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Perceptions of Benzodiazepine Dependence Among Women Age 65 and Older

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Abstract

A phenomenological study explored whether older women who are chronic benzodiazepine users identified themselves as dependent, how dependence was perceived, and how meanings and understandings shaped experiences of benzodiazepine use. Self-reported benzodiazepine dependence was associated with being unable to reduce use or a desire to discontinue use and reliance on benzodiazepines to remain comfortable and able to handle daily life. Themes included: 1) benzodiazepine dependence is similar to dependence to diabetes or blood pressure medications; 2) dependence is distinctive from addiction/abuse; 3) addiction/abuse is perceived as worse than dependence; and 4) concerns of addiction/abuse result in low-dose benzodiazepine use.

Keywords

aging; prescription drug abuse; women; qualitative research

INTRODUCTION

Chronic anxiety and sleep problems are common in older adults, though the treatment of these conditions can be challenging (Alwahhabi F., 2003; Krishnan & Hawranik, 2008). Patient's psychosocial problems can feel burdensome to healthcare providers who have limited time to counsel patients with complex care needs and feel that treatment options beyond prescribing medications are costly and available only for patients with adequate financial resources (Anthierens, Habraken, Petrovic, & Christiaens, 2005; Dybwad, Kjølsrød, Eskerud, & Laerum, 1997). Benzodiazepines are prescribed as anxiolytics or

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hypnotics; and physicians report that benzodiazepines can effectively treat anxiety (Cook, Marshall, Masci, & Coyne, 2007) and insomnia (National Institutes of Health, 2005).

At least 3–15% of any adult population in the world and 20–50% of women over 60 are prescribed benzodiazepines (Currie, 2003). Across 13 studies, current benzodiazepine exposure among older adults ranged from 10.7% to 42% (average 15.2%), with 1-year exposure ranging from 9% to 54% (average 32%) (Llorente, David, Golden, & Silverman, 2000). Research consistently finds old age and female gender to be associated with greater consumption of psychopharmacological medications such as benzodiazepines; women are twice as likely as men to use benzodiazepines (Isacson & Haglund, 1988; Isacson, 1997; Laurier, Dumas, & Gregoire, 1992; Perodeau, King, & Ostoj, 1992).

Though there are improvements in anxiety and sleep disturbance following acute benzodiazepine treatment, significant negative side effects, such as dependence, have been associated with chronic use; 35% of persons who take benzodiazepines regularly for four weeks or longer will develop dependence; after 4 to 6 months of daily use, the majority of users will develop dependence (Doweiko, 2011). Other negative outcomes include memory and reasoning impairment, deficits in attention and visuospatial ability, drowsiness, sedation, uncoordinated motor actions, hallucinations, euphoria, irritability, disinhibition, and confusion, all of which can increase the likelihood of falls, fractures, institutionalization, and motor vehicle accidents (Blow, 1998; Currie, 2003; Doweiko, 2011; Llorente et al., 2000; Longo & Johnson, 2000; National Institute on Drug Abuse, 2001; Scott & Popovich, 2001; Simoni-Wastila, Zuckerman, Singhal, Briesacher, & Hsu, 2005). Controversy remains over whether these risks are outweighed by the benefits of reduced anxiety and sleep problems (O'Brien, 2005; Rosenbaum, 2005).

When benzodiazepine use is limited to a 2- to 4-week period to treat acute anxiety and sleep disorders, the benefits may outweigh the risks; however, beyond short-term use, the benefits of benzodiazepines are unknown (Lader, 2011). Achieving an appropriate balance between underutilization of a beneficial medication and overutilization of a potentially harmful drug is an important clinical goal (Rosenbaum, 2005). Cook and colleagues found older chronic anxiolytic users lacked a desire to reduce or discontinue use or to minimize potential side effects (Cook, Biyanova, Masci, & Coyne, 2007) and physicians to not be concerned about the risks of chronic benzodiazepine use (Cook, Marshall et al., 2007). A sizeable number of older women who use benzodiazepines are chronic, regular users (Llorente et al., 2000).

Considerable research has focused on the increased risk for developing dependence following chronic benzodiazepine use. "Substance dependence," also commonly called addiction, is defined in the Diagnostic and Statistical Manual of Mental Disorders, 4th edition Text Revision as at least three of the following in the past year: physiologic tolerance; withdrawal symptoms; consumption of larger amounts or for longer than suggested; preoccupation with use or acquisition; persistent desire or unsuccessful attempts to quit; reduced social, occupational, or recreational activities because of use; and use despite adverse consequences (American Psychiatric Association, 2000). "Physiologic dependence" to benzodiazepines includes tolerance and withdrawal symptoms, but does not

include the drug-seeking or compulsive use behaviors that characterize addiction (O'Brien, 2005).

The experiences and perceptions of benzodiazepine use and dependence risk among older chronic benzodiazepine-using women have been largely neglected in the risks vs. benefits debate. While prior research has characterized benzodiazepine users and explored health outcomes related to benzodiazepine use, how chronic benzodiazepine users define and experience potential dependence remains unknown. Qualitative research methods are well-suited to uncover the personal meanings of phenomena and experiences, and reveal new insights quantitative methods are not designed to access (Carlson, Siegal, & Falck, 1995; Woodhouse, 1992). The primary aim of our study was to investigate the subjective experiences and meanings of benzodiazepine dependence in a sample of women age 65 and older who self-identified as chronic benzodiazepine users. Our focus was on whether older women who are chronic benzodiazepine users identified themselves as dependent, how users perceived dependence to benzodiazepines, and how meanings and understandings shaped individual experiences of benzodiazepine use.

METHOD

Design and sample

We used a descriptive phenomenological design, which enabled us to focus on the phenomenology and the subjective knowledge, meanings, and experiences in the lives of informants, which we recognize as situated within larger social, cultural, and political contexts, without any preconceived hypotheses (Hycner, 1985; Lopez & Willis, 2004). This exploratory approach was used to explore informants' understandings of and experiences with benzodiazepine dependence through semi-structured interviews to capture the depth and richness of subjective accounts.

English-speaking women aged 65 and older who self-identified as using a benzodiazepine on a near daily or daily basis (5 or more days per week) over the previous 3 months or longer for a sleep or anxiety problem (Cook, Biyanova et al., 2007) were recruited. Informants were primarily recruited through newspaper advertisements and flyers distributed in senior residences in a large metropolitan area. Forty-nine older women expressed interest. Of these, 29 were ineligible for participation because they a) did not take any medicine (n=3); b) reported using another non-benzodiazepine medicine for their sleep or anxiety problem (an over-the-counter sleep agent, painkiller, or antidepressant (n=24)); or c) did not know what medications they took (n=2). Two women who used a benzodiazepine were ineligible: one had used lorazepam for only one week and the other reported using clonazepam for epilepsy rather than for a sleep or anxiety problem. Three women who were eligible chose to not go through with the interviews for undisclosed personal reasons. Fifteen women were eligible, signed informed consent, and completed the interviews; of these, twelve women reported on their perceptions of benzodiazepine dependence.

Data collection

The first author conducted all interviews with the informants at mutually agreeable times in informants' homes or a private room in their residence building. Multiple-visit interviews (2 or 3 interviews per informant) occurred approximately one week apart and enabled the interviewer to develop rapport with informants, collect detailed accounts, allot enough time for informants to take breaks, and provide time for the interviewer to reflect on the data and to follow-up with questions to further understand informants' reports (Knox & Burkard, 2009; Mischler, 1986). During the initial interview, informed consent was obtained to conduct the digitally recorded interviews, each of which lasted 60 to 90 minutes.

Semi-structured interviews elicited descriptions of informants' beliefs and feelings about benzodiazepines; perceptions of how benzodiazepines affect their lives; and understandings and definitions of benzodiazepine dependence. An interview guide (Appendix) was developed with both original items and questions used in prior research (Cook, Biyanova et al., 2007; Perodeau et al., 1992; Voyer, McCubbin et al., 2004; Voyer, Cohen, Lauzon, & Collin, 2004). Open-ended questions enabled informants to provide detailed, expressively rich narratives with great depth of meaning and gave women a chance to discuss what is important to them, rather than to the investigator. The structure of the interviews enabled conversations to naturally progress and to focus on the dimensions of dependence important to informants. A detailed notebook of memos, observations, and impressions complemented the interviews (Mischler, 1986). Upon completion of the full interview series, informants were paid $30 cash as an honorarium for their time and participation. Interviews were professionally transcribed verbatim, with informants' details and identifying information removed, and managed in Atlas.ti software (Muhr, 1997) to enable systematic data management. Each informant was assigned an identification code and pseudonym known only to the first author. The University of Maryland, Baltimore County Institutional Review Board approved the study.

Data analysis

Analysis began with an initial read-through of each transcript for general meanings in the narrative. Aspects of the data concerned with an "insider's" perception of definitions and experiences related to benzodiazepine dependence were coded as such. Coding was an iterative process of reading and re-reading each transcript and questioning the data to help define and organize codes as well as to compare and contrast cases (Hycner, 1985; Lopez & Willis, 2004). As codes developed within individual transcripts, they were considered across cases at the group level. The process of reading, examining, and questioning the data helped define and organize individual codes into themes and sub-themes. Themes revealing the essence of informants' reports were then applied to the rest of the data, as appropriate. Our results are what developed from compiling a complete list of themes and the reports from each transcript relevant to each theme.

Two researchers independently coded and analyzed transcripts to reduce any bias of the researchers' preconceptions. Coded data were discussed in depth until discrepancies in interpretation were resolved. Our dialogue facilitated a productive exploration of the data and the process of reaching consensus on informants' meanings and ideas is a well-

established process in qualitative data analysis and helps to reduce researcher subjectivity (Hycner, 1985).

RESULTS

Study sample

Twelve women reported on their experiences of benzodiazepine use and meanings of benzodiazepine dependence. Informants ranged in age from 65 to 89; four women were currently married, five were widowed, two were divorced, and one woman had never married (Table 1). Despite attempts to recruit a culturally and ethnically diverse older sample, our informants were all of white European origin. All informants lived in their own homes; five women lived in a continuing care retirement community, and seven lived independently in a 55+ adult community or subsidized housing setting where no services were provided.

The majority of older women informants (n=9) identified themselves as being dependent on their benzodiazepine. Alprazolam was the most commonly used medication among our informants who perceived dependence to their benzodiazepine (n=7), followed by lorazepam (n=2) and diazepam (n=1). Informants' use of their current benzodiazepine medication ranged from more than a year to more than 40 years. Three informants did not perceive being dependent on their benzodiazepine and reported using clonazepam (n=1), temazepam (n=1), or alprazolam (n=1) for between 3 months to 2 years at the time of the interviews (Table 1).

Perceptions of dependence

Self-reported benzodiazepine dependence was associated with perceptions of being unable to reduce benzodiazepine use or a desire to discontinue use as well as feeling reliant on benzodiazepines to be comfortable and able to handle life (Table 2). There also was some confusion among informants over the concepts of dependence and addiction, and, for three informants, a denial of dependence.

Affirmations of dependence were combined with informants' reports of a desire to discontinue use as well as an inability to reduce use:

> Josephine: I do depend on it now…only in the sense that I take it every six hours and I guess that's about it and I really would like to be off of it…
>
> Carolyn: I tried to reduce it and couldn't, so I guess I'm dependent on it…
>
> Patricia: I think I need the medication; I'm depending on it. At this stage of the game I can't give it up, no. No, I'm dependent on it.

Informants also reported dependence as a result of having come to rely on benzodiazepines to feel comfortable and able to handle life:

> Lily: I have wished that…that my body worked right and I didn't have to depend on medication to…be one of the things to get me into a place where I can feel more comfortable.

> Iva: I really, I don't really think I can handle things without my meds. I mean I'm just really, really, really dependent on them at this point. All of them.

Affirmations of being dependent were also discussed alongside confusion regarding the concepts of dependence and addiction:

> Frances: I was concerned about…am I really dependent on this? Am I addicted or dependent?
>
> Interviewer: Do you feel that you're one or the other?
>
> Frances: I'm dependent.
>
> Rachel: …well, like I said I depend on it [alprazolam] but when I get low I get real upset so I really feel I'm depending on it. I don't know if I'm addicted to it, but maybe I am.

Three informants, Evie, Andrea, and Betty, did not perceive being dependent on their benzodiazepine. Evie, who used alprazolam as well as zolpidem, a non-benzodiazepine sedative-hypnotic, reported feeling dependent on zolpidem: "I'm dependent on the Ambien [zolpidem] because I can't sleep without it." Andrea, who did not state feeling dependent, reported being unable to sleep without temazepam: "…if I don't take it, I'm not sleeping…" Betty, too, did not report feeling dependent on clonazepam, which she begun using three months prior to the interviews following an anxiety attack: "I take them because I was told to…I don't think that's being dependent on them." Betty defined dependence as "you absolutely need it; otherwise you get crazy…you get really anxious," which she did not feel applied to her.

Meanings of dependence

Four themes surrounding informants' perceptions of dependence emerged from the analyses of data. First, benzodiazepine dependence was perceived as similar to dependence to other medications; second, dependence was distinguished from addiction/abuse; third, addiction/abuse was perceived as worse than dependence; and fourth, concern over addiction/abuse results in low-dose benzodiazepine use in our sample (Table 2).

Benzodiazepine dependence similar to dependence to other medications—

Being "dependent" on benzodiazepines was not perceived differently than being "dependent" on medications for other illnesses, such as diabetes or high blood pressure. For instance, Betty stated, "I think if somebody needs a particular medication, whether it be for diabetes or I mean they're dependent on it…" She also stated, "…you wouldn't feel ashamed if you needed a cancer drug…there's a stigma against…drugs for your mind." Lily shared a similar sentiment:

> …I have to take…high blood pressure medication and nobody says anything about…becoming dependent on it. Yeah, I'm becoming dependent on it because if I don't take it I'm going to end up with something worse and I feel the same way about the Ativan. If I don't take it, it's going to harm my body more than it's going to help me.

Dependence can be distinguished from addiction/abuse—Informants emphasized distinctions between benzodiazepine dependence and drug addiction/abuse. Unlike dependence, addiction/abuse was characterized by informants as taking higher quantities than prescribed, drug cravings, illicit drug purchasing and selling, needing rehabilitation, and to causing withdrawal symptoms:

> Patricia: I know I can't sleep, there's nothing abnormal about that. I take it more when I'm fearful, when I'm afraid of something or uneasy or…plain panicky…then I want it, I go and take it…But I'm not a dope addict. I'm not addicted.
>
> Lily: I don't look at it in the same way, look at like morphine that people become… addicted to morphine or that they're taking illegal drugs and then they become addicted and have to go into…rehab and that. To me it's a different, a whole different type of…thing with…Ativan…
>
> Frances: If I miss a night I live through it…but if I was addicted I would probably have gotten up in the middle of the night and take something, so I was just dependent on it.
>
> Carolyn: To me would be…taking more than…a lot more, not the way I do it. If I have a sudden…frightening experience and I take a half, I don't call that abusing. But if you take a lot of it…if you would take like four to six a day that would be abusing.

Addiction/abuse is worse than dependence—Nested within the distinctions informants made between addiction/abuse and dependence were reports of addiction being worse than dependence:

> Deborah: Dependence, I think, is not as bad as addiction. I don't know how to describe it, it's just, it's not as powerful a feeling I think.
>
> Patricia: …that to me is addiction: when you go out looking for someone to buy it…whereas if you get it from a pharmacy and you get it every three months, 90 pills…I don't think that you can put that in the same category as being addicted to a drug. Dependent on it, yes, one a day, I'm dependent on it for three months.

Concern over addiction/abuse maintains low-dose benzodiazepine use—A final theme that emerged from the data was the influence of informants' concern about addiction on the amount of benzodiazepine used. Perceiving that an increase in one's prescribed benzodiazepine dose would result in addiction kept informant's benzodiazepine use at regular, low doses.

> Evie: I'm afraid to take more than they tell me to of that kind of medicine [benzodiazepines]…because I would like to not be taking things that are addictive.
>
> Lily: I didn't want to ever get to the point where I was going up. Because like I say, I had discussed with [nurse practitioner], I had read…that it…could become addictive.

DISCUSSION

We explored the meanings and experiences of benzodiazepine dependence in a sample of women age 65 and older who were regular, chronic benzodiazepine users. Without providing standard definitions of physiologic dependence or addiction/abuse, informants were asked whether they identified as dependent on their benzodiazepine and how they perceived dependence. Most informants discussed being benzodiazepine-dependent, though they expressed confusion between the concepts of dependence and addiction/abuse, and denied being addicted. Reports of perceived dependence were influenced by feeling unable to reduce benzodiazepine use or the desire to discontinue use as well as to feelings of reliance on benzodiazepines to feel comfortable and able to manage life. Despite previous literature reporting harmful side effects of benzodiazepine use, our sample of older women denied being addicted or having fallen as a result of benzodiazepine use and only two informants suggested that their memory was made worse by benzodiazepine use (data not shown). Largely, informants downplayed the negative aspects of benzodiazepine use and considered the appropriate continuous use of a benzodiazepine to be a suitable response to managing chronic anxiety and sleep problems.

Several themes related to perceived dependence were revealed. First, benzodiazepine dependence was perceived as similar to dependence to other medications. This is interesting in light of the negative references to benzodiazepine use in the media and increasingly in healthcare (Gabe & Burry, 1988). One could imagine that benzodiazepine dependence would be thought of as worse than dependence to other medications given its poor reputation in the media. Our informants, however, did not report concerns over being dependent on benzodiazepines. Rather, benzodiazepine dependence was normalized as it was likened to dependence to medications for diabetes or high blood pressure; dependence to benzodiazepines, according to informants, led to improvements in the ability to live, similarly to other medications. Future research should explore whether benzodiazepine use is normalized among persons dependent on these medications as a result of rational beliefs or stigma and denial.

A second theme distinguished informants' perceptions of benzodiazepine dependence from addiction/abuse. Such data suggest a continuum of acceptable behavior, with addiction/abuse representing a higher-level problem than dependence. Our informants openly disclosed their dependence, but steadfastly denied being addicted; benzodiazepine use was perceived as different and less harmful compared to drug use by addicted persons. Addiction/abuse was associated with illegal drug use while dependence was associated with medications prescribed by healthcare professionals and obtained from legitimate sources, such as pharmacies. Drugs prescribed and provided by medical authorities and used as prescribed were given some level of social endorsement while drug seeking outside healthcare settings was morally questionable and associated with negative outcomes.

Lastly, we found perceptions of dependence and addiction/abuse to influence benzodiazepine use. Informants reported avoiding consumption of higher doses of benzodiazepines because of concerns of developing addiction. O'Brien (2005) has distinguished between drug-seeking persons who intentionally abuse benzodiazepines and

persons who are prescribed a benzodiazepine by a healthcare professional and develop dependence following chronic use, suggesting distinct types of benzodiazepine users as well as different profiles of persons with substance dependence. Future research should examine how chronic dependence to medications in low-doses is distinct from other clinically recognized drug dependence and whether older adults may be more likely to identify with a less stigmatized definition of dependence.

There are several potential limitations to our study. First, sampling for older women who regularly use benzodiazepines proved difficult despite the variety of recruitment approaches used. Older women may only want to discuss their benzodiazepine use with their healthcare providers because of the stigma surrounding mental health topics and drug use (Blow, 1998). Because our informants were volunteers there may be differences between our sample of women and older women who were unwilling or unable to participate. For instance, our sample may be healthier or perceive less severe dependence than women who did not volunteer. Our study also is limited by our small sample size, as well as by the homogeneous sample, as all informants were white women of European heritage. Future research should seek ways to compare our data to women who perceive more severe benzodiazepine dependence and to adults of other ethnic groups. We would expect culture to influence individual perceptions of medications and subsequent use (Chia, Schlenk, & Dunbar-Jacob, 2006), though how culture shapes perceptions of substance dependence is unknown. Future research should also continue to monitor benzodiazepine medication use patterns and potential increases in low-dose dependence following recent policy changes that have made benzodiazepine medications reimbursable under Medicare Part D.

Such limitations notwithstanding, our findings provide intimate knowledge about the individually mediated ways in which older women think about and consume their benzodiazepines. This information has been formerly left out of discussions surrounding the risks and benefits of benzodiazepine use and can be used to aid social workers in their discussions with patients and their considerations of best care practices to improve sleep and anxiety problems.

Our data reveal that medical professional’s attitudes and prescribing patterns have a powerful influence on perceptions of medications and subsequent use among older adults. Denial of dependence or addiction/abuse can be based on a medication having been prescribed by a medical authority. Betty did not believe she was dependent on clonazepam because her doctor recommended her use; she was “told to” take the medication. Patricia, who reported she was dependent on alprazolam, stated she was not addicted, which she perceived as an experience reserved for people who do not get drugs from a pharmacy. Identifying dependence using standard measures or drug-seeking behavior becomes problematic when healthcare providers influence decisions related to the quantity and duration of benzodiazepine use as well as facilitate the obtaining of benzodiazepines (Voyer, McCubbin et al., 2004; Voyer, Preville, Cohen, & Berbiche, 2010). For many, following medical professionals’ instructions for use is regarded as being a “good patient” (Holm, 1993). Social workers should be vigilant of the role that authority figures have on their older patients’ medication use and consider asking about perceptions of dependence to gauge risk of increasing doses.

Informants were not entirely passive care recipients, however, but were active in their own health care experiences. The meanings and expectations older adults have of benzodiazepine dependence and addiction/abuse influence use patterns. Though benzodiazepine dependence was not regarded as any worse than dependence to other medications, addiction/abuse was considered a condition worse than dependence, and informants avoided addiction/abuse by using low doses of their benzodiazepines. Women, such as those in our sample, who think more negatively about the addiction/abuse potential of benzodiazepines or have concerns about addiction/abuse may use lower doses while women with more positive perceptions of benzodiazepines and less knowledge of the risk of dependence may use benzodiazepines more often or less judiciously. Future research should examine benzodiazepine users' knowledge of the risks of dependence and how this may influence use patterns.

Individual user perceptions of medications and consumption patterns must be considered as the balance is sought between the benefits offered by benzodiazepines in alleviating sleep and anxiety problems and the risk of benzodiazepine dependence. Future research should expand this study to a larger sample of older adults in order to better understand the outcomes of low-dose chronic benzodiazepine dependence, as exemplified by our sample, which may differ from the poor outcomes of more severe substance abusers.

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Appendix. Interview Guide

What medications are you currently using? [Note the dose and frequency of each.]

1. What is this drug is for?
2. Where or from whom did you or do you obtain this medication?
    a. If from a doctor: Which doctor initially prescribed this for you? Does this same doctor continue to be the one who prescribes it for you today?
    b. PROBE: from husband or other family/friends?
3. When did you first use this drug? What happened then?
4. Why did you first use? What stressors were in your life at that time?
5. Have you ever missed a dose?
    a. If yes, what happened?
    b. If no, what would happen if you forgot to take a dose?
6. How do you get refills? How often?
7. Have you ever discontinued use? If so, why? And what made you return to using the drug?
8. Have you ever changed the dosage? If so, why? What happened?
9. Do you need a reminder to take your medicines?
10. Do you keep a reserve of any of your medications?
11. Have you ever been rejected from obtaining any prescription that you wanted or needed? Why do you think you were rejected? What did you do?
12. Does your doctor know about each of the medications you use? Why/why not?

Collection of beliefs and feelings data about benzodiazepine use

1. Could you discuss your opinion about what [name of benzodiazepine] does for you?
2. How does it work for you?
3. How does this fit into the rest of your life? (How does this fit in with any other substances you used/are using?).
4. How are benzodiazepines different from other medications that you take? Similar?
5. How has your benzodiazepine use changed over the length of time that you have been using this drug?
6. Have you ever done anything to change/stop your benzodiazepine use habits/ pattern? What happened?
7. Thinking about your use of [benzodiazepine], what comes to mind? What's the first thing you think about?
8. What knowledge of [benzodiazepine] did you have before you began use?
9. Do you see the use of [benzodiazepine] as central in your life, or not. What place does it have in your life?
10. How does benzodiazepine use impact your everyday life?
11. What emotions do you feel when using benzodiazepines? Happiness? Relief? Shame? Can you describe these feelings?
12. Are these feelings immediate? Does the feeling change over time?
13. How do you feel about taking your benzodiazepine? How do you feel if you don't take it? Does taking/not taking your benzodiazepine interfere with your day or night?
14. Do you know anyone who has had problems using benzodiazepines, maybe a family member or a friend?
15. Do your family/friends have any opinion about you using a benzodiazepine? Does your use affect your relationships in any way?
16. Do you want to discontinue your benzodiazepine at this time of your life?
17. Do you think that you *could* discontinue use of your benzodiazepine and be okay?
18. What do you think would happen if you stopped taking the medicine completely?
19. Do you think it is desirable to stop taking this pill?
20. Do you think you *will* discontinue use of your benzodiazepine some day? How do you think this will work?

Collection of data about how benzodiazepines affect informants

1. How does using benzodiazepines make you feel physically? (Probe for woozy, wobbly, etc).
2. How did it make you feel when you first started using?
3. How has the use of benzodiazepines impacted your weight or had other positive or negative effects?
4. Do benzodiazepines affect your ability to do things or your quality of life? How?
5. Do you enjoy the physical effects of benzodiazepines (i.e. get high) or does use of them only relieve unpleasant feelings?
6. What physical or psychological problems have been caused or exacerbated by your benzodiazepine use?

Collection of data about controversy over benzodiazepines

In the published research there has been some controversy regarding whether the benefits of benzodiazepines outweigh the potential risks of use. But, there have been few reports which ask users of these drugs to report their positive and negative experiences. What negative outcomes have you had as a result of using a benzodiazepine? What about positive ones? [*PROBE: Some negative outcomes described in the literature include noting that the rate of falls increases among users which increases the rate of hip fracture and hospitalization. Have you had any experience with this? Positive outcomes include the ability to manage anxiety and to improve sleep. Have you had any experience with this?*]

1. Do you feel that the controversy over whether the negatives of benzodiazepine use outweigh the positives is a legitimate concern?

Collection of data about benzodiazepine dependence

1. Do you feel that you are dependent on your benzodiazepine?
2. How would you define the term “dependence”? Is it different than “addiction”? How?
3. Where do you get your ideas about these definitions from?
4. Do you think that our society or certain cultural ideas influence drug dependence in any way?
5. Do you think there is a need to ameliorate drug dependence? How?

Table 1

Informant demographics and benzodiazepine use, by perceived dependence

Pseudonym	Age (yrs)	Marital status	Benzodiazepine medication (mg)	Length of Benzodiazepine use
Informants Who Perceived Being Dependent				
Carolyn	85	Married	Alprazolam 0.25	~15 years
Vicky	85	Never married	Alprazolam 0.25	4–5 years
Frances	77	Married	Alprazolam 0.5	5 years
Patricia	84	Widowed	Alprazolam 0.25	10–20 years
Lily	65	Divorced	Lorazepam 1.0	~20 years
Deborah	67	Widowed	Lorazepam 1.0	1+ year
Rachel	89	Widowed	Alprazolam 0.5	40+ years
Iva	68	Married	Diazepam 5.0 & Alprazolam 0.25	30+ years
Josephine	86	Widowed	Alprazolam 0.5	20 years
Informants Who Did Not Perceive Being Dependent				
Betty	75	Married	Clonazepam 5.0	3 months
Andrea	85	Widowed	Temazepam 7.5	2+ years
Evie	66	Divorced	Alprazolam 0.5	9–10 months

Table 2

Perceptions of dependence and themes

Perceptions of dependence
Inability to reduce benzodiazepine use or a desire to discontinue use
Reliance on benzodiazepines to feel comfortable and able to handle life
Confusion regarding concepts of dependence and addiction
Themes
Benzodiazepine dependence is similar to dependence to other medications
Dependence can be distinguished from addiction/abuse
Addiction/abuse is worse than dependence
Concern over addiction/abuse maintains low-dose benzodiazepine use