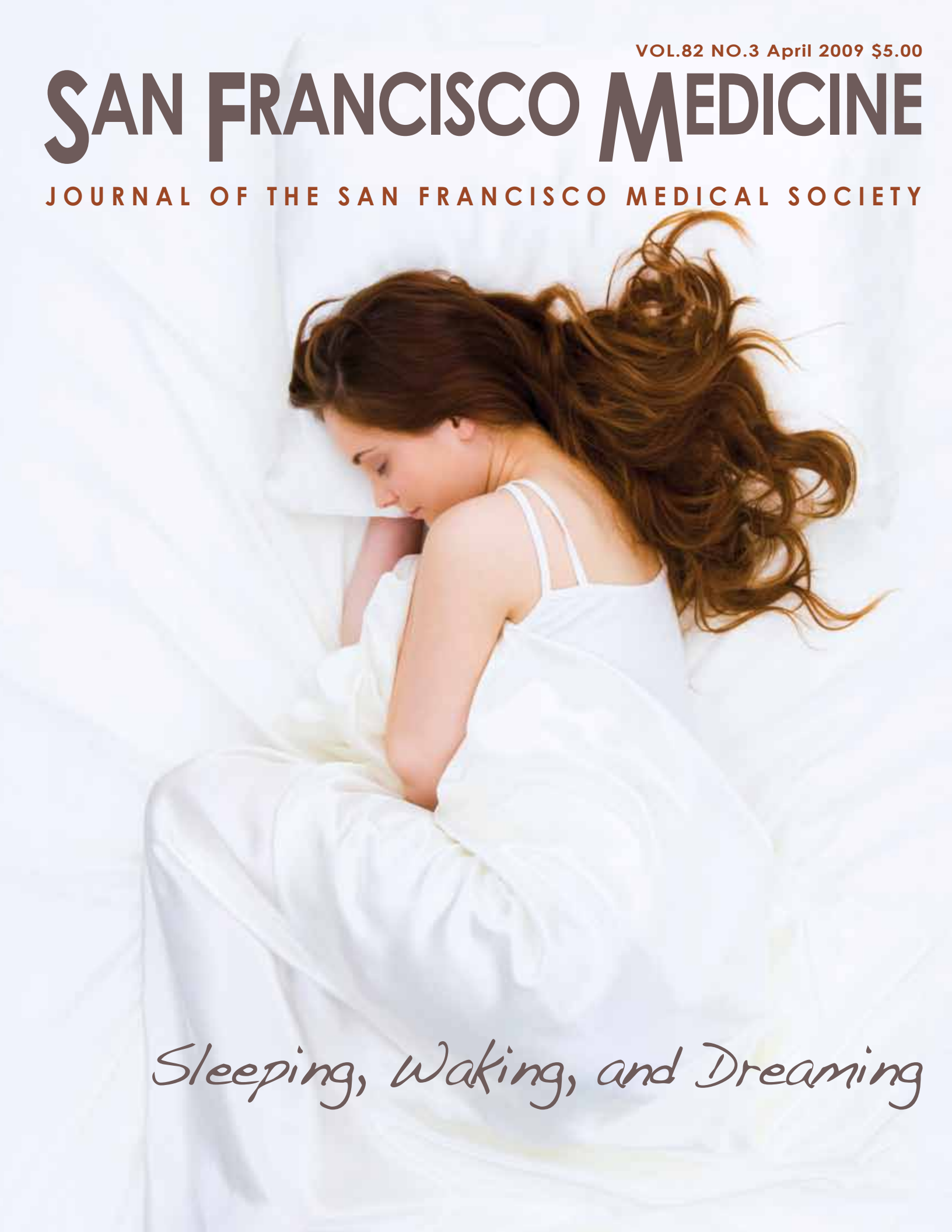


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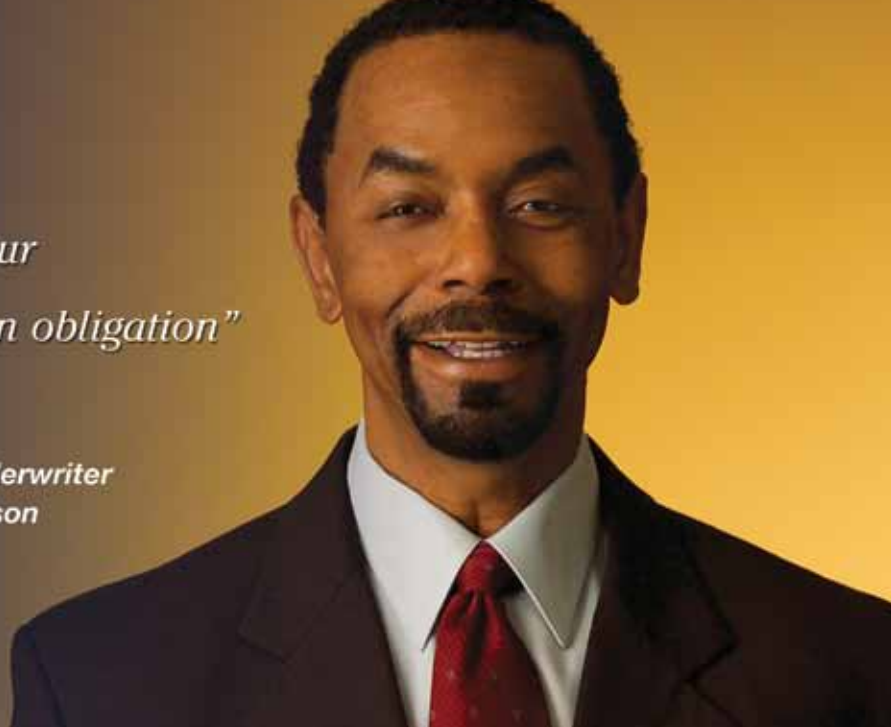
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Phone: 415.561.0850 ext.261
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Email: adenz@sfms.org
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Subscriptions:
\$45 per year; \$5 per issue
Advertising information is available on
our website, www.sfms.org, or can be
sent upon request.

Printing:
Sundance Press
P.O. Box 26605
Tucson, AZ 85726-6605

April 2009

Volume 82, Number 3

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A SAMPLING OF ACTIVITIES AND ACTIONS OF INTEREST TO SFMS MEMBERS

NOTES FROM THE MEMBERSHIP DEPARTMENT

A Way to Build Membership and Get a Break on Your CMA Dues!

Finders Keepers is a membership recruiting aid offered by the California Medical Association, which runs through September 30, 2009. Physician members are eligible for a 50 percent CMA dues reduction for recruiting three to four new active members, and a 100 percent reduction for recruiting five or more. Be sure that the new member enters your name as the referring member when they fill out their application (you will then be notified that they applied). Dues discount is contingent on CMA being able to confirm eligibility of the referred member. Members who have referred enough physicians for either of the discounts will receive that information with their 2010 dues statements. San Francisco Medical Society dues will still be due and payable. If you have any questions, contact Therese Porter in the Membership Department at (415) 561-0850, extension 268, or tporter@sfms.org.

Coming Soon—Valuable Assistance for EHR Readiness

The Health Information Technology for Economic and Clinical Health (HITECH) Act is a \$19.2 billion provision of the American Recovery & Reinvestment Act signed into law by President Obama on February 17, 2009. The HITECH Act is designed to encourage the widespread adoption of electronic health records (EHR), and physicians will be eligible for up to \$44,000 in reimbursements from Medicare or \$65,000 from Medicaid for “meaningful use” of a certified EHR starting in 2011.

SFMS is conducting a survey of its members to determine the current level of EHR usage by physicians and to ascertain areas in which SFMS can assist physicians in implementing an EHR

system. The survey initially went out in late March, and will be sent out again in mid-April.

Additionally, SFMS and CMA are working on ways to help educate physicians about the HITECH Stimulus Act and EHR readiness. Watch future SFMS and CMA communications for more information, including webinars and print materials.

Do You Work With Residents?

SFMS wants to reach out to residents in San Francisco’s residency programs. Thanks to arrangements made by both SFMS and CMA, dues for residents are complimentary for the duration of their residency. As with regular active membership, joining online is easy at www.sfms.org. If you are interested in helping promote membership among the residents with whom you work, contact Therese Porter in the Membership Department at (415) 561-0850, extension 268, or tporter@sfms.org for more information or assistance.

Don’t Miss Out on Important Communications from SFMS

Make sure that you get all the important membership information that SFMS sends out. If you have not been receiving the monthly email/fax Membership Updates and Action News please contact Therese Porter in the Membership Department at (415) 561-0850, extension 268, or tporter@sfms.org to make sure that we have your correct email and fax contact information. You may also make changes to your membership contact information on our website, www.sfms.org.

ADVOCACY REPORT

SFMS Supports Ban on Tobacco Sales in Pharmacies

Along with a solid list of health advocacy groups, including the CMA, UCSF School of Pharmacy, and many more, the

SFMS joined a group in legally defending San Francisco's new policy to keep tobacco products out of pharmacies. The case, for which the SFMS joined in an amicus brief, is currently before the Ninth Circuit Court of Appeals as Philip Morris USA Inc. v. The City & County of San Francisco and Mayor Gavin Newsom. The SFMS previously took this policy to the CMA and it was adopted as statewide medical policy. The case is widely seen as a national test case for this issue. Joining the lawsuit does not involve the use of SFMS funds for legal or other fees.

SFMS Endorses Alcohol Tax Increase

The SFMS Board of Directors has unanimously endorsed the proposal to increase alcohol taxes to help cover alcohol-related costs. In the recent round of California budgetary struggles, Governor Schwarzenegger asking for the equivalent of a five cents per drink alcohol excise tax increase. Unfortunately, alcohol industry opposition killed the tax. The Marin Institute, a private non-profit organization devoted to improving alcohol-related policy and reducing harms from drinking, released a 2008 report titled "The Annual Catastrophe of Alcohol in California." The report found that the economic cost to California from alcohol-related causes is \$38 billion per year. California alcohol taxes have not increased since 1992, and then by only a penny. State authorities around the nation are proposing such taxes and SFMS will take this proposal to the CMA and AMA this year to increase support.

SFMS Joins Legal Defense of Local 'Universal Health' Program

The SFMS has joined an amicus or "friend of the court" brief in support of Healthy San Francisco, the 'universal health' option developed by a Mayoral committee in 2006, with SFMS representation, and implemented in 2007. The program now has almost 40,000 enrollees. A restaurant association has sued to stop the mandated employer contribution to this program, but has lost each step in

this suit to date; they are now appealing to the Supreme Court.

The SFMS joins the Mayor, San Francisco Department of Public Health, and others in seeking to defend this program. Joining as an amici in this case does not involve the use of SFMS funds for legal or other fees. For more information on Healthy San Francisco, see www.healthy-sanfrancisco.org.

SFMS Member Honored by the Institute for Health and Healing

The SFMS would like to congratulate William H. Goodson, MD, the recipient of the 2009 Compassionate Caring Award. This award is presented annually by the IHH and honors those who have made extraordinary contributions to the health of their communities. Dr. Goodson has been specializing in the surgery and care of breast diseases for more than twenty years. His personal commitment and impact on the health and well-being of his patients and the community are exemplary and well-respected.

SFMS Seminar

Tuesday, May 19, 2009

Negotiating Physician PPO Agreements Effectively—The Blueprint for Success

This lunchtime seminar is a must for physicians and/or their office administrators who contract with third parties. Learn to understand and utilize your power in negotiating contracts and what to look for when reviewing and negotiating the contract. 12:30 p.m.—1:45 p.m. (12:15 p.m. registration/lunch). \$120 for SFMS/CMA members and their staff (\$99 each for additional attendees from the same office); \$165 each for non members. SFMS seminars require preregistration. Please contact Posi Lyon for more information at plyon@sfms.org or (415) 561-0850 extension 260.



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CPLH - an annual publication of CMA's Center for Legal Affairs - answers the legal questions most frequently asked by physicians. This year's CPLH offers more than 4,500 pages of comprehensive legal information including current laws, regulations, and court decisions related to medical practice in California.

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Charles J. Wibbelsman, MD




Sweet Sleep

When one considers the topic of this issue of the magazine—Sleeping, Waking, and Dreaming—it certainly is one that touches aspects of both our professional and personal lives. I remember being a junior in a Jesuit prep school in Cincinnati, just learning Homeric Greek. One line that I will always remember is from *The Odyssey*, in which, when writing about the many travels of Odysseus, Homer states more than once that Odysseus, becoming tired, went into a *ὑπνος ἠδύς* (sweet sleep). Indeed for many of us, resting one's head on a soft pillow after a particularly long and busy day, or taking a nap on a restful Sunday afternoon, makes us hope for such a "sweet sleep."

Sleep deprivation among physicians has changed many aspects of our profession. For many of us, an internship was, by definition, being on call every other night. For me, as a pediatric intern at Massachusetts General Hospital in the 1970s, this schedule also meant that one reported on Saturday morning for duty and did not sign out to the other intern until the end of the day on Monday. Unfortunately, such Spartan practices of training did not change until five years ago, when residency programs were mandated to limit the amount of time in training programs to an eighty-hour work week. These national limits on duty hours of residents were a direct result of the death of a young woman, Libby Zion, at a New York hospital in 1984. Sleep loss and fatigue may cause harmful medical errors. Tragically, there have been many reports in the news that a house officer, after being up all night and therefore sleep-deprived, was involved in a fatal accident when driving home. And yet while there often may be regulations regarding drug or alcohol use for attending physicians who are on call, are there any mandates for the number of hours that an attending physician may be on duty at a hospital? While we often counsel our patients on the importance of getting sufficient hours of sleep, how do we counsel ourselves to sleep well and be able to serve our patients in the best possible state of our own health?

For physicians treating patients with sleep disorders there are many challenges, as featured in the articles this month. So often when a patient presents with a sleep concern, such as the inability to fall asleep, or waking up in the middle of the night and not being able to return to sleep, the request for a hypnotic may more easily be granted with a prescription than by taking

what can be an extended period of time to get a good sleep history. For many patients, lack of exercise during the day and/or extended evening time on the computer to catch up on tasks, work of the day, or correspondence can decrease one's ability to fall asleep at the desired hour, resulting in insufficient sleep time. In my own practice of adolescent medicine, I frequently have patients who come in with the chief complaint of being tired all the time. When questioning such teens, I find out that they are on MySpace until 2:00 a.m. and then get up for school at 6:00 a.m. And the adolescent and parent wonder why the teen is tired. Often the adolescent response to lack of sleep during the week is to "catch up on sleep" during the weekend. This is not physiologic and does not work.

I trust that our readers will enjoy this issue of the magazine, both for their own personal information as well as for professional education. 

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Mike Denney, MD, PhD



Creative Dreaming

*Dreams offer themselves to all.
They are oracles, always ready to serve
as our quiet and unerring counselors.*
—Synesius of Cyrene

In his treatise *On Dreams (De insomniis)*, the fourth-century philosopher Synesius of Cyrene spoke for most of the ancients before him. He observed that dreams reveal truths that are “linked with the spheres” so as to explain the universe in “its own natural state of being.” Speaking about human imagination and creativity, Synesius said, “Now all of this is the waking state of the dreamer, or the dreaming state of the awakened.”

Through the ages and to the present day, dreams as conduits to creativity have faithfully served literature, music, and science. Many writers have created stories that they first imagined in dreams. Mary Wollstonecraft Shelley, who said that dreams were her “dearest pleasure,” was lying in bed in a dream state when she first imagined the character Frankenstein. Robert Louis Stevenson, who trained himself to remember his dreams, conceived of *Dr. Jekyll and Mr. Hyde* while sleeping. Samuel Coleridge fell asleep at his desk and in a dream imagined the words to *Kubla Khan*, his most famous poem. And both Stephen King and Amy Tan actively practice creative dreaming for their contemporary novels.

The world of music seems inseparable from dreams. The eighteenth-century Italian violist and composer Giuseppe Tartini told of a dream in which he played for the devil. When he awoke he remembered the music, and thus he composed his finest work, “The Devil’s Trill.” Mozart’s best compositions were those he first dreamt and then wrote. In 1965, Paul McCartney dreamed he heard a classical string ensemble playing a melody and that tune later became the famous song “Yesterday.”

Some of the most surprising discoveries in dreams are about science. The mathematical genius Srinivasa Ramanujan regularly was visited in dreams by a Hindu goddess named Namakkal who would present solutions to mathematical problems that Srinivasa would later verify. In 1869, Dmitry Mendeleev had a dream about the sixty-three known chemical elements that had been demonstrated by Boyle, Priestly, Lavoisier, and others. In the dream, Mendeleev saw these elements arranged in ascending order of atomic weights and grouped by their chemical properties. He awoke to devise the periodic table of the elements. The chemist


Friedrich Kekulé twice had dreams that led to major discoveries. In one he saw atoms whirling in a dance and thus conceived of the structural theory of molecules; and in another he dreamed of a snake that was eating its tail, a pattern from which he deduced the chemical structure of benzene.

One of the most dramatic dream events in biomedical research is the story of physiologist Otto Loewi, who worked on the problem of chemical transmission of nerve impulses. One night in 1921, Loewi awakened at 3:00 a.m. from a dream that described a research model. He immediately went to his lab, performed the experiment on frogs, and thereby demonstrated a neurochemical that was later named acetylcholine.

Yes, dreams seem to play an integral role on the creative path to discovery. Columbus was inspired to sail from Portugal by a dream in which God gave him the key to the oceans. Elias Howe dreamed he was captured by tribesmen who had spears with small holes in the tips, and thus he discovered the secret to inventing the sewing machine. Champion golfer Jack Nicklaus, when in a slump, dreamed of how to correct his swing so as to again win tournaments.

In her book *Listening to the Oracle*, psychologist Dianne Skaft tells of some of these dream events, and she urges us to become conscious of the value of dreams and to find practices that help us to realize dreams as our “quiet and unerring counselors.” Skaft says, “Hundreds of dreams present themselves during any given night. But some dreams carry special power to influence our attitudes and direction. We can identify oracular visions during sleep by noticing our response to them. Very often, we cannot get the image out of our mind. It glows in a certain way, or the shock of its strangeness disturbs our peace.”

In the world of literature, as Dorothy in *The Wizard of Oz* tells us, “The dreams that you dare to dream really do come true.” In the realm of music, the Swedish metal band Candlemass, in a song called “Ancient Dreams,” sings, “Believe in your dreams and a wonderworld will be revealed . . . built by dreams and magic the secret place that none have seen.”

On a more scientific and philosophical note, Syrenius of Cyrene says, “Thus, anyone who has prepared his mind to enjoy those greater things which the dream state held out to him, has twice profited: First he had delighted in the things beforehand, and secondly he is in a position to use them wisely.” 

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Song of a Dream

*Once in the dream of a night I stood
Lone in the light of a magical wood,
Soul-deep in visions that poppy-like sprang;
And spirits of Truth were the birds that sang,
And spirits of Love were the stars that glowed,
And spirits of Peace were the streams that flowed
In that magical wood in the land of sleep.*

*Lone in the light of that magical grove,
I felt the stars of the spirits of Love
Gather and gleam round my delicate youth,
And I heard the song of the spirits of Truth;
To quench my longing I bent me low
By the streams of the spirits of Peace that flow
In the magical wood in the land of sleep.*

—Sarojini Naidu

A Jungian Approach to Dreams

A Brief Overview

Thomas B. Kirsch, MD

Dreams have been of interest to mankind since biblical times. It is with the beginning of psychoanalysis in the late nineteenth century that the scientific study of dreams began. Freud's revolutionary study, *The Interpretation of Dreams*, was first published in 1899 and went through several revisions during his lifetime. The first edition sold less than 500 copies, and Jung was a recipient of one of those first copies. Jung worked with Freud from 1907 until 1913, at which point their divergent views on the nature of psychic energy led them to part ways.

After a period of several years of withdrawal, Jung emerged in the early 1920s with his own theories of the unconscious and dreams. Jung analyzed 68,000 dreams in his lifetime, and so both he and the field of analytical psychology, which is what he called his psychology, have focused a great deal of attention on listening to and understanding dreams. Dreams in their own language reveal hitherto unknown aspects of the individual and therefore can provide valuable information to the dreamer as well as to the therapist who hears the dream. Most doctors and even many psychiatrists do not know how to handle a dream when presented. There is both a fear and a fascination when one hears a dream. What does it mean and what is it trying to convey? What follows will be a brief summary of Jung's theory of dreams.

First and foremost, the dream is a natural and normal psychic phenomenon. It describes the inner situation of the dreamer and is a spontaneous self-portrayal in symbolical form of the actual situation in the unconscious. According to Jung, the dream is neither a disguise nor symptom

but it reveals in its own symbolic language some new information to consciousness. Therefore the therapist's task is not to discover latent thoughts behind a facade of manifest contents, as in Freud, but rather to unravel the dream's symbolic meaning. Jung prefers to stay as close to the manifest contents as possible when attempting to work out a dream interpretation. "I was never able to agree with Freud that the dream is a facade behind which its meaning lies hidden a meaning already known but maliciously, so to speak, withheld from consciousness. To me dreams are a part of nature, which harbors no intention to deceive, but expresses something as best it can."

Second, the term symbol is used by Jung in a different way. For Jung, a dream image never can be completely known. It is basically unknowable at its core. Therefore, one can associate around a particular image, but one can never know the image completely. Thus, a church steeple never can be fully equated or substituted for the penis. The specificity of the dream image is important, and Jung was critical of Freud's interpretations, which he saw as nothing but reductionistic. Everything either became elongated (penis) or round (uterus). Jung became very interested in specific images and traced their comparative nature in other cultures.

Third, Jung developed the concept of objective and subjective levels of dream interpretation. Any dream interpretation that equates the dream image with real objects is an interpretation on the objective level. Interpretation on the objective level is usually analytic, because it breaks down the dream content into memory traces that can be referred to external situations. My

impression is that this level of interpretation is similar to much of psychoanalytic dream work. On the other hand, an interpretation on the subjective level is one that brings back every part of the dream to the individual dreamer. Interpretation on the subjective level detaches the underlying complexes of memory from their external causes and regards them as tendencies of components of the subject. It is this level of interpretation where a kind of inner dialog occurs between the ego and the individual's unconscious, and where the archetypes are more readily experienced. I cannot go into archetypal theory here, because that would take us too far away from our topic.

A third level of interpretation is also present, which is the transference level. It is a combination of both the objective and subjective levels of interpretation.

A fourth aspect of Jungian dream theory concerns compensation. A fundamental aspect of Jung's theory is that dreams are compensatory to the conscious situation of the dreamer. This follows from the concept of the psyche as a self-regulating system balancing conscious and unconscious. Thus the dream tells only half the story. In working with dreams in a Jungian fashion, one needs to take the conscious situation and the day's residue into account, and then add the dream and associations to the mix. With all this information at hand, then the therapist and patient can begin to work out a possible meaning.

A fifth component concerns prospective and reductive interpretations. Connected to the compensatory function of dreams are two other functions: prospective and reductive. By prospective, Jung

Continued on page 14...

Waking Dreams

Healing with Images

Mary Watkins, PhD

What happened to those imaginary playmates of ours who ate more from the family dinner table than we did? And those secret places that we found down the alleys and in the woods where we were not supposed to go? Remember the long hours spent talking to the trees and to our dolls? Of gazing in the mirror at ourselves, wondering what we would grow up to be, trying on the costumes of our fancies? There were interminable days when we felt our future was sealed. In the morning we woke to discover that we had forgotten to punch holes in the jar top of our lightning-bug zoo, and in the afternoon our brother approached us in a way from which we could only suppose that he had detected the presence of pennies where quarters had before jingled in his piggy bank. . . .

We no longer leave food for Santa Claus or set a place at the table for our favorite dolls. Though we might still talk to children and animals, we do so with complete honesty only when alone. But when we see the child kicking that stone down the street from school with determination that proves it surely is not just a stone, or similarly avoiding the cracks in the pavement for fear of their harmful effects, do we not suppress a smile that would betray our understanding? Or is that smile lost in our notions of what foolishness is all about? No longer do we spend hours standing at the sink whipping soapsuds with Momma's eggbeaters in order to manufacture the building material of a snowy kingdom or an amorphous thing or two. Nor do we sit out by the sidewalk painting pictures with our buckets of water.

In days past, the sun would eat them up, leaving room for more of the visions that danced in our heads. But then the sun ate our last one, and once more the sidewalk became simply the concrete beneath the pedestrian's feet. The snowy villages and furry animals went down the drain for the last time and the stone lay still—though surely we have passed by it every day without noticing. . . .

We discarded the stuffed dogs, the fairy kingdoms, train empires, aspirations for stardom and for early death. We turned in the secret notions that we could fly (if only given a chance), or be a tree, a Robin Hood, or a dog. The imagination is laughable. It is a lot of silliness and fairy dust and pale pastel colors that caught us like cobwebs in our eyes, blurring what is really before us in life. Having rubbed them out of our own eyes, we laugh at and scorn those who waste their time dealing with "imagination"—who lock themselves up in their rooms with their closed eyes and fancy paints, talking to themselves. We dismiss them and continue with our practical having-come-to-terms-with-reality lives. . . .

The experience of waking dreams, so well integrated into the daily life of some cultures, in our own culture has been most often acknowledged only by mystics and poets, madmen and geniuses. The history of psychology relates how the elements of waking dreams, the experiential phenomena and the attending attitude, were slowly more popularly recognized and cultivated in the context of a "psychotherapeutic" worldview. By waking dream we mean not just an experience of dreamlike character received while awake, but an experience of the imagina-

tion undertaken with a certain quality or attitude of awareness. This conscious awareness differentiates the experience of imagination . . . from daydreams and hallucinations. . . .

As had others before them, the early psychologists discovered ways to elicit images through the cultivation of a half-dream state. They too viewed these waking dreams as coming from a source outside of who the person knows himself to be. For the psychologist, however, this source was not divine. It was the "subconscious"—an unknown region of the person, something *below*, not above. The people they observed having these visions were not honored shamans or holy men, but mediums and hysterics. The contents of the visions were not guarded as sacred knowledge through which healing and guidance were given but were more often taken as the proof that something had gone wrong, was off the track (into superstition and delusion). Instead of willfully attempting to establish the vision within the day world in order to bring one's activities into relation to it, the young psychology more often sought to elicit waking dreams in order to impose the seemingly more important day world onto them. . . .

We have skillfully tried to strain the mythical from the scientific, the imaginary from the real, metaphor from matter. We have used science to tell us just what "reality" really is, and we have taken our scissors of reason and accordingly trimmed into the wastebasket the apparently superfluous and contradictory. We have chased the gods from the stones, the animals, and the heavens in the hope that

Continued on the following page...

Waking Dreams Continued ...

we will be left with a clear and modern idea of matter and life.

When the last doll is tucked securely in the garbage pail, my friend, the imagination has not been overcome. We have, it is true, taken away a few more of its toys, but the imagination is a far deeper affair. It is not just a child to whom we toss toys as appeasement, to get it off our mind or nerves. It travels with us to the spaces behind closed doors to contemplate our fate and our faith. Our loneliness and our successes and failures. It sits with us at the breakfast table as we read the cries of the newspaper chroniclers and then head for work. It makes us turn one way or another on streets and lanes, and—once we've turned down them—holds out certain items for our query, fascination, wonder, or disgust. . . .

Metaphor uses matter in order to convey the immaterial. In doing so, it creates a third realm that lies between the other two. Through the waking dream, a journey is made possible. Either the gods or spirits are enabled to pass into our world, or we into theirs. The conjunction is envisioned not only as a bridge from one world to another but as a plane of coexistence of the two worlds. Through the connection of the two, the individual is able to obtain gifts of wisdom and self-knowledge from the divine benefactors. One could learn of the spirit world. The connection of the two planes—spiritual and material—through participation in the half-dream state is considered to bring health.


Author's note: The above are excerpts from my book Waking Dreams, originally published in 1976. I wrote the book as I found myself negotiating the gap between Jungian and archetypal theories that value experiences of the imaginal and some mainstream developmental American psychologies that relegated them to childhood, indigenous societies, and mental illness. Since then, the healing power of images as we experience illness, recovery, and dying has been underscored. By "healing" I refer not only to the literal healing of bodily tissues. I refer also to that less tangible, psychospiritual healing that flows from

our engagement of life meanings as we address challenges and losses that are part of illness and dying.

We now know to provide paper and paints to children with cancer and to lend an ear as they describe the images they have welcomed in their pictures. We know these images convey their psychological and spiritual experiences and need only be extended a simple invitation to pour forward. The same is true for adults. We know to help patients allow images to arise in relation to their illness, watching carefully for those that emerge from concentration on the site of pain or suffering. As people prepare for surgery and engage in recovery, attention to images that promote relaxation, peace, and equanimity anchor one in the midst of the fear and anxiety that break upon us as our health is thrown into question and our daily patterns are profoundly disrupted.

For all the ways that illness frightens, disappoints, and frustrates us, it also makes thinner the veil between waking and dreaming. Imaginal and ancestral figures and the landscapes they inhabit come forward and include us. More hidden aspects of our being and of imaginal realities can become more apparent. Those who have allowed the veil to part, as well as those on whom this is inflicted by the radical nature of their suffering, can become changed. If the doctor or nurse or respiratory therapist is able to pause, relax the professional hierarchy, and enter into conversation, he or she may well be graced by the insight and wisdom of the patient, informed as it may be by visionary experience.

Now we are more aware that images do not require a complex method of induction to come forward. The imaginal is not a realm that certain people have access to and others do not. It is a gift to humans and it is always ready to hand. A simple question and orientation of openness and spaciousness invite it: "Describe a peaceful place from reality or a dream where you could allow yourself to rest right now"; "When you focus on the site of your pain, what image comes forward?"; "Who from your past (or from your spiritual tradition) would like to accompany you as you go through this procedure?"; "What does

he or she say to you and how would you respond?"; "When you focus on your fear, what image comes forward? Can you greet it and allow it to speak to you?" 


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Jungian Approach to Dreams

Continued from page 12 ...

means that the dream is an anticipation in the unconscious of future conscious achievement. This does not mean that dreams are prophetic but that they present a preliminary exercise or sketch roughed out in advance, a combination of possibilities that are present in potential. Certain dreams have this prospective function, which is both integrative and synthetic. Initial dreams are one of those cases.

The reductive function of the dream operates as a negative compensation, expressing material that consists mainly of repressed infantile and childhood material. If a person has a too high an opinion of himself/herself, for example, then the dream in its compensatory aspect may very well present a negative view of the situation and the dreamer.

This concludes a brief survey of Jung's views on dreams. One notes that Freud and Jung had marked differences in how they approached dreams, specifically in the role of free association, the nature of the dream symbol, and the meaning of manifest content. In spite of the differences, however, psychoanalysts and Jungian analytical psychologists have been analyzing dreams as part of an effort to help individuals with their psychological problems. Both Freud and Jung believed that the dream was the royal road to the unconscious. 

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Early to Wake, Early to Write

Morning Meditations

Dennis Patrick Slattery, PhD

I can still hear the inner voice, very calm, serene, and emphatic: “Find your own time.” That was seventeen years ago. I did not understand the directive in that moment, but I did eventually find my own *time*: around 4:00 a.m., the time at which I rise and begin the day, seven days a week.

As I write this, it is 4:15 on a Saturday morning. From my early perch it is the time of *poiesis*, the wonderful Greek word for making or shaping something into a coherent and communicable form. It is the time of creation, perhaps even the time of *the* creation. To be between sleeping and waking is to be on another level, to be out of time, to be free of *Chronos*, to be closer to *kairos*, the right time or the auspicious time. One might even risk that this time is mythic time, because between being awake and asleep is when eternity might be brushed against for a short time. The point here is that it is a time that works for me. One must find one’s time, because to discover it and settle into it is your time of creation, contentment, and fullness.

At 4:00 a.m. it is serene, still, and soft, the time of dreaming rather than waking life. Perhaps more accurately, it is a between space, a transitional time between sleep and waking, between dreaming and thinking. Nor is it unusual, so attuned is my body to the rhythm of this engagement every morning, that I awake on many consecutive mornings at precisely 3:59 a.m. The precision of the body marking its own internal time and being in concert with the external clock attests to the uncanny rhythm of inner and outer temporality.

Outside my study window is darkness in delicious abundance. To work from a small lamp that pushes back the

darkness before sunrise is to continue the still space of a waking dream state. What this time out of time offers me is not so much needed space but the more essential solitude, the sweet smell of openness, with no outside sounds, no morning traffic, no cars gunning into action for the morning commute. It is instead a cushioned place of repose that I never tire of, morning after morning.

In addition, what rises from my bed with me are the remnants, often tattered segments, of dreams, pieces of plot that cling to my flannel pajamas and cotton robe. I often try to record these fragments in my journal after I make the morning coffee; I know these memorable shards of my other life will dissolve soon into the dark air if I hesitate in chronicling what I can recall quickly. When a particularly vivid dream insists on my hearing, its entire plot joins me in my reading chair, where I turn on one small pole lamp in order to preserve the darkness surrounding me like a penumbra. Pieces of that narrative, or one image from it, may then infiltrate the morning’s reading or writing. I have on several occasions made the dream plot a poem plot and fictionalized it into another reality, suitable for a larger public to read. If one is wise, one does not foreclose on any avenue the Muses may choose to turn into a creative sluice to carry precious cargo through one and into another venue. Powerful poetry, fiction, even prose gains its strength from its ability to coax the reader into a dreaming state of response, or a reverie where a different logic informs the apprehension one gains in reading. To read deeply is to be moved into that same *metaxis*, what the Greeks called the in-between state where the imagination sees anew, reformulates

what it knows, and springs forth with insights that perdure.

Having spent the past thirty-seven years making retreats at monasteries and Zen Buddhist centers across the United States and in Italy, I have discovered the rich insights of St. Benedict, founder of the Western monastic tradition, to be more than incidental to the scholar/writer’s life. I have secularized parts of his *Rules for Monasteries*, but the spirit cares not for these minor alterations. A firm believer in early morning meditation, Benedict insisted, “Let us arise, then, at last, for the Scripture stirs us up, saying, ‘Now is the hour for us to rise from sleep.’ Let us open our eyes to the deifying light, let us hear with attentive ears” (*Rules for Monasteries* 2). Yes, Benedict, but slowly, slowly, so the attention can be wrought from touching each hand against another reality—one of dream, the other of waking life.

Get up and read the Scriptures! He knew what I have learned slowly over time. This time of morning carries within it three qualities of consciousness. These I claim and name, but they are implicit in Benedict’s insights: porous, temporary, heightened/deepened.

Porous

When, occasionally, I am forced by life’s circumstances to miss a morning of early meditation, I lose a day of porosity. By this I mean that early in the morning, in such a *bardo* state, an in-between place of sleep and dreaming, with a waking state, wherein the psyche is porous, the spirit is receptive and the body is agreeable to receive new sensations, images, ideas, that are not, I believe, generated in me but enter from a much larger vat of

Continued on the following page ...

Early to Wake, Early to Write continued ... inspiration. Being porous means being receptive, as when the Virgin Mother of Christ is visited by the archangel Gabriel; we see her depicted most often in Medieval and Renaissance paintings engaged in a single action: reading. Reading is a porous activity; reading early before ego defenses are up, the phone is ringing, eggs are done, toast is burned, and the charge of the clock is answered is to get moving. Reading directs my openness to the unknown, to what is “other” that resides within and without. Reading at an early hour is another way of extending the dream state to the borderland of full waking consciousness. Ego has not set up its fortress; more is still possible.

A good friend, schooled deeply in the Buddhist tradition, related to me some time ago, when I told him of my practice of early rising, that 4:00 a.m. was a sacred time in the tradition of Buddhist meditation. The thinking was not unlike my own revelation: Blocks are not yet turned on to select carefully what is allowed in, what is denied access. There is in addition a greater sense of the Wholeness of Being, the awareness of a unitary reality undergirding difference, distinction, borders, boundaries, censors. This unitary reality is not fearful of some foreign idea sabotaging one’s belief system. In fact, quite the contrary: This new idea, contrary image, another narrative plot that swims against the stream of one’s comfortable story, is exactly what increases the blood flow of new thinking, more astute angles of vision and revision. Openness becomes a methodology so that the flow between the larger cosmic inflections and my own narrative designs can interact on a much higher frequency, create partnerships, disagree, compromise. The between-ness of things, conditions, and states of being are crucial for such dreaming to join waking life in new syntheses.

Temporary

I am neither strong enough nor interested enough to try to sustain such a level of consciousness for more than three hours. Around 7:30 a.m. I break from what I feel is a trance state, an altered

way of being conscious—which may be another way of identifying this *bardo* state of sleeping, dreaming, and waking life, for each has its own barometric pressure of awareness. Then I turn to the day world of physical chores that get me up and moving. Balance is the necessary and cultivated disposition so that tomorrow morning I am refreshed and anticipate another turn at the wheel of life itself. Henry James writes in his chapter on “Mysticism” in *Varieties of Religious Experience* that one of the mystical state’s treasures is that it is temporary. Its finiteness defines its greatest value. The mystical state, he goes on, is accommodating and merciful; it does not insist on being held permanently. Like sleep or waking life, it must rotate out with other dimensions of conscious and unconscious rhythms.


It is also a temporary state of being in contact with what Rudolf Steiner called, in one of his lectures delivered in Vienna in October, 1923, “one’s etheric body, a body within the physical body, whose intrinsic laws are temporal rather than physical. This body can appear in image form, and such cognition can be called Imagination” (“Anthroposophic Spiritual Science and Medical Knowledge,” p. 55). I sense his description of the etheric body and also feel its temporary nature. It is not unlike the temporary space of the imaginal body in deep moments of awareness, wherein I may sense the power of another reality knocking on the door of my more quotidian domicile.

Heightened-Deepened Consciousness

It seems like a paradox that in these morning hours of greatest repose and feelings of complete acceptance that what should arise out of it is a heightened-deepened awareness. Within this third state, poems arise unbidden. Initially I often simply transcribe them. In reading, the psyche’s powers of analogy seem more keen, fresh, purposeful, though I am not directing things one way or another. Reading is much more deep, dark, moist, where ideas and images, derive from and lead to one another. I feel closer to the root of an idea, a concept, a story, even intimate

with their origins. If myth has a time, for me it is early and dark, for I feel the mythic underbelly of ideas, where their deeper succulence resides.

I also sense a greater communion with the birth and the death of various realities, including my own fragile nature. It is a time of clarity and unity, of deepest transformation. Books, articles, poems, ideas, new ways of teaching a favorite novel or epic all appear within these early hours, like fresh blood from a recent transfusion. Memory itself is keener, more pronounced, less susceptible to slippage or to fogs from out of the woods.

These three attributes, then, comprise the early morning hours, full of the promptings from other realms. Sleep, dream, waking life, which often constellate in new patterns of awareness, are open to reimbursement in my external life, and full of temporary promptings that leave large residues in their wake. To exist with the angels of repose in this *bardo* state is what I get up for. I can never predict what is awaiting me in the dark precincts of my study chair. There night visions coagulate with morning readings to open corridors of knowledge I could never dream were possible! 

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Modern Dream Interpretation

A Flash History and a Few Tools for Working with Dreams

Gail Delaney, PhD

At the turn of the last century, thanks to Sigmund Freud, dream interpretation was yanked out of the darkness of superstition and presented as an expression of the dreamer's own conflicts and concerns. Thanks to Carl Jung, dreams came to be seen as agents of change and growth that reveal the dreamer's undeveloped characteristics and efforts to understand and resolve conflict as well as mature more fully as a human being. Medard Boss and Fritz Perls added the existential emphasis on the present moment and the dreamer's state of being/emotion. Boss, particularly, focused on the phenomenology of the experience of the dream and called for a liberation from the psycho-theoretical overlays that had kept the different schools of psychology at war for so long. By the 1980s dream work, including some good research, was moving away from an emphasis on symbols interpreted according to any given system to a focus on interpreting dream images as individually sculpted metaphors that express the dreamer's feelings, conflicts, patterns, growth potentials, and efforts at problem solving.

The Cultural-Formula Method

The first and earliest method of interpretation is the Cultural-Formula Method, in which the interpreter must be familiar with local religious, cultural, and mythological traditions that assign particular meanings to given images and themes. He matches these consensual interpretations to his "client's" dream. Joseph's interpretation of the baker's and the wine steward's dreams used cultural formulations current at the time and found in

Egyptian dream-book interpretations. Today, New Age and some Jungian therapists base many of their interpretations on myths and agreed-upon meanings of common symbols. The interpretation is provided by the interpreter, who is seen as having access to specialized knowledge. The dreamer may, after study of certain texts, gain the ability to interpret his own dream. Interpretations derived from this method range from the most absurd predictions to comforting reframing or enriching insights.

The Psycho-Theoretical-Formula Method

The Psycho-Theoretical-Formula Method, a variation on the Cultural-Formula Method, asks that the analyst interpret dream images and themes according to a particular psychological theory. Striking examples of this are the orthodox Freudian interpretations of long objects as phallic and two pears on a windowsill as the mother's breasts. In some Jungian analysis, certain images are interpreted as archetypes with agreed-upon meanings in the process of growth as seen by Jung, and other images are assigned masculine or feminine traits according to certain cultural and theoretical assumptions. The main role of the therapist is to match dream images to the interpretations laid down in the texts of a given psycho-theoretical model. The dreamer's role is to learn from the erudition and wisdom of the interpreter. Most modern therapists who belong to particular psycho-theoretical schools do not use this method as rigidly as many once did, and they often combine this method with others mentioned here.

The Associative Method

In the Associative Method, dreamers are encouraged to describe the thoughts and feelings that occur to them in connection with the dream. The dreamer associates, the interpreter matches associations to parallels in the dreamer's unconscious as understood by the interpreter according to his school's teachings. This was Freud's historical innovation, focusing the interpretation on the inner psychological life of the dreamer. But all this free-association took time, and many grew impatient with it. Freud himself wrote that while one must never abandon completely the associative method, a more efficient way to interpret, once one had enough experience with his theories, was to use his Psycho-Theoretical Formula, which he called symbol substitution. Like Freud, many of his followers came to think that a good part of this associative material was not only time-consuming but tangential or irrelevant, and they either dropped the method or began to develop ways to elicit associations nearer to experience. Some version of the associative method is a part of most modern dream interpretation.

The Emotion-Focusing Method

The best-known example of the Emotion-Focusing Method is that elaborated by Fritz and Perls and is known as the Gestalt Approach, which is often practiced in groups. The therapist's role is to encourage the dreamer to act out or role-play certain dream images selected and judged as important by the therapist. Since this school maintains that every image represents some aspect of the dreamer, role-playing is seen as assisting the dreamer to get in touch with dis-

owned parts of himself on a feeling level. The therapist often assigns other group members to role-play other images in the dream. The therapist directs the dream replay but resists making interpretations. This approach gives the dreamer an active role and often evokes strong emotions. The dream is mined mostly for its evocative parts, and these are rarely considered in the context of the entire dream drama. The feelings evoked are discussed as they relate to the dreamer's waking life concerns, and it is thought that simply getting in touch with previously unappreciated strong feelings can have a therapeutic benefit. Many therapists from different schools use some form of emotion focusing as a part of their dream work.

The Personal Projection Method

The Personal Projection Method usually contains elements of interpretations based on cultural and/or psycho-theoretical formulations and adds to these interpretations the personal associations and emotional responses of the interpreter. While this approach opens the door to wildly inappropriate projections of the interpreter or group members, in able hands it can bear fruit and save time. Psychoanalyst Joseph Natterson is one of the best-known proponents of interpretation arrived at through patient-therapist collaboration, which includes the therapist's personal associations and a joint venture in finding an interpretation. Montague Ullman has developed a group projection method that invites members of the group to listen to a dream and then, one by one, finish the sentence, "If this were my dream, it would mean. . ." The dreamer, after hearing all the interpretations, is free to choose any that seem to strike a chord. The therapist may or may not summarize the group's projections, selecting the ones she finds most appropriate.

The Phenomenological Method

The Phenomenological Method, elaborated in the 1950s by Medard Boss, roundly discourages any reference to psychological theories and insists that the interpreter play the role of coach, who helps the dreamer focus on the

phenomena (images and feelings) of the dream by having him relive and describe in great detail exactly what happened in the dream and how it felt to be there. Erik Craig and Steve Walsh, former president of the Medical Society, have written on this approach, which values the dreamer's role in retelling the dream until the experience is intensified to the point that new states of being are appreciated and insightful parallels to waking life are gained.

The Dream Interview

Loma Flowers and I have developed the Dream Interview, a largely phenomenological method designed to reduce interpreter projections and theoretical presumptions and increase the precision of the interpretation. The dreamer's recognition of the metaphoric bridges is triggered by the use of the dreamer's, not the therapist's, words that describe the major images, actions, and feelings of the dream. The therapist or interpreter is assigned the role of interviewer, posing a series of focused questions to the dreamer, who agrees to pretend that the interviewer comes from another planet and presumes very little about the dreamer's feelings, knowledge, experience, and life on earth. The goal is to get to the dreamer's most relevant associations in the dreamer's own words, which usually trigger a recognition of the metaphor. The dreamer can play both roles, but in the beginning, it is easier to have an external interviewer. An abbreviated version of this approach can be used in very short sessions when the interviewer is armed with appropriate questions and knows how to resist the terrible temptation of answering and interpreting for the dreamer. If a patient, in a visit to his family doctor, recounts a recurring nightmare, one or two deftly chosen questions can unlock the meaning of the dream and often point to a major stressor/conflict in the dreamer's life, not to mention a possibly secret suicidal wish.

A sample dream interview: A woman dreamed of a black cat on the windowsill of her bedroom. The cat runs all over the room, raises a ruckus, then leaves. The dreamer is in tears. This abbreviated version of the method has the

three key steps applied thus:

Step 1: Description

The interviewer asks the dreamer to describe the major elements of the dream as if describing them to someone from another planet.

Interviewer: What is a cat like? Pretend that I come from another planet and have never seen one. (Generic description)

Dreamer: Cats are sleek, agile, lovely to look at, aloof, distant; they love you when they want to and leave you when they want to.

I: What is the cat in your dream like? (Specific description)

D: Like my generic description, and it is a gorgeous black color.

Step 2: Recapitulation

The interviewer repeats the description to see if the dreamer wants to add or correct anything.

Step 3: Bridge

I: So is there anyone, any part of your self, or anything in your life that is like a gorgeous, black, sleek, agile cat that is lovely to look at, aloof, distant, loves you when it wants to, and leaves you when it wants to? That raises a ruckus in your bedroom and leaves you in tears?

D: Oh! My boyfriend. And he is black! You know, all my major boyfriends have been like cats. What I need is a dog! Someone who wants to hang out with me, is loyal and attached to me!

By using only the words the dreamer used, the reflection of her words triggered the recognition of the traits that she sees her boyfriend and cats share. Had the interviewer projected his much more positive feelings about cats, or any of various traditional or psychological interpretations of cats as the mother, the feminine principle, or an Egyptian goddess, this useful metaphor might have been lost and much time spent with tangential associations.

The material in this article is taken from my book, *All About Dreams*, which
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A Powerful Tool

Dream Interviewing in Physical Diagnosis and Treatment

Loma Flowers, MD

My recognition of the power of Dream Interviewing as a tool to unravel mind-body dilemmas was totally serendipitous, and the old memory is still vivid. I should never have met this surgical patient, let alone interpreted her dreams. The chain of events started with my beloved sister-in-law finding a breast lump. As the “family doctor” (before Google, even a psychiatrist was invaluable in these matters) and a cancer survivor myself, I referred her to my wonderful surgeon for the lumpectomy. She was fine—the lump benign, thank goodness—we were all very grateful, and I owed my surgeon a favor.

I ran into him when I visited my sister-in-law on the ward. (Remember when it was an inpatient procedure?) It was a Tuesday. He stopped me for more than the usual pleasantries and told me he was worried about another patient. He had done a partial colon resection for cancer on her two weeks previously. She had begun persistent vomiting a few days postoperatively and he was in a dilemma about whether to “go back in” or not. He was scheduled to leave town that weekend for a surgical meeting, but he would not leave her reoperation to another surgeon: “I always take care of my own patients.” So he had to decide and act by Friday.

He had reviewed the straightforward surgery carefully in his mind—over and over, I’m sure, as I look back on this now—and he just could not believe there was an obstruction. The prolonged delay in onset of the vomiting and his confidence in the surgery led him to a psychogenic origin. This left him in a dreadful position. He was not psychologically minded and I had heard through the grapevine that he

could be a bear in the OR to his team, who nonetheless greatly respected his surgical skills—not uncommon in those days. But he was also warm, kind, and sympathetic to his patients and their families. They adored him. So I thought that if *he* favored mind over body, it would be reluctantly and in the patient’s best interest.

He had asked for and received a psychiatric consultation. The psychiatric nurse assigned accurately identified the patient’s work stress, but the vomiting still continued. The surgeon felt he had to act—he was a surgeon after all, and the differential diagnosis was clear: either physical or psychogenic. The question was how to obtain the deciding evidence.

He asked me to see her. I resisted. He insisted. I worked part-time and deliberately avoided hospital work in those days when my children were small. But I had the privileges . . . and I owed him a favor. So though my sister-in-law went home on Wednesday, I continued to visit the ward that week. On Tuesday, I confirmed the consultation findings and thought, “If this vomiting is psychogenic, caused by her work stress, I need to help this patient resolve enough of this work stress to decrease the vomiting. How on earth am I going to do that in two days, when she is not psychologically minded either and resents being seen as ‘crazy’?”

When I first learned Delaney’s Dream Interview method of dream interpretation, I was profoundly struck by its elegant precision in elucidating psychodynamics. A picture is indeed worth a thousand words with this method. This precision had saved hours of the slower psychotherapeutic teasing out of issues in my private psychotherapy practice. Why not

here? Patients on medical wards are usually bored: There is little to occupy the mind and even less to do when they are sick. There is, however, ample opportunity to nap and sleep—and so to dream. Therefore, this tool came to mind as I watched this patient fill three emesis basins with gastric juices while I sat for barely an hour at her bedside.

I asked her, “Have you had any dreams since you’ve been in the hospital?” She thought for a minute and related the one she recalled. I breathed a sigh of relief. It was a blessedly simple dream, and the dynamic was pretty obvious. The descriptive definitions she gave me of the three images did the rest. Not only was the work issue confirmed, but we had the plan for resolution.

I included this dream in *New Directions of Dream Interpretation* (1993, Gayle Delaney, ed.). In brief, the patient is trapped at the bottom of a pit, dodging around to avoid a whip wielded by a woman at the top. She described the whip as an animal trainer’s whip. If you thought of a different kind of whip as you read her dream, you will now understand why this Dream Interview method is so powerful. The dreamer has the best view for insight into themselves, including, I believe, their body. The interviewer has only to inquire to get that information in usable form. But the interviewer must also refrain from telling the dreamer what she knows/should know/needs to know about her own dream. Curiosity is your best stance, like taking a good history.

The character using the whip was her supervisor and the dreamer was “dodging around like a little tiger.” Not (I checked)

Continued on the following page ...

A Powerful Tool continued ...

a pussycat! She eyed me with the hint of a smile as she got that key point in her dream's reconceptualization of her work issue. We were then able to focus clearly on strategies that human "tigers" use to fight their "trainers" when they have had enough of jumping through hoops at work. Once you think about things from this empowered point of view, solutions usually come to mind. They did for her. When I returned Wednesday the vomiting had lessened. As I recall, only one-and-a-half emesis basins that day. I was confident then that the surgeon was right. It was his clinical acumen, not vanity about his surgical skills, that led him to favor a diagnosis of psychogenic vomiting despite his disinterest in emotional issues. Physical bowel obstruction is unlikely to be responsive to dream interpretation.

The surgeon was free to leave for his meetings, but how to resolve the residual vomiting? My Wednesday visit was spent in searching for why she was not 100 percent better. Entirely because of the pit dream, I was totally confident that there must be a second psychological issue. My reasoning was that if work were the only psychodynamic, she should be cured, not half cured. When all else fails, review the history. I did and had it clearly in mind on Thursday.


Gazing desperately around the room at the cards and flowers, looking for inspiration and chatting about who sent what, I realized that she had not mentioned her son—in three days. A light flashed: most unusual behavior. We mothers can bore everybody to death about our children, given a sliver of opportunity. What was up?

It turned out that her brilliant son had become psychotic in college following drug use, and she had been unable to manage him at home and had not heard from him in years. Reflecting on her cancer diagnosis and mortality after her surgery, she began to worry about his fate, wondering how to find him and make some financial provision for him on her death. She had not revealed this story in more than a decade. At my prodding, she began to sob, and to retch as one does with violent crying.

A spontaneous dream had led to this insight. I used an incubated dream to keep us on course. I stayed with the patient a while to support her long-resisted relinquishment of her son's promise. I assured her of the importance of grief and crying to stop the substituted vomiting. I also explained that to the surgical ward staff, so they would not urge or medicate her out of it. Then I suggested she request a dream that would help. She was agreeable. She went to sleep saying, "I need a dream to help me with my grief."

Friday morning, she was up in a chair, sipping liquids, no vomiting since the day before. She welcomed me warmly, delighted with her improvement. Imagine my relief. It is one thing to practice a dream interpretation method and see emotional results; it is another to have concrete physical evidence. Moreover, she recalled a dream² from that night. The dream could illustrate Freud's theory in "Mourning and Melancholia," which basically states that you grieve the good things that are lost in a relationship, not the bad.

She had dreamed of her son at home at age five when all was well. They were playing Old Maid and he was laughing as he always laughed and cheating as he always cheated. She glowed with the pleasure of the good memories. Those good memories had been obliterated with the bad to protect herself emotionally from the pain, shame, and disappointment of his mental illness. In the face of her mortality, new maternal concerns surfaced and her intense emotions were somaticized in vomiting. I heard from the surgeon that she went home Saturday and did well.

This memorable case of dreams, mind, and body led to my twenty-eight-year partnership with Gayle Delaney to teach Dream Interviewing. We hope to disseminate its usage more widely in an era when health and time are precious to everyone. I lead a free monthly dream seminar for psychiatric residents and early career physicians—surgeons welcome—interested in learning the technique. The basics are simple, but proficiency requires practice, like any other skill. Yet the results can be ample reward. 

Loma K. Flowers, MD, has practiced psychiatry for forty years in the San Francisco Bay area, publishing on various practical aspects of her work, including dreams, diversity, and emotional competence. Her lifelong interest is the relationship between individuality and universality. She now confines her international private practice to preventive psychiatry, providing consultations to individuals and families as well as lectures and leadership of seminars and retreats for organizations. She is the founder and president of Equilibrium Dynamics, a nonprofit organization (www.EQDynamics.org) dedicated to teaching the fundamental principles and skills of normal personal and professional development.

Modern Dream Interpretation

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describes the Dream Interview in detail.


But for today, here is a cue card you can use to interview yourself or another dreamer.

Dream Interview Cue Card

Describe this image (person, animal, object, feeling, plot) to me as if I come from another planet and have never heard of it before. What is a ___ like? (Generic description) What is the one in your dream like? (Specific description)

So have I got it right? A ___ is (Recapitulate the dreamer's descriptive words, following the dreamer's tone). Any elaborations or corrections?

Is there anyone, anything, or any part of yourself that is like the ___ that you describe? (Bridge)

How so? Invite the dreamer to flesh out the ways the dream image bridges to some part of his life, to be sure the metaphor is a good strong bridge. If you find that it is not, go back and ask for a richer description. 

*Gayle Delaney, PhD, is codirector with Loma Flowers, MD, of the Delaney & Flowers Dream Center; founding president of the International Association for the Study of Dreams (www.asdreams.org); and author of *All About Dreams and In Your Dreams*. Her website is at www.gdelaney.com.*

What Dreams May Come

Imaging the Brain during Sleep

Bill Wine

Like many domains in the study of consciousness, dream research relies largely on phenomena that can only be known through introspection; that is, the dreamer alone is privy to the dream. Consequently, scientists and researchers have always depended on sleep journals to gather information and track sleep and dream activity.

But the study of human sleep has been enhanced in recent years by visual data made possible by imaging techniques, such as PET and functional MRI (fMRI), which provide maps of the changes in regional neural activity during the distinct stages of sleep.

PET, for instance, offers a noninvasive way to study the changes in blood flow in the human brain during sleep, while fMRI, although widely used, has the disadvantage of the level of difficulty involved in recording the electro-encephalogram (EEG) and measuring brainwaves simultaneously with the fMRI signal.

Further, PET and fMRI make it possible to measure activity in different regions of the brain by monitoring how rapidly cells consume glucose or the rate at which blood is flowing—and to where. And they not only allow just a surface look at EEG structures; they also provide a deep look into the brain.

Sleep rests the body, but not necessarily the mind. The brain doesn't merely click off at night. MRI pictures have shown furious mental activity from the base of the brain to its wrinkled covering, the cortex, or thinking dome. One theory holds that this "excitement" results from the consolidating of information learned during the day—retaining some memories and discarding others, as if going through

the mail and tossing the junk. By making new connections, a form of unsupervised learning results in new associations and insights.

Enter the common perception: "It came to me in a dream." Meaningful information can be obtained when the neuroimaging data are explained in the light of our current knowledge about brain function, aided by insights contributed from fields such as neuropsychology, cognitive psychology, primate brain anatomy, and cellular neurophysiology.

Channeling Freud

"The interpretation of dreams," wrote pioneer dream analyst Sigmund Freud more than 100 years ago in Vienna, Austria, "is the royal road to a knowledge of the unconscious activities of the mind."

For Freud—who began studying dreams after years of neurological research but gave up because there was no pictorial way to map the brain in the pre-electronic-scan era—dreams were saturated with latent meaning, teasing us with clues to deep-seated, subconscious fears, fantasies, desires, and dreads. And here people sit—and dream—a century later, still trying to decode the biology of just how we manufacture those dreams.

That's why, at the University of Pittsburgh Medical Center's Sleep Neuroimaging Research Center (SNRC), researchers delve into the brains of sleeping subjects with PET scans, usually employed to detect diseases such as cancer. Injecting subjects with mildly radioactive glucose, researchers trace the source of dreams to the limbic system, or the part of the brain that governs and controls emotions, influences senses such as sight and smell, and

contributes to the formation of memories. When people dream, the limbic system virtually explodes with neural activity, adding a layer and administering a jolt of drama.

"That's why so many dreams are emotional events during which we're running from danger or facing an anxious situation," says Eric Nofzinger, MD, the director of the SNRC and an expert clinician and clinical researcher in sleep disorders medicine. "The part of the brain that controls dreams also orchestrates our instincts, drives, sexual behavior, and fight-or-flight response."

And as people dream, the brain's logic-governing frontal lobes disengage, which is why so many of the events or scenarios in our dreams seem bizarre or surrealistic. This mosaic of regions, some active and some not, may explain why humans often recall dreams of people that look nothing like the real-life versions of themselves. Thus, perhaps the half-asleep portion of the brain governs facial identification.

Modern neuroscientists look at dreams in a somewhat different light than Freud did. Laboratory studies conducted several decades ago ended up linking dreams not to hidden urges but to the firing of neurons and the oscillation of chemicals in the most primitive part of the brain during the phase of sleep characterized by "rapid eye movement," or REM.

REM, discovered in 1953, is a physiological state beginning about ninety minutes after the onset of sleep. Characterized by heightened brain activation, rapid (unseeing) eye movement, increased breathing and heart rate, and

Continued on the following page ...

What Dreams May Come continued ... genital engorgement, this sleep state continues to fascinate sleep experts. And by a simultaneous paralysis of bodily movement: Humans are aroused yet fast asleep. This, in turn, causes experts to question: Did REM sleep become more or less synonymous with “dream sleep?”

When awake, people perceive something on the outside and then process the information in the cortex. Dreams reverse the process: They are internally generated and then converted from abstract thoughts to concrete perceptions. And because the reflective system in the frontal portions of the limbic brain is inactivated, the dreamer accepts the dream scene without exercising critical judgment or evaluation.

Viewed from this vantage point, dreaming is seen as chaotic and random, an attempt by the sleeper’s mind to account for all the heavy traffic driving through the brain. The higher brain centers—where memories, thoughts, and emotions reside—are seen merely as passive responders.

Or, as Allan Hobson, MD, and Robert McCarley, PhD, both of Boston-based Harvard University’s department of psychiatry, called it in their “activation-synthesis” model of dreaming, the mind makes “the best of a bad job in producing even partially coherent dream imagery from the relatively noisy signals sent up from the brainstem.”

This would seem to part ways with the father of psychoanalysis, giving Sigmund the proverbial Freudian slip. But in recent years, new findings have led scientists to reexamine their grasp of the dream state and the brain and to consider that the parts of the brain that control vision, feelings, and memory might be playing a more active role than was previously thought.

Deconstructing Dreams

Recent neuroimaging studies have shown that human REM sleep is characterized by a specific pattern of regional brain activity that can be linked to particular dream features. And it is the neuropsychological analysis of dream content

that would seem to offer new ways of interpreting dreams.

Additionally, several psychoanalysts have pointed to recent scientific findings as providing a biological foundation for at least some of Freud’s deductions gained from treating neurotic patients of the late nineteenth and early twentieth centuries.

“Twenty years ago,” says neuropsychologist and psychoanalyst Mark Solms, PhD, of London’s St. Bartholomew’s Hospital, “Freudian dream theory seemed absolutely untenable. Today, what we know about the brain mechanisms of dreaming is far more compatible with what Freud inferred.”

Some of the recent insights into the topography of dreaming have come from the development of neuroimaging techniques that have allowed investigators to actually observe the living, functioning brain. In one series of studies, the National Institutes of Health’s Allen R. Braun, DO, and his colleagues used PET scanning to examine brain activation by measuring blood flow during both the REM and non-REM stages of sleep.

The resulting portrait of the dreaming brain indicated a subjective experience of dreaming consistent with psychoanalytic theory, characterized by vivid images, intense emotions, and slivers of memory, all integrated in a way extremely different from the logical, orderly, self-aware manner of waking consciousness.

Moreover, that the emotional system is active during REM while the brain regions responsible for rationality shut down could be viewed as Freud’s ego giving up control during sleep and allowing the id to express itself through the basic drives and appetites. This, in turn, generates dream imagery that is less restrained and more colorful.

Yet there are contradictions, too. While Freud argued that the particular unconscious desires underlying dreams were censored and, thus, cloaked as something else, the PET study indicated that, during REM, the part of the brain responsible for generating such meaning-disguising symbols was inactive. All of which begs the question: Just where do dreams originate?

Most studies over the years have demonstrated that dreaming is most likely to occur during the REM stage, which, in a typical night’s sleep, occurs regularly about every hour and a half. Subjects awakened during REM report dreaming more than 80 percent of the time, compared to the 10 percent that subjects report when awakened during the other phases of the sleep cycle.

But if these dreams are set off more or less automatically by the pattern of stages during sleep, how do experts account for all that dream-related material discussed routinely by therapists and their patients—the abiding psychological conflicts, the residual childhood traumas, and the expression of unconscious desires?

Perhaps the REM stage is not the only stage of sleep during which dreams can be triggered. After all, non-REM sleep (NREM) does account for about 80 percent of our sleeping time.

Suppose, for example, that necessary stimulation occurred during the stage just before falling asleep at night, or during the stage just before awakening in the morning. And suppose that the level of censorship and disguise that Freud suggested is applied to unconscious motives—as a way of keeping certain thoughts and emotions that people are reluctant to admit from intruding on their consciousness—is less active and effective than he first thought.

Braun has suggested that it may be time to put the focus on Freud aside. “Perhaps,” he says, “it is simply the ghost of Freud getting in the way.”

The primary aim of the Sleep Neuroimaging Research Program is to identify function changes in different regions of the brain across the wake/sleep cycle in health versus disease, in the hopes of discovering alterations in function related to different disease states and thus providing clues to appropriate treatment for particular disorders.

Their approach to studying brain function during sleep is to combine several research methods in sleep analysis and functional brain imaging, such as

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Abnormal Sleeping Behaviors

A Summary from the Stanford Sleep Medicine Center

Eric Frenette, MD, FRCP(C)

Sleepwalking, night terrors, the impression of falling off a cliff, and the feeling of being chased and unable to flee are only a few of many conditions that can be experienced in sleep. While twitches can be normally encountered during sleep, excessive movement associated with purposeful behavior or night wandering should not be considered normal sleep occurrences.

Sleep is not a uniform process. Every night, we go through four or five sleep cycles lasting about 90 minutes each. Each cycle is divided into REM and non-REM sleep. REM sleep, or Rapid Eye Movement sleep, is the stage in which we dream. It makes up about 15 to 20 percent of the total sleep time. Non-REM sleep makes up the rest. When we fall asleep, we go into non-REM sleep, then REM sleep, and the cycle repeats itself. We also lump the abnormal sleep behaviors into the general category of parasomnias, each further divided into non-REM sleep parasomnia and REM sleep parasomnia.

Non-REM Sleep Parasomnia

Sleepwalking is the prototypical non-REM sleep parasomnia. It usually begins in childhood and can wax and wane throughout life. It starts in the deeper stages (slow-wave sleep) of non-REM sleep as patients exhibit their curious behaviors. Wandering is common. Milder forms may occur, like confusional arousal, during which the child will talk senselessly and go back to his normal sleep. These events tend to occur during the first part of the night, the part in which slow-wave sleep is more prominent. Urban legend has it that you should never wake a sleepwalker—advice that is *just* urban legend. Patients are usually unaware of their behavior and can't recall the events the morning after. Stress, prior sleep deprivation,

and sleep-disordered breathing are conditions that may worsen the problem and in some instances even cause it. It is important to look for these underlying factors and treat them if present. As for the sleepwalking itself, the important issue is to assure a safe sleeping environment so that no harm will occur to the walker.

REM Sleep Parasomnia

REM sleep behavior disorder, or RBD, is the prototypical REM sleep parasomnia. Normally, our muscle tone decreases significantly in REM sleep, except for the breathing and the eye muscles. In RBD, a condition occurring mostly in older adults, the loss of muscle tone does not occur, so dreams can be enacted. The dreams are mostly action-filled, as patients may dream they are fly-fishing and reenact all the gestures, or believe that they are being attacked and forcefully defend themselves. They can usually recall their dreams. The downside is that patient can hurt themselves and sometimes hurt their bed partner. RBD is typically seen in patients suffering from neurodegenerative diseases, like Parkinson's disease, but it can also happen without any underlying disorder.


Diagnosis

Making the diagnosis is the most important issue, because treatment depends on the correct diagnosis. Diagnosis is reached with a combination of interview, clinical exam, and sleep study. It is of the utmost importance to have a witness describe the events, as it will normally lead us toward the right track. An overnight polysomnogram is essential in corroborating the clinical findings and eliminating other frequent conditions. We essentially look for

arousal-like events from slow-wave sleep and video proof of abnormal behavior in non-REM sleep parasomnias. For RBD, we look for lack of muscle tone loss (persisting muscle tone) in REM sleep, along with the known disruptive behavior. Even though the patient might not have the behavior aspect, if he shows a significant increase in muscle tone in REM sleep and the clinical history is compatible with the diagnosis, then we can be relatively convinced that we are correct in assuming that the patient suffers from that pathology.

Treatment

Treatment is achieved with healthy sleep hygiene and general measures of bedtime security, like sleeping in a safe environment and removing potentially dangerous objects. We also sometime advise sleeping on the floor, in a sleeping bag, or even locking the room door to prevent wandering and potentially dangerous behaviors. If RBD is suspected, the bed partner has frequently already left the bedroom for a while, fearing injuries related to the active dream enactment behavior. More specific medical treatment is also available and is usually very effective. The most commonly used drug for treatment of RBD is clonazepam, of the benzodiazepine family. We have to be careful, however, as this medication can sometimes worsen sleep-disordered breathing, which is frequently present in elderly individuals.

No need to panic if you or a member of your family suffers from one of these disorders. The most important part is to make the adequate diagnosis, so that proper management and treatment can be correctly implemented. 

Eric Frenette, MD, is a neurologist at the Stanford Sleep Medicine Center.

Insomnia

A Common Sleep Disorder

Michelle Cao, DO

Insomnia is the most prevalent sleep disorder. Approximately one out of four adults experiences insomnia at some point in their lives, and more than 10 percent of the population considers it to be a chronic problem. Individuals complain of difficulty with sleep initiation, sleep maintenance, multiple awakenings throughout the night, difficulty falling back asleep, early morning awakenings, sleep that is chronically nonrestorative or poor in quality, or a combination of the above. These symptoms may result in daytime impairment such as fatigue or malaise, cognitive impairment, poor performance at work or school, irritability, or decreased motivation. Insomnia symptoms may also be associated with physical complaints including headaches, gastrointestinal symptoms, and body aches and pains. When daytime sleepiness (distinct from fatigue and tiredness) is present it should prompt a search for another potential sleep disorder, such as sleep apnea. Risk factors for insomnia include increasing age, female sex, substance abuse, shift work, unemployment, lower socioeconomic status, and other medical, psychiatric, and sleep disorders.

The relationship between insomnia and some psychiatric disorders seems to be bidirectional. Psychiatric disorders commonly associated with poor sleep include depression, anxiety disorders, psychotic disorders, and adjustment disorders. These conditions may cause sleep difficulties or exacerbate pre-existing insomnia. Similarly, poor sleep may exacerbate these psychiatric conditions. Irritability, loss of interest, mild depression, and anxiety are common among insomnia patients.


Individuals who suffer from insomnia tend to develop behaviors that unintentionally

end up perpetuating their sleep problem. These behaviors are meant as coping mechanisms to combat the sleep problem, but unfortunately they only add to the worsening of the sleep problem itself. For example, a common reaction to poor sleep is to spend more time in bed than before in an effort to get more sleep. This is rarely an effective strategy. In fact, when good sleepers are asked to extend their sleep, they start experiencing sleep difficulties. The tendency to respond to stress with worry and rumination is a risk for insomnia. Stressful times are commonly associated with the emergence of sleep difficulties; however, people differ in the extent to which stress interferes with their sleep. When poor sleep becomes a source of stress, those who tend to ruminate about being unable to sleep inadvertently worsen their problem because the worry creates a state of “hyper-arousal” that interferes with sleep.

Treatments of insomnia include pharmacologic regimens and sleep-focused cognitive behavioral therapy. The goal is to alleviate nighttime symptoms, achieve restorative sleep, and improve daytime function. Hypnotic medications are generally good for short-term treatment of insomnia. They have a significant side-effect profile. The newer generation of hypnotics, the non-benzodiazepines, have fewer and less severe side effects, as well as minimal addiction and tolerance potential than the older generation of hypnotics (the benzodiazepines). Some of the non-benzodiazepines include zolpidem, zolpidem extended-release, zaleplon, and eszopiclone.

Current data have shown that psychological and behavioral interventions are effective and are recommended as a

treatment option for adults with chronic insomnia. These treatments are efficacious for adults, including older adults and chronic users of sleep medications. Behavioral interventions include stimulus control therapy, relaxation training, cognitive therapy, and sleep restriction therapy. Together, these interventions are known as “cognitive behavioral therapy for insomnia,” or CBT-I. Ideally, a clinician who is specifically trained in behavioral sleep medicine delivers CBT-I.

The Stanford Sleep Medicine Center is an internationally known center for sleep medicine research and provides outstanding patient care for people with insomnia and other sleep disorders. The Insomnia and Behavioral Sleep Medicine program is an integral part of the new Stanford Sleep Medicine Center. Rachel Manber, PhD, who is a leading international expert in the area of behavioral sleep medicine, heads the program. The program is also a well-respected center for young scientists and clinicians who train to treat patients suffering from chronic insomnia and to conduct research to further improve care. The program offers treatments in both individual and group sessions. The group sessions are held once per week for five weeks, followed by every other week for the following four weeks, for a total of nine weeks. Because this is a highly specialized program, we often treat patients with chronic severe insomnia who have failed multiple pharmacologic therapies and previous behavioral modifications and counseling. 

Michelle Cao, DO, specializes in pulmonary disease, internal medicine, and critical care medicine at the Stanford Sleep Medicine Center.

Hypersomnia and Narcolepsy

A Difficult Diagnosis

Emmanuel Mignot, MD, PhD

Excessive sleepiness as a symptom is as common as insomnia, yet it is less understood and its treatment less codified, once sleep apnea and sleep deprivation have been eliminated as the major causes. The remaining etiologies, typically codified as “hypersomnia” (excess sleep) or “narcolepsy,” are difficult to diagnose. To solve this problem, we have set up a specialized “hypersomnia/narcolepsy” clinic.

The Stanford Center for Sleep Sciences has a twenty-year record of experience in research and clinical care in this area. It is renowned for having found the cause of narcolepsy—a deficiency, of autoimmune origin, of the brain peptide hypocretin. I direct the Stanford hypersomnia/narcolepsy clinic in the new Stanford Sleep Medicine Center, and I was instrumental in these discoveries. Using this knowledge, the program has developed novel biochemical-based diagnostic tools to diagnose narcolepsy. We specialize in seeing difficult cases, often giving second opinions and providing additional guidance on a therapeutic plan.

In some typical cases, the patient has other symptoms beside sleepiness, such as vivid dreaming, feeling weak in the legs or the face when laughing or joking (a symptom called cataplexy), or experience of sudden abrupt onset of sleepiness that helps in making a diagnosis of narcolepsy independently of the presence of sleep apnea. In these cases, research has shown that the cause of the sleepiness is due to an autoimmune attack of approximately 50,000–100,000 hypothalamic neurons that produce the wake-promoting, REM sleep-inhibiting neuropeptide hypocretin. A simple interview and sleep test showing rapid sleep onset and rapid transitions into

REM sleep during daytime naps during a test called the Multiple Sleep Latency Test (MSLT) is appropriate for a diagnosis. The judicious use of SNRI, stimulants such as modafinil, and sodium oxybate will most often greatly improve the clinical picture, restoring function to a level close to normal. Although, as in all areas of medicine, some patients are difficult, the most challenging task is to find the right combination of medication and doses to ensure that the patient can fulfill his full life potential (neither under- or overdosing).

Other cases with genuine narcolepsy-cataplexy are made more complex to diagnose, as cataplexy is absent, atypical—for example manifesting only as facial grimaces or sudden falls without triggers, or when there is a confounding additional problem such as severe sleep apnea and obesity or a genetic, neurological, or psychiatric disorder. In these cases especially, the use of genetic (DQB1*0602 typing, other) and biochemical hypocretin measurements in the cerebrospinal fluid can be very helpful, both in ensuring that there is genuine hypocretin deficiency and in facilitating aggressive therapy.

A difficulty in this area of clinical practice is the over- and underdiagnosis of narcolepsy or hypersomnia. As mentioned above, some patients with a biochemical basis of narcolepsy may not have cataplexy, or it may not present typically, and thus they are not properly diagnosed. We have seen countless obese patients where narcolepsy was obvious but because of the presentation, sleep apnea was considered the cause of their problem. This is extremely damaging to these patients, as proper therapy may change their lives. Similarly, as research has now shown an

autoimmune involvement, we are initiating immune therapy trials in patients close to onset, with partially positive results.

Most often, however, it is our experience that narcolepsy and hypersomnia are overdiagnosed. As mentioned above, when cataplexy is absent, only a minority of patients with unexplained (e.g., no sleep apnea, no sleep deprivation) excessive daytime sleepiness (5 to 20 percent) have hypocretin deficiency. Unfortunately, recent studies have shown that the MSLT can be positive for “narcolepsy” in 2 to 4 percent of the population even though most of these subjects do not complain of sleepiness or any problem. This is the same when the test comes back positive for “hypersomnia.” As with other tests, and unlike measuring CSF hypocretin (a very specific test), the MSLT has many false positives, especially when it is not well conducted, or conducted in the presence of psychotropic agents, or the patient also has sleep deprivation or sleep apnea. We therefore see many “narcolepsy” patients where the diagnosis of a central nervous system dysfunction causing the symptom is in doubt. In some cases, these patients are taking high doses of amphetamines without results, or they have very poor nocturnal sleep or some degree of sleep apnea. Thus it is difficult to know whether sleepiness is due to bad sleep or vice versa.

These cases are often challenging, as the symptoms may involve a combination of problems—for example, some irregular sleep/wake schedule and insomnia, depression/anxiety, sleep apnea and hypersomnia/narcolepsy, which all contribute to daytime sleepiness and the complaint. It is thus necessary to do the patient

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Obstructive Sleep Apnea

Better Sleep through Better Breathing

Shannon Sullivan, MD

Obststructive sleep apnea-hypopnea syndrome (OSA) occurs when the structures of the upper airway partially or completely close during sleep, leading to repetitive episodes of airflow limitation or cessation, hypoxia, and/or arousals. It may be characterized by snoring, witnessed apneas, choking or gasping, morning headaches, nonrefreshing sleep, or excess daytime fatigue or sleepiness. In children, the disorder may be more difficult to recognize, and it can be associated with growth delay, neurocognitive and behavioral problems, and poor school performance.

OSA develops from increased upper airway resistance. In adults, risk factors for this disorder include male sex, obesity, increasing age, large neck circumference, and certain anatomic features that functionally restrict the airway, such as midface hypoplasia, retronathia, tonsillar hyperplasia, and macroglossia.

In 1973, shortly after William Dement, MD, PhD, and colleagues established the world's first accredited sleep center at Stanford, the Stanford Sleep Medicine Center's Christian Guilleminault, MD, D Biol, coined the term "obstructive sleep apnea." OSA prevalence was originally estimated at 2 to 4 percent of middle-aged men and women, but due to increased detection and increasing rates of obesity, prevalence is now estimated to be 7 to 23 percent. In addition, the disorder tends to aggregate in families, and differences have been seen based on ethnic background, gender, and age. Research has established a clear link between OSA and the development of high blood pressure, as well as a host of other complications, including

coronary heart disease, heart failure, and stroke. Sleep-disordered breathing has also been linked to excessive daytime sleepiness, deficits in psychomotor and behavioral performance, increased automobile accidents, decrements in functional status and quality of life, and increased all-cause mortality.

The diagnosis of OSA is made using nocturnal polysomnography (PSG), commonly referred to as a "sleep study." After a thorough evaluation by a sleep physician, patients are typically scheduled to spend the night in a sleep lab, where monitoring of surface electroencephalogram, nasal and oral airflow, eye movements, muscle tone, limb movements, heart and respiratory rates, respiratory effort, and oxygen saturation and carbon dioxide levels occurs. Newer technologies and scoring criteria have sought to improve and standardize the detection of OSA, and some monitoring systems are able to be used in the home setting in carefully selected patients, although less information is available through these systems.

Treatment of obstructive sleep apnea is multidisciplinary and may involve specialists from multiple fields, including sleep medicine, otolaryngology, and dentistry. The mainstay of therapy is positive airway pressure, or PAP, delivered continuously or as alternating inspiratory and expiratory pressures, known as bilevel. PAP was first used for OSA in 1981. Now there is good evidence that correct use of such devices improves daytime symptoms and quality of life, and that it diminishes or abolishes negative health consequences associated with OSA. Use of a PAP device requires customization, including selecting an appropriate mask,


pressure, and machine type. Newer machines include comfort features, have auto-titrating capability, and have "smart cards," which can be downloaded at subsequent clinic visits to track residual breathing abnormalities and PAP performance.

Since 1981, when the first uvulopalatal pharyngoplasty (UPPP) was performed to treat OSA, surgery has played an expanding role in OSA therapy. In children, the first step in management of OSA is often a surgical evaluation for adenotonsillectomy. In adults, modified and traditional UPPP, genioglossus advancement, and other surgeries have been used with varying success. Surgeries aimed at opening the nasal breathing route—such as radiofrequency ablation of the turbinates, first performed at Stanford for OSA—and septoplasty may also be helpful in select patients. Bimaxillary or maxillomandibular advancement for the treatment of OSA, which was pioneered at Stanford by Nelson Powell, MD, and Robert Riley, MD, offers the best chance of surgical success, though it is also the most invasive procedure.

Dentists also play an important role in the diagnosis and treatment of OSA. They may be the first to observe signs of OSA and make a referral for evaluation; some can also make oral appliances to treat milder forms of OSA. Though these are not as effective as PAP therapy, such custom-made appliances have the advantages of portability and no power source requirement.

Other treatment modalities are also relevant for OSA treatment. For example, management of nasal symptoms for allergy sufferers is important, as improve-

ments in nocturnal breathing have been demonstrated when nasal airway patency is improved. Newer approaches in children, such as orthodontic rapid maxillary expansion, are also reported to be successful in selected individuals. Measures such as weight loss, avoidance of alcohol consumption and sleep deprivation, and body positioning are also important aspects of OSA treatment.

The Stanford Sleep Medicine Center faculty includes a multidisciplinary group of sleep physicians. At the helm are world-renowned leaders in the field, such as Christian Guilleminault, MD, D Biol, whose clinical work and research has propelled the field forward; Clete Kushida, MD, PhD, who is leading the largest-ever study of the impact of PAP therapy; and Emmanuel Mignot, MD, PhD, who discovered the cause and genetic markers for narcolepsy. The center is also respected as one of the top sleep medicine training programs in the country. If you or someone you know has loud snoring, irregular breathing during sleep, excessive daytime sleepiness or fatigue, or others symptoms of possible sleep apnea, speak with your physician or contact a sleep specialist. 

Shannon Sullivan, MD, is a pediatric pulmonologist at the Stanford Sleep Medicine Center.

New Stanford Sleep Medicine Center Opened in February 2009


Clete A. Kushida, MD, PhD

The world's first sleep clinic was established in 1972 at Stanford University by Drs. William C. Dement and Christian Guilleminault. Since that time, the Stanford University Sleep Disorders Clinic has grown to become one of the world's largest and best-known sleep clinics. Many of the pioneering and top discoveries in sleep medicine and basic research on sleep were made by our team of internationally recognized scientists. For the first time, our clinic and human sleep research laboratory will be housed in the same facility, which is the new Stanford Sleep Medicine Center. This center opened in February 2009 in the new Stanford Medicine Outpatient Center at 450 Broadway Street, Redwood City.

The success and excellent reputation of our sleep program is entirely dependent on the quality of our personnel. Our staff is comprised of twelve attending clinicians, eight postgraduate clinical fellows, managerial and administrative staff, office and support staff, research coordinators and assistants, and a large team of sleep technologists who attach recording electrodes and monitoring devices to patients and research subjects and monitor them during overnight sleep studies and daytime tests. The multidisciplinary clinicians on our staff are board-certified neurologists, pulmonologists, psychiatrists, psychologists, pediatricians, and ENT surgeons with the highest levels of training and expertise, who are able to diagnose and treat the full spectrum of sleep problems and the ninety-plus different recognized sleep disorders. In particular, the psychologists in our insomnia and behavioral sleep medicine program offer effective nonpharmacological treatments for insomnia in adults and children. Our human sleep research team specializes in the management of large, multicenter

clinical trials evaluating the efficacy and safety of new medications and devices developed for the treatment of insomnia, obstructive sleep apnea, and restless legs syndrome.

The highlights of the new Stanford Sleep Medicine Center include eighteen bedrooms for clinic patients and research subjects, eight patient examination rooms, two cognitive behavioral therapy rooms, a procedure room for endoscopic visualization of patients' upper airways, a patient fitting room for positive airway pressure masks and machines, and a research laboratory. Our new facility enables us to use the latest techniques and state-of-the-art equipment to diagnose and treat our patients' sleep problems. The eighteen sleep laboratory bedrooms have been optimized to provide the highest level of comfort, rivaling that of a first-class hotel and equipped with the latest monitoring technology. These bedrooms can accommodate both adult and pediatric patients six nights a week, and one of the bedrooms is outfitted with a special bed, toilet, and shower to accommodate patients weighing more than 300 pounds who are receiving a sleep study prior to undergoing bariatric surgery for weight loss.

Our large team of sleep specialists, researchers, technologists, and managerial and support staff look forward to diagnosing and treating more patients with sleep problems and contributing to sleep-related scientific breakthroughs in our new home in Redwood City. 

Clete A. Kushida, MD, PhD, is acting medical director of the Stanford Sleep Medicine Center and director of the Stanford University Center for Human Sleep Research. He is also an associate professor at the Stanford University Medical Center. The Stanford Sleep Medicine Center can be reached by calling (650) 723-6601.

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One Long Night

A Nonpatient's Perspective on Insomnia

Steve Heilig, MPH

"... in the jingle-jangle morning ..."
—Bob Dylan, "Mr. Tambourine Man," 1964

Anyone who questions the necessity of getting enough sleep might try a simple experiment—stay awake all night for two consecutive nights. Bob Dylan, America's bard, was writing about his wired, edgy feeling after just one such night. That can be not altogether unpleasant, and some people with depression even report a temporary improvement in their mood after such a night. But after two or more sleepless nights, one starts to get a first-person understanding of the reasons enforced sleeplessness has been used as a method of torture.

My mother used to find me in the hall, out on the patio, even out on the beach, passed out with a book. She thought I had been sleepwalking, but in fact I had gone out to those spots half-awake, looking for a place to try to read myself to sleep or to let the sound of waves lull me to sleep. It seems I had trouble sleeping from the start.

The only upside of my lifelong transient insomnia has been that I've read widely in many arenas, partly just to pass the time deep at night. How much of that late-night and early-morning reading I've retained is questionable, but I've also seen many cool night creatures and some very nice starry skies and vistas on my late-night walks—although I've been stopped and questioned more than once by suspicious police as well.

But the downsides are more nefarious. Evidence is building that sleep is vital to immune function, and I've wondered if my susceptibility to any viral infection that

passes through town is as related to my insomnia as to the epidemiological exposure I get from spending time in hospitals and with doctors and teachers. I have a couple of physician friends who swear that sleeping a lot keeps them resistant to colds; I've long been a skeptic, but now I suspect they are right. But the few physicians I have seen as a patient have not asked, nor had much to say, about sleep issues.

Even a single bad night can result in fatigue, obviously, but it can also produce difficulty concentrating, crankiness, a pronounced drop in energy in the afternoon, and so on. Prolonged sleeplessness can be tortuous. And it builds on itself sometimes—one bad night contributes to more, and soon I am in a catch-22 where I can't sleep for worrying too much about not sleeping. Finally, at the prospect of a third such night, I feel the need to resort to pharmaceutical remedies. The newer meds—Sonata, Restoril, and others—do seem subtler, producing less of a "hangover" than older ones. Antianxiety meds such as Xanax or Clonopin can help, but I am very reluctant to use benzodiazepines with any regularity. Some swear by decongestants such as Benadryl, but those do leave a fog the next day. "Natural" remedies such as valerian or melatonin have not been much help; a big dose of calcium, such as a handful of antacids, has sometimes been better (and thus the old homily recommending a glass of warm milk at bedtime). I've even tried that quasilegal "medical" herb that some people seem to think is good for everything that ails you, but it wasn't so for me. Eliminating caffeine and alcohol is something of a no-brainer, although it's difficult and makes for a duller life. Exercise is good, as it is for most things. A hot

bath can be enjoyable, even if it doesn't result in sleep.

As for my dreams, I have come to regard mine as akin to television commercials—mostly random garbage to be filtered out. Mine usually seem far too bizarre to interpret or to project much meaning upon, and to do so would feel narcissistic to me. Some of my dreams are traceable to obvious biological urges; some to physiological factors, as when I dream of drowning when I have a congestive upper respiratory infection (or when a large and opportunistic heat-seeking cat has crept onto my chest while I sleep on my back). Mostly I just enjoy and laugh at what dreams I can recall while being grateful for having slept enough to dream at all.

The darkest aspect of sleeplessness can be the tricks the mind and heart can play when the rest of the world slumbers. Life's problems seem amplified at 3:00 a.m., sometimes even insurmountable. One is more vulnerable to self-recrimination and the blues, and also to just dumb distractions. One rule I have is that when I catch myself thinking about work, I get up and read a magazine, or even a medical journal if I'm truly desperate.

It's a funny thing, to long for oblivion. Sleep is a mysterious necessity. I don't know how much I truly need each night, but I know I often don't get it. It's also one of those things that seem all the more desirable only when missing. I'm fairly resigned to missing it more often than I'd like, or than is good for me. **sfm**

Steve Heilig, MPH, is director of public health and education at the San Francisco Medical Society and is the editor of the Cambridge Ethics Quarterly.

Hypersomnia and Narcolepsy

Continued from page 25 ...

work of reconstruction, where one factor after the other is addressed and the effect noted, starting with the problems that are the most likely and the easiest to address. For example, in many cases, stopping the stimulants will often not exacerbate very significantly the symptoms once one to two weeks of rebounds are past. Behavioral therapy, sleep scheduling, light therapy, and CPAP therapy, sometimes with a sleep-inducing agent, may insure that body rhythms and sleep apnea are controlled. Indeed, surprisingly, in some patients even treating mild sleep apnea can have a very strong effect, whereas in others with severe sleep apnea, sleepiness is resilient. A key method in these interventions is not to persist if no effect is observed, and to avoid

giving a permanent, lifelong diagnosis. Modafinil, a nonaddictive stimulant, or atomoxetine can help daytime somnolence, sometimes at surprisingly small doses. Antidepressants may alleviate depression or anxiety, together with psychiatric care.

Once all this has been tried and excluded, a number of patients remain severely sleepy and likely have CNS dysfunction of unknown cause. We suspect that a subset have unknown infectious CNS etiologies, a subject of research in our Center. In these cases, stronger, preferably long-acting amphetamine-like stimulants can be added under careful supervision, as well as other drugs. In these cases, it is often difficult to separate sleepiness from fatigue, and therapy is exploratory.

The rare but typical presentation of Kleine-Levin syndrome should finally be

mentioned, as it has specific treatments. The syndrome affects adolescents and is characterized by sudden one- to two-week episodes of profound sleepiness (twelve to sixteen hours of sleep per day), cognitive difficulties (being in a fog, acting child-like), and, occasionally, hyperphagia and hypersexuality. Curiously however, these massive symptoms, often preceded by flu-like symptoms, last one to two weeks and then suddenly disappear, leaving a totally normal adolescent. The symptoms often recur, however, a few weeks to a few months later, and the process continues on and off until early adulthood.

In conclusion, there is more to sleepiness than obstructive sleep apnea. Narcolepsy, in particular, is well understood and its treatment well codified, with excellent results. In many cases, expert attention

is needed to disentangle a complex situation. Finally, there are also a number of other rare problems and pathologies that need specialized attention. ^{sfm}

Emmanuel Mignot, MD, PhD, is a professor of psychiatry and behavioral sciences and Director of the Stanford Center for Narcolepsy at Stanford University School of Medicine. Among his achievements is the discovery of the cause of the sleep disorder narcolepsy.

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The Secret History of Dreaming

A Book Review

Erica Goode, MD, MPH

The Secret History of Dreaming

By Robert Moss

New World Library, Novato, California
2009

Robert Moss knows the world of dreams, writes of them, reports types of dreams. His passion for this topic apparently began with three near-death experiences as a child and youth in Australia. His book is a historical sketch of the fascinating place that dreams have played in the lives of individuals, tribes, and—on occasion—whole societies (consider the sway held by luminary, pivotal persuaders such as a the Oracle at Delphi). Moss traces the role of dreams and dreaming as part of the warp of history as we know it, making a case for the collective conscious as humans evolve . . . or not.

Simply put, this historical compilation of examples of dreaming types, quality, and purposes underscores the universality of human dreams. But the urgings of dreams, of the epic poetry and metaphor embraced in dreams, can become, at times, revelatory as it guides an entire community of people caught in the intensity of that dream, made visual and verbal by the dreamer—often a leader. One type of poetic dream, called a traveling dream, evolves over time and can move a society along toward a plateau or a new summit of accomplishment.

Most dreams are more personal, however. Some primitive societies gather to discuss and share the most recent dreams each morning, with tribal elders often assisting in interpretations. Certain tent dwellers, with hammocks all providing symmetrical sleeping, heads together at the central pole, must agree to sleep

at the same moment that the cross-tent member wants to sleep. Without this, the tent balance is destabilized. These people, with practice, often share dreams, making comments upon the mutual dream when awake. An early Jesuit monk, traveling among the Iroquois in the seventeenth century, collected thirteen volumes of transcriptions of the tribal members' accounts of their dreams. Many were practical—"Where are the buffalo?"—some prophetic of horrible events to come to their people, which proved true as Americans spread west.

Larry Dossey, MD, who also reviewed this book, summarizes its world of "other dimensions" by stating, "Robert Moss is dragging us, kicking and screaming, into a new vision of consciousness, space, and time. Our understanding of consciousness can never be adequate without taking into account the dream elements chronicled by Robert Moss [in this book]. He describes how we can acquire accurate information in dreams about future and distant events. This book strikes the perfect balance between information and entertainment."

Moss devotes an entire chapter to dreams and medicine, as he notes the reliance upon some dreams for diagnostic precision. During Hellenistic times, the Greeks often arrived at diagnoses after taking cues that they attributed to the healing gods and goddesses (this was intuition, no doubt). The phrasing of the Hippocratic Oath, which refers to these gods and goddesses, is viewed by most present-day physicians as downright weird, since most know nothing of the original derivation. The author of the Oath, in 4000 B.C., taught that citizens

and physicians should heed dreams that could foreshadow the development of symptoms.

Galen (128-210), whom we all know as the first to clarify the circulatory pathway of the blood, also wrote volumes on wide-ranging topics, from mathematics to linguistics to pathology and psychiatry. As court physician to Marcus Aurelius, he cured gladiators and statesmen alike. Born in Pagamon, he owed his profession to a dream recounted to his architect father, Nikon, who had originally opposed his plans to become a physician. Nikon relented after hearing Galen's account of his dream, in which Asclepius appeared, "saving me from death, by directing me to lance an artery adjacent to a deadly abscess in my hand." Galen later wrote an essay detailing this and many other diagnostic/treatment dreams.

The source of the first medical guide written in America, by Cotton Mather, the famous Puritan minister, was said to be the Angel of Bethesda. This apparition apparently guided Mather to write his booklet in a dream of "this angel, whose face shines like the sun" (John 5:4). A statue of this angel stands in New York's Central Park today. Who knows how many other thinkers were guided to health via this volume? Mather had no prior knowledge of medicine, apparently.

In my own life, I have also experienced the power of dreams to influence people's behavior for the better. One example of this is a specific dream of Charles, a prisoner I had helped transition into the Washington, D.C., community years ago, as a lifeguard at the downtown YMCA. Charles was one of many children

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Chinese
Joseph Woo, MD



I had the pleasure of welcoming the Joint Commission to Chinese Hospital this past February for its unannounced triennial survey. As many of you know, the survey process has changed somewhat. While the tracer methodology begins the activities, the reports are different in that there are no more supplemental findings. Every event uncovered on the tracer triggers a requirement for improvement. However, they are further classified as to their impact on patients, whether direct or indirect.

We were visited by two RNs from the Joint Commission and a physician member of IMQ, who spent two-and-a-half days with us. Also, there was a life safety specialist in attendance for a full day. While we had our share of areas that we could improve, overall our performance was thought to be good, and we received many complements from the surveyors. For their selfless efforts, I must thank Vice-Chief of Staff Dr. Fred Hom and PI Medical Director Dr. James Yan, whose knowledge and influence on our medical staff has not only helped us regain accreditation but positively affects patient care on a daily basis.

Also, I must thank other members of hospital leadership for coming to their sessions and demonstrating to the surveyors the teamwork, camaraderie, and dedication of our staff. My hats off to Drs. Gustin Ho, Mai-Sie Chan, Seck Chan, Roger Eng, Rod Snow, Catherine Eng, Randall Low, Dong Lin, and Ervin Wong.

Most of all, thanks really go to the medical staff office, medical staff, and hospital personnel, who continue to provide such good care and comply with the edicts that are bestowed on us. So let's time our orders, conduct proper time-outs, and wash our hands... it's certainly not getting any easier, and of course there is more to come.

CPMC
Damian Augustyn, MD



Martin Brotman, MD, has been appointed president of the new Sutter Health West Bay Region. The new region will include CPMC, Novato Community Hospital, PFCPMC, Sutter Lakeside Hospital, Sutter Medical Center of Santa Rosa, and Sutter Medical Foundation North Bay. The new regional structure is designed to better align physicians and hospitals, share best practices, and deliver care of the highest possible quality to our patients.

CPMC won third place among large-sized companies in the second annual "California's Best Places to Work" program. This ranking demonstrates CPMC's leadership in creating and maintaining an exemplary work environment.

CPMC was named a recipient of the HealthGrades 2009 Distinguished Hospital for Clinical Achievement award. The HealthGrades Seventh Annual Hospital Quality and Clinical Excellence study identifies hospitals in the top 5 percent nationally, in terms of mortality and complication rates across 26 procedures and diagnoses, from heart attacks to total knee replacement. Hospitals achieving this level of care are designated Distinguished Hospitals for Clinical Excellence™ by HealthGrades and are identified on the organization's consumer website, HealthGrades.com. Many hospitals excel in a given service line, but what differentiates these top hospitals is their quality achievement across a broad range of procedures and treatments.

In recent appointments: Dr. Barbara Bishop has been reappointed for a second term as chair of the department of family medicine. Dr. Bishop has been a member of the CPMC medical staff since 1992. Dr. Vic Narurkar was recently appointed chief of dermatology. Dr. Narurkar has been a member of the CPMC medical staff since 1998. Dr. Richard Sundberg was recently appointed chief of gastroenterology. Dr. Sundberg has been a member of the CPMC medical staff since 1980.

Saint Francis
Wade Aubry, MD



Later this month on April 21, Saint Francis will host a Grand Opening of the Spine Care Institute of San Francisco. This Opening is the result of nearly two years of work in recruitment and strategic planning. The Institute welcomes orthopedic spine surgeon and Saint Francis Trustee Clement Jones, MD, who has been a member of the hospital's medical staff since 1993. Also on board is the Spinecare Medical Group, including new medical staff members and orthopedic spine surgeons James Reynolds, MD; Noel Goldthwaite, MD; Paul Slosar, MD; and Pain Specialist Jerome Schofferman, MD. The Spine Care Institute's physicians share a comprehensive approach to treatment and employ the latest technologies and minimally invasive techniques, which produce optimal patient outcomes. Along with the advanced treatment and technology comes the commitment to exemplary service—with the goal of responding to patient and physician inquiries within 24 hours. Members of the Medical Society are invited to join us at the opening on April 21 from 5:30 to 7:30 p.m. at 1199 Bush Street, Suite 200.

Saint Francis Radiation Oncologist John Meyer, MD, has organized a national radiation oncology conference entitled Radiotherapy Planning and Delivery 2009, which will be held in downtown San Francisco in April. Dr. Meyer, who is active in ASTRO, the American Society for Radiation Oncology, has organized several similar conferences over the years. I am honored to participate in the conference as a moderator on "Controversies in Adopting New Technologies," focusing on the national debate over proton beam therapy for early-stage prostate cancer.

UCSF
Elena Gates, MD



When a restless mind precludes sleep, UCSF's Osher Center for Integrative Medicine offers programs in mindfulness-based stress reduction (MBSR), including meditation, body awareness, and mindful movement. For quieting down mental chatter, "behavioral interventions such as relaxation practices are often a harder sell than sleep medications," says Ellen Hughes, MD, PhD, clinical professor of medicine and recent past director of education at the Osher Center. "But MBSR is unbelievably effective, cheaper than medication, and has no adverse side effects." While meditation can take longer to cure insomnia than medication, stress management techniques can often bring sweet, welcome sleep.

Eric Kezirian, MD, MPH, director of the division of sleep surgery, department of otolaryngology, reported in the December 2008 Archives of Otolaryngology—Head and Neck Surgery that people with obstructive sleep apnea burn extra calories at rest. Those with breathing problems during sleep burned an average 2,000 calories at rest, compared with 1,600 calories for those who slept soundly. Kezirian explained, "Repeated awakening during the night is like an adrenaline rush, increasing resting metabolic rates of even normals. Unfortunately, sleep apnea can leave patients too tired to exercise, which can outweigh this burning of calories at rest and lead to weight gain that often accompanies sleep apnea."

UCSF's sleep clinic targets eighty-four classified sleep disorders designated by the American Academy of Sleep Medicine. UCSF's sleep lab is in a hotel, so patients immediately feel more at home than they would in a hospital setting. "Our patients love it; they feel pampered. It's so quiet in the hotel," said Kimberly Trotter, clinical coordinator. Most patients are seen for insomnia or apnea, but UCSF's specialists also help with other sleep disorders, such as narcolepsy, limb movement disorders, and such parasomnias as sleep walking, talking, and night terrors.

Veterans
Diana Nicoll, MD,
PhD, MPA



Almost all colon cancers are essentially preventable, according to Judy Yee, MD, chief of radiology at the San Francisco V.A. Medical Center (SFVAMC). "Colon cancer screening aims to identify precancerous polyps, which are removed before they become cancer."

The problem is that fewer than 40 percent of Americans who should be screened for colon cancer actually get screened, mostly because conventional colonoscopy is viewed as invasive and unpleasant. Because of this, colon cancer remains the third most common cancer and the second leading cause of cancer death in the United States.

For more than a decade, Dr. Yee has been developing an alternative: virtual colonoscopy, which uses safe, noninvasive X-ray technology to create a detailed three-dimensional picture of the colon and surrounding organs in just a few minutes. Working with SFVAMC veterans in a series of landmark clinical trials, she has built up a formidable body of evidence demonstrating that virtual colonoscopy is as accurate as conventional colonoscopy in identifying precancerous lesions.

Her work is bearing fruit. In recently issued joint guidelines, the American Cancer Society, the U.S. Multi-Society Task Force, and the American College of Radiology endorsed virtual colonoscopy as a screening option. "Following that endorsement," reports Dr. Yee, "Medicare is now calling for public comment on potential national coverage of virtual colonoscopy for colorectal cancer screening."

Dr. Yee has literally written the book on the subject, *Virtual Colonoscopy*, published last year by Lippincott Williams & Wilkins. "I was able to pull together everything that I've learned and everything that we've developed here into the most current, complete textbook on the topic," Yee says. She reports that it is on its way to becoming the standard text in the field.

The Secret History of Dreaming
Continued from page 31 ...

of a single mother, his crime a killing at age fifteen. He told me of a dream: "My children were crying at the top of an empty project (building), and the chief of police stood in my way." He said that he had considered breaking parole and disappearing into the community, but after the dream, he decided to complete his parole. He actually noted that he would be letting me, the YMCA director, the parole officer, and his children down. After hearing his dream, I let him use my VW Bug each day, then drove him back nightly to Lorton Prison in Virginia.

Another dream was told to me by a woman project administrator for the EPA. I met her on a plane while reading Moss's book. She had been married, with three lovely daughters, a huge house (first in London and later on the East Coast), and a successful but distant and sometimes philandering husband. Then her recently deceased father said to her, in a dream, "Darling girl, are you happy? Do you want this life of privilege? Is it enough?" She pondered the dream, divorced her husband, and now is remarried to a widower whom she adores. She loves her life, despite reduced circumstances and his disabled teenaged daughter. Her grown daughters are thriving.

In summary, this *History of Dreams* is a fascinating, remarkable collection, even for the skeptical (just stop to reflect upon dreams of your own). To me, it is a reminder that sleep is a gift, with the remarkable wonder that a dream can provide. It is indeed our souls' gift of a nightly vacation, allowing our wisest selves to speak volumes of truth. **sfm**

Erica Goode, MD, MPH, is an internist at the Institute for Health and Healing, CPMC, and an associate clinical professor at UCSF. She is also on the Editorial Board for San Francisco Medicine.

Nancy Thomson, MD, Obituarist

Harvey Z. Klein, MD

Pathologist Dr. Harvey Zeesy Klein, aged 74, passed away August 28, 2008. He was born in Pittsburgh on April 23, 1934, attended school in Pittsburgh, and received his medical degree from the University of Pittsburgh in 1959. After his residency in pathology, he joined the Army and was stationed at Fort Baker, California, from 1964 to 1966. He discovered California to be his true paradise and remained in Sausalito, becoming a member of the San Francisco Medical Society in 1967. He joined the staff of Mt. Zion Hospital, where he eventually became chief of pathology. After Mt. Zion merged with UCSF, he became a clinical professor of pathology. He loved his work and “missed his microscope” whenever he was away too long. Dr. Klein’s passion, aside from work, was golf. He didn’t care that grass would grow on the carpet mats from all the golf “stuff” on the floor. He loved Hawaiian shirts, pink and purple polo shirts, and driving around in his old Dodge Dart convertible with the top down. He also enjoyed traveling to exotic places with his wife, Pat, whom he married in 1977. He loved watching sports on TV and eating his favorite snacks (jelly beans, chocolate, and berry pie). Those who were around him appreciated his sarcastic sense of humor, wit, and profound intelligence. He was generous, kind, and loving to everyone who knew him. He is survived by his wife, Patricia; son, Anthony; two daughters, Emily and Amanda; and twelve grandchildren as well as four dogs.

Sanford H. Lazar, MD

Sanford Hamilton Lazar, MD, aged 78, died peacefully at home on May 30, 2008, after enduring the debilitating effects of Parkinson’s disease, undergoing radiation treatment for prostatic cancer, and experiencing a recurrence of that cancer. Dr. Lazar was born in Chicago on June 18, 1929. After graduating from Chicago Medical School in 1954, he completed his internship at Cook County Hospital and then served two years with the United States Air Force in Wiesbaden, Germany. On his return, he did his orthopedic residency at the Cornell Hospital for Special Surgery, New York. He began his medical practice in San Francisco in 1960, joining the staff of Mt. Zion and Children’s and Marshall Hale Hospitals (now CPMC) and the San Francisco Medical Society in December 1961. He often worked with Dr. Frank Rainey until he passed away in 1989, and subsequently with Dr. Trent Andrews. Dr. Lazar closed his medical practice in December 2000 and moved to Sacramento, where he continued working as a consultant until March 2008. “Sandy” was known for his sense of humor, loyalty, compassion, friendliness, and love of bow ties. He also loved ice hockey and acting. He is survived by his cherished wife, Darrius; his son, Bruce Lazar; his sister, Ruth Sitkin; and numerous nieces, nephews, and grandchildren. The family is grateful to the medical staff of Mercy Hospital, Sacramento, and to caregivers Gus and Tim for their kindness and excellent care during Sandy’s last days.

Murray Persky, MD

Murray Persky, MD, passed away at home in San Francisco on January 17, 2009, at the age of 85. He was born in New York City to William Persky and Florence Salten on May 18, 1923. He chose not to enter the family poultry business. While he was in the U.S. Army during World War II, he was sent to medical school and he graduated from New York University School of Medicine in 1949. In 1957 he became board certified in internal medicine. He moved to San Francisco to study psychiatry at Langley Porter Institute of UCSF, achieving board certification in both adult and child psychiatry and seeing patients in his home office until well into his eighties. He joined the San Francisco Medical Society in 1964. Dr. Persky was dedicated to his profession and felt incredibly lucky to have found work that he loved so much. In addition, he lived a rich and engaging life, driving a taxi in Los Angeles, delivering babies in Appalachia, and tending a gored bullfighter in El Paso. He had a wonderful sense of humor, charming and challenging people at the same time by asking, “What are your three wishes?” He was an avid reader and loved tennis and running. A longtime member of the Dolphin South End Runners, he ran the Paris Marathon at age 59. He and his third wife, Anne McMullin, whom he married in 1992, roamed the world with their son, Nicholas. Besides Nicholas, Dr. Persky fathered five other sons over six decades: Tom, Chris, David, Aaron, and Joshua (who predeceased him in 1991). He lived to see his first grandchild born in November 2008.


What Dreams May Come

Continued from page 22 ...

polysomnography with spectral analysis of the EEG, PET studies of regional cerebral brain glucose metabolism, and fMRI studies of the brain. These methods provide high temporal and spatial resolution for measuring brain function during sleep.

With funding from the NIH, private foundations, and the medical field, the Sleep Neuroimaging Research Center’s programs study a spectrum of disease states including depression, insomnia, aging, and obstructive sleep apnea.

But Nofzinger, who has pioneered methods to define the brain mechanisms of human sleep disorders using functional neuroimaging, admits that only so much can be determined from imaging.

“We know that it’s not just the random firing of neurons during REM sleep,” he says. “There’s some method to the madness of dreaming: We’re still left with having to look at the psychological content of dreams.” 

Bill Wine is a Pennsylvania-based freelance writer. This article was reprinted with permission from RT-Image: The Weekly Source for Radiology Professionals.

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