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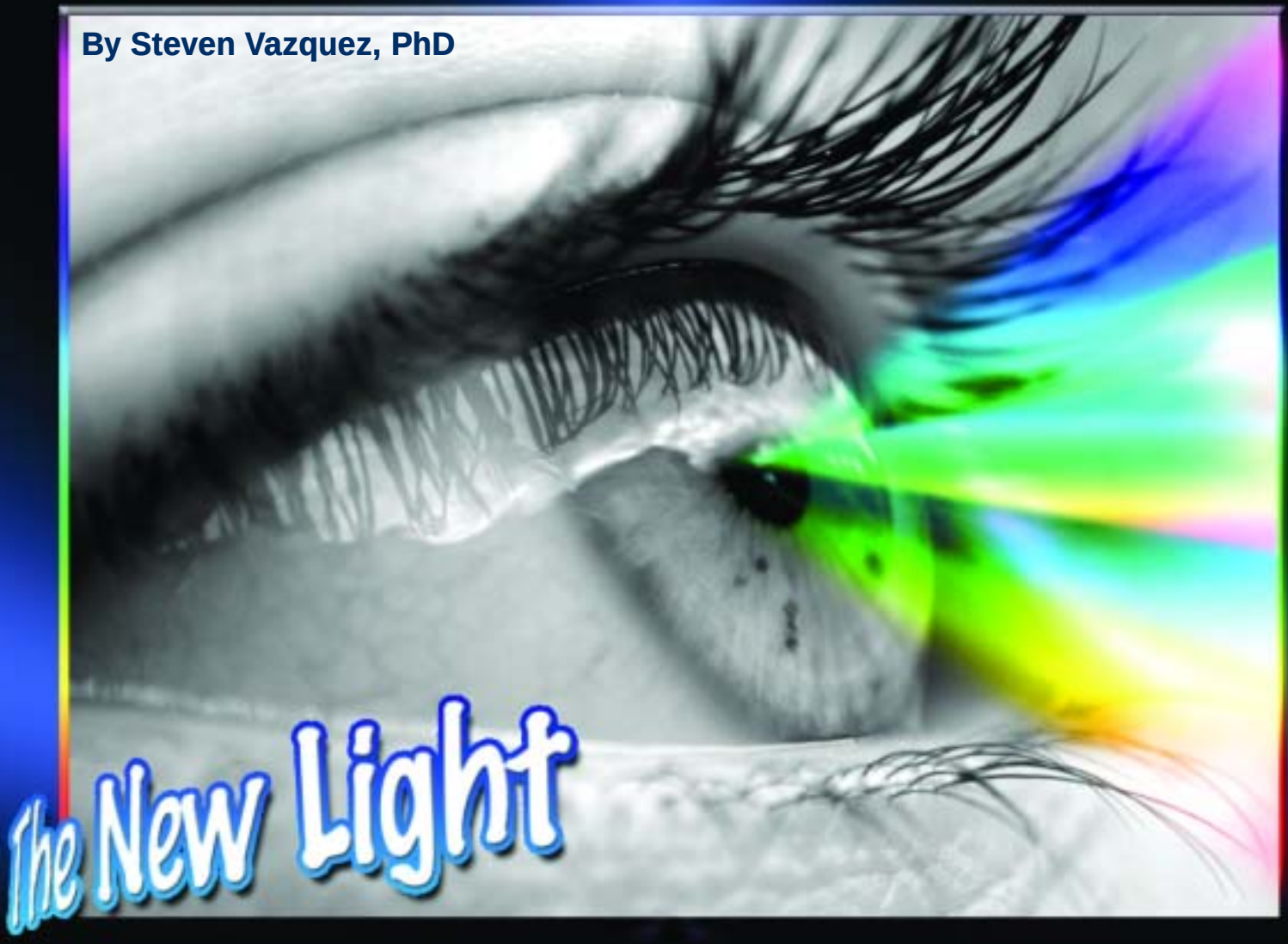

PSYCHOTHERAPY for Seasonal Affective Disorder (SAD):

A Case Study Introducing a New Therapeutic Modality

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Abstract

This article examines the factors of genetics, biochemistry, and circadian rhythms as etiological factors in seasonal affective disorder (SAD) and subsyndromes, and proposes that psychodynamic issues may also be contributors. The use of bright white light combined with antidepressants is the conventionally accepted form of treatment for SAD. This approach is examined and then an alternative method of treatment, Emotional Transformation Therapy (ETT), is proposed. Case studies using this method illustrate this new paradigm of treatment.

Introduction

In 1983 Kripke, Risch, and Janowsky published a scientific study in which a specific form of bright white light stimulation into the eyes improved depression, and in 1984, Rosenthal et al. first described seasonal affective disorder (SAD) as a subtype of depression that could be treated by light therapy. Along with all other forms of depression, the primary treatment for SAD prior to 1984 was psychotherapy, which was documented to have been substantially successful in treating depression in general (Epstein & Vlok., 1981; Dunn, 1979). Since 1984 there have been over 1,000 professional articles published on SAD-related topics, and hundreds of scientific research studies have been conducted on these issues (Lam & Levitt, 1999). Interestingly, none of this research compared this newer light treatment to its predecessor, psychotherapy, in order to ascertain if the newer approach was more effective than its predecessor. Since 1984, psychotherapy itself has undergone a dramatic metamorphosis in which several new "power therapies," such as Eye Movement Desensitization and Reprocessing (EMDR), Thought Field Therapy (TFT™), and Emotional Transformation Therapy (ETT), were developed that facilitate rapid changes in mood disorders. I propose an alternative paradigm about the theory and treatment of SAD and subsyndromal SAD depressive symptoms.

Seasonal affective disorder refers to mood disorders, such as depression, that only emerge at the onset of a specific season, endure throughout that season, and then cease when the season ends. In the case of winter depression, the symptoms must meet the *Diagnostic and Statistical Manual of Mental Disorders*, Fourth Edition (DSM-IV) criteria for depression, usually major depressive disorder (American Psychiatric Association, 1994). In addition to mood symptoms, seasonal winter depression typically has symptoms of atypical depressive hypersomnia and carbohydrate cravings. Subsyndromal SAD involves distinct mood disturbances related to the visual environment that do not meet the diagnostic criteria for SAD (Judd, Aksikal, & Paulus, 1997; Pincus, Davis, & McQueen, 1999). Some examples of subsyndromes include mood disturbances related to climate conditions, such as overcast skies, fog, or snow environments.

The Etiology of SAD

Almost all the scientific research about the etiology of SAD has been in the three topic areas: 1.) genetic factors, 2.) circadian rhythms, and 3.) biochemistry. Therefore, research findings reflect evidence of etiological influences almost exclusively regarding these topics (Lam & Levitt, 1999). University researchers and psychiatrists compose the vast majority of authors reporting SAD research. Psychotherapists have generally been more involved in private practice than in research, and many people with SAD are typically in psychotherapy. Psychotherapists tend to focus more on psychodynamic and cognitive factors that contribute to the formation of SAD. Since the topics of circadian rhythms, genetics, and biochemistry have dominated etiological research on SAD, without much exploration about the numerous psychodynamic factors related to SAD, it is unclear what proportion of the total etiological factors related to SAD are represented in the research. Because other factors, such as psychodynamic ones, have not often been selected for study, it is not known how much these three factors contribute to the etiology of SAD.

Different methods of gathering information yield different data. Scientific inquiry generally utilizes objective methods, such as questionnaires, testing, or physiological measures, to acquire data regarding the etiology of SAD. Conversely, psychotherapists use supportive listening and verbal questioning during sessions to acquire much of their data regarding etiological factors. It has been observed in psychotherapy sessions that much of the information about etiological factors is not initially conscious to the client. Instead, psychodynamic information is often revealed over a series of sessions. Because this information is initially contained in implicit memory, it is often not available until the therapist-client relationship supplies the appropriate foundation for elicitation. In addition, there are regressive psychotherapy techniques that can elicit memories that may reveal etiological factors. In the scientific study of human subjects, scientists are unlikely to bond with their subjects, which may prohibit access to much of this relevant information.

Researchers in the fields of sociology, psychology, and anthropology sometimes utilize the participant-observation method of study. These researchers may bond with their subjects when they live among them and become directly involved in their lives in order to acquire valid findings. While the participant-observation method itself is not being recommended for etiological research on SAD, the concept of interpersonal inquiry in psychotherapy bears a similarity to that research method and is proposed to be a valid alternative means of acquiring etiological data. Scientific inquiry about etiological factors in SAD appears to have omitted valuable psychodynamic factors that are commonly found in psychotherapy sessions.

Conventional SAD Treatment

The standard of care for the treatment of SAD is the combination of appropriately timed bright white light and antidepressants. The degree of brightness used for treating SAD with light ranges from 2,500 lux to 10,000 lux (Eastman, Young, Fogg, Liu, & Meaden, 1998). White lights used for treatment contain all of the colors of the spectrum and are composed of a spectral distribution that is very different than incandescent, fluorescent, or other common artificial lights. Light treatment is generally administered in either the morning or evening hours. With 10,000 lux light treatment, the length of time for usage is typically 30

minutes to one hour per day. This process takes place before the onset of the season of symptoms and is conducted once daily throughout the duration of the season (Lam & Levitt, 1999). This regimen takes place indefinitely for many years and is unlikely to permanently extinguish SAD (Leonhardt et al., 1994).

Because SAD did not exist as a diagnostic category before 1984, specific treatments for SAD were not studied before that time. However, because depression in general was studied and found to be effectively treated by psychotherapy (Rounsaville, Weissman, Prusoff, 1981; Steinmetz, Lewinsohn, & Antonuccio, 1983), it would be contrary to the research findings to assume that SAD was not relieved by psychotherapy. In fact, before 1984 I observed evidence in cases in which SAD was alleviated solely by psychotherapy. If the more basic forms of psychotherapy were successful in this endeavor, it would seem reasonable to consider that today's newer and more powerful types of psychotherapy, such as ETT, may achieve even greater success in treating SAD. Since 1984, scientists had considered psychotherapy to be an exclusive form of treatment for SAD. However, psychotherapy has been recommended to accompany white light treatment for SAD (Rosenthal, 1993). There have been only a few very recent studies that used cognitive psychotherapy as an adjunct to supplement light treatment (Rohan et al., 2003). This article proposes a form of psychotherapy as an exclusive means for treating SAD.

Emotional Transformation Therapy (ETT)

Emotional Transformation Therapy (ETT) is a new form of interactive psychotherapy that uses powerful techniques of visual brain stimulation to access both dissociated components of symptoms and rapid therapeutic change of emerging affect. Scientific research on the effects of visual light stimulation has identified the serotonin and norepinephrin neurotransmitter systems as mechanisms by which light therapy provides its benefits (Rao et al., 1992; Brewerton, Berrettini, Numberger, & Linnoila, 1987; O'Rourke, Wurtman, Brzenzinski, Nader, & Chew, 1987). Further research shows that light treatment is effective for relieving a wide range of mood disorders, not just seasonal depres-

sion (Kripke, Mullancy, Klauber, Risch, & Gillin, 1992; Kripke, 1998; Rosenthal, Genhart, Sack, Shiverer, & Wehr, 1987; Kasper, Ruhrmann, & Schuchardt, 1993; Deltito, Moline, Pollak, Martin, & Maremmani, 1991). Every scientific study that compares white light treatment with antidepressants has shown white light to be more effective for relieving mood disorders (Tuunaimen, Kripke, & Endo, 2004).

ETT not only provides these benefits but also substantially improves upon them by the use of the empirically validated principles of 1.) psychotherapy for the treatment of depression (Dobson, 1989; Elkin et al., 1989; Martin et al., 2001); 2.) the association between mood states and color sensitivity (Barrick, Taylor, & Correa, 2002; Todd, 1973; Stewert, Gaddy, Byrne, Miller, & Brainard, 1991); 3.) peripheral eye stimulation for rapid change of emotional states (Hugdahl, Franzon, Anderson, & Waldebo, 1983; Schiffer, 1977; Schiffer, Anderson, & Teicher, 1997; Schiffer, Anderson, Renshaw, Mass, & Teicher, 1998; Wittling & Roschmann, 1993); 4.) eye movement techniques for rapid change of emotional states (De Jongh, ten Broeke, & Renssen, 1998; De Jongh., ten Broeke, & Renssen, 1999; Faw & Nunnally, 1967; Marcus, Marquis, & Sakai, 1997; Rothbaum, 1997; Scheck, Schaeffer, & Gillette, 1998); and 5.) brainwave entrainment that elicits specific brainwave states conducive for each separate therapeutic purpose. Entrainment or "photic driving" occurs when a pulsing light shone into the eyes elicits a predominant brainwave state that quickly matches the rate of the light's pulsing (Glicksohn, 1986; Montagu, 1967; Vogel, Broverman, Klaiber, & Kun, 1969; Takigawa, 1988).

ETT is a synthesis of psychotherapy processes. It is an approach that 1.) efficiently evokes the precise underlying dissociated experience related to the current targeted psychological symptoms and then 2.) provides rapid relief of emergent emotional distress. This method allows one to plumb the depths of the psyche with a level of precision previously unavailable in psychotherapy. The term "transformation" refers to the experience of a rapid progression of emotional changes that lead to a new level of well-being in a short time. For example, the initial experience of helplessness during ETT often shifts to anger, which progresses to relaxation and ultimately to empowerment. These rapid emotional transformations typically facilitate 1.) shifts from destructive cognition to constructive cognitive perspectives, 2.) the vanishing of physical symptoms, 3.) behavior coming under voluntary control, and 4.) the emergence of spontaneous spiritual experiences.

ETT differs from conventional white light treatment for SAD in purpose and function as well as outcome. For example, ETT selects specific wavelengths (colors) of light for the purpose of evoking emotions for processing; white light treatment uses a combination of wavelengths of light to reduce emotions. Even the visual techniques used for viewing light are very different in the two methods. Conventional white light treatment simply uses random gazes at the light; ETT uses a large variety of very specific visual techniques that may involve direct viewing of the light, eye movements, or indirect viewing of the light. The facilitator selects techniques according to the moment-to-moment responses of the client. ETT differs from bright white light treatment for SAD in several other ways: 1.) ETT uses dim (under 150 lux) colored light vs. bright (2,500 lux to 10,000 lux) white light; 2.) ETT uses a facilitator vs. conventional light treatment, which is conducted alone; 3.) ETT seeks insight vs. conventional light treatment, which does not; 4.) ETT seeks permanent relief within a few sessions vs. conventional light treatment, which seeks temporary daily relief; 5.) ETT treatment is typically completed within 10 sessions vs. conventional light treatment, which may or may not be completed after hundreds of treatments over several years.

Color Sensitivity and Mood States

After observing hundreds of clients' responses to visual stimulation by 12 colors during psychotherapy, a content analysis revealed specific patterns of mood and cognitive themes that consistently arose in conjunction with each specific color. From these observations, a photosensitivity assessment has been developed that can be scored to yield an individualized profile of color sensitivity for each client (Dearing & Singg, 1996). Visual perception is clearly influenced by the perceiver's emotional state of mind and is such a consistent effect that it is well documented and used as a diagnostic indicator in conventional psychological testing (Barrick, 1994; Cohen & Hunter, 1978). In ETT, each color has been "mapped" according to the emotional themes related to that color. The total scores on all the colors yield a configuration of high and low scores for each color that are shown on a graph. There have been thousands of photosensitivity assessments performed to date, and yet there have been no two profiles that have been exactly the same.

The color graph can be used to select the wavelengths (colors) of light stimulation that palliate symptoms or that are most likely to elicit targeted emotions. It has been observed that each color resonates with the viewer in such a way that it evokes specific psychological themes. To resonate is to manifest sympathetic vibration. The premise of color-evoking mood themes has long been used in theater stage lighting and the arts in general. This premise has been developed further to acquire far more precision in ETT. Response to a color has been observed to depend upon how progressed the viewer's emotional development is in regard to the evoked theme. The matching of colors with emotional themes during psychotherapy allows for unusually rapid, yet safe, access to the depth of an emotional experience. For example, it has been repeatedly observed that yellow elicits anger. The response to a color during

expression about targeted issues provides evidence, in the form of visual distortions, about whether that color resonates with the client's issue. Clients who possess anger tend to report reactions to viewing yellow, such as describing the light as "intrusive, annoying, appearing too bright" or "looking reddish-yellow." After resolution of the emotional charge, the response to yellow, for example, tends to become "softer looking and appearing more clearly yellow; no longer intrusive." It has been repeatedly observed that when these elicited emotions are resolved, the responsivity to that wavelength of light changes to appear free of perceptual distortion. In addition, detailed "maps" have been identified in which the sequential progression of affective change can be roughly predicted when the appropriate color is matched with specific mood states.

Psychological Projection

There are a variety of projective tests, of which the Rorschach inkblot test may be the best known. The Rorschach inkblot test is based on the premise that when a person views an ambiguous visual target and is asked to describe what is perceived, the subject projects information about his or her psyche that reveals accurate psychological diagnostic data. This data can be derived from either conscious or unconscious sources (Schactel, 1943). ETT utilizes rhythmic-colored light as a visual target for a similar purpose. The following factors used in ETT amplify the projective effect: 1.) the light is a strobing visual target and yields an appearance of movement, depth, and shading; 2.) colors are used that are not used in most versions of the Rorschach; and 3.) a radiating light source is used as a visual target instead of reflected light, such as on the Rorschach. This type of visual target results in a continuous source of real time, in-session feedback that reflects the client's state of mind through changing visual perceptions as emotions change from moment to moment. In a similar manner, as in other projective tests, each type of visual perceptual variation has been catalogued in regard to its meaning. These visual distortions provide the facilitator with information upon which to base therapeutic interventions. This rapid feedback and intervention process may recur several times per session and produces an intervention cycle that can substantially speed up overall psychological processing.

This same principle of visual light stimulation evoking emotions from dissociated sources appears to be at work when light in one's visual environment yields emotional and cognitive responses projected from within one's psyche. Certain types of environmental visual stimulation, such as overcast skies, extended darkness, or fog, may serve as a psychological trigger to evoke delayed posttraumatic stress from early life experiences. However, the person being triggered may be unaware of the original trauma itself and may simply experience the emotion derived from it. Once the longer, darker winter nights trigger emotions related to trauma from the past, these emotions may be very difficult to deactivate. According to McKinzie and Wright:

> Decades after the original trauma, a similar trauma precipitates a similar gestalt and stimulates the same neuroanatomical site that is then reactivated but not consciously remembered. Once the original site is activated, it perseveres as a . . . focal point . . . which allows for recurrent acute episodes with little additional stimulation or provocation (1996).

Why does SAD emerge at some point during adulthood? Clients in psychotherapy sessions reveal that during times of high stress in adulthood, they appear to become more vulnerable to psychological triggers that activate unresolved affect. One possible related mechanism for the activation of SAD is the concept of the "affective bridge." An affective bridge consists of the linkage of similar emotional charges that serve to connect a current experience to previous experiences bearing the same emotional charge. For example, if a person experiences grief as a consequence of the death of a close friend, during the grief process, memories or feelings of grief related to previous losses tend to re-emerge to conscious awareness. However, the memories along an affective bridge may themselves be entirely different from one another and involve entirely different types of events. For example, grief from the death of a close friend may elicit a similar emotional experience related to the loss of a job or the breakup of a relationship. Many times the dissociated affect from a previous experience emerges without a conscious awareness of the related events until the related events are brought forth in ETT.

Mary's Case

Mary was a 68-year-old married female who reported having depression all of her life. She had been suicidal for a long time. She reported that her depression was always present but emerged consistently and strongly when the skies were overcast. Mary had all the symptoms of major depression according to DSM-IV criteria, plus the symptoms of hypersomnia and carbohydrate cravings. She reported diagnoses of medical conditions, such as osteoarthritis, fibromyalgia, and diabetes. Mary had tried several antidepressants, but they were not effective. She described the depressed feeling as feeling very heavy, like she was "buried in sand." Mary had been seeing another therapist for a long time but was referred to me to use light therapy for SAD. She was provided information about the standard of care (white light treatment combined with antidepressants). Then she was offered the option of ETT. It was explained to her that she did not technically have SAD, but instead suffered from a subsyndrome and a major depressive disorder. Mary chose ETT for treatment.

In the first session, blue-green light stimulation was administered as she was encouraged to describe her distress. Mary described a long and torturous relation-

ship with her mother, who was now deceased. She said, "I could never do anything right for my mother." Guilt and shame were reported. Red-orange light stimulation was used in conjunction with peripheral eye stimulation, which elicited the depth and scope of these feelings. When anger subsequently emerged, yellow light stimulation was used to facilitate a rapid progression through this emotion. She reported relief. Five days later she reported "feeling good, much less depressed. . .I couldn't believe it!"

The second session focused on extreme tension that she felt as a consequence of her husband criticizing her. Verbal expression was encouraged during red-orange light stimulation and peripheral eye stimulation. Mary, who was usually dissociated from affect and very intellectual, was able to access her strong emotions and then quickly release them. By the end of the session, she reported feeling "so much lighter and my body feels relaxed." Two days later, she reported that after the last session she felt "fantastic!" However, another major conflict with her spouse before this session resulted in renewed tension. Again, by the end of the session, she reported feeling relaxed.

The third session continued to focus on the same theme. Visual light stimulation continued to be used throughout the session. During this session, she was provided with new interactive skills to prevent and change the long relationship pattern with her husband. Relief of her tension was achieved by the end of the session through verbalizing during red-orange light stimulation.

The fourth session opened with Mary's reports that she felt better overall. Visual green light stimulation accessed dissociated affect. She cried for the first time in many years, but she felt better afterwards. This session started out focusing on anger at her husband and mother for criticizing her and evolved to grief issues about the death of her brother and others who loved her.

The fifth, sixth, and seventh sessions continued to focus on themes of grief during visual green light stimulation and brought more relief by the end of each session.

Finally, in the eighth session, Mary reported that she was no longer depressed and no longer emotionally reactive to overcast skies. She experienced complete relief of the depressive subsyndrome in a total of eight sessions, twice weekly. In one month, both lifelong depression and the subsyndrome were relinquished and did not return.

This case study illustrates the principles of this new paradigm regarding the identification of psychodynamic factors contributing to the formation of subsyndromal depressive disorder and the rapid treatment of the condition. Specific colors of light stimulation were used to evoke the dissociated affective themes related to the presenting symptoms. The visual environment of overcast skies provoked a depressive reaction that paralleled her response to a dominant critical relationship with her mother. By accessing the dissociated affect of the mother-daughter relationship and the grief from losses, she then had the information she needed to process the related unresolved emotion to completion. The relief of all depression, and particularly the moods related to overcast skies, took place through a variety of visual techniques. Instead of seeking temporary relief by the use of bright white light, long-term relief took place by seeking an integration of dissociated material. One month of twice-weekly sessions concluded the condition.

One type of psychological projection commonly seen in people with SAD during ETT sessions is the emotional response to visual environments that bears a similarity to previous emotional reactions to interpersonal relationships in early childhood. For example, if one perceives the visual environment to be "too bright and intrusive," it has often been observed that this reaction parallels an emotional experience that occurred in a relationship in which another person was perceived to be "too dominant and intrusive." These two experiences are linked by affective bridges. However, the memory and cognitive aspects of the previous experiences are usually initially dissociated. For example, darkness occurring early in the daytime (as in longer winter nights) may serve to repeatedly trigger a feeling of imminent danger that was originally experienced as a threatening parent. As the darkness continues to activate fear and anxiety on a daily basis, the anxiety appears to be relatively continuous. Until the unresolved emotions from the earlier life events are resolved, and dissociated aspects of the previous experience are integrated, the response to the current day environment will likely continue to evoke the same affect. However, it has frequently been observed that when the client simply recognizes the linkage between the two experiences, it temporarily reduces the impact of the visual environment upon the individual's mood state.

Visual stimulation has an unusual precision and speed for retrieving memory and emotion from previous experiences that are associated with the current emotions. This retrieval of emotion tends to occur naturally in the visual environment of everyday life. Psychological relief does not usually take place by simply evoking these emotions. It is important to process the emotions that arise. When ETT utilizes powerful, rapid visual and interpersonal processes to thoroughly transform and conclude these disturbing mood states, the condition tends to become extinguished.

In another case that classically possesses all of the symptoms that meet the criteria for SAD, Francine was relieved in one session. She lived in an extreme northern latitude where SAD is a common condition.

Francine's Case

Francine was a 59-year-old married female who experienced SAD every winter. Francine had been through several sessions of psychotherapy focused on numerous issues before she identified the

relief of SAD as her objective. She had been in an abusive marital relationship for many years. She had been diagnosed with multiple medical conditions, such as severe allergies, Lyme disease, peripheral neuropathy, and parasite infestation. On November 21, well after the onset of winter in her geographical location, the following session took place.

Therapist: (Using blue-green light stimulation at nine cycles per second.)

Francine: I feel grief-stricken because I don't have any close friends.

Therapist: Please try to talk about these feelings. (Changing light stimulation to green at 12 cycles per second.)

Francine: (Crying…) I am too sick to get out and make friends.

Therapist: Please look an inch and a half to the right outside the edge of the light source. (Peripheral eye stimulation.)

Francine: I feel stronger here but still hopeless.

Therapist: (Changes the color to yellow and elevates the rate of the light rhythm to 14 cycles per second.) It might help to talk about this a little more.

Francine: When my health is bad, I get full of fear, loneliness, and worse than hopeless!

Therapist: Please repeat that statement while looking at this light. Then take a deep breath and repeat the process a few times.

Francine: (After repeating the statement three times) I realize that places like the place I live in bothers me, because we haven't yet completely moved in. I am suddenly realizing that my current living circumstance reminds me of when I felt trapped at home with my grandmother when I was a child. I had to live apart from my mother, and my father had been gone a long time. The home that I lived in was in Texas, but it was dark and dank, and I was sometimes in pain there.

Therapist: Do you see a similarity between where you lived then and where you live now, as well as how you felt then and now?

Francine: Yes! In both cases I felt lonely and it was dark.

Therapist: (Changes colors to green for loneliness catharsis and then to orange for expressions about feeling negative toward herself.)

Francine: As I continue to think about and feel what I felt as a child, I feel like I am experiencing those same emotions… It is gradually feeling better. The color is beginning to look more clear.

Therapist: How are you doing now?

Francine: I feel so much better!

In a subsequent session five days later, Francine reported, "I had a tremendous change after our last session. I have tremendous energy! My SAD has left." The SAD symptoms did not return through the entire winter.

In Francine's case, visual brain entrainment and colors that matched her mental state were used to evoke emotions related to her symptoms. The dark environment and trapped and lonely emotions paralleled her childhood experience of a dark, dank home where she experienced trapped and lonely emotions. When this previous experience was elicited and processed to emotional completion, the SAD symptoms ceased and did not re-emerge. In this case, the recovery took place in a single session. More often it takes several sessions.

The sequence of colors used was selected on the basis of how each color matched the progression of emotional themes as they arose. Blue-green is used to facilitate an integration of her affect and cognition. Green has been observed to promote a progression through sadness. Yellow was selected for its propensity to catalyze feeling trapped into feeling empowered. Yellow-green facilitates resolution of the combined affect of sadness and anger. Finally, orange accelerates movement of self-hatred into self-esteem. Each of the colors provided the catalyst needed to ultimately achieve complete resolution of unresolved affect.

Discussion

This new paradigm for SAD proposes many new questions and issues for scientific research. First, studies could explore the hypothesis that psychodynamic issues are directly related to symptoms related to both SAD and subsyndromes. If further research validates this hypothesis, then the relationship between psychodynamic issues and genes, biochemistry, and circadian rhythms could be researched. One hypothesis is that genetics plays a role in susceptibility and the environmental stressors may activate genetic expression. Biochemical changes may be the result of psychodynamic issues rather than the precursor to them. The interface between emotional disturbance and malfunctioning circadian rhythms is fertile territory for scientific investigation.

It would be valuable to conduct scientific studies to compare the efficacy of the combination of white light treatment and antidepressants with ETT regarding SAD. If the psychodynamic hypothesis of the etiology of SAD is correct, it would require a therapeutic method that could 1.) reliably access the related implicit memory and affect, and 2.) rapidly and thoroughly process emerging emotions to fruition. Cognitive psychotherapy is a popular approach to research, but it may not have the aforementioned attributes. It is hypothesized that a form of affect-focused psychotherapy may have more value for this type of condition. ETT should be studied further to validate or invalidate its efficacy for this condition.

The role of color in mood sensitivity could be studied further. The particular mechanisms by which color accesses moods should be explored. The use of eye movement techniques in conjunction with specific colors may provide intriguing findings. While lateralized visual brain stimulation has been studied, the effects of a variety of positions of peripheral eye stimulation show enormous promise and could be systematically studied.

The role of attachment patterns in early life might be explored as to how they are analogous to one's visual environment. Psychological projection in

one's visual environment could be studied to ascertain a better understanding of how it triggers the psyche.

Conclusion

The new paradigm for understanding SAD with ETT and its subsyndromes may provide a powerful change in treatment outcomes. Instead of hundreds of hours of white light sessions needed to repeatedly alleviate SAD symptoms, it appears that ten sessions, or less than two months, can now achieve long-term benefits through ETT. Bright white light treatment and antidepressants can always be an option that some people may choose. If this entire paradigm and treatment consistently offered the benefits described in this article, millions of people could save hundreds of hours of precious time and avoid the side effects of antidepressants. This rapid, natural form of treatment could offer a low-risk option for a long-term resolution. This new form of light psychotherapy appears to have the potential to revolutionize the treatment for SAD.

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