as an accurate portrayal of what it means to live with SAD. Additionally, outsiders should find this work to be detailed enough to be identifiable if encountered in clinical practice.

Munhall described human beings as “active agents” who construct their own realities (2007, p. 10). Nursing, as a caring, holistic practice, encompasses caring for the human mind and spirit as well as for the physical body. This broad scope makes all forms of human research relevant to practice (Pope & Mays, 2006). Investigating patient worldviews from a nursing perspective provides a comprehensive illustration of the impact SAD has on the health states and lives of the participants. This worldview description contains insightful wisdom, which adds to the knowledge base of sensitive, caring nurses. Understanding the lifeworld of others fosters delivery of compassionate, informed care (Munhall, 2007).

Significance to Nursing Education

This study contributes new knowledge of the meaning of the lived experience of those who suffer from SAD. Landeen (2008) described the value of reflective practices of nursing students in understanding their patients and their own reactions to the patients they encountered. This reflexive process in turn helped educators to anticipate educational and supportive needs of students (Landeen). A phenomenological description of SAD enables nurse scientists and readers of this research to gain an insider’s view and helps them see SAD patients in multidimensional, sensitive ways. The reflexive nature of phenomenological studies reinforces reflexive listening and ways of learning in practice. This study also contributes to nursing education by assisting students and clinicians in the development of specialized care plans to meet the needs of those who suffer from SAD. This study may also serve to educate others in the therapeutic value of bright light.

Significance to Nursing Practice

The value of nursing research lies in the ultimate relevance of the study to clinical practice (Munhall, 2007). As discussed earlier, nurses are the health-care providers most often confided in by patients (Finch, 2005). Nurses in a wide variety of practice areas are likely to encounter those who suffer from SAD. This study has documented participants' individual experiences of SAD and provides information that may enhance nursing interventions. Understanding the lifeworld of SAD patients will offer key insights to nurses, assisting in the identification of elements of SAD in patient practice. Additionally, understanding the patient perspective aids as a reference in formulating reasonable nursing-care plans and in measuring of outcomes.

A phenomenological description of SAD provides a basis for devising nursing interventions or treatment strategies to assist patients in anticipating and coping with challenges unique to SAD sufferers. Finally, understanding the human experience of other people is fundamental to caring sciences (Pollio, Henley, & Thompson, 1997). A phenomenological description of the lived experience of SAD gives voice to this human condition. Learning of others' perceptual experiences, ways of living, ways of coping, and ways of being and living in the world enhances our ability to connect to one another. Phenomenological studies are relevant to nursing care from an ethical standpoint (Benner, 1994).

Significance to Nursing Research

The current paucity of phenomenological literature on SAD represents a significant knowledge gap. This gap presents an opportunity for nurse researchers to make an important contribution toward the awareness of SAD. The National Institute of Nursing Research (NINR, 2008) has put forth priorities for the advancement of nursing science. The NINR has prioritized the integration of behavioral and biological sciences and has suggested that nurses can contribute by researching issues of the quality of life.

The description of the lived experience of persons with SAD adds empiric knowledge. Such knowledge contributes personal descriptions to the existing knowledge base of nursing science. Personal insights have been conveyed by the participants in the extensive, rich descriptions that serve to inform and educate. Aesthetic knowledge is enhanced, as this study contributes to the development of a deep appreciation of the meaning of the lifeworld of persons with SAD (Carper, 1978). Ethical knowledge guides nurses to act in fair, right, and just ways.

Phenomenological research is well suited to the exploration of issues of the quality of life (Pope & Mays, 2006). Qualitative studies contribute to the body of nursing knowledge by expanding theoretical and conceptual thought. Van der Zalm (2008) wrote that revealing the nature of human experiences contributes to the empirical, moral, aesthetic, personal, and sociopolitical knowledge bases. A rich, thick description of the lived experience of SAD provides a knowledge base and also will provide direction for additional inquiry. This phenomenological study offers a strand of understanding in the intersubjective web of humanity.

Significance for Public Policy

A rich, dense phenomenological description is valuable when planning how best to care for the SAD population. Awareness of the lived experience provides a basis to advocate for resources to meet the needs of the people who suffer. Marquis and Huston (2000) wrote that nurses are in positions of power. As members of the largest health-care profession, nurses are charged with a responsibility to be vocal, visible, and active in shaping the future of health care (Buresh & Gordon, 2003). Giving participants an opportunity to share their experiences supports a proactive and empowered approach to nursing and health care. Phenomenological studies add a human dimension to the knowledge base and may serve as an underpinning for political action (van Manen, 1990).

Philosophical Underpinnings

Creswell (1998) outlined the following basic philosophical assumptions common to the qualitative perspective in general: 1. The nature of reality is considered to be subjective and multiple. 2. In qualitative inquiry the researcher and participant collaborate to create meaning. 3. The researcher acknowledges and reflects upon self values and considers that personal bias may influence the researcher’s perceptions. 4. Qualitative research is inductive; specifics may be examined to gain insight into the whole (Creswell).

Phenomenology is a philosophical perspective as well as a method for conducting research. Phenomenology is a qualitative standpoint with roots in psychology and philosophy. Edmond Husserl (1859-1938), the German philosopher and mathematician, is considered to be the founder of modern phenomenology as a philosophy and as an approach to scholarly inquiry (Wojnar & Swanson, 2007).

Husserl described the lifeworld as an individual's unique experience of being (Ekebergh, 2007). Phenomenology is applicable to the study of the human lived experience (Polit & Beck, 2004). The communication of scholarly work demands an organized approach to defining philosophical assumptions. Phenomenology, as with other qualitative paradigms, has established suppositions as to ontology, epistemology, axiology, rhetoric, and methodological approaches (Creswell, 1998). Various schools of phenomenological philosophy have evolved since Husserl's early work (Dowling, 2007). The following is a general overview of the commonalities or major aspects of phenomenology as a philosophical perspective.

Ontological Assumptions

Ontology (Polit & Beck, 2004) is the branch of philosophy that deals with *being*. Phenomenological philosophy assumes that the nature of reality can be communicated between people. Reality is subjective and multiple, meaning that several people may experience the same situation; however, individual interpretation may vary (Creswell, 1998). Aristotle is believed to have broadly defined aspects of ontology with his teachings of metaphysics (Corazzon, 2008). Husserl wrote of the science of consciousness, focusing on *intentionality*, the connection of one's being in the world. In his later works, Husserl expanded his philosophical view to include transcendental subjectivity, a process whereby one person may seek to understand the experience of another. This process involves bracketing one's own ideas, allowing a clearer path to relating to another (Wojnar & Swanson, 2007). Husserl sought to establish a philosophical science of the fundamental nature of being, which he called phenomena, or essences (Annells, 1996). Husserl also wrote of the *noeses* of consciousness, which refers to acts of thinking, feeling, judging, remembering, and perceiving. He postulated that wherever noeses exists, a personal perception, or *noema* is formed (Moustakas, 1994).

The German philosopher Martin Heidegger (1889-1976), a student of Husserl, sought to further refine a philosophical understanding of phenomenology to include his expanded ontological view (Wojnar & Swanson, 2007). Heideggerian phenomenology is based on the assumption that the metaphysical state of being is contextually situated. Heidegger wrote that the human lifeworld is influenced by culture, social factors, and historical epoch (Creswell, 1998). Heidegger also wrote of the concept of *dasein*, a German term that translates as the human way of being in the world (Wojnar & Swanson). All individuals are influenced by this assumption of dasein, the effect of life situations on the state of being.

Epistemological Assumptions

Epistemology is the study of the nature and origin of knowledge. Philosophically, phenomenology assumes that the human experience is subjective and complex and that it can be described through language (Burns & Grove, 2001). Phenomenological assumptions take into account the relationship between the researcher and those being studied (Creswell, 1998). Phenomenologists assume that interpersonal characteristics may influence how knowledge is conveyed and interpreted. Van Manen (1990) wrote that sources of artistic media, such as literary works, music, movies, personal journals, and literature, may also contribute as resources for understanding the lifeworld. Specifically, van Manen (2002) wrote of *insight cultivators*, which are discovered through undertaking reading, writing, and rewriting in the process of phenomenological inquiry.

Axiological Assumptions

Husserl believed that human lifeworlds are subjective experiences grounded in the perception of the individual (Benner, 1994). Phenomenology therefore embraces the value-laden nature of being (Creswell, 1998). Husserl believed that temporality (place in time) and spatiality (place in space) exert influence upon human existence and therefore have inherent value (Crotty, 1998). The mathematical term "bracketing," credited to Husserl, is the act of setting aside one's values in order to be open to experiencing an alternative reality (Dowling, 2005). As in algebra, placing brackets around a portion of a problem allows one to perform a mathematical computation while excluding the other elements or operations within the equation. In that same vein, *epoche,* a word used by Aristotle, is the holding in abeyance of preconceived values and notions (Moustakas, 1994). In phenomenology, bracketing refers to holding one's own ideas in abeyance in order to be open to appreciate the experience of others.

Heidegger postulated that epoche is not possible (Crotty, 1998). He believed that as human beings we are all influenced by individual lifeworlds and that interpretation of others cannot be totally separated from personal past and present influences. Van Manen has embraced this concept and has expanded it to include phenomenological participants, researchers, and the reader of the resultant text (van Manen, 1990).

Rhetorical Assumptions

Language is the primary means of communication between human beings. Phenomenology embraces language as a means to share and understand human ways of being. Heidegger put forth the concept of a "hermeneutic circle." This circle provides a visual illustration of Heidegger's concepts of the nature of being (Crotty, 1998). Key elements in Heidegger's hermeneutic circle are: being, dasein, forestructure, and existentials. Philosophically, phenomenology embraces all forms of human expression as outward manifestations of consciousness. Language is a primary means of sharing the data of the lived experience (van Manen, 2002).

The ability to communicate the essence of one's self is influenced by spatiality and temporality. Heidegger described the state of being as a cocreation shaped through discourse and reflection (Benner, 1994). Reduction, as originally conceived by Husserl, is the phenomenological device of getting past one's own interpretation of reality in order to see the essence of a lifeworld (van Manen, 1990).

A contemporary of Husserl and Heidegger, the French philosopher Maurice Merleau-Ponty (1908-1961) further described phenomenology beyond spatiality and temporality to include *corporality,* the physical body. Merleau-Ponty believed that the whole of one's existence includes the experiences of the physical body. This inclusion of corporality has made phenomenology an appropriate philosophical lens from which to view nursing science (Thomas, 2005). Common to all phenomenology is the assumption that the lifeworld can be described and related by the use of language.

Methodological Assumptions

Just as grand nursing theories contain the metaparadigmatic elements of health, person, nursing, and environment to address core truths, phenomenology as a philosophical perspective contains core assumptions (Tourville & Ingalls, 2003). These assumptions form the basic philosophical underpinnings. Phenomenology defines the lifeworld as four existential domains: lived space (spatiality), relationships (relationality), time (temporality), and body (corporality). The basic assumption of phenomenology is that through study, reflection, reduction, or other procedural means the lifeworld, or inner essential nature, can be revealed (Benner, 1994). Beyond this basic assumption, variations in approaches to phenomenology present the researcher with adaptations and alternatives. The two most basic branches useful to nursing are hermeneutic and descriptive phenomenology (Van der Zalm & Bergum, 2007).

Descriptive phenomenology places emphasis on relating universal essences, assumes consciousness is shared, and requires self-reflection and bracketing of preconceived ideas held by the researcher. In contrast, hermeneutic-interpretive phenomenology focuses on phenomena in context. The person is seen as a self-interpretive being, and the contextual influences of language, culture, and practice form a shared reality. Interpretive researchers actively cocreate meaningful interpretations of the phenomena with their participants (Van der Zalm & Bergun, 2007; Wojnar & Swanson, 2007).

The contemporary philosopher Max van Manen has interpreted and refined hermeneutic phenomenology as a philosophical and conceptual framework. In addition to spatiality, corporality, temporality, and relationality as interwoven elements of the lifeworld, van Manen incorporates *semiotics*, the science of interpreting signs. Rather than prescribing a set formula or sequential steps to conceptualize hermeneutic phenomenology, van Manen focuses on the act of writing itself as a vehicle to uncover the meaning of the experience of interest.

The contemplative process of descriptive and interpretive writing guides the direction of the research. The use of language and writing is seen by van Manen as the core of phenomenological understanding. As in the research process itself, van Manen invites the reader of the finished product to interpret through his/her own individual lens and to glean meaning from what is, and is not, reported. Philosophically, according to van Manen, all phenomenology is laden with personal meaning; this personal meaning is to be recognized, explored, and incorporated into one's own lifeworld. Van Manen's hermeneutic-phenomenological concepts have been successfully applied to add to the knowledge base of nursing science (Colvin, 2009; LePage, 2008; Munhall, 2007; Wyckoff, 2007).

Nursing scholarship extends beyond predictive and prescriptive interests. Revealing the nature of the human experience adds richer, deeper understanding of the meaning of the world of others. This type of understanding embraces the art and spirit of humanity and influences thoughtful professional practice (Annells, 1996; Van der Zalm & Bergum, 2007). This study has been informed by the traditions described by van Manen, acknowledging and exploring the researcher's own bias and influences while attempting to tease out the relevant aspects of the lifeworld of those who live with SAD. The researcher encouraged vivid descriptions from the participants. The researcher was also mindful of her own preconceived ideas by journaling and field notes. The journaling process itself is reflective in nature, bringing mindfulness and self-awareness into the research process. In the tradition of hermeneutic philosophy, writing and the interpretation of text are the vehicles by which one may understand and illuminate the lifeworld of others.

Scope and Limitations

This study was limited to English-speaking participants aged 21 and older who identified themselves as having SAD and having had some experience using therapeutic light. Participants lived in the United States at the time of the interviews. Geographic locations of the participants ranged from northern California to the New England States. Some interviews were conducted in person, and some via telephone. Self-reporting bias or the tendency to understate or overstate information is an inherent limitation of any personal accounting. Self-reporting bias may alternatively provide additional dimension to the participants' intended description. This study was also limited by the number of participants and by the extent to which participants were articulate enough or willing to disclose.

In hermeneutic phenomenology, the researcher's basic assumptions and the researcher's writing skill and ability to synthesize meaning from rewriting interview data influence the outcome and is a presumed limitation of this study. The work, although being overseen by an expert committee, has been conducted by a novice doctoral student with limited previous research experience.

All participants were informed of my purpose for conducting this research. All participants were informed that I am a professional registered nurse conducting research for a doctoral dissertation, interested in SAD, and specifically interested in light as a therapeutic modality. These facts may have influenced their responses, in that they may have wanted to tell me what they thought I wanted to hear. Journaling and self-reflection were employed throughout the research process.

Summary

SAD is a form of major depressive disorder affecting upward of 10% of people in areas where daylight is limited in winter (Leavitt, Boyle, & Joffe 2000; Marshall & Cheevers, 2003). This disorder is often unrecognized and undertreated, which contributes to excess suffering. A phenomenological approach to understanding the lifeworld of the SAD sufferer is intended to give voice to those who suffer and to help educate others. This study contributes to addressing a gap in current literature. A vivid description of what it is like to walk in the shoes of a SAD patient will provide a vehicle to promote recognition and empathetic understanding. Implications for nursing practice, research, education, and public policy have been presented in this chapter.

CHAPTER TWO

Review of the Literature

Introduction/Overview

Patterned in the traditions of Husserl and Heidegger, Moustakas (1994) wrote that in the course of phenomenological study, technical as well as nontechnical literature may be useful sources of data. Numerous quantitative studies have looked at various aspects of seasonal affective disorder (SAD) and the effectiveness of treatments; however, a paucity of peer-reviewed qualitative work is evident in current text. A literature search was conducted in January 2009 and was repeated in February 2010 utilizing CINHAL & PubMed from 1980 to the present. Using the terms "seasonal affective disorder," plus "phenomenology" and "seasonal affective disorder," plus "lived experience" produced only two articles, which were prevalence studies rather than descriptive accounts (Booker & Hellekson, 1992; Boyce & Parker, 1988). A number of works have described presenting symptoms of SAD; however, no in-depth description of the lived experience from the sufferer's viewpoint was located.

Phenomenological research methods vary in the amount and substance of preliminary literature reviewed prior to data collection. In keeping with previous studies guided by van Manen's methodology, a limited preliminary review of the general state of the science of SAD will be presented. Basic information regarding the history, prevalence, and etiology of SAD, plus information on therapeutic light, will be introduced.

History of SAD

The identification of seasonal patterns and light-exposure effects on mood in human beings dates back to Hippocrates (Westrin & Lam, 2007). The effect of lighting and environmental influences on health states was written by Florence Nightingale in her descriptions of early nursing practice (1860/1969). This historical tacit knowledge went largely ignored by traditional positivist medical and nursing scientists until the mid-1980s. There are numerous quantitative studies related to SAD and the effects of light treatment; however, this area of science still receives little if any attention in traditional nursing education.

Dr. Norman Rosenthal (2000) wrote a historical retrospective case-study analysis describing an interesting patient who came to him for treatment during his second year as a psychiatric research fellow at the National Institute of Mental Health (NIMH). The patient was Herb Kern, a scientist, whose identity is revealed at his own request. Kern had read of a newly published study by the NIMH showing evidence of the suppression of human melatonin by the application of bright light. Melatonin had been linked to circadian regulation and was known to influence sleep and waking states. Kern had long suspected that his own debilitating extreme mood swings were seasonally influenced.

The notion of melatonin suppression by environmental bright light provided a possible chemical basis for Kern's affective fluctuations. Kern maintained detailed written agendas, making it easy to track the extreme variations in his levels of functioning over previous years. A definite seasonal pattern was validated as his recurrent ebb and flow of mood, energy, and sleep ranged from winter depression to hypomania during summer months.

Operating on the assumption that light exposure and the resultant decrease in melatonin influenced mood, the first controlled interventional light study was documented. Rosenthal wrote that Kern became the first scientifically documented case of mood disorder to be successfully treated with light therapy. As a nod to qualitative learning, Rosenthal encouraged readers of his article to listen to their patients with an open mind. Rosenthal's willingness to explore Kern's hunch subsequently led to his life work with SAD (Rosenthal, 2000). This article confirmed the lack of knowledge regarding SAD prior to the 1980s and the continued relative infancy of understanding of this disorder. SAD first appeared in the revised third edition of the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders* in 1987 as a "seasonal pattern" descriptor of recurrent major depression. Rosenthal cited the relative lack of federal-funding priorities for SAD research and the lack of pharmaceutical-industry interest for the recent paucity of ongoing SAD research in the United States.

To honor Rosenthal's advice to listen to patients' experiences with an open mind, the following phenomenological study was undertaken. This hermeneutic-phenomenological study contributes to the understanding of SAD by presenting the insider's view of what it means to live with this disorder, which contributes to the overall body of nursing knowledge. This work, along with Rosenthal's case study described above, affirms the importance of addressing the disorder beyond traditional quantitative scientific methods. This study seeks to provide a meaningful and useful description of those who suffer with SAD.

Prevalence of SAD

Rastad, Sjoden, and Ulfberg (2005) conducted a quantitative study to determine the prevalence rates of SAD in Sweden. The Seasonal Pattern Affective Assessment tool was randomly sent to a stratified sample of 2,500 people living in central Sweden. Stratification ensured gender-and-age distribution among the potential responders. A response rate of 66.3% (n = 1,657) was obtained. Factor analysis was used to conclude that seasonal mood changes affected nearly twice as many females as males and that up to 19.3% of all responders reported that everyday life was adversely affected by seasonal depression. The authors concluded that the high prevalence of SAD in the Swedish population should warrant more attention from medical providers. This work underscores the need for awareness of this disorder by professionals.

Higher North American and European incidence rates of SAD correlate with higher latitudes north, where shorter exposures to natural sunlight occur in winter. While most authors agree that SAD rates are increased as one moves away from the equator, SAD can also occur in southern regions such as Texas (Levitt & Boyle, 2002; Palinkas, Houseal, & Rosenthal, 1996). Marshall and Cheevers (2003) reported that in the northern United States, including Alaska, approximately 10% of the population suffers from SAD. This represents a larger number of people known to suffer from other more well-known and well-researched mental-health diseases such as schizophrenia and obsessive-compulsive disorder.

Varying criteria may be used to measure the prevalence of SAD; therefore, inconsistent prevalence rates have been reported (Booker & Hellekson, 1992; Boyce & Parker, 1988; Levitt & Boyle 2002). Prevalence studies are helpful from a public-health and research standpoint, where resources may be allocated according to greatest need. This phenomenological study contributes a picture of SAD beyond prevalence metrics. The study also provides a glimpse into the lifeworld, adding understanding of what it means to live with the disorder.

Etiology of SAD

Two major theories have been proposed in the attempts to uncover the pathophysiology of SAD. Limited genetic studies have focused on monoamine and clock-associated genes as likely explanations of seasonality and depressive symptoms. Alternatively, the circadian neurotransmitter dysfunction theory has been more widely studied. The circadian neurotransmitter dysfunction theory postulates that a phase shift delay of circadian wakefulness, arousal, and sleep is altered in SAD patients. First studied in animals, melatonin produced by the pineal gland was found to be produced in response to darkness or, more precisely, suppressed by the application of bright light. Melatonin is known to affect circadian rhythm, arousal states, mood, sleep, and wakefulness (Lewy, Sack, Singer, White, Tana, & Hoban as cited in Rosenthal, 1989).

SAD patients have been found to have overall lower levels of retinal dopamine, indicating that dopamine may also play a significant role (Herbert, Beattie, Tam, & Yatham, 2004). Herbert and colleagues have also shown that the positive antidepressant effects gained with light therapy in SAD patients are reversed when tryptophan and catecholamines are depleted. These findings indicate that multiple biological mechanisms may contribute to SAD.

Therapeutic Light

Florence Nightingale wrote in 1860 that patients on the bright side of a hospital recovered better than those on the dark side. Her observations contributed to the construction of long hospital wings surrounded by gardens (Cramer, 2009). Hospitals built in the early 1900s routinely included solariums or sunrooms for the therapeutic benefit to the sick. In 1903, Dr. Niels Finsen won the Nobel Prize in medicine for research on the curative effects of phototherapy on tuberculosis, smallpox, and other diseases. Finsen's work sparked interest in light as a therapeutic antimicrobial agent until the advent of antibiotics (Nobel, 1963).

As recently as 1998, Wirtz-Justice reported that much of the established contemporary psychiatric community had little knowledge of light therapy or regarded it with disdain. Bright-light therapeutic devices are not sold as pharmaceutical or durable medical devices in the United States; thus there is little marketing of these devices directed toward the medical community. Despite numerous publications regarding the efficacy of bright light being at least equal to antidepressant medications, insurers still generally do not cover the cost of light-therapy devices (Lam & Levitan, 2000; Wirtz-Justice, 1998).

Using principles of evidence-based medicine, the American Psychiatric Association Council on Research commissioned an expert committee to examine the efficacy of light therapy (Golden, Gaynes, Ekstrom, & Hamer, 2005). The resultant meta-analysis showed that significant reduction in the depression symptoms of SAD is associated with bright-light therapy. The committee also found that the application of bright light is being successfully applied to other disorders such as major depression, obesity, and mood disorders. The experts also summarized evidence-based articles supporting light-therapy interventions applied to improve cognitive functioning in the elderly and in performance enhancement of athletes.

Postolache and Oren (2004) described light as the most powerful, fundamental zeitgeber affecting both plants and animals. They said that light is a melatonin suppressant and a circadian phase shifter. A zeitgeber is any exogenous cue regulating the endogenous timekeeping system of an organism. Postolache and Oren's meta-analysis supported the theory that bright light acts as a powerful influence on the suprachismatic nuclei of the hypothalamus influencing alertness and sleep-and-wake cycles. Bright light has also been shown to directly suppress melatonin, a hormone known to influence circadian rhythm (Postolache & Oren).

Postolache and Oren's review of the evidence-based literature highlighted data describing the alerting and antidepressant effects of light in seasonal as well as nonseasonal states. The authors also described the role of light in sports chronobiology and the application of light in circadian shifting. A brief summation of light-administration devices, such as visors, light boxes, and dawn simulators, and a comparison of light spectrums and treatment parameters were included in this work. The authors noted rare possible adverse effects, such as hypomania, the potential for some skin cancers, and the possible interaction with photosensitizing medications, that may be associated with bright-light therapy. Postolache and Oren summarized this work by stating that the effects and advantages of light therapy are dependent on wavelength, duration, and timing of administration. The application of light as a zeitgeber is useful in sports performance, management of shift work, and adaptation across time zones, as well as being a mood elevator in SAD.

Morera and Abreu (2006) set out to determine the biological effect of light fluctuations in non-SAD subjects. They demonstrated that melatonin peaks in winter and troughs in summer in healthy subjects. They concluded that this chemical fluctuation provides a sound biological basis for the seasonality of disorders such as SAD. Conducted in Spain at 28 degrees north and 16 degrees west, 10 healthy male subjects provided hourly serial blood samples for two experimental sessions, one in August and one in December. Serum-melatonin levels were assayed from the samples. The baseline General Health Questionnaire (GHQ-28) was completed by the subjects in summer and in winter. Nighttime melatonin levels were found to be 80% higher in the winter samples compared with the summer levels. Though limited by the small sample size, this study demonstrated seasonal physiological changes in healthy subjects. Scores on the GHQ-28 demonstrated a markedly higher correlation of melatonin and depression scores for the winter samples ($p < .01$). The authors reported no recidivism rate of the subjects, as the men recruited for the study were known to the researchers. Potential bias in the collection of GHQ-28 was not discussed. The authors reported that the subjects had given informed consent. The subjective nature of the GHQ-28 instrument and the relationship between the researchers and the responses on the depression items was not reported. This article provided data to support seasonal melatonin fluctuations in healthy male subjects.

Experiential Context

My psychiatric nursing experience and curiosity regarding light therapy has evolved into an intense interest of what it means to be profoundly affected by light. I personally do not have direct experience with major depression or SAD; however, I have treated depressed patients in my previous psychiatric nursing practice. Therefore, I used journaling throughout the research process to be cognizant of my possible preconceived perspectives. The use of open-ended interview questions and the avoidance of leading statements helped ensure that the voice of the participants was heard.

The use of personal journaling throughout the actual research process contributed to the depth of information and helped bracket my personal bias; it also helped avoid overshadowing or injecting a researcher voice onto the participants. Van Manen (1990) acknowledges that total *epoche*, or bracketing, is not possible and that reality is cocreated between the researcher and the informants. Therefore, the use of member checking was important in validating the voice of the participants.

Summary

Current literature reveals a paucity of qualitative research on SAD. The phenomenon of SAD and light treatment continues to receive relatively little attention from those practicing mainstream medicine and nursing. Though the American Psychiatric Association recognizes and has classified SAD as a form of major depression, relatively little funding for SAD research is currently available in the United States.

Prevalence studies indicate that SAD is seen more frequently in females and at higher latitudes, where sunlight is limited in winter. Several theories of the actual etiology of SAD exist. Despite the known therapeutic benefits of bright light in SAD and other disorders, mainstream medical practitioners remain to be educated in this area.

Hermeneutic-phenomenological studies are important to nursing science. This type of humanistic research contributes to the understanding of the lived experience of others. Using a hermeneutic-phenomenological approach, this researcher sought to contribute to the understanding of SAD from the perspective of the participants. The lack of significant proprietary or U.S. government-subsidized research in the area of SAD presented a unique opportunity for this nursing study to gain a phenomenological perspective of those who suffer.

CHAPTER THREE

Methods

Introduction/Overview

The purpose of this study was to explore, to gain an understanding, and to document the lived experience of persons with seasonal affective disorder (SAD). A hermeneutic-phenomenological nursing inquiry gives voice to those who suffer and helps address the lack of awareness of how SAD impacts lives.

Research Design

Hermeneutic phenomenology provides the philosophical as well as methodological underpinning for this inquiry into the lived experience of SAD. Several phenomenological researchers/philosophers have developed refinements and modernized traditions of applying general principles of hermeneutic phenomenology. Among these hermeneutic phenomenologists are Giorgi, Van Kaam, Moustakis, Colaizzi, and van Manen (Burns & Grove, 2001; Dowling, 2005). Since the mid-1980s, hermeneutic phenomenology has been successfully applied to nursing inquiry (Benner, 1994).

This nursing study into the lived experience of SAD was informed by the process described by van Manen (1990). The method incorporates descriptive as well as interpretive aspects of hermeneutic phenomenology. Breaking with Heideggerian tradition, van Manen rejected the notion of bracketing or suspending one’s own preconceived ideas. Rather, van Manen guides the researcher to explore and to acknowledge the role of the researcher in cocreating reality with the research participant (van Manen, 1990). This hermeneutic-phenomenological method ascribes the researcher's role as the instrument. This is evident in the acts of interviewing, observing, writing, and interpreting data obtained from participants.

Van Manen's method of framing human science includes attention to semiotics, the science of signs and representations. He wrote that communication and language itself, in addition to other sensory information, comprise encoded signs that may be communicated and interpreted between human beings. This study consisted of interviews that provided semiotic data to bridge intersubjective understanding between the researcher and the SAD sufferer. The result is a descriptive narrative picture of being-in-the-world and the essence of what it means to live with SAD.

Van Manen (1990, pp. 30-31) has provided six research activities that were applied to this study:

1. Turning to a phenomenon which seriously interests us and commits us to the world.
2. Investigating experience as we live it rather than as we conceptualize it.
3. Reflecting on essential themes which characterize the phenomenon.
4. Describing the phenomenon through the art of writing and re-writing.
5. Maintaining a strong and orientated pedagogical relation to the phenomenon.
6. Balancing the research context by considering parts and whole.

These activities were referred to throughout the study process. Informed by the tradition of van Manen's approach to phenomenological inquiry, the researcher was directed to consider the elements of the lifeworld. An exploration of the major assumptions of the lifeworld of those with SAD helped guide the researcher and the participants to focus a phenomenological lens, cocreating an image of the world of SAD. Temporality, or being in time, is particularly relevant as SAD is cyclical, changing one's life with the season. As the lived experience of SAD is described, temporality was found to be a major influence on the lived experiences of this particular population.

Spatiality and one's living in a geographic location were found to be major influencing factors in the lives of the SAD participants. Relationality, or the way one interacts or withdraws from others, was also found to be greatly influenced by SAD. Corporeality, or lived body experiences, was commented upon by a number of participants, along with altered abilities to interact with and within their lifeworlds. Many participants freely offered descriptions of SAD that included these elements. When they did not, there were very general question prompts designed to elicit information on the major lifeworld domains of phenomenology. (See Appendix F.)

Ethical Considerations/Protection of Human Subjects

This study explored the lived experience of SAD within the situated context of a hermeneutic-phenomenological research study. Human-subject protection was ensured and oversight was provided by the Institutional Review Board (IRB) of Barry University, as well as by the researcher's dissertation-committee members. Detailed written and verbal informed consent was obtained from each participant prior to recruitment or data collection. The researcher continued to maintain professional respect for individuals in exchange for the privilege of learning about their unique lifeworlds. Consideration of human subjects' free will and protection of rights has been given throughout the research process.

Methods

Volunteers were recruited from a public posting of an IRB-approved flyer (see Appendix F) and by snowball sampling. Approval was obtained to recruit via newsletter from a company that provides light-therapy products. (See Appendix G.) The company had agreed to post the electronic-recruitment flyer in their newsletter; however, after IRB approval, the company did not respond to follow-up communication. An alternative method of public posting and snowball sampling was effective in obtaining the number of participants to reach saturation of data. Two additional participants were recruited after saturation to strengthen research rigor.

Due to the presumed low incidence of SAD in the researcher's home state, IRB approval was obtained to conduct in-person interviews as well as telephone interviews. This approval allowed the researcher to recruit from a wide range of geographic locations. She was not restricted to participants who would be available for in-person-only interviews.

1) IRB approval was obtained to post the approved flyer in public places and to use a snowball-sampling technique. The researcher posted the flyer in public places such as churches and a holistic spa in Maine and to her personal e-mail list, asking friends to forward. Additionally, the researcher was able to announce and distribute recruitment materials at a large conference in Washington, D.C.

2) Potential participants contacted the researcher via e-mail or the phone number listed on the flyer. A password-secured e-mail account, SADresearch@gmail.com, was established for the sole purpose of communicating information regarding this study.

3) Potential participants received a return e-mail briefly explaining the study, as well as an inclusion-and-exclusion criterion-screening questionnaire. This e-mailed questionnaire also asked the potential participant how long he/she had suffered from SAD and to verify experience utilizing bright-light therapy. The potential participants who met the criteria were asked to provide a physical mailing address to send consent forms to and a telephone-contact number. The form also asked participants to indicate a pseudonym of their choice, which was used to ensure confidentiality in recording and reporting the final data. Telephone responders were asked identical questions. (See Appendix B.)

4) Upon receipt of the screening questionnaire, potential participants who met criteria and wished to participate were contacted via phone to confirm their interest.

5) Two copies of the consent form (see Appendix C) were then sent to the participant via U.S. mail along with a return-addressed postage-paid envelope. The participants were instructed to retain one copy of the consent and to return a signed copy to the researcher's home address. In-person participants were presented with the consent, and each section was reviewed; then participants were encouraged to ask questions and reread the information.

6) The researcher's telephone-contact number and the contact number of the

supervising committee chairperson were also included within the consent in the event the potential participant wished to gain additional information prior to signing the consent or to ask questions anytime during or after the study.

7) The consent contained information asking the participant to agree to take part in two face-to-face or telephone interviews, lasting approximately one hour each. Geographic constraints limited the principal investigator's ability to offer face-to-face interviews to all participants. The consent explicitly stated that the participant could withdraw consent at any point during the study without negative consequences. The form also indicated that the participant could refuse to answer any or all questions. The participant could ask for the recording to stop at any point. In the event the participant elected to stop recording, he/she would be withdrawn from the study, the data would not be used, and the tape would immediately be destroyed by cutting.

8) The consent also indicated that the initial interview would be tape-recorded and that the participant would receive an e-mailed transcript of the initial interview for verification.

9) The consent also made clear that this was a minimal-risk study; however, the researcher could elect to stop the interview at any point if the participant should become upset. Additionally, the researcher would assist the participant to access free community mental-health services in the participant's geographical region if the need arose during the interview process.

10) After receipt of the signed consent, the researcher telephoned the participant for the initial interview at a day and time indicated by the participant on the consent

form. At the onset of the phone call, prior to the interview, verbal consent was repeated and the participant was reminded that a recording device was being used.

11) At the conclusion of the initial interview, a tentative date for a follow-up member-checking interview call was established (generally 2-3 weeks). A verbatim transcript of the initial interview was prepared by an outside transcriptionist. A third-party confidentiality agreement was signed. (See Appendix D.) This agreement will be maintained in a locked cabinet in the researcher's home office and will be retained along with the other raw data of this study for a maximum period of three years. A hard copy of the interviews was used by the researcher in conducting thematic analysis.

12) With participant agreement, the transcripts of the initial interviews were e-mailed within 1-2 weeks of the initial interviews with a request for a member-checking interview date and time to be provided by each participant. During the member checking, interview participants had the opportunity to request changes, inserts, or deletions to the transcript. The researcher took field notes and added comments and impressions during the member-checking interview process. This second interview was not tape-recorded. The initial audio tapes were destroyed by shredding immediately after the second interview.

13) At the completion of the first interview, all applicants were given in person or mailed a $20 check along with a thank-you note from the researcher. This monetary gift was given in appreciation for the participant's time and effort in participating in the study.

14) Consents, transcripts, and field notes are stored separately in locked cabinets in the researcher's home office and will be retained for a maximum period of three years. After this time, all documents, paper transcripts, and field notes will be destroyed by shredding. Electronic transcripts will be deleted from the researcher's home computer or electronic storage device. Documents containing information linking codes of pseudonyms and actual names will be stored in a separate locked cabinet.

Alternative Procedures

Alternative procedures for potential participants were nonenrollment or withdrawal from the study at any point.

Benefits

There were no direct physical benefits to the participants of this study. Several participants expressed gratitude for being included, stating they felt a sense of accomplishment by contributing to the awareness of SAD. Several participants spoke of a sense of validation and said that participation in the study was of personal therapeutic benefit. Compensation of $20 was provided in appreciation for time and effort for the participants who took part in the initial interview. The compensation in no way comes close to the sincere debt of gratitude owed to participants, who showed the courage and the kindness to open their hearts and minds to allow the following description of SAD to be documented.

Risks

This was a minimal-risk study. No physical risks were associated with this study. Possible psychological or social risks were discomfort in talking about personal matters or concerns over social ramifications if confidentiality was not maintained. To minimize the risk concerning confidentiality, participants were required to select a pseudonym. The researcher maintained the security of documents by using locked storage cabinets in her home office. The security of electronic communication was maintained by the use of an exclusive password-protected e-mail address dedicated to this study. Additionally, the researcher's home computer is password-protected at the log-on level.

Confidentiality

Individual participants were required to use a pseudonym. Collected data such as transcripts identified participants by pseudonym only and were kept in a secure location in the researcher's home. Participants were given two opportunities to select a pseudonym of their choice, reinforcing the researcher's intent to maintain confidentiality. In the event a participant did not wish to select a pseudonym, the researcher planned to assign an arbitrary letter to the participant, for example, "Miss A." Consent forms containing actual names were stored separately in a locked cabinet in the researcher's home. A third-party confidentiality agreement was obtained from a transcript service. Recorded and transcribed data contained pseudonym identification only. (See Appendix D.)

Sample and Setting

This study included a purposive convenience sample of 12 English-speaking adults who identified themselves as having SAD and had experienced some form of bright-light therapy. This sample size is generally considered to be sufficient to reach saturation in phenomenological studies (Creswell, 1998). Saturation is the point whereby the researcher is no longer hearing novel information. The researcher was hearing similar data after 9 or 10 interviews; thus it was determined that an additional 2 participants were sufficient to confirm saturation.

After IRB approval for a maximum of 20 volunteers was obtained, the main method of recruitment was planned to be a flyer posting via newsletter from a company that provided light-therapy products. (See Appendix H.) The newsletter was electronically distributed to past purchasers of light-therapy equipment. This method was chosen due to the selective nature of the newsletter recipients and the high likelihood of reaching persons who met the inclusion criteria. Additionally, a snowball-sampling technique was to be employed, and the same flyer was printed or electronically posted in public places. (See Appendix E.) After IRB approval, the newsletter publisher/light-therapy company owner did not respond to multiple e-mails and telephone messages. Effective recruitment was obtained via physical and electronic posting of the IRB-approved flyer in public places and by word of mouth. In July 2009, the researcher attended a conference in Washington, D.C., where an announcement of recruitment for this study was made to a large national group of medical professionals. Participants were interviewed between July and October 2009.

Potential participants were asked to contact the researcher via e-mail if interested in taking part in the study. A screening response was then to be sent by return e-mail to the potential participants. (See Appendix B.) The first of up to 20 volunteers who met the inclusion/exclusion criteria were mailed two consent forms: one to sign and return postage-paid, the other to retain for their information. When consent forms were returned to the researcher, the participants were contacted via telephone at a day and time specified by the participant.

Due to the greater incidence of SAD in northern locations, it was expected that participants would be recruited from those geographic locations. For this reason, IRB approval was obtained for in-person interviews as well as for telephone interviews. Several respondents were ultimately found in the researcher's Florida location, as they had moved south due to problems with SAD. Additionally, several participants were recruited from the aforementioned nationwide audience of professionals who were present at the conference in the Washington, D.C. area.

Initial interviews took place only after inclusion and exclusion criteria were explained to the potential participants by the researcher and after written and verbal consents were obtained. At the conclusion of the initial interview, a second telephone interview was requested. Each participant agreed to the second interview, which was scheduled at the participant's convenience. Second member-checking interviews occurred 2 to 3 weeks after the first interviews.

Transcripts of the initial interviews were prepared. Electronic copies of the transcript were sent to the individual participants via e-mail with their consent. A paper copy of the transcript was used by the researcher for data analysis and will be securely retained by the researcher in a locked cabinet in the researcher's home office for a maximum period of three years from the date it was obtained. This written transcript was also used by the researcher as a reference for the second interview. Participants were generally given approximately one week to review the transcript before the second interview was conducted. The second interviews, which took place via telephone, all lasted less than 45 minutes. This second interview was used for member checking, as a means to verify the transcribed information from the initial interview. The audio tape of the first interview was destroyed immediately after the member-checking interview. All participants were informed that their participation in either interview was strictly voluntary and that they could choose to discontinue participation at any point without negative consequences.

Inclusion Criteria

Inclusion criteria were used to select individuals who were: (a) English-speaking adults at least 21 years of age; (b) self-identified as having SAD; (c) experienced with some form of light therapy as a treatment for SAD; (d) willing to be available for two telephone sessions or one in-person and one telephone interview session with the researcher.

Exclusion Criteria

Exclusion criteria were used to reject individuals who were: (a) non-English speaking or under age 21; (b) not personally experience with SAD or not experienced with any form of light therapy; (c) unwilling or unable to commit to two telephone sessions or one in-person and one telephone interview session with the researcher.

Access and Recruitment

Individuals were recruited for this study as described above. Data consisted of gathering recorded individual interviews. Interviews were conducted via telephone or in person. Van Manen postulated that the actual method of conducting interviews is not fundamentally important; the main objective in conducting interviews is to gather experiential data (Max van Manen, personal communication, April 24, 2009). Transcripts of the interviews were e-mailed to the individual participants and were used as a basis for member checking. Member checking ensured that the transcript accurately reflected the participant's intent.

Interview Questions

In qualitative traditions, information gained during interviews is considered to be data. Rubin and Rubin (2005) described qualitative interviews as in-depth, detailed, unbalanced interactions. The interaction is unbalanced because the researcher supplies the basic broad questions and the participant contributes detailed responses. Questions should serve to provide a basic focus; however, they should not be so narrow as to exclude important nuances or data that may not be expressly requested. In hermeneutic phenomenology, the transcript produced from the interviews becomes the primary source of data (van Manen, 1990). The primary question was: "Please tell me what it is like to live with seasonal affective disorder." See Appendix G for interview-guiding questions.

Demographic Data

Study participants were asked to provide their name, age at their last birthday, and gender. Participants were also asked to disclose how long they had suffered from SAD. Age was asked as a means to provide perspective on the length of time the participant had experienced SAD and to determine if any data were found to be age-related. The demographic data were used to screen and describe the population of the study. An e-mail address and a telephone number were requested for the purposes of appointment setting and for interview communication. Personal or identifying information provided during the interviews was reported, using pseudonyms to ensure confidentiality.

Data Collection

After IRB approval, recruited individuals were provided with written and verbal informed consent. Individuals were asked to participate in one tape-recorded interview and one nonrecorded follow-up telephone interview. The duration of the initial individual interviews was less than one hour each. After receipt of the signed consent form, the researcher contacted the informant by telephone. Prior to data collection, the researcher reviewed the terms of the written consent and verified the participant's willingness to be interviewed. The researcher verified permission for the call to be tape-recorded and also reiterated that a written transcript would be prepared from the ensuing interview. A telephone-jack recording device was connected, and the tape recorder was turned on after verbal consent was obtained. For the face-to-face interviews, the researcher and each participant met at a mutually agreed-upon location. A recording device suitable for indoor recording was used, and the participant was reminded of the recording in a similar fashion. The recorder was placed on a table between the participant and the researcher and was in full view at all times during the interview session.

All informants who participated in the initial interview were compensated by a check in the amount of $20. A second interview was explained and requested on the consent form and reinforced at the conclusion of the initial interview. The second interview served as a means of member checking and was not tape-recorded. At the time of the second interview, participants were given an opportunity to amend the transcript of the initial interview. The follow-up telephone interview generally lasted ten to thirty minutes, with the exception of one interview that lasted approximately forty-five minutes. Supplemental data was contributed by field notes, literature, participant poetry, media, and researcher observations.

Data Analysis

Van Manen (1990) wrote that reflective analysis is a process of insightful discovery. Thematic analysis in hermeneutic phenomenology extends beyond merely categorizing and counting statements from a transcript. Data analysis involves reading, rereading, writing, and rewriting in the attempt to identify and describe the experience of another.

For this study of the lived experience of persons with SAD, transcripts of communication with participants were prepared verbatim and verified with the participants for accuracy and intent. Phenomenological themes, or structures of experience, emerged in the process of reading and interpretive rewriting of the words of the participants (van Manen, 1990). Though van Manen rejects the notion of a step-by-step analytical formula for data analysis in human-science research, he offers guidance to the researcher by outlining the meaning of themes, the basis of the understanding of the lifeworld. This analytical process served as a guide during the data-analysis portion of this study.

The notion of the lived experience of persons with SAD was described by the identification of themes that emerged from the reading, writing, and reflective contemplation of the transcribed words of the participants. The use of extensive field notes assisted in providing contextual information and identified the researcher's own impressions formed during the research process. Adding to experiential data was the incorporation of poetry, literature, art, music, and other contextual semiotics (Max van Manen, personal communication, April 24, 2009). The researcher kept a personal journal noting ideas and references as they occurred for inclusion.

The actual process of interpreting the content of the narrative transcript to identify the themes of SAD was accomplished first by reading each transcript in its entirety and then by using of the selective highlighting approach described by van Manen (1990). During the process of rereading the transcript, the researcher highlighted phrases, or meaning units, using colored markers. These highlighted concepts were then used as source data for the composition of a textual description of the lived experience of SAD. The universality, or essential quality of the identified themes, was discovered by asking if the description of the phenomena of living with SAD would be accurately conveyed without the theme in question. The discovery and the reporting of universal as well as novel themes contributed to the descriptive narrative of the study. This process of first reading the verbatim transcript of the initial hermeneutic interview was employed throughout the data collection to inform the researcher when saturation occurred. The actual analysis of the member-checking interviews, field notes, and other contributing documents was not implemented until all the interviews were completed.

Research Rigor

Trustworthiness in qualitative work is comprised of the elements of credibility, dependability, confirmability, and transferability (Koch, 1994/2006; Lincoln & Guba, 2000). These elements are considered to demonstrate rigor, or trustworthiness, in qualitative work. Credibility, or believability, in the study was achieved through prolonged engagement and by reading and reflecting on materials such as field notes, documents, transcribed interviews, and diaries. Credibility was enhanced by the researcher's acknowledgment of her own bias and statements regarding personal motivations and assumptions as well as of her professional perspective. Credibility assumes faithful descriptions that are recognizable to others (Koch, 1994/2006; Munhall, 2007). Faithful adherence to accepted research methods contributes to the integrity and trustworthiness of the results. Using van Manen's framework, this study conforms to accepted hermeneutic-phenomenological methods ensuring relevant, trustworthy results.

Confirmability, according to Polit and Beck (2004), refers to the objectivity or neutrality of the quality of the data. In this study, confirmability means that another SAD sufferer will be able to read the description and recognize or confirm the accuracy of the depiction of the experience. The focus was placed on the objectivity of the descriptions and on whether those descriptions represent common experiences held by others in the same situation as the research individuals.

Dependability is the accuracy of the interpretation congruent with the data gathered. It is also the stability of the data over time and across settings. Both dependability and confirmability are established by providing audit trails or peer-review type of oversight of the research process (Munhall, 2007). Dependability in this study was enhanced by the process of member checking during a second confirmatory interview with the informants.

Transferability depends on the extent to which the findings of a study may be applied to other situations or individuals (Polit & Hungler, 1997). Transferability in this study was improved by the use of thick descriptions, full explanations of the research settings, informants, circumstances, and perspectives. A detailed description allows the reader of the final product to determine the significance and relevance of the findings to his/her own situation.

Summary

This chapter has provided information on the method of conducting this hermeneutic-phenomenological study into the lived experience of persons with SAD. The qualitative design was guided by the method described by van Manen. Human-subject protection was ensured by careful adherence to the method and to the IRB-approved protocol. Twelve adult English-speaking participants who suffer from SAD and have had some experience with bright-light therapy were recruited to share their lived experience. Transcripts were composed and analyzed from interview data obtained with the participants in order to identify themes and to uncover their lived experience with SAD.

CHAPTER FOUR

FINDINGS OF THE STUDY

People just don't get it [SAD] . . . they think you are just this person who is depressed, they don't understand how much it can affect you…being someplace where it is light and bright can really make a big difference.

Sunshine-participant

Introduction

This chapter presents the findings of this phenomenological inquiry into the lived experience of people with seasonal affective disorder (SAD). The 12 participants provided personal accounts of everyday life through their unique perspective of life with SAD. These personal accounts served as the data for interpretive analysis and thematic identification.

The researcher wishes to acknowledge the complexities and multiple realities of the participants' human lifeworlds, although these are implied in the phenomenological method. Individual participants were encouraged to share their unique perspective. Each perspective allowed the researcher to form an overall holistic picture of life with SAD as described by the participants.

This research study sought to explore the lived experience of the individual with SAD. Guided by van Manen's (1990) dynamic interplay of phenomenological research activities, the researcher found that major themes became evident. She gained additional insight into the experience by journaling and personal reflection throughout this phenomenological-research journey. Participants shared experiential data in the form of verbal statements, stories, and written poetry. Three themes unique to the lifeworld of SAD were identified: light seeking, autumn apprehension, and longing for validation. These themes emerged as the primary descriptive response to the question, “What is the lived experience of the individual with seasonal affective disorder?”

Additionally, participants described two other factors influencing their lives: disruption of physical energy and social withdrawal. Disruption of energy and social withdrawal are considered diagnostic criteria for major depressive disorders according to the *Diagnostic and Statistical Manual of Mental Disorders* (4th ed. DSM-IV). As SAD is a form of major depression, the second two themes are not particularly descriptive of, or unique to, the specific experience of living with SAD. The secondary themes of disruption of energy and social withdrawal are included in this work because they were woven into the stories of the participants. The secondary themes are common to other forms of depression and have been previously described in literature. They are acknowledged here; however, the major focus of the phenomenological-analytical process was placed on the primary themes identified by the words of the participants.

Throughout this study, the researcher gained a heightened awareness of societal references to dark and light as they became apparent to the researcher’s consciousness. These dark-and-light references can be found in music, art, and literature and are used extensively in advertising and marketing. The use of personal journaling assisted in identifying and noting these references in their situated context.

Characteristics of the Participants

A purposive convenience sample of 12 adults, 11 women and 1 man were recruited for this study. All were recruited from the public posting of the approved IRB flyer (see Appendix E) or by the word-of-mouth snowball-sampling technique. Ages ranged from 23 to 72 years. All participants except two described the onset of symptoms or the awareness of symptoms in their early 20s. Two described early onset with specific memories before or during teenage years. Participants' occupations were varied: an artist, a psychiatric advanced-practice nurse, a chaplain, a landscape architect, a physician, a marketing professional, a corporate attorney, a photographer, a student, and a retired homemaker.

Initial interviews occurred via telephone or in person. Follow-up member-checking interviews occurred via telephone. All participants were asked to select a pseudonym to protect their identity. Initial screening information provided by participants included the inclusion criteria of having SAD, having some experience with any form of light therapy, and indicating age at last birthday. All participants were considered to have SAD based on self-reporting. Experience with light therapy included a broad range of types of light-therapy devices.

Interviews were conducted in July, August, and September, and no participants were using formal light-therapy devices on a regular basis at the time of the interviews. All participants had used some form of light therapy in the past. Occupations and specific family circumstances were not questioned; however, this information was offered by several of the participants and is included in the following textual descriptions with permission of the participants. Provision of profession and family circumstances is included to illustrate the lived experiences of the participants.

Lei

Lei is a 49-year-old wife and the mother of a teen; she was interviewed in person in Washington, D.C., where she was attending a conference. She currently lives in a northwestern state and works full-time in a health-care profession. She had previously lived in the middle of the country, where she felt there was more sunlight. She describes herself as having had SAD for several years, with the symptoms becoming progressively worse in recent winters.

Psy Ns

Psy Ns is a 72-year-old woman who preferred to be identified as a psychiatric nurse. Psy Ns lives in the western United States, has an advanced nursing degree, and is semiretired. She indicated that she has experienced SAD for 30 years. Psy Ns was interviewed via telephone.

Amy

Amy is a 67-year-old woman from the northeastern United States who moved to southeast Florida to manage her symptoms of SAD. Amy met with the researcher in person.

T-Man

T-Man was the sole male participant in this study. Now 55 years old, he first became aware of SAD when visiting a Scandinavian country. T-Man grew up in the northeastern United States and has recently moved to South Florida, where he is hopeful his symptoms will be more easily managed. T-man was interviewed in person.

Bernadette

Bernadette is a 50-year-old artistic woman who feels she has had SAD since childhood. Having grown up in the northeastern United States, she now lives in South Florida. Bernadette was interviewed in person.

Sunshine

Sunshine is a 32-year-old woman who lives in the northeastern United States. She stated that she was born in the South and began having problems with SAD as an adult after moving to the New England area. Sunshine was interviewed via telephone.

Denise

Denise is a 35-year-old health-care professional now in private practice. She currently lives in the South Florida area and describes herself as having had SAD for 12 years. Denise was interviewed via telephone.

Jbones

Jbones is a 43-year-old triathlete, single mother, and marketing professional. Now living in South Florida, she described having had SAD in her young adult years while living in a Middle Atlantic State. Jbones was interviewed in person.

Ms. Piggy

Ms. Piggy is a 32-year-old corporate attorney living in a large northeastern city. She was interviewed via telephone.

Brandy

Brandy is a 59-year-old health-care professional who lives in New England. Brandy was recruited in person at a conference in Washington, D.C.; her formal interview was later conducted via telephone.

Julia

Julia is a 23-year-old woman from a Middle Atlantic State. Julia was interviewed via telephone.

Jane

Jane is a 25-year-old student from a large metropolitan area in a Middle Atlantic State. Jane was interviewed via telephone.

Data Collection

All initial interviews were tape-recorded and transcribed. Each participant was then e-mailed his/her own transcript as an attached Word document. As an added measure of privacy, the transcribed document contained a pseudonym only and a confidentiality statement. The transcript provided a reference for the second telephone interview.

The follow-up telephone call served as a means of member checking, which promoted rigor in phenomenological research. The second interview was used to explore or to clarify meanings and is referred to as the hermeneutic interview by van Manen (Max van Manen, personal communication, April 24, 2009). The researcher took handwritten notes during the member-checking interviews, adding minor clarifications, details, or additional data. No participants requested deletion of any material. With the exception of Bernadette, follow-up telephone calls tended to be of short duration, with most participants wishing simply to confirm the transcript or add cursory statements. Bernadette was interested in learning about the research process and how she could contribute additional material to educate others about SAD.

Data analysis was conducted using van Manen's methodology of phenomenological inquiry. All transcripts were then read, along with field notes, underlining words as data units, or potential themes. Transcripts were reread while highlighting words of interest and making additional notations. As essential themes emerged, they were used as headings on separate sheets of paper and used as "bins" to collect and to sort arrays of statements, words, ideas, and phrases provided by the transcribed and notated data units. The method of hermeneutic reduction described by van Manen is intended to orient the researcher to the themes as they emerged in the reflection and writing process. The researcher was guided by van Manen's (1991, pp. 30-31) six research activities:

1) Turning to a phenomenon which seriously interests us and commits us to the world.
2) Investigating experience as we live it rather than as we conceptualize it.
3) Reflecting on essential themes which characterize the phenomenon.
4) Describing the phenomenon through the art of writing and re-writing.
5) Maintaining a strong and orientated pedagogical relation to the phenomenon.
6) Balancing the research context by considering parts and whole.

These activities were neither linear nor followed in a step-wise fashion. Rather, these activities served as a guide to inform and to orient the researcher throughout the process of the exploration into the lived experience of SAD. The findings of this study are the product of multiple writings, reviews, and rewriting as the application of the evolutionary process demands.

Phenomenology represents the human lifeworld as a dynamic interplay in continual evolution. This work represents a snapshot along the life journeys of the participants as well as that of the researcher. Themes were identified, considered for their relevance to the notion of SAD, and challenged within the research framework. The words of the participants allowed the researcher to gain insight into the lived experience of SAD.

Emergence of Themes

In the performance of van Manen’s activities, three major themes emerged: light seeking, autumn apprehension, and longing for validation of SAD as a legitimate disorder. Two secondary themes were also apparent: social withdrawal and disruption of energy. The following sections provide the words of the individuals as they illustrate and illuminate the themes.

Light Seeking

Individuals expressed an unusual preoccupation with light. They also expressed various methods of obtaining light exposure in their everyday lives. This awareness of light and the activities to increase light exposure are referred to in this study as *light seeking*. This theme was described in a variety of ways by the participants.

Through speaking with the participants and reviewing the transcribed words, it became evident that light played a major role in each of the participant's lives. Individuals expressed a variety of methods used to increase light exposure. Some of the methods were deliberate and intentional; yet other light-seeking activities seemed to occur on a subconscious level. As the following descriptions portray, the participants spoke of a heightened awareness of light as an essential element in their lives.

Light-seeking behavior was apparent in the conversation with Lei. Sitting next to a large window in a hotel room in Washington, D.C., Lei spoke of her work environment and about her concern over the lack of natural sunlight. She expressed annoyance with her assigned office space and described her method of coping with the lack of light it affords.

Lei said:

> I have no real light in my office. I get up and go over to the office with windows frequently. I go over to the window office just to look out. I go and talk with the people there, even if I really don't feel like socializing with them. I just need to look out sometimes. Space is so hard to come by at my place, and asking for reasonable accommodation does not go over well you know. Something like SAD; you're supposed to just suck it up.

Lei showed insight into her light-seeking behavior and how it impacted her workday. T-Man came to an awareness of light seeking on his own as well. T-Man's novel way of increasing his exposure to light ultimately provided the key clue that led to his SAD diagnosis.

T-Man said:

> As October was rolling around, I was getting really depressed. One of the places I went to almost religiously at night was the supermarket. Then I read that people who are sensitive to the light go to the supermarket a lot because it is bright 24 hours a day. I was being treated for depression at the time. When I talked to my psychologist, he finally put it together and suggested perhaps I had SAD and gave me some information on light boxes. I still think supermarkets are great places to go for a good dose of light and psychological pickup.

T-Man sought solace in brightly lit supermarkets, which were available 24 hours a day. In another account of light seeking, Brandy's expression of being reborn by exposure to sunlight underscored the essential elemental nature of this theme.

Brandy said:

> I know tanning booths are really bad, but I admit I go in the winter; I know tanning isn't good for my skin. I don't really care about a tan, it just feels good. Our winters are very long and the days are very short. It's really sad, so you have to have something. We take vacations in the winter just to get some sun in New Mexico in January and New Zealand in February. Leaving the snow and cold and going to the beach in winter feels like being reborn. It's just instant; in a matter of hours, you just

> feel alive again and feel rejuvenated. The only problem is going back home.

Brandy sought light by the use of tanning beds and by physically visiting a sunnier climate during the short days of winter. Psy Ns also expressed light seeking in the form of intense artificial lighting. She offered the following account.

Psy Ns said:

> I have a special light in my kitchen, it's not really a light box, but it is a special light over the counter that I turn on especially when I am doing breakfast . . . that provides a lot of light. I do a lot of needlework, cross-stitching, quilting, all of that. I have a lot of those special lights to use so you can see. So I get time with that. Now that I think about it, I suppose that could be why I find this activity so therapeutic.

During our conversation, Psy Ns seemed to come to the realization that she was receiving therapeutic benefit from adding light to her day. She was obviously attracted to recreational crafting activities that required and afforded bright, intense lighting. She indicated that it had not occurred to her until this interview that she enjoyed crafting because of the light exposure associated with her needlework, cross-stitching, and quilting. Bernadette also described a heightened awareness of light and the measures she takes to ensure she is exposed on a regular basis.

Bernadette said:

> I get up early in the morning and sit outside to have my coffee. Late in the day, I swim or sit outside to catch the last nuggets

> of sunlight. My mood is directly related to the amount of light
> I get. I know that now, it's like recharging my mental battery.
> My bed is situated to capture the sun as it rises in the morning.

Bernadette was interviewed outdoors in Florida; she said she prefers to spend as much of her day outdoors as possible. As we were walking toward my car at the conclusion of the interview, Bernadette pointed to the windows in the condominiums of her complex. She said that when shopping for a home, her first priority was the number and location of the windows and the amount of light available in the rooms.

Bernadette also offered a poem about her life with SAD. It will be presented in the following chapter. Her poetry clearly reflects and reinforces the theme of light seeking. Bernadette wrote of blessed candlelight, nuggets of golden twilight, and delicious daylight, all reinforcing the relationship of light to a person with SAD. In more general terms, Amy revealed light seeking and the effect of a sunny climate on her well-being.

Amy said:

> Moving to Florida has been my light therapy. It's just a whole different outlook on life. Living in Rochester, I knew I was getting worse each winter. Miami, with all its faults, is like paradise for me. The sky is bright; things are green; I love to walk outside every day; and I just can't wait to see the sun. It's like night and day, feeling dead or alive, the sun is an essential part of my daily life.

Like Amy, Denise also now lives in Florida. She offered her perspective of the role of light on her life with SAD. Denise described a heightened awareness of light in general. Her words also illustrated a preoccupation with light and support of the theme of light seeking.

Denise said:

> I was always concerned about where the sun was. This was my first clue that I might have SAD. My husband can leave the curtains closed and have the house dark. Not me. If I am going to be awake and doing things, I need to have the lights on and the window curtains open, otherwise it just feels wrong.

Denise also described how light became an issue for her at her workplace:

Denise:

> One of the guys I shared an office with had this mood lighting. I would flip on all of the overhead lights so I could work and be able to think. This guy would say, “No, it’s too bright,” and I would say, “No, it’s too dark,” and we would argue about it. The mood lighting literally made me feel depressed; I wanted it to be nice and bright.

Denise offered her perspective of the role of light on her life with SAD. She described a heightened awareness of light in general. Her words also illustrated a preoccupation with light and support of the theme of light seeking. She described how light influenced her relationship with a coworker. Ms. Piggy was perhaps the most succinct on the matter of light seeking. When confirming inclusion criteria at the outset of our telephone conversation, Ms. Piggy offered the following simple words encapsulating her sentiments. “My light box is my savior and my sanctuary.”

Light seeking was expressed in a variety of ways by the participants. This heightened awareness of light and attempts to gather light exposure was heard in the voices of the individuals. Some participants went to great lengths such as vacationing in exotic locations; others made simple trips to the supermarket at night to increase light exposure. One participant seemed to gain self-awareness and insight during our conversation as she spoke of using intense lighting required for her chosen hobbies of quilting and needlework. This preoccupation with light and the various means the individuals described to gain light exposure was the strongest, most clearly evident theme apparent in the data. The original poetry composed by participant Bernadette also reinforces the importance light plays in the life of a person with SAD. This poem will be presented in Chapter Five.

Autumn Apprehension

Expressions of apprehension as autumn approached became evident as the words of the participants were vocalized and reiterated in the written text. Apprehension was expressed in terms of anxiety and impending doom. Ominous apprehension was palpable in many of the voices of the participants as they spoke of the autumn time of year. Participants spoke of apprehension and dread in anticipation of winter in stronger terms than were used to describe winter itself. Terms such as “unsafe,” “foreboding,” and “feeling like something bad was going to happen” described their anticipatory anxiety. Bernadette was especially eloquent in describing her autumn apprehension.

Bernadette said:

> Even now, when I smell autumn leaves, I almost feel sick with that feeling of depression . . . . Starting in October, about a month after the equinox, I would start feeling sluggish, feeling sick, not well, low energy every year, every coming winter. My memories of winter are black and white and gray . . . . no color at all. Somehow I have this memory of a dead cat, being sick, and everything being colorless. As soon as the leaves started dropping, knowing it was coming, was just as bad or even worse as being in the middle of it.

Bernadette was interviewed in a tropical, lushly landscaped setting near the outdoor pool at her condominium complex in Florida. Despite the beautiful surroundings, she had no difficulty expressing her sentiments. She shared her experience with SAD in words that brought the researcher to understand the fear and anxiety associated with autumn. Ms. Piggy also spoke of apprehension associated with autumn. Her words reinforce her trepidation prior to actual winter.

Ms. Piggy said:

> I very much look forward to summer, but as it ends it becomes this dreading feeling like, oh, no, what's going to happen. Once it starts getting dark earlier, I get this feeling of oh, no, what am I going to do? At least I'm aware of what's happening now, and I know when that's going to happen; well,

> it starts around now really or somewhere around October. It's very unsettling to feel like something awful is about to happen . . . like waiting for something to die.

In another example of the theme of autumn apprehension, Amy recounted her feelings when she lived in a northern state. She spoke in tones one would use when speaking of danger or of a lurking, sinister threat. The onset of winter was described by her.

Amy said:

> People would say, oh, the fall is so beautiful, you know the colors of the trees, and I would think, oh no, in just a short time there will be just bare branches . . . . looking like death to me, all those trees without leaves, I would shudder at the thought. I have family still up North and I never go up there past October, I do not want to face that, all that dread that comes with seeing the fall, then knowing that it will soon be gray. Something about that makes me feel unsafe.

Amy's sense of impending doom in autumn was powerfully stated. Her story gave additional voice to the theme of autumn apprehension. Sunshine also described her feelings as the season changes toward winter.

Sunshine stated:

> I love change normally, but in the fall, I dread it, going back to school was like going into a black box. All of that darkness of winter, and the dread, you know it is coming and it makes you

> feel like you want to shrink. It gets worse and worse as the days get shorter and it gets darker and darker, there is just this dread kind of feeling that pushes me down . . . . If something is upsetting, it makes it really hard to handle things, even little things are very upsetting. In the fall, it just gets darker and darker, and the sense of knowing what's ahead, that's just the worst.

Sunshine used the word "dread" multiple times to describe her feelings about autumn. She described leaving her work as a schoolteacher due to her difficulty with SAD. She related that as the school year progressed, she would become anxious, waiting and knowing that winter was coming.

Julia also explained her feelings about the oncoming winter in terms consistent with autumn apprehension. Julia lives in a northern city and was interviewed by telephone. She shared her insecurities and apprehension. Within a few minutes of the beginning of our conversation, Julia spoke about her past experience and her hopes for the coming winter.

Julia said:

> I dread winter so much, I worry . . . . Will I be able to manage better this coming winter? I already hate the idea of winter here . . . . I dread winter so much. For me, going into this winter, I have the light and I know what's going on in my life; so I'm hoping that it will make this winter a little bit easier. It's scary. All those layers, the cold . . . . and just thinking

> about having to walk around and change buses in the dark . . . .
> it's like being swallowed up by the dark.

In the same vein as the other individuals, T-Man expressed autumn apprehension as the days grow shorter. His use of the word "doom" accompanied the emotion in his voice as he spoke.

T-Man said:

> Once I started noticing the sunset earlier, getting dark earlier, I'd start thinking I'm not going to be able to take this much longer; I just hate it. It's an internal darkness, like contracting into myself. It's like sensing doom, like being on the edge, knowing you are falling into the dark pit . . . . very unsettling.

T-Man's imagery of standing on the edge of a dark pit was a powerful example of the apprehension associated with autumn. Mirroring the sentiments of the other individuals, Psy Ns also spoke of autumn and the theme of apprehension.

Psy Ns said:

> There is a true feeling of anxiety, it's like a sinister threat is looming, a dark cloud, like a bad premonition. It's as if you look at the world through sort of a screen, a dark screen. And this is before the real depression . . . . that comes later . . . . it's anxiety, a true apprehension.

Apprehension and dread of impending winter was expressed in multiple ways by the individuals with SAD. This apprehension coincided with autumn and signaled the shortening of days and loss of light. Disturbing terms such as "dread," "foreboding," and feeling like waiting for something to die" characterized the anxiety associated with autumn for the participants. Impending winter was expressed as impending doom. Participants reinforced this theme during member-checking interviews. The theme of autumn apprehension as it relates to health and nursing science will be examined in the following chapter.

Longing for Validation of SAD as a Legitimate Disorder

The personal stories of the participants in this study revealed that there was a gap in the understanding of SAD. This gap emerged as a theme in multiple ways. Some stories recounted a lack of understanding by spouses, families, friends, and even medical and mental-health professionals. Other stories told of how individuals themselves came to learn about SAD and how they wished they had gained awareness earlier. The researcher ultimately identified that the lived experience of SAD included a longing for validation of SAD as a legitimate disorder.

Longing expresses an emotion beyond simple desire. The words of the individuals described a longing to have SAD validated as a legitimate disorder. Participants described the lack of awareness by others and the impact this lack has upon their lives. Participant Brandy expressed frustration at the lack of awareness of SAD by others. Brandy approached the researcher in response to a public announcement made at a medical conference asking for referrals of potential volunteers for this study. She made it clear that she was normally a private person, but in response to a request to find interested individuals with SAD, she requested a business card and asked to be considered as a participant. Brandy stated that more people needed to know about SAD, and she was willing to participate if this study would help accomplish that end.

Brandy said:

> I don’t usually talk about it because people tend to minimize your feelings. Unless they have been there, they tend to just blow it off and say . . . . sure dark days are gloomy, right? It really makes you question yourself, like are there no other triggers to cause the depression? I know I talked to my doctor about feeling badly with everything in the book for three or four winters. He even thought I had chronic fatigue syndrome, after all kinds of tests, nothing . . . . I finally had to figure this out for myself. I really think he thought I was just a little bit crazy . . . . you know that crazy, hysterical-female stuff.

Like Brandy, Sunshine’s SAD was not recognized timely by medical professionals. Sunshine said that she too had suffered through several winter depressions before she was finally diagnosed with SAD. She seemed to feel that had she and her doctor been more aware of SAD, she would have been spared some of her suffering. Like a number of other participants, her symptoms were greatly affected by moving from one geographical location to another.

Sunshine said:

> It took me a while to figure out what was going on. I was born in Florida, and I lived in northern California. I never had this problem . . . . now here, the winter, it’s a different story. I

> found myself in the grocery store, and I couldn't figure out what to buy. It was like I couldn't think. It's just overwhelming, like your mind is gone. I would call this suffering. Still a lot of people don't get it; they don't even know about it.

Like Brandy and Sunshine, Julia also expressed a longing for validation of SAD. The phrase "people don't get it" was echoed by Julia as she described the lack of awareness and understanding others have toward her SAD.

Julia said:

> People just don't get it; it affects my interactions with other people, especially people closest to me. I just overreact to some little things, and it seems like little things are impossible to get resolved. My fiancé probably bears the brunt of it. I don't think he really gets it. Last winter, I got so depressed for no reason my dad had to come over and stay with me for a few days in the middle of the week . . . . I know it's hard for them to see that, they just don't see any real reason for me to be depressed. It's not like anything has really happened, like you can say, oh, the dog died.

Julia offered the researcher an awareness of the need to validate and legitimize SAD. Just as Julia expressed that people in her life did not understand her experience of SAD, T-Man also said that he was being treated for general depression for quite some time before a therapist suggested that he might have SAD. T-Man then educated himself by reading about SAD and built his own therapeutic light box.

T-Man:

> I remember feeling like I just needed to get away from the dark. No one really understood, they just think it's regular winter blues and you are just trying to stay out of the cold. Finally, my therapist suggested I try light therapy, but not until after some really tough winters. Not everyone believes it's real. Please tell everyone this is real.

Reinforcing the words of the other participants, Amy also asked to participate in this study because she felt that more people needed to understand what it means to live with SAD.

Amy said:

> I wish I knew what was really happening to me when my kids were small. I had never even heard of light therapy or of SAD back then. If I had known, or if my doctor would have recognized what was happening, I'm sure it would have made a big difference. Even now, I think a lot of people have no idea; they think you should just be able to snap out of it. When you talk with somebody who doesn't understand, it is almost impossible for them to understand. I was trying to tell my neighbor about it, and I asked her if she ever felt this way. She said no, and she looked at me like I was crazy.

During our interview, Jbones also expressed a longing for validation of SAD as a legitimate disorder. She spoke of a lack of understanding of SAD by others.

Jbones said:

> What makes it worse is that people who have never experienced it just don’t grasp how real and how debilitating it can be. There is such a lack of sympathy, or empathy, or even just a lack of understanding. People seem to think you should just step up and get over yourself, like this is not a genuine illness. Even doctors I went to didn’t have a clue; they never even considered seasonal affective disorder, no one even suggested light therapy.

Jbones’ words eloquently emphasized a desire to be acknowledged as a person with SAD, a disorder that impacts her life. A longing for validation of SAD as a legitimate disorder was heard again and again through the words of the individuals. In addition to the excerpts above, when asked what they would like others to know about SAD, many of the participants wished to express that SAD is *real*. As Jbones said, people expected her to “just get over yourself, like this is not a genuine illness.” This statement provided her inside view of not feeling understood or validated as having a legitimate illness. This theme was identified and reinforced by the participants throughout the original and the member-checking interviews. This theme of longing for validation will be further explored in the following chapter.

Social Withdrawal

Social withdrawal may not be unique to the lived experience of SAD; however, it is included in this study as a secondary theme to support a rich, thick description as told by the individuals. Social withdrawal was described in a number of interviews as participants spoke of how SAD affects their social relationships. A lack of understanding of SAD by significant others and the diminished desire for participants to interact were validated in a number of interviews. Social withdrawal experienced in SAD is important to fully illuminate the description of the participants' lived experience of SAD.

Lei spoke of how SAD affects her relationships at different times of the year. She became tearful when speaking of withdrawal from her husband and her daughter during the winter. Words such as "hibernation," and the metaphor of feeling like a turtle pulling into its shell, provided a view into the withdrawal as a part of her experience with SAD.

Lei said:

> I feel like a turtle, I just want to pull in and hide. Get me someplace where I can just pull in and sleep, not deal with whatever is there . . . . Some days I have no push, it's all I can do to get up and go to work. Basic things are affected, like weather, I'm even up to cooking dinner. Catch me around the summer solstice and I'm supermom; then count down to the equinox and I'm in hibernation mode. Where I live, we have morning fog and it burns off with the morning sun. I'm foggy

> and cranky in the winter, and I would just like to stay in bed and not bother with anyone; then the summer sun comes and sort of burns that off and the real me comes out.

Lei’s insightful picture of her social change in winter allowed the researcher a glimpse into her experience with SAD. Jane shared the following story, which depicts her experiences of social withdrawal.

Jane said:

> In the winter, I just don’t want to be around people, especially a lot of people. One Friday, I was supposed to go out with coworkers after work for a Christmas party, and I just couldn’t face it. I hid in another office until they left without me. They were looking everywhere for me, and I was hiding, like a child . . . . all those people, I just wanted to go home and be alone.

The story told by Jane clearly illustrated the impact of Jane’s social withdrawal. Her desire to be alone was very evident. In a similar experiential account, Sunshine related the following story. This example demonstrates how social withdrawal has affected her relationships with family and friends.

Sunshine said:

> My husband has a big family and we take turns hosting events during the holidays. One year, I did Christmas. When the day came, I just remember not wanting to have anybody there. I wanted to hide in the closet. It was awful. Now his family gets it; so I only host Easter; that’s my time of year. In the winter,

> it's too hard for me to deal with all that and all those people. It's too overwhelming. It's kind of like this winter cloud comes over you. My old, longtime friends know me, and it's okay with them if I'm really quiet and don't want to go out in the winter.

Julia spoke of isolation and social withdrawal in terms of missed opportunities. She spoke with regret about having these SAD symptoms while she was studying abroad in Sweden in the winter. She lamented not meeting people or interacting more with others during the time she spent there.

Julia said:

> I went to Sweden as a student in the winter, everybody has it there. It was cold and dark, and I stayed indoors and didn't have any of the experiences I should have had when you study abroad. It wasn't until after the year I came back from Sweden I figured out what was going on. I just stayed home a lot. I was not participating in life. This thing just changes my personality; I don't want to go out or be with people. During the winter, I just go to work, go home go to sleep pretty much right after work, even on Friday night.

Denise revealed that withdrawal from her loved ones made her realize she had a problem with SAD. Denise described herself as normally a very sociable person, a trait she credits to her Latin cultural heritage. When she found herself withdrawing, she sought help from a psychologist and was diagnosed with SAD.

Denise said:

> I found I just wanted to sit at home, away from people . . . . this is not me. Normally, I am a very social person, I like to go places and do things. I like to be with people. I found all I wanted to do was sit at home. When you are in the middle of it, you don't really realize what is going on; but I knew something was really wrong when I didn't care about being with even my family. That's when I said I will not stand for this. I couldn't do it to my child.

Denise related how withdrawal impacted her ability to parent her young child. Ms. Piggy spoke of how SAD impacted her ability to work as a corporate attorney. The impact of social withdrawal on this professional woman's career is unclear, but the reality that it affects her life was evident in this research study.

Ms. Piggy said:

> Sometimes going to the office is more than I can take. I prefer to be away from people, I sometimes feel helpless. I tend to be irritable and people don't understand why. It's easier to just withdraw, and just not bother with trying to be sociable.

Stories of social withdrawal were found in a number of the descriptions of the lived experience of SAD. Participants described situations where social withdrawal impacted their ability to parent, work, and enjoy contact with others. For participant Denise, withdrawal from her family provided the impetus to seek professional help for her SAD.   Jane illustrated how this theme impacted her relationships with coworkers, and Julia spoke of missed opportunities as an exchange student. Social withdrawal may present challenging therapeutic implications, which will be explored in the following chapter.

Disruption of Energy

Secondary themes not exclusive to SAD emerged in the words of the individuals of this study. In addition to social withdrawal, disruption of energy was also identified as a secondary theme. Participants spoke using various terms descriptive of disruption of energy. Words such as “lethargy,” “fatigue,” “tired,” “sleep,” “anxiety,” “loss of energy,” “slowed down,” and, “moving through jello” were used to describe generalized states of physical and mental depression.

Psy Ns related a Christmas story that described a unique way of coping with the lack of energy during the holiday season.

Psy Ns said:

> So you are on some insane merry-go-round of trying to get things done, trying to please everyone else, when you don’t even want to physically move. The extraordinary demands from trying to take care of the kids and dealing with what is going on in my own head . . . . and just that awful time of year. It was just too much; it just goes on and on; that’s how I saw the holidays. It got worse and worse for me; finally, the first year after my divorce, I vowed I didn’t have to run around in the dark. That year we had chili dogs and cheesecake for Christmas dinner; the kids were just fine with it. It was a

> turning point. Ever since that I have never dealt with Christmas or the holidays in the same way again. I don’t go through all that s--- anymore, ever. See, we had a chili-dog Christmas, and everyone survived.

The lack of physical energy was expressed in terms of parenting challenges for Jbones. She spoke of the lack of physical as well as mental energy.

Jbones said:

> In the winter in Ohio, I just hated the kids’ teachers; they would give kids these stupid school projects. If you don’t do it, all the other kids get an A and your kid doesn’t. I remember thinking, I do not want to have to get up, go out in the cold and dark to go and get this stuff and . . . . just not doing it, I just felt like I didn’t have the energy to make myself go and do it. That was it, I knew I had to make up my mind to do something about it.

Jbones’ discussion of not having enough energy to help her children with school projects was a strong example of this theme. Lei spoke of the lack of energy as being responsible for her inability to cook dinner after work in the winter. She spoke of not meeting her responsibilities to her family. She also expressed remorse over not faithfully using a light-therapy device to help her cope with her SAD symptoms.

Lei said:

> It feels like every day you have the flu, you know without the aches but just that intense . . . . "don't want to move" feeling. Like all the energy has been zapped out of you. Some days, I just can't even cook, you know . . . . I'm lucky if I can make it home from work, forget dinner. Then, of course, comes the guilt. It's the turtle effect; just get me somewhere where I can pull into my shell and sleep. I plan to do a better job of taking this more seriously this coming winter. I plan to get serious and use the light box.

The disruption of energy as the seasons change was expressed as a dichotomy of two lifeworlds by Sunshine. Rather than describing the lack of energy in the winter, Sunshine focused instead on the energizing effects of spring. She has adapted her career to correlate with the alternating seasonal-energy patterns she experiences.

Sunshine said:

> In the winter, I'm dormant, but in the spring, I can do anything; if something is upsetting, I can handle it, piece of cake. In the spring, I just have so much more energy. I play soccer outside with my kids; just being out there, even though it should tire me out, it's just the opposite. I work outside because I just feel better when I'm outside, especially when I can put in gardens. I work as a landscape architect; it's just perfect for me. The work comes at just the right time of year.

The participants revealed the theme of disruption of energy in the initial interviews and supported the theme via member-checking interviews. The seasonal variation of the theme was clear in Sunshine's analogy of a plant, being dormant in the winter and energized again in the spring. Psy Ns's chili-dog Christmas story reflected the theme and her unique way of coping with the demand for energy during the holidays. Jbones described her lack of energy in the winter and how this prevented her from providing support for her children's school projects. The various words and exemplars of the individuals described and supported the theme of disruption of energy in the lives of those with SAD.

Summary

Chapter Four presented the findings of this study. Descriptions of the participants, the recruitment methods, and the method of data analysis have been provided. The basic themes of light seeking, autumn apprehension, and longing for validation of SAD as a legitimate disorder were described. In addition, secondary themes of social withdrawal and disruption of energy were illustrated by the participants' words.

Rich texture and detailed descriptions were provided by the participants, resulting in the emergent themes. The researcher utilized the phenomenological process to uncover the meaning of the SAD experience. After reflection, writing, and rewriting, the participants nodded that the themes were accurate expressions of living with SAD.

CHAPTER FIVE

DISCUSSION AND CONCLUSION OF THE INQUIRY

Little darling, it's been a long, cold, lonely winter,
Little darling, it seems like years since it's been clear,
Here comes the sun, Here comes the sun and I say
It's all right.

George Harrison

Exploration of the Meaning of the Study

The overarching question explored in this study was "What is the lived experience of the individual with seasonal affective disorder?" Twelve participants were asked to provide their personal perspective of living with SAD. This chapter serves to explore the deeper meaning of the themes identified in this study.

Hermes, the mythological Greek messenger for whom the origin of hermeneutics is named, was charged with interpreting messages from the gods and delivering them in terms understandable to mere mortals (Mueller-Vollmer, 2006). In this hermeneutic-phenomenological study of individuals with SAD, the researcher, likewise, used the words of the participants as a basis for the following interpretive analysis. This analysis provides an appreciation for the meaning behind the words of the individuals. The individuals' words then serve as representative of experiences that will be related philosophically, theoretically, and in practical application to the professional practice of nursing (Gadamer, 1996).

Gadamer (1996) wrote that quantitative methods fall short of meeting the needs of many health-related scientific questions. States of health and illness are multidimensional, involving social, ethical, psychological, and moral aspects that may be studied and appreciated only through phenomenological methods (Gadamer). This study into the lived experience of persons with SAD describes an aspect of everyday life as expressed by the individual participants.

The art and science of nursing respects the holistic nature of health and the contextual lived experience. Nursing exists within society to serve fellow human beings in a respectful, socially aware manner. The professional practice of nursing is guided by a set of basic assumptions set forth as a guide. Nursing's Social Policy Statement (American Nurses Association, 2003) professes:

- Humans manifest an essential unity of mind/body/spirit.
- Human experience is contextually and culturally defined.
- Health and illness are human experiences.
- The presence of illness does not preclude health, nor does optimal health preclude illness.

These core values of the nursing profession clearly focus on the humanistic, holistic nature of nursing science. The holistic approach includes reflexive phenomenological knowledge such as presented in this study. The research was conducted and cocreated in partnership with the participants. Their voices provided a glimpse into the world of life with SAD.

Recruitment for this study may have been influenced by one of the major themes identified. As several of the participants stated, the diagnosis of SAD is still frequently overlooked by medical practitioners (Rosenthal, 2006). The general lack of awareness and wish to provide validation to others was reflected almost universally. The theme of longing for validation of SAD as a legitimate disorder was cited often as a motive for participants' willingness to be interviewed about SAD. Volunteers generally expressed gratitude for being able to participate in the study in order to help educate others about SAD.

The process of conducting this study may be visually represented by a prism. The phenomenological research process acted as a prism to illuminate and to describe the major themes of the lifeworld of others. SAD was represented by the beam of white light. Van Manen's phenomenological research process acting as a prism allowed embedded colored rays of emerging themes to become visible. As a prism allows one to visualize color from a ray of white light, the process of phenomenological research allows the outsider to appreciate the rich color and texture of the lifeworld of another.

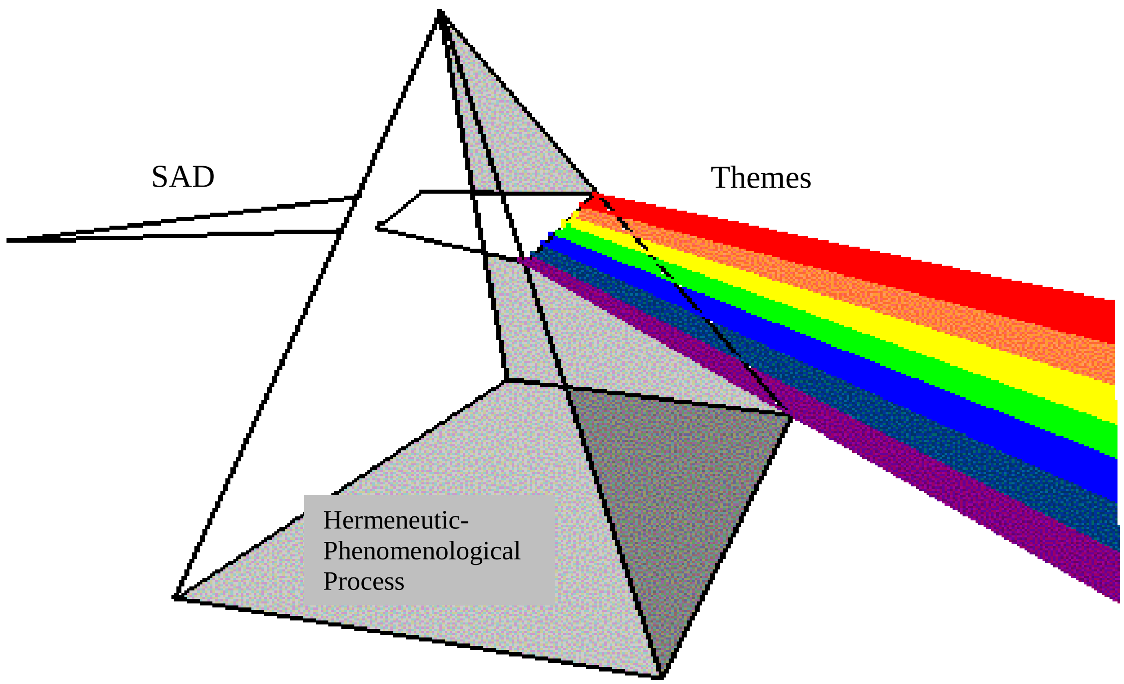


Figure 1. Downs' (2010) representation of the prism of phenomenological inquiry into the lifeworld of SAD.

In Figure 1, white light is analogous to SAD, while the prism acts to illuminate the themes imbedded within. This study uncovered the themes of light seeking, autumn apprehension, longing for validation of SAD as a legitimate disorder, social withdrawal, and disruption of energy. The phenomenological lens, or prism, allows one to see and appreciate the lifeworld of others. While the white light may have previously been visible, the phenomenological research process allows communication of a rainbow of deep understanding and appreciation of what is contained within.

Van Manen speaks of insight cultivators found in art, poetry, and music. In that spirit, Bernadette wrote a poem and requested that it be included in this document as part of her contribution. Bernadette e-mailed this poem after the conclusion of the member-checking interview. She composed this piece in the hope of educating others. Bernadette said that the poem describes her life and her relationship with SAD. The poem reflects themes of light seeking (delicious daylight); autumn apprehension (leaves as death knells); social withdrawal (hibernation beckons), and disruption of energy (thoughts assume a fetal position). Her very act of composing this poem demonstrates a longing for validation of SAD as a legitimate disorder. Bernadette's poem offers a glimpse into her world of living with SAD.

Living with Seasonal Affective Disorder

In autumn, dullness
the sound of brown leaves are tiny death knells
fading into the cold distance
sinking and curling as my thoughts
assume the fetal position

hibernation beckons; i so envy the bear
while i chase the last nuggets of golden twilight
mind racing west like a rabid wild-eyed prospector

Winter comes with
blessed candlelight, eyes aglow reflecting
rainbows of tiny lights by the thousands
all outrageous impostors celebrated
with gifts and hollow singing

i sleep, my hands bleeding in dark dreams, razor sharp
the silver moonlight is no substitute
for the gilded dawn i crave

Open the windows
Open the sky
Open my heart again to spring --
even Nature knows the return of light
carries an imperative to unfurl and grow

The forsythia's tiny suns burst forth
a tiny blue robin egg fills me with hope and joy
the world returns, the horizon expands

Summer's fecundity, teeming
songs with a long chorus of light followed by fireflies
a manic riot of endless golden meadows
and bees humming, locusts droning the sound
of life in its fullness

i savor the feast of delicious daylight, my senses clinging
to every moment, every heartbeat
until the foreboding descent of that first brown leaf

of autumn

Bernadette-participant

Interpretive Analysis of the Findings

This phenomenological inquiry yielded three basic themes: light seeking, autumn apprehension, and longing for validation of SAD as a legitimate disorder. Two secondary themes of social withdrawal and disruption of energy also emerged. The participants used various terms to describe these themes and how they impacted their lifeworlds. Additionally, the poem provided by Bernadette supports the themes identified and is used as an additional exemplar.

The researcher's own interest in light as a therapeutic modality provided the impetus to conduct this study. If one views individuals with SAD as light-sensitive beings, a study into their lived experience offers a perspective on the profound role that light may play in the lives of human beings. As a nursing study, the findings offer insights for the potential development of informed care and professional practice.

The interpretive process described by van Manen was employed throughout this study to arrive at these themes. Van Manen (2002) informed us that phenomenological inquiry does not yield absolute truths but strives to present a glimpse into the meaning of an aspect of the human lifeworld. Allowing the voice of the participants to tell the story of the lived experience of what life is like with SAD was accomplished by the process of applying van Manen's activities in conducting the study.

Van Manen (2002) described the practice of phenomenological exploration as "writing in the dark," an apt and fitting title to apply for this particular study. By reviewing the transcribed data using the highlighting process, writing, and rewriting, the themes apparent in the participants' words began to take shape in providing the essence of the themes. Three main themes that described living with SAD emerged: light seeking, autumn apprehension, and longing for validation of SAD as a legitimate disorder. Insight cultivators, collaboration, reflection, writing, and rewriting of the themes resulted in the emergence of two secondary themes. The secondary themes of social withdrawal and disruption of energy were found woven into the participants' stories and experiences.

The study aimed to describe the lived experience of individuals who suffer with SAD. The descriptions provided by the individuals have produced a rich text illustrating the identified themes. The illumination of the themes provides a method of dissecting and exploring fundamental areas of interest for practical application and additional analysis. This phenomenological study provides the listener's gaze, or the insider's view, of what it means to live with SAD (Madjar & Walton, 1999). The participants described the psychological, physical, and social impact SAD has had on their lives.

Light Seeking

> *Good Day Sunshine*
>
> *I need to laugh,*
>
> *And when the sun is out,*
>
> *I've got something I can laugh about.*
>
> John Lennon and Paul McCartney

These partial song lyrics are a representative example of the connection with light and mood. This popular upbeat song invokes positive images associated with a sunny day. Sunshine is often portrayed as a metaphor for happiness and positive feelings. Sunlight may also be taken for granted in our daily lives.

“Light is a construct so basic to life it is almost synonymous with life itself” (1974, p. 45), so says Kendrick Smith of Stanford University, the first president of the American Society for Photobiology. He wrote: “Sunlight is probably the most important single element in our environment; yet it has been largely ignored by the scientific community perhaps because of its ubiquity” (1974, p. 45). This statement may be true of the general public and may be reflective of the current state of quantitative research. However, the participants in this study were found to have attitudes toward light in sharp contrast to this norm. As demonstrated by the words of the participants, the theme of light seeking illustrated how the participants with SAD perceived light very differently from the general population referred to by Dr. Smith.

Despite now living in Florida, Amy, Bernadette, Denise, and T-Man continued to speak of a persistent hyper-vigilant, almost obsessive attitude toward light. This conscious awareness of the amount and location of light certainly did not meet the above description put forth by Dr. Smith. The individuals in the SAD study spoke of light as one would speak of the essential elements of food, water, sleep, or shelter. It was clear that light itself plays a major role in their states of well-being. Their continued light seeking demonstrates self-care and resilience in managing their SAD symptoms.

This construct of the heightened awareness of light in everyday life and the seeking of light was expressed in different ways by nearly all the participants. It is important to reiterate that the interviews took place in the months of July, August, and September. The participants spoke of seeking light in their everyday lives, not just during the winter months. This point suggests that a heightened light sensitivity in some form may be present throughout the year for these individuals. Listening to the participants and reflecting upon their words brings to mind self-health-promotion behaviors. Several participants described unconscious light seeking, such as in the case of nighttime supermarket visits and the use of tanning beds before more formal sources of light therapy were employed. The participants were found to have used combinations of formal light-therapy devices as well as environmental and incidental light sources.

Several of the participants had moved to a sunnier climate to manage their symptoms of SAD. The participants who had relocated themselves and their families felt that they no longer needed to use formal light therapy. They continued to express heightened awareness of SAD and maintained light-seeking behavior. Bernadette succinctly stated that she still consciously arranges her day to maximize her light exposure, ending as many days as possible outdoors to “catch the last nuggets” of sunlight. She also stated that when shopping for a home, the number and the location of the windows were her primary concern.

Amy also moved to a sunny climate more than 10 years ago, and she still describes her current home as “paradise.” Amy takes afternoon walks with her neighbor just to “get a little sunlight” every day. Living now in Florida, she expresses a sense of relief and says she has “a whole different outlook on life.”

Other participants seemed to have been more intuitively drawn to light. Psy Ns spoke of doing needlework, and later stated she was an avid reader and regularly used a strong reading lamp to accomplish her leisure activities. These instances of seeking environmental light intentionally or intuitively can be interpreted from a nursing standpoint as health self-care or as examples of resilient behavior.

On a biological level, studies have linked SAD with diminished environmental light; therefore, light-seeking behaviors may not be a surprising finding (Booker & Hellekson, 1992; Levitt & Boyle, 2002; Rosenthal, 2006; Wirtz-Justice, 1998). The intuitive nature and creative ways the participants found to expose themselves to light other than formal light therapy were unexpected, even surprising some of the participants themselves. Although the past history of some form of light therapy was an inclusion criterion, the participants were not directly asked about specific experiences with light. This information was generally offered and in some instances led to reflexive insights.

Individuals with SAD may intuitively seek the healthful benefits of light exposure. A few recent studies have investigated the effects of bright light on pain and postoperative healing in hospitalized patients (Walch et al., 2005). There has also been a recent increase in the health benefits of sunlight and vitamin D on bone health and cancer prevention (Holick, 2008). These quantitative studies reinforce the intuitive knowledge of the benefits of sunlight expressed by the individuals with SAD.

"Second to the need of fresh air is the need of light . . . . The sun is not only a painter but a sculptor."

Florence Nightingale (1969, p. 84).

Nursing has a special relationship with light. Florence Nightingale is known as the "lady with the lamp." The lamp (light) is often still used symbolically to represent the profession of nursing. The American Nurses Association has retained the image of a lamp and flame to symbolize the history of nurses as the keepers of the light (ANA, 2009).

Photographic depictions show Nightingale holding up a lamp, illuminating the profession with knowledge. As the first nurse researcher, she lit the way, ushering in an era of nursing scholarship. This representation of light as a symbol of knowledge and ideas is repeated throughout popular culture. The image of light as a phenomenon dates back to the conception of the earth. The first chapter of the book of Genesis describes light as God's creation with the proclamation "Let there be light" (*New living translation: 2nd ed.*, 2004).

Light is so basic to the shared human experience that it is widely used as poetic metaphor and in musical references. A characteristic lightbulb is often used symbolically to represent notions and ideas. In the science of physics, light is described as a form of electromagnetic radiation, occurring in waves and possessing energy or accelerated electric charges (Brandenberger, 2002). Light shares an association with rationality and logic. The Age of Enlightenment is a period in the history of intellectualism when philosophical thinking and the scientific process came to be valued above superstition and mysticism. In his analysis of historical literature, Heinemann says that “enlightenment signifies man’s coming of age” (Heinemann, 1944, p. 702).

The incorporation of light therapy has been known since ancient times, and light was an essential element in the initial concept of the Japanese healing art of Reiki (Zupanic-Slavec & Toplak, 1998). Light also has links with spiritualism. Holy icons are often portrayed artistically radiating beams of light or with illuminated aural emanations. In art history, the use of light and the creation of shadows represent a demarcation in styles of religious artistic expression. Solar worship was central to the ancient Egyptian religion, and pre-Socratic philosophy associated light with spirit or the soul (Werbolowsky & Iwerson, 2005).

In modern Western culture, a lightbulb is often used symbolically to portray an idea or knowledge. Thomas Edison’s invention of the lightbulb ushered in an era of man’s ability to control the forces of light to the degree that it was instrumental in the Industrial Revolution. Thus symbolic references to the lightbulb portraying a “bright” idea and to the ability of man to control environmental forces are subtle reminders of the profound impact of light on our daily lives. The use of bright-light therapy is an example of mastery over environment and offers the SAD sufferer a therapeutic modality to improve the quality of life.

Light is associated with happiness, joy, purity, beauty, optimism, and comedy. Light is also symbolic of good, in contrast to evil, which is often portrayed as darkness. The equation of light with goodness and dark with evil is seen throughout popular culture. Terms such as the “dark arts” and “light-hearted” convey the social values associated with the symbolic dichotomy of light and dark. Any number of product-packaging strategies shows sunrays depicting organic products or foods being marketed as healthful and wholesome.

Sunlight and therapeutic bright light are of interest to the practice of nursing. The influence of light on health states is exemplified in persons with SAD. The amount of light or lack thereof is directly proportional to the prevalence of the disorder (Rosenthal, 2006). Participants in this study confirmed this fact by their many statements regarding their changing outlook, energy, anxiety, and general functioning fluctuations with the seasons and with the amount of light exposure.

Spiritual light: Historically, light has played a part in most major religions, in mythology, in worship rituals, and in iconography (Werbolowsky & Iwerson, 2005). In most religions, light is considered to be an attribute of the deity and a life-giving factor (Schutzinger, 2003). The Old Testament begins with an account of the creation of light. The New Testament passages “The Lord is my light and my salvation” (Ps. 27:1) and “In thy light we shall see light” (Ps. 36:10) demonstrate the strong association between light and spiritual beliefs. The individuals in this study expressed a spiritual reverence toward light as well. As Bernadette’s poem reveals, light plays a profound role in her spiritual well-being: “i savor the feast of delicious daylight, my senses clinging to every moment, every heartbeat.”

Light also plays a central role in acts of worship, for example, the lighting of candles during religious services such as the candles in Hanukkah menorahs and the altar candles in Roman Catholic churches. Light is also used as a symbolic representation in demonstrations of devotion such as an eternal flame to honor the dead.

The Near Death Research Foundation (NDERF) has chosen artwork depicting a person with a full spectrum of light emanating from the head to symbolize his beliefs about the continuation of the spiritual self beyond the death experience (NDERF, 2009). Halos of light generally surround divinities in major works of art through the ages.

Walton and St. Clair's (2002) qualitative work with post-heart-transplant recipients identified the strong thematic spiritual experience of their patients. They described their findings of spirituality as a beacon of light providing illumination that was synonymous with hope for the transplant patients during difficult times. The language used by patients in this study further illustrates the strong associations among light, spirituality, and health.

Religious icons and works of art are rife with illustrations of light emanating from spiritual images. Health and spirituality have long been inextricably linked, from the Greek temples of Asklepios to the spiritual calling of the Nightingale nurses (Schweitzer, Gilpin, & Frampton, 2004). Thus connections exist between light, spirituality, and the profession and acts of nursing. This discussion of spiritual light has been restricted to the symbolic nature of light as an element affecting the commonly shared worldview of Western spiritual experience. Given the understanding that qualitative differences exist among experiences and perceptions of human beings, all personal associations of light and spirituality hold individual value. Spiritual light and the reverence for light were evident in the words of the SAD participants. Sunshine, who chose her pseudonym aptly, said that during the summer, when there is an abundance of light, she "can do anything." The relationship of light to the elements of the lifeworld of the participants will be explored in the analysis of the individual themes.

Psychological/Emotional Effects of Light: It is tacit knowledge that human beings generally feel better when exposed to sunlight. The *Places Rated Almanac* factors in the number of days of sunshine in determining the best places to live (Savagea, 2000). With rare exceptions, a sunny day evokes images of happiness and energy. The converse can be seen in persons with SAD at northern latitudes, generally above 40 degrees, where exposure to sunlight is minimal; artificial light therapy is often helpful (Sher, 2004). University of Massachusetts nurse researchers conducted a placebo-controlled study of women with mixed types of depression. Their findings indicated that bright-light therapy improves sleep, elevates mood, reduces fatigue, and increases energy levels in pre- and post-menopausal women with nonseasonal depression as well as in those with SAD (McEnany & Lee, 2005). The participants of this study reinforced these findings.

A small segment of the population with panic disorder may exhibit a hypersensitive photophobic response when exposed to certain wavelengths in the light spectrum. An Italian study reports that a greater number of photophobic panic-disorder sufferers are born in the winter months and potentially suffered a lack of early light exposure. Light exposure is thought to be fundamental to the development of the central nervous system and of visual structures (Bossini et al., 2009).

Symptoms of agitation in dementia patients have been studied and found to be affected and significantly alleviated by exposure to sunlight, especially morning light (Hartley, 2003; Skjerve, Bjorvatn, & Holsten, 2005). Positive emotional effects of light exposure have been noted in vascular dementia as well as in Alzheimer's-type disease. The phrase "sundown syndrome" has been coined to describe confusion in the elderly at night (Drake, Drake, & Curwen, 1997). This syndrome is characterized by increasing symptoms of dementia such as mental confusion and wandering behaviors late in the day as the sun recedes.

Japanese researchers studied the effect of light on healthy women (Kosaka et al., 1999). They found that healthy women reported that after the second exposure to the light, moderately bright light improved self-evaluations for alertness, mood, motivation, happiness, refreshment, concentration, and appetite. In this study, sleep cycles, and levels of reported anxiety improved after just four exposures to the therapeutic dose of light.

Emotional responses to sleep quality and quantity have been studied in relation to circadian physiology. Typically, night-shift workers report reductions in alertness and performance during shifts or significant difficulty attaining sleep of recuperative value during the day. As a result of circadian de-synchronization, night workers have been found to suffer more accidents and health complications than their day-working counterparts. Shift workers with atypical exposure to sunlight may be aided by the administration of prescribed phototherapy (Boivin & James, 2005).

Workers exposed to daylight in their office buildings report an increase in general well-being, better health, less utilization of health-care services, increased productivity, and increased overall worker satisfaction. The provision of daylight thus results in decreased businesses expenses. The benefits of sunlight exposure on workers are so great that many European building codes require workers to be within

27 feet of a window (Franta & Anstead, 1994). Study participant Lei illustrated this finding when she spoke of visiting coworkers with window offices regularly throughout her workday.

A few U.S. hospital designers are beginning to recognize the valuable role of light and environmental esthetics. Ulrich (1984) conducted a study of the effect of light on surgical patients. He compared patients assigned to a room offering a window view of a natural setting with a matched sample of patients having no window view. Twenty-three surgical patients assigned to rooms with windows looking out on a natural scene had shorter postoperative hospital stays, received fewer negative evaluative comments in nurses' notes, and took fewer analgesic medications than the 23 matched patients without the daylight view.

A similar study by West as cited by Heerwagen (1986) evaluated the effects of light on a population of prisoners. Inmates with windows and natural views were found to have significantly fewer sick calls than their windowless counterparts. This reinforces the link between light and feelings of well-being as described by those with SAD.

Physical/Scientific Light: The mind-body connection is well illustrated in studies of the effects of light on the human organism. The emotional, psychological, physiological, and spiritual effects of light on human beings are inextricably bound. The shared experience and the common phrase "a day at the beach" is a metaphor that implies life at its best.

In another example of the mind-body connection, salivary cortisol levels, an indicator of physiological stress, have been shown to be directly influenced by the application of light therapy in night-shift workers (James, Walker, & Boivin, 2004). The neurotransmitter dopamine has been shown to play a major role in light-transmission pathways. Dopamine's effect on the brain signals pleasure and well-being (Bossini et al., 2009). Serotonin, which influences moods and psychological states, has also been shown to be mediated by light.

The pineal-gland hormone melatonin is produced only during periods of darkness and plays a major role in sleep hygiene. Sleep is correlated with the body's immune system; thus light and darkness have the power to exert control over states of health and well-being (Nathan et. al., 1999). The National Aeronautics and Space Administration (NASA) has installed near-infrared bright-light lamps on shuttle missions to simulate daylight, helping astronauts maintain homeostasis. NASA scientists have studied increased cellular-mitochondrial action and decreased healing time of wounds with exposure to therapeutic light (Leahy, 2002).

While light applied to the eyes has been shown to clearly influence affective states, the application of light to the skin produces an equally remarkable physiological reaction such as in the synthesis of vitamin D. As this vitamin is essential to calcium absorption, light plays a role in maintaining healthy bones and in the prevention of diseases such as rickets. Canadian scientists Hargreaves and Thompson (1989) found a statistically significant decrease in dental caries of children whose classrooms were provided with full-spectrum lights over a period of 22 months.

Appropriate types and doses of light waves have been shown to be therapeutically beneficial in tissue repair and in some cases as an analgesic (Enwemeka, 2004). The use of phototherapy to lower bilirubin levels in jaundiced newborns can be traced back to the astute observations of a nurse, Sister J. Ward. In 1956, Sister Ward of Essex, England, noticed a marked improvement in the skin color of jaundiced babies whom she took outdoors for a dose of fresh air. Shortly thereafter, a vial of blood left exposed to sunlight was found to have a 10 mg/dl decrease in bilirubin, and the effect of visible light on bilirubin was confirmed (Maisels, 2005). Prior to this discovery, exchange transfusion was the only course of therapy for these newborns. “Bili-lights” are standard therapy in newborn-care units today.

The use of light therapy to treat acne vulgaris by combination blue-and-red Light Emitting Diode (LED) therapy appears to have excellent potential in the treatment of mild to severe acne. Unlike topical and systemic chemotherapeutic agents, this LED-phototherapy treatment appears to be both pain-free and side-effects free (Goldberg & Russell, 2006). Photodynamic therapy is also used to treat other skin conditions, such as superficial basal-cell carcinomas, vitaligo, and Bowen’s Disease (Clayton, Tait, Whitehurst, & Yates, 2006). Bright-light therapy is also the standard for prevention and treatment of SAD (Rosenthal, 2006). The findings of this SAD study illustrate the importance of light exposure and the need to view light as an important therapeutic modality.

From a nursing perspective, it is responsible to note that extensive sun exposure, along with the depletion of the ozone layer, has been linked to the rise of cutaneous cancers (Masso, 2006). Thus most commercial light therapy products limit the amount of ultraviolet spectrum rays emitted. Brandy acknowledged this concern when speaking of her exposure to tanning beds.

In 1870, scientists proved that sunlight kills bacteria and other microorganisms. In 1903, Dr. Niels Finsen of Denmark won the Nobel Prize in medicine for work showing that blue-violet and ultraviolet lights could kill the bacillus known to cause tuberculosis. Light therapy to control germs, known as heliotherapy, fell out of favor with the advent of antibiotics and the pharmaceutical industry's influence over physician-prescribing practices. Today, there may be a resurgence in interest in the use of ultraviolet light on multidrug-resistant organisms (Wald, 1994). The implications for future studies with light as an interventional and therapeutic modality may be an emerging frontier for nursing science.

Light Seeking

In this phenomenological study of SAD, the theme of light and light-seeking behavior became evident in the data of the spoken words of the study informants. The essential nature of the relationship between light and feelings of well-being, energy levels, and overall states of health became apparent. The other themes that will be explored in the following sections were found to be related to the amount of sunlight experienced by the individuals.

Light therapy is an ancient concept that may be seeing resurgence in use. As one of the most basic elements on earth capable of having a profound impact on the human organism, light therapy demands serious attention for potential applications and further nursing study. This phenomenological study offers one perspective of light and its influence on well-being in the participants with SAD. The potential for additional studies of light and its relationship with health is ripe for future investigation.

Light seeking was found to be a major theme influencing the lives of the individuals of this study. The meaning of light in popular culture, nursing, and society has been briefly explored. Light was found to directly influence the sufferers of SAD who participated in this study, and several of them expressed novel ways of incorporating light into their lives. Light as a therapeutic modality is discussed under implications for nursing.

Autumn Apprehension

When the leaves fall, I fall

Anonymous

Autumn apprehension was identified as a significant theme of this inquiry into the lived experiences of those with SAD. Bernadette used the word “foreboding” and described the sound of autumn leaves as “death knells” to express this theme. Other individuals used terms such as “unsettling,” “unsafe,” “dread,” “worry,” “like a sinister premonition,” “like something awful is about to happen,” and “like waiting for something to die” to describe their feelings of impending winters. These terms appear to be descriptive of anxiety states. The entomology of the word “apprehension” is linked to associations with words such as “fearfulness,” “uneasiness,” “angst,” “misgivings,” “trepidation,” “worry,” “nervousness,” and “dread.” These words mirror those used by the individuals in this study.

The word “autumn” is often laden with negative cultural references such as the “autumn of one’s life.” This phrase may refer to the decline in one’s abilities or the nearing end to one’s days on earth. The onset of the autumn season was described by the participants as a harbinger of darker days ahead.

Several individuals specifically mentioned October as the time of the onset of this feeling. Halloween is celebrated in North America on October 31. The holiday has roots in the celebration of the dead and is rife with dark symbolism, such as ghosts, goblins, and graveyards. These cultural symbols of death, evil, and darkness seem to coincide with the onset of anxiety and foreboding described by the SAD individuals.

The participants spoke of oncoming winter with great apprehension. This theme was described as occurring prior to the days actually becoming shorter. The intensity of the trepidation of winter for some was described as being as bad as experiencing the actual winter depression itself. The anticipation also moved several participants to vow to take early action before the onset of symptoms for the upcoming winter. Some participants used this apprehension as a motivating force. In demonstrations of self-care, individuals planned to put into place preventive measures such as scheduling vacation time or beginning light therapy early in the season.

Apprehension has been described in terms of anxiety states. Sexton and Dugas (2009) examined people with traits of intolerance to uncertainty and suggested that worry over uncertainty in itself may contribute to generalized anxiety states. In their work, they postulated that intolerance to uncertainty and worry distinguishes levels of anxiety states and overall vulnerability to mood disorders. Sexton and Dugas referred to intolerance to worry over uncertainty as a “dispositional characteristic” (p. 176). This characteristic was found to be highly correlated with pathological worry and trait anxiety and was found in several forms of depression. The unsettling, specific autumn apprehension described by the participants represents a characteristic of SAD not previously described in the literature.

Most people experience mild anxiety during challenges in life. True anxiety disorders are often debilitating and may lead to a significant disruption of life routines for sufferers and their families (Thobaben, 2008). Psychological symptoms of anxiety may include difficulty concentrating, irritability, emotional sensitivity, worry, inability to turn off anxious thoughts, difficulty concentrating, or feelings of impending doom (Thobaben). The participants in this SAD study used similar descriptors in relaying their feelings about autumn. Feelings of apprehension as described by the individuals were distressing. The fact that several of the participants specifically identified this apprehension as a motivating factor for self-care strategies has implications for clinical applications. Autumn apprehension spanned temporality, in that participants described the unpleasant state of anticipation even before the onset of winter weather or shortened daylight hours.

Enggasser and Young (2007) theorized a dual etiology of cognitive vulnerability in addition to biological factors leading to depression in people with SAD. They studied seasonal fluctuations of vegetative functions such as sleep, overall energy levels, and reported appetite in groups of volunteers. These volunteers were also rated for cognitive factors such as negative thinking and attitudes toward seasonality. Each measure was rated for severity and correlated prospectively and retrospectively with reported SAD symptoms. The authors maintained that this cognitive-vulnerability factor contributed to the severity of SAD. The study by

Enggasser and Young may provide context supporting the theme of autumn apprehension. They described anticipatory anxiety as a negative cognitive vulnerability. More plainly put, this may be a preconceived negative expectation of winter depression, prior to the onset of actual physical or physiological responses. Enggasser and Young proposed in their dual-vulnerability theoretical model that negative attributional styles and ruminative psychological responses are associated with more severe SAD symptoms. This supporting literature validates the theme of autumn apprehension and, more important, may provide insight for therapeutic intervention.

The concept of a dual-vulnerability model of cognitive vulnerability coupled with biological factors presents opportunities for holistic clinical approaches. Understanding this phenomenological perspective provides a rich view into the SAD experience. The fact that participants in this dissertation study often spoke of autumn apprehension as a motivating force also provides insight into the resilience shown by these participants. This idea is explored more fully under the implications of this study for nursing practice. Additionally, the perspective of the concept of a dual-vulnerability model offers the possibility of formulating effective simultaneous interventional-nursing modalities such as early-light therapy coupled with cognitive-behavioral therapy (Christopher, Jacob, Neary, & Fiola, 2009).

Longing for Validation of SAD as a Legitimate Disorder

The longing to be validated may have contributed to the relative ease of the recruitment of individuals for this study. Nearly all the participants offered to decline the $20, stating they were happy to contribute to helping educate others about

SAD. This trait is in alignment with self-advocacy or the demonstration of self-care of the participants.

Individuals with SAD do not present with discernable outward physical signs. Several participants, including the advanced-practice psychiatric nurse, described suffering with seasonal depression for a number of years before a diagnosis of SAD was made. This lack of awareness among professionals and the general public was a major factor motivating this particular study. It is hoped that this study will help promote awareness of SAD and will provide an empathetic view of those who suffer.

Several participants expressed frustration in the fact that others around them failed to understand the nature of SAD, adding that this type of major depression is not reactive, such as in response to a loss. When Julia said, "It is not like you can say the dog died," it became clear that SAD sufferers may not receive the social support that others with reactive or situational depression are usually given.

When individuals in this study were asked what they would like others to know about SAD, many of them responded that SAD is real. They also reflected that the diagnosis is often missed even by health-care professionals. Several individuals spoke of self-diagnosing or of being misdiagnosed for a number of years before SAD was correctly identified.

SAD was first described by Rosenthal and his colleagues in 1984. Its particular qualifiers for classification in the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders* (DSM) continue to be debated. The current fourth edition DSM places SAD as a modifier under the major-depression category. Citing the most recent science, Rosenthal has put forth the case that SAD should be given a classification of its own (Rosenthal, 2009).

Validity as measured for inclusion in the DSM requires descriptors, which have been proposed and debated by professionals taking into account the prevailing state of science (Spitzer & Williams as cited in Rosenthal, 1989). The value of diagnostic classification is to provide clarity in identification and guidance for decision making in the clinical setting. As the DSM continues to evolve and classification of mental disorders is debated among professionals, the concept of SAD has become more clearly defined. Spitzer and Williams postulated that disorders must meet the requirements of descriptive validity, predictive validity, and construct validity (Rosenthal, 2009).

Current DSM-IV criteria for SAD diagnosis under the category of major-depressive disorders are summarized here:

- major depression onset related to time of year;
- full remission at alternate times of year;
- two episodes in the previous two years;
- seasonal episodes of depression outnumber nonseasonal episodes (if any)

(Summarized from Rosenthal, 2009).

As the psychiatric community continually refines DSM, Rosenthal has argued that there is now evidence to justify SAD classification as an independent disorder with a distinct clinical presentation. He maintained that the scientific evidence distinguishing SAD as a valid and distinct disorder is overwhelming. Numerous studies provide biological evidence of impaired light-processing mechanisms that may be responsible for SAD symptoms (Lam & Levitan, 2000; Postolache & Oren, 2005; Rosenthal, 2009).

Despite DSM inclusion and the numerous studies regarding light influencing human biology, SAD has not previously been studied from a phenomenological perspective. This perspective adds the human aspect and provides the moral imperative to recognize and validate those who suffer. This SAD study addresses the gap evident in the literature to this point.

According to Canadian researchers, SAD patients had significant alterations in the functioning of the retinal-rod-photoreceptor system. Twenty-three normal subjects were compared with 27 matched SAD volunteers in this study performed in the winter. A measurement of retinal sensitivity was found to be significantly lower in the SAD subjects. Fifty-five percent of the SAD subjects scored as much as one full standard deviation below the control group, consistent with a retinal-hyposensitivity hypothesis (Hebert, Beattie, Tam, Yatham, & Lam, 2004).

The evidence for biological validation of SAD as a legitimate disorder has been mounting since the 1980s (Rosenthal, 2009). Given the prevalence rates of up to 10% of the population in areas with limited sunshine being affected by SAD, it is perplexing that many health-care professionals still remain unaware of the problem. The United Kingdom-based Seasonal Affective Disorder Association (SADA) receives approximately 1,000 inquiries weekly during the peak SAD months of December through February (Pointon, 2007). The organization’s mission as stated on their website (http://www.sada.org.uk/) is to educate the public and clinicians and to ensure recognition and acceptance of SAD as a legitimate and treatable disorder. The website acknowledges that strides have been made in the past 20 years; however, there is still much more education to be done for SAD suffers to be identified and receive evidence-based treatments.

As a mental disorder, SAD has an "invisibility factor," whereby it is frequently not recognized. German and Swiss authors Rusch, Klaus, Bohus, and Corrigan (2006) postulated that some individuals with mental disorders may experience a lack of perceived support in the form of the legitimacy of their illness. This lack, they said, may lead to feelings of discrimination and may also lead to self-stigma. It is important then for SAD, as well as other forms of mental disorders, to be viewed as real or legitimate. As T-Man succinctly stated, "Tell people this is real." Participants in this study demonstrated a form of self-advocacy, as sharing of their stories help to educate others. Informed nurses may contribute greatly to the perception of SAD as a genuine, valid, legitimate disorder.

Social Withdrawal

Winter Reflection

Walking alone within myself,
lonely paths lost on a winter's afternoon.
Cheeks numbed by the kiss of Jack Frost,
feeling neither wind nor breath,
withdrawn.

John Peterson, 2010

This poem illustrates the social withdrawal of winter depression. Peterson composed the phrases “being alone with myself,” “lonely paths,” and “withdrawn,” describing a forlorn, solitary state. The theme of social withdrawal also emerged from the words of the individuals with SAD.

Social withdrawal is typically seen in other forms of depression as well as with SAD (APA, DSM-IV, 1994). While this theme is not unique to the specific notion of SAD, it surfaced as a factor influencing the lives of the participants in this study. Social withdrawal was found to be a secondary theme imbedded in the words of the individuals with SAD.

Elements of social withdrawal due to depression are seen in literature, poetry, and musical lyrics. Coaxing one who has withdrawn can be heard in the following song lyrics. This song was reportedly written for Prudence, actress Mia Farrow’s sister. Prudence secluded herself while at an ashram in India, missing opportunities to interact with the Beatles during the height of their fame in the 1960s.

Dear Prudence, won't you come out to play.
Dear Prudence, greet the brand new day.
The sun is up, the sky is blue.
It's beautiful and so are you.
Dear Prudence, won't you come out to play.

John Lennon and Paul McCartney

Individuals who participated in this study described social withdrawal as problematic and as a troubling element of their SAD experience. Individuals did not seem to take enjoyment from solitude; rather they described avoiding social interactions often due to lack of energy or a feeling of just not wanting to be with others. This avoidance caused feelings of guilt for some and relational instability for others.

Bernadette revealed elements of self-imposed social withdrawal in her poetry "hibernation beckons; i so envy the bear." The act of hibernation is solitary. The descriptions of social withdrawal and the following theme of disruption of energy often seemed to be interwoven, just as the description of hibernation fits aspects of both themes. Turning away from others, retreating into one's self, these actions were echoed a number of times in the individuals' words.

Julia spoke with regret of missed opportunities when she described her experience as a foreign-exchange student in Sweden. Isolating herself, she said, "This thing just changes my personality; I do not want to go out or be with people." As a young woman, Julia described social isolation as causing her to miss out on the things she felt she should have been able to enjoy.

Social withdrawal in itself is not considered a psychiatric disorder. Social withdrawal may be a component of true disorders such as major depression, anxiety disorders, or SAD (Rubin & Burgess, 2001). Participant Denise said that when she retreated from her young child and did not want to be around her own family, she became aware of the need to seek help. This withdrawal signaled a major mood change, which gave her insight.

Stories of the avoidance of social situations in the workplace and with family or friends were related by a number of other individuals as well. Social withdrawal from loved ones may remove the person with SAD from those who may potentially offer recognition and supportive care. Sunshine described wanting to hide from relatives during the holidays at her own home. Social withdrawal may lead to worsening feelings of depression by compounding loneliness and decreasing psychosocial well-being (Cranford, 2004).

Sunshine has enlisted the cooperation of her family in coping during the winter. In a demonstration of a resilient attitude, Sunshine has adjusted her family entertainment schedule. Rather than hosting her relatives for Christmas, she now has a tradition of having her extended family over to celebrate the Easter holiday. She said that once Easter rolls around, she begins to feel more able to handle social events. Jane said that in the winter she tends to “keep to myself.” She also said that she has confided in a few close friends who understand her and that she feels more comfortable with them since they are sympathetic.

Social withdrawal in persons with SAD has been postulated to negatively impact the quality of life. The quality-of-life domain was measured in an interventional study by Michalak, Murray, Leavitt, and Levitan (2007). As a measure of SAD symptoms pre- and post-intervention with light and a placebo, subjects measured social isolation or contact as part of a quality-of-life questionnaire.

Zal (1997) wrote of atypical vegetative symptoms associated with SAD. “Reduced energy” and “social withdrawal” were terms used in Zal’s descriptive overview study. From a clinical standpoint, social withdrawal may prevent those who need help with SAD from seeking or receiving attention. Social support may act as a beneficial stress-buffering mechanism in those with depression; thus those who isolate themselves may be deprived of this benefit (Cranford, 2004; Hennessy, Kaiser, & Sachser, 2009, Kikusui, Winslow, & Mori, 2006).

The construct of social withdrawal may be viewed as being in opposition to the theme of longing for validation. This paradox illustrates the complexity of desires and emotions associated with the participants' experiences of SAD. Participants described not wanting to be around other people in social situations during their depressed times. Yet, they longed for people to understand and validate them and their struggles with SAD.

Social withdrawal may prevent those with SAD from seeking help. Some of the individuals in this study demonstrated effective coping by recognizing their propensity for withdrawal and using it as a motivating factor to seek help and support. Others, such as Sunshine, have recognized this tendency and enlisted loved ones' support to schedule seasonal events at opportune times.

The word "withdrawal" is synonymous with "removal," "extraction," and "taking out." Social withdrawal implies avoidance of other people and social situations. As social beings, humans live and thrive in families and groups. The removal of one's self from the group and the social support offered by others may compound negative feelings.

Mental-health scientists have postulated a connection between withdrawal and the social stigma of depression (Hickie et al., 2007). Those who freely discuss SAD and share their experiences with others may suffer from the stigma of having a mental disorder, or worse, may have their disclosure minimized. An example of minimization was given by Lei when she stated, "Something like SAD, you're just supposed to suck it up." Minimization and a lack of understanding and support was also evident when Julia said, "People just don't get it . . . it's not like anything has really happened . . . like you can say oh, the dog died." Statements such as this illustrate the lack of insight by others. These statements may also represent a fear of negative evaluation by others in social situations, in worklife, and within families. This lack of understanding and compassion by others may represent a social barrier, making it easier for the individual with SAD to withdraw rather than face other people.

Social withdrawal may be encountered in other forms of depression as well as with SAD. Inquiring about clients' social activities and contacts with others in their lives may provide an opportunity for nurses to open a dialogue with potential SAD patients.

Disruption of Energy

To be depressed is to sleep all day and never get a good night's sleep.

Unknown

The relationship between energy and light was very apparent in speaking with the participants of this study. The construct of energy disruption emerged as a secondary theme in the analysis of the transcripts and during member-checking interviews. Fatigue, the feeling of being physically tired, weary, or having low energy, is a prominent component of the Beck Depression Inventory (Carney, Ulmer, Edinger, Krystal, & Knaus, 2009). Energy disruption is not unique to SAD and has been written about extensively in mental-health and nursing literature (Todaro-

Franceschi, 2008). Thus the focus of this section is on the interpretive findings as they relate to the individuals of this study only.

Sunshine, a landscape architect, reported that she herself feels like a plant. In summer, she is alive and energetic; in winter, she is dormant. Several participants spoke of “hibernation,” “feeling heavy,” or like “walking through jello.” Listening to the participants’ words, the researcher’s impression was that the participants were solar-powered. The participants related a direct correlation between light exposure and physical and psychological energy.

Disruption of energy as a theme describes the up and down, surge and ebb, of energy described as the seasons changed. T-Man described being in a Scandinavian country in the summer and “loving the rush” of the long summer days; he described himself as having a surge of energy and being “borderline manic” with energy. Sunshine too spoke of the energizing effects of spring. The converse lack of energy was also apparent as Lei described winter “like all the energy has been zapped out of you.” The cycles of physical and psychological energy were described as influencing the participants’ power to live in the world.

Jbones spoke of putting her children on the school bus in the morning and going back to bed until they arrived home in the afternoon. Lei described the lack of energy in winter as extreme fatigue “like every day you have the flu.” The participants spoke of energy in palpable terms, describing how disruption of energy felt for them. The relationship between physical and psychological energy and feelings of well-being were described by the participants as being dependent upon and directly relational to the degree of light exposure.

The focus of this dissertation is not to explore the multiple meanings of the concept of energy. However, it is interesting to note that much of holistic- and alternative-medicine practices focus on vitalism, the notion that living organisms contain some form of energetic life force (Stenger, 1999). As a verb, “depress” literally means to slow down. Nurses are familiar with depressed respirations, meaning a decrease in respiratory rate. T-Man described feeling himself “contract” as the days get shorter. Decreased physical movement is often seen in major-depressive disorders. This decrease of energy is referred to as psychomotor retardation on the Hamilton Depression Rating Scale (Hedlung & Vieweg, 1979). One participant, Brandy, mentioned that her doctor considered chronic-fatigue syndrome before the diagnosis of SAD was made. This disruption of energy impacted the participant’s ability to enjoy life in the winter months.

Bernadette’s poem expresses this disruption of energy as she wrote of her “thoughts assuming a fetal position.” She also wrote of “envy for the bear in hibernation” as winter approached. Bernadette beautifully captured the alternating energy boost that accompanies summer: “a manic riot of endless golden meadows and bees humming, locusts droning the sound of life in its fullness.” This juxtaposition represents the seasonal fluctuations of energy experienced in SAD.

Lei said that her energy level dictated her ability to interact with her family and to fulfill her roles and responsibilities as she saw them. She expressed guilt over not having energy to fix dinner for her husband and child. The lack of energy affected her relationships as well as the way she viewed her own value within her family. The tendency to withdraw and the lack of energy were termed by Lei as “the turtle effect.”

Iverson (2004) conducted a comparison study of 48 depressed and 24 nondepressed control volunteers. Electronic-recording devices were used to quantify differences in physical energy of depressed and nondepressed volunteers. To support a direct relationship between depression and physical functioning, subjects were monitored for movements over a 24-hour period. As predicted, individuals who scored higher on a measure of depressive symptoms showed lower levels of energy expenditure in the form of fewer physical movements over the course of the day.

The poet Raven Storme expressed the connection between SAD and the disruption of energy in the following poem:

> *Snow is softly falling*
> *like frozen beautiful tears*
> *Isolated from the world*
> *stranded away from light*
> *How I ache to feel the joy*
> *and warmth of the sun*
> *instead of this endless night*
> *Days and nights so long*
> *so desolate and bleak*
> *Winters long and dreary*
> *chill has left me*
> *cold and weak.* -Raven Storme, 2010

This poem along with Bernadette's poetry presented earlier portrays the emotional and physical effects of SAD. Storme's closing line of being left "cold and weak" describes the loss of energy, or weakness, reflected also by the individuals of this SAD study. The theme of withdrawal is also reinforced in the lines "Isolated from the world, stranded away from light." Poetry that reflects the human existence can be a powerful tool to convey elements of the lifeworld.

Nurses who work with individuals with SAD may consider disruption of energy as a motivating factor in planning effective treatment. Allocation of rest times may prove to be an opportunity to provide therapeutic light. Placement of bright lights in normal rest areas such as the bedroom or areas where napping occurs may be an effective strategy to overcome SAD symptoms. Some of the resilient strategies demonstrated by the individuals are also discussed as they relate to nursing-practice implications.

Disruption of energy is generally described in the SAD literature (Levitt, Boyle, & Joffe, 2000; Lurie, Gawinski, Pierce, & Rosseau, 2006; Rosenthal, 2006). Several of the participants in this study had insight into their seasonal fluctuations of energy. Disruption of energy reflects the seasonal, temporal changes described by individuals with SAD. Individualized coping strategies presented by several participants demonstrated successful mastery, or resilient coping, over disruption of energy associated with SAD.

Implications of the Study for Nursing Knowledge

The ultimate goal of any research is to add to the body of knowledge. This phenomenological study informed by van Manen's method offers a humanistic view of what it is like to live with SAD. Participants' views provide a platform to devise holistic-nursing strategies for patients with SAD. While the findings of any particular phenomenological study may not be generalized to the greater population, nurses may gain a rich, appreciative perspective not possibly obtained by other research methodology. This study may be valuable for its transferability, or the ability to recognize and relate to similar themes, among those who have SAD.

The voices of the participants in this study echo an underlying strength that parallels concepts described by the mid-range resiliency theory and described by Gillespie, Chaboyer, and Wallis (2007). The nurse authors described the resiliency theory and the defining attributes of self-efficacy, hope, and coping. This theoretical view helps to further appreciate the lifeworld of those with SAD and may hold value for therapeutic application.

The resilience theory has been applied as an underpinning framework for numerous qualitative studies in mental health, developmental psychology, and nursing (Edward, Welch, & Chater, 2009). SAD is a recurring depression with periods of remission, during which reflection and proactive strategies may be formed. The application of the resiliency theory supports the conceptualization of the lifeworld of SAD within a holistic, strength-based context. This context may then form the basis for identification and implementation of effective therapeutic strategies.

In concert with resiliency, the participants in this study demonstrated a form of psychological reserve. The participants utilized creative adaptations to deal with recurrent major depressive episodes of SAD. Participants described unique coping strategies as exampled by innovative light-seeking behaviors, enlistment of social support, altering holiday activities, and adjustments in careers and living locations. Sunshine left the teaching field to work as a landscape artist. She said this career change fits perfectly for her, since people wants gardens in the spring and summer months when she has the energy to do this work. Several participants, including Amy, Bernadette, and Jbones, demonstrated a resilient coping style by moving to a sunnier location closer to the equator. In another example of resilient coping, Psy Ns provided her unique “chili-dog Christmas” family celebration.

Participants also spoke in hopeful terms of mastery over SAD and control by planning ahead to employ strategies to ward off symptoms before they occur. Hope, according to Gillispie, Chaboyer, and Wallis (2004), is a major defining characteristic of resilience and provides an impetus for personal growth. The participants in this study were interviewed before the onset of winter. Statements of hope, coupled with the very act of participating in the study, demonstrate an attitude of wanting to have influence or positive control over SAD. All participants stated in some manner that they wished to participate in this study to help others understand or to help spread the message about living with SAD.

The resilience theory holds that human beings are capable of mastery over life circumstances. This strength-based concept focuses on the human capacity to grow and to adapt successfully to changes despite adversity. Resilience is considered to be a learned process rather than an isolated phenomenon (Green, Galambos, & Lee, 2003). As such, resilience-building techniques may be employed as a therapeutic intervention. Listening to the voices of the individuals and hearing their methods of successful coping strategies may help others to do the same. The use of therapeutic light earlier in the year, enlisting support from relatives and friends, moving to a sunnier climate, and speaking out as an advocate to educate others all represent resilient coping with SAD.

Significance of the Study for Nursing Education

This study into the lifeworld of SAD aimed to present a phenomenological perspective of the lived experience of individuals with SAD. Understanding this view informs the reader of the multidimensionality of living with this form of major depression. Phenomenological studies allow nurses to approach patient care from a humanistic, holistic stance. The development of effective, informed therapeutic approaches, especially in mental-health care, requires listening to the words of patients.

Research rigor was demonstrated in this study by credibly reporting the words of the individuals. Dependability and confirmability were ensured by prolonged engagement with the data, by member-checking interviews, and by the addition of the descriptive poetry provided by Bernadette. Faithful adherence to the procedural method outlined provided scholarly trustworthiness.

The publication of the findings of this study will help disseminate knowledge of the phenomena and trustworthiness of SAD as a legitimate disorder. Informing nursing of this particular disorder will increase the likelihood of its recognition and compassion for those who suffer. Education regarding human resilience and strength-focused approaches should be incorporated into the theoretical and practical education of professional nursing practice (Edward, Welch, & Chater, 2009).

Significance of the Study for Nursing Practice

The discussion of SAD and the identification of the major themes of this study have practical therapeutic nursing applications. The high prevalence rate of SAD makes it likely to be encountered in many clinical areas of nursing. Learning from the words of the participants informs nurses to consider this diagnosis when presented with similar histories in clinical practice.

The stories of the SAD participants may offer clues for beginning therapeutic nurse-patient relationships. The emergence of the theme of the validation of SAD as a legitimate disorder provides a basis from which to approach those who may be suffering from SAD. The act of offering validation to patients acknowledges understanding of the validity and the serious nature of SAD and indicates compassionate care.

Light-seeking behavior as described by the participants was often expressed through creative means. The use of bright-light therapy as a treatment modality for SAD has been well established (Lam & Levitan, 2000; Pointon, 2007; Rosenthal, 1985).   The use of therapeutic light devices does not require prescriptive authority in the United States and therefore may be suggested by registered nurses at all practice levels. The recognition of alternative forms of light-seeking behaviors may also alert the nurse-clinician to consider asking about these behaviors when gathering historical information. The individuals in this study sought creative ways to increase light in their daily lives. This creative application of light may easily be offered as a nursing intervention.

The words of the participants underscore the seasonality, or temporality, of how time may be marked for those with SAD. Such differences are important in clinical practice as encounters with SAD patients are likely to be very different at various times of the year. Knowing that the participants of this study expressed extreme apprehension during autumn may help distinguish this specific type of anxiety from other potential sources. Recurring seasonal complaints such as anxiety and apprehension during the autumn months may signal the clinician to consider a diagnosis of SAD.

The examination of the theme of autumn apprehension in appreciation of Enggasser and Young’s (2007) cognitive-vulnerability model supports a theoretical basis for effective cognitive-behavioral therapy (CBT), in addition to therapeutic light, as a treatment modality. The cognitive-vulnerability model posits that one’s thoughts have influence over mood states. In individuals with SAD, the apprehension of winter was described as occurring before the days became noticeably shorter. According to the individuals, the apprehensive feelings originated with thoughts or cognitive patterns and beliefs about the coming winter. CBT is being administered by mental-health nursing professionals throughout the world and may successfully be delivered in appropriate cases by computer-assisted technology (Stuhlmiller & Tolchard, 2009). Building upon the resiliency theory, CBT and cognitive therapies in general draw upon the strengths of the individual to gain control over disorders such as anxiety states and depression.

Learning of the nature of autumn apprehension by the participants of this study may serve to alert astute nurse professionals to delve further when hearing these types of statements in clinical practice. Early, sustained interventions may help to interrupt the pattern of symptoms. The early implementation of light therapy at the first onset of autumn apprehension may prevent the onset of full-blown depression (Westrin & Lam, 2007).

Significance of the Study for Nursing Research

The aim of all nursing research is to gain knowledge (Burns & Grove, 2001). This phenomenological study adds to research knowledge by presenting a view into the lifeworld of the participants, who suffer from SAD. The major themes of; light seeking, autumn apprehension, and longing for validation of SAD as a legitimate disorder emerged from the words spoken by the individuals. These major themes describe the salient characteristics influencing the lives of the individuals with SAD. The major themes were confirmed by member checking and were reflected in the poetry offered by Bernadette. The major themes received phenomenological analysis and exploration in this chapter. Two secondary themes of social withdrawal and disruption of energy also were identified after prolonged engagement and analysis of the data. As components of depression in general, the secondary themes have received much research attention elsewhere (Carney, Ulmer, Edinger, Krystal, & Knaus, 2009; Givens, Katz, Bellamy, & Holmes, 2007; Goldberg, 2010; Rosenthal, 2009).

This study of individuals with SAD adds further support to the use of phenomenological research methods in providing a human dimension to nursing knowledge and to human science as a whole. By focusing on the human experience of SAD, this work complements quantitative studies of SAD. Insights gained through phenomenological discovery offer a unique view into the lived experience of other human beings. Munhall (2007) offered, “When the language of a lived experience awakens a person to the meaning of the experience, he or she gains a fuller understanding of what it means to be human” (p. 163). The goal of giving voice to those who suffer was accomplished by the use of direct quotes to support the themes and by the artistic poetry contributed by one of the participants.

The poetry added by Bernadette conveys the ebb and flow of the emotional states of SAD. Her poetic interpretation magnifies the symbolic meanings and the cyclical nature of the universe as seasons change. The words of the participants in this study reveal that the simple occurrence of the changing of the seasons and the natural progression of autumn to winter held intensely powerful influences for them. This type of contextual experiential information can be obtained and fully appreciated only by the use of qualitative, phenomenological research methods.

Significance of the Study for Public Policy

As the largest health-care profession, nursing should be at the forefront of influencing health-related public policy. Public policy includes political influence and resource allocation in the workplace at local, national, and international levels. Power and empowerment have been identified as key concepts when discussing policymaking (Buresh & Gordon, 2003; Oudshoorn, 2005).

Speaking out about SAD and its impact on health provides a platform for political advocacy for those who suffer. Recognition of SAD as a legitimate disorder will force employers to examine working environments and will support provision of workplace accommodations. Giving voice to those who suffer was a main intent of this study. Disseminating knowledge about SAD and its impact on the quality of life provides a picture for others to understand. This understanding informs and inspires advocacy.

Nurses may exert power directly or by promoting the empowerment of others. This study of individuals with SAD, along with knowledge of environmental design, may help influence the importance of lighting when designing health-care institutions as well as workplace environments. Occupational medicine researchers are learning of the physical effects of light exposure on human beings' health (Franta & Anstead, 1994; Pauley, 2004; Walch et al., 2005). Data from environmental studies and phenomenological works, such as this study of SAD, may be combined to advocate for the promotion of light-friendly, healthy living and working conditions. This study may help to empower others by illustrating the impact of personal workspace on productivity, employee morale, and feelings of well-being. As the science of photobiology grows, nurse advocates and policymakers will have additional evidence from which to support thoughtful decision making.

Phenomenological studies support humanistic, holistic approaches to care. This study offers the experience of these individuals and gives them voice. The words of the participants have provided a glimpse into the lifeworld of SAD. Informed with this knowledge, nurses are empowered to provide empathic individual interventions for others. Nurses are also in a position to share this knowledge with their patients, thereby providing empowering support for self-advocacy and self-efficacious behaviors.

Strengths and Limitations of the Study

The major strength of this study is the adherence to van Manen's hermeneutic-phenomenological method. This method has been successfully applied by various nursing scientists (Colvin, 2009; Le Page, 2008; Wyckoff, 2007). Phenomenological studies provide a view into the lifeworld of SAD not obtainable with other methods. The wide age range of the participants strengthened the study by providing perspectives across the life span. This study was also strengthened by the inclusion of the original poem supplied by Bernadette, one with intimate knowledge of living with SAD.

The research was limited by the purposive convenience sample. Though saturation was reached, the data were supplied by a limited number of participants. The participants all resided in North America. SAD is not limited to this geographic region; similar studies from other parts of the world may yield new regional or cultural themes.

The data-gathering interviews were conducted in July, August, and September. Considering the seasonality of SAD, this timing was intentional on the part of the researcher. The timing of typical SAD symptoms may have made it more difficult to recruit participants in winter months when participants were more likely to be depressed. It is not known if the actual data were influenced by the season of the interviews. The study was also limited by gender. Several males were sent consent packets; however, only one male participant followed through during the recruitment phase.

Recommendations for Future Study

This hermeneutic-phenomenological study addresses a gap in the literature of SAD. Opportunities for additional qualitative research may include geographic or regional differences. Gender differences in the lived experience of SAD would address a remaining literature gap. Since SAD is generally experienced during the winter months, it may be of interest to interview participants at different times of the year. This type of study may pose additional challenges for the recruitment and retention of participants.

Ongoing quantitative interventional studies regarding therapeutic interventions of light, antidepressant medications, negative ions, and cognitive-behavioral therapies are occurring mainly in Canada and Great Britain. Unfortunately, these types of studies have received limited national funding in the United States (Rosenthal, 2006). Nurses may be in a unique position to research the effect of light exposure on quality-of-life indicators such as patient sleep, wandering, or lengths of stay in clinical settings.

One participant mentioned early in the study that she felt particularly sensitive not only to light but also to the effect of pharmaceutical medications. A correlation study to explore this possible link may potentially yield new information. If a correlation is found, this type of information would be beneficial to medication prescribers. A grounded-theory study to develop a theory about the process that occurs as participants discover their SAD might incorporate themes from the current study. In-depth case studies may also provide additional perspectives on life with SAD.

Conclusions and Summary

This hermeneutic-phenomenological inquiry presented a window into the lived experience of those who suffer with SAD. One male and 11 female participants provided experiential data that were was gathered and analyzed utilizing the philosophical and methodological techniques advanced by van Manen (1990). Recorded interviews were transcribed, and each individual was provided a copy of his/her own transcript for use during a second, member-checking interview. In addition to interviews, one individual provided a poem revealing her life with SAD.

This view into the lived experience of SAD offers readers a chance to walk in the shoes of another. This descriptive type of experiential information can be used to inform sensitive, holistic nursing care. The three major and two secondary themes, along with the actual words of the participants, gave voice to those who participated. This glimpse into the world of SAD offers a basis for insightful, holistic nursing approaches for those who suffer.

Reference List

American Holistic Nurses Association. (2007). *Holistic Nursing*: *Scope and standards of practice.* Silver Springs, MD: AHNA.

American Nurses Association. (1995). *Nursing's Social Policy Statement*. American Nurses Publishing: Washington, DC.

American Nurses Association Insignia. Retrieved October 29, 2009, from http://www.nursingworld.org/

American Psychiatric Association. (1994). *Diagnostic and statistical manual of mental disorders* (4th ed.). Washington, DC: Author.

Annells, M. (1996). Hermeneutic phenomenology: Philosophical perspectives and current use in nursing research. *Journal of Advanced Nursing*, *23*(4), 705-713.

Benner, P. (1994). *Interpretive phenomenology: Embodiment, caring and ethics in health and illness.* Thousand Oaks, CA: Sage Publications.

Booker, J., & Hellekson, C. (1992). Prevalence of seasonal affective disorder in Alaska. *American Journal of Psychiatry*, *149*(9), 1176-1182.

Bossini, L., Fagiolini, A., Valdagno, M., Padula, L., Hofkens, T., & Castrogiovanni, P. (2009). Photosensitivity in panic disorder. *Depression & Anxiety*, *26*(1), E34-36.

Boyce, P., & Parker, G. (1988). Seasonal affective disorder in the Southern Hemisphere. *American Journal of Psychiatry*, *145*(1), 96-99.

Brandenberger, B. M. (Ed.). (2006). *Mathematics.* Vol. 2. New York: Macmillan Reference USA, 157-159.

Buresh, B., & Gordon, S. (2003). *From silence to voice: What nurses know and must communicate to the public.* New York: Cornell University Press.

Burns, N., & Grove, S. (2001). The *practice of nursing research: Conduct, critique & utilization* (4th ed.). Philadelphia: W. B. Saunders.

Byrne, M. (2001). Hermeneutics as a methodology for textual analysis-nursing applications. *AORN Journal*. Retrieved February 20, 2009, from http://findarticles.com/p/articles/mi_m0FSL/is_5_73/ai_74571586/pg_3?tag=content;col1

Carney, C., Ulmer, C., Edinger, J., Krystal, A., & Knaus, F. (2009). Assessing depression in those with insomnia: An examination of the Beck Depression Inventory: 2nd ed. *Journal of Psychiatric Research*, 43(5), 576-582.

Carper, B. (1978). Practice-oriented theory: Fundamental patterns of knowing in nursing. *Advances in Nursing Science*, *10*(1), 13-23.

Christopher, M., Jacob, K., Neary, T., & Fiola, L. (2009). Cognitive and behavioral changes related to symptom improvement among patients with a mood disorder receiving intensive cognitive-behavioral therapy. *Journal of Psychiatric Practice*, *15*(2), 95-102.

Clayton, T. H., Tait, J., Whitehurst, C., & Yates, V. M. (2006). Photodynamic therapy for superficial basal-cell carcinoma and Bowen's disease. *European Journal of Dermatology*, *6*(1), 39-41.

Colvin, M. (2009). *The meaning of professionalism of undergraduate nursing students: A phenomenological inquiry*. Unpublished doctoral dissertation, Miami Shores, FL: Barry University, 2009.

Cramer, O. (2009) Sunlight's impact on architecture and health. Retrieved February 9, 2009, from http://www.homeissues.com/viewarticle.cgi?article=156&category=4

Cranford, J. (2004). Stress–buffering or stress exacerbation? Social support and social undermining as moderators of relationship between perceived stress and depressive symptoms among married people. *Personal Relationships*, *11*(1), 23-40.

Creswell, J. (1998). *Qualitative inquiry and research designs: Choosing among five traditions.* Thousand Oaks, CA: Sage Publications.

Crotty, M. (1998). *The foundations of social research: Meaning and perspective in the research process*. Thousand Oaks, CA: Sage Publications.

Dowling, M. (2005). From Husserl to van Manen. A review of different phenomenological approaches. *International Journal of Nursing Studies*, *44*(1), 131-142.

Drake, L., Drake, V., & Curwen, J. (1997). A new account of sundown syndrome. *Nursing Standard*, *12*(7), 37-40.

Edward, K., Welch, K., & Chater, K. (2009). The phenomenon of resilience as described by adults who have experienced mental illness. *Journal of Advanced Nursing*, *65*(3), 587-595.

Ekebergh, M. (2007). Lifeworld-based reflection and learning: A contribution to the reflective practice in nursing and nursing education. *Reflective Practice, 8*(3), 331-343.

Enggasser, J., & Young, M. (2007). Cognitive vulnerability to depression in seasonal affective disorder: Predicting mood and cognitive symptoms in individuals with seasonal vegetative changes. *Cognitive Therapy Resources, 31*(3), 3-21.

Enwemeka, C. S. (2004). Therapeutic Light. *Rehab Management*. Retrieved July 4, 2009, from www.rehabpub.com/features/1022004/2.asp

Finch, L. (2005). Nurses' communication with patients: Examining relational communication dimensions and relationship satisfaction. *International Journal for Human Caring, 9*(4), 14-23.

Franta, G., & Anstead, K. (1994). Daylighting offers great opportunities. *Window & Door Specifier-Design Lab*. Spring, 40-43.

Gadamer, H-G. (1996). *The Enigma of Health.* Stanford, CA: Stanford University Press.

Gillespie, B., Chaboyer, W., & Wallis, M. (2007). Development of a theoretically derived model of resilience through concept analysis. *Contemporary Nurse, 25*(1-2), 124-135.

Givens, J., Katz, I., Bellamy, S., & Holmes, W., (2007). Stigma and the acceptability of depression treatments among African-Americans and whites. *Journal of General Internal Medicine, 22*(9), 1292-1297.

Goldberg, D. (2010). The detection and treatment of depression in the physically ill. *World Psychiatry, 9*(1), 16-20.

Goldberg, D., & Russell, B. (2006). Combination blue (415 nm) and red (633 nm) LED phototherapy in the treatment of mild to severe acne vulgaris. *Journal of Cosmetic Laser Therapy, 2*, 71-75.

Golden, R., Gaynes, B., Ekstrom, R., & Hamer, R. (2005). The efficacy of light therapy in the treatment of mood disorders: A review and meta-analysis of the evidence. *American Journal of Psychiatry, 162*(4), 656-662.

Hansen, V., Skre, I., & Lund, E. (2008). What is this thing called SAD? A critique of the concept of seasonal affective disorder. *Epidemiologia e psichiatria sociale*, *17*(2), 120-127.

Harrison, G. (1969). Here comes the sun [The Beatles]. On *Abbey Road*. [CD]. London: Apple Records.

Hartley, J. (2003). Light eases dementia agitation. *Nursing Times*, *99*(34), 6.

Hedlung, J., & Vieweg, B. (1979). The Hamilton rating scale for depression. *Journal of Operational Psychiatry, 10*(2) 149-165.

Heerwagen, J. H. (1986, Nov.). The role of nature in the view from the window. *International Daylighting Conference Proceedings II.* Long Beach, CA. 430-437.

Heinemann, F. H. (1944). Toland and the Age of Enlightenment. *Review of English Studies*, *20*(78), 125-146.

Hennessy, M., Kaiser, S., & Sachser, N. (2009) Social buffering of the stress response: Diversity, mechanisms, and functions. *Frontiers in Neurobiology, 30*(4), 470-482.

Herbert, M., Beattie, C., Tam, E., & Yatham, L. (2004). Electroretinography in patients with winter seasonal affective disorder. *Psychiatry Research, 127,* 27-34.

Hickie, I., Davenport, T., Luscombe, G., Rong, Y., Hickie, M., & Bell, M. (2007). The assessment of depression awareness and help-seeking behaviour: Experiences with international depression literacy scale. *BMC Psychiatry, 7*(48).

Holick, M. (2008). Vitamin D and sunlight: Strategies for cancer prevention and other health benefits. *Clinical Journal of the American Society of Nephrology*, *3*(5), 1548-1554.

Holtslander, H. (2008). Ways of knowing hope: Carper's fundamental patterns as a guide for hope research with bereaved palliative caregivers. *Nursing Outlook*, *56*(1), 25-30.

Iverson, G. (2004). Objective assessment of psychomotor retardation in primary care patients with depression. *Journal of Behavioral Medicine, 27*(1), 31-37.

James, F. O., Walker, C. D., & Boivin, D. B. (2004). Controlled exposure to light and darkness realigns the salivary-cortisol rhythm in night-shift workers. *Chronobiology International, 21*(6), 961-972.

Kikusui, T., Winslow, J., & Mori, Y. (2006). Social buffering: Relief from stress and anxiety. Philosophical *Transactions of the Royal Society of Biological Sciences, 361*(1476), 2215-2228.

Koch, T. (1994/2006). Establishing rigor in qualitative research: The decision trail. *Journal of Advanced Nursing*, *19*, 976-986.

Kohsaka M., Fukuda, N., Honma, H., Kobayashi, R., Sakakibara, S., Koyama, E., Nakano, T., & Matsubara, H. (1999). Effects of moderately bright light on subjective evaluations in healthy elderly women. *Psychiatry and Clinical Neurosciences, 53*(2), 239-241.

Krishnan, V., & Nestler, E. (2008). The molecular neurobiology of depression. *Nature, 4555*(7215), 894-902.

Lam, R., & Levitan, R. (2000). Pathophysiology of seasonal affective disorder: A review. *Journal of Psychiatry and Neuroscience, 25*(5), 469-480.

Landeen, J. (2008). Exploring the lived experience of psychiatric nursing students through self-reflective journals. *Journal of Advanced Nursing, 21*(5), 878-885.

Lee, T. (2003). Pathophysiological mechanism of seasonal affective disorder. *Journal of Affective Disorders, 46*(1), 25-38.

Lennon, J., & McCartney, P. (1966). Good day sunshine [The Beatles]. On Revolver. London: Northern Songs Ltd. Capitol Records, EMI.

Lennon, J., & McCartney, P. (1968). Dear Prudence [The Beatles]. On *The Beatles*. London: Northern Songs Ltd Capitol Records, EMI.

LePage, C. (2008). *The lived experience of individuals following ro en Y gastric bypass surgery: A phenomenological inquiry*. Unpublished doctoral dissertation, Miami Shores, FL: Barry University, 2008.

Levitt, A., & Boyle, M. (2002). The impact of latitude on the prevalence of seasonal depression. *The Canadian Journal of Psychiatry, 47*, 361-367.

Levitt, A., Boyle, M., & Joffe, R. (2000). Estimated prevalence of the seasonal subtype of major depression in a Canadian community sample. *The Canadian Journal of Psychiatry, 45*(7), 650-654.

Lincoln, Y., & Guba, E. (Eds.). (2000). *Handbook of Qualitative Research*. Thousand Oaks, CA: Sage Publications.

Lurie, S., Gawinski, B., Pierce, D., & Rosseau, S. (2006). Seasonal affective disorder. *American Family Physician, 74*, 1521-1524.

Madjar, I., & Walton, J. A. (Eds.). (1999). *Nursing and the experience of illness*. London: Routledge.

Magusson, A., & Partonen, T. (2005). The diagnosis, symptomatology, and epidemiology of seasonal affective disorder. *CNS Spectrums: The International Journal of Neuropsychiatric Medicine, 10*(8), 625-634.

Maisels, M. J. (2005). A primer on phototherapy for the jaundiced newborn. *Contemporary Pediatrics*. Retrieved August 15, 2009, from http://www.contemporarypediatrics.com/contpeds/article/articleDetail.jsp?id=165541

Marquis, B., & Huston, C. (2000). *Leadership and management functions in nursing*. Philadelphia: Lippincott Williams.

Marshall, F., & Cheevers, P. (2003). *Positive options for seasonal affective disorder (SAD)*. Berkeley, CA: Hunter House. .

McConville, C., McQuaid, M., McCartney, A., & Gilmore, W. (2002). Mood and behavior problems associated with seasonal changes in Britain and Ireland. *International Journal of Social Psychiatry, 48*(2), 103-114.

McEnany, G.W., & Lee, K. A. (2005). Effects of light therapy on sleep, mood, and temperature in women with nonseasonal major depression. *Issues in Mental Health Nursing, 26*(7), 781-794.

Michalak, E., Murray, G., Leavitt, A., & Levitan, R. (2007). Quality of life as an outcome indicator in patients with seasonal affective disorder: Results from the Can-SAD study. *Psychological Medicine, 37*(5), 727-787.

Morera, A., & Abreu, P. (2006). Seasonality of psychopathology and circannual melatonin rhythm. *Journal of Pineal Research, 41*, 279-283.

Moustakas, C. (1994). *Phenomenological research methods.* Thousand Oaks, CA: Sage Publications.

Mueller-Vollmer (Ed). (2006). *The hermeneutics reader*. New York: The Continuum Publishing Co.

Munhall, P. (2007). *Nursing research, a qualitative perspective.* Sudbury, MA: Jones & Bartlett.

Nathan, P.J., Burrows, G.D., & Norman, T. R. (1999). Melatonin sensitivity to dim white light in different seasons. *Human Psychopharmacology, 14*, 53-58.

National Institute of Nursing Research. (2008). Priorities for nursing research. retrieved December 13, 2008, from http/www.nih.gov/about/almanac/organization/NINR.htm

Near Death Experience Research Foundation (NDERF). (2009). Image retrieved December 24, 2009, from http://www.nderf.org

Nightingale, F. (1969). *Notes on Nursing: What it is, and what it is not*. Toronto: Dover Publications (original work published 1860), p. 84.

Nobel Lectures (1967). *Physiology or medicine 1901-1921*. Amsterdam: Elsevier.

Oudshoorn, A. (2005). Power and empowerment: Critical concepts in the nurse-client relationship. *Contemporary Nurse*, *20*(1), 57-66.

Palinkas, L., Houseal, M., & Rosenthal, N. (1996). Subsyndromal seasonal affective disorder in Antarctica. *The Journal of Nervous and Mental Disease, 184*(9), 530-534.

Peterson, J. (2010). *Winter Reflection*. Accessed February 24, 2010, from http://www.poems-and-quotes.com/sad/poems.php?id=1143610

Pointon, C. (2007). Are you sad or what? *Therapy Today*, *18*(8), 40-41.

Polit, D., & Beck, C. (2004). *Nursing research: Principles and methods* (7th ed.). Philadelphia: Lippincott Williams & Wilkins.

Pollio, H., Henley, T., & Thompson, C. (1997*). The phenomenology of everyday life.* Cambridge, UK: Cambridge University Press.

Pope, C., & Mays, N. (2006). *Qualitative Research in Healthcare*. Malden, MA: Blackwell.

Postolache, T., & Oren, D. (2005). Circadian phase shifting, alerting, and antidepressant effects of bright-light treatment. *Clinics in Sports Medicine, 24*(2), 381-413.

Rastad, C., Sjoden, P., & Ulfberg, J. (2005). High prevalence of self-reported winter depression in a Swedish county. *Psychiatry and Clinical Neurosciences, 59*, 666-675.

Rosenthal, N. (2000). A patient who changed my practice: Herb Kern, the first light-therapy patient. *International Journal of Psychiatry in Clinical Practice, 4*, 339-341.

Rosenthal, N. (2006). *Winter blues: Everything you need to know to beat seasonal affective disorder*. New York: Guilford Press.

Rosenthal, N. (2009). Issues for DSM-V: Seasonal affective disorder and seasonality. *American Journal of Psychiatry, 166*(8), 852-853.

Rosenthal, N., Sack, D., Gillin, J., Lewy, A., Goodwin F., & Davenport T. (1984). Seasonal affective disorder: A description of the syndrome and preliminary findings with light therapy. *Archives of General Psychiatry, 41*, 72-80.

Rubin, K., & Burgess, K. (2001). Social withdrawal. In M. Vasey & M. Dadds, (Eds.), The developmental psychopathology of anxiety, (pp. 407-434). Oxford, UK: Oxford University Press.

Rubin, H., & Rubin, I. (2005). *Qualitative Interviewing: The Art of Hearing Data.* Thousand Oaks, CA: Sage Publications.

Savagea, D. (Ed). (2000). *Places Rated Almanac*. Foster City, CA: Macmillan.

Schutzinger, C. E. (2003). Metaphysics of Light (pp. 583-584). *New catholic encyclopedia* 8 (2nd ed.). Detroit: Gale.

Schweitzer, M., Gilpin, L., & Frampton, S. (2004). Healing spaces: Elements of environmental design that make an impact on health. *Journal of Alternative and Complementary Health, 10*(1), supplement, S-72.

Sexton, K., & Dugas, M. (2009). Defining distinct negative beliefs about uncertainty: Validating the factor structure of the intolerance of uncertainty scale. *Psychological Assessment, 21*(2), 176-186.

Sher, L. (2004). Light therapy for depressive disorders. Special Report: Depressive disorders. *Psychiatric Times, 10*, 68.

Skjerve A., Bjorvatn, B., & Holsten, F. (2004). Light therapy for behavioral and psychological symptoms of dementia. *International Journal of Geriatric Psychiatry, 19*(6), 516-522.

Smith, K. C. (1974). *BioScience, 24*(1), 45-48.

Stenger, V. (1999). Bioenergetic fields. *The scientific review of alternative medicine*, *3*(1).

Stanford Encyclopedia. Hermeneutics. Retrieved February 21, 2009, from http://plato.stanford.edu/entries/hermeneutics/

Storme, R. (2010). Winter Depression. Retrieved February 24, 2010, from http://www.helium.com/items/917005-poetry-winter-depression

Stuhlmiller, C., & Tolchard, B. (2007). Computer-assisted CBT for depression and anxiety: Increasing accessibility to evidence-based mental-health treatment. *Journal of Psychosocial Nursing, 47*(7), 32-39.

Thobaben, M. (2008). Psychosocial perspectives Client Assessment: General anxiety disorder. *Home Health Care Management*, *21*(1), 67-69.

Thomas, S. (2005). Through the lens of Merleau-Ponty: Advancing the phenomenological approach to nursing research. *Nursing Philosophy*, *6*, 63-76.

Todaro-Franceschi, V. (2008). Clarifying the enigma of energy, philosophically speaking. *Nursing Science Quarterly*, *21*(4), 285-290.

Tourville, C., & Ingalls, K. (2003). The living tree of nursing theories. *Nursing Forum*, *38*(3), 21-36.

Ulrich, R. S. (1984). View through a window may influence recovery from surgery. *Science, 27*(224), 420-421.

Van der Zalm, J., & Bergum, V. (2007). Hermeneutic phenomenology: Providing living knowledge for nursing practice. *Journal of Advanced Nursing*, *31*(1), 211-218.

van Manen, M. (1990). *Researching lived experience: Human science for action sensitive pedagogy.* Albany: SUNY Press.

van Manen, M. (2002). *Writing in the dark: Phenomenological studies in interpretive inquiry.* London, Ontario, Canada: Althouse Press.

Walch, J., Rabin, B., Day, R., Williams, J., Choi, J., & Kang, J. (2005). The effect of sunlight on postoperative analgesic medications: A prospective study of patients undergoing spinal surgery. *Psychosomatic Medicine*, *67*(1), 156-163.

Wald, M. (1994, January 4). Ultraviolet faces revival to fight TB. *The New York Times.*

Walton, J., & St. Clair, K. (2000). A beacon of light: Spirituality in the heart transplant patient. *Critical Care Nursing Clinics of North America*, *12*(1), 87-101.

Werblowsky, R., & Iwersen, J. (2005). Light and Darkness. L. Jones (Ed.), *Encyclopedia of Religion*, Vol. 8. (2nd ed., 5450-5455). Detroit: Macmillan Reference.

Westrin, A., Lam, R. (2007). Long-term and preventative treatment in seasonal affective disorder. *CNS Drugs, 21*(11), 901-909.

Wirtz-Justice, A. (1998). Beginning to see the light. *Archives of General Psychiatry, 55*, 861-862.

Wojnar, D., & Swanson, K. (2007). Phenomenology: An exploration. *Journal of Holistic Nursing*, 25, 172-180.

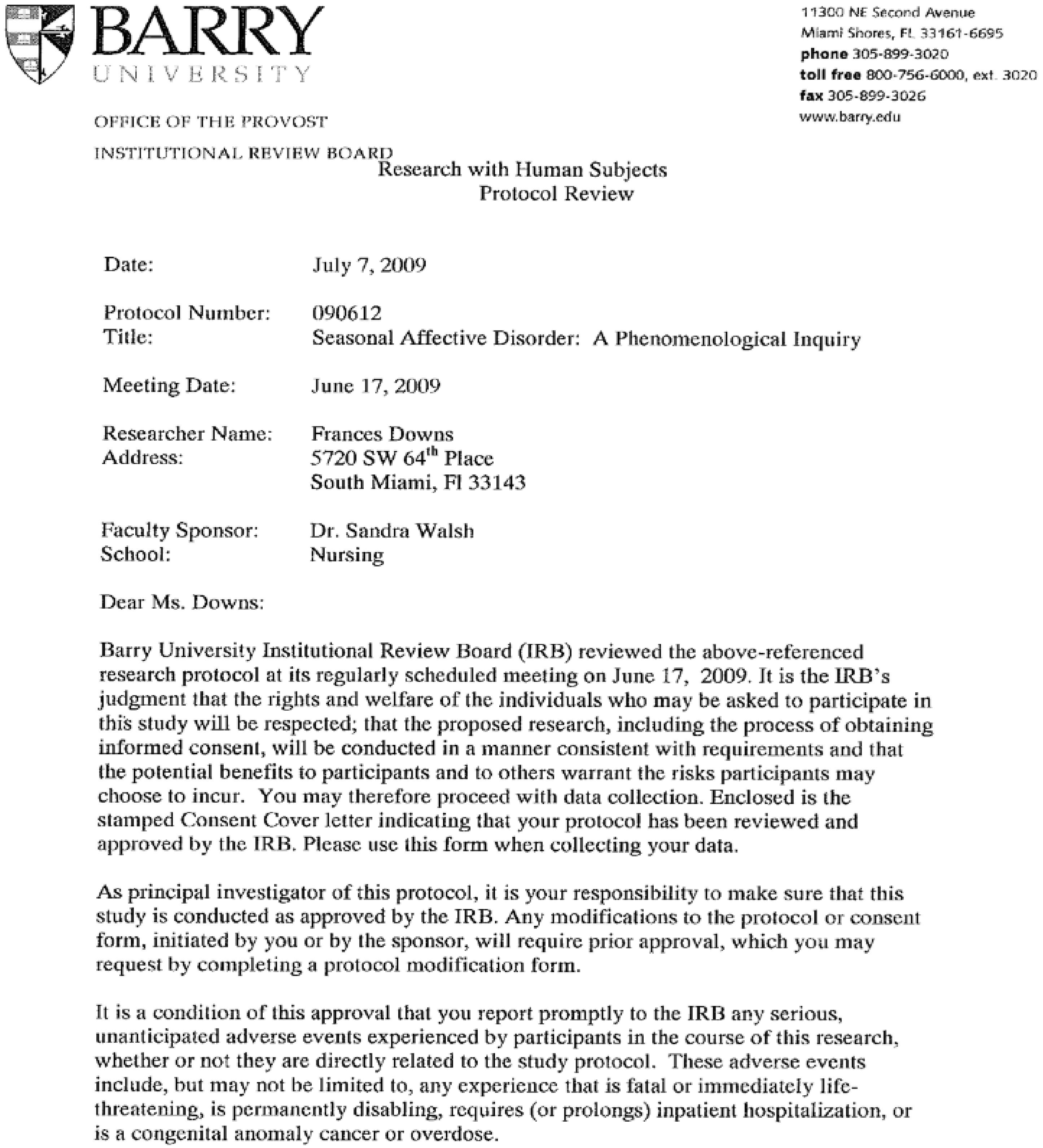
Wyckoff, M. (2007). Intracranial hypertension: A phenomenological inquiry. Unpublished doctoral dissertation, Miami Shores, FL: Barry University, 2007.

Zahourak, R. (2000). Alternative, complementary, or integrative approaches to treating depression. *Journal of the American Psychiatric Nurses Association*, *6*(3), 77-86.

Zal, H. (1997). Seasonal affective disorder: How to lighten the burden of clinical depression. *Consultant*, *37*(3), 647-649.

Zupanic-Slavec, Z., & Toplak, C. (1998). Water, air and light: Arnold Rikli (1823-1906). *Gesnerus*, 55(1-2), 58-69.

APPENDIX A IRB Approval Letter



BARRY
UNIVERSITY

OFFICE OF THE PROVOST
INSTITUTIONAL REVIEW BOARD

11300 NE Second Avenue
Miami Shores, FL 33161-6695
phone 305-899-3020
toll free 800-756-6000, ext. 3020
fax 305-899-3026
www.barry.edu

Research with Human Subjects
Protocol Review

Date: July 7, 2009

Protocol Number: 090612
Title: Seasonal Affective Disorder: A Phenomenological Inquiry

Meeting Date: June 17, 2009

Researcher Name: Frances Downs
Address: 5720 SW 64th Place
South Miami, Fl 33143

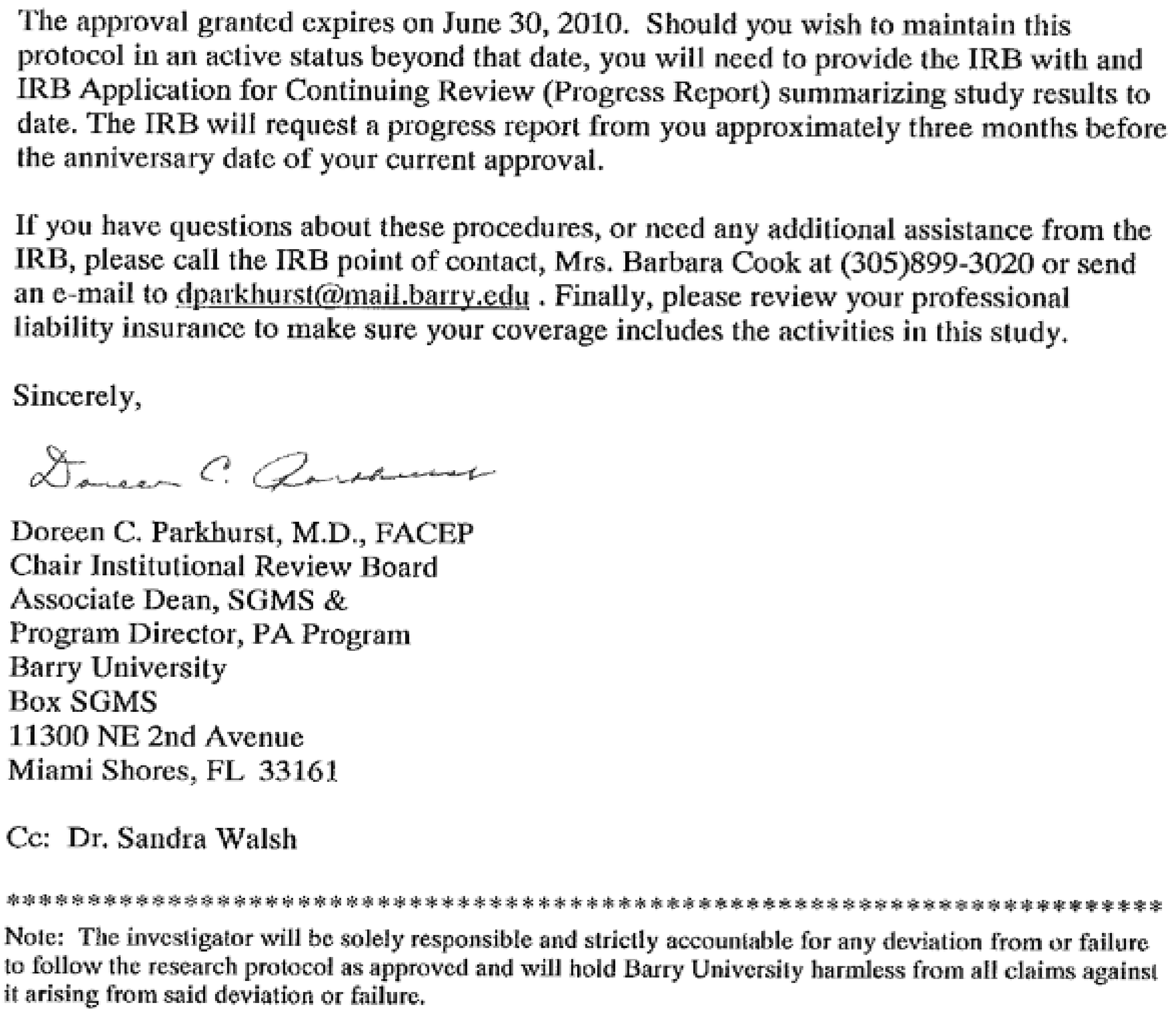
Faculty Sponsor: Dr. Sandra Walsh
School: Nursing

Dear Ms. Downs:

Barry University Institutional Review Board (IRB) reviewed the above-referenced research protocol at its regularly scheduled meeting on June 17, 2009. It is the IRB's judgment that the rights and welfare of the individuals who may be asked to participate in this study will be respected; that the proposed research, including the process of obtaining informed consent, will be conducted in a manner consistent with requirements and that the potential benefits to participants and to others warrant the risks participants may choose to incur. You may therefore proceed with data collection. Enclosed is the stamped Consent Cover letter indicating that your protocol has been reviewed and approved by the IRB. Please use this form when collecting your data.

As principal investigator of this protocol, it is your responsibility to make sure that this study is conducted as approved by the IRB. Any modifications to the protocol or consent form, initiated by you or by the sponsor, will require prior approval, which you may request by completing a protocol modification form.

It is a condition of this approval that you report promptly to the IRB any serious, unanticipated adverse events experienced by participants in the course of this research, whether or not they are directly related to the study protocol. These adverse events include, but may not be limited to, any experience that is fatal or immediately life-threatening, is permanently disabling, requires (or prolongs) inpatient hospitalization, or is a congenital anomaly cancer or overdose.



The approval granted expires on June 30, 2010. Should you wish to maintain this protocol in an active status beyond that date, you will need to provide the IRB with and IRB Application for Continuing Review (Progress Report) summarizing study results to date. The IRB will request a progress report from you approximately three months before the anniversary date of your current approval.

If you have questions about these procedures, or need any additional assistance from the IRB, please call the IRB point of contact, Mrs. Barbara Cook at (305)899-3020 or send an e-mail to dparkhurst@mail.barry.edu . Finally, please review your professional liability insurance to make sure your coverage includes the activities in this study.

Sincerely,

Doreen C. Parkhurst

Doreen C. Parkhurst, M.D., FACEP
Chair Institutional Review Board
Associate Dean, SGMS &
Program Director, PA Program
Barry University
Box SGMS
11300 NE 2nd Avenue
Miami Shores, FL 33161

Cc: Dr. Sandra Walsh

****

Note: The investigator will be solely responsible and strictly accountable for any deviation from or failure to follow the research protocol as approved and will hold Barry University harmless from all claims against it arising from said deviation or failure.

APPENDIX B INITIAL SCREENING OF POTENTIAL PARTICIPANTS

Thank you very much for considering participating in my research study. I am interested in learning more about SAD and people's experiences with bright light therapy. This study is being conducted as part of the requirements for my doctoral dissertation in nursing. This study will consist of an initial conversational interview which will be tape recorded and transcribed. You will then receive an e-mailed transcript of our conversation which we will review together in a subsequent telephone conversation.
The first 20 participants accepted to participate will be compensated $20 for their time and efforts.
Thank you again for considering participating in my study.
Frances C. Downs

1 I am over 21 years of age. _____Yes _____No
Please provide age at last birthday _______

2. I have Seasonal Affective Disorder _____Yes _____No
Approximate length of time I have had SAD ______(Years)

3. I have experience with bright light therapy _____Yes _____No

4. I wish to participate in 2 interviews to talk about SAD and my experience with bright light therapy. _____Yes _____No

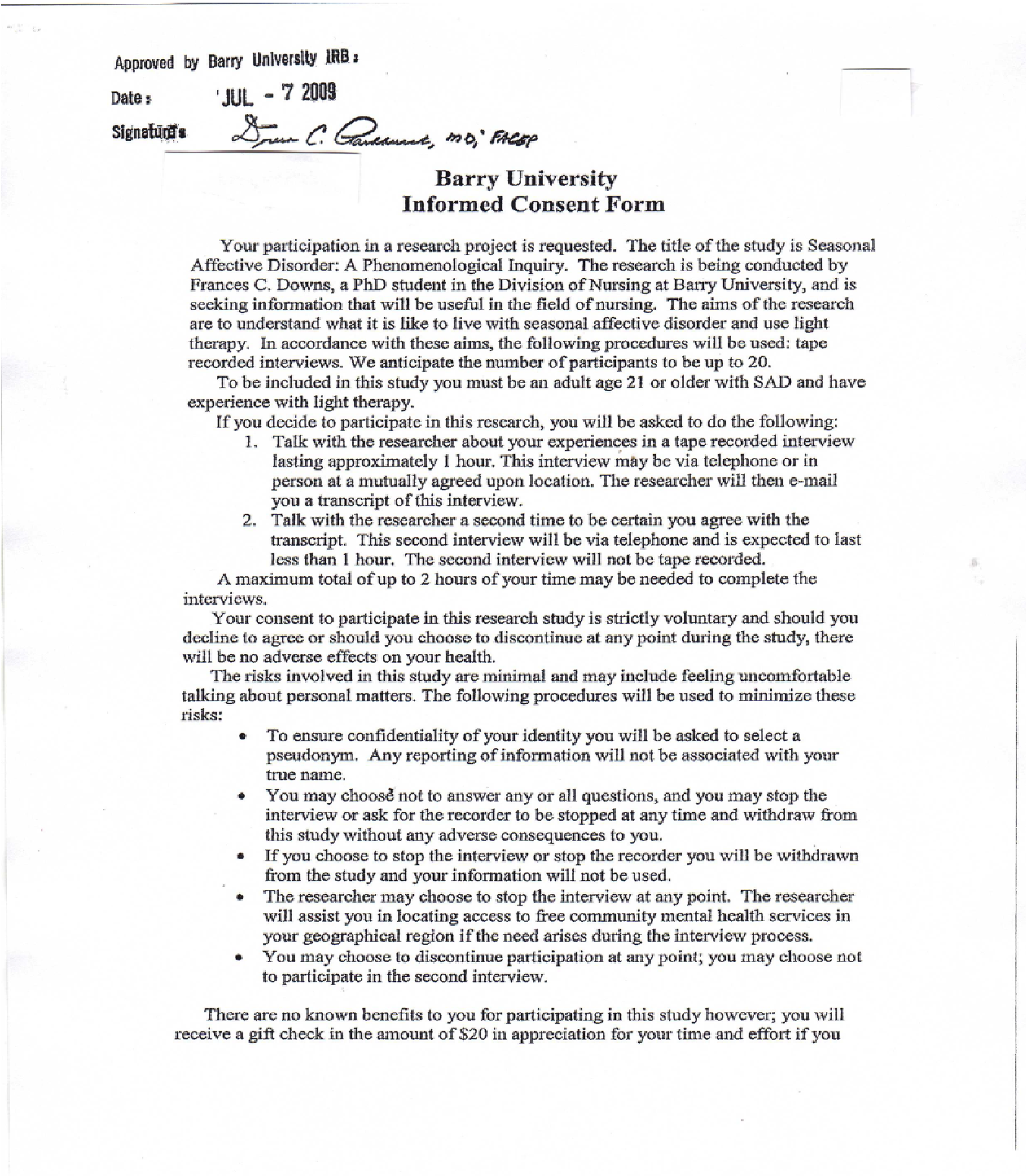
IF you have answered "yes" to all above questions and are willing to be interviewed, please copy and save this form as a word document, then and return completed form as an e-mail attachment to: SADresearch@gmail.com. Please provide a physical mailing address and telephone number to receive an official consent and a confirmation telephone call to schedule an interview.

Name___________________________ Gender: ____M _____F

Address_________________________
____
Phone:____________________________
e-mail___________________________ Best Time(s)/Day(s) to Call_____________
Signature________________________

Please indicate a pseudonym for purposes of confidentiality:_____________
If you have any questions or concerns regarding the study or your participation in the study, you may contact me, Frances C. Downs (786)303-6686, my supervisor (Dr. Sandra Walsh, at (305) 899-3800, or the Barry University Institutional Review Board point of contact, Barbara Cook, at (305)899-3020.

APPENDIX C



Approved by Barry University IRB:
Date: JUL - 7 2009
Signature: MD, FACEP

Barry University
Informed Consent Form

Your participation in a research project is requested. The title of the study is Seasonal Affective Disorder: A Phenomenological Inquiry. The research is being conducted by Frances C. Downs, a PhD student in the Division of Nursing at Barry University, and is seeking information that will be useful in the field of nursing. The aims of the research are to understand what it is like to live with seasonal affective disorder and use light therapy. In accordance with these aims, the following procedures will be used: tape recorded interviews. We anticipate the number of participants to be up to 20.

To be included in this study you must be an adult age 21 or older with SAD and have experience with light therapy.

If you decide to participate in this research, you will be asked to do the following:

1. Talk with the researcher about your experiences in a tape recorded interview lasting approximately 1 hour. This interview may be via telephone or in person at a mutually agreed upon location. The researcher will then e-mail you a transcript of this interview.
2. Talk with the researcher a second time to be certain you agree with the transcript. This second interview will be via telephone and is expected to last less than 1 hour. The second interview will not be tape recorded.

A maximum total of up to 2 hours of your time may be needed to complete the interviews.

Your consent to participate in this research study is strictly voluntary and should you decline to agree or should you choose to discontinue at any point during the study, there will be no adverse effects on your health.

The risks involved in this study are minimal and may include feeling uncomfortable talking about personal matters. The following procedures will be used to minimize these risks:

- To ensure confidentiality of your identity you will be asked to select a pseudonym. Any reporting of information will not be associated with your true name.
- You may choose not to answer any or all questions, and you may stop the interview or ask for the recorder to be stopped at any time and withdraw from this study without any adverse consequences to you.
- If you choose to stop the interview or stop the recorder you will be withdrawn from the study and your information will not be used.
- The researcher may choose to stop the interview at any point. The researcher will assist you in locating access to free community mental health services in your geographical region if the need arises during the interview process.
- You may choose to discontinue participation at any point; you may choose not to participate in the second interview.

There are no known benefits to you for participating in this study however; you will receive a gift check in the amount of $20 in appreciation for your time and effort if you participate in the initial interview. Also, your participation may help our understanding of how people experience SAD and light therapy.

As a research participant, information you provide will be held in confidence to the extent permitted by law. However, if you express an imminent intention to harm yourself or someone else, the researcher is obligated to share this information with appropriate mental health and/or law enforcement authorities.

Any published results of the research will refer to pseudonyms only, and no actual names will be used in reporting of the study. Audio tapes and transcripts of our interview will be kept in a locked file in the researcher's office. To protect your identity, your signed consent form will be kept separate from the data. Audio tapes will be destroyed by cutting after the second interview. All other data obtained from you during this study will be securely stored in a locked cabinet and destroyed after 3 years.

The services of P. Mills Transcription Service, a 3rd party transcription service may be used; a signed confidentiality agreement has been obtained from the transcriptionist.

If you have any questions or concerns regarding the study or your participation in the study, you may contact me, Frances C. Downs (786)303-6686, my supervisor Dr. Sandra Walsh, at (305) 899-3800, or the Barry University Institutional Review Board point of contact, Barbara Cook, at (305) 899-3020. If you are satisfied with the information provided and are willing to participate in this research, please signify your consent by signing this consent form.

Voluntary Consent

I acknowledge that I have been informed of the nature and purposes of this study by Frances Downs and that I have read and understand the information presented above, and that I have received a copy of this form for my records. I give my voluntary consent to participate in this research study.

Please indicate a convenient day and time you will be available for the first interview for approximately one hour.

Preferred Day(s) of the week__________________________

Preferred Time(s) __________________________________

Please indicate a pseudonym by which you would like to be called to protect your

confidentiality for this study. ____

______________________ __________

Signature of Participant *Date*

______________________ __________

Researcher *Date*

APPENDIX D

AGREEMENTSIGNED BY TRANSCRIPTION SERVICE PROVIDER

Confidentiality Agreement

I _______________________, transcriptionist for the study “Seasonal Affective Disorder: A Phenomenological Inquiry, I understand that I will have access to confidential information about study participants. By signing this statement, I am indicating my understanding of my obligation to maintain confidentiality and agree to the following:

- I understand that names and any other identifying information about study participants are completely confidential.
- I agree not to divulge, publish, or otherwise make known to unauthorized persons or to the public any information obtained in the course of this research project that could identify the persons who participated in the study.
- I understand that all information about study participants obtained or accessed by me in the course of my work is confidential. I agree not to divulge or otherwise make known to unauthorized persons any of this information unless specifically authorized to do so by office protocol or by a supervisor acting in response to applicable protocol or court order, or public health or clinical need.
- I understand that I am not to read information and records concerning study participants, or any other confidential documents, nor ask questions of study participants for my own personal information but only to the extent and for the purpose of performing my assigned duties on this research project.
- I understand that a breach of confidentiality may be grounds for disciplinary action, and may include termination of employment.
- I agree to notify the principle investigator or her supervisor immediately should I become aware of an actual breach of confidentiality or situation which could potentially result in a breach, whether this be on my part or on the part of another person.

______________________________	__________	____________________________
Signature	Date	Printed Name
______________________________	_____	____________________________
Witness Signature	Date	Printed Name

APPENDIX E FLYER / NEWSLETTER POSTING

SEASONAL AFFECTIVE DISORDER

Are you an adult 21 or older with SAD?
Have you had experience with bright light therapy?

If you answered yes to both of the above, you may qualify to take part in a research study.

This research study involves talking about SAD and the use of bright light in 2 interviews with a nurse researcher. The interviews may be via telephone or at a mutually agreed upon location. The total interview time is expected to be less than one hour each.

The purpose of this research is to create a description of what it is like to live with SAD. This study is being conducted by Nurse Frances Downs in partial fulfillment of requirements for the PhD in Nursing from Barry University, Miami Shores, Florida.

A check for $20 in appreciation of time will be given to the first 20 accepted participants. For more information contact:

Frances Downs, MSN, RN at:

SADresearch@gmail.com **or (786) 303-6686**

Your participation is completely voluntary and confidential

Faculty Supervisor:
Sandra Walsh, PhD, RN

APPENDIX F

INTERVIEW QUESTIONS

1. Please tell me what it is like to live with SAD.

Prompts:

A) Please describe how SAD affects your life. (Experiences-Stories)

B) Does SAD affect your relationships? (How)

C) How do you feel about winter? Summer?

D) Does SAD affect your physical body?

E) Tell me what it is like to use bright light therapy.

F) What would you like others to know about SAD?

APPENDIX G

Barry University

Research with Human Participants
Protocol Form

PROJECT INFORMATION

1. **Title of Project** Seasonal Affective Disorder: A Phenomenological Inquiry

2. **Principal Investigator** Frances Civilette Downs

Student Number or Faculty Number: 0332060
Name: Frances C. Downs
School – Department: School of Health Sciences Division of Nursing
Mailing Address: 5720 SW 64 place,
Telephone Number: (305) 662-6075 or (786) 303-6686
E-Mail Address: frandowns1@yahoo.com

> *NOTE: You **WILL NOT** receive any notification regarding the status of your proposal unless accurate and complete contact information is provided at the time the proposal is submitted.*

3. **Faculty Sponsor**
Name: Sandra Walsh, PhD, RN
School – Department: School of Health Sciences
Mailing Address: Barry University School of Nursing and Health Sciences
Telephone Number: (305) 899-3800
E-Mail Address: swalsh@mail.barry.edu

Faculty Sponsor Signature:________________________________ Date: ____________

4. **Is an IRB Member on your Dissertation Committee? Yes X___ No: ___**

5. **Funding Agency or Research Sponsor**

Doctoral Dissertation Research Grant Awarded by STTI-Beta Tau Chapter $1,000.

6. **Proposed Project Dates**
Start July 1, 2009

End June 30, 2010

A. Project activity STATUS is: (Check one of the following three as appropriate.)

__X _ NEW PROJECT
___ PERIODIC REVIEW ON CONTINUING PROJECT
___ PROCEDURAL REVISION TO PREVIOUSLY APPROVED PROJECT
(Please indicate in the **PROTOCOL** section the way in which the project has been revised.

B. This project involves the use of an **INVESTIGATIONAL NEW DRUG (IND) OR AN APPROVED DRUG FOR AN UNAPPROVED USE** in or on human participants.
___ YES **__X** NO
Drug name, IND number and company:
____

C. This project involves the use of an **INVESTIGATIONAL MEDICAL DEVICE (IMD)** or an **APPROVED MEDICAL DEVICE FOR AN UNAPPROVED USE.**
___ YES **__X_**NO

D. This project involves the use of **RADIATION** or **RADIOISOTOPES** in or on human participants.
___ YES **_X__**NO

E. This project involves the use of Barry University students as participants. (If any students are minors, please indicate this as well.)
___ YES Barry Students will be participants (Will minors be included? ___ YES
___ NO)
_X__NO Barry Students will participate

F. **HUMAN PARTICIPANTS** from the following population(s) would be involved in this study:

___ Minors (under age 18)
___ Abortuses
___ Prisoners
___ Mentally Disabled
___ Other institutionalized persons (specify)
___ Other (specify)
___ Fetuses
___ Pregnant Women
___ Mentally Retarded

____

G. Total Number of Participants to be studied: Maximum of 20.

Description of Project

1. Abstract

Seasonal Affective Disorder (SAD) is a form of major depression which occurs primarily in winter. Believed to occur as a biological response to lack of sunlight during shortened days, winter SAD is estimated to affect up to 10.5% of the population in higher latitudes. Diagnosis of SAD is made by confirmation of a history of at least two recurrent seasonal depressive episodes with remission during the summer, and without other situational precipitating factors. Bright light therapy has been demonstrated to be at least as effective as antidepressant medications in treating SAD. Light therapy is considered to be a complimentary alternative therapeutic modality which is in the realm of nursing practice.

Despite this relatively high incidence of SAD, many still report years of misdiagnosis or under-diagnosis of SAD due to lack of awareness by health care providers. Nurses are likely to encounter SAD sufferers in most types of practice areas. Various studies have addressed underlying pathology, symptoms, and treatments for SAD. However, no current phenomenological study exists in the literature to describe the lived experience of those who suffer. Giving voice to these patients will provide insight for nurses and other clinicians to relate to those who suffer from SAD. This phenomenological study has the potential to generate a rich description of this experience which may assist nurses in recognition and treatment of SAD.

2. Recruitment Procedures

Volunteers will be recruited from a flyer posting via newsletter from a company which provides light therapy products. This newsletter is electronically distributed to past purchasers of light therapy equipment and customers who have agreed to become members of the company list-serve. See **Apendix** E, Flyer. Additionally, this flyer will be posted in public places, and snowball sampling technique will be employed.

Due to the higher incidence of SAD in northern locations it is expected that participants will be recruited from areas of higher latitudes, however if local participants are found who meet the inclusion criteria they may be included in the study.

Inclusion criteria will consist of: 1) English speaking adults at least 21 years of age. 2) Self-identified as having SAD. 3) Have experience with light therapy as a treatment for SAD. 4) Willing to be available for two telephone sessions, or one in-person and one telephone interview session with the researcher.

Exclusion Criteria will be 1) Non-English speaking, or under age 21. 2) Not diagnosed with SAD or have experience with light therapy. 4) Unwilling or unable to commit to two telephone sessions, or one in-person and one telephone interview session with the researcher.

3. **Methods**

1) A posting requesting study volunteers will be placed in a newsletter from “Alaskanorthernlights.com”. This newsletter is electronically sent to past purchasers of light therapy products and persons who request to be on the mailing list via the company website. Additionally, flyers will be posted in public places such as a museum and grocery store billboards. Snowball sampling by word of mouth will also be employed as a recruitment technique.
2) Potential participants will contact the researcher via e-mail. A password secured e-mail account has been established for the sole purpose of communicating information regarding this study; **SADresearch@gmail.com**
3) Potential participants will receive a return e-mail briefly explaining the study, as well as inclusion and exclusion criterion screening questionnaire. This e-mailed questionnaire will also ask how long the potential participant has suffered from SAD and verify experience utilizing bright light therapy. The potential participants who meet the criteria will be asked to provide a physical mailing address to send consent forms, and telephone number. This form will also ask the participant to indicate a pseudonym of their choice, which will be used to ensure confidentiality in recording and reporting the final data. See Appendix B.
4) Upon receipt of the screening questionnaire-potential participants who meet criteria and wish to participate will be contacted via phone as listed on the questionnaire, to confirm their interest.

5) Two copies of the consent form will then be sent to the potential participant via U.S. Mail along with a return addressed postage paid envelope Appendix C. The participants will be instructed to retain one copy of the consent and to return a signed copy to the researcher's home address.

6) The researcher's telephone contact number as well as the contact phone number of the supervising committee chairperson will be contained within the consent in the event the potential participant wishes to gain additional information prior to signing the consent or for questions any time during or after the study.

7) The consent will contain information asking the participant to agree to take part in two face to face, or telephone interviews, lasting approximately one hour each. Geographic constraints may limit the principal investigator's ability to offer face to face interviews. The consent will explicitly state that the participant may withdraw consent at any point during the study without negative consequences. The participant may refuse to answer any or all questions.

8) The consent will also indicate that the initial interview, face to face or via telephone, will be tape-recorded and that the participant will receive an e-mailed transcript of the initial interview for verification. Face to face interviews will be conducted at a mutually agreed upon location.

9) The consent will also make clear that this is a minimal risk study however; the researcher may elect to stop the interview at any point if the participant should become upset. Additionally, the researcher will assist the participant to access free community mental health services in the participant's geographical region if the need arises during the interview process.

10) After receipt of the returned signed written consent, the researcher will telephone the participant for the initial interview at a day and time indicated by the participant on the consent form. At the onset of this phone call, prior to the interview, verbal consent will be repeated and the participant will be reminded that a recording device will be used throughout the interview.

11) At the conclusion of the initial interview a date and time for a follow up member checking interview call, will be established. A transcript will be prepared verbatim of the initial interview. The researcher will e-mail an electronic copy to

the participant and a hard copy will be prepared for the researcher to conduct an analysis. The use of an outside transcription service may be employed if funding is obtained. This outside transcription service will be required to sign a third party confidentiality agreement, see Appendix D. This agreement will be maintained in a locked cabinet in the researcher's home office and retained for a period of three years.

11) A follow-up interview is expected to occur 2 to 4 weeks after the initial interview. At this time the participant will have received, via e-mail, the transcript of the initial interview for review. The second interview will be conducted as a means of member checking, verifying the content and intent of the original interview. Participants will have the opportunity to request changes, insert or delete statements from the transcript. Audio tapes will be then destroyed by shredding immediately after the second interview. If for any reason the second interview does not take place, the audio tape will be stored in a locked cabinet in the researcher's home office and will be destroyed 90 days after the initial interview.

12) At the completion of the first interview the applicants will be mailed a $20 check via U.S. Mail, along with a Thank you note from the researcher. In event of a face to face interview, the participant will be handed a $20 check at the conclusion of the first interview. The check will be given if the person signs the consent and participates in any part of the interview. This monetary gift will be given in appreciation for the participant's time and effort in participating with the study.

13) Consents, transcripts and field notes will be stored separately in locked cabinets in the researcher's home office and retained for a period of three years. After this time all documents, paper transcripts, and field notes will be destroyed by shredding. Electronic transcripts will be deleted from the researcher's home computer and any electronic storage device at that time. Documents containing information linking codes of pseudonyms and actual names will be stored in a separate locked cabinet, apart form other study documentation.

4. Alternative Procedures

Alternatives are non-enrollment, or withdrawal from the study at any point.

5. Benefits

There are no direct benefits to participants of this study. Participants will receive a check for $20 as a gift if they participate in the first interview. Participants interviewed via telephone will have this gift check mailed to them via U.S. Mail. In-person participants will receive the check at the time of the first interview conclusion. The first 20 participants who consent and take part in any portion of the initial interview will be given a $20 check.

Giving voice to those who suffer from SAD may be therapeutic. Participation in a research study may provide participants with a sense of contributing to the state of science and to the welfare of others.

Publishing the results will allow professionals to gain insight into this disorder and may allow them to recognize descriptions of this type of disorder as well as provide empathetic care. In addition, the results may serve as a reference during active treatment to engage S.A.D. patients in group or individual therapy.

6. Risks

This is a minimal risk study. No physical risks are associated with this study. Possible psychological or social risks may be; discomfort in talking about personal matters, or concerns over social ramifications if confidentiality were not maintained. To minimize this, participants will be required to select a pseudonym. The researcher will maintain security of documents by using a locked storage cabinet in her home office. Security of electronic communication will be maintained by use of an exclusive password protected e-mail address dedicated this study.

7. Confidentiality

Individual participants will be required to use a pseudonym. Collected data such as telephone transcripts will identify pseudonym only and kept in a locked cabinet in the researcher’s home. Consent forms containing actual names will be separately stored in a locked cabinet in the researcher’s home. Third party confidentiality agreement will be obtained from a professional transcript service.

8. Consent

Attached is a copy of the consent form to be signed by the participant and statements to be read to the participant and informational letter directed to the participant. Participants will be given a copy of the consent forms.

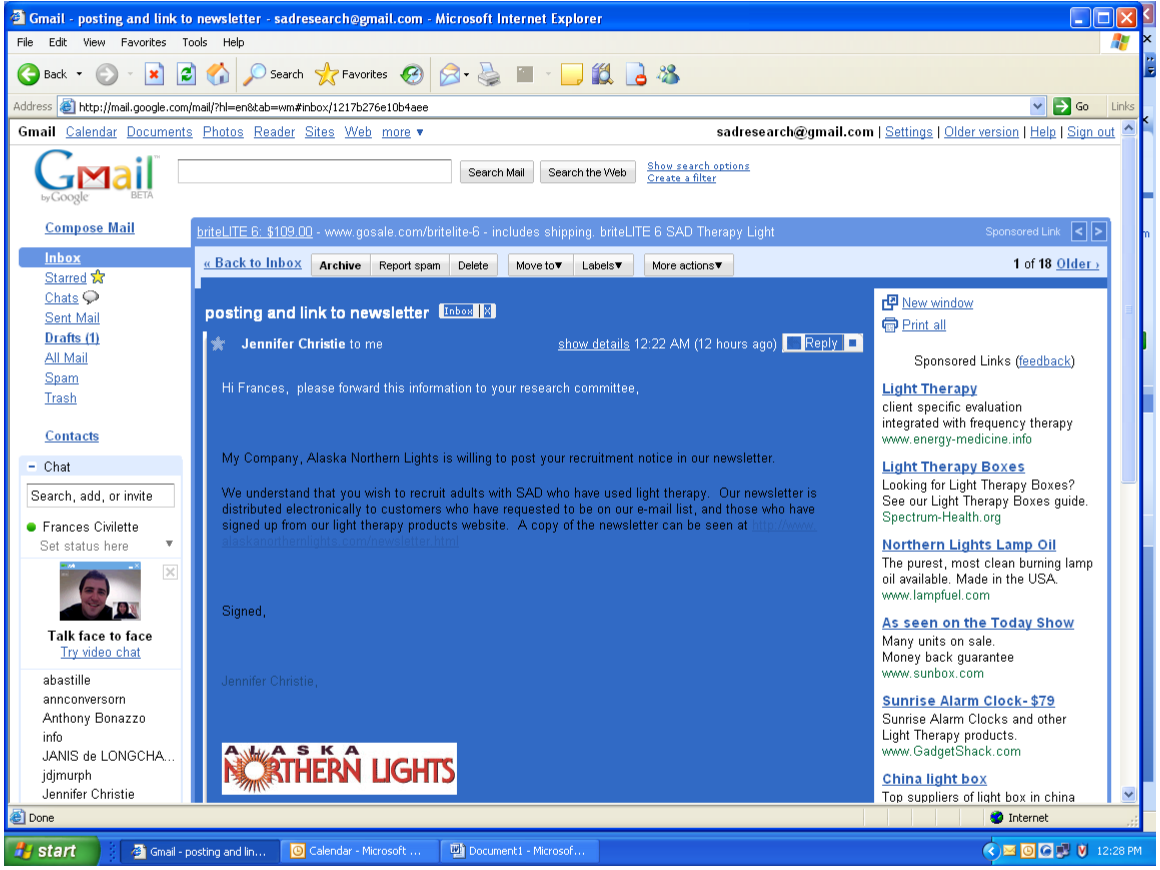
9. Certification

I certify that the protocol and method of obtaining informed consent as approved by the Institutional Review Board (IRB) will be followed during the period covered by this research project. Any future changes will be submitted to IRB review and approval prior to implementation. I will prepare a summary of the project results annually, to include identification of adverse effects occurring to human participants in this study. I have consulted with the department or program faculty/administrators and the Dean of the school which is to be the subject of research and have received prior approval to conduct the research and/or to disseminate the results of the study. A copy of that approval has been included with this protocol.

__________________________________ ____________________

Principal Investigator Date

APPENDIX H Offer to post recruitment in newsletter-Alaskanorthernlights.



posting and link to newsletter

Jennifer Christie to me show details 12:22 AM (12 hours ago)

Hi Frances, please forward this information to your research committee,

My Company, Alaska Northern Lights is willing to post your recruitment notice in our newsletter.

We understand that you wish to recruit adults with SAD who have used light therapy. Our newsletter is distributed electronically to customers who have requested to be on our e-mail list, and those who have signed up from our light therapy products website. A copy of the newsletter can be seen at http://www.alaskanorthernlights.com/newsletter.html

Signed,

Jennifer Christie,

ALASKA NORTHERN LIGHTS

E-Mail:

Jennifer Christie to me
show details 12:22 AM (12 hours ago) Reply

Hi Frances, please forward this information to your research committee,

My Company, Alaska Northern Lights is willing to post your recruitment notice in our newsletter.
We understand that you wish to recruit adults with SAD who have used light therapy. Our newsletter is distributed electronically to customers who have requested to be on our e-mail list, and those who have signed up from our light therapy products website. A copy of the newsletter can be seen at http://www.alaskanorthernlights.com/newsletter.html

Signed,

Jennifer Christie,

APPENDIX I

Frances Civilette Downs

2003	MSN Nursing Administration, Barry University, Miami Shores, FL
2000	BSN, University of Miami, Coral Gables, FL-Leadership Award
1978	ADN Miami-Dade College-Honors

2008-Present	Miami VA Medical Center, Quality Manager
2003-2008	Jackson Health System, Assistant Director
2001-2003	EMI Enterprises, Regional Director of Health Care Services
1995-2001	State of Florida Agency for Health Care Administration Nurse Consultant/Surveyor.
1993-1995	Av Med Medical Plan-Case Manager
Previous	Certified Emergency Nurse; Public Health; Mental Health Nursing

PUBLICATIONS

Downs, F. (2009) Always a Nurse: Leaders in our own gray movement. STTI Newsletter Publication. *www.nursingsociety.org/Membership/Benefits/.../April2009_Text.doc*

Downs, F. (2007) The servant leadership worldview in long-term care. *Annals of Long-Term Care.* American Geriatrics Society, *15*(8).

Downs, F. Newborn Medication Safety: Leave No Doubt Check it out. *Advance for Nurses.* September 4, 2006. Merion Publications.

SCIENTIFIC PRESENTATIONS

Downs, F., Reyes-Yera, M., Samos-Gutierrez, L. Poster Presentation: *Prolonging the Life of Feeding Tubes*; A *Multidisciplinary Approach.* Miami V.A. Medical Center Research Day. May 2009.

Poster Presentation: *Utilization of Evidence Based Practice Model to Guide Fall Prevention Program Development* .University of Arizona Conference on Evidenced Based Practice. Phoenix. February 2007. (First Author)

Presentation: *Magic T.V. Nurse Administered Minimally Guided Imagery in the Pediatric Emergency Department*. Sigma Theta Tau International Conference Montreal Canada, July 2006.

Moderator; Research Symposium: *Bringing evidence based practice to the bedside; an educational approach*. Sigma Theta Tau International Conference July 2006, Montreal Canada.

POSITIONS & HONORS:

Florida Nurses Association District 5 Director, 2005-2010

Awarded 100 Best Florida Nurses, FNA Centennial, 2009

Past President Sigma Theta Tau International-Beta Tau Chapter

University of Miami Faculty-Elected Undergraduate Leadership Award

Mentor: Robert Wood Johnson Grant Funded Mentorship Program w/University of Miami accelerated option BSN students.