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Active ageing, emotional care and the threat of stigma:
Identity management in older adults using sleeping medication
long-term

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Abstract

Key words: [Active ageing](#), [sleep-medication](#), self-care, addiction, stigma

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Abstract

Amid fears about the medicalization of old age, the high prevalence of sleeping medication use in older cohorts is a significant public health concern. Long-term use is associated with a plethora of negative effects, such as cognitive impairment and risk of addiction. However, little is known about the lived experience of older adults using sleeping medication longer term. Episodic interviews lasting approximately 90 minutes were conducted with 15 independently living adults, aged 65-88, who were using sedative-hypnotic or tricyclic sleeping medication for over 11 years on average. Thematic analysis shows that participants divided their rationale for use into two temporal periods: 1) to ensure physical ability in the daytime and 2) to ensure emotional stability at night. Long-term sleeping medication was thus characterized as a form of 'emotional self-management' of the negative emotions associated with later life, blotting out feelings of loss and loneliness by inducing sleep. Participants feared loss of access to their medication 'supply', employing strategies to ensure its continuity, whilst expressing shame about their dependence. However identity management, in the form of explanations, minimizations and social comparisons, functioned to downplay their addiction. Through this, long-term sleeping medication users were able to elude the spoiled identities and multiple stigma of both the 'out of control' addict *and* the unsuccessful older adult by asserting a positive identity; that of the 'new' older adult, actively medicating for success both day and night.

Introduction

Sleeping medication use by older cohorts often far exceeds clinical recommendations of four weeks maximum, despite long-term use being associated with a host of side effects that are particularly pronounced in older age, including dependence and addiction (Lader, 2011; NHS, 2015). However, little is known about the lived experience of older adults dependent on sleeping medication. This paper contributes to the sociological literature by drawing together work on medicalization, stigma and 'active ageing' practices to make sense of these experiences, arguing that identity management is necessary in the face of the multiple stigma of being both elderly and a dependent medication user.

Sleeplessness in Later Life

Various sleep 'experts' have described the Western world as being in the grips of a sleep disorder 'epidemic' driven by population ageing (Byles *et al.*, 2003; Coren, 1996). Due to changes associated with sleep architecture as one ages, older individuals have a decreased ability to fall asleep, whilst sleep itself becomes lighter and more fragmented (Byles *et al.*, 2003). In consequence, excessive daytime sleepiness and napping is common across older cohorts (Miles and Dement, 1980).

Given the rapidity of population ageing, the poor sleep of the elderly is considered a significant public health concern. However, there is uncertainty about whether high-income countries are indeed experiencing a true epidemic in sleep-related disorders or a gross surplus of diagnoses and drug prescriptions, driven by the medicalisation or pharmaceuticalization of sleeplessness (Abraham, 2009).

The Medicalisation & Pharmaceuticalization of Sleeplessness in Later Life

The social sciences have historically neglected the world of sleep, considering agency, consciousness and social engagement as wedded to wakefulness, whilst viewing sleep as a non-social, physiologically determined act. Recently sociologists, driven by an explosion in public, media and industry concern for sleep-related issues, have begun to uncover the biopsychosocial nature of sleep; at once a physiological need *and* a phenomenological subject produced by socio-cultural expectations of what is 'normal'

and 'abnormal.' This includes the establishment of the idealized 'norm' of eight hours of good quality, monophasic sleep, from which deviation is pathological (Crary, 2013).

In *At Day's Close*, Roger Ekirch (2006) describes the 'aspirational eight hours' as a culturally conditioned social construct, born as a result of heightened time-consciousness, sensitivity to productivity and the development of artificial lighting. Since, a plethora of epidemiological work has sought to link this construct to the achievement of optimal daytime performance *and* overall health and wellbeing (Williams and Wolf Meyer, 2013).

As such, the sociology of sleep has directed a large proportion of its' focus upon the rapid medicalisation of sleep (Baxter and Kroll-Smith, 2005) and its role in entrenching the 'normative ideal' of eight hours, construed as the bedrock of physical ability and emotional stability in later life and the 'ultimate performance enhancer' in terms of health, creativity and performance (Williams *et al.*, 2009). The classic medicalisation thesis is that the jurisdiction of Western or scientific medicine has expanded to include new domains of human life, redefining them as falling within medical, rather than legal or religious, domains (Conrad, 1992). This process of redefinition functions to afford 'illnesses' legitimacy and to thereby justify intervention by medical and allied professionals and their treatment through pharmaceutical products (Abraham, 2009).

Following Conrad and Schneider's (1980b) typology, the medicalisation of sleep can be understood as occurring on multiple levels.

At the 'conceptual level', recent decades have witnessed the rise of a vast lexicon of sleep disorders- diagnostic entities with predominantly pharmacologic solutions- whilst medical 'discoveries' have linked good quality sleep to the achievement of health and wellbeing in later life (Williams and Wolf-Meyer, 2013). Meanwhile, studies have identified a comorbid relationship between insomnia and negative health outcomes in older adults, including cognitive decline, increased risk of stroke, suicide and poorer quality of life (Byles *et al.*, 2003).

The medicalisation of sleep at the 'institutional level' is evident in its' widespread codification within Western medical settings, with sleep described as the 'third piece of the puzzle' by the National Sleep Foundation (2016) and 'the third pillar of health', joining alongside diet and exercise, by the Harvard Medical School's Division of Sleep Medicine (2016). Further, medicalisation at this level is particularly pronounced with regards to sleep 'disorder' 'treatment'; the most common a course of psychoactive sedative-hypnotic medications (Monk *et al.*, 2008). These include barbiturates (e.g. secobarbital), benzodiazepines (BZD) (e.g. diazepam) and newer 'z-drugs' (e.g. zopiclone) that cause central nervous system depression, with the aim of reducing

tension and anxiety (sedative effect) and/or to induce sleep (hypnotic effect). Tricyclic antidepressants (TCAs) (e.g. amitriptyline) are also popular for their sedative effect.

Critically, despite qualitative work revealing that GPs would prefer to offer non-pharmacological treatments for poor sleep (Siriwardena *et al*, 2010), prescribing rates of sedative-hypnotic drugs are rising, with NHS expenditure doubling between 2005-2010 (NHS, 2010). This increase is partly driven by the high prevalence of use across older cohorts; 20-40% of US over-65s report the consumption of a prescribed sleeping medication (Whalley, 2001), whilst 80% of new UK BZD prescriptions are made to those aged over 60 (NHS, 2010).

Quantitatively examining the 'medicalisation of sleeplessness' in the US setting, Moloney *et al* (2011) used a large sample of 3000 randomly chosen physicians per year to reveal that, from 1993-2007, patient complaints of sleeplessness more than doubled, whilst diagnoses of insomnia rose sevenfold. Simultaneously, prescriptions for sedative-hypnotics rocketed; BZD varieties increased by approximately fifty percent, whereas non- BZD prescriptions soared 30-fold. In 2007, an estimated 5.7 million complaints of sleeplessness and 6.1 million diagnoses of insomnia were made, yet a huge sixteen million prescriptions were written. These divergent curves, the authors suggest, demonstrate a clear and rapid medicalisation of sleeplessness.

The findings also evidence 'pharmaceuticalization', defined by Williams *et al* (2008a: 37), in their discussion of press coverage of non-medical uses of modafinil for excessive sleepiness, as "the transformation of human conditions, capacities or capabilities into pharmaceutical matters of treatment or enhancement." In this sense, the use of potentially harmful drugs is encouraged via 1) the gradual reframing and transformation of ideas of physical and emotional normalcy and 2) the offer of a 'magic bullet' with the ability to bring one's body in line with these norms through the enhancement of performance (Conrad, 2007). As such, the aspirational norm of 'eight hours' feeds the need for intervention, propelling poor sleepers to seek interventions to achieve the 'normative' state, such as the use of sleeping medication.

Dependence and the Double Bind of the Pharmakon

Very little attention has been paid to the 'invisible epidemic' of substance misuse among older people in the UK, with research hampered by the unpopularity of the specialty, difficulty in obtaining reliable data and a fragmented provision of addiction services which often fail to target older individuals (Widlitz and Marin, 2002). In addition, older adults fail to fit the 'stereotype' of the typical drug user as out of control and risking death through use (Booth-Davies, 1998). Thus, their problems with addiction and dependence remain unseen and underserved. This is particularly

problematic in the case of sedative- hypnotic use, where terminating or reducing dosage may trigger an acute withdrawal syndrome, especially in older adults (Lader, 2011).

Fernandez and Cassagne-Pinel (2001: 421) stress that drug dependence and addiction in older adults should not be reduced to physiology (i.e. what happens when withdrawn) but should rather be understood “in terms of a complex process requiring an analysis of psychological addiction.” For instance, those such as Coon and Mitterer (2014) deem dependency as evidenced by: 1) a *belief* that one cannot ‘cope’ without a substance and, due to this perceived reliance; 2) an overwhelming *desire* to continue with the drug experience and; 3) *anxiety* at the prospect of a threat to or loss of the substance. In addition, following Joyce (1969), individuals may suffer ‘symbol-dependence’; dependency to the ‘symbolic’ function- as opposed to the pharmacological properties- of sleeping medication; that is, its ability to keep them on a ‘chemical road to success’ (Warburton, 1978).

Due to their addictive potential, sleeping medications exist in a particularly complex matrix of social values and are acutely attuned to what Derrida (1993) has named the ‘double-bind of the pharmakon’; the impossibility of seeking remedy through medication without risk of encountering harm. In other words, any drug has the

capacity to be beneficial and detrimental, simultaneously. Keane (2002) has expanded upon Derrida's work, arguing that whether substances are viewed as medicine or poison, good or bad, is socially constructed; derived not of a drug's particular materiality but of the meanings that society ascribes to them.

In consequence, the chronic use of sleep medications has been associated with a sense of stigma, especially by older adults (Walker *et al.*, 2012). Users are thus required to negotiate and present their consumption in ways that sustain a positive identity. For instance, Lumme-Sandt *et al* (2000) sought to reveal the culturally shared 'interpretative repertoires' of drug use by the 'oldest-old' through 250 narrative interviews with adults aged over 90. A 'moral repertoire' was uncovered whereby respondents presented themselves as "morally acceptable and responsible users of drugs", by explaining and minimizing their usage (p. 1843). As sleeping medications have borderline social legitimacy- on the one hand allowing treatment of disordered sleep, whilst on the other offering potential risk of addiction or harm- it is likely, therefore, that sleeping medication users must also navigate such moral worlds and social judgment.

Overcoming Stigma and Identity in Later Life: Active Ageing

There is mounting evidence to suggest that Western older adults are already

stigmatized by virtue of their age; this stigma is said to manifest in 'ageism' - prejudice or discrimination based solely on a person's perceived age (Butler, 1969). Goffman (1986 [1963]: 129) has explained ageism as a consequence of the identity norms of Western culture, whereby youthfulness, physical ability and beauty are valorized and those failing at this "feel unworthy, incomplete or miserable; if not for any other reason, than because of ageing."

In response, the notion of 'active ageing' has sought to contribute to the de-stigmatisation and re-imagination of old age by "optimizing opportunities for health, participation and security in order to enhance quality of life as people age" (WHO, 2002: 12). In research and at events such as the UN (2002) *Second World Assembly on Aging*, it has been stressed that such 'opportunity' is contingent on the level of older individuals' engagement in activities of 'self-care', that function to delay or *deny* the 'Fourth Age' - typically referring to the period between the ages of 80-100- and its' associated biological, social and psychological 'problems' (Laslett, 1989). In this sense, the 'active ager' engages in a constant monitoring of health and modulates, adjusts and improves their health behaviours in response to the changing requirements of their everyday life (Rose, 2003). Indeed, examples of self-care have been covered widely in the literature, including physical activity (Pike, 2011) and the consumption of medications (Gill and Taylor, 2012). For instance, Canham and Rubenstein (2015), in

their qualitative study of twelve female benzodiazepine users aged 65-92, found that use functioned to overcome sleeping difficulties that would otherwise prevent daytime functioning and activity levels associated with younger individuals. However, Venn and Arber (2011) have shown that older adults view sleeping medication use as a threat to, rather than an enabler of, activity and autonomy. As a result, 75% of their sample consumed non-pharmaceutical alternatives.

It is suggested that the extension of the Third Age via engagement in self-care has the potential to not only improve the practical lived reality of ageing individuals but to also challenge the dominant negative social imaginary of old age. In fact, Jolanki (2004) has gone as far as to argue that 'active ageing' is emerging as the new paradigm of ageing, replacing- or at least *destabilising*- prevailing negative narratives of later life as a period beset with disease, decline and death. However, Gilleard and Higgs (2013) have warned against treating the Third and Fourth Age as equivalent terms representing chronologically bound, successive stages in the life course. Rather, they argue the Third Age is a generationally defined 'cultural field'; one that may have *negative*, as opposed to *positive*, ramifications for older adults.

For one, by valorizing the values of choice, pleasure and autonomy, captured in the lifestyles of individuals who, through self-care, are considered to be resisting the Fourth age and thus ageing 'successfully', active ageing may reinforce the ageist view that old age is a negative and undesirable state (Stenner *et al.*, 2011). Secondly, active ageing relies on romantic social representations of older age or, in other words, an 'oversocialised gaze' (Owen, 2006), whereby biological realities that inhibit ageing bodies from resisting the Fourth age are denied. Thirdly, some older individuals do not have the necessary recourses to hand in order to implement activities of self-care (Asquith, 2009). Lastly, the moral imperative that invades the active ageing discourse- that has become at once a public duty and a demonstration of life lived virtuously- has manifested in a 'victim-blaming ideology', whereby those who fail to resist the Fourth Age and 'age actively' are criticized, stigmatised and excluded (Lupton, 2003). Such individuals are particularly vulnerable to multiple stigma; being not only old, but *unsuccessfully* old (Holstein, 2010). For instance, older adults who use sleeping medication long-term risk the multiple stigma of being old and inactive, being unhealthy (given their disordered sleep) and being addicted or dependent. This raises the question, therefore, of how they themselves characterize their sleeping medication use both functionally and in moral terms.

Methods

Procedure

Interviews were conducted by GS between January-July 2015 using the episodic interview format (Flick, 1997), designed to elicit both episodic (linked to concrete circumstances) and semantic (abstract and decontextualized) data. As Holloway and Jefferson (2000) have argued, semistructured interviews have a tendency, due to their 'interrogational' nature and inclusion of 'why' questions, to elicit generalised statements. Asking an interviewee 'why' can abstract talk, disconnecting it from concrete events or experiences and therefore encouraging a speculative and 'hollow' answer. As this study aimed to illuminate personal experiences related to sleeping medication consumption, an episodic approach that encouraged participants to tell narratives, stories and 'episodes' about their own lives was employed.

The episodic interview relies upon an interview guide that seeks to orient the interview to the topical domains for which a narrative is required. The guide was divided into six key phases: explanation of the episodic principle, biography (description of self, history of use), meaning in everyday life (role of medication in a typical day, affect on leisure, work, relationships), central focus on the topic area (alternatives tried, interaction with other medication, experience of dependence,

management of medication by GP), general opinions (accessing information, reliance of society on medication generally) and, finally, evaluation by the interviewee. This structured approach offered older adults the ability to offer several short narratives as opposed to a arduous chronically ordered biography, as is often demanded by a narrative interview (Gabe *et al*, 2004). However, the episodic approach simultaneously offered participants flexibility in the recounting of experiences; a particularly useful feature when researching sensitive topic areas. For instance, though one question directly asked participants about their experiences of dependency, the majority of dependence/addiction discourse arose in response to other open-ended questions.

Sample

Fifteen participants aged between 65 and 88 years of age took part in this study. They were selected purposively (Patton, 2002) according to age (65 and over), location (South-West of England), living circumstances (living in their own homes) and sleep medication use (currently consuming). The majority was female (n= 12). This was expected, as a far greater number of older women are prescribed sedative-hypnotics than men (Johnell and Fastbom, 2009). The length of time participants reported having used sleeping medication ranged from three months to 40 years, averaging at 11

years. This was somewhat unexpected for the researchers, who did not specify long-term or dependent use in the invitation to participate.

Participants were obtained via adverts placed in places where older adults spend time, including libraries, churches and OAP centres, and then through snowball sampling.

Ethical approval was obtained from the Social Science and International Studies Committee at the University of Exeter. Interviews were conducted and recorded in participants' homes and transcribed.

Analysis

A manual framework analysis, a form of thematic analysis, was conducted according to the guidelines of Ritchie and Spencer (1994). This systematic approach enables the researcher to explore data in depth while simultaneously maintaining an effective and transparent audit trail, thus enhancing the rigour of the analytical processes. ~~(ibid)~~

This is achieved via a series of distinct yet interconnected stages that enable the researcher to move back and forth across the data, constantly refining emergent themes, until a coherent account emerges. Stages include: familiarization with the data, identifying a thematic framework, indexing, charting and mapping and interpretation. During familiarization GS immersed herself in the data by listening to audiotapes and transcribing the data. Then, using notes taken during familiarization,

both researchers developed a thematic framework based upon identified key issues, concepts and themes that was then used to filter and organise the data. Indexing required identifying sections of data that corresponded to these themes by employing a numerical system written in the margins beside the text. The researchers then 'charted' by arranging indexed pieces of data into charts of themes and sub-themes drawn during the thematic framework stage. The final stage, mapping and interpretation, involved interpreting the data as a whole. This involved reflecting on transcripts, identifying associations between themes and linking findings back to the literature. Framework analysis is therefore inductive *and* deductive, allowing for the inclusion of *a priori* identification of themes as well as emergent concepts from within the data itself.

Findings

The framework analysis revealed ~~five~~ four discrete themes: ~~active ageing~~ Daytime physical ability, ~~emotional care~~, emotional and psychological dependence and identity work, negotiating stigma, ~~dependence and the doctor-patient relationship~~, although they were strongly interrelated within the narratives.

Motivation for Use I: Daytime Physical Ability

The sample expressed core social values rooted in Protestant ethics and pragmatism, such as independence, control, productivity and self-discipline. These were expressed via demonstrations of active lifestyles; the majority claimed to partake in varied pastimes such as gardening, walking and volunteering, whilst four individuals worked part-time.

Critically, talk of remaining active was interspersed with morally loaded terms including 'should' and 'must', reflecting the view that older adults regard the prospect of becoming less active- and therefore burdensome- a personal and moral failure. For instance, Esther, an 88-year-old widow, was determined to demonstrate her continued physical ability in later life. She achieved this via identity management, making social comparisons between herself and other 'types' of less active older adults:

I shouldn't be tired, I should be having eight hours sleep, getting up and getting on with things. Not like those old people who fail to partake in the world or commit to anything, retire into their shells, sit, wait and give up.

In addition to stressing the importance of continued daytime activity, the sample condemned daytime napping, deeming it 'a waste of life' and indicative of 'laziness.'

Unintentional napping held especially negative moral connotations, as it was considered symptomatic of the physiological decline and loss of bodily control commonly associated with deep old age. As Maureen, a South African 75-year-old living in the UK explained:

I don't allow myself to really take an afternoon nap or anything like that. That is a no-no in my life. I'll take myself to have a power-nap, that's what I call it. But I would never nap; only old people do that, and I am not going to go down that line. My sleeping tablet is better than having a nap in the day, absolutely. I manage my life, and I manage my sleep.

Reflective of the dominant model of 'decline' associated with ageing and old age, Maureen demonstrated a strong resistance 'to going down the line' of the ageing process. She managed the potential negative identity of being elderly and therefore useless by reconstructing her own daytime napping as 'power-napping'; an activity that *enhances* an individual, making them *more* as opposed to *less* active, and thus reconstructing the nap as part of active ageing.

In line with Canham and Rubinstein's (2015) findings, the consumption of prescribed sleeping medication was deemed an integral component of remaining active in the

daytime period. Participants believed their use enhanced them, making them 'stronger', 'energetic' and 'able.' As such, use made activities 'possible.' However, the opportunities presented by sleeping medication came at a price. Reminiscent of Derrida's (1993) 'double-bind of the pharmakon', tablets taken in order to enhance daytime functioning made some participants feel 'listless', 'lethargic', 'drowsy', 'numbed', 'dopey', 'fuzzy' and even 'crucified.' Nevertheless, participants such as Sarah (65), a married businesswoman with a history of mental health problems, stressed that they were still 'better off' using sleeping medication:

They [zopiclone] do make you drowsy the next morning; it slows down your mental functioning, like your ability to hold conversations, think lucid thoughts...I've tinkered with them in the past; I've tried to cut down but it upsets me in a big way. I have terrible nightmares, panic attacks and a very low mood.

Thus, though the use of sedative-hypnotic medications with the propensity to induce a host of negative side effects may appear on the surface somewhat irrational, use required careful consideration of the side effects versus functionality provided in terms of 'ageing successfully' via engagement in physical activity during the day.

Motivation for Use II: Nighttime Emotional Stability

Almost without exception, the sample reported being prescribed sleeping medication in response to a negative life event; the tablets had then either remained in their lives or reentered at times of difficulty. For instance, two participants had been the victims of domestic violence and another of sexual abuse, three had experienced the death of a child, six had been widowed and one was terminally ill. Eight participants had a history of mental illness, including bi-polar disorder, generalised anxiety disorder and schizophrenia. Thus, the emotional and psychological relief from lived reality that use offered motivated sleeping medication use; a finding that came as a surprise to the authors. For instance, Hazel (88) began to take amitriptyline in response to the sudden death of her teenage son, later increasing her dose whilst nursing her terminally ill husband. For Hazel, sleeping medication offered respite from emotional worry and loneliness that was worse at nighttime. As she put it:

At the moment amitriptyline is to knock me out for a few hours; to satisfy my mind rather than to give me extra strength or anything of that sort.

Indeed, many participants described 'bedtime' as 'depressing', 'upsetting', 'worrying'; a time of reliving dark memories, deliberating current troubles and missing lost loves ones, ultimately manifesting in a fear of sleeplessness. In consequence, nights unaided by sleeping medication were characterised by anxiety and dread. As retired builder

Brian, (71), who had recently overcome a mental breakdown, explained:

I look forward to the night when I'm going to have a tablet, which is inevitable really, isn't it? You already relax, because you know that tiny little table is going to pop you over the edge and you're going to sleep. It's not being addicted to them, but being frightened of not sleeping.

In this sense, sleeping medication use went beyond a mechanism of physical self-care, as suggested by other research (Canham and Rubenstein, 2015). Rather, consumption was a response to emotional distress; a method of emotion management, employed at a specific time of day when participants felt especially emotionally 'out of control.' Sleeping medication achieved this in two ways. Firstly, it could 'knock out' the consumer, reducing the emotionally challenging time spent attempting to sleep. This effect was described as 'blissful', 'marvelous' and 'wonderful', compared to 'smoking a spliff' and 'being put under [anesthetic].' Secondly, by inducing sleep, medication could provide 'hours of not thinking about things'; a 'relief when you feel low.' As such, it provided respite from emotional distress. Such experiences correspond to existing research that has suggested the early hours of the morning are the 'darkest', with suicide rates per hour said to rise 10% after midnight, peaking between two and three in the morning (Perlis *et al.*, 2014). Indeed, studies have demonstrated that

nightmares, insomnia and simply being awake at night are all risk factors for suicide (Chakravorty *et al.*, 2015). Thus, the sample was engaged in actively pre-empting this plunge into negative thinking and emotional distress by medicating themselves to sleep through it.

Emotional and Psychological Dependence

Interestingly, however, many participants admitted that the effect of sleeping medication was primarily psychological, as/s opposed to physiological. Simple *knowing* that a tablet would be available for consumption that evening would instantly 'relax' and 'comfort' individuals- the latter a term used repeatedly throughout the data collection process- and thus induce sleep. This 'certainty' had apparently caused widespread levels of psychological dependence. For instance, many believed that they could not 'cope' without the substance either in terms of remaining physically able during the day and/or emotionally stable at nighttime. Brian (71) stressed that, without his tablet, he would feel so anxious that he would be unable to sleep. Hence, taking sleeping medication was an imperative:

I rely on it to calm me down when I go to bed. I can't not have it.

Furthermore, due to their perceived *need* for medication, the majority of the sample

expressed a great desire to continue with their drug experience. Mary (73) had suffered from depression, alcoholism and troubled sleep since her teenage years, attributing this to the sexual abuse she had endured as a child. She had finally turned to amitriptyline to sleep when her husband, mother and sister died within quick succession. Her 'need' for sleeping medication was explained in the following statement:

You clutch at that tiny little tablet. It's like my be all and end all...I've found since Tom died I panic when I shut my eyes. I'm terrified I'm not going to wake up; absolutely paranoid about it. I'm so scared of dying. Terrified of dying.

In addition, the sample experienced great anxiety at the prospect of any threat to, or loss of, access to sleeping medication. Participants evidenced high levels of concern regarding medication access, with provision usually controlled by an unreliable dealer; that is the doctor, primarily GPs, who were gatekeepers to their supply. Given the power differential contained in the negotiation, in which the doctor has the power to stop or restrict the prescription, participants spent quite a considerable amount of energy on justifying and obtaining their supply. This was achieved in a variety of ways. For instance, two participants sought to demonstrate their own reliable and controlled consumption to their doctor, acting highly compliantly and seeking permission before

altering dosages. These participants believed that developing a good rapport with their GP was essential to ensure the continued supply of their tablets. In contrast, other participants were incredibly non-compliant. For instance, Hazel (88), who had been prescribed Amitriptyline for use on alternate days for the past ten years, was avoiding her doctor, stating, *'I'd rather she didn't interfere, to be honest. 'Leave me alone!'* Rather, she had formed a sharing strategy with three other users to ensure a continued supply. In addition, Hazel had befriended her pharmacist, who would add Amitriptyline to other prescription slips. As she clarified:

I get on well with the chemist... I say I forgot to take the paper so she just pulls one off, and fills it in there. I don't have to go back to my doctor and renew.

In addition, many participants would carefully ration their sleeping tablets, 'sacrificing days' in order to ensure a good supply for special occasions. Olive (74), who lived in supported housing with her husband, explained:

If I'm going to do something special on a Sunday, I'll take one on Saturday night to make sure I can enjoy it.

Finally, participants kept 'reserves' of their sleeping medication by over-requesting. Joan (74) offered to show me her sleeping tablets and revealed a cupboard brimming

with zopiclone. She went on to explain:

I do get those repeat prescriptions because I think I don't want to not have it here. It's back up- I like the security now I know there's other packets there.

Such behaviour demonstrated high levels of initiative and occasional non-compliance in securing medication. Thus, the findings chime with other research which suggests older adults may regulate their medications independently outside of consultation; these writers, however, have discussed this in terms of taking *less* than the recommended dose (Cramer, 1998). In comparison, non-compliance within this sample functioned to ensure a consistent, long-term supply. This was exemplified by Betty (81), who had resorted to importing Bromazepam from South Africa to ensure she could take them until she was *'no longer on this earth.'*

Identity Work: Negotiating the Threat of Multiple Stigma

Though all participants had been consuming sleeping tablets long-term and demonstrated signs of emotional and psychological dependence, 'pill-popping' and reliance upon medication was widely criticised as immoral and 'against their principles.' The entire sample condemned society in general for being excessively reliant on drugs, whilst the majority condemned their own dependence. This reaction

was somewhat expected; the dominant 'biomedical' model of addiction has declared 'loss of control' as the cardinal characteristic of substance dependence, with addictive behaviours often characterized as a manifestation of weakness of character, irresponsibility and lack of self-discipline (SAMHSA, 1998). As such, long-term use of medication poses a risk to the Protestant work ethic of older cohorts and hence, the sample exhibited shame about their dependence, expressed in terms of moral failure:

I just regard it [taking sleeping medication] as a weakness...I mean, the other tablets I take are necessary to keeping my life going, but it's weak and needy that I can't stop taking these damn things (Graham, 70).

Thus, in line with North *et al.*'s (1995) sample of chronic benzodiazepine users, participants presented a number of rhetorical discursive arguments that sought to demonstrate the rational and responsible nature of their sleeping medication consumption. These arguments sought to protect them from the threat of multiple stigma; that of being old *and* an addict by exhibiting controlled consumption over chaotic excess, self-enhancement over self-destruction and success over failure. In addition, these discursive arguments were often emphasised by downward social comparisons, made between both themselves and other users of sleeping medication and/or older adults, by comparing either their medication type or behaviour

favourably against others. Ultimately, this 'identity work' functioned to avoid the multiple stigma of being both old and an addict.

For instance, the majority of the sample sought to display self-control by stressing the use of a low dosage. This fits with Crawford's (1994) thesis that health has become a moral performance of being a 'good person' in contemporary society. For instance, Margo (75) stated:

I am very, very disciplined in that only now and then do I take one tablet. I take half. I am disciplined in that half gets me over the edge, and when I still can't sleep I pop the other half.

Many participants also stressed that they had taken their sleeping tablets episodically and not continuously. Julie (71) lived in a retirement community and had been taking sleeping medication intermittently for forty years. Though she had used Bromazepam, and then zopiclone, for decades, with 'crippling' anxiety and depression greatly affecting her sleep, she believed that the 'irregular' nature of use was proof that she 'wasn't a drug addict yet.' Similarly, Olive (74), who took sleeping medication on a three days on-four days off basis offered this as proof that, whilst she 'relied on tablets to cope with life', she 'wasn't totally addicted.'

Meanwhile, 'irresponsible' and 'undisciplined' use by family and friends was highlighted. Downward social comparisons were made between those who had taken sleeping medication for longer, in higher doses and with alcohol, or used older, '*more addictive types*' that would '*knock you out*', '*leave you comatose*' and '*make you hooked*.' Furthermore, participants facilitated widely held stereotypes regarding the cognitive decline of older adults, particularly the 'forgetfulness stereotype' (Erber *et al.*, 1994) in order to distinguish themselves from incompetent elderly adults who would '*take the wrong tablet at the wrong time and really upset the apple cart*.' The group contrasted their own abilities to '*check up on things*' and '*be in control of prescriptions*' with other elderly individuals who '*sit in chairs and take things that carers give them without even thinking about it*.'

Ultimately, such assertions served to enable participants to elude the spoiled identities of both the 'out of control' addict *and* the inactive, emotionally unstable older adult. As such, their identity work was two-fold, permitting individuals to avoid a multiplication of negative social identity by asserting an alternative, positive identity; that of the 'new older adult', actively self-medicating for success.

Discussion & Conclusion

The strong moral work ethic of older generations, combined with a contemporary

intensification of ideas about individual responsibility over ageing, meant that participants gave precedence to values of self-responsibility, self-discipline and control. Having internalised the moral imperative of active ageing discourse, the sample, in line with Crawford's (1994) thesis, understood their health as an arena within which these values could be exhibited and their worth proven via demonstration of 'active' or 'successful' ageing.

Participants deemed good quality sleep integral to the achievement of 'successful ageing' and, consequently, its attainment had- like health generally (Crawford, 2006)- become a meaningfully charged fixation, a goal, a source of anxiety, a value for self and others, integral to identity and the driving force for a vast amount of social action. One such action was the long-term consumption of sleeping medication- a technology of 'self-care'- employed for the acquisition of the aspirational 'norm' of good quality, monophasic sleep and, ultimately, a positive, 'successful', older identity.

This was achieved via two distinct yet closely interconnected outcomes: 1) daytime physical ability and 2) nighttime emotional stability. With regards to the former, as identified in previous literature (Canham and Rubenstein, 2015), medication functioned to prevent daytime tiredness caused by poor sleep, thus enabling individuals to not only *cope* but *excel*; the majority led full and active lives commonly

associated with younger groups. In terms of nighttime emotional stability, an additional element to the self-care trope was identified: 'emotional-care', whereby consumption acted as a method of emotional management of negative emotions associated with later life, in particular loss and loneliness. This method was employed at 'bedtime', when participants felt most emotionally 'out of control.' This was achieved by 1) inducing sleep, thus reducing the emotionally challenging time spent lying in bed awake and 2) by providing an emotional 'break' from consciousness.

Critically, engagement in activities of active ageing has been portrayed as an inherently positive *choice* and *opportunity* for older adults to 'achieve their full potential' (WHO, 2002). However, with demands for control and responsibility in modern society simply shifting from the external state to the internal, individual self (Rose, 2003), claims of 'agency' and 'choice' can be dismissed as illusory. Though adults may appear to 'choose' to consume sleeping medication, they are left with little alternative when to sleep poorly, and in consequence become physically incapable and/or emotionally unstable, is to become a failed and worthless member of society. Indeed, participants clearly considered the enhancement of sleep as a *duty*, as opposed to a choice, suggested through the employment of words and phrases with clear moral undertones.

In addition, as opposed to 'reaching one's potential', certain acts of self-care- including the long-term use of sleeping medication- may have negative consequences for physical and mental health. For instance, the sample appeared to exhibit signs of psychological and emotional dependence to their medication; use was considered *necessary* for 'coping' with both daily life and nighttime emotions, whilst access was a constant source of anxiety, occupying much time and thought. Furthermore, in line with Harris' (2010) view that bereavement is oppressed within Western societies, it could be argued participants were using sleeping medication to constrict their grief as opposed to processing it, thus inflicting emotional harm.

Lastly, the sample appeared extremely aware of the 'double-bind' (Derrida, 1981) of sleeping medications and the risk of stigma. Though tablets offered the potential to evade identity markers associated with the stigmatic 'Fourth Age', two specters- dependence and addiction- were forever lurking; if consumption was not well executed, the sample were at risk of confounding an already stigmatic identity, becoming not only *old*, but the *addicted* old. Indeed, Farrimond and Joffe (2006) have argued that multiple sources of stigma not only interact, but amplify each other. In other words, being an older person *and* a compulsive addict is a multiple form of stigma; these factors coalesce to produce a highly spoiled social identity of a burdensome, inactive and out of control elderly person who has failed to age

successfully.

Thus, the sample were required to perform complex identity work, presenting themselves as adults on a 'chemical road to success' (Warburton, 1978). This involved the presentation of 'rhetorical discursive arguments' (Billig, 1987) regarding the nature of their consumption. Argumentative and persuasive in nature, episodes extracted from participants during interview sought to display controlled and sensible use, and ultimately therefore, their worth as individuals. In line with North *et al's* (1995) study, this was attempted via the provision examples of self-regulation. However, the participants within this study employed a number of additional strategies, including making downward social comparisons between themselves and other less disciplined or cognitively challenged users. Ultimately, such assertions served to enable participants to elude the spoiled identities of both the 'out of control' addict *and* the inactive, emotionally unstable older adult. As such, their identity work was two-fold, permitting individuals to avoid a multiplication of negative social identity by asserting an alternative, positive image; that of the 'new older adult', actively self-medicating for successful and controlled activity both in the daytime and at night.

Finally, despite both research and media campaigns highlighting the growth in issues of drug dependency in later life (Waters, 2010), older adults continue to account for

fewer than four percent of those receiving treatment across Europe (EMCDDA, 2008). Various explanations have been offered to account for this shortfall. For one, the stigma surrounding addiction, in combination with attitudes of perseverance and self-reliance held by older groups, results in limited help seeking (Turner, 1989). In addition, ageism has resulted in the social marginalization, pathologisation and therefore assignment of lower quality of life standards to older adults, resulting in a largely spoken yet powerful assumption that treatment provided to this cohort is a waste of healthcare resources (SAMHSA, 1998). This, in combination with the fact that older adults simply do not fit the addiction myth, means that older cohorts must attend mainstream services, mostly aimed at young males; treatment programmes are thus rarely accessed or adhered to (Blow, 2000).

Interviews are a performance in their own right (Silverman, 2013). It is not surprising that the participants spent a good deal of time on identity management when justifying their quite extensive medication use to a researcher. This may be atypical of the everyday experience of older medication users, whose use is often hidden and little discussed, either in formal health-care settings or within their home environments. The sample was limited, in terms of numbers, recruited primarily through posters. By definition, those living in their own homes have some measure of

independence so this may have been a more active cohort; differential samples, for example, in care settings may vary in their lived experience. On the other hand, this sample provided a window of insight into issues of embedded dependence for everyday sleep medication users, given this was not specified in advance as a criterion for inclusion.

In conclusion, this study contributes to the sociology of sleep by identifying the moral work around the multiply stigmatized identity of being elderly, unhealthy (by virtue of having disordered sleep) and dependent on sleep medication. As awareness of this largely invisible epidemic grows, unpacking the thinking of long-term users will be important as a way of tailoring patient-centred health interventions to them, either to reduce dependence or to offer non-pharmaceutical solutions to their articulated nighttime emotional distress.

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