Psychotic Depression associated with Benzodiazepene withdrawal

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ABSTRACT

Three cases of psychotic depression following benzodiazepene withdrawal are reported . All three patients had previously been well stabilised on their benzodiazepene for many years. One patient made a serious suicidal attempt and all three had to be admitted to hospital for treatment. Two patients had had previous mild depressions though none had previous psychotic symptoms. These illnesses appeared to be more severe than the patients' previous depression. Benzodiazepene withdrawal particularly among those with previous depressions should be carefully supervised and should depression supervene, tricyclic anti depressant therapy may be helpful.

INTRODUCTION

The problem of benzodiazepene dependence has recently been the focus of considerable public concern (BMJ Editorial 1984-"Benzodiazepene on trial") and a characteristic withdrawal syndrome has been reported . Prominent symptoms include anxiety, tension, sleep disturbance, emotional lability, some depression, irritability , muscle pains, distortions of taste all starting one or two weeks after withdrawal (Petersson and Lader, 1981). Abrupt withdrawal of high doses has occasionally been associated with the onset of fits and psychosis, (Schopf, 1983). Although mild depressive symptoms are a recognised feature of the withdrawal syndrome, little attention has hitherto been paid to the onset of depressive illnesses, but these have recently been reported (Olajide and Lader, 1984). We report here three patients who had been quite stable on their benzodiazepene for many years but developed life

threatening psychotic depressions requiring hospitalisation following the cessation of their benzodiazepenes.

CASE 1

The patient was a 38 year old married woman who was admitted to hospital in a state of psychotic depression associated with paranoid ideas and poorly formed auditory hallucinations.

The patient's father had had a depressive illness after being made redundant and her mother had a chronic anxiety state for which she took minor tranquillizers. Her development and early life was unremarkable and she first consulted her G.P. with marital problems. Following the birth of her second child , she took a small overdose and attended psychiatric outpatients. In 1978 she was started on Lorazepam 1mg.daily which she gradually increased to 7mg. daily until August 1984 when she herself decided to stop it quite abruptly. Over the next four months she became increasingly depressed , had crying spells, became agitated and became more withdrawn socially. She developed ideas of reference and believed that people were talking about her, and this stopped her going shopping or taking her son to school. She was admitted to hospital around four months after her last dose of Lorazepam but discharged herself only to be readmitted three weeks later in a state of even more severe depression. She had a depressed mood, crying spells, anorexia, ideas of reference and poorly formed auditory hallucinations. She described hearing unclear mumbling noises. She was treated with Amitriptyline 150mg. with good effect and was discharged twelve weeks later.

CASE 2

The patient was a 55 year old man admitted to hospital following a serious suicidal attempt made during an episode of psychotic depression.

His early life was unremarkable and little was known about his parents as they had died many years previously. He married aged 26, but his wife was chronically anxious and he had to do the housework and he developed impotence . He worked as a clerk but aged 53, he took medical retirement on the grounds of mild hypertension. In 1974, because of anxiety, his G.P.

prescribed Diazepam 5mg t.d.s .and he took these drugs for the next eleven years.However, he then became worried because he had taken these drugs for so long and his G.P. stopped them. Two weeks later he presented with sleep disturbance, early morning wakening, anorexia, weight loss and he became pre-occupied with his financial affairs to a near delusional extent. He said he could bring nothing but financial ruin to his wife and that she would be better off without him. After a sleepless night he took an overdose of Nitrazepam, drank a bottle of whisky, and left a suicide note. This indicated a serious suicidal intent but fortunately he was picked up by the police and admitted to hospital.

On admission he was severely depressed, with biological symptoms of depression, and had suicidal thoughts and delusions of poverty. His diagnosis was psychotic depression and he recovered well on a combination of chlorpromazine and amitriptyline.

CASE 3

The patient was a 64 year old woman who had psychotic depression with auditory hallucinations. She was the only child of deaf and dumb parents. She married and had four children and appeared to be quite well until she was 54 when she took an overdose during a reactive depression. One of her daughters had had an illegitimate daughter who she could not cope with and the child had to be fostered out and this upset the patient greatly. Around 1975 she was started on Lorazepam 8mg. daily by her G.P. and referred to outpatients for assessment for a further episode of reactive depression following a house move. Three months prior to her admission she herself reduced her Lorazepam from 8mg. to 2mg. and during this phase she seemed to be doing well. However, exactly one week after stopping the Lorazepam she became acutely ill. She became extremely agitated, wandered around the house and was unable to make reasonable conversation and had to be admitted to hospital.

On examination she was severely depressed, with sleep disturbance, early morning wakening and expressed guilt feelings over the episode when her grandchild had been removed from her daughter.She also had nihilistic delusions saying she was dead and that everyone else was dead. She claimed

people were spying on her, and said that colours had acquired a special significance. Thus, white meant purity, blue the truth, and red the blood of Christ. She could hear the voice of God who was angry with her for having sexual relationships with her husband and said she would go to hell because of this. She was treated initially with chlorpromazine and amitriptyline but because of a poor response, was given six E.C.T.s. The most likely diagnosis was thought to be psychotic depression but major depression with mood incongruent psychotic features and schizo-affective disorder (depressed type) were also considered possibilities.

DISCUSSION

The suggestion that these illnesses are related to benzodiazepene withdrawal derives from the fact that these three patients claimed they had been well a few months prior to their admission at a time when they had been taking their medication. It would clearly have been an advantage to establish more firmly that had they all been well by using a standardised interview both before and after drug withdrawal, so that more objective evidence of the onset of the illness state would have been documented . However as their cessation of therapy was unplanned and instigated by the patients themselves this was not feasible. Recent studies of Aprazolam withdrawal (Mellman and Uhde, 1986) have shown that tapering regimes of benzodiazepene withdrawal are associated with higher levels of anxiety and raised plasma cortisol than is found in the immediate post - withdrawal phase. However in these cases, particularly case 3, the onset of the acute psychotic depression seems to have started only after the complete withdrawal of Lorazepam, and in the other reported cases, depressive illnesses only seemed to start after complete cessation of the benzodiazepene (Olajide and Lader, 1984; Noyes et al, 1985).

Mild depressive symptoms have been recognised as a feature of the benzodiazepene withdrawal syndrome for many years, e.g.Hollister reported that eleven out of sixteen subjects of withdrawal from chlordiazepoxide developed some depression. Petersson and Lader (1981) found that 50% of their subjects had depression, though not depressive illness, with withdrawal from benzodiazepene. However, Hanna (1972) appears to be the first to report

a major depressive illness following benzodiazepene withdrawal and he treated his case with phenelzine. Depressive illnesses have also been noted in two benzodiazepene withdrawal studies; thus four of twenty-four out of the cases reported by Maletzky and Klotters and two out of thirty-six cases reported by Tyrer (1984) developed depression. The condition is therefore a relatively uncommon complication of the benzodiazepene withdrawal syndrome.

In another recent report, Schneiderian first rank symptoms were precipitated by the abrupt withdrawal of diazepam (Roberts and Vass, 1986). However in one of their two cases, alcohol and a tricyclic were also withdrawn, and so it is uncertain whether the reported symptoms were solely the result of benzodiazepene withdrawal.

A previous history of depression may be relevant as two of the four cases described by Olajide and Lader (1984) and one of the three cases described here had such a history. Our cases differ from those previously reported as these illnesses appeared to be rather more severe and life threatening, requiring hospitalisation and in one case E.C.T. The majority of patients who stop their benzodiazepene probably experience no more than a mild withdrawal syndrome. However, a small minority, particularly those with a predisposition to depression, may develop a more severe depressive disorder. Among such individuals it may be best to supervise withdrawal closely and institute tricyclic antidepressant therapy as soon as depression supervenes.

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DÉPRESSION PSYCHOTIQUE ASSOCIÉE A L'ABSTINENCE DES BENZODIAZÉPINES.

ABSTRAIT

Trois cas de dépression psychotique survenant à la suite de l'abstinence des benzodiazépines ont été rapportés. Les trois cas étaient stabillisés sur leurs benzodiazépines pour plusieurs années auparavant. Un patient a fait une tentative de suicide sérieuse, les trois cas ont été admis à l'hopital pour traitement. Deux patients avaient eu une dépression moyenne auparavant sinon acun n'avait souffert de symptomes psychotiques. Cette attaque semblait plus sévere que les dépressions antécédantes de ces malades. L'abstience des benzodiazépines, en particulier chez ceux ayant souffert de dépression auparavant , devrait être soigneusement surveillé , et au cas où une dépression survienne, les antidepresseurs tricycliques pourraient être utiles.

الموجز

الإكتئاب الذهاني المصاحب لسحب عقار البنزوديازيبين

يعرض هذا التقرير ثلاثة حالات من الإكتئاب الذهانى حدثت عقب سحب عقار البنزوديازيين، وكان المرضي الثلاثة يتناولون هذا العقار منذ سنوات طويلة ، وكان أحد هؤلاء المرضي لدية تاريخ سابق في محاوله الإنتحار ، وكان هناك تاريخ سابق لنوبات إكتئاب طفيف عند مريضين . ولم يكن لدي هؤلاء المرضى أى تاريخ ذهاني سابق . وتم إدخال الثلاثة المستشفى للعلاج، وكانت الإضطرابات الناتجة عن السحب أكثر شدة من الإكتئابات السابقة ، ويبدو أن سحب عقار البنزوديازبين بالنسبة لهؤلاء الذين لديهم تاريخ سابق للإكتئاب يجب أن يتم بحرص مع الأخذ في الإعتبار أن العلاج بمضادات الإكتئاب يكون ذو فائدة فى مثل هذة الحالات.