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Chronic use of benzodiazepines among older adults

Uso crônico de benzodiazepínicos entre idosos

ABSTRACT

OBJECTIVE: To analyze the perception of and motivation for the chronic use of benzodiazepine among older adults.

METHODS: A qualitative study was conducted on 22 older adults living in Bambuí, MG, Southeastern Brazil, who were taking benzodiazepines and had the clinical and cognitive ability to respond to interview questions. The collected data were analyzed on the basis of the “signs, meanings, and actions” model.

RESULTS: The main reasons pointed out for the use of benzodiazepines were “nervousness”, “sleep problems”, and “worry” due to family and financial problems, everyday problems, and existential difficulties. None of the interviewees said that they used benzodiazepines in a dose higher than that recommended or had been warned by health professionals about any risks of their continuous use. Different strategies were used to obtain the prescription for the medication, and any physician would prescribe it, indicating that a bond was established with the drug and not with the health professional or healthcare service. Obtaining and consuming the medication turned into a crucial issue because benzodiazepine assumes the status of an essential food, which leads users to not think but sleep. It causes a feeling of relief from their problems such as awareness of human finitude and fragility, existential difficulties, and family problems.

CONCLUSIONS: Benzodiazepine assumes the characteristics of polyvalence among older adults, which extrapolate specific clinical indications, and of essentiality to deal with life’s problems in old age. Although it relieves the “nerves”, the chronic use of benzodiazepines buffers suffering and prevents older adults from going through the suffering. This shows important difficulties in the organization and planning of strategies that are necessary for minimizing the chronic use in this population.

DESCRIPTORS: Aged. Benzodiazepines therapeutic use Drugs of Continuous Use Health Knowledge, Attitudes, Practice. Qualitative Research.

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RESUMO

OBJETIVO: Analisar a percepção e motivação do uso crônico de benzodiazepínicos entre idosos.

MÉTODOS: Estudo qualitativo desenvolvido com 22 idosos residentes em Bambuí, MG, sob uso de medicação benzodiazepínica e em condições clínicas e cognitivas para responder à entrevista. Os dados coletados foram analisados com base no modelo de “signos, significados e ações”.

RESULTADOS: As principais razões apontadas para o uso dos benzodiazepínicos foram “nervosismo”, “problemas de sono” e “preocupação”, decorrentes de problemas familiares, financeiros, dificuldades cotidianas e existenciais. Nenhum dos entrevistados referiu utilizar benzodiazepínicos acima das doses recomendadas nem foi alertado pelos profissionais acerca de quaisquer riscos sobre o seu uso continuado. Houve diversidade de estratégias na obtenção da prescrição do medicamento e qualquer médico fornecia a receita, o que indica que o vínculo é estabelecido com o medicamento e não com o profissional ou serviço de saúde. A obtenção e o consumo do medicamento tornam-se uma questão crucial, pois o benzodiazepínico assume a importância de um alimento essencial, que lhes permite não pensar e dormir. Oferece um alívio dos seus problemas, que incluem a consciência da finitude e da fragilidade humanas, dificuldades existenciais e familiares.

CONCLUSÕES: O benzodiazepínico assume características de polivalência entre os idosos, que extrapolam as indicações clínicas mais precisas, e de essencialidade para lidar com problemas da vida na velhice. Embora alivie o “nervoso”, o uso crônico de benzodiazepínicos tampona o sofrimento e impede a pessoa idosa de enfrentar o que ele representa. Isso mostra importantes dificuldades na organização e planejamento de estratégias necessárias para minimizá-lo nessa população.

DESCRITORES: Idoso. Benzodiazepinas, uso terapêutico. Medicamentos de Uso Contínuo. Conhecimentos, Atitudes e Prática em Saúde. Pesquisa Qualitativa.

INTRODUCTION

Benzodiazepines, which have been used in clinical practice since the 1960s, represent a class of medications with good anxiolytic potential and lower risks of dependence, drug-drug interaction, and death, even when taken at high doses.³ Nevertheless, they should be used with caution, particularly among older adults, because they have been associated with falls,¹⁵ exacerbation of cognitive decline, and sedation,⁹ particularly when used for extended periods.

International⁶ and national¹ studies indicate a high prevalence of benzodiazepine consumption in the older adult population, particularly among women; this difference is usually less pronounced among older adults.⁶ North Americans⁶ tend to rely on benzodiazepines because of their tranquilizing properties and efficiency in controlling stress in old age. Among Brazilian older adults^{1,2} the use of long half-life benzodiazepines associated

with sleep disorders and anxiety. Long-term use without specialized supervision¹ has been reported to be significantly greater among women also exhibiting symptoms of depression.² A study performed with rural workers²¹ indicated the use of psychotropic drugs as an attitude adopted to deal with “nervous problems”.

Gaining qualitative knowledge¹⁷ of the meaning of this use among older adults is crucial for the organization of healthcare services. In this study, we aimed to analyze the perception of and motivation for chronic benzodiazepine use among older adults.

METHODS

The present study had a qualitative approach and was performed on older adults participating in the Bambuí project (prospective population-based study), which

was developed in the municipality of Bambuí, MG, Southeastern Brazil. The cohort was formed in 1997. Details are described elsewhere.¹⁶

The survey was conducted in the urban area of Bambuí, state of Minas Gerais, Southeastern Brazil, which includes approximately 23 thousand inhabitants. According to official data,^a the population of the municipality has undergone intense urbanization since 1950; the rural population reduced from 84.0% in 1950 to 15.0% in 2010. It also exhibited accelerated aging, and the proportion of older adults showed a fivefold increase in 50 years. One-third of the population is living under poverty conditions.^a The older adult population has a rural origin, has a low education level, and is strongly influenced by the Catholic church.¹¹

There are no long-stay institutions for older adults in the municipality.¹¹ The public healthcare network includes six *Unidades Básicas de Saúde* (UBS – basic health-care units), each of which has a multiprofessional health team (one physician, one nurse, two nursing assistants, and six to seven community health agents), which is part of the *Estratégia de Saúde da Família* (ESF – Family Health Strategy). The Brazilian Unified Health System (SUS) also consists of a Health Center, a unit of the Center for Family Health support, two hospitals (one state hospital and one municipal hospital), and *Posto Avançado de Estudos Emanuel Dias* (Fiocruz), which is currently used for the collection of laboratory tests and the supervision of individuals chronically affected by Chagas disease.

The older adults for the study were selected among the participants of the seventh segment of the Bambuí project, and the inclusion criteria included being a current benzodiazepine user with clinical and cognitive abilities to respond to the interview questions.

The “signs, meanings, and actions” model developed by Corin et al⁵ was used to collect and analyze the data. The model allows the systematization of the context elements involved in the construction of the way older adults think about and act toward benzodiazepine use.

With its origin based on the definition of the *Geertzian* culture, this model seeks the systemization of the various elements of the context that influence the concretization of cultural logics.¹⁰ According to Geertz,¹⁰ culture is a universe of symbols and meanings that allows a group to interpret their experience and to guide their actions. Hence, each community specifically builds its universe of problems, emphasizing some, prioritizing this or that explanation, and encouraging a certain type of reaction. This method⁵ seeks to identify the signs, the meanings attributed to these signs, and the reactions that they trigger.

Uchôa²⁴ understands that the experience of the illness cannot be considered as a simple reflection of the pathological process in the biomedical sense of the term. It should be conceived as a cultural construction that is expressed in “specific ways of thinking and acting”. Kleinman¹³ emphasizes that the illness experience and the behaviors associated with it substantially vary among societies, which is more important than the actual disease. These experiences, which are subjective and from the inner world of people, are built on the basis of cultural representations of the person, subjectivity, the body, the world, and life. All these representations contribute to modulate the illness experience of individuals.⁵ This understanding is supported by the idea that the perception of professionals is almost always linked to biomedical knowledge, while the perception of the population is linked to a network of symbols articulating biomedical and cultural concepts.^{4,24}

In total, 22 interviews were conducted at the residence of the older adults to reconstruct the universe of representations (way of thinking) and of actions (ways of acting) associated with benzodiazepine use. The semi-structured interviews were recorded and transcribed, always starting with the question: “*Have you taken any medication in the last three months?*”. In the case of an affirmative answer, this was followed by the question: “*Do you remember which medications these were?*”. Issues related to use and to the older adult’s perception of the medication were explored on the basis of the answers given to the initial questions.

The transcribed interviews were attentively read to identify significant units and create analytical categories for the construction of a coding scheme. Content and interaction between the different categories and subcategories were analyzed, leading to the identification of the signs and meanings that the older adults attributed to benzodiazepine medication and the actions taken as a result of its use.

The survey was approved by the Ethics Committee of the *Centro de Pesquisa René Rachou* (René Rachou Research Center) according to the protocol 18/2010 (CAAE: 0018.0.245.000-10). Participants signed an informed consent form.

RESULTS AND DISCUSSION

Out of the 22 older adults studied, four were men and 18 were women, mostly married or widows/widowers, with children, and on a low income. Six were illiterate, three interviewees had more than eight years of education, and the others had between 1-5 complete years of schooling.

^a Instituto Brasileiro de Geografia e Estatística. Dados gerais e informações estatísticas da cidade de Bambuí. Rio de Janeiro; 2010.

Obtaining benzodiazepine (a controlled drug) requires the possession of a medical prescription, as stated in the pertinent legislation. Prescriptions were written by non-psychiatrist physicians because the city did not have this type of specialist at the time. Other studies have shown the same practice.¹⁸

The most commonly reported benzodiazepine was clonazepam, followed by bromazepam, lorazepam, or diazepam. The brand name of the medication has been omitted to preserve confidentiality.

Participants reported chronic consumption of the medication (from six months to 40 years); none of them used benzodiazepines at a dose higher than that recommended by the clinical and pharmacological guidelines, although they reported changing the type of benzodiazepine consumed.

Nerves under control, guaranteed relief

Participants, who came from lower classes and many of whom from rural regions, associated “nerves” as the cause of their sleeping difficulties:

“It [the medication] was prescribed to treat the nervous tension that we felt. Because my husband fell ill, we went to (a nearby city) (...) and spent everything we had. (...) They had to prescribe me a sedative. (...) They took me to the doctor, and he prescribed Clonazepam. It worked. I wasn’t sleeping.” (F16, age 74, widow, a user for 22 years)

“Ah, I’m a very nervous person. If I get nervous, then that’s it: I can’t sleep. There are days when we feel nervous for no reason. At other times, we keep thinking about being old, about our children scattered here and there (...).” (F13, age 76, married, a user for 20 years)

When talking about his “nerves”, a man explained that he and his daughter took the same medication:

“She also suffers from nerves, poor thing. Everyone’s nervous, and they never give the slightest sign of it. They all seem happy.” (M3, single, age 74, a user for four years)

This “lack of demonstrativeness” shows a strategy of the working class, which exhibits a spartan attitude toward suffering, expressing it differently.⁴ When questioned about the reason why they use the medication, men and women mentioned “nerves”, “nervousness”, and “confusion”, which are indicative of sleep problems, concern about the family, death of loved ones, and pain, as in these reports:

“Because I wasn’t sleeping. (...) I don’t know if it’s because I keep thinking about life that we’re on our own. There are days when not a single person comes

around here to talk to me. When they do, sometimes it’s just to annoy me.” (F10, age 86, single, a user for two years)

“I had something really bad, I was sick, a huge lump on my body. (...) I was so worried. I couldn’t sleep. Then he prescribed this medication. (...) I didn’t feel anything after that.” (F4, age 69, married, a user for six months)

“I get nervous, so the doctor prescribed me the medication, to sleep. I’d spend sleepless nights, suffering from those nerves, that feeling of confusion.” (M4, age 73, married, a user for 15 years)

The interviewees explained that they seek the rapid relief that they experience “in just half an hour” (M4) and also the chance to “not think” (F4) about the “nervousness” that afflicts them and about managing to sleep. However, there were people who used the medication without referring to difficulties in sleeping:

“I sleep well. It’s only because of my head. For old people, a sedative helps us bear the pain and the problems better... Not that I’m a nervous person or that I need it....” (F8, age 68, married, a user for more than five years)

This lady argued the following:

“They say I take too much medication; I say: ‘God and medicine allow us to continue living’.” (F13, age 76, married, a user for 20 years)

These older adults seek and find in benzodiazepine a powerful strategy to deal with “nervousness” and cope with their everyday problems. Duarte⁸ describes “nerves”, which is a privileged code of expression of the troubles of Brazilian lower classes, as a relational representation of the person with their life context, unlike that of certain social segments that are more attuned to the western psychologized and biomedicalizing view of psychiatry. This author attributes to the code of nervousness a true and integrated physical and moral representation of the person who can only exist within a specific cultural scenario and challenges the biomedical reductionism of the term “mental illness”. The author’s medical anthropological reading of nervousness opposes the following theories: a) biomedical, whereby these phenomena merely refer to the organic expression of mental illness; b) psychologizing, which sees them as an expression of emotions and of individual psyche; and c) sociological, which sees them as a reflection of class and/or gender conflicts as well as the resulting domination associated with them.⁸ All ethnographic, interpretative, and statistical literature about nervous states is somehow related to the issue of labor and social reproduction.⁸

Historically, a division of roles and spaces has been recognized, in which men had duties performed in the public and external space, while women were predominantly destined to private and domestic spaces. Therefore, considering the interdependence between gender and social class, this scenario was profoundly modified when women began leaving the house to work.^{8,19,23} However, no major differences were observed in men's and women's understanding of the chronic use of the medication, perhaps because men and women were out of the job market in which men were retired and women were housewives who had mostly never worked outside the home.

By admitting that the problem that led to the use of the medication no longer exists, this woman told us why she is not able to stop taking it:

"I wasn't sleeping or eating. I'd just think about the consequences because he (her son) drank, and the others picked on him. (...) He stopped drinking and I got better. (...) I think these medications are.. [sic] like a drug (...) You get addicted to that medication. So I'd like to go a day without taking it to see if I manage to sleep. (...) Just thinking about not taking it, I don't think I'll manage to sleep. (...) I don't let it run out. The blister pack there has about 10 pills left...." (F12, age 89, widow, user for more than two years)

Although the medication means "a drug" that is "addictive", the interviewees did not report consumption at abusive doses or frequencies. A similar positive evaluation was observed in national²⁰ and international studies.²¹ With regard to the negative effects of the medication, the following was reported:

"I got much worse; the malaise, the despondency (...) So I'm rather dubious. I said: 'I'm going to stop taking the medication' (...) thinking about trying it out. I'm going to stop taking it and tell the doctor I've stopped because you can't continue taking medication like that indiscriminately." (F8, age 68, married, a user for more than five years)

Continued use does not provoke any fears:

"I've been using this medication for a long time, and I don't have any problems." (M3, age 74, single, a user for four years)

"Nothing negative (...) I don't think I can stop. Because they're doing me good: I didn't use to talk to anybody. I didn't know how to have a proper conversation. It was horrible." (F1, age 75, widow, a user for more than five years)

The use of benzodiazepines is restricted not only to their biochemical effects but also to the social and cultural interaction^{4,8} experienced by the older adults with regard to their oral communication. Similar evidence

of significant psychological dependency, concomitantly with the underestimation or denial of potential side effects of benzodiazepines, was detected among older North American adults, with a strong resistance to withdrawal of the medication.^{6,7}

"It's better to go without rice than to go without it (benzodiazepine)." (F16, age 74, widow, a user for more than 22 years)

When seeking help, older adults receive the prescription for the medication to calm their nerves, and they will possibly use it indefinitely because in their speech, the signs of "relief", "goodness", and "not thinking" refer to the perceived effects of benzodiazepine. In light of the existential difficulties, this "relief" can be just as important as everyday "rice". Therefore, this represents a scenario of chronic use of the medication, similar to that indicated in the study of Rozemberg²¹ in which the medication serves as a "chemical prosthesis" that controls a state of mental disturbance, "nervousness" – and somehow compensates for the lack of prospects. Benzodiazepine has a status of an essential food and serves to temper the awareness of the person's own mortality and of human fragility when facing aging, solitude, family problems, and situations from which they see no way out.¹¹ For older adults, the availability of the professional who provides the prescription matters more than their specialized knowledge:

"I don't have a particular doctor. (...) Any doctor can prescribe the medication (benzodiazepine) for us." (F16, age 74, widow, a user for 22 years)

In most cases, there was not even a need for regular doctor's appointments because "anyone" can provide the prescription. A similar result was observed among Brazilian farm workers.⁵ The access to the prescription depends more on personal and family relationships and/or on the mediation of employees of the actual healthcare service; this process is not always simple:

"When I need a prescription, I don't even go there (to the healthcare service). She (female employee of the service) already knows. I call them and he delivers the medication to his secretary, a lady who lives right near me; she brings it to me and I continue taking it." (F1, age 75, widow, user for more than five years)

"There are days when they (female employees of the service) are really nice. They enter the building and the doctor walks by and stamps the prescription for us. Sometimes though, they are a bit nervous, so we schedule an appointment." (F16, age 74, widow, a user for 22 years)

This range of different mechanisms and strategies to obtain benzodiazepine indicates that a bond is not established with the professional or the healthcare service but

rather with the medication itself. The need to present a prescription is perceived by the interviewees as an obstacle and not as a precaution.

“The doctor only prescribed it once, and I continued taking it (...). I didn’t get the benzodiazepine (at the center), I’d buy it (...). Later on, the pharmacist wouldn’t do it anymore (sell without a prescription) (...) He said: ‘now it has to be with a medical prescription’. (...) if there were another pharmacist who didn’t require a medical prescription, then I’d buy it from him.” (F7, age 70, married, a user for two years)

These data are in accordance with those of another study¹⁸ in which older adults reported easy access to the medication and prescription without the need for a formal doctor’s appointment or medical guidance about the necessary precautions during treatment.

None of the participants referred to any type of warning regarding this medication, which contradicts the medical literature that emphasizes on the risks of benzodiazepine use in the older adult population.^{3,9,15} Only one woman reported that her daughter was warned by the “man from the drugstore” that this medication would not be suitable for an older adult. A Finnish study conducted on older adults who were chronic users showed that the guidance about the risks involved in its consumption reduced the regular use of benzodiazepines by 30.0%. On the other hand, an increase was observed among those who had not received the same guidance.²² Such interventions were more efficient among older adults of a relatively younger age and women.²² Cook et al^{6,7} noted that older adults with a greater daily frequency of benzodiazepine use and greater anxiety were less predisposed to reduce dosages or to plan ahead to stop taking benzodiazepine in the United States. With regard to the reason for not interrupting this medication, two women spoke about the guidance they received:

“Some days I talk to him (the doctor) (about stopping taking it), but he’s difficult to persuade. He tells me to take it again.” (F7, age 70, married, a user for two years)

“I don’t know. Why is it a controlled substance? Is it because we can’t be cured? Is that the reason? (...) They say ‘You can stop taking that medication’. I say ‘It was the doctor who prescribed it’. (...) I want to (stop). I’ve told him (the doctor) before: ‘Doctor, I can’t deal with this dosage...’ (referring to what she heard from the prescriber) ‘I’m not asking you if you can or can’t. You’ll buy the medication and take it’ (laughing).” (F10, age 86, single, a user for two years)

In addition, the medical professional did not answer her questions about the medication:

“I don’t know if it’s because of this medication, I’ve already spoken to him (doctor), but he didn’t say anything.” (F10, age 86, single, a user for two years)

This communication barrier indicates the clash between secular culture, a person suffering from “nerves”, and the professional culture that is almost completely separated from the nerves model, and it is also committed to some versions of contemporary psychologized knowledge of the person.¹⁹ The risks of a difference of opinion are greater when the outline of problems is poorly defined and subjected to multiple interpretations and conducts, as in the case of mental health problems.¹³ The interrogation about the meaning of the illness, in particular, is not restricted to medical information. Relationships between medical knowledge and commonsense conceptions may be established in both directions without depending on a single direction but rather “swinging” between the erudite thinking (of the professional) and commonsense thinking.¹²

Supplies and demands for services are located in a space of potential negotiation that largely determines the decision to interrupt or continue the treatment and the type of response to it. Regardless of the convergences and distances between the fields of perceptions, expectations, and practices of laypersons and professionals, services may not correspond to the needs of the assisted populations.¹³

CONCLUSIONS

Among older adults, “nerves”, this troubling, intangible, and incurable condition that their existential and family problems represent and that deprives them from sleep and peace of mind, can be “relieved” by the chronic use of benzodiazepines. The feeling of well-being that the medication causes “is addictive”, and becomes just as indispensable as their daily “rice”, even if it does not solve the root causes of their problems, which are related to their life context. Therefore, it is difficult to plan strategies to minimize the chronic use of this medication because by treating “nerves” as a disease, the healthcare service buffers the pain of life and simultaneously prevents the person from facing and attempting to address their problems.

This scenario requires a re-evaluation of the public policies that provide both support to professionals and other forms of care and advice regarding the meaning of the underlying “nervousness”. This is to cease the acritical and indefinite prescription of these legal drugs to the population who is known to be vulnerable to their adverse effects.

Otherwise, older adults have no choice but to continue visiting healthcare services in search of prescriptions for “an addictive drug” that “anyone” can prescribe. Then, they will continue taking benzodiazepines to help them “to not think” but “sleep”.

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