

4



Desiring a Good Night's Sleep *Order and Disorder in Everyday Life*

IN THIS CHAPTER, I CHANGE MY FOCUS TO EXAMINE THE LIVES of individuals and families as they are affected by disorderly sleep. I move from the disciplinary and institutional logics of sleep science and medicine and attend the forms of life that they produce, largely in the lives of individuals who see themselves in need of medical intervention. I am interested in the lives that individuals form for themselves and the effect they have on those around them. In order to establish their everyday lives as orderly, individuals integrate new pharmaceuticals, prosthetics, and behaviors into their self-care. These intimacies, these alliances with new objects, form emergent desires.¹ In some cases, these therapeutic intimacies are intolerable for individuals, who struggle to shape their everyday lives through varying means, sometimes opting out of medical treatment altogether. But there are similarities across individuals diagnosed with the same disorder, both in treatments available to them and in the consequences of finding nonmedical alternatives to managing their everyday lives. In relation to these similarities, I structure this chapter nosologically, by medical definitions of disorder. In so doing, I bring together cases of individuals and families who share symptoms but who resolve their disorders differently from one another. In some cases, their choices involve medical treatment. In other cases, individuals find nonmedical means to allay their sleep disorders. I draw on cases similar to these throughout the rest of Part II, examining how

Desiring a Good Night's Sleep

individuals with similar sleep disorders and their families form and are formed by the institutions they encounter, in particularly American ways, through their emergent relations with therapies, institutions, and the desire for sleep.

Early twenty-first-century American society has been marked with an intensified interest in sleep as an explanatory device for health and its impediments, a trend that differs substantially from medical discourses of the 1990s, in which sleep was largely ignored. This change has been brought about, in no small part, through direct-to-consumer advertising of sleep-inducing medications, now annually a multibillion dollar industry, as well as through the efforts of various individuals and institutions to popularize sleep. My interest in this chapter, in tracking this shift during the 1990s and the early 2000s, is to attend primarily to the alterations in treatment regimes, namely, the intensification of pharmaceutical therapies for health problems, and to elaborate what might be particular to this seemingly emergent pharmaceutical aspect of integral medicine's further development. "Pharmaceutical personhood" has become an ever more naturalized form of life in contemporary American society and in modern life more generally.² Beyond the reliance upon medications as a means of alleviation—which is new only in the sense of its intensification, inasmuch as medications and medicinal supplements have a protracted history—my interests are specifically in the "time-discipline" of pharmaceuticals,³ the ways that the use of pharmaceuticals produces particular kinds of spatiotemporal predispositions, desires, and intimacies and how these form and are formed by American everyday life. I see in pharmaceuticals and pharmaceutical use a reliance upon repetition, the formation of everyday rhythms that reinstate themselves through desirous means. Simultaneously, pharmaceutical regimes are also constituted by ideas about the everyday, about rhythm and spatiotemporal order. Contemporary pharmaceutical use depends upon a mode of en-framing that produces the spatiotemporality of the everyday inasmuch as it mitigates disorder through the formation of normative orders of desire and intimacy. In the early twenty-first century, American everyday life is tied to ideas of the therapeutic, emblemized in the repetitive use of pharmaceuticals. When a particular everyday rhythm is so vital, its disordering can have profound effects for individuals, their families,

and society more generally, and order can be reasserted by turning to the powers of medicine.

“We Don't Get Enough Sleep”

Marcus and Laura Burton were professional, upper-middle-class, white Americans from the suburbs of Minneapolis and, at the time of their interview, were in their early fifties. They had been together since their early twenties, having met as undergraduates while at a university in the Midwest. They were not unique in their sleep problems; in fact, neither was recognized as having a nosologically defined sleep disorder in the strict sense, other than being “tired, basically.” As they explained, they came to identify their health problems *primarily* as sleep problems, but the regulation of sleep was a difficult project for them, and social obligations often took precedence over desire for sleep. Marcus worked as a senior engineer in a medium-sized firm that he was part owner of, and Laura worked in a state-run hospital in various community outreach programs. Their two daughters were fully grown, graduated from college, and in the process of establishing their careers and families. Living in their empty nest, the Burtons had begun to tend to their sleep complaints, which now stood in stark relief to their other social obligations. What the Burtons evidence, and what they were clearly aware of, is that sleep disorders are also inevitably social disorders and that their health complaints affected both themselves as individuals and each other as bed partners. Their desire for sleep interfered with interpersonal intimacy, and this was related to Marcus's close relationship with stimulants. What marked the Burtons' interaction with their sleeping problems was a generous humor, directed both at each other as sleepers and spouses and at the role that sleep played, or failed to play, in their daily lives. This use of humor both deflected the force of sleep's disruptions from their daily lives, rendering it a sort of joking nuisance rather than an unrelenting irritation, and acted as a point through which their marriage was worked and reworked: desire for sleep became interpreted as another necessary aspect of their relationship as spouses and as bed partners, bringing together broad social obligations, cultural expectations of space, time, marriage, consumption practices, and their intersubjective biologies in an intimate chemistry of desire.

Desiring a Good Night's Sleep

What were you diagnosed with?

MARCUS BURTON: Well, it turns out I was basically diagnosed as tired. And—if I remember the specifics of it—he said on average I had 2.2 apnea events per hour, which didn't qualify as anything dramatic by any stretch of the imagination.

LAURA BURTON: It was actually under normal.

MARCUS BURTON: Yeah, what he said was less than normal. And my sleep was 87 or 88 percent efficient, as opposed to 82 percent for the population in general. And my favorite part of the whole thing was the nap assignment. And I think it was because I didn't have any significant apnea overnight they wanted to see what my sleep pattern during the day would be. So, when I finally arose at a quarter to ten, they gave me the prescription—if you will—to take five naps during the day, and I did that at 12, 2, 4, 6, and 7 [P.M.] (they decided they didn't need to wait until 8 for the last one, as I can fall asleep pretty easily). And as the day went on, I think I fell—I think it took a little longer to fall asleep each time. I think it took—

LAURA BURTON: But he fell asleep each time.

MARCUS BURTON: Yeah—doctor's orders. I think the last time it was twelve minutes it took me to fall asleep; the first time I think it was two and a half. But I was pretty tired. And the long and the short of it was I was tired, basically. I don't get enough sleep—we know that: We don't get enough sleep.

The Burtons, by all accounts, are “normal.” They are representative of a broader phenomenon in the contemporary United States, namely, that of a public in the making. The contours of this public are biological, and they work through and rework ideas about human biology and its relationships with society and culture on the basis of the formation of new desires and intimacies. A necessary component of this emergent biological public is the simultaneous elaboration of therapeutic normalcy. Studies of normalcy primarily focus on the means by which norms are enforced through institutional expectations and discipline and on how individuals interpellate themselves into normative forms of desire, into the masses.⁴ What is most often privileged in analyses of the normal in medicine are the end-focused effects of norm attainment; that is, once in-

Desiring a Good Night's Sleep

dividuals become normal or are resigned to their abnormality, the analysis ends. However, integral to the contemporary pharmaceutical society Americans find themselves to be mired in, therapeutic normalcy depends on a practice of medicine that can never reach its end. Therapeutic normalcy depends on an open, never-ending, unachievable normal that individuals aspire to—in this case, the normative ideal of eight consolidated hours of peaceful, natural sleep. Rather than leading to a therapeutic end, which might be understood as a “cure” (a temporally specific, end-focused process), pharmaceuticals depend on repetitive acts: days punctuated with medication, monthly refills of prescriptions, and annual checkups, resulting in both self-surveillance and institutionally based observation. In so doing, the clinic, rather than being a stable space, has become an ambient background of American everyday life, and one’s disorders of sleep are understood in the idiom of “health.” The Burtons help explicate these ideas further as they apply to “normal” Americans.

Marcus’s perceived abnormal sleep—high efficiency, few apnea events—was not a problem for the Burtons; rather, the problem was what had been increasingly taken as his normal sleep, or lack thereof. Marcus exhibited chronic sleep deprivation, which led first to his ability to test as “tired” and to nap on cue and second to his and Laura’s recognition of the deprivation as foundational to his continued health. Marcus and Laura were aware of the problems that sleep had caused in their lives and in their marriage, and this awareness is what motivated them to seek medical treatment, although the possibility that they could arrange their social lives in ways more amenable to sleeping was also available to them, however undesirable. Despite knowing that medicine might have solved their sleep problems, Marcus had deferred medical help, in part because his life had felt too “complicated.” What brought him back to the possibility of a medical intervention was preserving his marriage, as well as an ongoing understanding of his body’s rhythms as disruptive for himself and Laura.

What led you to seek medical treatment?

MARCUS BURTON: Well, Laura, and that I know that I snore. And I have had years of listening to my father and my brothers [snore], you know, as a child. And I know how loud it is. And I also know what it’s like to be sleep deprived in that I went through a phase of my life where I had a real hard time sleeping for about a month,

Desiring a Good Night's Sleep

and life's no fun when you're not sleeping. And, so, when Laura said, "It's really hard to sleep if you're making noise like that," and one day she got up and left—

LAURA BURTON: I went into the room across the hall.

MARCUS BURTON: You went across the hall and set up a camping cot and went to sleep. . . . I don't remember the exact chronology, but I had signed up for my sleep study the first time two or three years ago, so it wasn't something that I had—that I fought or didn't buy into, but I had gone to my GP, and he told me to contact some sleep institute. Laura was working at MCMC, and she said, "You can't go there; you have to go to MCMC," so I canceled the other one, and life got complicated, and two years went by. . . . She's in menopause, she has insomnia to begin with, and—

LAURA BURTON: I think that was what really brought you there, because I mean we've been married and sleeping together for thirty odd years, and I've been able to sleep through it until recently. And because my sleep cycle changed, my quality of sleep changed; unless I'm really, really tired, I can't fall asleep with him snarking in my ear. I just can't. But I think that's basically what happened. I think he's been constant, and it's me that changed.

Worth noting is that it was not so much a change in Marcus's condition that finally brought him to seek medical help but rather a change in Laura's body, her ability to sleep and tolerate Marcus's otherwise constant snoring (or "snarking" in their idiom) body. Only when Marcus's sleep disorder impinged upon their intimacy and desire for sleep did he finally seek a medical intervention. This disorder of intimacy, in turn, was based upon the interaction of Marcus's and Laura's desires for sleep; when the balance that had previously existed became too disrupted, therapy was necessitated.

Caffeine became a means of self-medication for Marcus, working in turn to conceal his sleep deprivation and, as the Burtons recount, also exacerbating the disorder generated by his "snarking."

LAURA BURTON: Did you talk about the coffee?

MARCUS BURTON: No. And, um, what she means by that is when I, when we, had the initial interview with the doctor he said, "Do you drink coffee?" and I said, "Yes," and he said, "*Well, how much?*" and

Desiring a Good Night's Sleep

I said, "Two, three pots a day." He said, "You mean cups?" "No, I mean pots, and, uh, but I always stop by about 3:30—I never drink coffee after 3:30." And that led him even further down the pipe to his conclusion that "Well, that you're really sleep deprived." He had a resident with him at the time—he was training somebody in—and said, "It's [caffeine is] a very potent stimulant, but it doesn't last very long, so if you're sleep deprived but you need to stay awake for twelve hours, you might drink three pots of coffee in a day," and [laughter] he said, "You know, you might really want to stop that." And, so I finally had a doctor tell me I was drinking too much coffee. No doctor had told me that before, because my blood pressure isn't high, and I never actually killed anybody or anything like that, although it can make me pretty edgy. So I stopped. Instead of drinking about [a cup of coffee]—I would typically have about five or six of those by eleven o'clock in the morning, and probably about three or four more in the afternoon, and coffee at lunch wherever I was. I hacked that down to about one or one and a half in the morning and one in the afternoon, and I just made a conscious decision to stop.

LAURA BURTON: And it made an incredible difference in how much he snores. Because he snores, way, way, way less now.

MARCUS BURTON: Or you're sleeping better.

LAURA BURTON: No, I'm telling you, I'm not sleeping better. Your snoring has gotten better. Or gotten—I don't know if you call it improved snoring if it's quieter. It's not as loud; it's not as often.

MARCUS BURTON: I still wake myself up. I still wake myself up on occasion with a snark here or there. But we still don't get enough sleep.

The use of so much caffeine (a quantity not out of step with that of other disordered sleepers) not only concealed Marcus's sleepiness (although how effectively it did so is questionable, since he was still aware of his sleepiness) but also exacerbated his predisposition to be a noisy sleeper. His desire for stimulation, his intimate relationship with caffeine, disrupted both his and Laura's sleep. Marcus may have been an extreme caffeine drinker before his recent reduction in consumption, but his modified levels of coffee drinking are in line with reports of average American caffeine consumption, which is estimated at two hundred milligrams daily for noncoffee drinkers and nearly twice that for those who drink coffee.⁵

Desiring a Good Night's Sleep

Like many Americans, if the National Sleep Foundation's Sleep in America polls are accurate, Marcus averaged less than eight hours of sleep per night. But whereas many Americans have reported difficulties with sleep onset, sometimes conflated with insomnia, Marcus manipulated his sleep duration to meet his everyday obligations, particularly work.

Can you describe a typical night's sleep before the diagnosis?

MARCUS BURTON: With me? Typically we would go to bed between twelve and one, and I would go to sleep in two minutes—

LAURA BURTON: Twenty seconds max.

MARCUS BURTON: Yeah. I would usually have to get up once in the night to hit the lavatory. I would typically get up around seven. I try and get at least six hours of sleep a night, knowing my ideal is seven. In terms of waking myself up snoring, to me it doesn't seem like a common phenomenon. But I know that it happens—I just couldn't—obviously I don't keep track on a nightly basis, but I would expect that I probably wake myself up once or twice a night. I realize that it has happened and roll over, or try to do something. I usually sleep on my back, and after the first snark of which I'm aware, I roll over to my stomach, because I'm convinced that it's physiologically impossible to snore while sleeping on my stomach.

While there is no proper medical treatment for Marcus's snoring, he and Laura worked to find means of minimizing its disruption of their sleep and realized ultimately that it was not simply his snoring that impacted their sleep but also a broader network of everyday demands and expectations. These everyday demands led them to modify their desire for sleep by developing intimacies with stimulants, everyday routines, and expectations of themselves and each other.

Thinking about oneself through one's desire for sleep and normalcy inevitably invites thinking about what kind of sleeper one is, whether a lark or an owl, light or sound, orderly or disordered. To know oneself through one's desires and rhythms of sleep is also to know how the spatio-temporal orders of American everyday life serve as either nuisances or foundations for one's life. Moreover, knowing oneself as a sleeper also invites understanding difference among kinds of sleepers, including such

Desiring a Good Night's Sleep

nonnormative patterns for Americans as napping and day sleeping, the former being short periods of supplemental sleep, and the latter being consolidated daytime sleep. In the following excerpt, Marcus and Laura ruminate on the kinds of sleepers they are and how this has impacted their everyday lives:

LAURA BURTON: All I know is that I've always been a night person, and I get a lot done at night.

MARCUS BURTON: And I'm just somebody who doesn't get much sleep. So I'm—whether I'm a night person, or a day person, or a morning person, it's hard to say, but—

LAURA BURTON: But I can power sleep, and you can't really do that. I mean, I can sleep for twelve hours.

MARCUS BURTON: Oh yeah, I can't. I have to be absolutely dead exhausted just beyond all get-out. If I'm tired I sleep for nine or ten hours, if I'm not I sleep for seven. And when I'm on a normal workday, it's five and a half to six, usually.

LAURA BURTON: And napwise—

MARCUS BURTON: I can take naps and you can't.

LAURA BURTON: Well, I can take naps, but twenty minutes isn't necessarily refreshing for me.

How common Marcus's and Laura's experiences as sleepers are is debatable, as is their status in relying upon sleep and its disorders as a means of understanding their individual subjectivities and intersubjective relations. However, their intimate knowledge of their own sleep habits and patterns as well as that of each other is profound. While they may not have been common at the time of our conversation, with their awareness, they offer an ideal type of the American sleeper at the turn of the twenty-first century: someone who not only perceives sleep as central to health and the ordering of everyday life but also conceives of her or his own desire for sleep and its nested intimacies as a vital means of thinking about oneself, social possibilities, and therapy as a means of mitigating possible concerns. If the Burtons are normal American sleepers—sleep deprived, wrapped up in intimate relations with institutions, chemicals, relationships, and seeking medical help for being “sleepy”—narcoleptics

offer a *model* of American sleep, with alertness and sleep always mediated by intimate relationships with pharmaceuticals.

Narcolepsy: Modeling American Sleep

A middle-class white American, Sam was in his early forties at the time of his interview and had become aware of his sleeping problems—narcolepsy with cataplexy (a sudden loss of muscle tone)—in his midteens, which his family doctor at the time understood as hypoglycemia. As Sam described it, he “had a very sketchy parenting situation as a youth, so it was not really pursued as a problem then and nobody worried about it too much.” He went on to explain that throughout his time in elementary school, the school nurse had treated his cataplexy events with naps supplemented with candy. As he aged, his cataplexy abated, but it was replaced with “excessive daytime sleepiness,” which plagued his high school years and life thereafter and eventually led him to seek medical diagnosis. In Sam’s words, “My father noticed my sleepiness and directly accused me of smoking pot or using pills. . . . He did not understand, and there was absolutely no way he would believe that it was not pot or drugs that made me sleep in class and during the daytime. No one could be that sleepy, or so he thought.” Sam went on to explain that when he was in his early thirties his narcolepsy began to express itself fully, affecting his “ability to work and play.” He sought medical help and was first diagnosed with depression. After a few years of treatment without the cessation of his symptoms, he sought new doctors. In Sam’s words, “The new doctors were just like the old doctors, and they started all over, barking up the depression tree. I went through all the steps again (shrinks, new meds, sleep hygiene, et cetera) before I decided that the doctors maybe couldn’t help me with this, so if I was going to get better I was going to have to figure this out on my own.”

Sam then quit his job to tend to his health full time. He went from doctor to doctor, from one specialist to another, until he was eventually diagnosed with narcolepsy—twenty years after his symptoms had begun. He was then prescribed “Dexadrine as well as a few other types of speed and knockout drugs,” explaining further, “But they all seemed to make me really sick.” At the time of our interview, Sam had decided to stop taking medication for his narcolepsy, which he explained as “choos-

Desiring a Good Night's Sleep

ing not to get on the drug grind that most narcolepsy patients are on.” In justifying his choice, he said, “Most of the meds are not yet tested long term, they make me ill, and I do not know any old speed users. I may sleep a lot, but I am *me* when I am awake, and not under the influence of meds. . . . I may have to use them again one day to function. But for now the challenge is for me and my narcolepsy doctor to figure out how to maximize my ‘good’ time.”

What Sam refers to as “the drug grind” is a crisis of desire and intimacy.⁶ It is a crisis that is spatiotemporally specific (it affects Sam at a moment in his life) yet has unfolding implications. It constitutes an event through which Sam’s life will change and be marked. Sam is caught between possibilities: a life of medication and normalcy, undercut by feelings of unease; a life without medication but with social limitations; and variations along the spectrum formed by these two choices. Sam emerges from this crisis with new desires, new intimacies: a new form of life measured against the expectations of spatiotemporal order embedded in American everyday life. Because of the variety of forces and possibilities that this crisis is composed of, Sam’s decision will always entail some doubts: Would another medication be better tolerated? Would some other management of behavior allow him to work? Would another doctor be able to find a more effective cure? This crisis of desire and intimacy brings together the social, the biological, the economic, and the chemical not only to produce treatments for health complaints but also to produce new complaints; this crisis of desire and intimacy both depends on old expectations of normal bodies and behaviors and produces new normative ideals of health and spatiotemporal orders of the everyday.

Consider, for example, the differences between the foundation of sleep medicine—the consolidated eight hours of sleep—and the actual sleep patterns of disordered sleepers. For every disordered sleeper and his or her bed partner, what is of primary concern is a lack of sleep. Increasingly, medical insurance plans in the United States have recognized the need to cover sleep studies and pharmaceuticals to normalize sleep. And to ensure that patients are properly diagnosed, the American Academy of Sleep Medicine requires accreditation of sleep professionals and their clinics, working to insinuate their authority between medical professionals, medical insurance policies, and patients. Insurance plans cover some treatments and not others; clinicians provide some diagnoses

Desiring a Good Night's Sleep

and treatments and not others; and, most important, individuals respond to some treatments and not others. Between what is provided and what could be, on the one hand, and what is responded to positively by individuals, on the other, invariably doubts occur. And it is in this gap between the lives of individuals and the spatiotemporal formations of everyday life that most individuals find themselves caught between their sleep disorders and their social obligations, trapped between desires and intimacies.

Sam's choice should not be misconstrued as resistance to medicalization; it is, rather, an attempt to produce another order of desire and intimacy: there is nothing beyond desire, only other models of biological, social, cultural, economic, political, and moral ordering. The side effect of Sam's decision is that he is forced to live outside dominant society: at the time of his interview, he had never finished college and had spent the previous seven years unemployed because of his need for naps and his inability to be at work when required. He lived abiding by only his own spatiotemporal rhythm, and although this rhythm overlapped at times with the dominant spatiotemporal orders of American society, it failed to be so synchronized as to qualify him as a "normal" sleeper. If resistance can be read in Sam's refusal of medical treatment, it should be read as a rejection of the dominant form of life endorsed by contemporary capital interests that would require him to treat his disorderly sleep through pharmaceuticals, not a rejection of everyday life altogether.

In contradistinction to Sam is Kate, a white woman in her mid-fifties at the time of her interview. Her narcolepsy symptoms had begun at around age fifty-one, and she struggled through her local medical community over the ensuing two years, attempting to be properly diagnosed. In addition to the excessive daytime sleepiness often associated with narcolepsy, she also experienced hallucinations at sleep onset and frequent insomnia. In part this latter symptom had led to her first diagnosis of depression, but when the symptoms failed to resolve themselves after she was placed on antidepressants, she sought further help. After being diagnosed with narcolepsy, she was first placed on Provigil and Adderall, but she developed what appeared to her to be restless legs syndrome as a side effect of the drugs. In consultation with her doctor, she was placed on Xyrem, which resolved her narcolepsy symptoms and her RLS. Also, a desired side effect of the Xyrem, as she explained, was that it "structured"

Desiring a Good Night's Sleep

her daily life, because she needed to ensure that regardless of what she was doing she would be able to take her required medication. The difficulty she faced with her initial Xyrem prescription, however, was its dosage. The drug had originated from Jazz Pharmaceuticals, and her doctor, unfamiliar with it, depended on the authorities at Jazz to guide his dosage of Xyrem for Kate. Unfortunately, the company started her at a much higher dosage than her body could handle, and she quickly became uncomfortable with the drug's effects. This led her doctor to lower the dosage and gradually work his way back to near the expected dosage ceiling. Despite her problems with Xyrem, Kate referred to it as a "godsend."

The model narcoleptic subject is Martin, a twenty-one-year-old white man at the time of his interview. He had had narcolepsy symptoms since around his sixteenth birthday, including frequent cataplexy attacks. In addition to carrying prescriptions for both Xyrem and Provigil, Martin had also been diagnosed with bipolar disorder, which was medicated with Lamictal; with attention deficit disorder with hyperactivity, treated with Focalin XR; and with persistent panic attacks, treated with Paxil CR and Xanax XR. To improve his daytime alertness, Martin was also prescribed Adderall XR, which was often used for ADHD. He also reported that when needed, he would supplement this array of drugs with additional Focalin and Xanax tablets. In conversation, Martin estimated that the cost of his monthly prescriptions ran upward of three thousand dollars, a cost that was offset by his parents' medical insurance plan; as he discussed his future employment possibilities, Martin was certain that he needed to find an employer with a comprehensive health care plan. Amazingly, with his multiple prescriptions, he experienced no side effects, a feat that Martin ascribed to his primary sleep physician, a psychiatrist who specialized in sleep disorder patients who carried multiple diagnoses. Also rather exceptional was Martin's susceptibility to the many drugs: each of them seemed to have exactly the effect desired. Because of this efficacy, he was thoroughly ensconced in the spatiotemporal order that comprised the pharmaceutical, economic, and social obligations and commitments that maintained his treatments. The area where his narcolepsy seemed to be a continued source of tension was his love life, in which he was unable to keep a steady girlfriend, his most recent being unable to cope with his narcolepsy despite his pharmaceutical normalization.

Desiring a Good Night's Sleep

What these three cases evidence is the varying degrees to which bodies tolerate medication, the degrees to which individuals are willing to resolve their sleep complaints by developing new desires and intimacies, and the degrees to which they are willing to accept dominant pharmaceutical answers to their experimentations with sleep and the spatio-temporal order of American everyday life. Sam and Martin tolerated the pharmaceutical treatments and their intimacies at opposite extremes of the spectrum. Neither resolution was entirely satisfactory: for Martin, the side effects of treatment circumscribed his dating life and his possible employment paths; for Sam, opting out of the pharmaceutical prescriptions for his narcolepsy entailed similar social impacts. Kate, however, seemed to be able to negotiate some middle ground in her pharmaceutical and intimate investments. Kate's negotiation of both the medical system and attempts to treat her symptoms eventually led to the correct diagnosis, but even then she needed to further negotiate the prescriptions given by her sleep doctor. With the right drug, Xyrem, Kate was able to return to her everyday social obligations, fully insinuating herself back into the dominant spatiotemporal order of everyday life. The drawback to Xyrem, as she noted, is the force the drug exerts on the daily life of its users, requiring them to take it at specific intervals, based on normative models of everyday life.

Unfortunately, for some narcoleptics, pharmaceutical treatments are necessary for integration into mainstream social life, particularly in terms of modern work, school schedules, and family life. For those who exempt themselves from the use of pharmaceuticals, and even for some who do not, napping treatments prove only marginally effective, often requiring social sanctions for their exercise. The increased pharmaceuticalization of sleep and its disorders in American society might decrease a tolerance for napping, with the expectation that disorderly sleepers will seek pharmaceutical help rather than negotiate social allowances for napping or for flexible work schedules. With pharmaceutical companies' increased persuasion for the medicalization of sleep in American society, the choice to decline medical treatment, as in Sam's case, may become increasingly rare and perceived as dangerously antisocial. The desire for normative sleep, regardless of the intimacies involved, dangerous or benign, may become hegemonic in its demands of individuals and their mediated relationships with the institutions that constitute the spatio-

temporal order of American everyday life. Like narcoleptics, who are often forced to opt in or out of social interactions on the basis of their desire for sleep, individuals with obstructive sleep apnea provide an example of the need for prosthetic therapies for the mediation of interpersonal intimacies.

Three (or More) in a Bed: Obstructive Sleep Apnea

In this section, I focus on three cases of apnics, the first being that of Dave Hargett, who interviewed in 2006 and had been the chairperson of the board of directors for the American Sleep Apnea Association since 2002 and who had decided to be an activist in regard to apnea throughout his retirement. This is followed by a discussion of a couple who are both sleep apnics, an increasingly common occurrence among bed partners. I focus here on the narratives of Rosaria and Robert Kristophsen, who exhibited different forms of sleep apnea and shared their bed space with two machines, making the scene of their marital intimacy also a scene of shared human-machine intimacies. I came to know Hargett through my year in the Chicago area, where I spent time with local patient support groups, in particular the apnea support group named AWAKE (Alert, Well, and Keeping Energetic), in which Hargett was foundational in forming, planning, and leading. The meetings of this group provide a space for the newly diagnosed and longtime apnics to discuss treatments and for knowledge about new technologies and therapeutics to be disseminated. As such, the meetings are not in the confessional idiom that Alcohol Anonymous meetings are but rather are about negotiating diagnoses and therapies. Secondly, they serve as social networking opportunities, and it was here that Hargett introduced me to the Kristophsens because of their frequent involvement in a number of support groups throughout the Chicago area, in which they took as their focus the need to help newly diagnosed apnics come to some understanding of the normalcy of being an apnic and the abilities to negotiate with one's therapeutic treatment, especially within the context of a shared bed and as intimates.

Hargett was diagnosed as a sleep apnic after a series of social travails and health complaints. At the time of his interview, Hargett had the physiology of a classic apnic, being slightly obese with a thick neck; he

Desiring a Good Night's Sleep

had recurrent health problems, some of which were related to his apnea, but others were related to his diet and lifestyle, including high blood pressure and a history of heart attacks. In our conversation, he discussed his personal experiences as a sleep apnic and the many complications it had produced in his life, as well as the history of the American Sleep Apnea Association and his leadership of local AWAKE groups, placing his life as a disordered sleeper in the context of attempting to help produce order for other apnics in their newly diagnosed lives and search for treatments. Hargett was diagnosed with sleep apnea at the age of forty-five, in 1993, when the disorder was still relatively newly recognized, and he reported exhibiting eighty-two or more apnea events an hour, a count that qualifies as severe apnea. This means that in the course of one hour, Hargett would choke to the point of waking up eighty-two times, barely sleeping through a single entire minute. In Hargett's description of his experience, marital intimacy played a central role. Unlike the experience of most apnea patients, however, Hargett's quest for treatment was motivated not by the discomforts of his bed partner but by an article published in the *Chicago Tribune*:

I was beginning to find myself getting up almost hourly at night to go to the washroom, to urinate. I had begun to think that—this is the summer before I got diagnosed—I probably had a bladder problem or a prostate problem, and I better go see the doctor about it. But meanwhile, in September of '93, I read an article about sleep apnea in the *Chicago Tribune*—that's when I figured out "I think the symptoms described in this are what I have." So unlike most patients, where it's the spouse that drives them to get diagnosed, I read about it, thought I recognized it in myself, asked my wife—she didn't believe it initially. It then took me a year to get my machine, partly because I just never pushed myself to go check it out.

Between the time of Hargett's self-diagnosis and eventual consultation with his primary care physician, he and his wife lived through his severe apnea. As Hargett narrated their negotiations of his sleep disorder, the spatial disruptions of their intimacies figured prominently, with his wife being displaced through her own need for sleep, first to an unused bedroom and eventually to the living room couch. This movement was framed as a result of her own inabilities to sleep through her bed partner's disrupted and disrupting sleep:

Desiring a Good Night's Sleep

I'm curious about your wife's sleep. She must be a very deep sleeper to have slept through your apnea events.

She wasn't. She was hitting me to try and get me to turn over. Of course most of the time I didn't even know it. She was getting very disturbed for a while. . . . She had put up with my snoring and hadn't really realized the pauses in breathing. So I think [my apnea] developed over time, worse and worse. . . . The summer I was having all of these difficulties, she moved into the other bedroom, which is sort of a temporary room where we have a Murphy bed; I was uncomfortable, but it was better. Except that there was a common wall, and pretty soon she was hearing me through that wall. So for a couple months she was sleeping out here on the sofa. . . . If she fell asleep first, she could maybe get some sleep. But if I went in there and fell asleep first and was snoring . . . she would have major problems trying to fall asleep. . . . We jokingly talk about one of the symptoms that's not in the literature is the bruised ribs from a spouse's elbow: "Wake up, honey, roll over."

What eventually took Hargett from his state of "sleep apathy" to being diagnosed with sleep apnea and eventual treatment was not the disrupted intimacies of the marital bedroom but rather a worsening of his performance at work, a series of minor automobile accidents, and concern with his overall health.

Being diagnosed with sleep apnea in the 1990s offered few treatments (primarily CPAP machines) and only a very limited variety of machines and masks. By the turn of the twenty-first century, the machinery involved with the treatment of sleep apnea had broadly developed, through the interests of both patients and designers and manufacturers, the latter seeing sleep apnea and its accoutrements as a site for possible sleep consumerism. The question of treatment and its successes structures the recounting of Hargett's experience as a sleep apnea patient, and it brings together the concerns of bedroom intimacy with compliance and patient education in his narrative of his eventual diagnosis:

I was in [my primary care doctor's] office at 3:30. At 7:30 that night, there was a home care company rep here with a machine and a mask, no choice. And she tried to explain things, and of course when she left and me and my wife are watching her get in the car we thought, "Oh my god, what did she say? Can I use this thing?" 'Cause when

Desiring a Good Night's Sleep

she was showing me how to use it, she had the mask in her hands, and she's bringing it to me, and she has it two to three inches from my face, and she powers on the air. Well, that's not a good way to introduce you; that's like the proverbial dog sticking his head out the car window, ears and hair flopping, because you get this rush of air, and it takes your breath away, and you think, "Oh my god, there's no way I can sleep with this damn thing." And so she left, and we're so panicked, and we're not sure what's going on, so we said let's both call in and leave word at work that we're not coming in tomorrow, 'cause we're not sure what's going to be going on tonight. So we finally got brave enough to go to bed, and I put the mask on, lay down, and got comfortable, and promptly fell asleep for five hours. So I knew there was something special going on when I didn't have to get up every hour to go to the bathroom. Now, my wife laid there those same five hours with her hand on my chest because I wasn't snoring, and she wanted to be sure my chest was going up and down to make sure I was still breathing. I was more rested the next day than she was.

Hargett's narrative is well honed, a result of his role as a support group leader and a public figure in the dissemination of knowledge about sleep apnea and its treatments. By bringing together his experience both as a patient during a less technologically expansive era and as a husband and bed partner, Hargett simultaneously evidenced his grandfatherly role among sleep apnics (despite his comparatively young age) and his everyman-ness as a disrupted and disrupting intimate and spouse. This was supplemented with an acknowledgment on his part for the need to become intimate both with his therapeutic technology and with himself as a more orderly sleeper.

On the Saturday, following his use of the CPAP machine, a day on which he would normally feel lethargic and nap, he finally realized the success of his treatment:

At 11:00 that night it dawns on me: "Hey dummy, you haven't felt sleepy today. You didn't take your two-hour nap; you kept going all day long." I literally walked out into the hallway and banged my head against the wall and said, "You dumb son of a bitch, this thing really works." For me I saw a major difference in how I felt, not so much how I really, really felt, but in the need for sleep, for that nap. So, of course, I didn't nap on Sunday; I saw a difference in four days.

Desiring a Good Night's Sleep

The line I use with most patients in my support groups these days is, “I saw a difference in four days; some people, it takes four weeks; some four months; and I actually know one person who struggled with CPAP for four years.”

Throughout Hargett’s narrative of his illness and treatment, he deployed thematic refrains about the beneficial effects of CPAP and BiPAP machines, the necessity for compliance on the part of patients, and the need for the patience of bed partners—all calls for reconfigured intimacies across bodies, between bodies and machines, and between individuals and their institutional roles. This is most evident in the following apocryphal story, related to Hargett by a representative from one of the sleep apnea technology companies, which Hargett retold in our conversation and at support group meetings:

This seventy-year-old man—I’ll call him Frank, his wife Mary—was diagnosed with apnea and prescribed a CPAP. So the home care rep comes in; she asked Frank to have Mary there because she always likes to show both partners how the machine worked and describe it. Sometimes the apnea patient, whoever it is, doesn’t always remember everything right or just doesn’t remember it at all, so it’s always nice to have both partners there. And the lady [Mary] says, “Oh, all right, I’ll be there”; she was real grumbly, and she said, “I’ll help him get started on this thing, but when he’s started and he’s feeling better, I’m out of there. This is not the man I married fifty years ago; he’s nasty, he’s irritable, he’s a terrible person to me these days. I can’t stand him anymore; I’m leaving, and we’re getting a divorce.” . . . Two weeks later the tech calls back to Mary and says, “How are things going?” And she says to the tech, “Frank just made us reservations at a local romantic hotel”—she was giddy.

Throughout Hargett’s narratives—his own and those he attributed to others—intimacy between partners and the need to adapt themselves and their bed partners to machines, to the noises and benefits of those machines, bring together diverse experiences of disorder. Complex relationships between human bodies and desires for sleep are brought into accord with the rhythms of therapeutic machines, and this intimacy is founded on the burgeoning capacity of the newly ordered, sleeping body and its prosthesis. There is always the possibility of noncompliance, that those involved will be unable to forge this intimacy, and there is also the

Desiring a Good Night's Sleep

possibility of even more complex therapeutic intimacies, involving more bodies and machines.

The success of apnea treatment is equally evident in the case of Rosaria and Robert Kristophsen, who, as mentioned above, were both apnics and found a reconfigured intimacy at the heart of their parallel diagnoses as disordered sleepers. Both were relatively young at the time of interview: Robert was thirty-five, and Rosaria was twenty-nine. They had been diagnosed one and three years before, respectively. Unlike Hargett, Robert and Rosaria had less stereotypical bodies for apnics, although Rosaria's neck was very short, which she cited as being one of the causes of her apnea. Robert, on the other hand, had no stereotypical associations with apnics, which he saw as a stumbling block to his diagnosis and eventual treatment; clinicians had thought that apnea seemed an unlikely cause of his poor sleep. What had led Rosaria to seek treatment was her father's diagnosis as a sleep apnic: his primary care physician had asked him if he had any children and if they had symptoms similar to his own. He noticed that when Rosaria would come home from college, she would spend much of her time napping on the living room couch and loudly snoring. He consulted with her, and after she took an online survey to identify symptoms, Rosaria came to understand her chronic sleep deprivation and sudden weight gain of seventy pounds as the result of severe sleep apnea. Similarly Robert's father had been diagnosed as an apnic, and while Robert was visiting his parents his mother noticed that he was a loud snorer. As Rosaria narrated their relationship, their shared lives as disordered sleepers were placed within the context of their intimacy as bed partners:

We met in May of '02, and Robert used to always complain that he could hear me snoring, and I was constantly tired—more so than him; he was a lot more energetic then. I was constantly tired, I'd wake up with extreme headaches, and one headache—I couldn't even go to work it was so bad. . . . We started dating in August of '02, and like I said, I was diagnosed and being treated by December of '03. I do think that exterior conditions of sleep apnea were affecting me more than they were affecting him.

Were you aware of symptoms in Robert after you got treated?

Yes, especially a few times I got worried because he choked and coughed. He used to fall asleep right away . . . and he'd start chok-

Desiring a Good Night's Sleep

ing. . . . He's snoring and stuff, and I didn't really realize that, because he usually came to bed after me, and by that time I was with my CPAP machine and I didn't hear him.

Their individual disorders served as a mechanism for their support of each other and acted as a foundation for their intersubjective understandings of each other as disordered sleepers, bed partners, and intimates, in some cases through the machines that both Rosaria and Robert relied upon for normal sleep. Their desire for sleep both molded and was molded by their desire as intimates. But their intimate relationships with their treatments allowed for new intimacies to unfold.

The Kristophsens' shared burden of sleep apnea diagnoses and their ability to negotiate each other and their individual health concerns were what endeared them to Hargett. The Kristophsens would routinely attend local AWAKE support groups to evidence how a couple could successfully found new intimacies despite sharing their bed with medical prostheses. As Robert related in our conversation:

We support each other. . . . We were kind of joking [when we were first diagnosed] that we were kind of like two elephants with [air] tubes, and someone said, "Well, can't you have the things [CPAP machines] with like a splitter?" and I was like, "No, she's at one pressure, and I'm on a different one, so we have our separate machines." We have to have, obviously, a nightstand on either side of the bed.

Rosaria narrated their shared duties with their machines, both in terms of their daily care for each other and with a view to their continued marriage and apnea symptoms:

I take care of cleaning the masks and our chambers and our hoses; he fills our chambers at night, and I empty them in the morning. So it's pretty much routine. . . . The only thing is that I don't know how to get Robert's chamber open to empty the water in it. I need to learn how to do that so that if he's ever in the hospital or something and can't do it himself, they say the spouse should know how to set up the equipment and put the mask on.

Rather than perceive their disorders as a site for tension between them or as individual burdens, the Kristophsens accepted them as a means to express their intimate relations with each other, as mediated through their relationships with each other's therapeutic machines. As in the case

Desiring a Good Night's Sleep

of Hargett and his wife and the narratives of other apnics that Hargett incorporated into his discussions of ongoing therapy for sleep apnea, the Kristophsens' collective treatment depended upon their intimacy with each other and with each other's therapeutic prosthesis. These relationships, as Rosaria made explicit, were often direct, such as in her cleaning and maintenance of both of their machines and in her learning how to operate Robert's machine as well as her own.

In the following, Robert and Rosaria reflected on the way sleep disorders affected their social relationships but also offered the possibility of reconfiguring those relationships:

ROBERT KRISTOPHSEN: The good thing is that we support each other and understand what each other is going through. We have different masks and different pressures, but . . . we have that support for each other. It's not a curse.

ROSARIA KRISTOPHSEN: Plus, I think, too, with our fathers having it, we realize how this is affecting our whole family and how it affected their spouses and us, and—everyone's involved in this. Whether our mothers have it or not, they're still involved.

This intimacy between Rosaria and Robert was achieved through their mutual understanding of each other's health complaints and the dependencies that such disordered sleep enforced in their use of technological prostheses. Apnics offer an example of bodies interacting with and extending themselves through prosthetic therapies, whereas other disordered sleepers offer cases of molecular therapies, pharmaceutical and chemical prostheses that alter human capacities through more discrete means, affecting bodies and their interactions with the world.

The Delicate Balance of Insomnia

At the time of our interview, Betsy was a white woman in her early fifties, having retired early from her career partly as a result of irresolvable insomnia. She described the impacts of her insomnia on her work life:

It made work difficult. It made me take drugs that I didn't want to take. But I couldn't manage my insomnia without taking drugs. I've had very demanding jobs, and I needed to be sure that I could function. Some people, I guess, can function well with little sleep, but I

Desiring a Good Night's Sleep

just don't function well with little sleep. . . . And as I look back, I think I would have made different decisions about work . . . and I probably would have done better with a less demanding job. I don't think it's good for you; I think it messes with your brain. I used to think I was unusual, but now I think I'm quite typical.

Betsy's case was exceptional, not as an insomniac, but as an insomniac who could jettison the obligations of work early in life: because of economic support from her husband and having already ensured that her children had made their way through school and established themselves in careers and with families of their own, Betsy had been able to muster out of the workforce. She explained her life outside work specifically as a reaction to the pharmaceutical ordering of her life that the obligations of working forced upon her:

Therapeutically what have you tried?

Oh, lots of drugs. Lots and lots of drugs. Everything from benzos to Xanax, antidepressants, and all the tricyclics. . . . Let's see, I've even taken muscle relaxers mixed with other drugs. And they're effective for a while, and then they all wear off. I've taken them for years, and when one stalls out I go back to the doctor and get a new drug. And drinking [alcohol] helps. But I know better than to do much of any of them. . . . I would get dependent on all of this stuff, and when it came time to change I would need to wean myself off of it.

How are you treating it now?

I am off all drugs. Since I moved here about five years ago, I am no longer working. I retired early. And so I have a lot more flexibility of time, I don't have to get up early in the morning, and I don't have the stress of a job. . . . I've been messing around with my insomnia since my life has changed a lot. And I just decided, about a year ago, to go off all drugs. Nothing seemed to be working. I mean, nothing worked for a long time without side effects. . . . It took about six months to get totally weaned off everything, so now I just practice good sleep hygiene.

This ability to except oneself from the obligations of work and the chemical dependencies that those obligations can generate among insomniacs is uncommon, and most insomniacs struggle to regulate their heterodox sleeping patterns in order to be fully integrated into the broader spatiotemporal

order of contemporary American society. Betsy's ability to treat her insomnia without pharmaceuticals and caffeine, but rather through the social management of her everyday life, is remarkable; for Betsy, living with insomnia and work meant being chronically sleep deprived, and attempting to manage the social and biological chaos produced by her sleeplessness led inevitably to investing herself fully in the everyday intimacies of contemporary social life, especially work, through reliance upon chemicals. Entrenching oneself in the everyday orders of desire and intimacy that work often necessitates only helps to exacerbate the unruliness of sleep disorders. Chemicals offer discrete forms of therapies, acting upon the biologies of those who employ them, in turn rendering emergent desires and intimacies and altering those extant intimacies and desires that make up individuals' everyday lives. This is no more apparent than in the case of REM behavior disorder.

REM Behavior Disorder: Inverted Intimacies

In the case of REM behavior disorder (RBD), new intimacies can be founded between bed partners, but the phenomenology of the disorder is psychologically and physiologically disruptive, and it produces crises in relationships because of its extreme symptomatic expressions. These effects are in part the result of the expectations of what such severely disordered sleep apparently explains about the intimacy of bed partners. What is involved in the negotiations of the cause of these bedtime behaviors is a clinical placement of RBD, and sleep disorders more generally, firmly in the realm of the physiological rather than the psychological; RBD as a boundary diagnosis is the site of contestation between sleep specialists and sleepers, because physicians attempt to explain its pharmaceutical fix of physiological problems despite what appears to patients (and sometimes to other researchers) as a dramatic psychological disorder. The problem faced internally by the researchers and clinicians who originally diagnosed RBD is that while treatment with small doses of the drug Clonazepam is "exquisitely effective," they have no idea how or why it works, according to Mark Mahowald, the neurologist involved in the initial diagnosis of the disorder. Moreover, as explained by Carlos Schenck, the psychiatrist who defined RBD, "It's natural for a lot of people, including physicians, to conclude that [RBD] must be a

Desiring a Good Night's Sleep

psychological or psychiatric disturbance because of the phenomenology of the experiences: screaming at night, running around, punching your wife—can't get more psychological than that." In the following, I draw on my fieldwork at MSDC, an interview with Schenck and his *Paradox Lost* (a collection of cases of parasomniacs), and the case of Mel Abel, a man diagnosed with RBD who was foundational in the concretization of the nosological category.⁷

RBD bodies relentlessly attack bed partners and their sleeping environments, and to rectify this, novel contraptions have often been employed. In the following, Mel Abel describes his attempts at physical restraints:

I started tying myself to the bed with a rope . . . when I started getting the bad dreams. . . . I got a piece of clothesline rope that I tied up at the end of the bed. . . . I got a loop on [one] end where I got a heavy belt going through . . . and put this belt around me, because I do turn and flip around a lot during the night.⁸

Other examples of makeshift remedies are similar. The most dramatic case described to me by Schenck is that of a couple who had installed a piece of Plexiglas between two single beds, so that they could sleep next to one another without the wife bearing the brunt of her husband's RBD aggressions. A desire to retain the scene of marital connection, of intimacy, has motivated these experimentations with sleeping space, and when they've proved ineffective, husbands and wives have finally separated into different spaces altogether.

Because of the age of onset in RBD, the first generation of patients diagnosed in the early 1980s were born in the 1930s and earlier and had been married for decades by the time of their search for medical expertise to fix their intimacy problems. In this marital context, the violence of the husband's sleeping behavior was subject to interpretation that assumed a psychological cause, despite expert protestations to the contrary. After years of what was often described by patients and their bed partners as relative bliss, disrupted sleep intervened to cause bedroom and marital strife, often in counterpoint to a waking life that retained earlier intimacies. The staff at MSDC came to largely accept that these RBD patients had serene daytime personalities, best captured in Schenck's introduction to *Paradox Lost*:

Desiring a Good Night's Sleep

Patients with RBD usually have calm and pleasant personalities, and do not display irritability or anger while being awake. Although this has not been rigorously proven in a scientific study, it is a generally accepted maxim by most clinicians familiar with RBD. . . . Only in RBD is this personality profile found so prominently. So what is it about RBD that the people who have it are almost always so pleasant and mellow?⁹

Scheck's question is a perverse one, mixing evolution, biology, society, and psychology into a strange causal chemistry. It is in this matrix of causal possibilities that RBD has developed, and this matrix continues to lend veracity to psychosomatic explanations for a disease that has been increasingly evidenced as physiological and without psychological components. In *Paradox Lost*, husbands recount their dreams and violent behaviors, and wives air their attempts to grapple with their troubled knowledge of their partner, who throughout the day is the polar opposite of his nocturnal self. In one case, a wife explained her husband's temperament: "He's so foreign to anger. Dumb things will make one angry, like other drivers or something, but I always say he just lets problems come and roll right off him. That's why these dreams are so shocking to me."¹⁰ She explained further: "At first I blamed it on the book [he was] reading. I blamed it on that and then I wondered if it was coffee. He was drinking coffee at night, but his stopping this didn't work. Then he said it was not enough sex," to which the husband explained that whenever he and his wife had sex he "never had a bad dream."¹¹ Throughout these intimate deliberations, partners negotiate being with one another against the backdrop of psychological and physiological distress. Explanations that stressed the former over the latter were ruined when psychiatry and neurology intervened, producing a pharmaceutical treatment that relied in no part upon psychological explanations for RBD.

The remedy for RBD is relatively straightforward, involving small doses of clonazepam, which is marketed as Klonopin in the United States and Rivotril elsewhere. Clonazepam is primarily used as an anticonvulsant, and Schenck and Mahowald, as they described to me, guessed about its use in attempting to suppress the dream enactment behaviors pharmacologically; they presumed that as an anticonvulsant it would trigger the loss of muscle tone, a loss that RBD bodies don't experience during REM sleep. In other words, while most sleepers are paralyzed during

Desiring a Good Night's Sleep

REM sleep, preventing them from acting out their dreams, sleepers with RBD are not, but the clonazepam works to produce this paralysis pharmaceutically. Clonazepam works in about 90 percent of RBD bodies and has the unexplained side effect of also curtailing violent dreaming. Some other treatments have included the use of melatonin and stress-reduction techniques, both of which have had dubious results, and dopaminergic pharmaceutical regimes, which are effective for most who exhibit RBD symptoms.

What I can only hint at here are the difficulties that a physiological diagnosis raises for couples who involve an individual with RBD symptoms and have explained the presence of his or her unruly behavior as necessarily psychological. Because popular explanations lend themselves to understanding RBD as some eruption of suppressed hostility, a pharmaceutical fix can be a disappointment; it can disrupt the intimacy developed from being with a partner with extreme sleep disruptions. This is especially the case when family life has been reorganized around the understanding of RBD as sublimated aggression, including, as mentioned above, the use of paraphernalia to maintain the marital bedroom scene. This can be the case despite the crises provoked by such interpretations of disordered sleep and machinations around it, which may have to do with this historical moment in the transition between psychological explanations and pharmaceutical treatments for the disorder. One element of this is the tension between the permanent fix that psychiatric therapy might provide and the chemical dependencies that contemporary medicine offers to RBD bodies: the condition never resolves itself and instead must be medicated against daily. Another element of this tension is that instead of the disordered sleep being understood as shared only by the couple, as necessarily a product of intimacy, it is conceptualized as a manifold concern; at the end of the day, the disordered sleeper's problem is her or his own to medicate or not, but the symptoms of it are shared by any proximate cosleeper or bedroom furniture and become integral to all social and biological relationships. Thus, the intimacy shared between disordered sleeper and bed partner is replaced with a pharmaceutical intimacy between the disordered sleeper and his or her medication, and this pharmaceutical intimacy is mediated by a clinician and is predicated on the need for medical intervention. But there may be a middle ground, an interpretive space of desire and intimacy where an

Desiring a Good Night's Sleep

ambiguous relationship between physiology and psychology, chemistry and cohabitation, might linger, as described by Schenck in our discussion of a case of a sleepwalker who was abused in her childhood:

For some [parasomniacs], yes, certainly there is a causal relationship [between abuse and the manifestation of a sleep disorder], but you still have to be genetically predisposed. . . . I saw a patient very recently that was fascinating. . . . She started sleepwalking—just uncomplicated sleepwalking—at the age of three that lasted pretty much weekly for a number of years. Then her father sexually assaulted her—actually began to sexually assault her—at the age of ten. Shortly thereafter she developed sleep terrors. The point is that she already had disordered arousal and a non-REM sleep parasomnia beginning at age three with sleepwalking. So the sleep terrors unmasked what was biologically there. Maybe she never would have developed sleep terrors, but she already had disordered arousal before the abuse, so that's kind of a mixed picture that way. If she was not a sleepwalker, maybe she would have developed horrible nightmares out of REM sleep and never had sleep terrors. . . . You can't be too biological—that's very bad. You have to be much more global and explore the psychology of the person and the family history as well. I think more often it's a mixture of the biological and the so-called psychosocial.

So far as extant explanations of RBD go, there are no “psycho-social” causes of the disorder; I offer this middle ground as an intimate space that might be deployed more globally to understand sleep and the relationships that it produces beyond the physiological and pharmaceutical fixes offered by contemporary sleep medicine. This might be unsatisfying or seemingly romantic, but it is a way to bring together the various kinds and qualities of intimacy and expertise across social forms, between patients and clinicians, between patients and their bed partners, between disordered sleepers and their treatments, and between pharmaceuticals and their mediators. If the dyad of psychology–physiology is brought into these social networks, a perverse chemistry of nature and culture can be seen operating in the expertise of oneself and in the sleep of others. Objective expertise might be replaced by subjective intimacies that bind actors together across bodies, diagnoses, therapies, and

Desiring a Good Night's Sleep

the relationships they produce and that constitute the order and disorder that make sense of disrupted sleep and its daily wages. Accepting sleep's desirous and intimate logics allows for treatments that might be primarily physiological or technological and also allows for recognition of the social and psychological fixes that are required to make sense of sleep disorders such as RBD and sleep apnea in intimate relationships. And, finally, such an acceptance allows for dialogical explanations to emerge between those who are experts on the sleep of others and those who are experts on their own disordered sleep and the disordered sleep of bed partners, thereby producing intimacies that provide means for thinking beyond pharmaceutical, technological, and nosologic fixations of sleep and its disorders.

Desire and Disorder, Order and Intimacy

Across kinds of sleep disorders, individuals confront personal desires for sleep that chafe against institutional orders. In some cases, these other desires for sleep can be resolved through medical interventions. In other cases, medical interventions prove intolerable for individuals and their families. In any case, individuals form their own orders, everyday lives that meet their desires and intimacies. The contexts of these everyday lives are the institutions that shape and are shaped by these same desires and intimacies. Our desires for sleep serve as a mechanism to connect these many institutions, which find their logic in appeals to our human nature. This natural basis for both individual behaviors and institutional orders makes everyday desires and intimacies appear to have long-standing, if not eternal, significance. Conceiving of our desires for sleep as founded in prehistorical, precultural nature is an appeal to primordial logic, a justification for contemporary formations that makes claims to a basis in reality despite being fictional. From this basis, individuals come to understand their alternative orders as *disorders*. Some institutions develop to mitigate these disorders, offering individuals other orders through which they might organize their lives. Simultaneously, these institutions offer yet other orders for everyday life and our desires and intimacies. Whether or not these other orders will succeed has as much to do with the ways that individuals and other institutions invest in them as with

Desiring a Good Night's Sleep

the alternatives they provide. In the following chapters, I trace the desires for sleep and the intimacies these desires produce—between individuals, between individuals and institutions, and between individuals and the many therapeutic possibilities they confront. Brought together, they provide a glimpse of the complexities of contemporary American sleep and its possibilities.