programmes, and encouraging dialogue with the media representatives and local mental health agencies. This list of voluntary guidelines was clearly not present in Goethe's day, and he would surely have ignored them, and a very early major European community public health initiative missed!

There have been profound changes in the representation of death by suicide, if the rather biased reportage of Seneca and his colleagues is anything to go by. How this informs us about society and the attitudes to mental illness will keep sociologists chattering well into the next millennium.

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# THE PROBLEMS OF SLEEP

Christopher Idzikowski

***Handbook of Sleep Disorders (Neurological Disease and Therapy Series 6)*** (\$198, 920 pp., 1990) is published by Marcel Dekker, New York. It is essentially an American book (with 24 out of 36 chapters originating from North America) with a distinctly American point of view. The book has been edited by Professor M. J. Thorpy, the Chairman of the Diagnostic Classification Steering Committee of the American Sleep Disorders Association. Professor Thorpy is also Director of the well known Sleep-Disorders Center, Montefiore Medical Center, New York.

SLEEP HAS HAD a place in psychiatry for many years, starting this century with Freud's psychoanalytic *Interpretation of Dreams*. The biological nature of sleep was revealed in the early 1950s with the discovery of rapid eye movement sleep (REM) by Aserinsky and Kleitman, and the experimental verification of its correlation with dreaming by Dement and Kleitman in 1957[1]. These findings stimulated considerable research and eventually led to an electrophysiologically based and committee-defined classification of sleep, in Rechtschaffen & Kales' *A Manual of Standardized Terminology, Techniques and Scoring System for Sleep Stages of Human Subjects* (US Government Printing Office, 1968). Broadly, sleep was divided into three main classes: (a) wakefulness and drowsiness, (b) non-REM sleep (stages 2–4 comprising slow wave sleep (SWS)), and (c) REM sleep.

This classification defined the sleep researcher's lexicon, and many more years of research followed. Various theories and hypotheses of sleep and sleep-stage function emerged. The most important theory was that sleep had a restorative function and the ensuing hypotheses that SWS enhanced body restoration and that REM sleep enhanced brain restoration. These hypotheses are still being tested.

What became very clear was that sleep was important for normal functioning. In a still continuing series of experiments, Rechtschaffen and his colleagues[2] have subjected rats to either total sleep deprivation or selective SWS or REM sleep deprivation. Death resulted after all types of deprivation: 11–32 days after total sleep deprivation, 16–54 days after REM deprivation and 23–66 days after SWS deprivation. Overall a reliable syndrome of effects occurred: (a) deaths, (b) debilitated appearance, (c) skin lesions, (d) increased food intake, (e) increased weight loss, (f) increased energy expenditure, (g) decreased body temperature, and (h) decreased plasma thyroxine. For the rat, the thyroid appears to be the first organ to be mortally impaired.

Epidemiological studies have also supported the need for adequate sleep. Using prospective data from the American Cancer Society, Kripke[3] revealed that habitually short or long sleep is associated with increased mortality across all age ranges, and Johnson & Spinweber found that poor and good naval ratings did not differ on laboratory measures of performance but poor sleepers received fewer promotions and less pay, and were admitted to hospital more often than good sleepers[4].

In another study, 7954 Americans were interviewed about sleep complaints and psychiatric symptoms on two occasions a year apart. Ford & Kamerow[5] reported the initial incidence of sleep problems was 10.2% for insomnia and 3.2% for hypersomnia. At this time, 40% of the insomniacs and 46% of the hypersomniacs had a psychiatric disorder, compared with the 16% of those who did not have a sleep complaint. The odds ratio of developing a new episode of major depression if insomnia was noted at both interviews was 39.8 compared with 1.6 if the insomnia had resolved by the second interview.

AFTER 20 YEARS of such research it is still not clear whether the electrophysiologically defined stages make a strong contribution to our understanding of sleep. Certainly, sleep disorders are not defined on the basis of increased or decreased durations of either SWS or REM sleep. In 1979, the original classification used by the American Sleep Disorders Association consisted of DIMS–(disorders of initiating and maintaining sleep), DOES (disorders

1. *Science*, **118**, 273; *Journal of Experimental Psychology*, **53**, 89.
2. *Sleep* (1989), **12**, 68.
3. *Archives of General Psychiatry* (1979), **36**, 103.
4. In *Sleep-Wake Disorders* (eds C. Guilleminault & E. Lugaresi), New York, Raven (1983).
5. *Journal of the American Medical Association* (1989), **262**, 1479.

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of excessive somnolence), disorders associated with circadian rhythms, and parasomnias. The *Handbook* is laid out in a manner similar to the new *International Classification of Sleep Disorders*, published by the American Sleep Disorders Association in 1990. An abbreviated version of this classification is as follows: (a) dyssomnias (intrinsic sleep disorders, extrinsic sleep disorders, circadian rhythm sleep disorders), (b) parasomnias (arousal disorders, sleep–wake transition disorders, parasomnias usually associated with REM sleep, other parasomnias), (c) medical/psychiatric sleep disorders (associated with mental disorders, associated with neurological disorders, associated with other medical disorders), and (d) proposed sleep disorders. After a professional series of introductory physiology and pharmacology chapters, sleep disorders are described as *dyssomnias* (e.g. narcolepsy, sleep apnoea syndrome), *insomnias* (e.g. insomnia, restless legs syndrome), *circadian rhythm sleep disorders*, *parasomnias* (e.g. REM sleep behaviour disorder, nocturnal enuresis) and *secondary sleep disorders* (e.g. epilepsy). It has two excellent postscripts which describe the use of hypnotics (by Mendelson) and stimulant drugs (by Parkes).

Intrinsic sleep disorders are those which arise from within the body. Psychological and medical disorders producing a primary sleep disorder such as sleep apnoea or narcolepsy are classified here and are discussed in detail in the *Handbook*. Disorders arising from within the body but which are not repeated as primary sleep disorders are classified in section 3 "Medical/psychiatric sleep disorders". The *Handbook* does not handle this section rigorously but there are helpful chapters on epilepsy, headache, degenerative neurological disorders, cerebrovascular disorders, Alzheimer's disease, and Parkinson's disease. Extrinsic sleep disorders are defined as disorders which originate from causes outside of the body. This section deals with inadequate sleep hygiene, environmental sleep disorders, disturbed sleep caused by drugs, food allergy insomnia, etc., and are not described systematically in the *Handbook*. Circadian sleep disorders include jet lag, shift-work disorders, delayed and advanced sleep phase syndromes, and non-24-hour sleep–wake syndrome. The state of circadian theories in clinical practice is perhaps reflected in the *Handbook*. Two chapters deal with the physiology and only one on the clinical consequences.

**The degree of deprivation experienced by Rechtschaffen's rats is immense if viewed on a pharmacological basis of sleep 'dose' by weight: many months of deprivation in man would be necessary to achieve comparable doses. A natural experiment in the form of 'fatal familial insomnia' is described in the *Handbook* by Lugaresi and Montagna. This disorder begins with insomnia and progresses to a dreamlike stupor, dysautonomia and extrapyramidal symptoms. Death occurs within 12–18 months. This peculiarly north-east Italian disorder is characterised by a degeneration of the anterior and dorsomedial thalamic nuclei. SWS is absent. REM may be present, but muscle paralysis is incomplete and so dreams are acted out. Drug treatments are ineffective.**

Some chapters are real gems. Busse & Reynolds' "Insomnia" is outstanding. This chapter describes the possible aetiology of insomnia, the effects of drugs on sleep, the sleep disturbance experienced by psychiatric patients and the possible treatments. Description and definition are considered painstakingly, and treatment regimes range from the *psychological* to the *pharmacological* (but different drugs for different patients). For pharmacological treatment, this chapter is worth reading in conjunction with Mendelson's chapter, "Hypnotics in the treatment of chronic insomnia". Three chapters deal with narcolepsy; Billiard's "Other hypersomnias" is enlightening although it does deal with the more uncommon pathologies.

The parasomnias receive individual attention in the *Handbook*. The most common are sleep walking, sleep terror and nocturnal enuresis; these were originally grouped as 'disorders arousal'. Nocturnal enuresis was originally thought to occur only during SWS but it has since been found that it can arise during any stage of sleep. Some parasomnias, such as nightmares and impaired sleep-related penile erections, occur primarily during REM sleep. Some disorders occur during the transition between sleep and wakefulness, such as restless legs syndrome, head-banging, nocturnal leg cramps and sleep-talking. Head-banging was originally called *jactatio capiti nocturna* and *rhythmie du sommeil*. The collective term 'rhythmic movement disorder' covers head-banging, head-rolling, and body-rocking. The parasomnias are generally not regarded as having pathological significance in the young, where they are most prevalent, but may be significant in adults.

"Proposed sleep disorders" is a collection of dubious syndromes which may represent abnormal and perhaps even pathological functioning such as short sleeper, long sleeper, subwakefulness syndrome, and pregnancy-associated sleep disorder, etc. These are not dealt with in the *Handbook*.

In general, stimulants are still suggested for hypersomnias, hypnotics for insomnias, positive airway pressure or surgery for apnoeas. When sleep is disturbed by motor activity the possible treatments vary depending on the aetiology, with anticonvulsants, primarily carbamazepine, recommended for epilepsy, and clonazepam for REM-sleep behaviour disorder.

Electrophysiology may provide a useful research tool in characterising some mental disorders. Depressed patients are reported as having: (a) sleep-continuing disturbances (taking longer to fall asleep, more awakenings during the night, and early morning awakening), (b) decreased SWS and a redistribution of it, with more SWS in the second sleep cycle compared with the first, and (c) faster onset of REM sleep in the first cycle, with increased phasic REM activity (e.g. increased rapid eye movements). In schizophrenic patients, the most consistent finding is disrupted sleep and a decrease of SWS. In contrast to depression, the normal temporal distribution of SWS is maintained. Changes in REM are variable and may be caused by disturbed affect. It has also been noted that SWS is inversely correlated with negative symptoms[6]

6. Ganguli *et al*, *Archives of General Psychiatry* (1987), **44**, 36.

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and ventricular:brain ratio[7], but these results are in need of replication.

*Handbook of Sleep Disorders* suffers from the same disadvantage which has befallen virtually every book on sleep published in the last ten years: there is no satisfactory underlying theory to unite what are essentially a disparate series of observations. *Principles and Practice of Sleep Medicine* by Kryger, Roth and Dement (W. B. Saunders, 1989) is similar to the *Handbook*, perhaps because most of the contributors are the same, but differs by spending more time on normal sleep. In Britain the scholarly *Sleep and its Disorders* by Parkes (W. B. Saunders, 1985) also lacks a unifying theoretical theme. These catalogues of disorder can be contrasted against Borbeley's *Secrets of Sleep* (Penguin, 1986) and Horne's *Why We Sleep* (Oxford University Press, 1988). Both of these books try to impose some order on sleep research, but neither approach Oswald's seminal and now classic *Sleep* (Penguin, 1966).

The *Handbook* is a catalogue of sleep disorders, but its systematic layout is very helpful. Most chapters describe the clinical features, epidemiology, aetiology, laboratory findings, the applicability of clinical polysomnography, differential diagnosis, and treatment. The book does not describe all the sleep disorders that are listed in the *International Classification of Sleep Disorders* but nevertheless it is comprehensive in its coverage of the disorders that are present.

7. Neylan *et al*, *Sleep Research* (1988), **17**, 130.

# THE DEMOCRACY OF THE DREAM

Jeremy Holmes

***The Mystique of Dreams: A Search for Utopia Through Senoi Dream Theory*** (University of California Press, Berkeley, $9.95 (pb), 146 pp., 1990) is by G. William Domhoff, Professor of Psychology and Sociology at the University of California, Santa Cruz. ***The Dreaming Brain*** (Penguin, London, £6.99, 319 pp., 1990) is by J. Allan Hobson, Professor of Psychiatry at Harvard and an internationally recognised dream researcher. ***Dreamwork in Psychotherapy and Self Change*** (Norton, New York, £25, 372 pp., 1990) is by Alvin R. Mahrer who is Professor of Psychology at the University of Ottowa, and author of numerous books on psychotherapy and dreams. ***Dream, Phantasy and Art*** (Routledge, London, £30 (hb), £10.99 (pb), 120 pp., 1991) is by Hanna Segal, former Freud Professor of Psychoanalysis at University College, London, and a leading Kleinian psychoanalyst and writer. ***The Rhetoric of Dreams*** (Cornell University Press, Cornell, $22.50, 217 pp., 1988) is by Bert. O. States, Professor of Drama at the University of California, Santa Barbara.

**For Freud, dreams were the product of a subversive unconscious, hidden messages smuggled through enemy lines, evading the censor by their bizarreness, throwing it off the scent with their metaphorical and metonymic transformations (as the neo-Freudian Lacanians would put it). The analyst is a cryptographer able to decode and so reconstruct the disturbing wishes which started this game of intrapsychic Chinese whispers.**

During the 1930s a young American anthropologist, Kilton Stewart, visited the jungle highlands of western Malasia. There he met and studied members of the Senoi tribe. A handsome and striking figure, long-haired and bearded, known as 'Torso' by his friends, he was something of an early hippy, interested in dreams (he had had a few months of analysis with Otto Rank in Paris), hypnosis, travel, socialism, and seduction. Later he spent time at the London School of Economics, where he wrote a long thesis on religious practices among the Senoi. During the war he set up as a hypnotherapist in New York, and in 1951 published an article entitled "Dream theory in Malaya". In this he described the "astonishing" Senoi tribal society, whose cultural life centred around dreaming. The adults met regularly to discuss their dreams in primitive 'dream workshops'; each morning the children would discuss their dreams with their parents, who would instruct them in a method of 'dream control' that could influence the outcome of subsequent dreams, and lead to enhanced sensuality and reduced anxiety. Most remarkably, this society, Stewart reported, was virtually free from aggression, competitiveness, and violence.

The paper went virtually unnoticed at first, but in the 1960s was taken up enthusiastically by the pioneers of the growth movement centred on Esalen in California. Stewart's ideas soon became part of the 'human potential' credo: dreams are good for you, they can be controlled, and may even prevent war.

However attractive this theory may be, its factual foundations are, according to Domhoff, extremely shaky. Stewart spent a total of only a few weeks with the Senoi (on three separate visits), and not the months which he later claimed. He never learned the local dialect. What he took to be dream workshops were in fact interminable village meetings. In his account he failed to distinguish between day-dreams and dreaming proper, or to notice that it was the shamans who discuss dreams (as they do in most systems of traditional healing), not the ordinary people. Nor

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