

Insomnia

The cure for insomnia? Get plenty of sleep.

W. C. Fields

The first thing to go is your sense of humor. Then goes the desire to do the things you used to do, then the desire to do anything at all. Parts of your body ache that you don't even know the names of, and your eyes forget how to focus. Words you once knew aren't there anymore, and there's less and less to say. People you once cared about fall by the way and you let them go, too.

Insomnia is a problem most insomniacs don't want to talk about. In fact, it's a problem many of us don't know *how* to talk about. "Oh, you know, a bad night," I say to a colleague's "What's wrong?" on one of my walking-into-walls days. "Why, Gayle, what do *you* have to lose sleep about? You've got no problems," says my colleague, eyebrows raised. If I'd been up with a bad tooth or a sick child, that's something he would understand. If I just plain can't sleep, that's weird. Anyhow, chronic insomnia is not just "a bad night." *Chronic* (i.e., lasting, constant, continuous) insomnia is a bad night that goes on and on.

Look on the Web, read what insomniacs say on Sleepnet.com and Talkaboutsleeeep.com, and you'll find stories of lives wrecked by this affliction, marriages ruined, educations abandoned, jobs lost, careers destroyed. *I can't work, I can't date, I can't connect with anyone anymore. I had to drop out of school. I used to be a lawyer; now I'm the walking dead. I was a teacher once; there's no way I could face a classroom now. It's like being punished for something, only I don't know what I did. Does anybody have any advice? Please, please, can somebody tell me what to do?* (Here—and throughout the book—I've italicized the words of insomniacs. Since most the names I'd attach to insomniacs' quotes would be pseudonyms, I've left names off, except where the speaker has told me she or he is willing to be identified.)

We reach for metaphors, analogies, figures of speech to say what “it’s like.” *It’s like someone opened a tap at the bottom of your body and just tapped out all the blood, and it’s just gone, there’s nothing left. It’s like some vital juice is drained away and what’s left is bone on bone. It’s like I’m wasting away, slipping away, losin’ it. It’s like I’m being sucked dry, eaten away, stolen away, swallowed up, coming unglued*—these are the terms I hear. *It’s a beast that can pounce on you without warning or cause. It chews you up and spits you out.*

When you have insomnia, you’re never really asleep, and you’re never really awake, says a character in the film *Fight Club*. *It’s a claustrophobia of crawling through a tunnel of unbroken, undifferentiated time, a nighttime landscape that’s neither sleep nor dream,* says an insomniac I interviewed. Says Romanian writer E. M. Cioran,

Normally someone who goes to bed and sleeps all night almost begins a new life the next day. . . . He has a present, a future, and so on. But for someone who doesn’t sleep, from the time of going to bed at night to waking up in the morning, it’s all continuous, there’s no interruption . . . no suppression of consciousness. . . . So, instead of starting a new life, at 8 in the morning you’re like you were at 8 the evening before. The nightmare continues . . . and in the morning that new life doesn’t exist. . . .

When that’s stretched out for months and years . . . you do not see what future to look toward, because you don’t have any future.

He adds, “And it requires an extraordinary will to not succumb.”

“Succumb to what?” asks his interviewer.

“To the temptation of suicide. In my opinion, almost all suicides, about 90%, say, are due to insomnia. I can’t prove that, but I’m convinced.” Studies corroborate Cioran’s suspicion, suggesting that insomnia may well be a risk factor for suicide. It is certainly a risk factor for alcoholism.

Insomnia has been with us as long as we’ve had language. Ancient Egyptian hieroglyphs record a lament for “three living hells,” one of which is “to be in bed and sleep not.” The sorrows of Job, in the book of Genesis, include the lament “When shall I arise, and the night be gone? I am full of tossings to and fro unto the dawning of the day.” In the Latin epic *Silvae*, a first-century-A.D. insomniac prays to Somnus, the Roman god of sleep, the “gentlest of the gods”: “By what crime or error of mine have I deserved that I alone lack thy bounty?” References abound, in the literary texts, diaries, letters, and legal documents of Europe and America of two hundred to five hundred years ago, to “restless” sleep, troubled

sleep, broken sleep. The Pharaohs' tombs held urns of sleep-inducing herbs to guard against sleepless nights in the life to come. Remedies are described in ancient Greece and Rome, in medieval and Renaissance Europe and England. They include anointing the soles of the feet with the fat of a dormouse, brushing the teeth with the earwax of a dog, anointing the temples with a mixture of camphor and woman's milk, drinking a potion made from the gall of a castrated boar, and drinking hemlock—which may have induced a longer sleep than intended.

Insomnia may come with the territory of being human, but it has, for a variety of reasons, become the plague of modern times. Surveys indicate that about a third of the American population suffers with it enough to complain about it, and that as many as 10 to 15 percent have it chronically. Incidence is this high in other industrialized countries, the United Kingdom, Europe, Japan. Among the poor, the female, and the elderly, the incidence is much higher—in people over sixty-five, estimates are as high as 60 percent. Since there are no outward and apparent signs for what we have, no wounds, scars, crutches, casts, wheelchairs, this is an invisible epidemic. Insomnia is not seen, and it's certainly not heard, since insomniacs are not speaking out. Sleep researchers estimate that seven out of ten people with sleep problems never even discuss the problem with a professional. "Insomniacs are seen as neurotics who should have more will power," says Stanford researcher Richard Coleman. "Knowing that they'll be granted little sympathy if they mention some of their miserable daytime symptoms . . . or ask for sick leave, insomniacs tend to keep their sleep complaints to themselves. . . . They prefer medication and go on secretly living with insomnia."

Mostly I have been reluctant to complain about insomnia to doctors, an insomniac wrote me. I'm becoming aware of how much I have internalized the stigma associated with it, the assumption that it's something I'm doing wrong, some emotional problem or bad sleep habits. From a U.K. insomniac, I hear, Most people don't want to talk about it because of the way we are regarded, I think. Some tell me, You're the first person I've talked to about this. I never talk about it to anyone. Some don't want to talk about it at all: you'll just see how neurotic I am. Several say that it's an issue too private or painful to go into, or that talking about it might make it worse: I find myself reluctant to talk about it, for fear of invoking it. From more than one I hear: I'm not an insomniac, I just can't sleep.

I understand, nobody wants to wear a badge that says *neurotic*. And yet, by not owning up to it, not naming it, we leave it, well, unnamed—unrecognized, undiagnosed, underresearched, underground, "the great

underground ailment of modern society.” Insomnia is, as one insomniac called it, *the world’s best-kept secret. It’s like a dirty little secret we sweep under the carpet, hoping it’ll go away.*

But for the chronic insomniac, it doesn’t go away.



When it began for me, I can’t remember. The truth is, I remember very little of my childhood. What I do remember is the following scene, played at various times throughout my youth, most vividly in my early adolescence: “But I can’t sleep!” I’d protest as my parents tried to wrestle me into bed at what they called a *decent* hour, meaning any time before 1 A.M.

“Nonsense,” said my father, “of course you can. “Everyone knows how to sleep. Why, even animals know how to sleep. Just close your eyes, relax, and you’ll get sleepy. It’s the most natural thing in the world, sleep.” My father was a normal sleeper, and to the normal sleeper, sleep is “the most natural thing in the world.”

“But Daddy, I *can’t!* I don’t know how!”

“Well, you get all wound up. Now if you’d only listen to your mother and go to bed earlier . . .” He knew it was something I was bringing on myself, some obstinacy of mine that I could change, if only I would do something different, *be* something different—if only I would *change my attitude, change my ways.*

My father was a doctor, an old-style family practitioner who carried a black bag and delivered babies at home, one of a heroic, vanished breed. But that didn’t mean he knew a thing about sleep. Sleep had no part in the medical school curriculum at Yale in the 1930s when he was there. Sleep has little part in medical curricula today, when doctors get an average of one to two hours instruction in sleep and sleep disorders. The advice he gave me is a version of the advice I’ve been hearing ever since: you’re stressed out, you’re anxious, you’re depressed, you have bad habits. These are the things insomniacs are still told. There may be—there often is—truth to such explanations, but they may also be ways of passing the buck back to the sufferer, a thing doctors have been known to do when confronted with problems they don’t well understand.

We also hear a lot of cheer-up-it’s-not-so-bad advice:

“Don’t worry about it—you probably just worry too much.”

“You probably just need more exercise—try yogi” (that’s not a typo). I do yoga stretches. I swim three times a week and walk on the days I don’t swim.

“As you get older, you need less sleep.” A myth that’s been called into question by recent research: we may get less sleep as we age, but it’s not clear that we *need* less sleep.

“You probably sleep more than you think you do—people often do.” I run this one by my partner, Bob. “No-o-o-o, I don’t think so,” he says. Too many of my sleepless nights have become his.

Psychophysiological insomnia is the diagnosis given to garden-variety insomniacs like myself, people who have no egregious psychological or medical problems. It’s a sort of catchall term for insomnia that cannot otherwise be explained. The *psycho* suggests that the mind (or psyche) is involved; the *physiological* suggests that the body’s there, too, except that nobody—neither the doctors nor the writers of the self-help books that crowd the bookstore shelves nor the researchers themselves—seems much interested in the body’s part. No doctor I ever saw showed the slightest curiosity about the cocktail of hormones, estrogen, progesterone, thyroid, that I ingest daily, though any of these might affect sleep. The *psycho* explanation is so much easier. When 501 physicians were interviewed about how they treated insomnia, “they revealed that they asked an average of 2.5 questions and their questions were most likely to be about psychological problems.” Fewer than a quarter “even asked about patients’ evening coffee intake.”

“Uh, Psychiatry handles that,” said my primary caretaker at my HMO when I asked him for a sleep med. I made an appointment with “Psychiatry” (which took six weeks) and talked to a nice man who made sure I wasn’t suicidal, referred me to an “antianxiety workbook,” and offered me an antidepressant, though I told him that antidepressants make me, well, depressed. “Sure, that’s how it works,” says a psychotherapist friend, Ilene, who works with patients referred to her by the HMOs. “The hardcore insomniacs get shunted to us. As though *we* know how to deal with it!” “The patient with a chronic complaint of insomnia (even though it may have a purely physical etiology) will usually be referred to the psychiatrist,” concludes a 1980 survey. Maybe this is why so few insomniacs take their problem to a doctor.

“Sleep in a dark, quiet room,” “Make sure you have a comfortable mattress”—these are things I get told. All very true, but what kind of an idiot would I have to be to have lived this long with this problem and not know this? “Go to bed earlier,” “Go to bed every night at the same time and get up at the same time,” “When you can’t sleep, get out of bed and do something else,” “Never use the bed to read or work.” All very well, but nothing I didn’t hear from my father those many years ago—except

now there are new names: *sleep hygiene* (a term that makes me feel like I'm not only a bad sleeper, but a dirty sleeper) and *sleep restriction therapy* (restrict time in bed to the hours you sleep consecutively) and *stimulus control therapy* (learn to associate the bed only with sleep) and *cognitive restructuring* (change your way of thinking about the problem) and *cognitive behavior therapy to deal with maladaptive thought patterns*. A real mouthful, that, but what it all comes down to is—*change your attitude, change your ways*.

Friends and family weigh in with further advice. “Oh, I had insomnia once. I just got up and did something else. I told myself, ‘Just cut this out,’ and after a week or so, I was fine. If I don’t worry about it, it goes away.” Everybody’s had a bad night now and then, so everybody’s an expert, right?

“You’re probably not ‘getting enough.’” *Sex*, he meant. But for some reason, most of the things that put other people out perk me right up: sex, hot baths, whiskey, meditation, eating carbohydrates at night, eating protein at night, eating nothing at all.

Or “A little warm milk—puts you right out.”

Or “A shot of whiskey does the trick.”

“A hot bath . . .”

“A big plate of pasta . . .”

“Have you tried melatonin?” Yes, I have tried melatonin. I’ve tried (nearly) everything anyone has ever told me worked for them, and it’s taken me some strange ways: lathering myself in sesame oil, brewing a Chinese herbal tea so foul that my dog fled the kitchen when it steeped, concocting a magnesium supplement that hissed and spat like something out of Harry Potter. I’ve driven across two counties to a guru who claimed to have the secret of sleep. I’ve tried valerian, kava kava, chamomile, skullcap, passionflower, homeopathic concoctions, l-tryptophan, 5-HTP, GABA, melatonin, Elavil, Zolof, trazodone, tricyclics, and pills whose names I never knew. I took the talking cure with a psychiatrist and a psychologist, and though the psychologist helped me sort out things, she hadn’t a clue why I sleep so badly or what I should do about it. I’ve tried most of the benzodiazepines—Librium, Valium, Xanax, Dalmane, Klonopin, Restoril, Halcion, and more Ativan than I care to remember or probably can remember, since this drug erodes memory. I’ve taken the nonbenzodiazepines Ambien and Sonata and, in the bad old days, I dipped into Nembutal, Seconal, and Miltown, as well as over-the-counter products like Sominex, Nytol, Sleep-Eze, and others whose names I’ve repressed. I’ve tried acupuncture, biofeedback, meditation, hypnosis,

self-hypnosis, relaxation tapes, ayurvedic medicine, adrenal support supplements, blackstrap molasses, wheat germ, bananas by the bunch, licorice root, SAM-e, St. John's wort, yoga positions, and at one point, I was swimming three to four miles a day. I've worn a magnet necklace. And yes, I have tried regularizing and restricting my sleep, cutting out all caffeine and alcohol, doing all those "sleep hygienic" things we're told to do. I thought I'd tried everything there was to try, but when I started talking to insomniacs, I realized I'd missed a few: I have *not* consulted a psychic, hung in a flotation tank, done cranial electrical stimulation, or slept with a cathode ion collector dish by the bed. I have not tried chelation treatment (getting the lead out), colostrom (don't ask), sleeping with my head pointed north or west, or ordeal therapy, unless you call vacuuming the house at 4 A.M., which I used to do, "ordeal therapy."

"If there's any illness for which people offer many remedies," says a character in Anton Chekhov's *The Cherry Orchard*, "you may be sure that particular illness is incurable."

"People cannot hear that I am an insomniac without offering some apparently entirely foolproof, it's-always-worked-for-me remedy, and they honestly seem to think, these people, that I must never have tried switching the light on and reading for a bit, or having a hot bath before I go to bed, or a cup of hot milk or counting backwards from a hundred, or one of the hundreds of low-level herbal remedies . . . none of which have any effect on proper, fuck-off insomnia." So says the main character of *Time for Bed*, a novel by British comedian David Baddiel. In one of his stand-up routines, Baddiel asks why, when people hear he's an insomniac, they say, "Really? Cos I fall asleep the second my head hits the pillow": *When I see someone in a wheelchair, I don't say, "Really, cos I can do this . . ."* and he hops around the stage on one leg. Says Bonnie, a San Francisco freelance artist, *If you had a physical disability, there'd be more understanding. When I got sick, it was, like, a blessing. I was in the emergency room. People understand that.*

When people can *see* a problem, they can understand and empathize. But when a condition is invisible—and when it goes on and on for no apparent reason—it calls forth a lot of dumb advice. Friends of mine who live with chronic pain, headache, back pain, arthritis tell me they get this kind of advice, too.

"You probably don't need that much sleep"—this we hear from friends, family, doctors, and even from some sleep researchers. "Insomniacs may be naturally short sleepers who are unaware of their lessened

need for sleep,” wrote a Stanford researcher in 1993. “Their notion that they need more sleep is an ‘erroneous assumption.’” “Worries by such insomniacs about a ‘lack of sleep’ are unjustified,” says British researcher James Horne, who is (as he told me) a good sleeper himself: insomniacs “just need to be reassured that their sleep is sufficient, despite what they believe in this respect.” As though I hadn’t tried, a million times, to convince myself that it was so, telling myself cheerily, as I looked in the mirror, “Well, maybe today I’ll be okay on four hours,” never mind those bright red eyes and the blue-black caverns under them. Trust me, if I were a short sleeper, I’d know it by now. I have known such people, been on intimate terms with one or two, men who seemed to suck energy from the air. I’m not one. I’m a person with normal sleep needs, trapped in a body that seems to think I’m someone else.

“Although [insomniacs] may report feeling ‘tired’ throughout the day,” says Horne, “it may not be sleepiness but lethargy and disinterest due to depression.” So—I only want more sleep because I’m depressed and trying to avoid my life? With all due respect, this is so ass-backward. The reason I want more sleep is so that I *won’t* feel depressed. I need sleep, *not* to avoid my life, but so that I can *live* it.



For half a century I’ve been hearing this kind of useless, well-intended advice from doctors, family, and friends. But with each passing year, I find it harder to take—harder to take the advice, harder to take the sleep loss, harder to tolerate the pills I ingest to minimize the sleep loss. The sad fact about sleeping pills is that they don’t make sleep better; they make it worse. And they make *me* worse: they impair memory, balance, coordination, things I’d like to hold on to as I age.

So I set out, in my fifty-eighth year, in search of some explanation of why, being of sound mind and reasonably untroubled life, I still can’t sleep. I want to know what is known about this beast, what the research is turning up, why there is not much better help for me today than there was half a century ago. I start with the library at the University of California, Berkeley, then I hit interlibrary loan, exhausting the patience of librarians and student assistants. I travel to Seattle, Chicago, Philadelphia, Denver, Washington, Prague, San Diego, Salt Lake City, and Minneapolis, to conferences where scientists, doctors, and sleep professionals gather to exchange the latest in research and clinical findings. I fly around the country to interview researchers. And I talk to insomniacs.

I track down everyone I've ever heard of or known who has insomnia—friends, friends of friends, relatives of friends, acquaintances, colleagues, students. I talk to taxi drivers, bartenders, strangers on planes, in airport lounges, in line at the movies. I place ads in the *New York Review of Books*, *The Nation*, the *Women's Review of Books*, the *East Bay Guardian*, Craigslist.org. I spend late night hours on the Web, surfing not only the insomnia sites but blogs and newsgroups I click into by chance. Whenever I talk about these issues in public or in print, I'm flooded with responses. I scarf up every story, every tidbit and trifle, however odd or inconsequential it may seem. When asked what my method is, I reply, "Total immersion."

I find out some strange and troubling things. I learn that insomnia is, of all the things that commonly go wrong with people, one of the least well understood. "We do not know the real causes of insomnia, nor do we know whether any treatments, including behavioral and psychological treatments, actually treat these causes," says Daniel Buysse, Department of Psychiatry, University of Pittsburgh School of Medicine. "We do not know . . . the nature of the basic neural mechanisms underlying primary insomnia. Nor do we know the identity of specific neurotransmitters that might be involved, or even whether specific neurotransmitter systems are involved. The genetics of the disorder are also not known," say Gary Richardson and Thomas Roth of the Sleep Disorders and Research Center, Henry Ford Hospital, Detroit. There is little agreement, reported James Walsh in 2006, about "the most basic of questions about the definition, prevalence, pathophysiology, and consequences of and treatments for this disorder (symptom? illness? complaint? syndrome? condition?)." These are some of the most eminent figures in the field saying these things: "We do not know . . . We do not know . . ." When, in June 2005, the National Institutes of Health (NIH) held a "Consensus Conference" on insomnia, researchers found that they were so far from consensus that they dropped the word and renamed it a "State of the Science" conference.

And yet in spite of how little is known, in spite of the vast numbers of people who suffer with insomnia and the enormous toll it takes, the NIH, the source of most biomedical research in this country, spent, in 2005, less than \$20 million on insomnia research, most of which went to treatments, therapies, and "management" of insomnia. Pharmaceutical giant Sanofi-Aventis spent \$123 million, that same year, advertising Ambien.

I learn that not much is known about sleep itself. Sleep science—or *sciences*, I should say, since the subject of sleep spans disciplines—is

a new field. It's been around about as long as I've had insomnia. It was born in 1953, in the lab of Nathaniel Kleitman at the University of Chicago, when Eugene Aserinsky, a graduate student, happened to notice, ninety minutes into the sleep of the subject he was observing, the eyes moving back and forth. The discovery of rapid eye movement (REM), as it was called, was revolutionary, overturning all previous understanding of sleep. Prior to this, sleep had been assumed to be a passive state, a state of quiescence when both brain and body were "turned off," but here, suddenly, was this complex activity—and it seemed, most intriguingly, to be related to dreaming. More has been learned about sleep since 1953 than in all the centuries before, but scientists are still unable to say how we sleep, or even *why*. We eat to take in nutrients, we breathe to take in oxygen and expel carbon dioxide, but there is no comparable explanation for why we sleep. We spend a third of our lives in sleep (or most people do). Birds do it, insects, fish, and vertebrates do it, and they put themselves at considerable risk to do it, rendering themselves insensible and vulnerable to predators—and nobody knows why.

"The mystery of sleep function," says Allan Hobson of Harvard Medical School, "is still impenetrable." It's a mystery so deep that the most prosaic of scientists waxes poetic on it, comparing sleep to "an unplumbed ocean," "a subterranean terrain," "an undiscovered continent," "a last frontier," "a vast unknown," "an enchanted world," a (sigh) "virgin territory." Everywhere you turn in this field, there are questions. Why do we need two different kinds of sleep? REM and the rest of sleep (which is called nonREM sleep and includes deep sleep, as well as the shallower stages 1 and 2) are as unlike one another as sleep is to wakefulness. In nonREM, the muscles are relaxed, the breathing is regular, and the consumption of energy by the brain is minimal; in REM, where the most vivid dreams occur, the brain is as active as it is during consciousness, the breathing and heart rate are faster and irregular—yet for all this activity, we are paralyzed, except for the eye movements and the odd twitch. Why, after a certain time in REM, do we shift back into nonREM, then back into REM, then back and forth for four to six alternating cycles throughout the night, with longer periods of REM toward morning? How is each stage maintained for the time it is and then terminated? What are dreams for?

"It's a fabulous field to work in," says Irwin Feinberg, a University of California sleep researcher, "because so many of the important questions are still unanswered. It's especially interesting now, when new infusions from neuroscience and molecular and genetic biology are bringing fresh

perspectives.” As I head off each summer to another conference, I get caught up in the excitement, wondering what breakthrough discovery I’ll be hearing about next. But when I get to the insomnia sessions, my heart sinks. In the hundreds of papers I sit through and read, I hear a great deal about insomnia as depression, anxiety, “dysfunctional beliefs and attitudes,” but very little about the neurophysiology or neuroendocrinology or genetics of the problem. I find the same tendency to chalk it up to the *psycho* that I find in the doctor’s office. The physiological is implied by the term *psychophysiological* insomnia, but it figures as *effect*, as the physiological reaction to the psychological or emotional upset that is thought to be the cause. Of course mind and body are not so easily differentiated; in fact, everything that’s been learned in recent years shows us that they’re so interdependent as to be inseparable—and this is especially so with sleep, which is, as James Horne calls it, “the meeting place for mind and body.” But in practical terms, people have to begin somewhere in their thinking about origins or *etiologies*, and they begin from where they are: a psychologist comes at a problem from psychology, a neurologist from neurology. Nearly everyone who comes at insomnia comes from psychology, with backgrounds and training and degrees and publications in psychology—in *Freudian* psychology, in the early days of sleep research—which has given this field a certain slant.

“What the *physiological* side is, we haven’t a clue,” admits Clete Kushida, director of Stanford University Center for Human Sleep Research; “we feel it’s there, but we haven’t been able to put our finger on it.” But how hard are researchers trying to “put a finger on it”? Of the \$20 million spent on insomnia research in 2005, about \$3.8 million went to investigations of the neurobiological mechanisms and pathophysiology of the problem, the kind of basic research that might lead to an understanding of the cause. The behavioral model (*change your attitude, change your ways*) “has had, perhaps, the unfortunate consequence of discouraging research into the neurobiology of the disorder,” concludes a 2004 study that looked at where research has been directed.

And yet sleep is a physiological behavior. Its mechanisms are fundamentally biological, and as with any biological system, there’s enormous variability. “Some people have better/stronger sleep systems, some weaker, just as there are short people and tall people,” explains insomnia researcher Michael Bonnet. Babies are born with different sleep propensities, as parents well know, many of which are now known to be genetic. The sleep system is a physiological system and, like all such systems, deteriorates with age. Even elders who are free of psychological and

medical problems lose the capacity for deep, sustained sleep—which suggests that some physiological mechanism wears out. And yet sleep also “lives in the world,” as Brown University researcher Mary Carskadon says. It is shaped by psychological factors, by emotional, familial, social, cultural, and environmental influences, and by everything in our lives. It is infinitely complex. It is shaped by psychological influences, by emotional, familial, social, cultural, and environmental influences, and by everything in our lives. It is infinitely complex.

Each year, scientists are learning more about the physiology of sleep, its neuronal and neuroendocrinal mechanisms, its genetic underpinnings. As sleep comes to be better understood, so will insomnia. “We used to think insomnia was something that happened only to crazy people,” said a psychiatrist I talked to at a sleep conference, “but it’s not possible to think of it that way anymore.” “Where once we assumed it was depression that caused insomnia, we know now there’s a *physiological* component,” says sleep researcher Tom Roth. In the half decade I’ve been attending sleep conferences, I sense that change is in the air. But the tendency to psychologize insomnia, neuroticize it, pin it on the character, attitudes, practices of the sufferer, dies hard.

Against that mind-set, this book speaks out.



In the pages that follow, I take you into this world of sleep research, a world most people do not know exists and one that I had no idea existed until I began this book, a world that’s vitally important to millions of people. For the estimated 70 million people in the United States who have sleep disorders, the discoveries made here, the therapies developed here or not developed, the brilliance and blind spots of these researchers make the difference between whether we function in our lives or not.

I start out, in chapter 2, by asking why a condition that affects so many people has been so long neglected. What is it about our culture that has made this long blackout, as it were, on an area so crucial to our well-being? For not only has insomnia been ignored, but sleep itself. “Sleep is for the weak,” “sleep is for slackers,” “the best don’t rest”—such are the slogans heard from students in the college where I teach and from entrepreneurs in Silicon Valley, high-tech capital of the world. (Silicon Valley is home not only to the defiantly sleep-deprived but also, ironically, to Stanford, world center of sleep research; it is also where I grew up.) Sleep machismo is rooted in the Protestant-capitalist values by which we

Americans live, infecting even the doctors we turn to for help and some sleep researchers as well. No wonder insomnia isn't taken more seriously, when sleep itself is not.

"Sleep is for sissies," and people who complain they're not getting enough aren't cool. Insomniacs are people who complain they're not getting enough, and I find a strong strain of moralizing, even dislike, in the words researchers use for us. I find us described as "overly concerned about sleep," "chronic complainers," "neurotic," "self-absorbed," "obsessive," "histrionic," "hypochondriac," "chronic anxiety neurotics." "Though we want to be neutral in our feelings toward patients, we'll admit among ourselves," writes Dr. Atul Gawande, that some patients "are a source of frustration and annoyance: presenting a malady we can neither explain nor alleviate, they shake our claims to competence and authority." (Gawande is talking about people with chronic pain, but he could as well be talking about chronic insomniacs.) I look, in the third chapter, "Blame the Victim," at medical problems that were once pinned on the attitudes, habits, psychopathology of the sufferers but were later discovered to be organic—conditions like ulcers, migraines, multiple sclerosis—and argue that insomnia may someday be on this list, along with the several sleep disorders, narcolepsy, restless legs syndrome, REM behavior disorder, that already are. I bring myself in to this chapter as a sort of case study, to show how a person's life and mind might get bent out of shape, might get bent *into* the shape of those negative stereotypes of insomnia, when she's unable to count on something so basic as sleep, so that when doctors and researchers see an insomniac who's stressed out, anxious, depressed, they may be looking the *consequence* of a sleep disorder and mistaking it for the *cause*. Throughout the book, I bring you back to the lived experience of those who struggle with insomnia on a nightly and daily basis, juxtaposing the view from the inside with judgments made from without. The view looks different, depending on where you stand.

In "Sleepless in Seattle," chapter 4, I take you to the conferences, where I talk with anyone who will talk with me and eavesdrop on anyone who won't. I'm struck, right off, by the difference between what goes on at the insomnia sessions—where researchers are still telling us to change our attitudes, change our ways—and what goes on in sleep research, where hard questions are being asked about the physiological mechanisms of sleep and wakefulness, the neuroendocrinological and genetic basis of sleep disorders. I look, in "The Brain of an Insomniac," chapter 5, at what neuroscience and neuroimaging are turning up about

these mechanisms and at recent discoveries that suggest there could well be a glitch in them that accounts for some kinds of insomnia—*some* kinds, that is, not all. Anything you can say about insomnia, you can only ever say about *some* insomnia, for this is a slippery beast that defies one-size-fits-all descriptions and prescriptions.

Stress is a catchall explanation that's often given for insomnia, an explanation that suggests we could get hold of this problem if we'd only relax (blame the victim, again). But it's not so simple, since insomnia itself is a powerful stressor. Studies are finding that exposure to stressors over long periods of time may ratchet the system up, that the stress systems of (some) people who have been exposed to early or prolonged stress may get stuck in the on position, leaving them more vulnerable to subsequent stressors, *physiologically* changed. I look, in chapter 6, at the *hyperarousal* researchers have been finding in insomniacs (*some* insomniacs, that is), the faster metabolism and heart rate and elevated blood pressure and levels of stress hormones that are evidence of a stress system on hyperalert. Research suggests a genetic component here, too, that the stress systems of some people, as of some animals, are more reactive than others'.

I turn, in the next chapters, to the treatments we're offered—drugs, behavioral modification, and sleep clinics—and the alternative treatments many of us seek out on our own. Are the drugs prescribed to us the drugs that are best for us, or are they what the pharmaceutical industry—one of the most powerful in the world—is pushing hardest? Or are they perhaps the drugs doctors feel most comfortable prescribing? *Hypnotics*, as sleep medications are called, after Hypnos, the Greek god of sleep, are *controlled substances*, governed by federal narcotics laws and monitored by the Drug Enforcement Administration: they can get doctors into trouble. How much easier to prescribe something that doesn't come under these controls—like antidepressants—which may be why these are so often given for sleep. I tell stories of people who've been messed up by drugs (myself included), and people who've been helped by drugs (myself included). I describe the new agents being developed that may someday give us a wider choice of medications that more precisely target our problem, and I look at a new and controversial drug that holds promise.

Behavioral modification, the subject of chapter 8, is the “nonpharmacological” treatment we are offered. It tells us to practice “sleep hygiene” and to regularize our schedules and restrict time in bed to the hours spent asleep, so that we'll consolidate our sleep into a solid block.

Insomnia researchers are keen on this approach and devote considerable research attention to it. It is effective with some insomniacs—*some*, again, though nobody really knows how many. It may actually be that the effort to get us to sleep in a single consolidated block is pushing against some deeply engrained natural tendencies. Studies that attempted to replicate preindustrial sleep conditions found that people tended to sleep in segments. Studies of sleep in earlier historical periods, and the few investigations of sleep in other cultures that I find, also suggest a biphasic or polyphasic sleep pattern. It may be that the shape sleep has today is a fairly recent development, an artifact of electric lighting and the industrial revolution. The sleep that is being studied in labs, the sleep of young, healthy, well-fed Western (male) subjects, may not be the “universal” it’s cracked up to be.

Again and again, sleep turns out to be larger than our conceptions of it, more complex than our tools or technologies or the stories we tell about it. I take you, in chapter 9, through a night at a sleep clinic, a darkly comic experience, where I learn how difficult insomnia is even to diagnose, since the gold standard for measuring whether we’re asleep or awake, the *electroencephalogram*, or EEG (which attaches electrodes to the skull to measure the electrical impulses of our brains), tells a very strange story about insomniacs, assuring us that we’re asleep when we’re sure we’re awake. Insomnia is a subjective state. There’s no blood test that it shows up on, no biopsy or x ray that picks it up, and it doesn’t even show up on the EEG. You know that a person has it only *by what that person says*, which makes it, as James Horne says, “one of the few disorders where the diagnosis lies with the patient and not the physician.” How much easier it is to tell us, as many clinics do, that we have “sleep disordered breathing,” or apnea, a condition easier to treat.

Insomniacs turn to alternative medicine, the subject of chapter 10, in droves. Mainstream Western medicine is good at fixing things, but for chronic conditions (which are by definition conditions that can’t be fixed), people seek out alternative therapies, where they find practitioners who take more time with them and who approach insomnia as though the body—the fluctuations of our hormones, the foods we eat—plays a part in the problem. Most of these methods, however, have had very little research. I turn, in chapter 11, to my own ways of dealing with the problem and the creative solutions others have found—tricks we’ve gleaned, techniques we’ve worked out, some from alternative medicine, some from knowing our bodies—many of which I’ve not seen written about elsewhere. (I’d originally titled this chapter “Outwitting Insomnia,”

but I came to feel as I wrote it that “Bedding Down with the Beast” was a more accurate description of what goes on at my house.)

I conclude, in chapter 12, with some speculations about what we might do to make change—and my “we” includes the professionals and the insomniacs together—so that there may come a time when more than a pittance is spent on this problem that affects so many millions, a time when the research is directed to a search for the causes, not the same, old treatments.



There’s no end to books on insomnia. A look at some titles tells you the promises they make: *Conquering Insomnia*, *Overcoming Insomnia*, *Stopping Insomnia*, *Relief from Insomnia*, *Natural Relief from Insomnia*, *Learn to Sleep Well*, *Seventy-Five Proven Ways to Get a Good Night’s Sleep*, *Sixty-Seven Ways to a Good Night’s Sleep*, *Fifty Essential Things to Do to Get a Good Night’s Sleep*, *Everything You Need for a Good Night’s Sleep*, *Solve Your Sleep Problem*, *How to Cure Your Sleep Problem*, *Sound Ways to Better Sleep*, *How to Get a Good Night’s Sleep*, *The Natural Way to Sleep*, *Don’t Just Lie There, Sleep Better Tonight!*, *Get a Good Night’s Sleep*, *Getting to Sleep*, *Learn to Sleep*, *Learn to Sleep Well*, *Nature’s Answer to Good Sleep*, *Easy Sleep*, *Power Sleep*, *Say Good Night to Insomnia*, *Idiot’s Guide to Getting a Good Night’s Sleep*. (And there are many more.) I feel, as I make my way through this stack, like I’m reading the same book, hearing the same, old advice: keep a regular schedule; avoid caffeine, alcohol, and sleeping pills.

More interesting are the books about the new sleep science. Some of these are written by the men who made sleep science: *Sleep: The Gentle Tyrant*, by Wilse Webb, research professor at the University of Florida; *The Secrets of Sleep*, by Alexander Borbely, director of the Sleep Laboratory, University of Zurich; *The Enchanted World of Sleep*, by Peretz Lavie, director of the Technion Sleep Laboratory, Israel Institute of Technology, Haifa; *Sleep and Dreaming*, by Jacob Empson at the Department of Clinical Psychology at the University of Hull; *Sleep*, by J. Allan Hobson, professor of psychiatry at Harvard Medical School and director of the laboratory of neurophysiology at Massachusetts Mental Health Center; and *The Promise of Sleep*, by William Dement, founder and longtime director of Stanford Sleep Research Center. There are also some fascinating popular science books: *Sleep and Its Secrets*, by Michael Aronoff, MD; *Sleep Thieves*, by Stanley Coren; *Counting Sheep: The Science and*

Pleasures of Sleep and Dreams, by Paul Martin. I love these books, and I devour them, but when I get to the chapters on insomnia, my heart sinks: “Keep a regular schedule,” “Avoid caffeine and alcohol.” But then, I remind myself, these books are not about insomnia—they’re about *sleep*. When I look for the popular science books about insomnia, I find *Insomnia: The Guide for Troubled Sleepers*, by Gay Gaer Luce and Julius Segal, published in 1969. I find *Natural Sleep*, by Philip Goldberg and Daniel Kaufman, and *Creative Insomnia*, by Douglas Colligan, both published in 1978. A quarter of a century has passed since anybody wrote a popular science book on insomnia. What can that mean?

What is missing from everything I read about insomnia is—the insomniacs. We’re there, of course, but only as numbers, figures, bars on charts or graphs, objects of scientific scrutiny. The electrical activity of our brains is monitored by the EEG, the results are recorded, tabulated, analyzed, but in all the books and articles I read, all the lectures and sessions I attend, I find us quoted three times (in 1976, 1978, and 2005). I find us referred to as *patients*, *insomnia complainers*, *complaining insomniacs*, *insomnoids*—and mostly, as *subjects*. But we’re more like objects than subjects, really: we have no speaking part in this literature, no voice.

Where are the books on insomnia written from the point of view of the insomniac? I find powerful first-person accounts of depression—William Styron’s *Darkness Visible*, Julia Manning’s *Undercurrents*, Andrew Solomon’s *The Noonday Demon*—that have done more to put a human face on this affliction than all the articles in the journals. But I find no such books on insomnia. Maybe the insomniacs are all too tired to write them, I think grimly, and decide, some years into writing this book, that it’s probably true. Insomnia is not an easy subject to write about. It’s an amorphous creature, *multifactorial*, as researchers say, meaning that there may be many factors working together to bring it on. It is difficult to get hold of, by researchers who research it, doctors who treat it, people who suffer from it—and writers who write about it. I can’t weave a spellbinding tale around the race for the cure because there isn’t one. Besides, as a friend once remarked, “who wants to read a book about a lot of sleepless nights? It’s a real snooze.” “Insomnia is a subject of keen interest to those who have it and great tedium to those who do not,” writes Laura Miller in the *New York Times*. Insomniacs do not, as a rule, go through the dramatic breakdowns and breakthroughs that make page-turners. The real drama for us is getting through the day.

But by not telling our side of the story, by not owning up to our experience, we have left the describing to people who don’t know what it’s

like to live with this condition, who do not, for the most part, know it from the inside. Nobody really knows what it's like to live inside another person's skin. I can't begin to guess what it would be like to lie down without earplugs and white noise machine and blackout curtains, to close my eyes and sleep till morning. "How do you do it?" I ask my partner, whose head hits the pillow and he's out. I want to pry open an eyelid, peer behind his eyeballs, find out what makes that curtain drop down on him but not on me. Insomniacs wouldn't presume to say what makes such restful slumber, but those who sleep well presume to know what's going on with us.

Everybody knows that worry, stress, depression can cause insomnia. That sleep is disrupted by "the throes of life" was written by Hippocrates in 4 B.C. People assume that since this is the sort of thing that keeps *them* awake, it must be the sort of thing that's keeping *us* awake: it's obvious, it's intuitive, it's universal. They don't get it that there are those of us whose sleep is never right, no matter what's going on in our lives, no matter what our lifestyle, habits, frame of mind. I sleep two, three, or four hours, sometimes five, and that's it. Too much happening in my life makes it worse, too little happening makes it worse; too much company, or too little; too much exercise, or too little; too much to eat, or too little. Any excuse my body can find not to sleep, it will find. Often, it needs no excuse at all. (Capricious, this sandman drops in from time to time, try as you may to entice him to stay the night: if this were a guy, you'd have ditched him long ago, but you need him too much, can't live without him, can't get through a day without him, and meanwhile, what's there by your side, lumpish, gray, and predictable as a scab, is—insomnia.) On those rare nights when I get seven unbroken, undrugged hours, I feel a rush of energy and optimism, like I could take on the world. You who sleep well and reliably have no idea what you take for granted. You cannot imagine.

In the 2005 study I referred to earlier, one of the three to quote insomniacs, University of Pittsburgh researchers brought together sixteen insomniacs in focus groups and actually *asked* them what they were thinking—unprecedented! The insomniacs expressed, above all, "the feeling that others (spouse, family, friends, co-workers, . . . professionals) could not really understand or minimized the impact of this experience" and that health professionals "either did not understand the full impact of insomnia on their lives or did not know what to do to effectively treat it." When I asked one of the researchers if anything had surprised him about these findings, he said, "The affect, the strength of feeling to what they said."

It doesn't surprise me. These are the sorts of things I hear:

Even when people are sympathetic, they're generally uncomprehending. . . . I've seldom appreciated anything as much as when an old friend told me he'd just gone through a few weeks of insomnia and had dimly begun to understand what I'd tried to tell him about for years.

I had two doctors who got it—when they had bad bouts of insomnia themselves.

I don't want sympathy but I want people to know this is terrible. I have friends who've survived horrendous things, like cancer, and they make me feel like such a wimp. Sometimes I wish they'd have a month of it, or even a week, then they'd know. I would wish on every doctor and every sleep doctor, that they should live with this and have to hang on to their jobs. Then we'd see some better treatments for insomnia, you bet.

I am really very tired of being told what it's like to live in my body by people who haven't a clue. I have come to feel that, when it comes to insomnia, there is truth to the old adage, *it takes one to know one*. As E. M. Cioran said, "I found everyone idiotic. Nobody understood what I understood. You see, there is a gang of insomniacs, there is a sort of solidarity, right, like people who have the same illness. We understand each other right away."



We know what it is to live in our bodies; we know where the ailing, failing parts are, we have ideas about what's gone wrong. We have inside information. Like the friend I had who drove a Jaguar that was always breaking down—he knew more about Jaguars than most mechanics. That's how it is with insomniacs and sleep. When there is something crucial to your existence that is constantly letting you down, you pick things up.

Anecdote is not highly regarded in scientific circles. Anecdote, say the scientists, is individual, particular, idiosyncratic, hit and miss. Science, they say, is systematic and general, a sure thing. Science produces, through methods of controlled experiments and statistical analysis, *evidence*. Anecdote is not evidence. Even a lot of anecdotes don't add up to evidence. But experience, say I (and others), has an authority, too, especially with a condition so subjective as insomnia. The inside story, the subjective account—what social scientists call an *ethnographic* perspective, a qualitative as opposed to a quantitative approach—is a useful

counter to the “objectivity” of science, necessary for assuring that the thick, rich textures of individual lives don’t get swept away by the broad brush of the statistical.

As a person coming to this subject from the alien field of literary studies, I find value in stories. Stories are how we get to know one another, how we glimpse the inner realities of one another’s lives. I listen to what the insomniacs have to say, their hunches and intuitions, what they think brought the problem on, what they know about dealing with it. I hear what insomniacs say, keeping an eye out for etiologies, trying to tease out patterns from the thicket of particulars, contrasting their accounts to the accounts of the researchers. I look for ways they corroborate the research, ways they contradict it, ways they qualify it. I find much in our experience that’s explained by the research, but I find much that is not. I find more kinds of insomniacs, more richness and diversity in our characters and experiences than I find described in the scientific literature, which lumps us all together and tars us with the same brush. Researchers pay lip service to the idea that insomnia is multifactorial, yet they approach us as a homogeneous rather than a heterogeneous population and prescribe for us as though one size fits all. They have caricatured us, not characterized us. “Chronic anxiety neurotics,” indeed.

Here’s an anecdote.

One summer in the mid-1980s, when I was at my mother’s, coming off the sleeping pills I’d get hooked on during the teaching year, she slipped me a clipping from a local paper: “Stanford seeking subjects for insomnia study.” I called the number and asked what was involved.

“We take you for six days and monitor everything.”

“Everything?”

“You know, temperature, heart rate, respiration . . .”

“Oh, good,” I said. “Which six days?”

“What do you mean, which six days?”

“Which six days of the menstrual cycle?”

“Oh, we don’t monitor for *that*.”

“Well, you certainly *should!*” popped out of my mouth before I could do a tactful edit. We both beat a hasty retreat: they no more wanted to deal with somebody so uppity than I wanted to waste my time with these folks who were so in the dark ages that they didn’t “monitor for that.” If there was one thing I knew, it was that, just before my period, I got insomnia a pill wouldn’t touch, and it happened invariably; if I ever happened to forget what time of month it was, the insomnia would remind me. *That* time of month wired me like strong coffee, not unpleasant,

exactly—there was this amazing energy—except that I couldn't sleep. Then when my period came, I'd fall into a deep, blissful slumber—for about a night.

"It may not be news to many women that the menstrual cycle can independently affect sleep," writes William Dement, head of the Stanford sleep clinic at the time I had my brief conversation with somebody there, "but for sleep scientists it has been a relatively recent discovery." It was only in 1998, when a National Sleep Foundation poll found that 25 percent of women report disturbed sleep the week before their period, that researchers began to wake up to this association. If someone at Stanford had stayed on the phone and talked to me that day—or talked to any one of the thousands of women who've passed through their clinic—they might have got to this understanding much sooner. Women have always known this: *It's so obviously hormonal—a few days just before my period, I could jump out of my skin: One night a month it would be virtually impossible for me to sleep. No matter what I did—warm milk, reading War and Peace, occasionally reverting to Nytol—nothing seemed to work. Then, bingo! I'd get my period the very next day.*

"Couldn't be," said a doctor to my friend Roberta, when she told him she thought her insomnia had been triggered by birth control pills. Now there is evidence that she may have been right. Anecdote may not be evidence, but it may lead the way to evidence. How, but by listening, being open to the particularities of people's experiences, even when they go against the grain of received wisdom—or *especially* when they go against the grain—do scientists come up with new ideas to investigate? Where does science begin, but in observation?

One way that insomniacs are not all alike is that many of us are women. Scientists (most of whom still are not women) have been slow to recognize that many conditions and diseases look different, follow different courses, and respond to different treatments when the patient is female. A woman scientist whose biography I wrote, Dr. Alice Stewart, taught me how important it is to listen to the women. Stewart was a British physician who set out to discover, in the 1950s, why childhood leukemia was on the rise. (She was doing *epidemiology*, tracking the causes or origins of diseases, before it was even called epidemiology, as far back as the 1940s.) She had a feeling that the mothers might remember something their doctors had forgotten, so she devised a questionnaire that asked them about their exposures to a wide variety of things, automobiles, buses, hens, rabbits, dogs, colored sweets—and whether they'd had an obstetric x ray. (It was common practice in the

1950s to x-ray women in the last trimester of their pregnancies.) “Ask the mothers? What can they possibly know?” objected her critics. But she persisted, distributing her questionnaires to the mothers of children who had died of cancer and the mothers of healthy children (these were the *case controls*, or comparison group). “Within 35 questionnaires,” she told me, “the answer leapt out: those that had had an obstetric x ray were running two to one in terms of an early cancer death.” Her study established that, when you x-ray a pregnant woman, you double the risk of a childhood cancer, a discovery that revolutionized medical practice. This is why, before a woman gets an x ray today, she gets asked if she’s pregnant.

Stewart advised her research team, “When you go to the mother, ask her questions about the child’s illness, let her talk. You mustn’t go and just ask the question you’re interested in, you must get all the information you can. Take it down *verbatim*. Never cut your information off at the source. You must cast as wide a net as possible, remain open to what the data are telling you, let the data shape the question.” I can still hear her saying this, in her stentorian British tones.

The researchers and clinicians who deal with insomnia have cut their information off at the source. They don’t try to hear what their subjects have to say, to find out what we know. Most sleep studies still do not include women, and doctors’ eyes still glaze when we say, “I think it might be hormones.”



This is a somewhat cranky book. You can’t live with this problem as long as I have, you can’t be blown off and written off as many times as I have, and not get cross. It’s a very personal book wrung out of my life’s blood, but if I didn’t think it was more than personal, I wouldn’t have bothered to write it. My frustrations are shared not only by insomniacs but by people with other sleep disorders—narcolepsy, restless legs syndrome, *hypersomnia* (excessive sleepiness)—who tell me how hard it is for them to get their problems taken seriously. They are also shared by many sleep researchers who have been trying to get the world to pay attention to sleep, a thankless task, since the world goes its ways, beating sleep back into narrower corners of ever-more frenetic lives.

It’s a cross book, but it’s also a labor of love for, the many people I see suffering with this problem. People tell me their stories, and I’m in awe of what they go through, the spirit, valiance, grace under pressure.

If you want to see courage, try going without sleep, as an insomniac once said. I hear from many women who sleep worse than I do, who are raising children *and* holding down nine-to-five jobs (or worse, who are not). I hear from more women than men, which is not surprising, since “sleep complaints are twice as prevalent in women,” as a 2003 NIH report states: in fact, “female sex is a risk factor for insomnia. Insomnia is a women’s issue: it is not solely a women’s issue, but it is certainly a women’s issue. One reason insomnia has been so neglected is, I suspect, that it affects the neglected: the female, the elderly, and the poor.

I should say too that the book is a labor of heartfelt appreciation, if not love, for the researchers and physicians and psychotherapists who deal with insomnia, some of whom have made an enormous difference in the lives of insomniacs. I may be critical, but I’m also grateful to anyone who takes the problem seriously enough to try to help. I know that many researchers and clinicians will agree with me that, in the words of the University of California at Berkeley researcher Allison Harvey, “we can’t rest yet.”

How we sleep, how much sleep we need, how we react to sleep loss, the rituals and practices we work out around sleep, and the stories we tell ourselves, are as individual and distinctive as our fingerprints. You and only you can know what works, because you’re the only one who lives in your body. What works for me may be anathema to you, just as the drug that puts you to sleep may send me over the moon. I hope that this extended meditation on sleep and insomnia (for that’s what the book has turned out to be) may encourage others to strike out in directions of their own, to come up with their own solutions—and to come *out* with these solutions, to share them with us all. I hope that it will encourage insomniacs to break the long silence about insomnia.

I’ve written the kind of book I wish I’d had, dealing with insomnia all these years. You might call it a field guide to insomnia, a user-friendly guide through a terrain most people don’t know or admit exists, a guide to navigating the reefs and shoals of sleepless nights and sleepy days, a book of consolations for the large number of people suffering with this problem, thinking they are alone. You are not alone, and it may help to know this, because insomnia is the loneliest of conditions: you’re awake when the rest of the world’s asleep, no matter who’s by your side, and then, when the world’s awake, you’re too wiped out to reach out and make contact.

If we find each other, we might help each other.

A How-To and a Who-For

This book is primarily for insomniacs and the people in their lives, but in the course of writing it, I began to hope that doctors and psychotherapists would read it, too. And the more scientific meetings I went to, the more I found myself wanting to enter into conversations with the researchers—conversations they were too busy to have with me. So I've ended up writing with several different audiences in mind, the insomniacs, the health care professionals who treat us, and the researchers.

This means that not everything in this book may be equally fascinating to everyone. So here are a few thoughts about reading it. If you're an insomniac looking for new ideas on how to deal with your problem and wanting to know how other people cope with theirs, the first three chapters will be of interest, along with chapter 7 (on drugs), chapter 8 (on behavioral modification), chapter 10 (on alternative approaches), and chapter 11, on "bedding down with the beast." If you're an insomniac who's curious about what the researchers are up to, you'll want to read the conference chapter, 4, and the science chapters as well (5, 6, and 12). I've been told that the conference chapter is very funny (if you bog down in chapters 2 or 3, skip to that). If you're a researcher wanting to know what your world looks like to an outsider (outsider to the field, that is, not to the condition), read that one, too, only don't take it personally. And, doctors and psychotherapists who deal with insomniacs (and that's every one of you), please read it all, know the experiential reality that lies behind a diagnosis of insomnia, know there are things you can do to help.

There's also a whole other discussion going on in the endnotes, material that I couldn't fit into the text because it took me in other directions. (A fuller version is on the Web) I myself am fascinated by endnotes, since I know that writers sometimes bury their most interesting points there, where they think nobody is watching; but I realize that not everybody is. Dip into these as you please.

Dip into any part of the book as you please. "As needed," as it says on the pill bottle: the book is here to help. When I was a graduate student, my advisor tried to warn me away from writing a dissertation on Shakespeare, cautioning me that I'd have to "master all the scholarship on the subject"—which would have been impossible. That's when I learned the difference between *reading* a book and *raiding* it for what I needed. Feel free to raid this book. If you come across a passage or passages that bog down, just speed up and skim until you come to a part

that's more engaging. If you're interested in insomnia, or in sleep, you'll find something in this book that's worth your while.

The book is, above all, for anyone who wants to understand what it feels like to live with insomnia, to move through the world and play by its rules with a serious and persistent sleep problem. Accordingly, I've sprinkled autobiographical accounts of my own experiences throughout, along with accounts of many insomniacs I've talked to and corresponded with over the past five years.