

Tricyclics and Caffeine Abuse: A Pilot Study

Saeed Shoja Shafti

Emeritus Professor of Psychiatry, New York, USA.

***Corresponding Author:** Saeed Shoja Shafti M.D, Emeritus Professor of Psychiatry, New York, USA.

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Abstract

While at least thirty percent of those with mental illness may be classified as having a 'dual diagnosis,' presently, urine testing for illicit drugs is routine on many psychiatric wards. On the other hand, caffeine, which has a specific diagnostic code in present taxonomies (1), is the most widely used behaviorally active drug in the world. While caffeine is applied for therapeutic purposes when combined with analgesics and antihistamines or in dietary supplements for weight loss, it exhibits a stimulating activity that eases physical and mental tiredness and helps to improve the thinking process.

Keywords: endoscope; instrument; light; diameter and female

Introduction:

While at least thirty percent of those with mental illness may be classified as having a 'dual diagnosis,' presently, urine testing for illicit drugs is routine on many psychiatric wards. On the other hand, caffeine, which has a specific diagnostic code in present taxonomies (1), is the most widely used behaviorally active drug in the world. While caffeine is applied for therapeutic purposes when combined with analgesics and antihistamines or in dietary supplements for weight loss, it exhibits a stimulating activity that eases physical and mental tiredness and helps to improve the thinking process. In this regard, caffeine, by blocking the A1 adenosine receptor subunit, may increase the levels of catecholamines and serotonin (5-HT) in the central nervous system (CNS) and reverse the monoaminergic system changes observed in depression, an effect that is comparable to antidepressants (2). Nonetheless, the pervasive habitual use of caffeine and its widely accepted integration into daily customs may have led to an underestimation of the role that caffeine may play in a caffeine user's daily subjective experiences and, thus, can make the recognition of caffeine-associated disorders particularly challenging (3). Also, while its function is more or less comparable to stimulants, its management is usually limited to self-imposed tapering strategies, and the lack of data regarding its psychopharmacologic management is tangible in academic literature. So, in the present article, an unsystematic management of caffeine abuse by a tricyclic preparation has been, briefly, depicted.

Case vignette:

A young gentleman, in his fourth decade of life, has been referred by his primary care physician to a mental health clinic for a psychiatric evaluation. His main reason for reference included bad temper and belligerence. Anyhow, after meeting with a consultant psychiatrist, in his initial interview, he stated that his irritability was mostly due to his marital problem and

frequent clashes with his spouse and her family. According to him, while he was really in love with his partner, he could not tolerate her limitless expectations and insults, which were entirely self-centered, nonsensical, and one-sided. Indeed, as stated by him, he was victimized by his partner's ceaseless fight with his family, which was originally due to their cultural dissimilarities. His wife, who was present in nearly all of his therapeutic meetings, though she confirmed the existence of the said conflicts, stated that those problems were not new and were not, as well, due to her greediness. According to her, his family, from the start, and due to their traditional values, could not accept her as their bride and had previously considered one of his cousins as his future wife-to-be. But in spite of all those conflicts or accusations, she believed that his unusual snappiness was mainly due to energizing beverages, which he was accustomed to drinking frequently, especially during stressful periods. The said problem, also, was not limited to familial conflicts, because he was always a freelancer and never devoid of monetary difficulties. The client, too, accepted his wife's claim regarding exaggerated consumption of energy drinks during the day, which had started during the last few years, but he denied customary misuse of major stimulants, like cocaine or amphetamine. However, he confessed to an episode of occasional and inadvertent exposure to a club drug (probably amphetamine) at a nightly party, a denial that could not be acknowledged easily by his psychiatrist. Also, he reported some random experiences with other substances like cannabis, alcohol, and tobacco, and also, the usage of some benzodiazepines, like clonazepam, alprazolam, and lorazepam, during the last few years, though, as stated by him, there was no habitual or compulsory misuse of them. Clinically, in addition to morbid irritability, which was enough to make his psychological, familial, and occupational grounds unbalanced, he was experiencing sleep problems, difficulty in concentration, and cheerlessness, which were qualitatively and quantitatively shifting. In reply to this question about whether he had ever tried to stop energy beverages, he replied that though he was able to stop

them, it was not with ease. For example, his prior attempts during the last few months included cycles of stopping them, which were frequently abrupt, and restarting them, usually after a brief gap, which was not more than a few hours or days, along with an interminable internal tension and subjective feeling of dimness. He believed that, since his career and household were not ever devoid of stress, he could increase his mental and physical stamina with those beverages, though, after a while, their effect was not satiating, and he was obliged to increase them. Thus, their usage had become, at least psychologically, compulsory. His partner, though confirming the said cycle, believed that energizing drinks, perhaps, could turn her impatient, droopy, and undersexed spouse into a chatty, fresh, and oversexed companion, though not constantly or completely. She believed that he was, matter-of-factly, addicted to them. Anyhow, based on available data and negative laboratory exams concerning opioids and stimulants, and by taking into consideration the primary ingredient of the available energizing beverage (there and then), which involved around 32 milligrams of caffeine per 100 cc of energy drink, his frequent drinking (around 6–10 cans per day), which could provide the necessary ground for caffeine-induced intoxication, withdrawal, or other related problems, and all would-be uncertainties regarding the linkage between mood and substance and their comorbidity, maybe he could be diagnosed as a case of Unspecified Caffeine-Related Disorder or Unspecified Other (or Unknown) Substance-Related Disorder. Accordingly, he was prescribed desipramine, 10 milligrams per day, which gradually increased to 50 milligrams daily during the next few weeks, and he was advised to decrease the said energy drink gradually; preferably, one can every three days. Also, his companion was advised to control her emotional expression more than before during the stabilization phase of management and the tapering phase of the said beverage. Also, they were advised to seek, conjointly, a marital therapist or family counselor as well. Since his marriage was in danger, and he was emotionally dependent on his partner, though he declined to visit a counselor, he accepted to act in accordance with the above-mentioned psychiatric recommendations. Eventually, after a few weeks, while he and his spouse were contented with respect to his mental well-being, he could take away efficiently and effortlessly from the said energizing drink. Desipramine was maintained for another six months and tapered and discontinued afterward. During the follow-up period (next eighteen months), his familial problems intensified. So, desipramine had been restarted and continued for another year. Likewise, he restarted energy beverage after a few months, though sporadically and to a lesser amount, which was somehow manageable.

Discussion:

Although consumption of low to moderate doses of caffeine is usually harmless, many clinical studies are showing that some caffeine consumers become dependent on it and may not reduce ingestion despite awareness of plausible health complications linked with continuous use. Several precise laboratory studies show that caffeine may create physiological and behavioral effects similar to other substances, and caffeine dependence is a clinically important disorder that affects a nontrivial percentage of caffeine consumers (4). Back to our case, a question may arise that maybe the client's positive response to desipramine and fruitful evasion from energy drinks was due to the medication's antidepressant effect on a primary mild to moderate major depressive disorder, not the reversing of a psychoactive-induced problem or suppressing of a craving, and the correction of mood had exhausted his drive for more self-medication; a question that may not be replied to explicitly. But, even as an antidepressant, desipramine usually has lesser anticholinergic, weight-fluctuating, or soothing side effects due to its greater affinity to inhibit presynaptic noradrenergic receptors (NA) in comparison with other TCAs, which may block more receptors like 5HT, muscarinic, alpha-1, and H-1. Likewise, due to its lesser sedative effect, it seems to be, psychologically, more activating than its equivalents. Therefore, it may be regarded as a favorite choice for people who may not tolerate undesirable psychotropic-induced side effects. On the other hand, in addition to the possible pharmacokinetic interaction between caffeine and different antidepressant drugs, which may enhance their clinical effect, some kind of pharmacodynamic synergism may also exist between caffeine and

some antidepressant medications, including desipramine (2, 5). Also, while, so far, no psychopharmacologic management of caffeine abuse has been reported, except for management of secondary induced symptoms, like sleeplessness or anxiety, desipramine has been used helpfully in the treatment of stimulant abuse, though not without comparable reservations (6–10). In addition, while a gradual reduction schedule, around 25 percent of the baseline dose every week or so, is recommended for reduction or cessation of caffeine, and it has been recommended that caffeinated beverages can either be gradually omitted or can be mixed with decaffeinated beverages with the ratio of caffeinated product decreasing over time, in the present case, gradual reduction of energy drink was pretty effective (1, 3). According to what is being said, though, academically, effective medications are available only for some psychiatric complications of caffeine or stimulant use, and neither class of drug is efficacious in treating caffeine or stimulant dependence itself, and psychosocial interventions remain the recommended treatment for dependence. Desipramine may be a good choice for management of caffeine abuse, especially when it is comorbid with depression, unless medical or psychiatric conditions challenge its trial (11–13).

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