

# Psychopharmacology for the Clinician

*The information in this column is not intended as a definitive treatment strategy but as a suggested approach for clinicians treating patients with similar histories. Individual cases may vary and should be evaluated carefully before treatment is provided. The patient described in this column is a composite with characteristics of several real patients.*

## Bright light for nonseasonal depression?

A 58-year-old man's condition was stable on a selective serotonin reuptake inhibitor (SSRI) after 3 major depressive episodes in 10 years. He disliked the idea of taking a drug for a long time and at one point took himself off the SSRI and started taking St. John's wort. However, the reappearance of symptoms of depression soon led him to go back on the SSRI. As discussed in previous columns,<sup>1,2</sup> on the advice of his physician he decided not to try over-the-counter preparations of S-adenosylmethionine, 5-hydroxytryptophan or fish oils. However, he sought a more natural treatment to prevent the recurrence of depression or treat another episode if it occurred. Information on the Web suggested that bright light treatment is effective for nonseasonal and seasonal depression. He wondered if he could use light instead of the SSRI and if he should try light instead of pharmacotherapy if he had another episode of depression when off antidepressants.

A Cochrane review examined 20 studies, many of which were considered poor in design and reporting, of light treatment for nonseasonal depression.<sup>3</sup> The response to bright light was significantly better than control treatments in high-quality studies and in those that used morning light treatment. Hypomania was more common after light than after control treatment. Two recent studies not included in the Cochrane review demonstrated bright light in the morning compared with placebo improved mood and sleep ef-

iciency in elderly patients with non-seasonal major depression<sup>4</sup> and improved depression during pregnancy.<sup>5</sup> There is reasonable evidence that short-term bright light treatment in the morning is better than placebo (usually dim light) for nonseasonal depression. However, there are no longer-term studies of bright light treatment for nonseasonal depression. Even studies of seasonal depression generally last 8 weeks or less, although there is a common belief that light is an effective treatment throughout the winter.<sup>6</sup> Also, there is no direct comparison of bright light and pharmacotherapy in the treatment of nonseasonal depression.

Why should bright light be effective during any season, given that most people have greater exposure to bright light in the summer than in the winter? There are 2 possible answers to this question. First, many people who work indoors have relatively short exposures to bright light even in summer. In one study carried out at latitude 45°N, people working at least 30 hours per week averaged only 91 minutes of bright light (> 1000 lux) per day, even on weekends.<sup>7</sup> This is probably less than the exposure of someone working outdoors in the winter. Second, the evidence suggests that bright light is best early in the morning. In most studies, patients were asked to use the light soon after waking. This is a time when most people would not be exposed to bright light outdoors.

If patients want to stop taking SSRIs and use bright light for maintenance

and preventive treatment, they should be informed that there is good evidence that SSRIs are effective in preventing relapse. However, although bright light preventing relapse in patients with nonseasonal depression is plausible, there is currently no evidence supporting (or opposing) this idea. Furthermore, the implications of longer-term use of bright light treatment are unknown. For treatment of a new episode, short-term light treatment may be effective, but there is currently no way of knowing if it is as effective as pharmacotherapy. If patients decide to use bright light anyway, they should be aware of the guidelines concerning bright light treatment (available on a variety of reputable, noncommercial websites, such as [www.columbia.edu/~mt12/blt.htm](http://www.columbia.edu/~mt12/blt.htm)). Bright light treatment is usually given at 2500 lux or more, which is well above normal indoor light levels. Although there are no direct comparisons of different intensities of light, the usual advice is for longer exposure at 2500 lux or shorter exposure at higher intensities, such as 10 000 lux. Although the best spectrum has not been investigated, a spectrum similar to that of daylight is usually assumed to be best and is provided by most commercially available lamps sold for the treatment of depression.

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*Psychopharmacology for the Clinician columns are usually based on a case report that illustrates a point of interest in clinical psychopharmacology. They are about 500–650 words long and do not include references. Columns can include a bibliography, which will be available only on the journal website and can be accessed through a link at the bottom of the column. Please submit appropriate columns online at <http://mc.manuscriptcentral.com/jpn>; inquiries may be directed to [jpn@cma.ca](mailto:jpn@cma.ca).*

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