

Representations Concerning Long-Term Use of Benzodiazepines Hypnotics, by Patients Over 65, Treated in General Practice. A Qualitative Study Using Individual Interviews

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Abstract

Aim: France is one of the largest consumers of hypnotic benzodiazepines (BZD) and anxiolytics. This consumption has increased in the last few years, especially for older patients. Duration of prescription is greater than in recommendations. The great majority of prescriptions emanate from general practitioners (GPs). The aim of this study was to explore patients' perception of long-term BZD use for hypnotic purposes in subjects over 65 years old.

Methods: A qualitative study by partially-directed individual interview was used. A diversified panel of patients was selected. There was a full transcription of interviews. A thematic analysis was then carried out by several researchers. The interviews were continued to the point of data saturation.

Results: Fourteen patients were interviewed between December 2012 and April 2013. In this study, participants bore witness to their strong attachment to their BZD hypnotic. The initial prescription is related to an important life event. Benefits extended beyond relief of initial symptoms, becoming an important element of daily comfort, rendering withdrawal difficult to imagine. However, patients were often conscious of the risks of taking BZD. Patients perceived repeated prescription by GPs as a guarantee of the drug's innocuousness. Very few GPs spontaneously proposed cessation of treatment.

Conclusions: Withdrawal must take into account the psychological dependence and fragility of elderly patients. The GP, with his knowledge of the patient's environment, could take a central role in prudent initiation and in directed withdrawal when this is necessary.

Keywords: Aged, Benzodiazepines, General practice, Substance-related disorders

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Introduction

In 2012, 11.5 million French people (20%) had taken, at least once, a benzodiazepine (BZD): 7 million with BZD for anxiolytic use, and 4.2 million for hypnotic use [1]. In 2009, France was the second highest consumer of anxiolytics BZD after Portugal and of hypnotics BZD after Sweden [2]. Prescriptions particularly concerned elderly people: 14.5% of 70-80 year olds vs. 10% of 40-50 year olds [1]. Prescriptions of anxiolytics increased in France between 2007 and 2012 amongst the over 80's [1,3].

Above 65 years old, risks related to the use of BZDs, anxiolytics

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and hypnotics, are well-known: falls [4-6], increased risk of neck of femur fracture [7], cognitive perturbation (anterograde amnesia), increased risk of dementia with long term use [8-11]. The risks appear to be reversible after cessation of treatment [12,13]. The risk of mortality, all causes included, is higher amongst those consuming BZD [14], notably hypnotics [15].

The yearly annual usage of BZD anxiolytics and hypnotics is superior to recommended doses [16], especially after aged 65 [17]. The reports from the High Health Authority (Haute Autorité de la Santé-HAS, 2007 & 2012) [18,19], the French Agency for Sanitary Safety of Health Products (Agence Française de Sécurité Sanitaire des Produits de Santé-AFSSAPS) [3] and the National Agency for the Safety of Medicines (Agence Nationale de la Sécurité du Médicament-ANSM) [1] concerning the misuse of BZD amongst elderly patients, have not led to a diminution of this overconsumption of BZD [1,3].

Physical and/or psychological dependence is favored by the duration and the dose used [1]. The consumption of BZD amongst elderly patients appears to reveal an excessive attachment to the product, even mild anxiolytic (or sedative)-related disorder according to the new criteria of DSM [5,20].

In France, more than 90% of BZD prescriptions emanate from GPs [1]. As the reduction of BZD prescriptions amongst elderly patients is a complex mechanism, for patients and GPs, we decided to focus on BZD hypnotics. The aim of this study was to explore the perceptions of long term BZD consumption for hypnotic purposes amongst patients over 65. The aim was to better understand attachment to the product and the role of general practitioners (GP) in its prescription.

Methods

Attachment to a drug is a complex phenomenon. A qualitative method was adapted in order to explore the perceptions and experiences of patients. Being asked to express themselves concerning personal life events and intimate elements of their relationship to the taking of medication, a semi-directed individual interview method was preferred [21].

Setting

To include patients, the study was proposed to GPs in the Auvergne region, contacted by personal connection with the researcher (PG) using the « snowball » method. In order to diversify the patient sample and limit the inclusion bias, the GPs were chosen amongst GPs in the Auvergne area according to socio-demographic data (gender, age) and practice (rural/urban, mode of practice). Selected GPs were to propose eligible patients for the study, whatever the motive for consultation. They were given 3 months to propose the study to their patients and to include the first 2 eligible patients. The patients, having given their consent, were then contacted by the researcher (PG). They received written information concerning the confidentiality and anonymity clauses and the possibility of withdrawing from the study. Their participation agreement was collected at the beginning of the interview.

Population

The patients, aged over 65, must have been taking a BZD for hypnotic use for at least 3 months. A reasoned sample was constituted according to variable descriptive (male-female ratio, home environment, marital status, level of studies, and socio-professional category), and to strategic data for the study (length of duration of treatment). Should not be included any characterized psychiatric disorders (depression, anxiety troubles, or psychosis) nor should be taken any antidepressants, neuroleptics or antipsychotics and mood stabilizers. Patients living in an institution, or diagnosed with dementia by their GP or suffering from a chronic pathology evolved and/or invalidating were also not eligible.

Data collection

The individual interviews took place at the patient's home. The interview guide (**Table 1**) was conceived using data from literature and French and International recommendations, from notes made in the course of discussion with patients, with a psychiatrist (PML) and with GPs (GT, CL, AB, PG). This allows exploration of the representations and the testing of knowledge concerning their hypnotic drug, the experience of attempts at withdrawal and perceptions concerning dependence (table1). An initial analysis was carried out: the emerging themes were added to the interview guide for the following interviews. The sessions were fully digitally recorded and re-transcribed on Microsoft Word. The gathering of information was terminated when new interviews no longer gave rise to new themes or new elements to a theme: data saturation was thus considered attained.

Data analysis

This was conducted according to the themed analysis method of verbatim. Two researchers (PG and GT) have independently encoded the interviews. Then, they met to cross-reference their analysis and identify themes and sub-themes. In the event of disagreement, a 3rd researcher (LM or CL) would decide upon the contradicting opinions. Data collection and analysis occurred concurrently, informing each other iteratively.

A retroactive validation was obtained by submitting the study data to the interviewees.

Ethical and methodological considerations

This study has received the approval of the Ethic Committee South-East VI (Comité de Protection des Personnes-CPP Sud Est-VI). The authors followed the COREQ grid to develop the study.

Results

Twenty-two GPs in the Auvergne were contacted by telephone then by email. Eight of them accepted to participate (**Table 2**) and they recruited 14 patients (**Table 3**). Those who refused evoked the lack of available time. The characteristics of the final sample are resumed in table 2. The 14 interviews took place between the 23rd December 2012 and the 25th April 2013 at the patient's homes. They lasted an average of 25 minutes. Saturation of data was reached with the eleventh interview. Three supplementary

interviews allowed confirmation of this. Six patients validated the results.

Data analysis permitted the emergence of 3 major themes.

The first time

For most patients, consumption has begun on the occasion of an

emotional shock, for example a bereavement, a separation or a serious illness: « At the beginning I really needed it and I don't know what I would have done without it » (P6) « I felt anxious, I thought about my illness which may well return » (P9).

The perceived benefits

Some patients bear witness to the effectiveness of their

Table 1 Interview guide.

<p>Treatment : Which ? Delay. First prescription. Trigger. Prescription conditions. Repeat question : « How was this drug presented to you ? »</p>
<p>Consumption : Knowledge of the drug. Information sources. Repeat question : « What do you compare it to ? » « Is there something about taking this drug which you do not like ? »</p>
<p>Perception : Place of this drug in the patient's life. Repeat question : « Is there something about taking this drug which you do not like ? »</p>
<p>Withdrawal : Attempts. Successes, failures. Motivation. Progress. Fear of withdrawal. Repeat question : « Have you already tried to reduce or stop taking this drug ? » « In your opinion, what could help you to stop ? »</p>
<p>Perspectives : « How do you envisage your future in relation to this drug ? »</p>

Table 2 GP's characteristics.

GP	Gender	Age	Duration of installation	Practice locality	Exercise
GP 1	male	53	+than 20 yrs	rural	Group
GP 2	male	64	+than 20 yrs	rural	Group
GP 3	female	38	-than 20 yrs	rural	Group
GP 4	female	50	+than 20 yrs	rural	Group
GP 5	male	65	+than 20 yrs	rural	Group
GP 6	male	62	+than 20 yrs	urban	Group
GP 7	female	37	-than 20 yrs	urban	Group
GP 8	male	35	-than 20 yrs	urban	Isolated

Table 3 Sample characteristics.

Patient	Sex	Age	Locality	Level of studies	Previous Socio-professional category	Which BZD ?	Declared total period of BZD consumption
1	Feminine	85	Rural	Certificate	Farmer	Lormetazepam	20 years
2	Feminine	66	Rural	CAP	Foreman	Bromazepam	19 years
3	Feminine	85	Rural	Brevet	Farmer	Zopiclone	17 years
4	Feminine	71	Rural	Certificate	Farmer	Lorazepam	35-40 years
5	Masculine	65	Rural	Certificate	Tradesman	Lorazepam	25 years
6	Feminine	71	Rural	None	Personal services agent	Zolpidem	4 years
7	Feminine	81	Rural	Certificate	Farmer/shopkeeper	Zolpidem	5-6 years
8	Feminine	85	Urban	Certificate	Manual worker	Prazepam	4-5 years
9	Feminine	79	Urban	Bac	Primary school teacher	Zolpidem	15 years
10	Masculine	87	Urban	Post Bac	Accountant	Oxazepam	29 years
11	Masculine	69	Rural	Bac	Primary school teacher	Zopiclone	30 years
12	Feminine	88	Urban	Certificate	No profession	Bromazepam	15 years
13	Feminine	74	Urban	Certificate	Accountant	Zolpidem	10 years
14	Masculine	87	Urban	Brevet	Qualified industrial worker	Lorazepam	34 years

treatment: « the (bromazepam) you take one and you are really fine! » (P2), « it's the drug which works best for me » (P6). They took their medication to reduce their psychological tension, even to suppress suicidal thoughts: « there are moments when I have to take it or I'm losing my head » (P11), « it is better that I take the tablet, like that I sleep and I don't do anything silly » (P8).

The drug had a role in relation to the outside world, such as family stability or the management of stress at work: « the poor thing (her husband), I look after him so much... I have everything on my shoulders... » (P2), « I was doing a stressful work so it had the advantage of relax me » (P10). It was described as a mean allowing a certain level of comfort: « (when) I take my tablets ... the next day I feel well » (P1).

Perceived negative effects

The length of time of consumption encouraged an idea of tolerance to the drug: « my memory has always been a little weak but should I attribute that to the (zolpidem) or to my age? » (P9), « if it hasn't hurt me up to now, then I must be used to it! » (P10).

It is the cognitive effects which are the most worrying: « What scares me is the brain » (P9). « They say .../... that one can contract Alzheimer's disease » (P1).

The effects of the drug were minimized, and knowledge about it erroneous: « It's a mild treatment » (P8) « to that it's really a sleeping pill, no I don't think so » (P8). For some, the treatment had a pejorative connotation: « it's a tragedy to be taking that! » (P2), « it's like tobacco, it's the same, it's the war between the two! » (P11).

Dependency and withdrawal

Attachment to the drug was strong: « that and my children are what help me to survive » (P13). The taking of the treatment often followed a form of ritual: « I take half my tablet; I lie down and go to sleep » (P1). Dependency was often feared. They retained often an impression of mastering the situation: « all the same, it's not natural to be obliged to get to sleep using medication » (P11), « it's a consolation that I only take half a tablet » (P9). Some patients acknowledge this dependence, evoking it in physical and psychological terms: « in brackets one might say that it is a need » (P7), « I cannot do without it: I am addicted » (P2). Some patients had adaptation strategies: they increased their consumption, or they tried changing products in order to diminish the dosage: « because I felt that a quarter was insufficient .../... I said « I'll move on to one half » (P10), « I must get used to what I take because if I change a little that will become something new » (P10).

Withdrawal Experiences of unplanned withdrawal did not put treatment in doubt: « when I forget, it can happen that I sleep well too! » (P10). The key elements to withdrawal appear to be motivation, fear of undesirable effects: « if one wants to it appears to me that it's possible » (P6), « I'm afraid that I might lose my memory » (P2). Alternative therapies tried (homeopathy and herbal therapy) were perceived as less effective: « it's very long with plants ... before they really start having an effect » (P2). Withdrawal failures generally left a feeling of powerlessness or lack of self-confidence: « I go to the limit in order to avoid taking

it but there is always a moment when I crack and end up taking it! » (P11), « I could try again but I know that it won't work » (P7).

Society and environment

The role of ageing

Age favors the consumption of BZD, modifying the relation to risks and diminishing the interest for withdrawal: « as long as my body will take it, I will take it » (P7) « I continue to take them after all, I am old enough to make a fuss! » (P14).

Society's injunction

Some patients receive negative feedback from their entourage, which creates a feeling of guilt: « my daughter-in-law says « you shouldn't take (bromazepam), you realize what you're doing... » (P12), « I don't talk about it because everyone says that it's not good » (P2). Others, on the contrary, feel comforted by the reassuring words of their close relations or even their GP: « at the same time, all my family are taking it » (P5), « for the nurse, it was normal » (P9). Information about the hypnotics came from the medias, from the drug instructions or from the GP : « there were 3 lines about the (zolpidem), it was entitled « A little good for a great harm » (P9), « the doctor said to me .../... that it was not particularly good » (P12). This did not systematically modify behavior: « one shouldn't listen to everything » (P1).

The role of the general practitioner

Certain patients were resigned to their GP's prescription: « I am obedient, it's not me the doctor » (P11), « for the moment I will not stop because he hasn't told me to stop » (P12). The GP was described by some patients as passive: « now he no longer says anything to me... » (P1). The absence of any challenging of the prescription was taken as a guarantee of absence of harmful effects: « when you must take it, you must take it, like all remedies » (P1). BZD became in this way a product of ordinary consumption, as essential as other prescribed medicines: « I say don't forget to prescribe my lorazepam » (P4). Few patients spoke of propositions by their GPs for stopping treatment. The advice for withdrawal was minimalist: « the doctor told me « You know that if you don't sleep one day you will sleep the next! » » (P9).

Discussion

In this study, the participants showed a strong attachment to their BZD hypnotic. The initial prescription is most of the time related to an important life event. The benefits extended beyond relief of initial symptoms, and introduced the issue of comfort, rendering withdrawal difficult to imagine. The patients were however often conscious of the risks of taking BZD. The regular renewal of prescriptions by GPs was taken as a guarantee that the molecule is innocuous. For the participating patients, few GPs proposed an end to treatment.

Attachment of patients to their treatment was related to its hypnotic property but also to the anxiolytic effect. Other qualitative studies have studied elderly patient perception of BZD treatment, both anxiolytic and hypnotic [22-24]. Anxiety was attenuated and they were better able to confront daily life

[23,24]. Some factors of resistance to withdrawal were stated: the benefit brought by stress control and the non-perception of side effects [22,23]. Dependency has specific characteristics in elderly patients: consumption interferes neither with professional or social life nor with perspectives seen as non-existent [25]. Their treatment appears as a response to ageing [26], a medicating of the existential [27].

The positive representation of the psychotropic drug plays a role in prolonged consumption [28], as well as in denial of the associated dangers [29]. These attitudes are nourished by the consumer's perceived messages. BZDs are, in France, inexpensive medicines reimbursed by medical insurance regimes.

Phillips has defined 'clinical inertia' in 2001 as "failure of healthcare providers to initiate or intensify therapy when indicated" and "recognition of the problem, but failure to act" [30]. This concept extended to the 'therapeutic inertia' [31], has been described by many authors, especially hypertension [32,33] and diabetes [34]. O'Connor describes three main causes of this concept [35]: doctor factors, patient factors and practice systems factors, but authors are unanimous: doctor factors is the most important. In our study, GPs are described by the participants as those who initiate and re-conduct treatment. The attitude of the practitioner is a determining factor at the time of initial prescription: a prescription for treatment described as temporary will incite the patient to respect the duration of the recommended treatment [36,37]. Gugliano also described the mirror concept [38]: "Clinical inertia also may apply to the failure of physicians to stop or reduce therapy no longer needed", named: "therapeutic momentum" [39,40]. A misunderstanding slows withdrawal: doctors think that the patients are requesting a hypnotic and patients feel that the doctor prescribes it too easily [23]. Finally, Lebeau has defined the concept of "appropriate inaction" [41], insisting that not intervening too quickly may have a benefit for the patient. Indeed, withdrawal places the GP in conflict with the necessity to ensure patient security [37] and their psychological well-being [42].

Withdrawal concerns the patient in their totality: their family and social context [26]. The consideration of this biological and social reality necessitates knowledge of the patient's environment [43]. GPs who know their patients and their life events are the best placed to intervene in withdrawal [44,45]. Several strategies have

been shown to be effective: an information sheet from GPs to patients, explaining the risks involved with BZD consumption over long periods [46,47], a brief intervention [48] or education sessions [49,50]. Measures of multi-discipline support (geriatric, psychiatric, pharmaceutical) reinforce effectiveness [18]. Behavioral and cognitive therapies equally have a beneficial role in withdrawal (HAS) although elderly patients tend to have lesser recourse [27].

Strengths and limitations of the study

As with any qualitative sample study of patients in a single department of France, these are not representative of the general population. Rigorous selection of a diversified panel of elderly patients has increased the external validity by creating data saturation. The researcher (PG) trained himself in the qualitative method through semi-directed interviews. He did not have great practical experience. He presented himself as a student writing a thesis in order to minimize the influence on patient discourse. The familiar site of the interview and the absence of observers had the effect of encouraging confidence in patients. Transcription of the interviews was carried out in an exhaustive fashion by the researcher who performed the interviews with the aim of objectivity and reproducibility in order to avoid subjective data interpretation. Researcher's triangulation allowed the limitation of personal interpretations. There was no triangulation of methods in this study. The method of focus groups did not seem appropriate for this subject, which touches sometimes on issues of distress and privacy. Validation by of data by the participants reinforced the internal validity of the study.

Conclusion

As shown in this study, Benzodiazepine occupies an important place in the lives of the elderly persons. Their attachment to the product is due to their fragility linked to their age and to life events which motivated a request to their GP for the initial prescription. Withdrawal should therefore take into account the psychological dependence and the comfort which the treatment brings. The GP who knows the personal as well as the medical history of the patient could well have a privileged role to play in prudent initiation, re-conduction of controlled prescriptions, and in managed withdrawal when this is necessary.

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