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Depression and anxiety disorders CHAPTER 3 Use in depression Benzodiazepines are not a treatment for major depressive illness. The only meta-analysis conducted found no advantage for benzodiazepines over placebo in depression.²⁰ However, there is some evidence that benzodiazepines may be helpful in preventing relapse of psychotic depression.²¹ Combining benzodiazepines with antidepressants during the early phase of antidepressant treatment (1–4 weeks) may improve depression to a greater extent than antidepressants alone.²² This improvement is not maintained with longer-term treatment.²² In the UK, the National Service Framework for Mental Health²³ at one time emphasised this point by including a requirement that GPs audit the ratio of benzodiazepines to antidepressants prescribed in their practice. NICE suggests that a benzodiazepine may be helpful for up to 2 weeks early in treatment, particularly in combination with an SSRI (to help with sleep and the management of SSRI-induced agitation).⁷ Use beyond this timeframe is discouraged. Limiting initial supply quantities to short periods (1–7 days) may reduce the risk of patients becoming long-term users of benzodiazepines.²⁴ Use in psychosis Benzodiazepines are commonly used for rapid tranquillisation, either alone or in combination with an antipsychotic.²⁵ However, a Cochrane review concluded that there is no convincing evidence that combining an antipsychotic and a benzodiazepine offers any advantage over the use of antipsychotics or benzodiazepines alone.²⁶ A further Cochrane review in schizophrenia concluded that there are no proven benefits, outside short-term sedation.²⁷ In contrast, another systematic review using different outcome measures found superiority over placebo for global, psychiatric and behavioural outcomes, but inferiority to antipsychotics on longer-term global outcomes.²⁸ A significant minority of patients with established psychotic illness fail to respond adequately to antipsychotics alone, and this can result in benzodiazepines being prescribed on a chronic basis.²⁹ There is, however, no evidence to support benzodiazepine augmentation of antipsychotics in schizophrenia and use should be reserved for the short-term sedation of acutely agitated patients.³⁰ Evidence supporting the use of benzodiazepines in tardive dyskinesia is weak³¹ but these drugs remain a treatment option in this condition. Adverse effects Headaches, confusion, ataxia, dysarthria, blurred vision, GI disturbances, jaundice and paradoxical excitement are all possible adverse effects. Benzodiazepines impair cognition, and long-term use has been associated with a range of cognitive deficits (e.g. memory, attention and processing speed), which may persist after withdrawal.^{32,33} The use of benzodiazepines has been associated with at least a 50% increase in the risk of hip fracture in the elderly.³⁴ This is probably because benzodiazepines increase the risk of falls. Benzodiazepines often cause anterograde amnesia and can adversely affect driving performance.^{35,36} Benzodiazepines can also cause disinhibition (see section on benzodiazepines and disinhibition in this chapter). Benzodiazepines have been linked to aggressive behaviour, although the association is modest and possibly related to dose and personality

Revision #1

Created 2026-01-04 20:15:10 UTC by Omar Ayman

Updated 2026-01-04 20:15:10 UTC by Omar Ayman