Understanding older peoples’ decisions about the use of sleeping medication: issues of control and autonomy

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Abstract

Poor sleep is known to impact on health and well-being in later life, and has implications for the ability of older people to remain active during the day. Medical treatments for chronic poor sleep have primarily included regular, long-term prescribing of hypnotics, which are known to impact on older people’s health, cognitive function and quality of life. Therefore
recent policy and practice has focused on reducing such prescribing, on encouraging older people to stop taking hypnotics long-term, and on finding alternative, non-pharmacological ways to manage poor sleep. However, little research has been undertaken to understand the perspectives of older people who choose not to seek professional help for their poor sleep, despite the potential impact of poor sleep on their health and ability to remain active. Through in-depth interviews with 62 older men and women living in their own homes in England, this paper explores the factors that deter older people from seeking professional help for their poor sleep. We argue that these are located in their perceptions of the normativity of poor sleep in later life, their beliefs about prescription sleeping medications, and their desire to maintain control and autonomy over their everyday/night lives.
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Introduction

Chronic sleep problems are known to have detrimental effects on health in later life, with those who suffer from poor sleep being more likely to be at risk of heart attacks, falls, stroke, obesity and depression (Ancoli-Israel 2005; Harrington and Lee-Chiong 2007). Untreated sleep problems among older people are also known to impact on quality of life, on daytime function and on recovery from illness (Haimov and Vadas 2009). Yet the most common form of treatment for chronic sleep problems in older people has been hypnotic drugs (Whalley 2001), which are themselves associated with risks of impaired cognitive function, falls and rebound insomnia (Morgan 1998; Martin 2002).

Hypnotics in the form of benzodiazepines (for example, diazepam, temazepam) were widely prescribed for sleep problems from the 1960s onwards, until reports in the late 1970s highlighted potential problems with their usage, such as physical and psychological dependence, even within relatively short periods of time (Paterniti et al. 2002; Authier et al. 2009). More recently, alternative non-benzodiazepine hypnotics, known as ‘z’ drugs (for example, zopiclone, zolpidem), have become available for the treatment of poor sleep, anxiety and depression. Yet whilst the benefits of such drugs in the short term are recognised, the prevalence and severity of their side effects in an older population remain unclear (Morgan 2010; van Vliet et al. 2009; NICE 2011; Wilson et al. 2010). Therefore, as a result of the ongoing debates surrounding the benefits and/or problems associated with the prescribing of hypnotics, there has been considerable research on, for example, the impact of taking hypnotics on older people (Beland et al. 2010; Busto et al. 2001, Morgan 1998), on GP attitudes to prescribing such medication (Rosman et al. 2011; Siriwardena et al. 2011), and
to a lesser degree, on the perspective of the older person taking hypnotics (King et al. 1990; Gabe and Lipschitz-Phillips 1982; Cook et al. 2007; Anthierens et al. 2007).

More recently, policy and practice objectives have focused on reducing hypnotic prescribing by general practitioners, on encouraging older people who have been on sleeping medication for long periods of time to reduce their reliance (Sonnenberg et al. 2011) and on offering effective non-pharmacological approaches to sleep management, such as cognitive behaviour therapy (CBT) (Sivertsen and Nordhus 2007; Morgan et al. 2003; Morgan et al. 2004).

In terms of the wider debate on general medication usage by older people, there have been suggestions that an anomaly exists away from the medical consultation, with people being compliant within the doctor’s surgery, whilst being averse to taking prescribed medications outside of it (Britten et al. 2004). This anomaly, Stevenson and Knudsen (2002) argued, is predicated on the perceived threat to personal agency and individual identity that people attribute to prescribed, and for the most part, unwanted, medications. As a way of resolving this, Lumme-Sandt and Vertanen (2002) suggested that older people adopt a different habitus of ‘compliant patient’ within a consultation and ‘personally responsible’ patient outside, by placing themselves in the field of medication where they can control how, when and what they take, as far as is possible (Bourdieu and Wacquant 1992; Lumme-Sandt and Vertanen 2002). Additionally, Lumme-Sandt et al. (2000) suggested that some older people may adopt a ‘self-help repertoire’ as part of taking personal control over their own health, which in turn influences their decisions about whether to take prescription medications. Similarly, North et al. (1995) argued that community dwelling older people use ‘adaptive repertoires’ which involve re-asserting control over how they take their medications in order to justify their usage of long term hypnotics.
Such approaches to understanding lay perspectives on the way medications are taken shift discourses away from medical profession based approaches whereby doctors seek to compel medication compliance or adherence by older people (Banning 2008; Salter 2010, Lawrence and Rittner 2010) to approaches which are situated within a personal perspective. Such an approach allows for an understanding not only of older people’s perspectives about taking medication, but also why they choose not to take prescription medication in general. However, any debates on approaches to medication usage necessarily must include discussions of the doctor-patient relationship within which medications are prescribed. Whilst in general terms the doctor-patient relationship has transformed over recent years, from one of doctor as authority, and patient as passive recipient of care, to one of greater patient empowerment and negotiated consultations (May et al. 2004; Edwards and Elwyn 2009), the same is not necessarily true for older people who remain more likely to regard the doctor as an authoritative figure (van den Brink-Muinen et al. 2006).

Sleep, although situated firmly within the paradigm of health and illness, is also anomalous in that whilst it is a biological necessity, it is in addition malleable in that the amount of sleep can be curtailed for a considerable time, or even, for shorter periods, avoided completely. A sociological approach to the study of sleep opens up the possibility of exploring the ambiguity that surrounds sleep, by using a qualitative approach to understand the significance of sleep within everyday lives and the meanings attributed to disturbed or poor sleep. The emergence of a sociological approach to the study of sleep has already demonstrated the significance of the social context of sleep (Hislop and Arber 2003; Meadows 2005; Brunt and Steger 2008; Venn et al. 2008). As Williams suggests the ‘How we sleep, when we sleep, where we sleep, the meanings we accord our sleep and with whom we sleep, for example, are all socially, culturally and historically variable matters that demand and repay our attention” (2005: 1). The adoption of a sociological approach to
understanding the meanings of poor sleep in later life, for example, has highlighted the significance older people place on remaining active, productive, and as far as possible, in control of their everyday lives beyond retirement (Venn and Arber 2011).

In this paper we seek to answer three questions, (a) how do older people perceive poor sleep in later life in relation to health and illness, (b) what are their beliefs about taking sleeping medication and the doctors who prescribe it, and (c) how do (a) and (b) contribute to their decisions about whether or not to seek medical professional help for poor sleep.

Methodology
The data analysed in this paper are from part of a large multi-disciplinary project investigating poor sleep in later life. This part of the project aimed to understand the meanings and experiences of poor sleep for older people living in their own homes and the strategies they used to improve their sleep.

Data collection was undertaken in two phases. Phase 1 comprised sending 2400 self-completion questionnaires to a stratified sample of older people living in their own homes in the Thames Valley area, equally divided by gender and age group (65-74 and 75+), via ten General Practices (GP). The questionnaire contained two parts: (a) the modified Pittsburgh Sleep Quality Index (PSQI) (Buysse et al. 1989), which asks detailed questions about sleep quality, duration and fragmentation in the previous month, and which provides a global sleep score between 0 and 21, with high values indicating very disturbed sleep, and (b) questions about age, employment, health and marital status. From those who returned the questionnaire (n=1158) and who indicated their willingness to take part in further studies, 62 men and women with a score of 6 or more on the PSQI (a validated indicator of clinically poor sleep) took part in Phase 2. This sub-sample was stratified by gender and age group and was diverse in terms of partnership status and socio-economic circumstances.
Phase 2 comprised an in-depth semi-structured interview in the respondent’s own home, lasting between 1 and 3 hours. Those who consented to have extracts of their interview appear in a module on ‘Sleep Problems in Later Life’ on the Healthtalkonline website (www.healthtalkonline.org) were video and/or audio recorded (n=39), and all other interviews were audio recorded. All participants received an honorarium in compensation for their time, and confidentiality and anonymity were assured for those respondents whose interview extracts were not to appear on the Healthtalkonline website. Pseudonyms are used to protect the anonymity of respondents, with their age indicated after quotations. Ethical approval was granted by MREC and the University of Surrey.

Questions during the interview focused on asking participants about perceptions of their patterns of sleep, sleep quality and attitudes to sleep disturbance, as well as about their strategies to improve sleep, and any medications taken to aid sleep (prescribed or over the counter). All interviews were fully transcribed and the software package NVivo8 was used to support a thematic analysis approach (Miles and Huberman 2002). Emerging themes were identified by reviewing respondents’ answers relating to perceptions of current sleep, visits to the doctor and attitudes to taking sleeping and other medications, as well as remedies to try and improve sleep. Factors that might influence older people’s decisions on whether to seek professional help for their poor sleep were explored.

Following a discussion of older people’s perceptions of poor sleep, the paper analyses their attitudes towards taking prescription medications for sleep.

Perceptions of poor sleep
All the older men and women in this study had a PSQI (Pittsburgh Sleep Quality Index) score of 6 or more (Buysse et al. 1989), a validated clinical indicator of poor sleep, and many complained of tiredness, of frustration at not being able to sleep, and of daytime fatigue.
which often led to a greater propensity to nap during the day. Yet of the 62 respondents, 41 had never taken any form of prescribed sleeping medication, a further 12 had taken them in the past, but were not taking them presently, and only 9 were currently taking prescribed sleeping medication for their sleep.

Participants were found to hold two perspectives on sleep (a) poor sleep was not seen as being akin to a health problem, whilst paradoxically also situating good sleep alongside eating well and exercising as being important for maintaining good health, and (b) poor sleep was regarded as something to be expected as part of the ‘normal’ ageing process

(a) Poor sleep is not a health problem

Most of the older people in this study were living with at least one health problem, and often two or more, varying in severity from arthritis and high blood pressure, to cancer, diabetes and chronic heart disease. Poor sleep was manifested in difficulty getting to sleep, frequent waking in the night (and sometimes being awake for long periods of time) and waking up early. Yet whilst acknowledging that poor sleep could be an issue, especially if a bad night’s sleep prevented daytime activities from being undertaken, it was not regarded as a ‘health’ issue:

How bad would it [sleep] have to be for you to go to the doctors and say “I am really not sleeping well”? (Interviewer)

It would have to be quite bad. I don’t think I would go to the doctor about it. I don’t regard it as an illness or a [health] problem. It is annoying not to sleep. Because one feels one ought to be sleeping, because it is a waste of time really, just lying there not sleeping, but no. Well, I would have to be quite bad. (Susan, 72 years)
Susan, did not regard poor sleep as being linked to health or illness, and her focus was more on the fact that laying awake was a ‘waste of time’, rather than the implications disturbed sleep may have for her health.

(b) Ageing and the Normativity of Poor Sleep

Recent physiological research on sleep in later life concurs that changes do take place to sleep as we age, and are characterised by greater difficulty initiating sleep and an increased likelihood of awakening after sleep onset (Dijk et al. 2010). It is acknowledged that chronological ageing is accompanied by normative physical changes to the ageing body, such as an increased propensity to daytime sleep (Venn and Arber 2011), and increased nocturia (Dugan et al. 2002). Hislop and Arber, in their study of sleep in women aged 40 and over, observed that, ‘women perceive sleep disruption as a normal “fact of life”’ (2003: 822), albeit an undesirable fact of life. This perception was echoed by the men and women in this study, who regarded poor sleep as being a fact of ‘ageing’ life, and one of the inevitable markers of old age, over which they had ultimately little or no control.

I have always accepted the fact that it [poor sleep] is probably something to do with age.... But though it is inconvenient sometimes now, it is just a routine that I have got into really, you know, coming downstairs, sitting outside for a little while and coming back up again. (Adam, 68 years)

Because poor sleep was regarded as synonymous with growing older, it was deemed to be outside the realm of medical intervention, unless the ability to function during the day was severely compromised. Additionally, this belief about the normativity of deteriorating sleep quality with increasing age, was reinforced by doctors during consultations about health issues, at which disturbed sleep was mentioned. William, for example, was told during a
routine check-up appointment for his stomach ulcers to expect to need less sleep as he got older:

The Doctor said ‘you will find you need less sleep as you get older’…. He said ‘but don’t get too concerned. The body will look after your sleep needs’. (William, 65 years)

Doctors carry great authority, especially for older people (Lupton 2007), and whilst it was seen as acceptable to visit the doctor for significant or serious health issues, concerns were expressed about ‘wasting’ the doctor’s valuable and restricted time for what were perceived as minor conditions, such as poor sleep:

I am aware of people who suffer from acute hypochondria. I have had relatives who are persistently going to the doctor and I only want to go to the doctor when I feel something is seriously wrong there. (Jeremy, 69 years)

Those who did talk to their doctor about their poor sleep, did so primarily because of other serious health issues that aggravated their poor sleep (such as rheumatoid arthritis or cancer) and were more likely to specify they had severely disturbed sleep. Their visits to the doctor were more regular and greater opportunities were available to discuss all health issues, including the impact of poor sleep on their daily lives.

Difficulty getting to sleep and waking up in the night were therefore regarded as a marker of ‘old age’, along with napping and dozing during the day, and getting up to go to the toilet in the night. Seeking medical help for poor sleep was consequently not seen as a priority. However, if older people felt their ability to continue to be active during the day
was compromised by poor sleep, and impinged on their ability to maintain control over their
daily routines and activities, they would consider seeking medical help.

**Maintaining control**

The majority of older people in this study preferred not to go to the doctor for *any* reason and
would often only go if their symptoms were considered to be concerning enough to indicate a
potentially serious health problem. Visits to the doctor were often only made as a last resort,
largely because of their expectations that they would be prescribed further medication.
Therefore avoiding going to the doctor was a way of maintaining control over current, and
sometimes complex, treatments and medications they were receiving from their doctor.

*Controlling current medication regimes*

A majority of the older people in this study (58/62) were regularly taking medication(s) for a
range of health issues, such as high blood pressure, arthritis and diabetes. Taking medication
on a daily basis was regarded as unavoidable, even when they were not always clear about
what medicines they were taking or why they were taking them:

> I have got various tablets which are supposed to relax this or relax that, ... ... you have
got to take tablets for blood pressure, and a tablet for inflammatory pains, and a tablet
which is the antidote to the first tablet for inflammatory pains, and tablets for this, that
and the next thing. (Alastair, 78 years).

> I take a lot of tablets. I take 20 odd tablets, that is my lunch time. So this is for the
heart, prostate and sleeping. Diabetes. ... That is the one I take for the prostate. ... I
know the names but I can’t remember them. I will go up and get them. I will bring
my box down, I will show you.... One of those was Metformin which is for diabetes.
Another one was a small aspirin.... That pink one is blood pressure and the tiny one there is blood pressure. This tablet here is a special one – this one - I don’t know what it is, I will get the box. To do with the heart? (Lawrence, 74 years).

Given a general reluctance to visit the doctor for what were considered ‘real’ health problems, a perception that poor sleep was not of itself a health problem, and concerns over maintaining control over existing medication regimes, it is unsurprising that only one third of the older people raised the issue of poor sleep within medical consultations.

In making decisions as to whether to seek help for poor sleep by taking prescribed sleeping medications, considerations were based on the perceived impact of such medications on their ability to maintain their daily routines. Men and women equally were concerned that if they visited their doctor for help with their poor sleep they would be prescribed some form of sleeping medication or tranquiliser.

Whilst current treatment advice for doctors in terms of sleep problems advises the initial adoption of non-pharmacological interventions, followed by prescription for short periods only of newer forms of shorter acting non-benzodiazepine ‘z’ drugs (NICE 2011; Dundar et al. 2004), all the older people in this study held the belief that the standard treatment proffered by their doctor for poor sleep would be the prescribing of conventional ‘sleeping pills’, which they identified as being harmful and addictive:

I don’t know that I’d go to the doctor about it really. I probably would go to a herbalist or someone like that I think, yes. I mean doctors only give you sleeping pills and it doesn’t sort the problem out. (Martha, 87 years)
The information that was given to the doctor was also controlled, so that the doctor would not be told, for example, if antihistamines were being taken to help with sleep, or partners’ medications were being used as an aid to sleep:

The missus has got some tablets out there. She takes them, they are painkillers, but on occasions I have taken one of those about that size, put them in a glass of water. They are pretty strong. And I do get a good night’s sleep with one of those. (Joe)

So you take those as a kind of sleeping pill, and the doctor doesn’t know?

(Interviewer)

Yes. Unofficially, yes. (Joe, 78 years)

Beliefs that only sleeping medication would be prescribed by their doctors for poor sleep prevented many of the older people seeking help, as did their perceptions of the moral inappropriateness of being reliant on such medication were it prescribed and taken.

**Morality of reliance and stigma of addiction to sleeping tablets**

Whilst maintaining control over their everyday lives was paramount for these older people, control over sleep could be relinquished to the body. Sleep was regarded for many as being a ‘natural’ state which was led by the body, regardless of how disturbed their sleep was, or how long the sleeper was awake in the night. Therefore, interference with this ‘natural’ state of (non)dormancy was often regarded as unnatural and unacceptable:

No, I have never taken a sleeping tablet. I don’t really believe in sleeping tablets, because I think, I might be totally wrong, but my idea of sleeping tablets is that they’re not a natural thing that’s happening. If you are in some sort of drug-induced state, I don’t think you’re sleeping. (Matthew, 66 years)
The respondents in this study adopted a ‘moral argumentation’ (Jolanki 2004) around rejecting prescription drugs for sleep in moral terms. Relying on tablets to help with sleep was regarded as morally inappropriate, in that it implied a weakness of character, and in turn implied an inability to maintain self-control. This is illustrated by Alfred and Dennis, who did approach their doctors for help with their sleep, but rejected medication because it represented reliance on something other than self, and an imposition:

So have you ever been to your doctor about sleep? (Interviewer)
Yes, I have mentioned this [problem sleeping] several times and he said ‘why don’t you try a hot drink before you go to bed’, or ‘I can give you some pills’. I don’t want sleeping pills. Because it’s a crutch isn’t it, you rely on those. (Alfred, 89 years)

I must have mentioned it [poor sleep] to the doctor once some years ago, because this is the only occasion when I have ever had sleeping pills. I have always tried to avoid those. And I think I probably took about two and the rest got left and taken back….I suppose I feel that they were imposing something on me…. I rebelled and stopped taking them anyway. And then never again. (Dennis, 72 years)

A strong moral work ethic, which continued into retirement, led to the respondents’ need to be active and productive, which may be affected by poor sleep the previous night and which impacts on their ability to be busy the next day, as commented by Cynthia “I will just be lolling around, a whole day is wasted, and there is too much to do”. However, the respondents held a belief that reliance on taking anything ‘unnatural’ to help with sleep was morally wrong (Lumme-Sandt and Vertanen 2002). As a result of this, even severely disturbed sleep, and its accompanying impact on the ability to be active the next day, was
preferable to a good night’s sleep that was obtained solely through taking prescription sleeping medication, for something that was not regarded as an illness. This is illustrated by Tom, who was taking regular medication for heart disease, and high blood pressure:

I don’t really like taking [sleeping] pills. Never have done, not because I can’t, but I don’t really approve of it. I don’t really approve of chemicals in the body. (Tom, 71 years).

Echoing the women in Gabe and Lipschitz-Phillips’ (1982) study who feared addiction as a sign of moral weakness, the stigma of addiction to sleeping tablets also had moral implications for the men and women in this study. Anita regarded taking sleeping tablets as a ‘last resort’, and held a perception that this would inevitably lead to addiction and a concomitant loss of control and choice over the appropriateness of taking them:

It would be the last resort, [sleeping medication] I don’t like taking any medication unless it’s critical that I take it. I wouldn’t want to take it regularly. Because I think you become addicted to them. You’d have to take more, whether that's right or not. (Anita, 79 years)

It is therefore unsurprising that of the 21 people who had ever discussed their poor sleep in a consultation with their doctor, only 9 were currently taking prescription sleeping medication.

In addition to the belief that poor sleep was not a health issue, fear of the side effects of taking sleeping medication prevented older people seeking medical help for their poor sleep. This fear often became a reality for those who did choose to seek, and subsequently
received sleeping medication. Such side effects included feeling drowsy the following day, which led to exasperation at losing control over their ability to be active and productive. As a result most of those who had sought help from their doctor for poor sleep declined to return for any further treatment in case they were prescribed sleeping medication again. Maintaining autonomy over their daily lives was a strong rationale for choosing not to return to the doctor for help with problems sleeping:

I don’t like taking tablets. She [doctor] actually gave me some and said ‘this is for you, you know, when you really feel you need it’. And I took one and I was asleep for about two days. It was awful. I just wasn’t in control at all. So I’m not taking any more of them. (Sandra, 71 years).

Medication compliance in older people is very much dependent on their acknowledgement and acceptance of an illness (Banning 2008). The older people in this study acknowledged the need to adhere to medication regimes for health conditions, such as taking tablets for high blood pressure, in order to maintain healthy and active lives. However, as poor sleep was not regarded as a health problem, taking prescribed sleeping medications was regarded at best with ambivalence, but more frequently as unwelcoming and detrimental to everyday life.

Reasserting control
Paradoxically, a small sub-sample of 5 of the older people would not seek medical help for their sleep problems because they assumed the doctor would not prescribe them sleeping medication, and therefore there was no point in seeking medical help. They expected that their own normative assumption that poor sleep was not regarded as a health problem would be echoed by their doctor, and therefore no treatment would be offered.
Additionally, amongst those who had sought and received medical help for poor
sleep, there was a concern that their doctor would stop regular sleeping medication
prescriptions. They would therefore not return to see their doctor, but would instead choose
to re-assert control over their sleep and their ability to undertake daily activities through other
methods. For example, Josephine was refused her long-term prescribed sleeping medication
by a different doctor than her own, so chose not to return, and tried an over the counter
remedy instead:

I had been taking sleeping tablets and I went to get a repeat prescription because you
have got to see the doctor and I saw not my – well I saw a GP who said, ‘How long
have you been taking these?…Ridiculous!’ he said, ‘You do know they are addictive’
and he said ‘No more repeat prescriptions’. So instead I take Veganin [painkiller].
(Josephine, 72 years)

The assumption that doctors would not prescribe sleeping medication or any other form of
treatment for poor sleep, together with a concern that existing prescribed medications would
be stopped, led some older people to seek alternative treatments from their pharmacist.

Control could also be reasserted by strategic manipulation of prescribed sleeping
medication, echoing the ‘adaptive repertoires’ of respondents found by North et al. (1995)
and the selective alteration of pharmaceutical treatment regimens by consumers in the home
by Fox and Ward (2008). As a result of taking many different types and numbers of pills,
older people made attempts, where possible to maintain, or regain control over medications
by controlling the timing and frequency of taking their prescribed sleeping medication.
Tablets were taken for as short a period as possible, until a better sleep pattern had been
achieved, then put aside until another bad spell of sleep occurred. Alternatively, sleeping
tablets would be taken in as small a dose as possible, and timed strategically to fit in with the activities they wished to undertake:

I feel I have got control. I mean it is only 3.75 [mg of sleeping pill] anyway. So it is only, you know, a very small amount. My daughter, who is a nurse, says it is not enough. You know, 3.75 anyway, she said ‘That is no good for a gnat really’. And as for half, it is a joke….. I know that tonight I have got to sleep [in preparation for visitors next day], but I will take half, and then I will leave the other half so that I can get it another time. (Joan, 68 years)

Additionally, those who had (reluctantly) received sleeping medication from their doctors, often only took the tablets for a short spell, and then stopped taking them altogether, with or without the doctor’s knowledge.

Well I think the last time I seriously took powerful sleeping tablets was a long, long time ago, about forty years ago…. But only as a temporary measure. You know I only took a course and then I stopped. I have never taken them for long. (Nigel, 80 years old)

Finally, some older people felt that control could be re-asserted over poor sleep through other, non-pharmacological means, such as exercise, or other recommended sleep hygiene practices as in avoiding coffee or alcohol near to bedtime. These methods of re-asserting control were to the greatest degree, undertaken by women, with very few men adopting self-help strategies:

I seem to be in control of it. I have so many bad nights and I know I haven’t got
anything on the next day, I seem to be able to you know, control it if you like. I will go for a long walk in the evening. I find activity like walking and going off on my own does help. I would never go to the doctor because I have licked it [coping with poor sleep], during the afternoon I could take a nap, an hour or so, before I cook supper. (Jennifer, 72 years)

Whilst acknowledging they had little or no control over treatment and medication regimes for serious health problems, these older people attempted to (re)assert control over areas that they, and often their doctors, did not perceive as a health issue, such as poor sleep. By controlling how, when and indeed, if, they took prescribed sleeping medication, they were able to (re)gain some autonomy over this aspect of their daily lives.

**Fear of relinquishing control**

Concerns were frequently expressed about the impact of sleeping medication and tranquilizers on their body. There was a fear that taking sleeping tablets would in some way harm them, and would signify that they had relinquished control over their body and over their ability to undertake the following day’s activities:

I felt that I wasn’t in control of the activities that I needed to be doing [after taking sleeping pills]. (Shirley 72 years).

I woke up [after taking a sleeping pill] and I thought ‘oh’ and I thought my head was square and filled with fuzz, grey fuzz and I thought ‘oh I don’t think I will be taking that’, it has never happened before. A weird, horrid feeling, so I don’t like not to be in control. (Emma, 66 years)
Of the few who had previously been prescribed benzodiazepine sleeping medication (and who had been taking them for some time), all had attempted to withdraw from their use, and to regain control of their lives, their body and their sleep, occasionally even without help from their doctors:

I was prescribed 2 mogadon at 41, on them for 27 years. I was swallowing mogadon and sleeping about an hour, so I decided that enough was enough, so I came off and they put me on some more tablets that were not habit forming..., and I wanted to come off those, so I said to [husband] ‘I think you had better go and sleep in another bedroom, because I am going to have some walking around nights I think’, which I did and it took me three months to come off those pills. (Mary, 80 years).

Taking sleeping medication was regarded by many as being morally inappropriate in that it was an ‘unnatural’ interference into a ‘natural’ state, implied a reliance on something other than self in order to maintain control over the functioning of everyday life. In addition to the way sleeping medication was perceived to impact on themselves, they also observed the adverse effects of such medication on others, and used this as a rationale for avoiding prescribed sleeping medication for poor sleep. Eight of the respondents said they chose not to take prescribed medication for poor sleep because of the experiences of others they had observed taking sleeping medication. They each knew of a relative, who had been prescribed some form of medication for difficulty sleeping over a considerable period of time, or had observed the impact of such medication in a work context:
Well ...she [doctor] did, suggested I go on some mild tranquillizer type medication and that would tide me over until I got a better pattern of sleep. And as I say, because of family, my mother had trouble, possibly because of her night duty, she was a nurse and she worked at night. And it obviously got her into a bad sleep pattern and she went on medication when she retired... And it affected her mentally, badly, in all sorts of ways. You know, it started off with mild stuff, and then went on to stronger stuff, and it led to dementia later on. (Penny, 67 years)

Observing at close hand the perceived short and long term effects of sleeping medications on the daily lives of others, such as impact on memory and behaviour, emphasised the loss of control over daily lives that taking prescription sleeping medication could have, and reinforced their belief that sleeping medications were to be avoided.

Discussion and Conclusions
Returning to the questions raised at the beginning of this paper, we have argued that older people do not perceive poor sleep as a health issue, but rather that it is a normal and expected part of ageing. We have also argued that older peoples’ inherent beliefs about the impact and effects of prescription sleeping medication, together with their expectations of the doctors that prescribe them, all combine to influence older peoples’ decisions about whether to seek professional medical help for poor sleep.

Of most significance, however, we have demonstrated that control is of paramount importance in influencing older peoples’ decisions about seeking medical help for poor sleep, manifested in their desire to remain in control of the way they live their lives, and to continue to be active and productive members of society, albeit within the limitations of their physical health and ageing bodies. In contemporary society, to be seen to be successful in later life
older people are expected to be active, productive and, as far as possible, healthy, so that to fail at being active in retirement is to be ‘unsuccessful’ at ageing (Katz 2005; Bowling 1993; Jolanki 2004). Successful ageing requires the older person to maintain control over their daily routines and activities, and over the way their bodies function in order to achieve those activities. Therefore lack of sleep only became important to the men and women in this study when their ability to be in control of their daily activities was severely compromised.

All of the 62 older people in this study had poor sleep, yet only 9 were currently using prescribed sleeping medication. Relinquishing control, either by relying on sleeping medication to achieve a good night’s sleep, or by showing weakness through ‘addiction’ to sleeping medication, was generally regarded as morally inappropriate and counter to the strong productive ethic of these older people. A fear of losing control through taking prescription sleeping medications has analogies with Pound et al.’s (2005) findings related to the desire to maintain control of medications in general. The older people in this study continued to hold beliefs about the power of medical authority, which was manifested in a desire not to waste their doctor’s time with issues they regarded as insignificant and as a normative part of ageing, such as poor sleep. Most held preconceived expectations that their doctors would most likely prescribe sleeping medication if they visited them for help with their poor sleep.

When sleeping medication was taken, control over its use was (re)asserted wherever possible, in practical ways, such as in the strategic timing and frequency of taking sleeping tablets, and in choosing whether or not to reveal to doctors or pharmacists which, (or even whose) medications were being taken.

Williams’ (2002) suggestion that claims that we live in a ‘sleep-sick society’ have led to sleep problems largely being managed by medical expertise, are at variance with the reality for the older people in this study. Sleep it could be argued is, to a certain extent, malleable in
that a small number of nights without good, restorative sleep may be regarded as acceptable (and inevitable) in later life and was therefore not seen as causing or contributing to health problems.

Poor sleep is often ignored, by both the medical profession and by the general public, yet it is fundamental in terms of optimising health and well-being in later life, and in enabling older people to achieve active, and productive lives. In adopting a sociological approach to studying sleep this paper reveals how sleep related practices, embedded within the daily lives of older people, reveal many sociological issues, such as autonomy and control, stigma, perceptions of the power of medical authorities, and the equating of active ageing with successful ageing. Further to this, a ‘sociology of sleep’, as Williams argues, ‘is relevant to most if not all domains of sociological inquiry and social scientific interest’ (2005: 171). The use of sleep as a topic for sociological enquiry by sociologists of health may therefore offer the potential to gain a greater understanding of lay perceptions of the links between ageing, health and illness in later life.
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