The long-term use of benzodiazepines: patients' views, accounts and experiences

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Background. Although a decrease in new prescribing has occurred for anxiolytic benzodiazepines, concerns have been raised that a 'core' of long-term users has been left behind. Typically, elderly people represent this 'core', using the benzodiazepines as hypnotics.

Objective. The present study focuses on the reasons why hypnotic benzodiazepines are used for protracted lengths of time. By examining patient experiences and cognitions, a deeper understanding may be gained of why patients continue to use benzodiazepines.

Methods. Elderly, long-term users of benzodiazepine hypnotics were interviewed using a semi-structured interview procedure. A comparison group of non-users of the drugs were given a brief interview to collect comparative data. Interview data were analysed from transcripts using qualitative methodology; statistical comparisons between the groups were made using non-parametric statistics.

Results. The long-term users had significantly fewer hours of sleep per night than the non-users. There was some evidence of tolerance and a suggestion that symptoms of withdrawal were maintaining continual use. None of the long-term users had clean knowledge of what their doctors thought of their use of benzodiazepines.

Conclusions. The data suggest that the power of the doctor may not be utilized to its full potential in the prevention of long-term use, that at least 50% of elderly benzodiazepine users would like to discontinue use, and that patients need information and advice on how to discontinue these drugs.

Keywords. Attitudes, benzodiazepines, elderly, long-term, withdrawal.

Introduction

Benzodiazepines are the most widely prescribed drugs for the management of anxiety and sleeplessness.1 It is estimated that in 1988, 13 million prescriptions for hypnotic benzodiazepines were issued.2 Despite the decrease in prescriptions for this drug group overall in the last few decades, the prescribing of hypnotic benzodiazepines is continuing to increase.3 Although a drop in new prescribing has occurred for anxiolytic benzodiazepines, concerns have been raised that a 'core' of long-term users has been left behind.4 Typically, elderly people represent this 'core', using the benzodiazepines as hypnotics.5–7

Social science research has concentrated on the issues concerning the chronic use of benzodiazepines, although this has been limited, and suggests that an understanding of the long-term use of these drugs extends beyond purely biomedical factors to sociological, political, cultural and economic factors.8 These studies have focused on these drugs used as tranquilizers, despite hypnotics being the most widely prescribed psychotropic drugs in England.9

The present study focuses on the reasons why hypnotic benzodiazepines are used for protracted lengths of time. By examining patient experiences and cognitions through semi-structured interviews, a deeper understanding may be gained of why patients continue to use benzodiazepines. The complexity of the issues involved in sleeplessness and the way in which people perceive and respond to this ill-defined condition, as related to benzodiazepine use, has had minimal attention within the research literature. The need for
Method

Design
A group practice on the outskirts of a city in the south of England agreed to support the study. Written permission was obtained from eight of the practising doctors for their patients to have an opportunity to participate in the study. Ethical approval was obtained from the local medical ethics committee.

All patients who had received a benzodiazepine prescription for hypnotic use continuously for a minimum of 1 year were identified through an audit of the practice’s repeat prescribing. A list of these patients was then sent to the respective doctors, who excluded those with hearing difficulties, anyone suffering from a serious illness and those in a crisis at the time of the study.

All patients were volunteers. Patients were initially contacted by a standardized letter from their doctor asking if they would be willing to be interviewed about how people feel about taking sleeping tablets and why they need to take them. It was assumed that response rates would be increased if patients were initially contacted by their doctor. An information sheet and consent form were included, outlining who was conducting the research, the approximate length of the interview and issues of confidentiality. A stamped addressed envelope was provided for volunteers to return their consent forms to the researcher. Consenting patients were then contacted by telephone and an appointment was made with the researcher.

Due to the low response rate (five patients) in this study, six patients from two additional practices, in a city in the south west of England, were interviewed. Ethical approval from a previous study being undertaken by the project supervisor was extended to cover these additional practices. The sample was selected by two doctors from personal lists. These patients were initially contacted by their doctor, either by telephone or by letter. The same procedure used by the initial consenting general practice was adopted for those patients who received a letter. For those patients who were contacted by telephone, written consent was obtained just before the interview commenced.

Patients’ experiences of using sleeping tablets were explored using a semi-structured interview, which was constructed to cover seven particular areas: type of benzodiazepine used; length of use and pattern of taking; social support; reasons for first using these tablets and current reasons; perception of doctor attitude and prescribing behaviour; wishes and efforts to stop taking the tablets; and general sleep quality.

Questions concerning personally or morally sensitive subjects were left as open as possible; answers were explored further depending on the response.

The semi-structured interview allows the interviewer to discover detail from the respondents about their own views. By giving the respondent freedom to give full answers the validity of the data may be strengthened. The flexibility of this method can bring out the affective and value-laden aspects of the interviewee’s responses and elicit personal attitudes, beliefs and feelings. This mode of data collection was consistent with the primary research objective: to examine the data from the point of view of the participants themselves.

Interview procedure
The interviews took an average of 75 minutes (range 50–120 minutes) and were conducted by the same interviewer. Notes were taken and each interview was audio-taped and later transcribed by the researcher. All interviews were conducted in the patients’ homes, although patients had a choice of having the interview at the general practice.

For ethical reasons, each respondent was told that they were under no obligation to answer every question. Participants were also told that they had the right to withdraw any information they provided, at any time during the study, and it would then be destroyed.

Respondents were told that the information they provided would be kept highly confidential and that anonymity would be maintained at all stages of the research process, by the use of a coding system. It was assumed that this would lower the likelihood of a potential bias created by social desirability and would encourage trust in the interviewer. Respondents were informed that their doctor would not have any access to information that they provided, to avoid fears that the information provided would affect their treatment.

Comparison study
It emerged throughout the course of data collection that a comparison group of the same age who do not necessarily take tablets to help their sleep was needed in order to determine whether any of the findings from the semi-structured interviews were unique to the particular sample or representative of this population age-group.

A brief interview was designed to collect comparative data on sleep pattern, subjective quality of sleep, social support and whether something with perceived or actual sleep inducing properties was taken at night.

The interviews were conducted in two afternoons in a local shopping high street. Twenty-one elderly persons were randomly approached by the researcher who introduced herself and outlined the purposes of the
Analysis of data collected
Data collected through the semi-structured interviews were analysed using appropriate qualitative techniques. The main research objective was to gain some understanding of and insight into continual use of hypnotic drugs in ways which do not require precise measurement or quantification. The two samples would be compared statistically on age, sleep time, subjective quality of sleep and social support.

Results
Participants
Information on the long-term use of prescribed hypnotic benzodiazepines was available from 11 volunteers. Fourteen patients initially volunteered to participate, all of whom were selected by their doctors according to study criteria. Two patients were unavailable during the time the interviews were being conducted and one patient was unobtainable. Ten females and one male were interviewed.

Comparative data from a sample who do not use hypnotic benzodiazepines were obtained from 20 elderly people. Twelve females and eight males provided information; each interview took approximately 2 minutes.

All participants in the comparison group reported that they did not use prescribed sleeping pills.

It should be noted that there was a higher frequency of females in the patient group, and this has been associated with subjective insomnia. It may be argued that the groups were unmatched.

Figures 1 and 2 show further characteristics of the two groups.

Non-parametric statistics were used because of the skewed distribution in the data sets, the small number of participants in each group and because of an outlier in the data gathered on age in the comparison group.

The Mann-Whitney test for unrelated samples was used to determine if the groups differed significantly in age. The groups did differ significantly, in that members of the comparative group were younger [Mann-Whitney W = 226.0, P < 0.05 (adjusted for ties)].

A significant difference was also found between the reported number of hours of sleep obtained on an 'average night' for the two samples [Mann-Whitney W = 119.5, P < 0.01 (adjusted for ties)]. The comparison group have more hours sleep per night than the sample of hypnotic benzodiazepine users.

To investigate whether age was related to sleep, a Spearman's rank correlation coefficient was performed for each group. It was found that for both groups there was no significant correlation. (Comparison group r = 0.209 P > 0.05 n.s. Benzodiazepine group r = 0.43 P > 0.05 n.s.). It may be concluded that sleep is not related to age for either group.

Tablet taking: type of benzodiazepine and pattern of use
The benzodiazepines taken by the sample at time of interview are listed in Table 1. Unfortunately, further information from one of these patients was not obtained, thus the following results are for 10 of the participants interviewed.

The median duration of benzodiazepine use was 8.5 years, with a range of 1–36 years. Six patients reported that they had used benzodiazepine hypnotics every night from the first time they were prescribed. One patient used her tablets every morning and every evening, and three patients used benzodiazepines less than five times a week.

Four participants had taken a different form of hypnotic benzodiazepine at some time (three had used nitrazepam, one had used triazolam), although not in combination with other benzodiazepines. One patient reported using 'over the counter' herbal sleeping
Four participants reported that they had used prescribed non-benzodiazepine hypnotics prior to using benzodiazepines. Three patients had used Mandrax, and one patient could not remember the name. All four who used prescribed sleeping tablets reported that they had taken tablets every night on a continuous basis ever since they were first prescribed. These patients had been using hypnotics for 20, 30, 42 and 45 years, with a median duration of 36 years.

**In-depth study**

It was found that participants gave information spontaneously which was not directly related to the research questions, but upon analysis appeared relevant to the research. Such reports will be included in the results.

**Reported efficacy of the prescribed sleeping tablets**

The following results and those presented in Table 2 display examples of what people said regarding the helpfulness of their tablets.

Two patients reported that their tablets did help their sleep, five gave equivocal comments, two reported that the sleeping tablets were virtually no help and one patient was unsure if the sleeping tablets were efficacious:

"I can't bloody sleep . . . maybe the tablets have something to do with it . . . but I can't sleep without them."

Two participants stated that the efficacy of the sleeping pill was increased by certain 'facilitators', for example, a slice of bread and a hot milky drink and reading a book. Both had been using hypnotics every night for 30 years or more.

Three people tended to take the drugs on an occasional basis. One patient who used sleeping tablets three times a week reported that on the nights when the tablets were not ingested sleep was minimal. Two other patients who used sleeping tablets less than five times a week reported that sleep was satisfactory without ingestion of the drug:

"I can go several nights without taking them, but then if I get two or three bad nights and begin to feel poorly they really are my life saver."

**Changes in dosage/pattern of use (for current benzodiazepines)**

Three patients stated that they had found that the sleeping tablets were not 'strong enough', two of whom had increased the dosage:

"I take one and a half because they are not very strong and one is not quite enough."

"I had to increase to two because I wasn't getting enough sleep."

One patient had not increased the dosage in response to finding the tablets "a little bit too mild":

"I will come down and make myself a cup of tea. You see I can come down and do all that after my sleeping tablet . . . I am not drowsy . . . it proves my tablets do not make me that sleepy."

One patient had increased the frequency of taking the sleeping tablets within 12 months of use:

"I used to take them once a week but then it is getting more frequent that I don't sleep."

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**Table 1**

<table>
<thead>
<tr>
<th>Benzodiazepine</th>
<th>Frequency (no. of participants)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Temazepam</td>
<td>5</td>
</tr>
<tr>
<td>Nitrazepam</td>
<td>3</td>
</tr>
<tr>
<td>Diazepam</td>
<td>2</td>
</tr>
<tr>
<td>Lormetazepam</td>
<td>1</td>
</tr>
</tbody>
</table>

**Figure 3** *Current duration of Benzodiazepine use*

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**Table 2**

<table>
<thead>
<tr>
<th>Patients' comments on the helpfulness of their tablets</th>
<th>Patients' comments on the lack of help of their tablets</th>
</tr>
</thead>
<tbody>
<tr>
<td>&quot;I am lost to the world&quot;</td>
<td>&quot;I will still be wide awake at 7 o'clock&quot; (a.m.)</td>
</tr>
<tr>
<td>&quot;They work just as they did 40 years ago&quot;</td>
<td>&quot;I take my tablets at 2 o'clock (a.m.) . . . and I just stay awake until 4 o'clock, I mean that is some time, I am so tired and I can't bloody sleep&quot;</td>
</tr>
<tr>
<td>&quot;Usually I go to sleep within 10 minutes of taking the tablet&quot;</td>
<td>&quot;10.30 (p.m.) I took one last night, I let them work on me and then round about 4 o'clock (a.m.) I usually drop off with the T.V. on . . . I wakes up (sic) about four times in the night. I can't sleep very well, wakes up to go to the toilet, gets up to have a drink. I'm up at 6 o'clock&quot;</td>
</tr>
<tr>
<td>&quot;They do not put you out just like that&quot;</td>
<td>&quot;They do not put you out just like that&quot;</td>
</tr>
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</table>
Five patients reported that they had not increased the dosage throughout the whole period of using these drugs.

**Reasons for use**
The reasons for first using sleeping tablets and for current use are listed in Table 3 for each patient.

Eight out of the 10 patients interviewed gave different reasons for initial and current use.

Four participants advocated that sleep was less important to them now that they were older, that they needed less. This was not the primary reason why sleeping tablets were used:

"When you get older you don't get much sleep . . . but I was alright before this pain started."

**TABLE 3**

<table>
<thead>
<tr>
<th>Reasons for first use</th>
<th>Current reasons for use</th>
</tr>
</thead>
<tbody>
<tr>
<td>Controlling somatic symptoms</td>
<td>Controlling somatic symptoms</td>
</tr>
<tr>
<td>Controlling somatic symptoms</td>
<td>Controlling somatic symptoms</td>
</tr>
<tr>
<td>Controlling somatic symptoms</td>
<td>Sleeplessness</td>
</tr>
<tr>
<td>Controlling somatic symptoms</td>
<td>Sleeplessness</td>
</tr>
<tr>
<td>Chronic stress</td>
<td>Doctors' orders</td>
</tr>
<tr>
<td>Chronic stress</td>
<td>Habit</td>
</tr>
<tr>
<td>Stress/worry</td>
<td>Habit</td>
</tr>
<tr>
<td>Sleeplessness</td>
<td>Control irritability</td>
</tr>
<tr>
<td>Pregnancy</td>
<td>Sleeplessness</td>
</tr>
<tr>
<td>Overworked</td>
<td>Sleeplessness</td>
</tr>
</tbody>
</table>

**Patient knowledge and perception of doctor’s attitude and prescribing behaviour in relation to benzodiazepine use**

All participants interviewed reported that they did not know what their doctor thought of their use of sleeping tablets. This was mainly due to the unseen repeat prescribing system: seven patients reported that they never saw their doctor when they received a prescription for their tablets, two participants reported that they did not know what the doctor thought because they did not like to trouble their doctor and one had recently changed doctors.

Three participants had discussed their medication with the doctor:

"(The doctor) might have asked me if I wanted to stop them or something, but I said 'Oh no, no way you are not, surely you are not going to take them from me?'"

"'They say 'Why do you take or want them?'. I say 'Well, I have got a bad neighbour', and it is left at that. I say I have got a bad neighbour and they give me what I ask for . . . I feel that doctors don't bother with older people.'"

"(The doctor) did suggest that I come off them, which I did for a month but I was quite ill. I could not sleep . . . and then (the doctor) suggested I go on temazepam."

It was found that three patients appraised the act of prescribing these drugs or the lack of doctor questioning about the tablets as indicative that the doctor approved of the use or that the tablets were safe to use:

"I don't think they (sleeping pills) hurt me very much, because when I ask for them I get a fair amount."

"I don't think (the doctor) is against it . . . (the doctor) has never queried it."

One patient believed that the doctor wanted him/her to be discriminative in their use:

"They give them to me, but I think they want me to be careful."

One participant appraised the doctor's prescribing behaviour as indicative of the drug's strength or danger:

"(The doctor) only allows me 30 of them at a time . . . you know they're strong."

Three participants reported that they were waiting for action from their doctor to stop use:

"I won't take myself off until I speak to (the doctor)."

"I don't stop unless the doctor says."

"The doctor won't take me off them."

**Wishes, efforts and past experiences of discontinuing tablets**

Five participants reported that they would like to stop, four reported that they would not like to stop and one reported that he/she could not stop.

Participants who said that they wanted to stop using sleeping tablets reported that actual discontinuation would be contingent upon:

(i) knowledge that they would be able to sleep without the tablets;
(ii) sources of distress being dissipated;
(iii) feeling that they could cope with stopping: ‘I would like to stop taking them if I thought I could get some sleep.’

Three participants reported that they had tried to stop but had to resume use the same night because it was impossible to sleep:

"I have tried to stop, but I read and I am still wide awake at 2 or 3 o'clock in the morning, so I have to get my sleeping tablets."

Two participants had managed to stop for longer periods; one participant had stopped using sleeping tablets for 5 days:
"I went without them . . . it was awful, my chest, I was in pain. Yeah, I started taking them again."

The second participant had stopped for 1 month:

"I was quite ill, I could not sleep. I was getting up at night and wandering around . . . if I don’t take a tablet then, well, it is just nasty dreams, very disturbed . . . it leaves me a bit upset and shattered the next morning."

Three participants had stopped using sleeping tablets and receiving prescriptions for several months or periods at a time over the years. No reports of disturbed sleep or illness were mentioned upon discontinuation.

Three participants had not attempted to stop: "I have never tried to stop because I don’t take them every night."

It emerged throughout the data analysis that ‘giving up’ was seen as problematic:

"I couldn’t possibly put myself through the problem of trying to give them up whilst I had all this worry."

"When the Mandrax was taken away it nearly killed me."

How people feel about using sleeping tablets
A range of feelings and concerns were expressed towards the use of hypnotics.

Four patients had ambivalent feelings about taking sleeping tablets but consumption was seen as a necessity:

"I don’t like being on them, I don’t want to be a slave to something."

Four participants reported that they did not worry about using sleeping tablets because use was legitimized by their doctor:

"The doctor said, so I just had them."

Two participants reported that the tablets controlled symptoms of physical illness and therefore did not worry about using them.

Three participants were worried about dependency.

"I don’t like to feel I have to depend on them . . . I can take one at night, I have never been tempted to take two."

Five participants indicated that taking tablets was habitual, as something not thought about or as part of an established schedule of taking a number of other prescribed medications:

"It is just like putting a comb through your hair, it is just a thing that you are used to."

"I takes (sic) my little one, my dizzy one and my diabetic ones, my asthmatic ones and my pain killers: I have them with a cup of tea."

Discussion

It was found that the group of long-term users of hypnotic benzodiazepines have significantly less hours of sleep per night than a randomly selected group of non-users. There was some evidence of tolerance to the hypnotic properties of the benzodiazepines used: there were reports that the drugs were not strong enough; there was an increase in dose by two respondents; and two people needed ‘facilitators’ which they believed increased the effectiveness of the tablet.

It may be argued that symptoms of withdrawal were maintaining continual use: it was found in this study that half of the research sample who had attempted to stop had suffered distressing outcomes. The descriptions that participants made of their attempts to discontinue drug taking are similar to those found in other studies. Participants reported sleeplessness, pain and subjective feelings of illness. Distressing dreams were also reported and this is consistent with other reports. It was because of these symptoms that participants reported that they reinstated the drugs. All participants had attempted to stop by sudden abstinence, which increased the likelihood of severe withdrawal symptoms. This suggests that patients need to be correctly informed about how to discontinue these drugs successfully.

This study found that none of the participants had clear knowledge of what their doctors thought of their use of benzodiazepines. It was apparent that repeat prescribing contributed to the lack of knowledge. The data collected from participants who reported that they had spoken with their doctors about the use of these drugs suggest that doctors need to be informed on how to introduce the idea of discontinuation to their patients without evoking distress, disappointment, fear and failure. Doctors also could provide practical information and reassurance concerning drug withdrawal.

Conclusion

The findings suggest that elderly long-term users of hypnotic benzodiazepines are a highly heterogeneous group in patterns of use, in the perceived efficacy of their tablets and in appraisal of doctor behaviour in relation to their benzodiazepine use. This is consistent with another study which found that long-term users of benzodiazepines are not a homogenous group, but show great variability. This indicates that research examining the long-term use of benzodiazepines should be directed to areas other than to identifying predictors of long-term use. It was also found, during the course of this study, that participants perceived ‘giving up’ their drugs as problematic, indicating that research is needed to examine the conceptions long-term users hold about discontinuing their drugs.

Participants were similar in their strategies to discontinue drug use. The consequences of these attempts, however, appeared to maintain the use of these drugs. The data suggest that the power of the doctor may not be utilized to its full potential in the prevention of
long-term use, that at least 50% of elderly benzodiazepine users would like to discontinue use, and that patients need information and advice on how to discontinue these drugs.

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