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Disturbing sleep and sleepfulness during recovery from substance dependence in residential rehabilitation settings.

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Subject Area:	Rrecovery < RESEARCH AREAS, Sleep < RESEARCH AREAS, Drug use/substance abuse < RESEARCH AREAS
Abstract:	<p>There is evidence that poor sleep mitigates recovery from substance dependence and increases risk of relapse. However, to date research literature is located within biomedical, clinical and psychological paradigms. To complement the extant work, this article offers a sociological exploration of sleep in the context of recovery from dependence on alcohol and/or other drugs. Drawing on qualitative data generated through interviews with 28 men and women living in residential rehabilitation settings in England, we provide a detailed exploration of sleep practices focussing on how these are enacted throughout the night. We offer the concept of 'sleepfulness' to suggest that sleep should not be understood simply as being other than awake; rather it involves a myriad of associations between diverse actants - human and non human - that come to 'fill up', enable and assemble sleep. Together these empirical insights and conceptualisations disturb the ontology of sleep and point to the fulsome dimensions of the category.</p>



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3 **DISTURBING SLEEP AND SLEEPFULNESS DURING RECOVERY FROM**
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5 **SUBSTANCE DEPENDENCE IN RESIDENTIAL REHABILITATION SETTINGS**
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22 **ABSTRACT**
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24 There is evidence that poor sleep mitigates recovery from substance dependence
25 and increases risk of relapse. However, to date research literature is located
26 within biomedical, clinical and psychological paradigms. To complement the
27 extant work, this article offers a sociological exploration of sleep in the context of
28 recovery from dependence on alcohol and/or other drugs. Drawing on
29 qualitative data generated through interviews with 28 men and women living in
30 residential rehabilitation settings in England, we provide a detailed exploration
31 of sleep practices focussing on how these are enacted throughout the night. We
32 offer the concept of *sleepfulness* to suggest that sleep should not be understood
33 simply as being other than awake; rather it involves a myriad of associations
34 between diverse actants - human and non human - that come to 'fill up', enable
35 and assemble sleep. Together these empirical insights and conceptualisations
36 disturb the ontology of sleep and point to the fulsome dimensions of the
37 category.
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3 **Keywords:** Recovery, Sleep, Drug use/substance abuse
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7 **INTRODUCTION**

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10 This article offers an empirical exploration of sleep practices as enacted in
11 residential drug and alcohol rehabilitation services. There is a growing
12 biomedical research literature on sleep, substance use, and recovery, which finds
13 sleep quality to be associated with relapse and recovery (Arendt et al. 2007;
14 Brower 2003, 2015; Roehrs and Roth 2008, 2012; Roth 2009). Recent
15 interventions to improve sleep in the context of recovery rely on forms of
16 cognitive behavioural therapy, although these have had limited success (Arnedt
17 et al. 2011; Smith et al. 2014). The aspiration of this paper however is not so
18 instrumental; rather we seek to provide a theoretically informed empirical
19 description of how sleep is practised in residential rehabilitation settings for
20 substance dependence. How do men and women in these environments perform
21 and enact sleep? What are they doing when they sleep? How, and to what extent,
22 are actants recruited to enable sleep? Indeed, what is sleep? These questions are
23 consistent with theoretical approaches inspired by synergies between science
24 and technology studies (STS) and medical sociology (Mol 2002). In particular,
25 what Sismondo (2015) refers to as the 'ontological turn', and Fox (2016) as a
26 'turn to matter'; that is, approaches which seek to explore the materiality of
27 bodies as they engage with other material and cultural relations. Rather than
28 presuming an *a priori* knowledge of things, such as 'the body' (Harris and Robb
29 2012), 'disease' (Mol 2002), 'addiction' (Fraser et al. 2014), or indeed 'sleep'
30 (Hsu 2015), this approach seeks to explore how these objects unfold in situated
31 spaces and contexts.
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5 We begin with a brief review of the relevant literature on the sociology of sleep,
6
7 move on to outline our theoretical, or perhaps more accurately, our
8
9 epistemological approach, which in turn informs the analysis of our empirical
10
11 data. To paraphrase Mol (2002), who writes about 'the body multiple', we might
12
13 think of 'the sleep multiple': an uncertain, provisional set of activities variously
14
15 connected yet recognized as sleep. Building on this, through the analysis of our
16
17 data, we develop the notion of *sleepfulness*. *Sleepfulness* implies that sleep can be
18
19 understood as an assemblage of associations of human and non-human actants
20
21 that 'fill' and enable sleep. By positioning our data in this analytical framing we
22
23 seek to extend sociological conceptualisations of, and debates within, the
24
25 sociology of sleep to which we now turn.
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32 **SOCIOLOGY OF SLEEP**

33
34 Williams (2005) highlights how the analysis of sleep and society operates on at
35
36 least three interrelated levels, with the broadest of these levels –
37
38 societal/institutional – focusing on the ways in which sleep is socially patterned
39
40 and organised. Schwartz (1970), for example, highlights how sleep is brought
41
42 under institutional control through scheduler integration and a supplementary
43
44 body of rights and obligations that surround the sleeper. As Melbin (1978)
45
46 notes, though, the night may no longer be the scheduler integration *par*
47
48 *excellence* and there is gain in considering the night as a 'frontier'. This concept,
49
50 which we return to below, 'gives coherence to a wide range of events: the kind of
51
52 people up and about at those hours, why they differ from daytimers in their
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3 behavior, the beginnings of political efforts by night people, the slow realization
4 among leaders that public policy might be applied to the time resource' (p.19).
5
6 Sociological work at the 'individual/(non)experiential level' highlights how sleep
7
8 is a liminal state which exists somewhere between consciousness and
9
10 unconsciousness, the biological and the social, the universal and the specific
11
12 (Williams 2005: 4-5). In this vein, others have explored how embodied
13
14 biographies of drug use, and the recalcitrant bodies of users, can mitigate the
15
16 cultivation of sleep understood as a 'body technique' (Nettleton et al. 2011). The
17
18 attention to body techniques begins to point to the limits of human intentionality
19
20 and the voluntary agency of sleep (Williams and Crossley 2008).
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28 Overwhelmingly, empirical analysis of sleep and society has focused on the
29
30 'social/interaction' level and the 'meanings, methods, motives and management
31
32 of sleep or sleeping in everyday/every night life' (Williams 2005: 1). In one of
33
34 the first empirical studies of sleep and society, Hislop and Arber (2003) offer the
35
36 notion of 'personalised sleep strategies' to capture the ways in which individuals
37
38 work at achieving sleep within given physical and social environments. Further
39
40 studies of couples (Meadows 2005), co-sleeping parents and children (Welles-
41
42 Nystrom 2005), carers of elderly relatives (Bianchera and Arber 2007) and
43
44 women in mid-life (Hislop and Arber 2003) all further demonstrate the socially
45
46 negotiated processes associated with sleep.
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53 Our own approach critically engages with and extends this existing work, in
54
55 particular we avoid privileging individual human agency, suggesting instead an
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57 analysis of a confluence of sleep practices that includes actants, which have
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3 scope for both intentional and unintentional agency (Hsu 2015). Although socio-
4
5 materialities have been largely absent from the existing literature, Moran-Ellis
6
7 and Venn (2007) neatly capture the diversity of human and non-human
8
9 materialities that enables children's sleep through their attachments to, for
10
11 instance: toys, pets, thumbs, as well as their anxieties, dreams and nightmares.
12
13 While we also emphasise socio-materialities, our approach is epistemologically
14
15 distinct from these existing sociological studies. The extant literature has
16
17 developed theories on sleep that centre on interpretations and meanings, and
18
19 the extent to which individual actors 'work' at and 'negotiate' their sleep.
20
21 Instead, we do not presume an *a priori* knowledge of sleep that is variously
22
23 interpreted and socially constructed, but rather take an ontological approach to
24
25 consider how sleep is 'enacted', 'assembled' and comes to 'hang together' (Mol
26
27 2002: vii).
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35 **TURNING TO NEW MATERIALISMS AND TROUBLING ONTOLOGIES**

36
37 Conceptual developments labelled by some scholars as the 'new materialisms'
38
39 (Fox 2016) have been usefully deployed for the study of drug addiction (Duff
40
41 2011; Fraser et al. 2014) and more recently 'non-human sleep' (Hsu 2015).
42
43 While others talk of an 'ontological turn' (Sismondo 2015: 441), what unites
44
45 these approaches is an ontological approach that presumes objects, such as the
46
47 body, disease, or addiction, are not variously socially constructed through the
48
49 lens of contrasting perspectives, but are instead understood as things that are
50
51 brought in to being and sustained through day-to-day socio-material practices
52
53 (Mol and Law 2004; Mol 2010; Duff 2013). As Mol (2002) explains:
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3 'If practices are foregrounded there is no longer a single passive object in
4
5 the middle waiting to be seen from the point of view of a seemingly
6
7 endless series of perspectives. Instead, objects come into being – and
8
9 disappear – with the practices in which they are manipulated. And since
10
11 the object of manipulation tends to differ from one practice to another,
12
13 reality multiplies' (p.5).
14
15

16
17 Following this approach, we are less interested in the meanings that individuals
18
19 invest in, or their proactive management of, sleep than the relational forces that
20
21 sustain it. Like a disease, or a body, sleep is not insulated from other related
22
23 practices, but it comes to stabilize as a recognizable 'thing' that is made up of a
24
25 'complex configuration' of things (e.g. discourses, practices, and objects) that
26
27 always harbour a degree of fragility (Mol and Law 2004: 57). From this position,
28
29 sleep may comprise, 'a coexistence of multiple entities with the same name' (Mol
30
31 2002: 151); like the body it therefore 'hangs together' although 'not easily' (Mol
32
33 and Law 2004: 57). To use the lexicon of science and technology studies (STS),
34
35 sleep can be understood as an 'assemblage' (Mol 2002: 150; Fox 2016). The
36
37 sociologist's task then takes the form of an exploration of those things recruited
38
39 to this configuration in order to examine, 'how ontologies of the body really work
40
41 "on the ground"' (Harris and Robb 2012: 669).
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49 In summary, STS inspired materialist approaches seek to query the ontological
50
51 status of objects such as, 'disease', 'illness', 'health', and 'sleep', suggesting they
52
53 can be empirically explored to describe the fragile configurations of material
54
55 things that come to settle in a recognisable form. But their configuration will in
56
57 turn vary depending on 'the contexts in which people find themselves' (Harris
58
59
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1
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3 and Robb 2012: 672). Explorations of ontologies on the ground, what Mol calls
4
5 'praxiographies' (2002:2), involve description of the ways objects are assembled
6
7 'within a wider network of social, material, and affective forces' (Duff 2013: 167).
8
9
10 Fox, for example, writes about a 'health assemblage', an 'eating-assemblage' and
11
12 an 'ill-health assemblage' (2011, 2016). A 'sleep assemblage', we can anticipate,
13
14 will be fashioned through various psychological, physical, and social relations
15
16 which, in the context of drug and alcohol treatment and recovery, can include
17
18 structured routines, therapies and psycho-social interventions. These make up,
19
20 and can extend our thinking on, what Moran Ellis and Venn (2007) call the
21
22 'arenas of night worlds'. Before we go on to describe these actants that enact
23
24 sleep in more detail, we first provide some information about our empirical
25
26 study.
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32 **STUDY DESIGN**

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35 Empirical data reported on in this paper were generated as part of a study of
36
37 sleep in two residential drug and alcohol rehabilitation services in England in
38
39 2014-2015. Centre One was located in a rural setting, and Centre Two in an
40
41 urban environment. In the former there were both men and women, in the latter
42
43 only women. Centre One provided predominantly 'primary' treatment. This
44
45 lasted between four and six weeks and involved supervised detoxification (as
46
47 needed), a treatment programme comprising group therapy, one-to-one
48
49 counseling, creative workshops and lectures (on art, writing etc),
50
51 complementary therapies such as yoga, and a requirement to participate in
52
53 household duties. Total abstinence was demanded, although smoking tobacco
54
55 was permitted. Days and nights were highly structured, with regular times for
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3 waking, meals, classes, bed, sleep and so on. Each day began with a collective
4
5 meeting and a 'thought for the day' and, when residents left, after successfully
6
7 completing their treatment, there was a formal gathering and small ceremony as
8
9 acknowledgement of their achievements. Centre Two provided 'secondary'
10
11 treatment where the aim was to build confidence and life skills. The programme
12
13 was less rigid. Residents collaboratively participated in daily activities such as;
14
15 shopping, cooking, eating, and budgeting. As their recovery progressed, residents
16
17 were able to come and go from the service and were permitted to have overnight
18
19 stays at home. Bedtime rules were more flexible than in Centre One, although
20
21 there was still a requirement that residents be in bed at night and up during the
22
23 day. In both centres all residents shared bedrooms.
24
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30 Ethical approval for the study was secured from Universities of York and Surrey.
31
32 The authors visited the centres to have informal discussions with staff about the
33
34 treatment programmes and house rules, complete a tour of the facilities, present
35
36 the research to staff and residents, and recruit residents who were willing to
37
38 participate. Participation in the study involved a qualitative face-to-face
39
40 interview, wearing an actiwatch, and completing a written sleep diary for two
41
42 weeks. An actiwatch is a small, wrist worn device which measures movement on
43
44 a minute-by-minute basis and has been used widely within clinical sleep
45
46 research as a proxy measure of sleep (Martin and Hakim 2011). After wearing
47
48 the watch and keeping a sleep diary for two weeks, individuals participated in
49
50 the face-to-face interview. Data from the actiwatch were downloaded via a
51
52 notebook computer and presented to participants in the form of a graph towards
53
54 the end of the interview. At that point, participants were invited to reflect on the
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3 actigraph results. These multiple forms of data enabled us to examine how
4
5 participants' accounts aligned with what are regarded as technical measures of
6
7 'being asleep', thus generating a richer understanding of the way sleep is
8
9 sustained and the extent to which it is *sleepful*. In this way we 'side stepped' an *a*
10
11 *priori* ontology sleep.
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16 Thirty-seven participants were initially recruited across the two sites. Of these,
17
18 28 were interviewed, 25 returned actigraphy data and 19 completed diaries. Of
19
20 the 28 people interviewed, 19 were women and 9 were men, with the youngest
21
22 aged 24 and the oldest 83 years, most were white British. There was greater
23
24 diversity in terms of participants' age, socio-economic and educational
25
26 backgrounds in Centre One. Seven of all those interviewed had been educated to
27
28 degree level, and a some were in professional occupations, although most had
29
30 left school at 16 years, some with few, if any, qualifications. All had previously
31
32 received support from either residential and/or community services for their
33
34 addiction. Interviews explored participants' biographies, substance use, personal
35
36 experiences of addiction treatments and accounts of sleep throughout their life
37
38 course, although particular attention was given to their sleep during the two
39
40 weeks prior to the interview when most had been wearing the actiwatch and
41
42 completing the diary.
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50 All interviews were carried out in the centres by two of the authors (RM and SN)
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52 of this paper, with the exception of three that were undertaken by a sociologist
53
54 experienced in sleep research. All interviews were audio recorded and
55
56 transcribed, and names of all participants have been changed for anonymity.
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3 Participant identifiers (001-028) were used to link the interview, diary and
4
5 actigraphy data and 'S1' and 'S2' are used to indicate whether interviews took
6
7 place in Centre One or Two respectively.
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12 Our analytic approach treated the data as accounts that provided clues as to how
13
14 sleep practices are done on the ground, and how they are sustained in relation to
15
16 activities and accoutrements (Harris and Robb 2012). Just as Mol's (2002)
17
18 interviews with patients living with atherosclerosis conveyed, 'a lot about legs,
19
20 shopping trolleys, or staircases' (15), our data, as we shall see, convey a lot about
21
22 - amongst other things - beds, drinks, radios, clocks, cigarettes, sweets and baths.
23
24 Although our participants reported that they were not using alcohol or other
25
26 non-prescribed drugs at the point of interview, their embodied biographies of
27
28 dependence permeate their sleep. It is to how men and women 'do' (cf Mol and
29
30 Law 2004: 45) sleep in drug and alcohol residential rehabilitation settings that
31
32 we now turn.
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39 **DOING SLEEP IN RESIDENTIAL TREATMENT**

40 *Sleepful nights: (de)stabilising sleep*

41
42 Echoing previous sociological studies of sleep and recovery from substance
43
44 dependence (Neale et al. 2012; Nettleton et al. 2011), the participants reported
45
46 how their sleep improved after entering residential treatment, and sometimes in
47
48 ways that they had not anticipated. Orla (013:S2), who was interviewed in
49
50 Centre Two and had previously been at Centre One, recalls how she 'was shocked
51
52 that I slept' on her first few nights in residential treatment: 'I got into bed, said
53
54 my prayers and I was completely asleep'; she adds 'I had my first good night's
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3 sleep for years'. This she associates with the treatment setting; a 'safe' and
4
5 'structured' place, where life has 'slowed down'. Melanie (001:S1) similarly notes
6
7 that her sleep improved:
8

9
10 Here I have been in a secure environment. No fear, no nothing. If I
11
12 collapse, if anything happened, if I am sad, if I am happy, if I am pissed off,
13
14 there is always - 24 hours - people around me. So to go out there, to the
15
16 real life, I tell you ...
17

18
19 Residential life brings protection but the anticipation of 'real life' seems daunting
20
21 for those who have previously managed its demands through recourse to
22
23 substances. As Christopher (006:S1) cautions 'recovery really starts when you
24
25 have to face up to problems... in the real world. We are a bit cocooned here and
26
27 it's safe'.
28
29

30
31
32 Yet reports of 'good nights' and immunity from a 'real world' belie a complex set
33
34 of practices that mediate sleep, and closer scrutiny reveals that nights can be
35
36 *sleepfulsome*. Betty (018:S2), for example, had been in recovery for many
37
38 months and, having progressed through a number of residential treatments,
39
40 reports her nights to be relatively peaceful: 'I'm actually happy with the amount
41
42 of sleep I'm getting compared to what it was like when I was drinking'. Yet her
43
44 account of her 'improved' sleep involves a fair degree of activity. When
45
46 discussing her actigraphy data, the interviewer points out that although she
47
48 describes her sleep as 'good', the actigram indicates fairly high levels of
49
50 movement during the night. Betty explains:
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55 I was probably up and down, coming out for a fag and coffee; plodding
56
57 around, not like jogging round the house doing star jumps! Probably did
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2
3 get up and down. It's usually... I don't tend to come down[stairs] that
4
5 much anymore during the night. I come in at half 11. I'm not usually here
6
7 on a weekend, so the 12 o'clock curfew is irrelevant, and then I'll come
8
9 downstairs and I'll have a coffee and go outside for a fag, and if someone's
10
11 up I might stay outside chatting with them for half an hour and then I'll go
12
13 upstairs and kind of just read books and stuff for a little while, and then,
14
15 so basically just read, self-study in my bed. I don't tend to do a lot.
16
17

18
19 'I don't tend to come down much' and 'I don't tend to do a lot' imply that she is
20
21 having better quality sleep compared with previous experiences. Although *prima*
22
23 *facie* 'disrupted' (cf. Hislop and Arber 2003), her sleep can be seen to involve a
24
25 fulsome set of socio-material things: chatting, self-study, coffee, a fag, and a book.
26
27 A sleep wake dichotomy can betray the extent to which sleep, in the 'arena of the
28
29 night' (Moran Ellis and Venn 2007), is accomplished through a busy engagement
30
31 with activities and artefacts. These social and material things are in the weave of
32
33 sleep. There is always something going on.
34
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39 *Sleepful nights: artifacts*

40
41 In Centre One the bedrooms are divided by wooden panels so designed, the staff
42
43 told us, to give residents a degree of privacy. Although, for Peter (003:S1), the
44
45 panels afford another use:
46
47

48 It is incredibly rare that I will just lie and do nothing. I find it very...almost
49
50 impossible to lie and do nothing and be awake. Actually, this is interesting
51
52 that I noticed [...], when I have been going to sleep as well I will quite
53
54 often be tapping on the wooden panels by the side of the bed or doing
55
56 stuff with my teeth like that. Some sort of little body movement or
57
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1
2
3 something. [...] I do it unconsciously, but then realise you are doing it
4
5 again. But sometimes it feels like some sort of distraction tool in some
6
7 way to just distract myself from my own head; and then, if I have noticed
8
9 it, I will go "stop it". Deep breaths - breathe in - if I remember to do it, it is
10
11 a really helpful way of helping me go to sleep.
12
13

14 Tapping facilitated by the proximity of the wall, becomes a 'sort of distraction
15
16 tool' associated with his embodied sleep. It provides a means to deflect thoughts,
17
18 as does the deployment of breathing techniques learned during therapy sessions
19
20 provided as part of his treatment. All are in the loose weave of the *sleepful* night;
21
22 the sleep and wakefulness divide further unravels as Peter reflects: 'I do it
23
24 unconsciously', a point we return to below.
25
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30 Phones, laptops and radios are ubiquitous in the network of actants that enable
31
32 the residents through their *sleepful* nights. Anna (026:S1) describes how last
33
34 night she put on a CD:
35
36

37 It's a book, *The Goldfinch*, and I must have gone to sleep, because when it
38
39 came to the end of the tape [sic] and I can't remember what the end of the
40
41 tape was, so I'd obviously gone to sleep, but then I was awake.
42
43

44 The CD meshes with sleep and enables her awareness that she had slept, thus
45
46 acting within the orchestration of *sleepfulness*. Like other residents, she is keen
47
48 to undo her reliance on such devices. Here we see traces of sleep hygiene; advice
49
50 espoused by sleep experts who would caution against using technologies at
51
52 night. These traces of expert discourse are examples of what Mol (2013) refers to
53
54 in her work on eating as 'ontonorms', a concept that she explicitly refuses to
55
56 define. Nonetheless, as a sensitizing notion, Mol uses it to demonstrate how
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3 eating is enacted (the 'onto') in accordance with authoritative advice on 'how to'
4 eat 'appropriately' (the 'norms'). Ontonorms, she argues, help us to look for the
5 ways science permeates daily life, and she encourages researchers to 'hunt' for
6 them (2013: 390). Prior to entering residential treatment, virtually all
7 participants described sleeping 'with' the TV, radio or music on, something
8 roundly regarded as unacceptable practice in the psycho-clinical guidance on
9 improving sleep. Peter (003:S1) again:

18 Well to distract me and help me sleep, very often I would fall asleep with
19 the laptop on. And that is something I have improved on. My instinct now
20 is not having my phone, and not having my computer... has been really
21 helpful. Because I'm not reliant, in the same way as I used to have to have
22 music on to get to sleep. That has quite often been the case with the
23 laptop and having a film playing in the background. It is like having a
24 comfort.

34 We see then technologies and tools as actants embedded in *sleepful* nights. Peter
35 no longer has his laptop but taps a wooden panel. He is not alone in drawing on
36 such accessories. Harry (002:S1) describes how he recruits communication
37 technologies as a buffer to memories that merge within sleep. Yet he also knows
38 he 'ought' to sleep without them:

46 I was staying up late watching TV so I could go to sleep, so my mind won't
47 be going around so much. I'd go up to bed, I'd always listen to Radio 4 for
48 an hour or two, and I learned a lot from the news and that [...] But I'm not
49 going to do that anymore, because I think that was depressing, it was just
50 a block, blocking out thoughts. I don't think it's healthy. Before I'd have
51 the TV on all night. I'll sleep, then when I wake up I watch TV again, go
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3 back to sleep. So I can't sleep without TV. Here there's no TV. I say OK, I
4
5 should get used to this.
6

7
8 Residents are clearly familiar with what Williams (2007) calls the social
9
10 etiquette of sleep; the 'oughts' of sleep as embedded in the norms and values of
11
12 Anglo-Saxon neo-liberal societies.
13

14
15
16 Residential treatment services may feel like safe spaces, but they are not
17
18 impermeable. Residents who 'ought' to be in bed at night are drawn to other
19
20 settings, phones for example, provide routes to global places. Ellie (020:S2),
21
22 when commenting on her anxieties associated with the anticipation of leaving
23
24 residential treatment, talks about what we can conceive of as *sleepful* activity:
25
26

27
28 I was on the phone last night to Minnesota. I was talking to people in
29
30 bloody Outer Mongolia, like in the rooms in NA [Narcotics Anonymous].
31
32 And I was really getting into it, and I looked at the clock, it was two
33
34 o'clock!
35
36

37 Thus networks extend beyond the bed, bedroom and even the Centre, especially
38
39 as technologies such as smart phones and laptops become part of our embodied
40
41 selves. Such technologies increasingly present in sleep spaces do not, as Hsu
42
43 points out, always wake up and sleep as 'anticipated', indicating 'the situational
44
45 agency they can exert' (2015: 10).
46
47

48 49 50 *Sleepful nights: atmospheres* 51

52
53 Thus the mediums through which anxieties transcend the spatial boundaries are
54
55 broadened and invoke affects. Tina, for example, finds the nighttime affords
56
57 opportunities to give expression to her emotions, a time when she cries because
58
59
60

1
2
3 she tries to 'keep my feelings to myself during the day' (004:S1). Tina's 'lived
4
5 body' *dys*-appears (Leder 1990) as thoughts, memories or worries infiltrate,
6
7 altering at the full plethora of sleep practices, pointing to their affective effect.
8
9 That anxieties come to the fore during the night is something that many people
10
11 might recognize, but for those whose feelings have for many years been numbed
12
13 through substance use, emotions can act differently. In particular, they can feel
14
15 strangely unfamiliar when not mediated by drugs or alcohol, further complicated
16
17 by the fact that those in recovery often have complex emotional biographies
18
19 (Nettleton et al. 2011). Although demographically diverse, all the study
20
21 participants reported histories of challenging life events and emotional isolation.
22
23 Regret, guilt, anger, fear and loneliness were palpable within the data. No longer
24
25 numbed through alcohol or drugs, but now prodded throughout the day in
26
27 counseling and therapy sessions, emotions become critical to the enactment of
28
29 sleep. Ollie says 'you're scared of the night sometimes' (030:S2); Agatha explains
30
31 'I wasn't sleeping because I was scared to sleep' (033:S2).
32
33
34
35
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37
38

39 Silence too is an actant that can be provocative; invoking affects especially
40
41 amongst those familiar to the drone of a television or radio. Silence enables other
42
43 noise, as when, for Tina (04.S1), the body audibly *dys*-appears:
44
45

46 When it is late and you can hear *bumph bumph bumph* [mimics the sound
47
48 of her heart beat]. And if I hear one beat that goes out of rhythm, like a
49
50 palpitation or something, I'll panic straight away. I am like, "Oh my god!".
51
52 So I have got to roll over, so I can't hear my heart beat. You know, I have
53
54 to have a distraction, so I'll try and think about something. I don't know,
55
56 the sky or something, animals or something.
57
58
59
60

1
2
3 The body interferes. The full bladder necessitates getting out of bed; decisions as
4
5 to whether to put on the light are complicated by the need to minimize
6
7 disturbance of roommates. Going to the toilet, then returning to bed or instead
8
9 opting to go and find a sofa, or another place to hang out, and then whether to
10
11 have a hot drink or a cigarette. The 'arena of the night' in residential treatment
12
13 affords situated choices as Elizabeth (024:S1) explains:

14
15
16 Well you have two or three alternatives. You can lay in the dark. What I
17
18 would do in the beginning, I took baths. I took a bath, but that [points to
19
20 the actigraph data] wouldn't show, because I take off the bracelet [the
21
22 actiwatch], and I would go down and get camomile tea. You're allowed to
23
24 do that and come back and try to sleep.
25
26

27
28 Beds, baths, lights, drinks, books, roommates, and radios are actants that come
29
30 and go and variously play in the multifaceted networks that make the
31
32 assemblage of *sleepfulness*.
33
34

35 36 37 *Assemblage of sleepfulness*

38
39 Assembling *sleepfulness* relies on devices that, like the actiwatch, contribute to
40
41 the performativity of sleep. The clock is perhaps the most ubiquitous 'inscription
42
43 device' (Latour 1987) in this context. Sleep discourse is replete with temporal
44
45 framings and the clock provides a means of reflexively assessing whether 'sleep'
46
47 was done:
48
49

50
51 I'd like turn over and I'd look at the clock to see what time it was, thinking
52
53 I might have slept and it might be coming up to morning time. But it
54
55 would always be ten past, and then I'd turn over and look at the clock,
56
57 twenty to, you know, so all throughout the night. (Helen 027: S1)
58
59
60

1
2
3 Here the clock authenticates sleep; Helen cannot rely on her embodied
4
5 assessment, so checks it to see whether she 'might have slept'. Elizabeth (024:S1)
6
7 similarly learns about her own 'sleep' from her roommates. She reports how she
8
9 felt that she had 'not slept', but then 'somebody in the room says "no I heard you
10
11 snore dreadfully, so you were asleep"'.
12
13

14
15
16 Clock time, temporal routines, temporal framings, roommates, and other
17
18 residents permeate the night in other ways. The temporal structuring of
19
20 residential treatment is rooted in 'ontonorms' (Mol 2013). Rules relating to the
21
22 ordering of days and nights vary in terms of rigidity between different
23
24 residential treatment centres. The imposition of a highly structured regime is a
25
26 means to operationalise the goals of rehabilitation, and the internalization of
27
28 proscribed bodily habits that are congruent with wider social norms (cf Foucault
29
30 1977). But we find the residents to be canny at navigating the proscribed ways
31
32 of sleeping, with some having honed their skills of side stepping societal norms
33
34 and expectations in order to source drugs or alcohol.
35
36
37
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39
40

41 Rules invite resistance which is a feature of nightlife in the two residential
42
43 treatment centres. Kirsty (011:S1) explains how in Centre One, after one in the
44
45 morning, residents can get up for half an hour and go downstairs to the
46
47 communal areas, and 'as long as you return to bed for an hour, you can go down
48
49 for another half hour'. She managed to work the system to get more time out of
50
51 bed:
52
53

54
55 I found a snag! If I made sure that I got up an hour and a half before I was
56
57 allowed to wake up, then I got an extra half hour, because I didn't have to
58
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1
2
3 go to bed. I could just stay downstairs. Because, by the time my half hour
4
5 was up, it was time to get up anyway.
6

7
8 So Kirsty goes downstairs and busies herself: 'you can get some cereal, sit on the
9
10 balcony, have a fag or whatever' to enable her through the night. The rules are
11
12 also generative of collective interactions and social dynamics that infiltrate and
13
14 broaden *sleepfulness*. As we noted above, according to Melbin, 'social life in night
15
16 time has many important characteristics that resemble social life on land
17
18 frontiers' (1978: 19). He suggests that 'nighttimers' perceive themselves as
19
20 'different' and 'they resent the neglect shown by people in the day' with the
21
22 consequence that a nighttime 'in-group feels comradely within itself' (1978: 19).
23
24 Karen (019:S2) eloquently describes such 'in-group' feeling and portrays the
25
26 mood of the night:
27
28

29
30 I would usually wake up around four, maybe go for a cigarette. And
31
32 there's always the danger, because they have really clear night time
33
34 boundaries, but if there are other people, if there were other opiate
35
36 addicts, there can be a culture that is created, and it's like the living dead,
37
38 that kind of ... and you know we gather kind of thing and it becomes quite
39
40 seductive, the environment, the lighting, it's dark, we're talking about
41
42 what we did and how we got there, and it's quite dangerous really. It's
43
44 dangerous because it becomes attractive; and it's behavioural. It's like
45
46 tapping in to those old behaviours, with a few boundaries being pushed.
47
48 Someone might have a little bit of contraband, sweets or... It sounds
49
50 really stupid on reflection, but pushing the boundary, so someone will go,
51
52 "oh look, I've got a bag of sweets", and we're sitting eating sweets. The
53
54 nurses come down and say 'come to bed', and we just laugh. And then
55
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3 they come down again and they leave you then, the nurses. And then you
4
5 know you're in the shit. I got put on a contract [formal punishment] for
6
7 that.
8
9

10 Thus the social configurations of the night are differentiated from those of the
11
12 day and are shaped by the specificities of the centres themselves and the
13
14 embodied biographies of those in recovery wherein some find collective
15
16 empathic appreciation of the lure of 'danger', the 'contraband' and testing
17
18 boundaries.
19
20

21
22
23 We might speculate that nighttime rules of other residential settings will
24
25 provoke activity, but these will of course vary according to the details of the
26
27 institutional aims and aspirations, as well as the demographic profiles and
28
29 backgrounds of the residents. There were even differences between the two
30
31 centres we studied, such as relations between residents in conjunction with the
32
33 emotional currents engendered within the particular atmospheres. These
34
35 dynamics change over time and are contingent on the relational networks that
36
37 are constantly reassembling sleep. Night-times take on particular atmospheres
38
39 (Anderson 2009; Galinier et al. 2010), heavy with affect such that social relations
40
41 take on situated dynamics. As we have seen here, solidarities and schisms may
42
43 be forged within the spatio-temporal specificity of residential 'therapeutic
44
45 landscapes' (Laws 2009) with residents variously engaging in these dynamics.
46
47
48
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51
52
53 Rules, rooted in ontonorms, can generate tensions in relation to embodied sleep
54
55 biographies. As we have seen, imposition of structures and sleep etiquette
56
57 provokes activity. It can also amplify anxiety and struggles within sleep. Kirsty
58
59
60

1
2
3 (011:S2) reflects on not being allowed out of her room in some rehabilitation
4 services, whereas here, 'being able to just come out and maybe make yourself a
5 cup of coffee, or have a chat with the nurses and stuff like that really help'.
6
7
8
9
10 *Sleepfulness* can therefore comprise techniques to counter affective atmospheres
11 (Anderson 2009) of the night, and the amelioration of isolation in bed. As Kat
12 (036:S2) puts it, whereas 'in the day I've got people I can talk to. Of a night I feel
13 more isolated.'
14
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20

21 Beds and bedrooms mingle with biographies. For some the bed is a site
22 associated with fear, violence or loneliness (Lowe et al. 2007; Williams 2007a).
23 While the ontologies associated with sleep hygiene presume the merits of
24 temporal and spatial remission, bodies doing sleep in recovery may not. As Ellie
25 (020:S2) puts it, being in bed is 'probably my most vulnerablest [sic] time. It's
26 when I'm alone; I don't like being on my own'. This affect, in the weave of sleep
27 adds to what Wetherall refers to as 'affective textures' (2012: 4) that form
28 through the ecological play of emotional practices. As we have seen, sleep
29 practices as 'affective practices' (Wetherall 2012: 3) in the context of recovery
30 from substance addiction are entangled. Both are linked to the recruitment,
31 resistance and responses to objects, norms, institutions, and interpretations that
32 fold in on bodies. *Sleepfulness* then implies that sleep is far from a form of social
33 remission (Parsons, 1951; Schwartz, 1970); it is (re)assembled through the
34 atmospheres of the night.
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55 **DISTURBING SLEEP ONTOLOGIES: THE SLEEP MULTIPLE**

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3 Through foregrounding 'the body we do' (Mol and Law 2004: 57), we find that
4
5 sleep comprises myriad material, social, normative, and affective processes that
6
7 are profoundly embodied. In combination these disturb the ontology of sleep,
8
9 revealing the elements of a sleep assemblage; the affective and agentic practices
10
11 as captured in our concept of *sleepfulness*. This concept challenges the sleep-
12
13 wake dichotomy and treats sleep not as a solid category but – to paraphrase Mol
14
15 (2002) - as 'the sleep multiple'; fluid, relational, dynamic and situated. Although
16
17 we draw on interview data reporting accounts of sleep, our analytic approach
18
19 does not seek to unearth how the participants proactively try to get to sleep, nor
20
21 focus on their personalized sleep strategies (cf Hislop and Arber 2003); instead,
22
23 we examine the ontology of sleep to explore how it is amassed within networks
24
25 of socio-material and affective relations. As we examine our data, sleep as a
26
27 stable object begins to unravel; the sleep multiple is also evident by the variety of
28
29 adjectives attached to it.
30
31
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37 Listening to sleep talk reveals it to be a permeable, complex and messy practice.
38
39 For example, as we interrogate references to 'improved sleep', we find
40
41 distinctions between embodied unconscious and conscious nights are not clear-
42
43 cut. Sleep as liminal, rather than dichotomous, emerges in particular in instances
44
45 of (un)consciousness reflexivity. Participants describe waking themselves up
46
47 when they are asleep. Trisha (012:S2) comments on how she unconsciously, yet
48
49 reflexively, wakes herself up from a bad dream, relieved that she 'managed to
50
51 pull myself out of the dream and I was so glad I managed to get out'. Another
52
53 feature of recovery is 'using dreams'. As Kirsty (011:S2) puts it, 'I've smoked
54
55 crack in my dreams and actually had a hit off it'. Melanie (001:S1) too reveals the
56
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58
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1
2
3 liminality of sleep laden with activities. She describes 'making plans for her
4 future', and 're-rehearsing past events' while asleep. An ontological mosaic
5 begins to emerge as we hear about numerous modes of sleep. Let us take for
6 example Helen's (027:S1) notions of 'light sleep', 'full sleep' and 'virtually asleep'
7 experienced during the day:
8
9

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11
12
13
14 In between meetings I'll go up and lie on the bed, have a nice heavy relax
15 where I feel that I am virtually asleep, but I can still sort of like hear
16 everything around me, if that makes sense. I'm a very light sleeper. I hear
17 the slightest of noises; they don't wake me. Well they do, I suppose. They
18 do. They don't wake me up, they don't wake me up that I'm awake, but I
19 hear them.
20
21
22
23
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27

28 This not only speaks of the liminality of sleep, but also indicates her response to
29 the onto-normativity as indicated by her awareness that she is breaching the
30 Centre's rules which dictate that day-time sleep is not permitted. She continues:
31
32
33

34 A couple of times I have gone and just laid on the bed, might just be quiet
35 because I can like not go into a full sleep, but enough to just be nice and
36 relaxed and you know, just keep looking at the clock to make sure that I
37 don't go into a sleep that I would be, "oh God, the bell's rang!" That has
38 happened a couple of times maybe, though on the days when I've had
39 headaches. (027:S1)
40
41
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48 Helen admits that on occasions she has slipped from being 'virtually asleep' to
49 'full sleep' during the day, but repairs this with her to reference to headaches.
50
51
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54
55 'Full', 'virtual' and 'light' are amongst a plethora of ways of doing sleep, indicating
56 a baggy ontological mosaic: the sleep multiple. Participants speak, for instance,
57
58
59
60

1
2
3 of: 'alcoholic sleep', 'anxious sleep' 'broken sleep', 'comatose sleep', 'conscious
4 sleep', 'catnaps', 'childhood sleep', 'decent sleep', 'deep sleep', 'disturbed sleep',
5
6
7 'dreaming sleep', 'exhausted sleep', 'healthy sleep', 'heavy sleep', 'natural sleep',
8
9
10 'pass out sleep', 'power naps', 'proper sleep', 'not proper sleep', 'scared sleep',
11
12 'unconscious sleep', 'unnatural sleep' and 'unwakeable sleep'. Participants reveal
13
14 an intuitive knowledge of sleep as a fractured object and not a tidy category.
15
16
17 However, within the data we also find slippage between, the presumption that
18
19 there is an *a priori* 'real' and 'natural' sleep as found in the dominant discourse
20
21 that presumes a bio-medicalised body.
22
23

24
25
26 Deidre's (035: S2) question illustrates this well. During the interview she asks
27
28 the researcher:

29
30 When I'm drinking [alcohol], is that sleep? I wouldn't have thought that
31
32 when somebody has been drinking they're in what is called a natural state
33
34 of sleep, so I wouldn't have thought that was sleep. And you tell me, is that
35
36 sleep?
37
38

39
40 Deidre's question presumes that the researcher will have access to a definitive
41
42 and authoritative answer to her question. There is, of course, a notion of 'natural'
43
44 sleep within the biomedical gaze on the *body-with-organs* (Deleuze and Guattari
45
46 1988). Within that paradigm, sleep is understood in terms of brain activity and a
47
48 complex interplay of neurological, biological, psychological and behavioural
49
50 mechanisms that play out over the 24-hour circadian rhythm, where variations
51
52 are evidence of 'abnormal' sleep (Ellis 2012: 294). And so Deidre is not alone in
53
54 presuming that there is an *a priori* scientific 'truth' that can account for a
55
56
57 biologically based 'natural sleep' that resides in the organic body. And indeed,
58
59
60

1
2
3 this bio-medicalised understanding of a 'natural' sleep infiltrates and becomes
4
5 reified within institutionalised routines explicitly designed to treat and restore it.
6
7 From a social constructionist perspective, this idea of 'natural sleep' is
8
9 recognised as a discursively produced rendering that, in turn, conveniently maps
10
11 on to institutionalized regimens that seek to restore productive and disciplined
12
13 bodies (Wolf-Meyer 2011: 880). 'Natural sleep' can therefore be expedient for
14
15 service providers and residents.
16
17

18
19
20
21 'Natural sleep' can also be seen as a further infiltration of an ontoform – the
22
23 'ought' of sleep, especially as residents accept that there is such a 'thing', and
24
25 hope that 'it' will be achievable. Anna (O26:S1), for example, 'craves' the day
26
27 when such 'real' sleep 'just happens'; when it becomes devoid of 'things':
28
29

30 I have this idea, a world of sleep, of going up to bed in a quiet room, a dark
31
32 room, being nice and warm, putting your head down and that's it ...
33

34 For her, a mark of natural sleep would be to sleep 'without the radio on'. But, of
35
36 course, sleep will never be devoid of actants for, as she notes, there could be a
37
38 bed, warmth, dark, quiet - it is still *sleepful* - but the assemblage is different to the
39
40 one she experiences during her stay in the rehabilitation centre.
41
42
43
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45 46 **CONCLUDING DISCUSSION** 47

48 This empirical paper provides an analysis of sleep using data generated through
49
50 interviews with residents in drug and alcohol residential rehabilitation services.
51
52 Our study participants indicate that sleep is an issue that is important to them
53
54 and with which they struggle, but it has been given little, if any, formal attention
55
56 through their treatment histories. The aim of this paper is not to offer pragmatic
57
58
59
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1
2
3 solutions to resolving sleep quality, but instead to provide a description of how
4
5 bodies 'do' sleep in the context of residential settings. We demonstrate that
6
7 participants sleep in a variety of ways and, after Mol (2002), sleep may be
8
9 conceptualized as 'the sleep multiple': that is, sleep is recognized as a discrete
10
11 embodied practice, but also as contingently assembled and situated. Our analysis
12
13 identifies myriad material accoutrements such as, radios, baths, beds, cigarettes,
14
15 drinks, roommates, phones, clocks, memories, dreams, and nighttime gatherings
16
17 that reveal how sleep is a fulsome practice. This list is not exhaustive. There is
18
19 still more going on besides: other 'actants', notably medication or sleeping
20
21 tablets, can be in the fray of sleep. The latter are of particular interest, and it is
22
23 noteworthy that most residents report a reluctance to take pills in case they
24
25 interfere with their aspiration for a presumed 'natural sleep'.
26
27
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31

32 The sleep assemblage is riven with tensions and contradictions. Indeed, our
33
34 study finds that while our participants presume a 'natural sleep' exists, the data
35
36 also expose sleep to be conceptually, ontologically and pragmatically baggy. We
37
38 propose that the notion of *sleepfulness* goes someway to capturing the
39
40 provisional and busy set of practices that enable what we do when we sleep.
41
42 *Sleepfulness* involves (un)conscious activities and actants that are both situated
43
44 and relational. We have seen here how, in rehabilitation services, there is a
45
46 plethora of interconnected practices that can comprise, amongst other things,
47
48 listening, tapping, crying, eating, smoking, reading, thinking, meditating,
49
50 fantasizing, moving, socializing, and gaming, that are associated with sleep in the
51
52 fullest sense. Thus we urge sociologists of sleep not to think of sleep difficulties
53
54 purely in term of *sleeplessness*, but more in terms of a *sleepful* variety of
55
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1
2
3 relational processes. This finding concurs with previous research that queries
4
5 assumptions that sleep is a state of social remission, indicating that the notion of
6
7 *sleepfulness* may be generalizable to other settings, although each will have their
8
9 own unique environmental configurations.
10

11
12
13
14 As well as contributing to debates on the sociology of sleep, our findings offer
15
16 empirical insights into the nighttime within drug and alcohol residential
17
18 treatment settings. Structured days and nights and the imposition of routines
19
20 within residential rehabilitation settings are designed to foster normative sleep.
21
22 Our data reveal that these environments are perceived as 'safe' and conducive to
23
24 'better' sleep, but 'better' sleep is more provisional and cluttered than
25
26 researchers might presume. For this group, 'better' is relative to their
27
28 experiences of substance-induced sleep. And as we disturb how sleep is done, we
29
30 find that the categorical weave of sleep untangles. The articulation of the fulsome
31
32 dimensions of sleep may be helpful for researchers operationalizing sleep in
33
34 other study designs, such as our own parallel research where we are seeking to
35
36 develop validated patient reported outcome measures (or PROMs), including one
37
38 measuring sleep quality amongst people using alcohol and other drugs (Neale
39
40 and Strang 2015a; 2015b). The findings presented here have prompted us to
41
42 think more critically to ensure that the sleep measure we develop will be broad
43
44 enough to capture the contradictions inherent in the sleep assemblage.
45
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52
53 This loosening of normative expectations of sleep through questioning its
54
55 ontology is also political in the sense that it reminds us that the prescription of
56
57 bodily practices is linked to the social spaces and wider contexts in which they
58
59
60

1
2
3 are produced. Sleep may seem personal, but it is imbued with the political
4
5 (Williams 2011) in ways that can become especially salient in the context of
6
7 substance dependence (Nettleton et al 2012; Nettleton et al 2013). Men and
8
9 women in recovery from drug and alcohol problems bring complex embodied
10
11 biographies that entwine their sleep and addiction to residential rehabilitation
12
13 settings and their sleep assemblages are fragile. This fragility may well be
14
15 disturbed as they relocate to other settings, where sleep has to be *(re)assembled*
16
17 in different environments, most especially where they may feel less 'safe' and
18
19 have to negotiate the 'real world'.
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41
42
43

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