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What's loneliness got to do with it? Older women who use benzodiazepines

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Abstract

Aim: We examined qualitative data from a larger study of benzodiazepine-using women older than 65 years, living in the United States, for subjective experiences of loneliness and social isolation.

Method: Data from semistructured interviews with seven participants discussed aspects of social isolation or loneliness. Following a phenomenological design, data were coded and analysed for experiences.

Results: Three themes emerged: 'Dislike being alone'; 'Loneliness and isolation'; and 'Social isolation causes negative feelings'.

Conclusion: Social isolation and loneliness are negative aspects of the lived experience for older benzodiazepine-using women and the loss of companions and transportation is important to this experience. Being isolated can cause depression, fear and insecurity. Future research should consider the role psychotropic medications have in coping with social isolation and loneliness among older adults. Clinicians should be aware of social isolation and loneliness in late life and discuss non-pharmacologic treatment options with their ageing patients.

Keywords

ageing; alone; benzodiazepine; loneliness; qualitative research; woman

Introduction

Benzodiazepines are a class of psychotropic medications commonly prescribed for the treatment of sleep and anxiety problems. Benzodiazepine prevalence use rates among older adults in North America, Europe and Australia range from 11 to 42% and older women use benzodiazepines more than older men (1–3). While research has investigated the risk factors and negative outcomes associated with benzodiazepine use (2,4–6), as well as older adults' perceptions of discontinuing benzodiazepine use (7,8), little research has examined the lived experience of benzodiazepine use among older community-dwelling women who use these medications. This information is vital to reducing poor outcomes, such as dependence, that

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are associated with benzodiazepine use. To collect such information, a qualitative study was conducted to give older women a voice and to collect personal descriptions of experiences, feelings and understandings of benzodiazepine use. From this larger study, we report here on one theme that emerged: social isolation and loneliness.

Research on benzodiazepine-using women who report loneliness or social isolation has been neglected despite loneliness and benzodiazepine use having several common risk factors. International research has found worsening health, widowhood, female gender and living alone to be risk factors for loneliness among older adults (9). Similarly, those who are divorced or widowed are more likely to use psychotropic medications (10) and older women (11) and persons who are less educated and more lonely (12) are at risk of long-term benzodiazepine use.

Loneliness is conceptualised here, as in previous studies (9,13), as an individual's subjective evaluation of feeling without companionship, isolated or not belonging. Loneliness is distinct from social isolation, which is an objective measure of the size and diversity of one's social network and frequency of social interaction (9,13). It is important to recognise that lonely people may have extensive and diverse social networks and socially isolated persons may not feel lonely (9,13).

The primary aim of this study was to examine qualitative data from a larger study of benzodiazepine-using women older than 65 years, living in the United States, for descriptions of loneliness and social isolation. Our focus on older women rather than older men is warranted given the greater proportion of older women who are both lonely and use benzodiazepines. To achieve our aim, the following question was asked of the data: What is the subjective experience of loneliness and social isolation for older women who regularly use a benzodiazepine for a sleep or anxiety problem?

Methods

Design and sample

Following a descriptive phenomenological design (14,15), a parent study aimed to understand participants' experiences and perceptions of benzodiazepine use. Semistructured interviews elicited subjective accounts with depth and richness. This exploratory approach enabled us to focus on the phenomenology and the subjective knowledge, meanings and experiences in the lives of participants, and how these were situated within a larger social, cultural and political context without presupposing any hypotheses (14,15). The University of Maryland, Baltimore County Institutional Review Board approved the data collection and analysis and participants' details and identifying information was removed from the transcripts. Each participant was assigned an identification code and pseudonym known only to the author.

Women older than 65 years, English speaking and self-identifying as using a benzodiazepine on a near daily basis (≥5 days/week) over the previous 3 months at minimum to treat a sleep or anxiety problem were recruited. Participants were recruited through newspaper advertisements and flyers distributed in independent and assisted living senior residences in

a large metropolitan area in the United States. Flyers asked interested women older than 65 years who use prescription pills to improve sleep or reduce anxiety to leave their contact information on a voicemail. Phone calls were promptly returned so potential participants could be screened. In total, 16 older women who reported using a benzodiazepine for a sleep or anxiety problem were eligible and willing to participate. From this parent study, a subsample of seven participants who shared experiences and perceptions of social isolation and loneliness are described.

Data collection

Interviews were conducted at mutually agreeable times in participants' homes or private meeting rooms in their residences. Multiple-visit interviews (two or three interviews per participant) occurred approximately 1 week apart and enabled the interviewer to develop rapport with participants, collect detailed accounts on the lived experience of benzodiazepine use, reflect on the data, follow up with questions to further understand participants' reports and allot enough time for participants to take breaks (16,17). At the initial interview, informed consent was obtained to conduct the digitally recorded interviews, which each lasted 60–90 minutes.

Semistructured interviews used open-ended questions (Appendix I) to enable participants to provide detailed narratives with great depth of meaning which were expressively rich (14,15). The interview guide was developed with both original items and questions used in prior research (7,18–20). Women's perceptions, feelings, meanings and experiences were sought and, as appropriate, additional probing questions were asked. The structure of the interviews allowed conversations to naturally progress and to focus on the dimensions of the lived experience of benzodiazepine use which were important to participants. These interviews were complemented by detailed memos, observations and impressions maintained in a field notebook (17). Upon completion of the interviews, participants were paid a $30 honorarium for their time and participation. Transcripts were professionally transcribed verbatim and data were managed in a textbase, Atlas.ti (21).

Data analysis

Analysis began by an initial read-through of each transcript for general meanings in the narrative. Those aspects of the data which concerned with an 'insider's' perception and experience of benzodiazepine use were coded as such. As codes for social isolation and loneliness emerged from the read-through of individual transcripts, these were considered at the group level. Coding was an iterative process of reading and re-reading each transcript and questioning the data to help define and organise codes as well as to compare and contrast cases (14,15). This study reports on the theme of social isolation and loneliness and related subthemes, which emerged following comparison across cases and reflection on participant's subjective meanings.

The data were independently coded and analysed by two qualitative data experts to reduce any bias of either researcher's preconceptions. Data were discussed in-depth until any discrepancies in interpretation were resolved. This 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 (14).

Results

Reports of social isolation and loneliness were discussed spontaneously by a subsample of seven participants in our study and emerged as an important theme from the data on the lived experience of benzodiazepine use for participants. Here we focus on these seven participants who all lived alone in their own homes and ranged from 65 to 86 years. Despite attempts to recruit a culturally and ethnically diverse sample, participants were all of white European origin; three women were widowed, three were divorced and one never married. Five of the seven participants also used more than one psychotropic medication (Table 1).

Thematic content

At the outset of the larger qualitative study, which examined the experience of benzodiazepine use in a sample of older women, an understanding of social isolation and loneliness was not explicitly sought. Rather, the theme of social isolation and loneliness became apparent during analysis as descriptions occurred within the context of the lived experience of benzodiazepine use among older benzodiazepine-using women. Subthemes include: dislike being alone; loneliness and isolation; and social isolation causes negative feelings.

Dislike being alone

'Being alone' and disliking this form of isolation was reported by Anne and Lily. Anne, an 86-year-old widow and mother of five, who lived in a one bedroom apartment, had begun regularly using benzodiazepines 8 years earlier to improve poor sleep following her husband's death. When asked whether she has any weaknesses, Anne stated, 'I don't like being alone too much which doesn't say much for me, does it? You should be happy with yourself'. Lily, a 65-year-old who had divorced after 42 years of marriage, reported having used lorazepam for several decades, primarily before bedtime, though she would also use it, if needed, during anxiety-inducing situations during the daytime. In discussing her concerns about possibly losing her car and how she will get to the grocery store or doctor's appointments, Lily states:

> … really the worst part of it is just being alone … Because I had never … had any experience with, nor did I ever particularly like being alone but I guess that was because I had always had family around me. You know, it was always kept busy … when I moved in here [senior living community] I left everybody, I felt like I left everybody behind because … my family, they all had their families to raise and … naturally it was something that I had hoped, well you know, when I got married well when you get old you have your husband and then you get to go and do things and … that wasn't the case. I was … just on my own at this point … it still is very difficult for me to accept the fact that this is what my life is now and probably will be.

Both Anne and Lily enjoyed the socialisation associated with family life and now dislike the status of living alone. Acceptance of living alone was also difficult for Lily.

Loneliness and isolation

Feelings of loneliness were reported by Evie, Mardie and Christine. Evie, a 66-year-old divorcee who lived in a subsidised apartment building, reported being lonely because, 'It's just different than living with people … There's nobody to talk to … it's not the same as when you live with people … You have somebody around all the time'. Mardie, a 75-year-old widow, reported being lonely since her husband's death. She also linked her loneliness to no longer having a car as she felt 'stuck' in her senior living community. Mardie stated being 'very lonely because I don't drive. That was my big mistake … I had stopped driving but I still have my license. I'm sorry I gave up the car because if I were still driving my life here would be much different'.

Christine, an 85-year-old woman who never married and lived with her dog in a small apartment, reported both social isolation and loneliness and related these to deteriorating eyesight and losing her ability to drive: 'I was very happy teaching, but I've been rather lonely since, because I can't drive and I can't read'. When asked if she would like more social interaction with residents of her community, Christine replied:

> I'd like to be in a way, but I find that a lot of people, older people, talk about each other and about their illnesses and this and that and honestly I'm not very interested … of course I'm used to living alone because after I left [*job as a teacher*] I always lived alone … I did much more entertaining than I do here.

Living without companions, feeling 'stuck' and not being able to drive contribute to feelings of loneliness for Evie, Mardie and Christine.

Social isolation causes negative feelings

Christine and Deborah both reported that being alone caused depression. Christine stated, '… when I'm alone a lot, I'm apt to feel a little depressed, but you get over it … and I do things that I can do, like I'm helping … with the pool for the healthcare people'. Deborah, a 67-year-old divorcee who lived in an apartment in a senior community, discussed wanting to live with one of her two sons. Deborah reported using lorazepam daily in the morning over the past year to reduce anxiety, but in response to why she began using duloxetine (an antidepressant) 10 years prior, she stated, 'I was living alone and didn't like it. I still don't like it … I'd like for one of my sons to live with me but that's not going to happen'.

For Patricia, an 84-year-old widow who lived in an apartment in an independent senior living community, being alone was particularly troublesome and caused insecurity, fear and trepidation. Patricia compared her current feelings about being alone to feelings from earlier in life:

Patricia: … being alone is a horrible thing … when I was 30 and alone, I was blissfully happy, I mean it didn't bother me that I wasn't married or anything … I mean it occurred but it wasn't a hindrance in any way. But being alone at 80 is much different, much worse.

Interviewer: What is the difference?

Patricia: Insecurity. Fear. Trepidations … insecurity the most … I feel very insecure, I feel like lost some times. When I wake up in the middle of the night and maybe I don't feel as well as I should, what should I do now? Should I call 911? Should I call my son? I can't call neighbours because they're all old and you don't want to wake anybody at 2 o'clock in the morning because you don't feel well … I get panic attacks because I'm alone.

When Patricia was asked when her alprazolam has had the most important influence on her life, she stated that earlier she:

> … needed it because I was worried about, I was fearful about … my longevity, whether I was going to live. And now … I need it because I am old, I'm 20 years older and I'm alone, which I wasn't at that time, and I have to fend for myself so I feel I need something to keep me nice and calm so I can think what I should do, shouldn't do.

Patricia cites needing alprazolam to remain calm because of the fear, insecurity and trepidation she feels when alone.

Discussion

This exploratory research found reports of social isolation and loneliness embedded within descriptions of the lived experience of benzodiazepine use in a sample of older community-dwelling women in the United States. Participants reported disliking being alone, loneliness and isolation, and negative feelings as a result of isolation. All participants lived alone and the majority were widowed or divorced, which is consistent with existing literature on the greater prevalence of loneliness and benzodiazepine use reported by persons who are widowed or divorced (9,10). Not having a car and feeling isolated in one's senior community was difficult for several participants. For several participants, psychotropic medications (both benzodiazepines and antidepressants) were reported to help manage feelings of depression and insecurity that resulted from social isolation. Whether or not medications reduced feelings of social isolation and loneliness for other participants is unknown. Additionally, it is not known if social isolation and loneliness are underlying causes of anxiety and sleep problems.

These findings are significant in light of the considerable negative physical and mental health outcomes associated with loneliness in later life. For instance, poor sleep quality; higher blood pressure (22,23); and greater depression (24,25), mortality (13) and suicide (26) have been associated with loneliness in older adults.

Our findings build on prior research, which suggests that older adults who feel lonely are at risk for psychotropic drug use (10,12). While there is no literature on how many older benzodiazepine-using women live alone, this number is likely to be high. Prior research has suggested that socially isolated older adults relate to their psychotropic medications in symbolic ways; medications can be viewed as having human qualities such as 'a helper' or 'a security' (27). Substituting social supports, activities or companions who offer 'help' or 'security' with benzodiazepines that symbolically fill these roles serves to medicalise social

isolation and loneliness. However, it is unknown whether psychotropic drug use is so prevalent because of the negative feelings caused by individuals' inability to cope with social isolation and loneliness or because non-pharmacological alternatives are lacking. It is also unknown whether medications are inadvertently prescribed to treat insomnia and anxiety symptoms resulting from social isolation and loneliness. A critical examination of whether older adults' social problems, such as social isolation and loneliness, are treated with medications is needed. It may be that benzodiazepines come to replace social supports and social activities.

Though this study is limited in the relatively small sample of women who were willing participants, to our knowledge this is the first attempt to qualitatively explore conceptions of social isolation and loneliness in a sample of older benzodiazepine-using women. Because participants 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 loneliness than women who did not volunteer. Future research should seek ways to compare our data to women who perceive more loneliness, to men and to adults of other ethnic groups. Despite these limitations, this exploratory study was most interested in participants' knowledge, meanings, and reflections on social isolation and loneliness, and the experience of benzodiazepine use; this goal was accomplished.

Interventions such as telephone befriending services among community-dwelling older adults in the UK (28) and videoconferencing with nursing home residents in Taiwan (29) have been found to alleviate feelings of social isolation and loneliness. These, and other innovative ways of connecting with and supporting older adults, should be considered as valuable clinical alternatives to medication use. Clinicians should be aware of how social isolation and loneliness can accompany some of the important social losses and changes in late life and discuss non-pharmacologic treatment options with their ageing patients.

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Appendix I

Semistructured Interview Guide

Life history:

I'd like you to tell me the story of your life; however, you'd like to tell it, whatever happened along the way. Start where you like and take as much time as you need.

Probe for information on:

1. Relationships – spouse/partners; children; friends
2. Education, lifetime roles/occupation

3. Residence and household composition
4. Physical and mental health status and conditions, disabilities
5. Mental health problems or worries

Thinking of yourself as a person, what would you say your strengths are? What things have helped you cope and get through life? What are your weaknesses?

Detailed medication history:

What medications are you currently using? (Note the dose and frequency of each.)

1. What is this drug for?
2. Where or from whom did you or do you obtain this medication?
3. Why did you first use? What stressors were in your life at that time?
4. Does your doctor know about each of the medications you use? Why/why not?

Beliefs and feelings about benzodiazepine use:

1. Could you discuss your opinion about what (benzodiazepine) does for you?
2. How does (benzodiazepine) 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 (benzodiazepine) use changed over the length of time that you have been using this drug?
6. Have you ever done anything to change/stop (benzodiazepine) use? What happened?
7. Thinking about your use of (benzodiazepine), what comes to your 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 use of (benzodiazepine) impact your everyday life?
11. What emotions do you feel when using (benzodiazepine)? 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 (benzodiazepine)? How do you feel if you don't take it? Does taking/not taking (benzodiazepine) interfere with your day or night?

14. Do your family/friends have any opinion about you using (benzodiazepine)? Does your use affect your relationships in any way?
15. Do you want to discontinue (benzodiazepine) at this time of your life?
16. Do you think that you *could* discontinue use of (benzodiazepine) and be okay?
17. Do you think you *will* discontinue use of (benzodiazepine) some day? How do you think this will work?

How benzodiazepines affect participants:

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

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Key Points

- Loneliness and social isolation are negative aspects of the lived experience for older benzodiazepine-using women.
- The loss of companions and transportation is important to feelings of isolation and loneliness.
- Psychotropic medications are perceived as helpful in coping with the fear, insecurity and depression that result from social isolation or loneliness.
- Clinicians should utilise non-pharmacologic interventions to address social isolation and loneliness among older adults

Table 1:

Participant demographics and psychotropic medication use

Pseudonym	Age (years)	Marital status	Benzodiazepine medication (mg)	Length of benzodiazepine use	Other psychotropic medications
Anne	86	Widow	Temazepam (7.5) and alprazolam (0.25)	12 years	Zolpidem, paroxetine
Lily	65	Divorcee	Lorazepam (1.0)	~20 years	—
Evie	66	Divorcee	Alprazolam (0.5)	9–10 months	Zolpidem, fluoxetine
Mardie	75	Widow	Alprazolam (0.5)	~2 years	Zolpidem, duloxetine
Christine	85	Never married	Lorazepam (0.5)	~4 years	Sertraline
Deborah	67	Widow	Lorazepam (1.0)	≥1 years	Duloxetine
Patricia	84	Widow	Alprazolam (0.25)	10–15 years	—