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Light Therapy and Risk of Hypomania, Mania, or Mixed State Emergence: Response to Benedetti et al.

TO THE EDITOR: We chose midday light for our randomized controlled trial of patients with bipolar disorder because of the findings from our pilot study (1). Three of our first four women with depression treated with antimanic drugs rapidly developed mixed states, which necessitated discontinuation of morning light therapy. However, we have recommended morning light therapy for patients who do not respond to 45–60 minutes of midday light therapy. The interpretation that morning light therapy is contraindicated is not consistent with our publications (1, 2).

Morning light therapy can elicit abrupt, large circadian rhythm phase advances that may precipitate bipolar switching, as has been described after eastward jet travel. Midday light therapy is far less likely to induce similar phase shifts and is a conservative initial treatment. The gradual emergence of group differences in our controlled study of midday light therapy (2) contrasts with the rapid improvement often seen with morning light therapy, which may reflect the relative circadian rhythm potency associated with the timing of light therapy.

The claim of “proven efficacy and safety” of early morning bright light treatment for bipolar depression is overstated. Many of the publications on morning light therapy and bipolar disorder in Dr. Benedetti’s review (3) included studies of seasonal depression and patients with both unipolar and bipolar disorder. Other studies were constrained by open trial

design, lack of a comparator group, brief duration, inclusion of antidepressants with adjunctive light therapy, and light therapy combined with sleep deprivation. Assessing hypomanic or manic symptoms with a valid measure is necessary to quantify the rate of their emergence (4). Only 12 of 43 studies (3) included the administration of a mania scale, which will bias the results toward underestimating the occurrence of mixed states and hypomania.

With due respect to our colleagues, the extensive list of authors who “have used [morning light therapy] in everyday clinical practice” (as have we) cannot supplant controlled clinical trial data. In his comprehensive survey (3), Dr. Benedetti reported that morning light therapy has been compared with placebo for bipolar disorder in only three studies. Using the Young Mania Rating Scale in two of the studies, symptoms were absent or rare, while the third study lacked a standard mania measure. With midday light therapy, we did not observe any mixed states, hypomania or mania, or significant differences in scores on the mania rating scale. Direct comparisons of midday and morning light therapy in a randomized controlled trial, with attention to gender-specific rates and predictors of hypomania or mania and mixed state emergence, would be a valuable contribution.

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Validating the Predictive Accuracy of the NAPLS-2 Psychosis Risk Calculator in a Clinical High-Risk Sample From the SHARP (Shanghai At Risk for Psychosis) Program

TO THE EDITOR: A web-based risk calculator (<http://riskcalc.org:3838/napls/>) for use in clinical high-risk populations was developed in the second phase of the North American Prodrome Longitudinal Study (NAPLS-2) (1). This calculator