Short Communication

CLINICAL INVESTIGATION

# Low-dose antidepressants for the treatment of insomnia

Submitted: 02 October 2021; Accepted: 12 October 2021; Published online: 18 October 2021

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## Introduction

Insomnia is one of the most common neurological illnesses. In developed countries, roughly 6% of adults suffer from insomnia as a disorder, with up to 50% of those experiencing temporary insomnia symptoms. Although insomnia isn't considered a serious mental illness, it shares many characteristics with depression. In order to provide a patient with an effective treatment for insomnia, a larger viewpoint is required, one that extends far beyond the prescription of hypnotics. Current treatment guidelines strongly advise using Cognitive Behavioral Therapy (CBT-I) as the first line of treatment for chronic insomnia disorder, with sleep-promoting medicines being used only as a last resort in individuals who do not respond to CBT-I. The use of medication for insomnia is, nonetheless, fairly prevalent in daily clinical practise. Apart from benzodiazepines and non-benzodiazepine (eszopiclone/zopiclone, zaleplon, zolpidem) hypnotics, sedative antidepressants are the most commonly used medications to treat insomnia [1]. Only one of them, doxepin, is licenced by the FDA for the treatment of sleep maintenance insomnia due to a paucity of methodologically sound randomised clinical trials in insomnia. Furthermore, recent guidelines discourage the use of other medications in this class for the treatment of insomnia other than doxepin. Sedative antidepressants, in our opinion, are a helpful treatment option for insomnia when the patient requires sleep-promoting medicines more than 3 times-4 times per week while being in CBT-I therapy [2,3]. When there is a concomitant mood or anxiety illness, sedative antidepressants should be explored because these patients are more likely to acquire hypnotic reliance. Furthermore, many insomnia patients' physiological parameters, such as hormone secretion, whole-body metabolic rate, and brain metabolic rate, are altered in a similar way to sad patients, which supports the use of tranquil antidepressants to treat them. The advantages and disadvantages of utilising sedative antidepressants in insomnia sufferers have been widely examined in previous articles. This is especially true with trazodone, which is commonly used as a sleep aid. The adverse effect profile and interactions with other medicines of sedative antidepressants are frequently stated as a worry with their use in insomnia. Indeed, while there is evidence for the efficacy of sedative antidepressants in promoting sleep, for example, in the form of a recent meta-analytic study for TCA, it is important to remember that these drugs should only be used in insomnia patients at very low doses, such as 3 mg-6 mg for doxepin and 25 mg-50 mg for trazodone. Many psychiatrists are surprised that such a little dose of a tranquil antidepressant might increase sleep. First and foremost, such modest doses are only appropriate for people with primary insomnia. Antidepressants must be taken at the indicated therapeutic dose if a concomitant mood disorder is present. Second, such treatment should only be utilised in conjunction with CBT-I behavioural therapies. Even low-dose pharmaceutical treatment begins to work when a patient limits his or her time in bed and employs stimuli management techniques. It usually means at least 2 hours before to going to bed (in the case of more rapid drug action the patient should be encouraged to shorten this time) [4]. Sedative antidepressants, in our opinion, are a safe class of medications when used in little dosages. We employ them in a variety of patient groups where hypnotics aren't appropriate, such as the elderly, those with sleep apnea, and those with a history of alcohol and substance misuse. Despite the fact that the usage of atypical antipsychotics, particularly quetiapine, is on the rise for the treatment of insomnia in patients with bipolar disorder and schizophrenia, we believe that sedative antidepressants are also a viable therapy choice. We believe that the use of sedative antidepressants at low doses is not linked to an increased risk of phase shift in bipolar disorder, based on our clinical experience and a study of published case reports [5]. Furthermore, we have discovered that low dosages (5 mg-10 mg) of citalopram given in the morning can be an effective alternative to sedative antidepressants in the treatment of insomnia.

## References


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