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Media constructions of sleep and sleep disorders: A study of UK national newspapers

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Abstract

Medicalisation, healthicisation and 'personal' strategies have been identified as the main factors contributing to the socially mediated experience of sleep and sleep disorders in modern societies. Medicalisation and healthicisation are publicly available discourses. But the degree to which apparently 'personal' strategies for managing sleep are presented in popular media has been underestimated. This study of the coverage of 5 UK newspapers shows that both medicalised and healthicised discourses are concentrated in the 'serious' press. The tabloid press is more likely to constitute sleep as a private realm and tabloid readers are therefore relatively less exposed to officially sanctioned forms of knowledge about sleep. Analysis of *Daily Mail* coverage shows, though, that women's 'personal' strategies for managing sleep are far from being private solutions. The *Mail* presents this topic as a component of its social construction of a 'Middle England' lifestyle, giving these apparently 'personal' solutions a political resonance.

Keywords: UK; Sleep; Sleep disorder; Medicalisation; Healthicisation; Mass media; Newspaper coverage

Introduction

A growing public interest in sleep and sleep disorders in recent years has been noted by a number of commentators (see Williams, 2005). The role of mass media in promoting 'new truth about sleepiness' has been pointed out by Kroll-Smith and Gunter (2005, p. 347). Elsewhere, Kroll-Smith (2003) has documented the role of the mass media and internet in the social construction of a new diagnostic category of 'excessive daytime sleepiness', suggesting that this has now been constituted as an important public health problem. Hitherto, though, studies of sleep and sleep disorder in the mass media have not differentiated publications targeted at different audience sectors. We therefore present an analysis of print media coverage which compares publications targeted at distinct subgroups of the UK population, focusing in particular on gender and class divisions. In pursuing this aim, our findings also help resolve a pressing theoretical issue that has

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divided sociologists of sleep, an account of which we now provide.

Social and cultural factors influencing the experience of sleep

Sociologists have identified three main factors which contribute to the socially mediated experience of sleep and sleep disorders in modern societies. The first two, medicalisation and healthicisation, are outlined by Williams (2002). They are culturally available discourses, providing explanatory frameworks and associated practices and techniques, which may influence or be used by individuals to understand and manage their sleep.

Medicalisation is influenced by the professional agenda of doctors and (increasingly according to Conrad (2005)) commercial interests such as pharmaceutical companies. Here disordered sleep and the general attempt to control sleep patterns is understood as a medical issue with scientific explanations and solutions. To some extent manufacturers of over-the-counter remedies and 'complementary' medicines participate in medicalising sleep, but some promoters of these have also been able to negotiate a somewhat 'alternative' identity and are therefore in an uneasy relationship with mainstream medical and pharmaceutical interests.

Healthicisation or 'surveillance medicine' (Armstrong, 1995) involves the perception that the maintenance of healthy or normal sleep patterns is an obligation of responsible citizenship. On the one hand this is part of reducing the risks to health and public safety when this is not done. On the other, it is an obligation to pursue a healthy, successful and well-adjusted life in a modern world that is increasingly unfriendly towards 'natural' sleep rhythms. Here, the expertise of psychologists and other non-medical advisers often come into play. A variety of sleep-promoting commercial products (e.g. special mattresses, scented pillows) are designed to assist the personal management (as opposed to medical management) of sleep patterns, as well as complementary and over-the-counter products which sleepers administer themselves.

A third area is described by Hislop and Arber (2003a) who label this a 'personalised' approach. This consists largely of strategies for managing sleep that are in part learned through childhood socialisation and the sharing of experience in informal social networks. Personalised strategies are also the responses of the individual to social structural constraints and additionally arising from an 'inner core' (2003a, p. 825) that is felt to lie at the centre of the self. In this personal arena, Hislop and Arber believe, medicalisation and healthicisation are often resisted or seen as irrelevant. Here, people deal with their sleep patterns in ways that are not consciously influenced by the previous two discourses, maintaining a possibly 'natural' relationship with sleep that is not particularly influenced by formally mediated systems of knowledge such as science, psychology or public health discourse. Hislop and Arber call this 'a core of self-directed personalised activity' which 'women…have always done' through such 'personal strategies' as 'taking hot baths, drinking cocoa [and] relocating to other rooms or beds' (2003a, p. 820)

Hislop and Arber are particularly interested in the position of women and claim, on the basis of focus groups involving middle-aged and older women, that medicalised, healthicised and personalised solutions to the management of sleep problems are generally interwoven in women's lives, with women opting for medicalised solutions or strategies informed by healthicisation only when the limits of personal strategies are reached. In choosing between these three kinds of response to sleep problems, women exercise 'self-responsibility' (2003a, p. 821) because 'ultimate responsibility for strategy choice rests with the individual' (2003a, p. 835). Additionally, choice of personalised strategies is felt to reflect women's belief that sleep is, or ought to be, a 'natural process' (2003a, p. 829).

Unlike medicalisation or healthicisation, which are widely promoted through mass media as well as through encounters in institutional and commercial settings, personalised strategies are seen by Hislop and Arber to arise from a mixture of individualised and informal sources. For example, the view that they are something that women have 'always done' (2003a, p. 820) suggests an historical source that is presumably passed down the generations. As well as arising from an 'inner core' (2003a, p. 825) they are communicated interpersonally, either between parent and child in the process of socialisation, or via women's informal family and friendship networks. No formal institutional mechanisms are identified as informing these personal strategies, nor do the authors mention any public arenas, such as mass media, in which knowledge of them is promoted.

Insofar as wider social factors play a role in generating personalised solutions, these are social structural: personalised strategies are women's