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RESEARCH ARTICLE

Sleep should not be this difficult: An interpretive descriptive study of older adults' perspectives on behaviour change elements in Sleepwell and experiences with benzodiazepine discontinuation

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Summary

Benzodiazepine receptor agonists are often used for insomnia in older adults contrary to current evidence. The harms outweigh the benefits, which are limited. Cognitive behavioural therapy for insomnia is the first-line recommended treatment. Sleepwell was created as a repository of evidence-based resources to promote cognitive behavioural therapy for insomnia and limit benzodiazepine receptor agonist use. This qualitative study uses an interpretive description design and reflexive thematic analysis to explore older adults' perspectives on behavioural change techniques used in Sleepwell resources. It also explores challenges and opportunities towards benzodiazepine receptor agonist discontinuation and cognitive behavioural therapy for insomnia use. Participants were recruited from the Sleepwell arm of a randomized controlled trial. Data were collected from 15 older adults using semi-structured interviews. Two main themes were developed: (1) sleep should not be this difficult; and (2) whether you know it, or learn it, drugs are bad. Two sub-themes were created within the first theme: (1) justification of benzodiazepine receptor agonist use to achieve sleep goals; (2) efforts of committing to cognitive behavioural therapy for insomnia. Several behavioural change techniques (e.g. information about consequences, anticipated regret, salience of consequences) were enablers of benzodiazepine receptor agonist-related behaviour change. For committing to cognitive behavioural therapy for insomnia, several behavioural change techniques (e.g. self-monitoring of behaviour, distraction, stimulus substitution) were beneficial, but social support, which was perceived as

Tulayla Katmeh at the time of research.

useful, was absent. Older adults experienced tension with benzodiazepine receptor agonist use and deprescribing, despite knowing or learning the potential consequences of benzodiazepine receptor agonists. Cognitive behavioural therapy for insomnia implementation was challenging. Embedded behavioural change techniques in the Sleepwell booklets were identified as helpful, but more (e.g. social support) are needed to optimize cognitive behavioural therapy for insomnia use.

KEYWORDS
benzodiazepines, cognitive behavioural therapy for insomnia, deprescriptions, health behaviour, health risk behaviours, insomnia

1 | INTRODUCTION

Ten to fifteen percent of people experience chronic insomnia regardless of age, and the prevalence of insomnia is higher in those over 65 years old (Crowley, 2011). Insomnia impacts mental and physical health outcomes, and results in economic burdens in the billions (Streatfeild et al., 2021).

Leading insomnia management strategies can be classified as pharmacological and non-pharmacological. Cognitive behavioural therapy for insomnia (CBTi) is the first-line recommended treatment (Qaseem et al., 2016). Traditionally, CBTi involved a time-limited program with in-person visits with a trained healthcare professional (Muench et al., 2022). High demand and a limited number of CBTi-trained professionals led to evolving delivery through alternate formats (e.g. self-guided approaches) that have shown efficacy and facilitate treatment access (Gao et al., 2022). Despite increases in CBTi delivery formats and evidence for first-line treatment, pharmacological interventions for insomnia remain prevalent.

The most prescribed pharmacological interventions are benzodiazepine receptor agonists (BZRAs), encompassing benzodiazepines (e.g. lorazepam, clonazepam, oxazepam) and z-drugs (e.g. zopiclone, zolpidem). Systematic reviews and meta-analyses find pharmacological interventions to be more efficacious than placebo, but report these effects as more apparent in the short term (Chiu et al., 2021; De Crescenzo et al., 2022). Harms with BZRAs can be significant and are numerous (Lucchetta et al., 2018; Schroeck et al., 2016; Sun et al., 2019). The BZRAs should not be used first-line for insomnia treatment and, if used, should be reserved for short-term management (Qaseem et al., 2016).

Deprescribing BZRAs is challenging and many factors promote continued use (Rasmussen et al., 2021). Multiple approaches to BZRA deprescribing have been explored, including interventions targeting policy, prescribers and patients (Reeve et al., 2017; Shaw et al., 2019). However, prescribers seldom recommend non-pharmacological treatments for insomnia (Davy et al., 2015). The most effective and sustainable interventions to decrease BZRAs for insomnia include involving patients in decision-making processes (Burry et al., 2022; Tannenbaum et al., 2014). These interventions are more likely to enhance patient motivation to deprescribe, improve knowledge, lower perceived necessity of BZRAs, and increase risk perception about BZRAs (Martin & Tannenbaum, 2017; Turner et al., 2020). This direct-to-patient strategy in the Eliminating Medications Through Patient Ownership of End Results (EMPOWER) demonstrated reductions in BZRA use through providing information on medications and dose reduction strategies whilst alerting participants to non-pharmacological options (Martin & Tannenbaum, 2017; Turner et al., 2020). However, studies to date have not explored direct-to-patient approaches with both BZRA deprescribing tools and information to support the use of CBTi and each of its components. To address this gap, a randomized controlled trial (i.e. the Your Answers When Needing Sleep in New Brunswick [*YAWNS NB*]) study was recently completed in a Canadian province that has a high prevalence of BZRA use in older adults (Murphy et al., 2022). The intervention, Sleepwell, is available as an online resource (mysleepwell.ca) and in printed booklets, and is a knowledge translation and mobilization initiative including a repository of evidence-based tools developed to: (i) increase awareness and use of CBTi; and (ii) help people stop using BZRAs. In the *YAWNS NB* study, Sleepwell booklets were compared with an existing intervention (i.e. EMPOWER brochures) and treatment-as-usual (TAU).

The Sleepwell intervention booklets were: "How to Stop Sleeping Pills", hereafter referred to as booklet 1, that includes information on BZRAs (e.g. risks) and how to stop them; and "How to Get Your Sleep Back", hereafter referred to as booklet 2, that focused on CBTi information (e.g. CBTi components and tools). The design of the Sleepwell booklets was underpinned by the behaviour change wheel (BCW) (Michie et al., 2011; Michie et al., 2014) and the theoretical domains framework (TDF; Atkins et al., 2017), along with embedded behavioural change techniques (BCTs) using the BCT taxonomy (Michie et al., 2013). Michie et al. define a BCT as "an observable, replicable and irreducible component of an intervention designed to alter or redirect causal processes that regulate behaviour", and is considered to be the "active ingredient" in behaviour change interventions (Michie et al., 2013). For example, booklet 1 had a section called "The Dangers of Sleeping Pills", featuring short text and pictures of older adults describing and depicting risks (e.g. falls, memory problems, driving impairment, etc.). The main overarching BCT in this section was natural consequences (BCT 5), with the following embedded BCTs: *information about health consequences* (5.1); *salience of consequences* (5.2); *information about social and environmental consequences* (5.3);

anticipated regret (5.5); and *information about emotional consequences* (5.6). A complete listing of the BCTs used in the Sleepwell booklets from the *YAWNS NB* study is available upon request.

Following the 6-month *YAWNS NB* study period, a qualitative study was conducted with participants in the Sleepwell arm focusing on BZRA and CBTi use and perspectives. Although qualitative studies have reported on older adult experiences with BZRA deprescribing (Evrard et al., 2022), there is limited literature with respect to older adults' perspectives on CBTi implementation (Granberg et al., 2022), and less so with combined deprescribing and CBTi implementation interventions.

2 | METHODS

2.1 | Methodology

A constructionist paradigm was used for this study (Braun & Clarke, 2022). Interpretive description (ID) was chosen as the qualitative methodology as it supports researchers to utilize perceptions and experiences of the target populations to develop deep understandings, and that understanding can be used to inform practice (Thompson Burdine et al., 2021). ID provides approaches to guidance for data analysis that include: familiarizing oneself with the data; coding the data; making sense of patterns in the data; and capturing analytic insights (Thorne, 2016). It is suitable to combine with other established qualitative designs deemed appropriate to answer the research question (Thorne, 2016). Braun and Clarke's reflexive thematic analysis (TA) (Braun & Clarke, 2022) was integrating, providing a structured and robust data analysis approach (Braun & Clarke, 2022; Thorne, 2016). Deductive analysis was used to explore older adults' perspectives on the embedded BCTs in the Sleepwell booklets. Inductive analysis was used to explore older adults' experiences with BZRA use and discontinuation. Data analysis included mapping codes and themes to the TDF domains (Atkins et al., 2017), to explain influences on behaviours.

Within both ID and reflexive TA, the importance of reflexivity is emphasized to generate accurate and credible study results (Thompson Burdine et al., 2021). The lead researcher (TK) maintained a reflexive journal during data collection and analysis, recording processes, feelings and assumptions.

The research was conducted by the lead author as part of a Master's in Psychiatry Research at Dalhousie University under the supervision of two co-authors and -supervisors (ALM, DMG).

2.2 | Recruitment

The sample for this study was drawn from the Sleepwell arm in the *YAWNS NB* study (Murphy et al., 2022), led separately by coauthors (ALM, DMG) comparing Sleepwell booklets, EMPOWER brochures, and TAU to evaluate the impact on BZRA and CBTi use in older adults (Murphy et al., 2022). Briefly, the YAWNS NB inclusion criteria were: (1) community-dwelling resident of New Brunswick, Canada; (2) aged 65 years or older; (3) current (minimum use: 3 bedtime doses per week) and long-term (≥ 3 months) user of BZRAs; and (4) initial indication for BZRA is or was insomnia (with or without mild to moderate anxiety) (Murphy et al., 2022). A complete list of exclusions is available in the protocol (Murphy et al., 2022).

Participants in the Sleepwell and EMPOWER arms of the study received the intervention by mail immediately after the baseline interview, and the TAU group was provided with the Sleepwell booklets after the exit interview (6 months; Murphy et al., 2022). During the *YAWNS NB* 6-month exit interview, participants were asked regarding future contact for research. Participants in the Sleepwell group who agreed to be contacted were eligible for the qualitative study. Purposive sampling was used and there were 166 eligible at the time of recruitment; this was narrowed to 76 who most recently completed the *YAWNS NB* study. More recent completion was hypothesized to allow participants to have better recall of their experiences with BZRA use and CBTi implementation. The lead author was unaware of whether participants had adjusted their BZRA(s) or had implemented CBTi during the *YAWNS NB* study. It was estimated that up to 15 participants would provide an adequate sample for the research purpose. Potential participants were contacted by telephone. Interested participants were sent the informed consent form.

2.3 | Patient partner inclusion in research

Two older adults were recruited from the *YAWNS NB* study population to serve as patient partners. They provided perspectives on aspects of the qualitative study design, analysis and interpretation based on their lived experiences. They were involved in six meetings over 8 months, and on three separate occasions, each was compensated with $100 grocery store gift card.

2.4 | Ethics approval

This research was approved as part of the *YAWNS NB* study by the Dalhousie University Research Ethics Board (REB file number 2020-5184).

2.5 | Data collection procedures

Interviews were conducted by telephone using semi-structured interviews from October 2022 to January 2023. The interview guide was developed considering the booklets' BCTs and literature citing barriers and facilitators to BZRA discontinuation and CBTi use. The patient partners gave feedback on the interview guide (e.g. suggested improvements to probes) and participated in practice interviews.

All interviews were audio-recorded. Participant consent was obtained and recorded for each interview. Audio recordings were transcribed verbatim (Braun & Clarke, n.d.; Braun & Clarke, 2022). Transcripts were then checked for accuracy against the audio. During transcription, identifiers were removed.

2.6 | Findings

A total of 76 participants were contacted and 43 were reached. Twenty-two were interested and were sent a consent form, after which seven indicated not being interested. A total of 15 participants were interviewed (Table 1), with interviews ranging from 20 to 60 min, and a mean of 30 min.

2.7 | Coding and theme development

A total of 30 codes were initially identified, which was then refined to 21 codes, including 8 deductive and 13 inductive codes (Table 2).

These codes were transformed into six clusters (knowledge; sometimes sleep is more important; dislike of medication; not feeling alone; belief in oneself; and solutions/directions/answers). From the clusters, an initial thematic map was developed (Figure 1).

Two overarching themes and two subthemes were then developed through the thematic mapping. The two main themes represented older adults' perspective and experiences with the Sleepwell booklets, BZRA discontinuation and CBTi use: (1) *sleep should not be this difficult*; and (2) *whether you know it, or learn it, drugs are bad*. The findings reveal the dilemma faced by participants in deciding what would cause more harm; BZRAs or lack of sleep.

TABLE 1 Demographics of interviewed participants.

Variable	N	%
Age (years)		
65–70	6	40
71–75	1	7
76–80	8	53
Self-identified gender		
Male	8	53
Female	7	47
Currently using medication to help with sleep?		
Stopped	2	13
Reduced	4	27
No change	9	60
Able to stop or reduce sleeping pills during the YAWNS NB study?		
Stopped	9	60
Reduced	2	13
No change	4	27

TABLE 2 Deductive and inductive codes contributing to the developed themes.

Deductive codes	Inductive codes
5.1 Information about health consequences	Awareness and understanding
5.5 Anticipated regret	Beliefs about sleep – importance of sleep for heath
5.2 Salience of consequences	Priority/severity of issue
12.4 Distraction	Belief about medication effectiveness
2.3 Self-monitoring of behaviour	Push and pull motivation
8.2 Stimulus substitution	Stuck-trapped-helpless-lost
6.1 Demonstration of behaviour	Scepticism around the booklet
6.2 Social comparison	Setting proper expectations – timeline
	Support from others – the value of help and belonging
	Booklets were an answer/a guide – hope
	Endorsing of the booklets
	Joining the study with the intention to stop
	Attitude about medication

2.8 | Sleep should not be this difficult

The interpretation of the data underscored the value and importance of sleep and what participants are willing to do to achieve this sleep. Sleep was prioritized over perceived harms of BZRAs, despite a general dislike of BZRAs and regardless of whether their harms were internalized as something that was already happening to participants or could be experienced in the future. Lack of sleep was harmful to functioning and quality of life. The experience of using BZRAs was less daunting and perceived to be more effective than committing to CBTi. Two important subthemes were created within this theme: (1) justification of BZRA use to achieve sleep goals; and (2) the effort of committing to CBTi.

2.8.1 | Justification of BZRA use to achieve sleep goals

Regardless of the journey with BZRAs and insomnia, participants commonly emphasized their strong desire to get good sleep as justification for BZRAs. This concept is strongly related to the belief that BZRAs effectively provide good sleep, and this was a prevalent idea across the data set.

> ID378: When you have a sleeping disorder like this, it is a physical pain. It really is, so you would do anything to stop the pain, even when they say it [the sleeping pill] is addictive.
> ID539: I had to get my sleep with this [health condition] …. it was important that I get sleep and you know, that kind of hooked me on [sleeping pills].

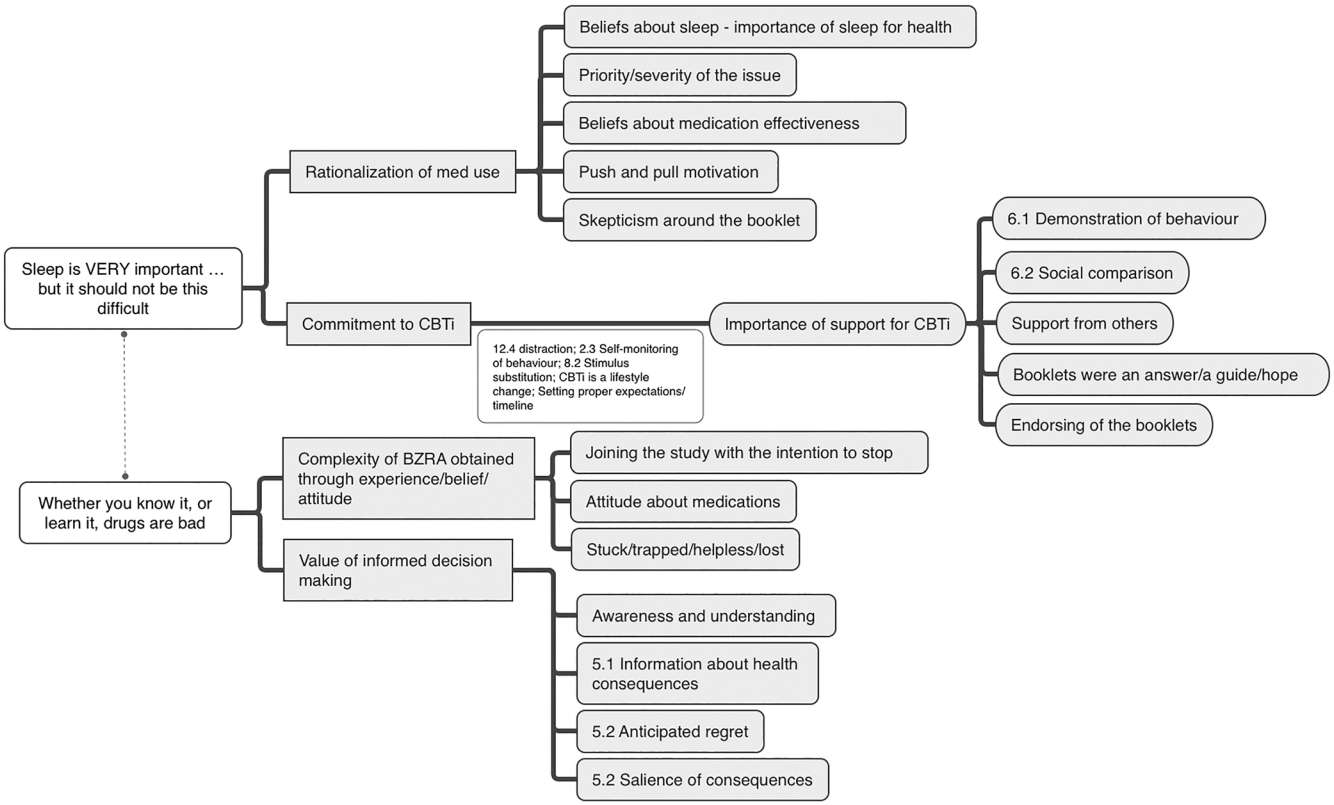

FIGURE 1 Initial thematic map of older adult participants' experiences with benzodiazepine receptor agonists (BZRAs) in the YAWNS NB Sleepwell group.

In their justification, participants also devalued other insomnia treatments and were sceptical about the legitimacy of Sleepwell's recommended resources (e.g. a book on CBTi).

> ID527: I felt booklet 2 pushed cognitive behavioural therapy and I felt it was flogging, promoting somebody's book … I saw that there was a couple of references to the book and then I think there was a discount available if I got the book, and I'm just looking and thinking, "this is kind of …. they are promoting that book."
>
> ID171: No … I don't believe in that kind of thing [CBTi]. So, it might be fine for some people, but my brain box is not set up for that. It just, it's either, "yes" or "no", and if it doesn't work, then I'm not wasting time on it … To me, it is like, I don't want to say hocus pocus, but I don't know, no, I can't be bothered.

When mapping to the TDF, the *knowledge* domain hindered behaviour change and, specifically, knowledge about the limits of BZRA effectiveness, which influenced justification. The BZRAs generally represented ease or simplicity compared with their discontinuation or other treatment approaches for insomnia. Rebound insomnia and withdrawal were also challenging for some participants and was a concept described as "the vicious cycle" in the Sleepwell booklets, in which withdrawal also causes insomnia. These effects reinforced BZRA use.

> ID527: I knew I shouldn't be taking them and the few times I said, "the hell with it, I'm going to stop taking them." I found it difficult. I stopped for a month or so, but it was just easier to continue taking them.

2.8.2 | The effort of committing to CBTi

Although there were numerous sentiments (e.g. hope, relief) regarding the positive aspects of CBTi, there were underlying concerns regarding the strenuous commitment, especially when juxtaposed against the perceived ease and simplicity of taking a BZRA. The two domains of the TDF corresponding to the BCTs that enabled behaviour change with CBTi and improved sleep were *skills*, and *motivation and goals*.

> ID539: Well, it's a course. It's like a university course or something, you know. You've gotta schedule yourself. You've got to do what the book suggests you do. You gotta follow it just like you were going to make a final exam or something, you know. … The book instilled that commitment in me.

> ID377: I felt, probably, a sense of relief. … Reading it is one thing. Doing it of course is absolutely another thing. But reading it was a sense of relief this would work, and I had to do it. And so, I had to pull up my socks more and so I did set those heavy-duty guidelines … It [stopping sleeping pills] is a slow process. It doesn't happen overnight … it takes a while.

Some participants found their commitment to engage with CBTi challenged by their interest, ability and life circumstances.

> ID528: I couldn't do the sleep study thing [filling out the sleep diary] because when I get up at night, I don't want to write nothing down and I forget.
> ID419: I had a lot of difficult family issues going on that outweighed anything else that I was trying to do.

Participants identified support and guidance as critical for committing to CBTi. The Sleepwell booklets guided participants to available self-help CBTi resources.

> ID539: They sort of pique your interest and point you into a direction and they give you a quick look at certain concepts so that you begin to realize that there is more to this than "oh, I think I'm going to taper off and stop", you know … introduces you to various procedures and various things you can do in a pretty straight forward and practical way and then when I got through booklet 2, I really had to get the book [Sink into Sleep] … this cognitive behavioural therapy business was really interesting and it put me into an area that I didn't have a name for and so I found it really quite helpful.

Participants identified sections of booklet 2 as helpful and worthy of effort with improving their sleep, and the corresponding BCTs were *self-monitoring of behaviour* (BCT 2.3), *distraction* (BCT 12.4), and *stimulus substitution* (BCT 8.2).

> ID378: That planner … it helped me do the fight [to discontinue sleeping pills]. … I was printing out blanks left, right, and centre. … That was the best tool for me. … I could see my hits and misses, and it helped me set goals.

The BCT *social comparison* (6.2) embedded in the stories in the booklets also validated participants' experiences and gave them a sense of support and belonging.

> ID413: I was reading that [the booklets' stories] and I saw myself in their stories. I thought, "these are real people. They've gone through it. I am going through the same thing", and I could identify with someone else. You know, it is not just me. Stories of people with the same problems and that there is a lot of people with the same problem.

The consensus among participants was that having support made using CBTi more manageable. People showcased the support they had, or desired to have.

> ID378: I had been looking for help. I couldn't keep doing this on my own and I couldn't be running to my doctor about it because nobody seems to understand.
> ID413: My wife sometimes would read to me a part of it [booklet], and we would go through it together. On my own it was a little bit difficult, but it was nice to have companionship.

2.9 | Whether you know it, or learn it, drugs are bad

A negative attitude about BZRAs was expressed by participants' desire to avoid harms.

> ID240: Well, I have a bit of an aversion to pills to start with. I try to take as few as I can and so I saw the ad for the sleep study [I thought] "well, why not?" I'll see if I can; if it will help me [stop the sleeping pills].

Others described the difficulty of stopping BZRAs and the trapped feeling that accompanies their use, further perpetuating the negative experiences with BZRAs.

> ID377: Once you got into it [taking sleeping pills], boy it's hard to get out without some kind of help.
> ID301: I felt that I needed to stop but I don't have any … confidence in myself and self-esteem. … I'm still anxious and still scared. It is like trying to do new things.

Generally, participants felt ill-informed about BZRA consequences. There was frustration around not being fully informed for decision-making.

> ID240: Well, I guess I found out I didn't know as much about sleeping pills as I thought I did, and the issue of pneumonia. … The fact that, you know, really, they're not a cure for insomnia. Once your body adjusts to the pill you probably have as much insomnia as you did without the pill.

The content in booklet 1 regarding the harms of sleeping pills was mapped to the TDF domain of *knowledge* and as an enabler of behaviour change. Participants sought more information about their BZRAs after reading the booklets to get help with decisions.

> ID378: Most of us, we just take drugs based on what our doctor tells us. … There is not enough research that goes into everything. … so I did the research.

Participants' learning about BZRAs and wanting to stop or reduce BZRAs were also coded with the BCTs *salience of consequences* (5.2) and *anticipated regret* (5.5). Participants better understood the potential future health consequences of continued BZRA use. In some cases, this increased their commitment to reduce or stop BZRAs.

> ID413: I just read it and I was glued to it because these people were falling and having accidents and stuff like that, and I didn't want to go there. I wanted to keep on driving a car as long as possible.
>
> ID378: I saw that woman on the floor, and she's either dead or in a coma. You know, that had an emotional impact on me because I don't ever want to put myself in that light. … The woman laying down and having fallen and I live 47 stairs up. I live in a flat on the top of a building with no elevators. Oh yeah, so that had great impact on me.
>
> ID527: When I finished booklet 1, I realized I really had to stop taking them. … If I hadn't read book [sic] 1, I probably wouldn't have said, "well hell, I'm going to stop this". It kicked me into doing it so that is very positive.

However, one participant did not find the information provided to be sufficiently motivating to discontinue their BZRAs and they remained committed to their use.

> ID171: I understood a little more [about problems caused by sleeping pills after reading the booklet] but I mean I'm not going to change my habit of taking my pills. It is not enough to change, not enough to change my idea … no not enough to apply any solutions.

3 | DISCUSSION

Two main themes were developed from older adults with BZRA use experience in this ID study using reflexive TA: (1) *sleep should not be this difficult*. Participants prioritized the importance of sleep for overall health, and identified the difficulty of BZRA discontinuation and the effort needed to implement CBTi; and (2) *whether you know it, or learn it, drugs are bad*. A dislike of medication was common and caused re-evaluation of BZRA use. Additionally, older adults' perceptions of the Sleepwell booklets and embedded BCTs showed that *information about health consequences* (5.1), *salience of consequences* (5.2), and *anticipated regret* (5.5), which mapped to the TDF domains of *knowledge* and *beliefs about consequences*, were identified as possible enablers of behaviour change in this study. These BCTs were primarily related to the second theme, *whether you know it, or learn it, drugs are bad*, and underscored the participants' desire to understand the risks and benefits of their BZRAs for making an informed decision about their medication. A recent systematic review similarly identified TDF domains *knowledge* and *belief about consequences* as barriers to deprescribing BZRAs (Evrard et al., 2022). Similarly, in the EMPOWER study, improved knowledge and increased risk perception of BZRAs were shown to trigger motivation in their study population (Martin & Tannenbaum, 2017). Other BCTs in this present study that were relevant motivators for CBTi use and BZRA discontinuation included *self-monitoring of behaviour* (2.3), *stimulus substitution* (8.2) and *distraction* (12.4). Whether participants self-identified for the *YAWNS NB* study with an aversion to BZRAs or developed it after reading the booklets, it ignited a re-evaluation of their use and more informed decisions around stopping or continuing their BZRA.

An inner personal conflict between perceived benefits and risks of BZRA use was commonly seen across participants. The PRIME (plans, responses, impulses, motives, evaluations) theory of motivation, which is part of the model of behaviour within the BCW and underpinned Sleepwell's development, represents this internal conflict with reflective and automatic motivation (Michie et al., 2014; West & Michie, 2020). Reflective motivation involves conscious thought processes and automatic motivation of wants, needs, impulses and reflex responses (West & Michie, 2020). Understanding harms of BZRAs and wanting to discontinue (i.e. reflexive motivation) is overpowered with beliefs in BZRA effectiveness and the ease of taking them versus a commitment to CBTi (i.e. automatic motivation). Both types of motivation can be a target for behaviour change. Improving knowledge of BZRA-related risks targets reflective motivation, which the Sleepwell booklets provided. However, there is an opportunity to target automatic motivation, which in this context, refers to beliefs about BZRA effectiveness and ease of taking them. The Sleepwell booklets did not specifically address data around the limited effectiveness of BZRAs, which may have impacted deprescribing and requires incorporation in future versions. This is particularly relevant as older adults' and prescribers' comfort and belief that BZRAs are effective has been reported previously as a barrier to deprescribing (Cook et al., 2007; Heser et al., 2018; Martin & Tannenbaum, 2017; Neves et al., 2019; Rasmussen et al., 2021; Williams et al., 2016). The current study demonstrates opportunities to challenge effectiveness beliefs during shared decision-making, as older adults clearly expressed desires to avoid unnecessary harms associated with BZRAs and frustration about not being fully informed about potential harms. Clinician–patient interventions, detailed or brief, have previously led to significant discontinuation in pharmaceutical therapies (Heather et al., 2004; Kuntz et al., 2018; Navy et al., 2018; Vicens et al., 2006, 2014). Future studies of BZRA deprescribing and CBTi implementation can extend these findings by exploring BCTs that address not only BZRA harms but the impact of providing effectiveness data on older adult motivation.

Although participants discussed challenges in committing to CBTi, they also identified several tools and resources within the

Sleepwell booklets as helpful and supportive in committing to CBTi. The corresponding BCTs included: *demonstration of behaviour* (6.1), *social comparison* (6.2), *self-monitoring of behaviour* (2.3), *distraction* (12.4), and *stimulus substitution* (8.2). Barriers to CBTi use are numerous and can include one or more from clinician-, patient- and system-levels (Koffel et al., 2018; Koffel et al., 2021; Roberts & Ulmer, 2023). Previous studies report that patients perceive CBTi as challenging, particularly the sleep restriction component (Koffel et al., 2020a; Koffel et al., 2020b; Latocha et al., 2023). This highlights the importance of communicating that challenge to prospective CBTi users. Utilizing a BCT, such as *action planning* (1.4), to address the TDF domain *behavioural regulation* can set better expectations and potentially address this barrier. Moreover, individualizing the implementation of various components of CBTi based on each person's needs are thought to improve access and use of this treatment (Baglioni et al., 2020; Espie, 2009). In other research, patients have identified a critical role of social support in CBTi treatment adherence (Koffel et al., 2020b; Koffel et al., 2021; Latocha et al., 2023). A network meta-analysis investigating the various forms of CBTi delivery methods found that having support through guided self-help, individual or group CBTi lead to better outcomes than unsupported self-help formats of CBTi (Gao et al., 2022). Sleepwell's use of the BCTs *demonstration of behaviour* (6.1) and *social comparison* (6.2) were found to help engage participants, but the Sleepwell resources lacked BCTs specifically addressing *social support* (BCT 3). This may have limited participant commitment to CBTi. Their limited social support around CBTi engagement combined with the lack of information regarding the limited effectiveness of BZRAs and potential experiences with the vicious cycle may partially explain the initial success with BZRA discontinuation or reduction in 73% of the sample during the YAWNS NB study, which declined to 40% at the time of interviews. Given the importance of support highlighted by participants in this study and other research, future research on self-help interventions such as Sleepwell should include how best to provide opportunities for social support.

Based on the findings of this study, self-help resources can successfully be used to inform older adults regarding the limited benefits and potential risks of BZRAs prior to treatment initiation and throughout the duration of treatment as part of shared decision-making. Mechanisms to reinforce information about risks that participants in this study found beneficial were providing written and pictorial information regarding health consequences, salience of those consequences, and anticipated regret regarding taking BZRAs. CBTi, as first-line insomnia treatment, should be encouraged with self-help resources. These should include BCTs for demonstration of behaviour, social comparison, self-monitoring of behaviour, distraction and stimulus substitution. Social support is valued by older adults, and can benefit those starting and maintaining CBTi. Coaching as a social support mechanism in self-help CBTi has been explored since the early 2000s and appears fitting with what older adults described as helpful in this study. However, future research should determine the preferred mechanisms for coaching roles whilst engaging in social support (e.g. text message, in-person) for older adults.

4 | LIMITATIONS

The sample of this study was recruited from the *YAWNS NB* study, which had specific inclusion and exclusion criteria, limiting the transferability of the results. Participants in YAWNS NB were self-selected in response to recruitment efforts, and may have been more motivated than other older adults to reduce BZRAs and try different insomnia management approaches. They may also have been more willing to describe their challenges and opportunities with BZRA discontinuation and using CBTi. Moreover, *YAWNS NB* participants who did not agree to be contacted regarding future studies may have had less pleasant or unsuccessful experience with the Sleepwell booklets and may not accurately represent older adults' experiences.

Participants were sent the Sleepwell booklets as part of a randomized controlled trial and were recommended to discuss the material with their healthcare professionals. This occurred during the earlier waves of the COVID-19 pandemic, which could have reduced participant access to health services as compared with non-pandemic times. The booklets also lacked a personalized approach to CBTi and BZRA deprescribing given the YAWNS NB study design.

During transcription of two early interviews, the style of questioning included some leading questions, which may have impacted the participants' answers. This was noted in the reflexive journal and improved for later interviews. Furthermore, two interviews were relatively short (20 min), which may affect the richness of the data set.

The first theme, *sleep should not be this difficult*, demonstrated the strong belief about the importance of sleep for overall health. Participants were not assessed or screened with any tools (e.g. Dysfunctional Beliefs About Sleep scale [DBAS-16]; Morin et al., 2007) regarding their sleep beliefs and potential cognitive distortions around sleep. Cognitive distortions regarding sleep may worsen insomnia and decrease adherence to behavioural insomnia treatments (Carney et al., 2010; Yu et al., 2020).

The Sleepwell booklets' content used combinations of images and text in the messaging. Some participants clearly noted the importance of images used in the booklets, while others did not distinguish between photos or text as the key influences on behaviour. It cannot be determined from this analysis if use of text without images would have the same impact.

The booklet intervention was underpinned by the BCW and TDF. A possible limitation to this approach included the use of BCTs that were based on tacit knowledge and existing literature regarding the influences on behaviour in this area. Whether the combination and intensity of BCTs used were the most fit-for-purpose is less well known for deprescribing and CBTi uptake. Additional studies to replicate these findings using this combination and intensity of BCTs would be beneficial. It would also be worthy to explore the implementation of modified versions of resources like Sleepwell in areas of high BZRA prevalence (e.g. institutional care settings) as this population was excluded in the YAWNS NB study.

5 | CONCLUSION

Older adults want to be informed regarding their medications and avoid harms associated with BZRAs. This presents an opportunity for a conversation about safe medication use and potential deprescribing. Challenges to BZRA discontinuation in this study included the strong belief of BZRA effectiveness and their ease of use. Additionally, CBTi as the non-BZRA treatment is seen as a challenging undertaking, and a lack of social support within Sleepwell resources may have limited CBTi uptake despite other enabling BCTs. Findings of this study demonstrate that older adults' perspectives on interventions like Sleepwell contribute important information regarding intervention improvements and BCTs that will enable behaviour change.

AUTHOR CONTRIBUTIONS

Tulayla Katmeh: Conceptualization; investigation; funding acquisition; writing – original draft; methodology; validation; visualization; writing – review and editing; formal analysis; project administration; data curation. **David M. Gardner:** Conceptualization; investigation; funding acquisition; methodology; validation; visualization; writing – review and editing; formal analysis; supervision; resources. **Niki Kiepek:** Supervision; formal analysis; investigation; validation; methodology; writing – review and editing. **Marilyn Macdonald:** Investigation; methodology; writing – review and editing; validation; formal analysis; supervision. **Andrea L. Murphy:** Investigation; conceptualization; funding acquisition; methodology; validation; visualization; writing – review and editing; formal analysis; supervision; resources.

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CONFLICT OF INTEREST STATEMENT

The authors declare that they have no competing interests.

DATA AVAILABILITY STATEMENT

The data that support the findings of this study are available from the corresponding author upon reasonable request.

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