Introduction

Paediatric Seasonal Affective Disorder (SAD) has been previously described, but mostly in children aged nine or older (3, 4, 10). The prevalence in 9 to 19 year old children was estimated to be between 1.7 and 5.5%, the rate being higher in older post-pubertal girls (10). The youngest children with SAD described in the literature include a six year old girl who was noted to have a pattern of winter difficulties dating from the age of two years, including irritability, crying and temper tantrums (7). More recently, a five year old child with a two-year history of seasonal affective changes was reported (5).

In the present report we describe a boy referred at the age of four years with a history of seasonal changes in behaviour dating back to infancy.

Case history

We assessed Sam with his parents at the Depression Clinic of the Children’s Department, Maudsley Hospital, London, UK, in April 1998, when he was 4 years 11 months old. His local paediatrician who wanted advice regarding a possible diagnosis of SAD had referred him from Scotland.

Abstract

A four year old boy was referred from Scotland, with a seasonal pattern of depressive symptoms dating back to infancy and meeting criteria for Major Depressive Disorder with Seasonal Pattern by the age of three years. There was consistency in reports between informants and across contexts and significant improvement with light therapy.

Key words

Seasonal affective disorder – depression – case-report – early-onset – light therapy

Background history

Sam was born by normal vaginal delivery in May 1993. There was hydramnios during pregnancy. He was diagnosed to have micrognathia and a cleft uvula. His developmental milestones were normal, except for slightly delayed speech.

Sam lives with his parents and two sisters, aged 8 and 11 years. Both parents had a history of slightly delayed speech. His eight year old sister was diagnosed to have a neuroblastoma at the age of 2 years 9 months, and had surgery and chemotherapy for eight months, with frequent hospital admissions. She had completely recovered by the time Sam was born. Although very upset at the time, his parents did not require any psychiatric help or medication. There was no significant family psychiatric history.

History of presenting complaints

Sam’s parents first noted difficulties at seven months. At this time, in December 1993, he presented with prolonged bouts of crying, poor feeding and sleeping. This was confirmed by Child Health records and the General Practitioner (GP) notes. No cause could be
found at the time. He developed an upper respiratory tract infection (URTI) of two days’ duration and gastro-enteritis of 4-days’ duration in January 1994. His difficulties remained till spring, and his parents clearly recalled that he was much better by his 1st birthday, in May 1994. His behaviour remained unproblematic for the next six months over spring and summer, despite an episode of otitis media and a URTI over that period. GP notes confirmed no contacts between July and December 1994.

From November 1994, when he was 1 year 6 months old, he was again noted to have a poor appetite, poor sleep, not wanting to play, and appearing very irritable. GP notes in December 1994 described Sam as being “not himself, listless... not willing to look up”. The GP considered various alternative diagnoses including viral illnesses, but was also concerned about his development and requested a developmental assessment. There was only evidence of slightly delayed speech and he had three weeks speech therapy for articulation difficulties. Again, this behaviour seemed to improve in spring 1995. Up to that time, his parents were not aware of a possible seasonal pattern to his difficulties.

In winter 1995, when Sam was 2½ years old, he was again very temperamental – crying for no reason, grumpy, irritable, unhappy and no longer affectionate towards his parents. His parents noted a clear-cut change over a period of a few weeks. The health visitor noticed an “ill-appearance” and “dull eyes”. Other parents also commented on the change. According to GP notes, he had a URTI in October and measles in November. The GP described him as lethargic and tired in November 1995 and January 1996. He was back to normal functioning in spring 1996, including a better temperament and enjoying playing outdoors, and remained well throughout the summer, this again, despite having minor viral illnesses in June and July. GP notes show no entries between July 1996 and October 1996.

He started attending playgroup in August 1996 at the age of 3 years 3 months. His health visitor assessed him in September 1996 and was extremely concerned about the “dark shadows under his eyes (despite excess sleeping), his listlessness, unclear speech and his poor appetite”. By October 1996, when he was 3 years 5 months old, he was noted to be “a different child” by his play-leader. In her report, the play-leader wrote that “having thought that Sam had initially settled very well”, she noticed that after October “he needed more encouragement to participate, whereas initially he had seemed to have lots of enthusiasm. ... He was also found to be sitting on his own quite often and had a very pale complexion, which was also commented on by others”. In addition to these changes, his parents had noted that he was aggressive, slapping his mother or sisters and hitting doors, not having displayed this kind of behaviour before. In October 1996, GP notes indicated that Sam was “lethargic”, with no apparent cause despite extensive investigations including blood tests. Again, in January 1997, GP notes reported mother’s concern of months of “anergia”. In February, he appeared to be “in a world of his own”, and there was concern about the possibility of a pervasive developmental disorder. This was excluded by a paediatric assessment in June 1997, when his parents reported that they were less concerned as he had recently improved. Sam developed two episodes of URTI in March and April 1997. During the summer of 1997 Sam was again fine, interacting very well with others and enjoying playing outdoors. He was very energetic, wanting to play till late at night. The play leader reported that “whereas Sam was plodding along” previously, he seemed to “waken up” after the Easter break. His enthusiasm had returned and he seemed to “find his voice, and needed to be told to quiet down”.

His parents also report a period of two to three days at the beginning of summer 1997, during which he was described as being mildly overactive, over-talkative, “too happy” and “funny”.

In winter 1997, when Sam was 4½ years old, he deteriorated again with similar symptoms to those previously described. The health visitor reported a “very obvious deterioration – he was lethargic, made little eye contact”, and she had difficulty in understanding his speech.

In February 1998, after contacting the Seasonal Affective Disorder Association, his parents organised two weeks of light therapy (10,000 lux, for 3–4 hours, at least twice a day). Sam’s behaviour improved within the next three to four days. His appearance, appetite and play were back to normal. His speech was clearer, he was more animated, and the “pale-look” went away. His parents felt that “his life was back”. He was also assessed by his health visitor while on light therapy. She was “amazed” at the change in Sam, as he was happy, talkative, “full of life”, and she confirmed all the improvements described by the parents. The lamp was returned at the end of the two weeks, and the improvements disappeared within three days. Sam then started to improve spontaneously in March 1998. A report from his nursery teacher in April 1998 confirmed that he was increasingly “involved with free group play activities and becoming quite mischievous at times ... quite different from the quiet little boy of the previous term.” She also noticed that “his concentration had increased, and he would chat away freely, he looked better physically, seemed more energetic and smiled more”. School staff agreed that he had “blossomed” since March.

Assessment

No abnormalities were found on physical examination; his height, weight and head circumference were within