

Pre-1950s Medicalisation of Sleep

Ramona Marinache

Department of Cultural Studies, Faculty of Letters, University of Bucharest,
Romania

Медикализация на съня преди 1950 г.

Рамона Мариначе

Катедра по културни изследвания, Факултет по литература, Букурещки университет,
Румъния

Author Note

Ramona Marinache  <https://orcid.org/0000-0002-4072-8253>

The author has no known conflict of interest to disclose.

Correspondence concerning this article should be addressed to Ramona Marinache,
University of Bucharest, Faculty of Letters, e-mail: ramona.marinache@unibuc.ro

Бележки за автора

Рамона Мариначе  <https://orcid.org/0000-0002-4072-8253>

Авторът няма конфликт на интереси.

Кореспонденцията, свързана с тази статия, да бъде адресирана до Рамона
Мариначе, Букурещки университет, Факултет по литература, е-майл:
ramona.marinache@unibuc.ro

Abstract

Many social studies emphasize that sleep medicalisation has emerged in the 1950s, with the rise of somnology. In this paper, I argue that the medicalisation of sleep is rather selective and incomplete. Building on the remark of one of the founding fathers of the sociology of sleep, Simon Williams' (2005), that if we revisited the nineteenth-century medical texts, we would notice evidence of early, pre-1950s medicalisation of sleep, I analyzed nineteenth-century public health policies and documents in Romania and found evidence that, during the nineteenth century and the first half of the twentieth century, sleep was, de facto, medicalised due to the general trend to medicalise the body. I outline two dimensions of this pre-1950s medicalization of sleep: the rationalization and the hygienisation of sleep.

Keywords: sleep, medicalisation, modernity

Резюме

Много социални изследвания подчертават, че медикализацията на съня се е появила през 50-те години на миналия век, с възхода на сомнологията. В тази статия твърдя, че медикали на съня е по-скоро селективна и непълна. Надграждайки забележката на един от бащите-основатели на социологията на съня, Саймън Уилямс (2005), че ако преразгледаме медицинските текстове от деветнадесети век, ще забележим доказателства за ранна медикализация на съня отпреди 1950 г., аз анализирах политиките и документите за обществено здравеопазване от деветнадесети век в Румъния, и открих доказателства, че през деветнадесети век и първата половина на двадесети век сънят де факто е бил медикализиран, поради общата тенденция за медикализация на тялото. Очертавам две измерения на тази медикализация на съня преди 1950 г.: рационализирането и хигиенизирането на съня.

Ключови думи: сън, медикализация, съвременност

ARTICLE INFO:

Original Article

Received: 18, 06. 2024

Revised: 29, 06. 2024

Accepted: 22, 07.2024

Introduction

The sociological study of sleep is an established one. Among social sciences, there is now little need to justify the necessity of this distinct scientific domain. The purpose of the first sociological ventures into sleep was to present its historical and cultural variations that reveal its social nature (Aubert & White, 1959; Melbin, 1978; Schwartz, 1970; Taylor, 1993). Thus sociologists, in their research relied on the previous work of historians and anthropologists. In their turn, anthropologists emphasized the cultural differences that appear in sleep practices and the body techniques involved in it (Benedict, 1989; Mauss, 1973). Historians, through their longitudinal and transversal studies, revealed the changes that occurred in sleep practices over the centuries (Kroker, 2007; Summers-Bremner, 2008); those changes that occurred in the time and place where sleeping happened, that is, usually, at night time (Ekirch, 2005), in the bedroom and bed (Wright, 1962). Additionally, geographers reinforced the anthropological findings on sleep, stressing the importance of mapping daily routines (Kraft & Horton, 2008). To all of these, one can add the re-reading of classical works of scholars such as Norbert Elias, Michel Foucault, and Max Weber, who captured instances of the complex relationship among issues like social, sleep, illness, and health in their depictions of how the modern societies were constructed. In doing so, they brought forth illustrations from everyday life, instances that today can be used as fundamentals in the sociological analysis of sleep.

The perspectives of social sciences on sleep tend to converge with those of medical doctors when attempting to obtain a comprehensive view of sleep. One core topic in the sociology of sleep has been its medicalisation (Williams, 2002). Starting from Simon Williams' (2005) observation regarding the existence of a pre-1950s medicalisation of sleep, I looked at Romanian society between the second half of the nineteenth century and the first half of the twentieth century. During this period, the body was medicalised as a whole, undivided, and sleep was medicalised implicitly at the same time as the body.

The data that I used depict the Romanian society during the nineteenth and early twentieth century. I used three types of data: histories of medicine and social hygiene; sanitation monographs; and, popular press featuring medical advice, mainly newspapers and magazines. In addition, I used a series of sanitary reports and works of medical historians in the public, and administrative domain. The data collected from these sources feature two main dimensions of the pre-1950s medicalisation of sleep: rationalization and hygienisation. Rationalization means, in this context, the implementation of scientific medical knowledge in

everyday life, following its spread in the population at large. As a consequence of the interdependencies between people and the environment in maintaining health, doctors also encouraged the hygienisation of sleep. Below, I will discuss some aspects of this interplay between environment and health and I will end with some theoretical implications related to the sociological study of sleep and the body.

Medicalisation

In social sciences, the discussion on sleep medicalisation is closely connected to the emergence of the medical profession with the changes and transformations it brought along. Castellani and Hafferty (2007, p. 337), for instance, described four changes undertaken by medicine. These changes are the following: the rise of professional medical reform (1890s - 1930s), professional dominance (1940s - 1960s), de-professionalisation (1970s - 1990s), and the organized effort to reclaim and redefine the professional medical status (1990s - present). These four stages originate in medicalisation and the expansion of its professional jurisdiction, the latter being implemented through sanitation and hygiene laws and the organization of scientific medical education (Conrad, 2007).

Medicalisation is a term that appeared in sociology in the 1970's at first being a way to criticize that more and more aspects of everyday life have become medical (Szasz, 1963; Zola, 1972). Foucault in the *Naissance de la clinique* (1963), was one of the first scientists to speak about this without ever using the word 'medicalisation'. Building on Foucault, Thomas Szasz (2007, p. xvi) demonstrated that the process started centuries ago with 'medicalisation from below' or self-medicalisation, followed, centuries later by 'medicalisation from above' when doctors became agents of control and power, agents of the modern states. Medicalisation is described as 'a process by which nonmedical problems become defined and treated as medical problems, usually in terms of illnesses or disorders' (Conrad, 1992, p. 210). This process takes place 'using medical language to describe a problem, adopting a medical framework to understand the problem, or using a medical intervention to treat it' (Conrad, 1992, p. 210).

Medicalization of sleep

Some sociologists have focused on sleep disorders and looked into how sleep became a medical problem. The process of medicalisation came to encompass several old or newly defined diseases or disorders of sleep like insomnia, apnea, snoring, or sleepiness, for which medical causes are identifiable, so the intervention has to be of a medical nature (Conrad, 2007).

The first reference to the existence of a 'chapter' of sleep in the medicalising process is the work of Williams (2002), who drew attention to the need for sociological studies of sleep medicalisation that would clarify how sleep is being 'colonized' by 'medical expertise'; he also introduced the concept of healthicisation of sleep which, unlike medicalisation, is a tendency to consider sleep problems as consequences of certain lifestyles. To remedy these problems, healthy life practices are needed, and not medical intervention (Hislop & Arber, 2003; Williams, Seale, Boden, Lowe & Steinberg, 2008).

An empirical examination of Williams (2002) thesis on the existence of a 'chapter of medicalisation' belongs to sociologists Hislop and Arber (2003). These researchers analyzed sleep problems and their management among women, with direct reference to insomnia. They proposed a distinct level of sleep management, an approach that differs from those offered by medicalisation and healthicisation (Hislop & Arber, 2003). It is the level of personalisation, which combines medical remedies with the adoption of healthy sleep practices. Along the same lines, Williams et al. (2008) introduced another process besides medicalisation and healthicisation, namely pharmaceuticalisation. The pharmaceuticalisation of sleep refers to the pharmaceutical consumption of analeptic drugs such as Modafinil and soporifics (which lie outside the medical framework) and to the biotechnological management of sleep problems (Williams, Gabe & Davis, 2009). Williams et al. (2008) showed that today medicalisation, pharmaceuticalisation, and healthicisation operate as processes with distinct experts of the conventional medical science and of the complementary (alternative) ones.

Other authors have focused explicitly on particular sleep problems, such as excessive daytime sleepiness, insomnia, and snoring, and also on the role media plays in the medicalisation of sleep. Kroll-Smith (2003) described the social construction of daytime sleepiness as a medical problem through the shaping of public perception and experiences of sleep in popular media. To this, we can also add several British studies that have examined and differentiated the social construction of insomnia and snoring along gender lines (Arber, Bote & Meadows, 2009; Arber, Hislop & Williams 2007; Meadows et al., 2008). As Conrad (2007) noted, surprisingly, sociologists looked only at deviant sleep and too little sleep as 'natural' life processes. Also, one may notice that much of this literature is centered exclusively on healthicisation, pharmaceuticalisation, and hygienisation (Williams, 2005), a family of approaches that use mostly post-1950s empirical data.

Thus, chronologically, sociologists placed the beginning of sleep medicalisation in the second half of the twentieth century, in the period of professional dominance of doctors. But one

conspicuous absence in the history of sleep and medicalization is the link between medicalisation of the body and sleep during the rise of the medical profession. A close reading of social histories of the body reveals the existence of considerable evidence of early medicalisation of sleep, much earlier than the second half of the twentieth century (see Le Breton, 1990; Foucault, 1963, 1987). They are often found in 'subchapters' about the medicalisation of the sick and healthy body. There are substantial clues about the early medicalisation of sleep in the eighteenth and nineteenth centuries. It is thus possible to imagine a new archaeology of sleep that could emerge from studies of the body. This early phase illustrates that sleep medicalisation had been in effect ever since the beginning of the medicalisation of the body, in the eighteenth century, when sleep was treated as a way to regain or maintain health.

In the nineteenth century the pioneers of public health in Romania, who implemented various public health policies, the interest in sleep has been constant. The medicine, hygiene, and public health works of the time, although not featuring sleep as a central topic, often included medical advice and stressed the importance of sleep as an adjunct in the treatment or prevention of various illnesses that affected or can affect the healthy body. The allopathic doctor was the only expert on the body and implicitly on sleep and they were not restricted to only giving direction and advice about the administration of hospitals. They also provided 'urban and municipal dispositions ... overwhelmingly medical and sanitary' (Barbu, 1967, p. 120). To paint the picture of the pre-1950s medicalization of sleep I analyzed social documents from the history of Romanian medicine and identified two dimensions of it: rationalisation and hygienisation.

Rationalisation

Rationalisation was one of the main forces that transformed the bodies in modernity (Elias, 1978; Turner, 1992). Rationalisation may mean different things, but in the context of medicalisation I will consider it an external regulation of sleep based on scientific medical knowledge, its abstract and precise concepts are necessary for the quantification and regularization of sleep (Ritzer, 2001). Rationalisation led to a body of norms and sets of models for sleep management organized along such concepts or criteria as social strata, class, gender, age, or its toolkit (all objects surrounding sleep). Thus, sleep begins to be governed by a set of principles and models imposed by physicians. Rationalisation was connected with the effectiveness of physical and intellectual activities, and with individual health. The rationalisation of sleep during the pre-1950s medicalisation period took place within several

spheres of social life. Sleep was rationalised in connection with disease, the relationship between sleep and the active period of the day, housing and spatial planning, and relative to the division of labor in society.

Public health narratives were embedding sleep into discourses on disease. For example, in a newspaper from 1882, readers were informed that sleep 'is based on a fatigue of the brain that occurs through the circumstance that a smaller amount of oxygen reaches the brain', because 'it is used periodically elsewhere' (Anonymous, 1882, p. 248). The importance of oxygen was stressed in several accounts as well. Oxygen deficit was linked with the weakening of attention, with thought interruption, blocking the sense of awareness, and with drowsiness. Thus, sleep was increasingly viewed as a physiological process and explained as such, which implies the existence of 'organs that get tired' as a result of the 'relentless' work of fibers and atoms in the 'human organism' (Anonymous, 1882).

Doctors also described sleep as simultaneously a symptom of disease, a cause of disease, and a means of regaining health. Thus one doctor would connect sleep and mental illnesses; presenting various neurological disorders noticed over time among school children, he stated that 'what came to be described as diseases of the nervous system originates in schools: nervousness, headaches, night terrors, chorea, hysteria, neurasthenia' (Felix, 1902, p. 126). For some pupils, the origins of these diseases, he argued, were found in genetics, faulty education, excessive learning, smoking, excessive reading, and lack of sleep. Sleep and its pathologies were often the cause and indicator of a disordered life. Headache and elevated nervousness were seen as causes of lack of sleep, along with anemia, neurasthenia, poor nutrition, and a polluted atmosphere (Felix, 1903). There were frequent references to drowsiness. Sleep appeared as an environmental issue that can be optimized, and controlled, thus, the implicit and explicit conclusion of these doctors was that the rationalisation of environmental factors prevents sleep problems.

Sleep had semiotic value for locating the illness in the organism. A doctor wrote that diseases such as pellagra 'usually occur in the spring and announce themselves by weakness, sadness, lack of sleep, numbness in the hands and feet' (Bravicianu, 1889, p. 92). Sleep problems were also starting to show the presence of mental illness by writhing, insomnia, and nightmares. Changes in sleep practices represented manifestations of mental illness or exhaustion. Physical and mental exhaustion was also seen as being caused by sleep interruptions (Felix, 1903). Medicalisation of sleep, especially of healthy sleep, contributes to the rationalisation of sleep through a series of prescriptions for healing through sleep,

prescriptions on the optimal number of hours of sleep, as well as through the regulation of living space (environment, rooms, and toolkit), aspects that I will describe below.

Another dimension of sleep medicalisation and rationalisation is the number of hours of sleep. Moral norms and authoritative recommendations on leading a healthy life further rationalised sleep (Foucault, 1963). The timing and length of sleep were also subject to medical examination. For health maintenance, a set of rules were given. Although the moment of falling asleep was not mentioned, being usually stated as 'early', 'at sunset', or 'in the evening', physicians indicated that sleep should be practiced at night (Samarian, 1938, p. 13). The afternoon nap should be avoided or practiced on a chair in order not to sleep for more than half an hour (Samarian, 1938). Doctors recommended that going to bed and waking up should happen according to the rhythm of nature. One such common recommendation said: 'Do not change the day into night - to sleep - and do not turn night into day' (Gomoiu, 1940, p. 132).

Regulating the number of hours of sleep became standardized by physicians, according to criteria such as age, residence, occupation, or education. By age, 'sleep should not be more than up to 8 hours for both toddlers and elderly and up to 7 hours for the others' (Bravicianu, 1889, p. 70). Quoting one of Darwin's colleagues in analyzing the division of scheduling of a young student's time, a doctor proclaimed that 'time division is the school's most important aspect, as we have learned from the citizens of The United States, more practically oriented than us, and we adopted their division which is resumed in the simple arithmetic formula $3 \times 8 = 24$: 8 hours of study, 8 hours of mandatory physical exercise, 8 hours of sleep' (Felix, 1892, p. 42).

Another set of regulations referred to the sleep environment. In assessing the diseases, doctors noted that an important factor in the spread and sometimes worsening of disease was the environment, the circumstances in which sleep took place. Thus, the doctor - in addition to information on the required hours of sleep by age, occupation, or environment groups – provided information about regulating the space sleep was conducted. This information is related mainly to the bedroom and to what can be called a sleep toolkit, meaning bed, mattress, bedding, or any other element that may be related to sleep. Doctors provided counsel to both the sick and the healthy. They advised that the bed should be soft and clean and that there should be a special room for sleeping, that must be spacious (Bravicianu, 1889).

Hygienisation

Pre-1950s medicalization led, besides the scientification of sleep, to its hygienisation. Sleep was sanitized in a way similar to other physiological states (Elias, 1978). The process of hygienisation by physicians materialized in-house cleaning through rules and regulations concerning the level of hygiene conducive to healthy sleep or a fast recovery from illness. There were regulations of all aspects of living that influenced sleep: physical and intellectual work, nutrition, and hygiene.

Discussing sleep hygiene in housing is not new. In an overview of the history of eighteenth and nineteenth-century Dutch bedrooms, historian Ileen Montijn (2008) reported the observations of physicians on the quality and quantity of air in the home, as well as its cleanliness it. The study outlines a sleep 'hygienisation movement', as part of the housing reform. Discussing twentieth-century hygiene, Maume, Sebastian, and Bardo (2010, p. 75) showed that physicians offered parents advice on sleep hygiene of children that would include 'a combination of appropriate environmental conditions that facilitates sleep'.. Over time, sleep hygiene has referred to multiple aspects of sleep practices, but the focus will be on the cleanliness of the body, the sleeping space, and sleep paraphernalia.

The recommendations of Romanian doctors regarding diseases were accompanied by guidance on the best ways of maintaining health and how the environment should be altered to facilitate it. Aiming to identify measures for the maintenance of good health, doctors follow in particular the interrelationship between social and natural, between people and the environment. Their recommendations referred to the frequency of washing the body, the clothes, and the objects in the house, and of cleaning the house, the yard, and the streets. In other words, doctors also address the hygienisation of sleep, the sleeping body, and the body preparing for sleep.

Thus, doctors became experts in all areas of daily life. They offered prescriptions on the size and layout of rooms for sleep, their hygiene, and how they should be preserved. Thus, in the 1880s, doctors began a campaign for the hygienisation of everyday life to reduce diseases and recovery time from an illness. This happened because the medical practitioners had, as it appears in many of their texts, the responsibility of modeling the 'medical consciousnesses' of the citizens through 'what is necessary and possible to be known in medicine' (Foucault, 1963, p. 52). Sleep was mentioned in the prenatal records and the ones nurses completed during their home visits to assess the state of hygiene and health for the whole family, as well as in social surveys. In these records, sleep was placed under the hygiene habits, together with fresh air, bathing, cleaning the house, and washing the clothing.

Below I will analyze the requirements related to the bedrooms, outdoor leisure, and body hygiene (Prodan, 1942).

The doctors of the nineteenth century, talking about practicing sleep under optimum conditions, deemed as insufficient the mere adhering to a sleep schedule and maintaining hygiene in the sleeping spaces. The bedroom air must be clean too. A large number of people sleeping in one room and the co-habitation of people and animals led to the 'damaging' of the air. It was therefore recommended that during sleep if it took place in a house, the windows stayed wide open. If windows cannot be opened, the room should be well-ventilated before sleep (Daniello, 1927; Popoviciu, 1942).

Doctors consider fresh air during sleep to be an essential factor for restful sleep and health. Sleeping outdoors was not recommended in any circumstance. For example, peasants from the marshy areas were advised to give up the 'habit of sleeping outside on summer nights, on the porch of the house, in the yard' or the field (Felix, 1902, p. 188). Damp air and mosquitoes, doctors said, could facilitate the occurrence of diseases. Sleep practiced in clean air was considered to be a necessary factor in healing diseases and in the recovery that took place after being cured. A doctor recommended that during the summer, fresh air should be ensured to an ill person, during the day as well as during the night, by opening the windows and giving up the habit of covering the chimney during the night. Doctors warned that in winter time it was also necessary to 'ensure the ventilation, through air renewal for 5-10 minutes every hour' (Zolog, 1934, p. 54). The quantity of air from the sleeping room was also closely regulated, and it should be at least 20 m³ per capita (Daniello, 1927).

Instructions on cleaning bedrooms were accompanied, as seen in the quotes above, by several prescriptions regarding the frequency of ventilation of the room, and of opening doors and windows. To all these, were added indications on avoiding 'excessive crowding of people in the sleeping room', as well as the preparation of the bodies for sleep were added (Orleanu, 1912, p. 215). As a consequence of establishing the fact that diseases were more easily transmitted in a crowded dormitory of boarding schools and an overcrowded house, there were several recommendations on the optimal number of people per sleeping room. Doctors also mentioned the need to separate the children's bedroom from the one of the parents. An article on family education regarding hygienic-sanitary rules drew attention to the fact that 'the result of health education for children in the family depends very much on the example given by the parents, an example that often was followed by children' (Stoichiță, 1946, p. 9).

Conclusions

This article put forth a succinct presentation of the pre-1950s medicalization of sleep. I used data from Romanian society from the second half of the nineteenth century until the end of the first half of the twentieth century. I have noticed that the pre-1950s medicalisation of sleep is manifested through the rationalisation and hygienisation of sleep. The rationalisation of sleep based on scientific knowledge occurred through the process of standardization, distinguishable through the principles of scientific medicine. Rationalisation redefined sleep in medical terms and provided scientific explanations of the consequences that sleep can have on health and disease. Physicians attempted to regulate sleep, based on health, age, and social position. Their recommendations have been accompanied by guidelines and medical advice on the importance of the relationships that humans have with the environment in practicing healthy sleep, thus taking place in the process of hygienisation. In this context, the medical regulations provided guidance on cleaning the air and the spaces and the objects which facilitated sleep. Medical advice also guides people's activities, such as washing the body and clothes, activities that should become pre-sleep rituals. This illustration of the first stages of the medicalisation of sleep is not an exhaustive one, it is my first endeavor into its realms.

References

- Anonymous. (1882). Felurimi [Kinds of things]. *Amicu Familiei* [Friend of the Family], 6(24), 247–248.
- Arber, S., Hislop, J., & Williams, S. J. (2007). Editors' introduction: gender, sleep and the life course. *Sociological Research Online*, 12(5).
<http://www.socresonline.org.uk/12/5/19.html>.
- Arber, S., Bote, M., & Meadows, R. (2009). Gender and socio-economic patterning of self-reported sleep problems in Britain. *Social Science & Medicine*, 68, 281–289.
<https://doi.org/10.1016/j.socscimed.2008.10.016>
- Aubert, V., & White, H. (1959). Sleep: A sociological interpretation I. *Acta Sociologica*, 4(2), 46–54. <https://doi.org/10.1177/000169935900400207>
- Barbu, G. (1967). *Arta vindecării în Bucureștii de odinioară* [The art of healing in the old-time Bucharest]. București: Editura Științifică.
- Benedict, R. (1989). *Chrysanthemum and the sword. Patterns of Japanese Culture*. Mariner Books.
- Bravicianu, D. (1889). *Noțiuni de igienă și medicină populară* [Hygiene and popular medicine notions]. Craiova: Filip Lazăr.

- Castellani, B., & Hafferty, F. W. (2007). Medical sociology. In C.D. Bryant and D.L. Peck (Eds.), *21st century sociology: A reference handbook* (pp. 331–339). New Delhi Sage Publications.
- Conrad, P. (1992). Medicalization and social control. *Annual Review of Sociology*, 18, 209–232. <https://doi.org/10.1146/annurev.so.18.080192.001233>
- Conrad, P. (2007). *The Medicalization of Society*. The Johns Hopkins University Press.
- Daniello, L. (1927). Profilaxia socială a tuberculozei [The social prophylaxis of tuberculosis]. *Buletin Eugenic și Biopolitic*, 1, 355–360.
- Elias, N. (1978). *The Civilising Process: The History of Manners* (Vol.1). Oxford Basil Blackwell.
- Ekirch, A.R. (2005). *At night's close: a history of night time*. W.W. Norton & Company.
- Felix, I. (1892). *Raport general asupra Igienei publice a capitalei 1891* [General report on public hygiene of the capital at 1891]. București, Carol Gobl.
- Felix, I. (1902). *Istoria igienei in Romania in secolul al XIX-lea și atrea ei la inceputul secolului al XX-lea*. [The history of hygiene in 19th century Romania and its? at the beginning of the 20th century]. București, Carol Gobl.
- Felix, I. (1903). *Istoria igienei* [The history of hygiene]. Bucharest, Carol Gobl.
- Foucault, M. (1963). *Naissance de la clinique*[Birth of the clinic]. Presses Universitaires de France.
- Foucault, M. (1987). *Mental illness and psychology*. University of California Press.
- Gomoiu, V. (1940). *Biserica și medicina* [The Church and medicine]. Brăila, Tipografia Presa.
- Hislop, J., & Arber, S. (2003). Understanding women's sleep management: beyond medicalization-healthicization? *Sociology of Health & Illness*, 25(7), 815–837. <https://doi.org/10.1046/j.1467-9566.2003.00371.x>
- Iorga, N. (1936). *Sfaturi pe întuneric. Conferințe la radio* [Advice in the dark. Radio conference]. București Fundația „Regele Carol II”.
- Kraftl, P., & Horton, J. (2008). Spaces of every-night life: for geographies of sleep, sleeping and sleepiness. *Progress in Human Geography*, 32, 509–524. <https://doi.org/10.1177/0309132507088117>

- Kroll-Smith, S. (2003). Popular media and 'excessive daytime sleepiness': a study of rhetorical authority in medical sociology. *Sociology of Health & Illness*, 25(6), 625–643. <https://doi.org/10.1111/1467-9566.00362>
- Kroker, K. (2007). *The Sleep of others and the transformation of sleep research*. University of Toronto Press.
- Le Breton, D. (1990). *Anthropologie du corps et modernité* [Anthropology of the Body and Modernity]. Paris PUF.
- Maume, D.J., Sebastian, R.A., & Bardo, A.R. (2010). Gender, work-family responsibilities, and sleep. *Gender & Society*, 24(6), 746–768. <https://doi.org/10.1177/0891243210386949>
- Mauss, M. (1973). Techniques of the body. *Economy and Society*, 2,(1) 70–88. <https://doi.org/10.1080/03085147300000003>
- Melbin, M. (1978). Night as a frontier. *American Sociological Review*, 43(1), 3–22. <https://doi.org/10.2307/2094758>
- Montijn, I. (2008). Beds visible and Invisible: hygiene, morals, and status in Dutch bedrooms. In L. Brunt & B. Steger (Eds.), *Worlds of Sleep*, (pp. 75-93). Frank & Timme.
- Orleanu, C. Gh. (1912). *Raport general asupra igienei, stărei sanitare....* [General report on hygiene, health status]. București Dimitrie C. Ionescu.
- Popoviciu, T. (1942). Ocrotirea mamei [The protection of the mother]. *Buletin Eugenic și Biopolitic*, 13(5-8), 214–229.
- Prodan, I. (1942). Ocrotirea mamei și a copilului în mediul rural [The protection of the mother and the child in the rural area]. *Buletin Eugenic și Biopolitic*, 13(5-8), 250–263.
- Ritzer, G. (2001). *Explorations in social theory. From metatheorizing to rationalization*. Sage Publications.
- Samarian, P.Gh. (1938). *Medicina și farmacia în trecutul românesc 1775-1834* [Medicine and pharmacy in the Romanian past 1775-1834]. Călărași Tipografia Cultura.
- Schwartz, B. (1970). Notes on the sociology of sleep. *Sociological Quarterly*, 11, 485–499. □ <https://doi.org/10.1111/j.1533-8525.1970.tb01320.x>
- Stoichiță, I. (1946). Educația pentru igienă și sănătate [Education for hygiene and health]. *Buletin Eugenic și Biopolitic*, 17(1-3), 7–27.
- Summers-Bremner, E. (2008). *Insomnia: a cultural history*. London Reaktion Books.
- Szasz, T. (1963). *Law, liberty, and psychiatry*. Macmillan.
- Szasz, T. (2007). *The Medicalization of everyday life*. Syracuse University Press.

- Taylor, B. (1993). Unconsciousness and society: The sociology of sleep. *International Journal of Politics and Culture*, 6, 463–471. <https://www.jstor.org/stable/20007102>
- Williams, S.J. (2002). Sleep and health, a sociological reflection on the dormant society. *Health*, 6(2), 173–200. <https://doi.org/10.1177/136345930200600203>
- Williams, S.J. (2005). *Sleep and society: sociological ventures into the (un)known*. Routledge.
- Williams, S.J., Seale, C., Boden, S., Lowe, P., & Steinberg, D.L. (2008). Waking up to sleepiness: Modafinil, the media and the pharmaceuticalization of everyday/night life. *Sociology of Health & Illness*, 30(6), 839–855. <https://doi.org/10.1111/j.1467-9566.2008.01084.x>
- Williams, S.J., Gabe, J., & Davis, P. (2009). The sociology of pharmaceuticals: progress and prospects. *Sociology of Health & Illness*, 30(6), 813–824. <https://doi.org/10.1111/j.1467-9566.2008.01123.x>
- Wright, L. (1962). *Warm and Snug. The History of The Bed*. London: Routledge.
- Zola, I.K. (1972). Medicine as an institution of social control. *Sociological Review*, 20, 487-504. <https://doi.org/10.1111/j.1467-954X.1972.tb00220.x>
- Zolog, M. (1935). Condițiunile de muncă ale elevilor în școală [The work condition of pupils in the school]. *Buletin Eugenic și Biopolitic*, 6(4-6), 139–146.