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.

Keywords: United Kingdom; sleep; ageing; medicalization; healthicization; ‘personalization’; sleeping medication; sleep remedies and OTC treatments.
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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 (Williams, 2002; Seale et al., 2007). 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 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’ (2004: 825). 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 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 et al. (2008: 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 (Williams et al., 2008; Harvard Medical School, 2007; National Sleep Foundation, 2011). 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 (National Health Service, 2011; National Sleep Foundation, 2011; British Broadcasting Organisation, 2011).

Kroll-Smith & Gunter (2005: 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; Conrad & Leiter, 2004; Williams et al., 2008; Busfield, 2010).

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 & 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: 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: 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 and colleagues 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 (Hislop & Arber, 2003; Meadows, 2005; Brunt & Steger 2008; Venn et al. 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 et al., 2011). However, most of this research has focused only on women, and has hitherto largely neglected older people. Hislop & Arber’s (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 & 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: 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: 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 et al. (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 (Dijk et al., 2010; Ancoli-Israel, 2005; 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 healthicization strategies do older men and women employ (or not) to reduce perceived sleep problems, and could these strategies be cast as ‘personalized”? and iii) why do older men and women differ in their approaches to sleep problems, and how are these differences situated within theoretical debates on medicalization, healthicization and ‘personalization’?

Following a description of the methods, the paper focuses particularly on gender differences among older people with poor sleep in relation to their approach to the use of prescribed medications, over the counter medications (OTC) and purposefully altering ‘lifestyle’/’behavioural’ factors to improve sleep; such as those reflecting ‘sleep hygiene’ practices, as in avoiding caffeine, alcohol and exercise in the evening.

**Methodology**
The data analyzed in this paper come from one 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 the community and the strategies they used to help with poor sleep.

Recruitment of participants and data collection was undertaken in two phases between August 2007 and July 2008. Phase 1 comprised sending 2400 self-completion questionnaires to a stratified representative sample of community dwelling older people in south-east England, equally divided by gender and age group (65-74 and 75+), through ten General Practice (GP) groups of family doctors. Practices were asked to exclude those with dementia or terminal illnesses and include only those who spoke English. A 52% response rate was obtained. The questionnaire contained two parts, the first was the modified Pittsburgh Sleep Quality Index, (PSQI, Buysse et al., 1989) which asks questions about quality, duration and fragmentation of sleep, taking of prescription medication for sleep and subjective assessment of sleep in the previous month. The PSQI yields a score ranging from 0 to 21, with a score of 6 and above being a clinical indicator of poor sleep. The second part contained questions about age, employment, health and marital status. From those who responded to Phase 1 by returning the questionnaire (n=1158) and indicating their willingness to take part in further studies, 31 men and 31 women were identified and invited to take part in Phase 2 of the study. Inclusion criteria included willingness to take part, and a score of 6 and above on the PSQI (a score indicating clinically defined poor sleep) This sub-sample was stratified by 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. All participants received an honorarium in compensation for their time, and confidentiality and anonymity were assured. Pseudonyms are used to protect
the anonymity of respondents, with their age indicated after quotations. Ethical approval was granted by the National Health Service Research Ethics Committee and the University of Surrey.

The interview focused on participants’ perceptions of their patterns of sleep, sleep quality and attitudes to sleep disturbance, as well as questions about strategies used to improve sleep, and any medications taken (prescribed or over the counter). All interviews were recorded and fully transcribed and the software package NVivo8 was used to support a thematic analysis approach (Miles & Huberman, 2002). Emerging themes were identified across all the interviews by reviewing respondents’ answers to questions pertaining to perceptions of current sleep, attitudes to taking sleeping medications and over the counter medications, and other behavioural approaches used to try and improve their sleep. Further questions probed where they obtained information about options for helping with poor sleep. In order to ensure data robustness, the transcript data were constantly checked for categories or themes which were not relevant or contradicted those already identified. Finally, selective coding revealed the main concepts within the data. A sub-sample of the interviews was also read by a Senior Researcher from the Healthtalkonline group at University of Oxford to check for coding errors or omissions.

Older men and women’s resistance to the medicalization of sleep

Among these older interviewees, who all had sleep that would be considered poor by clinical standards, gender was not an influencing factor in decisions concerning taking prescribed sleeping medications for poor sleep (Table 1). There was no gender difference in the minority who previously took, or were currently using sleeping medications (10 men out of
31, and 11 women out of 31), or in those who had never taken prescribed sleeping medication (21 men out of 31, and 20 women out of 31).

The reasons given by the two-thirds who had never visited a doctor about their poor sleep were based on their perceptions and experiences of taking prescribed medication, and the role of their doctors in prescribing such medication (Venn & Arber, 2012; Henry et al., forthcoming). Men and women who had previously taken prescribed sleeping medication reported experiencing side effects of drowsiness the next day and were concerned that taking prescription sleeping medications would prevent them doing all they wished to do. There was also a belief, even amongst those who had never taken sleeping medication, that they would become addicted and reliant on sleeping tablets. Such reliance was regarded as morally inappropriate and implied a weakness of character:

I wouldn’t want to take it [sleeping medication] regularly. Because I think you become addicted to them. You’d have to take more, whether that's right or not.

(Anita, 71 years old)

Respondents would also not visit their doctor for help or advice about poor sleep as they held a belief that they would only be prescribed sleeping medication, which for the same reasons as a fear of addiction, and side effects of drowsiness during the day, was seen as something to be avoided:
I don’t really approve of chemicals in the body. But then that’s because of my experience over the years in seeing friends of mine who are drug addicts actually. And I think, if I went, if I had to go to the doctor about my sleep, he’d probably turn round and give me a sleeping pill. Which I don’t like the idea [of]. (Sandra, 71 years old)

I did once take … was it a sleeping pill from the doctor many years ago, it is a possibility? I can’t remember why. And I woke up feeling so groggy, I said never again. I can’t remember what it was. No, I don’t like being out of control. (Emma, 67 years old)

As Williams (2000) notes in his discussion of biographical disruption and chronic illness, age may mediate between the experiences and responses to (chronic) illness. With respect to older individuals, chronic illness may be biographically anticipated and considered part of the ‘normal chaos’ (Beck & Beck-Gernsheim, 1995) of everyday life. This was echoed within the present study, with the older men and women believing that a decline in sleep quality was inevitable in later life, and was to be expected as part of the ‘normal’ ageing process. As a consequence, they were not necessarily looking for their sleep problem to be diagnosed within a medicalized paradigm at the level of the doctor-patient relationship:

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 [at night], sitting outside for a little while and coming back up again. (Adam, 68 years old)
In the face of increasing health problems, such as heart conditions, diabetes and arthritis, all of which require medical treatment, older men and women believed that poor sleep *per se* was not related to poor health. However, while both men and women prioritized the ‘body’ within discussions of sleep, women were more likely to also situate sleep alongside more abstract notions of ‘health’, ‘diet and eating well’. Drawing on her biography, Deborah explains how sleep and diet are, for her, intrinsically linked, and fall within the realms of personal and moral responsibility:

> I do think it’s [sleep] important because otherwise you are not going to get your body rejuvenated at all. It is like a proper diet isn’t it and things. And you need your good food. I think that it goes back again to how you were ever brought up. You had to have a good dinner every day. And you had to be in bed on time and sleep until your Mother told you had got to get up. And it was kind of that obedience that you grew up with. And it follows on really through your whole life. (Deborah, 73 years old)

Similarly, Jenny believes that good sleep is an important aspect of health:

> Ah [sleep is] terribly important. It goes alongside eating properly and exercising. You know, eating properly isn’t it, having exercise and sleeping are the three main things to keep you going to keep you functioning. To keep you healthy. (Jenny, 69 years old)

Men, on the other hand, would not seek help in the form of prescribed sleeping medications, and rarely considered alternative remedies or strategies. This was not only because of their perception that poor sleep was not an illness and unconnected with health, but also because
their conception of sleep was embedded within mechanical notions of the body and function. Men gauged their sleep needs largely by how they felt and were able to function the following day and were more likely to believe sleep was important only if lack of it interfered with their ability to remain active during the day:

Well it [sleep] is not that important to me, as long as it is not going to drag me down. (Doug, 67 years old).

Synonymous with this is that some of the men’s descriptions of sleep-related behaviours appeared tantamount to risk-taking behaviour.

I’ll drink tea and I’ll drink just about anything at any time of the day or night. In a normal evening, I would have probably a couple of pints of beer and occasionally, if I don’t go to the pub, well if I don’t go to pubs, I go to the bowls club, I might have a scotch out of the cabinet here, or a bottle of wine with an evening meal. And I would finish that off with a drop of whiskey or something. I suppose you could say careless sleeping! (Eric, 70 years old)

The emphasis on function and the descriptions of ‘risky’ ‘unhealthy’ behaviours, resonates with Meadows et al.’s (2008) study of working age men. While these notions would suggest that sleep could be positioned within paradigms which propose that men use unhealthy behaviour to define themselves as men (cf. Courtenay 2000), it is rather that men are embroiled within a function/non-function balancing act whereby sleep is necessary in order to fulfil gendered roles of father or husband, but could also prevent their enactment of these
roles (Meadows et al., 2008). This point is illustrated by Harry, who bases his requirements for sleep on his ability to function the following day:

Because I am not used to a good night's sleep, I can cope with not having much sleep. I can go through a night with not having sleep and I can still function okay the next day. (Harry, 65 years old)

In addressing our first question then, that is did these older men and women resist the medicalization of their sleep, the answer is yes, at the interactional level of the doctor-patient relationship, yet with the caveat that this resistance was also influenced by normative perceptions of ageing and sleep, and by gender. Poor sleep was not regarded generally as a medical issue, and more specifically not one for the medical profession to deal with, and was only tenuously linked to health for women, and for men not at all.

We turn now to addressing questions ii) and iii), by exploring the influence of gender on the strategies used to resolve perceived sleep problems which are enmeshed within issues of healthicization and ‘personalization’.

**Gendered Approaches to the Healthicization and ‘Personalization’ of sleep**

While older men and women shared similar concerns and perceptions of prescription sleep medication use, stark differences appear in men and women’s use of over the counter (OTC) and ‘behavioural practices’ with women much more likely to try OTC remedies (19/31) or adopt behavioural practices (26/31) than men (5/31, and 7/31 respectively), (see Table 1). Echoing Hislop & Arber’s (2003) study of mid and later life women (2003), women in particular explored a range of practices to try to help them ameliorate the effects of disturbed
sleep and in so doing were adopting a healthist approach to the management of their sleep problems.

Women tried a variety of OTC remedies, including sleep aids (e.g. Nytol), and their herbal counterparts, as well as antihistamines and painkillers. In common with many of the women, Susan tried a range of potential solutions before she found that antihistamines worked for her:

> I have tried Nytol. I have tried the herbs. I have tried various things I think like that. But they made me feel a bit funny. The only thing I really like are the antihistamines.

*Interviewer:* So how long have you been taking antihistamines?

*Susan,* 72 years old

> Quite a long time, I should think about fifteen years on and off.

Antihistamines and other over the counter remedies, such as Nytol and their herbal counterparts, were not only taken on a regular basis by women, but also taken strategically after periods of very poor sleep, to relieve extreme fatigue and to re-establish a better sleeping pattern:

> I take a herbal sleeping pill, one of the Nytols and I take one about every eight or nine days and that gives me a good sleep for that night and may be eight hours even....

*Interviewer:* That is interesting, so you’ll take that every eight or nine days.

*Yes.*

*Interviewer:* What prompts you to take it [Nytol]?

*Deborah,* 73 years old

> Well, because I suppose I am thinking “If I don’t get a good night’s sleep soon, I am just going to explode with everything around me”.

(*Susan,* 72 years old)
Similarly, while both men and women were aware of the adverse effects of drinking caffeinated drinks and alcohol before bedtime, and eating or exercising late in the evening on achieving a good night’s sleep, women were more likely than men to make changes to their ‘lifestyle’ or try ‘behavioural’ methods to induce sleep; such as changing their eating or drinking habits, altering their pillows and bedding, playing soft music and undertaking relaxation techniques. In addition to avoiding coffee and tea late in the evening, Shirley drew on her knowledge of relaxation techniques to help herself physically relax:

> I deliberately relax all my limbs in the way that I used to when I went to ‘keep fit’, you know, thinking [about] each bit in turn and telling it to relax. That’s probably the one that works best. And I don’t want you to get the wrong impression, if I say this, but if I tell myself the Lord’s prayer I get sleepy. (Shirley, 72 years old)

Jenny, who has in the past tried sleeping tablets, and has more recently tried Kalms, herbal Nytol and lavender oil, has also tried changing a range of personal behaviours to cope with her disturbed sleep, including giving up those things she really enjoys:

> Oh I try to have a very healthy diet. Well we both do, yes. I like cooking so we eat, hopefully we eat properly and we have our vegetables and all of that. And yes, I think so, I think sometimes if you go out for a meal and it’s a heavy meal, then I don’t sleep. Too much wine, I don’t sleep. Coffee late at night, I don’t sleep. So I’ve stopped drinking coffee in the evenings now, because I’m a coffee addict. (Jenny, 69 years old)
These elaborate and ‘creative’ strategies employed by the women can be situated alongside discussions with men, such as Tony:

Because, as I said, I always feel that, if I really need that sleep, if I am so tired, I would just go to sleep. And if I don’t go to sleep, then I just assume, I don’t need it. It is as simple as that. (Tony, 76 years old)

The men and women in this study drew on, or were exposed to, different spheres of influence that affected how or indeed if, they chose to seek solutions to their poor sleep. The women were much more likely than the men to explain that their knowledge about sleep and solutions for poor sleep emanated from the media, their family or friends as well as their own experiences. They had a greater knowledge about the options available for poor sleep, and often drew on a range of discourses about aids to sleep, adapting them to their own circumstances:

I take Veganin… we have taken it for years. My husband’s mother was a pharmacist and she had always recommended it as the thing to take if you have got a cold or a whatever, or headache or … so I have been taking them, you know. You see the adverts on the television for Nytol or something. (Josephine, 72 years old)

I have tried Melatonin too, because melatonin is something, if you travel a lot, is supposed to be helpful. You can only get it in America. Our Australian relations gave me some. I had a lavender pillow somebody gave me once, and I don’t know if it made much difference. I think pillows do make a lot of difference actually. Certainly
I have now managed to get a pillow, a German pillow, which is much softer, which my neck gets into better and that is more comfortable. (Susan, 72 years old)

These quotations do suggest that these older women have indeed ‘personalized’ their strategies for poor sleep in so much as they have ‘cherry-picked’ what works for them to create a ‘personalized’ toolkit of remedies and behaviours. Yet it is also important to point out that this toolkit is created from a compilation of a range of resources such as friends, pharmacies, self-help websites and discourses available in the popular press and other media resources. These are indeed ‘personalized’ strategies, but only in so far as they are drawn from a paradigm of healthicization informed by a variety of sources.

In contrast, men explained how they felt sleep was ‘natural’, would happen eventually, and that any interference with sleep through taking OTC sleeping aids or prescribed medication, was ‘unnatural’:

No, I just think it is the body taking over and it is a natural thing. (Timothy, 70 years old)

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 old)
While the body was relied upon to indicate when sleep was needed, there was also a belief amongst men that poor sleep could be improved through the mind, by adopting a positive approach or attitude:

I think it [poor sleep] is something I have got to work out for myself. I mean it’s all in the head, isn’t it really. I think anyway. It is just a case of getting myself sorted out, stop worrying about so many things. I do tend to worry an awful lot. (Adrian, 80 years old)

The men’s limited description of what they saw as influencing their sleep is not to suggest the absence of spheres of influence, but rather that they differ from women’s. As discussed earlier, men’s discourses stress the primacy of pragmatic functioning, personal responsibility, and being ‘their own worst enemy’. This, in turn, may be a reflection of how wider discourses become embedded differentially within men and women’s lives.

Just as older men and women drew on different spheres of influence to explain and manage their poor sleep, so too did they differ in their rationales for adopting strategies to improve their sleep, even when the strategies were the same.

**Blurring the boundaries: medicalization, healthicization, and ‘personalization’**

In this paper we have suggested that older men and women resist the medicalization of their sleep, and that women are much more likely than men to respond to a healthist approach to ameliorating poor sleep. However, there is one area where medicalization, healthicization, and ‘personalization’ blur, but in different ways according to gender, and that is in the use of painkillers as sleep aids, as they were known to induce drowsiness in addition to alleviating
Painkillers only available on prescription, such as Co-proxamol, and other painkillers which were also available over the counter, such as Syndol and Solpadol, were frequently prescribed by GPs for common chronic conditions such as osteoarthritis or rheumatoid arthritis. As also shown in Sale et al.’s (2006) study of older patients with osteoarthritis, painkillers were often used contrary to medical advice, by varying the dosage and the timing. Angela’s contention that she overtly takes nothing for her sleep is contradicted by her acknowledgement that she takes Co-proxamol to get to sleep:

No, I don’t take anything for sleeping. I just feel I am on enough anyway. If I do have a bad spell [of sleep], I will take a couple of Co-proxamol [to get to sleep] on top of everything else, and that always seems to do the trick, and in fact I am a bit naughty really. You are only supposed to take two at a time, four times a day, and I have found that if I actually take three, I don’t need the other five! (Angela, 69 years old)

Men also took painkillers as an aid to sleep, even though they denied taking any over the counter remedies specifically for sleep problems. Not only were prescribed painkillers, or those obtained over the counter, regarded as an acceptable aid for poor sleep, but some men also took their partners’ prescribed painkillers:

*Interviewer:* So have you ever gone to the chemist and said ‘Can you give me something for my sleep?’ Or taken anything like herbal tablets or lavender, any of those kind of things?
No, I haven’t. 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.

*Interviewer:* So you take those as a kind of sleeping pill?

Yes. Unofficially, yes. ... They are painkillers but they sort of relax you and you sleep like a log, you know. (Joe, 78 years old).

At the root of this perception by men that painkillers were acceptable for sleep problems, while other over the counter medications for sleep were not, is their belief that prescribed medication usage is primarily the responsibility of the medical profession, especially for those with complex health problems. Barry, for example, reflects that he would go to his doctor for medications but not to a chemist: ‘I wouldn’t [go to a chemist] because I’m on a certain level of medication, I’m on Warfarin and also I’m on other tablets as well for my heart and that, No I’d go to a GP’. Yet, as mentioned earlier, he would not go to the doctor for prescribed ‘sleeping’ medication for poor sleep: ‘I don’t think I would. I think we would sort of say well, that’s life we had better get on with it’ (76 years old).

Further to this, and illustrating resistance to medicalization, poor sleep was not seen as a matter for any health professional by men, including the pharmacist, so that while men may ask a pharmacist for advice about prescribed medication, they would not consult them for advice about sleep problems. Ray, for example, takes Warfarin for a heart problem, and an antidepressant, and trusts the chemist to manage any possible problems arising from polypharmacy, yet would not consult him for advice on sleep:
Interviewer: Have you ever gone to the pharmacy and said “Is there anything you can give me for sleep?”

No.... at the pharmacy we have got a splendid man and I would check out that, that which had been given to us [by his GP], didn’t conflict with what we had before, or in as much as I am taking Warfarin now.

Interviewer: But you wouldn’t take anything like that for sleep from them?

No, no, no. (Ray, 76 years old)

Therefore, while taking prescription sleeping medication was not seen as a ‘legitimate’ strategy by men and women because of their implication that sleeping pills are morally inappropriate and indicate a lack of self-control, taking painkillers was acceptable for women as part of their willingness to try a range of options for poor sleep, and for men because they were not seen as exclusively for sleep problems. In so doing, these older men and women are blurring the boundaries between medicalization, healthicization and ‘personalization’

Discussion and conclusions

We are said to live in a society dominated by the paradigms of medicalization and healthicization, in which we are all expected to assume the role of ‘informed patient’ or ‘consumer’ (Cant & Calnan, 1992; Lupton, 1997), and to ‘self-examine’ and apply a clinical frame of reference to our bodies (Hughes, 2000: 25). However, in fulfilling this expectation, the frame of reference through which our bodies are known to us is personal and subjective (Hughes, 2000); and ‘persons with comparable symptoms and limitations display extraordinary variation in how they perceive their health status, use medical care, and function in their social roles and in work’ (Mechanic, 1995: 1210-1211).
With this in mind, our paper has drawn on data from 62 older men and women whose sleep would be considered poor by clinical standards, and which might therefore be susceptible to medicalization. However, neither men nor women perceived a link between poor sleep and health problems, which may be associated with an ‘ordering’ of health problems, in that compared to chronic heart disease or diabetes, sleep was considered a ‘minor irritation’. Poor sleep was also perceived of as an inevitable accompaniment to later life and was to be expected as part of the ‘normal’ ageing process. On that basis, sleep problems were not conceived of as an illness and the medicalization of sleep within the interaction of the doctor-patient relationship was resisted by older men and women.

With that said, there was a clear distinction in the use of OTC medications and ‘behavioural’ practices. Older men and women engaged differently with issues of the healthicization and ‘personalization’ of sleep. Women did situate ‘sleep’ alongside more abstract discussions of ‘diet’ and health behaviours and drew on the discourses of the media, friends and family and their own experiences; whereas men solely relied on the ‘body’ to indicate when sleep was needed. In coping with poor sleep women were much more likely than men to experiment with self-help behavioural practices, and over the counter remedies and treatments to facilitate a good night’s sleep, illustrating ‘personalized’ strategies, within a framework of healthicization.

There is now an extant literature on help-seeking behaviour and gender. Despite extensive empirical evidence to suggest that men and women do travel through illness trajectories differentially, in recent years this literature has warned against viewing gender as a determining factor (Emslie et al., 1999; Macintyre et al., 1999). Galdas et al. (2005) also argue that gender comparative studies are unsuitable for formulating hypothesis regarding
men’s health. However, what is clear from the present study is that there are distinct differences in the widespread, repeated forms of practice (Hearn 2004) of men and women regarding sleep.

Findings from the present study also add to debates surrounding the ‘personalized’ strategies used to alleviate sleep problems. Hislop & Arber (2003) studied only women and set their argument against a backdrop of medicalization/healthicization. The prescription of sleeping pills, they argued ‘remains as an indicator of the medicalization of sleep, while the trend towards the healthicization of sleep as part of healthy lifestyle practice is reflected in the increased focus of the media, pharmaceutical and complementary health care industries on sleep’ (Hislop & Arber, 2003: 815). They argued that neither the medicalization nor the healthicization framework accurately encapsulates how women manage sleep and ignores the ‘hidden dimension of self-directed personalized activity’ (2003: 815).

While the present study would support many of Hislop & Arber’s arguments it also highlights the importance of asking ‘how personalized’ are these ‘personalized’ strategies (Williams, 2004). The older women within the present study did make reference to magazines, newspapers and friends as sources of knowledge. This would support Seale et al.’s (2007) contention that, within late modern societies, the distinction between medicalization, healthicization and the personalized is not necessarily obvious. This is further illustrated in this paper by the blurring of these three domains in terms of specific treatments or remedies, such as the manipulation of prescribed painkillers as an aid for sleep by both men and women.
Finally, we would highlight that there is a need to continue to include men within sociological studies of sleep and to explore more fully differences between and amongst men, such as in the intersection between age, ageing and masculinities. Findings from the present study support research which suggests that men are able to discuss sleep in terms of ‘risk’ and ‘reflexivity’ as they frame sleep as residing in a body that will ‘inform them’ if something goes wrong, and will ultimately ‘catch up’ and ‘fix’ any problem (Meadows et al., 2008). Findings also reflect Robertson’s (2006: 8) suggestion that how men achieve ‘health’ is “integrated into everyday life rather than being a distinct and defined activity”. Because of this, these practices are often not contextualised as being about ‘health’. Yet, as Williams (2008: 647) suggests, "masculinities . . . are multiple and contested (cf. Connell and Messerschmidt, 2005). Much remains to be done, therefore, to tease out these complex relations between the doing of sleeping and the doing of gender, particularly with regard to men and masculinities".
References


Table 1: Gender differences in use of prescription sleeping medication, over the counter remedies (OTC) and behavioural practices by older people with poor sleep

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<th>Behavioural Strategies</th>
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