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Gender differences in approaches to self-management of poor sleep in later life

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ABSTRACT

In this paper we seek to understand the influence of gender on the different approaches to managing poor sleep by older men and women through the conceptual framework of existing theoretical debates on medicalization, healthicization and 'personalization'. In-depth interviews undertaken between January and July 2008 with 62 people aged 65–95 who were experiencing poor sleep, revealed that the majority of older men and women resisted the medicalization of poor sleep, as they perceived sleep problems in later life were an inevitable consequence of ageing. However, older men and women engaged differently with the healthicization of poor sleep, with women far more likely than men to explore a range of alternative sleep remedies, such as herbal supplements, and were also much more likely than men to engage in behavioural practices to promote good sleep, and to avoid practices which prevented sleep. Women situated 'sleep' alongside more abstract discussions of 'diet' and health behaviours and drew on the discourses of the media, friends, family and their own experiences to create 'personalized' strategies, drawn from a paradigm of healthicization. Men, however, solely relied on the 'body' to indicate when sleep was needed and gauged their sleep needs largely by how they felt, and were able to function the following day.

Introduction

The study of sleep has historically been the remit of sleep medicine and sleep science and has only more recently arisen as a topic within the social sciences (Seale, Boden, Lowe, Steinberg, & Williams, 2007; Williams, 2002). Sociological debates which locate sleep within discourses of health and illness have reflected on the discussions surrounding approaches to resolving sleep disorders and sleep problems, and how these are severally and jointly conceptualised in terms of medicalization, healthicization, and 'personalization'. In this paper we seek to contribute to these broader sociological debates through an exploration of the narratives older men and women use to describe the management of their sleep problems within the context of their everyday lives.

Conrad and Leiter (2004, p. 825) explain that 'Medicalization occurs when previously non-medical problems are defined and treated as medical problems, usually in terms of illnesses or disorders, or when a medical intervention is used to treat the problem'. Medicalization may take place at different levels; interactional, as in the doctor–patient relationship; conceptual, as in using medical language to describe a problem; or institutional, when an organization adopts a medical approach for a particular problem (Conrad & Schneider, 1980; Williams, 2005). It has been suggested that sleep is one such 'problem' that is susceptible to medicalization from a series of experts, a variety of treatments, and within a range of clinical settings (Hislop & Arber, 2003; Williams, 2002). Indeed, the potential for the medicalization of sleep emanated firstly from a rise in our understanding of sleep problems and sleep disorders through an increased understanding of the physiological mechanisms of sleep from experts in sleep medicine and sleep science; and secondly via an increasing portrayal in the media of the potential dangers of poor sleep, which led to a growth of public interest in sleep issues and problems (Seale et al., 2007).

Additionally, the pharmaceutical industry plays a role in the medicalization of sleep through an increase in the availability of a plethora of sleep aids, and prescribed medications, such as benzodiazepines (Williams, 2005, 2011). Yet it has also been argued that there has been a shift in the debates surrounding the 'engines' of medicalization, as the medical profession are no longer regarded as its sole 'drivers' (Conrad, 2005). One component of this debate has focused on the changing role of the doctor–patient relationship. Kroll-Smith (2003), for example, suggests that textually mediated forms of authority are now bypassing the traditional

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doctor–patient relationship and creating a widening chasm between the number of individuals reporting insomnia-like symptoms and the number actually being clinically diagnosed with insomnia. Williams, Seale, Boden, Lowe, and Steinberg (2008, p. 266) advise caution here, in that the doctor–patient relationship is itself "sometimes used as a template or framing device" within media storylines and textually mediated forms of authority, "with patients often called upon or encouraged to visit their doctor".

Therefore while the media has played a significant role in reformulating sleep within a medicalized agenda, it has also engaged with more recent discourses on the healthicization of sleep that suggest the responsibility for health and wellbeing is laid firmly with the individual. Self-management of sleep is encouraged through the popular press, television, radio and self-help websites, as well as through increasing access to over the counter medications and remedies. We are encouraged to personally engage with ways to improve our sleep, and daytime functioning, by seeking aids for sleep problems (Harvard Medical School, 2007; National Sleep Foundation, 2011; Williams et al., 2008). Advice for coping with poor sleep also comes in the form of recommended 'sleep hygiene', such as avoiding caffeinated drinks and alcohol near to bedtime, and not eating or exercising too late (British Broadcasting Organisation, 2012; National Health Service, 2012; National Sleep Foundation, 2012).

Kroll-Smith and Gunter (2005, p. 346) propose there is now a 'new truth' being told about sleepiness, and what was once considered a private, 'routinely occurring state of partial consciousness' has become 'linked to public health vernaculars, and transformed into a reprobate condition'. 'Patients', therefore, are now framed as active consumers and 'expert patients' with an accompanying sovereignty of knowledge and expertise gained from websites, the media and through conversations with pharmacists, with a moral obligation to operate under a 'regime of total health' requiring personal observation and maintenance of health (Armstrong, 1993; Busfield, 2010; Conrad & Leiter, 2004; Williams et al., 2008).

However, the ways that this increased emphasis on the healthicization and self-management of sleep is interpreted and subsumed by individuals is also subject to debate. Hislop and Arber (2003) for example, in their paper on mid and later life women's sleep, suggest that a decline in the prescribing of hypnotic drugs may indicate that women are seeking alternative ways to cope with disturbed sleep. They proposed that, rather than resort to medications and doctors, mid-life women, 'have developed a range of personalized strategies over time to manage their sleep without recourse either to externally invoked healthy lifestyle practices, or medical intervention' (Hislop & Arber, 2003, p. 822). These 'personalized' techniques, such as consuming hot milky drinks and reading before bed, were said to enable women to cope with poor sleep. Critiquing this, Seale et al. (2007, p. 429) proposed that many of the personalized strategies employed by mid-life women are actually 'discussed and debated in the popular public forum of the *Daily Mail* [one of the UK papers that Seale et al. investigated], so they are far from being wholly private [or personalized] solutions'.

While being aware of other ongoing trends and debates about sleep, such as the pharmaceuticalization, biomedicalization and politicization of sleep, in this paper we wish to more explicitly re-examine aspects of medicalization, healthicization and 'personalization' within previously under-researched areas of the social context of sleep. Sociological approaches to the study of sleep have already demonstrated the significance of the social context of sleep and sleep problems with respect to a variety of social groups and within diverse settings (Brunt & Steger, 2008; Hislop & Arber, 2003; Meadows, 2005; Venn, Arber, Meadows, & Hislop, 2008), but with little attention paid to older men and women. This paper seeks to contribute to our sociological understanding of responses to perceived sleep problems in relation to debates about medicalization, healthicization and 'personalization' by exploring the approaches older men and women adopt to mitigate the impact of poor sleep on their daily lives, and to understand what influences their approaches. Our rationale for exploring this neglected area now follows.

Gender, sleep and ageing

There is now a growing body of literature which suggests that how, where, and when we sleep (Williams, 2005) are gendered (Bianchera & Arber, 2007; Venn, 2007; Venn et al., 2008; Walker, Luszcz, Hislop, & Moore, 2011). However, most of this research has focused only on women, and has hitherto largely neglected older people. Hislop and Arber (2003) research on women suggests that the interaction of the physical and emotional labour involved in caring for family members, and the worries and concerns associated with work and family responsibilities, compromise women's access to quality sleep. Bianchera and Arber (2007) similarly discuss how women's sleep was influenced by aspects of caregiving for family members at different points across the lifecourse.

Given the previous dominant focus on women's narratives within sociological studies of sleep, less is known about how men identify and respond to sleep problems. Including male voices not only allows the gendered dimension of 'sleep strategies' to be explored, it can also offer insight into the interplay between masculinities and health practices. According to Courtenay (2000, p. 1397), the resources available for constructing masculinities (in the West) are largely unhealthy with dominant men required to undertake socially masculinized, physically risky behaviours. Thus, it has been suggested that men see health as women's business and responsibility, men know little about their health, men tend to keep quiet about their health problems, and men tend to deny themselves the self-monitoring role manifest in healthicization (as doing health promotion is seen as 'female') (cf. Cameron & Bernardes, 1998). Within this paradigm, men are seen as unlikely to know much about sleep and considered less knowledgeable about health messages, and behavioural practices. Yet there are points of debate here. For example, Robertson (2003) notes that the historical suggestion that men do not take their health seriously can no longer be sustained (see also Williams, 2003, p. 60). Rather, men face a dilemma between showing they do not care about their health, and realising that they should care; as a result, caring for health has to be *legitimized* or explained in some way by men (Robertson, 2003). Indeed, in one of the few sociological explorations of men's sleep, Meadows, Arber, Venn, and Hislop (2008) showed how working age men's relationship with sleep was based on achieving a complex balance between masculine disregard for issues of health, and a need to function during the day. The men studied by Meadows et al. (2008) relied on their 'body' to be the informant of the need for sleep, while they made the decision as to how far sleep could be curtailed, without compromising their ability to accomplish the next day's activities.

Despite poor sleep being more common in later life, and the most common form of treatment for chronic sleep problems in older people being prescription hypnotic drugs (Ancoli-Israel, 2005; Dijk, Groeger, Stanley, & Deacon, 2010; Montgomery & Dennis, 2004; Whalley, 2001) there has been little sociological research on sleep among older men and women. It has also not always been clear whether those who are most likely to suffer everyday sleep disruption, such as older people, seek alternative options to prescribed sleeping medication and, if they do, what drives the options they choose. We therefore ask: i) do older men and women resist the medicalization of their sleep? ii) what